WHAT IS ERISA:

ERISA is a Federal Law called the Employee Retirement Income Security Act. It was enacted in 1974 to protect an employee’s pension plan but as employers started to add health insurance as a benefit of employment, health benefit plans were placed under the protection of this law.

WHAT DOES ERISA DO?

ERISA has jurisdiction over the claims process, payment of health benefits, and the appeals process of a denied or improperly paid health benefit.
Reference: Title 29 CFR 2560-503-1

WHICH HEALTH BENEFITS ARE UNDER ERISA JURISDICTION?

Any health benefit that is provided by an employer engaged in commerce.
Reference: Title 29 USC 18, Section 1003a.

WHICH HEALTH BENEFITS ARE NOT UNDER ERISA JURISDICTION?

Health Benefits that are provided by any government employer (Federal; State; County and City) and Health Benefits provided by a Church Employer. This also includes hospitals that are owned by a church.
Reference: Title 29 USC 18, Section 1003b.

WHO HAS THE RIGHT TO SUBMIT A CLAIM AND APPEAL A DENIAL OR UNDERPAYMENT OF A BENEFIT?

The patient or the patient’s legal personal representative.
Reference: Title 29 CFR 2560-503-1

WHO HAS NO RIGHT TO SUBMIT A CLAIM OR APPEAL A DENIAL OR UNDERPAYMENT OF A BENEFIT?

The provider of services or the provider’s medical biller.
Reference: Title 29 CFR 2560-503-1
WHICH HAS JURISDICTION OVER THE PAYMENT OF A HEALTH BENEFIT AND THE APPEALS PROCESS OF A HEALTH BENEFIT THAT IS PROVIDED BY AN EMPLOYER UNDER TITLE 29 USC 18, SECTION 1003A? A STATE HMO LAW OR ERISA?

The ERISA Law.
Reference: Title 29 USC 18, Section 1144a.

IS THERE ANY CASE LAW THAT PROVIDES FOUNDATION THAT THE ERISA LAW HAS JURISDICTION OVER HEALTH BENEFITS VERSUS STATE HMO LAWS?

Yes. Two United States Supreme Court Cases ruled that ERISA issues must be resolved at the Federal Level: Calad vs Cigna and Davilla vs Aetna.

WHAT IS THE BOTTOM LINE REGARDING ERISA?

Providers and Medical Billers have no rights under ERISA. The claim is the patient’s claim for payment of health benefits. The patient must appeal their health insurance company’s benefit determination. The appeals process is timed and must be followed to the letter. Any legal action must be resolved at the Federal Level, only when the appeals process of a health benefit determination has been exhausted.
Reference: Title 29 CFR 2560-503-1

The above information provides a foundation to the power behind the ERISA law. Providers and Medical Billers have a mindset that (a) when a patient is seen and services are provided, a claim is sent to the insurance company and the claim belongs to the provider; and (b) the insurance company is obligated to pay the claim to the provider. This is a mindset that must be changed.

1) If the provider is not contracted with the patient’s insurance company, the provider has no claim with the insurance company. Remember, we are not sending a claim to have the provider paid, we are sending a claim to have the patient’s benefit paid.

2) If the provider is not contracted with the patient’s insurance company, the insurance company has no legal obligation to send payment of the patient’s benefit, to the provider.

3) The insurance company’s sole obligation is to their member and to pay their member’s benefit per the terms of the contract between the insurance company and employer/member.

4) All appeals rights rest with the member. If a provider or medical biller sends an appeal, it is an appeal of the denial or incorrect payment of the patient’s benefit, not the debt owed to the provider.
(5) The patient, not the insurance company, owes the provider for services received. The insurance company has no obligation to pay the non-contracted provider anything.

(6) If the provider is contracted with the patient’s health insurance, any adverse benefit determination made is now a contractual issue between the provider and the patient’s insurance company. Therefore, ERISA has no say-so when a doctor is contracted with the insurance company. Any appeals made by the provider are per the terms of the provider’s contract with the insurance company, but it is still a benefit that is being denied if the claim is denied. The contracted provider must review the patient’s benefit manual to see if the denial is correct or incorrect when it pertains to a benefit denial. If the insurance company paid less than it was required to pay, this is also a contractual issue not an ERISA issue.

BEFORE APPEALING AN ERISA ISSUE

Step #1
The non-contracted provider could appeal the patient’s denial of a benefit or the incorrect payment of the benefit, only when the provider has a legal document, signed by the patient, making the provider their legal personal representative. An Assignment of Benefit form is insufficient to make a person their legal personal representative. An Assignment of Benefit form is a permission request, made by the patient, to have payment of their benefit sent to a designated representative. This is referenced in Title 29 CFR 2560-503-1. This would be the first step in the appeals process.

Step #2
The non-contracted provider must obtain a copy of the patient’s Summary Plan Description. This document is the bible for the medical care to be provided to the employee as well as the document outlining the appeals processes. This document will show how much the insurance company is supposed to pay, the benefits that are included and excluded, the timeframe for claims submission, the timeframe for paying a claim, and more. Without this document, you have no clue if the insurance company is correct with their benefit determinations. The carrier may have stated that all it pays is usual and customary. The SPD may also say this and it may also say that any amount that is above usual and customary is the patient’s responsibility to pay. So, if the carrier is required to pay UCR with the patient responsible for the balance, no need to appeal. The carrier performed their fiduciary responsibilities according to their contract. The Summary Plan Description is normally provided to the patient through the patient’s employer. This is to whom you must request this document. Try and obtain it from the patient first.
Step #3
You must make a demand for the name and specialty of the person who performed the adverse benefit determination. You must also make a demand for any and all documentation that was used to make the adverse benefit determination. This request is sent to the carrier that processed the claim. Under the ERISA law, the carrier is required to make full disclosure when denying or paying a benefit. The carrier has 30 days to respond to any demands for information. There is a $110 per day fine for every day beyond the first thirty days when the carrier does not respond. The patient would have to go to Federal Court and request this fine payment. This is also referenced in Title 29 CFR 2560-503-1.

Without any of the above three items, you cannot appeal. You must contact the patient for these items when their insurance company or employer refuses to respond to your requests. If the patient is unable to obtain these items, there isn’t much you can do to help. The patient will need to hire an attorney to obtain these documents.

Once you have the documentation to submit an appeal, understand that under the ERISA law, the patient has 180 days from the date of the denial to submit a Level 1 appeal. If you have been legally assigned as the patient’s legal personal representative, you must review the EOB to gain information such as:

(a) The benefit that was denied or incorrectly paid. Understand that even though the benefit appears to have been denied or paid incorrectly, it may be possible that the denial or payment was correct, based on what is documented in the Summary Plan Description.

(b) The section of the Summary Plan Description that describes the benefit that was denied. The carrier must direct the patient to the exact section of the SPD so that the patient can see that the carrier is correct with their determination.

(c) The information that the carrier requires to pay the benefit and overturn the denial. Sometimes an authorization/pre-certification number is required. Maybe a copy of the medical record is necessary. The carrier has an obligation to document this on the EOB.

It is very important to go over the Summary Plan Description, in detail, once you receive it. Look at the following sections:

(1) Claims Processing: Many times the patient is described as the one who must send the claim. There will be a time limit to submit the claims. There will be a location to send the claims.

(2) Benefits: There will be a listing of the benefits the patient is entitled to receive. There may be a limitation on how many times the patient may be allowed to receive the benefit. There will be a listing of those benefits that are excluded. There will be a description outlining what requires authorization or pre-certification and who does this.
(3) Payment: The SPD will detail the carrier’s payment responsibility and the patient’s responsibility. This includes co-pays, deductibles and non-covered services.

(4) Appeals: The appeal process is outlined in detail as to when an appeal is to be submitted, where, and to whom. Normally, there are two levels of appeal that must be performed prior to exhausting the appeals process. The SPD may dictate that arbitration is to be performed prior to legal action being taken. If the entire appeals process has not been followed through to the letter, any legal action will be dismissed.

(5) Legal Action: As stated, any and all legal action must wait until the appeals process has been exhausted. Any legal action must take place in Federal Court. It would be best to turn over any legal action to the patient, including any delays or denials from their insurance company.

**APPEALING AN ERISA ISSUE**

There are many reasons for appealing and these will be addressed as follows. With any and all appeals, you must inform the carrier that you are the patient’s legal representative and you must attach a copy of the document to prove this. Otherwise the carrier can ignore you.

**Timely Filing:**

The Summary Plan Description will outline the timeframe “for the patient” to submit their claim for benefits. With some carriers, this could be a ninety day timeframe. Regardless of any State Prompt Payment laws, remember that State law has no jurisdiction over claims issues when the claims and benefits are under the jurisdiction of the ERISA Law. If the provider submitted the claim, as a courtesy to the patient, most billing software programs have a report that can show when the claim was submitted. The provider must understand that the carrier does not have to accept this report as proof of timely filing. Again, you are not submitting the doctor’s claim because the doctor has no claim with the patient’s insurance company. You are submitting the claim, as a courtesy to the patient, to have the patient’s benefit paid. In your appeal letter, you can do the following:

(a) Inform the carrier that the claim submitted was done so as a courtesy.

(b) Inform the carrier that when they deny the claim, they are denying the patient’s claim.

(c) Inform the carrier that they do not owe you anything, rather the patient owes you for the entire amount of the bill.

(d) Inform the carrier that the claim was submitted in a timely manner per page X of the Summary Plan Description and you are attaching proof of timely filing.
(e) Inform the carrier if they deny the appeal, you will have no choice but to collect full charges from the patient.

(f) Inform the carrier that if they deny the appeal, you will cease sending claims as a courtesy and that all of their members will have to pay 100% of billed charges at the time of service.

(g) Inform the carrier that their member will be required to submit a second level appeal and may be required to hire an attorney to resolve this in Federal Court.

Unpaid Claim:

The Summary Plan Description may outline a timeframe for claims payment. The ERISA law does not have any timeframes for claims adjudication. That is left to the carrier. If the plan is under the jurisdiction of ERISA, a State’s Prompt Payment law may not have jurisdiction. Normally, when a claim has not been paid or denied within sixty days of the date of receipt of the claim, the claim can be considered as denied and the 180 day timeframe to appeal will begin.

You need to review the Summary Plan Description to determine if the services received is a benefit or not. If it is not a benefit, this could be why the carrier did not pay or deny the claim. The carrier may have denied the claim but sent the EOB to their member. The carrier is not obligated to send an EOB to a non-contracted provider. If the service is a covered service in the Summary Plan Description, you need to do the following in your appeal letter:

(a) Inform the carrier that the claim you sent was done so as a courtesy to their member.

(b) Attach a copy of the claim and a copy of a report showing when the claim was originally sent. Inform the carrier that what you are sending is a copy and not a duplicate claim.

(c) Attach the page from the Summary Plan Description, showing that the services recorded on the copy of the CMS 1500, is a covered service.

(d) Inform the carrier that you have no choice but to bill their member for your full charges because it is their member that owes you, not them and that from now on, all future claim will be submitted by their member, after the member pays you 100% of your billed charges.

(e) You will recommend that the patient file a grievance with the Department of Labor, EBSA Section; and the Internal Revenue Service, for what appears to be a denial of payment of a covered health benefit. After all, if it is a covered service, the claim should have been paid.
Incorrectly Paid Claim:

When we submit a claim, we expect the insurance company to pay 100% of the billed charges. However, experience tells us that the insurance company may pay less than 100% of billed charges. One thing we need to understand is that when the provider is not contracted, it is not the patient’s health insurance that owes the doctor for the medical care received by the patient. It is the patient that owes the doctor. The insurance company is not a party to the debt owed by their member. If the patient has health insurance, the patient will take the payment of their benefit and apply it to the debt that is owed by them. How the insurance company pays the member’s claim for benefits is based on the terms of their contract with the employer or member.

When we look at the EOB, we may see the original charge. We may also see an amount that the insurance company allowed for that service, if the service is a benefit. That amount may be correct or it may be incorrect. We have no clue unless we review the Summary Plan Description. The SPD may specify that all the insurance company is supposed to pay is the carrier’s usual and customary amount and this is usually described in the SPD. If all the carrier is supposed to pay is usual and customary, there isn’t much we can do to appeal this. This is what the insurance company is contractually allowed to pay. Any amounts that are above this fee is usually the patient’s responsibility. Sometimes the contract calls for the carrier to pay 80% of billed charges. I have yet to see any member contract that bases payment of the benefit at a percentage of a Medicare allowable. This is important to know because the EOB may say that payment is based on 125% of the Medicare prevailing rate, yet when you read the SPD, this is not so. This is grounds for appeal because the carrier is not paying what they contracted to pay. If the SPD does not specify an amount to pay, then we must assume that payment is at 100% of billed charges, otherwise, the contract would specify a lesser amount. When the EOB and SPD match as far as what the insurance company is supposed to pay, then you have no grounds for appeal. The patient must be responsible for the amount that the insurance company did not pay. This amount is normally called a non-covered service.

When you see an incorrect payment amount on the EOB and the SPD specifies differently, submit the appeal, showing the EOB and the payment page from the SPD and inform the carrier that they paid less than what is contractually required to be paid. Inform the carrier that if the correct payment is not received within a reasonable timeframe, you will have no choice but to bill the member for the difference between their payment and your charges. Also inform the carrier, that you will send a complaint to the Department of Labor, EBSA Department and the Internal Revenue Service for what appears to be a failure of the carrier to perform their fiduciary duties to abide by the written contract.
Inclusive Denials

There may be times when the claim is submitted with multiple procedures. The carrier may pay one procedure, normally the lesser amount of the two and then deny the larger procedure with the excuse that the denied procedure is inclusive with the primary procedure.

Prior to submitting a claim, it is our responsibility to ensure that the claim is complete and 100% accurate. This means we make sure that the procedures being submitted for payment are clearly documented as being performed during the visit and we check the National Correct Coding Initiative (CCI) edits to ensure that the procedures we are submitting as separate procedures are indeed, separate. We also make sure that we use the appropriate modifiers with the appropriate procedure codes.

The CCI edits were developed for use by the Centers for Medicare and Medicaid Services (CMS). Commercial insurance companies are not required to abide by these edits, yet you sometimes see documentation from the insurance company saying that they do. Some insurance companies say they abide by them, yet their inclusive denials say otherwise. Some insurance companies develop their own CCI edits. What they use as a standard and guideline is unknown to the provider community.

When a carrier performs a claim denial, they are denying the benefit that the member may be entitled to receive, so reviewing the SPD would be your first step in researching for your appeal. If the inclusive denial is indeed a benefit, you want to use this information in your appeal. The bottom line with every claim is, the service is a benefit or it is not a benefit. If it is a benefit, the carrier is required to pay the benefit. If the service is not a benefit, then it is a non-covered service and billable to the member.

You want to check the CCI edits and make sure that the services are not included with each other. Making a copy provides a strong foundation to your appeal. Just as you want to show foundation to your claim, by providing the health record, you also want the CCI edits to be an additional foundation.

You want to look at the CPT manual to look at the wording of the procedure codes. For example, let’s say that a diagnostic test was performed in addition to an E/M code. On Page 2 of the CPT Manual, it clearly states that diagnostic tests are not included with an E/M code. Again, the more documentation you can provide, from authoritative sources, the better your appeal foundation will be.
Speaking of authoritative sources, go to the various medical society websites and search for any references regarding the procedures you are appealing. For example, one insurance company stated that a Thrombolysis was included with Critical Care. Per the CPT manual, a Thrombolysis is not listed as being included with Critical Care. The CCI edits showed the procedures were not included. The carrier then denied the appeal by stating that Thrombolysis was not to be performed in the emergency room. By going to the American College of Cardiology, I obtained a reference paper that clearly stated that a Thrombolysis was to be performed in the emergency department within a specified timeframe. This paper established the standards for performing a Thrombolysis. When confronted with this evidence, the carrier then denied the second appeal by stating that the procedure was not a benefit. When reviewing the benefit manual, I showed the carrier that it was indeed a benefit. The carrier ended up paying for the procedure when I threatened to file a complaint with the EBSA and IRS as well as informed the carrier I was billing the patient for the non-covered service denial. I explained that I exhausted the appeals process, so the patient was eligible to go to court to have their benefit paid.

Once you have all of your information gathered, you want to add one more thing to your appeal. That is to make a demand for the information the carrier used to make an inclusive denial that is contrary to industry standards. The carrier is required to make full disclosure of how they made their benefit determination. In addition, you want the carrier to provide foundation to their denial. After all, you have to provide foundation to the claim you sent, make the carrier provide foundation to their denial. Their refusal to provide this information gives you grounds to file a complaint with the EBSA. You also tell the carrier that if they refuse to provide this information, their denial has no foundation, therefore you will take their denial to imply that the service is not covered and you are allowed to bill the member.

**Experimental Denial:**

Sometimes an insurance company will deny the claim by stating the procedure is experimental. There are many things to do to fight this. First, you must look and see if CPT assigned a procedure code to the service. It takes quite some time, a lot of investigating, and a lot of work to have the American Medical Association assign a code to a procedure. Normally, CPT will not assign a full code to a procedure that is experimental. Once a code is assigned, this means that the AMA has accepted the procedure. Second, you must look to see how other insurance companies are handling this procedure. If most are paying the procedure, especially Medicaid and Medicare, this means that the review committees for these carriers have reviewed the procedure and no longer deem the procedure as being experimental.
You want to visit the various medical societies to see what they have written about the procedure. You also want to obtain documentation showing how many times the procedure is performed during a given period. Next, you want to review the SPD to see if the procedure is covered under the patient’s plan. If the procedure is a diagnostic test, many SPDs use the blanket term, “diagnostic tests” in the covered service section. The procedure should be listed individually in the excluded section if it is not a covered service. Last, you should demand full disclosure from the carrier, to see the documentation they are using to make the determination that the procedure is experimental. Remember, personal opinion is insufficient cause to deny a claim. If the carrier used a consultant, you have every right to know who that consultant is, the consultant’s credentials, and the documentation used by the consultant to provide the carrier with their decision.

Working an ERISA appeal is not easy. We must fully understand that when we appeal, we do so as a courtesy. We are not appealing our claim because we have no claim when we are not contracted. We are appealing the denial or payment of a benefit that the member may or may not be entitled to receive. An air-tight appeal takes research, documentation, and perseverance. The rules for claims and appeals are protected under Federal Law. We must abide by the carrier’s appeals process. If the first level of appeal is denied, the carrier must provide foundation to their denial. When we submit a second level of appeal, the appeal must be reviewed by someone other than the person that reviewed the first appeal, but experience has shown that you normally get the same cookie cutter denial from the person that did the initial appeal. The denial rarely provides any documentation to support the denial. A second level appeal is required to have a de novo review. This means that it must be looked at as if the appeal is new. The carrier cannot change their denial as it fits them. They cannot deny the first appeal by saying the service is included, and then deny the second appeal by saying the service is not covered. Once the appeals process has been exhausted, then the decision to make the next step rests with the patient. They must decide whether to go to Federal Court or to drop the case. No matter what, the patient still owes for the care provided to them.

Use the ERISA law to its fullest. If you have a solid foundation to your claim and your appeal, then you must keep fighting to the end. Carriers don’t want to go to Federal Court when you have the documentation to support your appeal and claim. It is very costly to them, as well as timely. But, the ultimate decision in any case, rests with the patient. Never take on an appeal on your own. You could deny the patient their appeals rights by the time you decide to hand things over to the patient. This could open you and your provider to a potential lawsuit. Always involve the patient so it gives them an opportunity to work with their insurance company as well as the regulatory authorities when the insurance company becomes obstinate. Watch out for the insurance company that says the plan and payment of the benefit is under State Law. If they do this, turn this over to the patient and have the patient file a grievance with the Department of Labor, as well as hiring a lawyer to protect their rights under ERISA. Anytime you may have questions, you should seek advice from an attorney that specializes in ERISA cases.