



December 2011

Thank you for informing us that you are electing the HHS-administered process for external review. The instructions in the “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” will provide you with next steps in this process. This guidance was originally published on August 26, 2010 and is available at:

http://cciio.cms.gov/resources/files/interim_appeals_guidance.pdf. Specifically, you 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 changes:

1) In accordance with the interim final rules implementing section 2719 of the PHS Act on July 23, 2010 (as amended on June 24, 2011), external review is available for adverse benefit determinations and final internal adverse benefit determinations by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan’s or issuer’s requirements for 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), as determined by the external reviewer; and a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). (*See* 45 CFR §147.136(d)(1)(ii)(A)) These definitions of adverse benefit determinations and final internal adverse benefit determinations replace the language in the technical guidance.

2) The information requested to be sent to externalappeals@hhs.gov on page 5 of this technical guidance should now be sent to externalappeals@cms.hhs.gov and electronically copied to disputedclaim@opm.gov and should be sent by the earlier of January 1, 2012 or the date by which you are using the HHS-administered process. This information includes:

1. The products which are subject to the HHS-administered process
2. Contact information for designated personnel in the appeals department of the issuer, plan or third party administrator including:
 - Name(s)
 - Mailing address(es)
 - Telephone number(s)
 - Facsimile number(s)
 - Electronic mail address(es).

3. In addition, contact information for a designated individual who will be available to address urgent care cases outside of normal business hours (including weekends and holidays).

Please submit any questions to externalappeals@cms.hhs.gov.

Thank you very much,

Ellen Kuhn
Director, Appeals Division
Consumer Support Group
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

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