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DOL Issues More Guidance On Health Plan Appeals & Provides Grace Period On Implementing Certain New Standards

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Technical Release 2010-02

On September 20, 2010, the U.S. Department of Labor announced a grace period for complying with certain new standards for internal claims and appeals under the Affordable Care Act.

The new standards were promulgated under an interim final regulation issued by DOL on July 23, 2010. (For details on the interim regulation, see The ERISA & Employee Benefits Bulletin – August 2010, here). However, after the interim final regulation was published, plans and health insurance issuers stated they did not anticipate some or all of the new standards and that more time would be needed to change plans or polices, or to modify computer systems in order to come into compliance. Consequently, to give plans and issuers more time to implement procedures and make changes to computer systems, on September 20, DOL issued Technical Release 2010-02, which sets forth an enforcement grace period until July 1, 2011 with respect to the following four new standards for internal claims and appeals:

- the 24-hour timeframe for making urgent care claims determinations;
- the provision of notices in a culturally and linguistically appropriate manner;
- the requirement that notices provide additional content and specificity such as diagnosis and treatment codes;
- the requirement that unless a plan strictly adheres to interim regulation, a claimant will be deemed to have exhausted internal claims and appeals even if a plan has substantially complied with the interim regulation.

According to DOL, neither it, nor the Internal Revenue Service will take any enforcement action against group health plans, and the U.S. Department of Health & Human Services will not take any enforcement action against a self-funded nonfederal government health plan, so long as the plan is working in good faith to implement the additional standards.

Technical Release 2010-01

Earlier, on August 23, 2010, DOL issued Technical Release 2010-01, which provides a safe-harbor on compliance with the final interim regulation for non-grandfathered self-insured health plans that are not subject to a state external review process and that, therefore, are subject to a federal external review process. The safe-harbor will apply for plan years that begin on or after September 23, 2010, and until superceding guidance is issued by DOL.

According to DOL, during this safe-harbor period, it will not take any enforcement action against a self-insured group plan that complies with either of the following two compliance methods:

Voluntary Compliance with State External Review Processes. Compliance under this method occurs when a self-insure plan voluntarily complies with a state's external review process in a state that expand access to its external review process to plans that are not subject to applicable state laws (such as self-insured plans).

Compliance with Procedures Under Technical Release 2010-01. Compliance under this method occurs when a self-insured plan satisfies the external review requirements outlined in Technical Release 2010-01 that are based on the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners. The Technical Release sets forth the following procedures for "standard" and "expedited" external reviews.

Standard Review

1. Request for external review. A claimant must be permitted to file a request for an external review with the plan 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. Preliminary review. Within five business days of receipt of the external review request, the group health plan must determine whether:

a) the claimant is or was covered under the plan at the time the health care item or service was requested or provided;

b) the adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

c) the claimant exhausted the plan's internal appeal process, unless the claimant is not required to exhaust under the interim final regulations; and

d) the claimant has provided all information and forms required to process an external review.

Within one business day after completion of the preliminary review, the plan must issue a notification in writing to the claimant. If the request is complete but not eligible for external review, the notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification must describe the information or materials needed to make the request complete, and the plan must allow the claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization (IRO). The group health plan must assign an independent review organization (IRO) that is accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The plan must take action against bias and ensure independence. The plan must contract with at least three IROs for assignment under the plan and rotate claims assignment among them (or incorporate other independent, unbiased methods for selecting IROs). An IRO must not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between a plan and an IRO must provide that:

a) The IRO will utilize legal experts where appropriate to make coverage determinations.

b) The IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the claimant may submit additional information within 10 business days that the IRO must consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after 10 business days.

c) Within five business days after the date of assignment of the IRO, the plan must provide to the assigned IRO the documents and any required information considered in making the adverse benefit determination or final internal adverse benefit determination. A plan's failure to timely provide the documents and information must not delay the conduct of the external review. If a plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the plan.

d) Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the plan. Upon receipt of the information, the plan may reconsider its adverse benefit determination or final internal adverse benefit determination. The external review may be terminated as a result of the reconsideration only if the plan, upon reconsideration, reverses its adverse benefit determination or final internal adverse benefit determination and provides coverage or payment. Within one business day after making such a decision, the plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the plan.

e) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim *de novo* and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process applicable under the interim final regulations. In addition to the documents and information provided, the assigned IRO, to the extent information and documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

i) the claimant's medical records;

ii) the attending health care professional's recommendations;

iii) reports from appropriate health care professionals and other documents submitted by the plan or insurer, claimant or the claimant's treating provider;

iv) the terms of the claimant's plan to ensure that the IRO's decision is not contrary to the terms of the plan unless the terms are inconsistent with applicable law;

v) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

vi) any applicable clinical review criteria developed and used by the plan, if the criteria are inconsistent with the terms of the plan or with applicable law; and

vii) the opinion of the IRO's clinical reviewer or reviewers after considering the information described in the notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of the final external review decision to the claimant and to the plan.

g) The assigned IRO's decision notice must contain:

i) a general description of the reason for the request for external review, including information sufficient to identify the claim (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);

ii) the date the IRO received the assignment to conduct the external review and the date of the IRO decision;

10th Circuit Decides Discovery in Dual Role Cases

On September 8, 2010, the U.S. Court of Appeals for the 10th Circuit decided the appropriate standard for discovery in benefit denial cases that involve allegations of a dual role fiduciary with a conflict of interest.

The U.S. Supreme Court, in Metropolitan Life Ins. v Glenn (2008), *seemed to contemplate discovery for purposes of determining the nature and extent of a conflict that may exist when a plan administrator that evaluates a claim also must pay it. Courts subsequently split on whether or when discovery should be permitted in such cases. The 10th Circuit is the first U.S. Court of Appeals to address the issue directly.*

In Murphy v. Deloitte Touche Group Ins. Plan (2010), *the 10th Circuit ruled that the party seeking to supplement the administrative record through discovery bears the burden of showing its propriety under the familiar standards of Federal Rule of Civil Procedure 26(b) - namely, that discovery must be for relevant information that is reasonably calculated to lead to admissible evidence, without being overly broad, costly or cumulative. In determining whether a request is costly or burdensome, the 10th Circuit instructed courts to consider the necessity of discovery. For example, where the nature of the conflict is obvious on the face of the administrative record or the evidence supporting a denial is so one-sided that the result will not change, discovery into the nature of the plan administrator's conflict would be unnecessary.*

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 reaching 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 group health plan or to the claimant;

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

vii) current contact information, including the phone number, for any applicable office of health insurance consumer or assistance or ombudsman established under Section 2793 of the Public Health Service Act.

h) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make the records available for examination by the claimant, plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

4. **Reversal of plan'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 plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited Review

1. **Request for expedited external review.** A group health plan must allow a claimant to make a request for an expedited external review with the plan 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

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 emergency services, but has not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the plan must determine whether the request meets the reviewability requirements of a "Preliminary review" of a Standard External Review. The plan must immediately send to the claimant a notice that meets the "Preliminary review" notice requirements of a Standard External Review.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO pursuant to the requirements for referral to an IRO for a Standard External Review. The plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone, facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim *de novo* and is not bound by any decisions or any conclusions reached during the plan's internal claims and appeals process.

4. Notice of final external review decision. The plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the notice requirements for a Standard External Review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the plan.

ABOUT THE LAW FIRM:
The Amadeo Law Firm, PLLC, is a litigation and consultation boutique with offices in Frederick, MD & Washington, DC. The firm represents clients in commercial, employment, employee benefit, and government contracting matters.

The laws governing employee health and pension benefits are often complex and evolving. Employers, plan sponsors, and plan fiduciaries may need to seek consultation to ensure compliance with latest rules and applicable regulations.

The Employee Benefits Practice of the Amadeo Law Firm, PLLC, monitors employee benefit laws and regulations and provides sophisticated advice to employers, plan sponsors, and plan fiduciaries. The firm helps clients achieve workforce management goals related to providing employee benefits while also enabling them to devote their attentions to what matters most: their businesses.

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