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Medical Claims: An Overview

- ERISA's mandate that plan participants receive a full and fair review of their claims still applies
  - ERISA § 503, 29 U.S.C. § 1133
  - 29 C.F.R. § 2560.503-1

- The ACA has, however, expanded the requirements for health claim reviews with respect to non-grandfathered health plans
  - 29 C.F.R. § 2590.715-2719
  - The requirements will become a bigger factor in medical claim appeals as more plans give up their grandfathered status

The Regulatory Landscape

Full & Fair Review What is Required: All Health Plans

29 C.F.R. § 2560.503-1(g) – Every employee benefit plan must:

- Provide adequate notice in writing when claim is denied
- Set forth the specific reasons for such denial, referring to the relevant plan provisions
- Describe what information is necessary to perfect the claim and why
- Describe the plan's review procedures and the time limits applicable to such procedures
- Describe what internal rules, guidelines, or protocols the administrator relied on in making the adverse decision

Full & Fair Review What is Required: All Health Plans

- All of the basic requirements of 29 C.F.R. § 2560.503-1
- Additionally:
  - Increased timing to notify a claimant that it has not followed the plan's procedures for a pre-service claim
  - Claims procedures cannot require more than two appeals of an adverse benefit determination
  - No mandatory arbitration of claims, unless it is a voluntary appeal and does not preclude filing suit
  - Different timing rules for notifying a claimant of an adverse claim determination that vary depending on the type of claim (i.e., urgent care, concurrent care, preservice claims, and post-service claims)
  - Identification or specific guidelines or protocols used in determining the claim
  - An explanation of the scientific or clinical judgment relied upon in denying the claim.

Full & Fair Review What is Required: All Health Plans (Continued)

- Adverse Benefit Decisions: Timing
- **Urgent**: Decision within 72 hours (24-hour extension permitted); claimant has 48 hours to submit additional information. Appeals adjudicated within 72 hours
- **Pre-Service**: Decision within 15 days (15-day extension permitted). All appeals adjudicated within 30 days (even if multi-levels required)
- **Post-Service**: Decision within 30 days (15-day extension permitted). All appeals adjudicated within 60 days (even if multi-levels required). A post-service claim cannot be urgent

Full & Fair Review What is Required: All Health Plans (Continued)

- Provide at least 180 days to appeal an adverse claim determination
- Provide for a review that does not afford deference to the initial determination and that is conducted by someone who did not make the initial determination and who is not subordinate to the person who made the initial determination
- If the adverse determination was based on medical judgment, a health care professional with appropriate training or experience should be consulted in assessing the appeal
- Identify all medical or vocational experts whose advice was obtained on behalf of the plan
- Provide an expedited appeal process for urgent care claims
- Comply with various timing rules for an appeal decision, depending on the type of the medical claim
- Identify guidelines or protocols used in making the adverse appeal determination, and applying the terms of the plan to the claimant's medical circumstances

Full & Fair Review What is Required: Non-Grandfathered Health Plans 29 C.F.R. § 2590.715-2719

- There is now an express right to "review and respond"
- The claimant must receive any new or additional evidence considered, relied upon, or generated by the plan in connection with the claim as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided;
- Before the plan can issue a final appeal decision based on a new or additional rationale, the claimant must be provided with the rationale as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided; and
- If the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the claimant has a reasonable opportunity to respond

Full & Fair Review What is Required: Non-Grandfathered Health Plans 29 C.F.R. § 2590.715-2719

- Plans are required to avoid conflicts of interest:
  - The plan "must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision."
  - "decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits."
- Increased notice requirements and explanations to participants
- Plans must offer a voluntary external review of claims, which is binding
- Failing to comply with the regulations may result in a de novo review by the courts

External Review of Claims for Non-Grandfathered Plans

- Insured plans
  - if state insurance law provides an external review process that meets certain minimum standards under the NAIC Uniform Model Act, insurer must comply with the state's requirements.
  - If no state procedures, must use federal external review procedures
- Self-funded plans must comply with federal external review procedures
  - Alternative method – voluntary compliance with state process (if state permits)
  - Safe harbor for self-funded plans subject to federal external review process (DOL Technical Release 2010-01, modified by 2011-02)
    - To qualify for safe harbor, plan must contract with at least 3 IROs accredited by URAC or similar organization. TPA may contract with IRO but Plan remains responsible. *See* DOL FAQs I Q-9

External Review of Claims for Non-Grandfathered Plans

- Scope of federal external review limited to claims involving medical judgment and rescission of coverage
- Claimant has 4 months after receiving denial to request external review
- Within 5 business days, plan must perform preliminary review (whether claimant covered, benefit denial involved eligibility, claimant exhausted internal procedures, claimant provided all information to process, claim eligible for external review)
- Plan must give written notice 1 business day of completing preliminary review
- Plan assigns accredited IRO to review
  - Rotation or random selection with no financial incentives based on likelihood that it will support denials
  - IRO gives claimant written notice that review request is accepted
  - Within 5 business days after IRO assigned, plan must provide documents/information it considered

External Review of Claims for Non-Grandfathered Plans

- If IRO receives information from claimant, must forward to plan within 1 business day.
- Plan may reconsider denial
- IRO review is de novo and no deference to plan’s internal claims decision
- IRO must give written notice of final decision within 45 days of receiving external review request
- Plan must immediately implement IRO decision
- The IRO decision is generally binding, except that the claimant many still seek judicial review of the adverse claim determination

Appeals of Claim Denials

Claimant’s Counsel: Assessing an Appeal

- Step one: review the claim denial notification
  - Does it remotely comply with the claims regulations
  - Generally, only an explanation of benefits (“EOB”) is provided
  - What can you glean from the denial
  - When was the claim denied
  - Has the client been billed by the provider and, if so, did he or she pay the bill out of pocket
  - If your client is a provider, be wary of anti-assignment provisions
- Step two: calendar your appeal deadline for 180 days from the date of the claim denial letter (even though you likely have a bit more time)

Claimant's Counsel: Assessing an Appeal

- Step three: obtain the pertinent documents
  - Submit a § 104(b) request to the plan administrator, if you are able to determine who that is
  - Request from the plan or insurer a copy of the complete claim file
  - In sum, you should request
    - The plan document
    - The SPD
    - All documents that are "relevant" to the claim *see* 29 C.F.R. § 2560.503-1(m)(8)
    - The "claim file," including emails, activity logs, medical reports, and plan expert reports
    - Claims manuals, protocols, and an explanation of any codes on the EOB
    - Information on the reviewing doctors
    - All communications b/w plan fiduciary and plan counsel

Claimant's Counsel: Assessing an Appeal

- Step 4: review the plan documents and compare it to the denial letter
  - Does the rationale make sense
  - Determine what is needed to rebut it
- Step 5: identify the flaws in the adverse benefit determination
  - Process matters
  - Conflicted experts matter
  - Not following the plan matters
  - Selectively reviewing the record matters

Claimant's Counsel: Assessing an Appeal

- Step 6: consider the need for an expert witness
  - Typically arises in cases related to medical necessity
  - Treating physicians are helpful, but their opinions are not dispositive. *See Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003)
  - Is there medical literature that supports your position
- Step 7: prepare your appeal

Does an External Appeal Make Sense

- External review claims appear fairly rare
- Claimant's attorneys often doubt the impartiality of the reviewers
- Further delays the process if the claim is denied
  - Potential issues with limitations period
  - Consider *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604 (2013) (holding that an appeal does not toll the running of a plan's reasonable contractual limitations period)
- External review may make sense for certain low value claims, as opposed to litigation
- For urgent care claims, the expedited process may be beneficial

Considering Appeals: The Plan’s Perspective

Plan Counsel: Assessing an Appeal

- Review the documents submitted by the participant
- Compare the submitted documents to the reasons for the denial
- Has the participant addressed the issue(s) raised in the denial?
- Is the reasoning for the denial still consistent with the terms of the Plan given the additional arguments/documents from the Participant?
- Are there any conflict issues?

Questions