

Federal Agencies Issue Interim Final Regulations For Internal and External Claims And Appeals Procedures Under Health Care Reform Law

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (together, the "Health Care Reform Law") require non-grandfathered group health plans to provide both (i) internal claims and appeals procedures and (ii) external processes to review claims denials issued through the internal procedures. Each of the internal claims and external review procedures must meet minimum regulatory requirements beginning with the first plan year that begins on or after September 23, 2010 (i.e., January 1, 2011 for calendar year plans). The IRS, DOL and HHS have jointly issued interim final regulations establishing those minimum requirements.

Internal Claims and Appeals Procedures

The regulations require insured and self-insured group health plans, together with health insurance issuers providing benefits to the former, to maintain internal claims and appeals procedures that satisfy the DOL regulatory requirements in effect from time to time for claims procedures under ERISA covered plans, with a few enhancements.

- In addition to those actions characterized as adverse benefit determinations under the ERISA regulations, an adverse benefit determination will also include a rescission of coverage. You can read our summary of the recently issued interim final regulations restricting rescissions of coverage by clicking on the following link. [Federal Agencies Issue Interim Final Regulations For Health Care Reform Coverage Mandates](#)
- The maximum period for the determination of an urgent care claim is shortened from 72 hours to 24 hours after the plan's or health insurance issuer's receipt of the claim or appeal.
- In the case of an appeal of a denied claim, the plan or issuer must provide the claimant, free of charge, with any new or additional evidence being considered, and any new or additional rationale that may form the basis for a decision, sufficiently in advance of the date on which the decision on appeal must be provided, so that the claimant will have a reasonable opportunity to respond before that date.
- The plan or issuer must take reasonable steps to ensure the independence and impartiality of the persons involved in determining claims. For example, a plan or issuer cannot pay additional compensation based on the number of denials by a claims adjudicator.
- Initial determinations and decisions on appeal must be provided in a culturally and linguistically appropriate manner (see below), and will be required to include the following specific information relating to the claim: (i) date of service; (ii) health care provider; (iii) claim amount, if available; (iv) diagnosis code and its corresponding meaning; (v) treatment code and its corresponding meaning; (vi) denial code and its corresponding meaning; (vii) the plan's or issuer's standard, if any, that was used to deny the claim (e.g., medical necessity); (viii) in the case of a decision on appeal, a discussion of the decision; (ix) description of available internal appeals and external review processes, including information for initiating an appeal; and (x) the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act. The federal agencies intend to provide model notices in the near future.
- In any case where a plan or issuer fails to adhere strictly to all requirements of the internal claims and appeals procedure, the claimant will be deemed to have exhausted the internal claims and appeals procedure, regardless of whether the plan or issuer has substantially complied with these requirements or whether any error was de minimis. Any error, therefore, no matter how small, will entitle the claimant to

pursue external administrative review or judicial review.

- The plan or issuer must provide continued coverage or benefits pending the outcome of an internal appeal.

In addition, individuals in urgent care situations or receiving an ongoing course of treatment may be permitted to pursue an expedited external review concurrently with the internal appeals procedure.

External Review Process

Group health plans and health insurance issuers will be required to comply with either a State external review process or the (yet to be established) Federal external review process. If a health insurance issuer is subject to a State external review process that satisfies the consumer protections under the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act (NAIC Uniform Model Act), as specified in the internal final regulations, then the issuer must comply with the applicable State external review process and not the Federal external review process. In that case, the insured group health plan itself need not comply with either the State external review process or the Federal external review process, because the issuer providing benefits under plan is subject to the State external review process.

Self-insured plans generally will not be subject to a State external review process, so they must comply with the Federal external review process. Similarly, insured group health plans will be required to comply with the Federal external review process if they are not subject to any State external review process, or the applicable State external review process does not meet the specified minimum consumer protections.

In order to allow and encourage States to modify their external review processes, as necessary, to meet the minimum consumer protection standards of the NAIC Uniform Model Act, the interim final regulations treat all existing State external review processes as meeting those standards during a transition period for plan years beginning before July 1, 2011. Thus, during that transition period, any health insurance issuer that is subject to an existing State external review process must comply with that process and not the Federal external review process.

The Federal external review process will be similar to a qualifying State external review process and will meet similar consumer protection standards. The Federal external review process will also provide for expedited external review and additional consumer protections for claims involving experimental or investigational treatment, but it will not address claims denials based on a claimant's failure to meet eligibility requirements under the terms of a group health plan.

The federal agencies will address in future guidance how non-grandfathered self-insured group health plans currently maintaining an internal appeals process that otherwise meets Federal external review standards may satisfy requirements for the new Federal external review process.

Culturally and Linguistically Appropriate

A group health plan or health insurance issuer will satisfy the requirement to provide claims determinations in a culturally and linguistically appropriate manner if it provides those determinations in a non-English language upon request where (i) the plan covers fewer than 100 participants, and 25% or more of all participants are literate only in the same non-English language, or (ii) the plan covers 100 or more participants, and the lesser of 500 participants or 10% of all participants are literate only in the same non-English language. A plan meeting one of the these thresholds must also (i) include a statement in the English versions of all claims determinations that claims determinations are available in the non-English language, and (ii) provide all subsequent notices or determinations to a claimant in the non-English language once the claimant has requested non-English communications. In addition, if the plan or issuer maintains a telephone hotline or other customer assistance process that answers questions or provides assistance for filing claims and appeals, the assistance must be provided in the non-English language.

If you have questions or would like additional information about the new internal and external claims procedure requirements under the Health Care Reform Law, please feel free to contact Brian Dougherty at (215) 587-5919 or bdougherty@postschell.com.

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