DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

HHS Logo 1

TECHNICAL GUIDANCE- JUNE 22, 2011

DATE: JUNE 22, 2011

SUBJECT: INSTRUCTIONS FOR SELF-INSURED NONFEDERAL GOVERNMENTAL HEALTH PLANS AND HEALTH INSURANCE ISSUERS OFFERING GROUP AND INDIVIDUAL HEALTH COVERAGE ON HOW TO ELECT A FEDERAL EXTERNAL REVIEW PROCESS

This technical guidance sets forth instructions for electing and participating in a Federally-administered external review process administered by the U.S. Department of Health and Human Services (HHS). This technical guidance applies to health insurance issuers offering group and individual health coverage that are using a Federally-administered external review process in accordance with Technical Release 2011-02 ((TR 2011-02), available on the CCIIO website). This technical guidance also applies to self-insured, nonfederal governmental health plans and amends prior technical guidance pertaining to such plans that was released on September 23, 2010.[1] These provisions do not apply to plans and issuers that are grandfathered health plans.

Election of a Federal external review process

Self-insured nonfederal governmental plans and issuers using a Federally-administered external review process must either comply with 1) the HHS-administered process described in T.R. 2011-02, or 2) the private accredited IRO[2] process established by the Department of Labor and also described in T.R. 2011-02.

All health insurance issuers and self-insured nonfederal governmental plans using a Federally-administered external review process must submit the following information regarding their election of a Federal external review process to HHS via email at externalappeals@cms.hhs.gov by the earlier of January 1, 2012 or the date by which such plans and issuers use the Federal external review process:

1) For such issuers: Contact information for designated personnel in their appeals department, including name(s), mailing address(es), telephone number(s), facsimile number(s) and electronic mail address(es).

2) For such plans: Contact information for the plan administrator, including name, mailing address, telephone number, facsimile number, and electronic mail address.

[1] Prior technical guidance for self-insured nonfederal governmental health plans, released on September 23, 2010 is available at http://cciio.cms.gov/resources/files/technical_guidance_for_self_funded_non_fed_plans.pdf.
[2] The term IRO refers to an independent review organization.

3) For such issuers and plans: A statement as to whether they will be complying with the HHS-administered process or the private accredited IRO process.

Plans and issuers must notify HHS as soon as possible if any of the above information changes at any time after it is first submitted.

Additional instructions for participation in the HHS-administered process

Self-insured nonfederal governmental plans and issuers that choose to use the HHS-administered process should follow the instructions provided in "Technical Guidance for Interim Procedures for Federal External Review Relating to Internal Claims and Appeals and External Review for Health Insurance Issuers in the Group and Individual Markets under the Patient Protection and Affordable Care Act." This guidance was originally published on August 26, 2010 and is available at: http://cciio.cms.gov/resources/files/interim_appeals_guidance.pdf. Specifically, these health insurance issuers and self-insured non-federal governmental plans should follow the information under "Interim Federal External Review Process for Health Insurance Issuers in the Group and Individual Markets" (under Roman Numeral II beginning on page 4) with the following exceptions:

1) In accordance with the interim final rules implementing section 2719 of the PHS Act on July 23, 2010 (as amended), external review is available for adverse benefit determinations and final internal adverse benefit determinations as defined in 45 CFR §147.136(d)(1)(ii)(A), which include denials by plans and issuers that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational) and a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). These definitions of adverse benefit determinations and final internal adverse benefit determinations replace the language in the previous technical guidance.

2) The information requested to be sent to the externalappeals@cms.hhs.gov on page 5 of this previous technical guidance should be sent by plans and issuers under the jurisdiction of HHS that have chosen to use the HHS-administered process by the earlier of January 1, 2012 or the date by which such plans and issuers are using the HHS-administered process.

Instructions for participation in the private accredited IRO process

Technical Release 2010-01 issued by the Department of Labor on August 23, 2010, and modified by Technical Release 2011-02, describes the private accredited IRO process. Plans and issuers electing the private accredited IRO process should consult these technical releases, as well as any amendments that the Department of Labor makes to Technical Release 2010-01 (as modified) in the future, for instructions on how to participate in this external review process.[3]

[3] Department of Labor technical releases are available at www.dol.gov/ebsa/healthreform.