How to Appeal Commercial Health Plan Denials

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Disclaimer: *This manual is intended as an educational tool only. It is not intended as legal advice. Any references to particular health plans, insurers or utilization review entities is provided as an example only. The "Practice Tips" are merely suggestions for how to make the appeals process easier. We reserve the right to change our suggestions and/or opinions provided in this manual if the laws, regulations or interpretations of the applicable laws change or new information becomes available that we did not consider when developing this manual.*

WHO SHOULD USE THIS MANUAL

This manual is intended for in-network providers. Out of network providers should not have to file appeals. Even if you accept assignment, once the claim has been denied, you can bill the patient. Let the patient then file their own appeal.

This 'how to' manual applies to commercial health plan appeals only. Medicare has its own appeal procedures that apply to Medicare Part B and Medicare Advantage Plans. The rules are very similar to commercial health plans. The significant differences are mentioned briefly in this manual. For a full description of the Medicare appeals procedures, please go to https://www.medicare.gov/appeals-if-you-have-a-medicare-health-plan.

For Medicaid appeal procedures, consult your state Medicaid laws and regulations.

WHAT CAN BE APPEALED?

Adverse benefit determination: "Adverse Benefit Determination" means any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. [see 29 CFR 2560.503-1(m)(4)]

Rescission: Any cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. A health plan or issuer must not rescind coverage with respect to an individual once the individual is covered, except in the case of an act, practice, or omission that constitutes fraud, or an in tension all misrepresentation of material fact, as prohibited by the terms of the plan or coverage. [see Fed Reg Vol 75, No. 141, July 23, 2010].

Types of Adverse Benefit Determinations

1. Pre-service Claims. Denial by a URE of covered services based on medical necessity or determination the service was experimental/investigational *before* the care is initiated (denial at pre-authorization).

2. Concurrent Care Claims. When a patient has already started a plan of care and you are asking to continue or extend it, it is a "**concurrent care claim**"[1] under the ACA appeals rules and must be answered within 72 hours ***if you request the additional visits before the approved visits have been exhausted or your appeal qualifies as an urgent care claim (expedited appeal).***

When a commercial health plan denies additional visits but more PT/OT visits are *medically necessary* AND the patient still has covered benefits available to use, appeal immediately.[2]

> *Example: The utilization review entity (URE) pre-authorized 4 visits initially, then 2 more visits on your 2nd pre-auth request. Your plan of care was for 3x/wk for 4 weeks, or 12 visits. Therefore, the URE is cutting off care in the middle of the treatment plan. The patient has 20 covered visits per year and has only used 6. You are providing manual therapy that the patient cannot perform on him/herself at home. You are also doing therapeutic exercises with the patient that requires your hands-on expertise to ensure the patient is using appropriate recruitment patterns and/or the patient still requires exercises to be progressed to regain maximum functional improvement. (The patient is NOT just doing their home exercise program in your office.)*
>
> *Example: Patient is being seen for back pain treatment. Your plan of care was for 6 visits, which the URE approved. The patient was making progress and planned to be discharged but had an exacerbation before the 6th visit. Now you need to extend the plan of care to meet the discharge goals. The URE denies the additional visits stating further PT is not necessary because the patient is not making progress. The patient has unlimited PT visits on their benefit plan as long as it is medically necessary.*
>
> *Example: The URE cuts a post-op patient's visits off arbitrarily before the patient has progressed through the entire protocol.*

[1] Definition of a concurrent care claim - If a plan has approved an ongoing course of treatment over a period of time or number of treatments, any decision to shorten the approved course of treatment or whether to extend the course of treatment is a concurrent claim decision. The plan must notify the claimant of the benefit determination, whether adverse or not, **within 24 hours** after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

[2] If the patient's PT/OT benefits have been exhausted, then offer continued visits as private pay services.

3. Post-service Claims. Adverse benefit determinations made *after* care was provided based on a decision that care was not medically necessary, experimental or investigational. The patient has only 60 days to file a first level post-service appeal unless their health plan allows a longer time (many health plans allow 180 or more days).

Practice Tip: Don't run out the patient's appeal time trying to resolve the denial as the provider. Get the patient to file their own appeal within the 60-day time frame. You can pursue a provider claims administrative appeal for as long at your in-network agreement allows.

WHAT KIND OF APPEAL IS IT?

Pre-service Appeal. Health plans can take 30 days to decide an ordinary pre-service appeal. If care is already in progress, your request for more visits is a ***concurrent care claim***. Do <u>*not*</u> let the health plan characterize your appeal as an ordinary "pre-service" appeal. The only appeals that should be characterized as a pre-service appeal are services *that have not been started yet.*

Practice Tip: Request additional visits *before* the last visit is used if you need more visits at the end of *your treatment plan* so the request for additional visits can be characterized as a concurrent care claim (see definition below).

Urgent Care Claim. If you do not request the additional visits before the last visit is used, the request should still qualify for an ***expedited review*** if it is an ***urgent care claim***.

The definition of ***urgent care*** is defined as a Pre-Service Claim for medical care or treatment if application of the longer time periods for making decisions on other types of claims

(1) could seriously jeopardize the claimant's life or health ***or ability to regain maximum function or***

(2) would subject the claimant to ***severe pain*** that cannot be adequately managed without the care or treatment in question.

Who decides if the claim is expedited? If, in the opinion of a provider with knowledge of the claimant's medical condition, delayed treatment would subject the claimant to severe pain that could not be adequately managed without the care or treatment, the health plan is ***required*** to expedite the appeal. ("Provider" has been interpreted to mean "physician" in the Code of Federal Regulations.) Some states may recognize non-physician providers as providers whose opinion must be given deference to when determining whether to expedite an appeal. (See Appendix 1 for a list of states that require a physician statement to expedite an independent external review.)

Practice Tip: *Get a letter from the patient's physician stating that the appeal needs to be expedited if you can just to be on the safe side. Theoretically, you should not need this if it is a concurrent care claim where the patient is in the middle of their plan of care, assuming the physician already approved your plan of care, because the treatment in progress is being terminated early.*

Time limit to answer expedited appeals. Federal law requires an expedited appeal to be answered within 72 hours. State law may require the appeal to be answered in less time, so check your state laws if the health plan is fully insured.[3]

Practice Tip: *If a health plan does not answer a concurrent or urgent care appeal within the required time frame, the patient is entitled to proceed to the next level of appeal. Do NOT wait for answer to appeal longer than the time limit. Move on to the next level of appeal so you can get to an Independent External Appeal as quickly as possible.*

WHEN TO APPEAL

Concurrent or Urgent Care appeals should be appealed as soon as you receive the denial, which should have been within 24 -72 hours after you requested more visits.

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[3] State laws regulating insurance do not apply to self-insured health plans. If the health plan is self-insured, only federal ERISA laws apply and the time limit for answering an expedited appeal is 72 hours.

Practice Tip: *You likely got the denial for additional visits verbally or electronically. You need the written denial letter which states the reason for the denial and where to send the request for appeal. Don't wait for the health plan to snail mail the denial letter to you or the patient. Call the health plan and demand that they fax or electronically send the patient's denial letter to you.*

Practice Tip: *Some health plans only provide the mailing address for appeals in the denial letter. You need a fax number or instructions on how to electronically request an appeal. Tell them "this is a concurrent care claim entitled to an expedited appeal" and therefore you need to send an appeal request today.* ***Make sure they understand that you are asking for where <u>the patient</u> is supposed to send their appeal request, not you as the provider.*** *If you don't make it clear that you are asking for information on how the patient can appeal, they will likely tell you how to file a provider appeal – which is not necessarily entitled to any legal rights (only contractual rights).*

WHO SHOULD YOU APPEAL TO?

Do NOT appeal to the URE unless the health plan has delegated appeals decisions to the URE (not likely). The patient's Adverse Benefit Determination (Denial) letter will state who the patient should appeal to. Have the patient bring in their denial letter if you have not already received it from the health plan.

Note: "Reconsiderations" in commercial insurance are a voluntary level of appeal. (Exception: Medicare calls the first level of official appeal a "Reconsideration"). Peer-to-Peer reviews are considered a provider appeal. Neither are part of the patient's official appeal levels.

Practice Tip: *Do not waste your time asking for a Reconsideration or a Peer-to-Peer Review as these reviews are likely to be a waste of time (denials are usually upheld). Your goal is to get your appeal to the Independent External Review level (which will be the 2nd or 3rd appeal level, depending on the health plan) as quickly as possible for the best efficiency because the 1st level of internal appeal (and 2nd, if there is one) will likely rubber-stamp the URE's decision without any additional consideration being given.*

WHAT INFORMATION SHOULD YOU SEND FOR THE INTERNAL APPEALS?

The health plan should already have all the information the URE used to deny your claims. If they don't, you should send any treatment notes you believe they don't have. Your documentation should stand on its own to support the medical necessity of the additional visits you are requesting. If not, you should consult APTA's resources on defensive documentation.

Practice Tip: *Do not waste a lot of time looking up research to support your position that more care is medically necessary for internal appeals. The health plan probably won't look at it anyway. Just send the appeal request letter briefly rebutting the reason why the URE said further visits were not medically necessary. For instance, if the URE said the patient was not making progress, simply state the URE was wrong, progress was being made and to refer to the documentation as proof of it.*

WHAT INFORMATION SHOULD YOU REQUEST IN YOUR LETTER REQUESTING AN APPEAL?

The denial letter should have stated:

- The specific reasons for the adverse determination.
- Reference to specific plan provisions on which the determination is based.
- A description of additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- If an internal rule, guideline, protocol, or other similar criteria and was relied upon in making the adverse determination, copies must be provided free of charge to the claimant upon request, or
- If medical necessity is the issue, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- All the records the health plan relied up on when denying the claim (including your medical records).

Most denial letters from UREs are templates that repeat the same reasons for each patient. For example, a typical denial letter from AIM/Anthem may state:

> **Details from the Clinical Review**
> Physical therapy (PT) is care that aims to help you function, move and live better. Your doctor has asked for more PT for you. More PT can be done when you are making recent progress that helps you with your daily tasks. We reviewed the records we have. The records do not show that you made progress with your daily tasks. Based on the records we have, more PT is not medically necessary. We used AIM Specialty Health Guideline titled Outpatient Rehabilitative and Habilitative Services, Physical Therapy to make this decision. You may view this guideline at https://aimspecialtyhealth.com/resources/clinical-guidelines/rehabilitation-guidelines/.

Notice that the reference to the internal guideline is provided (though it may not really be on-point for your case). If a guideline or protocol is mentioned but no link or reference provided, you need to request it.

If the denial letter states not enough information was available to determine whether all the visits should be approved (as in the typical OrthoNet letters of the past that partially denied requested visits), the patient is entitled to know *precisely* what information is required from the URE/health plan in order to "perfect the claim" for covered benefits. *Ask for this information!*

The patient is also entitled to a copy of all the medical records that were considered when the denial decision was made. You should ask for a copy of all these records even if you already have a copy of your own records because you need to know exactly what records the URE/health plan reviewed and if they are missing anything. (Plus – it makes the health plan do some work!)

Practice Tip: *Move forward with an internal appeal whether or not you get copies of the medical records the URE/health plan reviewed before the appeal procedure. You might need them, however, for the independent external review, so try to get them at the internal appeal stage anyway so you will have them in advance.*

Other documents you should request: The patient is also entitled to a copy of their health plan benefits booklet ("Summary Plan Description" or "SPD" if it is an employer-sponsored health plan). Always ask for this if you don't already have it. The SPD has

valuable information in it about whether the health plan is self-insured, what the PT benefits limitations are, what the appeals procedures are and where to file grievances about the health plan.

See Appendix 2 for a sample letter requesting an internal appeal.

HOW LONG SHOULD THE INTERNAL APPEAL DECISION TAKE?

You should receive a decision on an urgent care claim within 72 hours under federal law. Check your state laws for a shorter time limit.

If the health plan does *not* respond within that time frame, federal law says you get to jump to the next level of review without waiting for the answer. For most plans, the next level will be the independent external review. Larger health plans are allowed to require 2 levels of internal review before jumping to the independent external review, but many do not. The health plan document will say whether a 2nd level of internal appeal is mandatory.

Practice Tip: *Look for language that explicitly says that level is mandatory vs. voluntary or optional.* ***Do not file any requests for optional internal appeals unless you want to waste your time and greater delay care.***

REQUEST AN INDEPENDENT EXTERNAL REVIEW UPON INTERNAL APPEALS BEING EXHAUSTED

Be ready to file your request for an IRO review as soon as you get the answer to the last level of internal appeals for the patient's health plan (most likely after the 1st level of appeal).

If the health plan is fully insured, you will request an appeal with the entity listed for your state in Appendix 1. If the health plan is self-insured, you need to refer to the health plan document or the patient's internal appeal denial letter to see who you need to send the appeal request to. If you are unsure, contact the entity (probably your state's department of insurance) that handles scheduling independent external appeals in your state to see if they can help you.

Physician Attestation that Appeal needs to be Expedited.

Appendix 1 tells you whether your state requires a treating physician to certify or attest that the appeal needs to be expedited. Some states have a specific form for the physician to fill out

or you may be able to just attach a physician attestation letter (see Sample Physician Attestation letter in Appendix 3).

Practice Tip: *Figure out if a physician certification or attestation letter is needed in advance when you are in the internal appeals phase so you can obtain this in advance and be ready to quickly request the independent external review.*

Fill out the required form for your state if the plan is fully insured and subject to state law. (see Appendix 1 for a link to your state's form.) Attach all items the form requests. If your patient has not yet received a written copy of the last denial letter and you have not been able to get the health plan to fax a copy to you, state that on the form – that the denial was just given verbally.

Attach a *brief* letter from the PT which covers the following talking points:

1. **Statement of care provided to date.** Patient was seen ___ times for physical therapy for [what] diagnosis.

2. **Information about denial.** Upon the expiration of these pre-authorized visits, a request for more visits was denied by [name of URE], the utilization review agent for [name of health plan]. State that the health plan rubber-stamped this denial in the 1st (and 2nd, if there was one) level(s) of appeal.

3. **Statement about qualification for concurrent/expedited appeal.** The patient has not completed his/her treatment plan, which was originally for ___ visits over the course of ___ weeks. (Alternatively, the patient reached the end of his/her plan of care but had not met all the goals, therefore an extension to th plan of care was medically necessary.) Therefore. this qualifies as a concurrent care claim and needs to be expedited. Additionally, the patient will not regain maximum function and/or pain will be unmanageable if care is delayed.

4. **Statement of Rebuttal to the health plan's reason for denial.**

5. **Statement of Medical Necessity.** Don't make this harder than it has to be!

   Sample statements could be:

   > "The patient was receiving hands-on manual therapy for joint and/or soft tissue mobilization that the patient cannot do on their own. S/he will not

be able to regain maximum function and/or have a reduction/alleviation of pain without further manual therapy treatment."

"The patient has not progressed through the exercise protocol required to regain maximum function. Further instruction is needed when the patient has made adequate physiological gains and is ready to progress to the next level."

"The post-op protocol requires ___ weeks of physical therapy. The patient has not progressed through the protocol yet and therefore still needs PT."

6. **State how many more visits you anticipate needing.** Be honest. If you are successful on this appeal, you will get *all* the visits you want approved. That said, do not ask for more than what is medically reasonable. If you look like you are over-utilizing PT, you will lose credibility with the reviewer.

Practice Tip: *If you use FOTO, gather the FOTO data that estimates the number of visits needed based on the diagnosis and the other data you would have entered on the patient on the first visit. This can be very powerful!*

Prepare for the Independent External Review

This is what you have been waiting for. The last level of review by an *independent* reviewer who is not connected to the health plan. *This is where you want to put your appeal efforts!*

The review will be a short phone call. It is very informal. The reviewer will likely be a physician.

Scheduling. The state entity in Appendix 1 will schedule your review with the Independent Review Organization if the health plan is governed by state law. On an expedited appeal, it should be schedule within a couple of days, but sometimes it is difficult to get everyone's schedules to align.

What to send in advance of the call. The reviewer *should* get records from the health plan in advance, but they won't likely have all the PT progress notes. Remember, the health plan only has what you sent them and may not even have what you sent the URE. As soon as the IRO is assigned, the patient should get a letter (by email or fax) stating how to submit additional information you want the reviewer to consider. If you were appointed as the Authorized Rep,

you should receive this correspondence. ***You should submit the evaluation and all your progress notes to date.*** Don't think you have to send research articles or anything else to support medical necessity, but you can if you wish to spend additional time on the case.

PT participation. The treating PT should participate in this call to make a brief statement at the beginning about the patient's course of treatment and why additional visits are required. The call will only take about 30 minutes, but you might want to block out an hour. You do not have to be the authorized rep to participate.

What to expect on the Independent External Review.

1. The reviewer should have looked at all the documentation you and the health plan submitted, including the adverse benefit determination letter, before the call. You/the patient will be permitted to make a statement about why you think additional PT is necessary. I recommend you briefly review the things in your PT record that show progress and medical necessity to draw the reviewer's attention to the things that support your case but don't bore him/her with a review of the entire case if s/he told you s/he already reviewed the records.

2. The health plan will not likely show up for the call. It simply isn't worth their time. Therefore, you don't have to be intimidated. If they do show up, they won't likely know enough about the facts of the case to rebut your position.

3. You'll probably get a clue about how the reviewer is leaning by the questions s/he asks you after your opening statement, but s/he probably won't give you a definitive decision.

4. The written decision should come within 1-2 days after the review. Hopefully you will get all the visits you want approved. The decision is binding on the health plan, so you do NOT have to get pre-authorization for those visits from the URE for the remainder of the treatment – not until you exceed the visits the IRO deemed were necessary. *This is what makes the independent external review your most efficient, least costly option to get more visits!*

FILING COMPLAINTS

Nothing changes if complaints are not filed. But you have no complaints until you have exhausted all levels of appeal. If the health plan did not fully comply with all the appeals rules, or the health plan/URE made false statements in their denial letter (i.e. that the patient had not made progress when s/he had), file a complaint with the entity that governs the health plan.

Fully insured health plans are governed by both state laws and federal ERISA laws (if the health plan is sponsored by the employer). Complain to your state insurance commissioner (same entity that scheduled the independent external review) and the EBSA (Employee Benefits Security Administration under the U.S. Dept of Labor) regional office for your geographic location.

Resources

29 CFR § 2560.503-1 - Claims procedure. Code of Federal Regulations under ERISA law governing appeals for employer-sponsored health plans, available at https://www.law.cornell.edu/cfr/text/29/2560.503-1

Has Your Health Insurer Denied Payment for a Medical Service? You Have a Right to Appeal, Affordable Care Act guidance on appeals from CMS available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/appeals06152012a#whatdenials

Great source for Claim and Appeal Procedures at https://complianceadministrators.com/claim-procedures/

State External Appeal Review Processes, Kaiser Family Foundation, accessed March 22, 2021.

How to file Medicare and Medicare Advantage Plan appeals: https://www.medicare.gov/appeals-if-you-have-a-medicare-health-plan

APPENDIX 1: State Independent External Review Appeal Links

State	External Appeal Form link	Does form require a *physician* certification to expedite the appeal	Other Notes
Alabama	https://www.aldoi.gov/Consumers/CoverageTips.aspx	NO	CALL: 334-241-4141
Alaska	https://www.commerce.alaska.gov/web/ins/Consumers/Health/ExternalHealthcareReview.aspx	YES	
Arizona	https://insurance.az.gov/sites/default/files/documents/files/APPEALS_PROVIDER_CERTIF.pdf	YES	
Arkansas	https://insurance.arkansas.gov/uploads/pages/request_form6.pdf	YES	
California	http://www.insurance.ca.gov/01-consumers/101-help/upload/CSD003IMR20150623_092616.pdf	NO	
Colorado	https://doi.colorado.gov/health-insurance	NO	CALL 303-894-7499
Connecticut	https://portal.ct.gov/-/media/CID/ExternalReviewApplicationpdf.pdf	YES	
Delaware	https://insurance.delaware.gov/wp-content/uploads/sites/15/2019/05/petition-for-iuro-assignment-proposed.pdf	NO	
Florida	https://www.myfloridacfo.com/division/consumers/needourhelp.htm	NO	

APPENDIX 1: State Independent External Review Appeal Links

Georgia	file:///C:/Users/KylaMeyer/Downloads/165340463IRO_Request_Form.pdf	NO	
Hawaii	https://hmsa.com/Media/Default/forms/request-for-external-review.pdf	YES	
Idaho	https://doi.idaho.gov/DisplayPDF?cat=Consumer&id=External%20Review%20Form	YES	
Illinois	https://insurance.illinois.gov/ExternalReview/ExternalReviewMain.html	YES	
Indiana	https://www.in.gov/idoi/2547.htm#2	NO	
Iowa	https://iid.iowa.gov/independent-review-organizations	YES	
Kansas	https://insurance.ks.gov/documents/department/publications/independent-medical-review.pdf	NO	800-432-2484 to get the form
Kentucky	https://insurance.ky.gov/ppc/newdoc_search.aspx	NO	
Louisiana	982	NO	
Maine	ce/consumer/individuals_families/h	NO	
Maryland	https://mmcp.health.maryland.gov/pages/IRO-Information.aspx	NO	
Massachusetts	https://www.mass.gov/service-details/external-review-process-overview	YES	
Michigan	https://www.michigan.gov/difs/0,5269,7-303-12902_35510_92612_92613_92614_92927-497211--,00.html	YES	

APPENDIX 1: State Independent External Review Appeal Links

Minnesota	https://www.health.state.mn.us/facilities/insurance/managedcare/complaint/external.html	YES	
Mississippi	https://www.mid.ms.gov/healthcare/external-review.aspx#:~:text=External%20review%20is%20available%20to,treatment%20from%20an%20insurance%20company.&text=You%20may%20submit%20a%20request,Life%20and%20Health%20Actuarial%20Division.	YES	
Missouri	https://insurance.mo.gov/consumers/health/externalreviewprocess.php	NO	CONTACT DEPARTMENT OF COMMERCE AND INSURANCEI @ 573-751-4126
Montana	https://csimt.gov/insurance/examinations/independent-review-organization-application/#:~:text=In%20Montana%20an%20Independent%20Review,health%20and%20long%2Dterm%20care.&text=3131%2C%20an%20IRO%20must%20obtain,is%20effective%20for%20two%20years.	NO	
Nebraska	file:///C:/Users/KylaMeyer/Downloads/NE-DOI-External-Review-Forms.pdf	YES	
Nevada	https://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/News-Notices/Bulletins/11-013(1).pdf	YES	

APPENDIX 1: State Independent External Review Appeal Links

New Hampshire	https://www.insurancebenefitadministrators.com/uploads/4/9/2/1/49212671/1016.pdf	YES	
New Jersey	https://www.nj.gov/dobi/division_insurance/managedcare/ihcap.htm#:~:text=The%20external%20review%20program%20is,prospective%2C%20concurrent%2C%20or%20retrospective.	NO	
New Mexico	https://hirrconsumer.osi.state.nm.u	NO	
New York	https://www.dfs.ny.gov/complaints/file_external_appeal	YES	
North Carolina	https://secure1.ncdoi.net/consumer/ext_review_entry.jsp	YES	
North Dakota	https://www.insurance.nd.gov/health	NO	CALL THE NUMBER ON THE DENIAL LETTER OR DIVISION OF INSURANCE @ 605-773-3563
Ohio	https://insurance.ohio.gov/wps/portal/gov/odi/consumers/health/how-to-appeal-health-coverage-decision	NO	DEPARTMENT OF CONSUMER HOTLINE @ 800-686-1526 OHIO INSURANCE PORTAL: https://gateway.insurance.ohio.gov/UI/ODI.Saap.Gateway.UI/Account.mvc/LogOn
Oklahoma	https://www.globalhealth.com/media/3637/external-review-request-form_082011.pdf	YES	
Oregon	https://dfr.oregon.gov/business/reg/health/Pages/external-review.aspx	YES	
Pennsylvania	ages/Customer-Service.aspx	NO	https://expressforms.pa.gov/apps/pa
Rhode Island	https://www.physiciansmutual.com/cs/docs/GC-RI.pdf	NO	
South Carolina	https://www.doi.sc.gov/	YES	

APPENDIX 1: State Independent External Review Appeal Links

South Dakota	https://dlr.sd.gov/insurance/external_review_health_major_medical.aspx	YES	
Tennessee	https://www.tn.gov/commerce/tenncare-oversight/mco-dispute-resolution/independent-review-process.html	NO	
Texas	https://www.tdi.texas.gov/consumer/external-review-process.html	NO	
Utah	https://insurance.utah.gov/consumer/health/independent-review	YES	
Vermont	https://dfr.vermont.gov/consumers/file-complaint/insurance/healthcare-external-appeal	YES	
Virginia	https://scc.virginia.gov/pages/External-Review-(1)	YES	
Washington	https://www.insurance.wa.gov/certifying-independent-review-organization-iro	NO	PORTAL LOGIN: https://fortress.wa.gov/oic/onlineservices/Login.aspx?module=FIN
West Virginia	https://www.wvinsurance.gov/Healthcare-Claim-Appeal-Information	YES	
Wisconsin	https://oci.wi.gov/Pages/Consumers/PI-203.aspx	NO	
Wyoming	_	YES	

APPENDIX 2: Sample Appeal Request Letter (to fax) for internal appeal

Insured's/Participant's name
Insured's/Participant's address
City, State, Zip
Policy Number

Date

Anthem BCBS
Attn: Appeals Department [or to whom the health plan document directs you to send]
Street address
City, State, Zip Code
Delivered via fax to: _____

RE: Request for Expedited Appeal of a Concurrent Care Claim – denied physical therapy visits

To Whom it May Concern:

My name is [insert patient's name] and I am the beneficiary of the health plan referenced above. I have been receiving physical therapy at [insert clinic name] for [diagnosis] pursuant to the referral of my [PCP or specialist], Dr. [insert physician's name]. So far I have had ___ visits of [what treatment interventions? manual therapy, therapeutic exercise, etc.?]. I was in the middle of my treatment plan when your utilization review agent, [insert name of URE], failed to authorize any additional visits on [date of URE denial]. *(or "At the end of my treatment plan my therapist determined more visits were medically necessary but your utilization review agent denied more visits.")* My PT and my physician believe additional visits of skilled therapy are medically necessary and disagree with the URE's decision. Therefore, this is a concurrent care claim and I am entitled to an expedited review because interruptions in my care could interfere with my ability to regain maximum function and/or result in my pain becoming unmanageable.

In order to have a full and fair review, I respectfully request a copy of the entire administrative file on my case, including the medical records or any other information that the adverse benefit determination was based on. If you need additional information for me to perfect my claim, you are required to tell me precisely what information you need and why it is necessary. Please forward these materials to me at [insert email or fax number where you want the documents sent].

Thank you,

_____
[patient's name]

APPENDIX 3: Physician Attestation that appeal must be expedited and coverletter to request the letter

Sample letter to physician to request the attestation letter

[on PT practice letterhead]

Date

RE: Assistance required to obtain authorization for PT visits
Patient: _____
DOB: _____

Dear Dr. _____,

Thank you for referring _____ to us for physical therapy. Unfortunately, this patient's insurance company did not approve all the physical therapy visits we requested in our plan of care and we are going to have to file an appeal with the health plan. Your patient's appeal needs to be expedited so care will not be interrupted. ***The health plan needs a letter from you stating that an expedited appeal is necessary.*** (If delay or interruption in care could potentially result in unmanageable pain or jeopardize the ability to regain maximum function, an expedited appeal is warranted under federal and state law.)

Since time if of the essence and we know you are busy, we have taken the liberty of drafting a letter for you that requests an expedited appeal on behalf of your patient. ***Please sign this letter and fax it back to us at [insert your fax number] as soon as possible so we can include it in your patient's appeal request.***

If you have any questions, please feel free to call us. Thank you in advance for your help!

Sincerely,

_____
Therapist's signature

Physician's Practice Name
Physician's Address
City, State Zip

Date

Name of Health Plan
Address for Appeals
City, State Zip

RE: Expedited Appeal Required
Patient: _____
DOB: _____
Insurance ID #: _____

To Whom it May Concern:

The above-named patient is under my care and is receiving medically necessary physical therapy services. I understand that additional medically necessary visits have been denied. I have consulted with the treating physical therapist and agree that an expedited appeal is necessary because interruptions in physical therapy plan of care or failure to extend this patient's course of medically necessary services could jeopardize this patient's ability to regain maximum function and/or result in severe or unmanageable pain. Therefore, in the best interest of this patient, please process the appeal request from the physical therapist and/or patient as an expedited appeal.

_____
Physician's Name (Printed or Typed)