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Health Insurance Appeals Update

October 15, 2010



- Centers for Medicare and Medicaid Services (CMS) Qualified Independent Contractor (QIC)
 - Medicare Part A Program
 - Medicare Part C Program
 - Medicare Part D Program
 - Southern Region of Medicare Part B Program
- Office of Personnel Management
- Department of Defense TRICARE Management Activity
- Department of Veterans Affairs
- More than 35 State Clients
- ISO 9001:2000 certification / continuous quality improvement
- URAC Accreditation



- **Pre-ACA ERISA Internal Claims and Appeals**
- DOL's ERISA internal claim procedure rules at 29 CFR 2560.503-1 (became effective January 20, 2001).
- Set new detailed standards for processing benefit claims under group health plans including:
 - Faster decisions on both initial claims and appeals of denied claims;
 - Procedures to insure fair treatment of claimants;
 - Comprehensive notice and disclosure requirements.
- **Pre-ACA State External Appeals**
- From 1990 to the present, most states adopted external review statutes covering fully insured ERISA plans and establishing IROs as the entities to review claim denials after the initial denial
- Self Insured plans exempt from State external review requirements - - although some self insured plans voluntarily adopt a second appeal level option
- NAIC Model Act available for States to adopt with most States applying the Model Act definition of adverse benefit determination narrowly and typically covering medical necessity disputes and not coverage decisions

March 23, 2010 Passage of the Affordable Care Act Including New PHSA Section 2719 Claims and Appeal Rights Provisions

- Patient Protection and Affordable Care Act (ACA) requires non-grandfathered ERISA plans and insurance issuers to comply with specific internal claim and appeal processes - - and external appeal processes, beginning with the first plan year on or after September 23, 2010 (January 1, 2011 for calendar year plans).
- A group health plan and a health insurance issuer offering group or individual health insurance coverage must have an effective appeals process for appeals of coverage determinations and claims. Enrollees must have the ability to receive continued coverage during the review process.
- Must establish external appeals process that meets the minimum consumer protections under the NAIC Uniform Review Model Act or the standards established by HHS.
- Requires provision of culturally and linguistically appropriate notice of appeal rights
- Requires an office of health insurance consumer assistance or ombudsman to be available to help with appeals

Interim Final Regulations and Subsequent Agency Guidance

- From the July 22, 2010 HHS Press Release:
- *“Consumers in new health plans in every State will have the right to appeal decisions, including claims denials and rescissions, made by their health plans. This includes the right to appeal decisions made by a health plan through the plan’s internal process and, for the first time, the right to appeal decisions made by a health plan to an outside, independent decision-maker, no matter what state a patient lives in or what type of health coverage they have.”*
- ERISA fully insured plans and individual insurance issuers are covered under the State external review requirements;
- ERISA self insured plans are covered under a Federal appeals process to be defined in forthcoming guidance;
- The Federal external appeal process will also apply to States that have not implemented the minimum consumer protections of the NAIC Model Act, as determined by HHS.

New Internal Claims and Appeals Process



- Mandates that the DOL claims procedure rules continue to apply, and layers on additional requirements for group health plans:
 - Rescissions included in definition of adverse benefit determination;
 - Urgent care claim notification period reduced from 72 hour maximum to 24 hours;
 - Claimant rights to review their file and present evidence and testimony during the internal claims process;
 - Conflict of Interest prohibitions;
 - Enhanced notice requirements;
 - Deemed exhaustion of internal claims and appeals
- Grandfathered plans excepted from new requirements

3 Model Notices:

The model notices are available at the DOL's website, www.dol.gov/ebsa and at the website for the HHS Office of Consumer Information and Insurance Oversight, www.hhs.gov/ociio/

Federal External Review Process (standard and expedited)

(Applicable to non-grandfathered ERISA self insured plans)

Standard Process:

Timing requirements: claimants have up to 4 months to file request for external review, plans have 5 business days to preliminarily review claimant's request, and then 1 business day to issue written notice to claimant about eligibility for external review;

Contract with at least 3 IROs accredited by URAC or another nationally-recognized accrediting organization

IRO reviews to be assigned on a rotating basis or via another unbiased procedure (i.e. random selection)

IRO to decide the claim *de novo* with no deference to the plan's decision rendered during the internal claim or appeal process

Federal External Review Process (continued)



- Final IRO written decision due no later than 45 days following receipt, and to include:
 - References to the evidence and documents considered by the IRO, including specific coverage provisions of the plan and evidence based standards that the IRO considered;
 - A discussion of the principal reason for the IRO's decision, including the rationale for its decision;
 - A statement that the IRO's decision is binding, except to the extent that other remedies may be available under Federal or State law to either the plan or the claimant, *and* a statement that judicial review of the decision may be available to the claimant;
 - Contact information for any applicable office of health insurance consumer assistance or ombudsman.
- **Expedited Federal External Review Process**
- Claimant entitled to request expedited review when (1) adverse benefit determination involves a medical condition where the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant; or (2) the final internal adverse benefit determination concerns 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 the facility.
- Like standard reviews, plan performs preliminary review and refers to contracted IRO
- IRO de novo review completed as expeditiously as the claimant's medical condition dictates, and no later than 72 hours after receipt

Safe Harbor for Self Insured Plans



- Interim Enforcement Safe Harbor for Self-Funded Group Health Plans (DOL Technical Release 2010-01)
 - Applies to non-grandfathered self insured GHPs that are not subject to a state external review process
 - Applies to plan years beginning on or after 9/23/10
 - DOL and the IRS will not take any enforcement action against a plan that:
 - Voluntarily complies with a State external review process (*contingent* on the State granting self insured plans access to its external review process); OR
 - Follows the Federal external review procedures contained in Technical Release 2010-01.

Enforcement Grace Period Announced by Federal Agencies

- **September 20, 2010: DOL Technical Release 2010-02 and HHS published Interim Procedures for Internal Claims and Appeals under the ACA**
- Establishes an enforcement grace period to July 1, 2011 for some but not all provisions contained in the internal claims and appeals procedures.
- Applies to both plans and issuers who have stated that they did not anticipate some or all of the additional standards and more time was needed to change plan or policy procedures and modification of computer systems.
- Grace period specifically applies to:
 - Timeframe for making urgent care claim decisions;
 - Requirement to provide notices in a culturally and linguistically appropriate manner;
 - Requiring broader content and specificity in notices; and
 - Involving a claimant's deemed exhaustion of the plan's internal claims and appeals process where a plan has not "strictly adhered" to the requirements under the IFR.
- Grace period applies to plans and issuers that are working in good faith to implement these requirements.

Recent DOL FAQs Regarding Claims and Appeal Rules Posted

- When less than full compliance with the standards set forth in the enforcement safe-harbor for the Federal external review process, compliance will be determined on a case-by-case basis under a facts and circumstances analysis.
- Plans can still be considered in compliance with the ACA's external review requirement (FAQ-8);
 - Example provided about plan contracting with less than 3 IROs:
 - “A plan may demonstrate other steps taken to ensure that its external review process is independent and without bias.”
- Plan does not have to contact directly with the IRO. Instead, a plan's third party administrator may contract with IROs on behalf of a plan (FAQ-9);
- Plans may contract with out-of-state IROs (FAQ-10).
- Urgent care decision timeframe clarification (FAQ-11)



Not surprisingly, submitted regulation comments reflect diverse stakeholder concerns - - from proper expansion of claimant rights compared to the perceived burdensome impact on plans and employers

Topical Areas of Comments Submitted:

- Scope of Appeal Review
- Conflict of Interest Standards
- Rulemaking Process
- Notice Requirements
- Fiduciary Role of IROs



Issues/Concerns from the Health Care Stakeholder Community

- Consumer Position:
 - Ability to appeal any adverse benefit determination
 - Simplified processes and notices – “One Door”
 - Ability to be heard
 - Independent, unbiased, quality, consistent reviews
- Industry Position:
 - Undermines concept that plans are better equipped to self regulate the process more effectively than a government run process
 - Concern about IROs expanding benefits beyond the scope of the appeal
 - Concern about IRO capacity to effectively handle all required appeals
 - Independent, unbiased, quality, consistent reviews
- IRO Position:
 - No conflict of interest
 - Non-Interference
 - Not considered a fiduciary
 - Independent, unbiased, quality, consistent reviews

Goals of IRO Program



- **Comprehensive Scope**
 - Consumer right to obtain unbiased external appeal for all claim or prior authorization requests denied in whole or in part
- **Ease of Consumer Access and Use**
 - Appeal process will keep consumer burden to that minimum which is necessary to bring the consumer's appeal position and arguments one time.
- **Prompt, Complete and Understandable Notice**
 - Prior authorization decisions should be made in a timeframe consistent with the urgency of the patient's medical condition
 - Retrospective decisions should be made within 30 days
 - Decision should be technically correct and comprehensible to the average lay person
- **Consumer Assistance**
 - Consumers should be offered option to consult and engage an independent advocate
- **IRO Accreditation Standards**
 - Current standards related to qualifications of clinical professional reviewers should be maintained
 - Standards related to non-clinical professional reviewers (e.g., legal reviewers, coding reviewers) require significant refinement
- **Independence/Conflict of Interest**
 - IROs independence from insurers should be strict and transparent to consumers
 - IROs performing external review services should have not other financial relationship with the plan
 - Regulators should be precluded from entering into case decision making
- **Effectuation**
 - IRO or regulator should have authority to obtain confirmation from plans that services and/or payment previously denied and overturned on appeal have been authorized/paid by plan
- **Compliance Monitoring**
 - Regulators should have funding and authority to audit plan and IRO compliance with appeal policies.
- **Reporting**
 - Case specific reporting should be required in all cases to assist in tracking case from adverse benefit determination to final appeal determination.

Independent Review Organizations



- Corporate Structure
 - Publicly traded organizations
 - Private for Profit
 - Not for Profit
 - Plan subsidiaries
 - Accredited/Not Accredited
- Range of Services
 - Medical Necessity/Experimental – most, some focus of specialty on specialty areas
 - Coverage and Benefit - limited
 - Rescission - limited
 - Pre-existing condition - most
 - Provider Reimbursement (correct coding – usual and customary reimbursement) – limited
- Credentials
 - URAC
 - ISO 9001/2008
 - QIO and QIO-like
- Staff and Consultant Qualifications
 - Medical Professionals (MDs, RN, DC, DPM, PT)
 - Legal
 - Coding and Reimbursement (CCS, RHIT)

IRO Contracts



- Items to Include in Contract
 - Conflict of Interest
 - Consider all affiliations
 - Consider termination vs. mitigation
 - Non-Interference of client
 - Indemnification
 - IRO is brought into a dispute it had no role in creating
 - Existing State and Federal protections for IROs (NAIC)
 - Consider cost of reviews associated with IRO assuming indemnification risk
 - Standards of Review
 - Notices/Distribution
 - Decision document requirements
 - Reviewer qualifications
 - Timeliness
 - Procurement of case file, consumer input and other evidence
 - Scope of Reporting and Analysis
 - Quality Assurance Activities and Financial Reports
 - Core Data Reports
 - Timeliness
 - Volume/Outcome
 - Trends
 - Optional Data Reports
 - Emerging dispute scenarios
 - Monitoring of internal appeal data
 - Benchmarking to assist with improved plan decision making and operations (e.g., customer service)
 - Payment
 - Standard and Expedited cases
 - Multiple Reviewers
 - Post decision conferences
 - Withdrawn cases
 - Set up fee



- Medical Reviewers

- URAC

- Actively practicing and Board Certified in recognized specialty
 - Is a *clinical peer* of the *attending provider*
 - Scope of licensure and professional experience encompasses service at issue
 - Five years experience and ability to evaluate alternatives to proposed treatment

- NAIC

- Expert in treatment of condition at issue
 - Knowledge about recommended service
 - Hold non-restricted license and active board certification
 - No history of disciplinary actions or sanctions

- State of California

- Knowledgeable in the treatment of the condition at issue, proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.
 - Non-restricted license in any state of the United States by recognized specialty
 - No history of disciplinary action or sanctions

Existing Qualifications for Coverage and Benefit Reviewers

- URAC – None Provided
- NAIC – None Provided
- State of Wisconsin
 - Experience in health insurance policies and certificates in review panels when appropriate
 - Licensed in Wisconsin
 - Trained in IRO standards
 - Knowledgeable about the issue subject to review
 - Credentialed every two years with on-going training and quality assurance



- Licensed Professional (JD, CPC)
- Trained in IRO standards
- Three to five years experience reviewing insurance coverage and benefit or coding and reimbursement denials or comparable experience
- Formal on-going training and verification of qualifications every two years
- Standards for Management and Oversight
 - Chief Legal Counsel
 - Formal Assignment Process
 - Formal quality assurance program specific to coverage and benefit appeals

Standards of Review for Coverage and Benefit Appeals



- De-Novo
- Independent (no fiduciary duty)
- Recognize and fairly address power imbalance
- Cost – not an explicit factor to be considered
- Administrative process (no formal rules of evidence)
- Information Considered
 - Mandatory
 - Summary Plan Document
 - Entire Subscriber Agreement
 - Current and Relevant Plan Coverage Policy
 - Case Specific
 - Case law
 - State provider and health code standards
 - Similar plan decisions
 - Supplemental evidence (e.g., call logs, claim history)

Contact Information



David Richardson

Division President

MAXIMUS Federal Services, Inc.

Office: 703.251.8659

Email: davidrichardson@maximus.com

Thomas Naughton, JD, LLM

Division Vice President

MAXIMUS Federal Services, Inc.

Office: 703. 251.8545

Email: thomasnaughton@maximus.com

Andrew Iserson, JD

Project Director

MAXIMUS Federal Services, Inc.

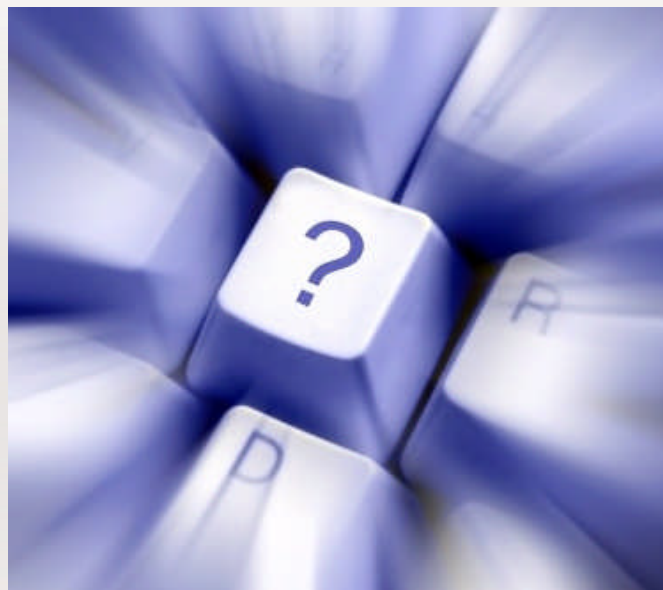
Office: 585.598.5003

Email: andrewiserson@maximus.com

Website: www.maximus.com



Questions / Discussion





For more information, please email us at:
webinars@maximus.com



@MAXIMUS_news