SITZMANN ▪ MORRIS ▪ LAVIS

Employee Benefits | Life Insurance | Retirement Planning

TO: Clients of Sitzmann Morris & Lavis Inc.

RE: Technical Guidance on Federal External Review Process for Self-Insured Plans

Interim Final Regulations were published on July 23, 2010, addressing internal claims and appeals and external review (see *SML Update* dated July 28, 2010). Additional guidance was required on the Federal external review process. On August 23rd the Department of Labor (DOL) published Technical Release 2010-01. This release provides guidance on the interim Federal external review process for self-insured group health plans. It details an interim enforcement safe harbor. In the case of fully-insured plans, the carrier has the primary responsibility to comply with the interim final regulations.

These requirements do not apply to grandfathered health plans.

Effective Dates: The interim enforcement safe harbor applies for plan years beginning on or after September 23, 2010 and until future guidance is issued.

Key Provisions:

There are two ways to comply:

1. Compliance with the Technical Release. The procedures detailed in the technical release, and outlined below, are based on the Uniform Health Carrier External Review Model Act supported by the National Association of Insurance Commissioners (NAIC Model Act). They do not include all of the consumer protections of the Model Act.

2. Voluntary compliance with State external review processes. States may choose to expand access to their State external review process to self-insured plans, and such plans may choose to voluntarily comply with the provisions of that State external review process.

Procedures

1. Request for external review. A group health plan must allow a claimant to file a request for an external review with the plan if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five business days following the date of receipt of the external review request, the group health plan must complete a preliminary review of the request to determine whether:

(a) 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;

(b) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

(c) The claimant has exhausted the plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and

(d) The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the plan must issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to

make the request complete and the plan must allow a claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The group health plan must assign an independent review organization (IRO) that is accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review. Moreover, the plan must take action against bias and to ensure independence. Accordingly, plans must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any 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 the following:

(a) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the plan.

(b) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(c) Within five business days after the date of assignment of the IRO, the plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the plan to timely provide the documents and information must not delay the conduct of the external review. If the plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the plan.

(d) Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the plan. Upon receipt of any such information, the plan may

reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the plan.

(e) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the PHS Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(i) The claimant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(iv) The terms of the claimant's plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;

(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(vi) Any applicable clinical review criteria developed and used by the plan, the criteria are inconsistent with the terms of the plan or with applicable law; and

(vii) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(f) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the plan.

(g) The assigned IRO's decision notice will contain:

(i) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(ii) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(iii) References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;

(iv) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(v) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;

(vi) A statement that judicial review may be available to the claimant; and

(vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(h) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

4. 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 immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited external review

1. Request for expedited external review. A group health plan must allow a claimant to make a request for an expedited review with the plan at the time the claimant receives:

(a) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

(b) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the plan must determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The plan must immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, 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.

4. Notice of final external review decision. The plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the plan.

Model Notices

Model notices have been posted on http://www.dol.gov/ebsa and http://www.hhs.gov/ociio/. Included are a notice of adverse benefit determination; a notice of final internal adverse benefit determination; and a notice of final external review decision. Copies of these notices are attached.

What's Next:

Prior to July 1, 2011, the Department of Health and Human Services (HHS) will issue further guidance as to which State external review laws have been determined to satisfy the minimum standards of the NAIC Model Act. The DOL, HHS and IRS will issue guidance on what process will replace the interim process described above no later than July 1, 2011.

Contact your SML Account team if you have any questions.

Date of Notice
Name of Plan **Telephone/Fax**
Address **Website/Email Address**

This document contains important information that you should retain for your records.
This document serves as notice of a final internal adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you may have the right to appeal (see the back of this page for information about your appeal rights).

Case Details:

Name:	**ID Number:**
Claim #:	**Date of Service:**
Provider:	

Reason for Denial (in whole or in part):

Amt. Charged	**Allowed Amt.**	**Other Insurance**	**Deductible**	**Co-pay**	**Coinsurance**	**Other Amts. Not Covered**	**Amt. Paid**

YTD Credit toward Deductible:	**YTD Credit toward Out-of-Pocket Maximum:**
Diagnosis:	
Diagnostic Codes:	**Requested Service(s)/ Treatment Code:**
Treatment Category (Subcategory):	**Denial Codes:**

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Background Information: *Describe facts of the case including type of appeal and date appeal filed.*

Final Internal Adverse Benefit Determination: *State that adverse benefit determination has been upheld. List all documents and statements that were reviewed to make this final internal adverse benefit determination.*

Findings: *Discuss the reason or reasons for the final internal adverse benefit determination.*

Model Notice of Final Internal Adverse Benefit Determination

Important Information about Your Rights to External Review

What if I need help understanding this denial? Contact us [insert contact information] if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? For most types of claims, you are entitled to request an independent, external review of our decision. Contact us [insert contact information] with any questions on your rights to external review.

How do I file a request for external review? [Insert instructions in place of detachable form at the bottom of this page. If there are no current procedures applicable, insert: Detach and send in the bottom of this form within [insert timeframe].]

What if my situation is urgent? If your situation meets the definition of urgent under the law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited external review by [insert instructions to begin the process (such as by phone, fax, electronic submission, etc.)].

Who may file a request for external review? You or someone you name to act for you (your authorized representative) may file a request for external review. [Insert information on how to designate an authorized representative.]

Can I provide additional information about my claim? Yes, once your external review is initiated, you will receive instructions on how to supply additional information.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us at [insert contact information].

What happens next? If you request an external review, an independent organization will review our decision and provide you with a written determination. If this organization decides to overturn our decision, we will provide coverage or payment for your health care item or service.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). [Insert, if applicable in your state: Additionally, a consumer assistance program may be able to assist you at [insert contact information].

Appeal Filing Form

[Insert Insurer Name] [Insert Name and ID Number]
[Insert Phone Number/ Mailing Address] [Insert Claim #]

Detach this form and send to: [Insert name and contact information]

NAME OF PERSON FILING APPEAL: _____
☐Covered person ☐ Patient ☐ Authorized Representative

OMB Control Number 1210-0144 (expires 01/31/2011)

Date of Notice:
Name of Plan **Telephone/Fax**
Address **Website/Email Address**

This document contains important information that you should retain for your records.
This document serves as notice of an adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal (see the back of this page for information about your appeal rights).

Case Details:

Name:	**ID Number:**
Claim #:	**Date of Service:**
Provider:	

Reason for Denial (in whole or in part):

Amt. Charged	**Allowed Amt.**	**Other Insurance**	**Deductible**	**Co-pay**	**Coinsurance**	**Other Amts. Not Covered**	**Amt. Paid**

YTD Credit toward Deductible:	**YTD Credit toward Out-of-Pocket Maximum:**
Diagnosis:	
Diagnostic Codes:	**Requested Service(s)/ Treatment Code:**
Treatment Category (Subcategory):	**Denial Codes:**

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Explanation of Basis for Determination:
If the claim is denied (in whole or in part) and there is more explanation for the basis of the denial, such as the definition of a plan or policy term, include that information here.

Important Information about Your Appeal Rights

What if I need help understanding this denial? Contact us at [insert contact information] if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? You have a right to appeal any decision not to provide you or pay for an item or service (in whole or in part).

How do I file an appeal? Detach and send in the bottom of this form within [insert timeframe, for example, X days from the date of this notice]. [If electronic notice, insert alternate submission instructions.]

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will be conducted within 24 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by [insert instructions for filing internal appeals (and, if applicable, simultaneous external review)].

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. [Insert information on how to designate an authorized representative.]

Can I provide additional information about my claim? Yes, you may supply additional information. [Insert any applicable procedures for submission of additional information.]

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us at [insert contact information].

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). [Insert, if applicable in your state: Additionally, a consumer assistance program may be able to assist you at [insert contact information].]

Appeal Filing Form

[Insert Name and ID Number] [Insert Claim #]
[Insert Patient Name]

Detach this form and send to: [Insert name and contact information]

NAME OF PERSON FILING APPEAL: _____

☐ Covered person ☐ Patient ☐ Authorized Representative

Date of Notice
Name of Plan **Telephone/Fax**
Address **Website/Email Address**

This document contains important information that you should retain for your records.
This document serves as notice of a final external review decision. We have **[upheld/overturned/modified]** the denial of your request for the provision of, or payment for, a health care service or course of treatment.

Historical Case Details:

Name:	**ID Number:**
Claim #:	**Date of Service:**
Provider:	

Reason for Denial (in whole or in part):

Amt. Charged	**Allowed Amt.**	**Other Insurance**	**Deductible**	**Co-pay**	**Coinsurance**	**Other Amts. Not Covered**	**Amt. Paid**

YTD Credit toward Deductible:	**YTD Credit toward Out-of-Pocket Maximum:**
Diagnosis:	
Diagnostic Codes:	**Requested Service(s)/ Treatment Code:**
Treatment Category (Subcategory):	**Denial Codes:**

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Background Information: *Describe facts of the case including type of appeal, date appeal filed, date appeal was received by IRO and date IRO decision was made.*

Final External Review Decision: *State decision. List all documents and statements that were reviewed to make this final external review decision.*

Findings: *Discuss the principal reason or reasons for IRO decision, including the rationale and any evidence-based standards or coverage provisions that were relied on in making this decision.*

OMB Control Number 1210-0144 (expires 01/31/2011)

Important Information about Your Appeal Rights

What if I need help understanding this decision?
Contact us [insert IRO contact information] if you need assistance understanding this notice.

What happens now? If we have overturned the denial, your plan or health insurance issuer will now provide service or payment.

If we have upheld the denial, there is no further review available under the appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). [Insert, if applicable in your state: Additionally, a consumer assistance program may be able to assist you at [insert contact information].]

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