CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Internal Claims and Appeals and External Review Process Overview

Center for Consumer Information and Insurance Oversight

April 12, 2017

Presentation Roadmap

- Summary of the Coverage Appeals Regulation
- Internal Claims and Appeals
- State External Review
- Federal External Review Programs
- Resources

Summary of the Coverage Appeals Regulation

Consumer Coverage Appeals Rights

- The Affordable Care Act 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 to 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 Center for Consumer Information & Insurance Oversight (CCIIO) website at http://cciio.cms.gov/resources/regulations/index.html#ea.
- These rules do not apply to grandfathered health plans under section 1251 of the Affordable Care Act.
  - 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** – A cancellation or discontinuance of coverage that has retroactive effect
- **Internal appeals** (conducted by 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 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 claimant's county is literate only in the same non-English language(s).
- If threshold is met, 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 the language services provided by the plan or issuer.

Internal Appeals

- What can be appealed?
  - All denials, 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 okay).

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*

- Claimant right to full and fair review.
  - Claimant has opportunity to see and respond to any evidence/rationale under consideration.
  - No conflict of interest for reviewers.
- *Requirement to provide continued coverage pending the outcome of an appeal* – concurrent care decisions – if the plan or issuer has approved an ongoing course of treatment, the insurer must provide 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) Standard timeframe could seriously jeopardize 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, would subject the 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

- May file orally and notice of 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

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

- Issuer waives 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

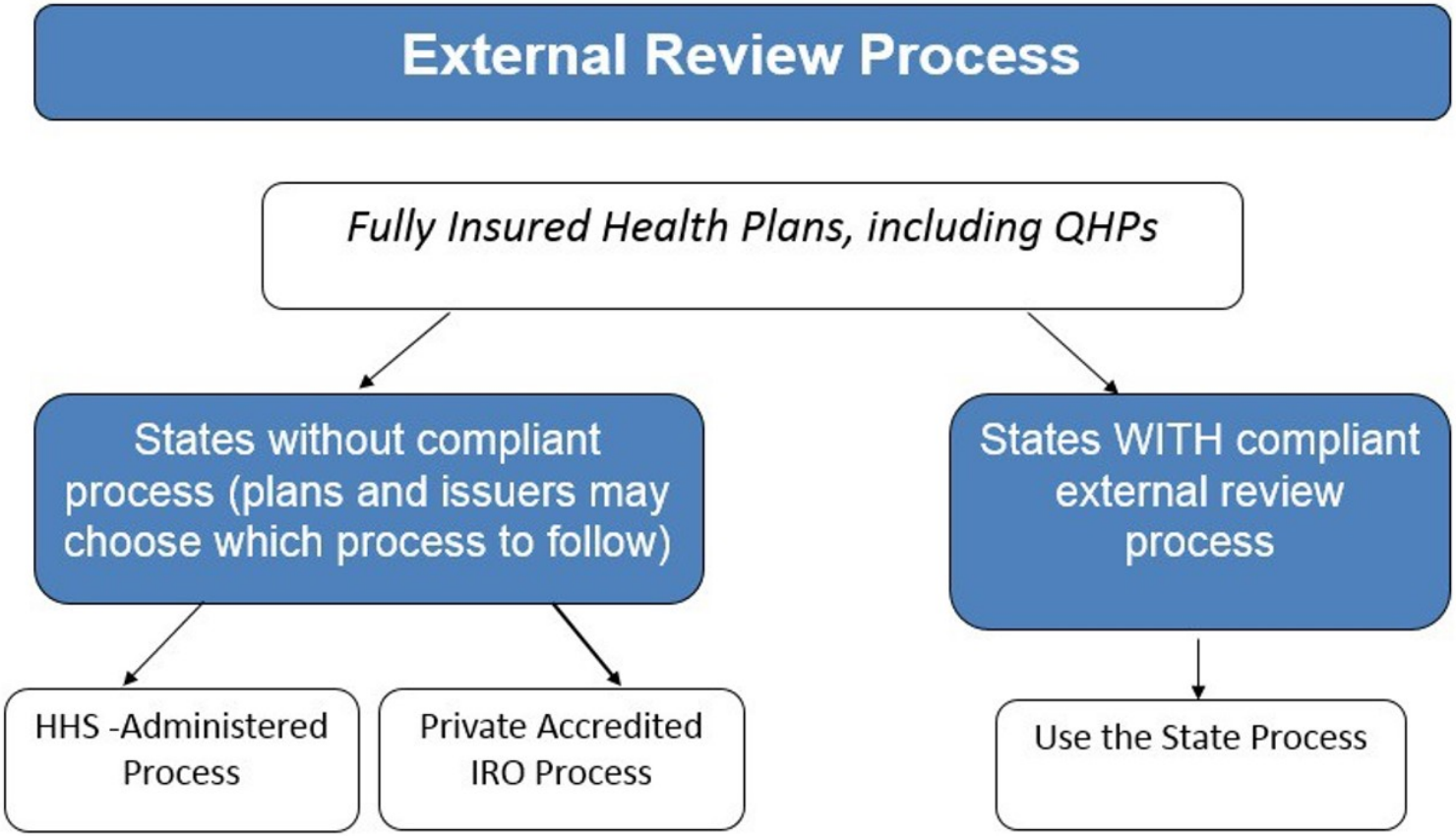
External Review – State Determinations

- HHS evaluated state laws and issued determinations finding the laws either met NAIC-Parallel standards, NAIC-Similar standards or neither.
- States may request redeterminations at any time.
- Plans and issuers in states with laws meeting neither the NAIC-Parallel nor NAIC-Similar standards must participate in a Federally-Administered process.

Examples of Minimum Requirements for State External Review

Standard	Federal Minimum Standards (NAIC-parallel) (required 1/1/18)	Similar Standards (NAIC-similar) (1/1/12 – 12/31/17)
Scope	External review of adverse benefit determinations (ABDs) based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit	Same
Written Records	The IRO must maintain written records and make them available upon request to the State, substantially similar to section 15 of the NAIC Uniform Model Act.	No requirement
Notice of Standard External Review Decision	Within 45 days	Within 60 days
Time to File an External Review Request	4 months	60 days

External Review Process



Federal External Review Programs

HHS-Administered
&
Private Accredited IRO Processes

Scope of Claims Eligible for Federal External Review

Applies to adverse benefit determinations (or final internal adverse benefit determinations) 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 or those 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 the coverage started (also called a “rescission”)

Federal External Review Process Requirements

- Protections are similar to those in the NAIC Uniform Model Act;
- Standards include:
  - Description of external review initiation;
  - Procedures for prelim. review of claim;
  - Minimum qualifications for IROs;
  - Process of approving IROs;
  - Random IRO assignment;
  - Standards for IRO decision-making;
  - Rules for providing notice of a final external review decision;

Federal External Review Process Requirements *continued*

- Standards include (continued):
  - Rules for expedited review of adverse benefit determinations and final internal adverse benefit determination;
  - Standards for evaluating claims involving experimental/investigational treatments;
  - Binding IRO decisions;
  - IRO reporting requirements; and
  - Notice of right to external review (on ABDs and within plan or policy documents).

HHS-Administered External Review Process

- Includes minimum consumer protections in NAIC-Parallel standards;
  - Federal government pays cost of appeal and no filing fee for consumers.
- Applies to adverse benefit determinations (or final internal adverse benefit determination) that involve medical judgment and rescissions; and
- Applies for health plans subject to the federally administered external review process that do not elect the 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 random assignment 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
External Review - State Process	The State Department of Insurance, the State Department of Health, or the plan
External Review - Federally-Administered Process (Plans in AL, AK, FL, GA, PA, & WI)	Health Plan 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 (Plans in AL, AK, FL, GA, PA, & WI)	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

- 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

Appendix C: Strict v. Similar Standards

Standard	Federal Minimum Standards (NAIC-parallel) (required 1/1/18)	Similar Standards (NAIC-similar) (1/1/12 – 12/31/17)
Scope	External review of adverse benefit determinations (ABDs) based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit	Same
Notice	Effective written notice of right to external review	Same
Deemed Exhaustion	1)Issuer (or plan) waives; 2)failure to comply w/internal appeals requirements (except de minimis violations); and 3)claimant simultaneously requests expedited internal appeal & external review	1)internal appeals process timelines unmet; and 2)In an urgent care situation, claimant files for external review without exhausting internal appeal
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.	Filing fee may not exceed $25; AND cost of IRO borne by issuer

Strict v. Similar Standards

Standard	Federal Minimum Standards (NAIC-parallel) (required 1/1/18)	Similar Standards (NAIC-similar) (1/1/12 – 12/31/17)
Claims Threshold	No claims threshold	Same
Time to File an External Review Request	4 months	60 days
IRO Assignment	IRO assigned on a random, rotational, or other independent/impartial basis	IRO assigned impartially with no claimant or issuer discretion
IRO Accreditation	State must maintain a list of nationally accredited IROs	Process for quality assurance of IROs

Strict v. Similar Standards

Standard	Federal Minimum Standards (NAIC-parallel) (required 1/1/18)	Similar Standards (NAIC-similar) (1/1/12 – 12/31/17)
Conflict of Interest	No IRO/clinical reviewer conflict of interest (no material, professional, familial, or financial COI w/issuer, claimant, provider, etc)	If the State contracts with or identifies 1 or more IROs, the State must ensure COI protections on the part of the IRO
Submission of Additional Information	1) IRO must consider additional info submitted by the claimant 2) claimant notified of right to submit additional info 3) claimant has 5 business days to submit 4) IRO has 1 business day to fwd to issuer (or plan)	--
Binding	Binding on plan or issuer and claimant	Binding on plan or issuer and claimant
Notice of Standard External Review Decision	Within 45 days	Within 60 days

Strict v. Similar Standards

Standard	Federal Minimum Standards (NAIC-parallel) (required 1/1/18)	Similar Standards (NAIC-similar) (1/1/12 – 12/31/17)
Notice of Expedited External Review Decision	Within **72 hours maximum** (or less, depending on medical urgency). If decision is provided orally, then written decision must be sent within 48 hours of oral decision	Within **4 business days** (depending on medical exigencies). If decision is provided orally, then written decision must be sent within 48 hours of oral decision.
Description of External Review	Description of external review process in SPDs /ABDs	Effective written notice of right to external review in SPDs/ABDs
Written Records	IRO must maintain written records for 3 years; substantially similar to §15 of NAIC Uniform Model Act	--
Experimental/ Investigational Review Procedures	Process for experimental/ investigational treatment, substantially similar to §10 of NAIC Model Act	Must be appealable, and at least be treated same as medical necessity