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# ERISA for Physicians

## Healthcare ERISA Claim Denials and Appeals

by

**Jin Zhou, DC**

[ERISAclaim@aol.com](mailto:ERISAclaim@aol.com)

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- Health Insurance through Employment in Private Sectors = ERISA = 80% of Physician's Business;
- ERISA Preempts Any State Laws When It Is "Related to" Employee Benefits Dispute (Medical Insurance Claim Dispute)---ERISA Shield;
- ERISA Does Not Provide Any Remedy except for SPD Statutory Penalty and "Contractual Damages" (Your Medical Bills);
- Any ERISA Appeals by Physicians Are Not Valid Unless Legal Assignment of Benefit from Patient Is Obtained;
- ERISA Guarantees Probably Best Disclosure from ERISA plans, Insurance Companies but Physicians Never Realized;
- Patients Bill Of Rights (PBOR) May Never Help Physicians and Patients Unless Physicians and Patients Really Understand ERISA.
- ERISA Is Poorly Understood by Physicians;
- ERISA Protects Health-care Providers Who Have Legal Assignment of Benefits and Have Completed At Least Two Levels of Appeals.
- There Are 2.5 Million ERISA Plans Covering 135 Million to 145 Million Americans in U.S.;
- 1.3 Trillion Dollars Are Spent in Healthcare in United States Last Year, about 14% of Entire National Domestic Product, ERISA Claims Dispute and Denials;
- Up to One-third of Healthcare claims Are Denied Nationwide Each Year, Significant Percentage of Healthcare claims Are Partially Denied;
- Physicians Are at Breaking Point in Their Business Survival As a Result of Managed Care Nightmare and Claims Denials under ERISA Shield.

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# ERISA for Physicians

## Healthcare ERISA Claim Denials and Appeals

### Table of Contents

<b>License Agreement</b> .....	i
<b>Navigating the CD Book</b> .....	iii
<b>Introduction</b> .....	viii
1. Who should read this book?.....	viii
2. Why is this book so different?.....	viii
3. How to Effectively Use This Book?.....	ix
4. Legal Disclaimer.....	ix
<b>I. What Is Erisa And How Does It Affect Healthcare Providers?</b> .....	1
A. ERISA Demystified for Physicians.....	1
B. ERISA Related Healthcare Facts.....	2
C. ERISA Overview.....	3
D. Misconception about ERISA.....	4
E. ERISA Regulates about 80 Percent of Healthcare Claims.....	4
<b>II. ERISA Basic Concepts, Principle And Application In Healthcare Claims</b> .....	6
A. Benefits v. Insurance .....	6
B. Fiduciary v. Insurance .....	7
C. Different Relationships and Conduct.....	8
D. Disclosure v. Discovery .....	8
E. Insurance-Benefits .....	9
F. Full and Fair Review.....	10
G. Standard of Judicial Review.....	10
<b>III. Problems In Healthcare Under ERISA</b> .....	13
A. Traditional Background.....	13
B. Current Problems.....	14
C. What's the Future and Patient Bill Of Rights.....	15
<b>IV. ERISA Statutory Design And Practical Problems Affecting Claims Denial And Appeal</b> .....	16
A. How To Determine If The Claim Is An ERISA Claim?.....	17
B. Parties.....	17
1. Plan Administrator.....	17
2. Fiduciary:.....	18
3. Third Party Claim Administrator (TPA).....	18
4. Utilization Review Organizations.....	20
5. Managed Care Networks or Organizations.....	20
C. Different Kinds Of ERISA Plans And Parties To Deal With.....	21
D. ERISA Claim Denial and Appeal Procedures.....	22
1. Assignment of Benefit, Legal Assignment of Benefit.....	22
2. Summary Plan Description (SPD).....	23
3. Plan Document.....	23
4. ERISA Regulation About Claims Denial Notice.....	23

E.	ERISA Fiduciary Rule.....	24
F.	Reasonable Expectation Doctrine.....	25
G.	Burdens of Proof.....	25
H.	Appeal Procedure Required.....	26
I.	Parties to Appeal with.....	27
J.	Middlemen During Appeals.....	27
K.	ERISA Qualified Appeals.....	27
L.	Mysterious Problems in ERISA Claims Appeals.....	28
M.	When to Retain an Attorney to File Lawsuit in Federal Court.....	28
<b>V.</b>	<b>Commonly Seen ERISA Claims Denials.....</b>	<b>30</b>
A.	Plan (Policy) Exclusion.....	30
B.	Medical Necessity.....	30
C.	Usual, Customary And Reasonable, PPO Discount, Bundling And Downcoding.....	32
D.	Pending Investigation and Physician Medical Records.....	32
E.	Pre-existing Condition Exclusion.....	33
<b>VI.</b>	<b>How To Maximally Comply With ERISA And Exercise ERISA Rights.....</b>	<b>34</b>
A.	How to Obtain Valid Legal Assignment of Benefit.....	35
B.	How to Obtain Summary Plan Description (SPD).....	36
C.	How to File Valid ERISA Qualified Appeals, Strategies.....	38
1.	Plan Administrator (Double Hats).....	38
2.	SPD, Statutory Penalty.....	39
3.	Burden of Proof and Causal Connection.....	40
4.	Disclosure, Reasonable Access to Plan Document.....	41
5.	Full And Fair Review.....	41
6.	Administrative Record.....	41
7.	Fiduciary Exemption.....	42
8.	TPA (Fiduciary or Nonfiduciary).....	43
9.	Certified Letters Perfected.....	43
10.	Computerizing And Automating ERISA Appeals.....	43
11.	What To Do When Appeals Completed Without Resolution Or Response?.....	43
<b>VII.</b>	<b>Sample Letters and Forms.....</b>	<b>45</b>
A.	Pre-Denial Request Letters.....	47
1.	Legal Assignment of Benefit.....	47
2.	Notice of Legal Assignment.....	50
3.	SPD Request Letter.....	50
B.	Initial/First Appeal Letter.....	56
1.	SPD Request Letter.....	56
2.	Appeal Letters.....	56
3.	Appeal Letter for Plan/Policy Exclusion, Chiropractic Exclusion.....	62
4.	Appeal Letter for Medical Necessity Denial.....	69
5.	Appeal Letter for Usual, Customary and Reasonable Denial.....	76
6.	Appeal Letter for PPO Discount, Mixed Bundling and Downcoding As Well As UCR Denials.....	76
7.	Appeal Letter for No Response Denial.....	89
C.	Second Level Appeal Letter.....	95
1.	SPD Request Letter.....	95
2.	Appeal Letters, Plan/Policy Exclusion, Chiropractic Exclusion.....	95

3.	Appeal Letter for Medical Necessity Denial.....	102
4.	Appeal Letter for Usual, Customary and Reasonable Denial.....	110
5.	Appeal Letter for PPO Discount, Mixed Bundling and Downcoding As Well As UCR Denials.....	117
6.	Appeal Letter to Attorney at Insurance Company.....	124
7.	Appeal Letter for Billing & Coding, Medical Necessity and Utilization Review Dispute.....	124
D.	Third Level Appeal, More Than Required but Necessary.....	142
1.	Appeal letter for Medical Necessity Dispute with Legal Demand for SPD Penalty.....	142
2.	Appeal letter for Medical Necessity Dispute with Appeal Futility.....	149
3.	Appeal Letter For Policy Exclusion And/Or Medical Necessity Dispute With Appeal Futility .....	157
<b>VIII.</b>	<b>Utilization Review And Third Party Denial.....</b>	<b>225</b>
A.	Third Party Review Not Liable under ERISA.....	165
B.	National Review Guidelines.....	165
C.	Strategy.....	165
D.	Sample Appeal Letters to The Third Party Utilization Review /Medical Necessity Review.....	190
<b>IX.</b>	<b>Selections Of ERISA Statutes And Regulations.....</b>	<b>196</b>
<b>X.</b>	<b>Case Law (Court Ruling) Study.....</b>	<b>198</b>
A.	U.S. Supreme Court .....	198
1.	<i>Pegram Et Al. v. Herdrich</i> .....	199
2.	<i>Firestone Tire &amp; Rubber Co. v. Bruch</i> .....	203
3.	<i>Varsity Corp. v. Howe</i> .....	203
4.	<i>Massachusetts Mut. Life Ins. Co. v. Russell</i> .....	204
5.	<i>Pilot Life Ins. Co. v. Dedeaux</i> .....	205
B.	District And Court Of Appeals.....	206
1.	<i>Hernandez v. Prudential</i> .....	206
2.	<i>Medical Alliances, LLC v. American Medical Security</i> .....	207
3.	<i>Fallick v. Nationwide</i> .....	207
4.	<i>Christopher Plumb v. Fluid Pump Service, Incorporated</i> .....	207
5.	<i>Principal Mutual Life Ins. Co. v. Charter Barclay Hospital</i> .....	208
6.	<i>Neuma v. Amp, Inc And Provident Life And Accident Insurance Company</i>	210
7.	<i>Washington Physicians Serv. v. Gregoire</i> .....	211
8.	<i>Rica F. Verkuilen v. South Shore Building and Mortgage Company, et al</i>	212
9.	<i>Roy A Jackson, Et Al. V E.J. Brach Corp</i> .....	212
10.	<i>Alan Kascewicz v. Citibank</i> .....	212
11.	<i>Juanita White v. Aetna Life Insurance Company and Aetna US Healthcare</i>	213
12.	<i>Carol A. Ward v. Alternative Health Delivery Systems, Inc</i> .....	214
13.	<i>Kimberly Crocco v. Xerox Corp., Et Al</i> .....	214
14.	<i>Gary A. Levinson v. Reliance Standard Life Insurance Company</i> .....	216
15.	<i>Dana Tait v. Barbknecht &amp; Tait Profit Sharing Plan, Et Al</i> .....	216
16.	<i>Simon V Allstate Employee Group Medical Plan And Rodney T. Daniels</i> ....	217
17.	<i>Simon v GE Life Disability</i> .....	217
<b>XI.</b>	<b>ERISA Claim Procedure and Enforcement.....</b>	<b>220</b>
A.	ERISA: DOL, PWBA Administrative Enforcement.....	220
B.	Department of Labor Issues Final Claims Regulations.....	221
1.	DOL Final Claims Regulations.....	221

1) Full and Fair Review.....	223
2) Notice of Appeal Determination.....	223
3) Relevant Document.....	<u>223</u>
2. DOL and Advisory Opinions.....	224
3. DOL Publications.....	224
1) Patients' Rights Claims Procedure Regulation	
2) Claim Appeal Final Rule	
3) DOL Delays Claims Regulations For Group Health Plans	
4) SPD Final Rule	
5) DOL Advisory Opinions	
6) How to File a Claim for Your Benefits	
7) Top 10 Ways to Make Your Health Benefits Work for You	
8) How to Obtain Employee Benefit Documents from the Labor Department	
9) Questions and Answers for Dislocated Workers	
10) Compliance Assistance for Group Health Plans	
<b>XII. State Laws.....</b>	<b>225</b>
A. ERISA Preemption?.....	
B. Illinois Managed-care Reform and Patient Right Act.....	225
<b>XIII. Glossaries Of Terms.....</b>	<b>226</b>
<b>XIV. Recommended Books And Publications.....</b>	<b>231</b>
<b>XV. Internet Websites And Links.....</b>	<b>243</b>
<b>Appendix A Complete Text Of Selected ERISA Statutes.....</b>	<b>244</b>
<b>Appendix B Complete Text Of Selected ERISA Regulations.....</b>	<b>310</b>
<b>Appendix C Complete Text Of Selected U.S. Supreme Court ERISA Opinions.....</b>	<b>319</b>
<b>Appendix D Complete Text Of Selected U.S. District And Appeals Court Opinions.....</b>	<b>408</b>
<b>Appendix E Complete Text Of Selected DOL Publications.....</b>	<b>585</b>
1. Patients' Rights Claims Procedure Regulation.....	586
2. Claims Procedure; Final Rule.....	589
3. DOL Delays Claims Regulations For Group Health Plans.....	616
4. Amendments to Summary Plan Description Regulations; Final Rule.....	620
5. DOL Advisory Opinions.....	640
6. How to File a Claim for Your Benefits.....	644
7. Top 10 Ways to Make Your Health Benefits Work for You.....	647
8. How to Obtain Employee Benefit Documents from the Labor Department..	650
9. DOL's Amicus Curiae regarding Disclosure of Attorney-Client Communications and Work Products by Plan Fiduciaries to Plan Participants and Beneficiaries.....	654
10. Questions and Answers for Dislocated Workers Compliance Assistance for Group Health Plans.....	669
11. Compliance Assistance for Group Health Plans.....	679
<b>Appendix F Illinois Managed-Care Reform And Patient Right Act.....</b>	<b>684</b>
<b>Appendix G Health Utilization Management Standards Of The American Accreditation Healthcare Commission (URAC), URAC Version 3. ....</b>	<b>704</b>

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## Introduction

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- 1. Who should read this book?**
  - 2. Why is this book so different?**
  - 3. How to Effectively Use This Book?**
  - 4. Legal Disclaimer**
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### **1. Who should read this book?**

This book is primarily written for physicians, clinics and hospitals or any health-care providers who deal with health-care claims under ERISA, for patients who obtained health insurance through employment in private sectors, up to 80% of U.S. health-care market. For 27 years, ERISA has been poorly understood by health-care provider community and their patients. Our nation has spent 1.3 trillion dollars in health-care expenses last year, about 14% of entire national domestic product, two of the four main causes (extremely high administrative costs and managed care problems) are directly associated with health-care coverage dispute and claims denials under ERISA.

Managed care market and health-care industry are facing most difficulties and frustrations, many of health-care professionals and medical facilities have changed their business dramatically due to such managed care challenge. This entire problem is directly related to ERISA statutory structure and administrative enforcement, yet health-care professionals never understand ERISA, let alone any compliance to ensure their ERISA rights. Health-care related litigation explosion is the news media everyday.

This book is mainly focused on ERISA claim denials and appeals, especially at such critical time when new federal final claim regulations are to be effective in January 2002 while health-care providers were hardly informed of this greatest protections for their business survivals.

This book is primarily written as a workbook for physicians, clinics and hospitals as well as any health-care providers, not primary for academic and legal community. This book does not cover basic codings and billings, Medicare, workers compensation, automobile related injuries as well as non-ERISA claims, traditional insurance claims.

### **2. Why is this book so different?**

While almost 80 percent of health-care claims are ERISA claims, regulated by ERISA for 27 years and our managed care problems escalated each year to almost a breaking point for physicians nationwide, ERISA remains a judicial mystery and courtroom drama. Nobody has been able to demystify ERISA and make ERISA and everyday health-care claim denials and appeals in one practical package for busy physicians in their day-to-day business practices. The author of this book has spent about seven years in researching, studying and implementing ERISA principles and applications, including ERISA statutes, regulations, applicable court

rulings and real-life claim processing, in everyday ERISA claim appeals practice, and has finally demystified extremely complicated and frustrated ERISA laws, developed a nation first ERISA compliance and appeals system, most comprehensive and practical handbook with numerous computerized sample appeals letters, covering almost every type of commonly seen ERISA denials and appeals, consistent with ERISA statutes and regulations as well as U.S. Supreme Court rulings. The purpose of this book is to demystify the existing federal laws, promote ERISA compliance by physicians, to file ERISA required and qualified appeals in order to enjoy maximal protections for physician's health-care claims.

### **3. How to Effectively Use This Book?**

It is important to understand that this book is about compliance, then protections and benefits. Any principles and strategies used in this book are based on existing and sounding legal principles, supported by statutes, regulations and case laws. It is advised that no expectation of overnight success or miracle shall be promised but great effort of new thinking, persistent studying and unprecedented action taking shall be made by physicians and their businesses.

This book is written in digital format on a CD, navigation system and tools are more sophisticated than paper format, however reading lengthy information on a computer screen is not popular or practical for most people. It is suggested that printing selective pages combined with digital navigation and researching tools will maximize benefits of this new book.

Text files of sample appeal letters for WordPerfect, Microsoft Word and general text word processor are enclosed in this book on the same CD. Some minimal modification or revision of basic information of these sample appeal letters will make this book one of the most time-saving and effective appeals practice for everyday busy physician's ERISA claim denials.

Due to its unprecedented nature of knowledge and system, many questions are expected from readers nationwide. It is not a guarantee of this author to provide individual answers for any possible questions about this book, questions posted through e-mail may be answered as an option from this author.

It is also necessary for future seminars with face-to-face discussion of ERISA claim denial and appeals. Any health-care professional organizations and medical societies with interest of further promotion of ERISA compliance and understanding of new Federal Final Claim Regulations may contact this author through e-mail or telephone for specific seminars.

ERISA litigation and court ruling are evolving constantly. New federal final claim regulations are scheduled to be effective in January 2002. Physicians and health-care providers are better protected in their medical claim practice by following up with these judicial and regulatory development. A Registration Form is enclosed with this book for readers in order to provide updated analysis of new court rulings, especially U.S. Supreme Court, and new development of final claim regulations. It is recommended for readers of this book to complete registration form and be informed of any new development in ERISA court rulings and regulatory updates, traditionally only available to legal community and insurance and benefits industry.

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## **I. What Is ERISA And How Does It Affect Healthcare Providers?**

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- A. ERISA Demystified for Physicians**
  - B. ERISA Related Healthcare Facts**
  - C. ERISA Overview**
  - D. Misconception about ERISA**
  - E. ERISA Regulates about 80 Percent of Healthcare Claims**
- 

### **A. ERISA Demystified for Physicians**

**Health Insurance through Employment in Private Sectors = ERISA = 80% of Physician's Business;**

**ERISA Preempts Any State Laws When It Is "Related to" An Employee Benefits Dispute (Medical Insurance Claim Dispute)---ERISA Shield;**

**ERISA Does Not Provide Any Remedy Except for SPD Statutory Penalty and "Contractual Damages" (Your Medical Bills);**

**ERISA Does Not Permit Physician's Lawsuit Unless At Least Two Levels of Appeals Are Completed and A Legal Assignment of Right to Sue Is Obtained from the Patient. (Legal Standing and Administrative Remedy Exhaustion);**

**Any ERISA Appeals by Physicians Are Not Valid Unless A Legal Assignment of Benefit Is Obtained from The Patient;**

**ERISA Provides The Best Disclosure from ERISA plans And Insurance Companies but Physicians Have Never Realized This Important Protection;**

**ERISA Might Be the Best Protection for Physicians If They Understand How ERISA Operates;**

**Patients Bill Of Rights (PBOR) May Never Help Physicians and Patients Unless Physicians and Patients Really Understand ERISA, Since PBOR Requires Both Internal of Two Levels and External Appeals/Reviews before A Lawsuit Can Be Filed, and Since Physicians Have Had Poor or No Understanding of Proper ERISA Internal Appeal Procedures for 27 Years;**

**ERISA Is Poorly Understood by Physicians;**

**ERISA Protects Health-care Providers Who Have Legal Assignment of Benefits and Have Completed At Least Two Levels of Appeals.**

**Without A Proper Legal Assignment of Benefits and Without Full Compliance with ERISA Appeal Procedures, Healthcare Providers Are Illegal Aliens in ERISA Land.**

## **B. ERISA Related Healthcare Facts**

**ERISA Regulates and Governs ERISA Claim Denials and Disputes;**

**Up to 80 Percent of Healthcare Claims Are ERISA Claims;**

**There Are 2.5 Million ERISA Plans Covering 135 Million to 145 Million Americans in the U.S.;**

**Up to One-third of Healthcare claims Are Denied Nationwide Each Year;**

**A Significant Percentage of Healthcare claims Are Partially Denied;**

**\$1.3 Trillion Are Spent in Healthcare in the U.S. Last Year, about 14% of Entire National Domestic Product, Two of the Four Main Causes for Escalating Health Care Costs (Extremely High Administrative Costs and Managed Care Problems) Are Directly Associated with Health-Care Coverage Dispute and Claims Denials under ERISA;**

**Physicians and Hospitals Rarely Filed Valid ERISA Appeals for 27 Years;**

**Physicians Are at Breaking Point in Their Business Survival As a Result of the Managed Care Nightmare and Claims Denials under the ERISA Shield;**

**Most Legislative Efforts and Litigations by Physicians and Patients Failed Due to ERISA Shield and the Lack of Understanding of ERISA by Patients and Physicians;**

**Legislation, Litigation and the Extremely High Cost Healthcare Administration Are Not Answers to Managed Care Nightmare and Physician's Business Survival Unless healthcare providers Gain A Reasonable Understanding and Practice of ERISA Claims Appeal Procedures.**

## C. ERISA Overview

ERISA stands for Employee Retirement Income Security Act of 1974. ERISA is the federal law that governs the administration of employee benefit plans and the rights of the beneficiaries under the plan. ERISA applies to all employee benefits plans "established or maintained" by an "employer" engaged in commerce or by an "employee organization" representing employees engaged in commerce or in any industry or activity affecting commerce.

ERISA was originally enacted by Congress in 1974 to provide federal uniform guidance and protections for employees in their retirement and benefits plans.

“In ERISA, Congress set out to protect . . . participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.” 2, as set forth in 29 U.S.C. 1001(b).” *Pilot Life Ins. Co. v. Dedeaux*, U.S. Supreme Court

Almost all health benefits plans offered through private employers are governed by ERISA, 29 U.S.C. §1001, et seq. A claimant challenging the denial of benefits must bring the claim under ERISA, and all other state law remedies are preempted. Due to such ERISA state law preemption and lack of or poor understanding of ERISA by healthcare providers, healthcare claim denials and disputes have significantly affected healthcare practice.

Employee plans by governmental agencies, church and school are not governed by ERISA.

Almost up to 80 percent of healthcare claims are ERISA claims because most people in United States obtained health insurance coverage through their employment in private sectors.

There are 2.5 million ERISA plans covering 135 million to 145 million Americans.

## D. Misconception about ERISA

The biggest misconception about ERISA is that ERISA is only for the self insured, ERISA is for only Fortune 500 companies, and ERISA is only for unions.

Another major misconception is that managed care plans ( HMO, PPO & POS) are ERISA plans, indemnity plans are not (or vice versa).

These managed care plans are only designed for reduced optional access to providers in exchange for premium reduction to manage cost cutting and health-care delivery, by itself, they have nothing to do with determining factors of ERISA definition, it is determined by who pays for the premium, who is the employer. Therefore if you work for Illinois or federal government, I work for AT&T or Motorola, we may be in different plans controlled or managed by the same insurance company or third party claim administrator (TPA). You're not in ERISA plan, I will be

in ERISA plan if my employer pays for employee group premium or provides claim benefits payment from company assets or funds. Therefore HMO or PPO may have ERISA plans and non ERISA plans, it has nothing to do with who controls the HMO or PPO network. Whether the plan is ERISA plan is determined by who pays or provides the benefits/health insurance and if the employer is in private sectors.

Another example as in small-business, as long as you have more than 1 person in the plan, the employer paid for the premium for the plan, there is an employer and employee in the plan, it is an ERISA plan.

In summary these are common misconceptions about ERISA plans

- a. ERISA applies only to self-funded employers.
- b. HMOs and PPO have a special exemption from law suits due to ERISA.
- c. Patients can't sue their self insured health plans because of ERISA.
- d. HMOs or PPOs have increased the amount of self-funding by employers.
- e. The states are powerless to regulate HMOs, POS or PPOs.
- f. All large employers are self-funded.
- g. Self-funding is growing.
- h. ERISA was intended to apply only to pensions, health care was an afterthought.

To physicians and health-care providers, it is needless to say that healthcare claim denials under managed care environment are a significant nightmare or problem. The question is how does that affect every healthcare provider's business survival.

## **E. ERISA Regulates about 80 Percent of Healthcare Claims**

Apparently, now we understand that ERISA is the federal law regulates about 80 percent of healthcare claims denials, if we do not understand how ERISA operates, we may never be able to enjoy the protections provided by ERISA to ensure our legitimate healthcare claims paid reasonably.

When our claims have been denied in part or wholly, we all have experienced endless problems and nightmares as well as frustrations from pursuing legitimate claim payment and disputes.

Since we never understood how ERISA operates, most of us are actually frustrated and felt hopeless. Especially when seeing numerous lawsuits filed by consumers and medical and health care organizations in federal court are being dismissed with disastrous results most of the time because of procedural and technicality problems: lack of legal standing and failure to exhaust administrative remedy-appeals, we are more frustrated and disturbed, in hope a new legislation will save us from "managed care abuse or nightmare".

The next big thing, Patients Bill Of Rights (PBOR), is still heavily debated in Congress with unknown certainty of its fate, however one thing is certain from both Republican and Democrats sponsored versions: both internal and external reviews/appeals have to be exhausted before a very limited extracontractual remedies, compensatory and punitive damages, are available, as in traditional insurance policy coverage dispute.

If healthcare providers never understand how to conduct effective and meaningful internal and external appeals, our future will still be hopeless. Because without exhaustion and completion of the required reviews and appeals, the door of justice is not opened to us.

Therefore ERISA is extremely important for healthcare providers business practice. Unfortunately in past 27 years, healthcare providers have never understood what ERISA is all about and how "insurance companies can play loopholes every time" in denying medical claims.

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## **II. ERISA Basic Concepts, Principle and Application in Healthcare Claims**

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|----------------------------------------------------|---------------------------------------|
| <b>A. Benefits v. Insurance</b>                    | <b>E. Insurance-Benefits</b>          |
| <b>B. Fiduciary v. Insurance</b>                   | <b>F. Full and Fair Review</b>        |
| <b>C. Different Relationships and<br/>Conduct.</b> | <b>G. Standard of Judicial Review</b> |
| <b>D. Disclosure v. Discovery</b>                  |                                       |
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### **A. Benefits v. Insurance (State Law Preemption, No Punitive)**

As discussed above, under ERISA, our healthcare claims are not insurance claims, but employee benefits claims. There is a big difference between benefits and insurance because they both are regulated under totally different federal and state laws.

If it is ERISA plan, benefits claims, it is regulated by ERISA. ERISA preempts any state laws when it is "related to" benefits determination. ERISA does not provide any extracontractual damage except for benefit claims. It means if the claim has been denied wrongfully, the claimant incurred loss of salary, compensations and any economic loss as a result of wrongful denial of the benefits claims by reckless and wrongful act of entities who administered and denied your claim, the claimant can not file lawsuit in federal court to ask for compensatory and punitive damages, or bad faith, as we normally understand it. As we all are excited about "Prompt Pay Law" enacted in many states to ensure prompt payment of healthcare providers claims after so many years of unreasonable delay, ERISA preempts this "Prompt Pay Law" completely if your patient obtained health insurance benefits through employment in private sectors, in another word, the claim is an ERISA dispute. Under ERISA, attorney fees for winning party is not guaranteed but up to trial judge's discretion, while state insurance coverage dispute generally will result attorney fee to the winning party and such attorney fee is clearly written in specific state laws. Many healthcare providers and medical state associations never understood this ERISA preemption of state law, attempted numerous lawsuits and fruitless state legislation to solve unreasonable delay problem for most of healthcare ERISA claims.

If your claim is not an ERISA claim, then it might be a non-ERISA claim, when your patient obtained health insurance from the church plan, school plan and governmental plan or individual insurance policy. If it is an insurance claim, insurance coverage disputes, your individual state laws are in control. In this scenario, all of those relevant state laws, insurance laws, managed care reform and patient's right act, consumer protection act and general contract laws will be applicable for your problems and disputes.

That means if you prevail in your lawsuits, you will be awarded attorney fees, possible pre and post judgment interests, compensatory (loss of wages) and possible punitive damages (bad faith).

An interesting and confusing phenomena is that even your patients are covered under same HMO, PPO, POS and managed by same insurance company or a third party, they may fall into different category, ERISA or non ERISA/insurance, benefits or insurance, federal court or state court, your life can be quite different because of different laws and regulations governing the claim denials.

Criteria to determine the types of ERISA or non-ERISA claim is to find out from the beginning of your claim process if your patient obtained health insurance coverage through employment in private sectors, or from governmental plan, church plan and school plan as well as some miscellaneous categories. If your patient is covered under ERISA plan, you must follow ERISA regulations in order to ensure prompt and reasonable payment. If your patient is not covered under ERISA plan, then you must follow applicable and relevant state laws.

Due to uncertainty and unguaranteed attorney fee under ERISA and traditional physician's failure in compliance in early stage of claim dispute, most ERISA attorneys do not take cases on contingency for healthcare claims dispute but demand for upfront retaining fee. This has greatly discouraged ERISA healthcare claim lawsuits in federal court.

Under ERISA, there is very specific regulation as to how soon an appeal must be filed after initial denial, usually 60 days, and how many appeals must be filed before lawsuits can be filed in federal court. While insurance coverage disputes has much longer statutes limitation for filing state law claims for insurance coverage disputes or insurance contract dispute.

Therefore, it is extremely important to understand that ERISA and insurance are totally different business even though your patients are all look like the same when they are covered under same HMO, PPO, POS or indemnity plan, managed by same insurance company or independent third party claim administrator.

## **B. Fiduciary v. Insurance (No Bad Faith in Exchange for Fiduciary Obligation and Greatest Disclosure)**

If your patient is covered under any ERISA plan, insurance company or third party administrator or plan sponsor in case of self-insured and self administered employee plan, is considered under federal law as your fiduciary. The relationship between patient, physician and insurance company is called fiduciary relationship, which is quite different from an insurance contractual relationship.

If your patient is covered by an insurance policy and non ERISA plan, the relationship between your patient, physician and insurance company is considered insurance contractual relationship.

Under each scenario, healthcare providers are not automatically considered as a party of such relationship without accepted or transferred legal rights and interests under ERISA plan or insurance policy, valid legal assignment and legal standing. Because ERISA has different regulations, for 80 percent of healthcare claims covered under ERISA, healthcare providers rarely obtained sufficient and valid legal assignment of legal right to pursue benefits dispute on

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### **III. Problems in Healthcare under ERISA**

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#### **A. Traditional Background**

#### **B. Current Problems**

#### **C. What's the Future and Patient Bill Of Rights**

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#### **A. Traditional Background, (No Compensatory & Punitive, No Contingency)**

It has been 27 years since Congress enacted ERISA in 1974, with congressional intent to protect participants and beneficiaries for their rights and benefits and to provide uniform federal regulation to accomplish this ERISA fiduciary rule of acting solely in interest of plan participant and beneficiary, to protect employers from being unreasonably punished for compensatory and punitive damages as insurance business in providing such employee benefits.

Needless to say that a lot has happened in 27 years in U.S. healthcare market, especially when managed care developed while most small-business owners are not self-insured and relied upon insurance companies to provide group insurance policies to administer employee benefit plans.

It has been judicially, medically and economically difficult to tell who is who and what is happening in mixed healthcare , employee benefits and insurance market.

As discussed above, insurance business is quite different from employee benefits business in its judicial interpretation, business management and economical results.

It has been almost a disaster for our nation due to such unanticipated and out of control problem for our healthcare , insurance business and employee benefits, labor market and American people's life quality.

The most important aspect of this disaster is the quality of American people's life has been significantly affected in current healthcare market. Due to ERISA preemption of punitive damage and current managed care structure, many life-and-death medical decision-makings were influenced by unreasonable and nonmedical business or benefits /insurance professionals and many lives of American people have lost and severe medical damages have been suffered yet nobody can be held accountable, subsequent medical consequences and endless lawsuits have turned many people's life upside-down.

One classical example would be recent Supreme Court unanimously ruling in PEGRAM et al. v. HERDRICH on June 12, 2000, which finally illustrated differences between eligibility determination and medical determination made by ERISA benefits professionals.

Second aspect of this problem is physician's business practice survival and escalating mega-litigation as evidenced by recent century landmark managed care litigation in federal court

in Miami Florida, involving AMA, seven major medical state associations and more than 600,000 healthcare providers and millions of patients. According to AMA, healthcare providers at this country are at breaking point due to unreasonable and uncontrollable insurance claim denials and delays.

The third and the most profound problem is skyrocketing and escalating healthcare cost for American people in today's healthcare and insurance/benefits market. Among many other reasons, self-inflicted and the self-imposed problems are the main reason for this problem due to lack of understanding and compliance with ERISA by healthcare providers, patients, insurance industry and benefits industry.

One of the main reason for this tragedy in past 27 years is that healthcare providers and patients never understood what ERISA really is and the difference between employee benefits and insurance.

We have enacted so many different laws but healthcare providers and patients are never effectively educated on how to comply and utilize these laws.

Before we can hope any improvement or change can be made by enacting Patients Bill Of Rights, we must ensure our healthcare providers and patients understand existing 27-year-old ERISA laws and regulations. Otherwise nothing is going to save us from next disaster in our nation's healthcare, benefits and health insurance market, ultimately American people's life quality.

## **B. Current Problems**

Specifically, in past 27 years, many factors have contributed to current problems. As discussed above, lack of understanding and compliance with ERISA by everybody is the main reason.

Under ERISA, any dispute is adjudicated in federal court instead of state court. An attorney is almost always required to represent plaintiff. In order to file ERISA lawsuit in federal court, plaintiff must have legal standing and have exhausted administrative remedy-appeals. The first appeal must be filed within 60 days after the initial denial notice was given. Unlike pension plan and long-term disability dispute, healthcare claims are traditionally filed by healthcare providers, patient assign his benefits of payment to healthcare providers. When dispute arises after healthcare claims are denied, healthcare providers are in better financial position and with much more medical knowledge to pursue claim reimbursement with insurance companies. Therefore healthcare providers and lawyers are involved in resolving such dispute, although the patient is the one whose claim has been denied.

However traditionally by the time a lawyer is consulted by healthcare providers or patients after failed long time negotiation between healthcare providers office and insurance company, it has been long past 60 days after initial claim denials within which (60 days) a written appeal must be filed as required by ERISA (ERISA version of "statute limitation") in order to pursue ERISA dispute in federal court, and healthcare providers nationwide have never successfully and effectively obtained ERISA valid legal assignment of benefit not only including right to receive claim reimbursement but also right to pursue on patient behalf, which was the main reason most physician's claims were dismissed in federal court under ERISA. So lawyers

have to do all of these appeals from the beginning which could take long time and still facing extreme uncertainty of prevailing due to lack of legal standing by healthcare providers, failure to exhaust administrative remedy by failure to file timely appeals and no guarantee of attorney fees under ERISA as well as possible plan exclusion of claims at issue. With such reality of money and time consuming and uncertainty of winning, most majority of ERISA lawyers will not take cases on contingency, unlike pension and long-term disability claims, but demand for a high retaining fee to represent the case. After so many failures and unsuccesses in 27 years in entire industry, it is very seldom that healthcare providers prevailed in federal court for ERISA claims dispute while nationwide disastrous medical claim denials and delays deteriorating every day. Because of this mechanism, lawyers are not encouraged to represent ERISA medical claim cases and healthcare providers are more and more hopeless. With state law preemption by ERISA and repeated failure in federal court and more disastrously lack of understanding of ERISA by healthcare providers, entire nation's healthcare providers turned to two solutions: medical association organized and sponsored class-action in federal court claiming racketeering violations and many other thinkable claims in federal and state courts, and turning to new federal legislation-Patients Bill Of Rights.

Although new legislation may provide for some hope for healthcare providers and patients, nothing is going to realistically protect healthcare providers and patients unless healthcare providers nationwide really understand ERISA and Patients Bill Of Rights.

ERISA has provided the best protection for healthcare providers and patients by mandating greatest disclosure and fiduciary responsibility, and newly promulgated final regulations by Department of Labor, Rules and Regulations for Administration and Enforcement; Claims Procedure. Unfortunately healthcare providers nationwide continue to avoid studying and complying with ERISA existing and newly promulgated regulations, but relied upon future legislation and class-action campaign or simply collecting from patients for unpaid medical claims.

### **C. What's the Future and Patient Bill Of Rights**

As evidenced by lack of utilization of recent numerous state versions of Patients Bill Of Rights due to lack of public and physician understanding, a new federal Patient Bill Of Rights will not provide any practical and meaningful protection for healthcare providers and patients if such lack of education and healthcare provider's compliance of appeal process continue to worsen without recognition and corrections by healthcare providers.

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## **IV. ERISA Statutory Design and Practical Problems Affecting Claims Denial and Appeal**

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- A. How To Determine If The Claim Is An ERISA Claim?**
- B. Parties**
  - 1. Plan Administrator**
  - 2. Fiduciary:**
  - 3. Third Party Claim Administrator (TPA)**
  - 4. Utilization Review Organizations**
  - 5. Managed Care Networks or Organizations**
- C. Different Kinds Of ERISA Plans And Parties To Deal With**
- D. ERISA Claim Denial and Appeal Procedures**
  - 1. Assignment of Benefit, Legal Assignment of Benefit,**
  - 2. Summary Plan Description (SPD)**
  - 3. Plan Document**
  - 4. ERISA Regulation About Claims Denial Notice**
- E. ERISA Fiduciary Rule**
- F. Reasonable Expectation Doctrine**
- G. Burdens of Proof**
- H. Appeal Procedure Required**
- I. Parties to Appeal with**
- J. Middlemen During Appeals**
- K. ERISA Qualified Appeals**
- L. Mysterious Problems in ERISA Claims Appeals**
- M. When to Retain an Attorney to File Lawsuit in Federal Court**

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### **A. How to Determine If The Claim Is an ERISA Claim?**

Although ERISA regulates about 80% of healthcare claims for 27 years, due to the fact that most people obtained health insurance benefits through employment in private sectors in USA, and healthcare claim delay and denial problems have escalated and deteriorated to the breaking point, ERISA has never been understood by healthcare providers and industry, even

most attorneys representing these healthcare providers and hospitals as well as patients. Most ERISA healthcare claim lawsuits filed in federal court are dismissed due to lack of legal standing (no assignment for right to sue, right to pursue legally) and failure to exhaust administrative remedy (not ERISA qualified appeals) and “not proper defendant” (insurance companies are not plan administrator).

It is extremely important to understand the basic but most important ERISA concepts and mechanisms, in order to comply with ERISA, federal law designed to regulate and govern ERISA healthcare claims, to enjoy statutorily provided protection and exercise ERISA rights if your claims are delayed or denied.

In order to demystify ERISA for healthcare providers, a dummy version of ERISA is created by this author (although miscellaneous exceptions shall be considered):

ERISA = HEALTH INSURANCE THROUGH EMPLOYMENT IN PRIVATE SECTORS = 80% HEALTHCARE CLAIMS.

Governmental Plans, Church and School Plans, One-person Self-employed Plan are not covered under ERISA.

ERISA dispute is adjudicated in federal court instead of state court.

ERISA regulations are enforced by Department Of Labor through Pension and Welfare Benefits Administration instead of Department Of Insurance in each state.

## B. Parties

### 1. **Plan Administrator**

The person or entity named to administer the day-to-day operation of the pension or welfare plan.

ERISA Section 3(16) (A) defines that the term administrator means the following:

“The person specifically so designated by the terms of the instrument under which the plan is operated; If an administrator is not so designated, the plan sponsor; or in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary of Labor may by regulation prescribe.”

Therefore, a plan sponsor will be deemed the plan administrator if the plan does not designate another person or entity as the plan administrator. Administrative functions can, however, be delegated, and when they are delegated to another party, such as an insurance company, that party may be deemed to be the plan administrator.

### 2. **Fiduciary:**

“Under ERISA, a fiduciary is someone acting in the capacity of manager, administrator, or financial adviser to a "plan".

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## V. Commonly Seen ERISA Claims Denials

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- A. Plan (Policy) Exclusion**
  - B. Medical Necessity**
  - C. Usual, Customary And Reasonable, PPO Discount, Bundling And Downcoding**
  - D. Pending Investigation and Physician Medical Records**
  - E. Pre-existing Condition Exclusion**
- 

### A. Plan (Policy) Exclusion

Plain and simple, the policy does not cover medical service provided in the claim. However there is a great distinction between different type of policy exclusions.

Absolute or specific exclusions: medical service or treatment provided in your claim is absolutely and specifically named unambiguously in policy language and plan document. In this case, a fiduciary or insurance company should provide specific explanation and specific reference to pertinent plan provision as required by ERISA and provides healthcare providers with reasonable access of plan document. A healthcare provider should file immediate appeal and requested for copy of SPD and plan document with that specific and absolute exclusion of your named medical service, because a fiduciary or insurance company has burden of proof to defend that specific exclusion determination and if you don't ask for it, they don't have to give you anything.

The second type of policy exclusion is by determination and discretion, because the fiduciary or insurance company believes the service claimed is not medically necessary or maintenance care or not safe procedure, because the fiduciary or insurance company believes they have been given such discretionary authority to make that determination. However the fiduciary under ERISA has to follow those fiduciary rules, exclusive benefits rule, adherence to plan document rule and prudent personal rule. They must disclose any information and document they used to reach that denial decisions, just in case they never have conducted any review as claimed but asked you to prove otherwise.

Once a denial decisions has been officially made, a fiduciary or insurance company has first burden of proof to support its denial decisions but a healthcare provider must request for such supporting document in writing within 60 days after initial denial notice received.

### B. Medical Necessity

This is probably the most common and most abused reason for denial.

First of all, burden of proof, if no official denial has been made and insurance company's requested for medical records with legal merits and causal connection for benefit determination, a healthcare provider has burden of proof to establish sufficient evidence for benefits. Once an official denial has been made by the fiduciary or insurance company, ERISA denial notice requirement mandate totally disclosure from the fiduciary or insurance company to inform claimant of reasons of denials and access to plan document and right to appeal.

Written Document Rule: any medical necessity determination has to be based on unambiguous, clear and specific language calculated to be understood by average plan participants, not only for lawyers or board certified neurosurgeons, written in plan document.

Any medical necessity review has to be done by appropriate clinical professional and has to be completely disclosed to attending healthcare providers.

A complete disclosure requests will probably resolve most medical necessity dispute, especially such document request is part of ERISA appeal with legal standing and two levels of appeals already.

Most medical necessity reviews are done by outside independent third parties and by anonymous reviewers. Most of them may not be conducted as claimed because most reviewers may not be qualified as claimed and medical necessity conclusion was automatic universal format without clinical rationale ever disclosed.

Qualified ERISA appeal and requests for plan document are most effective weapon for medical necessity review denial, otherwise medical necessity opinion is always a matter of opinion, an opinion is legally a matter of expression of medical assessment. Everyone is entitled to his opinion.

I would discuss specifically on medical necessity review judgment in subsequent chapters by sample appeal letters.

### **C. Usual, Customary and Reasonable As Well As PPO Discount, Bundling and Downcoding**

If you medical care is covered and medically necessary, now a price cuts would be most efficient to reduce your claim benefits. Usual, Customary and Reasonable (UCR) reduction is probably most popular claim dispute, for nonparticipating providers in case of managed care networks. Your claim simply get reduced by certain percentage of numbers and simply stating your fee is excessive, beyond and above the usual, customary and reasonable charges in your geographic area, while same patient with same providers for same services are reduced in different ways in the same calendar year.

UCR dispute and lawsuits are very popular, unfortunately due to lack of legal standing and failure to exhaust administrative remedy as well as UCR schedule request technicality failure, most claims were dismissed in federal court.

However, Department of Labor Advisory Opinion, 96-14A, specifically states UCR schedule is part of plan document under ERISA Section 104 (b) and is subject to disclosure upon specific request after claim denials. This Advisory Opinion is included in subsequent chapters of this book.

For participating providers, PPO discount by bundling and downcoding will be most commonly seen discount practice. The denial notice will state that because you are a participating provider and have agreed to accept PPO discounted payment as a payment in full, you're not allowed to balance bill your patient. On EOB to your patient, it will state that your claims have been covered and paid in full with PPO discount. You should not be billed for the amount above PPO discount.

The problem is that bundling and downcoding has never been part of PPO agreement. A PPO agreement is in general per procedure percentage discount and pre-agreed upon in PPO agreement, although managed care networks or insurance company are given power to change that schedule from time to time, but was never authorized to add-on bundling and downcoding as part of terms and conditions of PPO contract.

The practical problem is that when healthcare providers come forward to dispute, insurance companies will tell that only the insured or plan member can appeal not providers, when patients come forward to dispute, the answer is it is a PPO discount, your claim is fully covered and reimbursed, provider should never have billed you for that amount above PPO discount, although in fact it is a bundling and downcoding by factually denying one of the medical service as benefits denial, depriving both providers and patients of right to appeal.

The solution is very simple but effective, by following ERISA appeal procedures, requested for supporting plan document to justify that PPO discount by downcoding and bundling. I will discuss this specifically in subsequent chapters in sample appeal letters.

#### **D. Pending Investigation and Physician Medical Records**

One of the most commonly seen and frustrating situation is that a fiduciary or insurance company will send a questionnaire to the patient and medical records requested to physician's office.

Due to miscommunication or inefficiency of physician's office and patient confusion, this stage will never finish.

Patient should be educated by healthcare provider's office on prompt response to insurance company's requests, and healthcare provider's office should respond timely to such requests from the fiduciary or insurance company.

However if abuses are detected or observed by healthcare providers, the timely appeal should be filed with plan fiduciary or insurance company by requesting those investigation files to justify delay of payment.

Again state law does not apply in this type of situation in ERISA plans, especially while state Prompt Pay Law may require 30 days payment or response.

## **E. Pre-existing Condition Exclusion**

This is actually very common with patient switching jobs and insurance. ERISA and HIPAA have specific regulations about pre-existing condition exclusion and waiting period. A special understanding of "Certificate for Credible Coverage" is required for those new employees and employees changed jobs recently. A special publication on the subject by Department Of Labor is included in this book.

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## VII. Sample Letters and Forms

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### A. Pre-Denial Request Letters

1. Legal Assignment of Benefit
2. Notice of Legal Assignment
3. SPD Request Letter

### B. Initial/First Appeal Letter

1. SPD Request Letter
2. Appeal Letters
3. Appeal Letter for Plan/Policy Exclusion, Chiropractic Exclusion
4. Appeal Letter for Medical Necessity Denial
5. Appeal Letter for Usual, Customary and Reasonable Denial
6. Appeal Letter for PPO Discount, Mixed Bundling and Downcoding As Well As UCR Denials
7. Appeal Letter for No Response Denial

### C. Second Level Appeal Letter

1. SPD Request Letter
2. Appeal Letters, Plan/Policy Exclusion, Chiropractic Exclusion
3. Appeal Letter for Medical Necessity Denial
4. Appeal Letter for Usual, Customary and Reasonable Denial
5. Appeal Letter for PPO Discount, Mixed Bundling and Downcoding As Well As UCR Denials
6. Appeal Letter to Attorney at Insurance Company
7. Appeal Letter for Billing & Coding, Medical Necessity and Utilization Review Dispute

### D. Third Level Appeal, More Than Required but Necessary.

1. Appeal letter for Medical Necessity Dispute with Legal Demand for SPD Penalty
2. Appeal letter for Medical Necessity Dispute with Appeal Futility
3. Appeal Letter For Policy Exclusion And/Or Medical Necessity Dispute With Appeal Futility

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The following sample letters are included in this book. This makes this book very comprehensive and practical for busy physicians and healthcare providers in almost every healthcare settings, physician's offices, outpatient clinics, hospitals nationwide as long as the claims are ERISA claims in all 50 states nationwide.

In general, for most appeal letters, all the physician has to do is to complete one short paragraph of specific individualized reasons for denial found on denial notice, Explanation of Benefits ( EOB), in addition to necessary identification information for physician, patient and insurance company. It may take less than five minutes to complete entire process including printing certified letter labels and complete postage.

**Points to remember:**

ERISA appeals have two secrets for most cases: 1) Appeal letter is mainly a procedure significance required by ERISA, to request disclosure from insurance company, as medical records requests to physicians from insurance companies, but this time the burden of proof is on insurance company, after denial decision is made; 2) In most cases entire appeal process is procedure only without rebuttal or dispute or medical merits because most of the time insurance companies will not disclose plan document, practice guidelines and the clinical rationale as requested in these sample letters as required by ERISA. If there is no evidence to dispute medical merits, then do not waste time on unnecessary argument that is not causally connected with and supported by specific reasons for denial and supporting document and evidence from insurance company or plan administrator. In past 27 years, physicians nationwide spent countless hours and huge financial resource in arguing medical necessity merits or unexplained coding and billing denial but never file ERISA required appeals. The result of this "noncompliance practice" in claims dispute is automatic dismissal of physicians lawsuit in federal court after more money is spent in litigation because the court find physicians never have obtained legal standing and competed required ERISA appeals as failure to exhaust administrator remedy, even though hospitals and physicians' offices wasted entire year on the phone and sending certified letters demanding for payment from insurance companies, filing complaints with each individual state Department of Insurance, joined every medical association and donated and contributed to every political action package and class actions through medical associations. American Medical Association describes this picture as physicians nationwide are almost at breaking point after tried everything and failed on almost everything.

Solution is very simple, if the claim is ERISA claim, follow the ERISA laws by complete required two levels of ERISA appeals. If no compliance with ERISA by insurance company or plan administrator, then go back to the court, you will be most likely the winners instead of losers in this modern healthcare and managed care market.

For efficiency and automation, a word file is included in this book for each sample letter that can be opened by most word processors on any computer so there's no need or retyping. File formats are in three types: \*.doc for Microsoft Word, \*.wpd for WordPerfect and \*.rtf for any word processor.

## **SAMPLE LETTERS AND FORMS**

### Legal Assignment of Benefit, A1

Text file “assignment.pdf” is for new patient, this form shall be used in every written communication with plan administrator, a fiduciary or insurance company in order to establish ERISA rights, transferred and assigned from patient, to receive and possibly pursue legally for reimbursement and plan document.

Text file “assignment2.pdf” is for established patient with any change of required information, such as employment, change of insurance, change of name and home address or same patient who has not been seen in the same facility for more than three months, to ensure the accuracy of information on file, otherwise instructions for new patient should be followed when communicating with insurance companies and plan fiduciary.

## IX. Selections Of ERISA Statutes And Regulations

### Statutory & Regulatory Disclaimer

The author of this book is providing this information for educational and reference purposes only. The user of this book should be aware that, while great effort has been made to keep the information timely and accurate, there will often be changes in legislative work and statutory development, and delay between official publication of the materials and their appearance or modification of these references. Therefore, the author of this book makes no express or implied guarantees. The *Federal Register* and the *Code of Federal Regulations* remain the official source for regulatory information published by the Department of Labor and appropriate judicial and governmental agencies. The information provided with this book is only the selections of statutory and regulatory publications and does not represent official and legal publication. For official and legal publication or any legal questions, the user of this book is advised to consult with a licensed legal professional and any official publications.

The author of this book will make every effort to correct errors brought to his attention.

Electronic Code of Federal Regulations can be found on Internet at:

<http://www.access.gpo.gov/ecfr/> (Government Printing Office, GPO), GPO is beta testing a new online version of the Code of Federal Regulations, which is updated on a daily basis.

U.S. Code Online via GPO Access [[wais.access.gpo.gov](http://wais.access.gpo.gov)]

ERISA related Statutes and Regulations can also be found on Internet at

<http://www.dol.gov/dol/pwba/> Department Of Labor, Pension and Welfare Benefits Administration Web Site

Complete text of these selected ERISA statutes is included in this book under Appendix A.

### Selections: ERISA in the United States Code

<a href="#"><u>29 USC 1002</u></a>	<a href="#"><u>ERISA 3</u></a>	<b>Definitions.</b>
<a href="#"><u>29 USC 1003</u></a>	<a href="#"><u>ERISA 4</u></a>	<b>Coverage.</b>
<a href="#"><u>29 USC 1021</u></a>	<a href="#"><u>ERISA 101</u></a>	<b>Duty of disclosure and reporting.</b>
<a href="#"><u>29 USC 1022</u></a>	<a href="#"><u>ERISA 102</u></a>	<b>Summary plan description.</b>
<a href="#"><u>29 USC 1023</u></a>	<a href="#"><u>ERISA 103</u></a>	<b>Annual reports.</b>
<a href="#"><u>29 USC 1024</u></a>	<a href="#"><u>ERISA 104</u></a>	<b>Filing and furnishing of information.</b>
<a href="#"><u>29 USC 1025</u></a>	<a href="#"><u>ERISA 105</u></a>	<b>Reporting of participant's benefit rights.</b>
<a href="#"><u>29 USC 1104</u></a>	<a href="#"><u>ERISA 404</u></a>	<b>Fiduciary duties.</b>
<a href="#"><u>29 USC 1131</u></a>	<a href="#"><u>ERISA 501</u></a>	<b>Criminal penalties.</b>
<a href="#"><u>29 USC 1132</u></a>	<a href="#"><u>ERISA 502</u></a>	<b>Civil enforcement.</b>
<a href="#"><u>29 USC 1133</u></a>	<a href="#"><u>ERISA 503</u></a>	<b>Claims procedure.</b>

<a href="#"><u>29 USC 1134</u></a>	<a href="#"><u>ERISA 504</u></a>	Investigative authority.
<a href="#"><u>29 USC 1140</u></a>	<a href="#"><u>ERISA 510</u></a>	Interference with protected rights.
<a href="#"><u>29 USC 1141</u></a>	<a href="#"><u>ERISA 511</u></a>	Coercive interference.

ERISA Federal Regulations Enforced by Department Of Labor, Pension and Welfare Benefits Administration

Complete text of "PART 2560-RULES AND REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT" is included in this book under Appendix B

**CFR** Code of Federal Regulations Pertaining to PWBA

**Title 29** Labor

**Chapter XXV** Pension and Welfare Benefits Administration, Department of Labor

<u>Part</u>	<u>Name</u>
<a href="#"><u>2509</u></a>	Interpretive Bulletins Relating to the Employee Retirement Income Security Act of 1974
<a href="#"><u>2510</u></a>	Definitions of Terms Used In Subchapters C, D, E, F, and G of This Chapter
<a href="#"><u>2520</u></a>	Rules and Regulations for Reporting and Disclosure
<a href="#"><u>2530</u></a>	Rules and Regulations for Minimum Standards for Employee Pension Benefit Plans
<a href="#"><u>2550</u></a>	Rules and Regulations for Fiduciary Responsibility
<a href="#"><u>2560</u></a>	Rules and Regulations for Administration and Enforcement
<a href="#"><u>2570</u></a>	Procedural Regulations Under the Employee Retirement Income Security Act
<a href="#"><u>2575</u></a>	Adjustment of Civil Penalties Under ERISA Title I
<a href="#"><u>2580</u></a>	Temporary Bonding Rules
<a href="#"><u>2582</u></a>	Rules and Regulations for Fiduciary Responsibility
<a href="#"><u>2584</u></a>	Rules and Regulations for the Allocation of Fiduciary Responsibility
<a href="#"><u>2589</u></a>	Rules and Regulations for Administration and Enforcement
<a href="#"><u>2590</u></a>	Rules and Regulations for Health Insurance Portability and Renewability for Group Health Plans

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## X. Case Law (Court Ruling) Study

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### A. U.S. Supreme Court

1. *Pegram Et Al. v. Herdrich*
2. *Firestone Tire & Rubber Co. v. Bruch*
3. *Varsity Corp. v. Howe*
4. *Massachusetts Mut. Life Ins. Co. v. Russell*
5. *Pilot Life Ins. Co. v. Dedeaux*

Complete text of these Supreme Court opinions is included in this book under Appendix C

### B. District And Court Of Appeals

1. *Hernandez v. Prudential*
2. *Fallick v. Nationwide*
3. *Medical Alliances, LLC v. American Medical Security*
4. *Christopher Plumb v. Fluid Pump Service, Incorporated*
5. *Principal Mutual Life Ins. Co. v. Charter Barclay Hospital*
6. *Neuma v. Amp, Inc And Provident Life And Accident Insurance Company*
7. *Washington Physicians Serv. v. Gregoire*
8. *Rica F. Verkuilen v. South Shore Building and Mortgage Company, et al*
9. *Roy A Jackson, Et Al. v. E.J. Brach Corp*
10. *Alan Kascewicz v. Citibank*
11. *Juanita White v. Aetna Life Insurance Company and Aetna US Healthcare*
12. *Carol A. Ward v. Alternative Health Delivery Systems, Inc.*
13. *Kimberly Crocco v. Xerox Corp., Et Al.*
14. *Gary A. Levinson v. Reliance Standard Life Insurance Company*
15. *Dana Tait v. Barbknecht & Tait Profit Sharing Plan, Et Al*
16. *Simon v. Allstate Employee Group Medical Plan And Rodney T. Daniels*
17. *Simon v GE Life Disability*

Complete text of these Federal Court opinions is included in this book under Appendix D

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### DISCLAIMER for Case Law Study Notes

The opinions expressed in this book by this author are personal opinions and study notes. These opinions and views are not legal opinions or advice. The user of this book is advised to consult with a licensed legal professional for any legal questions or concerns.

### A. U.S. Supreme Court

It is extremely important to study and understand U.S. Supreme Court rulings on ERISA issues and to develop our ERISA claim appeal strategies consistent with U.S. Supreme Court rulings, because U.S. Supreme Court rulings are final rulings, final interpretation of statutes and regulations. If our appeals are consistent with U.S. Supreme Court rulings, the likelihood of prevailing our appeals on judicial process will be greatly increased unless Congress changed statutes.

There are many issues that have been ruled by U.S. Supreme Court that can be very favorable to physicians, such as fiduciary disclosure obligations, that have not been understood and realized by physicians and patients. There are many issues that have been ruled less favorable to physicians, such as no legal standing or assignment to the third party assignee, such as health-care professional associations, and no compensatory and punitive damage for reckless claim denials, and state law preemptions, however these are U.S. Supreme Court rulings that's final and most authoritative interpretation of our statutes. As U.S. Supreme Court pointed out in *Pegram et al. v. Herdrich*, for these and other unavailable remedies under ERISA, legislative but judicial approach is advised. Therefore physicians and patients should not waste time and energy in bringing any legal actions under ERISA to seek for compensatory and punitive damages through judicial approach and filing ERISA actions under the name of health-care professional associations and organizations. For any of these changes, go to congress not court house.

One of the popular public demand by physicians and health-care providers is to demand health-care professional associations to file class actions under ERISA to ask federal court to issue court orders for insurance companies to change or stop in proper claim practice and seek for compensatory and punitive damages. If we understand what U.S. Supreme Court has ruled on the issue, we probably would never have done any of these judicially meaningless lawsuits to frustrate ourselves.

On the other hand, if we understand U.S. Supreme Court final rulings on plan fiduciary definition, fiduciary disclosure obligations and legal standings for health-care professionals, we would greatly enjoyed protections offered by ERISA.

The new federal final claim regulations, to be effective in January 2002, are consistent with most recent U.S. Supreme Court rulings in *Pegram et al. v. Herdrich*.

Although ERISA litigation is evolving everyday and too many issues are not clearly settled among different federal Court of Appeals, principles guiding our actions remain the same and have never changed, comply with existing federal statutes and regulations, lobby for new rules, rather than filing lawsuits in federal court without available legal standing and seeking for statutorily unavailable remedies.

Highlight and underline are added by this author. Yellow highlighting is added by this author to interesting sentences and paragraphs to save time in navigating lengthy legal reading.

1. ***Pegram et al. v. Herdrich***—Greatest Fiduciary Disclosure

Greatest fiduciary disclosure, medical decisions by erisa plans are not preempted by ERISA, current managed care problems presently without remedies under ERISA are better dealt legislatively but judicially.

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## **XI. ERISA Claim Procedure and Enforcement**

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### **A. ERISA: DOL, PWBA Administrative Enforcement**

### **B. Department of Labor Issues Final Claims Regulations**

#### **1. DOL Final Claims Regulations**

- 1) Full and Fair Review**
- 2) Notice of Appeal Determination**
- 3) Relevant Document**

#### **2. DOL and Advisory Opinions**

#### **3. DOL Publications**

- 1) Patients' Rights Claims Procedure Regulation**
- 2) Claims Procedure; Final Rule**
- 3) DOL Delays Claims Regulations For Group Health Plans**
- 4) Amendments to Summary Plan Description Regulations; Final Rule**
- 5) DOL Advisory Opinions: 96-14A, 97-11A**
- 6) How to File a Claim for Your Benefits**
- 7) Top 10 Ways to Make Your Health Benefits Work for You**
- 8) How to Obtain Employee Benefit Documents from the Labor Department**
- 9) DOL's Amicus Curiae regarding Disclosure of Attorney-Client Communications and Work Products by Plan Fiduciaries to Plan Participants and Beneficiaries**
- 10) Questions and Answers for Dislocated Workers Compliance Assistance for Group Health Plans**
- 11) Compliance Assistance for Group Health Plans**

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### **A. ERISA: DOL, PWBA Administrative Enforcement**

Just like IRS enforces tax codes administratively and tax court interprets tax codes judicially, Department Of Labor (DOL) enforces ERISA regulations administratively through Pension and Welfare Benefits Administration, PWBA. DOL/PWBA is in charge of developing relevant ERISA regulation consistent with ERISA statutes, U.S. Code, and enforcing ERISA regulations.

It is well known to general public and physicians that DOL/PWBA is in charge of pension and labor business but it is very poorly understood that DOL/PWBA is the federal agency in charging of welfare, and employee health-care benefits administration, that is any health insurance through employment in private sectors, 2.5 million ERISA plans, covering up to 135-145 million Americans and about 80% of healthcare claims and physicians business.

It is very unfortunate fact that ERISA claims procedure and enforcement are almost unknown to physicians nationwide for 27 years. ERISA statutes and regulations have been around for 27 years with DOL enforcing ERISA regulations. ERISA claim procedure and enforcement are rarely discussed or promoted in healthcare provider community. Even when managed care claim denials have frustrated our entire nation and disturbed many physicians' lives and businesses, ERISA is still poorly known and understood by physicians.

Physicians nationwide are looking to next big thing, Patients' Bill Of Rights (PBOR), in hope to solve their problems in claim denials. Regardless what final version of PBOR will be written into federal law, ERISA and PBOR are still ERISA, with increased appeal requirements and increased but very limited compensatory and punitive damage, which was not available under ERISA presently. Employee benefits are still employee benefits under ERISA, would not be the "insurance".

Without understanding of mechanism of ERISA and PBOR, physicians and their patients will not be able to realize the protection promised and intended by PBOR, because very limited compensatory and punitive damage will not be available until both internal and external appeals are exhausted, let alone physicians rarely file internal appeals for 27 years and no understanding of what legal standing under ERISA means.

Before the old regulations are understood by physicians, the new regulations for ERISA claim appeals are coming out and to be effective next January in 2002. Because physicians nationwide never understood what ERISA means, this new final claims regulation is rarely discussed among physicians and hospitals. But physicians have to wake up and start to comply with the ERISA if we expect any protection from federal laws.

## **B. Department of Labor Issues Final Claims Regulations**

### **1. DOL Final Claims Regulations**

On November 21, 2000, the Department of Labor, DOL/PWBA, issued new final regulation governing ERISA claims procedures for employee benefit plans. This final regulation was originally designed to apply to all ERISA claims filed on or after January 1, 2002., but it was delayed, by DOL on July 6, 2001, for its application to group health insurance plans, under which the employees are covered by group insurance policy with employer paying premiums for employees. This new final regulation still applies to disability and welfare plans, under which employees are covered by employer self-insured or self-funded plans, regardless if the employer or another insurance company administers the plan, which is still significant percentage of ERISA plans.

Group Health Insurance Plans will have to be in compliance with new final regulation as of the first day of the first plan year on or after July 1, 2002, but no later than January 1, 2003 (the date formerly was January 1, 2002). For calendar-year plans, the compliance date will be January 1, 2003.

According to DOL publication, Fact Sheet---Patients' Rights Claims Procedure Regulation, November 20, 2000, the final regulation has provided much more protection for patients and physicians. These new protections are:

### **Faster Decisions**

*Faster* decisions on initial claims - rather than 90 days (or more) under current regulation, the new rule would require decisions (in most cases) *not later than*:

- 72 hours for urgent care claims
- 15 days for pre-service claims
- 30 days for post-service claims
- One 15 day extension for pre- and post-service claims
- *Faster* decisions on appeal of denied claims - rather than 60 days (or more) under current regulation, the new rule would require decisions (in most cases) *not later than*:
  - 72 hours for urgent care claims
  - 30 days for pre-service claims
  - 60 days for post-service claims

### **Fairer Process**

- Claimants have more time to file appeals - 180 days, rather than current 60 days.
- If treating physician determines the claim is "urgent," plans must treat as urgent.
- Plans cannot impose fees or costs as a condition to filing or appealing a claim.
- Arbitration permitted, but only with full disclosure regarding the process, arbitrator, relationships, right to representation, and only if claimant agrees after completing internal appeal.
- Review must be *de novo*.
- Decision maker on appealed claims must be different than the person deciding initial claim.
- Plans must consult with appropriate health care professionals in deciding appealed claims involving medical judgment.
- Plans may not require more than two levels of review of denied claims. If more than one level, both levels must be completed within time frame applicable to one level.
- Special rules for the continuation or extension of approved benefits or services to be provided over time ("concurrent care decisions"). Individuals receiving approved care over a period of time must have an opportunity for review before benefits are reduced or terminated. Also, urgent care requests for an extension of approved benefits must be decided within 24 hours.
- Plans must have procedures and safeguards for ensuring and verifying consistent decision making.
- Plans must notify claimant of defective filing of claim in case of pre-service claims.
- If plans fail to make timely decisions or otherwise fail to comply with the regulation, claimants may go to court to enforce their rights.

### **Fuller Disclosure**

- Plans must provide participants a full description of the plan's claim procedures.
- Plans must provide specific reasons for denials, including identification of and access to any guidelines, rules, protocols relied upon in making the adverse determination.
- Plans must provide participants access to all documents, records and other information relevant to the benefit determination, without regard to whether the plan relied on the material.
- Plans must disclose the name of medical professionals consulted as part of the claims process.

Among many improvements or protections, the most significant protections are more while and specific defined definitions of "Full and Fair Review", Notice of Appeal Determination, and "Relevant Document"

### 1) **Full and Fair Review**

The claimant has at least 180 days, following receipt of a notification of a denial, to appeal. The review must be conducted by an independent named fiduciary who is neither the original decisionmaker nor his subordinate. The claimant may submit additional documents, records or information, which must be taken into account on review, by the new decision maker regardless of previous decision maker's opinions or determination. The plan must provide the claimant reasonable access to all "relevant" documents (defined below) upon written request and free of charge. Where the appeal involves medical necessity or experimental claims, the named fiduciary must consult with a health care professional, or a clinic peer, with same specialty or training, who was neither the medical professional consulted in the initial determination, nor his subordinate. Plans are permitted to require only two levels of review, provided that both may be conducted within the applicable time frames, 60 days.

### 2) **Notice of Appeal Determination**

The plan administrator or fiduciary must provide written or electronic notice of denial ( an adverse benefit determination, new name for denial) that must include the same information as notices for initial determination. In addition, the **notice on appeal** must include a statement that claimants are entitled to receive, upon request and free of charge, copies of all documents, records and other information "relevant" to their claim for benefits, whether or not relied upon making a determination. The notice also must provide a description of any voluntary appeal or alternative dispute resolution procedures.

### 3) **Relevant Document**

Relevant document is defined as a document, record, or other information if it was **relied upon** in making the determination, or was **submitted** to the plan, **considered** by the plan, or **generated or obtained** in the course of making the benefit determination, **without regard** to whether such document, record, or other information and was **relied upon** in making the determination. Subparagraph (m)(8) further provides that the claimant should receive any information demonstrating that, in making the adverse benefit determination, the **plan complied with its own processes** for ensuring appropriate decisionmaking and consistency. Additionally with respect to **group health and disability claims** under subparagraph (m)(8), a document, record, or other information is considered "relevant" if it constitutes **a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for that claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the determination.**

This new rule definition and requirement are consistent with last year U.S. Supreme Court unanimously ruling in Pegram et al. v. Herdrich, in that a fiduciary is obligated to disclose the characteristics of the plan and of those who provided service to the plan and any information that affects material interest of plan participant and beneficiary.

It is only with clear and the correct understanding of these ERISA laws and regulations as well as case laws from U.S. Supreme Court and federal courts that physicians can really enjoy and realize the protections designed in any existing and new federal laws.

It is the firm belief of this author that appeal strategies and appeal sample letters contained in this book are developed from and consistent with these federal laws and regulations as well as real-life interpretations of ERISA laws and regulations from various case laws and court rulings.

## **2. DOL and Advisory Opinions**

In the course of enforcing ERISA regulations, DOL issues advisory opinions from time to time as part of its administration and enforcement of ERISA regulations. Among many of such advisory opinions, two of them are significant to physicians in regard to claims appeal and disclosures: Advisory Opinion 96-14A and 97-11A. Advisory Opinion 96-14A is of opinion that usual, customary and reasonable (UCR) schedule used by an insurance company/plan administrator in denying claims is "relevant documents" under ERISA 104 (b) and is subject to disclosure upon specific request. Advisory Opinion 97-11A states a TPA contract with plan is relevant plan document and subject to disclosure under the same section of ERISA. Both of these two opinions are enclosed in this book under the Appendix E.

## **3. DOL Publications**

- 1) Patients' Rights Claims Procedure Regulation
- 2) Claim Appeal Final Rule
- 3) DOL Delays Claims Regulations For Group Health Plans
- 4) SPD Final Rule
- 5) DOL Advisory Opinions
- 6) How to File a Claim for Your Benefits
- 7) Top 10 Ways to Make Your Health Benefits Work for You
- 8) How to Obtain Employee Benefit Documents from the Labor Department
- 9) DOL's Amicus Curiae regarding Disclosure of Attorney-Client Communications and Work Products by Planned Fiduciaries to Plan Participants and Beneficiaries
- 10) Questions and Answers for Dislocated Workers
- 11) Compliance Assistance for Group Health Plans

Complete text of these DOL publications are included in this book under Appendix E.

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## XII. State Laws

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### A. ERISA Preemption?

### B. Illinois Managed-care Reform and Patient Right Act

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### A. ERISA Preemption?

State law is preempted generally when it is related to ERISA benefits determination. While "related to" is a very complicated legal question, and very often requires judicial interpretation, there are several basic steps that can be used to make some basic determination, such as quantity and quality doctrine. In general for any ERISA plan, if the question is related to the quantity of employee benefits, it is generally an ERISA issue; if the question is related to the quality of medical care, it is not any ERISA issue. Most state laws, designed to regulate somebody claim processing in ministerial functions, such as initial claim processing and utilization review, are not preempted by ERISA. For more specific and in-depth understanding of preemption issue, please refer to the aforementioned U.S. Supreme Court ruling in PILOT LIFE INS. CO. v. DEDEAUX, and U.S. 9th Circuit Court of Appeals ruling in WASHINGTON PHYSICIANS SERv. v GREGOIR.

Although this book is not primarily written for state law insurance dispute, relevant state law concerning registration and licensing of utilization review by third party of any ERISA plan is clearly not preempted by ERISA. A specific discussion in this regard was covered in previous chapters.

### B. Illinois Managed-care Reform and Patient Right Act

Illinois Managed-care Reform and Patient Right Act is included with this book under Appendix F.

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## XIII. Glossaries Of Terms

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**Advisory Opinion:** Administrative Interpretation and Opinion from The Department Of Labor (DOL), federal administrative enforcement agency of ERISA statutes, in response to an individual inquiry as to DOL's administrative advisory interpretation as to how ERISA statutes apply to a particular situation. Advisory Opinion is a federal administrative enforcement instrument instead of judicial interpretation of ERISA statutes, it has most authoritative administrative guidance, subject to judicial final review.

**Beneficiary:** A person designated by a participant, or the specific terms of any ERISA plan, who is or may become entitled under a specific ERISA plan to a benefit.

**Certificate of Credible Coverage:** Under HIPAA, group health plans and health insurance insurers are required to provide certificate to each plan participant to certify the amount of previous credible or qualified health coverage when this plan participant is no longer covered under the plan, such certificate must provide written certification of the period of credible coverage under a plan that may be applied to a new plan's pre-existing condition period.

**Church Plan:** A Group Health Plan sponsored by churches or other qualified religious institutions for its employees as defined by section 414 (e) of the Internal Revenue Code.

**Coinsurance:** The percentage of payment responsibility of medical expenses by the employee or insured after the deductible has been satisfied, commonly 20% of eligible coverage, while the plan or insurer pays the balance, as a cost sharing mechanism.

**Coordination of Benefits (EOB):** Method of coordinating and prioritizing benefits payable under more than one health plan under which an employee is eligible for so that total benefits from different plans do not exceed 100 percent of eligible and total medical expenses.

**Co-payment (CoPay):** See Coinsurance.

**Deductible:** Specific payment responsibility by the employee or insured for each calendar year before any direct payment or reimbursement is available from the plan or insurer as a method of cost sharing between the plan and participant.

**Discretionary Authority or Control:** The reasonable exercise of a power, right or control to act in an official capacity with freedom to decide within the bounds of plan term or facts, such as freedom to decide in the capacity of plan administrator as to plan eligibility and benefits determination as well as interpretation of plan terms.

**DOL:** U.S. Department Of Labor that has administrative enforcement authority over the regulatory and administrative provisions of ERISA statutes through Pension and Welfare Benefits Administration, PWBA.

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- Health Insurance through Employment in Private Sectors = ERISA = 80% of Physician's Business;
- ERISA Preempts Any State Laws When It Is "Related to" Employee Benefits Dispute (Medical Insurance Claim Dispute)---ERISA Shield;
- ERISA Does Not Provide Any Remedy except for SPD Statutory Penalty and "Contractual Damages" (Your Medical Bills);
- Any ERISA Appeals by Physicians Are Not Valid Unless Legal Assignment of Benefit from Patient Is Obtained;
- ERISA Guarantees Probably Best Disclosure from ERISA plans, Insurance Companies but Physicians Never Realized;
- Patients Bill Of Rights (PBOR) May Never Help Physicians and Patients Unless Physicians and Patients Really Understand ERISA.
- ERISA Is Poorly Understood by Physicians;
- ERISA Protects Health-care Providers Who Have Legal Assignment of Benefits and Have Completed At Least Two Levels of Appeals.
- There Are 2.5 Million ERISA Plans Covering 135 Million to 145 Million Americans in U.S.;
- 1.3 Trillion Dollars Are Spent in Healthcare in United States Last Year, about 14% of Entire National Domestic Product, ERISA Claims Dispute and Denials;
- Up to One-third of Healthcare claims Are Denied Nationwide Each Year, Significant Percentage of Healthcare claims Are Partially Denied;
- Physicians Are at Breaking Point in Their Business Survival As a Result of Managed Care Nightmare and Claims Denials under ERISA Shield.

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