July 7, 2011

Revised Rules and Model Notices on External Review

As part of healthcare reform, non-grandfathered plans are required to comply with new claims and appeal rules that are broad reaching and require accelerated resolution and new disclosure language. See our Conner Strong & Buckelew Updates from 3/24/11 and 10/14/10 for background on the claims and appeal requirements and other earlier guidance. Due to the enormity of the changes, employees and plan sponsors have been forced to review their processes to ensure compliance. In many instances, employers have begun to consider outsourcing the decision-making process entirely, including final decision-making authority when their plans are self-funded.

Non-grandfathered and new group health plans will need to be aware of newly amended rules for internal claim procedures and external reviews. The regulators have also issued revised model notices as part of new technical release guidance on state and federal external review processes along with other related guidance. Instructions for insurers and self-funded, nonfederal governmental plans electing to use a federal external review process have also been provided. The revisions address a variety of employer concerns and provide a helpful reduction of the compliance burden. The amendments are generally effective July 22, 2011, but certain enforcement grace periods still apply.

Some highlights of this latest guidance include the following:

- Plans are permitted to follow the original DOL claims procedure rule (requiring decision making as soon as possible, consistent with the medical exigencies involved, but in no event later than 72 hours), provided that the plan defers to the attending provider with respect to the decision as to whether the claim constitutes “urgent care.”
- There is no longer an automatic requirement to provide diagnosis and treatment codes in claim denial notices. Plans are permitted to provide notification of the opportunity to request diagnosis and treatment codes (and their meanings) in all notices, and provide this information upon request.
- The scope of claims eligible for federal external review is temporarily narrowed to claims involving medical judgment or coverage rescission.
- The rules contain a general requirement that claimants should not have to follow an internal claims and appeals procedure that is less than full, fair, and timely, but there is now an exception to the strict compliance standard for certain minor errors. Claimants are also entitled, upon written request, to an explanation of the plan’s basis for asserting that it meets the exception.

- Plans need to give non-English language denial notices only if at least 10% of residents in the claimant's county are literate in the same foreign language.
- Self-insured ERISA plans using a federal safe harbor for external review must contract with at least two independent review organizations (IROs) by January 1, 2012, and states now have until December 31, 2011 to adopt compliant external review processes, which are subject to eased requirements for minimum consumer protections until January 1, 2014.

Plans must update their list of relevant consumer assistance programs and ombudsmen (if applicable) at the beginning of the year. The new technical release includes the current list of state consumer assistance programs. The regulations and technical releases, including the current model notices and previously released frequently-asked-question (FAQ) guidance, are available at www.dol.gov/ebsa/healthreform. Questions concerning the information contained in the technical releases may be directed to the DOL Office of Health Plan Standards and Compliance Assistance at 202-693-8335.

Should you have questions about this or any aspect of healthcare reform, contact your Conner Strong & Buckelew account representative toll free at 1-877-861-3220. For a complete list of Legislative Updates issued by Conner Strong & Buckelew, visit our online Resource Center.

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