WINNING THE APPEALS GAME
HOW TO WIN AT THE INSURANCE GAME
OR
USING ERISA TO TURN THE TABLES ON THE INSURANCE COMPANY

CURRENT TRENDS
- Reduction of fees
- Increased denials as "not covered by plan" after the fact
- Use of "evidence based medicine" to deny claims
- Listing "overutilized" treatment as "experimental"
- Recoupment of funds without due process

HAVING A BAD DAY!
- Policy exclusion
- Coverage issue
- Pre-existing utilization review
- Medical necessity
- Re-pricing
- Bundling
- Downcoding
- Recoupment
- Experimental
- Mixed

WHEN DO YOU USE ERISA?
- ERISA- Employee Retirement Income Security Act
- ERISA- for coverage issues by plan
  - Rules for claims processing
  - Benefits to the employee
  - Mandated by Federal Law

VERIFICATION OF BENEFITS
- Is patient under ERISA?
- Who is administering the plan?
- What is the address of the plan administrator?
- If told procedure is not covered, there is a restriction on foot care, etc., ask whether this is an employer policy or the insurance company policy.
ERISA OR STATE LAWS?

ERISA APPLIES IF EMPLOYER FUNDED PLAN.
Doesn’t matter if self-funded or group plan.
Represents 80% of insurance policies
Applies in benefits issues (e.g., coverage, exclusions, etc.)
ERISA PREEMPTS STATE LAWS
NON-ERISA
GOVERNMENT, SELF-PAY, MEDICARE, SCHOOL PLAN
Subject to state laws.
Coding issues, Medical Necessity, Fee Schedules

LEGAL ASSIGNMENT

1. The right of reimbursement for services rendered and cause of actions.
2. The right to collect or pursue, and the right to enforce ERISA benefits.
3. The right to receive any applicable plan documents and any applicable remedies.
4. The right to sue on behalf of the patient.
5. Any other rights permissible under state and federal laws.
6. The reason the benefits are being assigned, mainly for the provider who agrees to provide healthcare services.
7. The patient’s and/or insured’s signature.

WHO IS ENTITLED TO PURSUE BENEFITS?

B-3: When a claimant has properly authorized a representative to act on his or her behalf, is the plan required to provide benefit determinations and other notifications to the authorized representative, the claimant, or both?

Nothing in the regulation precludes a plan from communicating with both the claimant and the claimant’s authorized representative. However, it is the view of the department that, for purposes of the claims procedure rules, when a claimant clearly designates an authorized representative to act and receive notices on his or her behalf with respect to a claim, the plan should, in the absence of contrary directions from the claimant, direct all information and notifications to which the claimant is otherwise entitled to the representative authorized to act on the claimant’s behalf with respect to that aspect of the claim (e.g., initial determination, request for documents, appeal, etc.). In the regard, it is important that both claimants and plans understand and make clear the extent to which an authorized representative will be acting on behalf of the claimant.

WHAT’S IN THE SPD?

• Plan Administrator name, business address, and business phone number.
• Statement that Plan Administrator may be served with service of legal process.
• Description of premiums, deductibles, coinsurance and co-payment amounts.
• Requirements relative to eligibility for plan participation and benefits.
• Annual or lifetime caps or other limits on benefits.
• Extent preventive services are covered.
• What circumstances coverage is provided for tests, devices and procedures.
• Provisions regarding use of networks, composition of network, out-of-network benefits, and conditions or limits on selecting primary care or specialty physicians.
• Provisions regarding preauthorization or utilization review.
• Procedures governing claims for benefits, applicable time limits, and remedies available under the plan for redress of claims denied in whole or in part.
FULL AND FAIR REVIEW

- UNDER ERISA ANY DENIAL OR “ADVERSE BENEFIT DETERMINATION” REQUIRES “FULL DISCLOSURE”.
- “ADVERSE BENEFIT DETERMINATION” MEANS ANY REDUCTION FROM WHAT YOU BILLED.
- “FULL DISCLOSURE” ENTITLES BENEFICIARY TO INFORMATION ON:
  - HOW CLAIM WAS DETERMINED
  - WHO REVIEWED CLAIM, DOCUMENTS USED IN DECISION, CREDENTIALS OF REVIEWER
  - FEE SCHEDULES
  - METHODS USED TO DETERMINE BREAKDOWN, ETC.
- FULL AND FAIR REVIEW REQUIRES...
  - DISCLOSURE OF PLAN DOCUMENT (SPD)
  - REQUIRES DECISION MAKER, FIDUCIARY, TO CONSIDER EVIDENCE BEFORE RENDERING A DECISION.
  - ONLY INFORMATION DISCLOSED CAN BE USED IN ANY DECISION OR SUBMITTED AS EVIDENCE IN FEDERAL COURT.

ERISA APPEALS

- OBTAIN “LEGAL ASSIGNMENT OF BENEFITS”
- NEED COPY OF SUMMARY PLAN DOCUMENT
- IDENTIFY THE “PLAN ADMINISTRATOR” OR “FIDUCIARY”
- ERISA ALLOWS TWO LEVELS OF APPEALS
  - 1ST - WITHIN 180 DAYS OF ADVERSE DETERMINATION
  - 2ND - AFTER 30 DAYS FROM FIRST APPEAL
  - PENALTIES OF $110.00 PER DAY IF INFORMATION IS NOT SUPPLIED. PENALTIES BEGIN ON 30TH DAY FROM DATE RECEIVED.
  - 3RD - APPEAL TO LEGAL DEPARTMENT OF PLAN ADMINISTRATOR AFTER 30 DAYS. DEMAND LETTER FOR PENALTIES (90 DAYS FROM INITIAL DENIAL)
- INDEPENDENT MEDICAL REVIEW OVERIDES ERISA LAW

EXPERIMENTAL DENIAL

- WITH ERISA THE DEFINITION OF “EXPERIMENTAL” IN THE SPD IS WHAT OVERRIDES THE “CORPORATE” MEDICAL DEFINITION.
- TERMS OF THE PLAN MUST CONSIDER THE PATIENT’S “INDIVIDUAL CIRCUMSTANCES”.
- MEDICAL POLICIES ARE INTERPRETED AT THE SOLE DISCRETION OF THE PLAN.
- IN THE CASE OF A CONFLICT BETWEEN THE MEDICAL POLICY AND THE PLAN THE PLAN WILL GOVERN.
- CONCLUSION MUST BE DETERMINED BY LANGUAGE OF THE PLAN NOT THE “COVERAGE POLICY BULLETIN” (38)
RECOUPMENT ACROSS INDIVIDUAL PLANS IS ILLEGAL UNDER ERISA

PATIENT A

ERISA

PATIENT B

ARCHITECT

U.S. STEEL

BLUE CROSS

NETWORK CONTRACT

BLUE CROSS CANNOT TAKE FROM U.S. STEEL TO PAY RECOUPMENT FROM ARCHITECT CO.

ILLEGAL RECOUPMENT

- RECOUPMENT ACROSS INDIVIDUAL PLANS IS ILLEGAL UNDER ERISA
  - INSURER CANNOT TAKE FUNDS FROM PATIENT B TO SATISFY A DISPUTE WITH PATIENT A UNDER A SEPARATE PLAN.
  - PATIENT'S CONTRACTS UNDER FEDERAL LAW OVERRIDES YOUR NETWORK AGREEMENT.
  - RECOUPMENT OF BENEFITS FROM PATIENT B SETS UP AN "ADVERSE BENEFIT DETERMINATION"

- SPECIFIC STATUTES THAT APPLY
  - Theft or Embezzlement from Employee Benefit Plan (18 U.S.C. Section 664)
  - False Statements or Concealment of Facts in Relation to Documents Required by the Employee Retirement Income Security Act of 1974 (18 U.S.C. Section 1027)

WHAT TO DO IF INSURANCE WANTS RECOUPMENT

- DO NOT IGNORE - APPEAL IMMEDIATELY
  - REQUEST REASON FOR REFUND REQUEST.
  - CAN SEND REGULAR APPEAL TO INSURER.
    - IF MED. NECESSITY ISSUE SEND TO MEDICAL DIRECTOR OVER REFUND CO.
    - IF ERISA SEND WARNING LETTER TO INSURANCE COMPANY.

- IF NO RESPONSE OR MONEY RECOUPED FROM OTHER PATIENTS
  - SEND ERISA APPEAL TO ALL PLAN ADMINISTRATORS OF RECOUPED PLANS.

WHAT DO I DO WHEN???

INSURANCE ACTION

- 1. WARNING FOR OVERPAYMENT
- 2. MONEY IS TAKEN ANYWAY OR WARNING IS IGNORED

YOUR RESPONSE

- 1. USUAL APPEAL
  - WARNING TO INSURANCE CO. LETTER
  - WARNING TO 3RD PARTY (FAIR DEBT PRACTICE ACT)

- 2. ERISA LETTERS 30-60-90 DAYS UNTIL RESPONSE TO INS. CO. AND EMPLOYER TO EACH PATIENT EFFECTED

COMMON LAW CASES

Federated Mutual Insurance Company v. Good Samaritan Hospital, 214 N.W.2d 493 (Neb. 1974).


BOTH CASES DETERMINED THAT A 3RD PARTY WAS NOT RESPONSIBLE FOR ERRORS MADE BY INSURER.