

Dr. Jin Zhou
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[President Obama Signing PPACA on 03/23/2010](#)



[President Gerald R. Ford Signing ERISA on 09/2/1974](#)



[**New Federal Health Claim Appeals Regulations Effective on Sept. 23, 2010
from HHS, DOL & IRS, For All Group Plans & Individual Policies**](#)

**Webinars On 2011 New Federal Health Claims Denials & Appeals Laws
Reimbursement Mandates Under PPACA**

PPACA & ERISA Law - Reference Links



[UNITED STATES DEPARTMENT OF LABOR](#)

[Affordable Care Act](#) (Links to DOL)

[Patient Protection and Affordable Care Act: Statutory Laws](#) [PDF] [PDF]

- ✓ [Regulations on Internal Claims and Appeals and External Reviews](#): [Interim Final Rule](#) • [Amendment to IFR](#) • [Corrections](#) • [NAIC Uniform External Review Model Act](#) • [News Release](#) • [Fact Sheet](#) • [Public Comments](#)
- ✓ [Guidance, EOB's & FAQ's](#): [TR11-02](#) • [TR11-01](#) • [TR10-02](#) • [TR10-01](#) • [EOB1](#) • [EOB2](#) • [EOB3](#) • [FAQ I](#) • [FAQ II](#) • [FAQ III](#) • [FAQ IV](#) • [FAQ V](#) • [FAQ VI](#) • [Consumer Assistance Programs](#)
- ✓ [Grandfathered Health Plans](#): [Regulation](#) • [Fact Sheet on Regulation](#) • [FAQ's](#) • [Summary Chart](#) • [Model Notice](#) • [Amendment to IFR](#) • [Fact Sheet on Amendment](#)
- ✓ [Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections](#): [Regulation](#) • [Fact Sheet](#) • [Patient Protection Model Notice](#) • [Lifetime Limits Model Notice](#) • [Dependents Model Notice](#)
- ✓ [Extension of Coverage For Adult Children](#): [Regulation](#) • [Fact Sheet](#) • [FAQs](#) • [IRS Guidance](#)

[Employee Retirement Income Security Act — ERISA](#)

- ✓ [ERISA Claims Regulation - 29 CFR 2560.503-1](#): [Regulation](#) • [FAQ](#) • [Fact Sheet](#) • [Claims Guide](#) • [Claims Card](#)
- ✓ [ERISA SPD Regulation - 29 CFR 2520.102-3](#): [Amendments to Summary Plan Description Regulations](#) • [Fact Sheet](#) • [News Release](#) • [SPD Rights Fact Sheet](#) • [SPD from DOL](#)

[ERISA Claims Reg = 6 Page Long for 36 Years](#) & [PPACA Claims Reg = 4 Page Long Since 09/23/10](#)

PPACA & ERISA Law - Reference Links



UNITED STATES DEPARTMENT OF LABOR

Affordable Care Act (Links to DOL)

Effective Date: Sep 23, 2010 – No Delays or Extension ⁽⁹⁾
Except for 3 Minor & Moot Standards, For Doctors & Hospitals

03-18-2011: DOL, HHS & IRS Technical Release No. 2011-01

“Extension of Non-Enforcement Period Relating to Certain Interim Procedures for Internal Claims and Appeals under the Patient Protection and Affordable Care Act”

“This guidance is intended to ensure that plan participants and beneficiaries are promptly accorded the important protections under the Affordable Care Act that provide for fuller and fairer processing of claims, the right to appeal claims that are denied, and the right to obtain effective external review of denials on appeal.”

“Accordingly, this guidance seeks to minimize both cost and delay, and avoid confusion for participants and plans alike.”

“Note: T.R. 2010-02 and this Technical Release 2011-01 describe circumstances in which the Departments will not treat a plan or issuer as being out of compliance for purposes of enforcement by the Departments. However, these documents do not address the rights of private parties in private litigation.”

Ensuring no administrative enforcement extension or delays for PPACA Claims Regulations' effective date on September 23, 2010, except for 3 minor new standards, out of 7 new standards, (Standards #2, #5, #7, & #6, such as 24-hour decision-making for urgent care claims, Spanish or Chinese Notices (EOB's) or possible AIDS/HIV diagnosis and abortion treatment on Notices (EOB's)

Health Reform Law 2011 Mandates for Claims Reimbursement & Appeals

Effective on Sept. 23, 2010 from HHS, DOL & IRS

PPACA Claims Regs – 4 Pages, for 193 Millions under ERISA & PPACA

ERISA Claims Regs – 6 Pages, for 176 Millions for 36 Years

4 + 6 = 10 Pages For All Group Health Plans And Individual Policies As Well As All Healthcare Providers

- 03/16/2011: Congress (GAO) PPACA Denial Report: 39% - 59% Appeals Reversed Initial Insurance Denials But A Very Small % (0.5%-OH) Of The Denials Were Appealed
- 03/04/2011: AMA: 51% Of Doctors In TX Are Going Broke, 69% Due To Insurance Denials & Delays
- 03/31/2011, HHS & DOL Report to Congress: 82.1% of Large (>500) Group Plans Are Self-Insured
- 04/15/2011: DOL PPACA Research Studies & Surveys – 73% with Out-Of-Network Coverage (DOL, BLS, NBS 2009, page 11 of 135)

Objectives Of The Webinar

- A. Brief Review Of DOL Health Reform Law Claims Regulations Website:
[Http://www.DOL.Gov/EBSA/Healthreform/](http://www.DOL.Gov/EBSA/Healthreform/)
- B. Understanding That New Federal Health Reform Law And Claims Regulations Are Effective Now, And They Are Federal Mandates, Not Optional, For All Non-Medicare health Care Claims;
- C. Understanding of Basic Scope Of New Federal Health Reform Laws And Claims Regulations, PPACA, Patient Protection And Affordable Care Act;
- D. Basic Understanding Of New Federal Internal And External Appeals Processes
- E. Basic Understanding Of ERISA Claims Regulations
- F. Basic Understanding Of New Federal External Appeals Regulations
- G. It is Impossible to Learn It All In 60 Minutes. Options Available To Master New Federal Claims Regulations and Become PPACA / ERISA Claims Specialist For Maximal Compliant Claims Reimbursement .

About Speaker



Dr. Jin Zhou is a national speaker, consultant, author and publisher of healthcare ERISA claim denials and appeals, regulation education and compliance. He pioneered, authored and published the nation's first ERISA *Healthcare Claim Appeal System* in a CD book, and the nation's first website (www.ERISAclaim.com) in ERISA healthcare claim denials, appeals, claim regulation education and compliance.

Dr. Jin Zhou defines successful reimbursement as maximal reimbursement for what you are legally entitled to under applicable laws, ERISA, Medicare and specific plan provisions as well as MCO Contracting.

Dr. Zhou's Dx: Reimbursement Nowadays = 30% coding/billing/MCO contracting + 70% Applicable Claim Regulations.

Dr. Zhou reminds providers that all MCO contracting with ERISA Plans are subject to ERISA claim regulation + Plan SPD's.



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PPACA Claims Regulations For All Payers & Providers

Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act; Interim Final Rule [7/23/2010] [[PDF](#)]

“SUMMARY: This document contains interim final regulations implementing the requirements regarding **internal claims and appeals and external review processes for group health plans and health insurance coverage in the group and individual markets** under the Patient Protection and Affordable Care Act. The regulations will generally affect **health insurance issuers; group health plans; and participants, beneficiaries, and enrollees** in health insurance coverage and in group health plans. The regulations provide **plans and issuers** with guidance necessary to **comply with the law**.

DATES: Effective date. These interim final regulations are effective on **September 21, 2010.**”

“(iii) **Claimant.** Claimant means an individual who makes a claim under this section. For purposes of this section, references to **claimant include a claimant's authorized representative.**” [[page 43355](#)] (PPACA = Providers If Getting Paid)

PPACA Claims Regs Adopt ERISA As Minimum Standards

PPACA Claims Regulations Adopt ERISA Claim Regulation, 29 CFR 2560.503-1, In Its Entirety As PPACA “Minimum Appeals Standards” For Group Health Plans and Individual Policies.

“(i) Minimum internal claims and appeals standards. A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements applicable to group health plans under [29 CFR 2560.503-1](#), except to the extent those requirements are modified by paragraph (b)(2)(ii) of this section. Accordingly, under this paragraph (b), with respect to health insurance coverage offered in connection with a group health plan, the group health insurance issuer is subject to the requirements in [29 CFR 2560.503-1](#) to the same extent as the group health plan.” [[Page 43355](#)]

PPACA Claims Regs Adopt ERISA As Minimum Standards

- PPACA claims regulations will govern all claims processing, reimbursement, denials and appeals for almost all healthcare claims outside Medicare: ERISA claims and non-ERISA claims as well as all individual policies.
- PPACA claims regulations adopted ERISA claims regulation in its entirety as PPACA internal appeals process, and adopted NAIC's external model as PPACA external appeals process.
- PPACA also provides new patients and providers protections as the most significant reimbursement law changes in 45 years since Medicare was created.
- It is extremely urgent and important for all hospitals and providers to know and comply with PAPCA for claims reimbursement.

PPACA Claims Regulations Are Federal Law Mandates, Not Optional

HHS, DOL & IRS: “Fact Sheet: The Affordable Care Act’s New Patient’s Bill of Rights”

http://www.healthreform.gov/newsroom/new_patients_bill_of_rights.html

HHS, DOL & IRS News Release: “Administration Announces New Affordable Care Act Measures to Protect Consumers and Put Patients Back in Charge of Their Care”

<http://www.hhs.gov/news/press/2010pres/07/20100722a.html>

HHS, DOL & IRS: “Fact Sheet: The Affordable Care Act: Protecting Consumers and Putting Patients Back in Charge of Their Care July 22, 2010

http://www.healthcare.gov/news/factsheets/protectconsumers_factsheet072210.pdf

“The appeals rules today will extend important protections and simplify the system for consumers,” said Labor Secretary Hilda Solis. “And they will ensure that consumers in new health plans have access to internal and external appeals processes that are clearly defined, impartial, and designed to ensure that, when health care is needed and covered, consumers get it.”

Confusions or Actions?

Federal Mandate for Reimbursement Practice

- **Lack of Information, Misinformation and Frustrations are faced by all on New Obama Health Reimbursement Laws.**
- **Health care providers should be informed of all specific and accurate statutory provisions on all new Obama health law mandates for claim appeals.**
- **Although the new Obama health law will not convert non-ERISA plans to statutorily defined ERISA plans, this new health law will adopt existing ERISA claim regulation and state external review model act from NAIC for additional 32 million Americans.**
- **After the legislation becomes the law of land for America health care, it is time for everyone who truly cares about reimbursement and compliance to forget about yesterday's legislation enthusiasm, set aside personal emotions and political preferences, to get hands on today's new reality, statutory and regulatory compliance and reimbursement by learning and mastering new rule of the game for health care reimbursement through compliance”**

DOL Estimates 193 Million People To be Affected By New Appeals Rules

PPACA v. ERISA

- 1. PPACA = 100% ERISA + External (NAIC) Appeal**
- 2. PPACA ERISA Internal = 100% ERISA + 6 New Additional + 1 New Continued Coverage Standards**
- 3. PPACA NAIC External = ERISA Plan >>> Federal NAIC External; Non-ERISA Plan >>> State NAIC External Appeal**
- 4. PPACA = 100% ERISA Compliance by Plan or >>> External Appeals or Federal / State Courts**
- 5. PPACA External Appeal = “0” Unless & When ERISA Internal Appeal Is Completed**

Are Most Plans Going To Stay Grandfathered?

Helping make sense of health care reform (San Francisco Chronicle, August 10, 2010)

"Q: Are most plans going to stay grandfathered?"

(Borzi) A: I had the strong sense that most companies, at least initially, would want to stay grandfathered to see what the whole panoply of regulations would look like, and then decide. What I hear is that a lot of the large companies don't want to do the analysis to decide (whether it makes sense to stay grandfathered). They are just going to assume they are not grandfathered."

"Borzi is head of the U.S. Department of Labor's Employee Benefits Security Administration"

Most Health Plans to Lose Grandfathered Status, Survey Says

Most Health Plans to Lose Grandfathered Status, Survey Says *(Workforce Management - August 11, 2010)*

- “Ninety percent of employers expect their health care plans to lose their grandfathered status by 2014 under the health care reform law because of changes they expect to make, according to a survey released Tuesday, August 10.”
- “Most large employers would rather have the flexibility to change their benefit programs than be tied down to the limited modifications allowed under the new law,” Ken Sperling, leader of Hewitt’s health management practice in Norwalk, Connecticut, said in a statement.”
- “Fifty-one percent of employers with self-funded plans expect their plans to lose grandfathered status in 2011, and 21 percent expect that to happen in 2012. Forty-six percent of employers with fully insured plans expect to lose grandfathered status in 2011, and 18 percent expect that in 2012.”

Majority of Large Employers Revising Health Benefit Programs for 2011, According to Survey Results

Majority of Large Employers Revising Health Benefit Programs for 2011,
According to Survey Results (PDF) [22 pages] August 2010 (*National Business
Group on Health*)

“Key Findings

Changes as a Result of Health Care Legislation

- While there was uncertainty about the regulations determining grandfathered plan status, the majority of employers (53%) were still planning to make changes to their plan designs.
- To comply with the law, employers are having to remove lifetime dollar limits on overall benefits (70%), make changes to annual limits on specific benefits (40%), remove annual dollar limits on overall benefits (26%), and remove pre-existing conditions exclusion clauses for dependent children under age 19 (13%).
- Employers are still evaluating retiree health offerings as a result of new provisions related to taxation of retiree drug subsidies as well as changes in Medicare Advantage plans.”

Healthcare Industry Is Ready, How About You?

2/16/2011: [New Claims Appeals and Review Rules Present Some Opportunities to Claimants and Concomitant Risks to Plans](#) (*Roy Harmon III via Health Plan Law*)

"The regulations require 'strict adherence' to the new claims procedure. Substantial compliance or de minimus violations are not, the regulations state, sufficient to avoid the determination of non-compliance."

2/14/2011: [Guidance on Non-Grandfathered Plans' Claims and Appeals Procedure Required by Affordable Care Act \(PDF\)](#) (*The Segal Group, Inc.*)

"[This article] concludes with lists of action steps, including what non-grandfathered group health plan must do to comply with the new internal claims and appeals procedures and what they must do to implement the new external review appeal rules."

The New Healthcare Reform and Provider Reimbursement Laws

As A Reimbursement Expert, We Must Set Side Our Personal Feelings and Political Preferences, Recognize and Master Statutory & Regulatory Powers, & Get Paid Legally!

**An ERISA Claim Specialist Wins On:
Laws, Facts, and Strategy**

Most Difficult Hurdle = Be Emotional & No Strategy

What Does Obama Healthcare Law Mean To Healthcare Providers And Health Plans?

- On 03/23/2010, The Final Health Reform Bill Has Been Signed By President Obama Into The Law Of The Land For More Than 95% Americans, As The Most Significant Changes Since Medicare Was Created 45 Years Ago.
- On 07/22/2010, New Federal Health Claim Appeals Regulations Promulgated by HHS, DOL & IRS.
- On August 24, 2010, New Federal EOB's Laws and Federal External Reviews Laws Released by IRS, DOL & HHS.
- On 09/23/2010, New Federal Appeals Regulations Go Into Effect for 193 Million Americans over the time from 09/23/2010 According to DOL [Preamble of the Interim Final Rules, Page 43339-40]
- Contrary to Popular Misconceptions, New Federal Appeals Regulations, Concurrently with Existing Federal Claim Regulation, ERISA, For 35 Years since 1974, Will Mandate ERISA for All Group Health Plans, Governmental Plans and Individual Policies for Both Grandfathered and Non-Grandfathered Plans
- In 2011, 18% of Large ERISA Plans (>100p) and 30% of Small ERISA Plans Will Relinquish Grandfather Status, and 31 Million People Enrolled in Group and 10 Million in Individual Policies

What Does Obama Healthcare Law Mean To Healthcare Providers And Health Plans?

- **New Federal Appeals Regulations Basically Have Three Levels of Standards:**
 1. **Minimum: Entire Existing ERISA Claims Regulations**
 2. **Additional Six Standards (from Definitions to Full & Fair Reviews and New EOB's)**
 3. **Continued Coverage Standards**
- **Although New Appeals Regulations Do Not Apply Directly to Grandfathered Health Plans, Grandfathered ERISA Plans Must Comply With Existing ERISA Claim Regulations and May Relinquish Their Grandfather Status after Making Disqualifying Changes.**
- **New Federal Appeals Regulations Provide Claimants Who Appealed With Most Immediate and Powerful Protections and Remedies, Through Expedited External Appeals, Continued Coverage and Lawsuits If A Health Plans Fail To STRICTLY Adhere To ALL Requirements of The New Federal Appeals Regulations.**

What Does Obama Healthcare Law Mean To Healthcare Providers And Health Plans?

- ERISA Internal And External Appeals Mandatory for All, The Health Bill incorporates or adopts existing ERISA claim regulation in its entirety as internal ERISA appeal mandates, and Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners as external ERISA appeal mandates as final and binding authority to all parties, in absence of judicial appeals.
- Upgraded and extended existing ERISA appeal regulation with new EOB requirements,
- Greater patient and provider rights to access to entire claim file and to present evidence and testimony as part of the appeals process

What Does Obama Healthcare Law Mean To Healthcare Providers And Health Plans?

- **To receive continued coverage pending the outcome of the appeals process.**
- **New Federal UCR Fee Centers And New Federal Simplified, Uniform Standards For Claim Processing And Appeals**
- **Provides consumer assistance on mandatory ERISA internal and external appeals.**
- **Immediate Benefits for millions**
- **6 Months to come into complete ERISA Compliance by all**
- **ERISA has been the only governing federal law for claims denials and appeals procedures for about 176 million Americans covered under employment-based health plans for the past 35 years.**
- **President Obama Wanted You To Do New ERISA Appeals**
- **The New Federal Reimburse Laws Will Eventually Eliminate Most Managed care Abuses**

New Federal EOB Laws & Federal External Review Laws

- ✓ Interim Procedures for Federal External Review • Technical Release • Model Notice of Adverse Benefit Determination • Model Notice of Final Internal Adverse Benefit Determination • Model Notice of Final External Review Decision
- ✓ First Time in History, One EOB Format For Whole Country: EOB for Initial Denials, EOB for Final Internal Appeals and EOB for External Appeals;
- ✓ New PPACA EOB's = 100% ERISA EOB Reg's (Sec. (g) (j) + PPACA Reg's Sec. (b)(ii)(E) [Page 43355-56]
- ✓ New PPACA EOB's = One Page on "Important Information on Your Appeals Rights" + "Appeal Filing Form"
- ✓ NAME OF PERSON FILING APPEAL: Covered Person, Patient, **Authorized Representative**

EBSA News

- ✓ **Interim Final Rules on Internal Claims and Appeals and External Review Processes:** [News Release](#) • [Regulation](#) • [Fact Sheet](#) • [NAIC Uniform External Review Model Act](#)

EBSA News

Release Date: July 22, 2010

Contact Name: HHS Press Office or DOL Press Office or Department of Treasury Press Office

Phone Number: 202.690.6343/202.693.4676/202.622.2960

Administration Announces New Affordable Care Act Measures to Protect Consumers and Put Patients Back in Charge of Their Care

New Regulations Give Patients Right To Appeal Health Plan Decisions; New Grants Program Strengthens State and Territory Consumer Assistance Programs

The Affordable Care Act: Protecting Consumers and Putting Patients Back in Charge of Their Care

- **New regulations that give consumers in new health plans in every State the right to appeal decisions, including claims denials and rescissions, made by their health plans.** (1) The rules issued by the Departments of Health and Human Services, Labor, and the Treasury give consumers:
 - The right to appeal decisions made by their health plan through the plan's internal process,
 - For the first time, the right to appeal decisions made by their health plan to an outside, independent decision-maker, no matter what State they live in or what type of health coverage they have. States will work to establish or update their external appeals process to meet new standards, and consumers who are not protected by a State law will have access to a Federal external review program.”

**The Affordable Care Act: Protecting Consumers and Putting Patients
Back in Charge of Their Care**

“Next year, an estimated 31 million people in new employer plans and 10 million people in new individual plans will benefit from the new appeals rights announced today. The number of individuals in employer plans who will benefit is expected to rise to 78 million by 2013, for a total potential of 88 million Americans who will be guaranteed the right to appeal decisions made by their health plan.”

Internal Appeals

“The internal appeals process will guarantee a venue where consumers may present information their health plan might not have been aware of, giving families a straightforward way to clear up misunderstandings. Under the new rules, new health plans beginning on or after September 23, 2010 must have an internal appeals process that:

- Allows consumers to appeal when a health plan denies a claim for a covered service or rescinds coverage;
- Gives consumers detailed information about the grounds for the denial of claims or coverage;
- Requires plans to notify consumers about their right to appeal and instructs them on how to begin the appeals process;
- Ensures a full and fair review of the denial; and
- Provides consumers with an expedited appeals process in urgent cases.”

External Appeals

“If a patient's internal appeal is denied, patients in new plans will have the right to appeal to an independent reviewer. External appeals have helped consumers get the care they deserve: one study found that - in States that had external appeals - consumers won their external appeal against the insurance company 45% of the time.⁽²⁾

While 44 States provide for some form of external appeal, the laws governing these processes vary greatly and fail to cover millions of Americans. The new rules will ensure that consumers with new health coverage in all States have access to a standard external appeals process that meets high standards for full and fair review.

These standards were established by the National Association of Insurance Commissioners (NAIC). States are encouraged to make changes in their external appeals laws to adopt these standards before July 1, 2011. The NAIC standards call for:”

External Appeals

- “External review of plan decisions to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- Clear information for consumers about their right to both internal and external appeals - both in the standard plan materials, and at the time the company denies a claim.
- Expedited access to external review in some cases - including emergency situations, or cases where their health plan did not follow the rules in the internal appeal.
- Health plans must pay the cost of the external appeal under State law, and States may not require consumers to pay more than a nominal fee.”

[DOL Fact Sheet](#), [[Printer Friendly Version](#)] July 22, 2010

External Appeals

- “Review by an independent body assigned by the State. The State must also ensure that the reviewers meet certain standards, keep written records, and are not affected by conflicts of interest.
 - Emergency processes for urgent claims, and a process for experimental or investigational treatment.
 - Final decisions must be binding so, if the consumer wins, the health plan is expected to pay for the benefit that was previously denied.
- If State laws don't meet these standards, consumers in those States will be protected by comparable Federal external appeals standards. In addition, people in health plans that are not subject to State law - including new self-insured employer plans - will be protected by the new Federal standards.”

DOL Estimates 193 Million People To be Affected By New Appeals Rules

“The Departments make the following estimates about plans and issuers affected by these interim final regulations: (1) There are approximately 72,000 large and 2.8 million small ERISA-covered group health plans with an estimated **97.0 million** participants in large group plans and **40.9 million** participants in small group plans; (2) there are 126,000 governmental plans with 36.1 million participants in large plans and **2.3 million** participants in small plans; and (3) there are **16.7 million** individuals under age 65 covered by individual health insurance policies.” [[Page 43339-40]]

137.0 + 38.4 + 16.7 = 193 Million (Over The Time)

Final Regulations Also Set Forth Six New Requirements

These interim final regulations also set forth six new requirements in addition to those in the DOL claims procedure regulation.

- a) Clarification of meaning of adverse benefit determination
- b) Expedited notification of benefit determinations involving urgent care
- c) Full and fair review
- d) Avoiding conflicts of interest
- e) Notice (New EOB Standards)
- f) Deemed exhaustion of internal claims and appeals processes.

Deemed exhaustion of internal claims and appeals processes

“In the case of a plan or issuer that fails to **strictly adhere** to all the requirements of this paragraph (b)(2) with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process of this paragraph (b), regardless of whether the plan or issuer asserts that it substantially complied with the requirements of this paragraph (b)(2) or that any error it committed was de minimis. Accordingly the claimant may **initiate an external review** under paragraph (c) or (d) of this section, as applicable. The claimant is also entitled to pursue any available **remedies** under section 502(a) of ERISA or under **State law**, as applicable, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.”

Continued Coverage Standards

“(iii) Requirement to provide continued coverage pending the outcome of an appeal. A plan and issuer subject to the requirements of this paragraph (b)(2) are required to provide continued coverage pending the outcome of an appeal. For this purpose, the plan and issuer must comply with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.”

Loss of Grandfather Plan Status

Grandfathered Health Plans:

Fact Sheet • Regulation • FAQs • Table • Model Notice

1. Cannot Significantly Cut or Reduce Benefits
2. Cannot Raise Co-Insurance Charges
3. Cannot Significantly Raise Co-Payment Charges
4. Cannot Significantly Raise Deductibles
5. Cannot Significantly Lower Employer Contributions
6. Cannot Add or Tighten an Annual Limit on What the Insurer Pays
7. [Cannot Change Insurance Companies] (No Longer Effective)

Loss of Grandfather Plan Status

- **Cannot lower the employer contribution toward the cost of any tier of coverage by more than 5% below the contribution rate that was in place as of March 23, 2010.**
- **Cannot change certain plan limits:**
 1. **If the plan did not have lifetime or annual limits as of March 23, 2010, it will lose grandfathered status if those limits are later added.**
 2. **If the plan did have a lifetime limit on all benefits, but not an annual limit, the plan will lose its grandfathered status if it later add an annual limit that is lower than the lifetime limit as of March 23, 2010.**
 3. **If a plan had an annual limit for all benefits, it will lose grandfather status if the plan later lowers the annual limit.**



So, What the Heck Is ERISA?

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.

Employee Retirement Income Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure; Final Rule [11/21/2000] [ONLY 7 (SEVEN) PAGES FOR 35 YEARS]



Federal Register

Tuesday,
November 21, 2000

Part VIII

Department of Labor

Pension and Welfare Benefits
Administration

29 CFR Part 2560
Employee Retirement Income Security Act
of 1974; Rules and Regulations for
Administration and Enforcement; Claims
Procedure; Final Rule

**President Gerald R. Ford Signing
the Employee Retirement Income Security Act of 1974
September 2, 1974**





Department of Labor

"A group health plan is an employee welfare benefit plan established or maintained by an employer or by an employee organization (such as a union), or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement, or otherwise.

Most private sector health plans are covered by the Employee Retirement Income Security Act (ERISA).
Among other things, ERISA provides protections for participants and beneficiaries in employee benefit plans”

ERISA DEFINITION - 29USC1002

ERISA Governs Both Self-Insured & Fully-Insured

“Sec. 1002. Definitions

For purposes of this subchapter: (1) The terms “employee welfare benefit plan” and “welfare plan” mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise.....”

ERISA DEFINITION - 29USC1002

(A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).”

ERISA Does Not Govern

ERISA Does Not Govern

- Governmental Plans
- Workman's Compensation
- Church Plans
- Medicare
- Individual Policies
- School Plans (under Govntl or Church)
- Personal Injury Cases

Supreme Court on ERISA

U.S. Supreme Court Unanimous Ruling

Aetna v. Davila

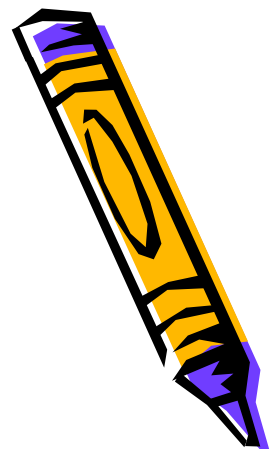
06/21/04

"Held: Respondents' state causes of action fall within ERISA §502(a)(1)(B), and are therefore completely pre-empted by ERISA §502 and removable to federal court. Pp. 4–20."

"We hold that respondents' causes of action, brought to remedy only the denial of benefits under ERISA-regulated benefit plans, fall within the scope of, and are completely pre-empted by, ERISA §502(a)(1)(B), and thus removable to federal district court. The judgment of the Court of Appeals is reversed, and the cases are remanded for further proceedings consistent with this opinion. It is so ordered."

Specific Solutions

By Jin Zhou



I. Executive Brainstorming

Hospital CEO's, CFO's, COO's, Senior Executive And Management Teams Must Be Educated On PPACA & ERISA And Medicare Claim Regulation, And PPACA & ERISA Enforcement Deadline On July 01, 2011 & Impact On Hospitals Bottom Line.

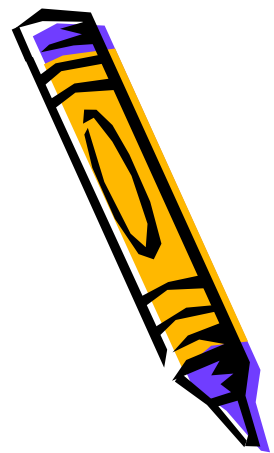
II. “Art Of War” On Reimbursement – Compliance Pays

Hospitals And Healthcare Facilities Must Have Executive Crisis Turnaround Strategies To Lead And Guide The War On Reimbursement Crisis In compliance With PAPCA.



Specific Solutions

By Jin Zhou



III. PPACA & ERISA Appeals Department

Hospitals And Healthcare Facilities Must Establish Special PPACA & ERISA Appeals Department, Beyond And Above Traditional Coding And Billing, With Highly And Specially Trained Specialists & Experts To Manage Reimbursement Crisis Through Compliance And Risk Management – Special Appeals Department (SAD)

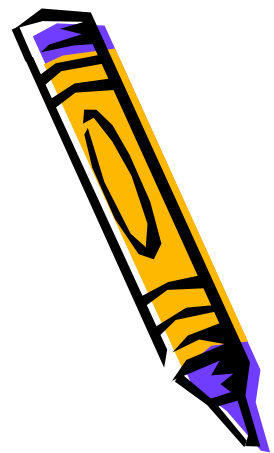
Successful Appeal With Optimal Payments Is the Last Step of Successful Healthcare Delivery & Your Healthcare Financial Management

Reimbursement Nowadays = 30% Coding/Billing/MCO Contracting + 70% PPACA & ERISA Claims Regulations



Specific Solutions

By Jin Zhou



IV. Training of Claim Specialists:

Hospitals And Healthcare Facilities Must Train, Educate Or Hire ERISA & PPACA Claims Specialists (ECS) And Medicare Claim Specialists (MCS) To Staff Special Appeals Department (SAD)

Two Step Process To Initiate This Practice With Three-day Training Programs, Then Perfect This Renovation With 12-day ERISA & Medicare Claims Specialists Certification Programs To Make Your Own Certified Specialists

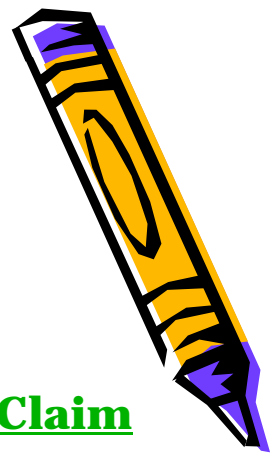
Must Turn SVU (Special Victim U) into SAD, Special Appeal Dept.
(Rand & Harvard for DOL & Congress: “dual expertise”)

V: MANAGED CARE CONTRACTING MUST BE IN COMPLIANCE WITH ERISA, OR OTHERWISE FINANCIAL SUICIDAL CONTRACTING.



Specific Solutions

By Jin Zhou



VI. PPACA & ERISA Appeal Compliance = Medicare Claim Appeal Compliance

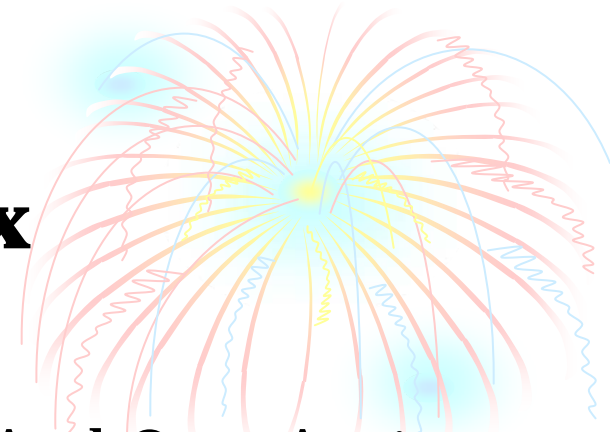
If Medicare, Why Not For PPACA & ERISA for More Money?

Medicare Claim Specialists:

- **Medicare Regulations Mandate QIC for Dual Knowledge & Expertise [CFR §405.968 (c) (1)]**
- Medicare Claims Specialist Must Have Dual Knowledge And Expertise, Similar To The Requirements For Medicare Second Level Appeal (Reconsideration) Panel Members (QIC's)
- Dual Knowledge & Expertise = Coding & Billing + Medicare Claim Regulation + Sufficient Medico-legal + Appeal Strategy
- “(c) Qualifications of the QIC's panel members. (1) Members of a QIC's panel who conduct reconsiderations must have sufficient medical, legal, and other expertise, including knowledge of the Medicare program.” 70 Fr 11472 § 405.968 (C) (1)
- PPACA & ERISA Claims Specialist must have Dual PAPCA & ERISA Knowledge + Billing & Coding Knowledge = PPACA & ERISA Specialist
PPACA & ERISA Claims Specialist must have “sufficient medical, legal, and other expertise, including knowledge of the PPACA & ERISA Claims Regulations (Medicare program).”



Albert Einstein's Dx



“Insanity: Doing The Same Thing Over And Over Again And Expecting Different Results.” --- Albert Einstein.

If You Still Remembered U.S. Supreme Court ERISA & Your Money Talk, And Now Listen To Albert Einstein:

“**Billing And Coding** Insanity: Doing The Same Thing Of **Non-ERISA** Over And Over Again And Expecting Different Results Of **Not Getting Denied**.”

= **You Are Insane**, A Dx By US Supreme Court & Albert Einstein.

Employee Retirement Income Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure; Final Rule [11/21/2000]

§ 2560.503–1 Claims procedure.

“(a) Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, **this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.”**

ERISAclaim.com

So, What the Heck Is ERISA?

**Health Insurance through Employment in
Private Sectors**

= ERISA =

**80-90% of Physician's Business of Non-
Medicare Claims**

**81% of Insured Americans are Covered by
Private Health Insurance in 2006**

201.7 million/249.8 million = 80.74%

U.S. Census Bureau, Issued August 2007

DOL ERISA FAQ B2

Assignment of Benefit vs. Legal Assignment of Benefit

Your Traditional Assignment Is “No Good”!

“B-2: Does an assignment of benefits by a claimant to a health care provider constitute the designation of an authorized representative?”

No. An assignment of benefits by a claimant is generally limited to assignment of the claimant’s right to receive a benefit payment under the terms of the plan. **Typically, assignments are not a grant of authority to act on a claimant’s behalf in pursuing and appealing a benefit determination under a plan.** In addition, the validity of a designation of an authorized representative will depend on whether the designation has been made in accordance with the procedures established by the plan, if any.”

Court Ruling on B2 Assignment

Assignment of Benefit vs. Legal Assignment of Benefit

Tenet Healthcare Ltd. v. UniCare Health Plans of Tex., Inc., 2008 U.S. Dist. LEXIS 96324 (S.D. Tex. **Nov. 26, 2008**)

“The Fifth Circuit, however, has distinguished between the “rights of a beneficiary as referred to in ERISA, to receive covered medical services or reimbursement, and one entitled **to receive payment as an assignee of such a beneficiary.**” *Hermann Hosp. v. MEBA Medical and Benefits Plan*, 959 F.2d 569, 576 (5th Cir. 1992). **An assignment of a right to payment does not convert Tenet into a “beneficiary” for purposes of standing to sue under § 1132(c).** Because Tenet is not a plan participant or a beneficiary, it has no right to review Sylvester’s Plan documents under § 1024(b)(2), and therefore cannot recover civil penalties under § 1132(c).”

DOL ERISA FAQ B3

Assignment of Benefit vs. Legal Assignment of Benefit

ERISA Assignment = As Good As Your Patients

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,

DOL ERISA FAQ B3

Assignment of Benefit vs. Legal Assignment of Benefit

ERISA Assignment = As Good As Your Patients

DOL FAQ B3 (continued)

“the plan should, in the absence of a contrary direction 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 this 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.”

ERISA § 2560.503-1 (b)(4)

ERISA Outlawed Anti-Assignment

- (4) “The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, within the meaning of paragraph (m)(1) of this section, a health care professional, within the meaning of paragraph (m)(7) of this section, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant; and”

Assignment of Benefit vs. Legal Assignment of Benefit **Court Ruling on B3 Assignment**

Spectrum Health v. Valley Truck Parts, 2008 U.S. Dist. LEXIS 102040, *4 (W.D. Mich. **Dec. 7, 2008**),

“Courts have recognized that health care providers, as assignees and beneficiaries under ERISA, **have standing to seek both attorney fees and statutory penalties authorized by ERISA.**”

“This language of assignment is **sufficient to authorize Spectrum to pursue a claim for benefits** for the provided services from the Plan, either for itself or on Clark’s behalf. Defendants did not object to Spectrum’s asserted authorization/assignment at the time Spectrum furnished it to Valley Truck, nor do they even address it in their briefs.”

Legal Assignment of Benefit
**Court Ruling on B3 Assignment with
Anti-assignment SPD?**

Spectrum Health v. Valley Truck Parts, 2008
U.S. Dist. LEXIS 102040, *4 (W.D. Mich. Dec. 7,
2008)

“Moreover, as Spectrum correctly notes, the regulations provide that a plan’s claim procedures may not **“preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination.”** 29 C.F.R. § 2650.503-1(b)(4). Thus, Spectrum may properly assert a claim for benefits due Clark pursuant to the Plan.”

DOL ERISA FAQ B5

What Does ERISA Require To Disclose?

“B-5: For purposes of furnishing relevant documents to a claimant, what kind of disclosure is required to demonstrate compliance with the administrative processes and safeguards required to ensure and verify appropriately consistent decision making in making the benefit determination?”

What documents will be required to be disclosed will depend on the particular processes and safeguards that a plan has established and maintains to ensure and verify appropriately consistent decision making. See 65 FR at 70252. The department does not anticipate new documents being developed solely to comply with this disclosure requirement.....”

DOL ERISA FAQ B5

What Does ERISA Require To Disclose?

“Rather, the department anticipates that claimants who request this disclosure will be provided with what the plan actually used, in the case of the specific claim denial, to satisfy this requirement. The plan could, for example, provide the **specific plan rules or guidelines governing the application of specific protocols, criteria, rate tables, fee schedules, etc.** to claims like the claim at issue, or the specific checklist or cross-checking document that served to affirm that the plan rules or guidelines were appropriately applied to the claimant’s claim. Plans are not required to disclose other claimants’ individual records or information specific to the resolution of other claims in order to comply with this requirement. See § 2560.503-1(m)(8)(iii). See question D-12.”

DOL ERISA FAQ C12

ERISA Definition for a Denial Anything < 100% Claimed

“C-12: If a claimant submits medical bills to a plan for reimbursement or payment, and the plan, applying the plan’s limits on co-payment, deductibles, etc., **pays less than 100% of the medical bills, must the plan treat its decision as an adverse benefit determination?”**

Under the regulation, an adverse benefit determination generally includes any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. In any instance where the plan **pays less than the total** amount of expenses submitted with regard to a claim, while the plan is paying out the benefits to which the claimant is entitled under its terms, the claimant is nonetheless receiving **less than full reimbursement** of the submitted expenses.”

DOL ERISA FAQ C12

ERISA Definition for a Denial Anything < 100% Claimed

“Therefore, in order to permit the claimant to challenge the plan’s calculation of how much it is required to pay, the **decision is treated as an adverse benefit determination under the regulation.** Providing the claimant with the required notification of adverse benefit determination will give the claimant the information necessary to understand why the plan has not paid the unpaid portion of the expenses and to decide whether to challenge the denial, e.g., the failure to pay in full.”

ERISA Definition for a Denial

Anything < 100% Claimed, DOL FAQ C12

“This approach permits claimants to challenge whether, for example, the plan applied the wrong co-payment requirement or deductible amount. **The fact that the plan believes that a claimant’s appeal will prove to be without merit does not mean that the claimant is not entitled to the procedural protections of the rule.** This approach to informing claimants of their benefit entitlements with respect to specific claims, further, is consistent with current practice, in which Explanation of Benefits forms routinely describe both payable and non-payable portions of claim-related expenses. See § 2560.503-1(m)(4).”

ERISA Regulation for Claims Denial Notice: ERISA EOB REQUIREMENTS

- (i) The **specific reason** or reasons for the adverse determination;
- (ii) Reference to the **specific plan provisions** on which the determination is based;
- (iii) A description of any **additional material** or information necessary for the claimant to perfect the claim and an explanation of **why** such material or information is necessary;
- (iv) A description of the **plan's review procedures** and the time limits applicable to such procedures, including a statement of the claimant's **right to bring a civil action** under section 502(a) of the Act following an adverse benefit determination on review;

ERISA Regulation for Claims Denial Notice: ERISA EOB REQUIREMENTS (Continued)

(v) FREE OF CHARGE, COMPLETE DISCLOSURE:

- (A) If an **internal rule, guideline, protocol**, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was **relied upon** in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion **will be provided free of charge to the claimant upon request**; or
- (B) If the adverse benefit determination is based on **a medical necessity or experimental treatment or similar exclusion or limit**, either an explanation of the **scientific or clinical judgment** for the determination, applying the terms of the plan to the claimant's medical circumstances, or **a statement that such explanation will be provided free of charge upon request**.

ERISA Regulation About Claims Denial Notice: EOB (Continued)

- (vi) In the case of a claim involving **urgent care**, a description of the **expedited review process** applicable to such claims.
- (2) In the case of a claim involving **urgent care**, the information may be provided to the claimant **orally as soon as possible, but not later than 72 hours** after receipt of the claim by the plan provided that a written or electronic notification is furnished to the claimant not later than **3 days after the oral notification**.

ERISA Claims Denial Notice for Appeal

1. The **specific reason** for the denial
2. Reference to the **specific plan provisions** on which the benefit determination is based;
3. statement that the claimant is **entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents**, records, and other information relevant to the claimant's claim for benefits.
4. A statement describing any voluntary appeal procedures offered by the plan and the claimant's **right to bring an action** under section 502(a) of the Act;

ERISA FULL AND FAIR REVIEW

- (1) plan shall **establish and maintain** a procedure by which a claimant shall have a reasonable opportunity **to appeal** an adverse benefit determination to **an appropriate named fiduciary of the plan**, and under which there will be **a full and fair review** of the claim and the adverse benefit determination.

ERISA FULL AND FAIR REVIEW

Continued

- 2. Provide claimants **at least 180 days** following receipt of a notification of an adverse benefit determination within which to appeal the determination;**
- 3. Provide claimants **the opportunity to submit** written comments, documents, records, and other information relating to the claim for benefits;**

ERISA FULL AND FAIR REVIEW

Continued

- 4. Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.**

ERISA FULL AND FAIR REVIEW

Continued

- 5. De Novo by Fiduciary:** Provide for a review that **takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;**

ERISA FULL AND FAIR REVIEW

Continued

- 6. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;**

ERISA FULL AND FAIR REVIEW

Continued

“The term ‘**health care professional**’ means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with **State law.**”

ERISA FULL AND FAIR REVIEW

Continued

- 7. Provide for the **identification** of medical or vocational **experts** whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;**

ERISA FULL AND FAIR REVIEW

Continued

8. Provide that the health care professional engaged for purposes of a consultation shall be an individual **who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;**

De Novo By Health Care Professional

ERISA FULL AND FAIR REVIEW

Continued

9. Provide, in the case of a claim involving **urgent care**, for **an expedited review** process pursuant to which--
- (A) A request for an expedited appeal of an adverse benefit determination **may be submitted orally** or in writing by the claimant; and
 - (B) All necessary information, including the plan's benefit **determination on review**, shall be transmitted between the plan and the claimant **by telephone, facsimile**, or other available similarly expeditious method.

Overpayment Claim Is Legally an Retrospective or Retroactive Adverse Benefit Determination

As define in ERISA § 2560.503-1(m)(4), and explained by DOL ERISA FAQ C12, any payment or denial less than 100% as claimed by the claimant constitutes an adverse benefit determination – denial, regardless prospectively or retrospectively / retroactive. The law governing the overpayment claim dispute is 100% same as for current claim or prospective claim denials.

This is similar to Medicare Claim Regulation:
(cont'd)

Overpayment Denial Appeal ERISA Compliance Strategies

- 1. Identify Legal Types of the Claims, ERISA, Governmental, Medicare, Medicaid, PI, WC, Individual Policy, and Other Non-ERISA, So You Know what Law Governs Your Dispute – Most Important;**
- 2. Read Denial EOB's Very Carefully to Determine If It Is a Coverage or Benefits Limitation Denial or Provider Discount Dispute, So You Know If ERISA /SPD or PPO Contract Control Your Dispute;**
- 3. Read Overpayment Explanation Very Carefully to**

Overpayment Denial Appeal ERISA Compliance Strategies

See If There Is Allegation or Accusation for Criminal or Civil Fraud, So You Know If You Should Play As Defense or Offence, Or Need a Lawyer For Criminal Concerns;

- 4) Gathering the Facts First, Applying the Applicable Laws Second, Don't Speculate on the Crucial or Any Facts, Don't Panic or Get Mad, It is the Nature of the Healthcare Business;
- 5) Don't Foolishly Accept, Agree and Acknowledge That Was an Overpayment, But an Retrospective Adverse Benefit Determination;

Overpayment Denial Appeal ERISA Compliance Strategies

4. Overpayment Appeal Is as Same as Regular Appeal For Governing Laws, But Different in Burden Of Proof Responsibility, as the Plan Must Prove Everything, and The Money Is in Your Pocket and Time Is On Your Side When The Table Is Turned Around on The Burden of Proof Game – Very Important;
6. Be Aware Who You Are Dealing With, Insurer, TPA, Payer, Collection Agency, A lawyer/Law firm Working As a Collection Agency But Posing as Legal Rep. for the Plan, Why Important?
7. Winning Magic = Facts, Laws and Superb Strategy.

ERISA TIMELINE FOR APPEAL & LEGAL ACTIONS

ERISA provides **180 days** for claimant to appeal, failure by claimant to appeal within 180 days will foreclose his/her right to appeal;

Claimant would argue any overpayment claims after 180 days of initial EOB may not be valid, and

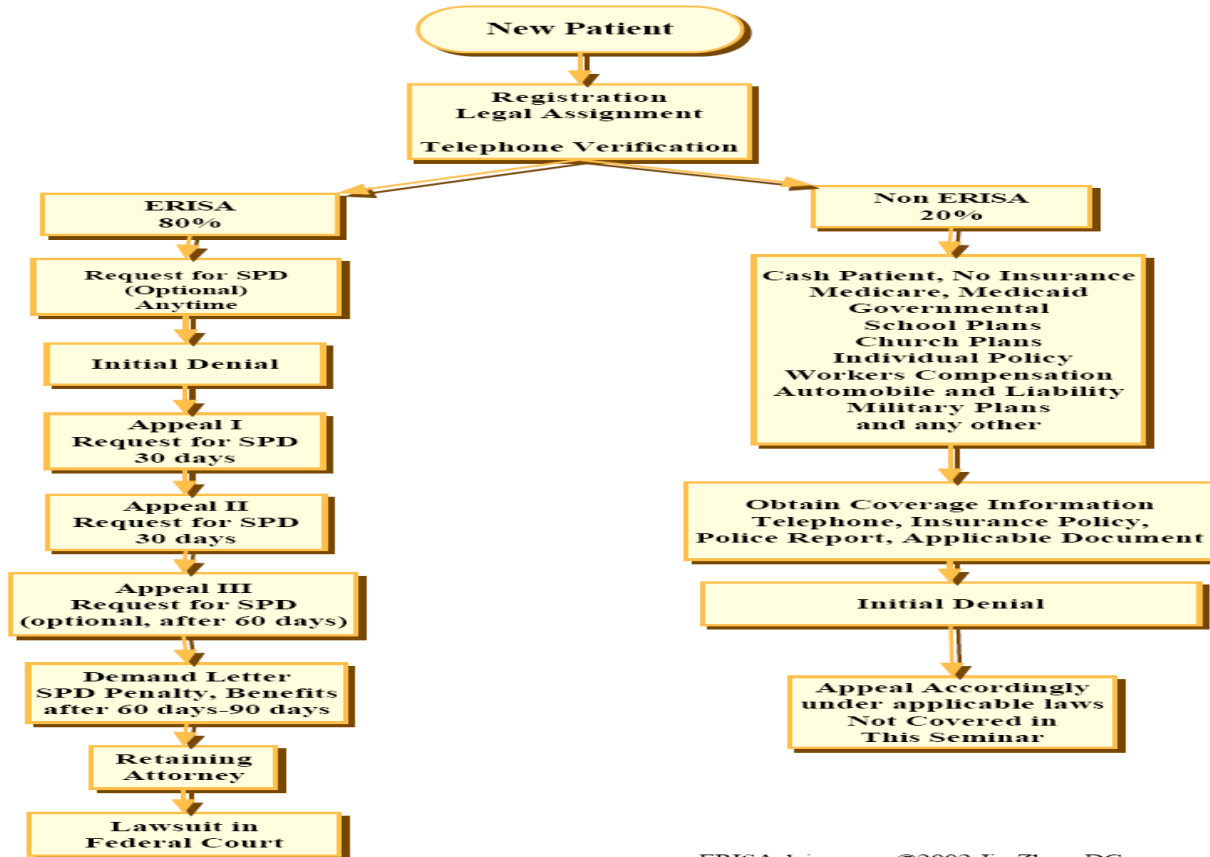
ERISA recognizes the time limit set forth in the plan SPD within which any party can bring a legal action (usually 1 – 2 years) under the plan, Legal Action Clause, which will also legally limit the time line for a plan to bring overpayment claims.

ERISAclaim.com

ERISA Appeal Flow Chart

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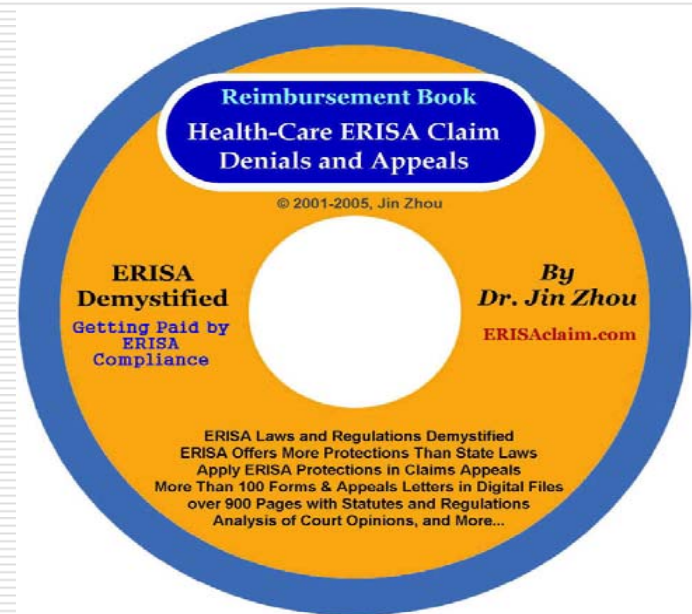
ERISA Claim Appeal Overview



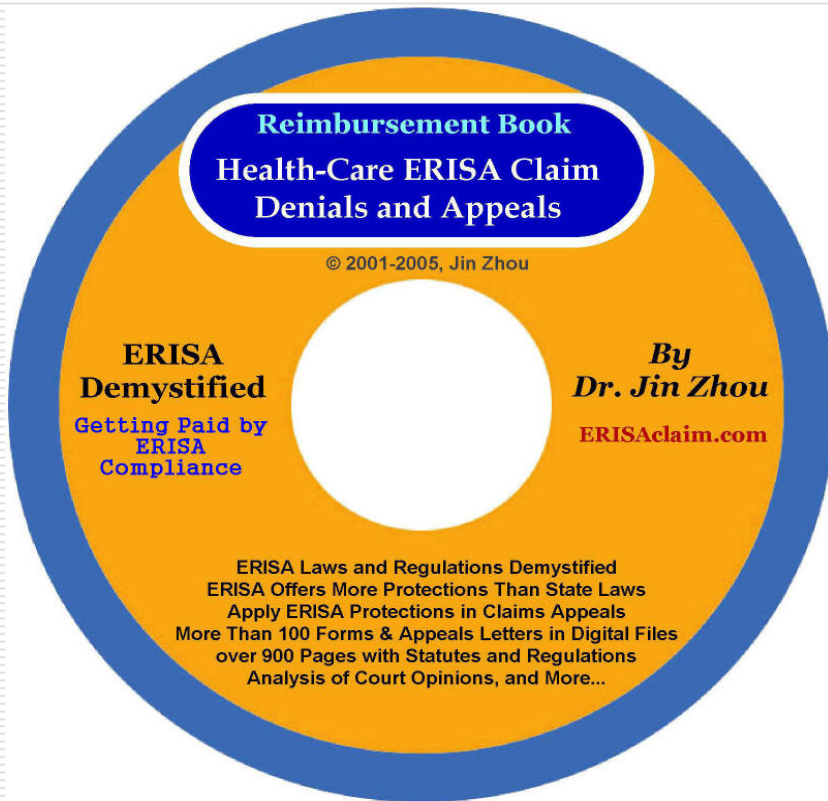
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Reimbursement = 30% Coding/Billing + 70% PPACA & ERISA Claims Regulations

Successful Reimbursement Is Defined As Maximal Reimbursement For What You Are Legally Entitled To Under Applicable Laws, PPACA, ERISA, Medicare, TriCare, FEHB, State Laws, And Specific Policy & Plan Provisions.



ERISAclaim.com
The Solutions by PPACA & ERISA Claims
Appeals Specialist & Department
--- Appeal CD Book & System



- A.** ERISA Is 36 years Old In USA & ERISA Has Complete Control Over Your Claims For Money
- B.** Coding, Billing & State Laws Are Pre-empted By ERISA If Conflicted With ERISA
- C.** ERISA Goals **within 1-6 Months:**
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 2. ERISA Claim Specialist
 3. ERISA Appeals Department
- D.** ERISA CD Book with All Forms and ERISA Appeal Letters in Word Format at \$450.
- E.** PPACA & ERISA Ready Before July 01, 2011

How Can You Learn More About PPACA & ERISA, Or Become a PPACA & ERISA Claims Specialist or Expert?

**It's Impossible to Cover All in One-hour Webinar,
but more on How to Appeal Every Denials
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Healthcare Reform Law PPACA Claim Specialists: New Legal Assignment of Benefits Required Under New Federal Provider's Bill of Rights - 01-17-2011

2011: Healthcare Reimbursement under New Health Reform Laws - With Criminal, Prompt Pay Enforcement, And More PPACA & ERISA Claims Specialists - 01-03-2011

Are You Ready For 2011 New Federal Prompt Pay Laws Under Health Reform PPACA? – For PPACA & ERISA Claim Specialists - 12-21-2010

Health Reform Law Pays For More Certified PPACA & ERISA Claim Specialists - More Healthcare Experts Ready To Cash In On New Patient's Bill of Rights - 12-17-2010

First National Healthcare PPACA & ERISA Claims Specialist Certification Class Under Health Reform Laws Held For Provider State Association - 11-22-2010

How Can You Learn More About PPACA & ERISA, Or Become a PPACA & ERISA Claims Specialist or Expert?

[New Protections for Out-of-Network Providers Under New Federal Health Laws and Regulations – Free Webinars Announced from ERISAclaim.com 08/17/2010 Hanover Park, IL](#)

[New Webinars, Seminars & Certification Classes Announced for New Federal Health Claim Appeals Regulations on July 22, 2010 from HHS, DOL & Treasury 08/05/2010, Hanover Park, IL](#)

[New Health Reform Law Claim Denial Appeal Book Announced for Healthcare Providers to Comply with New PPACA Deadline – 09/23/2010 06/28/2010, Hanover Park, IL](#)

[New Health Reform Law Appeal Certification Class Announced for Hospitals to Comply with New PPACA Deadline – 09/23/2010 06/24/2010, Hanover Park, IL](#)

[Health Reform for Out-Of-Network Providers: Receiving Insurance Checks Directly? – Free Webinars on Why and How 04/05/2010, Hanover Park, IL](#)

[The New Hospital ERISA Appeals Department Program Announced for Hospital In-House Denial Management and Financial Crisis Turnaround 02-08-2010 \(click to read more\)](#)

Q & A for 20 Minutes Dr. Jin Zhou Contact

Q & A For 20 Minutes Any Questions on PPACA & ERISA?

Or Contact Dr. Jin Zhou

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Fax: 630-736-1439

Thank You For Attending!

Check Out ERISAcclaim.com for More Educational Events
