

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Office of Consumer Information and Insurance Oversight**

**Technical Guidance For Interim Procedures for Federal External Review Relating to Internal Claims and Appeals and External Review For Health Insurance Issuers in the Group and Individual Markets under the Patient Protection and Affordable Care Act**

**SUMMARY:** This document sets forth the interim procedures for the external review processes for health insurance issuers in the group and individual markets under the Patient Protection and Affordable Care Act.

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**CUSTOMER SERVICE INFORMATION:** Information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) website ([http://www.cms.hhs.gov/HealthInsReformforConsume/01\\_Overview.asp](http://www.cms.hhs.gov/HealthInsReformforConsume/01_Overview.asp)) and information on health reform can be found at <http://www.hhs.gov/ociio/> and <http://www.healthcare.gov>.

**SUPPLEMENTARY INFORMATION:**

**I. Background**

The Patient Protection and Affordable Care Act (the Affordable Care Act), Pub. L. 111-148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (the

Reconciliation Act), Pub. L. 111-152, was enacted on March 30, 2010. The Affordable Care Act and the Reconciliation Act reorganize, amend, and add to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans.

Section 2719(b)(1) of the PHS Act requires that health insurance issuers comply with the State external review process in their State if that process includes, at a minimum, the consumer protections set forth in the Uniform External Review Model Act issued by the National Association of Insurance Commissioners (“NAIC Uniform Model Act”). If the State external review process does not meet this standard, section 2719(b)(2) provides that health insurance issuers shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to a State external review process that meets the standard in Section 2719(b)(1).

The Departments of Health and Human Services (HHS), Labor, and Treasury published an interim final rule (IFR) implementing PHS Act section 2719 on July 23, 2010, at 75 FR 43330. The IFR includes a transition period prior to July 1, 2011 during which time HHS will work with States to assist them in making any necessary changes so that the State process provides, at a minimum, the consumer protections under the NAIC Uniform Model Act, and thus applies to health insurance issuers under section 2719(b)(1). This technical guidance establishes the interim external review processes that apply during this transition period. This interim

process will vary somewhat for three categories of States. During this transition period, HHS will not take any enforcement action against a health insurance issuer that complies with this technical guidance as explained below:

- In States with external review laws in effect on March 23, 2010, for plan or policy years beginning prior to July 1, 2011, a health insurance issuer is deemed, under the Secretary's authority under section 2719(c) of the PHS Act, to comply with the statutory requirements in section 2719(b) as set forth in 45 CFR §147.136 if it follows that State's external review process to the extent applicable during this transition period. HHS encourages States with external review laws that do not currently apply to all of its fully insured market to extend the protections of the law to the entire fully insured market in its State.
- In States that have passed external review laws between March 23, 2010 and September 23, 2010, under this guidance, the process provided for under those laws will apply in that State, pursuant to section 2719(b)(2) of the PHS Act.
- In States that have not passed an external review law that is in effect on September 23, 2010, a health insurance issuer must follow the interim external review process that is set forth in this technical guidance. This process will be administered by the Office of Personnel Management (OPM).

Prior to July 1, 2011, HHS will issue further guidance as to which State external review laws have been determined to satisfy the minimum standards of the NAIC Uniform Model Act as identified in 45 CFR §147.136, and which States, following consultation, will be subject to the Federal external review process provided for under 45 CFR §147.136(d). HHS and the

Departments of Labor and Treasury will also issue guidance on the standards for the Federal external review process that will replace this interim process. It was necessary to adopt the interim procedures for external review for insured coverage and self-insured group health plans in the guidance issued by the Departments of HHS, Labor and Treasury for purposes of expediency and thus, they do not necessarily indicate the substance of the final process to be developed by HHS for health insurance issuers, nor the substance of the process HHS will follow to determine whether State laws meet the minimum standards of the NAIC Uniform Model Act.

## **II. Interim Federal External Review Process for Health Insurance Issuers in the Group and Individual Markets**

External review is available for both individuals who purchase a health insurance policy and participants and beneficiaries in group health plans who purchase a health insurance policy from the health insurance issuer. In accordance with the interim final regulations, external review is available for adverse benefit determinations and final internal adverse benefit determinations as defined in 45 CFR §147.136, which include denials of claims, adverse coverage determinations and rescissions. However, external review is not available for participants and beneficiaries in group health plans to resolve disputes about eligibility to participate in an employer-sponsored group health plan other than those disputes that are related to rescissions.

For purposes of this guidance, the definitions contained in the interim final regulations under PHS Act section 2719 apply.

To facilitate the external review process, all health insurance issuers in the individual, small and large group markets operating in the States with no external review that is in effect on

September 23, 2010 must provide the following information electronically by September 23, 2010 to externalappeals@hhs.gov:

- Indicate whether or not PHS Act Section 2719 is applicable to them (i.e. they participate in the health insurance market) and, if so, the products to which it does or does not apply. For each product to which it does not apply, please specify the reason(s) (i.e. if a product is grandfathered).
- If PHS Act Section 2719 is applicable, contact information for designated personnel in their appeals department, including name(s), mailing address(es), telephone number(s), facsimile number(s) and electronic mail address(es). In addition, contact information for a designated individual who will be available to address urgent care cases outside of normal business hours (including weekends and holidays). This information should be provided by September 23, 2010 and electronically copied to disputedclaim@opm.gov. This contact information will be used by OPM to contact the health insurance issuer after a claimant initiates an external review.

#### **A. Procedures for providing standard external review**

This section sets forth procedures for providing external review during the interim federal external review process. Standard external review is external review for adverse benefit determinations and final internal adverse benefit determinations that do not meet the criteria for expedited review (as described in Section B of this guidance).

1. Request for external review. A claimant or authorized representative (“claimant”) may file a written request for an external review with the external review examiner (“examiner”) within four months after the date of receipt of a notice

of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Notice to claimants. An adverse benefit determination or a final internal adverse benefit determination must contain a notice to the claimant that the claimant can request an external review of the adverse benefit determination or a final internal adverse benefit determination. The notice must meet all of the requirements contained in 45 CFR §147.136(b)(2)(ii)(E) and 45 CFR §147.136(b)(3)(ii)(E). The notice must inform the claimant that the claimant can request an external review in writing by sending it electronically to [DisputedClaim@opm.gov](mailto:DisputedClaim@opm.gov); by faxing it to 202-606-0036, or by sending it by mail to: P.O. Box 791 Washington, DC 20044. In addition, the notice must inform the claimant of the following: that if the claimant has any questions or concerns during the external review process, the claimant can call the toll-free number 877-549-8152; and that the claimant can submit additional written comments to the external reviewer at the mailing address above. The claimant should also be notified that if any additional information is submitted, it will be shared with the health insurance issuer in order to give the health insurance

issuer an opportunity to reconsider the denial. Lastly, health insurance issuers must provide claimants with the Privacy Act Statement. This Statement can be downloaded at

<http://www.hhs.gov/ociio/regulations/consumerappeals/index.html>. Health insurance issuers must electronically provide to HHS samples of each of their notices that contain this appeals information. This information should be provided at [externalappeals@hhs.gov](mailto:externalappeals@hhs.gov). If these notices are changed during the plan or policy year, updated copies must be electronically sent to HHS at [externalappeals@hhs.gov](mailto:externalappeals@hhs.gov).

3. Independent reviewer qualifications. Review will be conducted by an independent third party with clinical and legal expertise and with no financial or personal conflicts with the health insurance issuer.<sup>1</sup>
4. Procedure for preliminary review. When the examiner receives an external review request, the examiner will contact the health insurance issuer.
  - a. Within five business days of receipt of request by the examiner, the health insurance issuer must provide to the examiner all of the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination including:
    - i. Claimant's certificate of coverage or benefit;

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<sup>1</sup> This process reflects the intent of the NAIC Uniform Model Act by ensuring the independence of the external review process. However, this interim process does not include many of the requirements set forth in the NAIC Uniform Model Act that will be incorporated in the permanent federal external review process. For example, this interim process does not provide for random assignment to independent review organizations, but it achieves the goal of this provision by ensuring no financial relationship between the issuer and the body making the final external review decision. The NAIC Uniform Model Act is available at <http://www.dol.gov/ebsa> and <http://www.hhs.gov/ociio/>. Future guidance will address the minimum consumer protections required under the Federal external review process after the interim transition period.

- ii. A copy of the adverse benefit determination;
- iii. A copy of the final internal adverse benefit determination;
- iv. A summary of the claim;
- v. An explanation of the health insurance issuer's adverse benefit determination and final internal adverse benefit determination; and
- vi. All documents and information considered in making the adverse benefit determination or final internal adverse benefit determination including any additional information that may have been provided to the health insurance issuer or relied upon by the health insurance issuer during the internal appeals process.

This information can be provided electronically at [DisputedClaim@opm.gov](mailto:DisputedClaim@opm.gov), by fax at 202-606-0036 or by priority mail at the mailing address listed in (A)(2).

- b. The examiner will review the information from the health insurance issuer and may request additional information that it deems necessary to the external review. If the examiner requests additional information, the health insurance issuer shall supply the information as expeditiously as possible and within five business days.
- c. If the examiner determines that the claimant is not eligible for external appeal, the examiner will notify the claimant and the health insurance issuer in writing.

5. Review Process.

- a. The examiner will review all of the information and documents timely received. In reaching a decision, the examiner will review the claim de novo

and not be bound by any decisions or conclusions reached during the health insurance issuer's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the PHS Act.

- b. The examiner will forward all documents submitted directly to the examiner by the claimant. Upon receipt of any information submitted by the claimant, the examiner must within one business day forward the information to the health insurance issuer. Upon receipt of any such information, the health insurance issuer may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the health insurance issuer must not delay the external review. The external review may be terminated as a result of the reconsideration only if the health insurance issuer decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making a decision to reverse, the health insurance issuer must provide written notice of its decision to the claimant and the examiner. The examiner must terminate the external review upon receipt of the notice from the health insurance issuer.
- c. The examiner must provide written notice of the final external review decision as expeditiously as possible and within 45 days after the examiner receives the request for the external review. The examiner must deliver the notice of final external review decision to the claimant and the health insurance issuer.

d. The examiner's final external review decision notice will contain:

(i) A general description of the reason for the request for external review, including information sufficient to identify the claim<sup>2</sup> (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial, including denial codes);

(ii) The date the examiner received the assignment to conduct the external review and the date of the examiner's decision;

(iii) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(iv) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(v) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the health insurance issuer or to the claimant;

(vi) A statement that judicial review may be available to the claimant; and

(vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

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<sup>2</sup> If the notice involves a denial unrelated to a specific claim, only name and ID number are necessary for identification. The reason for the denial should be clear in the narrative provided in (A)(5)(d)(iv).

- e. After a final external review decision, the examiner must maintain records of all claims and notices associated with the external review process for six years. The examiner must make such records available for examination by the claimant or health insurance issuer upon request.
- 6. Reversal of health insurance issuer's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the health insurance issuer immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

**B. Expedited external review.**

- 1. Request for expedited external review—A claimant may make a written or oral request for an expedited external review with the examiner at the time the claimant receives:
  - (a) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal, or an adverse benefit determination if the adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility , and the claimant has filed a request for an expedited internal appeal; or

(b) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

2. Notice to claimants. An adverse benefit determination or a final internal adverse benefit determination must contain a notice to the claimant as set forth in paragraph (A)(2). In addition, claimants must be notified that in urgent care situations, their requests for expedited review can be initiated by calling the toll free number 877-549-8152.
3. Independent reviewer qualifications. Review will be conducted by an independent third party that meets the requirements in paragraph (A)(3)
4. Procedure for preliminary review. When the examiner receives an external review request, the examiner will contact the health insurance issuer.
  - a. Immediately upon receipt of request by the examiner, the health insurance issuer must provide to the examiner all documents and information required under (A)(4).
  - b. The examiner will review the information from the health insurance issuer and may request additional information that it deems necessary to the external review.
  - c. If the examiner determines that the claimant is not eligible for expedited external appeal, the examiner will notify the claimant and the health insurance issuer as

expeditiously as possible.

5. Review Process.

- a. The examiner must comply with the requirements set forth in (A)(5)(a).
- b. The examiner will forward all documents submitted directly to the examiner by the claimant. Upon receipt of any information submitted by the claimant, the examiner must immediately forward the information to the health insurance issuer. Upon receipt of any such information, the health insurance issuer may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the health insurance issuer must not delay the external review. The external review may be terminated as a result of the reconsideration only if the health insurance issuer decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Immediately after reversing the decision, the health insurance issuer must provide notice of its decision to the claimant and the assigned examiner. This notice can be provided orally but must be followed up with written notice within 48 hours. The examiner must terminate the external review upon receipt of the initial notice from the health insurance issuer.
- c. The examiner must provide notice of the final external review decision as expeditiously as the medical circumstances require and within 72 hours once the examiner receives the request for the external review. For individuals in urgent care situations who are also in an ongoing course of treatment for that condition, this external review decision will be provided within 24 hours. The examiner

must deliver the notice of final external review decision to the claimant and the health insurance issuer. This notice can be initially provided orally but must be followed up in writing within 48 hours.

- d. The examiner's final external review decision notice must comply with the requirements set forth in (A)(5)(d)
  - e. After a final external review decision, the examiner must maintain records as required in (A)(5)(e).
6. Reversal of health insurance issuer's decision. The health insurance issuer must comply with the requirements established in (A)(6).