Claims Appeals and External Review Requirements Amended

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On Friday June 24th, The Internal Revenue Service (IRS), Department of Labor (DOL) and Department of Health and Human Services (HHS) (the Departments) jointly published an amendment to interim final rules related to the Internal Claims and Appeals and External Review Processes requirements contained in the Patient Protection and Affordable Care Act (PPACA). The Departments also released additional guidance in Technical Release 2011-02.

Fully-insured employers will generally rely on carriers for appeals and reviews

The PPACA requires group health plans to maintain an internal claim and appeal process that meets certain standards and to provide for an expanded external review process. The rules apply to both employer-sponsored health plans and to health insurance carriers (referred to as "health insurance issuers" by the Departments). Since the rules apply directly to the health insurance company, employers who sponsor fully-insured health plans can generally rely on their carrier to implement the appropriate appeals and review processes. Self-funded employers will need to coordinate compliance responsibilities with their plan administrator. We have asked each of the plan administrators how they plan on responding to the new guidance and we will relay that information to all self-insured clients.

Enforcement of certain rules further delayed

In welcome news to employers and insurers, the non-enforcement period for implementing an external review process has been extended to January 1st, 2012. The guidance also changes the requirement for self-insured plans to contract with Independent Review Organizations (IROs). Self-funded plans must now contract with at least two IROs by January 1, 2012 and with at least three IROs by July 1, 2012.

Other changes to the requirements

The amendment also makes a number of other changes which will ease some of the compliance obligations contained in the rules including:

- Expanding the time in which a plan must notify an individual of a benefit determination for urgent care claims from the original requirement of 24 hours to 72 hours.
- Requiring that notices state that diagnosis and treatment codes are available upon request instead of requiring notices to automatically provide the codes.
- Provides limits on an individual's ability to pursue an external or judicial review.
- Limits the requirement to provide statements in other languages to situations when at least 10 percent of the residents in the applicable county speak a particular non-English language. The rules contain a list of affected counties.
- Temporarily narrows the type of claims eligible for the federal external review process to claims involving medical judgment or rescissions of coverage. On the other hand, the Departments clarified that once an IRO has made a ruling, the plan or insurer must pay a disputed claim according to the IRO's opinion even if the plan or insurer intends to seek judicial review of the decision.

Summary

HHS also released a technical guidance document with additional information on implementing the culturally and linguistically appropriate standards for claim and appeal notices. All documents and guidance are available from the HHS Center for Consumer Information & Insurance Oversight (CCIIO) at http://cciio.cms.gov/resources/regulations.