STATE OF WISCONSIN

Fact Sheet on the Independent Review Process in Wisconsin

OFFICE OF THE COMMISSIONER OF INSURANCE PI-203 (R 01/2019)

This fact sheet provides general information on the independent review process in Wisconsin. If you have specific questions on how it may apply to your situation, please contact your insurance company or the Office of the Commissioner of Insurance (OCI).

What is an independent review?

An independent review is a process allowing an outside expert to provide a second look at your claim. Because the reviewer is not affiliated with you or the insurer, the reviewer is able to conduct an independent and unbiased review of your claim.

What types of disputes can be decided through independent review?

An independent review is available whenever your health plan denies you coverage for treatment because it maintains the treatment is not medically necessary or it is experimental, including a denial of your request for out-of-network services when you believe the clinical expertise of the out-of-network provider is medically necessary. The treatment must otherwise be a covered benefit under the insurance contract.

An independent review is also available whenever your health plan denies you coverage for treatment on the basis of a preexisting condition exclusion.

You may also request an independent review if the insurer rescinds your health insurance policy or certificate. Rescission means the insurer retroactively cancels your policy or modifies the terms of the policy because it maintains you did not answer the health questions on the application for insurance completely and accurately.

If you and your insurer disagree about whether or not your dispute is eligible for independent review, you may request it be sent to an Independent Review Organization (IRO). The IRO will decide if it has the authority to do the review.

What types of disputes are not eligible for independent review?

You may not request an independent 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 independent review, even if you believed the treatment was medically necessary.

Also, if your dispute involves an administrative issue such as whether your premium was paid on time, it is not eligible for an independent 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 independent review described in this publication. These plans generally have a different appeal process, which is explained in your member materials.

Who conducts the independent reviews?

The independent review process provides you with an opportunity to have your dispute reviewed by experts who have no connection to your health plan. The IRO assigns your dispute to a clinical peer reviewer who is an expert in the treatment of your medical condition. The clinical peer reviewer is generally a board-certified physician or other appropriate medical professional.

In some cases, the IRO will also consult with an attorney or other insurance expert. The IRO has the authority to uphold or reverse the health plan's decision.

When can I request an independent review?

Whenever your insurer makes a coverage denial determination, it must provide you with information on your appeal rights, including its internal grievance procedures and your right to request an independent review. In most cases, you will need to complete your health plan's internal grievance procedure before requesting an independent review.

How do I request an independent review?

The insurer's final written decision on your grievance should include a notice explaining how to request an independent review. Send your written request for independent review to the address provided in the insurer's final written decision within **4 months** of the date the grievance procedure was completed.

Be sure to include:

- Your name, address, and phone number
- An explanation of why you believe the treatment should be covered
- Any additional information or documentation supporting your position
- If someone else is filing on your behalf, a statement signed by you authorizing the person to be your representative
- Any other information requested by your insurer

What documents should I provide to help the IRO make a determination?

You may provide the IRO any information you think will support your case. This may include your medical records and test results, a letter from your physician or research articles from peer-reviewed medical journals.

What if I need care now?

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

If you need immediate medical treatment and believe the time period for resolving an internal grievance will cause a delay, jeopardizing your life or health, you may ask to bypass the insurer's internal grievance process.

When you obtained your coverage, your health plan should have provided you with written information explaining the independent review process. You may also contact the health plan to request information on the independent review process.

When you have the information you need, send your request for an expedited independent review at the same time you send the insurer your expedited grievance request. The IRO's medical director or other medical professional will review your request and decide if an immediate review is needed. If so, it will review your dispute on an expedited basis.

If the IRO decides your health condition does not require its immediate review of your dispute, it will notify you to first complete the internal grievance process.

Is there a cost involved?

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

How long does the independent review process take?

Within 5 business days, the insurer must send to the IRO:

- all relevant medical records and other documentation used in making its decision
- all of the documentation you sent to support your request

The IRO then has 5 business days to request any additional information it may need from the insurer or from you, and no more than 30 business days to make its decision.

If the IRO determines this time period could jeopardize your life or health, the insurer must send its documentation within 1 day and the IRO then has 2 business days to request any additional information. The IRO must notify you and the insurer of its decision no later than 72 hours after receiving the review request.

How does the IRO make its decision?

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

It may reverse an insurer's denial based on an experimental treatment determination if it determines the treatment has been approved by the FDA, when required, and also when medically and scientifically accepted evidence clearly demonstrates the treatment is proven safe and can be expected to produce greater benefits than the standard treatment without posing a greater adverse risk.

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 independent review process.

Additional information on the federal external review process may be found from the U.S. Department of Health and Human Services at The Center for Consumer Information & Insurance Oversight's website: www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/External-Appeals.html.

For more information on the entire appeals process, see the *Consumer's Guide to Health Insurance Grievances and Complaints* publication available on OCI's website.

If you have a specific complaint about your insurance, you should first attempt to resolve your concerns with your insurance agent or with the company involved in your dispute. If you do not get satisfactory answers from the agent or company, contact OCI. A complaint form is available on OCI's website at ociaccess.oci.wi.gov/complaints/public/.

OCI's Website
oci.wi.gov

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