Blue Cross Blue Shield Association

2011 Internal Audit; Anti-Fraud; Compliance & Ethics; Privacy Conference

Claims & Appeals Procedures Under the Affordable Care Act

May 16-19, 2011
Orlando, Florida

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Topics

- General Application
- Grace Periods
- Claims Procedures
- Appeals Procedures
- External Review Procedures

General Application

Pre-Affordable Care Act

State Requirements

- Insured plans
- Non-ERISA self-funded plans (?)

Department of Labor

- ERISA group health plans only
- Insurers (as fiduciary of ERISA group plan)

URAC/NCQA Standards

- Voluntary

Under Affordable Care Act

Comply with State Requirements

Dept of Labor Claims Procedure Rule

- Group and individual coverage
- Applies directly to insurers

Affordable Care Act Requirements

URAC/NCQA Standards

- Voluntary

Grandfathered Plans

Insured individual coverage

- Neither DOL nor Affordable Care Act applies

Insured group coverage

- Affordable Care Act does *not* apply
- DOL applies to insurer as fiduciary:
  - For ERISA groups, but
  - *Not* for non-ERISA groups

Grandfathered Plans

Self-funded ERISA plans

- Affordable Care Act does *not* apply
- DOL applies

Self-funded non-ERISA plans

- Neither DOL nor Affordable Care Act apply

Consider . . .

Adopting single set of procedures applicable to:

- Individual and group plans
- Insured and self-funded plans
- Grandfathered and non-grandfathered plans

Other Types of Plans

FSAs and HRAs

- Group health plans
- Self-funded plans

Swipe cards

- Claims subject to procedures?

Other Types of Claims

- PBMs
- Mental health vendors
- EAPs
- Others claim processers

Grace Periods

First Grace Period

Compliance Grace Period to 7/1/11

- 24 Hour Notice for Urgent Care Claims
- Culturally appropriate notices
- Additional content in notices
- Strict compliance & deemed exhaustion

Good faith implementation

Second Grace Period

Extended Grace Period

- Plan years > 1/1/2012

Applies to:

- 24 Hour Notice for Urgent Care Claims
- Culturally appropriate notices
- **Some** of the additional content in notices
  - Diagnosis codes (and meanings)
  - Treatment codes (and meanings)
- Strict compliance & deemed exhaustion

Second Grace Period

Other Content Extension

- First plan year > July 1, 2011

No good faith implementation

New regulations to be published

Provisions going away?

Claims Procedures

Terms

Claimant

- Authorized representative

Claim for benefits

- Provider “claims”

Adverse benefit determination

Terms

Adverse benefit determination

- Denial or reduction of payment (in whole or in part)
- Copayments, coinsurance, deductibles
- Rescissions*

Applies to virtually every claim

- EOBs: Notices of adverse benefit determination

Basic Requirements

Reasonable claims procedures

- Description of procedures in CoC
- No undue inhibition/hampering of claims
- Safeguards for:
  - Consistency
  - Accordance with plan documents

Basic Requirements

Procedures for "authorized representative"

- Claimant may identify
- Plan may require written authorization
- Urgent care situation—health care professional must qualify

Communications with "authorized representative"

Basic Requirements

No conflict of interest

Maintain independence & impartiality

- Hiring, compensation, etc., ***not*** based on denial of benefits

Incorrectly Filed Claim

Submission of pre-service claim

- Not in compliance with procedure
- Submitted to correct unit
- Sufficiently specific

Special notice requirement

- Provide within 5 days (24 hours if urgent)
- May be oral

Claim Processing

Post-service claims

- Notice within 30 days (only if adverse)
- 15-day extension (with notice)

Pre-service claims

- Notice appropriate to medical circumstances (whether or not adverse)
- Maximum of 15 days
- 15-day extension (with notice)

Claim Processing

Urgent care claims

- Notice ASAP (whether or not adverse)
- Within 72 hours (ACA 24 hour requirement subject to grace period)
- No extension

Concurrent care decisions

- Reduction in ongoing course of treatment
- Notice sufficiently in advance to allow appeal
- Notice if urgent care—24 hours

Notice Content

Readily understood by claimant

State specific reason

Refer to specific plan provisions

Appeal procedures

- Expedited procedures for urgent care claims

Explain scientific/clinical judgment

Notice Content

Internal guidelines

- Provide or make available on request
- Third parties' proprietary guidelines

Information to identify the claim*

- Date of service
- Provider
- Amount of claim (if applicable)
- *But not diagnosis & treatment codes*

Notice Content

Reason(s) for denial*

- Description of plan's standard (if used)
- *Not denial code*

Internal and external review*

Ombudsman Office (if available)*

- *See* DOL Technical Release # 2011-01 at:
- http://www.dol.gov/ebsa/newsroom/tr11-01.html

Notice Content

But not . . .

- Culturally & Linguistically appropriate

Model Notice

http://cciio.cms.gov/regulations/consumerappeals/model_notice_of_adverse_determination.pdf

Model Notice in Spanish (DOL version) available at http://www.dol.gov/ebsa/consumer_info_health.html

Inadequate Notice

Tolling of appeal deadline

- Deadline for appeal begins with notice

Exhaustion of remedies?

- Substantial compliance with requirements
- Not strict compliance (grace period)

Rescissions

Rescissions are adverse benefit determinations*

- Individual and group markets
- Subject to claims and appeals procedures

***Not* underwriting decisions**

Appeal Procedures

Terms

Benefit determination on review

- Benefit determination following appeal

Final internal adverse benefit determination

- Adverse benefit determination:
  - Upheld after final level of review or
  - Standing after process deemed to be exhausted

Basic Requirements

Reasonable opportunity to appeal

Opportunity to submit information

- Written comments
- Documents, records & other information

Copies of all relevant information

Take into account all information

Basic Requirements

Medical Professional consult

No deference to initial decision

- Different reviewer, not subordinate
- Different medical review, not subordinate

Identification of experts

At least 180 days to appeal

Basic Requirements

Limit on internal appeals:

- One appeal for individual coverage
- Two appeals for group coverage

Appeal Processing

Post-Service Claims

- One appeal process:
  - Respond in 60 days
- Two appeal process:
  - Respond in 30 days

Pre-Service Claims

- One appeal process:
  - Respond in 30 days
- Two appeal process:
  - Respond in 15 days

Appeal Processing

Urgent Care Claims

- ASAP
- Not to exceed 72 hours

Concurrent Care Decisions

- Before benefit is reduced or terminated

Appeal Processing

Full & Fair Review

- Provide access to and copies of all relevant information
- Provide new and additional evidence ASAP
- Explanation of new or additional rationale for decision
    - In time for reasonable opportunity to respond

Coverage pending appeal

Notice Content

Readily understood by claimant

State specific reason

Refer to specific plan provisions

Access statement

- Entitled to copies of all relevant documents

Explain scientific/clinical judgment

Notice Content

Internal guidelines

- Provide or make available on request
- Third parties' proprietary guidelines

Statement of right to file suit

- ERISA 502(a)
- State law?

Notice Content

Alternative dispute resolution

- Contact DOL or Department of Insurance

Information to identify the claim*

- Date of service
- Provider
- Amount of claim (if applicable)
- *But not diagnosis & treatment codes*

Notice Content

Reason(s) for denial*

- Description of plan's standard (if used)
- Discussion of the Decision
- *Not denial code*

External review process*

Ombudsman Office (if available)*

- *See* DOL Technical Release # 2011-01 at:
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Notice Content

But not . . .

- Culturally & Linguistically appropriate

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External Review Procedures

Application

State Process applies:

- When State process meets NAIC standards (as determined by CCIIO) and
- Plans are subject to State law

Federal processes apply:

- To every other plan

Issues Eligible for Review

NAIC process: medical judgment

- Medical necessity
- Appropriateness
- Health care setting
- Level of care and
- Effectiveness

Federal processes:

- All adverse benefit determinations
- Includes rescissions & other non-medical issues

Federal Processes

For insured plans:

- Office of Personnel Management controls process
- Specific notice requirements (for adverse benefit determination notices)

For ERISA self-funded plans:

- Direct control of process

For non-ERISA self-funded plans

ERISA Plan Safe Harbor

Request for external review

- Up to 4 months after final determination

Plan's preliminary review

- Within 5 business days
- Determine whether:
  - Claimant was covered under plan
  - Decision based on eligibility for group health plan
  - Internal processes exhausted
  - All information provided

ERISA Plan Safe Harbor

Issue notice within 1 business day

- If request is complete but ineligible:
  - Explain reasons for ineligibility
  - Provide EBSA toll-free number
- If request is incomplete:
  - Information to perfect request
  - 4 months/48-hour deadline

Refer to Independent Review Organization

- Contract with at least 3 and rotate claims

ERISA Plan Safe Harbor

Contract with each IRO must

- Have no financial incentives for denial
- Require IRO to:
  - Use legal expertise as necessary
  - Notify claimant of acceptance
  - Forward information from claimant to Plan
  - Review the claims de novo
  - Provide written notice of final decision in 45 days
  - Maintain records for 6 years

Expedited process for urgent care

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2010 Lawyers Conference

Questions?

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