

## Table of Deadlines for Non-Grandfathered Health Plans to Implement New Claims Procedures Requirements

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 [PDF of table»](#)

Read the accompanying article about claims procedures requirements [here](#).

Health Care Reform Requirement	Old Implementation Deadline	New Implementation Deadline
<b><i>Handling pre-certification requests in urgent care situations.</i></b>		
<p>Urgent care claims must be decided as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim by the plan.</p> <ul style="list-style-type: none"> <li>• This supersedes DOL claims regulations that allow 72 hours to decide urgent care claims.</li> <li>• An urgent care claim is a pre-treatment request for medical care or treatment for which time periods that apply to non-urgent care claims could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.</li> </ul>	<p>Enforcement grace period until July 1, 2011</p>	<p>Enforcement grace period extended until plan years beginning on or after January 1, 2012</p>
<b><i>Scope of Claims Appeals</i></b>		
<p>Decisions to rescind coverage are eligible for internal claims and appeals, whether or not the rescission has an adverse effect on any particular benefit at the time.</p>	<p>Required for plan years beginning on or after September 23, 2010</p>	<p>No change in deadline</p>

Health Care Reform Requirement	Old Implementation Deadline	New Implementation Deadline
<ul style="list-style-type: none"> <li>• A rescission is a decision to retroactively terminate coverage under the health plan.</li> <li>• Rescission decisions require at least 30 days advance written notice to the participant.</li> </ul>		
<b><i>Duty to Notify of New Information or Grounds for Denying Claim</i></b>		
<p>If, during the course of the claims appeal, the plan identifies new or additional evidence or a new or additional rationale for a denial, the plan must provide the evidence or rationale to the claimant and a reasonable opportunity for the claimant to respond to the new evidence or rationale.</p>	<p>Required for plan years beginning on or after September 23, 2010</p>	<p>No change in deadline</p>
<b><i>Avoiding Conflicts of Interest By Those Deciding Claims and Claims Appeals</i></b>		
<p>To avoid any conflicts of interest on the part of those deciding claims and claims appeals, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual (such as a claims adjuster or medical expert) cannot be based on the likelihood that the individual will support the denial of benefits.</p>	<p>Required for plan years beginning on or after September 23, 2010</p>	<p>No change in deadline</p>
<b><i>Providing Notices in a Culturally and Linguistically Appropriate Manner</i></b>		
<p>Notices relating to claims and claims appeals must be provided in a culturally and linguistically appropriate manner when a significant portion of the participants are literate only in the same non-English language.</p> <ul style="list-style-type: none"> <li>• applies to plans that meet the following minimum thresholds:             <ul style="list-style-type: none"> <li>○ for plans that cover fewer than 100 participants, if 25% or more of all plan participants are literate only in the same non-English language</li> <li>○ for plans that cover 100 or more participants, if the lesser of (1) 500 or</li> </ul> </li> </ul>	<p>Enforcement grace period until July 1, 2011</p>	<p>Enforcement grace period extended until plan years beginning on or after January 1, 2012</p>

Health Care Reform Requirement	Old Implementation Deadline	New Implementation Deadline
<p>more participants or (2) 10% or more of all plan participants are literate only in the same non-English language</p> <ul style="list-style-type: none"> <li>• If a threshold has been met, then the plan must meet the following requirements:                             <ul style="list-style-type: none"> <li>○ all English language notices relating to claims and appeals must include a prominent statement in the non-English language offering to provide such notices in the non-English language</li> <li>○ if a claimant asks to receive the non-English language, then all subsequent notices must be provided in the non-English language</li> <li>○ if the plan maintains a customer assistance process (such as a telephone hotline) that answers questions or provides assistance with filing claims and appeals, the plan or issuer must provide such assistance in the non-English language.</li> </ul> </li> </ul>		

***Additional Content Requirements for Claims and Claims Appeal Notices***

<p>Any time that a claim is not paid in full, the notice of adverse benefit determination (such as an explanation of benefits) and any final internal adverse benefit determination must include the following information</p> <ul style="list-style-type: none"> <li>• information sufficient to identify the claim involved, including:                             <ul style="list-style-type: none"> <li>○ date of service</li> <li>○ health care provider</li> <li>○ claim amount (if applicable)</li> </ul> </li> </ul>	<p>Enforcement grace period until July 1, 2011</p>	<p>Enforcement grace period adjusted until plan years beginning on or after July 1, 2011, except that plans have until plan years beginning on or after January 1, 2012 to comply with the requirement to include diagnosis and treatment codes (and their corresponding meaning).</p> <p>The Department of Labor has posted a model notice of adverse benefit determination here: <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a></p>
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Health Care Reform Requirement	Old Implementation Deadline	New Implementation Deadline
<ul style="list-style-type: none"> <li>○ the diagnoses code and its corresponding meaning</li> <li>○ the treatment code and its corresponding meaning</li> <li>● the reason or reasons that the claim was denied or not paid in full, including:                             <ul style="list-style-type: none"> <li>○ the denial code and its corresponding meaning</li> <li>○ a description of the standard used in denying the claim</li> <li>○ in the case of a final denial of the claim, a discussion of the decision</li> </ul> </li> <li>● a description of available internal appeals and external review processes, including information on how to initiate an appeal</li> <li>● the availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman.</li> </ul>		

***External Claims Appeals Process***

<p>Health plans must provide an external review with an independent review organization (IRO) once a claimant has exhausted the plan's internal claims appeal procedures</p> <ul style="list-style-type: none"> <li>● Plan must allow four months to request the external review from the date the claimant receives a final notice (or from the date of the initial adverse benefit determination when an internal review is not necessary)</li> <li>● Plan must have an unbiased method for selecting an IRO, such as rotating claims among three contracted IROs</li> <li>● Plan must allow for expedited external review in urgent care situations</li> </ul>	<p>Required for plan years beginning on or after September 23, 2010</p>	<p>No change in deadline</p>
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Health Care Reform Requirement	Old Implementation Deadline	New Implementation Deadline
<b><i>Deemed Exhaustion of Internal Claims Appeals Procedures</i></b>		
If a health plan fails to strictly adhere with all new claims and claims appeal requirements, the claimant is deemed to have exhausted the claim's appeals process and may immediately seek an external review or file a lawsuit seeking ERISA or applicable state law remedies.	Enforcement grace period until July 1, 2011	Enforcement grace period extended until plan years beginning on or after January 1, 2012