Health Care Reform Alert: Claims Procedure Rules For Non-Grandfathered Plans Revised

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New regulations provide some relief and clarification for plan administrators processing group health plan claims. The Departments of Health and Human Services, Labor, and the Treasury recently issued amendments to the Interim Final Regulations for internal claims and appeals and external review processes required under the Patient Protection and Affordable Care Act (PPACA). The Department of Labor also issued Technical Release 2011-02 regarding external review. The internal claims and appeals and external review processes apply to non-grandfathered group health plans and are effective July 22, 2011.

The following is a summary of the changes.

Urgent Care Claim Review. Prior regulations required urgent care claim decisions to be communicated within 24 hours. The amended regulations require urgent care claim determinations to be made within 72 hours, which is consistent with pre-PPACA Department of Labor claims procedure regulations.

Diagnosis and Procedure Codes. Denial notices need not include diagnosis and procedure codes. Under the amended regulations, denial notices must provide that diagnosis and treatment codes will be provided upon request.

Culturally and Linguistically Appropriate Notices. The amended regulations change the non-English language threshold requirement for providing notices in a culturally and linguistically appropriate manner as required by PPACA. The culturally and linguistically appropriate notice requirement applies if ten percent or more of the population in a claimant's county of residence is literate only in the same non-English language. If that threshold is met, the plan must offer certain non-English language services, and notices must include a statement in the applicable non-English language indicating how

the language services may be accessed.

Deemed Exhaustion of Internal Claims and Appeal Process. Under the amended regulations, a claimant may not proceed directly to external review for good faith minor violations of the internal review process requirements that do not, and are not likely to, harm the claimant.

Claims Eligible for External Review. After September 20, 2011, only claims involving medical judgment and rescission of coverage will be eligible for external review.

Payment Immediately after External Review. The amended regulations require plans to pay benefits pursuant to an external review decision, even if the plan intends to seek judicial review.

Independent Review Organizations. Under Technical Release 2011-02, self-insured plans must contract with at least two independent review organizations (IROs) to provide external review by January 1, 2012 and with three IROs by July 1, 2012. Prior guidance had required plans to contract with three IROs.

State External Review Processes. The transition period deeming state external review processes to be compliant with PPACA has been extended from July 1, 2011 to January 1, 2012.

Sponsors of non-grandfathered plans should confirm that claims procedures are administered in compliance with the interim final regulations. Plan documents may need to be amended to take advantage of the relief provided by the amended regulations. For example, a plan document that requires urgent care claim determinations to be made within 24 hours would need to be amended to allow for the new 72 hour deadline.

More information, including the amended regulations, Technical Release 2011-02, a revised model notice of adverse benefit determination, a revised model notice of final internal adverse benefit determination, and a revised model notice of final external review decision is available at: www.dol.gov/ebsa/healthreform.

For more information about this topic, please contact any member of the Williams Mullen Employee Benefits & Executive CompensationTeam.

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