
Health Care Reform Update: New Guidance and Transitional Relief for PPACA Claims and External Review Procedures

by Lori Partrick


The Departments of Labor, Treasury and Health and Human Services have amended the interim final rule issued in July 2010 regarding internal claims and appeals and external review requirements under the Patient Protection and Affordable Care Act ("PPACA").¹ The Department of Labor has also published a related technical release providing additional guidance and revised model determination notices. These amendments may require updates to the claims procedures included in summary plan descriptions of affected plans.

On June 24, 2011, the Departments of Labor, Treasury and Health and Human Services (the "Departments") jointly issued interim final regulations amending the internal claims and appeals and external review requirements in regulations published in July 2010. The July 2010 claims procedure regulations and 2011 amendments affect non-grandfathered self-insured or insured group health plans. A detailed discussion of the July 2010 regulations can be found in our [client alert dated September 9, 2010](#).

Amendments Applicable to Internal Claims and Appeals Processes

The July 2010 interim final regulations included procedural requirements that would supplement the original ERISA claims procedures regulation. The 2011 amendments clarify or ease a number of those rules.

Urgent Care Claims. The July 2010 regulations accelerated the maximum notice period for benefit determinations for urgent care from 72 hours after receipt of the claim, as required under the original ERISA claims procedure regulation, to 24 hours, taking into account the medical exigencies. The 2011 amendments generally revert to the 72-hour rule in the ERISA claims procedure regulation, provided that the plan defers to the attending provider as to whether the claim involves "urgent care."

 ¹ For information on PPACA, see our client alerts dated [March 30, 2010](#), [May 13, 2010](#), [September 8, 2010](#), [September 9, 2010](#), [April 11, 2011](#), and our white paper dated [July 12, 2010](#).

Notice of Adverse Benefit Determination Requirements. The July 2010 regulations included several new requirements on the content of adverse benefits determinations, including a requirement that any notice of adverse benefit determination must include the diagnosis code and the treatment code and an explanation of their meaning. The amended regulations eliminate this requirement. Instead, all notices of adverse benefit determination must provide notification of the opportunity to request the diagnosis and treatment codes (and their meanings). The amended regulations clarify that a request for such information may not, in itself, be considered a request for an internal appeal or an external review.

Strict Adherence. The July 2010 regulations provided that if a plan failed to strictly adhere to all regulatory requirements for processing a claim, the claimant would be deemed to have exhausted his or her internal appeals and could proceed directly to external review or a court of law, even if the underlying error was de minimis. The amended regulations provide an exception to the strict adherence standard for errors that are:

- Minor;
- Not prejudicial;
- Attributable to good cause or matters beyond the plan's or issuer's control;
- In the context of an ongoing good-faith exchange of information; and
- Not reflective of a pattern or practice of non-compliance.

Any plan relying on this exemption is required to provide, upon written request, an explanation of its basis for asserting that it meets this standard.

Culturally and Linguistically Appropriate Notices. PPACA requires notices of available internal claims and appeals procedures to be provided in a culturally and linguistically appropriate manner. The July 2010 regulations established rules for providing claims denial notices in a non-English language upon request and other related requirements, using a compliance threshold based on the number of participants in the plan and the number or percentage of participants who are literate in the same non-English language. The amended regulations establish a single threshold and require that claims denial notices be provided in a non-English language upon request if ten percent or more of the population in the claimant's county (based on U.S. Census Bureau survey data) are literate only in the same non-English language. The counties and applicable languages are listed in the preamble to the amended regulation, and the list is to be updated annually on the Departments' websites if there are changes to the list of counties determined to meet the ten percent threshold. If this threshold is met, a plan must:

- Provide claims and appeals notices, upon request, in the applicable non-English language;
- Provide oral language services (such as a telephone customer assistance hotline) that include answering questions in the same non-English language and providing assistance with filing claims, appeals and requests for external review; and
- Include a statement in the English version of all notices, prominently displayed in the applicable non-English language, regarding the availability of language services and how to access them.

The amended regulations do not include the requirement of the July 2010 regulations to "tag" and "track" all individuals who request documents in a non-English language so that any future notices will be provided automatically in the applicable non-English language.

Amendments Applicable to Federal and State External Reviews

PPACA provides that non-grandfathered plans must make available a state or federal external claim review process for denied claims. The July 2010 regulations and a technical release issued by the Department of Labor on August 23, 2010 established rules for compliance with this requirement. The changes made by the 2011 amendments and technical release include changes to the scope of claims eligible for external review, modification of the transition period for states to implement external review processes, and modification of the federal external review processes.

Scope of Claims Eligible for External Review. Under the July 2010 regulations, any adverse benefit determination (other than a determination relating to eligibility under the terms of a group health plan) would be eligible for external review, including determinations based on contractual or legal interpretations. The amended regulations temporarily suspend the original rule and narrow the scope of claims eligible for external review to claims involving medical judgment or a rescission of coverage. The amended regulations provide examples of the types of claims that involve medical judgment, such as the appropriate setting for medical care, whether treatment by a specialist is medically necessary, and whether a medical condition is a preexisting condition. These rules will apply with respect to claims for which external review has not been initiated before September 20, 2011. As noted above, the suspension is temporary. It is expected to be lifted by January 1, 2014.

State External Review Processes. The July 2010 regulations provided a transition period for plan years beginning before July 1, 2011 for states to implement external review processes that comply with required minimum consumer protections. The 2011 amendments extend the transition period through December 31, 2011, and establish a set of temporary consumer protection standards that will apply under certain circumstances until January 1, 2014.

Federal External Review Processes. The August 2010 technical release provided for an interim enforcement safe harbor for self-insured plans permitting the plans to contract privately with accredited independent review organizations (IROs) to perform external reviews. The safe harbor included a requirement that plans contract with at least three accredited IROs and rotate assignments among them. The technical release issued with respect to the amended regulations provides that in order to be eligible for the enforcement safe harbor, a self-insured plan will be required to contract with at least two IROs by January 1, 2012 and with at least three by July 1, 2012 and to rotate claims assignments among them.

What Plan Sponsors of Non-Grandfathered Plans Need To Do

Employers should review their claims procedures and model determination notices to ensure that their documentation complies with the amended regulations. (New model notices of adverse benefit determination and final internal adverse determination have been posted at www.dol.gov/ebsa.) This review may require updating contracts with service providers to ensure compliance with mandated procedures and to allocate liability for any failure to adhere to the new requirements.

If you have any questions about the content of this publication, please contact the Pillsbury attorney with whom you regularly work or the Executive Compensation & Benefits group.

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