HHS-Administered Federal External Review Process

March 14, 2012

MAXIMUS Federal Services

HHS Federal External Review Process Presentation Agenda

- Introduction to MAXIMUS
- Rules and Regulations – Overview
- The External Review Process
- Contact Information
- Resources
- Questions and Answers

HHS Federal External Review Process

Introduction: MAXIMUS
(OPM and HHS Contractor)

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HHS Federal External Review Process

MAXIMUS Federal Services, Inc.

- URAC Accredited Independent Review Organization (IRO)
- Contractor for states and Federal agencies to provide independent medical reviews
- All panelists fully credentialed to standards exceeding URAC and NCQA criteria
- Credentialing independently verified by URAC

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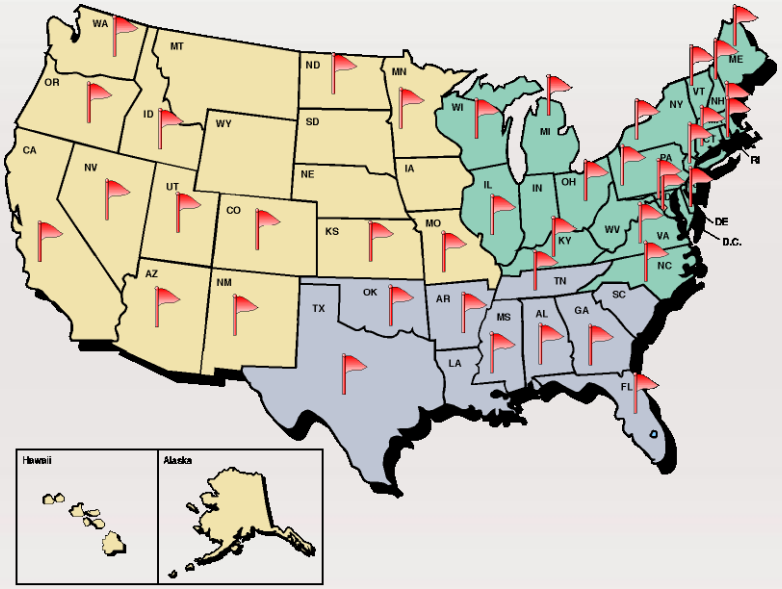
Medical Expert Panelists- Physician reviewers actively practice in 40 states



Rules and Regulations: Overview

Rules and Regulations – Overview

The HHS Federal External Review Process

- Established by Public Health Service Act section 2719. Implementing regulations appear at 45 C.F.R. 147.136.
- Regulations and Guidance are available on the CMS Center for Consumer Information & Insurance Oversight (CCIIO) website at http://cciio.cms.gov/resources/regulations/index.html#ea.
- These rules do not apply to grandfathered health plans under section 1251 of the Affordable Care Act.
  - Questions and Answers about Grandfathered status may be found at http://cciio.cms.gov/programs/marketreforms/grandfathered/index.html.

Definitions

- Claim - Any request for benefits including pre-service (prior authorization) and post-service (reimbursement)
- Internal *appeals (conducted by plan/issuer)*
  - Adverse benefit determination
  - Final internal adverse benefit determination
- External *review (conducted by Independent Review Organization (IRO)) – review of a plan or issuer's denial of coverage or services*
  - Results in a final binding external review decision – issued by IRO

Notice Requirements for Adverse Benefit Determinations

1. Describe reason(s) including specific plan provisions, scientific judgment used
2. Describe any additional information needed to improve or complete the claim
3. Provide sufficient information to identify claim
4. Notification of internal appeals & external review rights
5. Notification about ombudsman office availability
6. Provide notification that Culturally & Linguistically Appropriate Services (CLAS) are available

Special Situations – Urgent Care

- May file orally
- Notice of decision may be oral (must be followed by a written notice within 48 hours)
- Individuals in urgent and concurrent care situations may initiate an internal appeal and external review simultaneously

Special Situations – Deemed Exhaustion

An internal appeal is deemed exhausted in the following cases:

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

Which External Review Process Applies?

Health Insurance Issuers:

- Issuers in States and Territories with an external review process that meets or is sufficiently similar to the necessary minimum consumer protections set forth in HHS regulations, 45 C.F.R. 145.136. must continue to use the State external review process.
- Issuers in States and Territories without a compliant external review process (as determined by HHS) must participate in a Federally-Administered process (either the HHS-administered external review process or private accredited IRO process) by January 1, 2012.

Which External Review Process Applies?

Transition Period:

- States and Territories with external review laws found to meet the requirements of an NAIC-similar process may provide external reviews until January 1, 2014.
- All States and Territories must have external review laws that meet the standards of an NAIC-parallel process by January 1, 2014 or plans and issuers in those states will be required to use a Federally-Administered process.

Which External Review Process Applies?

Self-insured plans subject to ERISA and/or the Internal Revenue Code:

- Self-insured plans in States without a compliant external review process on or after January 1, 2012 may use the private accredited IRO process.

- Self-insured plans in States WITH a compliant external review process may also use the private accredited IRO process unless the plan agrees to submit to the state's jurisdiction and the state agrees to take jurisdiction over the plans.

Which External Review Process Applies?

Self-funded, non-federal governmental plans:

- If the plan is in a State WITH a compliant process the plan may choose the HHS or private accredited IRO process, or the plan may use the state process (IF the State agrees to administer an external review program for its self-funded, non-federal governmental plans).

- In States without a compliant process or States with a compliant process that do not agree to administer an external review program, plans may choose either the HHS or private-accredited IRO process.

Scope of claims eligible for external review - STATE

For insurance coverage and self-insured non-federal governmental plans subject to a State external review process the scope of claims eligible for external review at a minimum must include adverse benefit determinations (and final internal adverse benefit determinations) based on:

- medical necessity,
- appropriateness,
- health care setting,
- level of care,
- effectiveness of a covered benefit, or
- experimental and investigational treatments.

Scope of claims eligible for external review - FEDERAL

- The Federal external review process (the HHS-administered external review process and the private accredited IRO process) applies to adverse benefit determinations (or final internal adverse benefit determinations) involving:
  1) 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, as determined by the external reviewer
     - EXCLUDES determinations that involve only contractual or legal interpretation without any use of medical judgment
  2) Rescissions of coverage (whether or not the rescission has any effect on any particular benefit at that time).

The External Review Process

Claimants may file a written request for an external review within 4 months after the date of receipt of the notice of adverse benefit determination (ABD) or final internal ABD.

To request an external review:

- **Call Toll Free: 1-888-866-6205**
  to request an external review request form
- Fax this form to: (202) 606-0036

  OR
- Mail the external review request form to:

  P.O. Box 791

  Washington, D.C. 20044

  OR
- Submit an electronic request to: disputedclaims@opm.gov

  OR
- Access the Claimant Portal at: www.externalappeal.com (forthcoming)

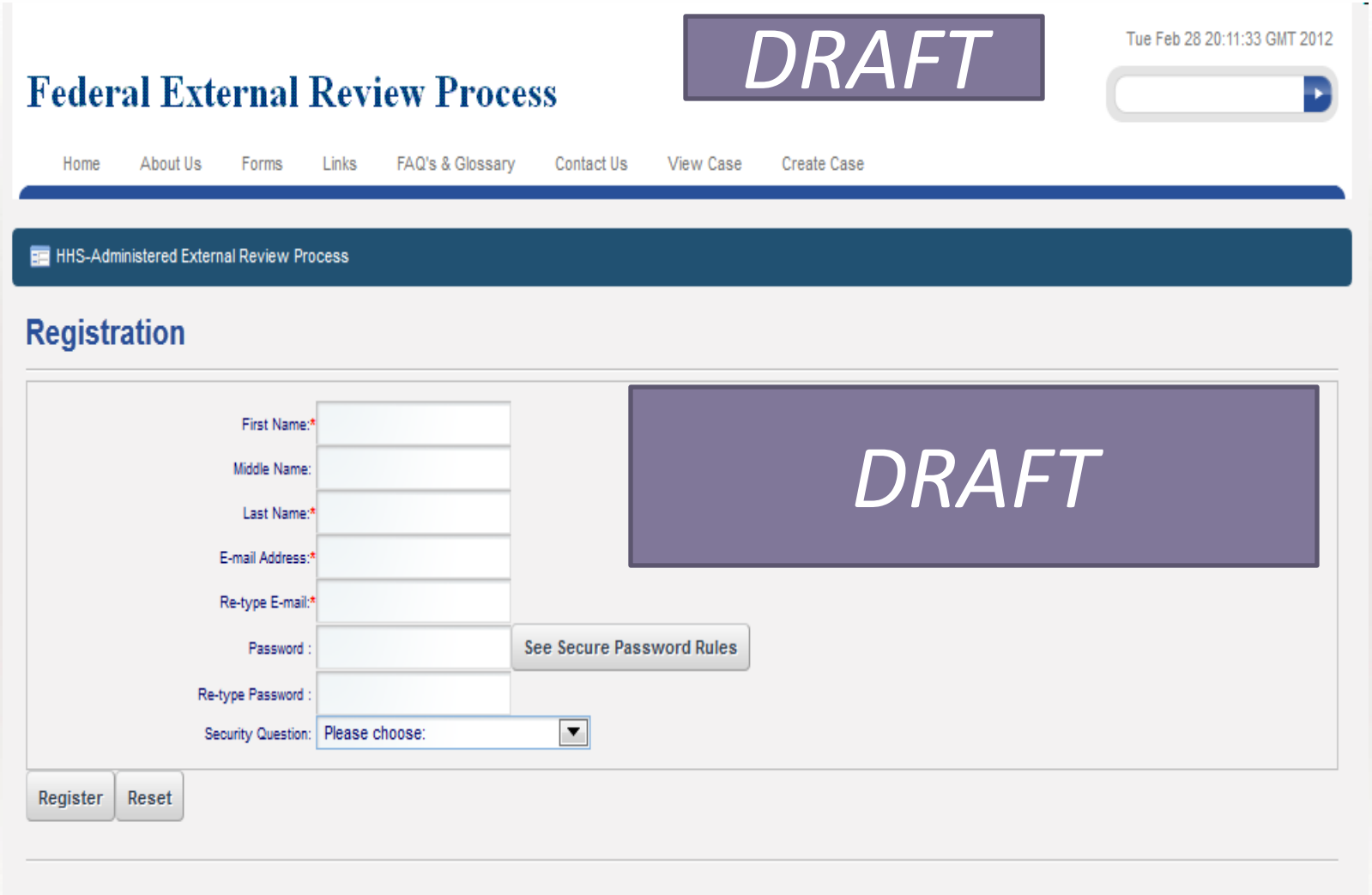
Note: There is no charge to the claimants or to the issuer

HHS Federal External Review Process – Electronic Filing

Electronic Filing – *Forthcoming*

- A web-based portal is being implemented that will be available for filing of external review requests, claims information, and communication with MAXIMUS
- Fully secure, requiring multifactor authentication
- Will allow issuers to securely upload case file documents eliminating need for hardcopy communication and protect patient privacy
- Will provide claimants access to ongoing information as their external review is processed.

HHS Federal External Review Process – Electronic Filing



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The information provided on the request form will be used to obtain the relevant documents from the issuer. Claimants may also submit supporting information and documents .

For example, claimants may choose to provide:

- Documents to support the claim, such as physicians' letters, reports, bills, medical records, and explanation of benefits (EOB) forms
- Letters claimants sent to their insurance plan or issuer about the issue
- Letters received from the plan or issuer about the issue

Claimants are not required to provide additional information.

HHS Federal External Review Process – Standard Review

Preliminary Review:

When the external review examiner receives the external review request the examiner will contact the plan or issuer to provide notification that it must forward any information considered in making the ABD (or final internal ABD) within five days. This includes:

- Claimant's certificate of coverage or benefit;
- A copy of the ABD;
- A copy of the final internal ABD;
- A summary of the claim;
- An explanation of the plan or issuer's ABD; and
- All documents and information considered in making the ABD or final internal ABD including any additional information provided to the plan or issuer or relied on during the internal appeals process

Preliminary Review (continued)

- The external review examiner will review the information provided by the plan or issuer and may request additional information.
- The external review examiner will notify the claimant and plan or issuer in writing if it determines that the claimant is not eligible for an external review.

HHS Federal External Review Process - Standard Review

- The examiner will review all of the information timely received and consider the claim de novo without being bound by any decision reached during the plan or issuer's internal claims and appeals process.
- Upon request by the plan or issuer, the examiner will forward all documents submitted by the claimant to the plan or issuer. Upon receipt of any such information, the plan or issuer may reconsider its ABD or final internal ABD. This reconsideration must not delay review. The external review may be terminated if the plan or issuer decides to reverse its decision and provide coverage or payment after reconsideration. The plan or issuer must provide written notice to the claimant and examiner within one business day after making the decision to reverse. The examiner must terminate the external review upon receipt of the notice from the health insurance issuer.

HHS Federal External Review Process- Standard Review

The examiner must provide written notice of a final determination on the external review to the claimant and plan or issuer as expeditiously as possible, but no later than 45 calendar days from the date of receipt of the request for external review.

The final external review decision notice will contain:

- A description of the reason for the requested external review with sufficient information to identify the claim
- The date the examiner received the external review assignment
- References to evidence or documentation considered in decision
- Discussion of the reasoning for the decision including rationale and any evidence-based standards relied on
- A statement that the decision is binding except to the extent that other remedies may be available under State or Federal law to either the claimant or plan or issuer
- A statement that judicial review may be available to the claimant
- Current contact information for any applicable health insurance consumer assistance or ombudsman

HHS Federal External Review Process –Standard Review

- The examiner must maintain records of all claims and notices associated with the external review process for six years and make the records available for examination by the claimant or plan or issuer upon request.
- Upon receipt of a final external review decision reversing the ABD or final internal ABD, the plan or issuer must immediately provide coverage or payment for the claim.

HHS Federal External Review Process – Expedited Review

- An expedited timeline is followed in cases where the claim meets the criteria set forth in 45 CFR 147.136 (d)(2)(ii).
  - The examiner will contact the plan or issuer once the examiner receives a request for expedited review and request all documents and information required under a standard review
  - The examiner will review all information received from the plan or issuer and may request additional information that it deems necessary to the external review
  - The examiner will notify the claimant and plan or issuer as expeditiously as possible if the examiner determines that the claimant is not eligible for external review

HHS Federal External Review Process – Expedited Review

- The examiner will review all of the information timely received and then consider the claim de novo without being bound by any decision reached during the plan or issuer's internal claims and appeals process.
- The examiner will forward all documents submitted by the claimant to the plan or issuer. Upon receipt of the information the plan or issuer may reconsider its ABD or final internal ABD. This reconsideration must not delay review. The external review may be terminated if the plan or issuer decides to reverse its decision and provide coverage or payment after reconsideration. The plan or issuer must immediately provide notice to the claimant and examiner after making the decision to reverse. This notice may be oral but must be followed up with written notice within 48 hours. The examiner must terminate the external review upon receipt of initial notice from the plan or issuer.

HHS Federal External Review Process – Expedited Review

- The reviewer shall make a final determination on the external review and communicate it to the claimant and plan or issuer within 72 hours from the time of receipt of the request or sooner depending on medical circumstances of the case.
  - If the claimant is notified orally, the reviewer will follow-up with written notice within 48 hours after delivery of the oral notice.
- The examiner's final external review decision and records maintenance must comply with the same requirements as for final external review decisions in standard external review
- Upon receipt of a final external review decision reversing the ABD or final internal ABD, the plan or issuer must immediately provide coverage or payment for the claim.

SUMMARY: Standard vs. Expedited Cases

	Standard Review Case	Expedited Review Case
Request for External Review	Within 4 months of ABD	May file simultaneous to internal appeal
Final Determination Letter	Within 45 days of request for external review	Within 72 hours (verbal notice) followed by written letter (within 48 hours after verbal)

Contact Information and Resources

Contact Information For Patients/Claimants

Technical Assistance is available by calling Toll-Free Telephone:

1-888-866-6205

- Available 24 hours/7 days per week
- Claimants may leave messages and receive instructions on submitting expedited external review requests
- TTY for hearing impaired
- Interpreter through the AT&T language line
- Translated brochures are available upon request, under CLAS standards

Claimants may find information on their external review request by going to the Claimant Portal at: www.externalappeal.com (forthcoming)

MAXIMUS Contact Information

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Resources

MAXIMUS Website: www.externalappeal.com

Consumer Information: www.healthcare.gov

HHS Federal External Review regulations and sub-regulatory guidance: http://cciio.cms.gov/resources/regulations/index.html

States/Territories in the HHS-Administered Federal External Review Process: http://cciio.cms.gov/resources/files/external_appeals.html

E-Mail Inquiries to MAXIMUS: ferp@maximus.com

E-Mail Inquiries to CMS/CCIIO: externalappeals@cms.hhs.gov

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Questions / Answers