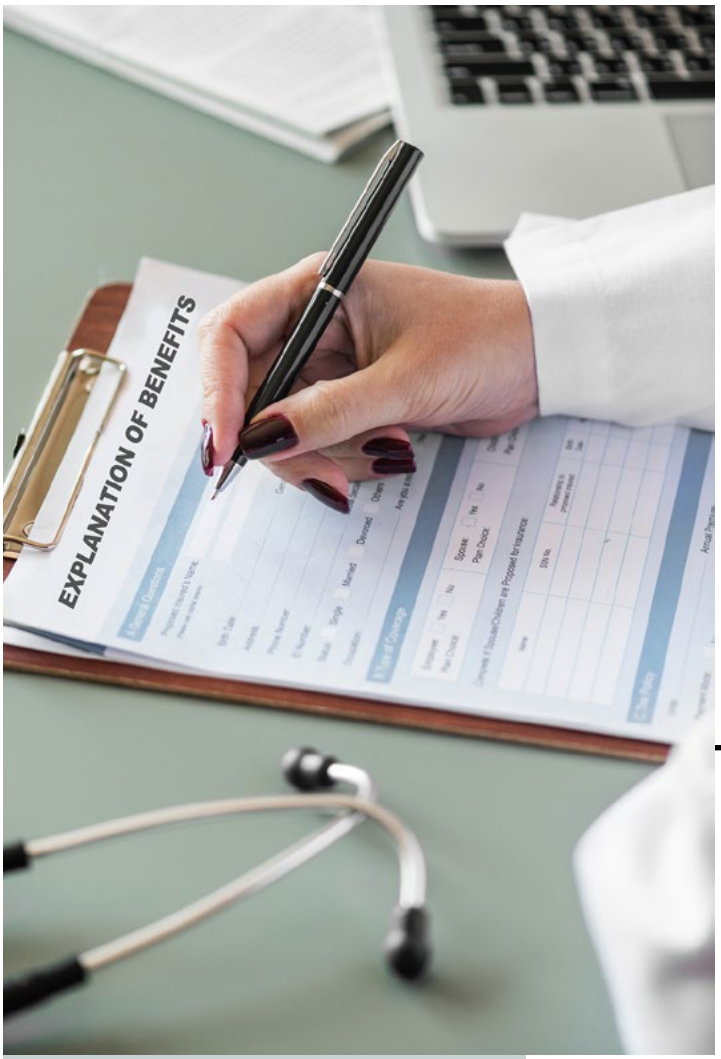

EXPLANATIONS THAT BENEFIT

WRITTEN BY JON JABLON, ESQ.

In the course of working with many different third-party administrators, it has become clear that every TPA operates differently. Claims processes are no exception; although federal law prescribes certain rules and regulations for the basics of what must be done and how, TPAs and health plans are left to their own devices to figure out the nuts and bolts of their particular processes. The only real requirement is that those processes fit in with the regulators' rules and vision for how the industry should operate.

As a form that is given to a claimant along with payment (or, perhaps more relevantly, without payment), the Explanation of Benefits (or EOB) form is often the first, and sometimes the only, document a claimant sees that explains why the claim was adjudicated as it has been.

For that reason, although it would probably not be accurate to suggest that the regulators treat EOBs as "special" compared to any other regulations, in practical matters the EOB can be considered to be perhaps more important to get right than certain other things. That's because it's the first line of defense when denying or partially denying a claim, and the primary vehicle for a health plan's justification of its denial.

29 USC § 1133 and accompanying regulations address a plan's internal appeals procedures and require that claimants must be notified of the reasons why a claim has been denied and must be given a reasonable opportunity for a full and fair internal review of a claim[1].

The regulations go on to require that a group health plan provide – among other things – the specific reason for the denial, reference to the specific plan provisions upon which it has been based, a description of the plan's appeals procedures, and a way to connect an applicable clinical judgment to the plan's provisions.

Those rules seem fairly straightforward – but due to the numerous situations that courts and regulators have encountered through the years, there are some nuances in this language that are perhaps not quite clear, and which TPAs should be acutely aware of when addressing matters such as EOB compliance. As usual, the black-letter law leaves room for interpretation.

In one particular case, for instance, a health plan required arbitration as a mandatory stage of plan appeal, after the initial written appeal was denied. The EOB, however, was silent on that requirement.

The court in that case applied the normal doctrine that courts use to rectify cases of inadequate notice: the health plan was directed to allow the claimant to file a late appeal, despite the timeframes stated within the applicable plan document and the fact that those timeframes had run out.

Known as "tolling," this remedy effectively stops the "countdown" of the appeal time requirement due to inadequate notice from the plan. In this case, then, the timeframes for appeal stated in the plan document were deemed inapplicable, since the plan did not adequately communicate them.

One can argue that the plan document's inclusion of the relevant information should be sufficient to convey the information to a claimant – but according to courts, plan members can only reasonably be expected to know what is shown to them with respect to a specific case, rather than in the Plan Document in general.

As one court put it, "[j]ust as a fiduciary must give written notice to a plan participant or beneficiary of the steps to be taken to obtain internal review when it denies a claim, so also, we believe, should a fiduciary give written notice of steps to be taken to obtain external review through mandatory arbitration when it denies an internal appeal.[2]"

Even though the arbitration itself is not explicitly governed by ERISA, once it was made a part of the plan's claim procedures, it became a provision that must be brought to the claimant's attention. This case and others like it demonstrate that simply including a provision in the Plan Document is sometimes not enough to adequately inform a claimant of that provision.

That's an example of a situation where plan provisions (timelines, specifically) were actually ignored by a court, because the plan and TPA failed to adequately disclose certain plan requirements on the EOB.

Where does it end, though? Surely the regulations can't list every conceivable item that must be present on the EOB; even if a very long list were created, there would always be some new situation not previously contemplated.

Hence, there is case law like this, that is designed to both give guidance in this specific instance, but also help inform future interpretations of these same rules. For instance, if a health plan required mediation rather than arbitration, surely the case law described above would still apply, even though it's not an identical situation. It's close enough, though, that the required "good faith, reasonable interpretation" of unclear regulations can be colored by this example.

In a longstanding series[3] of somewhat more egregious examples of deficient EOBs, courts have opined that the regulations explaining the EOB requirements are not designed to invite "conclusions," but instead "reasons" or "explanations."

Zebu Compliance Solutions

ZebuCompliance.com • support@zebucompliance.com • 888.395.8029

Why Choose Zebu Compliance Solutions?

Because healthcare needs solutions. Health spending is approaching 20% of GDP, with outcomes in the bottom 20% of developed countries. Fraud, abuse, carelessly wasted resources and redundant paperwork burn almost half of our healthcare dollars with an ROI of ZERO.

Yes, Zebu will save you time. We'll save you hassle. We'll save you from compliance mistakes. We might even save your bacon in an audit. But our bottom line is about our nationally shared bottom line. About spending the right dollars for the right care. About delivering care not because there is something we could do to the patient, but because there's a right thing we should do for the patient. And we want to help you do those things, profitably, and for all the right reasons.

Healthcare done right is justice for everyone: providers, payers, and most importantly, patients. We're passionate about making a difference, and look forward to making a difference with you.

- Francesca Hartop, Founder/President

ClaimScrub™

Medical claims done right.

Full verification of correct coding and coverage for claims. Supports pre-service, post-service, and audit implementations.

- Inpatient, Outpatient, Specialty Claim Support
- Plan-specific coverage rules
- Updated daily by certified coders using original sources
- Custom Edit Engine
- Historical Edit Module
- Bundling, 3-day rule, post-op periods, related care, duplicate billing, split claims
- Medicare reference pricing
- Payment Calculation for RVUs and Fee Schedules
- Patient Pre-Service Share of Cost Estimations

EPStaffCheck™

Your provider panel: Be the first to know.

Monitor your provider panel, as well as staff and vendors, for exclusion, licensing, and disciplinary status with Medicare, Medicaid, OIG, State, NPDB and regulatory boards.

- Sanctions and Exclusions
- Malpractice settlements
- State Board licensing and disciplinary status
- License renewal reminders
- Social Security Death Index (SSDI)
- Open Payments Records
- Medicare Opt-Out Status
- Auditor-Approved Documentation Trail
- Monthly and Annual Management Reports
- Plus: Enhanced Service for Third-Party Accountability

So, rather than state that a claim is denied because pre-authorization was not given, the EOB should state *why* pre-authorization was not given, and *therefore* the conclusion[4]. Put simply, and again parroting the established regulations, "[a]n ERISA fiduciary must provide the beneficiary with the *specific reasons* for the denial of benefits.[5]"

Noncompliance, or an instance of a questionable nature, is somewhat common with reference-based pricing. The prevailing attitude seems to be that since reference-based pricing is such a fundamental change to the plan itself, there's so much else going on that an EOB note such as "claim denied due to reference-based pricing" is somehow sufficient.

Based on courts' interpretations of the prevailing regulations, a remark this generic would neither be literally compliant with the text of the regulations, nor satisfy the intent of the regulations (which is to provide the claimant with information sufficient to file a meaningful appeal on the merits, or ultimately file suit to enforce benefits pursuant to ERISA)[6].

My mention of the intent of the regulations was deliberate. In the legal system, intent is not always necessary to be held liable; at the risk of going on a tangent, there's something called "strict liability" which imposes legal liability even without intent or even knowledge of wrongdoing.

In the process of interpreting ERISA, this country's courts have in some situations refused to apply a comparable doctrine of strict liability to violations of ERISA. In other words, sometimes a violation occurs, but the offending fiduciary is not held liable, due to other actions of that fiduciary.

To illustrate this, consider a situation where a claimant is given a compliant EOB containing one denial reason, the claimant appeals, and the health plan or its TPA denies the appeal, and also cites additional reasons for the denial that were not provided on the original EOB.

For some context, it isn't compliant with ERISA to provide additional denial reasons after the claimant has already exhausted or "used up" the available appeals, since that wouldn't afford the claimant the opportunity to actually appeal the newly-given denials reasons[7].

In some situations, though – when the claimant is given the opportunity to appeal the other denial reasons, despite already having exhausted appeals for the initial denial reason – compliance with one provision of ERISA has actually saved the fiduciary from noncompliance in another area.

In a situation like this, the health plan is not in compliance when it issues a separate denial reason after already denying appeals for the initial denial reason – but the fiduciary was able to "cure" its noncompliance by providing the claimant ample opportunity to appeal the new denial reasons.

Sometimes referred to as "substantial compliance[8]," courts have noted that certain instances of technical noncompliance can be excused as long as the purpose of the regulations[9] is not frustrated. In this case, that purpose is ensuring that claimants receive adequate recourse to appeal claims denials, which has been done.

As a final note, although the majority of this article discusses procedural matters related to EOBs, it's worth taking a brief look into the substance of denials. Although the relevant regulations provide that the claimant must be given the "specific reasons" for the denial of benefits, an interesting nuance of this rule apparently involves a sort of meta-reasoning: as one court put it, "The administrator must give the 'specific reasons' for the denial, but that is not the same thing as the reasoning behind the reasons…[10]"

Admittedly, that sounds very odd. The nuance is that although the Plan Administrator must provide a reason for denial, the Plan Administrator, oddly, isn't required to provide a good reason. The fiduciary duty extends to providing a reason, and then the law places the burden on the claimant to refute that reason.

Of course, the regulations explaining what must be present on an EOB are designed to give the claimant the tools it needs to refute the denial – but the fact remains that the Plan Administrator may provide a nonsensical reason for denial, and the Plan Administrator has then literally satisfied its duty to compliantly notify the claimant of the specific reason for the denial. After all, the law does not assume that Plan Administrators are perfect, or even logical; only that they explain themselves.

According to one particular court, requiring the Plan Administrator to explain its 'reasoning behind the reasons' "would turn plan administrators not just into arbitrators, for arbitrators are not usually required to justify their decisions, but into judges, who are.[11]"

Interestingly, despite the doctrine of "substantial compliance" noted above, perhaps courts should adopt a doctrine of "substantial *noncompliance*," which can place a fiduciary out of compliance for providing an egregiously poor reason for denial, and thus violating the spirit of the law, despite following the black letter of the law.

Regardless, the regulations are neither clear nor all-inclusive – but there is case law designed to educate Plan Administrators regarding things that must be on an EOB, and what doesn't need to be. The rules are not as intuitive as the regulations make them out to be…but then again, in this industry, what is? ■

Attorney Jon Jablon joined The Phia Group's legal team in 2013. Since then, he has distinguished himself as an expert in various topics, including stop-loss and PPO networks, focusing on dispute resolution and best practices. In 2016, Jon assumed the role of Director of The Phia Group's Provider Relations department, which focuses on all things having to do with medical providers – including balance-billing, claims negotiation, PPO and provider disputes, general consulting, and more.

References:

1 Chappel v. Lab. Corp. of Am., 232 F.3d 719, 726 (9th Cir. 2000).

2 Id.

3 Accord VanderKlok v. Provident Life and Accident Ins. Co., 956 F.2d 610 (6th Cir. 1992); Wolfe v. J.C. Penney Co., 710 F.2d 388 (7th Cir. 1983); Richardson v. Central States, Southeast and Southwest Areas Pension Fund, 645 F.2d 660, 665 (8th Cir. 1981)

4 Weaver v. Phx. Home Life Mut. Ins. Co., 990 F.2d 154, 158 (4th Cir. 1993)

5 Makar v. Health Care Corp. of Mid-Atlantic (CareFirst), 872 F.2d 80, 83 (4th Cir. 1989) (dicta), emphasis preserved.

6 See Halpin v. W.W. Grainger, Inc. 962 F2d 685 (CA7 Ill, 1992)

7 Urbania v Cent. States, Southeast & Southwest Areas Pension Fund, 421 F3d 580 (CA7 Ill 2005).

8 Lacy v. Fulbright & Jaworski, 405 F.3d 254, 256-257 & n.5 (5th Cir. 2005).

9 Robinson v. Aetna Life Ins., 443 F.3d 389, 393 (5th Cir. 2006).

10 Gallo v. Amoco Corp., 102 F.3d 918, 923 (7th Cir. 1996), internal citations omitted.

11 Id.