

West Virginia Offices of the Insurance Commissioner

GUIDE TO EXTERNAL REVIEW PROCESS

West Virginia law gives you the right to an external review when health care services are denied by your insurer on the basis that the services are not medically necessary or that the services are experimental or investigational.

WHAT IS AN EXTERNAL REVIEW?

- An external review is a request that you make to the state for an independent review of a denial of services by your insurer.
- Reviews are conducted by Independent Review Organizations (IROs) that are certified by the state and have a network of medical experts to review your health insurer's denial of services.
- You must complete the attached application and submit the application and all supporting documentation to the West Virginia Offices of the Insurance Commissioner to request an external review.

WHEN AM I ELIGIBLE FOR AN INDEPENDENT EXTERNAL REVIEW?

To be eligible for an independent external review, the following conditions must be met:

- The service that is the subject of the review request must be a covered benefit under the terms of your health insurance policy or at least something that could be a covered benefit under certain circumstances.
- Unless you meet the standard for expedited external review (see below), you must have completed the internal review process provided by your insurer and received a final decision from your insurer. However, this requirement need not be met if your insurer agrees in writing to submit its decision to an independent external review prior to completion of the internal review. In addition, if you have requested an internal review from your insurance company and have not received a decision from your insurer within the required time frames, you may proceed to an external review without having received a final decision from your insurer concerning the internal review. Even if you meet the standard for an expedited external review, you must continue to pursue all internal review options available to you while simultaneously proceeding with an expedited external review.
- You must submit your request for an independent external review to the West Virginia Offices of the Insurance Commissioner within 180 days of the date that you were first eligible to request a review. Normally, this will be the date of the health insurer's written, final denial decision on the internal review.

- Your request for an independent external review must not be for the purpose of pursuing a claim or allegation of health care provider malpractice, professional negligence, or other professional fault.

ARE THERE TYPES OF HEALTH INSURANCE FOR WHICH EXTERNAL REVIEW IS NOT AVAILABLE?

In general, an independent external review is available for most health insurance coverage. However, service denials relating to the following types of insurance coverage or health benefit programs are not reviewable under West Virginia's external review law:

- Medicaid, the West Virginia Children's Health Insurance Program (CHIP), Medicare, or services provided under these programs but through a contracted health insurer.
- All other government-sponsored health insurance or health services programs.
- Health benefit plans that are self-funded by employers.

CAN SOMEONE ELSE REPRESENT ME IN MY EXTERNAL REVIEW?

Yes, you may designate anyone you would like, including your treating health care provider, to represent you. To do so, you must fill out the section of the external review request form entitled "Appointment of Authorized Representative." You may revoke this authorization at any time.

HOW DO I REQUEST AN EXTERNAL REVIEW?

You may request an independent external review by filling out the attached "Request for Independent External Appeal of a Healthcare Decision" form and submitting it to the West Virginia Offices of the Insurance Commissioner together with the required supporting documentation. There is no cost to you for an external review.

Please be sure to include all of following with your request:

1. A completed external review request form.
2. A copy (if you received one) of the letter from your health insurer denying your request at the final level of their internal review process.
3. A photocopy of your insurance card or other evidence that you are insured by the health insurance company named in your external review request form.
4. A copy of your certificate of coverage or your insurance policy benefit booklet, which lists your benefits, if available.
5. Any medical records, statements from your treating health care providers, or other information that you would like the independent review organization to consider in reviewing your case, including lower level internal review decisions.

You may call the Offices of the Insurance Commissioner at 304-558-6279 ext. 1264, if you need help with the 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 independent external review.

If you are requesting a standard review, send completed forms and all attachments to:-

Independent External Review
West Virginia Offices of the Insurance Commissioner
PO Box 50540
Charleston, WV 25305-0540

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

WHAT IS THE STANDARD REVIEW PROCESS AND TIME FRAME?

- Within 7 business days after receiving your application form, the Offices of the Insurance Commissioner will complete a preliminary review to determine whether your request is complete and whether your case is eligible for an external review. If the request is not complete, the Offices of the Insurance Commissioner will inform you or your representative what information or documents are needed in order to process your application. You will have 10 days to supply the needed information or documents.
- If the request for external review is accepted, the Offices of the Insurance Commissioner will select and retain an independent review organization to conduct the review and notify you and the insurer.
- Within 10 days after receiving notice of the acceptance of the review, the insurer must provide you and the selected independent review organization with all information in its possession that is relevant to the review. If you would like, you or your representative will then have 10 more days to submit new or additional information to the independent review organization. During this 10-day period you or your representative may also present oral testimony via teleconference to the independent review organization and the insurer. However, oral testimony will be permitted only in cases where the Insurance Commissioner determines that it would not be feasible or appropriate to present only written information. If you or your representative would like to discuss your case with the independent review organization and your insurer in a telephone conference, you can request this by checking the appropriate box in the external review request form or by contacting the Offices of the Insurance Commissioner no later than 10 days after receiving notice of the acceptance of the review.

- At the end of this second 10-day period, the record of the case will be closed and no new information may be submitted. The independent review organization will then have
- 20 days to review all of the information and documents received, and render a decision upholding or reversing the determination of the insurer.

HOW DO I REQUEST AN EXPEDITED EXTERNAL REVIEW?

Because the standard process for handling an external review can take 45 days, expedited (fast-tracked) external review is available for those persons who would be significantly harmed by having to wait. You may request an expedited review by checking the appropriate box on the review request form and by having your treating health care provider complete the certification form that is attached to the review request form. Your health care provider must state that in their medical opinion adherence to the time frame for standard review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. Expedited reviews must be completed in 72 hours.

If you are pursuing an internal review with your insurer and anticipate that you may be requesting an external review on an expedited basis, please call the Offices of the Insurance Commissioner at 304-558-6279, Extension 1264, in advance, so that accommodations can be made to receive and process your request as quickly as possible.

WHAT HAPPENS WHEN AN INDEPENDENT REVIEW ORGANIZATION MAKES ITS DECISION?

- If your review was expedited, in most cases you and your health insurer will be notified of the independent review organization's decision immediately by telephone or fax. Written notification will follow.
- If your review was not expedited, you and your health insurer will be notified in writing.
- The decision of the independent review organization is binding on the health insurer and is enforceable by the West Virginia Offices of the Insurance Commissioner. The decision is binding on you as well, except that it does not prevent you from pursuing any other claim or remedy you may have through the courts under federal or state law.

If you have any questions, please contact the West Virginia Offices of the Insurance Commissioner at 304-558-6279, Extension 1264.

REQUEST FOR INDEPENDENT EXTERNAL REVIEW OF HEALTHCARE DECISION

ENROLLEE INFORMATION

Enrollee's Name: _____ Patient's Name: _____

Mailing Address: _____

Phone Numbers: Daytime (____) _____ Evening (____) _____

Enrollee's Insurance ID#: _____ Insurance Claim/Reference #: _____

INFORMATION ABOUT YOUR EMPLOYER

Employer's Name: _____

Employer's Phone Number: _____

Is the insurance you have through your employer a self-funded plan? _____ (If you are not certain please check with your employer).

INFORMATION ABOUT YOUR INSURANCE COVERAGE

Health Insurance Company's Name: _____

Insurer Mailing Address: _____

Insurer Telephone Number: (____) _____

Person at Health Insurance Company Involved with Your Appeal: _____

INFORMATION ABOUT YOUR TREATING HEALTHCARE PROVIDER

Name of Healthcare Provider: _____

Type of Provider: Medical Doctor or Other (please specify): _____

Provider Mailing Address: _____

Provider Phone Number: (____) _____

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 healthcare provider, to act as your personal representative. You may revoke this authorization at any time.

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

Signature of Enrollee (or legal representative)*

Date

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

Address of Authorized Representative: _____

Phone Numbers: Daytime (____) _____ Evening (____) _____

REQUEST FOR A TELEPHONE CONFERENCE**(Fill out this section only if you would like to request a telephone conference.)**

If you, your representative or your treating healthcare provider would like to discuss your case with the independent review organization and your insurer in a telephone conference, check the box below and explain why you think it is important to be allowed to speak about your case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. Your request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

Yes, I want a phone conference. My reason for requesting a phone conference is that:

HEALTH CARE DECISION IN DISPUTE

Describe your health insurer's decision in your own words. Include any information you have about the healthcare services, supplies or drugs being denied, including dates and names of healthcare providers. Explain why you disagree with the insurer. Attach additional pages if necessary. Also attach pertinent medical records and (if possible) a statement from your treating healthcare provider indicating why the disputed service, supply, or drug is medically necessary.

EXPEDITED REVIEW

You may request that your external appeal be handled on an expedited basis (see page 4). To complete this request, your treating healthcare provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

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

REQUEST FOR EXTERNAL REVIEW AND RELEASE OF MEDICAL RECORDS

I, _____, hereby request an external appeal and authorize my insurance company and my healthcare providers to release all relevant medical or treatment records to the independent review organization and the West Virginia Offices of the Insurance Commissioner. I understand that the independent review organization and the Insurance Commission will use this information to make a determination on my appeal and that the information will be kept confidential and not be released to anyone else. I understand that neither the Commissioner nor the external appeal entity may authorize services in excess of those covered by my healthcare plan. This release is valid for one year.

Signature of Enrollee (or legal representative)*

Date

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

WHAT TO SEND AND WHERE TO SEND IT

1. This completed application form signed and dated (see section above).
2. A copy of the letter from your health insurer denying your request at the second and final level of their internal appeals process.
3. A photocopy of your insurance card or other evidence that you are insured by the health insurance company named in this application.
4. A copy of your certificate of coverage or your insurance policy benefit booklet, which lists your benefits.
5. Any medical records, statements from your treating healthcare providers or other information that you would like the independent review organization to consider in reviewing your case.

Call the Insurance Commission at 304-558-6279 ext. 1264, if you need help with this application or if you would like information on alternative ways to complete your request for independent external review.

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

Independent External Review
West Virginia Offices of the Insurance Commissioner
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Charleston, WV 25305-0540

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

EXPEDITED APPEAL CERTIFICATION BY TREATING HEALTHCARE PROVIDER

(This form is for the purpose of providing the certification necessary to trigger an expedited review)

NOTE TO THE TREATING HEALTHCARE PROVIDER:

Patients can request an independent external appeal when an insurer has denied a healthcare service, supply or drug on the basis of a utilization review determination that the requested service, supply or drug does not meet the insurer's requirements for medical necessity, appropriateness, healthcare setting, and level of care or effectiveness. The West Virginia Insurance Commission oversees external appeals. The standard process for handling external review can take up to 45 days. Expedited review is available only if the patient's treating healthcare provider certified that adherence to the time frame for standard review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. Expedited review must be completed in at most 72 hours.

GENERAL INFORMATION:

Name of Treating Healthcare Provider: _____

Mailing Address: _____

Phone Number: (____) _____ Fax Number (____) _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

Patient's Health Insurer Member ID#: _____

CERTIFICATION:

I hereby certify that: I am a treating healthcare provider for _____ (hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard review of the patient's external appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that, for this reason, the patient's appeal of the denial by the patient's health insurer of requested medical services should be processed on an expedited basis.

Treating Healthcare Provider's Name (Please Print Legibly)

Signature

Date