



INDEPENDENT HEALTHCARE APPEALS PROGRAM FREQUENTLY ASKED QUESTIONS (FAQ)

1. WHAT IS IHCAP?

IHCAP stands for the Independent Healthcare Appeals Program. In July of 2000, the Delaware legislature recognized that Delaware Citizens would benefit from standardizing the final appeal level of adverse healthcare coverage decisions made by their health insurance carriers. The IHCAP is coordinated by the Department of Insurance (DOI).

2. WHAT IS THE DIFFERENCE BETWEEN REQUESTING AN IHCAP AND FILING A COMPLAINT WITH THE DOI?

The DOI has the authority to investigate or mediate your health insurance complaints. The insurance carrier is responsible for coordinating IHCAP. The staff of DOI is very happy to explain the process, but they are unable to contact the insurance company on your behalf.

4. WHAT IS AN ADVERSE HEALTHCARE COVERAGE DECISION?

An adverse healthcare coverage decision occurs when your insurance carrier denies, reduces or terminates health care benefits.

5. WHAT IS AN APPEAL?

An appeal is a request to reexamine or review an adverse determination made by a health insurance carrier that denies, reduces or terminates health care benefits.

6. ISN'T MY COMPLAINT OR MY PHONE CALL TO THE INSURANCE COMPANY THE SAME AS AN APPEAL?

No. Working with you or your doctor over the phone is a normal way of doing business for an insurance company.

Many complaints are handled by an insurance company's customer service representative and may be as simple as getting clarification or sending in more information.

An appeal request is a **formal** process. Each health insurance carrier can have different ways to start this appeal process. Some may require a written request, others may require you to call a special number and some may allow you to ask the customer service representative to initiate it over the phone.

If you feel that your situation is appropriate for IHCAP, it is very important that you file your "OFFICIAL" appeal with the health insurance carrier. Make sure your request is clear. Here are a few suggestions on how to be sure that your concern is identified as an appeal:

1. If you are on the phone, ask the customer service representative, to explain or mail you the company's appeal procedure.
2. Ask her/him what you need to do to file an appeal.
3. Be sure to use the word "Appeal" instead of "complaint" to avoid any confusion.
4. Obtain an address from the customer service representative so you can send your request in writing.

7. CAN ALL ADVERSE HEALTHCARE COVERAGE DECISIONS GO TO IHCAP?

No, you must meet the following criteria...

- o Must be a covered health service;
- o Must not be an excluded or exhausted benefit; and
- o Must be filed within 4 months of the date of the final decision of your health insurance carrier.

8. WHAT IS A COVERED HEALTH SERVICE?

A covered health service is what is included in your health care contract with the insurer.

9. WHAT IS AN EXCLUDED OR EXHAUSTED BENEFIT?

Many healthcare contracts have limitations on the number of times you can use a service, or a limit on the amount that can be spent. Other contracts will include language that indicates certain procedures or services are excluded.

For example, you cannot use IHCAP when...

1. Your insurance contract says you can have 15 physical therapy visits, but your doctor says it is medically necessary for you to have 30 visits. You cannot use IHCAP to make your insurance company pay for something you did not contract for.
2. Your insurance contract says that dental surgery is excluded, but it is medically necessary for you to have a root canal in order to eat solid food. You cannot use IHCAP to make your insurance company pay for something you did not contract for.

10. WHO CAN FILE A REQUEST FOR AN EXTERNAL APPEAL WITH DOI?

All requests for IHCAP are done through your healthcare insurance company. The insurance company forwards the actual "Petition for External Review" to the DOI.

11. CAN I FILE AN APPEAL JUST BECAUSE I THINK THE INSURANCE COMPANY WAS WRONG?

No, as mentioned above the question must be about a covered health service that was denied because the insurance carrier claims it is not a medically necessary service.

In addition, denials based upon the insurance company's determination that a procedure, therapy, test or medication is cosmetic or experimental are also appropriate for appeal and IHCAP.

WHO DECIDES WHAT IS MEDICALLY NECESSARY?

By ordering a procedure, therapy, test or medication your physician is suggesting that the services are medically necessary. Unfortunately, her or his decision is not the only factor involved when determining if a service is medically necessary. By asking the insurance company to pay for a service, you are agreeing to allow them to review your healthcare and make decisions about whether or not it is covered by the healthcare contract you purchased. The carrier will exclude any procedure, therapy, test or medication that is not medically necessary as not being covered by your health contract.

What this means is that any denial, reduction or termination of benefit may be appropriate for appeal *so long as it is not an excluded or exhausted benefit*, if the insurance company claims "it is not medically necessary."

DOES FILING AN APPEAL MEAN THAT I CAN HAVE THE SERVICE?

No, filing the appeal only means that the decision of the insurance company will be re-examined. When an appeal is accepted for IHCAP, it means that an external company will also review the decision.

If the External Review Organization (ERO) assigned by IHCAP decides in favor of your appeal, the insurance company will be expected to pay for the service.

If the ERO determines that the insurance company was correct in its decision, the appeal decision will be in favor of the carrier and you have no further recourse with the State.

WHO CAN I CALL IF I STILL NEED MORE INFORMATION?

Delaware Department of Insurance
Consumer Services Division
841 Silver Lake Blvd
Dover DE 19904
302.674.7310
800.282.8611