

Delaware External Claim Review Information Packet

Please read this packet carefully. This packet contains important information about how to request an External Claim Review in the State of Delaware.

I. External Review Process

A. Independent Health Care Appeals Program

You may apply to the Independent Health Care Appeals Program for a review of any decision to deny, reduce, or terminate covered benefits if you have already completed the administrative rights of appeal process and you contest the final claim review by the insurer. Within 60 days of the date the final claim review was issued by the insurer, you or your authorized representative may file a request for an External Review with the insurer. Upon receipt of a request for an External Review, the insurer will send a copy of the request to the Delaware State Insurance Department.

B. Review Procedures

The Department will, at the time of the receipt of the request for an External Review, assign an Independent Utilization Review Organization (IURO) from the list of certified IUROs and will so inform the insurer. The IURO will notify you or your authorized representative in writing that they have been assigned to conduct an External Review. Included in the notice will be a statement that you or your authorized representative may submit additional information and supporting documentation that the IURO will consider when conducting the External Review. Such additional information must be submitted within seven days of receipt of the notification.

Within seven calendar days after the date on which the insurer receives notice of the IURO assigned, the insurer will provide to the assigned IURO all documents and information utilized in making the final decision to deny, reduce, or terminate benefits, as well as the final written decision from the insurer. If the denial, reduction, or termination of benefits by the insurer is based on grounds other than medical necessity or the appropriateness of services, review of the final decision will be through the Department of Insurance. If a denial, reduction, or termination of benefits should be reviewed by both an IURO and by the Department of Insurance, or where there is ambiguity as to where the review should be conducted, the review will be conducted by an IURO.

The Department of Insurance will refer any appeals that are incorrectly filed with it to the Department of Health and Social Services, where such appeals will be treated as timely if they were filed with the Department of Insurance within the time restraints shown. The Department of Health and Social Services will forward any appeals that are incorrectly filed with it to the Department of Insurance and appeals that are incorrectly filed with the Department of Health and Social Services will be treated as timely if they were filed within the time constraints shown.

C. Decision by an IURO

The IURO will promptly review your pertinent medical records to determine whether the insurer's denial, reduction, or termination of benefits deprived you of medically necessary services covered by your health benefits plan, based on applicable, generally accepted practice guidelines developed by the federal government, national or professional medical practice societies, boards, or associations, and any applicable clinical protocols or practice guidelines developed by the insurer. The IURO will complete its review and make its written determination within 45 days of receipt of a completed application for an appeal review. In no event will appeals involving an imminent, emergent, or serious threat to your health, as determined by the treating health care practitioner, exceed 72 hours. Upon completion of the review, the IURO will state its findings in writing and make a determination of whether the insurer's denial, reduction, or termination of benefits deprived you of medically necessary services covered by your health benefits plan. If the IURO determines that the denial, reduction, or termination of benefits deprived the person of medically necessary covered services, it will send a determination to you and the insurer. The determination will be binding on the insurer and the insurer will promptly notify you of what action it intends to take to implement the determination.

Nothing will be construed to require the insurer to pay for services not otherwise covered under the plan.

D. Expedited Review

The IURO will have procedures to provide for an expedited review of the insurer's denial, reduction, or termination of a benefit decision when a delay in receipt of the services could seriously jeopardize your health or well being.

E. Confidentiality

Your medical records provided to the insurer and the IURO and the findings and recommendations of the IURO are confidential and will be used only by the Department, the IURO, and the insurer. The medical records and findings and determinations will not otherwise be divulged or made public so as to disclose the identity of any person to whom they related and will not be included under any materials available to public inspection.

The insurer may at any time determine to provide the requested medical services by so notifying the IURO or the Secretary, and you. Such notification will terminate the External Review process.

II. Definitions

IURO (Independent Utilization Review Organization) means an organization certified by the Secretary of the Insurance Department to provide independent Medical Necessity or appropriateness of services review of the final decision of the insurer to deny, reduce, or terminate benefits.

Medical Necessity means the providing of covered health care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, disease, or its symptoms in a manner that is:

- (1) In accordance with generally accepted standards or medical practice;
- (2) Consistent with the symptoms or treatment of the condition; and
- (3) Not solely for anyone's convenience.

III. Obtaining Medical Records

A. Requesting Medical Records

You have the right to ask for a copy of medical records. Your request must be in writing. Your request must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

B. Designated Decision Maker

If you have a designated health care decision maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision maker or a person designated in writing by your health care decision maker unless you limit access to your medical records only to yourself or your health care decision maker.

C. Confidentiality

Medical Records disclosed under any State Regulations remain confidential.

IV. Documentation

If you decide to file a request for review, you must give the person who will be responsible for processing the review any material justification or documentation for the review at the time the review is filed. You must also give that person the address and phone number where you can be contacted.

V. Confidentiality

If you participate in the review process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other person.

VI. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.