Guidelines for Appeals Process under Health Reform

Background

- The Patient Protection and Affordable Care Act (PPACA) includes provisions broadly intended to protect patients. One such provision will maximize enrollee rights when they have a dispute with plans, enhancing internal appeals procedures and access to external review.

- On July 22, the Department of Treasury, the Department of Labor (DOL), and the Department of Health and Human Services (HHS) jointly released Interim Final Rules clarifying and adding new rules to the appeals process.

- Grandfathered plans are exempt from the New Rules.

- Consistent with existing DOL regulations, plans must provide an opportunity for continued coverage pending the outcome of an expedited internal appeal. Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for expedited advance review.

- Notice of the appeals process is required to be provided to enrollees in a culturally and linguistically appropriate manner, and must include detailed information about the claim, a clear explanation of the adverse determination, and a description of the appeals process.

New Appeals Process Rules

1. The definition of “adverse benefit determination” was revised to be more broadly defined. It now includes eligibility determinations (in addition to medical necessity and benefit determinations).

2. Carriers are required to make urgent UM determinations within 24 hours after receipt of the request. This applies to initial determinations, not appeals. Because Blue Shield does not require prior authorization for urgent services as defined in DOL regulations, this rule will not require any changes to Blue Shield’s current processes.

3. Members are allowed to receive, free of charge, any new or additional evidence considered, relied on, or generated in connection with the appeal. Members will have an opportunity to review this information and respond prior to the final review date.
4. Appeals must be handled in a manner that ensures independence and impartiality of the person making the decision.

5. Notices of denial and appeal responses must include specific information, in addition to the information currently required by the DOL. In general, the information required is much broader in content than currently necessary. For example, the new requirements mandate treatment and diagnoses codes be included in the notices, along with a description of all codes used.

External Review Programs

- Plans subject to state laws (insured plans) must continue to follow those requirements. Blue Shield of California insured plans already participate in state-regulated independent medical review.

- Plans subject to federal laws (most self-funded ERISA plans) must now provide an external review process that meets federal guidelines.

Effective Date and Grace Period

- Non-grandfathered plans must comply with these appeals rules and regulations on their first plan year following 9/23/10.

- On 9/20/2010, further information was released from the HHS and DOL that established a grace period for compliance with certain aspects of the new rules and regulations, delaying their implementation until 7/1/11.

- The specific items subject to the grace period are:
  1. Reviewing an urgent care claim for benefit determination within 24 hours of receipt. Again, Blue Shield does not require these determinations for urgent care services.
  2. Providing notices in a culturally and linguistically appropriate manner.
  3. Providing notices with much broader content, such as including treatment and diagnosis codes.

- During the grace period, no enforcement action will be taken by the authorities as long as the plan is working in good faith to implement the new requirements above.
What Insured Customers Need to Do

- Blue Shield’s appeals processes are in full compliance with California and PPACA current requirements. We are upgrading our systems to have all necessary programming completed prior to the end of the grace period to be in compliance with those items as well.

What Self-Insured Customers Need to Do

- Blue Shield has developed an external review program that will offer our non-grandfathered, self-funded customers a complete turn-key solution for compliance with the appeals mandates.

- This new external review service will be offered in addition to the current fiduciary services that Blue Shield currently offers self-funded customers. Blue Shield will not charge additional fees for administering the external review service.

- Blue Shield will only offer external review services to customers that have purchased our fiduciary service.

How the External Review Process will Work for Self-Insured Customers

- Blue Shield has contracts in place with four Independent Review Organizations to conduct the external reviews. The Independent Review Organizations will be assigned to external reviews by Blue Shield on a rotating basis.

- The Independent Review Organizations that Blue Shield has contracted with are:
  - Advanced Medical Reviews in Santa Monica, California
  - National Medical Reviews in Trevose, Pennsylvania
  - IMEDECS in Landsdale, Pennsylvania
  - Medical Review Institute of America in Salt Lake City, Utah

- Fees charged by the IROs will be passed through to the self-funded customer as they are incurred.

- Under the external review process:
  - The member will contact Blue Shield to initiate an external review of their appeal.
  - If eligible for external review, Blue Shield will notify the member that the appeal will be submitted to an Independent Review organization (IRO).
The IRO will review the appeal and work with the member and Blue Shield to gather any additional information needed for review.

The IRO will notify the member and Blue Shield of the outcome of the review and their decision to either uphold or overturn Blue Shield’s original appeal ruling.

Blue Shield will notify the customer of the outcome.

If overturned, Blue Shield will implement the IRO’s decision and notify the member and the customer that the decision has been implemented.

Other Considerations

- Although a self-funded customer is not required to have Blue Shield administer their external review process, according to the PPACA they will still need to meet the external review requirements as mandated by the Department of Health and Human Services.

- If a self-funded customer elects not to take advantage of the claims fiduciary service from Blue Shield, then Blue Shield will only administer the initial internal member level 1 appeal. All additional and subsequent reviews and compliance with the external review requirements will be the responsibility of the customer.

- For further questions about this service please contact your account manager.