

Legislative Brief

Health Care Reform: Federal External Review and Model Appeals Notices



The Patient Protection and Affordable Care Act (PPACA) requires non-grandfathered group health plans and health insurance coverage to adopt an improved internal claims and appeal process and to follow minimum requirements for external review. On August 23, 2010, **interim procedures for external review** of claim appeals were issued by the Departments of Treasury, Labor and Health and Human Services. The Departments also announced the availability of **model notices** related to internal claims and appeals and external review.

This Kapnick Insurance Group Legislative Brief summarizes the procedures and model notices. Please read below for more detailed information. For a copy of the procedures, see www.dol.gov/ebsa/pdf/ACATEchnicalRelease2010-01.pdf. See below for links to the model notices.

Model Notices

Non-grandfathered health plans and issuers may use the model notices to satisfy PPACA's requirements related an improved internal claims and appeal process. The following model notices have been issued:

- Model Notice of Adverse Benefit Determination, available at www.dol.gov/ebsa/IABDModelNotice2.doc.
- Model Notice of Final Internal Adverse Benefit Determination, available at www.dol.gov/ebsa/IABDModelNotice1.doc.
- Model Notice of Final External Review Decision, available at www.dol.gov/ebsa/IABDModelNotice3.doc.

Model language for the description for the internal claims and appeals and external review procedures in the summary plan description provided to participants and beneficiaries will be posted on the Departments' websites in the future.

Health Care Reform Requirements for External Review

PPACA requires that plans and health insurance issuers in states without an applicable state external review process must implement an effective external review process that meets minimum federal standards. PPACA, along with the interim final regulations issued on July 23, 2010,¹ provide a basis for determining when plans and issuers are to follow a state external review process and when they have to follow the federal process.

In general, if a state has an external review process that meets, at a minimum, the consumer protections contained in the interim final regulations, an issuer (or plan) subject to the state process must comply with that process. For plan years beginning before July 1, 2011, HHS will work with states to make any necessary changes to the state process.

Plans and issuers that are not subject to a state external review process (including self-insured plans) must follow the federal process. The federal process will apply to plan years beginning on or after September 23, 2010.

Interim Compliance Guidance for Self-Insured Plans

The DOL has released [EBSA Technical Release 2010-01](http://www.dol.gov/ebsa/pdf/ACATEchnicalRelease2010-01.pdf), which provides interim compliance guidance on the federal external review process for self-funded plans. For health insurance coverage offered in connection with a group health plan, the issuer has primary responsibility to comply with the external review rules. Final guidance is expected to be issued by July 1, 2011.

¹ See www.federalregister.gov/a/2010-18043.

Legislative Brief

Health Care Reform: Federal External Review and Model Appeals Notices

For plan years beginning on or after September 23, 2010, and until future guidance is issued, the DOL and IRS will not take any enforcement action against a self-insured group health plan that complies with one of the following interim compliance methods:

- *Compliance with the procedures outlined in Technical Release 2010-01.* These procedures are based on the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners (the NAIC Model Act) in place on July 23, 2010.
- *Voluntary Compliance with state external review processes.* Alternatively, states may choose to expand access to their state external review process to plans that are not subject to the state laws, such as self-insured plans. These plans may choose to voluntarily comply with the provisions of that state external review process.

Federal External Review Procedures for Self-Funded Plans

Technical Release 2010-01 sets forth procedures for external review for self-insured group health plans. There are procedures for both standard review and expedited review.

Standard External Review Procedures

Request for External Review

Group health plans must allow claimants to request an external review of a claim within four months of receiving notice of an adverse benefit determination or final internal adverse benefit determination. If the deadline falls on a weekend or federal holiday, the deadline is extended to the next business day.

Preliminary Review

Within five business days of receiving the request for external review, the group health plan must complete a preliminary review the request to determine whether:

- The claimant is or was covered under the plan at the time the health care item or service was requested, or in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
- The adverse benefit determination or final adverse benefit determination does not relate to the claimant's failure to meet the plan's eligibility requirements;
- The claimant has exhausted the plan's internal appeal process, unless the claimant is not required to do so under the interim final regulations; and
- The claimant has provided all the information and forms required to process an external review.

Within one business day of completing the preliminary review, the plan must issue a written notice to the claimant. If the request is complete but not eligible for external review, the notice must include the reasons it is not eligible and contact information for the DOL's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notice must describe the information or materials needed to complete the request and the plan must allow the claimant to perfect the request within the four-month filing period, or 48 hours after receipt of the notice, whichever is later.

Legislative Brief

Health Care Reform: Federal External Review and Model Appeals Notices

Referral to Independent Review Organization

The group health plan must assign an independent review organization (IRO) to conduct the external review. The IRO must be accredited by URAC or by a similar nationally recognized accrediting organization. To avoid bias and ensure independence, the plan must contract with at least three IROs and rotate claims assignments among them. The IRO may not be eligible for financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between a plan and an IRO must provide that:

- The IRO will utilize legal experts where appropriate to make coverage determinations under the plan.
- The IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the claimant may submit, within 10 business days, additional information in writing that the IRO must consider. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- Within five business days after the assignment of the IRO, the plan must provide to the IRO the documents and information considered in making the adverse benefit determination or final adverse benefit determination. If the plan does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final adverse benefit determination. Within one business day of making its decision, the IRO must notify the claimant and the plan.
- If the IRO receives information from the claimant, it must forward it to the plan within one business day. The plan may then reconsider its adverse benefit determination or final internal adverse benefit determination, but may not delay the external review. The external review may be terminated because of the reconsideration only if the plan decides to reverse its decision and provider coverage or payment. The plan must provide written notice of its decision to the claimant and the IRO within one business day, and the IRO must terminate the external review upon receiving the notice.
- The IRO will review all documents that are timely received. The IRO will review the claim *de novo* (i.e., from the beginning) and will not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process.
- The IRO must provide written notice of the final external review to the claimant and the plan within 45 days of receiving the request for external review.
- The IRO must maintain records of all claims and notices associated with the external review process for six years. It must make the records available for examination by the claimant, plan, or state or federal oversight agency upon request, unless the disclosure would violate state or federal privacy laws.

Reversal of Plan's Decision

Upon receipt of a notice of a final external review decision, reversing the adverse benefit determination or final internal adverse benefit determination, the plan must immediately provide coverage or payment for the claim, including immediately authorizing or immediately paying benefits.

Expedited External Review Procedures

Request for Expedited External Review

A group health plan must allow a claimant to make a request for an expedited external review after receiving an adverse benefit determination if:

Legislative Brief

Health Care Reform: Federal External Review and Model Appeals Notices

- The timeframe for a standard review would seriously jeopardize the health or life of the claimant and the claimant has filed a request for an expedited internal appeal; or
- The final adverse determination involves an admission, availability of care, continued stay or health care item or service for which the claimant has received emergency services but has not been discharged from a facility.

Preliminary Review

The plan must determine whether the request meets the standards for an external review immediately upon receiving the request for expedited external review. It must also immediately send a notice to the claimant of its determination regarding eligibility for review.

Referral to Independent Review Organization

If the plan determines that the request is eligible for external review, it will assign an IRO in accordance with the standard external review requirements. The plan must provide all necessary documents and information related to the claim to the assigned IRO electronically or by telephone or fax or any other available expeditious method. The assigned IRO must consider any information that is available and appropriate under the procedures for standard review. The assigned IRO must review the claim *de novo* and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

Notice of Final External Review Decision

The plan must require the IRO to notify the claimant of the final external review decision as expeditiously the claimant's medical condition or circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the IRO must provide written confirmation of the decision to the claimant and the plan within 48 hours of providing the initial notice.

Interim Compliance Guidance for Issuers

Technical Release 2010-01 also contains an interim enforcement safe harbor for insurance issuers. This safe harbor will apply for plan years beginning on or after September 23, 2010, and until future guidance is issued. During this limited enforcement period, HHS will not take any enforcement action against an issuer that complies with an interim compliance method. This method will be detailed by HHS on the Office of Consumer Information and Insurance Oversight website, at www.hhs.gov/ociio/. The method will involve use of state process or a temporary HHS process.

By July 1, 2011, HHS will issue additional guidance as to which state external review laws have been determined to satisfy the minimum standards of the NAIC Model Act and regarding the process that will replace the interim process.

This Kapnick Insurance Group Legislative Update is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

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