



Internal Claims and Appeals and the External Review Process Overview



*CCIIO
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The information provided in this presentation is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. Links to certain source documents have been provided for your reference. We encourage all assisters to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information. *This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.*

Agenda

1. Summary of the Coverage Appeals Regulation
2. Internal claims and appeals
3. State external review
4. Federal external review programs
5. Resources

Summary of the Coverage Appeals Regulation

Consumer Coverage Appeals Rights

- The Affordable Care Act (ACA) ensures a consumer's right to appeal health insurance plan decisions, to ask that a plan or issuer reconsider its decision to:
 - deny payment for a service or treatment,
 - say you aren't eligible for coverage after you file a claim, or
 - rescind coverage.
- If the plan upholds its initial decision, consumers may be eligible for a second look by an independent 3rd party reviewer.

Summary of Coverage Appeals Regulation

- Established by Public Health Service Act Section 2719. Implementing regulations appear at 45 C.F.R. 147.136.
- Regulations and Guidance are available on the CMS CCIIO website at:
<https://www.cms.gov/cciiio/resources/regulations-and-guidance/index.html#ExternalAppeals>
- These rules do not apply to grandfathered health plans under Section 1251 of the ACA.
 - Information about grandfathered status may be found at:
<https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Grandfathered-Plans.html>

Internal Claims and Appeals

Definitions

- **Claim** – any request for benefits, including pre-service (prior authorization) and post-service (reimbursement)
- **Rescission** – cancellation or discontinuance of coverage that has retroactive effect
- **Internal appeals** (conducted by a plan/issuer)
 - Adverse benefit determination
 - Final internal adverse benefit determination
- **External review** (conducted by Independent Review Organization (IRO))
 - Review of a plan or issuer's denial of coverage or services
 - Results in a final binding external review decision (issued by IRO)

Internal Claims

How much time do plans/issuers have to make a benefit determination?

- Pre-service (prior authorization): **15 calendar days**
- Post-service: **30 calendar days**
- Urgent care: **maximum 72 hours**
(or less, depending on medical urgency of case)

Notice Requirements for Adverse Benefit Determinations

1. Describe reason(s) including specific plan provisions, scientific or clinical judgment used
2. Describe any additional information needed to improve or complete the claim
3. Provide sufficient information to identify claim
4. Notification of internal appeals & external review rights
5. Notification about health insurance consumer assistance or ombudsman office availability
6. Provide notification that Culturally & Linguistically Appropriate Services (CLAS) are available

Culturally and Linguistically Appropriate Manner

Applicable non-English language: a non-English language is applicable when 10% of a claimant's county is literate only in the same non-English language(s).

If the claimant's county meets this threshold, plans and issuers are required to provide:

- Oral language services and assistance with filing claims and appeals (including external review) in any applicable non-English language;
- Notices, upon request, in any applicable non-English language; and
- In English versions of notices, a statement prominently displayed in the non-English language indicating how to access language services provided by the plan or issuer.

Internal Appeals

- What can be appealed?
 - All denials and any reduction, termination, or failure to provide or make payments (in whole or in part) for a benefit, including rescissions, issues of eligibility for coverage after a claim has been filed, medical necessity denials and experimental/investigational denials
- How long does a consumer have to file an appeal?
 - 180 days from receipt of denial
- How to file an appeal?
 - In writing (unless urgent – then oral is acceptable)

Internal Appeals (continued)

- How many levels of internal appeal?
 - Group market: 1 or 2
 - Individual market: 1
- How long before a decision is made for internal appeals?
 - Pre-service (prior-authorization): 30 calendar days
 - Post-service: 60 calendar days
 - Urgent care: maximum 72 hours (or less, depending on medical urgency of case)

Internal Appeals (continued)

- The claimant has a right to a full and fair review.
 - S/he has opportunity to see and respond to any evidence or rationale under consideration
 - Reviewers must not have any conflicts of interest
- Plans/issuers are required to provide continued coverage pending the outcome of an appeal.
 - Concurrent care decisions: if a plan/issuer has approved an ongoing course of treatment, it must provide an opportunity for an appeal or review before reducing/terminating coverage (except where reduction or termination is due to a plan amendment or termination).

Special Situations – Urgent Care

Definition:

- 1) The standard appeal timeframe could seriously jeopardize a claimant's life or health or ability to regain maximum function; or
- 2) In the opinion of a physician with knowledge of the claimant's medical condition, the standard appeal timeframe would subject a claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Special Situations – Urgent Care

- A claimant may file orally and notice of an appeal decision may be oral (must be followed by a written notice within 3 days).
- Individuals in urgent and concurrent care situations may initiate an internal appeal and external review simultaneously.

Special Situations – Deemed Exhaustion

In the following cases, an internal appeal is deemed exhausted, allowing a consumer to move to an external review without completing the internal appeals process:

- The issuer waives an internal appeal;
- Urgent care situations (expedited external review may be initiated at the same time as expedited internal appeals); and
- Failure to comply with all requirements of the internal appeals process except in cases where the violation was:
 1. De minimis
 2. Non-prejudicial
 3. Attributable to good cause or matters beyond the plan's or issuer's control
 4. In the context of an ongoing good faith exchange of information, and
 5. Not reflective of a pattern or practice of non-compliance.

State External Review

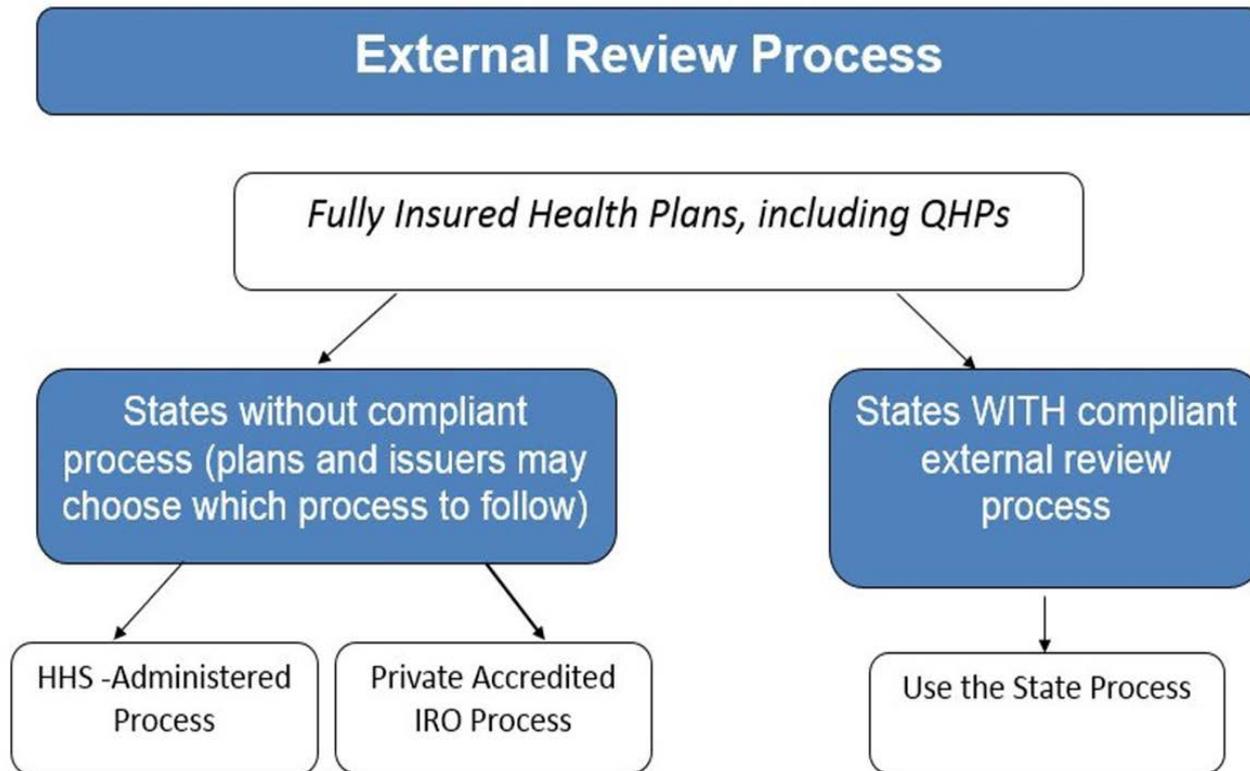
Minimum Requirements for State External Review

Standard	State Minimum Review Standards
Scope	External review of ABDs based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit
Notice	Effective written notice of right to external review
Deemed Exhaustion	<ol style="list-style-type: none"> 1. Issuer (or plan) waives exhaustion requirement 2. Failure to comply with internal appeals requirements (except de minimis violations) 3. Claimant simultaneously requests expedited internal appeal & external review
Filing Fee	Plan or issuer must pay the cost of an IRO conducting the external review. State laws that expressly allowed a filing fee as of November 18, 2015 may continue to allow nominal filing fees.
Claims Threshold	No minimum dollar amount on claim
Time to File an External Review Request	4 months
IRO Assignment	IRO assigned on a random, rotational, or other independent/impartial basis
IRO Accreditation	State must maintain a list of nationally accredited IROs
Notice of Expedited External Review Decision	<p>Within 72 hours maximum (or less, depending on medical urgency)</p> <p>If decision is provided orally, then written decision must be sent within 48 hours of oral decision.</p>

Minimum Requirements for State External Review (continued)

Standard	State Minimum Review Standards
Conflict of Interest	No IRO/clinical reviewer can have a conflict of interest (COI)(e.g., material, professional, familial, or financial COI with the issuer, claimant, provider, etc.)
Submission of Additional Information	<ol style="list-style-type: none"> 1. The IRO must consider additional info submitted by the claimant. 2. The claimant must be notified of his/her right to submit additional information. 3. The claimant has five business days to submit additional information. 4. The IRO has one business day to forward to issuer (or plan).
Binding	Binding on plan or issuer and claimant
Notice of Standard	Within 45 days
External Review Decision	
Description of External Review	Description of external review process in Summary Plan Descriptions (SPDs)/Adverse Benefit Determinations (ABDs)
Written Records	IRO must maintain written records for 3 years; substantially similar to Section 15 of NAIC Uniform Model Act
Experimental/ Investigational Review Procedures	Process for experimental/investigational treatment, substantially similar to Section 10 of NAIC Uniform Model Act.

External Review Process



**Federal External Review Programs
HHS-administered and
Private, Accredited IRO Processes**

Scope of Claims Eligible for Federal External Review

Applies to adverse benefit determinations (ABDs) (or final internal ABD) involving:

1. Medical judgment

■ INCLUDING, BUT NOT LIMITED TO:

- Determinations that involve medical necessity
- Appropriateness
- Health care setting
- Level of care
- Effectiveness of a covered benefit
- Experimental and investigational treatments

■ EXCLUDES:

- Determinations that involve only contractual or legal interpretation and do not involve medical judgment
- Determinations related to participant or beneficiary eligibility for coverage under the terms of a group health plan without any use of medical judgment

2. Cancellation of coverage effective back to the date coverage started (also called a “rescission”)

Federal External Review Process Requirements

- Protections are similar to those in the NAIC Uniform Model Act
- Standards include:
 1. A description of the external review initiation
 2. Procedures for a preliminary review of claim
 3. Minimum qualifications for IROs
 4. A process for approving IROs
 5. Random IRO assignment
 6. Standards for IRO decision-making
 7. Rules for providing notice of a final external review decision
 8. Rules for expedited review of ABDs and final internal ABDs
 9. Standards for evaluating claims involving experimental/investigational treatments
 10. Binding IRO decisions
 11. IRO records retention, and
 12. Notice of a claimant's right to an external review (on ABDs and within plan or policy documents)

HHS-Administered External Review Process

- Includes minimum consumer protections in NAIC-parallel standards
 - The Federal government pays the cost of an appeal and there are no filing fees for consumers
- Applies to ABDs (or final internal ABDs) that involve medical judgment and rescissions
- Applies to health plans subject to the federally-administered external review process that do not elect a private accredited IRO process

Private, Accredited IRO External Review Process

- Plans must contract with at least 3 IROs and rotate external review assignments among them.
- The plan may use an alternative process for IRO assignment. However, the Departments will expect plans to document how any alternative process constitutes an impartial assignment method, and how it ensures that the process is independent and unbiased.
- The plan is not permitted to provide financial incentives to IROs based on the likelihood that the IRO will support the denial of benefits.

How to Request an Appeal or External Review

Process	Who Receives the Request
Internal Appeals	Health Plan or Issuer
External Review - State Process	The state Department of Insurance, the state Department of Health, or the plan/issuer
External Review - Federally- Administered Process (in AL, AK, FL, GA, PA, TX*, and WI, as of April 2018) * plans and issuers in Texas must use a Federal External review process beginning June 30, 2018	Health Plan/Issuer or HHS- Administered Process Contractor

Where to File Complaints Regarding the Coverage Appeals and External Review Processes

Process	Who Should Receive the Complaint
Claims and Internal Appeals	Either the state Department of Insurance or the state Department of Health
External Review - State Process	Either the state Department of Insurance or the state Department of Health
External Review - Federally – Administered Process (in AL, AK, FL, GA, PA, TX*, and WI, as of April 2018) * plans and issuers in Texas must use a Federal External review process beginning June 30, 2018	CCIIO

Appendices

Appendix A: Summary of Appeals Regulation

- IFR published July 23, 2010
 - Amended IFR: June 24, 2011
- Selected sub-regulatory guidance
 - DOL Technical Release 2010-01, August 23, 2010
 - HHS Technical Guidance: August 26, 2010
(Description of Interim HHS Federal Process)
 - DOL Technical Release 2011-01, March 18, 2011
 - HHS Technical Guidance, January 12, 2017 (HHS Election Instructions for Self-Funded, Non-Fed Govt. Plans)

Appendix A: Summary of Appeals Regulation (continued)

- Selected sub-regulatory guidance (continued)
 - DOL Technical Release 2011-02, June 22, 2011
 - HHS Technical Guidance, March 15, 2013 (Extension of the Transition Period for the Temporary NAIC-Similar Standards)
- Final Rule published November 18, 2015 (Extension of the Transition Period for the Temporary NAIC-Similar Standards)

Appendix B: Resources

- MAXIMUS Website: www.externalappeal.com
- Consumer Information: www.healthcare.gov
- HHS Federal External Review regulations and sub-regulatory guidance:
<http://cciio.cms.gov/resources/regulations/index.html>
- State External Appeals Review Processes:
https://www.cms.gov/CCIIO/Resources/Files/external_appeals.html