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Group Health Plans and Health Insurance Issuers: Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act

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## General Comment

See attached file(s)

## Attachments

**IRS-2010-0021-0010.1:** Comment on FR Doc # 2010-18043

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September 21, 2010

Submitted electronically at www.regulations.gov

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-9993-IFC, RIN 0991-AB70
P.O. Box 8016
Baltimore, Maryland 21244-1850

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration, Room N-5653
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
Attention: RIN1210-AB45

Internal Revenue Service
CC: PA: LPD: PR, Room 5025
P.O. Box 7604, Ben Franklin Station
Washington, DC 20044
Attention: REG-125592-10

**Re: AOTA Comments on Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act (File Codes OCIIO-9993-IFC, RIN 0991-AB70/ RIN 1210–AB45/REG–125592-10)**

The American Occupational Therapy Association (AOTA), the national professional association representing the interests of more than 140,000 occupational therapy practitioners, appreciates the opportunity to comment on the interim final rules that implement provisions of the Patient Protection and Affordable Care Act (P.L.111-148) regarding internal claims and appeals and external review processes.

In addition to a guarantee of external review, AOTA strongly supports the following specific provisions regarding *internal* claims and appeals procedures:

(1) The internal claims and appeals processes of plans and issuers must provide for full and fair review of adverse benefit determinations including rescissions of health care policies;

(2) In the case of urgent care claims, plans and issuers must notify a claimant of a benefit determination (whether adverse or not) as soon as possible but not later than 24 hours;

(3) A plan or issuer must provide a claimant, free of charge, with any new or additional information or rationale regarding a claim as soon as possible and sufficiently in advance of a final adverse benefit determination;

(4) Plans and issuers must avoid conflicts of interest by ensuring that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision;

(5) Plans and issuers must provide notice to enrollees in a culturally and linguistically appropriate manner (this is also applicable to external review);

(6) The failure of plans and issuers to "strictly adhere" to all the requirements of internal claims and appeals processes with respect to a claim will allow a claimant to seek external review including judicial review if necessary; and

(7) Individuals in urgent care situations and individuals receiving an ongoing course of treatment may proceed with expedited external review at the same time the internal appeals process is pursued.

**Recommendations to Improve the Interim Final Rule**

Occupational therapy providers have considerable experience with health insurers' processes for internal and external review of claims. Occupational therapy is a unique profession and it treats a wide variety of conditions, illnesses, disabilities and risk factors. Hence, knowledge and experience in occupational therapy and in the conditions it treats are critical to fair and judicious reviews in claims.

The interim final rule provides good guidance by emphasizing the National Association of Insurance Commissioners' model law (© 2010 National Association of Insurance Commissioners Model Regulation Service—April 2010.)

AOTA cannot overemphasize the importance of having Occupational Therapy practitioners included in the membership of all Individual Review Organizations. In many instances, health insurance disputes focus on the medical necessity of critical ancillary services provided by OTs and other therapists. When a determination is being made related to the provision or non-provision of such a service, it is critical that knowledgeable, experienced practitioners/providers are part of the review and decision making process. Occupational therapy is a profession dedicated to the maximization of performance and function so that individuals can live healthy and productive lives. Access to needed OT services can ensure that businesses have a cadre of a healthy and contributing, long-term employee, that children with autism or sensory disorders receive care that helps them develop optimally, and that people adapt to disability, illness or other problems to maintain independence and productive living.

**Standards for External Review and the Importance of the Involvement of an Occupational Therapy Practitioner if the Adverse Benefit Determination Relates to Occupational Therapy, Rehabilitation, or Habilitation Services**

For health insurance coverage, if a state external review process that applies to and is binding on an issuer includes – at a minimum – the consumer protections in the National Association of Insurance Commissioners (NAIC) Uniform Model Act in place on 7/23/10, then the issuer must comply with the state external review process and not with the federal process. (The External Review model adopted 4/10 is available at: www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf) In that model act are concepts and requirements AOTA believes should be stressed by the federal requirements on states and in the future federal requirements.

The NAIC standards require the following and states are encouraged to make changes in their external appeals laws to adopt the NAIC standards before July 1, 2011.

1 **External review of plan decisions to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of covered benefit.**

2 **Clear information** for consumers about their right to both internal and external appeals – both in the standard plan materials, and at the time the company denies a claim.

3 **Expedited access** to external review in some cases – including emergency situations, or cases where their health plan did not follow the rules in the internal appeal.

4 **Health plans must pay the cost of the external appeal** under State law, and States may not require consumers to pay more than a nominal fee.

5 **Review by an independent body** assigned by the State. The State must also ensure that the reviewers meet certain standards, keep written records, and are not affected by conflicts of interest.

6 **Emergency processes for urgent claims** and a process for experimental or investigational treatment.

7 **Final decisions must be binding** so, if the consumer wins, the health plan is expected to pay for the benefit that was previously denied.

For AOTA, these guidelines are critical to an effective appeal. AOTA would like to see more specificity on definitions of "medical necessity, appropriateness, health care setting, level of care" and particularly on "effectiveness of covered benefit." All of these terms are the crux of determining whether or not to pay for treatment and should be carefully explicated so that consumers know on what basis their claims will be judged. For instance, "effectiveness of covered benefit" should be defined in terms of relationship to existing evidence and not applied randomly to individual claims. While some latitude is important for the reviewers to exercise professional judgment, there must also be some parameters to assure fair treatment for all insured.

The NAIC model also states:

In addition to the documents and information provided pursuant to the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

1. The covered person's medical records;

2. The attending health care professional's recommendation;

3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

4. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

5. The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

6. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; and

7. The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (1) through (6) to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

In the section in the interim final rule on investigational treatment reviews there is a requirement that the independent reviewers have experience in the practice area and the condition. AOTA believes strongly that such requirements should also apply to IRO's or whatever structures are conducting the independent external reviews. Peer reviewing is a standard used by many insurance providers and is also the practice in Medicare under the Maximus Federal Services review.

Having Occupational Therapy practitioners included in the membership of all Individual Review Organizations or available to be contracted with to review such claims will lead to more effective, efficient and streamlined processes for both the insurers and the insured. Use of qualified personnel from the profession under consideration in the review must be a standard for all state and federal review processes. When a determination is being made related to the provision or non-provision of such a service, it is critical that the involved practitioners/providers are part of the decision making process. Occupational therapy is a profession dedicated to the maximization of performance and function so that individuals can live healthy and productive lives and access should be determined not by other professionals (e.g., nurses or physical therapists) but by those familiar with the "applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations." AOTA would further comment that the word "medical" be deleted in any federal guidelines so as to convey more clearly that the intent is to cover physician and other professional societies and associations.

**Conclusion**

AOTA believes the interim final rules are a significant step forward in establishing appropriate requirements for internal and external reviews and appeals processes. Nonetheless, we believe that the rules could be further strengthened in significant ways as listed above. If you have any questions, please feel free to contact AOTA Federal Affairs Department directly at fad@aota.org. Thank you for your consideration of our comments.

Sincerely:

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