



Internal Claims and Appeals and the External Review Process Overview



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CCIIO

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Agenda

1. Summary of the Coverage Appeals Regulation
2. Internal Claims and Appeals
3. State External Review
4. Federal External Review Programs
5. Resources

Summary of the Coverage Appeals Regulation

Consumer Coverage Appeals Rights

- The Patient Protection and Affordable Care Act (PPACA) ensures a consumer's right to appeal group health plan and health insurance plan (plan and issuer) decisions, asking a plan or issuer to reconsider its decision, including, but not limited to:
 - Denying payment for a service or treatment,
 - Determining the consumer isn't eligible for coverage after they file a claim, or
 - Rescinding coverage that was improperly approved.
- If the plan or issuer upholds its initial decision, consumers may be eligible for a second review by an independent third-party reviewer.



Summary of Coverage Appeals Regulation

- Established by Section 2719 of the Public Health Service Act. Implementing regulations are at [45 C.F.R. 147.136](#).
- Regulations and guidance are available on the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight (CCIIO) website at [CMS.gov/cciio/resources/regulations-and-guidance/index.html#ExternalAppeals](https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html#ExternalAppeals).
- These rules do not apply to grandfathered health plans under Section 1251 of the PPACA.
 - Information about grandfathered status may be found at [CMS.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Grandfathered-Plans](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Grandfathered-Plans).



Internal Claims and Appeals

Definitions

- **Claim** – any request for benefits, including pre-service (prior authorization) and post-service (reimbursement)
- **Rescission** – retroactive cancellation of a health insurance policy
- **Internal appeals** (conducted by a plan/issuer)
 - Full and fair review of its decision (i.e., its adverse benefit determination, or ABD)
 - Final internal ABD
- **External review** [conducted by an 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 the 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

- Provide sufficient information to identify claim
- Describe reason(s), including specific plan provisions or scientific or clinical judgment used
- Describe any additional information needed to improve or complete the claim
- Notification of internal appeals and external review rights, the plan's review procedures, and time limits
- Notification about health insurance consumer assistance or ombudsman office availability
- Provide notification in a culturally and linguistically appropriate manner



Culturally and Linguistically Appropriate Manner



Applicable non-English language: A non-English language is applicable when 10 percent of a claimant's county is literate only in the same non-English language(s).

If the claimant's county meets this threshold, 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 language services provided by the plan or issuer.

Internal Appeals: The Appeals Process

- What can be appealed?
 - A determination that:
 - The benefit isn't offered under the consumer's health plan
 - The consumer received health services from a health provider or facility that isn't in their plan's approved network
 - The requested service or treatment is "not medically necessary"
 - The requested service or treatment is an "experimental" or "investigative" treatment
 - The consumer is no longer enrolled or eligible to be enrolled in the health plan
 - It is revoking or canceling the consumer's coverage going back to the date they enrolled because the plan or issuer claims that the consumer did something that constitutes fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage
- How long does a consumer have to file an appeal?
 - 180 days from receipt of denial
- How to file an appeal?
 - Generally in writing (unless urgent – then oral is acceptable)

Internal Appeals: Necessary Documentation

- A claimant should keep copies of all information related to a claim and denial, including:
 - Explanation of Benefits forms or letters
 - Copy of request for internal appeal
 - Any additional information
 - Copy of any letter/form signed, if a representative filed appeal
 - Notes and dates from any conversations



Internal Appeals: Additional Information

- How many levels of internal appeal?
 - Group market: One or two
 - Individual market: One
- 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: Claimant Rights



- The claimant has a right to a full and fair review.
 - They have the opportunity to review and respond to any evidence or rationale under consideration.
 - Reviewers must not have any conflicts of interest.
- Plans/issuers are required to provide continued coverage pending the outcome of an appeal.
 - Concurrent care decisions: If a plan/issuer has approved an ongoing course of treatment, it must provide an opportunity for an appeal or review before reducing or terminating coverage (except where reduction or termination is due to a plan amendment or termination).

Special Situations: Urgent Care

Definition:

- The standard appeal timeframe could seriously jeopardize a claimant's life or health or ability to regain maximum function; or
- In the opinion of a physician with knowledge of the claimant's medical condition, the standard appeal timeframe would subject a 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 (Cont.)

- A claimant may file orally, and notice of an appeal decision may be oral (must be followed by a written notice within three days).
- Individuals in urgent-care situations may initiate an internal appeal and external review simultaneously.



Special Situations: Deemed Exhaustion

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

- The plan or issuer waives an 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:
 - *De minimis*;
 - Non-prejudicial;
 - Attributable to good cause or matters beyond the plan's or issuer's control;
 - In the context of an ongoing good-faith exchange of information; and
 - Not reflective of a pattern or practice of non-compliance.

State External Review

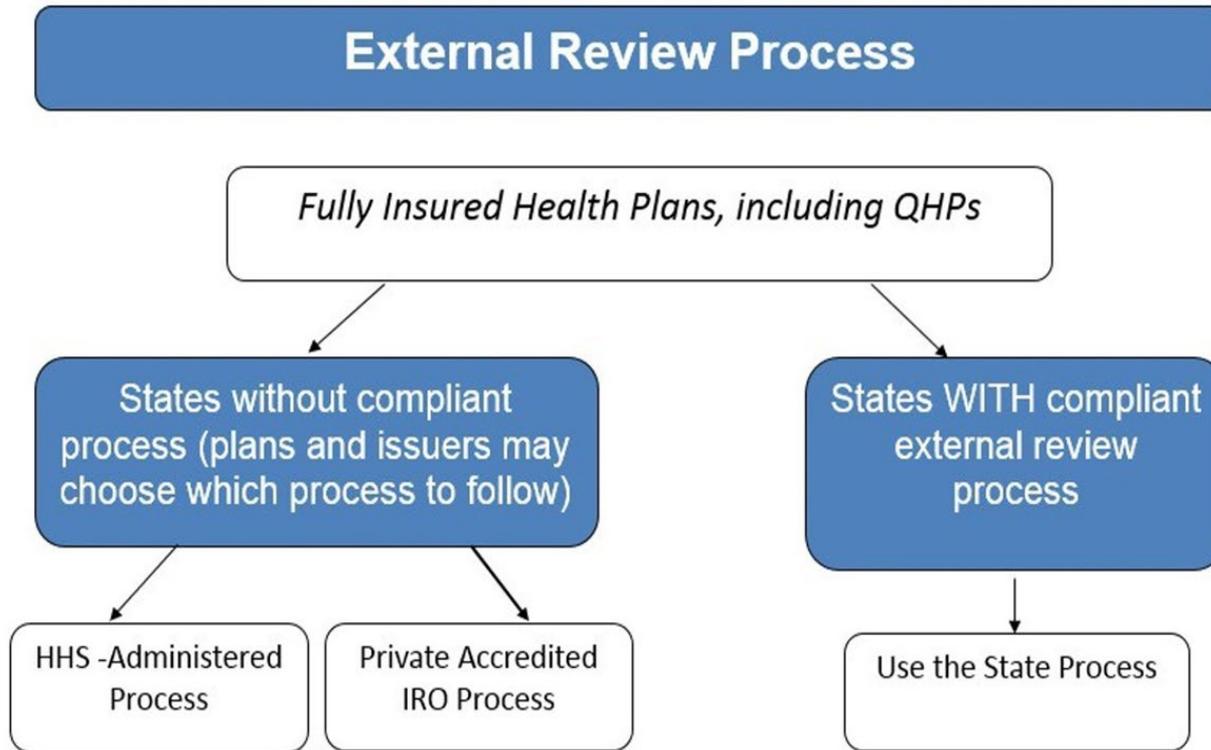
Minimum Requirements for State External Review

Standard	State Minimum Review Standards
Scope	External review of ABDs based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit
Notice	Effective written notice of right to external review
Deemed Exhaustion	<ul style="list-style-type: none"> • Issuer (or plan) waives exhaustion requirement • Failure to comply with internal appeals requirements (except <i>de minimis</i> violations) • Claimant simultaneously requests expedited internal appeal and external review
Filing Fee	<ul style="list-style-type: none"> • 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.
Claims Threshold	No minimum dollar amount on claim
Time to File an External Review Request	At least four months
IRO Assignment	IRO assigned on a random, rotational, or other independent/impartial basis.
IRO Accreditation	State must maintain a list of nationally accredited IROs
Notice of Expedited External Review Decision	<ul style="list-style-type: none"> • 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.

Minimum Requirements for State External Review (Cont.)

Standard	State Minimum Review Standards
Conflict of Interest	No IRO/clinical reviewer can have a conflict of interest (COI)(e.g., material, professional, familial, or financial COI with the issuer, claimant, provider, etc.)
Submission of Additional Information	<ul style="list-style-type: none"> • The IRO must consider additional information submitted by the claimant • The claimant must be notified of their right to submit additional information • The claimant has five business days to submit additional information • The IRO has one business day to forward to issuer (or plan)
Binding	Decision is binding on plan or issuer and claimant
Notice of Standard External Review Decision	Within 45 days
Description of External Review	Description of external review process in Summary Plan Descriptions (SPDs)
Written Records	IRO must maintain written records for three years, substantially similar to Section 15 of NAIC Uniform Model Act
Experimental/Investigational Review Procedures	Process for experimental/investigational treatment, substantially similar to Section 10 of NAIC Uniform Model Act

External Review Process



**Federal External Review Programs:
HHS-administered and Private, Accredited IRO
Processes**

Scope of Claims Eligible for Federal External Review

Applies to ABDs (or final internal ABD) involving:

- 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 and do not involve medical judgment
 - Determinations related to participant or beneficiary eligibility for coverage under the terms of a group health plan without any use of medical judgment
- Rescission of coverage if improperly applied according to 45 CFR § 147.128

Federal External Review Process Requirements

- Protections are similar to those in the NAIC Uniform Model Act
- Standards include:
 - A description of the external review initiation
 - Procedures for a preliminary review of claim
 - Minimum qualifications for IROs
 - A process for approving IROs
 - Random IRO assignment
 - Standards for IRO decision-making
 - Rules for providing notice of a final external review decision
 - Rules for expedited review of ABDs and final internal ABDs
 - Standards for evaluating claims involving experimental/investigational treatments
 - Binding IRO decisions
 - IRO records retention
 - Notice of a claimant's right to an external review (on ABDs and within plan or policy documents)

HHS-administered External Review Process



- Includes minimum consumer protections in NAIC-parallel standards
 - The Federal Government pays the cost of an appeal, and there are no filing fees for consumers
- Applies to ABDs (or final internal ABDs) that involve medical judgment and rescissions
- Applies to health plans subject to the federally administered external review process that do not elect a private, accredited IRO process

Private, Accredited IRO External Review Process

- Plans must contract with at least three 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 an impartial assignment method 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 or issuer
External Review – State Process	<ul style="list-style-type: none">• The state Department of Insurance, or• The state Department of Health, or• The plan/issuer
External Review – Federally Administered Process (in AL, AK, FL, GA, PA, TX, and WI)	<ul style="list-style-type: none">• Health plan/issuer, 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	<ul style="list-style-type: none">• The state Department of Insurance, or• The state Department of Health
External Review – State Process	<ul style="list-style-type: none">• The state Department of Insurance, or• The state Department of Health
External Review – Federally – Administered Process (in AL, AK, FL, GA, PA, TX, and 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 on August 23, 2010
 - HHS Technical Guidance: August 26, 2010 (Description of Interim HHS Federal Process)
 - DOL Technical Release 2011-01 on March 18, 2011
 - HHS Technical Guidance: January 12, 2017 (HHS Election Instructions for Self-Funded, Non-Federal Government Plans)
 - DOL Technical Release 2011-02 on 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: [Externalappeal.com](https://www.externalappeal.com)
- Consumer Information: [HealthCare.gov](https://www.healthcare.gov)
- HHS Federal External Review regulations and sub-regulatory guidance:
[CCIIO.cms.gov/resources/regulations/index](https://www.cciio.cms.gov/resources/regulations/index)
- State External Appeals Review Processes:
[CMS.gov/CCIIO/Resources/Files/external appeals](https://www.cms.gov/CCIIO/Resources/Files/external%20appeals)

Appendix C: Strict vs. 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	<ul style="list-style-type: none"> • Issuer (or plan) waives; • Failure to comply with internal appeals requirements (except de minimis violations); and • Claimant simultaneously requests expedited internal appeals & external review 	<ul style="list-style-type: none"> • Internal appeals process timelines unmet; and • 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.	<ul style="list-style-type: none"> • Filing fee may not exceed \$25; and • Cost of IRO borne by issuer