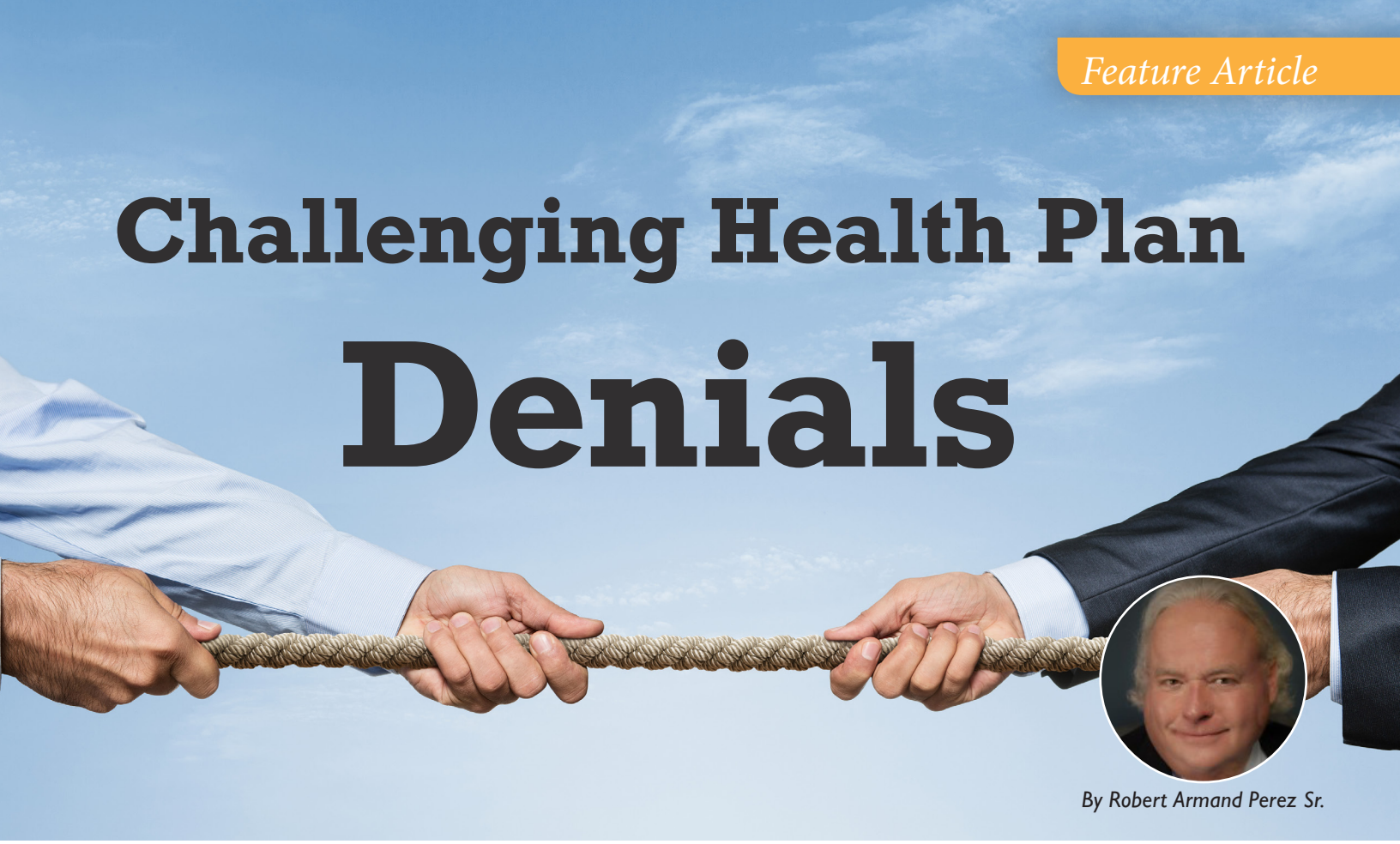
Challenging Health Plan Denials



By Robert Armand Perez Sr.

There is a rising cost of healthcare in the United States and a lack of consensus on how to pay for healthcare. Premiums continue to increase. A pervasive problem encountered by consumers is the denial of claims that are submitted for treatment. It is estimated that the rate of denial of health insurance claims is 3.9 percent.[1] They can be denied for a variety of reasons such as typographical errors, incorrect or incomplete coding or billing, terminated contract numbers, or incorrect demographic information. Many times, the denial can be resolved by the healthcare provider simply re-submitting the claim. Without appropriate editing and review, it is unlikely that this will result in having a claim paid. Billing services can increase the revenue to the provider by proper analysis that will help reverse payment denials.[2]

Healthcare plans are either governed by the Employee Retirement Income and Security Act (ERISA) or state law. Most health insurance coverages outside of the government sector[3] or church[4] plans are covered by ERISA.[5] The claim process for non-ERISA health insurance coverages, including those that are non-employee based such as individual policies, many times will also have a process for appealing denied claims that are similar, if not identical to those that are available under ERISA.

The Claim Denial

Most healthcare denials are never appealed. If the ERISA claim is decided incorrectly and the appeal rights are not fully communicated, the incorrect denials simply remain undisturbed.[6] The ERISA statute requires a "full and fair review" of a denial of payment or authorization of treatment after a written notice of the reasons for the denial.[7] The related claim regulations structure the process with procedural and substantive requirements.[8] Health insurers and self-insured plans usually fail to fully comply. Unfortunately, there is little or no penalty for violating the claim regulations. In contrast, the financial incentives to violate the regulations and avoid paying the claims are great. Both insurance-based plans and a number of ERISA plans that are self-funded have similar incentives.[9]

Generally, the patient/plan participant assigns the payment benefit to his/her medical provider who files the claim with the insurer plan.[10] However, many healthcare plans prohibit assignment of the rights to the benefits. This includes the right to appeal the denial. These anti-assignment plan provisions are generally enforceable.[11] Insurance based plans have a conflict of interest in paying claims. Even in the self-insured plans involving a third-party administrator (TPA) who administers the plan, there is a recognized conflict of interest.[12] The claim administrator with a conflict of interest may not make the appeal process clear to the participant.

One of the fundamental concepts of ERISA is that the employee benefits must be administered according to a written plan. Accordingly, the benefits must be administered in accordance with the terms of that document.[13] When a claim is denied, a written notification must be provided to the participant stating the plan provision that supports the denial. The notification must comply with the claim regulation requirements.[14] The typical explanation of benefits (EOB) sent to the patient does not comply with these regulatory requirements. Different time frames for appeal exist. They are related to the type of claim such as a pre-service claim, i.e. a pre-authorization, a post-service claim, or an urgent care claim.[15]

The Appeal Process

A participant's appeal process is triggered when a denial is issued. In an ERISA healthcare claim, the denial notification to the plan participant is critical to assure the due process rights of the claimant.[16] These basic claim regulations are applicable to all benefit claims, including healthcare claims.[17] The denial notice must include:

"(i) the specific reason or reasons for the adverse determination;

(ii) reference to the specific plan provisions on which the determination is based;

(iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, and

(iv) a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action of the act following an adverse benefit determination on review."[18]

In addition to these core regulatory notice requirements for all ERISA claims, there are additional requirements for group health plans. A group health plan must provide the guideline, the protocol, or other criteria relied upon to the claimant or state that a copy of it will be provided to the claimant upon request. If the denial is based on lack of medical necessity or experimental treatment, there must be an explanation of the scientific or clinical judgment that applies the terms of the plan to the claimant's medical circumstances or states that the explanation will be provided upon request.[19] After the administrative appeal, the denial of benefits may be reviewed by a district court.[20]

However, the participant must exhaust all of the administrative remedies under the plan before an action can be filed in federal court under ERISA.[21] Healthcare claims are subject to additional regulations.[22] When the healthcare plan administrator fails to follow the regulatory claim procedures, the claimant will be deemed to have exhausted the appeal process and the court should review the claim *de novo*. The claim must be processed within 30 days of receipt unless a 15-day extension is necessary and obtained by written notice of the extension.[23] The statutory intent of ERISA is to assure that the plan beneficiary has an opportunity for a full and fair review before litigation.[24]

Due Process Protections

The Sixth Circuit has held that an insurer's failure to comply with the procedural requirements to provide the specific reason(s) for the denial was a significant error and required the claim denial to be overturned. The proper remedy for a failure to provide appropriate administrative review is to have the district court "reconsider [the denial of benefits] after the [claimant] has been given the opportunity to submit additional evidence" rather than remand the case to the plan for further consideration.[25]

When the plan administrator fails to provide the specific reason(s) for denial, the claimant is not adequately apprised of the deficiency such that he or she can cure the deficiency with additional evidence. Also, when the denial notice contains insufficient information about the steps for obtaining a review, the claimant should be given the opportunity to submit additional evidence in litigation. The claim procedures of the plan fiduciary must contain "administrative processes and safeguards" designed to ensure that plan provisions are interpreted and applied consistently, and that decisions are made according to plan documents.[26] The concept of substantial compliance exists and the plan administrator may be determined to have substantially complied with the regulations. Thus, if the claim denial fails to inform and the claimant does not make a timely appeal, the claimant is bound by the record without favorable evidence.

Notice is Crucial

The reason why the notification in the claims process is so critical is that unlike litigation in federal court under other statutes, the reviewing court is generally limited to the evidence that is presented to the claim administrator prior to litigation. Although an ERISA review is truly not an administrative review, such as with a Social Security claim, it is treated in an analogous way. In the Sixth Circuit the process is defined in case law that is similar in other circuits.[27] Because of the limitations on what the court can review with some exceptions, the requirement to give proper notice enables the claimant to assemble the necessary evidence to ultimately prevail on the claim. Therefore, the requirement to give proper notification when the claim is denied is not merely a regulatory requirement, it is the keystone of the full and fair review that is statutorily required.[28] Unfortunately, some courts have adopted the concept of "substantial compliance"[29] with the regulatory notice requirements without full understanding of how critical proper notification is to the statutory scheme. The regulatory violation tends to be conflated by the court with the accompanying improper denial of benefits. Failure to comply with the regulatory notice and procedural requirements can result in no remedy at all.[30]

Judicial Review

ERISA defines who may bring an action. A healthcare provider may if there is a valid assignment of benefits.[31] Sometimes, only the healthcare provider is given more information on the denial than the patient in an explanation of benefits (EOB). Although this assignment of benefits from the patient is common, the policy/plan may contain an anti-assignment of benefit clauses[32] as many policies/plans do. This generally precludes the provider from having standing. After the appeal process, if the claim is still unpaid, the claimant may have the district court review the matter but limited to the administrative appeal evidence previously considered.[33] As a practical consideration, healthcare providers do not have access to the plan documents. Providers may not know how to appeal claims other than re-billing them. Providers state clinical findings rather than referring to the plan language. Providers may not have the time to effectively pursue the appeal. High dollar claims for treatment, such as experimental treatment and denials based on lack of medical necessity, require action on the part of the patient/claimant who may need assistance to effectively appeal the denial. As a generalization, health insurance carriers and third-party administrators do not understand the requirements they must follow in the claim regulations, even if the process is contained within their own plan/policy documents. Claim administrators violate the claim process and the regulations

routinely. This significantly prejudices the claimant.

An external review by an independent review organization (IRO) may be available for certain types of treatment denials. There are benefits and pitfalls for the beneficiary who chooses this review without understanding the nuances of the procedure and the problems of submitting his or her claim without experienced guidance. For many reasons, it does not result in an objective review that was contemplated when the external review was designed.

Conclusion

The healthcare industry is now approximately 20 percent of the gross domestic product. The denial of payment can constitute a huge shifting of costs within the overall framework of the economy.[34] The total cost for healthcare for a family of four in an employer-based plan in 2018 is $28,166 according to the annual Milliman Medical Index.[35] The ever climbing cost of healthcare and the struggle to determine, in our economy, how the care should be paid, incentivizes denials and cost shifting to patients and physicians and away from the employer-based plan and the insurance companies that underwrite it. The consumer that is caught in this conundrum may be risking household savings to be able to cope with the denial. A plan participant should seek legal counsel if it is a high dollar claim that has been denied. Relying on the healthcare provider is ill-advised for many reasons. When a claim is denied, prompt action is necessary as the time limits are set and initiated when a denial is sent. The failure to take timely action is fatal to a successful outcome. This results in an unfortunate shifting of the costs and the distortion of the overall economics of the healthcare system with which the nation struggles.

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1 AMA's 2009 National Health Insurance Report Card Analysis (HTTP://www.ama-assn.org/ama1/pub/upload/mm/368/2009-nhirc-long.pdf).

2 Advanced Health Analytics "Denial & Appeal Survey" March 2010.

3 29 U.S.C. § 1002(32).

4 29 U.S.C. § 1002(33)(A).

5 29 U.S.C. § 1001, *et seq.*

6 Caroline E. Mayer, *The Claim Game*, AARP THE MAGAZINE, Nov.-Dec. 2009, at 32 (quoting Connecticut's health care advocate Kevin Lembo as stating that ninety-six percent of denials are not appealed); General Information on How To File Insurance Appeals, ADVOCACY FOR PATIENTS WITH CHRONIC ILLNESS, INC., http://www.advocacyforpatients.org/hifile.html.

7 29 U.S.C. § 1133.

8 29 C.F.R. § 2560.503-1.

9 In 2010, fifty-nine percent of covered workers were in a self-funded plan, up from forty-four percent in 1999. THE KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2010 ANNUAL SURVEY 154 (2010), http://ehbs.kff.org/pdf/ 2010/8085.pdf.

10 D. Brian Hufford, Managed Care Litigation: The Role of Providers in Health Care Litigation: What You Need to Know After Pegram. 487, 501 (Practicing Law Inst. ed., 2000).

11 *Brown v. Blue Cross Blue Shield of Tennessee, Inc.*, 827 F.3d 543 (6th Cir. 2016). *Children's Hospital Medical Center of Akron v. Youngstown Assoc. in Radiology, Inc.*, 2018 W.L. 4539282 (N.D. Ohio September 21, 2018).

12 *Univ. Hosps. of Cleveland v. Emerson Elec. Co.*, 2002 F.3d 839, 844 (6th Cir. 2000).

13 29 U.S.C. § 1004(a)(1)(D).

14 29 C.F.R. § 2560.503-1.

15 29 C.F.R. § 2560.503-1(f)(2), *et seq.*

16 *Vanderklok v. Provident Life and Accident Insurance Co.*, 56 F.2d 610 (6th Cir. 1992).

17 29 C.F.R. § 2560.503-1(g)(i-iv).

18 29 C.F.R. § 503-1(g)(i-iv).

19 29 C.F.R. § 2560.503-1(g)(v).

20 29 U.S.C. § 1132(a)((1)(B).

21 *LaRue v. DeWolff, Boberg, & Assocs.*, 552 U.S. 248, 259 (2008).

22 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F).

23 29 C.F.R. § 2560.503-1(f)(2)(iii)(B).

24 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1(h).

25 *Vanderklok v. Provident Life and Accident Insurance Co.*, 56 F.2d 610, 617 (6th Cir. 1992). See also, *Univ. Hosps. of Cleveland v. S. Lorain Merchants Ass'n. Health & Welfare Benefit Plan & Tr.*, 441 F.3d 430, 434 (6th Cir. 2006). Uniquely, the claimant has due process rights that devolve from the statutory and regulatory requirements.

26 29 C.F.R. § 2560.503-1(b)(5).

27 *Wilkins v. Baptist Healthcare System, Inc.*, 150 F.3d 609 (6th Cir. 1998).

28 29 U.S.C. § 1133.

29 *Kent v. United of Omaha Life Ins. Co.*, 96 F.3d 803, 807 (6th Cir. 1996).

30 Vukadin, Katherine T. (2011) "Delayed and Denied: Toward an Effective ERISA Remedy for Improper Processing of Healthcare Claims," *Yale Journal of Health Policy, Law, and Ethics*: Vol. 11: Iss. 2, Article 3. Available at: http://digitalcommons.law.yale.edu/yjhple/vol11/iss2/3.

31 *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1277 (6th Cir. 1991).

32 *City of Hope Nat'l. Med. Ctr. v. Healthplus, Inc.*, 156 F.3d 223, 229 (1st Cir. 1998).

33 *Wilkins v. Baptist Healthcare System, Inc.*, 150 F.3d 609 (6th Cir. 1998).

34 U.S. healthcare spending grew 4.3% in 2016 and as a share of the gross domestic product accounts for 17.9%. https: //www.cms.gov/Research-Statistics-Data-And-Systems/Statistics-Trends-And-Reports/National-HealthExpendData\NationalHealthAccountsHistorical.html (visited 8/3/2018).

35 https://www.usatoday.com/story/money/business/2018/06/06/health-care-costs-price-family-four/676046002/.