Appealing a Denial From Your Health Benefit Plan – *A How-To Guide*

Your insurer denies a claim or coverage. What can you do?

Consumers have the right to know why an insurer denied a claim or terminated their coverage as well as the right to appeal such an **adverse benefit determination** (**ABD**).

What exactly is an ABD?

An **ABD** can involve a denial based on a determination by the insurer that a benefit (service, treatment, drug or device) is:

- Not medically necessary.
- Considered experimental/investigational.
- Excluded in the health plan or that the member did not follow the plan delivery rules.
- Denied because the member is not a plan participant.
- Denied because the plan was rescinded (withdrawn) because the member provided fraudulent information.

How does an insured appeal an ABD?

Appeals for **ABDs** must first be sent to the insurer to complete the **Internal Appeals** process, unless there is a medical urgency (see section regarding **Expedited Appeals**).

Internal appeals may be submitted by the insured or an individual, including a provider authorized to act on behalf of the covered person. Your insurer is required to respond within 30 days of receiving your appeal or three days if it is an expedited (medical emergency) appeal. See your plan document for appeal instructions. If, upon completion of the **internal appeals** process, your insurer continues to uphold its denial, you will have the opportunity to request an **impartial review** of the denial. The final denial letter from the insurer will have the addresses you need to further appeal as well as the timeframe. The type of denial you receive will determine what entity does the reevaluation.

Who is responsible for conducting an impartial review?

If your **ABD** is denied because:

- The benefit is not considered medically necessary/experimental/investigational, the appeal is sent to your insurer. The insurer will forward your appeal, including their records regarding your denial, to an **independent review entity** (**IRE***) who will make the determination.
- The benefit is limited or excluded in your health benefit plan. You will be directed by your insurer to write to the **Health Policy Utilization Review branch** of the **Kentucky Department of Insurance** for a coverage denial review and determination.
- A plan delivery rule is not followed or any other reason for an **ABD.** You will be directed by your insurer to write to the **Division of Consumer Protection** of the **Kentucky Department of Insurance** for a review and decision.

***What is an IRE?** An **IRE** is a company (not associated with your insurer) certified by the Kentucky Department of Insurance to perform medical external reviews. The **IRE** uses experts to review the denial and decide whether the request for coverage was medically necessary and covered under the plan. The **IRE** can take up to 45 days for a standard appeal, but only 72 hours to make a decision for an expedited or emergency appeal.

What urgent medical situations qualify for an expedited appeal?

An appeal for a denial of a benefit based on medical necessity shall be considered an expedited appeal when your doctor certifies in writing that one or more of the following apply:

- You are hospitalized.
- It is determined to be urgent care.
- The decision to deny coverage could seriously jeopardize your life, health or the ability to regain function.
- If in the opinion of your treating physician you would be subjected to severe pain that cannot be adequately managed without the care that is the subject of the review.
- The treatment is considered experimental/investigational and it is determined the treatment will be significantly less effective if not initiated promptly.

If my medical condition qualifies for an expedited appeal, do I have to complete the internal appeal process first?

The expedited internal and expedited external appeals can be reviewed at the same time.

Do these rights apply to me?

They only apply if you are **covered under a fully-insured plan issued in Kentucky.** These rights **do not** apply to all policies including Medicare supplements, student health plans connected with a university, or employer self-funded plans.

Is there additional help available?

Yes, if you have any questions regarding appealing an ABD or other health insurance matters regarding fully-insured health benefit plans issued in Kentucky, you may contact the **Division of Consumer Protection**.

800-595-6053 (Kentucky residents only) or 502-564-6034
Ask to speak to a consumer complaint investigator.

Kentucky Department of Insurance
Division of Consumer Protection
P.O. Box 517
Frankfort, KY 40602

Online: http://insurance.ky.gov/Home.aspx?Div_ID=4