STATE OF NEVADA

Governor's Office

CONSUMER HEALTH ASSISTANCE

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Standard Description and Instructions for Health Care Consumers to Request an External Appeal Review

The Nevada Revised Statutes (NRS 695G.241) gives you the right to an external appeal when health care services are denied by your Managed Care Organization (MCO), Health Management Organization (HMO) or insurer on the basis using *"Adverse Determination" meaning a determination of a managed care organization to deny all or part of a service or procedure that is proposed or being provided to an insured on the basis that it is not medically necessary or appropriate or is experimental or investigational. The term does not include a determination of a managed care organization that such an allocation is not a covered benefit. (NRS 695G.012)*

What is an External Appeal?

- An external appeal is a request that you make to your health plan for an independent review of the denial of services or procedures by your health plan once you have exhausted all the appeal – grievance processes within the managed care organization.

- The reviews are conducted by External Review Organizations (ERO) certified by the Nevada State Division of Insurance. The ERO have a network of medical experts to review your health plan's denial of services.

Eligibility for an External Review

To be eligible for an external review:

- You or your provider must have received a final adverse determination as a result of your health plan's internal utilization review appeal procedures

- The Insured is required to pay $500 or more for the health care service

- if the managed care organization fails to render a decision within the period required to render the decision set forth in the health care plan

- if the managed care organization submits the adverse determination to the ERO without requiring the insured to exhaust all procedures set forth in the health care plan for reviewing the adverse determination within the managed care organization.

What are the timeframes for requesting an External Review (ER) ? **STANDARD ER**

- Within 60 days after receiving a final adverse determination, the insured, physician or authorized representative may request and external review to the health plan , failure to adhere to timeframe negates ability to appeal.

- Within 5 days of receiving the request for external review the Health Plan will notify the Governor's Office for Consumer Health Assistance to assign a ERO.

- Within 5 days of notification for GovCHA of the assigned ERO, the health plan will submit all documents and materials relating to the final adverse determination to the ERO.

How do you request an **EXPEDITED EXTERNAL Review**?

- The physician / health care provider may request an EXPIDITED EXTERNAL REVIEW (72 hour) with proof that failure to proceed may jeopardize the life or health of the insured.

FINAL DETERMINATION BY THE ERO IS BINDING ON THE MCO AND MEMBER.

Eligibility for Medicare and Medicaid External Standard or Expedited Appeals?

If **Medicare** is your only source of coverage you need to contact Medicare.gov, the process is also on your Medicare Summary Notice.

If **Medicaid** is your only source of coverage you need to contact Medicaid for your appeal rights.

Federal employees appeal through OPM.

If you have any questions, please contact GovCHA at 702-486-3587 or 1-888-333-1597