12-2019

OFFICE OF THE COUNTY EXECUTIVE
ALL-EMPLOYEES MEMORANDUM

DATE: September 16, 2019

ALL EMPLOYEES MEMORANDUM

NEW INTERNAL APPEALS PROCESS AND EXTERNAL REVIEW PROCESS FOR THE EMPLOYEE MEDICAL HEALTH PLAN OF SUFFOLK COUNTY (EMHP)

Effective August 1, 2019

As a result of the recently negotiated Memorandum of Agreement (2019 MOA), the EMHP is no longer a grandfathered health plan under the federal health care law known as the Affordable Care Act (or ACA). As such, the EMHP is now required to comply with the Internal Claims and Appeals and External Review Processes required under the ACA. The new processes will be implemented for claims incurred[1] on or after August 1, 2019.

The current process that includes two levels of internal appeals will remain. These two levels of internal appeals will continue to be handled by the appropriate Claims' Administrator, referred to as the Third Party Administrator (or TPA). The TPAs subject to this process are Empire Blue Cross Blue Shield, WellDyneRx, and Beacon Health Options, (Appeals concerning Medicare prescriptions administered by Express Scripts, Inc. (ESI) follow Centers for Medicare and Medicaid Services rules – see your annual Welcome Packet from ESI for details). For example, if Empire BlueCross BlueShield ("EBCBS") denies services, the claimant must appeal to EBCBS twice before moving onto the next steps in the appeal process.

The law requires that after these two levels of internal appeals (except for Urgent Care claims where only one level of appeal is required) are "exhausted", the claimant[2] has a right to seek an External Review of the denial. **Before that External Review, the claimant still can appeal to the EMHP Labor/Management Committee** ("Committee"). However, this level of review is optional. If the claimant wants to proceed directly to External Review without appealing to the Committee, s/he may do so. The decision of the External Reviewer is final and binding and cannot be appealed to the Committee. However, if the claimant appeals to the Committee and is not satisfied with the decision of the Committee, s/he can still file a request for an External Appeal.

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[1] An expense is incurred on the date the service or supply is received.

[2] A "claimant", as used in this AEM, will mean the member, patient and/or appellant who is eligible for benefits under the EMHP in accordance with the Plan rules.

It is important to know that not all appeal denials are eligible for External Review. Those claims that are not eligible are set forth later in this AEM. Even though they may not be eligible for External Review, the denial can still be appealed to the Committee.

Below is a chart explaining the appeals process and attached a glossary of terms used in this process.

Claims that can be appealed are now broken out into four (4) categories:

- Urgent,
- Concurrent,
- Pre-service (e.g., pre-authorization) and
- Post-Service

Different time frames and deadlines apply to each of the different categories of claims. The time frames set forth indicate when the applicable TPA (EBCBS, WellDyneRx, or Beacon Health Options) must issue a decision on your claim or internal appeal.

Unless otherwise indicated, the following are the maximum time frames (calculated from the date of receipt) for making initial claims determinations and internal appeal determinations.

	Urgent[3]	**Pre-service**	**Post-Service**
INITIAL CLAIM DETERMINATION[4]			
Initial Benefit/Claim Determination[5] (Notice usually given as EOB) Response time by TPA	As soon as possible based on medical exigencies, but in no event longer than 72 hours (For an improperly filed claim, notice (including proper procedures for filing urgent care claim) will be given within 24 hours)	15 days (For an improperly filed claim, notice (including proper procedures for filing pre-service claim) will be given within 5 days)	30 days (may be extended by 15 days due to circumstances beyond the TPA's control; notification must be provided before the expiration of the initial 30-day determination period)
Concurrent Claim involving a decision to reduce or terminate an approved course of treatment,	Notification of the termination or reduction will be given sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.		
If additional information is needed, must be requested by TPA and Notice must be given:	As soon as possible but no later than 24 hours after receipt of claim	Before expiration of initial 15 day period	Before expiration of initial 30-day period

[3] In the case of an Urgent Care Claim, if a health care professional with knowledge of medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be the authorized representative.

[4]/[5] Remember all claims for benefits under the EMHP must be filed with the applicable TPA within one year of date of service. This means the initial filing of your claim or request for prior authorization ("Initial Claim Determination").

	Urgent[3]	Pre-service	Post-Service
Extension Time allowed if additional information is requested	Additional information must be provided within 48 hours. Notice will be provided earlier of receipt of information or end of 48-hour period.	Additional information must be provided by claimant within 45 days ("45 Day Period"). Notice must be provided the earlier of within 15 days following receipt of information or by the end of the 45-day period.	Additional information must be provided by claimant within 45 days ("45 Day Period"). Notice must be provided the earlier of within 15 days following receipt of information or by the end of the 45-day period.
INTERNAL APPEALS			
First Level Appeal			
Time Appellant has to file appeal of denial[6]	180 days of initial adverse determination (usually the EOB[7])		
Time Notice of Initial Review (Appeal) of the Adverse Benefit Determination must be provided	As soon as possible based on medical exigencies, but in no event longer than 72 hours	15 days	30 days
Concurrent	As soon as possible before the benefit is reduced or treatment is terminated		
Extension	None	None	None
Second Level Appeal			
Time Appellant has to file appeal of denial of First Level Appeal	There is only one level of appeal for Urgent appeals	60 days from date of Adverse Benefit Determination following First Level Appeal	
Time Notice of Review (Appeal) of the First Level Appeal Adverse Benefit Determination must be provided	N/A	15 days	30 days
Extension	N/A	None	None
Optional Voluntary Appeal (before to the EMHP Labor/ Management Committee)			
Time Appellant has to file appeal of denial	60 days from date of Adverse Benefit Determination following Second Level Appeal		
Time Notice of Optional	The Committee will make a determination no later than the date of		

[6] A "denial" is also referred to as an "Adverse Benefit Determination".
[7] Explanation of Benefits letter/form you received from the applicable TPA.

	Urgent[3]	Pre-service	Post-Service
Voluntary Appeal determination must be provided	the next Committee meeting (or date of second meeting if appeal is filed less than 30 days from next meeting or if more information is required). Notice will be provided within five (5) business days after determination is made.		
External Review			
Standard (Non-Urgent Care) Claim			
Time Appellant has to file request[8] for External Review	Must be filed within 4 months of final adverse benefit (second level internal appeal) determination [9] (if an Optional Voluntary Appeal is filed, this time is tolled until a decision is rendered on the voluntary appeal by the Committee)		
Timeframe notice of Preliminary Review of Standard Claim must be provided	Within five (5) business days receipt of request for external review of a standard claim, preliminary review will be completed to determine whether: ▪ Claimant is/was eligible under the Plan; ▪ Claim satisfies the requirements and is eligible for external review; ▪ Claimant has exhausted internal claim and appeals processes; ▪ Request is complete and all information has been provided. Claimant will be notified within one day of completion of review whether or not eligible for external review or to requested additional information. If request is complete and eligible for external review, TPA will assign to an accredited IRO.		
Timeframe for making final decision and notification	The IRO will provide notice of its final decision within 45 days after the IRO receives the request for the external review.		
Expedited External Review Of An Urgent Care Claim			
Timeframe notice of Preliminary Review of Urgent Care Claim must be provided	Immediately upon receipt of a request for expedited external review the TPA will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the Standard Claim external Review process). Claimant will be notified immediately whether or not eligible for external review or to request additional information. If request is complete and eligible for external review, TPA will assign to an accredited IRO.		

[8] The applicable TPA will coordinate the preliminary review of the request and if eligible, refer the claim to an Independent Review Organization ("IRO"). The cost of the IRO will be paid for by the Plan. Each of the plan's TPAs will have assigned an IRO that is accredited by URAC (or a similar nationally recognized accrediting organization) to conduct the external review.

[9] If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. For Urgent Care claims, this time frame begins to run after *first* level appeal determination.

	Urgent[3]	Pre-service	Post-Service
Timeframe for making final decision and notification	The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review.		

Internal Claims and Appeals Process - Requirements[10]

When it makes an *adverse benefit determination*, a plan must provide a claimant with the right to a full and fair review. The claimant must be given 180 days to file an appeal (1st level), and the plan requires that an appeal be filed in writing (except for *urgent care* appeals, which may be oral).

An **adverse benefit determination** means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan[11] or a determination that a benefit is not a covered benefit;
- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion;
- The limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or
- A rescission of coverage[12], whether or not there is an adverse effect on any particular health benefit.

Levels of Internal Appeals

- While only two mandatory levels of internal appeal are allowed, the Committee has decided to add a third, optional voluntary level of appeal, consistent with current practice. Once the applicable TPA renders its decision on the second level appeal the claimant may appeal to the Committee or request an External Review.

- After the claimant "exhausts" the first two levels of appeal, and the voluntary appeal to the Committee, the claimant may appeal the denial for External Review – see below.

External Review Appeals

Claimants may only seek External Review after receipt of a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny the initial claim in whole or part and a claimant has exhausted the Plan's internal claims and appeals process (remember - this requires filing two appeals with the administrator who rendered the initial "denial"; an appeal to the Committee is optional, not required).

Seeking External Review before Exhausting Internal Claims and Appeals Process

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[10] "Health Claims" mean major medical, hospital, prescription drug, mental health and substance use disorder services and/or treatments.

[11] Eligibility determinations will continue to be made by the Employee Benefits Unit ("EBU"). Appeals to the EBU must follow the same time frames set forth above.

[12] "Rescission of coverage" means the retroactive cancellation or discontinuance of coverage in cases of fraud/intention misrepresentation or due to non-payment of premiums, including COBRA premiums (e.g., due to a divorce of which Suffolk County was not notified until after the effective date of the divorce). These claims will be treated as post-service claims.

Under limited circumstances, a member may be able to seek external review before the internal claims and appeals process has been completed as follows:

- If the Plan waives the requirement, in writing, that the claimant completed its internal claims and appeals process first.

- In an urgent care situation. Generally, an urgent care situation is one in which the patient's health may be in serious jeopardy or, in the opinion of a health care professional, the patient may experience pain that cannot be adequately controlled while waiting for a decision on internal appeal.

- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and member may proceed to external review.

Claims Eligible for External Review

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an Independent Review Organization (IRO) only under the following circumstances:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The applicable TPA will determine whether a denial involves a medical judgment and is therefore eligible for External Review[13].

- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims **Not** Eligible for External Review

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.
- A determination that the claimant is not eligible for coverage under the terms of the Plan.
- Claims that are untimely, meaning request for review was not made within the four (4) month deadline for requesting external review.
- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).
- Claims that relate to benefits other than health care benefits.

Expedited External Review of an Urgent Care Claim

An expedited external review may be requested in the following situations:

- The adverse benefit determination regarding an initial claim involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the patient's

[13] The TPA will provide written notification to the claimant, which will address if the claim is not eligible for review or if more information is needed, within six (6) days of receipt of the claimant's request for External Review. If the request is for an expedited review, the Plan's TPA will expeditiously determine if the request meets the criteria summarized above and must immediately notify the claimant of the eligibility determination.

life or health, or would jeopardize his/her ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal.

- The "final" adverse benefit determination after exhausting the Plan's internal appeals procedure (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

The decision of the IRO in the External Review Process is final and binding on the Plan, its TPAs and the claimant. There are no further appeals after the External Review Process.

NOTE: All notices sent to claimants relating to Internal Claims and Appeal Review and External Review will contain a notice about the availability of Spanish, Chinese, Tagalog, Navajo language services. Assistance with filing a claim for internal review in Spanish, Chinese, Tagalog, Navajois available by calling the member services number on your identification card. Notices relating to internal review will be provided in Spanish, Chinese, Tagalog, and Navajoupon request.

SPANISH (Español): Para obtener asistencia en Español, llame al Empire 1-800-939-7515 TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa Empire 1-800-939-7515; Beacon Health 1-866-909-6472; WellDyneRx 1-855-799-6831.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 Empire 1-800-939-7515; Beacon Health 1-866-909-6472; WellDyneRx 1-855-799-6831。

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' Empire 1-800-939-7515; Beacon Health 1-866-909-6472; WellDyneRx 1-855-799-6831.

DENNIS M. COHEN
Chief Deputy County Executive

Distribution:
One copy per employee/retiree

Glossary of Terms:

A pre-service claim is a request that a service or treatment be approved (in whole or part) before it has been received.

An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan's TPAs will not deny benefits for these procedures or services if it is not possible for the

claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.

A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit or a request for an extension of a previously approved treatment or service.

A post-service claim is a request for a service or treatment that you have already received (and is not a Pre-Service Claim). Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- Be received by the Plan Administrator or TPA;
- Name a specific individual participant and his/her Social Security Number;
- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is NOT a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this AEM;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal; or
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan.

If a claim is not complete or lacks required supporting documents, the Plan Administrator or TPA, as applicable, will notify the claimant about what information is necessary to complete the

claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

A health care professional, for the purposes of the claims and appeals provisions, means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

A Notice of Adverse Benefit Determination is provided to you when the Claims Administrator denies your initial claim, in whole or in part. The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim.

A Notice of Adverse Benefit Determination Upon Appeal is a written (or electronic, as applicable) notice of the appeal determination that must be provided to you following the review of your appeal by the applicable TPA.