

Appeals Frequently Asked Questions

Have the Appeals provisions of the Affordable Care Act been fully implemented?

1/9/12: Yes. The provisions had varying implementation effective dates ranging from Sept. 23, 2010 to Jan. 1, 2012.

What has changed or is new in the appeal process?

1/9/12: New requirements include:

- A broader definition of “adverse benefit determination” (ABD) to include a rescission of coverage
- Improved member adverse benefit determination notices that explain new federal external review rights when applicable, offer diagnosis and treatment code information upon request, provide information regarding consumer assistance for the appeals process, and in specified counties, offer provision of notices in culturally and linguistically appropriate languages
- Additional criteria to ensure members receive a full and fair review, including the opportunity to review their file and present evidence
- New conflict of interest criteria to guarantee the impartiality of the decision-maker.

Do the Appeals provisions impact individual plans?

1/9/12: Yes. To address certain relevant differences in the group and individual markets, health insurance issuers offering individual health insurance coverage must comply with new requirements.

- The scope of the internal claims and appeals process has been expanded to cover initial eligibility determinations. This protection is important since eligibility determinations in the individual market are frequently based on the health status of the applicant, including pre-existing conditions.
- Only one level of internal appeals may be required. This allows the claimant to seek either external review or judicial review immediately after an adverse determination is upheld in the first level of internal appeals.
- Health insurance issuers must maintain records of all claims and notices associated with their internal claims and appeals processes and make such records available for examination upon request, free of charge.

ABD/EOB Changes

What changes did customers and members begin seeing on July 1, 2011?

1/9/12: Additional language was added to ABDs (including EOBs) to further explain internal appeal and external review rights and provide information regarding consumer assistance or ombudsman services for the appeals process.

Did plans that are grandfathered see these changes?

1/9/12: With limited exception, changes to ABDs were made for all health plans.

Do EOBs have a new design or look?

1/9/12: We introduced a new EOB design in 2012. The redesign is not due to health care reform requirements, but is the result of a decision to improve the member experience. The new EOB is more user-friendly, features more white space, clearer type and shaded boxes to highlight important information, and includes the required health reform content.

Claims and Continuation of Coverage

Are urgent care claims subject to more expedited review procedures?

1/9/12: Health plans and issuers must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as defined in the Department of Labor (DOL) claims regulations as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim, unless the claimant fails to provide sufficient information to make the determination.

If a customer delegates the appeal process to UnitedHealthcare, how will the external review process be handled?

1/9/12: If a customer delegates the appeal process to UnitedHealthcare, UnitedHealthcare will facilitate the external review process with the applicable external review organization.

What does the Act require in terms of the "continuation of coverage"?

1/9/12: The Act requires plans and issuers to provide continued coverage pending the outcome of an internal appeal. Plans must comply with the requirements of the DOL claims regulations, which generally prohibit a plan or issuer from reducing or terminating an ongoing course of treatment without providing advance notice and an opportunity for advance review.

External Review

What is the scope of the federal external review process?

1/9/12: The original broad scope of the claims eligible for federal external review was temporarily suspended until Jan. 1, 2014. As a result, administrative appeals are not currently eligible for federal external review. The federal external review process applies only to claims that involve medical judgment, as determined by the external review agent, or a rescission of coverage.

What is an example of a claim involving medical judgment?

1/9/12: Such a claim might pertain to:

- The appropriate health care setting for providing medical care
- Whether treatment is medically necessary or appropriate
- Whether the treatment involves "emergency care" or "urgent care"
- A determination that a medical condition is pre-existing

What are the options for a self-funded customer after the Independent Review Organization (IRO) has reviewed and made a determination?

1/9/12: The IRO's decision is binding. If the IRO overturns a denial, the service must be either authorized or paid.

Is it possible to customize external review to include another level of appeal "owned" by the client?

1/9/12: The decision of the IRO is binding for plans subject to reform requirements and these plans may not impose another level of 'mandatory' appeal/review.

When does an IRO get involved in the process?

1/9/12: Typically, IROs are engaged to conduct external review following completion of the internal appeals process.

Which IRO vendors does UnitedHealthcare use?

1/9/12: We have contracts with four vendors to support the External Review Program:

- Managing Care, Managing Claims, Boston
- Medical Evaluation Specialists, Boston
- Advanced Medical Review, Los Angeles
- Medical Review Institute of America, Salt Lake City

How were the IROs selected?

1/9/12: These vendors were selected because of their national accreditation for quality reviews, a wide national spectrum of specialist physician review networks and their ability to meet strict compliance requirements, including turnaround times and provider specialty match.

How do plans know whether to follow state or federal rules on external review?

1/9/12: Fully Insured plans in those states that do not have a federally compliant external review process must utilize the federal external review process. As of Jan. 1, 2012, 14 states were deemed to be non-compliant by the applicable federal agencies. That list is subject to change as states potentially change their external review laws.

Do we use the same IROs for clients who have Rx carved in as those with Rx carved out?

1/9/12: The existing rotation of IROs applies to Rx as well.

Language Literacy

How extensive is the requirement to provide ABDs and other notices in a “culturally and linguistically appropriate” language?

1/9/12: The federal government has identified states and counties that have 10 percent or more of their population, based on 2010 census data, literate only in Spanish, Chinese, Navajo or Tagalog. In these jurisdictions, the language requirement applies.

Does the requirement involve both written and oral translation?

1/9/12: ABDs must be issued in a culturally and linguistically appropriate manner upon member request, in the counties specified by the federal government. Oral translation services must also be offered.

If we need to translate any of the materials we send to customers or members, who pays the cost?

1/9/12: UnitedHealthcare will cover the costs when we handle the appeal. If self-funded customers handle their own appeals, they are responsible for the cost.

Treatment and Diagnosis Codes

What does the Act require in terms of providing treatment and diagnosis code information to members?

1/9/12: ABDs must include a statement notifying members of their opportunity to request treatment and diagnosis code information. Any request for diagnosis and treatment code information may not be (and is not) considered a request for an internal appeal or external review.