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REFORM Update

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The Departments (Department of Treasury, Department of Labor and the Department of Health and Human Services) recently issued amendments to the interim regulations addressing internal and external claim appeal and review requirements. These amendments are effective on July 22, 2011.

The health care reform acts included provisions to guarantee that plan participants would be afforded a full and fair review of all claims submitted to the plan. To ensure this review, health care reform implemented and modified internal claim review requirements. In addition, health care reform implemented an external review process for self-funded plans and fully-insured plans not subject to state external review programs. The regulations set forth a set of requirements which state external review programs must meet.

The details associated with the internal claim appeals and external review requirements were addressed in the following Reform Updates:

- ***Reform Update 13*** (http://www.mcwent.com/Reform_Update/Reform_Update_13.pdf) – Offered a broad overview of the internal and external claim review and appeals requirements of health care reform.
- ***Reform Update 15*** (http://www.mcwent.com/Reform_Update/Reform_Update_15.pdf) – Provided model notice language for claim appeals and reviews, as well as alternatives for meeting the external review requirements until the federal review process is established.
- ***Reform Update 18*** (http://www.mcwent.com/Reform_Update/Reform_Update_18.pdf) – Discussed the delay in enforcing certain aspects of the internal review process.
- ***Reform Update 25*** (http://www.mcwent.com/Reform_Update/2011/Reform_Update_25.pdf) – Discussed additional delays for enforcing various aspects of the internal review process.

The latest amendments to these requirements will make it easier for health plan vendors and employers to adopt the required changes.

Internal Claim Review and Appeal Changes

The Departments have received a number of comments from health insurance carriers, health plan administrators and employers regarding the changes made by the health care reform laws to the internal claim review and appeal procedures. Their concerns prompted the following amendments:

- **Removal of 24-hour turnaround time for urgent care claims.** Health care reform instituted a 24-hour turnaround time for pre-service urgent care claims. The effective date for this provision had been delayed by previous guidance. However, many commentators

indicated difficulty with administering this reduced timeframe. This amendment removes the 24-hour turnaround time, which means pre-service urgent care claims will continue to be held to the current 72-hour determination period.

The removal of the 24-hour turnaround applies only if the plan or carrier defers to the attending physician to determine if the claim constitutes "urgent care." In addition, the amendment also reminds plans that 72 hours is considered the outside limit for claims determination. If a claim can be decided more quickly, then the plan is obligated to issue the determination when it is complete.

- **Change to the mandatory requirement to provide diagnostic and procedure codes along with an explanation of their meanings on adverse benefit determinations.** Health reform added new content requirements to adverse benefit determinations in an attempt to make these notices more understandable to the average plan participant. One of the requirements, to include diagnostic and procedure codes, had already been delayed, because vendors needed more time to prepare. The Departments received a number of comments, particularly with regard to privacy. In many cases, adverse benefit determinations are addressed to the subscriber, and the privacy of such detailed information would be easily compromised if the claimant is the spouse or adult child of the subscriber.

  Other commentators felt this information was important in helping members to fully understand an adverse benefit determination. Thus, the amendment now requires plans to include a statement in all adverse benefit determinations that the diagnostic and procedure codes, along with their corresponding meanings, are available upon request.

- **Modification of strict compliance with the claim review and appeal process.** Health care reform stated that if a plan did not strictly follow the claims review and appeal process, then the claimant was not required to exhaust the claims review and appeal procedures before requesting an external review or other remedies available under state law or ERISA. Commentators expressed concern that even a relatively minor error in processing a claim or appeal could cause the process to be deemed exhausted. The amendment offers some relief for strict compliance with the claim review and appeal process, by including exceptions for violations that are:

  1. De minimis
  2. Non-prejudicial
  3. Attributable to a good cause beyond the plans' or issuers' control
  4. In the context of an ongoing, good faith exchange of information
  5. Not reflective of a pattern or practice of non-compliance

- **Revision to requirements for culturally and linguistically appropriate notices.** The initial regulations used the percentage of participants who spoke the same non-English language as the measure for determining whether the plan must provide communications in that non-English language. The amended rule requires employers instead to look at the claimant's county of residence in determining if notices must be distributed in a non-English language. Specifically, if a claimant resides in a county in which 10% or more of the population is literate only in the same non-English language, then the plan must:

    1. **Provide a customer service phone line that can provide assistance with filing claims or answering questions in that non-English language.**
    2. **Provide a translated notice in that non-English language upon request.**
    3. **Include a statement in that non-English language about the availability of assistance in the non-English language. Model notice language was amended to include this statement in Spanish, Chinese, Tagalog and Navajo.**

    The Departments will provide guidance in the form of a list of counties, identified by American Community Survey data and published by the United States Census Bureau. This list will be updated annually on the Departments' website. Fortunately for Michigan employers, no counties in Michigan appear on this list. An actual copy of the guidance, including the list of counties, can be found at http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=25131.

These changes to the internal claim review and appeal process are good news for both employers and health plans. The amendments provide needed relief on the most problematic changes to the process required by health care reform.

External Review Changes

The Departments also amended the latest guidance issued on the external review process. Health plans and state review programs were challenged by the requirements, so the primary purpose of these amendments is to ensure that a reasonable external review process is available for insured and self-funded plan participants.

The following changes or clarifications apply to the external review requirements:

- **Clarification on the final determination of an external review.** The final determination of the external review process is binding. The plan or insurance carrier must provide benefits once the external review process determines that a claim is payable. Benefits must be provided without delay, even if the carrier or health plan intends to seek a judicial review.

- **Narrowed scope of claims eligible for external review.** A wide variety of claims were eligible for external review based on the initial regulations. (Initially, an exception was made for claims denied because a participant was ineligible for benefits at the time a service was incurred.) Most state external review processes, and the guidance from the National Insurance Association of Commissioners (NAIC) on external reviews, apply only to claims denied for specific reasons. In response to comments, the amendment narrows the

scope of claims eligible for external review and submitted on or after September 20, 2011 to:

- ✓ **Claims denied based on medical judgments.** The determination on claims denied due to a medical judgment will be eligible for external review.
- ✓ **Claims denied due to a rescission of coverage.** Please note that a rescission of coverage is generally a termination of coverage that applies retroactively.

For example, claims denied for reaching a coverage limit, or denied because the service is excluded from coverage, would not be eligible for an external review at this time.

This change is worded as a suspension of the broader definition of claims eligible for external review, and may be lifted in the future, pending stakeholder comments to the Departments. The amendments include a number of examples to demonstrate the type of situations that may be considered medical judgments, including:

- ✓ A health plan limits coverage for physical therapy to 30 visits per year. However, the plan will provide coverage for additional visits if these are preauthorized pursuant to an approved treatment plan based on the medical necessity of additional visits. The provider submits a treatment plan and provides documentation that additional visits are medically necessary, but the plan declines coverage for the 31st visit. This claim would be eligible for external review because extended visits are covered by the plan if deemed medically necessary.
- ✓ A health plan does not provide coverage for services incurred out-of-network, unless the needed service cannot be provided by a network provider. A participant seeks treatment from an out-of-network provider for a rare health condition requiring specialized care, because he or she does not think proper treatment can be provided by an in-network provider. The plan denies coverage. This claim would be eligible for an external review because the denial is based on the medical necessity of using an out-of-network provider.

- **Extension of the transition period for states' external review process.** Many states had external review processes in place prior to the passage of health care reform. The state review process generally applied to fully insured plans, and varied from state to state. In the initial guidance, the Departments indicated that the state review process would have to satisfy specified minimum requirements in order to meet the external review requirements outlined by the health care reform legislation. The Departments allowed a transitional period to give states time to modify their processes to meet these minimum requirements.

  This amendment extends the transitional period until December 31, 2011, and also modifies the minimum requirements. States will be required to comply with the less-stringent minimum standards set forth in the NAIC's Uniform Model Act; HHS will issue determinations on whether the state process meets the minimum requirements. As of January 1, 2014, if HHS determines that the state process is not compliant with the requirements of health care reform, then the insurer will become subject to the federal external review process.

- **Modification of the safe harbor for external review process.** The federal government did not establish the external review process as of the effective date of the external review requirement. They offered two safe harbor options for health plans. One option allowed plans to establish their own external review process by contracting with at least three independent review organizations (IROs) that are used randomly for any needed external reviews. The Departments received numerous comments that IROs were not prepared for the influx of business that the safe harbor created.

  The safe harbor was modified by the latest amendment. To be eligible for the safe harbor, self-insured plans will be required to contract with at least two IROs by January 1, 2012 and at least three IROs by July 1, 2012. Plans must meet the requirements for rotating assignments. Plans that want to use a different random assignment than those outlined in previous guidance should be aware that the IRS and DOL will closely review any alternative process for random assignment.

- **Release of more details on the federal review process.** The federal review process will apply to all self-insured non-federal government health plans and fully insured plans in states that do not have an external review process. In addition, it will also apply to states that are not compliant with the HHS requirements. These organizations will choose between two federal external review options. The first option is a process administered by HHS through the Office of Personnel Management. The other option is to engage a privately accredited IRO for self-funded plans, which appears to be simply an extension of the safe harbor option included in previous guidance.

  Health plans will need to select either the federal process administered by HHS or the IRO process. Plans using the federal review process must make an election of the option they will use, but the timing of this election is not particularly clear. The additional guidance issued with the amendments indicates that the election must be made on “the earlier of January 1, 2012 or the date by which the plan uses the external review process.” Thus, it appears a decision on all plans must be made by January 1, 2012, and that an earlier decision will be needed only if the plan requires an external review.

  The election is made via e-mail to HHS at externalappeals@cms.hhs.gov. The following information should be provided:

  1. For issuers: Contact information for designated personnel in the appeals department, including names, addresses, phone and fax numbers and e-mail addresses.
  2. For plans: Contact information for the plan administrator, including name, address, phone and fax numbers and e-mail address.
  3. A statement as to whether they will be complying with the HHS-administered process or the privately accredited IRO process.

  The guidance also offered additional instructions for participating in the HHS process. Details can be found at http://cciio.cms.gov/resources/files/hhs_srg_elections_06222011.pdf.

Employers should consult with their insurance carriers or their third party administrators (TPAs) to determine which external review process to use. An election needs to be made by January 1, 2012 or sooner, if a final adverse benefit determination is eligible for an external review.

Finally, the Departments also issued new model notices for adverse benefit determinations, final adverse benefit determinations and final external adverse benefit determinations. New notices were needed due to the changes introduced by this latest guidance, and can be found with Technical Release 2011-02 at http://cciio.cms.gov/resources/files/appeals_srg_06222011.pdf.

The internal claim review and appeal requirements and external review requirements are complicated. Fortunately, insurance carriers and TPAs will generally handle the internal claim review and appeal procedures for employers. States will handle the external review requirements in many cases, although many TPAs have also stepped up and coordinated an external review process for their clients. While insurance carriers and TPAs will have to modify their processes to comply with these amended requirements, most of these changes will make the internal and external claim review requirements more reasonable for carriers and administrators.

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