Understanding Your Healthcare Rights

The Louisiana Department of Insurance does not make determinations of medical necessity.

However, if your health insurance plan denies a medical service because it views the treatment as not medically necessary, you have a right to appeal the decision with the health plan.

What should I do if my health insurer has denied my claims for a treatment or procedure as not medically necessary?

If your claim was denied, you may have options. Louisiana has laws in place that outline the appeals process. Your health insurance company is required to provide notice that internal appeals processes are available and instructions to you on how to request an internal appeal.

What does the law say about appeals?

The Louisiana Legislature approved Act 326, which added the Internal Claims and Appeals Process and External Review Act (the "Act") to the Insurance Code. The Act is comprised of Louisiana Revised Statutes 22:2391 to 2453. The Act, in part, helped provide uniform standards for health insurers to maintain or create internal claims and appeals processes.

In the event that your claim is denied (referred to as adverse determination), the law also provides standards for external review procedures. An external review gives a policyholder the opportunity for an independent review of the health insurer's decision.

After you receive an adverse determination, you are able to appeal the decision within 180 days after the receipt of notice. In most instances, you appeal your adverse determination by submitting a written request to your health insurance company within this time period. Instructions for how to appeal an adverse determination should be included in the notice of adverse determination that the health insurance company is required to send you.

What happens if I file an appeal and it is denied?

If the health insurance company denies your internal appeal, you will receive notice of a final adverse determination from the company. If you receive a notice of a final adverse determination, you may be able to request an external review by an impartial independent review organization (IRO) that is randomly assigned by the Louisiana Department of Insurance.

Your request for an external review must be submitted within four months of the receipt of the notice of final adverse determination. In most instances, you appeal your final adverse determination by submitting a written request for an external review to your health insurance company. The notice of final adverse determination sent by the health insurance company to you should provide instructions on the process you should follow to request an external review.

How do I know if I qualify for an external review of my claim?

You may request an external review if the following conditions are met:

- The internal claims and internal appeals process must be exhausted. In most instances, this means you must have received a notice of final adverse determination from your health insurance issuer.
- The adverse determination and final adverse determination at issue must involve medical necessity, appropriateness, health care setting, level of care, effectiveness, experimental or investigational treatments, or a rescission of coverage. Rescission refers to the cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

What circumstances would prevent me from getting an external review?

You may request an external review if the following conditions are met:

- When the health care service or treatment you are requesting is not a benefit that is covered or payable under the policy or certificate of coverage.
- External reviews are not available for limited benefit plans, short-term plans, workers' compensation plans, or self-funded ERISA-qualified health plans.

What if my claim for a treatment or procedure involve an urgent matter?

An expedited internal appeal and an expedited external review are available if the treatment or procedure that is the subject of the adverse determination is one that delay in the rendering of a decision by the health insurance company or the IRO would seriously jeopardize your life or health or your ability to regain maximum function. An expedited internal appeal is filed after receipt of a notice of an adverse determination. An expedited external review can be filed after the receipt of a notice of an adverse determination or after the receipt of a notice of a final adverse determination. If an expedited external review is filed after the receipt of a notice of an adverse determination, it must be filed at the same time that the expedited internal appeal is filed. The IRO assigned will determine if the expedited internal appeal should be skipped and the matter reviewed as an expedited external review.

What if my claims involve a treatment or procedure deemed experimental or investigational?

The procedure for an internal appeal involving an experimental or investigational treatment or procedure are basically the same as those described for internal appeals in the first portion of this document.

The procedure for seeking an external review of an experimental or investigational treatment or procedure are not different for you. The request for an external review of an experimental or investigational treatment must still be submitted within 4 months. However, the external review process is somewhat different when an experimental or investigational service is at issue. The largest difference in the procedure is that an IRO assigned to an experimental or investigational external review must select one or more clinical peers to review the health insurance company's determination. Clinical peers are not required for external reviews that do not involve experimental or investigational service

If you have questions about navigating the appeals process, please contact the Louisiana Department of Insurance Office of Consumer Advocacy and Diversity at 1-800-259-5300 or (225) 219-0619.