



Webinar: How to Interpret the New Internal & External Appeals Regulations

For Health Plans, Medical Management Organizations & TPAs

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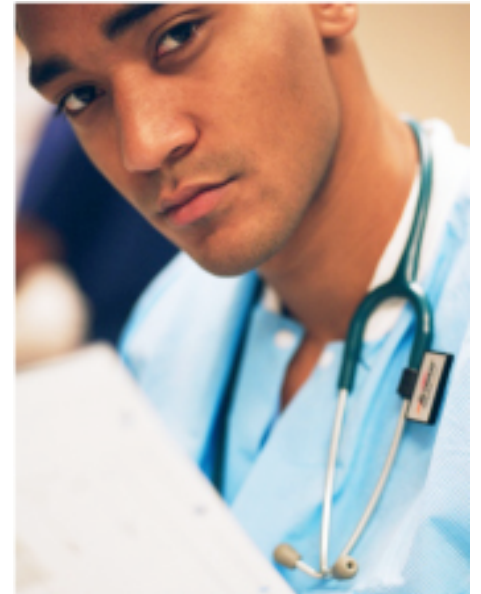
Webinar Overview

- We're all learning here
- Lots of conflicting information floating around
- VERY complex for multi-state plans
- Not sure anyone quite understands all the details yet – including the new Office of Consumer Information and Insurance Oversight!
- I'm not a lawyer, please seek legal advice



What Was The Point?

- Inconsistent claims and appeals processes
- Patchwork of consumer protections
- Applicable processes and protections depended on:
 - Plan subject to ERISA or not
 - Group or individual, plan or issuer
 - Self-funded or fully-insured
 - Subject to State internal claims/appeals laws or not
 - Subject to state external laws or not



What Was The Point?

- PHS Act section 2719 enacted to ensure that plans and issuers implement more uniform internal and external claims and appeals processes and to set a minimum standard of consumer protections.
- Level the playing field.
- Less consumer confusion.



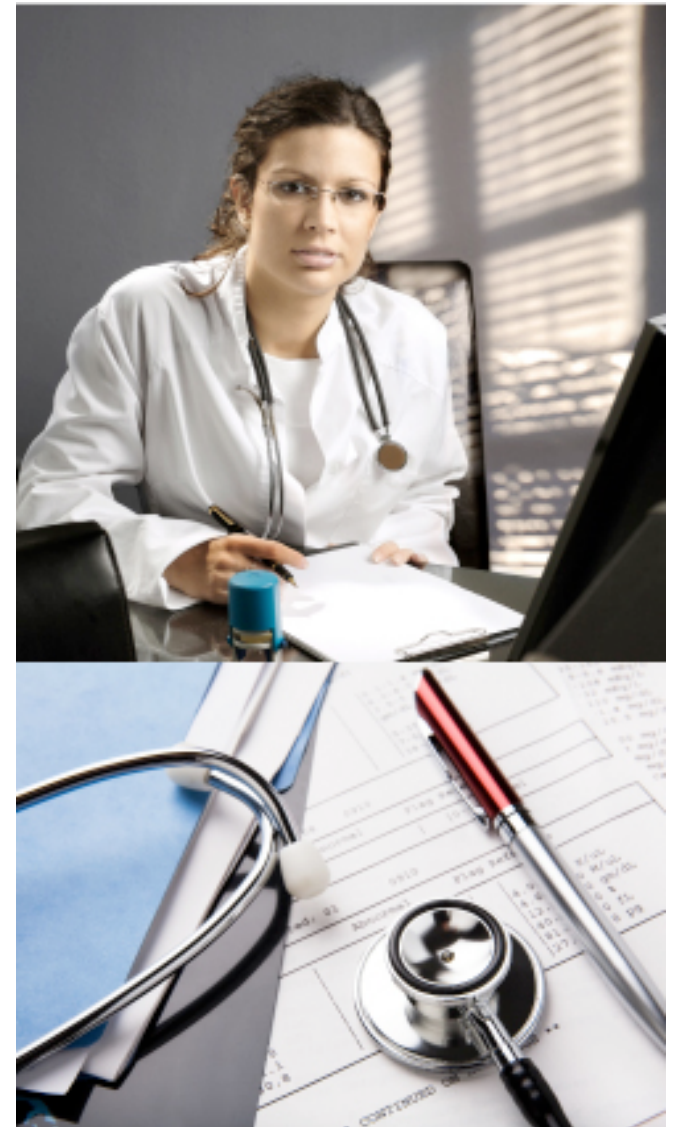
Who Does This Apply To?

- The rules are effective for plan years beginning after September 22, 2010, and will affect all group health plans, including those not previously subject to ERISA's claims procedure requirements (e.g., church plans, state and local government plans).
- The rules also apply regardless of whether a plan provides benefits on an insured or self-insured basis.
- Plans that enjoy "grandfathered" status under the health reform law are exempt from the new regulations as long as they maintain that status.



Internal Claims and Appeals

- Group health plans and issuers offering group or individual coverage are required to implement an effective internal claims and appeals process.
- As a starting point, group health plans must adopt the DOL's regulations governing claims procedures in accordance with Section 503 of the Employee Retirement Income Security Act (ERISA).



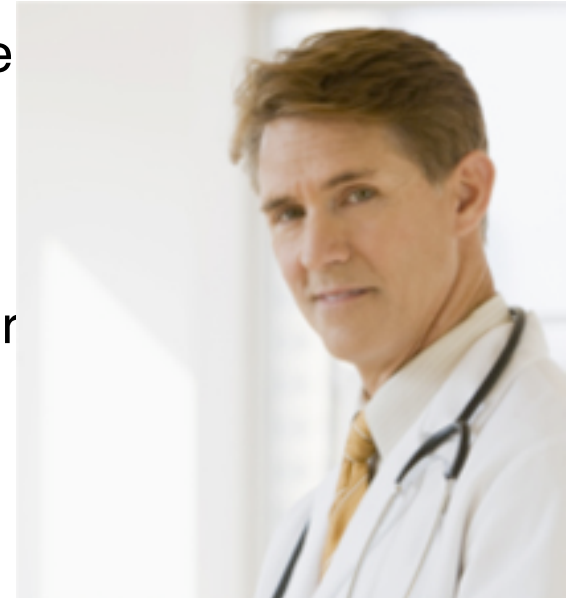
Internal Process Changes

- Expanded definition of adverse benefits determination.
- Reduced timeframe for deciding urgent care claims.
- Additional protections to ensure a full and fair review.
- Avoiding conflicts of interest.
- Culturally and linguistically appropriate notices and additional content requirements for notices.
- Strict adherence to the claims procedures.
- Continued coverage during an appeal.



External Review Process

- Non-grandfathered plans and issuers of non-grandfathered policies must adopt either a state external review process or the federal external review process.
- Most health insurance issuers, insured plans, certain self-funded plans, and multiple employer welfare plan arrangements will generally be subject to state external review processes.



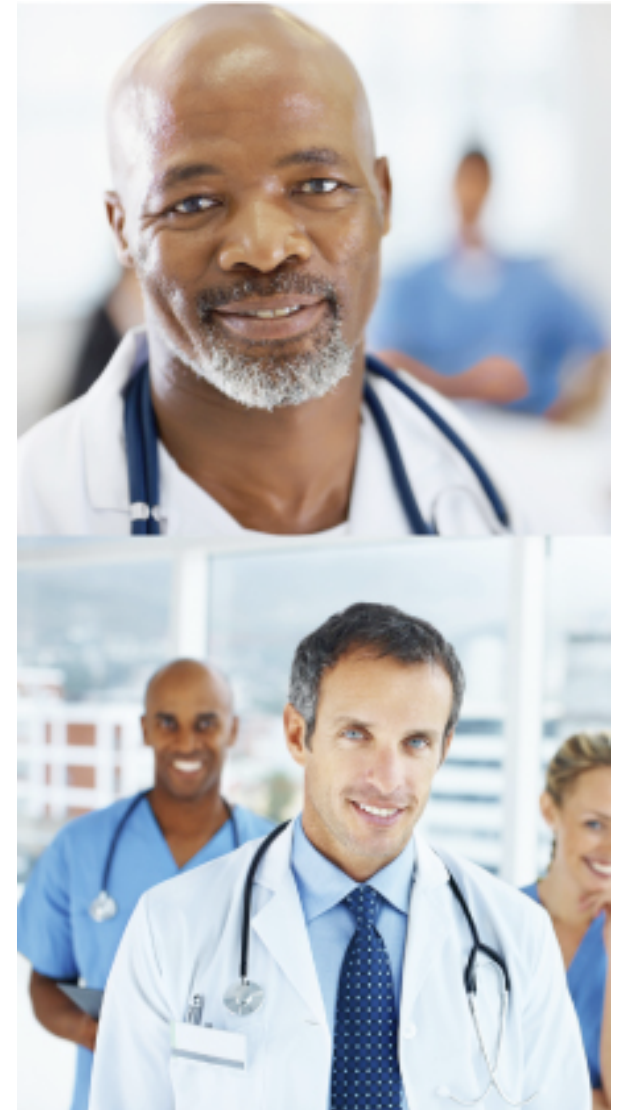
External Review Process

- HHS will determine whether state external review processes meet minimum standards. All states are considered to be in compliance for plan years beginning before July 1, 2011.
- 6 states did not have external review processes at the time of enactment.
- HHS will work with states to amend laws – if states do not meet minimum standards by July 1, 2011, plans and issuers in those states will have to comply with the federal process.



External Review Process

- Self-funded plans will be in compliance if they voluntarily comply with a state's external review process (*If the state expands access to plans that are not currently subject to the law.*) OR if they create their own process mirroring the federal external review process. (If there's a state plan that applies, *must* comply with it)
- Plans and issuers in states without a state external process must comply with the federal external review process through HHS. Technical Guidance issued September 20, 2010.



External Review Process

- The agencies will issue further guidance no later than July 1, 2011 to replace the interim federal external review process
 - Does this mean everything you're working on now can change?
 - Of course, it's the government!



Basic External Review Process

- Allow claimant to file for up to 4 months after adverse benefit determination
- Within 5 business days, complete preliminary review
- Within 1 day provide notice to claimant – eligible for external review or not
- Assign to accredited IRO – contract with 3 IROs and rotate among them or use some other unbiased selection method
- Claimants allowed 10 days to submit additional info and plans have opportunity to reverse adverse determination



Basic External Review Process

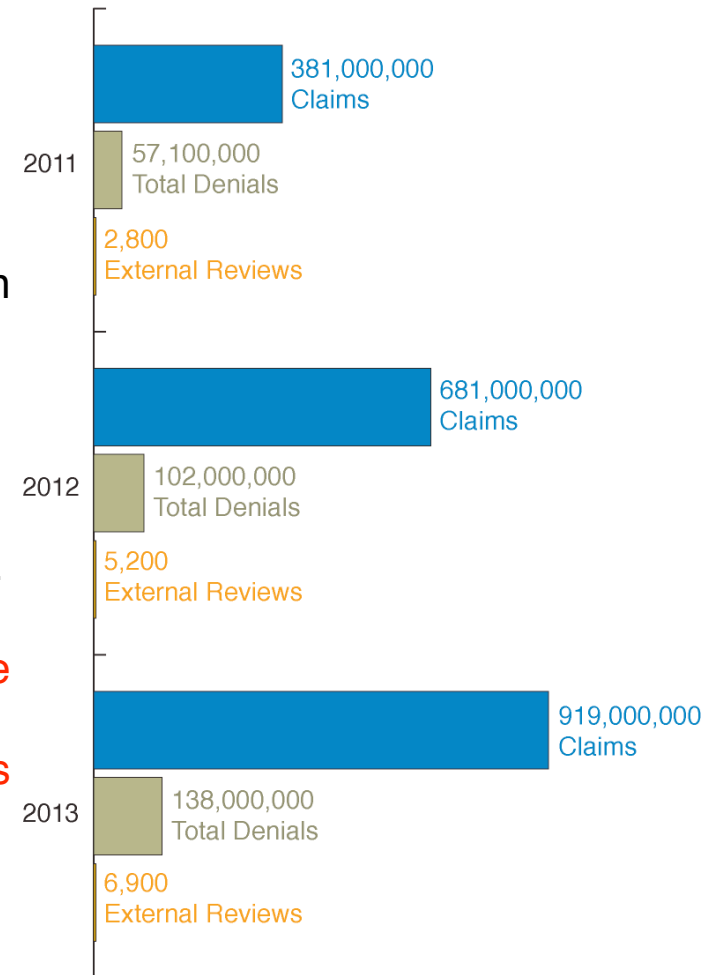
- IRO reviews *de novo*: not bound by any decisions reached during the plan's internal claims and appeals process.
- IRO determinations are binding on the plan and the claimant (though they may have other legal remedies).
- Must allow for an expedited process with immediate eligibility review, electronic/phone/fax transmission to IRO and determination within 72 hours.



Breaking Down External Reviews

- Historically, 1.3 requests for external appeals are filed per year for each 10,000 covered lives.
- Nationally, around 2,600 new external appeals in 2011.
- By 2013 it will approach 7,000.
- Perspective: 2,600 out of approximately 381 million claims
- Nonetheless, you still have to do it, and can be fined \$100 per day for each individual to whom the failure relates
- Good News – Safe Harbor granted to July 1, 2011. See DOL Technical Release 2010-02. **UPDATE:** Following presentation of this material, an attendee pointed out that the Safe Harbor applies to Internal Review Processes, not External Review Processes. Thank you for the clarification!

Volume of External Reviews



AllMed's Solution

- AllMed will continue to offer the same support for internal claims/appeal processes that we always have:
 - Pre-authorizations
 - 1st and 2nd level internal appeals
 - State appeals in select states
 - Rescission reviews
- AllMed also has developed an External Review product offering to meet the interim federal requirements and is committed to transitioning that process to maintain compliance for our customers when the final rules are issued.

AllMed's Solution

Types of reviews:

- Medical Necessity
- Administrative (though eligibility determinations are not included in the rules)
- Panel reviews for
 - Experimental/Investigational
 - Rescissions

AllMed's Solution

- Plan does preliminary review for eligibility for external review
- AllMed notifies member if eligible and sent to AllMed, allow 10 days for additional information
- AllMed provides all additional information to plan for opportunity to reverse adverse determination

AllMed's Solution

- If no reversal by plan, AllMed completes review and issues notice to member in:
 - 7 additional days for standard requests (17 days total)
 - 48 hours for expedited requests
- Stricter conflict of interest provisions with our peer reviewers
- Stricter qualifications for experimental/investigational reviews
- Translations as necessary
- Adherence to 6-year record retention rules

AllMed's Solution

- Tracking additional data elements to facilitate reporting to:
 - All state agencies as requested
 - All customers
 - Any federal or other oversight agencies as requested

AllMed's Solution

- Important to keep internal and external review processes separate.
- Execute separate contracts
 - Different timing
 - Different tracking/reporting
 - Different notice/translation requirements
 - Different review process (panels, de novo, etc.)

Important Links:

- Regulation Text:
<http://edocket.access.gpo.gov/2010/pdf/2010-18043.pdf>
- HHS Federal Review Process Technical Guidance:
http://www.hhs.gov/ociio/regulations/consumerappeals/interim_appeals_guidance.pdf
- DOL Technical Releases 2010-01 and 2010-02:
<http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf>
<http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-02.pdf>
- Model Notice of Final Adverse Determination:
<http://www.dol.gov/ebsa/IABDModelNotice2.doc>
- OCIIO FAQs:
http://www.hhs.gov/ociio/regulations/implementation_faq.html

Important Links:

- EBSA FAQs:
<http://www.dol.gov/ebsa/faqs/faq-aca.html>
<http://www.dol.gov/ebsa/faqs/faq-aca2.html>
<http://www.dol.gov/ebsa/faqs/faq-aca3.html>
- Guidance on the culturally/linguistically appropriate notice standards:
http://www.hhs.gov/ociio/regulations/consumerappeals/guidance_for_individual_market.pdf
- NAIC Model Act – contains model notices and requests for external review and physician certification that request meets expedited requirements:
http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf

Questions and Answers

(Follow this slide – please note,
similar questions may be grouped)



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Questions & Answers

- If a claim is determined to be unbundled, is this considered to be an adverse determination and therefore subject to the external review process?
- So, if you don't pay the claim at 100% the participant now has internal and external appeal rights?
 - I believe so. The Overview of the Regulations, page 43332, states “Failure to make a payment in whole or in part includes any instance where a plan pays less than the total amount of expenses submitted with regard to a claim, including a denial of part of the claim due to the terms of a plan or health insurance coverage regarding copayments, deductibles, or other cost sharing requirements”
- Must the company be accredited specifically as and IRO. As long as they are accredited by URAC for Health Utilization Management does that suffice?
- Can they be URAC accredited in HUM and still be considered an IRO?
 - I believe so. The DOL Technical Release 2010-01 states “The group health plan must assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review.”

Questions & Answers

- Is a request for pre-certification of an urgent care service included in the urgent care turn around time frame within 24 hours? Most plans indicated the care management company must be notified within the next business day.
- Define Urgent Care Claim?
 - I believe so. In consumer information on the EBSA website, urgent care claims are defined like this, “Urgent care claims are a special kind of pre-service claim that requires a quicker decision because your health would be threatened if the plan took the normal time permitted to decide a pre-service claim. If a physician with knowledge of your medical condition tells the plan that a pre-service claim is urgent, the plan must treat it as an urgent care claim.”
- If ER or Urgent care do not require prior authorization, would this provision apply
 - I don’t believe so, unless there is a payment adjustment retrospectively.
- If additional documentation is submitted, how are we billed for it?
 - If AllMed is your IRO vendor, you’re not billed for receiving the additional information and having an opportunity to reverse your final adverse determination. If you decide to reverse your decision and cancel the external review, you will be charged a small administrative fee.

Questions & Answers

- Is there any requirement to communicate by phone with the patient?
 - No, there is no requirement to communicate by phone with the patient. The IRO can choose to notify the patient by phone within 72 hours on expedited requests but must follow in writing within 48 hours.
- The letters that you are sending out, where did you get the language for them? Do you get it from your clients or from the regulations?
 - Please see the “Important Links” pages in this presentation – some of the model notices are from the NAIC model act and some are from technical guidance that has been issued after the regulation was enacted.
- Will unions be able to take these as a final answer or can they still file a grievance on an denial that has been held up in the appeal process?
 - I’m sorry, I do not know the answer to this question. I will continue to search for the answer and get back to you if I find guidance.

Questions & Answers

- Does your notification go to the member or do you handle on a subscriber level?
 - The regulations use the term “claimant” which could be a member or a subscriber or an authorized representative. AllMed will take guidance from our customers as to who/where the notices should be sent.
- If member is in a group who has info in Spanish and they move to another group that does not meet this translation requirement...is the plan still obligated to provide Spanish documentation to this person?
 - The regulation’s preamble states that once a member’s translation need has been identified, all future notices must be translated. There is no mention of the member changing plans and how that affects requirements. Best practice would, of course, be to always provide the notice in the language you know is needed by the member and not switch back to English.

Questions & Answers

- Has the government defined what qualifies for an external review, or is it at the request of the member?
 - Any final notice of adverse determination can be appealed to external review following exhaustion of the plan's internal appeal process. If the claim is an urgent claim, the member may be able to request both the internal and external processes to run simultaneously.
- As a current client of AllMed, will we need an amended contract, or will the current contract stand?
 - Current clients will need a contract amendment as this is a new product offering and will require at least a pricing addendum. Please contact Greg Leavitt Greg@allmedmd.com or 800.400.9916 and he will facilitate this for you.
- How does this affect Board of Trustees' Appeals Committee decisions. Do they no longer have the final word?
 - My understanding is that a BOT Appeals Committee is another level of an internal appeal process which means the member would still have a right to external appeal following the committee's determination. I am not a legal expert, so you may want to check this with your own legal counsel.

Questions & Answers

- I know right now when an AllMed review is done as a pre-determination of coverage or as a standard appeal, AllMed has requested that we not share their identity with the patient. Is this no longer the case?
 - We do prefer you not share the peer reviewer's identity with the patient in order to protect peers from harassment. If you have an obligation to release the peer's information we ask that you notify us first so we can warn the peer reviewer and give them guidance as to how to handle phone calls they may receive.
- If the Fund is an ERISA self-insured, self-administered Plan which has participants in 37 states, would the Fund be subject to the federal external review guidelines or the state's guidelines in the state in which the Fund is located?
 - My understanding is that the determination as to which state rules apply is based on the state the member resides in, not the state in which the fund is located. I am not a legal expert, so you may want to check this with your own legal counsel.

Questions & Answers

- On the adverse benefit determination, the "standard" must be included. What is a "standard?" Please give an example.
 - A standard might be a national guideline such as Milliman Care Guidelines, Interqual Intensity of Service criteria, a specialty-society's standard of care guideline, or some other evidence-based standard.
- Can you explain and give an example of the additional criteria required; "provide...any new or additional evidence considered...or generated by the plan in connection with a claim sufficiently in advance to allow claimant time to respond prior to any adverse benefit determination?"
 - One example might be a determination you sought from a peer specialist through your IRO as part of your internal review process. This would be new information that you have and the claimant does not.
- For non-clinical external reviews (e.g. acupuncture excluded under the plan), how will AllMed handle these external reviews? What are the qualifications of the individuals performing these types of reviews?
 - AllMed has a panel of non-clinical reviewers such as acupuncturists who perform reviews for us. We will continue to use this panel and they are credentialed just as our physician reviewers are credentialed, taking into account the types of certifications and licenses available to them.

Questions & Answers

- Does this apply to Self Insured books of business?
 - Yes, this does apply to self-insured plans.
- Is it only the member that can request it? Or can it come from the MDO or Facility?
 - Provider appeals are not included in these rules, they apply only to consumer appeals.
- Can you comment on concurrent review for Sunday morning hospital discharge. How does this apply?
 - Concurrent review falls into the realm of “urgent care claim” and would be subject to the 24-hour internal claims process rules.
- Can you expand on the \$100/day fine for non-compliance?
 - We haven’t seen any enforcement regulations issued yet, but we can extrapolate that \$100/day per patient affected by non-compliance could translate into \$1,000,000 per day for a 10,000 member health plan. Yikes!
- Who handles the administrative reviews?
 - We have a panel of health law attorneys, retired judges and the like who will be processing administrative reviews for AllMed.

Questions & Answers

- Can you clarify the 24 hour turnaround time for expedited review?
 - The 24 hour rule applies to urgent care claims which used to have a 72-hour window for determination which has been shortened to 24 hours. This is described in the amendments to Section 503 of ERISA.
- URAC expects a median turnaround time of 5 days. If AllMed is accredited, how does a 17 day turnaround meet URAC compliance?
 - The median 5-day TAT is a median across ALL cases processed and that standard applies to independent reviews that support internal appeal processes. URAC is in the process of implementing new IRO standards that contain separate provisions for external vs. internal appeals.
- If an appeal request comes in without any new/updated clinical information, do you review only the prior information used for the original denial?
 - Yes.

Questions & Answers

- I think you said that you are responsible for sending the notification to the member that the ERO has been accepted, right?
 - In general, the plan will send the notice that the request is eligible for the external review and we would then send the notice that we have received the request and the claimant has 10 days to submit additional information. This process is customizable to accommodate different procedures our customers may request.
- Do you have any language that could be submitted in the denial and internal appeal letters advising members of their right to an external review?
 - On the “Important Links” page of this presentation is a link to the NAIC’s Model Act. You should be able to find this language in the model notices at the end of their document.
- Would a benefit reduction include both an R&C reduction AND a contracted discount reduction...or just the former?
 - I’m not sure. I think both but am not a legal expert and you should probably consult your own counsel on this issue. Any action that results in an adverse determination notice to the member can be appealed under these rules.

Questions & Answers

- How about the cost of those cases? Same ALLMED rates?
 - You'll need to talk to Matt (matt@allmedmd.com) or Greg (greg@allmedmd.com) about rates but in general, external appeals are much more labor intensive and require special handling by our staff so their price will be a bit higher. The preamble to the interim rules quotes an average price in excess of \$600. AllMed's price is *considerably* lower than that!
- What if a PPO Provider appeals the claim for the unbundled claim? The PPO provider would have to write off the balance, not patient responsibility.
 - If the patient does not receive a notice of adverse benefit determination, then there would be no appeal rights available or necessary.
- Would AllMed allow in the External Review Process, to allow letters/notifications to insured to be handled within the TPA, or is the IRO required to notify the insured?
 - It appears from the regulation that the IRO should be the entity to send the notices. We would be happy to customize our letters/notices for you if you'd like.

Questions & Answers

- Does the Internal Review process have to be exhausted before the External Review Process is implemented?
 - Yes, unless the request is for an urgent care claim in which case the member may be able to request the internal and external processes to run simultaneously.
- Can you provide a link to the regulations?
 - Please see the “Important Links” slides I’ve added to this presentation.
- Does the review company have to be certified by any agency (ex URAC)?
 - Yes, the IROs you contract with must be accredited by URAC.
- Do we need to issue Notices that serve at Member or at subscriber level (foreign language request)?
 - If I understand this question correctly, you’re asking whether the translation requirements apply at the subscriber or member level. Those requirements apply at the member level and all notices go to the “claimant” which I believe would generally be the member unless the member is a minor. I’m not a legal expert, please seek legal advice on this.

Questions & Answers

- Does this apply only to commercial insurance plans, not to Medicare or TRICARE?
 - These rules apply only to commercial plans, not Medicare or government-sponsored plans such as TRICARE.
- Who decides what is urgent - the physician, the member or the plan?
What is urgent to a member might not be urgent medically
 - The plan needs to make a formal determination whether the request is urgent based on the information provided by the physician. On the “Important Links” page of this presentation is a link to the NAIC Model Act. This document includes model forms that can be provided to physicians to certify the urgency of the patient situation. You’re right, “urgent” to a member or provider might not qualify as urgent under the rules. We see this all the time in current processes where a member has surgery scheduled for tomorrow and the provider makes a request for an expedited determination so they don’t have to bump the surgery. Historically, health plans have tried to accommodate these requests so as not to burden their providers and members, but these situations do not qualify as urgent under any claims/ appeals rules.

Questions & Answers

- Is the 5 day mean turn around time for IRO URAC accreditation? That is not the standard for the UM accreditation.
 - Yes, the 5-day median TAT is for IRO accreditation where the mix of cases include some with 24-hour TAT and some with up to 45-day TAT based on type of review, federal or state regulations, etc.
- Will AllMed be available to work requests due over weekends and holidays based on the new stricter turnaround times?
 - Yes, AllMed will accommodate whatever timing requests are required and will cover weekend and holiday hours as necessary to be in compliance.
- UPDATE: Following presentation of this material, an attendee pointed out that the Safe Harbor applies to Internal Review Processes, not External Review Processes. Thank you for the clarification!