ARIZONA DEPARTMENT OF INSURANCE & FINANCIAL INSTITUTIONS

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CONSUMER GUIDE TO THE HEALTH CARE APPEALS PROCESS

This document is intended to provide a brief description of the Health Care Appeals process. A more detailed explanation is provided in the **Health Care Appeals Information Packet** available from your health insurer. You can also find a copy of a generic packet on our website.

If you file a complaint with the Arizona Department of Insurance & Financial Institutions (Department) related to an Adverse Determination (see definition below) that is subject to the health care appeals process, the Department must require you to first exhaust the health care appeals process with your insurer. The Department cannot address your complaint during the health care appeals process unless your complaint is about an issue other than an Adverse Determination under the health care appeals laws (Arizona Revised Statutes § 20-2530 through 20-2541).

What is the Health Care Appeals process?

Arizona law requires health insurance, dental and vision plans to provide their members with a way to appeal an Adverse Determination.

Adverse Determination means that a requested service or a claim for service or a denial, reduction, or termination of service, in whole or in part, is:

- Not medically necessary or appropriate, including the health care setting, level of care or effectiveness of a treatment or service
- Experimental or investigational
- Not a covered service

A "denied claim" is when you have already received care, and the insurer has denied payment for that care. A "denied service" is when the plan does not authorize a treatment or service that you have not received yet, and that that you or your doctor believe is medically necessary and covered by your policy. When your health insurer denies a claim or service, it must advise you of your right to appeal the denial.

If you are the member and want to file a health care appeal, you may find it helpful to work with your treating provider for documentation to support your appeal. In Arizona, the majority of health care appeals the Department receives are submitted by treating providers. No special forms are required, but we do have forms on our website that may be helpful. There is no cost to a member or provider for any level of health care appeal.

The appeals process generally consists of the following levels of review:

For urgently needed services not yet provided:
- Expedited Medical Review
- Expedited Appeal
- Expedited External Independent Review

For standard services or denied claims:
- Initial Appeal
- Voluntary Internal Appeal (some plans may not offer this level)
- External Independent Review

All levels of health care appeal are to be sent directly to an insurer. The first level(s) of appeal are processed by the insurer. The last level, External Independent Review, is handled by the Department.

Urgently needed services not yet provided

Expedited Medical Review

An Expedited Medical Review is the first step for urgently needed services that you are waiting to receive, but your insurer has denied the services. The Expedited Medical Review starts when your treating provider sends a certification with supporting documentation to your insurer that delaying the requested treatment or service could cause a significant negative change in your medical condition. The insurer has 72 hours after receiving your treating provider's certification and appeal to notify you and your doctor by phone and in writing. If the insurer continues to deny the requested service after Expedited Medical Review, it must inform you of your right to request an Expedited Appeal, the next step in the appeal process.

Expedited Appeal

If the insurer denies the requested service following Expedited Medical Review, and you still want to appeal the decision, your treating provider must immediately submit a written appeal to the insurer and provide any additional reasons and/or documents supporting the request for the service. The insurer has three business days after receiving the appeal to make a decision. If the insurer still believes that it should not cover the requested medical or health-related service, the insurer must inform you and your treating provider by phone and in writing of the denial and of your right to immediately proceed to an Expedited External Independent Review, the next step in the appeal process.

Expedited External Independent Review

You must act within 4 months after you are notified that your Expedited Appeal for services was denied to request an Expedited External Independent Review. Within one business day of receiving your notice asking for an Expedited External Independent Review, the insurer must send your newest appeal request, and all documentation used to make its earlier decisions, to the Department.

If the request for Expedited External Independent Review is an issue of medical necessity, the Department forwards the submitted materials to an Independent Review Organization (IRO) selected by the Department. The IRO is under contract with the State

of Arizona and is not related to your insurer. The independent reviewer that evaluates your case must be a provider who typically manages the medical condition for which the treatment is being denied, and may not have any conflict of interest that will prevent a fair and impartial decision. The IRO has 72 hours to notify the Department of its decision. The Department then has one business day from when it receives the decision to notify you, your treating provider and your insurer of the decision.

If the request for Expedited External Independent Review is for a question of coverage under the policy for a treatment or service, the Department has two business days to review the information provided by the insurer and determine if the denied service is covered under the insurance policy. The Department will notify you, your treating provider and your insurer of its decision.

Standard services or denied claims

Initial Appeal

Initial Appeal is the first step in the standard appeals process for denied claims and services. You may request an Initial Appeal by calling in or sending your request in writing to your insurer. You have up to two years after your insurer denies your claim or request for a covered service to request an Initial Appeal. The insurer has 30 days (15 days if the plan uses the Voluntary Internal Appeal level) to make a decision if the service has not yet been provided. For a service already provided, the insurer has 60 days (30 if the plan uses a Voluntary Internal Appeal level). The insurer must notify you and your treating provider of their decision. If the insurer still denies your claim or request for service after the Initial Appeal is completed, you may then request a Voluntary Internal Appeal (if offered by your plan) or an External Independent Review.

Voluntary Internal Appeal *(group and grandfathered individual plans may elect to offer) (this level is not used for Individual and Small Group Marketplace plans)*

If your insurer denies your claim or request for service after an Initial Appeal, and requires you to use the Voluntary Internal Appeal process, you have 60 days from the Initial Appeal decision to request a Voluntary Internal Appeal.

For denied services, your insurer has 15 days to make its decision and to notify you. For denied claims, the insurer has 30 days to make its decision and to notify you of the decision. If the insurer still denies your claim or request for service, you can then request an External Independent Review.

External Independent Review

The last step in the appeal process for denied services or denied claims by your insurer is the External Independent Review. You have four months after your insurer notifies you that your Initial Appeal (or Voluntary Internal Appeal if required) was denied to request an External Independent Review. When you submit your request for the External Independent Review, your insurer has five business days to acknowledge your request, and to send all policy and appeal documentation, including documents used to make its earlier decision(s), to the Department.

For medical necessity cases, when the Department receives the documentation from the insurer, it has five days to forward the materials to an Independent Review Organization (IRO) selected by the Department. The IRO is under contract with the State of Arizona and is not related to your insurer. The IRO assigns your matter to a reviewer. The reviewer must be a provider who typically manages the medical condition that is the subject of the appeal, and cannot have any conflict of interest that will prevent a fair and impartial decision. The IRO has 21 days to notify the Department of its decision. The Department then has five business days from when it receives the IRO's decision to notify you, your treating provider and your insurer of the decision.

For cases involving an insurer's denial of coverage for a medical service or claim, the Department has 15 business days to review the information provided and determine if the denied service or claim is covered under the policy. The Department will notify you, your treating provider and your insurer of its decision. If the Department is unable to determine if the claim is covered under the policy, it may send the case to an Independent Review Organization (IRO) for medical review. A provider will review the record and determine if the service or claim is covered under the insurance policy. The reviewer must be a doctor who typically manages the medical condition that is the subject of the appeal, and may not have any conflict of interest that will prevent a fair and impartial decision. The IRO has 21 days to notify the Department of its decision. The Department will notify you, your treating provider and your insurer of the decision within five business days.

After External Independent Review

For medical necessity decisions made by an IRO, the IRO's decision is a legally binding decision. If you or the insurer disagree with the decision, either party may file a petition to a state court.

For coverage cases, if you or the insurer disagree with the Department's determination regarding whether a claim or service is covered under the terms of a health insurance policy, either party may request a hearing by the Arizona Office of Administrative Hearings. Hearings must be requested within 30 days of receiving the Department's determination letter. The Department's determination letter will include instructions for requesting a hearing.

It's important to keep in mind that neither the Independent Review Organization, the Department nor the Office of Administrative Hearings can require any insurer to pay a claim or provide a service that is excluded from coverage by the terms of a policy. In addition, the Office of Administrative Hearings does not make medical necessity determinations.

What types of policies do not qualify for the Heath Care Appeals process?

Individuals with the following types of health care coverage are not eligible to participate in the Arizona health care appeals process:

- Medicare, Medicare Advantage or Medicare supplement plan
- Medicaid (AHCCCS) plan

- Long-term care plan
- Short term or long term disability plan
- Federal Employee Plan
- Self-funded or self-insured plan
- Workers' compensation claims

These other types of plans commonly have an appeals process of some kind that you may use, and you should check your policy documents.

Individuals with complaints concerning how you were treated by a health care provider, a dispute over how much was paid when no service was denied, health care benefit reductions due to usual and customary charge limitations, deductibles, and coordination of benefits issues are not eligible for Arizona's health care appeals process.

Helpful hints

Send ALL levels of health care appeal to the insurer, using information on the CONTACT US page of the appeals information packet specific to your plan.

Be mindful of deadlines involved with each level of health care appeal.

Include Documents: If you file a health care appeal with your insurer, include as much supporting documentation as possible that shows why you believe the denied service or claim should be covered. When filing an Expedited Medical Review, the doctor's written certification and supporting documentation that delaying treatment will negatively impact your medical condition must be included.

This is only a brief description of the way the appeals process will generally work at most insurers. Refer to the **Health Care Appeals Information Packet** available from your insurer for more details regarding how your insurer handles appeals for your specific plan, along with the contact information on where to send your appeal request. A packet should be available on your insurer's website. The Department has a sample packet on our website. If you are not able to locate this information, contact your insurer or the Department of Insurance & Financial Institutions at www.difi.az.gov.

Persons with disabilities may request materials be presented in an alternative format by contacting the ADA Coordinator at (602) 364-3100. Requests should be made as early as possible to allow time to procure the materials in an alternative format.