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REFORM Update

Issue Fifteen September 2010

September 8, 2010

The U.S. Department of Labor issued Technical Release 2010-01 on August 23, 2010. It establishes interim procedures for reviewing internal health plan claims and appeals as well as procedures for the external reviews the health care reform acts require. It also provides additional information and model notices to help employers and health plans comply with the new requirements.

The health care reform acts require every individual and group health plan to have an internal and external claim review and appeals process to ensure claim denials receive a full and fair review. Employers will have to change their claim review and appeals process to meet the complex federal requirements. The full details are explained in *Reform Update*, Issue 13 at http://mcgrawwentworth.com/Reform_Update/Reform_Update_13.pdf.

These new requirements are effective as of the first day of the first ERISA plan year following September 23, 2010. Grandfathered plans can delay this effective date until the plan is no longer considered grandfathered.

First, the Technical Release includes the wording plans can use in their notices to explain a claim denial and the plan's final decision on any appeals. These model notices are available at www.dol.gov/ebsa.

Remember, in addition to ERISA requirements, an internal claim denial must now include:

- Date of service
- Health care provider
- Claim amount
- Diagnosis and procedure codes along with a description of what these codes mean
- The denial code along with a description of what the code means
- Description of any standard the plan used to deny the claim, such as lack of medical necessity

When an appeal is denied, the plan must explain the decision and offer any recourse available to the claimant under an internal or external claim appeal process.

If your plan is insured, your insurance carrier will be responsible for using this new model wording in documents explaining why it has denied a claim. If your plan is self-funded, your third party administrator usually informs employees it has denied a claim. Your organization should verify your TPA is adopting the newly required wording.

Next, the Technical Release tackles the external review process. Currently, certain fully insured plans may be subject to an external review process that is handled by the state. For now, these plans may simply comply with existing state laws and meet the requirements for an external review. After July 1, 2011, the state process needs to meet health care reform requirements in order to be acceptable.

The previous round of guidance seemed to delay the effective date of these requirements until the first day of the first plan year on or after July 1, 2011 because it would take time to develop a federal review process. However, with this latest round of guidance, that does not seem to be the case. The Technical Release offers two possible safe harbors your plan can adopt to provide external reviews until the federal government establishes its official process:

1. Voluntary compliance with state external review process
2. Compliance with this technical release

The DOL is taking a non-enforcement stance if a plan meets either of the two safe harbors noted above.

Voluntary Compliance with State External Review Process

States may allow plans not typically subject to state processes (such as self-funded plans) to use their external reviews. If the state chooses to allow your plan to use its process and your plan voluntarily complies while these interim rules are in effect, the DOL and the IRS will not take any enforcement action against your plan.

The state review process may be the easiest safe harbor to adopt if the state allows it. The guidance was just released, so there is no word yet on whether states intend to allow all plans to use their processes. Your third party administrator will usually know whether the state process will be made available in states where your employees reside.

Compliance with this Technical Release

If your plan cannot or does not wish to participate in the state review process, your organization can establish its own temporary external review process. The Technical Release includes the following procedure for establishing a compliant external review:

1. ***Request for external review***: A group health plan must allow a claimant to file a request for an external review. The plan must allow the claimant four months after a final claim denial to request that review. If the four-month deadline falls on a Saturday, Sunday or federal holiday, then the filing deadline is extended to the next day that is not a Saturday, Sunday or federal holiday. Employers will need to create a process for claimants to request the external review and inform them of this process if the plan denies the internal appeal.
2. ***Preliminary review***: The employer or plan must complete a preliminary review within 5 business days of receiving a request. External reviews do not apply to certain types of claim denials, for example, when a claim is denied because a participant was not eligible

at the point of the claim. The preliminary review merely determines whether the claim is actually eligible for external review. The preliminary review determines whether:

a. The claimant was covered under the plan when the health care item or service was requested or, in the case of a retroactive review, when the service was rendered.
b. The claim was denied because a claimant was not eligible under the terms of the group health plan.
c. The claimant has exhausted the plan's internal claims and appeals process (unless the claimant is not required to do so for some reason, such as the plan did not follow the internal review procedures).
d. The claimant has provided all the information and forms required to process an external review.

3. ***Referral to an Independent Review Organization***: The group health plan must select an Independent Review Organization (IRO) accredited by URAC or any other nationally recognized accrediting organization to conduct the external review. Employers must ensure the IRO is independent and unbiased. Therefore, employers must rotate reviews among at least three IROs or use another independent, unbiased, random method, such as randomized selection. The IRO must not receive any financial incentive to deny benefits.
4. ***Reversal of plan's decision***: If the IRO decides to overturn the initial denial, the plan must immediately provide coverage or pay the claim. The IRO has the final say on the claim, unless other options are available under state and federal law.

An IRO contract must include the following elements:

- The IRO will use appropriate legal experts to determine coverage under the plan.
- The IRO will notify the claimant in writing that they have been requested to conduct the external review. This IRO notice will include a statement that within 10 business days the claimant may submit in writing any additional information that the IRO should consider when it conducts the external review. The IRO may accept and consider additional information after 10 business days.
- Within 5 business days the plan must send the chosen IRO all documents and any information it considered when it denied the claim. Failure to submit documents and information must not delay the external review. If the plan does not provide the documents and information, the IRO may end the external review and decide to grant the claim. Within one day of making that decision, the IRO must notify the plan and the claimant.
- The IRO must send the plan copies of any information the claimant submitted within one business day after receiving them. After receiving this information, the plan may reconsider the denial; however, reconsidering the denial cannot delay the external review process. If the plan decides to grant the claim, the plan must notify the IRO within one business day. The IRO can end the external review process when it receives the notice.

- The IRO must examine all the information and documents received as soon as possible. In making a decision, the assigned IRO will do a fresh review of the claim and not be bound by decisions or conclusions the plan reached during its internal review and appeal process. In addition to the documents and information provided, the IRO can use the following resources in its review process, providing the information is readily available:
  - The claimant's medical records.
  - The attending health professional's recommendations.
  - Reports from the health care professional and other documents submitted by the plan, the claimant or the claimant's treating provider.
  - The terms of the claimant's plan to ensure the IRO decision does not contradict those terms, unless the terms violate applicable laws.
  - Appropriate practices including applicable evidence-based standards and other practice guidelines developed by the federal government, national or professional medical societies, boards or associations.
  - Any applicable clinical review criteria the plan developed and used, unless the criteria violate the terms of the plan or applicable law.
  - The opinion of the IRO's clinical reviewer or reviewers after considering all available and relevant documents described in this Technical Release.
  - Within 45 days of receiving the request to conduct an external review, the assigned IRO must notify both the claimant and the plan of its decision in writing. The Technical Release also includes model wording for this statement. A model notice is available at http://www.dol.gov/ebsa. The notice must include the following:
    - A general description of the reason for the request for an external review, including enough information to identify the claim sufficiently (such as date of service, provider name, diagnosis codes, procedure codes and so on).
    - The date the IRO received the assignment to conduct the external review and the date of the IRO's decision.
    - References to any evidence or documents the IRO used in making the decision.
    - A discussion of the principal reason or reasons for the decision.
    - A statement that the decision is binding along with any recourse available under state or federal law.
    - A statement that judicial review may be available to the claimant.
    - Current contact information for any applicable office of health insurance consumer assistance or ombudsman.

If the IRO decides to reverse the plan's decision, the plan must immediately cover or pay the claim.

The IRO must keep records of all claims and notices associated with an external review process for six years. These records must be available to the plan, the claimant, and state or federal oversight agencies upon request, unless the disclosure would violate state or federal privacy laws.

Claimants must also be allowed to request an expedited external review in certain situations:

- If a lengthy review process would seriously jeopardize the life or health of the claimant or affect the claimant's ability to regain maximum function. The internal and external expedited reviews can run concurrently.
- If under the internal appeal process the claim has been denied and a lengthy review process would seriously jeopardize the claimant's life or health or affect the claimant's ability to regain maximum function. It will also apply if the denied claim involves an admission, the availability of care, continued stay or emergency services when the claimant has not yet been discharged from a facility.

The expedited external review process includes the same steps as a normal external review, but they need to be done more quickly:

1. ***Preliminary Review***: The employer or plan must conduct the expedited preliminary review immediately upon request to determine the following:
    a. The claimant is or was covered under the plan when the health care item or service was requested or, in the case of retroactive review, if the participant was covered when the service was rendered.
    b. The claimant was eligible under the terms of the group health plan.
    c. The claimant has exhausted the plan's internal claims and appeals process (unless the claimant is not required to do so, because, for example, the plan did not follow the internal review procedures).
    d. The claimant has provided all the information and forms required to process an external review.
2. ***Referral to an Independent Review Organization***: Once the plan determines the situation qualifies for an expedited external review, the plan must select an IRO randomly and immediately transmit all relevant information. The IRO will need to conduct the review. The information must be provided as soon as possible through electronic means or even through a phone call.

    Once it receives the appropriate information and documents, the IRO can make the determination.
3. ***Notice of Final External Review Decision***: Following the normal notification requirements, the IRO must provide the final review decision to the plan and the claimant no later than 72 hours after the request for an expedited review. If the IRO provides the final decision orally, it must confirm the decision in writing within 48 hours.

Your action steps to comply with these requirements will depend on your current plan and the claim review and appeal steps you are taking today.

Concluding Thoughts

The Technical Release clarifies that the safe harbor is a temporary measure to allow external reviews before the actual federal review process is established. When the federal process is established and available to employer plans, these safe harbors will no longer apply.

For the internal communication requirements, your organization should confirm your insurance carrier or TPA is including the new elements in the model notices.

Complying with the external review process will be a bit trickier. If your plan is fully insured, Michigan's current process satisfies the requirements. If your plan is self-funded, your plan will need to research its options to meet the safe harbor. Michigan has not yet commented on whether it will offer the state review process to self-funded plans. This option would be the easiest way to meet the safe harbor. However, if Michigan does not offer the option, your plan will need to develop an external review process. First, check to see whether your TPA is willing to spearhead this process. If not, your first step will be to create forms or a process for a claimant to request an external review and an expedited internal review. Next, your organization will need to contract with at least three IROs. The IROs must meet the requirements discussed in this Update. The plan should also inform employees that this option is available once the internal review process is exhausted.

This *Update* outlines temporary measures. Employers and their plans will need to comply with the official federal external review process once it is established.