# FEHB Program Carrier Letter

**All Carriers**

**U.S. Office of Personnel Management**
**Insurance Operations**

**Letter No. 2010-20** **Date: October 19, 2010**

Fee-for-Service [16] Experience-rated HMO [16] Community-rated HMO [16]

**SUBJECT: Internal Claims and Appeals and External Reviews under the Affordable Care Act**

On July 23, 2010, the United States Department of Health and Human Services, the Department of Labor, and the Department of Treasury jointly issued interim final regulations implementing section 2719 of the Affordable Care Act ("the ACA") governing internal and external health plan claim appeals for group health plans. These regulations apply to group health plans that are not grandfathered plans in accordance with the ACA for plan years beginning on or after September 23, 2010; however, the Office of Personnel Management is requiring **all** carriers, regardless of whether the plan is considered grandfathered or not under the ACA, to comply with these new regulations.

Some carriers may already comply with some of the requirements found in these regulations. However, this letter is intended to highlight the most important ways in which these regulations may impact the way you handle claims and appeals.

Claim Processing and Appeal Requirements

Generally, the new regulations specify time periods to decide to pay or deny a benefit claim and to decide appeals of adverse benefit determinations. The ACA identifies four categories of benefit claims: Urgent Care requests; Pre-Service claims; Post-Service claims, and Concurrent Care decisions.

**1. Urgent Care request (*)**

An urgent care request is any service that if not quickly decided could seriously jeopardize the member's life or health or the member's ability to regain maximum function. A claim is also an urgent care request if in the opinion of a physician with knowledge of the member's medical condition would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request, or if that physician says the individual's condition constitutes an urgent care claim.

What you must do:

- Provide a decision as soon as possible but no later than 24 hours after receipt of the request. You may convey this information verbally – over the telephone – unless the member has expressly requested a written notice.
- If the member fails to provide sufficient information for you to determine whether the service is covered then you must notify the member within 24 hours after receiving the claim of the specific information necessary to complete the claim. The member must then be given at least 48 hours to provide the needed information.

- Notify the member of your benefit determination as soon as possible but no later than 48 hours after the earlier of 1) your receipt of the specified information, or 2) the end of the time period given the member to provide the requested additional information.

Members must be able to request expedited review of an urgent care claim both verbally and in writing, and all claims information (including notification of benefits determination) must be transmitted from you by telephone, facsimile, or another timely method.

**2. Pre-Service Claims**

A pre-service claim is any claim for a benefit that must be approved in advance of obtaining medical care, such as precertifications, prior approvals, and required referrals.

What you must do:

- You must notify the member of your benefit determination within 15 days of receipt of the claim.
- You may extend this period one time up to an additional 15 days if you (1) decide the extension is necessary due to matters beyond your control, e.g., the member fails to provide sufficient information, and (2) notify the member within the initial 15-day period of the circumstances requiring the delay and the date by which you expect to make your decision. If the extension is required because the member failed to submit all of the information necessary to decide the claim, then you must give the member at least 60 days to provide the needed information.
- If a member or authorized representative fails to follow your procedures for filing a pre-service claim, you must notify them (verbally or in writing) of the mistake within 5 days following the failure (within 24 hours for urgent care requests)
- You must also notify the member of a failure to follow pre-service claim procedures when the request (1) is received from a person or unit that customarily handles benefit matters; and (2) names a specific member, specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

**3. Post-Service Claims**

A post-service claim is any claim that is not a pre-service claim.

What you must do:

- You must notify the member of your benefit determination within 30 days of receipt of the claim.
- You may extend this period one time up to an additional 15 days if you (1) decide the extension is necessary due to matters beyond your control, e.g., the member fails to provide sufficient information, and (2) notify the member within the initial 30-day period of the circumstances requiring the delay and the date by which you expect to make your decision. If the extension is required because the member failed to submit all of the information necessary to decide the claim, then you must give the member at least 60 days to provide the needed information.

**4. Concurrent Care Decisions and Continued Coverage Throughout the Appeal**

The regulations require you to provide continued coverage of approved ongoing treatment while an internal appeal is pending. You may not reduce benefits or terminate such a course of treatment without

providing advance notice and providing the member an opportunity to appeal and obtain a determination before the reduction or termination goes into effect.

If a situation involving a concurrent care decision is also an urgent care request, then you must notify the member of your benefit determination within 24 hours of receipt of the claim (provided that you receive the claim at last 24 hours before the end of the relevant period of time or number of treatments).

**Providing Free Evidence and Any New Rationales to the Member before Reconsideration**

You must provide members with free copies of any new or additional evidence you considered, relied upon, or generated in connection with the claim. The regulations require you to provide this information as soon as possible and sufficiently in advance of the date on which your reconsideration decision is due.

If the reconsideration is based on a new or additional rationale, then you must provide this rationale free of charge to the member as soon as possible and sufficiently in advance of the date on which your reconsideration decision is due.

**Independent and Impartial Claims Review and Avoiding Conflicts of Interest**

The new regulations stipulate that plans and issuers must ensure that claims and appeals decisions are independent and impartial. To this end, regulations impose the following requirements:

- The individual who decides the reconsideration under your plan must consult with a health care professional with training relevant to the claim for any adverse benefit determination that is based in whole or in part on medical judgment, including whether a given treatment is experimental, investigational, or not medically necessary or appropriate.
- Regardless of whether you relied on the advice of an expert in making a benefit determination, you must still identify for members any medical or vocational experts whose advice you obtained in connection with a member's adverse benefit determination.
- No health care professional considered in the initial adverse benefit determination may be involved in the reconsideration process. Nor may a health care professional involved in the reconsideration be the subordinate of anyone consulted in connection with the initial adverse benefit determination.

**Notification in a Culturally and Linguistically Appropriate Manner (*)**

The new regulations require you to provide all relevant claims notices in a culturally and linguistically appropriate manner. For plans with fewer than 100 participants at the beginning of a plan year, this means providing notices upon request in a language other than English if 25 percent or more of all plan participants are literate only in that language. For all other plans, this means providing notices upon request in a language other than English if the lesser of (1) 500 or more participants or (2) 10 percent or more of all plan participants are literate only in that language.

If you are required to provide notices upon request in a language other than English, then you must also do the following:

- Include a statement on the English versions of all notices that is written in the non-English language and offers notices in the non-English language;
- Provide all subsequent notices in the non-English language once an individual requests notices in that language; and

- Provide any other form of customer service (such as a hotline) in the non-English language.

Additionally, the new regulations state that your notices must include the following: **(*)**

- Any notice of an adverse benefit determination must include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning
- Any notice that includes the reason or reasons for the adverse benefit determination or for the decision on reconsideration must also include (1) the denial code and its corresponding meaning, and (2) a description of your standard, if any, that was used in denying the claim. A reconsideration decision must include a discussion of the decision.
- You must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal. OPM will provide updated model brochure language to help you meet this requirement.

**Rescissions**

The interim final regulations state that any adverse benefit determination is appealable, and they change the definition of "adverse benefit determination" to include any form of rescission. The regulations use a definition of rescission that does not include retroactive disenrollment for failure to pay premiums. Consequently, disenrollment for failure to pay continues to be both permissible and not subject to appeal under the new regulations. However, the new rules and the definition of rescission will have the following affects on Carriers' procedures regarding other forms of retroactive disenrollment:

(1) The Act generally provides that carriers can retroactively disenroll a covered individual for failure to pay, for fraud, or for an intentional misstatement of fact. However, the Department of Labor has subsequently published Questions and Answers that permit retroactive elimination of coverage due to delay in administrative record-keeping. It also permits retroactive termination back to the date of an event that triggers loss of eligibility (e.g., divorce) if the plan is not made aware of an individual's change in eligibility.
(2) The carrier can only rescind coverage (even in these narrow circumstances) after giving the covered individual 30 days' notice.
(3) Disenrollment for failure to pay is not appealable to OPM (no change), but any disenrollment for fraud or for an intentional misstatements of fact is a an appealable adverse benefit determination.
(4) Carriers must provide coverage until the end of any appeal, including any appeal of a rescission.

**Not Complying with these Regulations (*)**

If you do not strictly adhere to these requirements for appeals and reviews then the member is deemed to have exhausted the internal claims and appeals process. This means that the member may immediately initiate an external review with OPM.

We encourage you to review the new regulations and other regulations relevant to this carrier letter. In addition to the regulatory changes mentioned in this carrier letter, these regulations may contain requirements that we have not included in this letter because we already expect your claims procedures to comply with those requirements. If you have any questions concerning your obligations under the new regulations, please contact your contract specialist.

Sincerely,

William B. Zielinski
Associate Director
Retirement and Benefits

**(*)** Since we drafted this guidance, the Department of Labor issued interim procedures for internal claims and appeals (Technical Release 2010-02) that grants a grace period until July 1, 2011, for a group health plan that is working in good faith to implement these additional standards but does not yet have them in place. The sections referenced with an asterisk **(*)** are given this grace period.