CENTERS FOR MEDICARE & MEDICAID SERVICES

Internal Claims and Appeals and the External Review Process Overview

October 2024

This information is intended only for the use of entities and individuals certified to serve as Navigators, certified application counselors, or non-Navigator assistance personnel in a Federally-facilitated Marketplace. The terms "Federally-facilitated Marketplace" and "FFM," as used in this document, include FFMs where the state performs plan management functions. Some information in this presentation may also be of interest to individuals helping consumers in State-based Marketplaces and State-based Marketplaces using the Federal Platform. This material was produced and disseminated at U.S. tax filer expense.

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Agenda

- Summary of the Coverage Appeals Regulation
- Internal Claims and Appeals
- State External Review
- Federal External Review Programs
- Resources

Summary of the Coverage Appeals Regulation

Consumer Coverage Appeal Rights (Slide 1 of 3)

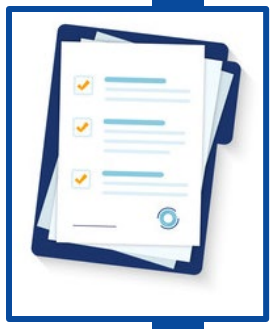
- The Affordable Care Act (ACA) ensures a consumer's right to appeal group health plan and health insurance issuer (plan and issuer) decisions, asking a plan or issuer to reconsider its decision, including, but not limited to:
  - Denying payment for a service or treatment in whole or in part,
  - Determining the consumer isn't eligible for coverage after they file a claim, or
  - Rescinding coverage based on a plan or issuer's claim that you gave false or incomplete information when you applied for coverage.
- If the plan or issuer upholds its initial decision, the consumer may be eligible for another review (known as external review) by an independent third-party reviewer.

Consumer Coverage Appeal Rights (Slide 2 of 3)

- Coverage Appeals vs. Marketplace Appeals
  - Coverage Appeals: A consumer's rights to appeal coverage decisions made by the plan or issuer.
  - Marketplace Appeals: A consumer's rights to appeal certain eligibility determinations made by a Marketplace, about a Marketplace eligibility determination.

Consumer Coverage Appeal Rights (Slide 3 of 3)

- The No Surprises Act (NSA) expanded external review rights by ensuring that:
  - Any adverse benefit determination that involves consideration of whether a plan or issuer is complying with surprise billing and cost-sharing protections under the NSA is eligible for external review.
  - Section 110 of the NSA and its implementing regulations extend these protections to grandfathered plans* to make external review available to individuals enrolled in grandfathered health plans or coverage.
  - Expanded scope of external review is applicable for claims as of January 1, 2022.



*Note: *An individual health insurance policy purchased on or before March 23, 2010. These plans weren't sold through the Marketplace, but by insurance companies, agents, or brokers. They may not include some rights and protections provided under the Affordable Care Act.*

Summary of Coverage Appeals Regulation and Guidance

- Established by Section 2719 of the Public Health Service Act. Implementing regulations are at 45 C.F.R. 147.136
- Regulations and guidance are available on the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight (CCIIO) website at External Appeals Regulations
- Interim final rules titled “Requirements Related to Surprise Billing; Part II” (September 2021) are at Requirements Related to Surprise Billing
- Consumer information is available at HealthCare.gov: Appealing a health plan decision

Internal Claims and Appeals

Definitions

- **Claim**– Any request for benefits, including pre-service (prior authorization) and post-service (reimbursement).
- **Adverse Benefit Determination**–A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and any rescission of coverage.
- **Rescission**–Retroactive cancellation or discontinuing of health coverage.

Appealing a Coverage Decision

- Do your consumers know how to file an internal appeal?
- Are there any challenges they face with pursuing an internal appeal or external review?

Ways to Appeal a Coverage Decision

- **Internal appeals**
  - Conducted by a plan or issuer
  - Involves a full and fair review of its decision (i.e., of its adverse benefit determination, or ABD)
  - Results in a final internal determination
- **External review**
  - Conducted by an Independent Review Organization, or IRO
  - Involves a review of a plan's or issuer's ABD
  - Results in a final binding external review decision (issued by the IRO)

Internal Claims

- How much time do plans and issuers have to make a benefit determination?
  - Pre-service (prior authorization): **15 calendar days**
  - Post-service: **30 calendar days**
  - Urgent care: **Maximum 72 hours** (or less, depending on medical urgency of case)

Notice Requirements for Adverse Benefit Determinations

- Send written or electronic notification.
- Provide sufficient information to identify claim.
- Provide the specific reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the plan or issuer's standard.
- Describe internal guidelines or criterion used in making the adverse determination; and inform the consumer that the copy of the internal requirements will be provided free of charge upon request.

Notice Requirements for Adverse Benefit Determinations (Cont.)

- Describe reasons, including specific plan provisions or scientific or clinical judgment used.
- If the ABD is based on a medical necessity or experimental treatment or similar exclusion, provide either:
  - An explanation of the scientific or clinical judgment for the ABD; or
  - A notice that such explanation will be provided free of charge upon request.
- Describe any additional information needed to improve or complete the claim.
- Provide notification of internal appeals and external review rights, the plan's or issuer's review procedures, and time limits.
- Provide notification about health insurance consumer assistance or ombudsman office availability.

Culturally and Linguistically Appropriate Manner

- Applicable non-English language: a language when 10 percent of a claimant's county is literate only in that same non-English language(s).
- Provide notification in a culturally and linguistically appropriate manner.
- For any applicable non-English language:
  - Oral language services including assistance with filing claims and appeals (including external review) in any applicable non-English language;
  - Notices, upon request, in the applicable non-English language; and
  - In English versions of notices, a statement prominently displayed in the applicable non-English language indicating how to access language services provided by the plan or issuer.

Internal Appeals: The Appeals Process

- What can be appealed?
  - A determination that:
    - The benefit isn't offered under the consumer's health plan or coverage.
    - The consumer received health services from a health provider or facility that isn't in their plan's or issuer's approved network.
    - The requested service or treatment is "not medically necessary".
    - The requested service or treatment is an "experimental" or "investigative" treatment.
    - A denial or reduction in benefits based on a determination that the consumer is no longer enrolled or eligible to be enrolled in the health plan.
    - The health plan or issuer is canceling or discontinuing the consumer's coverage going back to the date they enrolled because the plan or issuer claims that the consumer did something that constitutes fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

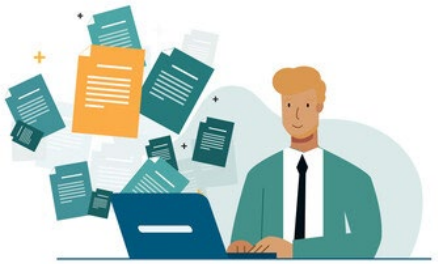
Internal Appeals: The Appeals Process (Cont.)

- How long does a consumer have to file an internal appeal?
  - 180 days from receipt of denial
- How to file an internal appeal?
  - Generally, in writing (unless urgent – then oral is acceptable)

Internal Appeals: Recommended Documentation

A claimant should keep copies of all information related to a claim and denial, including:

- Explanation of Benefits documents
- Copy of request for internal appeal
- Any additional relevant information



- Copy of any letter/form signed, if an authorized representative filed appeal
- Notes and dates from any conversations with the plan or issuer about the denial of coverage

Internal Appeals: Additional Information

- How many levels of internal appeal?
  - Group market: One or two
  - Individual market: One
- How long before a decision is made for internal appeals?
  - Pre-service (prior authorization): **30 calendar days**
  - Post-service: **60 calendar days**
  - Urgent care: **Maximum 72 hours** (or less, depending on medical urgency of case)

Internal Appeals: Claimant Rights

- The claimant has a right to a full and fair review.
  - Each claimant has the opportunity to review and respond (by providing written comments, documents, records) to any evidence or rationale under consideration.
  - Reviewers must not have any conflicts of interest.
- Plans/issuers are required to provide continued coverage pending the outcome of an appeal.
  - Concurrent care* decisions: If a plan or issuer has approved an ongoing course of treatment, it must provide an opportunity for an appeal or review before reducing or terminating coverage prior to the end of the course of treatment (except where reduction or termination is due to a plan amendment or termination).

**Concurrent care is when more than 1 individual provides services that are more extensive than consultative services at the same time.*

Special Situations: Urgent Care

Definition of Urgent Care:

- The standard appeal timeframe could seriously jeopardize a claimant's life or health or ability to regain maximum function; or
- In the opinion of a physician with knowledge of the claimant's medical condition, the standard appeal timeframe would subject a claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Special Situations: Urgent Care (Cont.)

- A claimant may file orally and notice of an appeal decision may be oral (must be followed by a written notice within three days).
- Individuals in urgent care situations may initiate an internal appeal and external review simultaneously.

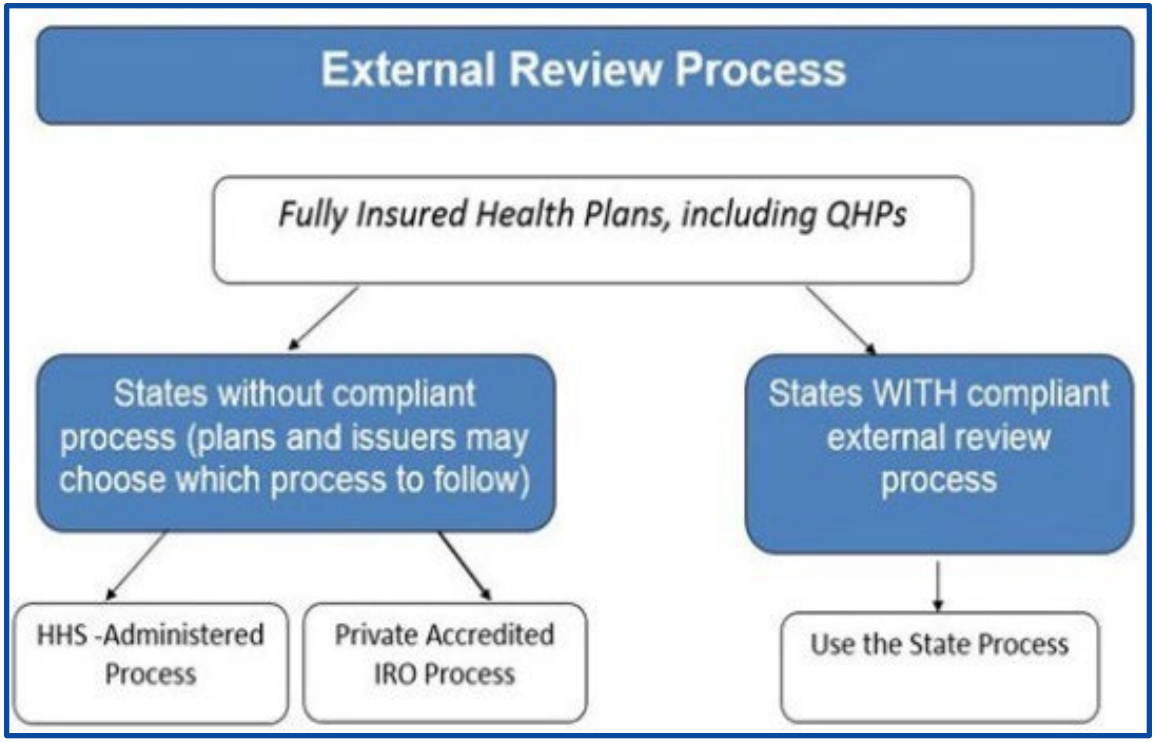
Special Situations: Deemed Exhaustion

In the following cases, an internal appeal is deemed exhausted, allowing a consumer to move to an external review without completing the internal appeals process:

- The plan or issuer waives an internal appeal;
- Urgent-care situations (expedited external review may be initiated at the same time as expedited internal appeal); and
- Failure to comply with all requirements of the internal appeals process except in cases where the violation was:
  - De minimis;
  - Non-prejudicial;
  - Attributable to good cause or matters beyond the plan's or issuer's control;
  - In the context of an ongoing good-faith exchange of information; and
  - Not reflective of a pattern or practice of non-compliance.

State External Review

External Review Process



* A list of state external review processes is available at Affordable Care Act: Working with States to Protect Consumers. States listed in the "Meets Parallel" column have a compliant state external review process that "parallels" federal standards. States listed in the "HHS Administered Process/Independent Review Organization Process" column do not have a compliant state external review process, and health insurance plans and issuers in those states must follow a federal external review process.

Minimum Requirements for State External Review (Slide 1 of 3)

Standard	State Minimum Review Standards
Scope	External review of ABDs based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or No Surprises Act (NSA) compliance matters.
Notice	Effective written notice to consumers of right to external review
Deemed Exhaustion	• Plan or issuer waives exhaustion requirement • The plan or issuer has exhausted the internal appeals process (including compliance with internal appeals requirements, other than de minimis violations). • Claimant simultaneously requests expedited internal appeal and external review concerning a claim involving urgent care.
Filing Fee	• Plan or issuer must pay the cost of an IRO conducting the external review. • State laws that expressly allowed a filing fee as of November 18, 2015, may continue to allow nominal filing fees.*
Claims Threshold	No minimum dollar amount on claim

**To be considered nominal, a filing fee must not exceed $25, it must be refunded to the claimant if the adverse benefit determination (or final internal adverse benefit determination) is reversed through external review, it must be waived if payment of the fee would impose an undue financial hardship, and the annual limit on filing fees for any claimant within a single plan year must not exceed $75.*

Minimum Requirements for State External Review (Slide 2 of 3)

Standard (Cont.)	State Minimum Review Standards (Cont.)
Time to File an External Review Request	At least four months after the receipt of a notice of ABD or final adverse benefit determination
IRO Assignment	IRO is assigned on a random, rotational, or other independent/impartial basis.
IRO Accreditation	State must maintain a list of nationally accredited IROs.
Notice of Expedited External Review Decision	• Within 72 hours maximum (or less, depending on medical urgency) • If decision is provided orally, then written decision must be sent within 48 hours of oral decision.
Expedited External Review	• Must be available if the ABD (or final internal ABD) concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services, but has not been discharged from a facility; or • Involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the claimant or jeopardize the claimant's ability to regain maximum function.
Conflict of Interest	No IRO/clinical reviewer can have a conflict of interest (COI) (e.g., material, professional, familial, or financial COI with the plan or issuer, claimant, or provider).

Minimum Requirements for State External Review (Slide 3 of 3)

Standard (Cont.)	State Minimum Review Standards (Cont.)
Submission of Additional Information	• The IRO must consider additional information submitted by the claimant. • The claimant must be notified of their right to submit additional information. • The claimant has five business days to submit additional information. • The IRO has one business day to forward to plan or issuer.
Binding	Decision is binding on plan or issuer and claimant.
Notice of Standard External Review Decision	Within 45 days or IRO's receipt of request for external review.
Description of External Review	Description of external review process in Summary Plan Descriptions (SPDs) or other evidence of coverage substantially similar to Section 17 of the National Association of Insurance Commissioners (NAIC) Uniform Model Act.
Written Records	IRO must maintain written records for three years, substantially similar to Section 15 of the National Association of Insurance Commissioners (NAIC) Uniform Model Act.
Experimental/Investigational Review Procedures	Process for experimental/investigational treatment, substantially similar to Section 10 of the NAIC Uniform Model Act.

Expansion of External Review to Include NSA Compliance Matters

- Effective January 1, 2022, the NSA and implementing regulations expanded the types of ABDs eligible for external review related to a health plan's or issuer's compliance with NSA protections such as:

  - Patient cost sharing and surprise billing for emergency services;
  - Patient cost sharing and surprise billing protections related to non-emergency care provided by nonparticipating providers at participating facilities;
  - Whether patients are in a condition to receive notice and provide informed consent to waive NSA protections; and
  - Whether a claim for care received is coded correctly and accurately reflects the treatments received because adjudication of the claim involves medical judgment.

External Review of NSA Compliance Matters – States with External Review Processes That Meet Minimum Requirements

- States that can accommodate external review of NSA compliance matters will refer NSA compliance matters to the state's external review process.
- States with an external review process that cannot accommodate NSA compliance matters* can:
  - Refer such matters to the HHS-administered process; or
  - Alternatively, plans and issuers subject to a state external review process that cannot accommodate external review of NSA compliance matters may use the accredited IRO contracting process under the federal external review process (FERP), if the FERP IROs can accommodate review of NSA compliance matters.

*Consumers with private health insurance can reach out to their state's Department of Insurance for more information about the process for review of NSA compliance matters in their state.

Guidance for States, Plans, and Issuers on State External Review Processes

Examples of NSA Compliance Matters Subject to External Review Scenario #1

Scenario:

- Jane gives birth to a baby at an in-network hospital. The baby is born prematurely and receives certain neonatology services from a nonparticipating provider during the same visit as the birth.
- Jane was given notice about cost-sharing and surprise billing protections for these services and gave informed consent to waive those protections. Jane's plan determines that protections for emergency services under the NSA and implementing regulations do not apply because the treatment did not involve "emergency services", and Jane provided consent to receive out-of-network health care.
- Jane receives an ABD, which states that she is subject to cost-sharing requirements that are greater than the requirements that would apply if the same services were provided in an in-network emergency department.

Examples of NSA Compliance Matters Subject to External Review Scenario #1 (Cont.)

Poll Questions:

- Is Jane's ABD eligible for external review?
  - Answers:
    - No. Neonatology (post delivery services) is not an emergency.
    - Yes. This is a medical judgment ABD.
- Are your consumers aware of the new protections against surprise billing?
    - Answers: [Yes, No]

Conclusion:

- The plan's determination that treatment received by the individual did not include emergency services involves medical judgment. Accordingly, the claim is eligible for external review.

Examples of NSA Compliance Matters Subject to External Review Scenario #2

Scenario #2:

- A group health plan generally provides benefits for anesthesiology services. The individual undergoes a surgery at an in-network health care facility and, during the course of the surgery, receives anesthesiology services from an out-of-network provider.
- The plan decides the claim for these services without regard to the NSA protections related to items and services furnished by out-of-network providers at in-network facilities. As a result, the individual receives an ABD for the services and is subject to cost-sharing liability that is greater than it would be if cost sharing had been calculated in a manner consistent with NSA protections.

Conclusion:

- Whether the plan was required to decide the claim in a manner consistent with NSA protections involves considering whether the plan complied with NSA protections or consideration of health care setting and level of care. Accordingly, the claim is eligible for external review.

➢ **Are your consumers aware of the new protections against surprise billing?**

Federal External Review Programs: HHS-administered Process and Accredited IRO Processes

Scope of Claims Eligible for Federal External Review

Applies to ABDs (or final internal ABD) involving:

- Medical judgment
  - INCLUDING, BUT NOT LIMITED TO:
    - Determinations that involve medical necessity
    - Appropriateness
    - Health care setting
    - Level of care
    - Effectiveness of a covered benefit
    - Experimental and investigational treatments

Scope of Claims Eligible for Federal External Review (Cont.)

- EXCLUDES:
  - Determinations that involve only contractual or legal interpretation and do not involve medical judgment
  - Determinations related to participant or beneficiary eligibility for coverage under the terms of a plan or coverage without any use of medical judgment

- Rescission of coverage
- NSA compliance matters

Federal External Review Process Requirements

- Protections include minimum consumer protections in the NAIC Uniform Model Act
- Standards include:
  - A description of the external review initiation process
  - Procedures for a preliminary review of claim by the plan or issuer
  - Minimum qualifications for IROs
  - A process for approving IROs
  - Random IRO assignment
  - Standards for IRO decision-making
  - Rules for providing notice of a final external review decision
  - Rules for expedited external review
  - Standards for evaluating claims involving experimental/ investigational treatments
  - Binding IRO decisions
  - IRO records retention

Federal External Review Process Requirements (Cont.)

- The federal external review process may not impose any costs, including filing fees, on the claimant requesting the external review.
- Applies to:
  - Health plans not subject to an applicable state external review process. Such health plans can follow one of the two federal external review processes:
    - HHS-administered Federal External Review Process; or
    - Accredited IRO Federal External Review Process.

HHS-administered External Review Process

- The HHS-Administered FERP works with MAXIMUS, a designated federal contractor that performs the administrative functions of the external review on behalf of HHS.
- MAXIMUS website: HHS-Administered Federal External Review Process

Accredited IRO External Review Process

- Plans must contract with at least three IROs and rotate external review assignments among them.
- The plan may use an alternative process for IRO assignment.
  - However, the Departments will expect plans to document how any alternative process constitutes an impartial assignment method and how it ensures that the process is independent and unbiased.
- The plan is not permitted to provide financial incentives to IROs based on the likelihood that the IRO will support the denial of benefits.

How to Request an Appeal or External Review

Process	Who Receives the Request
Internal Appeals	Health plan or issuer
External Review – State Process	• The state department of insurance, or • The state department of health, or • The plan or issuer
External Review – Federally Administered Process (in AL, FL, GA, TX, and WI)	• Health plan issuer, or • HHS-administered process contractor

Resources

- Internal Claims and Appeals and the External Review Process job aid: CMS.gov/technical-assistance-resources/appeal-help/appeal-decision.pdf
- Consumer Information: HealthCare.gov/appeal-insurance-company-decision/appeals/
- HHS-Administered Federal External Review Process (MAXIMUS): Externalappeal.cms.gov/ferpportal/#/home
- Regulations and guidance: CMS.gov/cciio/resources/regulations-and-guidance#External_Appeals