DEPARTMENT OF
Professional & Financial Regulation
STATE OF MAINE

- OFFICE OF SECURITIES
- BUREAU OF INSURANCE
- CONSUMER CREDIT PROTECTION
- BUREAU OF FINANCIAL INSTITUTIONS
- OFFICE OF PROF. AND OCC. REGULATION

Maine Bureau of Insurance

Long-term Care Insurance Claim Denial Appeals Process

Two Levels of Internal Appeal. State law requires insurance carriers to provide an insured or insured's representative with two levels of appeal of a long-term care insurance claim denial. Both appeals are internal company appeals and may be requested for any reason. The first level appeal must be made within 120 days of receipt of the claim denial. The second level appeal must be made within 120 days of receipt of the first level appeal decision. At the second level appeal, the insured or insured's representative may request the opportunity to appear before the insurer via teleconference or other appropriate technology. The internal appeals process must be exhausted before a claim denial can go to external review.

Claim Denials Eligible for External Review. If the insurer denies a claim because the insured has not met a clinical standard for benefit eligibility (generally, the ability to perform certain activities of daily living, or the existence or degree of cognitive impairment), the insured has the right to request an external review. External review is also available for claim denials based on whether the insured is subject to one of several permitted policy exclusions (i.e., preexisting condition, mental or nervous disorder, alcoholism and drug addiction, etc.).

The Bureau oversees the external review process and contracts with several independent review organizations (IRO) to conduct reviews. To request an external review, an insured or his or her representative must submit a written request to the Bureau within 120 days after the second level appeal is denied. The insured or his or her representative should contact the Bureau if he or she is unsure whether the claim denial is eligible for external review.

As part of the external review process, the insured or his or her representative may request a hearing. The hearing is organized by the IRO. The insured or representative can participate by teleconference, submit material supporting the claim, and ask the insurer questions. No decision is made at the hearing.

The insurance company must pay for the external review. The only costs to the insured or his or her representative will be for things like postage and time off from work to attend the telephone hearing if they choose to participate.

The External Review Decision. The IRO is required to complete the external review within 30 days of receipt of the completed review request. In rendering a decision, the reviewer must consider all relevant clinical information relating to the insured's physical and mental condition and all relevant clinical standards and guidelines, not just the ones the insurer relied upon.

The external review decision is **binding only on the insurance company**. If the decision is not in the insured's favor, her or she can take private legal action if they so choose.

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