HOW MEDICAL REVIEWERS CAN AVOID BAD FAITH CLAIMS AND ERISA VIOLATIONS

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I. Risks of Being Sued

Medical reviewers' decisions on life, health and disability benefit claims are coming under increasing scrutiny by judges and juries who lack medical training and expertise. Professionals who make decisions on such benefits claims can take steps that will result in more of their decisions being upheld when challenged in litigation. Unfortunately, lawsuits for denial of benefits will be filed, despite the thoroughness of medical review programs. However, the goal of risk management in employee benefits programs is to minimize the exposure to risks of lawsuits and to provide opportunities for extricating the company from lawsuits at an early stage. Medical reviewers who employ risk management techniques in reviewing claims can assist significantly in avoiding litigation.

There are various risks faced by insurance companies and medical claims reviewers. Most of these take the form of lawsuits by disgruntled beneficiaries against an insurer or ERISA plan administrator on a variety of legal theories. Once there is an understanding of the legal theories used in these claims, a company and its medical reviewers can better protect against the risk of being sued.

II. Types of Claims

To understand why certain procedures must be in place and followed closely, medical advisors need to understand the types of lawsuits that can be filed in health, life and disability benefits disputes.

A. Contract Claims

1) Written Contracts

The claim most frequently asserted is based on the written terms of the benefits agreement. In the individual insurance policy setting, this is the individual policy sent to the policyholder. However, it also includes any modifications subsequently and validly made by the insurance company. For modifications to be effective, insurers must have proof that such modifications were sent and received by the insured.

In the group policy setting, the group health insurance master policy or employee welfare benefit plan is technically the governing document. However, individual certificates, booklets or summary plan descriptions may be the only documents the beneficiary ever receives. If those documents vary from the terms of the master agreement, the group can be bound by them, if they are more favorable to the beneficiary, rather than the actual master plan language. This points up the importance of uniformity in all written documents.

2) Oral and Written Representations

In addition to the actual written contract between the member and the company, claimants often rely on other written or oral representations made to them. Medical review personnel can make verbal statements to a claimant which are not strictly in accordance with the written policy language or which are misunderstood. Such oral and written misrepresentations can form the basis of a modified "contract" between the member and the benefits provider under certain circumstances. Thus, employees must be careful in any communications with beneficiaries and their representatives.

3) Estoppel

If such oral or written representations are relied upon to the member's detriment, then he or she can claim that the company is prevented (or estopped) from rescinding those oral or written representations. Thus, it is important that medical advisors document any statements made to a claimant and ensure that those statements indeed comply with the terms of the policies being discussed.

B. "Bad Faith" Claims

In most situations where there is a contract between two parties, the parties have the contract terms as their only recourse for any wrongs which occur in administration of a contract. However, courts have become increasingly willing to allow parties to a contract to sue on other unique bases, primarily on tort theories of liability. These theories open up a potential for recovery of greater damages such as emotional distress and punitive damages to deter such acts in the future. Examples include purposeful delay in processing a claim, denial of a claim for an improper or illegal reason, outrageous
behavior to an insured either in person or over the phone. These types of lawsuits, which often have only a few hundred or a few thousand dollars of actual benefits in dispute have resulted in multi-million dollar verdicts against life, health and disability insurance companies.

C. ERISA Claims

ERISA (Employee Retirement Income Security Act, 29 USC § 1000, et seq.), is a federal statute which governs insurance companies or plan administrators who provide welfare benefits to groups of employees, i.e., the typical employer who purchases a group life, health or disability insurance plan for its employees or provides such benefits in a self-funded setting. Certain exclusions exist, such as for government plans (states, cities, counties and school districts). Individual life, health and disability insurance policies are not covered by ERISA and remain governed by state contract and insurance law.

ERISA permits, under certain circumstances, a judge to give great deference to the actions of an insurance company or plan administrator. However, in order to be entitled to this deference on its decision making, the ERISA plan must contain "discretionary" language which allows the administrator to make such decisions. If the benefit plan gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan, then the court must review the benefits decision under an "arbitrary and capricious" standard. Under a deferential standard, the court can disagree with the ultimate decision to deny benefits, but if that decision was made in a good faith process then the court must uphold it. If the plan does not contain such discretionary language, or if it is not clear, the court will apply a de novo standard of review and no deference will be given to the administrator's decision. Furthermore, the court will not necessarily be limited to the evidence that was available to the plan or its medical reviewers.

ERISA is an important defensive tool for insurers and plan administrators. However, it means that the process used by medical staff to make claims decisions will be closely scrutinized by the court. The insurance company must prove that it acted in good faith, i.e., it made a careful and well reasoned review based on all of the evidence available at the time. The specific ERISA regulations on claim denial process and appeals must be carefully followed. (29 CFR § 2560.503, et seq.)

III. Dos and Don'ts for Medical Reviewers

Given the previous background, you can see why benefit providers must take actions to minimize their exposure to risk. These actions don't mean that there won't be a lawsuit, but that hopefully lawsuits will be less frequent and there will be a better chance of winning.

A. Data Collection

"Bad faith" claims or ERISA claims that an insurer was arbitrary are frequently premised on incorrect or incomplete information utilized by medical reviewers in making claim decisions. Incorrect and incomplete data can lead to erroneous conclusions and charges that the medical reviewer has acted in "bad faith" in denying a claim.

1) Current Claim

Obviously, all data concerning the current claim should be collected, including: medical reports, physician and hospital records, nursing notes, orders, admitting and discharge summaries. Such backup documentation is not routinely provided by medical providers and hospitals. Requests for such information must be made promptly so as not to unduly delay a response to the claim. Medical reviewers should make sure they have access to all information concerning the current claim or they could be subject to charges of failing to complete a thorough investigation, resulting in allegations of "bad faith." Furthermore, such oversights could constitute "arbitrary or capricious" actions under ERISA, resulting in an award of benefits to the claimant.

These precautions do not have to be taken in connection with every claim processed, which would obviously be impractical. However, upon receipt of a questionable claim or when faced with the possibility that an exclusion will apply, every "benefit of the doubt" must be given to the insured. In these cases it is crucial to have complete claim documentation to support a denial.

In cases involving health benefits claims for "experimental" treatment, medical reviewers who are specialists in the particular disease should be consulted and be provided with all medical records, peer reviewed literature, protocols, consent forms, case studies or unpublished data on outcomes, etc. These cases are very difficult for insurers to win and extra efforts should be made during the medical review process to ensure the review is thorough. Reviewers should be encouraged to talk to the providers who are proposing the treatment as well as the claimant's other local treating physicians,
who may acknowledge the experimental nature of the treatment.

2) Prior Claims

Frequently decisions are made on a particular claim in a vacuum. Again, this leaves the reviewers open to charges of an inadequate investigation. In any type of questionable claim, the insured’s prior claim history should be reviewed in the event that it reveals information which could support the insured’s current claim, or that prior similar claims were paid. Also, prior medical records may reveal information which support a denial of a claim - such as pre-existing conditions, conditions covered by collateral sources or duplicate charges and claims.

3) Use of Questionnaires and Forms

Insurance companies sometimes send questionnaires and forms to the insured or the medical provider to answer routine questions. Frequently these forms are not returned, are sent back blank or with unintelligible responses. Reviewers must avoid making decisions on incomplete or unintelligible information. It cannot be assumed, because there is no response, that the answer is actually "no" to the question asked. The form should be sent back or other contact made to obtain the missing information.

It is also extremely important to utilize words in such forms that can be understood by a lay person. Any medical or insurance terms should be clearly defined on the form itself, so that there can be no later claim of misunderstanding. Any ambiguity in terminology will likely be construed in favor of the claimant, not the company.

Forms also offer the insured and/or medical providers an opportunity to explain in detail the claim, treatment or procedures utilized. Frequently, claimants may just want a chance to explain their side of the claim, and feel that at least they have had an opportunity to provide input into the claims decision.

4) Reliance on Information From Others

If a claim denial is based on information received from others, such as an independent medical examiner or claimant’s medical provider, the claimant should be given an opportunity to explain, rebut or supplement the information. If a medical reviewer disagrees with a treating physician, some attempt should be made to offer the physician a chance to respond. This may also have the side benefit of uncovering an error in the medical reviewer’s opinion that can be corrected before the final claims decision is made.

Similarly, if the decision is made on the basis of opinions from medical reviewers who are not physicians actually treating the insured, the records should contain input from the insured’s own treating medical practitioners. This will avoid claims that the insurer did not bother to consult the treating physician, even if the company ultimately disagrees with that physician. Courts and juries are usually persuaded by the argument that a treating physician knows what is best for a patient, rather than second guessing by a hired consultant or an insurance company employee.

B. Staffing

Proper staffing of the medical review department is crucial.

1) Medically Trained Personnel

It is extremely important to have access in the medical review department to medically trained personnel. Obviously, it is impractical to hire all claims analysts with a medical background. However, insurers and claims administrators must have nurses, doctors, physician’s assistants and other licensed medical practitioners both within the company and as outside consultants.

Many insurance companies prefer to actually have medically trained personnel as full-time employees in a medical or claims review department. This alternative is very effective because these employees are not only medically trained but they are familiar with prior claims, plan and insurance policy language and insurance company policies and procedures. However, a review by such individuals is open to the criticism that they are employees of the company who are biased towards denial of claims.

Also, these medically trained employees are subject to the criticism that they are not actual practitioners, and therefore, are not as aware as treating physicians of current medical trends. Therefore, it is important that such medically trained personnel have prior practical experience in the medical community and can prove that they have kept up with the medical literature, training and education.

Frequently, rather than having medically trained personnel on staff, insurance companies retain medically trained personnel as outside consultants. These consultants are much less likely to be subject to claims of bias or inexperience. These outside consultants are used
frequently enough that they have the necessary familiarity with insurance company policies and procedures, yet they are able to maintain an independent practice in the community. In particular, such consultants make very good witnesses at trial, are not perceived as being as biased and jurors may have knowledge of them.

The use of consultants is extremely effective in claims for experimental treatment or unusual medical conditions. The practitioner/consultant will usually appear to a jury to be more enlightened and up to date on recent medical developments or areas of specialty than a former general practitioner or an insurance company staff person. Even if the insurer has medical professionals on staff, a cadre of specialists in the community should be cultivated to assist with difficult or novel claims.

2) Continuing Education and Research

Obviously, all staff must have access to continuing medical education. This can be accomplished by routine seminars for claims department personnel or circulation of medical information and updates or industry newsletters concerning medical issues of current interest.

a) Medical Education

Medical affairs staff must keep apprised of current developments in medical fields. The developments occur so quickly that it warrants assigning one or more staff members to do nothing but monitor new developments in medicine and not only keep company staff advised of such information, but update claims processing manuals to reflect changes in the medical community’s view of certain procedures or treatments.

b) Insurance Code and ERISA

In addition to updating the medical reviewers on medical developments, it is important that they be aware of and trained on the insurance code, unfair claims practices regulations and ERISA claims processing procedures. There is nothing more embarrassing than a medical reviewer testimony during a deposition or at trial that he or she has never heard of or seen the insurance code, unfair claims practices act or ERISA claims processing guidelines. The in-house legal department can be very effective in keeping staff updated on new developments in the law.

c) ERISA Procedures

ERISA regulations contain a number of requirements for claims processing and appeal. The appeal procedures must be contained in a notice to the insured, i.e., in the policy and booklet; time limits must be followed; certain information must be gathered and reviewed; specifics regarding the reasons for denial must be provided; a procedure must exist for claimant to review material upon which the denial is based and submit additional documentation. See 29 CFR § 2560.503 et. seq.

C. Policy and Procedure Manuals

Good manuals can be very effective in thwarting extra-contractual damage claims if it can be proven that standard policies and practices were followed in an individual case. On the other hand, out of date policies or failures to follow procedures can create a "bad faith" claim where one never existed.

1) Manuals

Generally the insurance industry uses policies and procedures outlined in manuals. However, many manuals are too inflexible and read as mandates rather than as suggested guidelines. Manuals should always allow for claims to be handled on a case-by-case basis, taking into account the circumstances of each individual claim.

2) Update

Nothing is worse than an out-of-date manual which contains incorrect policies and procedures or inaccurate medical information. Again, staff should be assigned to routinely update manuals with new policies and procedures or new medical information.

3) Expert Input to Policies/Manuals

Manuals should not be prepared in a vacuum, but should be developed with the assistance of medical professionals and legal counsel where appropriate. Medical policy must be based on the input of medically trained persons if it is to be meaningful. Specialists in particular medical fields should be consulted on specific procedures outside the expertise of general practitioners.

4) Training

Manuals, policies and procedures are useless if staff do not know of them or use them. Medical reviewers must be thoroughly trained and the information must be available for them to use. Manuals should be generally accessible or on each medical reviewer’s desk. Again, an established policy which supports an insurer’s decision in a case, may be useless if the medical reviewer was unaware of the policy, procedure or manual.
cal reviewers must follow these manuals when providing advice to an insurer or plan administrator.

D. Processing Claims

The actual processing of the claim involves all of the above factors previously mentioned. If a company has established good procedures and has qualified, well-trained staff, processing should be "a piece of cake." However, frequent delays, workload or other external factors can create processing errors or other problems.

1) Timeliness

The number one factor in losing cases appears to be delay by the insurance company. Medical reviewers must determine whether additional information is needed and if so, request it immediately upon receiving a claim.

During periods of delay, which may be justified, the claimant must be kept apprised of the claim status, even if no decision has been made yet.

2) Use of Policy Language During Review

The courts have been critical of medical reviewers who apply standards that are either not within the policy language or differ from those that are. In Pirozzi v. Blue Cross-Blue Shield, 741 F. Supp. 586, 591 and 593 (E.D. Va. 1990), the court, in holding for the subscriber in a HDC-ABMT cancer case, declined to give much credence to the internal criteria used by Blue Cross because "the criteria are not part of the Plan and the Plan nowhere states that the Blue Cross plan criteria are determinative of a treatment's experimental status." In Bucci v. Blue Cross & Blue Shield, 764 F. Supp. 728 (D. Conn. 1991), the court held for the subscriber in a HDC-ABMT cancer case, noting that the criteria used by the insurer were not "incorporated in nor referenced to in the policy."

Where the medical reviewer denies coverage on the basis of the policy language and the decision is based on the method described in the policy and its terms, the courts have generally upheld the insurer's denial. The reviewer should consider carefully the criteria in the policy when determining whether or not the treatment is covered. Once the decision has been made to follow certain criteria, the insurer should stay with those listed in the policy and not use other factors unless the insurer is willing to invite litigation on the grounds that it acted arbitrarily and capriciously in denying coverage.

3) Reasons for Denial

Most claim denials are based on one or more clauses, exceptions or exclusions in the contract. However, frequently reviewers do not cite all reasons for the denial, choosing instead to cite only one of the major exclusions for coverage. This action can come back to haunt the company if the insured later files a breach of contract or extra contractual damages lawsuit. The insurance company may be estopped to assert other bases for the denial or may be deemed to have waived such additional reasons for the claim denial.

The insurance company should carefully establish standard form letters which encourage reviewers to cite any and all potentially possible reasons to support their claims denials. In addition, such communications to the insured should contain a standard reservation of rights clause which reserves the company's right to assert other bases of denial in the future. Standard computerized claims forms can be printed with such a reservation of rights on the form. However, the best protection is to ensure that all possible bases for denial are asserted in addition to the reservation of rights paragraph.

4) Post-Decision Actions

Insurers’ actions taken after denial of the claim can formulate the basis for a "bad faith" claim. They can forget to notify the insured or provider of the decision, send conflicting reports, deny a claim after initial acceptance, or cite support for the denial based on information received after the decision was made. Again, clear procedures and safeguards can help to avoid such oversights.

IV. Conclusion

Implementing some of the above-suggested procedures may seem costly. However, even one million dollar "bad faith" verdict avoided by implementing new policies and procedures can justify the cost.

Jurors and judges tend to be outraged by proof of dilatory actions by medical reviewers or other procedural problems. This can lead to a plaintiff's verdict even where the initial claim denial was justified.

Implementation of such policies and procedures will not guarantee that someone will not file a lawsuit. However, they increase the chances of avoiding the filing of such claims, and substantially increase the insurance company's chances of disposing of such claims by way of legal motions and upholding a medical reviewer's decision.