Oklahoma Insurance Department

External Review Process

This provides general information on the external review process in Oklahoma. If you have specific questions on how it may apply to your situation, please contact your insurance company or the Oklahoma Insurance Department (OID).

If you are denied coverage or payment under your health insurance plan, you can appeal to your carrier internally. Contact your carrier or look in your plan benefit packet for more information on how and where to file an internal appeal.

If you are not satisfied with the outcome of your internal appeal, or if your carrier waives the internal appeal, a new law provides you with an additional way to resolve some disputes involving medical decisions. You or your authorized representative may request that an Independent Review Organization (IRO) review your health plan's decision.

What is an external review?

External review describes the process that provides you with an opportunity to have your dispute reviewed by experts who have no connection to your health plan. Once you are determined to be eligible for an external review, the OID will randomly assign an IRO to your request.

Who conducts the external reviews?

The external reviews are conducted by IROs that are certified by the OID, in addition to possessing a national certification. In order to be certified, the IRO must demonstrate that it is unbiased and that it has procedures to ensure that its reviewers are qualified and independent.

What types of disputes can be decided through external review?

An external review can address a decision based upon requirements for medical necessity, appropriateness, health care setting, and level of care or effectiveness, including decisions against treatment that is experimental or investigational. There is no minimum dollar amount for the value of your claim for it to be eligible for external review.

What types of disputes are not eligible for external review?

No health benefit plan covers all medical expenses. You may not request an external review if the requested treatment is not a covered benefit. For example, if your policy specifically excludes coverage of weight loss treatment, your request to have the insurer cover your weight loss treatment would not be eligible for external review, even if you believed that the treatment was medically necessary. In addition, if your dispute involves an administrative issue such as whether your premium was paid on time, it is not eligible for an external review. However, you would be able to ask the insurer to review your concerns through its internal grievance process.

If you have coverage through Medicare, Medicaid, or another federal plan, or if you are covered through your employer's self-funded plan, you are not eligible to request the external review described here. These plans generally have a different appeal process, which is explained in your member materials.

When can I request an external review?

Whenever your insurer makes a coverage denial determination that is eligible for an external review, it must provide you with information on your appeal rights, including its internal grievance procedures and your right to request an external review. It must also explain how you can obtain additional information on its internal grievance and external review processes. In most cases, you will need to complete your health plan's internal grievance procedure before requesting an external review.

How do I request an external review?

After you receive the insurer's final decision on your internal appeal, you can send an application for an external review to the OID.

Click here for the External Review Request Form.

You have 4 months from the date of the decision or final decision to request an external review.

What if I need care now?

Generally, you must complete your health plan's internal appeal procedure before requesting an external review. However, you do not need to complete this process if both you and the insurer agree to proceed directly to external review or if you need immediate medical care.

If you need immediate medical treatment and believe that the time period for resolving an internal appeal will cause a delay that could jeopardize your life or health, you may ask to bypass the insurer's internal appeal process. When you obtained your coverage, your health plan should have provided you with written information explaining the external review process. You can also call the health plan's toll-free telephone number to request information on the external review process. Call the OID at 800-522-0071 or 405-521-2828 before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

Is there a cost involved?

There is no cost to you for requesting an external review. Your health plan is required to pay the IRO's fees.

How long does the external review process take?

Generally, once your request has been determined to be eligible for external review, an IRO has up to 45 days to return a decision. However, in the case of an expedited review of an urgent medical decision, the timeframe is much shorter.

How does the IRO make its decision?

The IRO must consider all of the documentation and other information provided by you and by the insurer, including medical or scientific evidence, the applicable insurance contract and any legal bases.

Does my health plan have to abide by the decision?

Yes, the decision of the IRO is binding.

What if I have more questions?

Your insurer's customer service department should be able to answer any questions you may have regarding the external review process.

You may also contact the OID by phone at 800-522-0071 or 405-521-2828.