Maine Bureau of Insurance

Requesting an External Review for Health Insurance

What is an "external review"?

Consumers may be entitled to an external review to resolve a dispute that involves medical issues with an insurance company. An external review is an additional step in the appeals process after the insurance company denies paying your health insurance claim. The review is done by an independent review organization. Typically, the external review is held after the health insurance carrier's internal appeal process has been completed (usually two appeals).

The Bureau of Insurance contracts with external review organizations (EROs) which are independent from insurance companies. If you qualify for the external review, the Bureau will assign your case to one of these organizations.

The EROs will have the appropriate health experts review your case. For example, if your case involves a mental health issue, then a psychiatrist or other suitable mental health professional, who is experienced with your diagnosis, will be assigned to review your case. The ERO also ensures that the health professional has no conflicting relationship with your insurance company.

How do I qualify for an external review?

To qualify for an external review, your insurance policy has to be in a "fully-funded" plan. In other words, it has to be a true insurance policy, and not from a "self-funded" plan that is funded by your employer (usually large employers). You can find out if your plan is a fully-funded health plan by asking your insurance carrier or the human resource department where you work. Please note that some "trusts" are self-funded but qualify for external review.

When a health insurance claim is denied, State law requires fully-funded health insurance carriers and some trusts to provide you with two levels of appeal. The process for the appeals that are conducted by the insurance company must follow rules established by the Maine Bureau of Insurance. If you are not satisfied with the decisions of the two appeals to the insurance company, you can request an external review.

You must apply for the external review within 12 months after the second level appeal is denied.

Also, to qualify for external review, your complaint has to involve one of the following:

- *Medical Necessity* - health care services or products that a physician or health care practitioner would provide to a patient in order to prevent, diagnose, or treat an illness, injury or disease. Occasionally, an issue may be deemed medically necessary but is not covered in the policy. If there is clearly no coverage in your policy, then you do not qualify for the external review.

- *Pre-existing Conditions* – health conditions that you may or may not have when you start coverage under a new insurance policy.

- *Experimental or Investigational* – the treatment is determined to be scientifically unproven by insurance company standards.

- *Medical Diagnosis, Care or Treatment*

Will I be required to pay for the external review?

You will not be required to pay for the external review. The only costs to you will be for things like postage and time off from work to attend the hour-long telephone hearing if you choose to participate.

How do I request an external review?

Call or write to the Bureau of Insurance to request an external review. Once it is determined that you qualify for external review, a packet will be sent to you that includes an authorization and a contact sheet.

The contact sheet needs to be filled out by you if you want to participate in the telephone hearing. You can list yourself, your health care provider (with his or her permission), and you can also request a particular representative from the insurance company to participate if you like. The External Review Organization (ERO) that the case is assigned to will use this contact sheet to schedule the hearing and provide the information you need to join the telephone hearing. After 1) filling out the contact sheet, 2) sign the authorization and 3) mail these to the Bureau of Insurance along with 4) a copy of the second level appeal denial letter you received from the insurance company.

Your insurance carrier will send your medical records and other information in your file to the ERO and a copy of those records or a list of what they sent to you. At the same time, you will have an opportunity to submit additional materials that you would like the ERO to consider when reviewing your case. Any documents that you submit to the ERO will be copied and sent to your insurance carrier. This procedure allows everyone to have the same information when the case is reviewed.

What happens during the hearing?

The hearing is conducted by telephone as the EROs are located throughout the country. The ERO will either telephone you at the number you provided or give you a toll-free number to call on the pre-arranged day and time that you agreed to. Your healthcare provider's participation is not necessary, but they may help you to explain your position more clearly. If your healthcare provider cannot participate in the telephone hearing at the prearranged time, ask him or her to submit a written statement in support of your case prior to the phone call. The ERO will also contact your insurance company representative and connect them to the conference call if they so choose.

Each ERO may have its own way of conducting the hearing but generally, all participating parties will first be introduced. The physician hired to hear your case will be present on the conference call. The ERO coordinator will ask you if you have any information you'd like to present to the physician reviewer. You will have about 15 minutes to present your information. This is your time to explain the reasons why you feel your case is justified. Use this time to get your important points across. If you have one of your healthcare providers take part in the conference call, he or she will also have a chance to speak. Very few people who have an external review hire an attorney to represent them but if you do, they will also have an opportunity to address the issues.

Your insurance company will have the same amount of time to justify their denial of your claim. After their presentation, if any, you will have an opportunity to ask the insurance representative questions if you like. The ERO may also ask you or the insurance company questions. The conference will end after about 45 minutes to an hour.

When will I learn the results of the review?

The ERO is required to complete the external review within 30 days after it initially receives the case for review. They will review all the materials submitted and the information presented at the hearing. They will send you and your health insurance carrier a written decision within a week after the hearing.

The external review decision is **binding only on the health insurance carrier**. In other words, if the ERO decision is in your favor, and the issue regards care that you already received, the insurance company must comply. If the case involved care that you had not yet received, the decision is also binding so long as you are still insured with the same carrier. If the decision is not in your favor, you can take further private legal action on your own if you so choose. You can do this only after exhausting all the appeals available to you, including the external review.

What is the Bureau of Insurance's role in the external review process?

The Bureau's only role is to arrange for the external review. When the ERO begins the process, the Bureau's role is ended. We cannot forward any paperwork from your file to the ERO. The external review is the last step in the official appeals process monitored by the Maine Bureau of insurance.

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