

# Coverage Appeals

This fact sheet provides information and guidance that Navigators and certified application counselors (collectively, assisters) need to know to help consumers appeal an eligibility decision made by their health insurance issuer.

Note: This job aid provides information on health insurance issuer appeals only. Consumers can appeal both Marketplace and health insurance issuer decisions, but the appeals process is different for each. For guidance on Marketplace appeals, refer to [SOP 10—Request A Marketplace Eligibility Appeal](#).

Overview.....	2
Consumer Rights .....	2
Adverse Benefit Determination Notice .....	2
Culturally and Linguistically Appropriate Manner .....	3
Types of Appeals .....	4
Internal Appeals Process .....	4
Special Appeals Situations.....	7
External Review Process Overview .....	8
Steps for External Review Process .....	9
State External Review .....	10
Federal External Review Process .....	11
Resources .....	13

Version 1.0 June 2022. This information is intended only for the use of entities and individuals certified to serve as Navigators or certified application counselors in a Federally-facilitated Marketplace. The terms “Federally-facilitated Marketplace” and “FFM,” as used in this document, include FFM where the state performs plan management functions. Some information in this manual may also be of interest to individuals helping consumers in State-based Marketplaces and State-based Marketplaces using the Federal Platform. This document is intended only as a summary of legal requirements and to provide operational information and does not itself create any legal rights or obligations. All legal requirements are fully stated in the applicable statutes and regulations. The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law. This material was printed, published, or produced and disseminated at U.S. taxpayer expense.

## Overview

### Consumer Rights

If a health insurance plan denies a benefit, refuses to pay for a service that has already been received, or rescinds coverage, this is called an adverse benefit determination (ABD). As described under the [2015 final rule for internal claims, appeals and external review](#), the Affordable Care Act (ACA) ensures a consumer's right to appeal group health plan and health insurance plan (plan and issuer) decisions, asking a plan or issuer to reconsider its decision.

If the plan or issuer upholds its initial decision, the consumer may be eligible for a second review (known as external review) by an independent third-party reviewer.

Additionally, section 110 of the No Surprises Act (NSA) expanded external review rights by:

- Making available external review for any adverse benefit determination that involves patient cost-sharing and notice and consent covered by the protections under the NSA; and
- Making external review of NSA compliance matters available to individuals enrolled in grandfathered health plans or coverage.

This expanded scope is applicable for claims as of January 1, 2022.<sup>i</sup>

### Adverse Benefit Determination Notice

A claim is any request for benefits, including pre-service (prior authorization) and post-service (reimbursement). Plans and issuers are required to make a benefit determination within an established timeframe.

An adverse benefit determination (ABD) is a 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 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; and any rescission of coverage.

Exhibit 1 lists the required timeframe for health insurance issuers to make a benefit decision depending on the type of claim.

### Exhibit 1 - Benefit Determination Timeframes

Type of Claim	Benefit Determination Timeframe
Pre-service (prior authorization)	Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 calendar days
Post-service (reimbursement)	Within a reasonable period of time, but not later than 30 calendar days
Urgent care	As soon as possible, taking into account the medical exigencies, but not later than 72 hours

When providing notice of ABDs, plans and issuers must:

- Provide information sufficient to identify the claim.
- Provide the diagnosis and treatment codes and their meanings.
- Describe reason(s), including denial code and its meaning, as well as a description of any standard used in denying the claim.
- Provide a description of available internal appeals and external review processes, including how to initiate an appeal.
- Disclose the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsperson.

### Culturally and Linguistically Appropriate Manner

When 10 percent of a county is literate only in the same non-English language(s), plans and issuers providing notices related to ABDs, appeals, and external reviews are required to provide for enrollees in that county:

- Oral language services and assistance with filing claims and appeals (including external review) in the applicable non-English language;
- Notices, upon request, in the applicable non-English language; and
- In English versions of notices, a statement prominently displayed in the applicable non-English language indicating how to access language services provided by the plan or issuer.

## Types of Appeals

There are two ways to appeal a health plan decision:

- **Internal appeal.** If a consumer is appealing an eligible ABD, they may ask the insurance company to conduct a full and fair review of its decision. If the case is urgent, the insurance company must speed up this process.
- **External review.** If a consumer disagrees with an issuer’s decision after an internal appeal, they can request an external review by an independent third party. This means that the insurance company no longer gets the final say over whether to pay a claim. An external review may be completed by either a state or a federal external review program.

Exhibit 2 describes who receives the appeal request for each type of appeal.

**Exhibit 2 – What Entity Receives Appeal Requests**

Process	Who Receives the Request
Internal appeals	<ul style="list-style-type: none"> <li>▪ Health plan or issuer</li> </ul>
External review – state process*	<ul style="list-style-type: none"> <li>▪ State Department of Insurance, or</li> <li>▪ State Department of Health, or</li> <li>▪ Health plan or issuer</li> </ul>
External review – federally administered process (in AL, FL, GA, PA, TX, WI, American Samoa, Guam, Northern Mariana Islands, and Virgin Islands)	<ul style="list-style-type: none"> <li>▪ Health plan or issuer, or</li> <li>▪ HHS-administered process contractor</li> </ul>

\* A list of the external review processes that apply to each state and territory is available at [CMS.gov/CCIIO/Resources/Files/external\\_appeals](https://www.cms.gov/CCIIO/Resources/Files/external_appeals).

## Internal Appeals Process

There are three steps in the internal appeals process:

1. The consumer files a claim.
2. The health plan denies the claim. The insurer must notify the consumer in writing and explain why they denied the claim within the required timeframe, as described above.
3. The consumer files an internal appeal. To file an internal appeal, the consumer needs to:
  - Complete all forms and processes required by their health insurer. The issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
  - Submit any additional information that the consumer wants the insurer to consider, such as a letter from the doctor.



Note: The Consumer Assistance Program in a consumer's state can file an appeal for them.

Additional information on filing an appeal can be found at [HealthCare.gov](https://www.healthcare.gov).

Consumers can appeal the following determinations:

- The benefit isn't offered under the consumer's health plan.
- The consumer received health services from a health provider or facility that isn't in their plan's approved network.
- The requested service or treatment is "not medically necessary."
- The requested service or treatment is an "experimental" or "investigative" treatment.
- The consumer is no longer enrolled or eligible to be enrolled in the health plan.
- The issuer is revoking or canceling the consumer's coverage going back to the date they enrolled because the plan or issuer claims that the consumer did something that constitutes fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

A consumer has 180 days from receipt of denial to file an appeal. Consumers should generally file an appeal in writing. However, if the appeal is urgent, an oral appeal is acceptable. When filing an appeal, consumers should keep copies of all information related to the claim and the denial, including the documents described in Exhibit 3. When asked to submit information to the plan or issuer, consumers should keep original documents and submit copies to the insurance company.

#### Exhibit 3 - Appeals Process Documentation

Appeals Process Documentation	
<ul style="list-style-type: none"><li>▪ The Explanation of Benefits (EOB) forms or letters showing what payment or services were denied.</li><li>▪ A copy of the request for an internal appeal sent by the insurance company.</li><li>▪ Any documents with additional information sent to the insurance company (like a letter or other information from a doctor).</li></ul>	<ul style="list-style-type: none"><li>▪ A copy of any letter or form a consumer is required to sign if they choose to have their doctor or anyone else file an appeal for them.</li><li>▪ Notes and dates from any phone conversations a consumer has with their insurance company or their doctor that relate to the appeal. Include the date, time, name, and title of the person they talked to and details about the conversation.</li></ul>

At the end of the internal appeals process, the insurance company must provide the consumer with a written decision. If the insurance company still denies the service or payment for a service, the consumer can ask for an external review. The insurance company's final

determination must include instructions on how the consumer can ask for an external review (for more information on external reviews, refer to [External Review Process Overview](#)). Exhibit 4 lists the timeline for issuers to make an internal appeals decision based on the appeal type.

**Exhibit 4 - Internal Appeals Decision Timeframes**

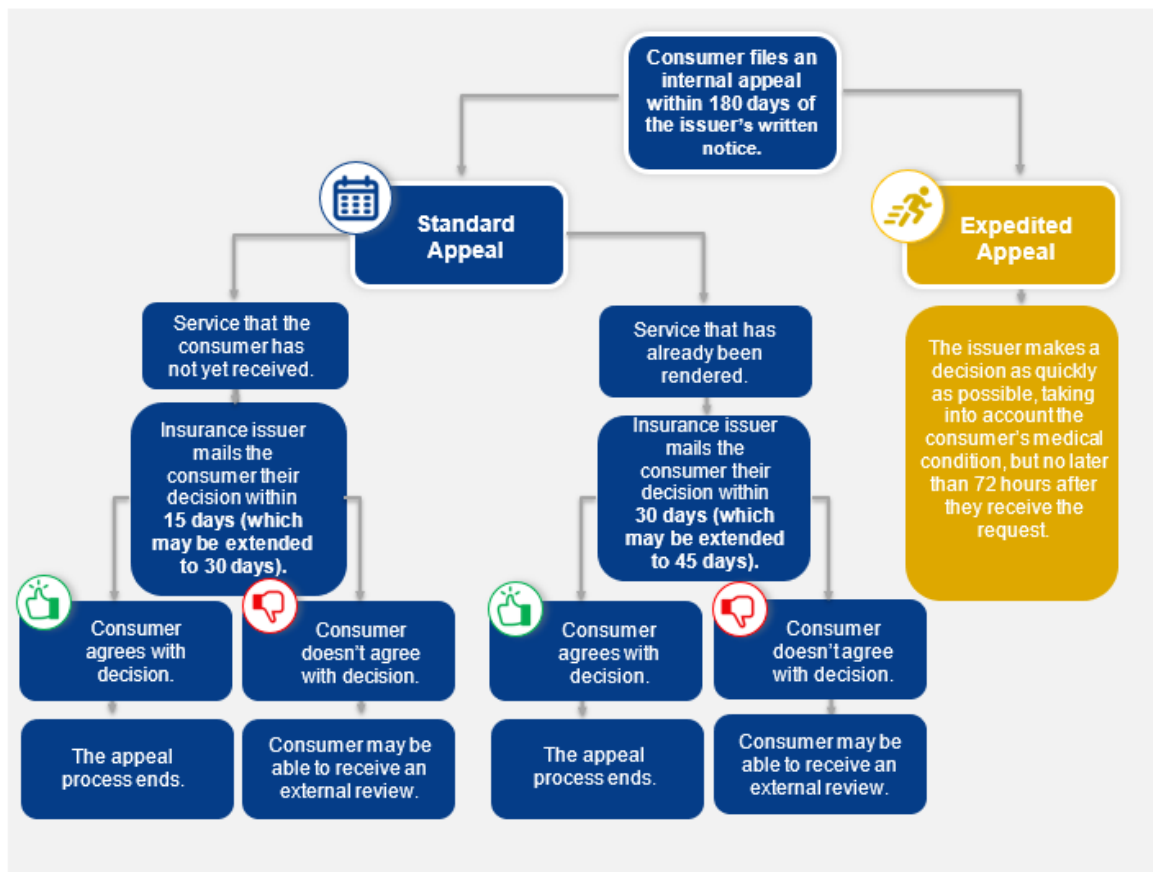
Type of Claim	Internal Appeals Decision Timeframe
Pre-service (prior authorization)	15 calendar days* (May be extended one time by the plan for up to 15 days, if necessary due to matters beyond the control of the plan and notifies the claimant)
Post-service (reimbursement)	30 calendar days* (May be extended one time by the plan for up to 15 days, if necessary due to matters beyond the control of the plan and notifies the claimant)
Urgent care	As soon as possible, taking into account the medical exigencies, but not later than 72 hours

\*The plan must notify the claimant of an extension prior to the expiration of the initial period.

Exhibit 5 summarizes the internal appeals process.



Exhibit 5 - Internal Appeals Process



## Special Appeals Situations

There are special situations that issuers must consider when reviewing an appeal.

### *Urgent care*

An urgent care situation occurs when:

- The standard appeal timeframe could seriously jeopardize a consumer's life, health, or ability to regain maximum function; or
- In the opinion of a physician with knowledge of the consumer's medical condition, the standard appeal timeframe would subject a consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

In these urgent situations, a consumer may file orally, and notice of an appeal decision may be delivered orally (but must be followed by a written notice within three days). Individuals in urgent care situations may initiate an internal appeal and external review simultaneously.

A final decision about the urgent appeal must come as quickly as the consumer's medical condition requires and no later than 72 hours after the request is received. This final decision can be delivered verbally but must be followed by a written notice within 48 hours.

### *Deemed exhaustion*

In the following cases, an internal appeal is deemed exhausted, allowing a consumer to move to an external review without completing the internal appeals process:

- The plan or issuer waives an internal appeal.
- Urgent care situations (expedited external review may be initiated at the same time as expedited internal appeals).
- Failure to comply with all requirements of the internal appeals process except in cases where the violation was:
  - *De minimis* (i.e., small scale or of insufficient importance);
  - Non-prejudicial;
  - Attributable to good cause or matters beyond the plan's or issuer's control;
  - In the context of an ongoing good-faith exchange of information; and
  - Not reflective of a pattern or practice of non-compliance.

## **External Review Process Overview**

If a consumer disagrees with an issuer's decision after an internal appeal, they can request an external review. Plans and issuers in all states must offer an external review process that meets the federal consumer protection standards performed at either the state or federal level.

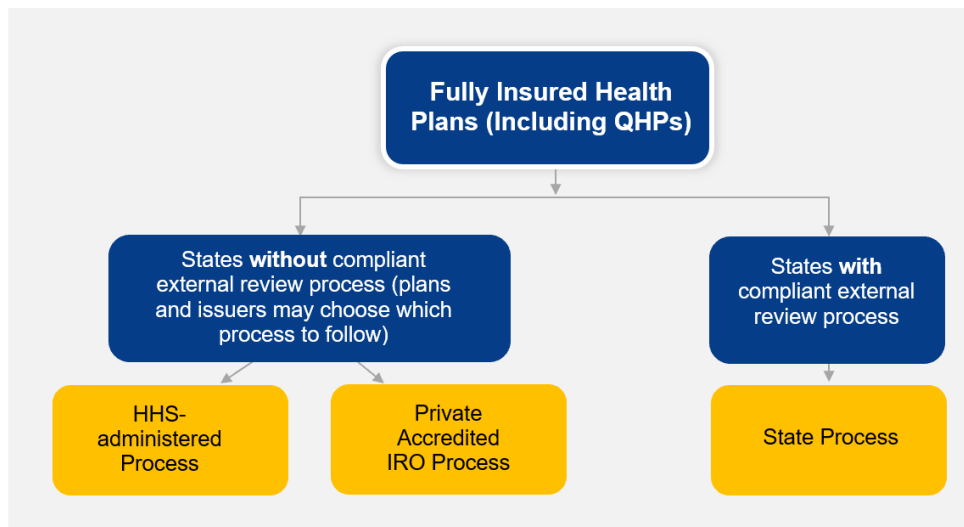
- **State review:** States may have an external review process that meets or goes beyond the minimum federal consumer protection standards. If so, plans and issuers in that state will follow the state's external review processes. For self-funded group health plans subject to a state external review process which meets the minimum standards of the NAIC Uniform Model Act, the plan must comply with the applicable state external review process and is not required to comply with the federal external review process.



- If a plan or issuer has contracted with an IRO or is using a state external review process, a consumer may be charged a filing fee. If so, the charge can't be more than \$25 per external review request and must be refunded if the ABD is reversed or waived if it would impose an undue financial hardship.
- **Federal review:** If a state does not have an external review process that meets the minimum federal consumer protection standards, the Department of Health and Human Services (HHS) oversees an external review process for plans and issuers in the state.
  - In states where the Federal Government oversees the process, plans and issuers must choose to participate in either an HHS-administered process or contract with independent review organizations (IROs). If a plan or issuer is using the HHS-administered federal external review process, there's no charge to file an external review request.

Exhibit 6 illustrates the state and federal external review process.

**Exhibit 6 - State and Federal Review Processes**



## Steps for External Review Process

Instructions for requesting an external review are found in health plan documents. There are two steps in the external review process:

1. The consumer files a written request for an external review within four months after the date they receive a notice or final determination from their insurer that their claim has been denied.

A consumer may appoint a representative (like their doctor or another medical professional) who knows about their medical condition to file an external review on their behalf. If the consumer is using the HHS-administered process, an authorized representative form is available at [Externalappeal.cms.gov/ferportal/public/docs/Appointment%20of%20Representative%20Form.pdf](https://externalappeal.cms.gov/ferportal/public/docs/Appointment%20of%20Representative%20Form.pdf).

2. The IRO issues a final decision. An IRO either upholds the plan or issuer's decision or decides in the consumer's favor. The plan or issuer is required by law to accept the IRO's decision.

Standard external reviews are decided as soon as possible, but no later than 45 days after the request was received. Expedited external reviews are decided as soon as possible, but no later than 72 hours depending on the medical urgency of the case, after the request was received. Exhibit 7 summarizes the external review process.

Exhibit 7 - External Review Process



## State External Review

### *Minimum Requirements*

The scope of claims meeting minimum state review standards applies to ABDs based on:

- Medical necessity
- Appropriateness
- Health care setting
- Level of care

- Effectiveness of a covered benefit
- No Surprises Act (NSA) compliance matters,<sup>ii</sup> including:
  - Patient cost sharing for emergency services.
  - Patient cost sharing related to care provided by nonparticipating providers at participating facilities.
  - Whether patients are in a condition to receive notice and provide informed consent to waive NSA protections.
  - Whether a claim for care received is coded correctly and accurately reflects the treatments received and the associated NSA protections related to patient cost sharing.

## **Federal External Review Process**

The Federal external review process includes two options that plans or issuers can follow:

- HHS-administered federal external review process; or
- Accredited IRO federal external review process.

### *Scope of Claims Eligible for External Review under the Federal External Review Process*

The scope of claims eligible for external review under the federal external review process (both HHS-administered and accredited IRO) includes ABDs (or final internal ABDs) involving:

- Medical judgment, including, but not limited to:
  - Determinations that involve medical necessity
  - Appropriateness
  - Health care setting
  - Level of care
  - Effectiveness of a covered benefit
  - Experimental and investigational treatments
- Rescission of coverage, if improperly applied; and<sup>iii</sup>

- NSA compliance matters, including:
  - Patient cost sharing for emergency services
  - Patient cost sharing for care provided to patients by nonparticipating providers at participating facilities
  - Whether patients are in a condition to receive notice and provide informed consent to waive NSA protections
  - Whether a claim for care received is coded correctly and accurately reflects the treatments received and the associated NSA protections related to patient cost sharing and surprise billing

#### *Federal External Review Process Requirements*

The federal external review process requirements include minimum consumer protections in the NAIC Uniform Model Act. This Act provides uniform standards for the establishment and maintenance of external review procedures, as described earlier. The federal external review process does not impose any costs, including filing fees, on the claimant requesting the external review.

#### *HHS-administered External Review Process*

Plans and issuers that elect to use the HHS-administered federal external review process and consumers whose plan or issuer is participating in the HHS-administered federal external review process will work with a designated federal contractor which, in consultation with and on behalf of HHS, performs the administrative functions of the external review. This contractor is [MAXIMUS Federal Services, Inc. \(MAXIMUS\)](#).

#### *Accredited IRO Federal External Review Process*

If a plan or issuer elects to use the accredited IRO federal external review process, the plan or issuer must contract with at least three IROs and rotate external review assignments among them. The plan or issuer may use an alternative process for IRO assignment. However, the plan or issuer is expected to document how any alternative process constitutes an impartial assignment method and how it ensures that the process is independent and unbiased. The plan or issuer is not permitted to provide financial incentives to IROs based on the likelihood that the IRO will support the denial of benefits.

#### *Additional Information about External Reviews Related to NSA Compliance Matters*

If a state external review process cannot accommodate external reviews of NSA compliance

matters, HHS is offering states the opportunity to refer external review requests that involve NSA compliance matters to the federal HHS-administered external review process. States that HHS has previously determined meet the minimum standards for state external review may direct plans and issuers to use the federal HHS-administered process for external review of NSA compliance matters and will still be considered to have an applicable state external review process.

Alternatively, plans and issuers subject to an applicable state external review process that cannot accommodate external review of NSA compliance matters may choose to use the accredited IRO-contracting federal external review process for NSA compliance matters only. However, plans and issuers must meet all requirements under those rules, including the requirement to make any necessary changes to existing contracts with IROs to accommodate external reviews of NSA compliance matters, as well as updating plan documents.

## Resources

- Assister Webinar: [Internal Claims and Appeals and the External Review Process Overview](#)
- Consumer Information: [Healthcare.gov/appeal-insurance-company-decision/appeals/](#)
- HHS-Administered Federal External Review Process (MAXIMUS): [Externalappeal.cms.gov/ferportal/#/home](#)
- Regulations and guidance are available on the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight (CCIIO) website: [CMS.gov/ccio/resources/regulations-and-guidance#ExternalAppeals](#)

---

<sup>i</sup> Requirements Related to Surprise Billing; Part II Interim final rules with request for comment, 86 FR 55980 (Oct. 7, 2021), [Federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii](#).

<sup>ii</sup> NSA compliance matters were added to the scope of state external reviews beginning January 1, 2022.

<sup>iii</sup> [45 CFR §147.128](#)

