Vermont Department of Banking, Insurance, Securities & Health Care Administration

Division of Health Care Administration

Bulletin HCA-104

Independent External Review of Health Care Decisions

June 3, 1999

Regulation H-99-1, effective date July 1, 1999, implements the process for independent external review of health care decisions created by 8 V.S.A.§4089f. This will affect all health benefit plans offered in Vermont, defined as any "policy, contract, certificate or agreement entered into, offered or issued by a health insurer, as defined in 18 V.S.A. §9402(7), to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services." 8 V.S.A. §4089f (a)(1).

Summary of the Regulation

Within 90 days of exhausting the insurer's internal appeals process, an insured may request independent external review of an insurer's decision to deny, reduce or terminate health care coverage or to deny payment for a covered health care service. In addition to the requirement that internal appeals be exhausted, an appealable decision is one that concerns denial of a service that would cost at least $100.00 and is based on one of the following reasons: lack of medical necessity, limit on selection of a health care provider in a way that is claimed to be inconsistent with the plan or applicable law or regulation, experimental or investigational treatment or off-label use of a drug, and/or involves a medically-based decision that a condition is preexisting.

The insured must file a request for such an appeal with the Division of Health Care Administration. Before accepting the request and assigning it to an independent review organization, the Division will review the request to determine whether the service reasonably appears to be a covered service under the insured's contract, and that the submission is otherwise complete. The Division will notify the insured and insurer to submit information relevant to the appeal, and will then forward the information to the independent review organization. If the insured so requests at the time of filing, he or she may have a telephone conference with the independent review organization, the treating provider and a clinical representative of the insurer. Regulation H-99-1 should be consulted for the varying time lines for decisions regarding medical care not yet rendered, emergency and urgent situations, and other decisions. The decision of the independent review organization is binding on the insurer.

This process is not available to individuals appealing health care decisions made by Medicaid or Medicare programs, the Department of Corrections in relation to inmates, or

to mental health or substance abuse health care decisions. These have existing appeals processes mandated by law.

Impact on Insurers:

Personnel and Cost Issues

The insurer pays the reasonable and necessary costs of the external review by the independent review organization. Insurers must have personnel available 24 hours a day, seven days per week to assist the Division and independent review organizations in processing expedited appeals. These individuals must be prepared to immediately access, retrieve and deliver medical records and other information from internal appeals files to the Division staff member on call.

Without liability to insureds, insurers must continue services already being provided in the case of pending expedited appeals. In the case of services requiring preauthorization, insurers may be required to provide the service pending the outcome of the appeal. In the latter instance, however, the insured will be responsible for reimbursing the insurer if the insurer's denial is upheld.

Internal Appeals

Section 10.203 (D) of Department Rule 10 establishes standards for grievance review processes for managed care plans. Any health plans subject to and in compliance with the requirements of §10.203 (D) of Department Rule 10 are deemed to be in compliance with section 4 of Regulation H-99-1,"Internal Appeals." All other health insurers will need to adopt internal appeals procedures that incorporate the elements required by section 4 of Regulation H-99-1.

Form Changes and Effective Dates

As part of notification to insureds of adverse decisions on their internal appeals, all insurers need to provide insureds with the Division-approved description of processes for further review of complaints or appeals (see below). Inclusion of this information in denial letters should begin as soon as possible, and no later than July 1, 1999, as insureds receiving final denials on internal appeals within 90 days prior to July 1, 1999 will be eligible to use the independent external appeals process.

In addition to any necessary changes in descriptions of your internal appeals process, definitions of the following terms in all health benefit plan contracts must be consistent with Regulation H-99-1: "experimental or investigational services" H-99-1 §3K; and "medically necessary care" H-99-1§ 3T**.** Health insurance policies issued or renewed on or after July 1, 1999 must conform to the provisions of this regulation. Existing health insurance contracts or forms with terms affected by this regulation may continue to be used through June 30, 2000. If any provisions of the existing contracts or forms conflict

with provisions of this regulation, the Division and the independent review organization will use whichever provision is more beneficial to the insured.

Information to Be Sent to the Division

The Division must have a current list of names and contact information for informed health insurer personnel who will be the point of contact for independent external review requests and appeals. **Please note that in expedited appeals involving emergency situations, these contact persons must be prepared to immediately access, retrieve and deliver medical records and other information from internal appeals files to the Division staff member on call.** The Division must, at all times, have on file accurate contact information for insurer personnel who can respond immediately **seven days a week, 24 hours a day (including nights, weekends and holidays). It is the responsibility of the insurer to keep this list up to date at all times.**

Please make all necessary arrangements and mail this contact information to the following address as soon as possible, but no later than June 25, 1999:

External Appeals Program
Division of Health Care Administration
Vermont Department of Banking, Insurance, Securities and Health Care Administration
89 Main Street - Drawer 20
Montpelier, Vermont 05620-3601

Fax: 802-828-2949

Other Information

A copy of Regulation H-99-1 is enclosed. The Division will be developing relevant forms and consumer information materials. These will be posted on the Division's web site. The main address for the Department's web site is http://www.state.vt.us/bis/.

During business hours (7:45 A.M. to 4:30 P.M.), you may call the Division at 802-828-2900 with general questions or with information concerning specific appeals. A recording at the same number will provide directions for reaching Division staff after hours in the case of an expedited appeal.

Insurers must include the following Division-approved language in letters to insureds notifying them of decisions at the final level of internal review (the bolded items must be at least 16 point type, the remainder of the body text at least 12 point type). This information must also be given verbally when the decision on internal appeal is conveyed in a telephone call to the insured:

NOTICE OF RIGHT TO APPEAL YOUR HEALTH INSURER'S FINAL DECISION

You may have a legal right to have our decision reviewed by an organization that is neutral. This is called Independent External Review.

You must ask for this review no later than 90 days after receiving this notice.

Call the Division of Health Care Administration at 800-631-7788 to ask for this review. If it is not an emergency, call between 7:45 a.m. and 4:30 p.m., Monday through Friday. If it is urgent or an emergency, call 24 hours a day, 7 days a week, including holidays. The recording will tell you how to reach the person on call.

Division of Health Care Administration
External Appeals Program
Vermont Department of Banking, Insurance, Securities and Health Care Administration
89 Main Street - Drawer 20
Montpelier, Vermont 05620-3601

800-631-7788 or 802-828-2900

If you are appealing the denial of a mental health or substance abuse service, call the Division of Insurance of the Department of Banking, Insurance, Securities and Health Care Administration at 802-828-3301. If it is not an emergency, call between 7:45 a.m. and 4:30 p.m., Monday through Friday. If it is urgent or an emergency, call 24 hours a day, 7 days a week, including holidays. The recording will tell you how to reach the person on call.

The Office of Health Care Ombudsman can provide information and help with appeals.

The Office of Health Care Ombudsman
P.O. Box 1367
264 North Winooski Avenue
Burlington, Vermont 05402

Voice: Toll-free: 800-917-7787 or 802-863-2316

TTY: Toll-free: 888-884-1955 or 802-863-2473

Elizabeth R. Costle, Commissioner
Department of Banking, Insurance, Securities and Health Care Administration