



PPACA: Interim Procedures for Federal External Review and Model Notices Relating to Internal Claims and Appeals and External Review

On August 23, 2010, the U.S. Departments of Labor (DOL) Health and Human Services (HHS) and Treasury collectively released interim guidance to establish procedures for the federal external review process required by healthcare reform. The guidance contains a limited enforcement safe-harbor for self-funded group health plans.

The departments also jointly released model notices that non-grandfathered plans and health insurance issuers can use to satisfy new notice requirements under PPACA regarding adverse benefit determinations and appeals of adverse benefit determinations.

The interim guidance, titled Technical Release 2010-01, as well as the model notices, are available on DOL's website, www.dol.gov/ebsa.

Background

We had previously reported on the fifth set of Interim Final Regulations relating to internal claims and appeals, and the external review process. Please visit our web page at www.abpmtpa.com, click on "News and Information" and select "Health Care Reform Information" to review that article.

To summarize, the requirements to implement internal and external claims and appeals processes apply for plan years beginning on or after September 23, 2010, but apply only to non-grandfathered plans. The model notices and Technical Release also apply only to non-grandfathered plans.

Note: Plans will need to strictly adhere to all requirements of internal claims and appeals processes. If a plan does not strictly adhere, the claimant is deemed to have exhausted the internal claims and appeals process and may go directly to external review or litigation, with the ability to expand discovery should litigation be chosen. Plans will need to follow claims procedure to the letter; non-adherence will create issues.

Notices for Appeals of Adverse Benefit Determinations

More information will need to be included with adverse benefit determinations or final internal adverse benefit determinations. Denial codes must also be included, along with a description of a plan's standard, such as medical necessity, used in denying the claim. The notices of final internal adverse benefit determinations must include a discussion of the plan's decision, along with a description of available internal appeals and external review processes, including information on how the claimant may file an appeal with health insurance consumer assistance or ombudsman established for this purpose.

This is where model notices come into play. The model notices can be found at the website for the HHS Office of Consumer Information and Insurance Oversight, www.hhs.gov/ociio/.
The Federal External Review Process

A new, mandatory federal external review process will apply to non-grandfathered plans that are not now subject to a state's statutory external review process. In Montana, fully insured plans must comply with the state's independent peer review statutes, set forth in Montana's insurance code at §§ 33-37-101, et. seq., MCA. The Montana statute and corresponding regulations, in effect since 1999, differ from the National Association of Insurance Commissioner's (NAIC) Model Act and do not apply to self-funded plans.

The Montana Insurance Commissioner has already obtained interim legislative approval to enact changes to this law to comply with PPACA requirements, but those changes need to go through the legislative process next year and thus may not be effective for some time.

For self-funded plans, which are not subject to the state insurance law discussed above, there will be similar external review rules and requirements, which will be enforced by the U.S. Department of Labor for ERISA plans and the U.S. Department of Health and Human Services for non-ERISA self-funded plans.

Safe Harbor

The Technical Release mentioned above provides an enforcement safe harbor for non-grandfathered, self-insured group health plans that are not subject to the state's external review process. This interim safe harbor applies to plan years beginning on or after September 23, 2010, until superseded by further guidance.

The DOL and IRS will not take enforcement action against a self-funded group health plan that does either of the following:

1. Voluntarily complies with a state external review process (if that process meets the NAIC's model requirements); or
2. Complies with the external review procedures detailed in the Technical Release.

As previously noted, Montana's external review statute may not meet the NAIC model requirements until further legislative enactment. Thus, the federal external review procedure will have to be used.

Obligations and Administrative Requirements for Federal Review

In order to comply, plans will be required to:

1. Allow claimants to file a request for external review within 4 months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination;
2. Complete, within 5 business days of receipt of the request for external review, a preliminary review of the request, to determine if:
 - a. the claimant is or was covered under the plan;

- b. the denial was based on the claimant's ineligibility under the terms of the plan, thus making the claim not eligible for federal external review;
- c. claimant exhausted internal process, if required; and
- d. claimant provided all necessary information to process the review.

3. Then, within 1 business day after completion of the above, the plan must notify the claimant in writing if the request is not eligible or if it is incomplete.

If the claim is complete but not eligible for external review, the written notice must include reasons for its ineligibility and contact information for the DOL's Employee Benefits Security Administration (including its toll-free number).

If the claim is incomplete, written notice must describe what information is needed to complete the request, and also give the claimant the remainder of the four-month filing period or the 48 hour period following the claimant's receipt of the notice, to cure the defect.

4. If the claim is eligible for external review, the plan must assign the request to an independent review organization (IRO).

Plan's Relationship With IROs

A plan must contract with at least three IROs that are accredited by URAC or other nationally-recognized accrediting organizations to which external reviews will be sent on a rotating basis, or assigned on another unbiased basis.

The Plan/IRO contract must provide that the assigned IRO will use legal experts when appropriate to make coverage determinations under the plan. These circumstances might include questions based on legal technicalities, such as whether the decision was based on failure to follow appeals procedure.

The IRO must notify the claimant of the request's eligibility and acceptance for external review and that the claimant can submit in writing, within 10 business days, additional information which the IRO must consider during its review.

The plan must provide to the IRO within 5 business days after the IRO's assignment the documents and information considered in the plan's denial of the claim.

If the plan does not provide documents and information, the IRO may terminate its review and reverse the claim denial. If this happens, the IRO needs to notify the claimant and the plan within 1 business day of its decision to reverse, then the plan has to carry out the IRO's decision.

The IRO reviews the claim de novo (brand new), and will not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process. It can consider additional information and documents to the extent available and appropriate, beyond what was provided as part of any earlier review. This includes materials outside of the plan's claims file.

The IRO must complete its review and provide notice of the decision to the plan and the claimant within 45 days of its receipt of the external review request. The model notice is available on DOL's website.

Expedited Federal External Review Process

The Technical Release sets out procedures for expedited review in the following situations:

1. Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for expedited review.
2. Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of claimant or would jeopardize claimant's ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services but has not been discharged from a facility.

If the plan gets one of these, it must "immediately" conduct the preliminary review previously described above, and then "immediately" provide a written notice to the claimant detailing whether the claim is eligible for external review and, if not eligible, why not and what materials are needed to complete the request. "Immediately" probably means within 24 hours.

If the claim is ripe, the plan will assign it to an IRO which has to, in turn, decide the external review request as expeditiously as the claimant's medical condition requires but in no event more than 72 hours after the IRO receives the request for expedited review.

Issues To Consider

Since self-funded group health plans will be subject to the federal external review process, they should begin examining their appeal procedures to determine if they will need to be modified to comply with federal standards. The state appeal process is probably not an option, since it is out of date. Allegiance will be providing proposed new claims and appeals language within the next month for consideration.

How will plans find accredited IROs? Allegiance will assist with this process.

How much will external review cost plans?