PROPOSED AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure  The Missouri Consolidated Health Care Plan is amending sections (1), (3), and (5).

PURPOSE: This amendment revises the claim submission and initial benefit determinations time frames, updates the name and appeal contact information for the third-party administrator.

(1) Claims Submissions and Initial Benefit Determinations PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than [fifteen (15) days] twenty (20) business days from the date the vendor receives the claim. The vendor may extend the time period up to an additional [fifteen (15)] thirty (30) days if, for reasons beyond the vendor’s control, the decision cannot be made within the first [fifteen (15)] twenty (20) days. The vendor must notify the member prior to the expiration of the first [fifteen- (15-) ] twenty- (20-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than [fifteen (15)] thirty (30) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member’s life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor [as soon as possible thereafter] within three (3) business days.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than [thirty (30) days] twenty (20) business days after the vendor receives the claim. If, because of reasons beyond the vendor’s control, more time is needed to review the claim, the vendor may extend the time period up to an additional [fifteen (15)] thirty (30) days. The vendor must notify the member prior to the expiration of the first [fifteen- (15-) day] twenty- (20-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than [fifteen (15) days] thirty (30) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously-approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously-approved course of treatment in sufficient time to allow the member or the member’s provider to appeal and obtain a determination before the benefit is reduced or terminated.
(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member’s right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan’s dental or vision benefit offering, the following definitions apply:

1. Adverse benefit determination. An adverse benefit determination means any of the following:
   A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual’s eligibility to participate in the plan;
   B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or
   C. Any rescission of coverage after an individual has been covered under the plan;

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination;

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant’s authorized representative;

4. External review. The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by [UMR, Aetna] Anthem, and Express Scripts, Inc. 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 a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time);

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law;

6. Final external review decision. A final external review decision means a determination rendered under the external review process at the conclusion of an external review;

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—
   A. The termination or discontinuance of coverage has only a prospective effect; or
   B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual’s coverage under the plan based on a determination of the individual’s eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

   A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

   B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should
be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-2.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan’s medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member decided within thirty (30) twenty (20) business days [for post-service claims and fifteen (15) days for pre-service claims] from the date the vendor received the first level appeal request.

(a) If, because of reasons beyond the vendor’s control, more time is needed to review the appeal, the vendor may extend the time period up to an additional fifteen (15) thirty (30) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) twenty- (20-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) thirty (30) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first. Written confirmation of the decision will be sent by the vendor within fifteen (15) business days.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working business days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall will be responded to in writing to the member decided within thirty (30) twenty (20) days [for post-service claims and within fifteen (15) days for pre-service claims] from the date the vendor received the second level appeal request.

(a) If, because of reasons beyond the vendor’s control, more time is needed to review the appeal, the vendor may extend the time period up to an additional fifteen (15) thirty (30) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) twenty- (20-) day period, explain the reason for the delay, and request any additional information. If more information is
requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than \[\text{fifteen (15)}\] thirty (30) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first. \textbf{Written confirmation of the decision will be sent by the vendor within fifteen (15) business days.}

(V) For members with medical coverage through [UMR] Anthem—

(a) First and second level pre-service, \textbf{first and second level post-service}, and concurrent claim appeals must be submitted in writing to—

\begin{itemize}
  \item [UMR Appeals]
  \item PO Box 400046
  \item San Antonio, TX 78229
  \item or by fax to (888) 615-6584
  \item \textbf{Anthem Blue Cross and Blue Shield}
  \item Attn: Grievance Department
  \item PO Box 105568
  \item Atlanta, Georgia 30348-5568
  \item or by fax to (800) 859-3046
\end{itemize}

[(b) First and second level post-service appeals must be sent in writing to—

\begin{itemize}
  \item UMR Claims Appeal Unit
  \item PO Box 30546
  \item Salt Lake City, UT 84130-0546
  \item or by fax to (877) 291-3248
\end{itemize}]

[(c)](b) Expedited \textit{pre-service} appeals \textit{must} be \textit{communicated} \textit{submitted} by calling \[(800) 808-4424, \text{ext. 15227} \] \textbf{877 333-7488} or by submitting a written fax to \[(888) 615-6584, \text{Attention: Appeals Unit (800) 368-3238.}

[(VI) For members with medical coverage through Aetna—

(a) First and second level appeals must be submitted in writing to—

\begin{itemize}
  \item Aetna
  \item Appeals Resolution Team
  \item PO Box 14463
  \item Lexington, KY 40512
  \item or by fax to (859) 425-3379
\end{itemize}

[(b) Expedited appeals must be communicated by calling (800) 245-0618 or by submitting a written fax to (859) 425-3379, Attention: Appeals Resolution Team.]

C. The internal review process for adverse benefit determinations relating to pharmacy and the Pharmacy Lock-In Program consists of one (1) level of internal review provided by the pharmacy vendor. 

(I) Pharmacy appeals. Pharmacy appeals and Pharmacy Lock-In Program appeals must identify the matter being appealed and should include the member’s (and dependent’s, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician’s name, the drug name and quantity, the cost of the prescription, if applicable, and any applicable reason(s) relevant to the appeal including: the reason(s) the member believes the claim should be paid, the reason(s) the member believes s/he should not be included in the Pharmacy Lock-In Program, and any other written documentation to support the member’s belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

\begin{itemize}
  \item Express Scripts
  \item Attn: Clinical Appeals Department
  \item PO Box 66588
  \item St. Louis, MO 63116-6588
  \item or by fax to (877) 852-4070
(III) All Pharmacy Lock-In Program appeals must be submitted in writing to—
  Express Scripts
  Drug Utilization Review Program
  Mail Stop HQ3W03
  One Express Way
  St. Louis, MO 63121

(IV) Pharmacy appeals will be reviewed by someone who was not involved in the original
decision and the reviewer will consult with a qualified medical professional if a medical judgment is
involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-
service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal
request.

(V) The Pharmacy Benefit Manager will respond to Pharmacy Lock-In Program appeals in
writing to the member within thirty (30) days from the date the Pharmacy Benefit Manager received the
appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of
internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review
within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—
  HHS Federal Request
  MAXIMUS Federal Services
  3750 Monroe Ave., Suite 705
  Pittsford, NY 14534
  or by fax to (888) 866-6190
  or to request a review online at
  http://www.externalappeal.com/

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns
during the external review process and can submit additional written comments to the external reviewer at
the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five
(45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse
benefit determination involves a medical condition of the claimant for which the timeframe for completion
of a standard external review would seriously jeopardize the life or health of the claimant; or would
jeopardize the claimant’s ability to regain maximum function; or if the final internal adverse benefit
determination involves an admission, availability of care, continued stay, or health care item or service for
which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the
appeal will provide the member, free of charge, with any new or additional evidence or rationale
considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or
the appeal and will give the member an opportunity to respond to such new evidence or rationale before
issuing a final internal adverse determination.
(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines. Decisions concerning eligibility for Medicare primary members may not be able to be granted pursuant to these guidelines if the decision is contrary to the rules controlling eligibility for Medicare Advantage plan as put forth by Centers for Medicare and Medicaid. Valid proof of eligibility must be included with the appeal if the enrollment request includes addition of dependent(s). Payment in full for all past and current premiums due for enrollment requests must be included with the appeal if it cannot be collected through payroll deduction:

(j) MCHCP may approve an appeal regarding plan changes retrospectively for subscribers who are new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier, except that no changes will be considered for HSA Plan elections after the first MCHCP Health Savings Account contribution has been transmitted for deposit to the subscriber’s account. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees’ Cafeteria Plan;

and

(K) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancelation or an appeal of a deadline that is statutorily mandated; and

(L) MCHCP may approve an appeal to change a subscriber’s medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.