PPACA INTERNAL CLAIMS/APPEALS & EXTERNAL REVIEW COMPLIANCE CHECKLIST

(The following is a checklist of important components of PPACA's internal claims and appeals and external review rules)

- ☐ Does the plan/policy comply with ERISA's existing claims procedures?

- ☐ Are rescissions included as an adverse benefit determination (regardless of whether the rescission has an adverse effect on any particular benefit at the time)?

- ☐ Does the plan/policy provide that it will defer to the attending provider with regard to the decision as to whether a claim constitutes "urgent care"?

- ☐ Does the plan/policy provide the claimant (free of charge) with

  - ○ new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with the claim,

  - ○ any new or additional rationale for a denial at the internal appeals stage, and

  - ○ a reasonable opportunity to respond to such new evidence or rationale?

- ☐ Does the plan/policy provide that any of the hiring, firing, promotion or similar decisions involving claims personnel of the plan/issuer may not be based on the likelihood that the claims personnel will support the denial of benefits?

- ☐ Are claims and appeals notices under the plan/policy provided in a culturally and linguistically appropriate manner, i.e., does the plan/policy

  - ○ offer language assistance services,

  - ○ offer translation of such notices upon request, and

  - ○ provide statements on claims notices of the availability of language assistance in any applicable non-English language (meaning generally a common non-English language spoken in the county where the claimant lives, provided that 10% or more of the

population does not speak English well or at all, if such language is listed on the Department of Labor or Department of Health and Human Services website)?

- [ ] Do claims and appeals notices under the plan/policy

  - ○ provide information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), and a statement that the diagnosis and treatment codes (and corresponding meanings) are available on request;
  - ○ include the denial code and its corresponding meaning, and a description of the plan's or issuer's standard, if any, that was used in denying the claim (as well as a discussion of the decision, if the notice pertains to the final internal adverse benefit determination);
  - ○ provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
  - ○ disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act?

- [ ] Does the plan/policy provide that if the plan or issuer fails to strictly adhere to the claims and appeals procedures, the claimant is deemed to have exhausted the internal claims and appeals process and may move directly to court or an external review, except where the failure to strictly adhere to the claims and appeals procedures

  - ○ was de minimis,
  - ○ was non-prejudicial to the claimant's right to external review,
  - ○ was attributable to good cause or matters beyond the plan's or issuer's control,
  - ○ is not reflective of a pattern or practice of non-compliance by the plan or issuer, and
  - ○ was in the context of an ongoing good-faith exchange of information?

- [ ] Does the plan/policy allow a claimant to request a written explanation of both any alleged violation of the claims and appeals procedures by the plan/issuer and the plan/issuer's assertion that it meets the exception (discussed above) to the "strict adherence" standard, with the written response to such requests to be provided within 10 days?

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- [ ] Does the plan/policy provide that if an external reviewer or a court rejects a claimant's request for immediate review on the basis that the plan has met the exception to the "strict adherence" standard, the plan/issuer will notify the claimant with 10 days after such rejection of his or her right to resubmit to the plan/issuer and pursue an internal appeal of the claim?

- [ ] Does the plan/policy provide for external review either under an approved state external review procedure or under a federal external review procedure?

- [ ] If the plan is a self-insured plan, does the external review provided by the plan meet the following criteria:

  - ○ Within 5 business days of receipt of a request for external review, the plan must complete a preliminary review to determine if the claim is eligible for external review, with notice of determination of this review sent within 1 business day after completion;

  - ○ The plan must contract with at least 2 Independent Review Organizations ("IROs") by January 1, 2012, and with at least 3 IROs by July 1, 2012, and any particular IRO must be randomly assigned to any particular case;

  - ○ The plan must provide the assigned IRO with all documents and information on the claim under review within 5 business days of the claim's assignment to the IRO;

  - ○ The plan must provide that the IRO will decide the claim de novo; and

  - ○ The IRO must provide written notice of its decision within 45 days of the IRO's receipt of the external review request.

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