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April 26, 2011

Re: Benefits Claims, Appeals and External Review Timeline for Non-Grandfathered Self-Insured Group Health Plans

Dear Clients & Other Friends:

This letter compliments our prior letter dated March 29, 2011, titled "*Grace Period Extension and (Some) Relief for Self-Insured Health Plan Sponsors Implementing New Claims, Appeals and External Review Processes.*"*

In preparing our summary of the new benefits claims, appeals and external review rules, we determined that a step-by-step timeline, highlighting the timeframes for notices and decisions under these new rules, would be helpful to affected plan sponsors and TPAs. The attached timeline is the result of our efforts to highlight and simplify the required timing rules.

We hope you find this timeline to be useful as you apply these new rules to non-grandfathered self-insured plans. If you have any questions or we may assist you in working through these or other Health Reform matters please do not hesitate to contact us.

Sincerely,

Theodore K. Rice

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* Our March 29, 2011 letter is available at this weblink:
http://www.khblaw.com/docs/2011_03_29_Grace_Period_Extension_for_Claims_Appeals_External_Review_Process.pdf.



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BENEFITS CLAIMS, APPEALS AND EXTERNAL REVIEW TIMELINE FOR NON-GRANDFATHERED SELF-INSURED GROUP HEALTH PLANS

This Benefits Claims, Appeals and External Review Timeline outlines and highlights procedures that are in effect for non-grandfathered self-insured group health plans for plan years beginning on or after January 1, 2011. This timeline is based on law and regulatory guidance issued as of April 21, 2011. For more information, see our March 29, 2011 newsletter titled "Grace Period Extension and (Some) Relief for Self-Insured Plan Sponsors Implementing New Claims, Appeals and External Review Processes."¹

INTRODUCTION: TYPES OF CLAIMS

Pre-Service Claim: A claim for benefits that requires advance approval and must be filed in advance of obtaining medical care (for example, filed in connection with pre-authorization procedures).

Urgent Care Claim: Any pre-service claim for medical care or treatment with respect to which the regular, pre-service claim timeframes:

- could jeopardize the claimant's life, health or ability to regain maximum function; or
- would subject the claimant to severe pain that cannot be adequately managed without the claimed care or treatment.

Claim shall be treated as an urgent care claim automatically if a physician with knowledge of the claimant's medical condition determines that the claim involves urgent care.

Post-Service Claim: A claim for benefits that is not a pre-service or urgent care claim.

Concurrent Care Claim: A claim for benefits that occurs where the Plan approves an ongoing course of treatment, including:

- treatment to be provided over a period of time;
- a specified number of treatments; or
- any requested extension beyond the initially approved period or time or number of treatments.

Change in Claim Type: Generally, the claim type is determined initially when the claim is filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. *For example:* an initially-determined urgent care claim is re-characterized as a pre-service claim if the urgency subsides.

STEP #1: CLAIMANT FILES INITIAL CLAIM

Claim Filing Timeframes:

- Pre-Service Care Claims and Concurrent Care Claims: Prior to health care service or treatment.

¹ This March 29, 2011 newsletter is available at: http://www.khblaw.com/docs/2011_03_29_-_Grace_Period_Extension_for_Claims_Appeals_External_Review_Process.pdf.

- Urgent Care Claims: As needed. These claims should include the following information:
 - identity of claimant
 - a specific medical condition or symptom; and
 - a specific treatment, service or product for which payment is requested.
- Post-Service Care Claims: Must be filed within 90 days following receipt of medical service, treatment or product, unless:
 - it was not reasonably possible to file the claim within such time; and
 - the claim is filed ASAP, but not later than 12 months after the date of receipt of the medical service, treatment or product.
 - Special timeframes apply in the case of claimant's legal incapacity.

When a claim is "Filed" with the Plan: A claim for benefits is treated as filed by the Plan on the date:

- it is hand-delivered to the Plan's claim address; or
- it is deposited in the U.S. Mail for first-class delivery in a stamped envelope to the Plan's claim address.

STEP #2: PLAN DECIDES AND NOTIFIES CLAIMANT OF INITIAL BENEFIT DECISION

Decision Timeframes:

- Pre-Service Care Claims: Within a reasonable time appropriate to the claim, no later than 15 days after receipt of claim.
- Urgent Care Claims: ASAP, taking into account medical exigencies, no later than 24 hours² after receipt of claim. This includes notices for incorrectly filed or incomplete claims.
- Concurrent Care Claims:
 - For urgent care claims made at least 24 hours prior to the initially approved period of time or number of treatments, no later than 24 hours after receipt of claim.
 - For all other requests to extend a concurrent care decision, the decision must be made in the timeframes for pre-service, urgent care or post-service claims.
- Post-Service Claims: Within a reasonable time, no later than 30 days after receipt of the claim.

Extensions for Decision Timeframes: Extensions relating to the above timeframes are permitted when:

- The claimant voluntarily agrees to extend the above timeframes.

² This applies for plan years beginning on or after January 1, 2012. Until then, decisions regarding urgent care claims must be rendered ASAP but no later than 72 hours after receipt of the claim.

- The plan is not able to decide a pre-service or post-service claim within the above timeframes due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that:
 - The claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim; and
 - The extension notice includes a description of the matters beyond the plan’s control that justify the extension and the date by which a decision is expected.
- No extension is permitted for urgent care claims.

Notice of New or Additional Rationale or Evidence: If the plan bases an adverse benefit decision on new or additional rationale or evidence, the claimant must be provided with:

- the new rationale or evidence as soon as possible, and
- a reasonable opportunity to respond prior to the due date for the initial benefit decision.

Notification of Initial Benefit Decision	
Pre-Service and Urgent Care Claims	The plan’s decision is provided to the claimant whether or not the decision is adverse.
Definition of “adverse”	<ul style="list-style-type: none"> • Any claim denied in whole or in part. • A rescission of coverage, whether or not it has an adverse effect on a particular benefit at that time.
Written Notice of Adverse Determination ³	<p>To be provided in a manner calculated to be understood by the claimant, including:</p> <ul style="list-style-type: none"> • A statement of the specific reason(s) for the decision; • Reference(s) to the specific plan provision(s) on which the decision is based; • A description of any additional material or information necessary to perfect the claim and why such information is needed; • A description of the plan procedures and time limits for appeal of the decision, and the right to obtain information about those procedures and the right to sue in federal court; • If the decision involves scientific or clinical judgment, either <ul style="list-style-type: none"> ○ An explanation of the scientific or clinical judgment applying the terms of the plan to the claimant’s medical circumstances, or ○ A statement that such explanation will be provided at no charge upon request; • A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request); and

³ Model Notice available at <http://www.dol.gov/ebsa/healthreform/index.html> (last visited on April 21, 2011).

Notification of Initial Benefit Decision (continued)	
Written Notice of Adverse Determination (continued)	<ul style="list-style-type: none"> • The diagnosis and treatment codes and their meanings.⁴ <p>With respect to an <u>urgent care claim</u>:</p> <ul style="list-style-type: none"> • An explanation of the expedited review methods available for such claims must be provided. <p>Notification of the plan's adverse decision may be provided orally, but written notification must be furnished no later than three days after the oral notice.</p>

STEP #3: CLAIMANT FILES INTERNAL APPEAL

Appeal Filing Timeframe:

- Pre-Service, Urgent and Post-Service Claims Appeals: Must be filed within 180 days following the claimant's receipt of adverse benefit decision.
- Concurrent Care Claims Appeals: Must be filed within 30 days of the claimant's receipt of the plan's decision to reduce or terminate a course of treatment.
- Failure to comply with this deadline may cause the claimant to forfeit any right to any further review of an adverse decision under plan procedures or in a court of law

STEP #4: PLAN DECIDES AND NOTIFIES CLAIMANT OF INTERNAL BENEFITS APPEAL DECISION

Decision Timeframes:

- Pre-Service Care Claims: Within a reasonable time appropriate to the medical circumstances, no later than 30 days after receipt of the request for review.
- Urgent Care Claims: ASAP, taking into account medical exigencies, no later than 72 hours after receipt of the request for review.
- Concurrent Care Claims:
 - To reduce or terminate an initially approved course of treatment, before the proposed reduction or termination takes place.
 - For all other requests for review concerning claims to extend a concurrent care decision, the decision must be made in the timeframes for pre-service, urgent care or post-service appeals.
- Post-Service Claims: Within a reasonable period, no later than 60 days after receipt of the request for review.

⁴ For plan years beginning on or after January 1, 2012.

During the appeal process: Claimants must be provided with:

- An opportunity to present evidence and testimony;
- Reasonable access to and copies of all documents, records and other information that is relevant to the claim for benefits; and
- Any new or additional rational or evidence that the plan is using as a basis for an adverse benefit determination on appeal, as well as a reasonable opportunity to respond prior to the due date for the benefit decision on appeal.

Notification of Decision on Appeal	
Definition of “adverse”	<ul style="list-style-type: none"> • A denial, reduction or termination of a plan benefit. • A failure to provide or make payment (in whole or in part) for a plan benefit.
Written Notice of Adverse Determination on Appeal ⁵	<p>Provided to the claimant whether or not the decision is adverse, including:</p> <ul style="list-style-type: none"> • Specific reason(s) for the appeal decision; • A reference to the specific plan provision(s) on which the decision is based; • A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request); • A statement of the right to sue in federal court; • A statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; • If the decision involves scientific or clinical judgment, disclose either: <ul style="list-style-type: none"> ○ An explanation of the scientific or clinical judgment applying the terms of the plan to the claimant’s medical circumstances, or ○ A statement that such explanation will be provided at no charge on request. • The diagnosis and treatment codes and their meanings.⁶ <p>Notice of an adverse decision on appeal of an <u>urgent care claim</u> may be provided orally but written notice must be furnished <u>no later than 3 days</u> after the oral notice.</p>

⁵ Model Notice available at <http://www.dol.gov/ebsa/healthreform/index.html> (last visited on April 21, 2011).

⁶ For plan years beginning on or after January 1, 2012.

STEP #5: CLAIMANT FILES REQUEST FOR EXTERNAL REVIEW WITH THE PLAN

External Review Filing Timeframes:

- Standard External Review: Must be filed within 4 months after receipt of benefits denial notice.
- Expedited External Review: May be requested by a claimant if:
 - The expedited internal appeal timeframe would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed an expedited internal appeal; or
 - The request for external review concerns a final internal benefits denial involving:
 - A claimant's medical condition where the standard external review timeframe would seriously jeopardize the claimant's life or health or ability to regain maximum function; or
 - An admission, availability of care, continued stay, or health care item or service for which claimant received emergency services, but has not yet been discharged.

STEP #6: PLAN RENDERS PRELIMINARY REVIEW DECISION AND NOTIFIES CLAIMANT

Decision Timeframes:

- Standard External Review: Plan must render the preliminary review determination no later than 5 business days following receipt of external review request. The preliminary review must determine whether:
 - The claimant is/was covered under the plan when the health care item or service was requested (for retroactive reviews, was covered when the health care item or service was provided);
 - The benefit denial does not relate to the claimant's failure to meet the plan's eligibility requirements;
 - The claimant has exhausted the plan's internal appeals process;
 - The claimant has provided all the information and forms to process the external review.
- Expedited External Review: Plan must "immediately" assess whether the request meets the above reviewability requirements.

Notice Timeframes:

- Standard External Review: Plan must notify claimant of preliminary review determination within 1 business day of completion of preliminary review.
- Expedited External Review: Plan must "immediately" notify claimant of preliminary review determination.

When a claimant may supplement an incomplete external review request: Claimant may supplement an incomplete request by the end of the remainder of the 4-month filing period, or, if expired, 48 hours following receipt of the preliminary review determination notice.

STEP #7: REFERRAL TO INDEPENDENT REVIEW ORGANIZATION (IRO)

Plan must refer review to an Independent Review Organization (“IRO”): Plan must contract with at least three IROs to ensure against bias and ensure independence.

- Plan may contract through TPA, but doing so does not relieve plan from responsibility for ensuring that external review took place.
- No required timeframes set for contacting IROs following completion of the external review determination.

Plan may participate in state’s external review process: As an alternative to contracting directly with IROs, the plan may comply with a state’s external review process if the state’s process:

- is made available for self-insured group health plans; and
- satisfies the requirements of DOL Tech. Release 2010-10.⁷

Required Content of Plan/IRO Agreements	
Legal Experts	The IRO will consult legal experts to make coverage determinations, as appropriate.
Plan Must Provide Information to IRO	Plan must provide IRO with all documents and information considered in making the benefit denial <u>within 5 business days</u> after the assignment date. <ul style="list-style-type: none"> • If plan fails to timely provide such information, IRO may terminate the external review, reverse the denial, and notify the claimant <u>within 1 business day</u>.
Reconsideration by Plan	IRO must provide plan information received from claimant <u>within 1 business day</u> and the plan may reconsider the denial. <ul style="list-style-type: none"> • If plan, upon reconsideration, decides to reverse the benefits denial, plan must provide written notice to the claimant and IRO <u>within 1 business day</u> of reconsideration. • IRO may then terminate the external review process.
Timeframe for Notice to Claimant	“Timely manner” for IRO’s notice of: <ul style="list-style-type: none"> • acceptance of claim for review, and • deadline for claimant’s submission of additional information (within 10 days from notice).
Standard of Review	De novo.

⁷ Although available for fully-insured plans, the state external review process is not currently available for self-insured plans in Minnesota.

Required Content of Plan/IRO Agreements (continued)	
Other Documents	<p>In addition to documents and information provided by claimant, IRO may also consider/request:</p> <ul style="list-style-type: none"> • Claimant’s medical records, • Recommendation of attending health care professional, • Reports from health care professionals, • Documents from claimant, plan, insurer, claimant’s treating provider, • Governing plan terms, • Appropriate practice guidelines, evidence-based standards as applicable, • Applicable clinical review criteria developed and used by plan, and • Opinion of the IRO clinical reviewer(s).

STEP #8: IRO DECIDES AND NOTIFIES CLAIMANT OF FINAL EXTERNAL REVIEW DECISION

Decision Timeframes:

- Standard External Review: IRO must render and notify claimant within 45 days following receipt of external review request.
- Expedited External Review: IRO must render and notify claimant “as expeditiously as claimant’s medical condition or circumstances require,” but no later than 72 hours following receipt of expedited external review request.

Binding Nature of IRO’s Decision: IRO’s final decision is binding upon the plan. However, binding nature is not intended to trump access to the courts for claimant, plan or insurer.

Notice of Final External Review Decision	
Written Notice of External Review Decision ⁸	<p>Provided to the claimant whether or not the decision is favorable, including:</p> <ul style="list-style-type: none"> • General description of the reason for external review request, including: <ul style="list-style-type: none"> ○ Date(s) of service, ○ Provider, ○ Claim amount (if applicable), ○ Diagnosis and treatment codes (and meanings), and ○ Reason for prior denial; • Date IRO received the assignment to conduct the external review;

⁸ Model Notice available at <http://www.dol.gov/ebsa/healthreform/index.html> (last visited on April 21, 2011).

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Notice of Final External Review Decision (continued)	
Written Notice of External Review Decision (continued)	<ul style="list-style-type: none"> • Date of IRO decision; • References to evidence/documentation considered in reaching the decision, including specific coverage provisions and evidenced-based standards; • Discussion of principal reason(s) for IRO's decision; • Statement that the IRO's determination is binding, unless other remedies are available; • Statement that judicial review may be available to claimant; and • Phone number and contact information for the applicable offices of health insurance consumer assistance or ombudsman. <p>Notice of decision on an <u>expedited external</u> review may be provided orally but written notice must be furnished <u>no later than 48 hours</u> after the oral notice.</p>