

FOR IMMEDIATE RELEASE No. 18-032

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New External Review Process for Healthcare Claims Provides Additional Protection for Alaskans

October 22, 2018 ANCHORAGE – This month, the Alaska Division of Insurance rolled out an external review process for health insurance adverse benefit determinations. Alaskans who are covered by fully insured health or dental insurance plans now have a process by which to have a nationally accredited, independent review organization assess whether an insurer's denial is justified.

"This effort illustrates the division's goal to provide the greatest level of protection for Alaska healthcare insurance consumers and ensure that coverage determinations are correct and adequately supported from a clinical perspective," said Lori Wing-Heier, director of the Division of Insurance.

Earlier this year, the division adopted regulations and received federal approval. Since then, the division registered ten nationally accredited independent review organizations to adjudicate external review requests and also developed procedures, forms, and guidance documents to facilitate external review requests. A federal grant provided one hundred percent of the funding to adopt the regulations and create the infrastructure to develop and implement the external review process.

An external review is available when a of a specific claim or requested service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, or level of care or treatment effectiveness. External review is also available when an insurer denies medical services or treatment considered to be experimental or investigational. The health insurance external review provisions apply to the individual and group markets; they do not apply to federally funded plans like Medicare and Medicaid or to employer self-funded health insurance plans (most self-funded plans provide external appeal rights administered by the employer). The process does not cover coverage determinations based on the insurance contract, such as network provider status, deductibles, and coinsurance issues.

To learn more about the program and to download resources such as the <u>Consumer Guide to External Review</u>, visit <u>ExternalReview.alaska.gov</u> or contact the Consumer Services Section at (907)269-7900 or 1-800-INSURAK (in state, outside Anchorage).

The Division of Insurance is an agency housed within the Alaska Department of Commerce, Community, and Economic Development (DCCED) tasked with protecting insurance consumers in Alaska. For additional information about the division, visit www.commerce.alaska.gov/web/ins/. For information about DCCED and its other agencies, visit commerce.alaska.gov.

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ATTACHED: Standard External Review Process Flow Chart

State of ALASKA **DIVISION OF INSURANCE (DOI)** STANDARD EXTERNAL REVIEW DOI checks to determine **INSURERED** may file **EXTERNAL HEALTH REVIEW (EHR)** NO if filed within 180 days of written REQUEST to **REQUEST received by DOI.** adverse determination. extend 180 day period. 3 AAC 28.958(a) YES Internal grievance process exhausted? Upon adequate justification, the YES DOI will extend the 180 day period. 3 AAC 28.958(b) YES NO NO **DOI sends EHR** Allowable YES **REQUEST to INSURER** exception? **INSURER has 5 working days** in 1 working day. to review EHR REQUEST. 3 AAC 28.958(c) NO 3 AAC 28.958(d) **CASE REJECTED CASE REJECTED** INSURER has 1 working day after review to notify DOI **If INSURER** DOI has 1 working day to and INSURED if REQUEST qualifies for EHR. determines the assign Independent Review **REQUEST** is eligible (Failure to meet the timeline results in immediate Organization (IRO) and notify coverage approval or INSURER may voluntarily for EHR. **INSURER and INSURED.** reverse its adverse determination) 3 AAC 28.958(i) 5 AAC 28.958(e) Upon assignment, INSURED has If incomplete, INSURER must If INSURER determines REQUEST 5 working days to submit any provide written notice to is NOT eligible for EHR—Must additional information to IRO. **INSURED** and **DOI** about what provide reason and appeal rights 3 AAC 28.958(i)(3)(d) is missing. to INSURED and DOI. 3 AAC 28.958(f) 3 AAC 28.958(g) Upon assignment, the INSURER has 5 working days to submit all pertinent DOI agrees? information to the IRO. If the insurer **INSURED** provides requested 3 AAC 28.958(h) fails to meet this deadline, the IRO information. may terminate the proceedings, reverse the INSURER's determination YES YES NO and immediately notify the INSURER, **INSURED** and DOI. 3 AAC 28.958(j) **CASE REJECTED** YES **INSURER** may reverse If reversed, determination based on **INSURER must** IRO has 45 days to

Note! This document is designed to provide a general understanding of the steps in the standard EHR process and is not a complete description of the regulatory requirements.

NO

issue standard EHR

decision to DOI and

INSURERED.

3 AAC 28.958(p)

immediately

COVER BENEFIT.

3 AAC

28.958(q)

additional information.

3 AAC 28.958(m)+(n)

IRO has 1 working day to

submit any documents

received from INSURED

to INSURER.

3 AAC 28.958(I)