

Title 210 – NEBRASKA DEPARTMENT OF INSURANCE

Chapter 87 – HEALTH CARRIER EXTERNAL REVIEW

001. Authority

This regulation is adopted by the director pursuant to the authority in Neb. Rev. Stat. §§ 44-1305(1)(c), 44-1306(1)(b), 44-1315(1)(b), 44-1315(2)(b), and 44-1317(1)(b).

002. Purpose

The purpose of this rule is to adopt the forms required pursuant to the Health Carrier External Review Act, Neb.Rev.Stat. §§ 44-1301 through 44-1318.

003. Notice of Appeal Rights

A health carrier required to provide notice pursuant to §44-1305(1) shall provide the notice in the form in Appendix A, hereby made a part of this regulation. The health carrier may provide the notice in a form substantially similar to the form in Appendix A, if the form of such notice has been reviewed and approved by the Director.

004. External Review Request Form

A covered person or person acting on behalf of a covered person requesting an external review pursuant to §44-1306(1)(b) shall provide the notice in the form in Appendix B, hereby made a part of this regulation. The form in Appendix B must be provided by the carrier with all final adverse benefit determinations, published on a carrier's website, and otherwise available upon request.

005. Independent Review Organization External Review Annual Report Form

An independent review organization requested by the director to prepare a report regarding requests for external review under Neb. Rev. Stat. 44-1315(1) shall provide the report in the form in Appendix C, hereby made a part of this regulation. The independent review organization may provide the report in a form substantially similar to the form in Appendix C, if the form of such report has been reviewed and approved by the Director.

006. Health Carrier External Review Annual Report Form

A health carrier requested by the director to prepare a report regarding requests for external review under Neb. Rev. Stat. 44-1315(2) shall provide the report in the form in Appendix D, hereby made a part of this regulation. The health carrier may provide the report in a form substantially similar to the form in Appendix D, if the form of such report has been reviewed and approved by the Director.

007. Description of External Review Procedures

007.01 Each health carrier shall include a description of the external review procedures in or attached to all health coverage plan materials dealing with the carrier's grievance procedures including but not limited to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons as required by Neb. Rev. Stat. § 44-1317.

007.02 The description required under subsection 007.01 shall include a notification of the availability of an external review process, the circumstances under which a covered person may use the external review process, the procedures for requesting an external review, and the timelines associated with an external review. The description shall appear in 10 point font.

008. Severability.

If any section or portion of a section of this chapter, or the applicability thereof to any person or circumstance, is held invalid by a court, the remainder of this chapter, or the applicability of such provision to other persons shall not be affected thereby.

Appendix A –Notice of Appeal Rights

NOTICE OF APPEAL RIGHTS

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact¹ us when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.¹

Appeals: All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [health carrier to insert address of where appeals should be sent to the health carrier] within **180 days** of the date you receive our denial.² We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have that pertains to your claims. We will notify you of our decision in writing within **30 days** of receiving your appeal.³ If you do not receive our decision within **30 days** of receiving your appeal³, you may be entitled to file a request for external review.

External Review: We have denied your request for the provision of or payment for a health care service or course of treatment. Once you have completed the internal grievance or appeals process as set forth above, you may be entitled to a standard external review of your claim denial if our decision involved making a judgment as to the medical necessity, experimental or investigational nature, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. You may submit a request for external review within 4 months after receipt of this notice to the Nebraska Department of Insurance at Nebraska Department of Insurance, PO Box 82089, Lincoln, NE 68501-2089. You may telephone the Department of Insurance for more information at (877) 564-7323. The form required to request an external appeal will be provided with a final adverse benefit determination. In addition, the forms may be accessed on our website or on the Department of Insurance Website at www.doi.nebraska.gov. For standard external reviews, a decision will be made within **45 days** of receiving your request. You may be entitled to an **expedited external review** of an adverse determination. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, and our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you may be entitled to file a request for expedited external review of our denial, upon certification by your treating physician. You may not have to complete the internal appeals process to request an expedited external review. The expedited external review may be requested once the internal appeal has been submitted. For details, please review your Benefit Plan Document, contact us or contact the Nebraska Department of Insurance.

¹ See address and telephone number on the enclosed Explanation of Benefits if you have questions about this notice.

² Unless your plan or any applicable state law allows you additional time.

³ Some states and plans allow you more (or less) time to file an appeal and less (or more) time for our decision. See your Benefit Plan Document for your state's internal appeal process.

Appendix B –External Review Request Form

This EXTERNAL REVIEW REQUEST FORM must be filed with the Nebraska Department of Insurance within FOUR (4) MONTHS after receipt from your insurer of a denial of payment on a claim or request for coverage of a health care service or treatment. The Department of Insurance Mailing Address and Telephone Number is:

Nebraska Department of Insurance
PO Box 82089
Lincoln, NE 68501-2089
(877) 564-7323
www.doi.nebraska.gov

EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME: _____ Covered person/Patient Provider Authorized Representative
(choose one)

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____ Patient Name: _____

Address: _____

Covered Person Phone Number: Home (____) _____ Work (____) _____

INSURANCE INFORMATION

Insurer/HMO Name: _____

Covered Person Insurance ID number: _____

Insurance Claim/Reference number: _____

Insurer/HMO Mailing Address: _____

Insurer Phone Number: (____) _____

EMPLOYER INFORMATION

Employer’s Name: _____

Employer’s Phone Number: _____

Is the health coverage you have through your employer a self-funded plan? _____ . If you are not certain please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider: _____

Address: _____

Contact Person: _____ Phone Number: (____) _____

Medical Record Number: _____

REASON FOR HEALTH CARRIER DENIAL (Please check one)

The health care service or treatment is not medically necessary.

The health care service or treatment is experimental or investigational.

SUMMARY OF EXTERNAL REVIEW REQUEST (Enter a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier)*

*You may also describe in your own words the health care service or treatment in dispute and why you are appealing this denial using the attached pages below.

EXPEDITED REVIEW

~~If you need a fast decision, you~~ You may request that your external appeal be handled on an expedited basis if a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient’s ability to regain maximum function. To complete this request, your treating health care provider must fill out the attached form: Certification of Treating Health Care Provider for Expedited Consideration of a Patient’s External Review Appeal.

Is this a request for an expedited appeal? Yes _____ No _____

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier’s denial, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Nebraska Department of Insurance. I understand that the independent review organization and the Nebraska Department of Insurance will use this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other – Please Specify)

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other—Please Specify)

Address of Authorized Representative: _____

Phone Number: Daytime () Evening ()

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

DESCRIBE IN YOUR OWN WORDS THE DISAGREEMENT WITH YOUR HEALTH CARRIER. INDICATE CLEARLY THE SERVICE(S) BEING DENIED AND THE SPECIFIC DATE(S) BEING DENIED. EXPLAIN WHY YOU DISAGREE. ATTACH ADDITIONAL PAGES IF NECESSARY AND INCLUDE AVAILABLE PERTINENT MEDICAL RECORDS, ANY INFORMATION YOU RECEIVED FROM YOUR HEALTH CARRIER CONCERNING THE DENIAL, ANY PERTINENT PEER LITERATURE OR CLINICAL STUDIES, AND ANY ADDITIONAL INFORMATION FROM YOUR PHYSICIAN/HEALTH CARE PROVIDER THAT YOU WANT THE INDEPENDENT REVIEW ORGANIZATION REVIEWER TO CONSIDER.

WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FOUR (4) ITEMS BELOW ARE INCLUDED*)

1. **YES**, I have included this completed application form signed and dated.
2. **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;
3. **YES****, I have enclosed the letter from my health carrier or utilization review company that states:
(a) Their decision is final and that I have exhausted all internal review procedures; or
(b) They have waived the requirement to exhaust all of the health carrier's internal review procedures.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. You should contact Department of Insurance at the address and telephone number below.

4. **YES**, I have included a copy of my certificate of coverage, my insurance policy benefit booklet, which lists the benefits under my health benefit plan OR provided a copy of my member ID number.

*Call the Nebraska Department of Insurance at (877) 564-7323 if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

If you are requesting a standard external review, send all paperwork to:

Nebraska Department of Insurance
PO Box 82089
Lincoln, NE 68501-2089
www.doi.nebraska.gov

If you are requesting an expedited external review, call the Nebraska Department of Insurance before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

PHYSICIAN CERTIFICATION
EXPERIMENTAL/INVESTIGATIONAL DENIALS
(To Be Completed by Treating Physician)

I hereby certify that I am the treating physician for _____ (covered person's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements:

In my medical opinion as the Insured's treating physician, I hereby certify to the following:

(Please check all that apply) (NOTE: Requirements #1 - #3 below must all apply for the covered person to qualify for an external review).

1) The covered person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.

2) The covered person has a condition that qualifies under one or more of the following:

[please indicate which description(s) apply]:

Standard health care services or treatments have not been effective in improving the covered person's condition;

Standard health care services or treatments are not medically appropriate for the covered person; or

There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

3) The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.

4) The health care service or treatment recommended would be significantly less effective if not promptly initiated.

Explain: _____

5) It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments.

Explain: _____

6) Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional sheets as necessary)

Physician's Signature

Date

Appendix C – Independent Review Organization External Review Annual Report Form

Nebraska Department of Insurance
Independent Review Organization External Review Annual Report Form

<u>External Review Annual Summary for 20_____</u>		<u>Due by [insert date] for the previous calendar year.</u>	
<u>Each independent review organization (IRO) shall submit an annual report with information for each health carrier in the aggregate on external reviews performed in Nebraska only.</u>			
<u>1. IRO name:</u>		<u>Filing date:</u>	
<u>2. IRO license/ certification number:</u>			
<u>3. IRO address:</u>			
<u>City, State, ZIP:</u>			
<u>4. IRO Website:</u>			
<u>5. Name of person completing this form:</u>			
<u>Email:</u>	<u>Phone:</u>	<u>Fax:</u>	
<u>6. Person responsible for regulatory compliance and quality of external reviews:</u>			
<u>Name:</u>		<u>Title:</u>	
<u>7. Total number of requests for external review received from the Nebraska Department of Insurance during the reporting period:</u>			
<u>8. Number of standard external reviews:</u>			
<u>9. Average number of days IRO required to reach a final decision in standard reviews:</u>			
<u>10. Number of expedited reviews completed to a final decision:</u>			
<u>11. Average number of days IRO required to reach a final decision in expedited reviews:</u>			
<u>12. Number of medical necessity reviews decided in favor of the health carrier:</u>			
<u>Briefly list procedures denied:</u>	<hr/> <hr/>		

<u>13. Number of medical necessity reviews decided in favor of the covered person:</u>		
<u>Briefly list procedures approved:</u>	<hr/> <hr/>	
<u>14. Number of experimental/investigational reviews decided in favor of the health carrier:</u>		
<u>Briefly list procedures denied:</u>	<hr/> <hr/>	
<u>15. Number of experimental/investigational reviews decided in favor of the covered person:</u>		
<u>Briefly list procedures approved:</u>	<hr/> <hr/>	
<u>16. Number of reviews terminated as the result of a reconsideration by the health carrier:</u>		
<u>17. Number of reviews terminated by the covered person:</u>		
<u>18. Number of reviews declined due to possible conflict with</u>	<u>health carrier:</u>	
	<u>covered person:</u>	
	<u>health care provider:</u>	
<u>Describe possible conflicts(s) of interest:</u>	<hr/> <hr/>	
<u>19. Number of reviews declined due to other reasons not reflected in #18 above:</u>		
<u>Briefly list these reasons:</u>	<hr/> <hr/>	

Please submit to:
Nebraska Insurance Department
PO Box 28089
Lincoln, NE 68501-2089
www.doi.nebraska.gov

Appendix D – Model Health Carrier External Review Annual Report Form

Nebraska Department of Insurance
Health Carrier External Review Annual Report Form

<u>External Review Annual Summary for 20_____</u>		<u>Due by [insert date] for the previous calendar year.</u>	
<u>Each health carrier shall submit an annual report with the information in the aggregate by State and by type of health benefit plan.</u>			
<u>1. Health carrier name:</u>		<u>Filing date:</u>	
<u>2. Health carrier NAIC number:</u>			
<u>3. Health carrier address:</u>			
<u>City, State, ZIP:</u>			
<u>4. Health carrier website:</u>			
<u>5. Name of person completing this form:</u>			
<u>Email:</u>	<u>Phone:</u>	<u>Fax:</u>	
<u>6. Total number of requests for external review received from the Nebraska Department of Insurance during the reporting period:</u>			
<u>7. From the total number of external review requests provided in Question 6, the number of request determined eligible for a full external review.</u>			

Please submit to:
Nebraska Insurance Department
PO Box 28089
Lincoln, NE 68501-2089
www.doi.nebraska.gov