STATE OF WISCONSIN

# Fact Sheet on the Independent Review Process in Wisconsin

OFFICE OF THE COMMISSIONER OF INSURANCE PI-203 (R 01/2011)

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).

As with any other product or service, you may some day have questions or complaints about your health insurance plan. You may be able to resolve a complaint by contacting the health plan's customer service department. You can also file a written grievance with the insurer. All insurance companies offering health benefit plans in Wisconsin are required to have an internal grievance process to resolve any complaint you may have with the plan. You may, at any time, contact OCI with your question or problem.

If you are not satisfied with the outcome of your grievance, 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 independent review?**

The independent review process provides you with an opportunity to have your dispute reviewed by experts who have no connection to your health plan. You choose the IRO from a list of review organizations certified by OCI. 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.

**Who conducts the independent reviews?**

The independent reviews are conducted by IROs that are certified by OCI. In order to be certified, the IRO must demonstrate that it is unbiased and that it has procedures to ensure that its clinical peer reviewers are qualified and independent.

**What types of disputes can be decided through independent review?**

There are several types of disputes eligible for an independent review.

An independent review is available whenever your health plan denies you coverage for treatment because it maintains that the treatment is not medically necessary or that it is experimental, including a denial of your request for out-of-network services when you believe that the clinical expertise of the out-of-network provider is medically necessary. The treatment must otherwise be a covered benefit under the insurance contract. Also, the total cost of the denied coverage must exceed $295.

An independent review is also available whenever your health plan denies you coverage for treatment on the basis of a preexisting condition exclusion. In addition, you may request an independent review if the insurer rescinds your health insurance policy or certificate. Rescission means that the insurer retroactively cancels your policy or modifies the terms of the policy because it maintains that you did not answer the health questions on the application for insurance completely and accurately. There is no minimum cost requirement for denials based on a preexisting condition exclusion or a rescission.

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

**What types of disputes are not eligible for independent review?**

No health benefit plan covers all medical expenses. 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 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 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 brochure. These plans generally have a different appeal process, which is explained in your member materials.

**When can I request an independent review?**

Whenever your insurer makes a coverage denial determination that is eligible for an independent review, it must provide you with information on your appeal rights, including its internal grievance procedures and your right to request an independent review. It must also explain how you can obtain additional information on its

internal grievance and independent review processes. 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?**

After you receive the insurer's final decision on your grievance, choose an IRO from the list provided by the insurer. Then send a written request for independent review to the insurance company at the address provided in its grievance decision letter. The insurer must receive your request for an independent review 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 that the treatment should be covered,
- any additional information or documentation that supports your position,
- if someone else is filing on your behalf, a statement signed by you authorizing that person to be your representative, and
- any other information requested by your insurer.

Your insurer should have provided you with a list of certified IROs and with detailed information on how to request a review with its written grievance decision.

**What documents should I provide that will help the IRO make a determination?**

You may provide the IRO any information that 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 that the time period for resolving an internal grievance will cause a delay that could jeopardize 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 can also call the health plan's toll-free telephone number to request information on the independent review process and to request a copy of the list of certified IROs. When you have the information you need, send your request to the IRO at the same time you send it to the insurer. 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 that your health condition does not require its immediate review of your dispute, it will notify you that you must 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?**

The insurer must send all relevant medical records and other documentation used in making its decision and all of the documentation you sent to support your request to the IRO within five business days. The IRO then has five business days to review the information and to request any additional information it may need from the insurer or from you. After it receives the information it needs, the IRO has thirty business days to make its decision.

If the IRO determines that this time period could jeopardize your life or health, the insurer must send its documentation within one day and the IRO then has two business days to request any additional information. The IRO must make its decision within 72 hours after receiving all of the information it needs.

**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. It may only reverse an insurer's denial based on an experimental treatment determination if it determines that the treatment has been approved by the FDA, and also that medically and scientifically accepted evidence clearly demonstrates that 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.

You may also contact OCI at the address, phone number, or electronic mail address below. OCI has a new brochure, *Consumer's Guide to Grievances and Complaints*, to help with the entire appeals process.

**For information on how to file insurance complaints, call:**

(608) 266-0103 (In Madison)
or 1-800-236-8517 (Statewide)

**For your convenience a complaint form is included on OCI's Web site at:**

oci.wi.gov/com_form.htm

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