



*The Commonwealth of Massachusetts  
Health Policy Commission  
Office of Patient Protection  
50 Milk Street, 8<sup>th</sup> Floor  
Boston, MA 02109  
(800)436-7757 (phone)  
(617)624-5046 (fax)*

## **REQUEST FOR INDEPENDENT EXTERNAL REVIEW OF A HEALTH INSURANCE GRIEVANCE THROUGH THE OFFICE OF PATIENT PROTECTION**

If your health insurance company will not pay for treatment that you believe you need, you may be able to ask the Office of Patient Protection (OPP) to have an outside medical expert to review your insurance company's decision. This process is called an external review. If a patient's medical condition is urgent, you can request an expedited (fast) external review.

- **Standard External Review** - For a regular external review, you must first file a grievance with your insurance company, asking for an internal review of the decision. If after the internal review the answer is still no, you can request an external review within four months of receiving a "final adverse determination" letter from your insurance company. A final adverse determination is the letter from your health insurer telling you that your claim is being denied based on medical necessity, appropriateness of health care setting and level of care, or effectiveness of treatment, and that you have exhausted the insurer's internal appeals process.

Next Steps :        Complete pages 2-8 of this form  
                          Attach final adverse determination letter and other documentation  
                          Send form and documents to OPP (see checklist on page 2)

- **Expedited External Review** – If your health care professional certifies that a delay in treatment would pose a serious and immediate threat to your health, you may request an expedited external review. You can request an expedited external review within four months of receiving an adverse determination or final adverse determination letter from your insurance company. You may choose to file a request for an expedited external review at the same time that you request an expedited internal review from your insurance company. If you file the request for an expedited internal review and expedited external review at the same time, you do not need a final adverse determination letter, but include the first denial letter or adverse determination from your insurance company.

Next Steps :        Complete pages 2-8 of this form  
                          Ask your health care provider to complete pages 9-11 of this form  
                          Attach adverse determination or final adverse determination and other documents  
                          Send form and documents to OPP (see checklist on page 2)

- **Continuation of Coverage** – If you want your health insurance company to pay for your treatment while your case is being reviewed, you and your health care professional may request continuation of coverage within two business days after the day you receive the adverse determination.

Next Steps :        Complete the standard or expedited external review request as described above  
                          Complete the continuation of coverage request on page 9

**EXTERNAL REVIEW CHECKLIST – WHAT TO SEND AND WHERE TO SEND IT**

Please be sure to complete all applicable sections of the form, and include **all** of the following. Incomplete external review requests cannot be processed. Please include:

- This completed application form (pages 2-8 for standard external review).
- If you are requesting **continuation of coverage** and/or an **expedited external review**, the completed forms at pages 9-11 where applicable.
- A copy of the final adverse determination or denial letter from your health insurer (or the first adverse determination letter if you are filing a request for expedited external review at the same time that you are filing a request for expedited internal review with the insurer).
- A copy of your insurance card and/or your insurance company and insurance ID number
- Any medical records, statements from your treating health care providers, or other information that you would like the independent review agency to consider in reviewing your case (the independent review agency will request records of the treatment that is the subject of the adverse determination).
- A check or money order for \$25 made out to the Commonwealth of Massachusetts (unless you ask OPP to waive the fee on page 8). If you fax your external review request, you may mail the check or money order to OPP separately.
- Send the completed application form and other documents to OPP by fax or mail. If you are requesting **continuation of coverage** or an **expedited external review**, fax your application to OPP, then call 800-436-7757 to advise OPP that you faxed the request.

Fax: 617-624-5046

Mail: Office of Patient Protection  
 Health Policy Commission  
 50 Milk Street, 8<sup>th</sup> Floor  
 Boston, MA 02109

**Questions?** Call OPP at 800-436-7757

**PATIENT INFORMATION**

1. Patient's Name:	
2. Mailing Address:	
3. Phone:	
4. Patient's Date of Birth:	



**INFORMATION ABOUT YOUR TREATING HEALTH CARE PROVIDER**

Name of health care provider who ordered the service which was not covered:

Type of Provider: Physician Other (please specify): \_\_\_\_\_

Provider Mailing Address:

\_\_\_\_\_  
\_\_\_\_\_

Provider Phone Number: \_\_\_\_\_

**INFORMATION ABOUT YOUR HEALTH HISTORY**

If you want the external review agency to consider records of your previous treatment, please list the provider(s) and dates here. Attach additional sheets if needed.

Provider Name: \_\_\_\_\_

Provider Mailing Address:

\_\_\_\_\_  
\_\_\_\_\_

Provider Phone Number: \_\_\_\_\_

Dates of treatment: \_\_\_\_\_

**AUTHORIZED REPRESENTATIVE FORM**

Fill out this section only if someone else will represent you in this review. You can represent yourself, or may ask another person, including your health care provider, to act as your personal representative. You may revoke this authorization in writing at any time.

I hereby authorize \_\_\_\_\_ to pursue my external review on my behalf.

\_\_\_\_\_  
Signature of Patient or Legal Guardian\*

\_\_\_\_\_  
Date

\* Specify if signed by parent, guardian, conservator or other: \_\_\_\_\_

Please note: If the patient is 18 or older, he or she is usually a legal adult and must sign. Parents or other family members cannot authorize the release of another adult's records

Address of Authorized Representative:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_



**PERMISSION ABOUT SPECIFIC HEALTH INFORMATION**

Please write your initials and sign below to authorize the release of any of the following information:

\_\_\_\_I specifically give permission, as required by M.G.L. c. 111, § 70F, to release information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment, to the external review agency.

\_\_\_\_I specifically give permission, as required by M.G.L. c. 111, §70G, to release information in my record about my genetic information to the external review agency.

\_\_\_\_I specifically give permission to release information in my record about alcohol or drug treatment to the external review agency. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the re-disclosure of this confidential information.

\_\_\_\_\_  
Signature of Patient or Legal Guardian\*

\_\_\_\_\_  
Date

\* Specify if signed by parent, guardian, conservator or other: \_\_\_\_\_

Please note: If the patient is 18 or older, he or she is usually a legal adult and must sign. Parents or other family members cannot authorize the release of another adult’s records

**AUTHORIZATION TO REFER CASE TO ANOTHER STATE AGENCY**

With your permission, OPP may refer this case, including medical records and medical information released by this authorization, to the Massachusetts Division of Insurance or the Office of the Attorney General for further investigation and possible action against the insurer.

I understand that other state agencies may not be covered by federal privacy laws, and that they may be able to further share the information that is given to them. Note that medical records and medical information are exempt from disclosure under the Massachusetts public records law (M.G.L. c. 4, § 7(26)(c)).

Please check one of the following:

- YES, I give my permission to OPP to refer my case to the Division of Insurance, the Office of the Attorney General or another relevant state agency.
- NO, I do not give my permission to OPP to refer my case to another state agency.
- Call me first to discuss the referral of my case to another state agency. I understand that you will need my written permission to share medical information.

\_\_\_\_\_  
Signature of Patient or Legal Guardian\*

\_\_\_\_\_  
Date

\* Specify if signed by parent, guardian, conservator or other: \_\_\_\_\_

Please note: If the patient is 18 or older, he or she is usually a legal adult and must sign. Parents or other family members cannot authorize the release of another adult’s records



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Complete this form only if you are requesting review of a claim for behavioral health services
(includes mental health or substance use disorder treatment)

REQUEST FOR EXTERNAL REVIEW AND RELEASE OF PSYCHOTHERAPY NOTES

The Office of Patient Protection (OPP) will assign your case to one of the three external review agencies: Independent Medical Expert Consulting Services, Inc. (IMEDECS), the Island Peer Review Organization (IPRO) or ProPeer Resources, Inc. (ProPeer). This form will authorize the release of psychotherapy notes to the agency that conducts the review. This authorization may be revoked at any time by writing to OPP, but information previously released in reliance upon the authorization will not be affected by the revocation.

I \_\_\_\_\_, hereby request an external review of the matter described on page 3 of this application.

I authorize my HMO, health insurer and/or health care providers to release all relevant psychotherapy notes related to the matter described in this request for external review to the external review agency named by OPP to review my request. I understand that the external review agency will review my medical records to make its decision, and that without my authorization, the agency will be unable to review my request.

This release is valid for six months from \_\_\_\_\_ (today's date).

I understand that the external review agency may not be covered by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the state Fair Information Practices Act. Note that according to 958 CMR 3.416, no external review agency or reviewer shall, except as specifically authorized by an appropriate release signed by a patient or representative authorized by law, release medical and treatment information or other information obtained as part of an external review, except to OPP and as otherwise authorized or required by law.

I understand that OPP may not be covered by federal privacy laws, and that OPP may be able to further share the information that is given to it. Medical records and information are exempt from disclosure under the Massachusetts public records law (M.G.L. c. 4, § 7(26)(c)), and OPP will not share your records with anyone without your written permission or unless otherwise required by law.

Signature of Patient or Legal Guardian\*

Date

\* Specify if signed by parent, guardian, conservator or other: \_\_\_\_\_

Please note: If the patient is 18 or older, he or she is usually a legal adult and must sign. Parents or other family members cannot authorize the release of another adult's records

## EXTERNAL REVIEW FEE AND FEE WAIVER

The patient seeking an external review is usually responsible for the first \$25 of the cost of the review and the insurance company pays the remainder. If the external review is resolved completely in your favor, the Commonwealth of Massachusetts will refund your \$25 payment.

Enclose a check or money order for \$25 made out to the Commonwealth of Massachusetts, or request a waiver of this fee.

I have enclosed the check or money order for \$25.

Waiver Request: I am requesting that the Office of Patient Protection waive the \$25 fee because the payment of the fee would result in extreme financial hardship for me. Check one of the boxes below:

My income is less than or equal to 300% of the federal poverty level (FPL) according to the chart below

### 2015 Guidelines – 300% FPL

<b>Family Size</b>	<b>Annual income</b>	<b>Monthly income</b>	<b>Weekly Income</b>
1	\$ 35,310	\$2,943	\$ 679
2	\$ 47,790	\$3,983	\$ 919
3	\$ 60,270	\$5,023	\$1,159
4	\$ 72,750	\$6,063	\$1,399
5	\$ 85,230	\$7,103	\$1,639
6	\$ 97,710	\$8,143	\$1,879
7	\$110,190	\$9,183	\$2,119
8	\$122,670	\$10,223	\$2,359

My income exceeds the guidelines but payment of the \$25 would cause me extreme financial hardship because:

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## REQUESTS FOR EXPEDITED REVIEW

A patient may request an expedited external review in the event of a serious and immediate threat to the patient's health or if the patient has received emergency services but has not been discharged from the facility. If you are requesting an expedited review, please complete the entire application (pages 2-11).

If this is a request for an Expedited Review, please check the appropriate box (Check One):

The health insurance coverage denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized. *No further action is required.*

The patient's health care provider believes that delay in the services or treatment denied by the health insurance company would pose a serious and immediate threat to the health of the patient. **IF SO, a physician or health care provider must complete pages 10 and 11, labeled "Certification for Expedited External Review."**

I sent to the form to the health care provider via:  Mail  Fax  Email  Other: \_\_\_\_\_

Name of Health Care Provider:	
Address:	
Phone:	

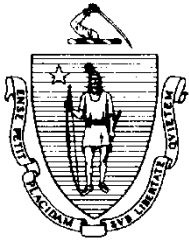
### CONTINUATION OF COVERAGE: REQUEST TO HAVE COVERAGE CONTINUE DURING THE EXTERNAL REVIEW

If the subject matter of the external review involves the termination of ongoing services, the patient may apply to the external review agency to seek continued insurance coverage for the terminated service during the period the review is pending. Any such request must be made **before the end of the second business day** following receipt of the final adverse determination from the insurer (final adverse decision not required if you are filing a request for expedited external review at the same time that you are filing a request for expedited internal review to the health plan). The review agency may order the continuation of coverage or treatment where it determines that substantial harm to the patient's health may result if the coverage or treatment is not continued or for other good cause as the review agency determines. Any such continuation of coverage will be at the insurer's expense regardless of the final external review determination.

I am requesting continuation of services that were previously authorized by the insurer.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date



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CERTIFICATION FOR EXPEDITED EXTERNAL REVIEW

A patient or the patient's authorized representative, if any, may request an expedited external review if the physician or health care provider who ordered the services certifies that delay in the provision or continuation of health care services that are the subject of an adverse determination would pose a serious and immediate threat to the health of the patient.

In the above circumstance, the physician or health care provider must complete this certificate and immediately fax it to the Office of Patient Protection at 617-624-5046 in order for a patient to be eligible for an expedited external review of a medical necessity determination. **The patient must complete pages 2-9 as well. OPP cannot consider any request for external review until the entire application is received.**

Name of Patient: \_\_\_\_\_

Patient's Phone Number: \_\_\_\_\_

Patient's Health Plan Member ID Number (if available): \_\_\_\_\_

Name of Physician/Health Care Provider completing this form:

\_\_\_\_\_

Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact Person:

\_\_\_\_\_

Phone Number:

\_\_\_\_\_

Fax Number:

\_\_\_\_\_

It is my clinical opinion, with knowledge of the patient's medical condition, that an expedited decision is necessary; any delay in providing the recommended health service could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is subject of the appeal.

\_\_\_\_\_ YES

\_\_\_\_\_ NO

*Continued on next page*

If YES, explain the nature of the serious and immediate threat to the health of the patient (attach additional documents if needed):

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I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

\_\_\_\_\_  
Physician/Health Care Provider's Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Physician/Health Care Provider's Office Stamp:

**Fax this completed certification to 617-624-5046.**

Pages 2-9 may be faxed with this certification or may be sent separately but the request cannot be processed without a complete application.

If you have any questions, please visit our website at [www.mass.gov/hpc/opp](http://www.mass.gov/hpc/opp) or call the Office of Patient Protection at 800-436-7757.