STATE OF ALASKA
DIVISION OF INSURANCE

Utilization Review, Grievance Procedures, and External Review Regulations
Frequently Asked Questions

Note: This document is designed to provide general guidance. It does not cover all of the detailed requirements established under the applicable Alaska regulations in 3 AAC 28.900 – 3 AAC 28.989

General Questions

1. What is the general purpose for the utilization review, internal review/grievance procedures, and external review regulations?

- The regulations establish procedural requirements for consumer protections to meet national standards developed through the National Association of Insurance Commissioners (NAIC) for health care insurance companies related to
  - **utilization review and benefit determinations (3 AAC 28.900 – 3 AAC 28.918)**
  - **internal review/grievance procedures (3 AAC 28.930 – 3 AAC 28.938)**
  - **external review (3 AAC 28.950 – 3 AAC 28.982)**
  - **general provisions (3 AAC 28.989)**

2. Who can represent a covered person in internal and external review processes?

- A covered person may be represented by themselves or an "authorized representative," which could be a family member, treating health care professional, or other identified representative.

3. Is there a charge for requesting a grievance/internal review or an external review?

- No. The insurance company is required to pay the costs.

4. What is the deadline to file an internal or external review?

- While it is not recommended to delay filing a review, a covered person has up to **180-days** from the date of an initial adverse determination to file for a review. Once the insurer has issued the final adverse determination notice, the covered person has up to 180-days to file for an external review. The deadlines may be extended if the covered person can provide acceptable extenuating circumstances.

5. Are there specific requirements for a health care insurer to provide notice to a covered person about benefit coverage determinations?

- Yes. Notices must be set out in a manner calculated to be understood by a person with average knowledge of health and medicine and there are several other specific requirements in regulation.

6. Is the health care insurer required to provide notices in languages other than English?

- When more than 10 percent of the population residing in a recognized geographical area are literate only in a non-English language, the insurer must provide notices both in English and in that language. In Alaska, the following two regions meet this standard:
  - Aleutians East Borough – 11% Spanish; 22% Tagalog
  - Aleutians West Borough – 12% Tagalog

7. Why is a change necessary?

- The changes improve the Alaska Division of Insurance's authority to protect healthcare insurance consumers and ensure compliance with national standards.

Utilization Review Questions

8. What is "utilization review?"

- Simply put, it is a way for insurers to make health care benefit coverage determinations using specific guidelines.

9. Is my health insurance company required to have written utilization review procedures?

- Yes. Insurance companies must have written procedures for utilization reviews based on established guidelines for medical necessity, health care setting, level of care, appropriateness, or effectiveness of medical care services or treatments to determine whether claims are covered by the plan. This may include pre-authorization procedures in which medical professionals evaluate a claim to determine whether a type or duration of treatment is medically necessary. The written procedures must include items such as data sources, clinical review criteria, data collection processes, and other information.

10. Why do health care insurers engage in utilization review?

- Utilization review, which can occur before, during or after treatment, is designed to help control costs and ensure appropriate coverage under the insurance contract.

11. How long does the standard utilization review process take?

- Prospective utilization reviews performed prior to treatment are due within **five working days**, unless extended for five working days upon notice to the covered person.
- A retrospective utilization review performed after a customer has received medical treatment is due within **30 working days** from receiving the claim, but may be extended for 15 working days when caused by circumstances beyond the insurer's control and upon notice to the covered person.
- Utilization reviews performed during authorized treatment are due sufficiently in advance of a benefit reduction for the covered person to file a grievance and receive a determination prior to the benefit reduction.

12. If a covered person's request for utilization review is incomplete, can the health care insurer deny the request?

- Not necessarily. If a covered person did not provide enough information for either a prospective or retrospective utilization determination, the insurance company may extend the determination timeline as referenced in the previous bullets, but must notify the covered person of the problem during the initial review period and allow up to **45-days** for the covered person to respond with additional information. If the covered person fails to respond, the health care insurer could issue an adverse determination.

13. What about the time lines for an expedited utilization review for urgent care?

- An insurance company has **24-hours** for determinations when a covered person's life, health or ability to regain maximum function could be seriously jeopardized or when a health care professional determines that the requested treatment is necessary to manage severe pain.

14. Is the health care insurance company required to notify the covered person of a benefit denial?

- Yes. The notice must be in plain language and must have explanations of the medical codes involved, applicable health plan provisions, scientific or clinical judgments, appeal rights, and other information depending on the determination.

15. What rights does a covered person have when a health care insurance company denies coverage?

- A covered person has a right to receive a plain language notice designed to be easily understood, which includes the basis for the determination, the applicable policy terms, explanations of medical codes, and any documentation used to reach the determination.
- A covered person can file a grievance to request an internal review and, in some cases, may be able to bypass the internal review procedures and file for an external review.
- Upon denying coverage, an insurance company is required to provide an explanation of the person's rights to request an independent external review, contact the Division of Insurance for assistance, or file a civil suit in superior court upon completing the insurer's grievance procedures for internal review.

Grievance/Internal Review Questions

15. What is a grievance/internal review process?

- Health care insurers are required to have grievance processes to allow a covered person the opportunity to request an internal review of the insurer's initial benefit coverage determination. This process may include the covered person providing additional information to the insurance company, such as an opinion or explanation from the medical provider, to support changing the initial coverage determination. Grievances may also be filed for other matters, such as those pertaining to the contractual relationship between the covered person and the health care insurer, but these issues may not be subject to external review processes.

16. Who can file a grievance/request for internal review?

- The covered person or their authorized representative may file the request (family member, doctor, attorney, etc.).

17. Does a covered person have the right to attend the internal review?

- No. The covered person has the right to submit comments, documentation and other materials and to receive reasonable access to and copies of all documents, records and other information relevant to the person's request for health care coverage.

18. Who makes the decision in an internal review?

- The insurance company makes the determination, but evaluations for issues such as medical necessity must be based on a review by a clinical peer in the same or similar specialty that would usually provide the services. The clinical peer reviewer cannot be the same person who made the determination to deny the claim initially.

19. How long does a standard internal review process take?

- An insurance company is expected to make a determination in a reasonable period, with up to a maximum of **30-days** to issue a prospective or retrospective determination.

20. Can a covered person jump to a faster review process in certain circumstances?

- Yes. For example, a covered person may request an expedited review without exhausting the internal review process if, due to a medical condition, waiting for a standard internal and external review processes would (1) seriously jeopardize the life or health of the covered person or (2) jeopardize the covered person's ability to regain maximum function.

21. What is the timing for an expedited internal review of an urgent care request?

- A health care insurance company has **72-hours** to make a determination.

22. If the health care insurance company denies the claim at the internal review stage, it is known as a "final adverse determination." The insurer is required to provide a plain language notice a final adverse determination to the covered person which includes the basis for the determination, the applicable policy terms, explanations of medical codes, and any documentation used to reach the determination. The notice must also include the covered person's right to request an independent external review, contact the Division of Insurance for assistance, or bring a civil action in superior court.

External Review Questions

23. What is an external review?

- The external review process allows a covered person to challenge a health care insurer's final adverse determination. The process involves an analysis and determination by a division-

approved or nationally accredited third party, known as an **Independent Review Organization (IRO)**, regarding the insurer's final adverse determination or denial of benefits. The Alaska Division of Insurance is responsible to assign an IRO on a rotating basis to provide an independent, unbiased evaluation of the insurance company's adverse determination.

24. When can an external review be requested?

- Generally, the request for external review must be made within **180-days** of the final adverse determination.
- Except in limited cases, a covered person must exhaust the insurer's internal review/grievance processes and receive a final determination from the health care insurer before an external review process is allowed.
- If health care insurer fails to meet regulatory requirements, including timelines, for internal reviews, the covered person may request an external review without exhausting the internal review process. A health care insurer may also waive the covered person's obligation to exhaust internal review procedures.
- The request for external review must be based on the health care insurer's denial of coverage due to medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment.

25. Does a covered person have to authorize a release of medical records in order to make a request for external review?

- Yes.

26. How long does the external review process take?

- The IRO has up to **45-days** to issue a standard external review decision and up to **72- hours** to issue an expedited external review decision. However, the IRO is expected to issue the decision as soon as possible.

27. What happens if the IRO's decision reverses the insurance company decision?

- The insurance company is required to comply with the IRO's decision and immediately approve coverage.

28. When can a covered person request an expedited external review?

- If a covered person's life, health, or ability to regain maximum function are jeopardized by the adverse determination, or the covered person's emergency treatment or ongoing health care services in a facility are at stake, the covered person may be eligible for an expedited external review. Expedited external reviews are reserved for upcoming or ongoing treatment and are not allowed to resolve issues regarding past medical service or treatment.

- An expedited external review may also be requested in cases where the denial of coverage was for experimental or investigational treatment and the treating physician certifies in writing that the treatment in question would be significantly less effective if not promptly initiated.

28. Can the IRO issue a verbal decision?

- Yes, but a written confirmation of a verbal decision must be issued within 48 hours.

29. What if I don't agree with the IRO decision?

- An external review decision is binding on the covered person and the insurer, except to the extent the covered person or the insurer has other remedies under applicable federal or state law. You may want to discuss legal options with an attorney.

Other General Considerations

30. What kinds of complaints are not subject to external review?

- The external review process is designed for resolving complaints about adverse determinations based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment. It is not designed for resolving disputes of a contractual nature, such as whether the insurer properly applied a covered person's deductible or copay amounts or whether the insurer properly determined dependent eligibility status.

31. Will the Alaska Division of Insurance assist a covered person with issues that are not subject to the external review standards?

- Yes. The Consumer Services Section provides assistance for Alaskans on a wide range of insurance issues to ensure that insurers are complying with consumer protection laws. In cases where a request for external review is outside the scope of the regulations, the issue may nevertheless be evaluated as a complaint.