Know Your Rights – External Review of Denials

Your denial may be eligible for an Independent External Review. An External Review is a free service to help you if your health carrier denies coverage of certain covered benefits as explained below.

There are two types of External Review available:

1. The Independent External Review process administered by the Virginia Bureau of Insurance (Bureau). This process is available when your insurer denies coverage of certain services. Learn more about the process in this document and by visiting the Bureau's External Review webpage. scc.virginia.gov/pages/External-Review-(1). **You are encouraged to contact the Bureau to discuss your situation and what options are available to you before submitting External Review forms.**

   State Corporation Commission
   Bureau of Insurance - External Review section:
   ExternalReview@scc.virginia.gov
   (804) 371-9032 or
   1-877-310-6560; option #4

2. The federally-administered Balance Billing External Review process, which is available when your insurer covers a service but indicates that the provider can balance bill you or bill you for a cost share that is higher than that allowed under the federal No Surprises Act (NSA). Additional information about the NSA External Review process can be found at: https://externalappeal.cms.gov.

Examples of adverse benefit determinations that are not subject to either External Review process are administrative denials, such as benefit exhaustion and policy exclusions.

Contact the Bureau of Insurance if you have a complaint related to an administrative denial:

State Corporation Commission
Bureau of Insurance – Consumer Services section:
BureauofInsurance@scc.virginia.gov
1-877-310-6560

If the plan is a managed care health insurance plan (MCHIP), include the following language: For help with an appeal and understanding your rights, you may contact the Office of the Managed Care Ombudsman at:

State Corporation Commission
Office of the Managed Care Ombudsman
Ombudsman@scc.virginia.gov
1-877-310-6560; option #3

External Review Eligibility Information

Independent External Review Administered by the Virginia Bureau of Insurance

Required by § 38.2-3559 of the Code of Virginia

If we have denied your request for the provision of or payment for a health care service or course of treatment, you may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Commission.

If the covered person's adverse determination involves **(i) cancer or (ii) a medical condition where the time frame for completion of an expedited internal appeal of an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function**, the covered person or his authorized representative may file a request for an expedited external review.

If the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is **experimental or investigational** and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, the covered person or his authorized representative may file a request for an expedited external review.

If the covered person or his authorized representative files a request for an expedited internal appeal with the health carrier, he may file at the same time a request for an expedited external review of an adverse determination. The independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited internal appeal prior to conducting the expedited external review.

If the covered person or his authorized representative files a standard appeal with the health carrier's internal appeal process, and the **health carrier does not issue a written decision within 30 days** following the date the appeal requesting a review is filed and the covered person or his authorized representative did not request or agree to a delay, the covered person or his authorized representative may file a request for external review and shall be considered to have exhausted the health carrier's internal appeal process.