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Health Care Reform Alert

September 14, 2010

Interim Procedures for Federal External Claims Review

In a previous Health Care Reform Alert (click here to view alert), we discussed the internal and external claim review procedures required under the Affordable Care Act (ACA). Both health insurance issuers and group health plans must follow the Department of Labor's (DOL) claim review procedures, as modified by the Interim Final Regulations (Interim Regulations) under the ACA.

As for the external review procedures, health insurers and certain non-ERISA self-funded group health plans must follow the applicable state external review statutes, provided that they contain the requisite consumer protections found in the NAIC Uniform Health Care Carrier External Review Model Act in place on July 23, 2010 (NAIC Model Act). States will have until July 1, 2011 to bring their external review statutes into compliance.

Non-grandfathered self-funded health plans (and all plans in states that fail to act in a timely fashion) must use the federal external review procedures. On August 23, 2010, the DOL issued Technical Release 2010-1, which sets forth interim federal external review procedures that are to be followed by these group health plans, until superseded by future guidance that is currently being developed. Grandfathered plans do not have to comply with these new claim procedures.

Non-grandfathered plans will have to comply by the first day of the plan year beginning on or after September 23, 2010 (*i.e.*, January 1, 2011, for calendar year plans). Plans that must comply will have to include these new federal procedures in their summary plan descriptions (SPDs).

The Federal External Review Procedures

1. **Request for Review** – A group health plan must allow a claimant to file a request for an external review within four months of the date of receipt of an adverse benefit determination or final internal adverse benefit determination.
2. **Preliminary Review** – Within five business days of receipt of the request, the Plan must determine whether: (a) the claimant was covered under the Plan at the time the medical expense was incurred, (b) the adverse determination relates to the claimant's failure to meet the Plan's eligibility requirements, (c) the claimant has exhausted the internal review process or is not required to, and (d) the claimant has provided all the information needed for an external review.

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Note – *These provisions seem to allow a request for external review to be made following an initial claim denial. It is less clear, however, whether such a request can be denied if the internal review process has not been exhausted, but, presumably, that is the case.*

Within one business day following the preliminary review, the plan must notify the claimant in writing as follows: (a) If the request is complete, but not eligible for external review, the notice must include the reasons why and contact information for the DOL's Employee Benefits Security Administration unit at 866.444.EBSA, and the information must be supplied. (b) If the request is not complete, the claimant must be told what information is needed and that it must be supplied by the later of: (i) the end of the four month filing period, or (ii) 48 hours following the receipt of the notice of incomplete information.

3. **Referral to an Independent Review Organization** – The Plan must refer the claim to an independent review organization (IRO) that is accredited by URAC, or by a similar nationally-recognized accrediting organization, to conduct the external review. Plans must contract with at least three IROs and rotate claim assignments among them (or use some alternative random chance allocation method). The IROs cannot obtain any financial benefits for denying claims.

   Note *– It is unclear how many such accredited organizations currently exist. If every group health plan in the country has to contract with at least three IROs, it might create a supply-demand imbalance. The guidance also does not address licensing requirements for IROs, state or federal.*

   The guidance outlines certain provisions that must be included in a Plan's contract with an IRO, including a provision that the IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

   Note *– This seems to indicate that the federal external review procedure will be available for challenging a range of claim denials, and is not limited to those denials based on medical judgment (e.g., medical necessity, or experimental or investigational procedures/treatments, etc.). The scope of the IRO's Plan interpretation authority is not explained in this guidance. Before entering into any contract with an IRO, you should seek legal counsel.*

   The IRO must review the claim *de novo* (*i.e.*, without any deference to prior determinations). The guidance also lists the range of documents and other materials the IRO may consider during the course of its review. The IRO must provide a written decision within 45 days of receiving the claim, and the guidelines list all the items of information the IRO decision must contain.

Note *– The guidance does not address the standard for judicial review of an IRO decision. Would ERISA's current standards apply to an IRO's adverse benefit determination (i.e., one that agreed with the Plan's internal appeal denial)? Would a court have to review the IRO decision de novo? If not, what would be required for the court to apply a deferential standard of review? These questions remain unanswered.*

4. **Reversal of Internal Plan Decision** – If the IRO reverses the Plan's internal adverse determination, the Plan must immediately provide coverage or payment for the claim.

   Note *– This guidance does not address whether a Plan Administrator can appeal an IRO's decision reversing a benefit denial. Under ERISA, a fiduciary can bring an action to enforce the terms of a Plan, and presumably could challenge the IRO's decision on that basis, but the DOL guidance is silent on this point. If Plans can appeal IRO reversals in court, but must pay claims immediately based on the IRO's reversal, this presents Plans with the practical and inefficient problem of having to recover those payments from numerous health care providers.*

5. **Expedited Review** – Requests for expedited external review can be made if the adverse benefit determination involves a medical condition for which the time frame for an internal review to be completed would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function.

   Preliminary reviews of expedited requests must be made immediately, and a notice sent that complies with the information required for standard preliminary review determinations. Requests eligible for an external review must be referred to an IRO without delay, and all required information must be sent to the IRO electronically, or by telephone or facsimile, or any other available expeditious method. The IRO's decision must be made as fast as the claimant's medical circumstances require, but in no case later than 72 hours after it receives the request. If the initial notice of the decision is not provided in writing, a written notice confirming the determination must be sent within 48 hours.

6. **Forms** – The DOL has published three model forms for communicating initial adverse benefit determinations, final internal adverse benefit determinations, and final external review decisions. The model notice forms are available at:

   http://www.dol.gov/ebsa/IABDModelNotice1.doc
   http://www.dol.gov/ebsa/IABDModelNotice2.doc
   http://www.dol.gov/ebsa/IABDModelNotice3.doc

Action Steps

Grandfathered plans can ignore these new claim requirements. This is a reason for plans to retain grandfathered status, at least until the state and federal governments clarify these requirements.

Non-grandfathered, self-funded ERISA plans, and insured ERISA plans and non-ERISA self-funded state government plans, whose state laws do not comply with the consumer protections under the NAIC Model Act by July 1, 2011, must comply with these federal external review procedures very soon. This will require amending plan documents and SPDs to accurately describe these newly required procedures. It will require negotiating contracts with IROs. It may also involve revising contracts with the Plan's current third party administrator.

If you have any questions about these new claim and review regulations, or any other changes imposed by the ACA, please contact any of the Honigman attorneys listed on this Alert.