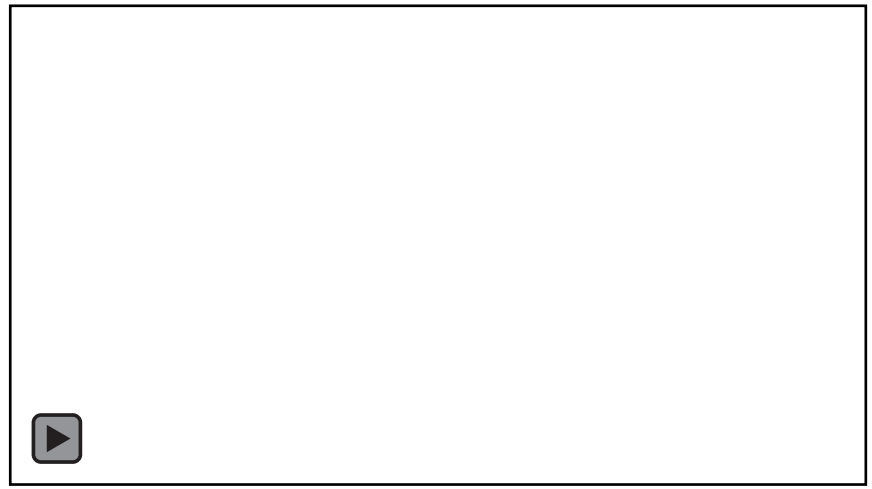
Navigating the Medical Appeal Process for Self-Insured Employer Plans



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Agenda

- Issue Description
- Case Example
- Appeals Process
- Types of Appeals
- Time Limits
- Observations
- Participant Issues
- Ideas

Issue Description

- What are the reasons behind the low health plan appeal rates and the extent to which health benefit plan participants may lack information or an adequate understanding of the claim procedure requirements?
- Do claim denials, including Explanation of Benefits (EOB) forms, and Advanced EOBs, adequately inform plan participants of the specific reasons for adverse benefit determinations in language calculated to be understood by lay persons?
- What information or assistance may be needed to enable participants to perfect their claims, their appeal rights, and their rights to obtain documents and information?
- What role do plan administrators, insurers and claims administrators have in the claims and appeals process?
- Whether unique issues or concerns arise with respect to prescription drug claims and appeals?

Case Example

Patient background: Cancer patient that had previously finished chemotherapy at the beginning of the plan year. Had a chest port and once a month had to be admitted to the hospital for an infusion.

- Patient appealed a denied service to remove the chest port, and shift to an injection dosage for adjuvant therapy medication.
- Patient leads an active lifestyle and complained of pain and sensitivity due to where the port was located. Concern for risk of infection with the port.
- The drug that would be more conducive to an active lifestyle was not on the preferred list; provider would need to provide medical necessity indicating the preferred drug wasn't tolerable.
- The preferred drug took extra time to administer. It was painful and more expensive than the new requested drug. More side effects.
- Provider notes did not support the need to shift to an alternate treatment.

Case Example Cont'd

Member Experience

- Confusion and frustration on how the appeal process works and why claim denied
- Didn't know how to appeal and where to file the appeal, and what needed to be included
- Lengthy process
- Insurance carrier was providing conflicting information
- Didn't understand why their employer was involved and why an exception couldn't be made
- Claim went through appeal process and still denied

Employer Experience

- Timeframe to review and make a decision on the appeal is short
- Employer is put in the middle and typically doesn't have the medical expertise needed
- Required a third-party medical review to provide an opinion for consideration
- Negative employee experience with denied appeal decision and the employer was involved in the personal details

Appeals Process for Self-Insured Employer Plans

First Level Appeal

If initial determination results in a denial, members are informed with appeal rights and instructions to file with the medical carrier.

Second Level Appeal

If the claim is denied during 1st level appeal, the member is referred to their employer who may partner with an Independent Review Organization (IRO).

External Review Process

Finally, if the member is not satisfied with the employer's decision, they may request an external review through an Independent Review Organization with the medical carrier.

Appeal Types

Urgent Care requires prompt attention to avoid adverse consequences but does not pose an immediate threat to life

Pre-Service Claims require prior authorization prior to receiving

Post Service Claims filed after service has been received

Concurrent Care Claims requires ongoing course of treatment for a specific period of time

Appeal Time Limits

Type of Claim	1st level Urgent Care	1st level Pre - Service	1st level Post - Service	2nd level Pre - Service	2nd level Post - Service	Concurrent Care Claims	External Review Program
Appeal Reviewer	Claim Admin.	Claim Admin.	Claim Admin.	Company*	Company*	Claim Admin.	IRO (through Insurance)
Participant Appeal Deadline	180 days from receiving adverse benefit determination	180 days from receiving adverse benefit determination	180 days from receiving adverse benefit determination	60 days from receipt of 1st level appeal decision	60 days from receiving 1st level appeal decision	24 hours prior to end of approved treatment	4 months after receiving Company decision
Employer/Insurance Decision Due	72 hours	15 days	30 days	15 days	30 days	24 hours from receipt of request	Standard External Review - 45 days Expedited External Review - 72 hours

*Company partners with an Independent Review Organization (IRO) that helps examine 2nd level appeals

Observations

Member/Employee

- Members appreciate the right to appeal a claim when they don't agree with a claim decision
- Prior authorizations are not always filed by provider, or filed timely
- Inconsistent education between providers and insurance about what is required to make claim decisions or appeal a claim
- Member confusion on how and where to file an appeal
- Poor or confusing language in letters of denial to members
- Lengthy process while a member is going through medical condition

Employer

- Missed deadlines for appeals by members or providers
- Potential negative employee experience with overall appeal decisions
- Communication barriers with diverse workforce population
- Employer is not a medical professional and has to partner with IRO to make decisions
- Members do not always have an advocate to help support their appeal process
- Out of Network Provider appeals that don't agree with Insurance reasonable/customary rates

Participant Issues

- Participant Awareness of Their Rights?
  - What are their sources of information?
  - Explanation of Benefits
  - Summary Plan Description – e.g., on two pages of 100+ page SPD
- Mechanism to Appeal?
  - Written submission
- Basis for Denial?
  - Claims Administrator Policy, Procedure, Guidelines
  - Claims Administrator Exclusion Policy for Certain Billing Codes
- Timeliness

DOL Reg. §2560.503-1(g)(1)(v)(A)

- “If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request”

PWBA Notice, 12/17/2001—Questions and Answers on the Benefit Claims Procedure Regulation, Q/A-C16

"The regulation provides that if an internal rule, guideline, protocol, or similar criterion was relied upon in making an adverse benefit determination, the notification of the adverse benefit determination must either set forth the rule, guideline, protocol, or criterion or indicate that such was relied upon and will be provided free of charge to the claimant upon request. It would be sufficient, in the view of the Department, in such a case, to indicate that an internal rule, etc., had been relied upon without specifying the identity of the specific rule and that the specific rule, etc. would be furnished to the claimant upon request. A notice that merely indicates, however, that a rule, guideline, protocol, or similar criterion may have been relied upon does not provide the claimant any specific information about the basis on which his or her claim was decided. Inasmuch as plans will know in every instance what rules, protocols, guidelines, etc. were relied upon in making a determination, providing an indication whether such was relied upon should not be difficult. Moreover, the Department is concerned that the routine inclusion of such a statement in all adverse benefit determination notifications may undermine the significance of the required disclosure. See section 2560.503-1(g)(1)(v) (A). For similar reasons, a general statement in an adverse benefit determination notice would not be considered as satisfying the requirements of section 2560.503-1(g)(1)(v) (B). Also see section 2560.503-1(j)(5)(i) and (ii)."

Ideas

- Participant Awareness of Their Rights
  - Single, Stand-Alone Page Prominently Describing Next Step
  - With EOB – or on EOB
  - Unique-colored paper
  - Refer to SPD for more details
- Pre-Appeal, Third-Party Phone Number – e.g., provider-peer-to-peer phone access
  - Revise carrier and provider initial deadlines for incomplete or additional information requests (allow more time to exchange information before denying)
- Patient Navigator
- Electronic Submission Form Option – with status indicator (maybe QR code on stand-alone form)
- Billing Codes and Related Exclusion Policy Must Be Defined

Questions