Independent External Review of a Denied Claim

- Please read this information if you are not a member of a self-funded health plan and your claim was denied:
  - for medical necessity; or
  - for a pre-existing condition; or
  - as an experimental or investigational service.
- If your claim was denied for any other reason, or if you are a member of a self-funded health plan, you do not have the right to an independent external review. You do not need to read this information.

Anthem Blue Cross and Blue Shield (Anthem BCBS) offers two levels of internal appeal. The second level appeal is not required by Anthem BCBS before you initiate further action. However, we welcome the opportunity to provide you with both levels of review.

**When You May Request an External Review of an Adverse Level Two Appeal Decision:**
You or your authorized representative may be dissatisfied with the outcome of an Appeal relating to an adverse health care treatment decision rendered by Anthem BCBS. If so, you or your authorized representative may make a written request for external review to the Bureau of Insurance.

- An adverse health care treatment decision is a decision made by us, or on our behalf, denying payment for a covered service involving issues of medical necessity, pre-existing condition or experimental or investigational services.
- The request for external review must be made within 12 months of the date you have received the final adverse health care treatment decision.

**When you May Request an Expedited External Review**
You or your authorized representative may make a written request for external review to the Bureau of Insurance without exhausting all levels of Anthem BCBS’s internal grievance procedure if:
1. Anthem BCBS has failed to make a decision on an appeal within the time period required.
   - First level appeal decisions must be issued within 20 working days (except where we require additional information and notify you of the delay).
   - Second level appeal decisions must be issued within 30 working days.
2. Anthem BCBS and you both agree to bypass the internal appeals process.
3. The life or health of the member is in serious jeopardy.
4. The member has died.

**How to Initiate an External Review**
You may request help with initiating an external review by writing to the Bureau of Insurance at State House Station 34, Augusta, Maine 04333 or by calling 1-800-300-5000. You may also call the telephone number on the back of your health plan ID card.
You are not required to pay a filing fee when requesting external review.
How External Review Decisions Are Made
The Bureau of Insurance will oversee the external review process and will contract with and select an independent review organization. Anthem BCBS will pay for the cost of the external review, but you are responsible for the cost of any outside representation or assistance you use. In making a decision, the independent review organization will consider the appropriateness of the requested covered service based on the following:
1. All relevant clinical information relating to the member’s physical and mental condition;
2. Any concerns expressed by the member concerning his or her health status; and
3. All relevant clinical standards and guidelines, including those standards and guidelines relied upon by us or our utilization review entity.

The Member May:
- Submit and obtain evidence relating to the adverse health care treatment decision under review;
- Attend the external review;
- Ask questions of any representative of Anthem BCBS present at the external review. If you wish to ask questions of a particular representative, provide the name of the representative or whatever information you have which would identify the representative at the time you request the external review; and
- Use of outside assistance during the review process at the member’s own expense.
- The external review decision must be made in writing and must be based on the evidence presented by Anthem BCBS and the member or the member’s authorized representative.

When External Review Decisions Are Made
The Independent Review Organization is required to render a written decision within 30 days after it receives a completed request for external review from the Bureau of Insurance. However, an external review decision must be made as expeditiously as a member’s medical condition requires. It must be made no more than 72 hours after receipt of the completed request for external review if:
- The 30-day time frame described above would seriously jeopardize the life or health of the member; or
- The 30-day time frame described above would jeopardize the member’s ability to regain maximum function.

If the independent external review organization overturns Anthem BCBS’s denial of your claim, Anthem BCBS will arrange for the processing of appropriate benefits within 30 days of our receipt of all documentation necessary to process your claim.

Binding Nature of the Decision
The external review decision is binding on Anthem BCBS. The member or the member’s authorized representative may not file a request for a subsequent external review involving the same adverse health care treatment decision for which the member has already received an external review decision.

You may seek assistance from or file a complaint with the Bureau of Insurance by writing to the Bureau of Insurance at State House Station 34, Augusta, Maine 04333 or by calling 1-800-300-5000.