AppealTraining.com Webinar Series

ERISA Appeals

Overcoming the "FAKE" Appeal Process

What is ERISA

Employee Retirement Income Security Act – federal law governing employer-sponsored benefit plans. Claim impact:

- Can be fully-insured or self-funded
- Self-funded plans exempt from state laws which govern insurance but not necessarily quality of care
- Strict Disclosure laws
- Claims Procedure Regulations

Scope

Majority of “commercial payer” designation is likely governed by ERISA

- Exceptions – state, county, federal employees and religious organizations
- ERISA regulates about 60 - 80% of non-Medicaid/Medicare healthcare claims
- Impact – coverage for 2.3 million ERISA Plans (125 million Americans) is under near constant disruption, changes often without consumer input/awareness

Mandatory Coverage Impact

- State mandatory laws exempt (fertility, MN/SA, obesity) but ERISA's standards evolving:
  - **NMHPA and WHCRA '98**
    - dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/nmhpa
    - dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra
  - **Mental health parity '08**
    - dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity
  - **ACA expansion preventative care**

Terms To Know

ERISA Fiduciary – persons or entities with discretionary control over plan assets and must act in the interest of the plan members.

Responsibilities:

- Manage plan in “prudent” way
- Insure compliance (including disclosure)
- Determine who makes final coverage decisions and who defends decisions
- Currently under scrutiny to clarify fiduciary and co-fiduciary roles and liability

Aetna "Non Fiduciary" Process

Aetna makes initial coverage decision. Plan's fiduciary decides appeals and defends

- Aetna not responsible for the appeal or final claim determination
- Forwards appeals to plan's claim fiduciary
- Provides denial letter/rationale
- Upon request, provides all documentation
- Fiduciary conducts own independent evaluation of the claim and writes decision
  - aetna.com/about/pdf/TalkingPoints.pdf

Terms To Know: SPD

Summary Plan Description (SPD)

- SPD is detailed document explaining benefits, UR requirements, limitations and appeal rights
- It must be provided to a “qualified party” upon request and applicable portions of the SPD must be cited in any adverse determination or provided upon request.
- Providers often must demonstrate proof of being a “qualified party”

Providers' Rights Muddied

FAQ B2: Does an AOB by a claimant to a health care provider constitute the designation of an authorized representative? An AOB is generally limited to assignment of the claimant's right to receive a benefit payment...*Typically*, assignments are not a grant of authority to act on a claimant's behalf in pursuing and appealing a benefit determination under a plan. The validity of a designation may depend on the specific procedures established by the plan, if any.

www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation

CIGNA Plan Procedures?

- Appeal/IDR for contractual disputes
- Coding to Billing Dispute Administrator
- 6 Different Forms
- What can be appealed and by whom:
  - **Precert for TX not rendered (Customer)**
  - **Precert not obtained (Provider)**
  - **Claim reimbursement (Provider)**
  - **Benefit denials/Max Reimb (Customer)**
  - **Experimental (Customer)**
  - **Medical necessity, LOS (Either)**

www.cigna.com/health-care-providers/coverage-and-claims/appeals-disputes/

Provider v Beneficiary Rights

Provider Appeal Process

- No specific time frame for an appeal decision may exist.
- Carriers may not have to disclose clinical information considered or divulge reviewers names/credentials
- Carriers do not necessarily have to consider new information not submitted with original claim
- Carrier can make final decision without consulting employer.
- Providers do not necessarily have recourse to sue or seek disclosure penalties.

ERISA Appeal Process

- ERISA requires an appeal decision in 60 days.
- ERISA requires disclosure of clinical criteria and reviewers name/credentials
- ERISA requires consideration of new documents/records submitted with appeal
- ERISA requires SPD to specify who has final decision making authority - “Plan Fiduciary”
- ERISA allows for $110 penalty for disclosure violations and redress in federal court

Final Term: Disclosure

- Dol.gov has disclosure guides/model disclosure notices/disclosure checklists
- ERISA Health Benefit Disclosure Requirements can apply to benefit information (VOB), pre-service claims (UR Requests), claims processing, benefit calculations and appeals
- Monetary penalties ($110/day) can be awarded for failure to disclose and coverage granted
- ACA expanded both benefits and disclosure requirements – ex preventative care/MH parity
- Litigation provides thousands of examples

Problem: Authorization

Eligibility/preauth processes don't work:

- 91% of docs see poor impact on care
- No protection against payer errors
- UM is well-regulated (state/federal) and AMA pushing for more protections
- ERISA disclosure protection can provide leverage to advocacy role
  - www.ama-assn.org/practice-management/sustainability/prior-authorization-research-reports

Killian v Concert Health - 7th cir

Member called for surgery preauth. Gave outdated hospital name. Rep could not find name but authorized admit. Claim processed out-of network. Court said:

“the fiduciary has an obligation to convey complete and accurate information material to the beneficiary's circumstance, even if that requires conveying information about which the beneficiary did not specifically inquire “

www.debofsky.com/blog/2013/11/court-recognizes-fiduciary-breach-claim-when-health-insurer-gives-erroneous-information.shtml

King v BCBS of IL - 9th cir

Member called for coverage info. SPD had been amended 12 times. Court criticized the SPD/modification summaries because all would need to be with the SPD to determine available benefits

"Plan participants should be able to rely upon plan administrators to provide them with accurate information concerning their ERISA benefit plan"

https://www.mslawllp.com/plan-administrators-cannot-violate-their-fiduciary-duties-by-failing-to-provide-proper-notice-of-policy-amendments-erisa-plan-exclusionslimits-may-not-be-enforceable/

Disclosure Protection Uses

- Written Pretreatment Request for Benefit Clarification. See ERISA Samples A/B/C.
- Casual inquiry v benefit claim inquiry: “Full disclosure of the plan provisions allows the assignee to perfect claims for … (customize with treatment description)”
- Additionally, please provide forms, anti-assignment provisions, SPD
- • “U.S. Dept of Labor has stipulated that when a claimant clearly designates…”

VOB vs SPD

Carrier disclaimer may negate VOB but the SPD must be accurate regarding coverage and must be followed to the letter. It must clarify

– out-of-network coverage

– precertification procedures

– Definitions of medical necessity, UCR, experimental

Problem: Quality Clinical Review

- Carriers often do not provide credentials of reviewer or clinical review criteria “dialogue”
- Clinical practice guidelines are highly variable in quality.
- CPG are often used along with internal payer guidance of even more dubious quality.
- Court concluded a employer liable to assist the plaintiff obtain copies of TPA “Resource Tools” for speech therapy. Awarded $30.00 per day for 309 days it was withheld.

/www.benefitslawadvisor.com/2018/10/articles/erisa-plan-administration/are-you-doing-enough-to-avoid-erisa-statutory-penalties/

Kamins v UHCNY, UBH, Empire

United Behavioral Health parity issues:

- UBH may require evidence care is necessary to prevent “acute” deterioration
- UBH may require MH patients to have had “acute changes” in conditions
- UBH guidelines ignore patient motivation and clinician assessments of patient readiness for lower level of care
- UBH guidelines prohibit coverage for borderline personality disorder if primary
  - www.psych-appeal.com/wp-content/uploads/2015/02/2015-02-06-First-Amended-Complaint.pdf

Disclosure Protection Uses

FAQ9: Health plan requires preauth for 9th visit for depression. What can I request for compliance with MHPAEA?

- Summary Plan Description (SPD)
- Specific language regarding preauth
- Specific underlying processes, strategies, all evidence considered
- Analysis of how NQTL complies with MHPAEA

dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf

Problem: Payment Calculation

Dermatologist contested payment amount. Was directed to third party repricer. Left message but missed the returned call:

- Filed suit for incorrect payment, breach of fiduciary duty, failure to provide SPD
- “The appeals process is a fake process designed to waste time.” Griffin v Team Care/Central States

//cases.justia.com/federal/appellate-courts/ca7/18-2374/18-2374-2018-11-26.pdf?ts=1543255262

Problem: Payer “Savings” Fee

- North Cypress v Aetna - Suit by providers (UCR) and countersuit by Aetna (fraudulent billing/waivers)
- The Byzantine complexity of the US healthcare system can bamboozle even the savviest of consumers, decision reads.
- Court noted symbiotic relationship when payer uses 3rd party repricer and earns “saving fee” Reversed/remanded

law.justia.com/cases/federal/appellate-courts/ca5/16-20674/16-20674-2018-07-31.html

ERISA Compliance - Data

For plans subject to ERISA, documentation and data used to calculate each of the minimum payment standards, including the UCR amount, for out-of-network emergency services are considered to be instruments under which the plan is established or operated and would be subject to the disclosure (within 30 days of request)

- OON emergency – cite www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31_Final-4-20-16.pdf
- All other UCR – cite www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/1996-14a

ERISA Full & Fair Review

- 180 to appeal
- submission of comments, documents, records
- reasonable access to all documents, records, and other info relevant to decision
- allows for submission of new information
- no deference to the initial adverse benefit determination and review by the plan fiduciary
- in denials involving medical judgment, plan must consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment
- Can be used for poorly worded refund/recoupment requests involving ERISA plans

Appeal Letter Templates

- AppealTraining.com has the following ERISA appeal categories:
  - **Stalled Claims see ERISA**
  - **Medical Necessity. See ERISA Regulations Subcategory**
  - **Specialty Care. See Maternity/Newborn Care – See Newborn Mothers Health Protection Act**
  - **Specialty Care. See MentalNervous/Substance Abuse (3 letters: parity, authorization, UCR calculation disclosure)**

Appeal Letter Templates

- AppealTraining.com webinar has the following ERISA appeal templates:
  - **ERISA Pre-treatment Benefit Inquiry. See Sample A, B, C**
  - **ERISA Request for Reviewers Credentials. See Sample D**
  - **ERISA Request for Clinical Criteria (mental health). See Sample E**
  - **ERISA Expertimental/Investigational. See Sample F**
  - **UCR Payment Calculation. See Sample G**

Appeal Letter Templates

- AppealTraining.com webinar has the following ERISA Level II appeal templates all of which reference the payer's lack of response to previous disclosure requests:
  - **Lack of UCR Disclosure. See H**
  - **Clinical, Quality, Compliance Appeal. See I**
  - **Lack of Full and Fair Review. See J**