April 11th, 2019

Attention: Jennifer Miner
State of Connecticut Insurance Department
PO Box 816
Hartford, CT 06142-0816

RE: Report required by Docket No. MC 18-79

Dear Ms. Miner,

In accordance with the January 14, 2019 Stipulation and Consent Order, Docket MC 18-79, OptumRx agreed to review its practices and procedures identified as concerns during the market conduct examination of its Utilization Review practices.

The purpose of this letter is to inform you OptumRx's Utilization Review staff has completed a review of its practices and procedures to ensure compliance with Connecticut Statutes. In order to address Stipulation 3 a-b, the following corrective actions were taken:

Stipulation 3(a): The examiners verified that one (1) determination not to certify care failed to provide proper Connecticut external appeal language.

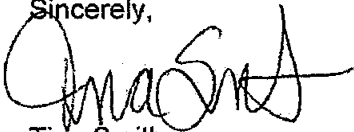
OptumRx Corrective Actions: The letter providing notification not to certify care has been updated to ensure it contains appropriate Connecticut external appeal language and has been placed into production. The current template is included.

Stipulation 3(b): The examiners verified that the Company did not have sufficient documentation for regulatory review.

OptumRx Corrective Actions: A letter providing notification not to certify care has been created for requests for medication and/or diagnosis that are not a covered benefit and excluded from coverage in accordance with the terms and conditions of the member's plan benefit. We anticipate that this template will be implemented by May 23, 2019. The approved template is included.

We trust our letter and supporting documents will satisfy your requirements in the Department's Stipulation. If you require further detail in this matter, please do not hesitate to contact me.

Sincerely,



Tina Smith
Manager, Public and Regulatory Affairs – External Audit Management OptumRx
2300 Main Street, Irvine, CA, 92614
949.988.6185

OPTUMRx®

OptumRx Prior Authorization Department
CA106-0286,
3515 Harbor Blvd.,
Costa Mesa, CA 92626

PROOF PROOF

DATE

RE: Coverage Review Denial
Patient: MBNAM
Physician:
File ID: PANMBR

MBNAM
MBADDR1
MBADDR2
MEMCITY, RI MEMZIP

Date of Request:
Date of Decision: DATE

Dear MBNAM:

若需要中文协助，请拨打 1-800-711-4555.
Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih 1-800-711-4555.
Para obtener asistencia en Español, llame al 1-800-711-4555.
Para sa tulong sa Tagalog, tawagan ang 1-800-711-4555.

This letter is to inform you that we are unable to approve the request for BRNDNAM made by your physician. The basis for the request does not meet the plan coverage conditions for the following reason(s).

Your UnitedHealthcare prescription drug program benefits are determined by OptumRx. For certain drugs, more information is needed to determine coverage eligibility. In these cases, your physician must supply the additional information needed to determine if the coverage conditions have been met. The information your physician provided was reviewed and a letter was sent to your physician informing him or her of the decision. Your physician can discuss this denial with a pharmacist by calling 1-800-711-4555.

We encourage you to discuss this decision with your physician. If you choose to receive this drug, you may be responsible for paying an additional cost or copayment.

You, your physician or your health care professional have the right to request the information we reviewed to make this coverage decision free-of-charge. This includes reasonable access to and copies of all documents, records, communications, and other relevant information and evidence regarding your benefit determination. You also have the right to receive, upon written request and at no charge, the internal rule, guideline, or clinical criteria for BRNDNAM coverage. Diagnosis and Treatment codes (if applicable) are available upon request. Members may access a secure website by logging into myuhc.com to review a variety of information including clinical review criteria used to make determinations. UnitedHealthcare's Administrative and Medical Policies are available on our website at www.unitedhealthcareonline.com.

Please note that the information in this letter is not a treatment decision. Treatment decisions are made between you and your physician. Coverage for these services is subject to the terms and conditions of your health benefit plan including exclusions, limitations, conditions and patient eligibility. You are responsible for deductibles, coinsurance, copayments and items not covered by the plan. Coverage will not be provided for services above the plan's limit, unless your plan states otherwise and where applicable and as permitted by laws. For example, annual dollar limits are not permitted on Essential Health Benefits as defined and pursuant to the Affordable Care Act.

PROOF PROOF

If you would like your physician or health care professional to discuss this case with a clinical reviewer, he or she may call the UnitedHealthcare Health Care Professional Services Line at 1-800-711-4555. The outcome of this peer-to peer review does not count as the appeal.

If you don't agree with our decision, you or your authorized representative has the right to an appeal.

Typically, you have 180 days from your receipt of this letter to submit an appeal request. If you don't comply with these requirements, you may forfeit your right to challenge a denial or rejection. Inquiring about the appeals process does not change the time frame to submit an appeal. When we receive an appeal request, we review it and notify you within 30 calendar days for services not yet received and within 60 calendar days for services already received. We will notify you in writing of our decision.

The following information is helpful to us when reviewing an appeal:

- A written appeal request asking us to reconsider our decision
- The specific coverage decision you would like us to review
- An explanation of why the requested service should be considered for coverage
- Any additional information that supports your position, including narratives, letters and treatment notes from your physician or health care professional.
- You or your representative have the right to ask your physician or health care professional for this information.
- A copy of this letter

Mail or fax this information to:

UnitedHealthcare Appeals and Grievances Unit
P.O. Box 30573
Salt Lake City, UT 84130-0573
Fax: 1-801-938-2100
Urgent appeal fax: 1-801-994-1058

The person who reviews your appeal will not be the person, or a subordinate of that person, who made the original decision.

UHS can provide you assistance to prepare an appeal of an adverse benefit determination. To request assistance, please call Customer Care at the toll-free number listed on your member ID card or 1-800-711-4555.

<u>Urgent appeals</u>

An urgent appeal may be available to you if the patient's medical condition is such that the time needed to complete a standard appeal could seriously jeopardize the patient's life, health or ability to regain maximum function, or, if in the opinion of a health care professional with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the heath care service or treatment being requested. You have two options available to you: an internal urgent appeal review or an external urgent appeal review. These options are not available for health care services that have already been provided.

Internal Urgent Appeal Review: You have the option to request an urgent internal appeal review by UnitedHealthcare. If we confirm that an urgent appeal is needed, we will complete our review within 72 hours from receipt of the appeal.

To request an urgent appeal:

Urgent appeal fax: 1-801-994-1058

Telephone: Call Customer Care at the toll-free number listed on your member ID card.
You may request an urgent external review at the same time as requesting an urgent internal appeal for urgent care.

External Urgent Appeal Review: You also have the option to request review by an independent review organization. You must first exhaust UnitedHealthcare's internal appeal process UNLESS you meet one of the following circumstances below.

Bypassing the Internal Appeal Process:

If any of the following circumstances apply, you may be able to bypass UnitedHealthcare's internal appeal process and file a request for an urgent external review with the Connecticut Insurance Department:

1. **you have a medical condition for which the time period for completion of an urgent internal appeal would seriously jeapardize your life or health or would jeopardize your ability to regain maximum function; or**
2. **the adverse determination involves a denial of coverage based on a determination that the recommended or the requested health care service or treatment is experimental or investigational and your treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiatied; or**
3. **we have failed to strictly adhere to the requirements under the law with respect to making utilization review and benefit determinations of a benefit request or claim or with respect to receiving and resolving appeals/grievances**

The urgent appeal application must be filed with the Connecticut Insurance Department immediately following receipt of UnitedHealthcare's initial adverse determination or at any time during the adverse appeal determination.

If the expedited appeal is not accepted on an urgent basis, and you have not previously exhausted the internal appeals process, you may resume the internal appeal process until the internal appeals process is exhausted.

If the internal appeals process was previously exhausted, your rejected urgent appeal will automatically be eligible for consideration for standard appeal. You are not required to submit a new application.

If you choose to file an urgent external appeal, you must submit your appeal on the "Expedited Request Form" and "Request for External Appeal" application form available on the Department of Insurance website. You may also request a copy of the forms by calling Customer Care at the toll-free number listed on your member ID card.

You may contact the Commissioner's Office or the Office of the Healthcare Advocate at any time for assistance or when you believe you have been given erroneous information at:

PROOF

State of Connecticut Insurance Department
Commissioner's Office
P.O. Box 816
Hartford, CT 06142-0816
Telephone: 1-860-297-3801
Toll-Free: 1-800-203-3447
Email: cid.admin@ct.gov

PROOF

Or

State of Connecticut
Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
Phone: 1-866-HMO-4446
Fax: 1-860-297-3992
Email: Healthcare.advocate@ct.gov

The following language is required by the Connecticut Insurance Department:

i. such appeals are sometimes successful,
ii. such covered person or covered person's authorized representative may benefit from free assistance from the Office of the Healthcare Advocate, which can assist such covered person or covered person's authorized representative with the filing of a grievance pursuant to 42 USC 300gg-93, as amended from time to time, or from the Division of Consumer Affairs within the Insurance Department,
iii. such covered person or covered person's authorized representative is entitled and encouraged to submit supporting documentation for the health carrier's consideration during the review of an adverse determination, including narratives from such covered person or covered person's authorized representative and letters and treatment notes from such covered person's health care professional, and
iv. such covered person or covered person's authorized representative has the right to ask such covered person's health care professional for such letters or treatment notes.

What this means to you

1. You have the right to be represented by someone else regarding this decision. To have someone else represent you, call us at the toll-free number on your member ID card and we will send you the form needed to designate another representative.
2. You or your representative may accept our decision as it stands.
3. You or your representative may choose to file an appeal, such appeals sometimes succeed. You or your representative may benefit from free assistance from the State of Connecticut Insurance Department Consumer Affairs Division or the Office of Healthcare Advocate, which can help with this request.

Availability of Consumer Assistance/Ombudsman Services

There may be other resources available to help you understand the appeals process. If your plan is governed by ERISA, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you can contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789. Your state consumer assistance program may also be able to assist you at:

State of Connecticut
Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
Phone: 1-866-HMO-4446

Fax: 1-860-297-3992
Email: Healthcare.advocate@ct.gov

Other member rights
If your plan falls under the standards established by the Employee Retirement Income Security Act (ERISA), and you have exhausted appeals under the plan, you may also have the right to file a civil action under ERISA in a court of competent jurisdiction.

If you have questions about this letter, please call Customer Care at the toll-free number listed on your member ID card.

Sincerely,

OptumRx

Visit myuhc.com® to view your claims and Explanation of Benefits statements, look up benefits, update account information, find a physician or facility or learn more about healthy living. Registration is easy and gives you access to useful tools and information to help you take charge of your health and health care.

PROOF PROOF

PROOF PROOF

Appeal FAX COVER SHEET

TO: United Healthcare Pharmacy Appeals	Date:
Fax Number:	Patient Name:
	From:
	Fax Number:
	Phone Number:

Comments:

To submit an Appeal, please fax this cover sheet to the appropriate fax number along with:

1. Letter of Appeal
2. Original denial information
3. Applicable medical records

To submit a **Standard** Appeal: Fax number - (801) 994-1345

To submit an **Urgent/Expedited** Appeal: Fax number - (801) 994-1058

Please include description of urgency

Please Note: Generally, an urgent or expedited appeal is available when the patient's condition is such that applying standard time frames for deciding the appeal could jeopardize the patient's life, health, or ability to regain maximum function, or subject the patient to severe pain.

It is very important that you submit this form to one of the fax numbers above. Submission of the form to another address may result in a delay in our receipt and resolution of the appeal.

CONFIDENTIALITYNOTICE: Information accompanying this facsimile is considered to be United Healthcare's confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it is addressed. Such recipient shall be liable for using and protecting United Healthcare's information from further disclosure or misuse, consistent with applicable contract and/or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties. If you believe you received this information in error, please contact the sender immediately.

NOTICE OF DENIAL

[Letter Creation Date]

[Member Name]
[Member Address]

RE: Member Name: **[Member Name]**
Plan Name: **[UnitedHealthcare]**
Group Name: **[Group Name]**
Identification Number: **[Member ID]**
Case Number: **[Case Number]**
Doctor Name: [**Prescriber Name]**
Medication Name: [**Drug Name]**
Denial Code and Description: **[Reason Code]** see description below

Dear [Member Name],

On behalf of [UnitedHealthcare], [OptumRx®] is responsible for reviewing pharmacy services provided to [UnitedHealthcare] members. We received a request from your prescriber for coverage of [Drug Name, Strength, and Formulation], on [Date of Request].

We reviewed all of the information you and/or your doctor sent to us. Unfortunately, we must deny coverage for [Drug Name].

Why was my request denied?
These are the principal reasons for the determination. We reviewed the information provided by you and/or your doctor. We also reviewed the payment policies and the limitations, exclusions, and other terms and conditions of your plan benefits, including any appropriate Pharmacy Schedule of Benefits and Riders. This request was denied because you did not meet the following criteria:

For ***coverage denials (Medical Nec)*** *on drugs requiring PA, ST, QL &* ***Tier Exception*** *insert the following text:* Based on the information provided, you do not meet the established medication-specific criteria or guidelines for [Drug Name] at this time. [**Insert Decision Notes** The following clinical guideline was used to support this denial. This clinical guideline/rule is available free upon request and also at your plan's website noted below.]

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*For **off-label denials**, insert the following text:* The requested medication is not a covered benefit. The U.S. Food and Drug Administration (FDA) has not approved this medication for use in your condition, and the clinical information submitted by your doctor does not meet the criteria established for off-label drug use, in accordance with the terms and conditions of your plan benefit. **[Insert Decision Notes** The following clinical guideline was used to support this denial. This clinical guideline/rule is available free upon request and also at your plan's website noted below.]
*For **non-formulary denials**, insert the following text:* The requested medication is not covered because it is not on the listing or formulary of approved drugs for your plan benefit. Please discuss alternative drug therapy with your doctor. **[Insert Decision Notes]**
*For **plan exclusion denials**,(Excluded Medications, UHC Plan Exclusions & UHC BenefitMax) insert the following text:* The requested medication and/or diagnosis are not a covered benefit and excluded from coverage in accordance with the terms and conditions of your plan benefit. Therefore, the request has been administratively denied. **[Insert Decision Notes]**

The reason(s) [OptumRx] did not approve this medication can be found above. This denial is based on the [Drug Name] drug coverage policy, in addition to any supplementary information you or your prescriber may have submitted.

Because the claim(s) for this medication was processed according to the above plan term(s), we unfortunately cannot approve your request. Our decision does not reflect any view about the medical appropriateness of this coverage. Only you and your doctor can make decisions about your care. We notified your doctor about this denial and s/he has the option to discuss this with a physician or pharmacist reviewer.

How can I obtain the material(s) used to review this request?
You have the right to ask for and receive (free of charge) access to, and copies of all documents, records and other information related to your case, as well as copies of any internal rule, guideline or protocol that we used to make this denial decision. Internal rules, guidelines and protocols are also accessible at [www.uhcprovider.com]. You also have the right to ask for and receive (free of charge) an explanation of the scientific or clinical judgment that we relied on in making this denial decision. Diagnosis and Treatment codes and their corresponding meanings (if applicable) are available upon request.

To request copies, please call us at [1-800-711-4555], or write to the address below:

[OptumRx

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c/o Prior Authorization Guidelines
P.O. Box 25183
Santa Ana, CA 92799]

We honor your request within [thirty (30) calendar days] after we receive it. Please know that your request will not change the time frame in which you have to file any appeal request.

{Suppress for Tier Exceptions}
{Please note that this decision only affects whether your prescription plan will pay for this medication. Only you and your prescriber can decide what is best for you and your treatment. You may still buy this medication (at full cost) at your local pharmacy.}

What if my prescriber wants to discuss this decision with a peer?
The provider or representative of his/her office has the right to a conference with a clinical peer upon request to discuss the above decision. This conference will not be considered a grievance of the adverse determination. To speak with someone concerning this matter, please call [OptumRx] at [1-800-711-4555].

APPEAL PROCESS

What if I don't agree with this decision?
You have the right to appeal any decision that denies payment for an item or service (in whole or in part). You may also submit written comments, documents or other information relevant to the appeal.

If you are not satisfied with this decision, you or your authorized representative may request an appeal. Your request for appeal must be submitted within [180 calendar days] after receiving this notice.

An urgent appeal may be available if your health is considered to be in serious jeopardy or if your doctor thinks that you may experience pain that cannot be effectively controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an urgent appeal. (Please see "How do I file an appeal?" further in this notice for details on filing an urgent appeal.)

Who may file an appeal?
You or your provider, acting on your behalf with your consent, may file an appeal.

How do I file an appeal?
You have the right to appeal this medication coverage decision within [180 calendar days] from the date of this denial notification. You or your prescriber can get appeals information, including independent appeal rights, by calling [the toll-free member number listed on your health plan ID card]. You can also review your plan's prescription drug benefit information or contact your benefits office for more detailed information regarding the appeal process.

Your request for an appeal will not affect other benefits available under your plan benefits. If you want to appeal, please send a request, along with any written comments, documents, records, or information that supports the coverage of the medication, to:

[UnitedHealthcare Appeals

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[P.O. Box 30573
Salt Lake City, UT 84130-0573]

Phone: [Please call the toll-free member number listed on your health plan ID card.]
Fax: [1-801-938-2100]

In addition, *[UnitedHealthcare Appeals]* can provide you with assistance in filing your appeal. You may contact the Appeals Coordinator at *[the toll-free member number listed on your health plan ID card]*.

We will complete your appeal review no later than [15 calendar days] following your request being received.

{Include For Non-Formulary Exception Request Denial}
{Exception Requests Appeal for Coverage of Clinically Appropriate Non-Formulary Drugs
If your denial is for a non-formulary exception request, the following timeframes will apply:

Standard (non-expedited) requests – we will notify you, your authorized representative, and the prescriber of the determination no later than [72 hours] after receipt of the request. If the request is granted, the excepted drug will be covered for the duration of the prescription, including refills.

Expedited requests due to exigent circumstances -- we will notify you, your authorized representative, and the prescriber of the determination no later than [24 hours] after receipt of the request. If the request is granted, the excepted drug will be covered throughout the exigency. (Exigent circumstance is when you are suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.)}

If you believe your situation is urgent, you may request an urgent appeal by calling [UnitedHealthcare] at [the toll-free member number listed on your health plan ID card]. If your situation meets the definition of urgent under the law, your review will be completed within [72 hours].

{Suppress for Plan Exclusion Denials}
{Bypassing [UnitedHealthcare's] Expedited External Review:

If any of the following circumstances apply, you may be able to bypass [UnitedHealthcare's] internal appeal/grievance process and file a request for an expedited external review with the Connecticut Insurance Department:

1. You have a medical condition for which the time period for completion of an expedited internal appeal/grievance would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
2. The adverse determination involves a denial of coverage based on a determination that the recommended or the requested health care service or treatment is experimental or investigational and your treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; or

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3. We have failed to strictly adhere to the requirements under the law with respect to making utilization review and benefit determinations of a benefit request or claim or with respect to receiving and resolving appeals/grievances.

You, or your provider acting on your behalf with your consent, may also simultaneously file a request for an internal appeal/grievance and an expedited external review with the Connecticut Insurance Department Consumer Affairs Unit. You can request an external review if you meet any of the above three requirements, otherwise you must wait until denial of the [UnitedHealthcare] first level of internal appeal. Please contact the State of Connecticut Insurance Department for more information. Their address is: **Connecticut Insurance Department, P.O. Box 816, Hartford, CT 06142-0816 or call 860-297-3910 or 1-800-203-3447.**}

If (you) the covered person or the covered person's authorized representative chooses to file a grievance of an adverse determination:

1. Such appeals are sometimes successful,
2. Such covered person or covered person's authorized representative may benefit from free assistance from the Customer Services Division, which can assist such covered person or covered person's authorized representative with the filing of a grievance pursuant to 42 USC 300gg-93, as amended from time to time, or from the Division of Consumer Affairs within the Insurance Department,
3. Such covered person or covered person's authorized representative is entitled and encouraged to submit supporting documentation for the health carrier's consideration during the review of an adverse determination, including narratives from such covered person or covered person's authorized representative and letters and treatment notes from such covered person's health care professional, and
4. Such covered person or covered person's authorized representative has the right to ask such covered person's health care professional for such letters or treatment notes, which are encouraged to be submitted for consideration during the review of an adverse determination.

{Include for Plan Exclusion Denials Only}

{Please not that by CT law, if the services are denied because they are not a covered benefit under your plan, or your benefits for these services have reached their limit, then the appeal process is concluded after your final internal appeal and no further appeal or External Review is allowed under the plan.}

{Suppress External Review Process for Plan Exclusion Denials Only}

EXTERNAL REVIEW PROCESS

What is an external review?

An external review is a complete re-examination of your case by an independent review organization (IRO).

Who may file an external review?

You or your provider, acting on your behalf with your consent, or your authorized representative may request an external review.

How do I file an external review?

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Once you have exhausted [UnitedHealthcare's] internal appeal process, you may file a request for External Review. Individuals who request an urgent care appeal do not need to complete their [UnitedHealthcare's] internal appeal process prior to requesting an external review.

You can request an external review if you meet any of the three requirements noted in "Bypassing [UnitedHealthcare's] Internal Appeal/Grievance Review Process," otherwise you must wait until denial of the [UnitedHealthcare's] first level of internal appeal. Please contact the State of Connecticut Insurance Department for more information. Their address is: **Connecticut Insurance Department, P.O. Box 816, Hartford, CT 06142-0816 or call 1-860-297-3910 or 1-800-203-3447.**

OTHER RESOURCES TO HELP YOU (EMPLOYER GROUP PLAN)

[If member state of residence has a CAP Contact]
Availability of Consumer Assistance/Ombudsman Services
There may be other resources available to help you understand the ("appeals" or "grievance" process.

Your state consumer assistance program may also be able to assist you at:

[Insert contact information]

If you are not satisfied with this decision, you or your authorized representative may contact the State of Connecticut Insurance Department Commissioner's Office to request its review of this decision:

Connecticut Department of Insurance
Customer Services Division
100 Market Street
Hartford, CT 06103

Consumer Services:
(800) 203-3447
http://www.ct.gov/cid

If you have any additional questions, please call us toll-free at [OptumRx Customer/Member Services Phone Number].

Sincerely,

[OptumRx]

cc: [Prescriber Name]

This document and others if attached contain information from OptumRx that is proprietary, confidential and/or may contain protected health information (PHI). We are required to safeguard PHI by applicable law. The information in this document is for the sole use of the person(s) or company named above. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately and return the document(s) by mail to OptumRx Privacy Office, 17900 Von Karman, M/S CA016-0203, Irvine, CA 92614.**

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Nondiscrimination Notice and Access to Communication Services

OptumRx and its family of affiliated Optum companies does not discriminate on the basis of race, color, national origin, age, disability, or sex in its health programs or activities.

We provide assistance free of charge to people with disabilities or whose primary language is not English. To request a document in another format such as large print or to get language assistance such as a qualified interpreter, please call the number located on the back of your prescription ID card, TTY 711. Representatives are available 24 hours a day, seven days a week.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to

OptumRx Civil Rights Coordinator
11000 Optum Circle
Eden Prairie, MN 55344
Phone: 1-800-562-6223, TTY 711
Fax: 855-351-5495
Email: **Optum_Civil_Rights@Optum.com**

If you need help filing a complaint, please call the number located on the back of your prescription ID card, TTY 711. Representatives are available 24 hours a day, seven days a week. You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone, or by mail:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

This information is available in other formats like large print. To ask for another format, please call the telephone number listed on your health plan ID card.

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Multi-language Interpreter Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

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ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

□□□□□ □□□: □□□ आप □□□□□□ **(Hindi)** □□□□□ □□, □□□□ □□□□ □□□□□□□ □□□□□□, □□:□□□□□□ □□□□□□□ □□□□ □□□□□□ □□□□ □□□□□□ □□□□ □□ □□□□□□□□□ □□□-□□□□ □□□ □□□□ पर □□□ □□□□□

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍:
ប្រសិនអ្នកនិយាយ**ភាសាខ្មែរ**(Khmer)ស្រាវជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'íígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee néého zinígíí bine'dę́ę́' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

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STATE OF CONNECTICUT
Insurance Department
Appeals & External Review Guide

RIGHTS

GUIDANCE

APPEAL

ASSISTANCE

October 2013

A Consumer's Guide to Appealing Health Insurance Denials

Introduction

This guide is designed to assist consumers who have been denied coverage or reimbursement for services under their health insurance plan. This overview provides information on the appeal process through your insurance company, as well as information on filing for an independent review through the State of Connecticut External Review Program.

Why was my request denied?

When you receive a denial notice, your insurance company is required to disclose to you the reason for the denial. These reasons might include:

- Services are deemed not "medically necessary"
- Services are no longer needed in that health care setting or level of care
- The effectiveness of the health care services has not been proven
- Services are considered experimental/investigational for treatment of this condition

It is important to understand the reason why your request for services has been denied by your insurance company. This will enable you to work with your doctor to obtain medical documentation to support your need for these services.

What are my rights as a consumer if I am denied services?

If you receive a denial based on the reasons above, you have the right to appeal this decision to your insurance company for another review(s).

If you are unsuccessful, you have the additional right to have this decision reviewed by an Independent Review Organization which is not connected to your insurance company by applying for the State of Connecticut External Review Program.

How do I appeal this denial with my insurance company (Internal Appeal)?

When your insurance company sends you notification that they have denied your pre-authorization or claims request, they must also inform you of your right to appeal this decision.

If you disagree with the decision of the insurance company, you have 180 days to file a grievance (appeal) of this decision. Each denial letter from an insurance company will give you very specific information on how to file an appeal and where this request should be sent.

If you choose to file an appeal, it is important that you follow the appeals instructions printed in the denial letter and act within the designated timeframes. If you don't file your appeal within these timeframes, you lose your rights to further review of the decision.

What information is my insurance company required to provide upon request?

To assist you in your appeal, you are entitled to request from your insurance company "free of charge" reasonable access to, and copies of all documents, records and other information relevant to your request for services. Information on how to request this information is printed in your denial letter.

What information is helpful to submit to my insurance company when filing an appeal?

It is important that you send supporting documentation to your insurance company with your appeal. You should be aware that you have the right to ask your treating physician to provide information that would be helpful to your appeal.

Important information to submit with your appeal might include:

- A letter of support from your treating physician indicating the medical reasons that the requested service should be approved
- Treatment notes from your treating physician that provide information on the medical care provided to you
- The results of any relevant tests or procedures related to the requested service
- Your own personal narrative or the narrative of an authorized representative describing the need for the requested service
- For experimental or investigational treatments, any current medical literature or studies documenting the medical efficacy of the requested services

Where may I receive free assistance in preparing my appeal?

You have the right to assistance in filing your appeal from the following State agencies:

Connecticut Insurance Department
P.O. Box 816
Hartford CT 06142
Consumer Affairs Unit - 800-203-3447
www.ct.gov/cid
cid.ca@ct.gov

Office of the Healthcare Advocate
P.O. Box 1543
Hartford CT 06144
866-466-4446
www.ct.gov/oha
Healthcare.advocate@ct.gov

What should I do if my appeal for services is of an urgent nature?

All insurance companies are required to have a process in place for expedited handling of urgent care appeal requests.

Urgent care appeal requests are conducted when you or your provider believes that:

- Standard timeframes for processing of a standard appeal would seriously jeopardize your life or health or your ability to regain maximum function; or
- Your treating physician feels that you would experience severe pain that cannot be adequately managed without these services; or
- Your request is for a behavioral health service described below in Table 1.

Table 1

Urgent Care Review of Specified Behavioral Health Services

If you are seeking services related to a substance use disorder or co-occurring mental disorder, your request will automatically be handled as an urgent care appeal. For services related to a mental disorder, your request will be considered urgent for the following services:

- *Inpatient Services*
- *Partial Hospitalization*
- *Residential Treatment*
- *Intensive Outpatient Service necessary to avoid an inpatient setting*

Please Note: Urgent care appeals are not available when services have already been rendered.

Who reviews my appeal at the insurance company?

Your insurance company is required to select a clinical reviewer who is a physician or health care professional in the same or similar specialty as typically manages your medical condition, procedure or treatment. For appeals of certain behavioral health services as shown in Table 1, insurance companies are required to have a reviewer with a specified board certification in a relevant specialty to the requested services.

What if my appeal to the insurance company for a reconsideration of their initial denial is unsuccessful?

Check the appeal determination letter from your insurance company to see if there are any additional appeals remaining with the insurance company. Some insurance companies have one level of internal appeal, while others have a second level internal appeal, which is often voluntary.

Once you have exhausted your insurance company's internal appeal process, you may file a request for External Review. Individuals who request an urgent care appeal do not need to complete their insurance company's internal appeal process prior to requesting an external review.

If my request is still denied and I have exhausted all my appeals with the insurance company, what are my rights to External Review?

Once you have exhausted all the mandatory internal appeals with your insurance company, you may file for an external review. For urgent care requests, you may submit for External Review immediately after any insurance company denial.

The External Review process is a protection for consumers who disagree with the determination of their insurance company. The Connecticut Insurance Department contracts with independent review organizations to conduct an independent and impartial review of the request for services to determine if the correct claims determination was made by the insurance company.

The decision of the independent review organization is binding on all parties. This means that if the independent review organization finds in favor of the applicant, then the insurance company is required to approve the services that were previously denied.

How do I know if I qualify for an External Review?

To be eligible for Connecticut's External Review you must meet the following criteria:

1. You must have exhausted the internal appeal requirements of your plan*.

Your letter from the company will state that this is the "final determination".

** Urgent care requests are exempt from this requirement.*

2. The denial reason must qualify you for an external review.

If the denial reason listed in your final determination letter is "not medically necessary", experimental/investigational, eligibility denial, or a rescission of your policy, then your denial qualifies for consideration under the external review program.

3. The services you request must be covered under your plan.

Requests for External Review must be for services that are provided under your insurance plan.

<u>Please note</u>: If the services are denied because they are not a covered benefit under your plan, or your benefits for these services have reached their limit, then the grievance process is concluded after your final internal appeal and no further appeal or External Review is allowed under the plan.

4. You must file your complete request within 120 days of the final determination letter.

It is important to file within the timeframes so that you retain your right to further review of this denial.

5. Your coverage must be provided by a fully insured plan issued in the State of Connecticut or you must be covered through the State of Connecticut employee plan.

Self-insured plans are not included in the Connecticut External Review Program. Your employer can tell you if your plan is "self-insured" and direct you to any grievance and external review options available under that plan.

How can I qualify for an expedited External review?

The External Review Program provides for expedited handling of urgent care External Review requests.

Expedited external review requests are conducted when your provider certifies that:

- Standard timeframes for processing of a standard External Review would seriously jeopardize your life or health or your ability to regain maximum function; or
- Your treating physician feels that you would experience severe pain that cannot be adequately managed without these services; or
- If you are seeking services related to a substance use disorder or a co-occurring mental disorder, your request will automatically be handled as an expedited External Review. For services related to a mental disorder, your request will be expedited for the following services: Inpatient Service, Partial Hospitalization, Residential Treatment or Intensive Outpatient Service necessary to avoid an inpatient setting. See Table 1.

__Please Note__: Expedited External Reviews are not available when services have already been rendered.

What do I need to submit to request an External Review?

The External Review application has an "External Review Checklist" to ensure that you submit all information that is necessary for acceptance of your request. The required items to initiate an External Review are:

- External Review Application
- Copy of your medical insurance ID card*
- Copy of the Final Denial Letter from your insurance company. For expedited reviews, attach the last denial letter received.*
- $25 Filing Fee or a Request for Waiver of the Filing Fee based on Federal Poverty Level Table 2 below.

** Your insurance company is required to provide you with a free copy if you do not have these items.*

For expedited requests, your medical provider must complete a Physician Certification Form attesting to the need for an expedited process. However, certain behavioral health services as shown in Table 1 are automatically reviewed on an expedited basis and do not require a physician signature.

For external reviews involving a denial of services as Experimental/Investigational service, your medical provider must complete a Physician Certification Form attesting to the recommended experimental treatment.

What if I can't afford the $25 Filing Fee?

The filing fee will be waived by the Insurance Department for any indigent individual or those individuals who are unable to pay the $25 fee. An indigent individual means an individual whose adjusted gross income (AGI) is less than 200% of the federal poverty level as shown in Table 2 below.

In addition, the filing fee is waived for any covered person who has already paid the maximum fee of $75 per calendar year.

Table 2
Guidelines for Waiver of Filing Fee

Number of family members	*200% of 2013 Federal Poverty Level*
1	$22,980
2	$31,020
3	$39,060
4	$47,100
5	$55,140
6	$63,180
7	$71,220
8	$79,260 *

** Add $4,020 for each additional family member*

What medical information should I submit with my External Review?

Along with your request for an External Review, you have the opportunity to submit additional medical documentation that has not been submitted previously. Providing complete medical documentation gives you the best opportunity to have a thorough and comprehensive review of your request for services.

Please Note: All previously submitted medical information submitted by you or your treating physician to the insurance company, as well as all documents or information that your insurance company considered in making their determination, will automatically be sent to the Independent Review Organization for consideration in the external review.

You should be aware that you have the right to ask your treating physician to provide new information that would be helpful to your external review. This might include:

- A letter of support from your treating physician indicating the medical reasons that the requested service should be approved
- Treatment notes from your treating physician that provide information on the medical care provided to you to date
- The results of any relevant tests or procedures related to the requested service
- Your own personal narrative or the narrative of an authorized representative describing the need for the requested service
- For experimental or investigational treatments, any current medical literature or studies documenting the medical efficacy of the requested services

Who will review my External Review?

The Insurance Department contracts with Independent Review Organizations (IRO) to perform all External Reviews. Your External Review will be assigned to one of these contracted IROs.

IROs are independent organizations with no affiliation with your insurance company. This ensures that you receive an impartial review.

IROs are required to assign an individual clinical reviewer to your External Review who holds a license in the same or similar specialty as typically manages the medical condition under review. For appeals of certain behavioral health services as shown in Table 1, IROs are required to have a reviewer with a specified board certification in a relevant specialty to the requested services.

The clinical reviewer will review the following information:

- Any documents or information that your health carrier used in making their determination
- Submitted medical records
- Consulting reports submitted by appropriate health care professionals
- Current practice guidelines and evidence based standards for treatment of your condition
- Clinical review criteria used by your health plan
- Any other material submitted in support of your appeal

The IRO will conduct an impartial review and make a determination on whether the medical services are medically necessary and should be approved, or if the review involves an eligibility or rescission determination by the health plan, whether the insurance company decision should be reversed.

The decision of the IRO is independent of the insurance company and the State of Connecticut Insurance Department, and the decision is binding.

How soon can I expect a decision on my External Review?

When your External Review request is assigned to the Independent Review Organization (IRO), your health plan will automatically transfer your appeals file to the IRO for inclusion in their review. The IRO's clinical reviewer will then conduct an independent review.

Based on the type of External Review request, the IRO will notify you of their decision within the timeframes as shown in Table 3 below.

Table 3
Timeframes for External Review Decisions

Standard External Review	45 Days
Experimental/Investigational Reviews	20 Days
Expedited External Reviews	
▪ Specified Behavioral Health Reviews	24 Hours
▪ Experimental/Investigational	5 Days
▪ All Others	72 Hours

How will I be notified of the IRO's decision?

The IRO will make one of the following decisions:

- Uphold the denial of services
- Reverse the denial of services (overturn the denial)
- Revise the denial of services (partially overturn the denial)

You will be notified directly by the IRO of their decision and a copy of their decision will also be shared with the Insurance Department, the insurance company and your treating physician. If your determination results in a "reverse" or "revise" decision, your insurance company will be responsible for reprocessing your claim in accordance with the terms and conditions of your plan. In addition, your $25 application fee will be refunded to you when the determination is "reverse" or "revise".

All decisions of the IRO are final and the decision is binding on all parties. There is no provision under External Review for further appeal of this decision.

How often are External Reviews successful in overturning an insurance company's determination?

The External Review Program has been successful in helping consumers receive an independent and impartial review of their health insurance denials. It is important to note that over the past 3 years, between 30% and 40% of all denials are overturned through the program.

Where should I send my External Review request?

Please mail your External Review to:

Connecticut Insurance Department
Attn: External Review
P.O. Box 816
Hartford CT 06142-0816

For overnight delivery only:
Connecticut Insurance Department
Attn: External Review
153 Market Street, 7th Floor
Hartford CT 06103

What if I have further questions on the External Review process?

For information on the External Review program:

Connecticut Insurance Department
Consumer Affairs Unit - 1-860-297-3910
www.ct.gov/cid
cid.ca@ct.gov

For free assistance with preparing your appeal:

Office of the Healthcare Advocate
1-866-466-4446
www.ct.gov/oha
Healthcare.advocate@ct.gov

STATE OF CONNECTICUT – INSURANCE DEPARTMENT

REQUEST FOR EXTERNAL REVIEW

Return Request to:
CONNECTICUT INSURANCE DEPT
Attn: External Review
P.O. Box 816 • Hartford, CT 06142-0816

For Overnight Mail Only:
CONNECTICUT INSURANCE DEPT
Attn: External Review
153 Market Street • Hartford, CT 06103

Telephone: 1-860-297-3910 **Email:** externalreview@ct.gov

APPLICANT *(Person requesting the external review)* (Applicant must be 18 years or older)

Applicant Name: ______________________________

Applicant Address: ______________________________

Applicant Daytime Phone: ______________ E-mail: ______________

Check One: ☐ Enrollee/Patient ☐ Parent of Minor Child under 18 ☐ Authorized Representative *(See page 2)*

ENROLLEE/PATIENT *(Person for whom requested services were denied)*

Enrollee Name: ______________________________

Enrollee Address: ______________________________

Enrollee Phone: ______________________________

INSURANCE INFORMATION

Insurance Company/Health Plan Name: ______________________________

Subscriber Name: ______________________________

Subscriber Insurance ID: ______________ Dependent Insurance ID: ______________

Coverage is: ☐ Individual Plan
☐ Group Plan - Employer Name: ______________________________

PROVIDER INFORMATION

Treating Medical Provider: ______________________________

Address: ______________________________

Contact Person: ______________________________

Email: ______________ Telephone: ______________ Extension: ______________

PLEASE EXPLAIN THE REASON FOR THE APPEAL

Indicate clearly the type of service(s) and the specific date(s) of service being denied. Attach additional pages if necessary.

____

____

____

STATE OF CONNECTICUT – INSURANCE DEPARTMENT

REQUEST FOR EXTERNAL REVIEW

APPOINTMENT OF AUTHORIZED REPRESENTATIVE: *(Complete if applicant is other than patient or parent of a minor child.)*

I appoint ______________________________, to act as my authorized representative for the purposes of section 38a-591g of the Connecticut General statutes, dealing with external review of final adverse determinations for medical necessity.

I authorize ______________________________to make any request; to present or to elicit evidence; to obtain review information; and to receive any notice in connection with my review, wholly in my stead. I understand that personal medical information related to my review may be disclosed to the representative indicated.

Signature of Patient (parent if patient is under 18 years old) Or Legal Representative* (Guardian, Conservator or Other – Please specify)	**Relationship** (If other than patient)	**Date**

* Legal Representatives must attach legal authorization to represent

This designation will expire one (1) year from the date it was signed, upon revocation or upon a final determination being rendered upon the action, whichever occurs sooner. Upon expiration, a new designation must be written in order to be valid. You may cancel this designation in writing at any time.

CONSENT FOR EXTERNAL REVIEW and RELEASE of MEDICAL RECORDS

I, ______________________________ hereby authorize the release of medical records necessary for the external review. I understand that these records may be obtained from the Insurance Company/Health plan, the Utilization Review Company, and/or any relevant medical provider(s) and will be utilized solely for the purpose of conducting this external review and may be viewed by an auditor of the Insurance Department for quality review and examination of record purposes.

I understand that by providing my e-mail address I consent to receiving communications on an electronic basis in relation to this request from the Connecticut Insurance Department and the designated review entity. Any communications containing personally identifiable information, including medical information, are protected by state and federal privacy laws.

I understand that the decision of the independent review organization is binding and that neither the Commissioner nor the independent review organization may authorize services in excess of those covered by my health benefit plan.

Signature of Patient (parent if patient is under 18 years old) Or Legal Representative* (Guardian, Conservator or Other – Please specify)	**Relationship** (If other than patient)	**Date**

* Legal Representatives must attach legal authorization to represent

STATE OF CONNECTICUT – INSURANCE DEPARTMENT

REQUEST FOR EXTERNAL REVIEW

EXTERNAL REVIEW CHECKLIST

Your request will not be processed if we do not receive all required items.

REQUIRED ITEMS
(√) Check all items enclosed

1. ☐ **External Review Application** – Completed, signed and dated.

2. ☐ **ID Card** – Copy of the patient's insurance identification card

3. ☐ **Final Denial Letter** – Written notice from your health plan telling you that you have exhausted the internal appeals/grievance process. For expedited External Reviews please attach the last denial letter received.

4. ☐ **Filing Fee**
Check or money order for $25
payable to *"Treasurer, State of Connecticut"*

- OR - ☐ **Request for Waiver of Filing Fee**
By checking this box, I attest that the covered person is indigent or unable to pay the filing fee, or the covered person has already paid the maximum fee of $75 per calendar year.

EXPEDITED REQUEST: ☐ Yes ☐ No *Not available if services have already been delivered.*
(√) Check appropriate box

5. ☐ **Behavioral Health Denial**
(Automatically expedited – No Physician Certification Needed)
The denial of services is related to (A) a substance use disorder; or (B) co-occurring mental disorder; or (C) a mental disorder requiring 1) Inpatient Services, 2) Partial Hospitalization, 3) Residential Treatment, or 4) Intensive Outpatient Services necessary to keep a covered person from requiring an inpatient setting.

- OR -

☐ **Physician Certification Form – Supplement A**
Required for Expedited Requests – Completed and signed by your physician

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EXPERIMENTAL/INVESTIGATIONAL DENIAL: ☐ Yes ☐ No
Services have been denied as experimental and/or investigational by your insurance company

6. ☐ **Physician Certification Form – Supplement B**
Required for Experimental/Investigational Denials – Completed and signed by your physician

---

OPTIONAL:

7. ☐ **New Medical Information Enclosed**
Medical documentation not previously submitted including additional supporting documentation from your treating physician.

Please note: All previously submitted medical information will automatically be forwarded to the independent review organization by the health plan for consideration in this external review.

Need assistance? Please call our Consumer Affairs Unit at 1-860-297-3910.

REQUEST FOR EXTERNAL REVIEW

IMPORTANT INFORMATION

- **Filing Deadline**
  You have 120 days to file your external review after receipt of the final denial letter indicating that the internal appeals have been exhausted.

- **Expedited external review for urgent care or life-threatening situations**
  Expedited external review requests should be filed immediately following receipt of any adverse determination. Your doctor must sign the Physician Certification Form to authorize this request unless your request is for a behavioral health service that is automatically considered urgent.

- **Additional new medical information**
  It is important when filing an External Review to submit complete documentation to support your request for approval of the denied services or treatment. You may ask your treating physician to provide information to support your External Review.

Important supporting documentation may include:

- Letters of support from treating providers
- Detailed provider treatment notes
- Enrollee/parent narratives describing the health issue, when it arose and accompanying symptoms

Please note: All previously submitted medical information will automatically be forwarded to the independent review organization by the health plan for consideration in this external review.

- **External Review Consumer Guide**
  The Connecticut Insurance Department has published an important guide to assist you in understanding the External Review process. If you have not yet received your Consumer Guide from your health plan, you may download a copy of "A Consumer's Guide to Appealing Health Insurance Denials" from the "Forms and Application" section of our website at www.ct.gov/cid.

MAILING INSTRUCTIONS

Please mail your application for External Review to:

Connecticut Insurance Department
Attn: External Review
P.O. Box 816
Hartford CT 06142-0816

For overnight delivery only:
Connecticut Insurance Department
Attn: External Review
153 Market Street, 7th Floor
Hartford CT 06103

Need assistance? Please call our Consumer Affairs Unit at 1-860-297-3910.

STATE OF CONNECTICUT – INSURANCE DEPARTMENT

REQUEST FOR EXTERNAL REVIEW

SUPPLEMENT A – Expedited Requests

PHYSICIAN CERTIFICATION FORM

NAME OF ENROLLEE/PATIENT: ______________________________

Notice to the Treating Health Care Provider

The enrollee/patient listed above has requested an external review because his/her health carrier has denied a health care service or course of treatment on the basis that the service does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service.

In order for the covered person to obtain an expedited external review, the patient's treating health care provider must certify that the standard external review process of 45 days would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

Please Note:

- Expedited reviews are only available if services have not yet been rendered.
- External Reviews for a denial of services related to (A) a substance use disorder; or (B) co-occurring mental disorder; or (C) a mental disorder requiring 1) Inpatient Services, 2) Partial Hospitalization, 3) Residential Treatment, or 4) Intensive Outpatient Services necessary to keep a covered person from requiring an inpatient setting will automatically be expedited and do not require this Form.

I certify that I am the treating physician; that adherence to the time frame for conducting a standard external review for the above named patient 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 for this reason, the patient's appeal of the denial by the health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

Physician Signature	**State Medical License #**	**Date**

Name of Treating Physician: ______________________________

Physician Address: ______________________________

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Supplement – A

STATE OF CONNECTICUT – INSURANCE DEPARTMENT

REQUEST FOR EXTERNAL REVIEW

SUPPLEMENT B – Experimental/Investigational Denials

PHYSICIAN CERTIFICATION FORM

NAME OF ENROLLEE/PATIENT: ______________________________

Notice to the Treating Health Care Provider

The enrollee/patient listed above has requested an external review because his/her health carrier has denied a health care service or course of treatment based on their determination that this drug, procedure or therapy is experimental and/or investigational.

In order for the covered person to obtain an external review of an experimental/investigational denial, the treating physician must certify that the covered person's medical condition meets certain requirements.

I certify that I am the treating physician for the patient named above in this external review and that I have requested the authorization for a drug, device, procedure or therapy which has been 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 as shown below.

In my medical opinion as the insured's treating physician, I hereby certify that ***one or more*** of the following situations is applicable:

- Standard health care services or treatments have not been effective in improving the medical condition of the covered person.
- Standard health care services or treatments are not medically appropriate for the covered person.
- There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment.

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.

______________________________ ______________ __________

Physician Signature **State Medical License #** **Date**

Name of Treating Physician: ______________________________

Physician Address: ______________________________

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Supplement - B