



Appealing Health Insurance Coverage Denials

Victoria Veltri, JD, LLM
State Healthcare Advocate
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Discussion Areas

- Patient rights – self vs. fully insured
 - Federal law
 - Connecticut law
 - Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program
 - What is OHA's role?
- Understand the key kinds of evidence needed to justify a treatment or service;
- Define and evaluate medical necessity, experimental and investigational status;
- Determine if an expedited appeal is necessary;
- Know the key elements of an effective argument;
- Monitor an appeal through the process;
- Know when to call Office of the Healthcare Advocate (OHA) for help.
- Review of the PPACA and MHPAEA

Patient Rights

Self vs. fully insured

- When considering the claims adjudication process, as well as options to contest an adverse determination, it is important to know whether a patient's insurance is self or fully insured.
- The distinction between the two determines which laws are applicable and what services must be covered.

Patient Rights

Self insured

- A self-insured (or self-funded) group health plan is one where the employer assumes the financial risk for its employees' health care benefits. Simply put, self-insured employers pay for each claim as they are incurred. Typically, self-insured employers will contract with a managed care organization (MCO) to administer the benefits.
- Self-insured plans are subject to federal law, but not state law and therefore do not have to offer benefits that include state mandates.

Patient Rights

Fully insured

- Fully insured plans are those where an employer and employee or an individual pay a premium to the insurer. The insurer assumes the financial risk for the services that members receive.
- Plans of this type are subject to federal *and* state law, and must include all of Connecticut's mandates.
- It's important to note that although the State of Connecticut employee plan is self-insured, it also includes all of Connecticut's mandates.

The Patient's Bill of Rights

- Health plans can no longer limit or deny benefits to children under 19 due to a pre-existing condition.
- Effective January 1, 2014 no one can have coverage denied or limited due to a pre-existing condition.
- Patients can choose the primary care doctor they want from the plan's network and women may select their OB/GYN as their PCP.
- Individuals under 26 may be eligible for continued coverage under their parent's health plan.
- Lifetime limits on most benefits are banned for all new health insurance plans.
- Insurers can no longer cancel coverage for an *honest* mistake on the application.
- Insurance companies must now publicly justify any unreasonable rate hikes.
- Imposes reasonable medical loss ratios on fully insured plans – 80% for small group and individual, 85% for large groups.
- Phases out annual limits on your health benefits by 2014.
- Prevents health plans from requiring higher co-pays or cost-sharing, as well as requiring prior approval, before seeking for out-of-network emergency room services.

Preventative Services

Effective September 23, 2010, non-grandfathered plans must cover the following services without cost sharing.

Covered Preventive Services for Adults

1. Abdominal Aortic Aneurysm
2. Alcohol Misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults over 50
7. Depression screening for adults

Preventative Services for Adults

8. Type 2 Diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk
11. Immunization vaccines for adults, including Hepatitis A , Hepatitis B , Herpes Zoster , HPV, Influenza, MMR, Meningococcal , Pneumococcal , Tetanus, Diphtheria, Pertussis, Varicella
12. Obesity screening and counseling for all adults
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
14. Tobacco Use screening for all adults and cessation interventions for tobacco users
15. Syphilis screening for all adults at higher risk

Preventative Services

Covered Preventive Services for Women, Including Pregnant Women

1. Anemia screening on a routine basis for pregnant women
2. Bacteriuria urinary tract or other infection screening for pregnant women
3. BRCA counseling about genetic testing for women at higher risk
4. Breast Cancer Mammography screenings every 1 to 2 years for women over 40
5. Breast Cancer Chemoprevention counseling for women at higher risk
6. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
7. Cervical Cancer screening for sexually active women
8. Chlamydia Infection screening for younger women and other women at higher risk
9. Contraception

Preventative Services

Covered Preventive Services for Women, Including Pregnant Women

10. Domestic and interpersonal violence screening and counseling for all women
11. Folic Acid supplements for women who may become pregnant
12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
13. Gonorrhea screening for all women at higher risk
14. Hepatitis B screening for pregnant women at their first prenatal visit
15. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
16. HPV DNA testing every three years for women 30 or older

Preventative Services

Covered Preventive Services for Women, Including Pregnant Women

17. Osteoporosis screening for women over age 60 depending on risk factors
18. Rh screening for all pregnant women and follow-up testing for women at higher risk
19. Tobacco Use screening and interventions for all women
20. Sexually Transmitted Infections (STI) counseling for sexually active women
21. Syphilis screening for all pregnant women or other women at increased risk
22. Well-woman visits to obtain recommended preventive services

Preventative Services

Covered Preventive Services for Children

1. Alcohol and Drug Use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children of all ages
4. Blood Pressure screening for children
5. Cervical Dysplasia screening for sexually active females
6. Congenital Hypothyroidism screening for newborns
7. Depression screening for adolescents
8. Developmental screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children at higher risk of lipid disorders

Preventative Services

Covered Preventive Services for Children

10. Fluoride Chemoprevention supplements for children without fluoride in their water source
11. Gonorrhea preventive medication for the eyes of all newborns
12. Hearing screening for all newborns
13. Height, Weight and Body Mass Index measurements for children
14. Hematocrit or Hemoglobin screening for children
15. Hemoglobinopathies or sickle cell screening for newborns
16. HIV screening for adolescents at higher risk
17. Immunization vaccines for children from birth to age 18, including: Diphtheria, Tetanus, Pertussis, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, HPV, Poliovirus, Influenza, MMR, Meningococcal, Pneumococcal, Rotavirus, Varicella

Preventative Services

Covered Preventive Services for Children

18. Iron supplements for children ages 6 to 12 months at risk for anemia
19. Lead screening for children at risk of exposure
20. Medical History for all children throughout development
21. Obesity screening and counseling
22. Oral Health risk assessment for young children
23. Phenylketonuria (PKU) screening for this genetic disorder in newborns
24. STI prevention counseling and screening for adolescents at higher risk
25. Tuberculin testing for children at higher risk
26. Vision screening for all children

Connecticut Mandates

Connecticut law requires that fully insured plans cover certain services or follow specific eligibility criteria. The list briefly identifies these mandates:

- Preexisting Condition Coverage
- Availability of Psychotropic Drugs for plans with mental health benefits
- Experimental Treatments for options that have completed Phase III clinical trials.
- Mental Health Parity
- Coverage eligibility on parent's plans for children must continue until the child marries, end CT residency, receives employer sponsored benefits or turns 26. Stepchildren have the same status.
- Group health insurance must offer coverage for comprehensive rehabilitation services
- If policy covers physical therapy, it must provide coverage for occupational therapy.

Connecticut Mandates

- Birth-to-Three
- Hearing aids for children 12 and under
- Medically necessary orthodontic processes and appliances for treatment of craniofacial disorders for children under 18
- Neuropsychological testing to assess the extent chemotherapy or radiation treatment has caused the child to have cognitive or developmental delays without pre-authorization
- Medically necessary general anesthesia, nursing, and related hospital services for in-patient, outpatient, or one-day dental services.
- Emergency medical care for the accidental ingestion or consumption of controlled drugs.
- Hypodermic needles and syringes with prescription
- Off-label cancer drugs
- Protein modified food and specialized formula

Connecticut Mandates

- Medically necessary equipment, drugs, supplies, laboratory and diagnostic tests for all types of diabetes, as well as outpatient self-management training.
- Diabetes Self-Management Training
- Continuation of ongoing coverage for medically necessary Rx that has been removed from formulary
- Prostate Screening
- Lyme disease treatment including not less than 30 days of IV antibiotic therapy, 60 days of oral antibiotic therapy, or both, and further treatment if recommended by a rheumatologist, infectious disease specialist, or neurologist.
- Pain Management
- If policy covers ostomy surgery, policy must also cover up to \$1000 per year for medically necessary ostomy-related appliances and supplies.
- Colorectal cancer screening
- Home health care including (1) part-time or intermittent nursing care and home health aide services; (2) physical, occupational, or speech therapy; (3) medical supplies, drugs and medicines; and (4) medical social services, subject to limitations.

Connecticut Mandates

- Ambulance Services and 911 Calls
- Benefits for isolation care and emergency services provided by mobile field hospitals.
- Coverage for health care services rendered to an injured insured person if the injury is alleged to have occurred or occurs when the person has an elevated blood alcohol level or is under the influence of drugs or alcohol.
- Baseline mammogram for woman 35 to 39 and one every year for woman 40 and older. Additional coverage must be provided for a comprehensive ultrasound screening of a woman's entire breast(s) if (1) a mammogram shows heterogeneous or dense breast tissue based on BI-RADS or (2) she is at increased breast cancer risk because of family history, her prior history, genetic testing, or other indications determined by her physician or advanced-practice nurse.
- Direct access to participating in-network ob-gyn for gynecological examination, care related to pregnancy, and primary and preventive obstetric and gynecologic services required as result of a gynecological examination or condition (includes pap smear). Female enrollees may also designate participating ob-gyn or other doctor as primary care provider.

Claim Management

- Suggestions for minimizing denials of claim submissions for reimbursement:
 - Confirm insurance coverage, including any secondary or tertiary coverage, with patient
 - Coordination of Benefits provisions can be complex
 - Initial submission should:
 - Be complete – include treating provider, ICD-9 (or 10), CPT and any necessary modifiers;
 - Be timely – failure to submit a claim in a timely manner may waive the patient's liability for the balance;
 - Be responsive – if a carrier requests additional information, respond as quickly as feasible to the request to permit the claim processing to continue.

Claim Management

- Keep track of your correspondence with the carriers concerning claim management and utilization review
 - When and who you spoke with, as well as the content of the communication
- Thorough documentation can be a critical tool in supporting an effective claim
- It can also bolster a case to overturn an adverse determination, depending on what the practice was told and by whom.

Adverse Determinations

- When a request for service is denied, if you don't receive the following from the carrier, request it:
 - Exactly what has been denied.
 - What is the basis for the adverse determination?
 - This may be plan design, medical necessity, experimental, etc.
 - Self vs. Fully insured?
 - Screening vs. diagnostic?

Adverse Determinations

C.G.S. 381-482(a) defines medically necessity as “health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.”

Adverse Determinations

C.G.S. 381-482a:

“For the purposes of this subsection, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.”

Adverse Determinations

Proving medical necessity

- It is important to remember that medical necessity must be determined using generally accepted standards of medical practice for whichever service has been requested, with supporting documentation from the clinical record.
 - Detailed documentation is critical to supporting medical necessity!
- Ensure that the criteria that carriers use in their utilization review process are consistent with the standards of practice, as well as law.

Mental Health/Substance Use Adverse Determinations

- Automatically considered urgent care requests
- Changes urgent request timeframe from 72 hours to 24 hours
- Enhances definition of clinical peer to mean one who holds a nonrestricted license in the same or similar specialty for the medical condition, procedure or treatment under review and:
 - for a child or adolescent substance use disorder mental disorder:
 - Holds a national board certification in child and adolescent psychiatry or child and adolescent psychology, and
 - Has training or clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, or
 - For an adult substance use disorder or an adult mental disorder, holds a national board certification in psychiatry or psychology, and has training or clinical experience in the treatment of adult substance use disorders or adult mental disorders.

Expedited Appeals

When is it appropriate to file an expedited appeal?

- If delaying the service or treatment would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, it would be appropriate to consider filing an expedited appeal.

Adverse Determinations

For concurrent reviews, “treatment shall be continued without liability to the covered person until the covered person has been notified of the review decision.”

Internal Appeals process

	Initial Determination	Initial Determination Extension	Missing Information	Failure to Meet Filing Procedures	Appeal Determination
Medical Necessity Reviews					
Prospective	15 days	15 days	Notification prior to the end of the initial benefit determination period. Must allow 45 days for receipt of missing information.	5 days	30 days
Concurrent	15 days	None	Notification prior to the end of the initial benefit determination period. Must allow 45 days for receipt of missing information.	5 days	30 days
Retrospective	30 days	15 days	Notification prior to the end of the initial benefit determination period. Must allow 45 days for receipt of missing information.	5 days	60 days
Expedited	72 hours	None	24 hours - must allow 48 hours for receipt of missing information.	24 hours	72 hours
Non-medically necessary reviews	30 days	15 days			20 bus. days + ext of 10 bus. days

External Appeals process

Eligibility Determinations

		Determination by:	Notification of ineligibility by:
Filing Deadline	Standard review – 120 days Expedited review - 120 days after adverse determination	Health carrier	Health carrier
Contract ineligible for external review process due to:			
- Dental, vision, self-insured non-governmental plan, other state, Worker’s Comp, Medicare/Medicaid		Commissioner	Commissioner
- No active coverage for DOS - Not covered benefit - Internal appeals not exhausted - Missing information or forms - Denial not based on medical necessity		Health carrier	Health carrier
Non-medically necessary reviews	30 days		20 bus. days + ext of 10 bus. days 28

External Appeals process

Eligibility Determinations				
Task	Completed by:	Standard review	Expedited Review	Notification to member by:
External Review Received – send to carrier	CID	1 business day (BD)	1 day	
Preliminary Review – Confirm member is covered, service is covered, internal appeals exhausted <i>or</i> is expedited, all forms received and completed correctly.	Health carrier	5 BD plus 1 BD to notify	1 day	Health carrier
Accepted for Full Review – Assign IRO & notify member of right to submit additional information	CID	1 BD	1 day	CID
Documents sent to IRO	Health carrier	5 BD	1 day	
Full Review process	IRO	45 days (20 days if experimental)	72 hours (5 days if experimental)	IRO

Upcoming changes to the Adverse Determination process

Public Act 13-3 included significant changes to the adverse determination process that become effective October 1, 2013. For mental health and substance use only:

- Mental health and substance abuse must be considered and processed as urgent care requests.
- For substance use treatment requests, insurers must use the ASAM PPC or internal criteria that are consistent with it.
- For mental health treatment requests for children or adolescents, insurers must use the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument or internal criteria that are consistent with it.
- For mental health treatment requests for adults, insurers must use the American Psychiatric Association or the most recent Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare or internal criteria that are consistent with it.

Upcoming changes to the Adverse Determination process

- The definition of “clinical peer” for the mental health and substance abuse adverse determination process for children will require that reviewers:
 - hold a national board certification in child and adolescent psychiatry or child and adolescent psychology, and have training or clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, or
 - For adult substance use or mental disorder, reviewers hold a national board certification in psychiatry or psychology, and have training or clinical experience in the treatment of adult substance use disorders or adult mental disorders.
- Insurers must use specific criteria that are more clinically appropriate and, if they use different criteria, must demonstrate that their criteria are equivalent to the statute and post it on their website with a detailed comparison. A link to these criteria must be included in each adverse determination.
- The Insurance Department shall prepare and issue report that states the methods used to check for mental health parity.
- Expedited review requests must be completed within twenty-four hours.

Upcoming changes to the Adverse Determination process

- The following apply to all utilization review processes:
- Codifies that a peer-peer following an initial adverse determination *does not constitute* an appeal. It instead is a conference.
- Brings Connecticut into compliance with federal law by requiring continuing coverage of ongoing treatment throughout the concurrent review and appeal process without liability to the member.
- Health insurers must post their criteria on their website, as well as a comprehensive comparison of the relevant clinical criteria to their own, if they don't use the professional criteria.



- ❑ Focus on assisting and educating consumers to make informed decisions when selecting a health plan
- ❑ Assist consumers to resolve problems with their health insurance plans
- ❑ Identify issues, trends and problems that may require executive, regulatory or legislative intervention – Systemic Advocacy

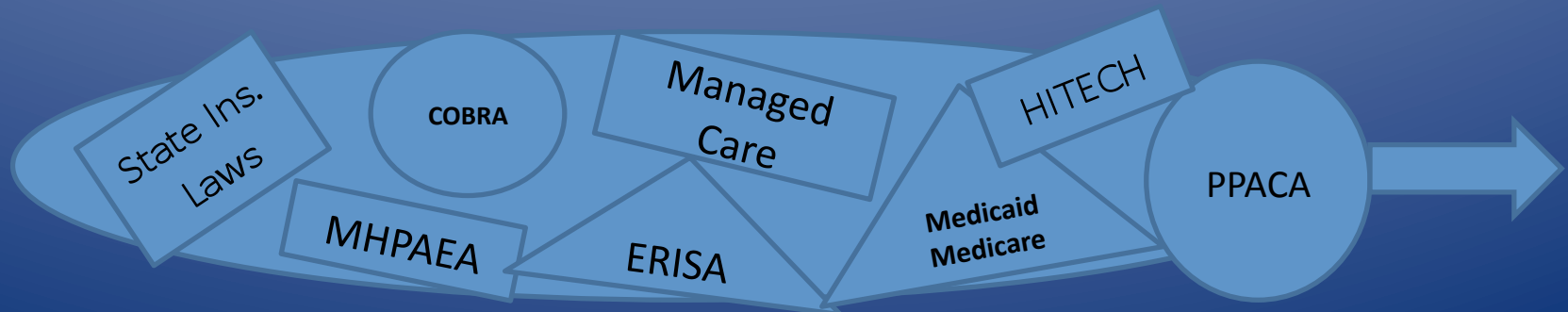
Our Work is Guided by Principles

- Principles for Policy Action
 - http://www.ct.gov/oha/lib/oha/documents/final_draft_-_oha_principles_for_determining_policy_action.pdf
 - Access to quality healthcare; for our State to be competitive, our people must be healthy
 - Reduction in healthcare system waste; innovation is essential to maximize value
 - Healthcare industry watchdog; cost shifting practices burden the State's economy, providers, payors, and consumers
 - Social Justice; OHA has a duty to represent the collective voice of 3.5 million healthcare consumers



Office of the Healthcare Advocate

Connecticut's Federally Recognized Health Insurance Consumer Assistance Program



ACA in CT

- Plans must meet minimum requirements to be allowed to sell in the Exchange
- Behavioral Health Services Must be Provided
- Plans allowed to sell are “Qualified Health Plans” or “QHPs”
- Exchange Board voted to require plans to meet additional standards to become QHPs

ACA in CT

- Additional Requirements
 - Plans must offer a standardized plan design but can offer additional innovative plans
 - Plans must contract with sufficient number of ECPs for timely access for low-income and medically underserved areas
 - Must contract with 75% ECPs in each county
 - Must contract with 90% FQHCs or FQHC lookalikes in CT

ACA in CT

- Additional Requirements (cont'd)
 - Network adequacy standards must be disclosed (current law does not require transparency)
 - Exchange required to perform independent monitoring of networks
 - Plans may be rejected on the basis of being a price outlier
 - Plans requested to submit plans on innovation and quality—can be given favorable scoring
 - Exchange required to move toward active purchasing

ACA in CT (cont'd)

- Medicaid Low Income Adult Program
 - initial expansion paid at 50% by feds
 - will be 100% in 2014
 - Expected to enroll approximately 50,000 additional people
 - MH/SU benefits to be provided through the CTBHP
- CT Medicaid program ahead of the curve on most coverage
- Medicaid will expand to 133% of FPL in 2014-no asset test
- Medicaid is using care coordination and delivery system reforms in ACA – PCMH, ICO

MH/SU in CT

- For those in public programs: HUSKY A, B, C, D, benefits are administered through the Connecticut Behavioral Health Partnership (CTBHP)
- Benefits are dictated by federal Medicaid law, CHIP law or state law (Charter Oak)
- Other support benefits offered through DCF & DMHAS—community-based services

MH/SU in CT (cont'd)

- Community-based services include:
 - EMPS (DCF pays but approx. 33% are insured)
 - IICAPS (DCF pays but private insurance does not)
 - EDT
 - MDFT
- Services are also provided through the court system, schools and the DOC
- Private insurance does not cover community-based services

MH/SU in CT (cont'd)

- Services provided under the CTBHP and under community-based services by DCF and DMHAS
 - Primarily provided by the non-profit sector
 - Paid at public program rates
 - Not cost adjusted
 - HIGHLY popular

MH/SU in CT (cont'd)

- For people in insurance plans regulated by the state of CT (called fully-insured plans)
 - State law mandates coverage of all Dx in the DSM
 - State law mandates that broad range of provider types are reimbursed for their services
 - Providers must agree to contract rates from carriers
 - Financial parity required

MHPAEA

- Mental Health Parity and Addiction Equity Act
 - Passed Congress in 2008
 - Interim regulations issued in 2010
- MHPAEA does not require grandfathered self-insured small group plans to offer mental health benefits.
- MHPAEA does not require large groups to cover mental health benefits, though most do.
- MHPAEA requires parity in financial requirements and treatment (nonquantitative and quantitative limitations)

MHPAEA (cont'd)

- MHPAEA –
- Cannot apply limitations more stringently than applied to physical health
 - Quantitative treatment limitations = co-pays, visit limits, deductibles, etc.
 - Nonquantitative treatment limitations=criteria design and application, network recruiting, reimbursement rate setting, formulary design, etc

What about the MHPAEA?

- ACA regs make MHPAEA applicable to new Exchange plans
- MHPAEA does NOT apply to Medicaid in CT because Medicaid is not operated as full risk managed care
- MHPAEA still operating on interim federal regulations
- Enforcement needs to be beefed up
- Recent legislative committee report critical of oversight of insurers—see <http://www.cga.ct.gov/pri/docs/2012/ASUT-Committee%20Report-12-18-12.pdf>