PRESS RELEASE

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NEW STATE PROGRAM REVERSES 13 MEDICAL DECISIONS BY INSURANCE COMPANIES

In the first six months of a new consumer-oriented program at the Arizona Department of Insurance, 61 individuals appealed adverse decisions by their health care insurers.

Arizona Insurance Director Charles R. Cohen said the Health Care Appeals Program gives consumers the ability to appeal to his agency adverse decisions by health insurers, including whether a procedure is medically necessary.

"The purpose of this program is to assure that Arizona consumers have a process available to them to enforce their rights to the health care coverage they have paid for and are entitled to," Cohen said.

Of the 61 cases submitted to the Insurance Department, 34 decisions by insurance providers were upheld, 13 were ruled in favor of patients, and 10 are pending. One case was partially upheld in favor of the insurer, two appeals were withdrawn because they did not meet the program's criteria, and one was reversed in favor of the patient by the insurance company.

"I am confident that as the public becomes more aware of this program, we will see greater utilization," Cohen said.

The law creating the new program, which went into effect last July 1, also prohibits a health care insurer from restricting a doctor or other health care provider from discussing with patients health care issues, medical needs, treatment options and health care risks or benefits.

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Under the program, the appeals process generally must include four separate levels of review. To begin the review process, consumers must make the request to their insurance company. Appeals may involve cases in which an insurer denies a request for a service or a request for payment of a claim for a service already received.

The four levels of review are:

- Expedited Medical Review for urgent medical cases, to be completed within one business day of the request for review.

- Informal Reconsideration, to be completed within 30 days of the request for review.

- Formal Appeal, to be completed within 30 days of the request for review, or 60 days in the case of denied claims for services already received.

- External Independent Review, generally to be completed within 30 days of the request for review.

Cases that reach the External Independent Review stage are evaluated by the Insurance Department to determine if the request involves questions about whether the policy covers a particular service.

Appeals that involve questions of medical necessity are referred to one of more than 125 independent medical professionals to review and render a decision.

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