
Appeals and external review

If your claim was denied

You can appeal an insurance company's decision to deny a claim or a decision to pay less than the amount billed. The Division of Financial Regulation can explain the appeals process. Call one of our consumer advocates or file a complaint to get help. Here is an overview.

Complaint and appeals process

- Your insurance company must acknowledge nonemergency complaints and appeals within seven days.
- Your insurance company must make a decision and respond within 30 days.
- Your insurance company must have a process for responding to emergency complaints (expedited review) more quickly.
- If your insurance company rejects your first appeal and your plan is through an employer, you may have the right to a second appeal.
- Your insurance company has seven days to acknowledge each appeal and 30 days to respond.
- If your insurance company rejects all appeals, you have the right to an independent external review to determine:
 - Whether treatment is medically necessary.
 - Whether treatment is experimental or investigational.
 - Whether treatment is for continuity of care.
 - Other "adverse benefit" issues such as the insurance company rescinded or ended your coverage.

External review and your rights

Under external review, you may ask your insurance company for an independent (external) review to determine whether treatment is:

- Medically necessary
- Experimental/investigational
- For continuity of care
- Delivered in an appropriate setting at an appropriate level of care

Independent review organizations (IROs) are independent of the insurers. They review medical records and other materials to decide if the insurer made the correct decision. Do not forget that you have to finish the company's internal appeal process first unless you both agree to go directly to external review.

External review process

- Apply for external review through your insurance company within 180 days from the written decision you want to appeal.
- The insurer then submits a form to the Division of Financial Regulation.
- The division randomly assigns the case to one of the IROs with an approved contract.
- The IRO determines if the dispute qualifies for external review.
- If so, the IRO reviews the case and issues a written decision based on expert medical judgment. The IRO must consider:
 - Your medical records
 - The recommendations of your medical providers
 - Scientific and cost-effectiveness evidence
 - Standards of medical practice in the United States
- An IRO has 30 days to issue a decision after you apply to the insurance company for an external review. If the doctor certifies that your life or health would be seriously jeopardized under the ordinary timeframe, an insurance company may request an expedited review. For expedited reviews, a decision must be issued within three days of the request.
- Insurers are bound by IRO decisions. However, patients may pursue legal action as a last option to overturn a denial.

IROs must provide the division with a brief description of each decision and an annual report summarizing outcomes.