Anthem Blue Cross
Health. Join In.

As we continue to move forward with the implementation of health care reform, we have received questions about our implementation of the new requirements around grievances and appeals. Following is a list of the most commonly asked questions related to this provision. Keep in mind we continue to receive guidance and more information from the federal government, so this information is likely to change and be updated as we move forward.

Q: What pieces of the requirements are required for implementation on July 1, 2011 vs. January 1, 2012?

A: Please see chart below for an overview of the provisions and the implementation timeframes:

Current Requirement	Compliance Required Next plan year after 9/23/10	Compliance Required 7/1/11, regardless of plan year dates	Compliance Required Next plan year after 1/1/12
Internal appeals process	X		
Independent Review Organizations	X		
Dx/Tx Tagline on Adverse Benefit Determinations (NOTE: UM Letters will not include a tagline, but will include the dx/tx codes & descriptions)			X
Other data elements on Adverse Benefit Determinations (amount and date of the claim, service provider and reason for denial)		X	
Appeals process description: (Include the enhanced description of internal/external appeals process)		X	
State-specific contact information, if applicable, for the state's office of health insurance consumer assistance/ombudsman		X	

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Current Requirement	Compliance Required Next plan year after 9/23/10	Compliance Required 7/1/11, regardless of plan year dates	Compliance Required Next plan year after 1/1/12
Appeals process – bypass internal: Giving claimants the right to bypass internal appeals and go to external appeal or litigation if the insurer or plan fails to "strictly comply" with the rule			X
Language notification Spanish tagline (NOTE: Verbal translation support will be provided through Customer Service as it is today)			X
Urgent Care Decisions – Requires urgent care requests be decided as soon as possible, but no later than 24hrs after sufficient information is provided			X

Q: Have you adjusted your processes to satisfy the federal and state mandates requirements with regards to both internal claims appeals and external review processes?

A: As we continue to move forward with the implementation of health care reform, we have received questions about our implementation of the new requirements around grievances and appeals. Keep in mind we continue to receive guidance and more information from the federal government, so this information is likely to change and be updated as we move forward.

Q: Is your organization following the federal or state process for ASO & FI business?

A: Currently we are following the federal process for ASO ERISA business. For fully insured business there are no changes until the state defines any new processes based on the guidance within ACA.

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Q: Which IROs have you contracted with to do the external reviews required under ACA?

A: At this time we are contracted with MCMC, Advanced Medical Review and AllMed to conduct our third party external reviews under PPACA.

MCMC: MCMC is a URAC accredited, national provider of independent medical reviews, examinations and related services. MCMC has an extensive panel of credentialed reviewers – performing in excess of 50,000 independent medical reviews and 18,000 independent medical examinations annually.

With over 20 years of vast expertise, MCMC offers a variety of programs and services to assess, improve and assure the delivery of quality health care. MCMC's clients include many of the nation's largest group health, auto liability, disability and workers' compensation insurers, as well as TPAs, PBMs, self-insured employers, labor unions, and law firms. For more information, please visit their website.

Advanced Medical Reviews: As a URAC accredited independent review organization, **Advanced Medical Reviews** delivers a single source solution for our clients' managed healthcare administration needs.

Utilizing numerous quality assurance protocols, a highly trained compliance staff, and three "in-house" medical directors, our clients are assured the highest quality standard throughout the review process. Advanced Medical Reviews assists our clients to increase their operational efficiency through specialized reports, data mining, and technology integration.

Our commitment is to provide our clients with a fully integrated, compliant, and cost-effective service emphasizing continuous quality improvement, innovation, and client satisfaction. For more information please visit their website.

AllMed: Founded in 1995, AllMed Healthcare Management is a URAC-accredited independent review organization (IRO), serving leading healthcare payer and provider organizations nationwide. Our independent review services help to improve healthcare utilization, quality and physician performance, while reducing unnecessary costs.

- For payers, AllMed provides independent medical review services that help utilization review, medical management and claims professionals control healthcare costs, while doing what's right for each member, every time.

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- For hospitals and ASCs, AllMed provides external medical peer review services that help them to evaluate practitioner performance, leading to improved healthcare quality and patient safety.

All reviews are conducted by AllMed's panel of over 400 leading peer specialists, who are licensed, board-certified and in active practice. For more information please visit their website.

Q: Does an ASO client have to use your appeals process?

A: ASO clients can either create their own, compliant external review process, or they can choose to use our review process. We have developed a standard appeals process for new and renewing ASO groups with nongrandfathered plans beginning September 23, 2010. The process is designed to allow for the most accurate and timely processing of the appeals:

- The ASO group with nongrandfathered plan(s) fully delegates appeals adjudication authority to us
- We prefer to use the standardized first level mandatory review process with the second level voluntary process
- After the first level process is complete, members are offered an external review at the same time they are offered the second level review
- Second level voluntary options include panel review, independent peer medical review or other process consistent with the company reviewing the appeal
- Members are not required to complete any voluntary level before pursuing an external review

For most of our customers and members, the external appeal process will not change right away. For existing fully insured group members in states that already have external review, the process will stay essentially the same until July 1, 2011.

Q: How are you ensuring compliance with the various provisions and changing guidance?

A: We have a team of experts analyzing the requirements to ensure we are implementing the provisions and requirements quickly and efficiently and in the best interest of our customers and clients. We continually review and analyze the requirements as more information becomes available. In some cases, the additional information requires us to update or adjust our interpretation. In the absence of final regulations, we continue to adapt as necessary.

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