

## Compliance with Certain Claims and External Review Requirements Delayed

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March 31, 2011

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The Departments of Labor, Health and Human Services, and Treasury have extended the deadline for non-grandfathered health plans to comply with certain requirements of health reform's claims and external review provisions. Specifically, compliance with the following requirements has been extended until the first day of the plan year beginning on or after January 1, 2012 (i.e. January 1, 2012 for calendar year plans):

- Notification of determinations of urgent care claims must be provided within 24 hours;
- Notices of benefit determinations must be culturally and linguistically appropriate; and
- Notices of benefit determinations must include the specific diagnostic code and treatment code and the meaning of the codes.

Further, the effective date of the provision allowing a participant to immediately bring a lawsuit or request external review if the plan does not strictly adhere to the requirements of the claims procedures has also been delayed until the first day of the plan year beginning on or after January 1, 2012. Finally, the requirement that additional claims information be disclosed in an adverse benefit determination, including (i) information sufficient to identify the claim, (ii) the reason for the adverse benefit determination, (iii) a description of available internal and external appeals processes, and (iv) the availability of an office of health insurance consumer assistance program or ombudsman, has been extended to the first plan year beginning on or after July 1, 2011 (i.e. January 1, 2012 for calendar year plans). The guidance is available for review [here](#).