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Administrative Letter 2011-05

To: All Insurers Licensed to Write Accident and Sickness Insurance, Health Maintenance Organizations, Health Services Plans, Dental and Optometric Services Plans, and Dental Plan Organizations

Re: Internal Appeal of Adverse Benefit Determinations and External Review of Adverse Determinations

The purpose of this administrative letter is to provide a summary of the new internal appeals and external review process under Virginia law, and to provide guidance for the submission of form filings and complaint system filings revised to comply with these new requirements.

Chapter 788 (House Bill 1928) of the Acts of Assembly, effective July 1, 2011, enacts a new chapter within the Code of Virginia (the Law) that requires a health carrier to establish an internal appeals process and adds requirements for external review consistent with the requirements set forth in the federal Patient Protection and Affordable Care Act (PPACA). The provisions of the bill expire on July 1, 2014. Additionally, 14 VAC 5-216-10 et seq., the Rules Governing Internal Appeal and External Review (the Rules), details internal appeal requirements and further defines external review provisions. The Law and Rules extend to adverse benefit determinations and adverse determinations made on or after July 1, 2011 and are applicable to all plans offered by health carriers except those specifically excluded in Virginia Code § 38.2-3557 and 14 VAC 5-216-10, ***regardless of whether or not the health benefit plan is grandfathered***.

This letter highlights substantive requirements under the new provisions of the Law and Rules, but should not be relied on solely. A checklist that outlines the requirements of the internal appeals process, notice requirements, and new reporting requirements, as well as flowcharts that describe the internal appeal and external review processes and timeframes can be found on the Bureau's website at: http://www.scc.virginia.gov/boi/co/index.aspx

Complaint System Filings

Code of Virginia § 38.2-5804 requires all Managed Care Health Insurance Plans (MCHIPs) to file their complaint systems with the State Corporation Commission and the State Health Commissioner. In order to expedite and facilitate the review and approval of MCHIP complaint and appeal procedure filings, the Bureau encourages

MCHIPs to complete and return the checklist with any filing of its new or revised complaint and appeals process, indicating the appropriate document and page number where the required provision can be found.

Internal Appeals Requirements

For all adverse benefit determinations, as defined in the Rules, including rescissions and contractual denials, health carriers shall:

- Make available an internal appeals process.
- Provide instructions for filing available internal standard or urgent care appeals with each issuance of an adverse benefit determination, to include contact information to file an internal appeal, and certain contact information for the Bureau, or Office of the Managed Care Ombudsman if the health carrier is an MCHIP.
- Provide reasons for the denial and specific plan provisions used in the determination.
- Ensure a full and fair review of the denial.
- Make available an expedited internal appeals process for urgent care appeals, as defined in the Rules.

In the case of an adverse determination, initial or otherwise, that is based on medical necessity, appropriateness, healthcare setting, level of care, or effectiveness, and adverse determinations related to services determined to be experimental/ investigational in nature, the health carrier shall provide in a written notice the circumstances when a person may be eligible for external review, as required by the Code of Virginia § 38.2-3559. In addition, the notice of an adverse determination shall include the health carrier's website and telephone number at which the person may obtain the forms necessary to request an external review. In the case of a final adverse determination, the health carrier must provide the forms needed to request an independent standard or expedited external review and the required disclosure about the person's external review rights.

Additional Provisions for Internal Appeals

- Health carriers may offer a two-level internal appeal process for group plans only. A one-level internal appeal process is required for individual plans.
- New timeframes are required for submission of internal appeals and the health carrier's response to standard and expedited internal appeals.
- Before the health carrier can make a final adverse benefit determination that relies on any new or additional evidence generated directly or indirectly by the

health carrier, the health carrier must provide this information free of charge to the covered person sufficiently in advance of the final adverse determination deadline. The covered person must have a reasonable opportunity to respond to the new information prior to the deadline.

- Benefit determinations on an urgent care appeal must be transmitted between the health carrier and the covered person by the most expeditious method available to include telephone and facsimile.

- Concurrent review can mean utilization review conducted not just during a patient's stay in a facility, but during a course of treatment in an outpatient health care setting. The health carrier must provide continued coverage pending the outcome of any internal appeal of a concurrent review decision.

- If a health carrier reduces or terminates an approved course of treatment or number of treatments, the health carrier must notify the covered person sufficiently in advance of such reduction or termination to allow the person time to file an internal appeal and obtain a determination before the benefit is reduced or terminated.

External Review Changes

- External review (ER) will no longer be limited to MCHIPs, Final Adverse Decisions (FADs) or Virginia contracts; ER will be available for review of adverse determinations and final adverse determinations rendered by health carriers licensed in Virginia.

- A covered person may elect to be represented by an authorized representative for ER.

- A covered person must exhaust the internal appeal process before requesting ER except as noted below:
    - Adverse determinations based on a determination that services are experimental/investigational may be expedited with written certification by the treating physician that services would be less effective if not initiated promptly.
    - Expedited ER for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness denials may be requested simultaneously with an expedited internal review; the Independent Review Organization (IRO) will review and determine if internal appeal should be completed prior to ER.
    - Failure by the health carrier to render a standard internal appeal determination within 30 or 60 days and the covered person has not requested or agreed to a delay.

  - Health carrier may waive the exhaustion requirement.

- The Commissioner of Insurance will no longer render an order; instead, the decision that results from the review by the IRO is final and binding on the health carrier and the covered person (except to the extent that the covered person has remedies available under federal or state law). The IRO will communicate its decision to the covered person, the health carrier and the Bureau.
- ER will include different processes for various situations to include:

  - Standard ER of medical necessity
  - Expedited ER of medical necessity
  - Standard ER of experimental/investigational
  - Expedited ER of experimental/investigational

- Written certification by a physician will be required in order to qualify for an expedited ER and for an experimental /investigational ER.

- ER for experimental/investigational review will be conducted by a panel of physicians; process provides for a "tie breaker," if needed.

- Time for the covered person to file a request for ER is increased from 30 days from the date of the decision to 120 days from the date of receipt of a notice of the right to an ER.

- Total timeframes for the review processes are similar to the previous process with the exception of the time provided for parties to provide documentation (5 days for a standard appeal, rather than 20 days).

- Medical record documentation shall be provided directly to the IRO rather than to the Bureau.

- IRO is required to forward information received from the covered person to the health carrier for reconsideration, which shall not delay the ER.

- If the health carrier's reconsideration results in reversal, the health carrier shall notify the Bureau, the covered person and the IRO in writing of its decision; ER will be terminated by IRO upon receipt of such notification.

- At the completion of an ER, the IRO shall inform the covered person, the health carrier and the Bureau of its decision to uphold or reverse the adverse determination or final adverse determination.

- There is no longer a filing fee (previously $50.00).

- There is no longer a minimum cost of denied services threshold (previously the minimum was $300.00).

- The cost of the ER will be paid by the health carrier to the IRO in all cases.

- Each health carrier and each IRO shall maintain records of ER and make an annual report to the Bureau.

- Health carriers must meet disclosure requirements relating to ER including informing covered persons of ER procedures, providing covered persons with Bureau contact information and informing covered persons of the requirement to authorize release of medical records for the purpose of ER.

- Self-insured employee welfare benefit plans whose plan sponsor's headquarters is located in Virginia may "opt-in" to participate in the ER process.

The Role of the Bureau of Insurance

- The Bureau's duties:

    1. Oversight of determinations of ineligibility.
    2. Assign eligible requests to a qualified and approved IRO on a random basis, taking into consideration the nature of the health care services which are the subject of the ER.
    3. Approve IROs based on required minimum qualifications including full Utilization Review Accreditation Commission (URAC) accreditation; the Bureau shall reapprove qualified IROs every two years unless the Bureau determines that the IRO is not meeting minimum qualifications or if the IRO's decisions are consistently unclear or incomplete.
    4. Maintain a list of approved IROs.
    5. Track annual reports received from the IROs and health carriers.
    6. Assist covered persons with filing an ER request.

- After receiving a request for ER, the Bureau shall forward the request to the health carrier for review of eligibility; the health carrier shall inform the Bureau and the covered person of eligibility and in the case of ineligibility, the right to an appeal of that determination by the Bureau.

- Bureau will no longer contract with IROs and will therefore no longer reimburse or bill for IRO services.

A copy of the revised Rules and the required forms are available on the following website at: http://leg1.state.va.us/000/reg/TOC14005.HTM.HTM#C0216

Form and Complaint System Filings

The Bureau recognizes that carriers have had little time to modify forms and procedures to address the new requirements for internal and external appeals. In consideration of this short time-frame, and in accordance with Virginia Code § 38.2-316 I, the Bureau will *temporarily* exempt forms developed or modified exclusively to effect compliance with the Law and Rules from the approval requirements of § 38.2-316 until January 1, 2012. The exemption will only apply to endorsements, amendments, and riders to be attached to previously approved contracts, and to explanation of benefit forms, submitted specifically to adhere to the requirements of the Law and Rules. It should be noted that this temporary exemption extends only to the approval requirements that would otherwise apply under § 38.2-316 and does not extend to processes or procedures that carriers must implement to comply with the Law and Rules.

Similarly, the Bureau will provide carriers with an extension through January 1, 2012 to secure approval of their complaint system filings as required pursuant to § 38.2-5804. Again, however, this extension applies to the filings themselves and not to the implementation of appropriate processes and procedures to effect compliance with the Law and Rules.

It should also be noted that most MCHIPs with stand-alone dental and vision products will be required to establish a revised complaint and appeals process with revised forms and notices since these types of products should no longer include provisions for an external appeal process available through the Bureau of Insurance.

Any and all forms or MCHIP complaint procedures revised or modified to address the requirements identified in the Law and the Rules, including, but not limited to new or revised endorsements, amendments, riders and explanations of benefit forms, and MCHIP complaint system filings must be filed with and approved by the Bureau on or before January 1, 2012. Although the Bureau is providing this delayed period for form filings and MCHIP complaint system filings, full compliance with the processes and procedures of the new Law and Rules is required and expected on and after July 1, 2011.

This temporary exemption will not be employed with respect to any particular filing unless and until it is specifically **requested** by the submitting health carrier or MCHIP in accordance with this letter, and the following information is included. The Bureau will screen submissions as they are received and will reject the exemption request if one or more of the required items below are not included.

1. A statement that any and all forms or procedures included in the submission include provisions specifically drafted to address the requirements of the Law and Rules.

2. If an amendment, endorsement, or rider is submitted, an identification of any and all contracts or policies to which the amendment, endorsement or rider will apply and the corresponding approval date(s) of such contracts or policies in Virginia.

3. A red-lined identification of all Law and Rule related changes to the forms or procedures.

4. A Certification from an officer of the health carrier or MCHIP stating:

(a) The forms or procedures included in the submission were developed and drafted to address the requirements of the Law and Rules; and
(b) The carrier or MCHIP understands and agrees that the exemption applied to this submission is temporary and that forms or procedures included in the submission remain subject to review in accordance with applicable Virginia laws and regulations. Form(s) may not be issued or issued for delivery in Virginia after the expiration of the temporary exemption period if the form(s) have not been approved by the Bureau prior to January 1, 2012. MCHIPs must have a complaint system filing approved by the Bureau on or before January 1, 2012. The carrier or MCHIP will be responsible to make corrective actions necessary as a result of the Bureau's review, including, but not limited to amending noncompliant form language or procedures.

Please refer any questions regarding this matter to:

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Sincerely,

Jacqueline K. Cunningham
Commissioner of Insurance

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