Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
REQUIREMENTS FOR UTILIZATION REVIEW ORGANIZATIONS INTERNAL CLAIMS AND APPEALS PROCEDURES			
▪ **Internal Claims and Appeals Procedure** • Applicability - Applies to **health benefit plans** in individual and group markets. -Applies to non-grandfathered individual and small group plans and for denial of medical necessity of contraceptives for non-grandfathered large group plans.		PHSA §2719 45 C.F.R. §147.136 La. R.S. 22:2394 La. R.S. 22:2392(26) La. R.S. 22:2392(31) 45 C.F.R. §156.122(c)	
▪ **Internal Claims and Appeals Procedure** • Standard for procedure: - Group and individual plans must provide an "effective internal claims and appeals process."		45 C.F.R. §147.136	
▪ **Internal Appeals Procedure** ▪ La. R.S. 22:2401 An internal review and appeals process must meet the requirements in 42 U.S.C. 300gg-19 and applicable state and federal regulations promulgated by the U.S. Dept. of Labor (DOL), the U.S. Health and Human Services (HHS) and the Louisiana Department of Insurance (LDI). ▪ **Minimum Requirements:** 1. Must have internal claims and appeal process in effect. 2. Provide notice to covered persons, in a culturally and linguistically appropriate manner, of available internal and external appeals processes and the availability of the Office of Consumer Advocacy of the LDI to assist such persons with the appeals process. 3. Allow covered persons, upon request and free of charge, to review and have copies of all documents relevant to the claim for benefits and to submit comments and documents relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination, and to receive continued coverage pending the outcome of the appeals process where required by applicable law or the plan document or policy.	.	La. R.S. 22:2401	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
▪ **In General, Group and Individual Plans Must Meet Same Requirements for Internal Claims and Appeals Procedure**		45 C.F.R. §147.136 29 C.F.R. § 2560.503-1 45 C.F.R. §156.122(c)	
▪ **Definitions of Adverse Determination and Final Adverse Determination** • Adverse determination (AD) means any of the following: (a) A determination that a request for a benefit under the health insurance issuer's (HII) plan does not meet the HII's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit. (b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a HII (or a URO) of a covered person's eligibility to participate in the health insurance issuer's health benefit plan. (c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit under a health benefit plan. (d) A rescission of coverage determination. (e) External reviews are only available for adverse determinations and final adverse determinations that involve medical necessity, appropriateness, health care setting, level of care, effectiveness, experimental or investigational treatment, or a rescission. Internal reviews and appeals shall apply to any adverse determination or final adverse determination • Final Adverse Determination - (FAD) means an adverse determination, including medical judgment, or a covered benefit that has been upheld by a health insurance issuer or its designee utilization review		La. R.S. 22:2392(1) La. R.S. 22:2392(24) 45 C.F.R. § 147.136(a)(2) 29 C.F.R. § 2560.503(m) La. R.S. 22:2401	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
organization, at the completion of the health insurance issuers internal claims and appeals process procedures provided pursuant to R.S. 22:2401.			
INTERNAL CLAIMS PROCEDURES			
▪ **Internal Claims Procedure Minimum Requirements:** 1. Required to include a description of: a. Claims procedures b. Procedures for obtaining prior approval c. Preauthorization procedures d. Utilization Review Procedures e. Exceptions Process f. Applicable Time Frames 2. Claims procedure cannot unduly inhibit the initiation or processing of claims • The claims procedures for a plan will be deemed to be reasonable only if: 1. (b)(2)- A description of all claim's procedures and the applicable time frames is included as part of a summary plan description. 2. (b)(3)- The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. Examples: There cannot be a fee required as a condition of filing a claim or appealing an AD or denial of a claim for prior approval is not allowed if the person was unable to seek prior approval (unconscious, etc.). 3. (b)(4) - The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination.		29 C.F.R. § 2560.503-1 45 C.F.R. § 147.136 45 C.F.R. § 155.122(c)	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
4. (b)(5) - The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants. 5. (b)(6) - For a plan established pursuant to a collective bargaining agreement, the plan complies with 29 C.F.R. § 2560.503-1 (c)-(j) if the agreement sets forth or incorporates by reference (a) provisions concerning the filing of benefit claim and initial disposition of benefit claims and (b) a grievance and arbitration procedure to which ADs are subject. If the plan sets forth or incorporates by reference the grievance and arbitration procedure to which ADs are subject, but does not set forth or incorporate provisions concerning the filing of benefit claim and initial disposition of benefit claims, then the plan is deemed to comply with 29 C.F.R. § 2560.503-1(h)-(j), but not (c)-(g). 6. (c)- Additional requirements (c)(1)- A claimant must be notified of failure to follow plan's procedures for filing a pre-service (pre-authorization) claim and given notice of proper procedures as soon as possible**,** but not later than 5 days following the failure for a standard claim or not later than 24 hours following the failure for an urgent care claim. (c)(2)- The claims procedures do not contain any provision and are not administered in a way that requires a claimant to file more than two appeals of an AD prior to bringing a civil action under section 502(a) of the ERISA. (c)(3)- If a voluntary level of appeal is offered, (i) the plan must waive any right to assert that the claimant failed to exhaust administrative remedies because the claimant did not submit to the voluntary level of appeal; (ii) the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time any such voluntary appeal is pending; (iii) a claimant is allowed to elect the voluntary level of appeal only after exhaustion of appeals allowed by 29 C.F.R. §2560.503-1(c)(2); (iv) the plan provides to the claimant, upon request, sufficient information relating to voluntary level of appeals to enable the claimant to make an informed judgment about whether to		29 C.F.R. § 2560.503-1(b) 29 C.F.R. § 2560.503-1(c)(2)	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
submit a benefit dispute to the voluntary level of appeal and must include a statement that the decision of the claimant as to whether to use the voluntary level of appeal will have no effect on the claimant's rights to any other plan benefits as well as information on the rules for the voluntary level of appeal; and (v) no fees or costs are imposed on the claimant as part of the voluntary level of appeal. (c)(4) - The claims procedures do not contain any provision for the mandatory arbitration of AD, except to the extent that the plan provides that (i) arbitration is conducted as one of the two appeals in paragraph (c)(2) and in accordance with the requirements applicable to the appeals and (ii) the claimant is not precluded from challenging the decision under Section 502(a) of ERISA. 8. (e) - Claim for benefits. A claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. This includes any pre-service claims and any post-service claims. 9. (f) - Timing of notification of benefit determination. (1) Standard claim - If a claim is denied in whole or in part, written or electronic notification shall be given to claimant of the AD within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan**.** An extension is allowed but notice of the extension must be given by the plan to the claimant before the end of the original 90-day period and cannot exceed 90 days from the end of the initial period. (2) Urgent care claim - or denial of an urgent care claim, plan administrator must notify claimant of benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review. - If the claimant failed to provide sufficient information, the plan must notify the claimant of the information needed to complete the claim within 24 hours of receipt of claim. The claimant is given 48 hours to provide the information necessary to complete the claim. Notification of the benefit determination must be made no later than 48 hours after receipt of the needed information or the end of the period given to the claimant to provide the additional information. - Written notification of the AD is also required.		29 C.F.R. § 2560.503-1(c)(3) 29 C.F.R. § 2560.503-1(c)(4) 29 C.F.R. § 2560.503-1 45 C.F.R. § 147.136(a) 45 C.F.R. § 147.136(b) 29 C.F.R. § 2560.503-1(f) 29 C.F.R. § 2560.503-1(f)(i)	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
(3) Concurrent care claim- Where claimant is receiving an ongoing course of treatment, any reduction or termination of the treatment constitutes an AD. Notice of such reduction or termination must be given in sufficient time to allow the claimant to appeal and obtain a determination or review of AD before benefit is reduced or terminated. Any request by claimant to extend ongoing course of treatment that is a claim involving urgent care and shall be decided as soon as possible and notice of the benefit determination, whether adverse or not, shall be made within 24 hours after receipt of the claim by the plan, provided that the claim is made at least 24 hours before the expiration of the prescribed time period or number of treatments. -Written notification of the AD is also required. (4) "Pre-service claim"- Notice of benefit determination, whether adverse or not, must be given within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. Extension of this time period is allowed. Any extension required by failure of claimant to provide sufficient information must include specific description of required information and claimant given 45 days to provide such information. -Written notification of the AD is also required. (5) "Post-Service Claim"- Notice of AD must be given within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the claim by the plan. Extension of this time period is allowed. Any extension required by failure of claimant to provide sufficient information must include specific description of required information and claimant given 45 days to provide such information.	.	29 C.F.R.§ 2560.503-1(f)(ii) 29 C.F.R.§ 2560.503-1(f)(iii)	
10. Manner and content of AD notification- (1) Written or electronic notification required for ADs. (2) Notice must include: (i) specific reason for AD; (ii) reference to specific plan provisions on which AD is based;		29 C.F.R. § 2560.503-1(g) 29 C.F.R. § 2560.503-1(g)(1) 29 C.F.R. § 2560.503-1(g)(2) .	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
(iii) description of additional material or info necessary for claimant to have claim processed and an explanation of why the information is needed; (iv) description of plan's review procedures and time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an AD; (v) Identification of any internal rules, guidelines or protocols on which AD was based, notice that such copies of rules can be requested free of charge, and for ADs based on experimental treatment an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge. (3) AD of urgent care claim, the notice can be oral, but must be followed by written or electronic notification as set forth above not later than 3 days after the oral notification. 45 C.F.R. § 147.136(b)(2)(ii)(E) and (b)(3)(ii)(E) provide additional notice content requirements for internal claims and appeals. (1) The issuer must ensure that notice of adverse benefit determination includes information sufficient to identify the claim involved, date of service, provider, and claim amount. (2) Upon request, the issuer must provide the diagnosis code, its corresponding meaning, the treatment code and its corresponding meaning associated with any adverse benefits determination. (3) The issuer must also ensure that the reason(s) for the adverse benefit determination or final adverse benefit determination includes denial code and corresponding meaning as well as a description of the issuer's standard. (i.e. if denied on medical necessity, the description must include medical necessity standard). In the case of a final adverse benefits determination, the notice must include discussion of decision. (4) Notice must provide description of internal appeals and external review processes, including information on how to institute an appeal. (5) Notice must disclose the availability of, and contact information, for any consumer assistance or ombudsman established under PHSA § 2793 to assist enrollees with internal claims and appeals and external review processes.		45 C.F.R. § 147.136(b)(2)(ii)(E) 45 C.F.R. § 147.136(b)(3)(ii)(E)	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
45 C.F.R. § 147.136(b)(2)(ii)(F) and (b)(3)(ii)(F) governs group and individual plans, respectively, when the internal claims and appeal process is deemed to have been exhausted. If an HII fails to adhere to the requirements of the internal claims and appeal process, the claimant is deemed to have exhausted the internal claims and appeals process. The claimant can initiate an external review and pursue any other remedies allowed by law, including judicial review, upon such exhaustion.		45 C.F.R. § 147.136(b)(2)(ii)(F) 45 C.F.R. § 147.136(b)(3)(ii)(F)	
Notice requirement specific to Individual Health Plans, pursuant to 45 C.F.R. § 147.136(b)(3)(ii). Individual Health Plans are subject to three additional notice requirements for internal claims and appeals). pursuant to 45 C.F.R. § 147.136(b)(3)(ii).		45 C.F.R. § 147.136(b)(3)(ii).	
Pursuant to 45 C.F.R. § 147.136(b)(3)(ii)(A), a health insurance issuer must treat any decision to deny coverage in an initial eligibility determination as an adverse benefit determination thus is subject to review.		45 C.F.R. § 147.136(b)(3)(ii)(A)	
Pursuant to 45 C.F.R. § 147.136(b)(3)(ii)(G), individual plans can only have one level of internal appeals. Once a health insurance issuer has issued an adverse benefit determination following the internal appeal, the claimant should be allowed to seek external review of the determination by an outside entity.		45 C.F.R. § 147.136(b)(3)(ii)(G)	
Pursuant to 45 C.F.R. § 147.136(b)(3)(ii)(H), health insurance issuers offering individual coverage must maintain records of all claims and notices associated with their internal claims and appeals processes for at least 6 years and such records must be made available for examination upon request.		45 C.F.R. § 147.136(b)(3)(ii)(H)	
"Exceptions Process" – a required process to allow enrollees/members request a drug not covered by the plan's formulary drug list (PDL). • **Standard Exceptions Process**- Enrollee is permitted to request a standard review of coverage decision for a prescription drug that is not covered by the plan. HII must make coverage determination and notify enrollee and prescribing provider of coverage determination **no later than 72 hours** after it receives the request.		45 C.F.R. §156.122(c)(1)	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
• **Expedited Exceptions Process**- An expedited review can be sought to review a coverage decision for a prescription drug based on exigent circumstances. Exigent circumstances exist when an enrollee is suffering from a serious health condition that may jeopardize the enrollee's life, health, or ability to regain maximum function, or when the enrollee is undergoing a current course of treatment using a non-formulary drug. HII must make coverage determination on an expedited exceptions process based on exigent circumstances and notify enrollee and prescribing provider of coverage determination **no later than 24 hours** after it receives the request. • **External Review Process for Exceptions Process**- An enrollee, the enrollee's designee, or the enrollee's prescribing provider will be able to request that an IRO review the exception request and the denial of that request (adverse coverage determination) by the plan. *The timing will be the same as that applied to the standard or expedited initial exceptions process review*. A State may determine that a health plan in the State satisfies the requirements of this paragraph (c) if the health plan has a process to allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan that is compliant with the State's applicable coverage appeals laws and regulations that are *at least as stringent as the requirements of this paragraph (c)* and include: **(A)** An internal review; **(B)** An external review; **(C)** The ability to expedite the reviews; and **(D)** Timeframes that are the same or shorter than the timeframes under paragraphs (c)(1)(ii), (c)(2)(iii), and (c)(3)(ii) of this section.		45 C.F.R. § 156.122(c)(2) 45 C.F.R. § 155.122(c)(3) 45 C.F.R. § 155.122(c)(4)i	
INTERNAL APPEALS PROCEDURES			

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
▪ **Internal Appeals Procedure Minimum Requirements** (1) There must be a full and fair review of the claim and any AD under the appeals process. a. Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination b. Claimants have opportunity to submit written comments, documents, records, and other information relating to the claim for benefits. c. Claimant, upon request, is provided free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. d. The appeal must take into account all comments, documents, records, and other information submitted by the claimant related to the claim, without regard to whether the information was submitted with the initial benefit determination. (2) Full and fair review requires the following: (i) Claimants must be given opportunity to file appeal within 180 days following receipt of notice of AD. (ii) Review must not give deference to the initial AD and must be conducted by a fiduciary of the plan who is neither the individual who made the AD being appealed, nor the subordinate of such individual. (iii) For ADs based on medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, that the fiduciary will consult with a health care professions with appropriate training and experience in the requisite field and that the health care professional is neither an individual consulted in connection with the AD or the subordinate of such individual. (iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination		29 C.F.R. § 2560.503-1(h) 29 C.F.R. § 2560.503-1(h)(1) 29 C.F.R. § 2560.503-1(h)(2) 29 C.F.R. § 2560.503-1(h)(3) 45 C.F.R. § 147.136(b) 29 C.F.R. § 2560.503-1(h)(3)	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
(v) Provide that the health care professional engaged for purposes of a consultation for appeal shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and (vi) For urgent care claims, provide an expedited review process pursuant to which a request for expedited appeal of AD can be made orally or in writing and all necessary information regarding claim can be transmitted by telephone, fax, or other expeditious method.		45 C.F.R. § 147.136(b)(3)(ii)(G)	
(i) Timing of Notification of Benefit Determinations Under Review (1)(i) Standard Claims- Notification of decision of appeal of AD must be given to claimant not later than 60 days after receipt of the claimant's request for review by the plan. An extension is allowed if written notice is given to claimant of need for extension before end of 60-day period. (2) Group health plans. *See* 75 Fed. Reg. 43334 where requirements apply to individuals plans. (i) Urgent Care Claims - Notification as soon as possible, but in no event later than 72 hours after receipt of claimant's request for review of AD. (2)(ii) Pre-Service Claims - Group and Individual Plans - If there is one level of internal appeal, then notification of decision must be provided not later than 30 days after receipt by the plan of the claimant's request for review of AD. If a group plan has two levels of internal appeals, then notification of decision for *each* level must be given not later than 15 days after receipt by plan of the claimant's request for review of AD. (2)(iii) Post-Service Claims- Group and Individual Plans - If there is one level of internal appeal, then notification of decision must be provided not later than 60 days after receipt by the plan of the claimant's request for review of AD. If a group plan has two levels of internal appeals, then notification of decision for this level must be given not later than 30 days after receipt by plan of the claimant's request for review of AD.		29 C.F.R. § 2560.503-1(i) 29 C.F.R. § 2560.503-1	
(j) Manner and content of notification of benefit determination on review			

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
(1) Written or electronic notification of decision of appeal of benefit determination. (2) Notice must include: (i) specific reason for AD; (ii) reference to specific plan provisions on which ABD is based; (iii) statement that claimant is entitled to receive, upon request and free of charge, access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. (iv) statement describing any voluntary appeal procedures offered by the plan and claimant's right to obtain information about the procedures. (v) statement of the claimant's right to bring an action pursuant to Section 502(a) of ERISA. (vi) dentification of any internal rules, guidelines or protocols on which AD was based, notice that such copies of rules can be requested free of charge, and for ABDs based on experimental treatment an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge. (3) AD of Urgent Care claim, the notice can be oral, but must be followed by written or electronic notification as set forth above not later than 3 days after the oral notification.		29 C.F.R. § 2560.503-1(j)	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
▪ Definitions of AD and FAD • Adverse Benefit Determination- defined by incorporating the definition under the Department of Labor's regulations governing claims procedures at 29 C.F.R. § 2560.503–1(m) and includes a rescission of coverage. • Final Adverse Benefit Determination- the upholding of an AD at the conclusion of the internal appeals process or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted.		45 C.F.R. § 147.136(a)(2) 29 C.F.R. § 2560.503–1(m) La. R.S. 22:2392(1) La. R.S. 22:2392(24)	
▪ Additional Requirements for Internal Review and Appeals for Group & Individual Health Plans 1. Expanded Definition of Adverse Benefit Determination • Definition of adverse determination is broader that DOL claims procedure regulation because it includes a rescission of coverage. • Rescission- cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. • The denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit can include both pre-service claims (resulting from utilization review) and post-service claims. • There does not have to be any adverse effect from a rescission for such to be deemed an adverse determination. • Scope of group health coverage for internal claims and appeals process is expanded to cover initial eligibility determinations for individual health plans. Denial of eligibility is subject to review. 2. Full and Fair Review • An HII must allow a claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.		45 C.F.R. § 147.136(a) La.R.S. 22:2392(1) 45 C.F.R. § 147.136(b)(2)(ii)(A) 45 C.F.R. § 147.136(b)(3)(ii)(A) 45 C.F.R. § 147.136(b)(2)(ii)(C) 45 C.F.R. § 147.136(b)(3)(ii)(C)	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
• In addition to complying with DOL claims procedure regulation, HII must provide claimant, free of charge, any new or additional evidence considered, relied upon, or generated by HII in connection with the claim. • Evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of FAD is required to provide to give the claimant a reasonable opportunity to respond prior to such notification date. • Before HII can issue AD based on new or additional rationale, such rationale must be provided to claimant, free of charge, and as soon as possible and sufficiently in advance of date on which the notice of AD required to given claimant a reasonable opportunity to respond prior to such notification date.		45 C.F.R. § 147.136(b)(2)(ii)(D) 45 C.F.R. § 147.136(b)(3)(ii)(D)	
3. Avoiding Conflicts of Interest • The adjudication of claims must be done to ensure independence and impartiality of persons making decision. • Decisions regarding hiring, compensation, termination, promotion, etc. (claims adjudicator or medical expert) cannot be made based upon likelihood that individual would support a denial of benefits. Ex.: No bonuses allowed for number of denials made by claims adjudicator and plan cannot contract with medical expert simply because of expert's reputation as denying similar claims or normally denying claims.			
4. Enhanced Notice • A HII is required to provide notice to enrollees in culturally and linguistically appropriate manner where a single threshold is met for the percentage of people who are literate only in the same non-English language for both the group and individual markets. The threshold is set at 10% or more of the population residing in the claimant's county, as determined by the American Community Survey data published by the U.S. Census Bureau. Each notice sent by a HII to an address in such a county/parish must include a one-sentence statement in the relevant non-English language about the availability of language services. This sentence can be		45 C.F.R. § 147.136(b)(2)(ii)(E) 45 C.F.R. § 147.136(b)(3)(ii)(E) 45 C.F.R. § 147.136(e)	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
included in all plans in all relevant non-English languages for an entire state if it makes publication of the notices easier. • HII must also provide customer assistance process (such as telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request. • Plans have to comply with parts (g) and (j) of the DOL claims procedure regarding the manner and content of notice of issuance of AD. • Group and Individual Plans have the following additional notice content requirements: (i) The issuer must ensure that notice of adverse benefit determination includes information sufficient to identify the claim involved, date of service, provider, and claim amount. (ii) Upon request, the issuer must provide the diagnosis code, its corresponding meaning, the treatment code and its corresponding meaning associated with any adverse benefits determination. (iii) The issuer must also ensure that the reason(s) for the adverse benefit determination or final adverse benefit determination includes denial code and corresponding meaning as well as a description of the issuer's standard. (i.e. if denied on medical necessity, the description must include medical necessity standard). In the case of a final adverse benefits determination, the notice must include discussion of decision. (iv) Notice must provide description of internal appeals and external review processes, including information on how to institute an appeal. (v) Notice must disclose the availability of, and contact information, for any consumer assistance or ombudsman established under PHSA §2793 to assist enrollees with internal claims and appeals and external review processes.		45 C.F.R. § 147.136(b)(2)(ii)(E) 29 C.F.R. § 2560.503-1(g) 29 C.F.R. § 2560.503-1(j) 45 C.F.R. § 147.136(b)(2)(ii)(E)	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
5. Deemed Exhaustion of Internal Process • If an HII fails to adhere to the requirements of the internal claims and appeal process, the claimant is deemed to have exhausted the internal claims and appeals process. The claimant can initiate an external review and pursue any other remedies allowed by law, including judicial review, upon such exhaustion. • However, there is an exception to the strict compliance standard for errors that are minor and meet certain specified conditions: error was de minimis, non-prejudicial, attributable to good cause or matters beyond the HIIs control, in the context of an ongoing good faith exchange of information, and not reflective of a pattern or practice of non-compliance. • The claimant would be entitled, upon written request, to an explanation of the HII's basis for asserting that it meets the minor errors standards.		45 C.F.R. § 147.136 45 C.F.R. § 147.136(b)(2)(ii)(F) 45 C.F.R. § 147.136(b)(3)(ii)(F)	
6. Individual Plans Can Only Have One Level of Internal Appeals • Once the HII has issued an AD following the internal appeal, the claimant should be allowed to seek external review of the determination by an outside entity. **7.** Recordkeeping Requirement • HIIs offering individual coverage must maintain records of all claims and notices associated with their internal claims and appeals processes for at least 6 years and such records must be made available for examination upon request. **"Exceptions Process"** – a required process to allow enrollees/members request a drug not covered by the plan's formulary drug list (PDL). • Standard Exceptions Process- Enrollee is permitted to request a standard review of coverage decision for a prescription drug that is not covered by the plan. HII must make coverage determination and notify enrollee and prescribing provider of coverage determination no later than 72 hours after it receives the request. • Expedited Exceptions Process- An expedited review can be sought to review a coverage decision for a prescription drug based on exigent circumstances. Exigent circumstances exist when an enrollee is suffering from a serious health condition that may jeopardize the enrollee's life, health, or ability to		45 C.F.R. § 147.136 45 C.F.R. § 147.136(b)(3)(ii)(G) 45 C.F.R. § 147.136(b)(3)(ii)(H) 45 C.F.R. § 156.122(c)(1) 45 C.F.R. § 156.122(c)(2)	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
regain maximum function, or when the enrollee is undergoing a current course of treatment using a non-formulary drug. HII must make coverage determination on an expedited exceptions process based on exigent circumstances and notify enrollee and prescribing provider of coverage determination no later than 24 hours after it receives the request. • External Review Process for Exceptions Process- An enrollee, the enrollee's designee, or the enrollee's prescribing provider will be able to request that an IRO review the exception request and the denial of that request (adverse coverage determination) by the plan. The timing will be the same as that applied to the standard or expedited initial exceptions process review. • A State may determine that a health plan in the State satisfies the requirements of this paragraph (c) if the health plan has a process to allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan that is compliant with the State's applicable coverage appeals laws and regulations that are at least as stringent as the requirements of this paragraph (c) and include: (A) An internal review; (B) An external review; (C) The ability to expedite the reviews; and (D) Timeframes that are the same or shorter than the timeframes under paragraphs (c)(1)(ii), (c)(2)(iii), and (c)(3)(ii) of this section.		45 C.F.R. § 155.122(c)(3) 45 C.F.R. § 155.122(c)(4)i	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
External Review Requirements for UROs			
Notice of Right to External Review - Notice of right to request a standard external review within four months of receipt of an AD or FAD must be provided in writing to covered person. Notice of right to request an expedited external review within four months of receipt of an AD or FAD may be made in writing, but also may be submitted orally or electronically or via other means established by the Commissioner. Notice must be provided when: 1. AD provided at end of internal claims process. 2. FAD issued at end of internal appeals process. Notice of an AD must include the following: 1. Statement with substantially equivalent language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us. In order to request an external appeal, you should send your request in writing to our office at the designated address included in this notice." 2. For notice of an AD, the right to an expedited review pursuant to La. R.S. 22:2437. 3. Notice must include notice that person can simultaneously file a request for expedited internal appeal and expedited external review for claims where the condition at issue is one that would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function or where the AD involves denial of coverage based on reason that treatment is experimental or investigational. Note that the IRO assigned will make the determination as to whether an expedited internal review must be completed before the expedited external review is conducted. 4. Notice that if the HII has failed to conduct the internal review within the 30-day time period, that an		La. R.S. 22:2433 La. R.S. 22:2434 La. R.S. 22:2436 La. R.S. 22:2437 La. R.S. 22:2438	

Requirement (Description)	Further Review Required and/or Misc. Notes	Legal Reference	Requirement Met Policy Page & Section Ref.
▪ Notice of a FAD must include the following: 1. Right to expedited external review pursuant to La. R.S. 22:2436 if: (a) the time for conducting an expedited internal review for a contested service or treatment would pose imminent threat to the covered person's health, including, but not limited to severe pain, potential loss of life, limb, or major bodily function, or the immediate deterioration of the health of the covered person; (b) the FAD concerns care provided to a covered person for emergency services, but the covered person has not been discharged from facility. (c) the FAD concerns a denial of coverage based on an experimental or investigational treatment and the treating physician certifies that the delay in appealing an AD would pose imminent threat to the covered person's health, including, but not limited to severe pain, potential loss of life, limb, or major bodily function, or the immediate deterioration of the health of the covered person. 2. Covered person would have right to seek standard external review in the foregoing instances if they so choose. 3. Notice needs to include a copy of the description of the standard and expedited external review procedures the HII is required to provide pursuant to La. R.S. 22:2445, including the provisions that give the covered person the opportunity to submit additional information and including the forms needed to process an external review. 4. Notice must include an authorization form by which the covered person authorizes the HII and the treating provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.			