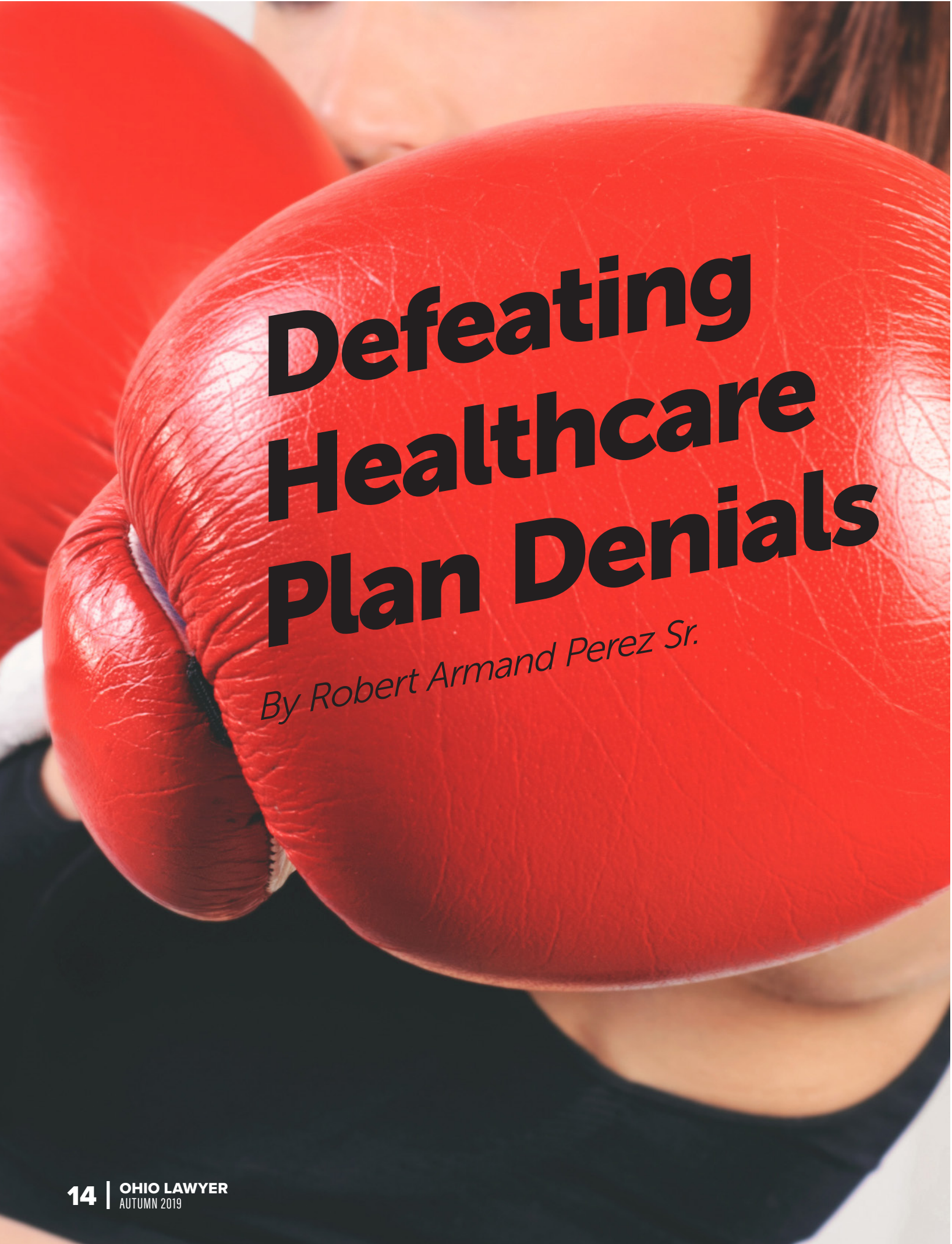

Defeating Healthcare Plan Denials

By Robert Armand Perez Sr.

Healthcare costs are rising in the United States and there is no consensus on funding. Premiums and out-of-pocket costs continue to increase while healthcare payors have incentives for denying claims.

Most employer-based healthcare plans are governed by the Employee Retirement Income Security Act (ERISA).[1] State law controls healthcare plans in the government employer sector[2] or for a church[3] employer. The claim process for appealing these denied claims is similar to that of an ERISA healthcare plan.[4] Ohio has statutory provisions for non-ERISA adverse determinations.[5]

The Claim Denial

Healthcare denials beyond errors are frequently not appealed. If an ERISA claim is improperly denied payment and the appeal rights are not fully communicated, the improper denials will remain undisturbed. The ERISA statute requires a "full and fair review" of a denial of payment after a written notice of the reason(s) for the denial is provided.[6] The related claim regulations structure the process with procedural and substantive requirements.[7] Health insurers and self-insured plans usually fail to fully comply. In contrast, the financial incentives to violate the regulations and avoid paying the claims are great. ERISA based plans, whether insured or self-funded, and non-ERISA plans have similar incentives. Generally, the patient[8] assigns the payment of benefits to his/her medical provider who files the claim with the healthcare plan. However, many healthcare plans prohibit assignment of the rights to the benefits, including the right to appeal the denial. These anti-assignment plan provisions are generally enforceable.[9] Plans have a recognized conflict of interest when paying claims.[10] The claim administrator may obscure the appeal process to the patient.

A core principle of ERISA is that the employee benefits must be administered according to a written plan.[11] When a claim is denied, a written notification must be provided to the patient that complies with the claim regulation requirements.[12] The typical explanation of benefits (EOB) sent to the patient does not.

The regulations set times for action. Different time frames for appeals exist. They are related to the type of claim whether a pre-service claim, i.e. a pre-authorization, a post-service claim or an urgent care claim.[13]

The ERISA Appeal Process

In an ERISA healthcare claim, the denial notification to the patient triggers the due process rights of the patient.[14] The claim administrator has a fiduciary duty to the patient.[15] These basic claim regulations are applicable to all benefit claims, including healthcare claims.[16] 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."[17]

In addition to these core regulatory notice requirements for all ERISA claims including non-healthcare claims, there are additional requirements for group healthcare plans. A group healthcare plan must provide the guideline, the protocol, or other criteria relied upon to the patient or state that a copy of it will be provided to the patient 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 patient's medical circumstances or states that the explanation will be provided upon request.[18] After the administrative appeal, the denial of benefits may be reviewed by a district court.[19] However, the participant *must exhaust* all of the administrative remedies under the plan *before* an action can be filed in federal court under ERISA.[20]

Healthcare claims are subject to additional Affordable Care Act (ACA) regulations.[21] Scrupulous compliance with the regulations is required with stated exceptions.[22] When the healthcare plan administrator fails to follow the regulatory claim procedures, the patient will be deemed to have exhausted the appeal process. These ACA regulations mandate continued coverage and treatment during the appeal if the adverse determination or denial involves the reduction or termination of treatment.[23] The claim appeal must be timely processed and one extension may be obtained by written notice.[24] The statutory intent of ERISA is to assure that the patient has an opportunity for a full and fair review before litigation.[25]

Due Process Protections

The Sixth Circuit holds that an insurer's failure to comply with the procedural requirement to provide the specific reason(s) for the denial is error, which may require the claim denial be overturned. The remedy for a failure to provide appropriate administrative review is to have the district court "reconsider [the denial of benefits] after the [patient] has been given the opportunity to submit additional evidence" rather than remand the

benefit determination to the plan for further consideration.[26]

When the plan administrator fails to provide the specific reason(s) for denial, the patient does not know how to cure the deficiency with additional evidence. If there is insufficient information to obtain a full review, the patient should be given the opportunity to submit additional evidence in litigation. The claim administrator should have safeguards designed to ensure that plan provisions are interpreted and applied consistently, in accord with the plan documents.[27] If the claim denial fails to adequately inform the patient and the patient does not make a timely appeal, the patient is bound in litigation with the record lacking favorable evidence.

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Fair Notice is Crucial

Notification of rights is critical in the claim process. Unlike litigation under other statutes, the reviewing federal court is limited to the evidence that is presented to the claim administrator **prior to litigation**. Although an ERISA review is not a true administrative review, it is treated in an analogous way.[28] Because of the limitations on what the court can review, the requirement that the claim administrator give proper notice enables the patient to assemble and submit the evidence necessary to prevail on the claim.

The notice requirement is not merely a regulatory requirement, it is the keystone of the statutory requirement for a "full and fair review."[29] Unfortunately, some courts have adopted the concept of "substantial compliance"[30] with the regulatory notice requirements. A regulatory violation tends to be conflated by the court with the accompanying improper denial of benefits. The plan's failure to comply with the regulatory notice and procedural requirements can result in the patient losing his or her legal remedy.

Ohio Statutory Procedure

The state of Ohio has a procedure similar to the federal regulatory scheme for ERISA claims.[31] This code section applies to insured healthcare plans that are not subject to ERISA[32] but subject to the insurance laws of the state of Ohio.[33]

Similarly, under the Ohio statute, any adverse benefit determination requires notice to the patient.[34] The time frame for these internal appeals must be within the time frames provided under the federal regulations.[35]

External Review

An external review of a claim denial usually addresses the alleged lack of medical necessity or the efficacy of experimental treatment. The patient may voluntarily use this process. Under both federal and Ohio state law there are provisions for external reviews by an independent review organization. This is required by the ACA[36] for plans that are not subject to state insurance laws.

Insurance companies that are subject to state law in states that have established an external review process must meet the consumer protection standards of the federal statute. In contrast, if the healthcare plan is not subject to state regulation,[37] the federal law controls the external review. If the healthcare benefits are insured, they are subject to the state insurance law. Ohio provides for an external review process similar to the federal review process.[38] Both the external review under the federal and the Ohio external review require exhaustion of the internal appeals. The external review can be valuable if there is active participation by the patient to assure that the external review entity is properly informed of the policy/plan provisions and has relevant adequate evidence to make an informed decision. Unfortunately, many times this is not the case. The Ohio statute states what an independent review organization should consider when conducting the review. Those mandated considerations are extensive.[39] The external review may be binding on the healthcare plan or insurer, but the patient may have other options available under applicable federal or state law.[40] An external review under both Ohio and federal law is voluntary. The strategy of whether to elect this external review varies according to the facts and the type of denial. There are benefits and pitfalls for the patient in this external review process. Without experienced representation, the external review may not result in the objective determination that was contemplated in the design of the external review.

Judicial Review

A patient may obtain judicial review of the adverse determination. ERISA defines who may bring an action. A

healthcare provider may bring an action if there is a valid assignment of benefits and the plan does not prohibit it.[41] Sometimes the healthcare provider is given more information on the denial than is the patient. The patient may only receive an EOB, which is usually insufficient to inform or meet the notice requirements. Although a patient assignment of benefits is common, the plan may contain an anti-assignment of benefit clauses.[42] This precludes the healthcare provider from bringing a claim for treatment. Only the patient may bring the action in court.
After the appeal process, the district court's review is limited to the administrative appeal evidence previously considered.[43] The standard of review, depending on the language of the plan, may be the difficult to meet "arbitrary and capricious" standard of review.[44] This standard and the limitation to the record before the claim administrator mandates early involvement by experienced counsel. If it is a non-ERISA matter brought in state court, the procedures are different and not subject to these limitations.

General Considerations

Healthcare providers do not have access to the plan/policy documents. Providers may not know how to appeal complex claims or have the time. The patient must act on high dollar claims, such as experimental treatment and denials based on lack of medical necessity. Many health insurance carriers and third-party administrators of self-insured plans do not understand their obligations, follow the claim regulations, or their own plan/policy documents. Claim administrators routinely violate the claim procedures and regulations. Tight regulatory time limits require immediate attention after the denial. The patient must initiate a timely appeal.

Conclusion

Wrongful denials of payment shift costs. The ever-climbing cost of healthcare creates a struggle on payment. There is an incentive to deny payment and shift the cost to patients and physicians. The consumer paying for a denied claim dwindles household savings. A patient should promptly seek legal counsel when a high-dollar claim is denied. Relying on the healthcare provider is ill-advised. A claim denial requires prompt action and time deadlines are set when a denial is sent. The failure to take timely action is fatal to a successful outcome.

About the Author

Robert Armand Perez, Sr. limits his practice to representing individuals with disability, health, life insurance and pension issues mostly under ERISA. He earned his J.D. from the Indiana University School of Law and his B.A. and M.S. in health administration from the University of Cincinnati. He is a member and former trustee of the Ohio Association for Justice and a member the American Association for Justice where he served as chair of the insurance section. He is a member of the American Bar Association, the OSBA, the Federal Bar Association and the Cincinnati Bar Association.

Endnotes

[1] 29 U.S.C. § 1001, *et seq.*
[2] 29 U.S.C. § 1002(32).
[3] 29 U.S.C. § 1002(33)(A).
[4] For consistency, the term "plan" is used for ERISA Plans and non-ERISA policies.
[5] O.R.C. § 3922.
[6] 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1(g).
[7] 29 C.F.R. § 2560.503-1.
[8] For purposes of this article, we will refer to plan participants, plan beneficiaries, claimants and patients as the "patient." There are occasions where the patient may be someone other than the plan participant or claimant, as is the case in treatment of minor children. However, for purpose of consistency, we will use the term "patient."
[9] *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).
[10] *Univ. Hosps. of Cleveland v. Emerson Elec. Co.*, 2002 F.3d 839, 844 (6th Cir. 2000).
[11] 29 U.S.C. § 1004(a)(1)(D).
[12] 29 C.F.R. § 2560.503-1.
[13] 29 C.F.R. § 2560.503-1(f)(2), *et seq.*
[14] *Vanderklok v. Provident Life and Accident Insurance Co.*, 56 F.2d 610 (6th Cir. 1992).
[15] *Moore v. Lafayette Life Ins. Co.*, 458 F.3d 416, 438 (6th Cir. 2006).
[16] 29 C.F.R. § 2560.503-1(g)(i-iv).
[17] 29 C.F.R. § 2560.503-1(g)(i-iv).
[18] 29 C.F.R. § 2560.503-1(g)(v)(A) and (B).
[19] 29 U.S.C. § 1132(a)(1)(B).
[20] *LaRue v. DeWolff, Boberg, & Assocs.*, 552 U.S. 248, 259 (2008).
[21] 29 C.F.R. § 2590.715-2719(b).
[22] 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F)(2).
[23] 29 C.F.R. § 2590.715-2719(b)(2)(iii).
[24] 29 C.F.R. § 2560.503-1(f)(2)(iii)(A) and (B).
[25] 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1(h)(1).
[26] *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.
[27] 29 C.F.R. § 2560.503-1(b)(5).
[28] *Wilkins v. Baptist Healthcare System, Inc.*, 150 F.3d 609 (6th Cir. 1998).
[29] 29 U.S.C. § 1133.
[30] *Kent v. United of Omaha Life Ins. Co.*, 96 F.3d 803, 807 (6th Cir. 1996).
[31] O.R.C. § 3921, *et seq.*
[32] O.R.C. § 3921.01(L).
[33] O.R.C. § 3922.01(P).
[34] O.R.C. § 3922.03(E).
[35] O.R.C. § 3922.04(B); 29 C.F.R. § 2560.503-1.
[36] 42 U.S.C. § 300gg-19(2010).
[37] 29 U.S.C. § 1002(i).
[38] O.R.C. § 3922.05.
[39] O.R.C. § 3922.07(A)-(G).
[40] O.R.C. § 3922.12(A)-(B).
[41] *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1277 (6th Cir. 1991).
[42] *City of Hope Nat'l. Med. Ctr. v. Healthplus, Inc.*, 156 F.3d 223, 229 (1st Cir. 1998).
[43] *Wilkins v. Baptist Healthcare System, Inc.*, 150 F.3d 609 (6th Cir. 1998).
[44] *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 552 (6th Cir. 1998).