Underpaid on Out-of-Network Reimbursements? Keep ERISA Best Practices in Mind

BY PETER J. BRACHMAN AND ERIC D. CHAN

Providers seeking to recover payment from noncontracted, employee-sponsored health benefit plans sometimes elect to bring legal claims under the federal Employee Retirement Income Security Act of 1974 (ERISA). Plans and their administrators inevitably respond to such suits with highly technical arguments purporting to show that the providers are not entitled to bring an ERISA lawsuit in the first place. If they are disregarded, these “traps for the unwary” can stymie an ERISA lawsuit in the very early stages.

For instance, plans and administrators often argue that providers cannot maintain an ERISA suit because they have not obtained an adequate assignment of benefits (AOB) from their patients. And even where valid AOBs have been obtained, plans often argue that their governing plan documents contain an “anti-assignment” clause that allegedly defeats the AOB. These excuses, of course, have nothing to do with the fact that the provider has not been properly paid. But plans nevertheless argue that they must be overcome if the provider wants its day in court.

I. Strategies for Combatting Procedural Roadblocks to Payment

Fortunately, providers can anticipate and overcome these obstacles by following best practices in how they deal with plan administrators and with patients in the normal course, starting with patient intake and insurance verification processes. The following are just a few of these best practices.

A. Draft Broad Assignments of Benefits Forms

The statutory language of ERISA permits “beneficiaries” and “participants” of a plan to sue for ERISA benefits. Courts have long recognized, however, that patients receiving medical care or treatment (e.g., beneficiaries and participants) may assign their rights and benefits to their health care providers, and that such an assignment permits providers to sue under ERISA—by “standing in the shoes” of their patients.

For instance, plans and administrators often argue that providers cannot maintain an ERISA suit because they have not obtained an adequate assignment of benefits (AOB) from their patients. And even where valid AOBs have been obtained, plans often argue that their governing plan documents contain an “anti-assignment” clause that allegedly defeats the AOB. These excuses, of course, have nothing to do with the fact that the provider has not been properly paid. But

1. Explicitly Include the Right to Appeal Adverse Determinations by the Plan

Another common tactic used by plans and administrators before litigation is to refuse to consider appeals made by out-of-network providers unless the providers obtain a special written authorization from the patient designating the provider as the patient’s “authorized representative.” Obtaining such authorization can be inconvenient and time-consuming, and in any case ERISA does not require it: assignees of benefits “step into the shoes” of the patients, and are accorded all of the patients’ rights, including the right to appeal.

Regardless, the best practice is to explicitly include (i) the right to appeal on the patient’s behalf in the AOB

Peter J. Brachman is a litigator in the Los Angeles office of Hooper, Lundy & Bookman PC. He represents hospitals, hospital systems, ASCs, and ancillary providers in disputes with health plans and plan administrators, with an emphasis on managed care disputes. He can be reached at (310) 551-8157.

Eric D. Chan is an associate in the litigation department of Hooper, Lundy & Bookman PC. His practice is focused on complex business litigation and arbitration on behalf of providers, with a particular emphasis on managed care litigation. He can be reached at (310) 551-8158.
form, and (ii) language appointing the provider as an “authorized representative” for this purpose. Though plans and their administrators may continue to ignore supposedly “unauthorized” appeals even after being provided with an AOB confirming that appeals by the provider are authorized, obtaining a proper AOB and proceeding with appeals will build an administrative record that will be important in later litigation.

2. Clarify Patient Responsibility

AOB forms may also be used to clarify to patients that they remain financially responsible for all charges that the plan does not pay, and further, that they are responsible for any and all co-payments, co-insurance and deductibles called for by the plan.

This is important because ERISA plans and administrators have recently attempted to argue that providers supposedly lack standing where patients are not financially responsible for charges. In fact, this issue is currently pending in an appeal before the U.S. Court of Appeals for the Ninth Circuit. The Department of Labor has agreed with providers that there should be no requirement that providers attempt to collect payment from their patients prior to seeking recovery for the ERISA plans.

In addition, clauses regarding patient responsibility may be important in cases where plans are seeking to recoup funds from providers based upon alleged waiver or discounts of copayments, coinsurance and/or deductibles. For instance, in one case where a hospital waived the patient’s deductible and copayment, the plan argued that there was no coverage at all because the hospital’s waiver voided the insurance contract. The court held for the provider, reasoning that the patient’s intake form stated that she would be financially responsible to pay for her care in the event that the plan did not pay. Trustmark Life Ins. Co. v. Univ. of Chicago Hosps., 207 F.3d 876, 884 (7th Cir. 2000).

B. Design Insurance Authorization/Verification Protocols to Anticipate Common ERISA Defenses

Another important tool is to ensure that proper procedures are in place that can help prevent plans from manufacturing after-the-fact reasons for nonpayment. In a recent federal court decision in California, Care First Surgical Ctr. v. ILWU-PMA Welfare Plan., No. 14-cv-1480-MMM-AGR, a surgery center plaintiff alleged that it had routinely asked ERISA benefit plans during verification and/or authorization calls prior to providing treatment whether the plans had an “anti-assignment clause.” Each time it asked, the surgery center was told that the plan had no such clause. The court’s ruling identified these facts as one important factor in permitting the plaintiff to plead that the plan had waived its right to assert its purported anti-assignment provision.

This and other court decisions throughout the country demonstrate that oral statements made during authorization and/or verification calls can legally bind plans. Indeed, such statements may be accorded heightened importance given that providers rarely, if ever, have access to governing plan documents. It is worth ensuring that scripts used during verification and/or authorization calls with out-of-network plans are designed to elicit information not only about coverage and levels of payment, but potential reasons for denial of payment. This last category can include not only anti-assignment clauses, but also whether a plan excludes procedures and treatments that the provider intends to perform.

II. Conclusion

These “best practices” demonstrate how attention to seemingly routine patient intake processes can substantially affect later ERISA litigation. However, there is no “one size fits all” when it comes to the language of assignment of benefits forms, call scripts, or other internal procedures, which must always be tailored to the needs and circumstances of each provider.