A Consumer's Guide to Internal Appeals and External Reviews

The Iowa Insurance Division, Consumer Advocate Bureau
http://www.insuranceca.iowa.gov
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Introduction

Consumers may believe they know what medical services are covered under their health insurance policy. However, insurance companies can deny claims for a variety of reasons. Receiving a claim denial may come as a surprise to a consumer and can create a high financial burden. It is crucial for consumers to understand that receiving a denial letter is not the end of the line. After receiving an initial denial, insurance companies often provide consumers with means of appealing the decision. If the denial is upheld on the first appeal, consumers could be eligible for a second appeal that may be conducted internally by the insurance company, or externally by an independent review organization. The following two options will be discussed in detial in this guide:

Internal Appeals: Within your policy documents, there are provisions relating to filing an appeal directly with your insurance company should you believe your claim was denied improperly. An internal appeal typically has several steps the consumer must specifically follow prior to the company reviewing the file. This guide will explain the purpose of appeals, identify what plans are eligible, and take you step-by-step through the preparation process.

External Review: If your internal appeal(s) remain denied, you may be eligible for an external review conducted by an independent review organization (IRO). This right may be guaranteed by the terms of the plan or by law. Much like an internal appeal, there are several formalities you must specifically follow to ensure eligibility and proper processing of an external review. This guide will help explain what those formalities are, determine if your plan is eligible, and help guide you through the process of preparing your file for submission to the IRO.

This is a guide for consumers to aid them through a process that, at times, might be difficult to understand. The information provided is not legal advice and should not be construed as such. If you have any questions about this document, you can contact the Iowa Insurance Division, Consumer Advocate at insuranceca@iid.iowa.gov or call us at 1-877-955-1212.

Chapter 1: Information to Consider Before You File an Appeal

Before you go through the process of filing an appeal, it is important to understand the type of health insurance you have, why your claim was denied, and the appeals process. This chapter provides the necessary background information that should make the appeals process easier.

Step 1

- Understand your insurance before filing an appeal

Before going through the process of filing an appeal, it is important to understand your insurance, including the benefits it provides, its limitations, deductibles, and co-insurance. It is wise to read through your benefits booklet to gain a better understanding of your insurance. If you don't have your policy, you can request a copy from your health insurance company, and they are required to provide a copy within 30 days of receiving a written request. If you have a group health plan, you can request a copy from the human resources department of your employer. Your insurance policy should provide information on the following:

- Your health care benefits and the limits on those benefits
- Cost sharing information (co-pays, deductibles, and coinsurance)
- Exclusions or limitations in the policy
- How the policy defines medical necessity, experimental, and investigational
- The benefits that require pre-authorization
- How to appeal a decision
- Where to obtain a list of medical providers in your network

Understanding these aspects of your health insurance plan will ensure that you understand the decision made by the insurance company and whether that decision seems proper. Also, having a better understanding of the issue will help you when you are going through the appeals process.

Step 2

• Examine the Denial Letter and Explanation of Benefits (EOB)

When your insurance company denies your claim, it is required to send you a letter notifying you of the denial and the policy provision that applies. If the denial was retrospective (meaning the service has been provided), the denial letter should include an "explanation of benefits" (EOB). The EOB is an important document to keep because it provides you with information about your claim. The EOB has information on:

- The charges in the claim
- What portion of each claim was covered by insurance
- The reason all or part of your claim was denied

NOTE: *Appendix A contains a list of several reasons an insurance company may use when denying your claim. Appendix B contains helpful information regarding documenting communications with your insurance company about denied claims.*

Step 3

• Identify Your Type of Insurance Coverage

First, it is important to identify the type of health insurance plan you have. The type of health insurance plan will affect the laws that are applicable to your plan and whether your plan is regulated at the state or federal level. Also, the type of plan you have can have an impact on your appeals rights. You can classify plans based on whether they are individual or group.

How You Obtained Coverage	Type of Plan
I am enrolled in a health insurance plan through my employer. Or, my family and I are in enrolled in a health plan through my spouse's employer. Or, I am under age 26 and enrolled in a health plan through a parent's employer.	Group health plan
I purchased health insurance for myself or my family through an agent, or directly from an insurance company.	Individual health plan

***NOTE**: Medicare and Medicaid have their own appeals procedures. If you are enrolled in Medicare or Medicaid, contact these programs using the telephone number on the back of your membership card to learn about the appeals rights available.*

Step 4

• If You Have a Group Plan, Determine if it is Grandfathered or Self-Funded

Determining whether your health insurance plan is grandfathered or non-grandfathered is important because provisions of the Affordable Care Act (ACA) expanded the appeals rights for non-grandfathered plans. Grandfathered plans are exempt from certain provisions of the ACA. If you have an individual health plan you do not need to make this determination.

A grandfathered health plan is a plan that was in existence the day the ACA was signed, March 23, 2010, and has not made significant changes regarding consumer costs or benefits. A plan that was in existence before March 23, 2010 but has made significant changes to consumer costs or benefits will have lost its grandfathered status.

To determine if you are enrolled in a grandfathered or non-grandfathered plan, contact the human resources department of your employer or your health insurance company. Also, the status of your plan may be found in your benefits booklet.

Step 5

• Determine Whether Your Group Plan is Self-Funded or Fully Insured

Group health insurance plans can also be categorized by whether they are self-funded or fully insured. A self-funded plan is one in which an employer, not an insurance company, provides the funds to make claim payments for policyholders. Most large employers that offer health insurance choose to self-fund their plans. Employers that offer self-funded plans typically enter into agreements with insurance companies to administer their health plans. These entities are known as third-party administrators (TPAs).

Other group health insurance plans are fully insured. In a fully insured plan, the employer has entered into a contract with an insurance company to provide health insurance for its employees for a premium. The insurance company is responsible for paying medical claims for covered medical services and treatment. The employer is only responsible for paying the premium to the insurance company.

Knowing whether your group health plan is self-funded or fully insured is important because it has an impact on laws your plan must follow. Self-funded plans are regulated at the federal level, by the United States Department of Labor (DOL). Fully insured plans in Iowa are regulated by the Iowa Insurance Division.

Step 6

• Understand the Appeals Process

Appeals generally consist of three stages. Please be aware that not all denied claims will be eligible for external review. Also, please note that not all appeals will progress through all three stages.

Stage 1

Receiving a denial, reduction, or termination in payment for services or coverage (covered in Chapter 1)

Stage 2

Filing an internal appeal to your health insurance company (see Chapter 2)

Stage 3

Filing an external review to an independent review organization (IRO) (see Chapter 3)

Chapter 2: How to File an Internal Appeal

If your insurance company denies a claim, you will receive an EOB and letter that will explain your right to file an internal appeal (this may also be called a "grievance"). An internal appeal or grievance means that someone within the insurance company who was not part of the original decision to deny your claim will take a second look at your file and determine if the denial was proper. Some plans only require one internal appeal, but some plans require two levels of internal appeals.

Internal Appeal Step 1

• Know Your Deadline for Filing an Internal Appeal

You only have a certain amount of time to file an internal appeal. The denial letter will specify the amount of time you have to file. Many insurance companies require that the internal appeal be filed within 180 days (approximately 6 months) from notification of the denial. However, it's important to double-check your particular policy. If information about how to file an internal appeal is not in the denial letter, check your policy, or call the insurance company's customer service line.

DO NOT WAIT until you are close to the deadline to file your appeal. Remember that it may take several days for your appeal to get to your insurance company via mail. Also, you will need time to get supporting information (medical records, doctor's notes, letters of medical necessity, etc.). Finally, even if the insurance company gives you 6 months to file an appeal, your medical provider could send your bills to you directly when your claim is denied by the insurance company. It is in your best interest to appeal your decision as soon as possible to resolve your matter.

Internal Appeal Step 2

• If Necessary, Appoint an Authorized Representative

You have the right to appoint an authorized representative to file an internal appeal on your behalf. Sometimes your medical provider will be willing to act as your authorized representative. You can also appoint a trusted friend or family member as your authorized representative. To appoint an authorized representative you need to prepare a written document that has:

- Your name and policy number
- The name of your representative
- Contact information for your representative (mailing address, telephone, and fax or email address if your representative has either of these)
- A statement that you are voluntarily authorizing this representative to act on your behalf
- Your signature
- The date next to your signature

Your insurance company may have its own form for naming a representative, or it may have a space for naming a representative on its appeals form. Once you have completed the written requirements, mail or fax the documents and the internal appeal request to your insurance company. Be aware that once you appoint an authorized representative, that person will get all correspondence related to the appeal and you will not.

If you later change your mind, you can revoke your authorization of the representative at any time. The revocation must be in writing and include your name, policy number, the name of your representative, your signature, and the date. The revocation should be sent to the same address as the authorization.

Internal Appeal Step 3

• Gather Supporting Documents

To help increase the possibility of overturning the adverse determination, it is in your best interest to collect additional information to support your appeal. The type of information that will be helpful to your claim depends on the reason for the denial. Here are some examples:

- If your claim was denied as not covered under your policy, you should review the policy and find the language that supports payment of your claim and your argument.
- If your claim was denied as being not medically necessary, you should ask your medical provider for your medical records and a letter explaining why the denied treatment was prescribed and why other forms of treatment were not appropriate.
- If your claim was denied as being "experimental or investigational," you should ask your medical provider for your medical records, studies establishing the effectiveness of this service, and a letter explaining these studies and the treatment rationale.

It may take some time for your medical providers to produce the supporting documents you request. Allow several weeks to get your medical records and a letter from your medical provider, especially if you are requesting them from a large hospital or clinic. Medical records departments and doctors are busy and need time to handle a request. If you have an authorized representative, you will need to sign Health Insurance Portability and Accountability Act (HIPAA) release forms to allow your medical provider to release your medical information to your representative. You will need to call your medical provider's office to have these forms emailed, faxed, or mailed to you.

Internal Appeal Step 4

• Write an Appeal Letter

Write a letter to the insurance company. The letter should explicitly request an internal appeal for your denied claim. At the top of the letter, include the following:

- The date
- The address indicated in the denial letter as the place to send an internal appeal
- Your name as the patient's name
- Your date of birth
- Your primary insured's name (if you are a spouse or dependent on the policy)
- Your policy number
- The denied claim number
- The date you received the service that was denied

Once you have included all information, you can write your letter. The first sentence can be as simple as, "I am writing to request an internal appeal of the above claim." Then, explain why you believe the claim should be covered. Include as much detail as possible. Also, even though you may be angry or frustrated, be calm and respectful in your tone. The letter should clearly lay out the *facts* of your situation, not just your emotions.

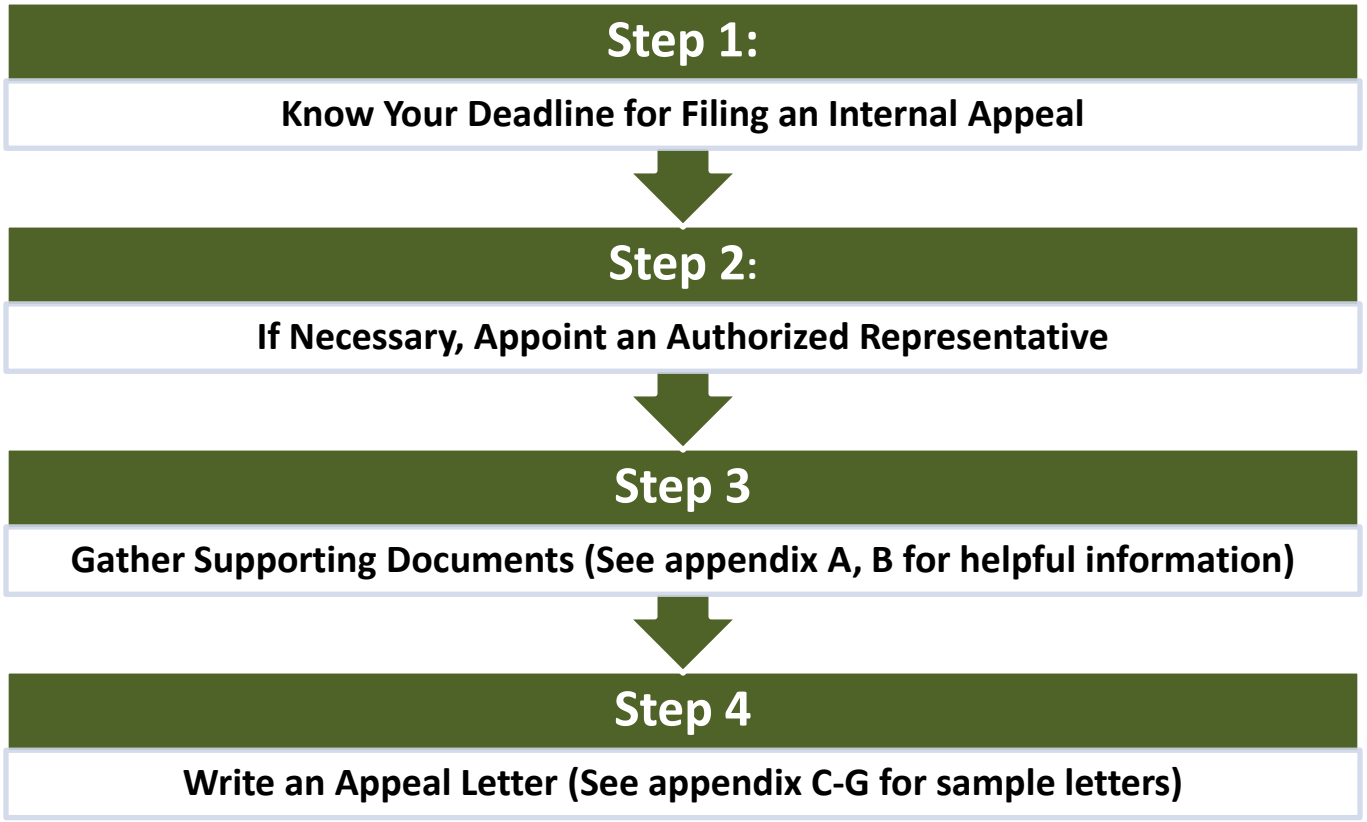
Include a description of any supporting documents you are enclosing with your appeal. Be sure to include your (or your representative's) contact information in the letter.

Finally mail your letter via certified mail so you have proof that you sent the appeal, as well as proof of the date you sent it. A response should come in 30-60 days. The denial letter will specify the amount of the time the insurance company has to respond.

If your internal appeal is denied, you may be able to file for external review. The next chapter explains which denials are eligible and how to file.

NOTE: *Appendix sections C-G contains sample letter templates. They are an excellent starting point to assist you in obtaining the documents, necessary records, or filing your appeal.*

SUMMARY OF STEPS FOR AN INTERNAL APPEAL



NOTE: *Appendix I also contains an appeals checklist which you may wish to review prior to submitting your appeal.*

Chapter 3: How to File an External Review

In an external review, your medical records are sent to an independent third party called an independent review organization (IRO for short). The Iowa Insurance Division has certified organizations that can serve as IROs in Iowa and will select one that is appropriate for your particular claim. The IRO will then review your claim and determine if the denial of your claim was proper. The IRO will uphold, modify, or overturn the decision of the insurance company. If the IRO agrees with your insurance company, you may file an appeal with the district court within 15 days. If the IRO disagrees with the insurance company, the decision is binding and the insurance company must pay the claim(s).

External Review Step 1

• Determine If Your Claim is Eligible for External Review

Although any denied claim is eligible for an internal appeal, external review is only available in certain circumstances. There are **3 threshold questions** you need to ask yourself before you seek an external review:

1) Do you have the right kind of health plan?

If it is both grandfathered and self-funded, it may not be subject to Iowa's external review laws. You can contact your employer's benefits coordinator/personnel department/human resources department to determine what type of plan you have. If your plan is both grandfathered and self-funded, ask the benefits coordinator whether the plan offers its own external review process, or chooses to participate in Iowa's process.

If you have an individual plan, your plan is subject to Iowa's external review laws.

2) Why was your claim denied?

Under Iowa Law, only claims that have been denied for specific reasons are eligible for external review. External reviews are meant to address medical questions, not contractual ones.

External review **is** available if the denied service is a covered benefit but was reduced, denied, or terminated for failing to meet your insurance company's requirements for:

- Medical necessity
- Appropriateness
- Health care setting
- Level of care
- Effectiveness, **or**
- The service or treatment is experimental/investigational

You **cannot** get an external review for a claim that was denied because:

- The service is limited or not covered by the express language of the policy
- You went to an out-of-network provider

Note: *If your claim was denied for one of these reasons and your appeal is unsuccessful you can still file a complaint with the Iowa Insurance Division's Market Regulation Bureau. For more information call 877.955.1212 or visit* *http://www.iid.state.ia.us/file_a_complaint*.

3) Have you exhausted your internal appeal rights, or do you qualify for an exception to this requirement?

Your insurance company is required to send you a letter notifying you of its final internal appeal decision. If your internal appeals were all denied, this letter should prominently state that it's a "final adverse determination." This letter should also provide you with information about the external review process.

It is important to keep the final adverse determination letter as proof that you have gone through all the levels of internal appeals available to you (in legal terms, that you "exhausted" your internal appeal rights). You almost always need to exhaust your internal appeal rights before your claim is eligible for external review.

However, there are exceptions to this rule. You do not need to have a final adverse determination letter if any of the following apply:

- You filed an internal appeal and have not received a written decision from your insurance company within 30 days of the date you filed it. However, if your insurance company asked for an extension, and you allowed it, this exception doesn't apply, and you still need to have a final adverse determination letter.
- Your insurance company has agreed to waive its internal appeal process.
- You have a medical condition for which the time frame for completion of an internal review or grievance would seriously jeopardize your life, health, or ability to regain maximum function (this qualifies you for an expedited external review; see the next section for more details).
- Your claim was denied as experimental or investigational, and your doctor certifies that the denied service or treatment would be significantly less effective if not promptly initiated (this qualifies you for an expedited external review; see the next section for more details).

External Review Step 2

• Determine Whether to File a Standard or Expedited External Review

If you have determined from the questions above that your claim is eligible for an external review, the next step is to consider which type of external review is most appropriate for your claim, either standard or expedited.

The great majority of external reviews are standard external reviews. This means the IRO has 45 days from the date the request was received to issue a decision.

For urgent situations, expedited review is available. In an expedited external review, the IRO issues a decision within 72 hours of receiving the request. Expedited external review is available only in the following circumstances:

- Your doctor certifies that exhausting internal appeals OR the standard 45 day external review would seriously jeopardize your life, health, or ability to regain maximum function.
- Your claim was denied as experimental or investigational and your doctor certifies in writing that the service would be significantly less effective if not promptly initiated.
- The final adverse determination concerns any one of the following in relation to emergency services, and you have not yet been discharged from the facility:
    - An admission
    - Availability of care
    - Continued stay
    - A health care service

External Review Step 3

• Know Your Deadline for Filing an External Review

The deadline for filing an external review is set by Iowa Law. Therefore, all health insurance plans have the same deadline of **4 months** from the date of your final adverse benefit determination letter.

External Review Step 4

• Gather Any New Supporting Documents

You do not need to resend the records and materials that you included with your internal appeal, because your insurance company is required to send everything it considered in making the final adverse determination to the IRO. However, you may submit any new or additional records and medical provider letters if you wish. Again, the type of information that will be helpful will depend on why your claim was denied. Allow yourself several weeks if you need to request medical records from a doctor or hospital because it will take time for them to process your request.

External Review Step 5

• Obtain a Copy of the External Review Form from the Iowa Insurance Division

You can obtain a copy of the external review form by visiting the Iowa Insurance Division, Consumer Advocate website at http://www.insuranceca.iowa.gov From there, you will see the heading "Health"" at the top of the homepage. Click the health heading. On the next page you will find a link the External Review Request Form. Once you fill out the form, you can fax or email the form to the Market Regulation Bureau using the contact information provided. You can also call the Iowa Insurance Division at 515.281.6348 or toll free at 877.955.1212 to request that the form be mailed to you.

When filling out the form, read the instructions carefully. The first page of the form will tell you which sections you need to fill out, because it varies depending on the reason for your denial. The second page will have information about what needs to be included along with the form (proof of your final adverse determination, waiver, or no response in 30 days).

Also, if your claim was denied as experimental or investigational, you will need to have your treating physician complete and sign a section of the form. Again, give the physician plenty of time before the deadline to complete this section.

External Review Step 6

• Appoint an Authorized Representative, if Needed

There is a section in the external review form for appointing an authorized representative. This is similar to the process of appointing an authorized representative for an internal appeal. If you want more information about appointing an authorized representative, please refer to the section under Internal Appeals (Internal Appeals Step 2).

External Review Step 7

• Send the Completed Form to the Iowa Insurance Division and Wait for the IRO Information

The external review form will tell you where to send the completed form. Do not send any medical records, medical provider letters, or other supporting document along with the form to the Market Regulation Bureau. It cannot send this information to the IRO on your behalf, and it will likely not be able to send the information back to you on time to submit it yourself.

After you submit a completed external review form to the Iowa Insurance Division, the following events and time limits apply:

- Within 1 business day after getting your request, the Iowa Insurance Division sends a copy to your insurance company.
- Within 5 business days after your insurance company gets your request, they are required to review it and determine if you are eligible for external review.
- Within 1 business day after this, the insurance company must notify the Iowa Insurance Division and you (or your authorized representative) in writing whether your request is complete and eligible.
- The Iowa Insurance Division will then determine if you are eligible for an external review.
- Within 1 business day after deciding you're eligible, the Iowa Insurance Division will assign an IRO to your claim, and notify you or your representative in writing of the IRO's contact information.

External Review Step 8

• Send the IRO Any New Supporting Documentation

Once the IRO has been selected, you have only **5 business days** to send the IRO any new supporting documentation. As with internal appeals, you should write a letter in business format. Label each of your supporting documents with a letter or number, and provide the list of documents in the letter. Briefly explain how each document proves your claim should be covered. Again, be calm and respectful in your letter, and provide specific dates and details. If you can, email or fax your information to the IRO so that it gets there as soon as possible. If you can't, send it via certified mail with signature confirmation.

***NOTE**: Appendix sections C, D, F, and G contain sample letters you can use when submitting your external review or additional information to the IRO.*

External Review Step 9

• Wait for the IRO's Decision

The IRO will assign a medical reviewer who is a physician with a background in the area of your prescribed treatment. The physician will consider all the information submitted by all parties to the action. The IRO is not bound by any decision or conclusions the insurance company made during the internal appeal process.

The IRO will send the Iowa Insurance Division, your insurance company, and you (or your authorized representative) written notice of its decision within 45 days of receiving your request for an external review. This decision must explain the reasoning for the decision and reference all evidence and evidence based standards in reaching the decision.

If the IRO decides your insurance company must cover the claim, its decision is binding on the insurance company. The insurance company must cover the service immediately after getting the IRO's decision and continue to pay for it.

If the IRO agrees with your insurance company and determines that the service should not be covered, you can appeal to the district court. You (or your authorized representative) may appeal the IRO's decision by filing a petition for judicial review in the district court of the county you live in. You only have 15 days to file this petition. The Iowa Insurance Division cannot help you file this petition or refer you to private attorneys. If you are concerned about being able to afford an attorney, you can get information about low-cost or no-cost legal service organization at the Consumer Advocate's website: http://www.insuranceca.iowa.gov.

SUMMARY OF STEPS FOR AN EXTERNAL REVIEW

Step 1:

Determine If Your Claim is Eligible for External Review

Step 2:

Determine Whether to File a Standard or Expedited External Review

Step 3

Know Your Deadline for Filing an External Review

Step 4

Gather Supporting Documents (See appendix A, B for Helpful Information)

Step 5

Obtain a Copy of the External Review Form from the Iowa Insurance Division

Step 6

Appoint an Authorized Representative, if Needed

Step 7

Send the Completed Form to the Iowa Insurance Division and Wait for the IRO Information

Step 8

Send the IRO Any New Supporting Documentation

Step 9

Wait for the IRO's Decision

APPENDIX

Appendix A contains a list of the most common reasons an insurance company will deny your claim (Page 24).

Appendix B contains a list of general procedures you should follow when communicating with your insurance company, including information on keeping a detailed written record (Page 25).

The appendix also contains sample letters for situations that are common during the appeals process. The purpose of the sample letters is to help consumers understand what information should be included in each type of correspondence. The following pages contain sample letters for these scenarios:

Appendix C: Letter to insurance company requesting documentation (Page 26).

Appendix D: Letter to medical provider requesting medical documentation (Page 27).

Appendix E: Letter to insurance company requesting an internal appeal (Page 28).

Appendix F: Letter to insurance company requesting an external review if the plan is self-funded (Page 29).

Appendix G: Supporting letter to independent review organization (IRO) (Page 30).

Appendix H contains a glossary of terms used throughout this guide and on common health insurance terms. It is not intended to be an exhaustive list (Page 31).

Appendix I is a detailed appeal checklist you should review while preparing your denial for an internal appeal (Page 39).

Note: *Please know that appeals are unique and may require a different format. The sample letters are merely examples to help guide you through the process*

APPENDIX A: Common Reasons an Insurance Company Will Deny Your Claim

The service is not covered under your policy

Your insurance company will deny your claim if you received a service that is not covered under the terms of the policy. For example, most major medical policies don't cover dental work unless it was caused by an injury. Also, if you have an individual policy and you had a pre-existing condition when you began that policy, you may have a rider that excludes coverage for services related to that condition.

The service is covered by the policy, but the provider was "out-of-network"

Most insurance companies have "networks" of doctors, hospitals, and other health care providers for their policyholders to choose from. In-network providers have agreed to accept a pre-determined price for services in exchange for the volume of patients the insurance company can provide.

If a health care provider is "out-of-network," it means he or she has not made an agreement with the insurance company to charge certain amounts for specific services. Since the health care provider has not made an agreement with the insurance company, he or she is free to charge whatever they like. An insurance company may cover a smaller percentage of the bill, or it may not cover the bill at all. However, the provider can still hold you personally responsible for whatever your insurance did not cover. This is known as "balance billing."

You did not get pre-authorization for the service

Pre-authorization, (a.k.a. pre-certification) is a common cost control measure insurance companies use for services that have the potential to be very expensive. Pre-authorization means that the provider has to contact the insurance company and get permission BEFORE he or she provides a certain service. For example, many plans require pre-authorization for inpatient psychiatric treatment or major surgeries. If the service you received required pre-authorization, and your provider did not get it, the service may not be covered.

The service was not "medically necessary"

Even if the service you received is listed as a benefit in your policy, your insurer may not pay if it determines that a different service would have solved your health issue. For example, insurance most likely would not cover sinus surgery if this were the first time you'd ever had a sinus infection. The insurer would probably require evidence from your medical records that you have chronic sinus infections that can't be treated by medication before it would consider sinus surgery medically necessary.

The service was "experimental or investigational"

Most insurance companies won't cover a service unless there is medical research to support the service as being effective for treating a particular illness or condition. If your provider recommends that you undergo "cutting edge" treatment that hasn't been subjected to much research, the treatment may not be covered. Also, if a service is provided only to "take a look around" to find out more about the possible cause of your health issue, the service may be excluded from coverage as "investigational." For example, MRIs and PET scans are often denied as being "investigational."

APPENDIX B: Communicating With Your Insurance Company

When contacting your insurance company, it is preferred that you do so in writing. Having a written record of your communications with the insurance company will ensure that there is a record of what was communicated. This will help prevent disputes as to what was communicated.

However, if you do contact your insurance company via telephone, it is a good idea to keep detailed records of communications. Communications records can help you keep track of who said what and when they said it, which can be very helpful if any confusion or dispute arises later. Your records should include:

- The date and time of the communication
- The name of the person you talked to
- The type of communication (phone, email, letter, in-person)
- What was communicated

Keeping detailed records is important because your insurance company may honor a mistake if you can provide proof of that mistake. If the only proof of a mistake is a phone communication, your insurance company may deny the conversation took place, or may assert that your summary of the conversation is not factually accurate. Even if you take detailed notes and obtain the name of the individual on the other end of the line, an insurance company may deny the accuracy of your version of events.

NOTE: *An insurance company CANNOT drop your coverage in retaliation for filing an appeal or an external review. If you believe that an insurer has improperly dropped your coverage as a response to the filing of an appeal or grievance please contact the Iowa Insurance Division in order to obtain information on submitting a formal complaint against your insurance company. Retaliatory rescission or cancellation is in violation of both Federal and Iowa Law and the IID will investigate such allegations.*

APPENDIX C: Sample Letter for Requesting Documentation from the Health Plan

[Date]

[Name of Insurance Company]

[Address of Insurance Company]

ATTN: Consumer Appeals

RE: [Name of Patient] [*can optionally include name of insured if different than patient]*

Policy #: [Policy #]

Claim #: [Claim #]

To Whom It May Concern:

My name is [name], and I am writing to you today regarding filing an appeal for [description of denial]. In order to proceed, I request that you please provide me with the following:

- A copy of all materials considered as part of the decision to deny the above claim

My medical provider and I will need these as we prepare to appeal your determination on the claim referenced above.

I look forward to hearing from you soon.

Sincerely,

[Your Signature]

[Your printed name]

[Your Contact Info]

APPENDIX D: Sample Letter for Requesting Documentation from a Medical Provider

[Date]

[Name of Medical Provider]

[Address of Medical Provider]

RE: Requesting Supporting Documentation for my Insurance Denial

Dear Sir or Madam.

My name is [name] and I received treatment at your facility on [insert date(s)]. I received treatment from [medical provider name].

I have been denied coverage for this treatment by my insurer. My insurer has denied the treatment because [insert reason for denial]. I am contacting you because I believe you may have documentation that will support my claim. I am requesting that you please provide me with the following:

- Any information to refute the denial.
- My pertinent medical records.
- The treating health care professional's recommendation in the form of a letter of medical necessity.
- Consulting reports from appropriate health care professionals.
- The most appropriate practice guidelines, which include evidence based standards developed by national or professional medical societies or federal government.

As you know, I have a limited timeframe to file my appeal and I ask that you please respond to my request at your earliest convenience.

I greatly appreciate your assistance with my appeal. If you have any questions please contact me using the information provided below. Thank you.

Sincerely,

[Your Signature]

[Your Name]

[Your Contact Info]

APPENDIX E: Sample Letter for Requesting an Internal Appeal (First-Level)

[Date]

[Name of Insurance Company]

[Address of Insurance Company's Appeals Department]

RE: [Internal Appeal for Name of Consumer]

Policyholder: [Name of Policyholder]

Patient: [Name of Consumer]

Insurer: [Name of Insurance Company]

Policy #: [Policy #]

Claim #: [Claim #]

To Whom It May Concern:

I am formally requesting an internal appeal of my [coverage, denial of coverage, pre-authorization, etc.] for my [treatment]

I received treatment from [medical provider] on [date]. The reason for my denial was listed as [denial reason]. The treatment I received was prescribed by [medical provider] and this treatment should be covered.

The next paragraph should then describe your situation and provide relevant facts that support your belief that the claim should be covered. This is an opportunity for you tell your side of the story and describe what exactly happened.

If you have included supporting documentation, describe the documents you included. Also, number the documents using letters or numbers and organize them in a way that is easy for the reader to understand. You can simply list the items and their corresponding numbers, if that would be easier. Use your supporting documents to bolster your case by referencing specific portions of the supporting documents and then describing why they favor your claim.

This paragraph should inform the Insurer that you can be reached for questions or additional documentation.

I look forward to hearing from you soon.

Sincerely,

[Your Signature]
[Your Name]
[Your Contact Info]

APPENDIX F: Sample Letter for Requesting an External Review

NOTE: This letter will only be needed for plans that are grandfathered and self-funded. If you have a plan that is not grandfathered and self-funded, you can request an external review using the Iowa Insurance Division External Review Request Form.

[Date]

[Name of Insurance Company]

[Address of Insurance Company's Appeals Department]

RE: Request for external review

Policyholder:	[Name of Policyholder]
Patient:	[Name of Consumer]
Insurer:	[Name of Insurance Company]
Policy #:	[Policy #]
Claim #:	[Claim #]

To Whom It May Concern:

I am formally requesting an external review of the final adverse benefit determination I received on [date], which is included with this appeal.

I filed my internal appeal on [date], in response to [reason for denial, medical necessity, experimental, or investigational, etc.]. You have reviewed my internal appeal and have upheld your original decision.

> *After making your request for an external review, if you have any additional information to share that was not included in your internal appeal, this is the time to bring it to the Insurer's attention. For example, "I have learned that my primary physician gained pre-authorization for the treatment I received." If you have something similar to include, this is the time to do so. But, keep the statement(s) simple and fact-based.*

I look forward to hearing from you soon.

Sincerely,

[Your Name]
[Your Signature]
[Your Contact Info]

APPENDIX G: Sample Supporting Letter to Independent Review Organization (IRO)

NOTE: Due to the similarities of the internal appeal letter and the sample supporting letter to an IRO, you may be able to save time by updating your internal appeal letter and submitting it to the IRO in support of your external review.

[Date]
[Name of Independent Review Organization (IRO)]
[Address of Independent Review Organization (IRO)]

RE: [External Review for *Insert Name of Consumer]*
Policyholder: [Name of Policyholder]
Insured: [Name of Consumer]
Insurer: [Name of Insurance Company]
Policy #: [Policy Number]
Claim #: [Claim Number]

Dear Sir or Madam:

I am contacting you in regard to an external review I have requested for a denial of treatment from [insurer]. [Name of insurer] has denied coverage for the treatment I received from [medical provider]. I received treatment because of my [insert condition]. [Name of insurer] has denied coverage for my treatment based on the treatment being [insert reason for denial, medical necessity, investigation, experimental, etc.] I have formally appealed this decision with [insurer] and they have notified me of their Final Adverse Benefit Determination. I request that you please consider this letter and the supporting documentation I have included when reviewing this matter.

The next paragraph should then describe your situation and provide relevant facts that support your belief that the claim should be covered. This is an opportunity for you tell your side of the story and describe what exactly happened.

If you have included supporting documentation, describe the documents you included. Also, number the documents using letters or numbers and organize them in a way that is easy for the reader to understand. You can simply list the items and their corresponding numbers, if that would be easier. Use your supporting documents to bolster your case by referencing specific portions of the supporting documents and then describing why they favor your claim.

This paragraph should inform the Insurer that you can be reached for questions or additional documentation.

I appreciate your time and I look forward to hearing from you soon.

Sincerely,

[Your Signature]
[Your Name]
[Your Contact Info]

APPENDIX H: Glossary of Health Insurance Terms

A

Adverse Benefit Determination- means a determination by a provider or insurer that admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. Adverse benefit determination does not include a denial of coverage for a service or treatment specifically listed in plan or evidence of coverage documents as excluded from coverage.

A consumer should keep the Adverse Benefit Determination they receive from their health insurance company. This document will be useful if the consumer wants to file an appeal.

Agent – Someone who sells and services insurance policies. In Iowa, all insurance agents must be licensed by the Iowa Insurance Division. They are also known as "producers."

Appeal – A request for reconsideration of a decision by a health plan, usually after a denial.

C

Claim – When you or your doctor request payment of benefits from your insurance plan after you've received treatment or services (reimbursement).

Coinsurance – A percentage of a health care medical provider's charge for which the patient is financially responsible under the terms of the policy (a.k.a. a "co-payment" or "co-pay")

Coordination of Benefits – When you are covered by two or more insurance plans, this determines how much each plan will pay for a benefit. Total

reimbursement should not exceed 100 percent of the cost of care. This is common when two people in a household have separate insurance plans.

Co-payment – A co-payment is a patient's share of a health care bill. It usually is a small, flat-dollar amount, such as $10 or $25 for an office visit.

Coverage - The scope of protection provided to the insured person under an insurance contract. When used to refer to a health plan, it means the benefits available.

Current Procedural Terminology (CPT or treatment code) – There are five – digit codes developed by the American Medical Association that doctors use to communicate with health plans about the tasks and services they provide to a patient. Medicare refers to these as Healthcare Common Procedure Coding System (or HCPCS) codes.

D

Deductible - The dollar amount you pay for covered charges during a calendar year before the plan start paying claims.

Drug Formulary – See Formulary

E

Eligibility – Whether a person qualifies for coverage or not. If you were eligible, and then lost eligibility, health plans may cancel your coverage and deny any claims incurred after eligibility was lost. Should this happen, you may be able to appeal the decision to the health plan under the ACA.

Exclusions – Clauses in a health insurance contract that deny coverage for specific medical treatments and supplies. Examples of commonly excluded "events" include elected cosmetic surgery, gastric bypass surgery, treatment in clinical trials, gender reassignment surgery, or treatment that is deemed experimental.

Explanation of Benefits (EOB) – This is a notification sent to you from your insurance company after they have processes a claim. It should explain what services the medical provider claims to have provided, what the insurance

company paid, and what amount was not paid. Many of these EOB's contain fine legal language regarding coverage.

External Review – Review of plan or issuer's denial of coverage or services by an independent review organization (IRO). This review happens after the internal review process has been exhausted, or when circumstances qualify the external review as being urgent and the IRO's decision is needed for a quick response. The insurance company is bound to the decision reached in the external review.

F

Final Adverse Benefit Determination – An adverse benefit determination that has been upheld by a health plan at the completion of the internal appeals process. If a consumer wants to appeal a final adverse benefit determination, they would request an external review from their health plan.

Formulary – A list of prescription drugs a health care plan covers; coverage amount varies by tiers.

G

Grandfathered Plan – (also sometimes referred to as an "old" plan) A plan that is exempt from some of the changes of the health care reform because it was in existence before March 23, 2010 and hasn't made significant changes to the plan design. If a plan is grandfathered, it must disclose this status. New people and their dependents can be added to a grandfathered plan.

Group Policy – An insurance contract between an insurance company and an employer or other employee entity *(i.e. a union)* to cover employees or group members. Eligibility for coverage is defined by the employer. For example, an eligible employee might be defined as "employees working over 30 hours per week for the employer." These policies are popular with workers because they are usually less costly than if the workers tried to buy the same kind of coverage as individuals.

H

Health Insurance – A policy or product that provides coverage to someone for doctor, hospital, and other medical expenses for prevention and treatment of illness or injury. It can be issued as an individual or group policy

Health Maintenance Organization (HMO) – A type of health carrier that requires subscribers to get all their care from a group of medical providers (except for some emergency care). The plan may require the subscriber's primary care doctor to provide them with a referral before they can see a specialist or go the hospital. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan.

Health Provider – The company or group that provides your health plan to you.

HIPAA (Health Insurance Portability and Accountability Act of 1996) – A federal law enacted in 1996. The law makes it easier for people to change jobs without the risk of being unable to obtain health insurance or having to wait for coverage due to pre-existing medical conditions. The law also creates standards that deal with the privacy of health information, which helps stop improper use of your medical records.

I

Independent Review Organization (IRO) – An independent an unbiased group or entity that conducts external reviews of final adverse determinations made by insurance companies; the reviews are at the request of the insured. The cost of such a review falls on the insurance company to pay, and their determination is final and binding on the insurance company.

Individual Policies – This policy consists of individuals and their dependents who buy health insurance from an insurer, or an agent or broker who represents the insurer. People usually buy their own health insurance because they don't qualify for government (such as Medicare or Medicaid) or employer-sponsored coverage.

In-Network Medical provider – A health care medical provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an HMO or PPO). The medical provider agrees to the managed care organization's rules and fee schedules and agrees not to bill patients for amounts beyond the agreed upon fee.

Insurance – A contract to transfer risk from individuals to an insurance company. In exchange for a payment called a premium, the insurance company agrees to pay for claims covered under the terms of the policy.

Insurance Commissioner – The official in Iowa who enforces the state's insurance laws, and makes reasonable rules and regulations to implement provisions of these laws. The Insurance Commissioner also conducts investigations, examinations, and hearings related to enforcement activities.

Insured – When you are covered by insurance, you are known as the "insured."

Internal Appeal – This is the first stage of an appeal when you (or an authorized representative) ask a health plan to reconsider a decision it had made about your benefits ("adverse determination"). The plan will review your appeal and will notify you of whether or not it thinks their initial decision was decided correctly. Some internal appeals have multiple levels.

L

Limitations – These are exclusions, exceptions, or reductions of coverage in an insurance policy. An example might be a health insurance policy with a pre-existing condition limitation.

M

Major Medical Insurance – Health insurance to cover medical expenses over and above that of a basic health insurance policy. Major medical policies pay expenses both in and out of the hospital.

Medically Necessary – Covered health care services required to maintain the health of a patient in line with the geographical area's standards of medical practice. These are often defined in the policy.

N

Non-grandfathered – A plan that is required to implement the changes required by health care reform because it either came into existence after the law was passed (March 23, 2010), or was in existence before the law but made significant changes causing it to lose its grandfathered status.

O

Out-of-Network Medical provider – A health care medical provider (such as a hospital or doctor) that is not contracted to be part of an organization's (HMO's or PPO's) network. Depending on the managed care organization's rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network medical provider.

Out-of-Pocket Limit – The maximum coinsurance a health care plan requires a person to pay for covered charges, after which the insurer will pay 100% of covered expenses up to the policy limit.

P

Patient Protection and Affordable Care Act (PPACA or ACA) – The comprehensive federal legislation signed into law on March 23, 2010 (a.k.a. health care reform). The major provisions of the bill will take effect during the five years that follow.

Post-Service Claim – Claims that get submitted by you or your doctor after you've received medical services, such as requests for reimbursement or payment for services provided. Most claims for group health benefits are post-service claims.

Preauthorization – This is a procedure managed care plans use to control plan members' use of health care services through pre-approval. See also term "prior authorization."

Pre-existing Condition – A health problem you had before your new health insurance plan began. Coverage for a pre-existing condition depends on the health insurance plan. Determining a pre-existing condition sometimes relies on a previous diagnosis or treatment that was recommended for symptoms related to your condition.

Pre-Service Claim – A request for authorization from your health plan before you get medical care or treatment. For example, if you (or your medical provider) have to get your plan's authorization before having a procedure in order for the plan to pay for it, that request is known as pre-service claim. If you plan denies authorization, that is known as a pre-service denial.

Preferred Medical provider Organization (PPO) – This is a network of health care medical providers who work with health insurance plans. A health insurance plan often pays more if members get their care from doctors or hospitals that contact with a PPO. The medical providers and hospitals are called "network" medical providers. Members pay more if they go to a doctor or hospital not listed in the plan's network. The medical providers in this PPO have agreed to accept negotiated fees for their services.

Prior Authorization – This is a managed care procedure to control your use of health care services through review and pre-approval. See also "pre-authorization."

Providers – Institutions and individuals licensed to provide health care services, such as hospitals, doctors, naturopaths, medical health clinicians, pharmacists, etc.

R

Rider – An attachment to a policy that modifies the conditions of the policy by expanding or decreasing its benefits, or excluding certain conditions from coverage.

S

Self-funded – When an employer or organization assumes responsibility for the covered health care expenses of its employees. Usually the employer sets up and contributes money to an account solely to pay claims. Sometime the company handles the claims internally, but often an independent organization, such as a third-party administrator (TPA), processes employee claims and make claim payments out of the employer's self-funded plan account. Some plans are not subject to state insurance laws; most self-funded plans are regulated under federal law by the U.S. Department of Labor.

T

Third-Party Administrator (TPA) – For health insurance, it's a person or company hired by an employer to manage health care claims processing, and pay medical providers. The TPA is not the policyholder or the insurer.

U

Urgent Care Claims – This is an expedited claim you can make if withholding medical care endangers your life or causes you prolonged pain or discomfort. Your medical provider with knowledge of your situation will decide if your condition is urgent or not.

Utilization Review – A health insurance company's review to determine if the health care services a medical provider or facility gives to a member or group of members is necessary and appropriate.

Special thanks to the Washington State Office of the Insurance Commissioner for their assistance in completing this glossary.

APPENDIX I: Appeals Checklist

Document	X	N/A
Cover letter requesting a formal appeal including: Date of Request Name of Insured Individual Policy ID# Claim Number(s) Date of Service		
Copy of the Explanation of Benefits (EOB)		
Copy of your health insurance policy		
Name and phone number of the medical provider or physician		
Letter of medical necessity from medical provider or physician		
Additional supporting documentation from physician including office notes		
Lab test results if applicable		
X-ray reports if applicable		
Copy of prior approval if applicable		
Copy of the prescription		