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Healthcare re-FORUM

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Modifications to Appeals Regulations

On June 22, 2011, the Departments of Health and Human Services (HHS), Labor and the Treasury (the Departments) jointly released amendments (Amended Rules) to their July 23, 2010, Interim Final Regulations on internal claims and appeals and external review (2010 IFR). The 2010 IFR and subsequent guidance issued in August and September 2010 and March 2011 required non-grandfathered group health plans and insurers offering group or individual coverage to implement effective processes for both internal appeals and external review beginning with the first plan year on or after September 23, 2010.

The Departments also issued a variety of other guidance on June 22, 2011. The Amended Rules and other guidance are based on feedback received from insurers, health plans and consumer advocates, and make changes to both the internal claims and appeals procedures and external review process. Implementation timeframes for these process requirements, including changes made by the most recent guidance, may vary depending on the specific requirement and plan year.

Changes to Internal Claims and Appeals Procedures:

Time Limit for Urgent Care Claim Decisions:
The 2010 IFR set a time limit of 24 hours for making decisions on urgent care claims.

> *Amended Rules:* Health plans or insurers are required to provide notification of benefit determination for an urgent care claim as soon as possible and no later than 72 hours after receiving the claim. The health plan or insurer must defer to the attending healthcare provider's determination that the claim involves urgent care.

Diagnosis and Treatment Codes:
Health plans or insurers were required by the 2010 IFR to include diagnosis and treatment codes (and their corresponding meanings) on all adverse benefit determinations.

> *Amended Rules:* Health plans or insurers are required to include a statement on adverse benefit determinations notifying members of their opportunity to request the related diagnosis and treatment codes (and their meanings), and to provide such information upon request.

Bypassing Internal Claim and Appeals Process:
The 2010 IFR stated that members could seek immediate external review or other available remedies under state or federal law if the health plan or insurer did not "strictly adhere" to internal claims and appeals requirements.

> *Amended Rules:* Exceptions are allowed for minor errors meeting certain conditions.

Non-English Language Assistance:
Health plans and insurers were required by the 2010 IFR to provide non-English language assistance and translation of claims and appeals notices when certain thresholds of non-English language literacy were met. These thresholds varied depending on whether a member had individual or group coverage.

> *Amended Rules:* Non-English assistance for all members is based on whether the member resides in a county in which 10 percent or more of the population is literate only in the same non-English language. The Amended Rules list 225 U.S. counties in which this threshold was met as of June 22, 2011—in most of these counties, the non-English language is Spanish. Notices sent to addresses in one of these 225 counties must include a statement in the applicable non-English language indicating how to access language services. The health plan or insurer must provide oral language services in the non-English language, and written notices in the non-English language upon request.

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Changes to the External Review Process:

Scope of the Federal External Review Process: Under the 2010 IFR and earlier guidance, any adverse benefit determination was eligible for federal external review except for a denial based on a member's failure to meet the eligibility requirements of a group health plan.

> ***Amended Rules:*** If federal external review is not initiated before September 20, 2011, adverse benefit determinations will only be eligible for such review if they involve medical judgment as determined by the external reviewer, or rescission of coverage. The scope of federal external review may be further modified by January 1, 2014.

Binding Character of External Review Decisions: The 2010 IFR stated that an external review decision was binding to both the plan or insurer and the claimant, except to the extent other remedies were available under state or federal law.

> ***Amended Rules:*** Even if a health plan or insurer intends to seek judicial review of an external review decision, it must provide benefits without delay if required by the external review decision. The Amended Rules also clarify that if a final external review decision upholds a denial of benefits, a plan or insurer may still subsequently decide to provide those benefits.

Transition Periods for External Review Processes: Under the 2010 IFR, a health plan or insurer had to comply with either a state external review process that met certain consumer protections based on the NAIC Uniform External Review Model Act, or a federal external review process.

> ***Amended Rules and Other Guidance:*** This requirement, and the timing of its implementation, was described and modified as follows:

- Self-insured plans subject to ERISA must follow a federal external review process by contracting with three independent review organizations (IROs) (the IRO Federal Process). Plans must contract with at least two IROs by January 1, 2012, and at least one additional IRO by July 1, 2012.
- Insurers and self-insured non-federal governmental plans must follow an applicable state external review process through December 31, 2011. After January 1, 2012, if a state process is deemed by HHS to be NAIC-parallel, the state process will still apply. If HHS deems the state process NAIC-similar, the state process will apply until January 1, 2014, at which time a federal process will apply unless the state process is deemed NAIC-parallel. If the state process is deemed neither NAIC-parallel nor NAIC-similar, a federal external review process will apply, and insurers and self-insured non-federal governmental plans can choose to participate in either an HHS-administered process through the Office of Personnel Management (OPM Federal Process) or the IRO Federal Process.

For More Information:

For more information, please review the internal claims and appeals and external review regulations and guidance available on both the Department of Labor website (http://www.dol.gov/ebsa/healthreform/) and the HHS Center for Consumer Information and Insurance Oversight (CCIIO) website (http://cciio.cms.gov/). Both websites should be reviewed as neither lists all the relevant guidance.