

Healthcare Reform Appeal Timeline

Compliance Plan Anniversary Dates
July 1, 2011 thereafter

The Affordable Care Act will support and protect consumers; and patients will be in charge of their care. The Obama Administration is announcing new regulations that will allow consumers to appeal decisions made by their health plans and the availability of resources that will be sued to help give consumers more control of their health care decisions. The new regulations give consumers the right to appeal decisions, including claim denials and rescissions made by the health plans. For the first time, the right to appeal decisions made by their health plan to an external independent decision-maker will be required to meet new standards. The fees for the external review process are currently under the plan's responsibility. Grandfathered health plans are not subject to the external appeal regulations.

Sample Appeal Guidelines

Claim Administrator will conduct a full and fair review of your appeal. The appeal may be reviewed by:

1. an appropriate individual(s) who did not make the initial benefit determination; or
2. a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if the denial is maintained, the appellant will receive a written explanation of the reasons and facts relating to the denial.

Appeal of Emergent Care Request for Benefits (Adverse Notification Determination Prior to Claim Submission)

Any person receiving a copy of Medical Care Management's adverse determination may appeal in writing to Medical Care Management. All available medical information must be provided at no cost to the Plan. Medical Care Management's determination will be reviewed by an appropriate licensed certified specialist who has not previously reviewed the case. All parties who were notified of the original determination will be notified of the appeal decision.

Appeal of Urgent/Emergent Request for Benefits (Adverse Notification Determination)

Type of Request for Benefits or Appeal	Business Hours/Days
If the appellant's information is incomplete the claim administrator will send the declination letter within:	24 hours
The appellant must provide a completed information request within:	48 hours after receiving the declination
If the request for emergent benefits is complete and not approved the claim administrator will send a Notification denial within:	72 hours
If the request for emergent benefits is not complete and resubmitted and is not approved, CLAIM ADMINISTRATOR will send a Notification denial within:	48 hours after receiving the completed request
If the appellant appeals the adverse notification determination or declination of notification, the must appeal within:	180 days after receiving the denial
Upon receipt of the appeal review, CLAIM ADMINISTRATOR will notify the appellant of the decision within:	72 hours following the receipt of your appeal and required

Appeal of Urgent/Emergent Request for Benefits (Adverse Notification Determination)

Type of Request for Benefits or Appeal	Business Hours/Days
If the Appellant's request an Independent Review Organization, (IRO), the external review appeal request must be submitted for the review within:	120 days of receipt of the original denial or response to your appeal
The IRO will complete the review of a non emergent claim or benefit appeal within:	45 days
The IRO will complete a requested expedited review of an emergent claim or benefit appeal within:	72 hours

Appeal of Pre-Service Request for Benefits (Pre-Determination)

Pre-Service Request for Benefits: a Pre-Determination Request for Benefits which the Plan must approve or in which you must notify the CLAIM ADMINISTRATOR before non-Urgent Care is provided.

Appeal of Pre-Service Request for Benefits (Pre-Determination Request)

Type of Request for Benefits or Appeal	Business Hours/Days
If the request for a pre-service review does not contain clean claim information, CLAIM ADMINISTRATOR will notify the appellant within:	5 days
If the request for pre-service review does not include the necessary clinical information for review, CLAIM ADMINISTRATOR will notify you within:	15 days
The appellant must then provider completed information within:	45 days after receiving an extension notice*
The appellant must appeal the denial no later than:	180 days after receiving the denial
CLAIM ADMINISTRATOR will notify you of the first level appeal decision within:	15 days after receiving the first level appeal
The appellant must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
CLAIM ADMINISTRATOR will notify you of the second level appeal decision within:	15 days after receiving the second level appeal*
The appellant may request the appeal be submitted to an Independent Review Organization, (IRO). The External Review Request must submitted within:	120 days of receipt of the original denial or response to your appeal
The IRO must complete the review of a non emergent claim or benefit appeal within:	45 days
The IRO must complete a requested expedited review of an emergent claim or benefit appeal within:	72 hours

* A one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control

Post-Service Claims Appeal

If a claim for benefits is wholly or partially denied, an Explanation of Benefits (EOB) will be furnished to the covered individual and the provider of services. This EOB will give the reason(s) the claim was denied. If the covered individual or provider of services does not agree with the claim decision or alleges that a contractual prompt payment requirement was not followed in the administration of a claim, he or she may submit an appeal. Relevant information supplied by the covered individual or healthcare provider should be included with the appeal.

For claims denied or partially denied for not being notified, the appeal must include:

- the admission history and physical;
- the discharge summary; and
- the operative and pathology reports (if applicable).

An appeal requested without proper documentation may not be considered. All written appeals should be sent to the Plan Administrator’s address printed on the Medical/Prescription ID cards. These appeal provisions shall be applicable where a provider makes a complaint that a prompt payment contract was not followed.

The appealing party will be notified in writing of the results of an appeal for failure to provide Notification, and/or a denial or reduction in benefits after receipt of all necessary information to make a determination. Failure to provide such written notice will not grant the appeal. All available medical information must be provided at no cost to the Plan. The Plan Administrator shall be under no obligation to respond to an appeal of a claim based upon complaints that have previously been addressed by a prior appeal.

If the individual does not agree with the decision, the appeal may be elevated per plan document guidelines. The final decision will be in writing and will include specific references to the Plan provisions on which the decision was based.

Post-Service Claims	
Type of Claim or Appeal	Business Hours/Days
If the appellant’s claim is incomplete, CLAIM ADMINISTRATOR will notify the appellant within:	30 days
The appellant must then provide completed claim information within:	45 days after receiving an extension notice
The appellant must appeal the claim denial no later than:	180 days after receiving the denial
CLAIM ADMINISTRATOR will notify the appellant of the first level appeal decision within:	30 days after receiving the first level appeal
The appellant must file the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The appellant will be notified of the Second level appeal decision generally within:	30 days after receiving the second level appeal
The appellant may request an appeal be submitted to an Independent Review Organization, (IRO). This request must be submitted for the review within:	120 days of receipt of the original denial or response to your appeal
The IRO must complete the review of a non emergent claim or benefit appeal within:	45 days
The IRO must complete a requested expedited review of an emergent claim or benefit appeal within:	72 hours

Update on Claim Procedure Rules Enacted as Part of Healthcare Reform

1. Updated and standardized EOB information
2. Full description of the plan’s claims procedures
3. Specific reasons for denials including guidelines used to make decisions
4. Participants have access to all documents and records used in making the decision—medical consultants used in making the decision must be disclosed

Filing Claims

1. Benefit plans must have reasonable procedures for the filing benefit claims
2. Describe all claims procedures and time framed in the SPD