



Alert

Employee Benefits & Executive Compensation
Client Service Group

To: Our Clients and Friends

July 1, 2011

Updated Claim Procedure Requirements For Non-Grandfathered Health Plans

The Internal Revenue Service, Department of Health and Human Services and Department of Labor have revised the interim final regulations governing internal claims and appeals and external reviews for non-grandfathered group health plans under the 2010 health reform law. They have also revised the forms for adverse benefit determinations ([here](#), [here](#) and [here](#)) and updated the list of state consumer assistance programs ([here](#)). Many of the changes ease the burden of plan administration. Click [here](#) to see our prior Client Alert on this topic.

The changes, which are described more fully below, are:

- Plans no longer have to comply with 24-hour response time for urgent claims.
- Plans only need to provide diagnosis and treatment codes and their meanings upon request.
- Claimants will not be able to seek immediate external or judicial review if a plan's failure to strictly adhere to the claims procedures is minor and meets certain requirements.
- The scope of claims eligible for external review and the requirements for state external review processes have been modified.
- The requirements for providing notices in non-English languages are reduced, but plans may now be required to provide oral language assistance.

Deadline for Urgent Care Claim Processing Lengthened

The 24-hour deadline for denying an urgent care claim has been removed. Plans are still obligated to respond as soon as possible, taking into account the medical circumstances, but no later than within 72 hours after receipt of the claim. However, under the revised rules a plan is now required to defer to the attending provider as to whether the claim is for urgent care.

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Diagnosis and Treatment Code Reporting Requirements Reduced

Under the prior regulations, a notice of claim denial had to include both the diagnosis and treatment codes and their corresponding meanings. The new rules require only that information be provided upon request and that the claim denial notice include a statement that this information is available upon request.

Strict Adherence Standard For Claim Processing Revised

Under the prior regulations, if a plan failed to adhere strictly to any of the new internal claims procedure requirements or any prior rules, the claimant could immediately pursue third-party external review or judicial review. This “strict adherence” standard was a source of concern that any violation, no matter how minor, could result in immediate litigation.

Now, a violation will not give rise to an immediate right to sue or to external review if it meets all of the following criteria:

- It is minor,
- It does not prejudice the claimant’s rights,
- It is attributable to good cause beyond the plan’s control,
- It is in the context of an ongoing good-faith exchange of information with the claimant, and
- It is not reflective of a pattern or practice of non-compliance.

A claimant may request a written explanation of the plan’s basis for believing it meets these standards. Also, if a claimant’s request for immediate external or judicial review is denied, the claimant may continue in the internal appeal process, even if the deadline for internal appeals has passed.

Modifications to External Review Rights and Requirements

Under the prior regulations, any claimant whose appeal has been denied could obtain external review of the denied claim. Now, until further notice by the Departments, only claims that involve medical judgment or rescission of coverage are eligible for external review.

The new medical judgment limitation is intended to limit the external reviewer’s authority to interpret plan language or pre-empt other fiduciary or administrative actions under a plan, but some room for plan interpretation remains. The regulations give the following examples:

- If a claim for treatment is denied because the treatment does not meet the plan’s definition of medical necessity, the external reviewer would review the determination of medical necessity.
- If out-of-network treatment is denied because the plan does not cover out-of-network benefits unless the service cannot be effectively provided in-network, the external reviewer would review whether the service can be effectively provided in-network.
- The external reviewer would consider whether a particular setting (e.g., inpatient or outpatient) is appropriate for the claimant’s condition.

Standards and deadlines for state external review processes have also been revised. For fully-insured plans in states whose external review process provides consumer protections equivalent to those in the NAIC Uniform Model Act, the state's external review process will apply and the issuer of the insurance policy--not the plan--is required to comply with the applicable external review standards.

The compliance deadline for state external review processes has been extended to December 31, 2011. Additionally, the requirements for state-administered external review standards have been relaxed for periods before January 1, 2014, to give states more time to implement fully the protections required by the prior regulations.

The deadlines for self-insured plans that set up their own independent review process to contract with independent review organizations to satisfy the enforcement safe harbor established by the IRS and Department of Labor has also been extended. Now, a plan must have contracts in place for two independent review organizations by January 1, 2012, and with three such organizations by July 1, 2012.

Non-English Notice Requirements Reduced

Under the prior regulations, a plan had to provide a notice of claim denial in a non-English language if a specified percentage of the plan's enrollees spoke that language. In addition, if a participant specifically requested notice in a non-English language, the plan was required to provide all future notices to that participant in that language (sometimes called "tagging and tracking").

Plans are now required to include in a notice of claim denial only a brief disclosure in an applicable non-English language that the claimant may request the notice in that language. For this purpose, the applicable non-English language is based on the county to which the notice is being sent. If at least 10% of the population in that county is literate in the same non-English language, then the notice must contain the brief disclosure in that language. The tagging and tracking requirement has also been eliminated.

However, plans are now required to provide oral language services (for example, through a telephone hotline) to assist enrollees who primarily speak a non-English language. The availability of and contact information for these services must be included in any notice of claim denial.

Conclusions

While some of the changes are favorable to plan sponsors, the additional requirement to provide language services may result in additional costs for plan sponsors and their claims administrators. Additionally, the limited carve-out from the strict adherence standard does not provide much relief. Finally, the "medical judgment" standard for external reviews is sufficiently vague that it will likely not meaningfully limit the number of claims sent to external review.

If you have any questions regarding anything discussed in this Alert, the attorneys and other professionals of the Employee Benefits and Executive Compensation group of Bryan Cave LLP are available to answer your questions.

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