

HEALTH REFORM IMPACT

What you need to know NOW

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

New Rules Flesh Out External Appeals Process, Required Notices for Internal Claims

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As discussed [here](#) several weeks ago, the health reform law created a new “external” right of appeal for group health plan participants whose claims are denied at the internal plan level. Federal regulations issued last month detailed several aspects of this new requirement but left other issues unanswered, including the applicable standard of review (i.e., whether the plan’s denial is entitled to any deference on review), the process for initiating external appeals, and the guidelines to be used by independent review organizations (IROs) in conducting external appeals. These issues were reserved for future guidance.

On August 23, 2010, the U.S. Department of Labor (“DOL”) provided that guidance. The rules announced last week apply to plan years beginning after September 22, 2010 (until superseded by future guidance), and apply to self-insured group health plans that will be operated on a “non-grandfathered” basis.¹ If a self-insured plan is located in a state having external review processes and the state expands those laws to apply to self-insured plans, the plan may choose to comply with either the state process or the new federal rules.

Some of the more salient features in the new external appeal rules are discussed below.

Standard of Review. External reviews must be conducted by an IRO on a “de novo” basis. In effect, this means prior denials at the plan level will no longer be entitled to any deference on review. This is a major change from current law, under which courts (previously the only forum for “external” review) did not generally overturn plan-level denials unless the denial was without reasonable basis in the evidence. Thus, denials of coverage at the administrative level will be subject to much greater scrutiny in the future.

Initiation of External Review. Certain timeframes apply to the conduct of external reviews. First, claimants may request an external review at any time within four months after receiving

¹ For insured plans, responsibility for compliance rests with the issuer. Issuers offering coverage in a state that subjects them to state external review laws are subject to those laws, while issuers not subject to state external review laws must comply with the federal process.

notice of a denial at the plan level. Following a request, the plan has only five business days to conduct a “preliminary review” regarding:

- (i) the claimant’s underlying eligibility for plan coverage (e.g., worker classification issues);
- (ii) whether the claimant has exhausted the internal appeals procedure; and
- (iii) whether the claimant has provided all forms and information needed to initiate an external review.

Within one business day after completing its preliminary review, the plan must notify the claimant whether the external review may proceed. If the request is complete but the participant is not eligible for external review, the notification must specify the reasons for ineligibility and provide the toll-free telephone number of the Employee Benefits Security Administration. If the request is incomplete (for example, additional forms are needed under (iii)), the notification must specify that information. The claimant then has 48 hours (or the remainder of the four month period, if longer) to provide the information.

Assignment to IRO. Group health plans must contract with at least three accredited IROs to handle external review claims and must rotate assignments among the IROs in an impartial manner. Contracts with each IRO must contain certain provisions, including the plan’s obligation to provide the IRO all information considered during any earlier denial. The contract must also allow claimants at least 10 business days (after assignment of their case) to submit information not considered during the internal appeal. Upon receiving this information, the IRO must forward copies to the plan within one business day. IROs may also consider certain other evidence when deciding cases, including recommendations of the claimant’s attending physician, the claimant’s medical records, and “appropriate practice guidelines” developed by medical societies and/or the federal government. IROs may also allow their own clinical reviewers to review any relevant information but must render their decision within 45 days of assignment of a case. The decision must include a discussion of the IROs “principal reason or reasons” for its decision. If the decision reverses a plan’s earlier denial of coverage, the plan must immediately provide payment or other coverage of the claim at issue. DOL has issued a model format for IRO decisions that can be found [here](#). It is worth noting that while claimants may have additional appeal rights if their claim is denied by the IRO (e.g., a court case under ERISA), IRO decisions to award coverage will be final and binding on plans.

Special “expedited” review procedures are also available to claimants for urgent or on-going emergency medical situations, when abiding by the standard appeals process would jeopardize the claimant’s life or health. The expedited review procedures require the plan to conduct its preliminary review “immediately” (rather than having five business days) and all information must be transmitted to the IRO electronically or in another “expeditious method” (telephone, facsimile, etc.). The IRO must issue its final decision as soon as reasonably possible in light of the claimant’s medical condition and in no case more than 72 hours after receiving the case. This expedited review is separate from a claimant’s right to receive a 24-hour *internal* review of “urgent” care claims under health reform.

New Internal Appeal Notices. In addition to the new external review claims rules, DOL has released model notices for use when notifying claimants of an adverse determination at the internal (plan) level. The notices vary based on whether an additional, internal level of appeal

is available following the denial and are [located here](#) (if additional internal appeal rights are available) and [here](#) (if no additional internal appeals rights are available). Each notice references the separate, external review process available upon exhaustion of the plan's internal appeals process.

Like other health reform requirements, the new appeals rules will require immediate attention from employers who sponsor self-insured health plans. Amendments to plan documents and participant disclosures will be needed (DOL has promised model language for inclusion in Summary Plan Descriptions soon), and sponsors will want to verify that their plan administrators are pursuing necessary agreements with IROs. Although IRO contracts will likely be fairly standard, plan sponsors will want to understand how the new rules are likely to affect plan operations (and costs) in the future.

If you have questions regarding the information in this alert, or with respect to other provisions of the health reform legislation as it relates to your employee benefits plans, please contact any of the attorneys in our Employee Benefits Practice Group listed below.

Also, please [click here](#) to visit our special Web page for Health Reform IMPACT.

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