

Claims Processing Guide

In General

This Guide deals with the more general areas of claims processing and administration such as:

A. Examiner

- Scope of Duties
- Examiner's Checklist
- Common Examiner Deficiencies
- Levels of Authority
- Examiner and Medical Technology
- Examiner and Participant Calls

B. Encyclopedia of Processing and Administration Topics

- Beneficiary
- Legal Options of the Beneficiary
- Claim Processing-Overview
- Confirmations
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- Files and Record Retention
- Forms and Proof of Losses
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- ERISA and Punitive Damages

D. Overview of Processing and Administration

- Defensive Benefit Administration
- Exposure of Plan Supervisor to Claims-Related Errors
- Benefit Administration Philosophy
- Claim Practices to Avoid

Examiner

Scope Of Duties

Basics of Benefit Examiner's Duties

The benefit examiner must follow basic rules:

- *Act as a Fiduciary*
Fairness to all, willingness to go the extra mile for all parties, etc.
- *Be As Accurate As Possible*
A small error to one is a large sum to another.
- *Be Courteous*
Soft, friendly words help a lot.
- *Be Timely*
Mail in on Monday must be acted upon by Wednesday.
- *Keep People Informed*
Tell parties of delays, inform the employers of denial, holdups, etc.

Public Relations Aspects

How medical benefits are handled plays an important role in shaping participants' perceptions of the quality of these benefit plans. Not a new thought, but here are some statistics to back it up. A survey of over 30,000 employees' attitudes toward their benefits reveal that 64% of those who felt positive about the processing of their medical benefits also had positive feelings about the quality of their health care plan. Only 31% of employees who had negative feelings about the way their medical benefits were handled felt good about their health care plan. Furthermore, 63% of employees who were positive about dental benefit processing felt positive about the quality of their dental plans. Just 21% of those with a negative response to benefit administration felt good about their dental plans.

Telephone Discipline

The telephone should be used frequently by the examiner.

- Other coverage
- Details on accidents
- Names of other physicians/hospitals
- Important dates.

The above are only a few of the instances where the telephone may be helpful.

To maintain telephone discipline, the following are needed:

- Log of details (dates, persons, etc.)
- Follow-up with hard copy confirmation of details.

Examiner As A Fiduciary

Whether an examiner is a fiduciary in the strict legal sense will depend on the facts and circumstances of each case.

Everyone's interests will be best served, however, if the examiner acts as a fiduciary.

The result of this assumption is simple. The examiner should show an equal caring to all parties to the arrangement: the employers and its money, the participant, the insurer, reinsurer and the providers. When the examiner is properly positioned with an exactly neutral, yet helpful attitude to all the parties, good results will be found.

The moment an examiner becomes partial to the needs and rights of any of the parties shown above, such examiner ceases to be a fiduciary.

In addition, the examiner must be mindful of the following:

- *The Laws and Regulation*
State Insurance Laws
Insurance Department Regulations.
Federal Laws (Internal Revenue Code, Fair Labor Laws, Discrimination, e.g.).
Medicare, Medicaid, CHAMPUS and similar.
- *Judicial Decisions*
- *Needs of the General Public*

Examiner's Checklist

An examiner, like an aircraft pilot, should have a checklist to avoid an accident; e.g., mispaid benefit.

1. Information regarding participant complete and accurate?
 - Social Security Number
 - Name
 - Address.
2. Is the provider tax ID number available?
3. Is there a claim for benefit?
 - Hospital bill (UB92)
 - Physician bill (HCFA1500).
 - Prescription drug charges.
4. Is the information legible?
5. Is the covered person eligible for coverage?
 - Breaks in coverage.
 - Any HMO-Indemnity plan problems.
 - COBRA, extension, leave, disability issue
 - Clear trail from enrollment card, charge card, etc.
 - Nonverified or ineligible dependent
 - Nonstudent over age nineteen (19).

6. Is physician a valid provider?
 - Midwife
 - Physicians' assistant
 - Palmist
 - Veterinarian.
7. Is there a valid diagnosis by ICD-9?
8. Is service identified by CPT procedure code?
9. Are services and procedures consistent?
10. Is provider licensed to perform procedure?
11. Is the bill valid or is there any implications of being phony?
12. Is bill itemized? Balance due statements are not acceptable.
 - Is bill arithmetically correct?
 - Is service utilization excessive?
 - Are charges reasonable and customary?
13. Is this a possible preexisting condition?
14. For hospitalization was it required to be precertified?
15. Is the accident/illness possibly work-related?
16. What second surgical opinion needs to be applied?
17. Is there a Preferred Provider Organization?
18. Was there possibly a misuse of the hospital emergency room?
19. Was the surgery performed outpatient if it is on the outpatient candidate list?
If not, is there a valid explanation such as medical necessity or distance from facility?
20. For nonemergency surgery were preadmission tests performed? If not, is there a valid explanation such as medical necessity or distance form facility?
21. Is subrogation a possibility? Who has the liability?
22. Is COB a possibility?
 - Spouse employed
 - Large unassigned bills
 - Copies of bills – not originals
23. Is the person a *key* person to the employer?
24. Are all of the key numbers consistent and accurate?
 - Social Security
 - Provider EIN
 - Patient Number
 - Service dates.
25. Is benefit assigned?
26. Any existing overpayments to be recovered?
27. Is benefit for an auto accident?
 - Auto accident report.
 - No fault or auto medical benefits.
28. Is covered person actually responsible for charges?
29. Are patient and physician related?
30. Do patient and participant live at different addresses?
 - Validity of coverage on dependent.

- Possibility of separation/divorce.
- 31. Are any of the submitted charges excludible?
- 32. Have maximums been exceeded?
- 33. Has out-of-pocket maximum be reached?
- 34. Has stop-loss specific or aggregate attachment points been reached?
- 35. Have individual/family deductibles been met?
- 36. Is diagnoses metal/nervous?
- 37. Has the claim been filed within the ninety (90) day period?
- 38. Has plan supervisor promptly paid the benefit?
- 39. Is physician or hospital an identified overcharger?
- 40. If an accident, is deductible or copayment rate modified?
- 41. Any special deductibles for physician visits or prescription drugs?
- 42. Inside limitation to intensive care charges?
- 43. Has care been medically necessary?
- 44. Has care been made in the most appropriate medical setting:
 - Ward vs. ICU
 - Hospital vs. Outpatient
 - Inpatient vs. Home Care.
- 45. Have inside limits on mental/nervous been applied?
- 46. Are submitted charges on Covered Expenses list?
 - Shown in Plan Document
 - Shown in Encyclopedia as covered expenses.
- 47. Would charges be not covered by one of the plan exclusions?
- 48. Does the procedure code show inconsistency as regards to age and sex?

The examiner should avoid any practice which has the potential for getting the plan supervisor into a lawsuit. Examples are these:

- Whenever a participant makes either oral or written inquiry about the terms of the plan, fully answer specific questions and refer to plan provisions which cover points raised.
- If a benefit is to be denied, advise the participant that the Plan Supervisor will consider any additional facts or information he may wish to present for its consideration. Include a good faith sentence advising him/her that the examiner stands ready to answer any additional questions.
- Exercise promptness in investigation and keep in frequent communication with the participant.
- Avoid partial payments, if possible, prior to completion of claim investigation. However, when benefits are paid which are less than the full charge under the determination of *reasonable and customary*, carefully follow all the guidelines.
- Never express personal sentiments about merits of a benefit or a characterization of persons in any memoranda or benefits records. This will avoid embarrassment and perhaps liability should the record be subpoenaed.
- Never imply that future payments will be paid automatically. Future benefits are paid only on their merits. The danger is than an implied or stated guarantee may be construed strictly against the plan, particularly if the participant has taken an action or changed his position based on the implied or state guarantee.

- When an analysis of a doubtful benefit does not reveal a convincing basis for payment, discuss the benefit with a supervisor or see if the doubt can be resolved.
- Never indicate to a participant that the benefit has been referred to a physician or attorney.

A good set of guidelines for the examiner to follow is contained in the

NAIC model fair claim practice guides:

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

- Misrepresenting pertinent facts or plan provisions relating to coverage at issue.
- Failing to acknowledge and act reasonably prompt upon communications with respect to benefits arising under plans.
- Failing to adopt and implement reasonable standards for the prompt investigation of benefits arising under plans.
- Refusing to pay benefits without conducting a reasonable investigation based upon all available information.
- Failing to affirm or deny coverage of benefits within a reasonable time after proof of loss statements have been completed.
- Not attempting in good faith to effectuate prompt, fair and equitable settlements of benefits in which liability has become reasonably clear.
- Compelling employees to institute litigation to recover amounts due under a plan by offering substantially less than the amounts ultimately recovered in actions brought by such employees.
- Attempting to settle a benefit for less than the amount to which a reasonable person would have believed entitled by reference to written or printed advertising material accompanying or made part of a plan.
- Attempting to settle benefits on the basis of an Enrollment Form which was altered without notice to, or knowledge or consent of the employee.
- Making payments to employees or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made.
- Making known to employees or beneficiaries a plan of appealing from arbitration awards in favor of employees or beneficiaries for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.
- Delaying the investigation or payment of benefits by requiring an employee, beneficiary, or provider, to submit a preliminary report and then requiring the subsequent submission of formal proof of loss forms, both of which contain substantially the same information.
- Failing to promptly pay benefits, where liability has become reasonably clear, under one portion of the plan coverage, in order to influence settlements under other portions of the plan coverage.
- Failing to promptly provide a reasonable explanation for denial of a benefit or for the offer of a compromise settlement.

Common Examiner Deficiencies

There are three main types of examiner deficiencies which have the potential for problems to the Plan Supervisor.

- Lack of promptness

- Lack of good faith
- Poor procedure.

Failure To Handle Benefits Properly

- Failure to acknowledge communications promptly
- Failure to initiate and conclude investigation with reasonable dispatch
- Failure to provide necessary forms, instructions and reasonable assistance promptly to covered persons
- Failure to affirm or deny liability within a reasonable time after proof received.

Failure To Handle Benefits in Good Faith

- Failure to attempt in good faith to effect fair and equitable settlement when liability has become reasonably clear
- Failure to promptly provide a reasonable explanation of benefit denial when participant requests it.
- Knowingly misrepresenting to participants facts or plan provisions relating to coverage involved
- Failure to pay a benefit under one portion of the plan in order to influence a settlement under another portion
- Compelling suit to recover amounts due by offering substantially less than the amount ultimately recovered in a suit
- Directly advising a participant not to obtain the services of an attorney
- Misleading a participant as to the applicable statute of limitations.

Improper Benefit Handling Procedure

- Failure to offer settlement under applicable first party coverage on the basis that payment should be assumed by another person or insurer except as provided by the plan (e.g., Workers' Compensation)
- Failure to make provision for adequate benefit handling personnel, systems and procedures to effectively service the plan
- Failure to adopt reasonable standards for investigation of benefits arising under the plan.

Levels Of Authority

Each plan supervisor should establish reasonable levels of authority for the examiner. The general outline of such authority levels are set forth as follows:

Rule 1. As a person gains knowledge and experience such person may do these things:

- Adjudicate large and/or more complex claims

- Identify claims which need special handling or training
- Monitor and approve and audit work of others.

Rule 2. The basis for separating easy from difficult claim are these:

- Amount is over \$5,000, e.g.
- Preexisting
- Subrogation and/or coordination
- Eligibility in question
- Possible misrepresentation of a late applicant
- Difficult definitions (borderline hospital, e.g.)
- Extension of coverage (disability, e.g.)
- Will go into stop-loss
- Possible litigation
- Possible insurance department complaint
- Attorney involved.

Rule 3. Difficult claims are generally earmarked for referral to next higher examiner level.

Examiner And Medical Technology

Introduction

The collision course is this:

- Plan document administered by the examiner excludes experimental procedures and covers only what is reasonable and customary care.
- New technologies come on-line which do become clear cut plan benefits but yet rapidly become accepted medical practice.

This difficult area of adjudication will be coming up with increasing frequency as: (a) plans are pressured more and more by stop-loss carriers to not pay, and (b) technological advances come online.

The subject-Problem

An example of such difficulty is the procedure autologous bone marrow transplantation as a support adjunct to high dose chemotherapy.

- Plans have in the recent past excluded this procedure as either investigational or experimental as regards to its safety ad/or effectiveness.
- Physicians view the procedure as good medicine when all other treatment courses have been exhausted and the illness had become life-threatening.

Both the providers and the plans have been anxious to see the controversy litigated so that a resolution of the conflict might be reached.

Review by Court

In reviewing such a conflict between the plan and the provider, a court will use either of two standards.

Most Deferential – Arbitrary and Capricious

This is the less rigorous of the two methods. It would be used where the plan administrator has clear written authority to construe terms of the plan. The administrator must be reasonable, fair, not abusive, etc. and must take into account all available evidence; if so, the court will let the decision stand. Where the administrator has a financial interest in the outcome of the decision, the courts will be less deferential, however.

Less Deferential – De Novo Review

This is the more rigorous of the standards to be applied by the court. With this review, the court will use the ordinary principles of contract laws. The court will replace the decision power of the administrator with its own and will directly intrude into the facts and evidence.

Examiner Involvement in Participant Calls

Unscreened participant calls may decrease the examiner's production by one-third to one-half; such unscreened calls will increase the stress level of the examiner, subject the benefit administrator to errors and potential public relations problems with the participant, and as a direct consequence, the employer.

The examiner must handle the calls if they involve the examiner's adjudication, of course. This is only fair to all concerned. The trick is – the calls should be handled not unscreened but rather *prescreened*. The examiner should respond, having all of the facts, files questions, issues, etc. well in mind.

Encyclopedia Of Claims Processing Topics

Beneficiary

In General

These are the persons who may receive benefit payments:

- Beneficiary of a death benefit
- Participant with unassigned benefit
- Provider under a benefit assignment.

Beneficiary Of A Death Benefit

The beneficiary designation must be in the possession of the Plan Supervisor. The usual situs of the beneficiary is the Enrollment Form. It may be changed.

Incomplete, inadequate, improper and unintended beneficiary designations are common. The reason why there are so few problems from poor beneficiary designations is that deaths are uncommon.

Certificates to plan participants with death benefits indicating the beneficiary to be on *file with the Plan Supervisor* are acceptable but certainly not the ideal. This technique is quite practical, however.

Small death claims by most documents can be paid to persons who appear to the supervisor to be most deserving and needful of the death proceeds.

There are numerous death benefit/beneficiary problems which are mentioned, but beyond the scope of this Guide because they are too rarely seen in practice.

- Benefit payments to legal representatives (estate, guardian, court, e.g.)
- Benefit payments to disallowed beneficiaries (criminal involvement, e.g.)
- Benefit payments to trustees and assignees
- Where participant and beneficiary die simultaneous
- Where there has been a divorce and there are several Mrs. Y's

There are also several legal issues which may come up in practice:

- Unclaimed plan benefits going to the state as abandoned property under the escheat laws
- Paying benefits, contested by several beneficiaries, into a court order by a interpleader action
- Beneficiary declining benefits for tax reasons and filing a disclaimer of interest.

Participant With Unassigned Benefit

Where Participant X submits a \$20 drug bill which he has paid, the benefit check would be sent to X at this last shown address. If Participant X has died, the executor/administrator of X's estate would deposit the check to X's estate.

Benefits must be paid to the proper person. The covered person has the right to assign benefits to a provider; when done, the assignments must be honored.

Parents have the right, by established practice, to assign benefits, due their children, to themselves.

To overlook an assignment can subject the plan to a double liability. This is because the assigned may claim benefits even if the participant has already been paid the benefits.

Usually the provider form will indicate that an assignment of benefits has been made. If assigned and non-assigned expenses are processed on the same day, the non-assigned expenses should be applied toward any applicable deductible before assigned expenses are applied. Additionally, when a plan has first dollar benefits, they should be sued to cover assigned expenses being processed on the same day.

If a valid assignment is presented after the benefits have been allowed, the provider should be notified that the claim was paid prior to receipt of the assignment so the provider may bill the proper party.

Assignments are not to be ignored. Each one received requires some action. Either:

- Honor the assignment in payment
- Inform the provider that benefits have already been paid

- Notify the provider that the assignment has not been properly executed
- Advise the provider the benefits are not payable.

Assignments cannot unilaterally be revoked by the plan. If the plan wishes to withdraw an assignment, the examiner should secure an agreement in writing of the withdrawal from the assignee. If an agreement cannot be reached, a joint check to both parties should be issued.

Legal Options Of The Beneficiary

When a benefit is denied in error there are several unfortunate results to the plan, its sponsor and its supervisor if the Plan Supervisor is shown to have been arbitrary, capricious or grossly negligent in its denial actions:

- Consequential damages
- Economic loss
- Mental distress
- Punitive damages
- Statutory penalties.

Consequential Damages

This is where there is payment as a remedy for an injury which results from a delay in benefit payments. Consequential damages may result from emotional distress, as well as an economic loss, from a benefit settlement delay.

Economic Loss

If the participant had to sell his home at a loss because of the delay in benefit settlement. There might be an award for an economic loss.

Mental Anguish

While difficult to assess, there have been awards made because the participant endured mental anguish.

Punitive Damages

Where the payer was wanton, negligent, fraudulent, malicious, etc. punitive damages, may be assessed.

Statutory Awards

Most state statutes permit participants, if they win, to recover their attorney's fees if such are reasonable as part of their benefit settlement.

Needless to say, the examiner should be careful not to suffer any extra-contractual penalties.

- Be prompt
- Be polite
- Be fair and act as a fiduciary
- Keep good records (memos, letters, etc.)
- Be thorough in investigating
- Rely on adequate legal and medical advice.

Claim Process-Overview

In General

The Employer as Plan Administrator bears the responsibility for the plan's funding and benefit payments. The Plan Administrator hires the Plan supervisor to run the day to day functions of the plan. The Employer's representative who deals with the Plan Supervisor on a regular basis is the Plan Coordinator. The names of these persons are set forth in the Schedule of Benefits of the Plan Document.

Applying For A Claim

Participants give the benefit requests to either the Plan Coordinator or the Plan Supervisor. The Plan Administrator has the final authority for benefit adjudication and processing but delegates this responsibility and authority to the Plan Supervisor. In the event of a legal action the cost of such action is to borne by the Plan Administrator.

Limitations

Benefits are declinable when submitted for payment more than ninety days after incurred; such may be waived by the Plan Administrator or the Plan Supervisor if extenuating circumstances prevented such benefit application being timely made. Rertinent information relative to the benefit must be submitted, if requested, before such benefit will be processed. The adjudication may require written proof of such pertinent facts in order to process the benefit. Such may include medical examination or autopsy; these are done at the plan's expenses however.

Notification Of Decision

When the Plan Supervisor has processes the benefit to the point of payment, it has thirty days to make payment; if not the Plan Supervisor shall give the Beneficiary written notice of a delay explaining the special circumstances for such delay. ERISA claim paying requirement is this-claim must be paid within ninety (90) days of receipt unless delay is due to investigation, etc.

If the benefit is denied written notice of such denial shall be furnished the beneficiary setting forth these items of information:

- Specific reason for denial
- Request for any material fact(s) which would perfect the payment of the benefit
- Reference to specific items in the plan document a Booklet causing such benefit denial
- Explanation of the benefit review procedure.

Benefit Review Procedure

Within a sixty (60) day period after receipt of a benefit denial letter, the beneficiary may appeal the denial by written request. The Plan Supervisor shall fully and fairly review the denial appeal. The beneficiary shall be privileged to see and review pertinent plan documents. The Plan Supervisor shall respond to the appeal denial within sixty days of its receipt.

Confirmations

Introduction

Beneficiaries (including provider-assignees) call in with these questions:

- Is patient a covered person?
- Does plan cover proposed care or treatment?

Most Plan Supervisor's will arrange their confirmation service by having a clerical person assume such responsibility with these tools:

- Computer terminal which gives instant access to covered persons with their effective and termination date, if any.
- Extract of principal plan benefits and provisions of the plans under contract.
- A log to maintain showing dates, originator, participant and employer.
- A standard or *canned* speech to be given to the provider.

Written, follow-up confirmations may be given.

Legal Background

The reader should read *Kanne v. Connecticut General Life Insurance Company*, 893 F.2d 1283 (11th Cir. 1990) and *National Benefits v. Mississippi Methodist Hospital*, 748 F.Supp. 459 (S.D. Miss. 1990).

The Problem

Confirmation process is not a plan function which has the ERISA protection and comfort level. Rather, it is a normal run-of-the-mill commercial transaction. Therefore, state law and state court decisions apply. This is bad news for the Plan Supervisor because the state penalties are harsh, the likelihood of being sued is great, etc.

The Solution

With the confirmation process, do this:

- Take incoming inquiries by phone
- Response may be by phone if urgent
- Always follow-up with written confirmation.

Reasons for this Procedure

Put in reasonable caveats to confirmation which will hold up in court. Honor the provider as an assignee-beneficiary.

Consent To Treatment Statement

Many Plan Supervisors are unaware of how valuable in claim's adjudication the participant's consent to treatment statement may be. Consider the facts:

- Teaching hospital; elaborate regimen of high tech medicine; expenses are substantial.
- Questionable that care is neither medically necessary nor usual and customary nor experimental. It is generally difficult from the UB-92 bill review, hospital reports and hospital notes to clearly substantiate the true nature of treatment.

The solution might be to freeze payments until copies of the signed consent to treatment statement are obtained.

In one instance, upon so requesting, the consent statements revealed the entire treatment by the teaching hospital was under a grant of experimentation by the ABC Drug Laboratory Company, making the claim clearly deniable.

NOTE: One Plan Supervisor spent at least six long, hard months in its efforts to wrest the consent statement from a large and prestigious teaching hospital.

Files And Record Retention

In General

The Plan Supervisor's benefit files are usually open-shelf, with the main division by plan (in plan number order) and the secondary division by participant (in alpha order).

The files are expandable. In each file are the papers subdivided by covered person. In each covered person the benefits are in order by worksheet number with the most current on top. To each worksheet are stapled all of the papers, bills, etc for the worksheet.

The files are usually permitted to give in size without bounds. If the larger, expandable file is filled, a second one is begun.

Reasonable rules to follow when setting up or maintaining the claim file are these:

- Save envelopes only if date is important and not elsewhere available.
- Mark all duplicates as *DUPLICATE*.
- Separate claim alphabetically by covered person, and covered event (injury, hospitalization, e.g.).
- Scotch tape small items of paper (dug bill, e.g.) to regular size piece of paper.

When the plan supervisor loses a self-funded plan, the transition may be handled in one of two ways:

New Plan Supervisor Takes Over All New Claims

With this method, the claims submitted after the termination date, regardless of when they were incurred, are the responsibility of the new plan supervisor. Comments on this method are as follows:

- Employer usually prefers this method because it avoids paying both the new plan supervisor for its work and the old plan supervisor for the runout work.
- Often is done if the employer is hostile to the old plan supervisor.
- Carries with it a significant risk in that responsibility for claims in transit is often unclear.

New Plan Supervisor Takes Over Claims Incurred After Termination Date

The run out claims are the responsibility of the old plan supervisor, the new plan supervisor picks up only claims incurred after the termination date. Comments on this method are as follows:

- While more expensive to the employer (the old supervisor is paid for the run out work and the new supervisor is paid for the current work). The comfort factor of the employer is knowing which supervisor has the responsibility.

Items To Be Furnished to New Plan Supervisor

At minimum, the new plan supervisor should be given the following items of information:

- For each covered person, covered expenses applied towards the deductible and out-of-pocket limitation for the benefit year to date.
- If appropriate, information given to the excess loss carrier (candidates for medical case management, meeting 50% of specific e.g.).
- Current census and/or most recent fixed cost invoice (excess loss premiums, etc.), including COBRA details.
- Copies of any ongoing agreements (drug card, utilization review, e.g.).

Record Retention

The involved parties (old and new plan supervisor and the employer) should carefully contemplate the issue of the retention of records. It is the writers' belief that the interest of all are best served by: (a) the old plan supervisor handles the run out claims, and (b) the old plan supervisor retains the plan records which it created and maintains during its watch. While admittedly such recommended approach is more costly (by some small or modest amount), it is much safer for all concerned.

The following events frequently occur after the termination date which will put the old supervisor on high alert and which will demand that the old supervisor be able to recreate with great precision all of the facts and circumstances surrounding the inquiry:

- Insurance department complaint
- Attorney representing an aggrieved participant relative to a denial of benefit or COBRA matter
- DOL inquiry or audit
- Stop-loss wishing to come on-site for an audit or requesting information on a submitted claim
- Medicare secondary payer program inquiry form HCFA
- Inquiry from the Veterans Administration relative to the plan taking a secondary position; or perhaps denying altogether a benefit involving a VA institution.
- Accountant wishes to do a plan audit at request of employer or the DOL.

Without the complete records, the challenged plan supervisor will be in trouble unless it has all of its records readily available.

As regards to record retention, three authorities should be referenced:

- ***Plan Supervisor Agreement***

Each agreement will vary on records retention but each should speak to the matter.

- ***ERISA §107***

The section is reproduced in its entirety:

Act Sec. 107. Every person subject to a requirement to file any description or report to certify any information therefore under this title or who would be subject to such a requirement but for an exemption or simplified reporting, requirement under section 104(a)(2) or (3) of this title shall maintain records on the matters of which disclosure is required which will provide in sufficient detail the necessary basic information and data from which the documents thus required may be verified, explained or clarified, and check for accuracy and completeness, and shall include vouchers, worksheets, receipts and applicable resolutions, and shall keep such records available for examination for a period of not less than six years after the filing date of the documents based on the information which they contain, or six years after the date on which such documents would have been filed but for an exemption or simplified reporting requirement under section 104(a)(2) or (3).

- ***State TPA License Laws (Applicable in 21 States)***

The typical records retention requirement is reproduced as follows (North Carolina's): Every administrator shall maintain at its principal administrative office for the duration of the service contract and for five years thereafter adequate books and records of all transactions between the administrator, insurer or self-funders and participants. Such books and records shall be maintained in accordance with prudent standards of insurance record keeping. The Commissioner shall have access to such books and records for the purpose of examination, audit and inspection. Any trade secrets contained in such books and records, including, but not limited to the identity and addresses of participants shall be confidential; except the Commission may use such information in any proceeding instituted against the administrator.

The insurer or self-funder shall retain the right to continuing access to such books and records.

In light of the previous demands on the plan supervisor it appears that the best interest of all parties would be served were the old plan supervisor to always retain its records.

There is, however, no obstacle to such records being reproduced (usually at the employer's expense) by the old plan supervisor and such copies being sent to the new plan supervisor.

Record Security

To provide ultimate security to the corporate-claims system these capabilities should be considered:

- Make sure that all data are password protected and that passwords are modified at periodic, but irregular intervals, when an individual having knowledge of the password changes positions, and when a security breach is suspected or identified.
- Provides mechanisms to detect unauthorized users and prohibit access to anyone who does not have an appropriate user ID and password.
- Maintain a multi-level system/user authorization to limit access to system functions, files, databases, tables, and parameters from external and internal sources.
- Maintain updates of user controlled files, databases, tables, parameters, and retain a history of update activity.
- Protect data ownership and integrity from the detailed transaction level to the summary file level.

Further certain audit trails should be set in place:

- The claim as received from the provider of health care services, physician, supplier, or billing service.
- The claim as paid to the provider of health care services, physician, or supplier.
- All adjustments made on the claim.
- The check or the electronic funds transfer record sent to the provider of health care services, physician, or supplier.
- The remittance advice as sent to the provider of health care services, physician, or supplier.

Forms And Proof Of Loss

The examiner receives Submission Forms and proofs of expense in the mail.

- See examples of completed Submission Forms and proofs of expense in the mail.
- See examples of proof of expense:

Hospital Claim	UB-92 (HCFA 1450).
Physicians Claim	HCFA 1500
Prescription Drug	No set form

Each of these proofs of expense and the Submission Form are briefly described.

In General

Two versions of the Submission Form follow:

- Form A. Employer Verification.
- Form B. No Employer Verification.

Benefit processing is expedited when any bill is sent with a Submission Form. The main advantages are: ease of identification, current information on other coverages, employee-supplied details on an accident and current information on dependent's status. Where the employer signs the statement, the Plan supervisor has the best possible information on employment status and whether injury

was work-related or actively-at-work status. Where benefits are assigned and providers file for benefits directly, a submission will not be received – but a request for such completed form may be appropriate. Where a recent form is on file, bills for non-accidents, of small or modest size, or with obvious correlation to known medical conditions, for which bills have been previously filed, may be processed without a Submission Form.

Submission Forms are essential where a current form is not on file or where injury or dependent status is of processing concern.

Required Information

Most of the time the required information is known by the participant and the form is easily completed.

- Employer's name
- Employee's name and Social Security number
- Address information is valuable and picks up new address. This information should be transferred to the Plan Supervisor's basic employee records.
- Of considerable value is the spouse information relative other coverages: name of employer, existence of other coverage and name of other insurers for COB purposes.
- The employee's description of the illness, the date of first treatment and the name and address of the treating physician.
- The employee's description of the accident including time, place and cause as well as whether or not it was work-related.
- When the benefit is for a dependent, such dependent's name, birth date, relationship to insured is required. The dependent's marital status is requested. If the child is over 18, the name of the school attending is requested. If the dependent was employed when benefit incurred, the employer's name and address is requested.

When the participant submits the form by signature, such form serves as release of information authority.

Employer's Statement

Some employers wish to have all benefit submissions pass through their offices before going to the Plan Supervisor for processing. Employer confirmation of employment status, actively-at-work status and whether injury was work-related, will occasionally be helpful in avoiding a benefit processing error. Employer confirmation is not needed when the Plan Supervisor's and the employer work in harmony in recordkeeping and the Plan Supervisor's records are well maintained.

Summary of Purposes of Claim Submission Form

The Submission Form serves these specific purposes:

- Establishes participant's belief of eligibility – both to the participant and the covered person who is the actual claimant.
- Fixes the accident or illness causing the claim.
- Provides participant's consent as to the correctness of the submitted information.

- Provides examiners with a current release of information statement.
- Gives examiner insight into possible subrogation, coordination of benefits or workers compensation exclusion.

Hospital Bill Reviews

The examiner should review the hospital for general reasonableness. If it fails such test it should be audited.

Duration

These are the alert factors for excessive durations:

- Length of stay exceed those certified or in excess of PAS (Professional Activities Standards) Guides if hospital stay was not certified
- Weekend admission rule was violated
- Prolonged (over 45 days) psychiatric stay
- Medical case management was/is appropriate.

Billing Accuracy

The dailies shown in a detailed hospital bill will often indicate billings errors (mechanical in nature, e.g.), irrelevant service codes or similar.

Noncovered Tests

Hospital screening tests, not specifically ordered by the physician are not covered.

Medical Necessity – Admission

These are some instances of a hospitalization which is not medically necessary:

- Diagnostic in nature and which could as well been done outpatient
- Minor surgery normally done outpatient
- Routine exams, physical work-up, e.g.

Benefit Investigations

Introduction

Examiners are to pay all valid benefits as soon as practicable. Usually the process is simple. Often, however, further investigation is needed.

Only pertinent and factual information is sought. To gather such additional information further delays the processing time. This causes hardships and difficulties on all parties. Additional information should be requested only when absolutely necessary.

Examples When Additional Information Is Needed

These are some examples:

- Incomplete claim form
- Conflicting statements on the claim form
- Suspected fraud or foul play
- Itemized bills needed
- Pre-existing condition inquires during contestable period
- Coordination of benefits inquires
- On-the-job injuries and illnesses
- Losses incurred during the contestable period
- Questionable eligibility
- Possible subrogation.

The many sources of additional information are further discussed.

Claimant

The Benefit Submission Form should contain the basic statement of the claimant.

Hospital Records

Hospitals keep complete medical records for every patient. These records usually include the record of admission, history and physician's notes, progress and discharge notes, operative report, and a

summary. This information is valuable in evaluating claims for possible preexisting conditions, questionable diagnoses, and possible over-utilization.

Repeated Similar Accidents

Repeated similar accidents, causing injuries for which there is little objective evidence but predominately subjective complaints, require careful evaluation of extent and duration of disability.

Misnaming Claimant

Submitting all family expenses under one name to take advantage of one deductible. Examiners should routinely check to be certain that charges for each family member are properly identified.

Inconsistent Names and Addresses

Inconsistent names or addresses, difficulty in contacting a claimant or provider by phone or letter. While family surnames and addresses may differ for legitimate reasons (e.g., wife retains maiden name, child resides at school), such differences can also be misused to conceal other coverage. For providers, name and address differences (or use of PO Box without a street address) should be investigated to obtain enough information to validate the credentials of the professional or facility and to explain the differences to the examiners satisfaction.

Retaining an Attorney

Retaining (with exceptional speed) an attorney to reply to a claim denial, as the initial form of appeal. Most individuals will appeal a denial by phone or personal letter before incurring the expense of hiring an attorney.

Summaries of Medical Notes

When requesting additional medical information, try to obtain medical records which contain the original notes, rather than summaries of the patient's history.

Inconsistent Provider Information

Provider billing records can also be helpful in detecting duplicate coverage information. The provider's bill indicate receipt of insurance payments, or completion of insurance forms. If these notations are not consistent with your file, ask the provider to explain.

Over Informative Provider

Provider supplies a deluge of information. When practitioners and facilities respond to the examiner's request for a copy of their licenses with excessive information (multiple pages of educational

background, brochures detailing the success of the facility's special programs, etc.) be aware that this may be an attempt to avoid the issue. For example, multiple academic degrees and the publication of scientific papers do not compensate for the absence of a physician's license.

Duplicate Coverage Not Indicated

With over 60% of female adults now in the labor force, it is very common for a family to have coverage under two or more group plans, most of which contain nonduplication provisions as a method of reducing premium costs, and preventing anyone from profiting from medical expenses. Nevertheless, some may attempt to secure full benefits from several carriers by indicating that no other coverage exists. Familiarity with the group health benefits provided by major employers in your area will help you to identify these situations. When the examiner's plan is allegedly the only carrier, photocopies of bills should be questioned. It is appropriate to request original bills from the claimant and to listen to or review carefully the response, if the claimant indicates he/she cannot or will not provide them.

Large Unassigned Bills

Large unassigned bills, especially where there is no indication of other coverage. The participant may have attempted to conceal eligibility for benefits in order to obtain *clean* bills to submit to several insurance carriers. Over time, this has been found to be the most common characteristic of many types of fraudulent claim activity. Most participants are not in the financial position to pay large medical bills on a cash basis at the time service is rendered. Since most providers of service require some evidence of ability to pay, the examiner should expect to see evidence that the charges had paid, or that the provider had secured an authorization for direct payment benefits. When a very large unassigned bill or several moderately large unassigned bills are received for a single participant or several family members, it may be appropriate to send a letter to the provider requesting confirmation of date(s) and type(s) of service, the charge for the service(s), and the status of the patient account (whether the charges have been paid, or the provider is holding an authorization).

For large unassigned bills, benefit payment should be withheld, and a delay notice sent, until the provider has replied to the confirmation letter.

It is good practice to utilize a provider confirmation letter:

- *Always* - when the provider's receipt does not show the patient's full name.
- *Periodically* - when there are multiple similar charges over a long period of time.

Altered Bills

Most fraudulent situations involve repeated submission of the same types of charges. Although alterations of any bill or claim form warrant investigation, services listed on a physician's monthly patient billing statement and drug bills are commonly found to be most susceptible to alteration. A digit may be added to drug charge, or the charges altered to a monthly statement easily. To a participant, the result of changing a %3.50 charge into a \$13.50 charge may be viewed as *profit* rather than criminal gains. Yet thousands of dollars have been illegally secured in this manner. Dollar amounts in different type-face or handwriting, or different colored inks are the most obvious indications of this type of activity. Checking total charges can also be revealing. Keep in mind that pharmacists use a consecutive numbering system when filling new prescriptions. When many prescription numbers are listed on a bill, a sudden change

from a series of numbers beginning with 65-XXX, written in black ink, to a group of non-consecutive numbers in blue ink, is reasonable cause for confirming the charges with the pharmacist.

Benefits Not Filed Timely

Late claims are expensive; records may have been stored; information is not readily retrievable, e.g.

Benefits Are Not Covered

Experimental, custodial, e.g.

Non-Occupational

Plans may (1) workers compensation excluded or (2) non-occupational.

Subrogation

The resolution of subrogation-related benefit is difficult. The *spotting* of a potential subrogatable benefit may be difficult also.

Prescription Drugs

Particularly difficult to control are costs with prescription drug cards. In monitoring abuse, care should be given to these reports:

- Drug costs by participant
- Frequent *refillers*
- Participant with high number of prescriptions
- *Exceptional* drug reports (drug abuse)
- Illegal card use.

Physician Charges

There are many areas of potential abuse which must be monitored.

- Physicians with excessive charges
- Physician benefit assignments in error
- Physician duplicate billing
- Physicians in group practice double billing
- Physician admission on weekends
- Physician over testing claiming defensive medicine.

Liens

Introduction

Kinds of Liens. A lien is a claim which one person has upon the property of another as a security for some debt or charge. It is a charge imposed upon specific property by which it is made security for the performance of an act.

Hospital, Medical and Nursing Liens. Some states have statutes providing liens in favor of hospitals (and in some for doctors and nurses) for services rendered to patients. The theory of these liens is to encourage emergency service to injured persons, and any of the statutes limit application to person injured in an accident involving a third party. If benefits are payable for a bill in connection with which the examiner receives a notice of hospital, medical or nursing lien the examiner should comply with the terms of the notice or lien, up to the amount of the bill or benefit maximum, whichever is less.

Medical Assistance Program Liens. Some states have enacted statutes providing subrogation rights and /or liens in favor of medical assistance to persons with private health care coverage. The purpose of these liens is to permit direct reimbursement to the program for public assistance benefits intended to be solely and adjunct to private health insurance. If benefits are payable for an expense in connection with which the examiner receives a notice of medical assistance program lien, the examiner should comply with the terms of the notice or lien, up to the amount of the expense or benefit maximum, whichever is less.

Attorney's Lien. An attorney who represents a claimant or third party automatically requires a lien up to the amount of the fee against the amount of benefits recovered in consequence of professional services, by either statute or common law. In matters not heard before a court or referee(s), and therefore not subject to the jurisdiction of an outside authority, the purpose of the attorney's lien against the amount so recovered. For this reason, in claims not involving lawsuits or disability benefit hearings or appeals, it is essential that all benefit drafts issued in settlement of a claim in which an attorney represents the covered person, whether issued to the insured, to an assignee or to a direct payee, be mailed to the attorney and not to the payee. In claims not involving lawsuits and hearings or appeals in which an attorney represents an assignee, benefit drafts issued to that assignee should be mailed to the attorney.

Carrier Lien. In some disability benefit law jurisdictions, New York for example, after the plan has paid disability benefits to a covered person in connection with a disability for which it may later recover Workers' Compensation benefits, employer's liability or a judgment or settlement from a third party responsible for causing the disability, there is a statutory lien upon the proceeds of such recovery, up to the amount of disability benefits paid, after necessary expenses incurred by the covered person in effecting such recovery have been deducted. In these situations, it is incumbent upon the plan to give timely notice with claim for reimbursement of benefits paid, to all parties in interest, including the proper statutory authority.

Settlement of Lien

In those situations where the plan filed an official lien requesting recovery of benefits it has paid on a claim involving Workers' Compensation, subrogation or state statutory disability benefits, the plan is sometimes requested to accept less than the amount due as full settlement. Some examples of

circumstances giving rise to possible settlement would be a request by the insured's attorney to reduce the amount of the lien because of hardship, or a request by participant's attorney for a fee for collecting the lien, or settlement by the insured with the other carrier for less than the amount of the lien.

Tax Liens

A District Director of the Internal Revenue Service may send a Notice of Lien (or Levy) against a tax delinquent who is presumed to be covered by the plan and who may have benefits presently pending or may submit one at some future time. The Internal Revenue Service Tax Lien applies to benefits due and payable to the taxpayer at the time the Notice is received, in an amount not exceeding the tax delinquency. It does not apply to benefits due at a future time. Plan benefits become due when the covered loss is incurred. Benefits due the participant by virtue of loss of time and/or incurring of covered medical expenses on or before the date on which the Internal Revenue Service Notice is received are subject to the Lien, benefits accruing thereafter are not.

Punitive Damages

In General – Insured Plans

With fully insured plans, the examiner must be alert to several serious legal consequences which may occur when a claim is mishandled.

- Punitive damages
- Breach of privacy.

Punitive Damages

Punitive damages may take any of these (3) forms:

Compensatory Damages. A breach takes place if it is determined that a plan wrongfully withheld benefits due on a claim. The term, compensatory damages, refers to an award made by the court in an amount equal to the amount of benefits withheld plus any interest which may have accrued from either the date of loss or date of claim. This amount is usually determined in accordance with the terms of the plan.

Extracontractual Liability. In recent years, under some circumstances courts of certain states such as California, Arizona and Alabama have awarded the claimant amounts additional to the amount payable under the plan provisions. Such amounts are termed extracontractual and fall into three categories.

Consequential Damages. When a delay in receiving benefits for a loss has been the direct cause of further loss to a claimant, consequential damages may be awarded. When such a loss is claimed, it must be demonstrated that the reasons for the delay were not proper. Examples of circumstances which may lead to an award of consequential damages would include:

- The claimant who suffers economic loss through the sale of property in order to pay medical bills that would have been covered under the plan
- The claimant who suffers mental distress through the stressful situations created by a delay or refusal to pay benefits.

Punitive Damages (Exemplary Damages). If a claimant suffers economic loss or mental anguish due to a delay or denial of a claim and it can be proven that the claims administrator or insurer acted in bad faith, punitive damages may be awarded. Bad faith can be defined as unfair or unreasonable handling of a claim.

Statutory Penalties. Most states allow successful plaintiffs to recover attorney fees from the defendant. Some states also assess insurers for punitive damages. These are amounts designated by the state to punish the company.

Recovery of Mispaid Claims

In General

The general question is this: plan (TPA, insurer, or similar) mispays a claim; upon discovery, it seeks a refund, or restitution. What are the conditions under which such restitution is legally proper?

In the discussion, ancillary issues are ignored. These would include: subrogation, definitions, questions of claim process etc.

General Rule

At heart of the matter rest the theory of *unjust enrichment*.

- Where the mispayment was due to a mistake of fact the plan would be eligible for recovery from the provider. This is the case even if the mistake were due to lack of care.
- If the provider has changed its position so as to make it unfair to repay, such repayment is not required.
- If not having the facts was due to the plan's error, recovery will be denied.
- Generally, a mispayment cannot be recovered if any or all of these condition are met:
 1. Money voluntarily paid
 2. No duress, fraud or compulsion was exerted
 3. Plan had full knowledge of all facts
 4. Beneficiary did not act improperly
 5. Unjust enrichment is not present
 6. Beneficiary would be hurt unfairly if repayment were made.

Repayment Rules

Basic Rule

If Plan makes a payment in the erroneous belief, induced by a mistake of fact, that the terms of the insurance contract required such payment it is entitled to recovery.

Plans Lack of Care Will Not Prevent Recovery

If the plan made the error set forth above due to its lack of care, it still entitled to recovery.

Provider Had a Chance of Position

Recovery is not permitted if the provider has relied upon the correctness of the payment and the refund would place it in an unfair position. The refund must not be inequitable or unjust to the provider.

Mistake v. Uncertainty

Plan is uncertain as to the payment but made the payment anyway – Which later develops to be a mistake. Because the plan did not do its homework, it is denied recovery.

Plan pays benefit to provider hospital believing it to be the assignee. It is not but since it is owed the money by the participant, it may keep the money and refuse to refund it to the plan.

Particular Errors Considered

Unspecified. Arithmetic errors would be reversible, if other conditions met.

Extent of Overpayment. Hospital bill was \$20,000 to be covered by plan's assigned benefits of %14,000. Plan is error paid 523, 000. Hospital refunded \$3,000 on ground of unjust enrichment, but the \$6,000 overpayment could be kept by the hospital on ground of change of position.

Nature of Accident or Illness. Where the true nature of the illness, accident, etc. was an honest mistake, recovery is not predictable because the case law is widely divergent.

Relevant Court Decisions

Plan, in error, overpaid the hospital. Since the hospital was due the money anyway, the error was totally that of the plan, hospital received the money in good faith and without the knowledge of the error, the Court held that the hospital did not have to return the money.

Plan paid his benefit checks which were intercepted, forged and cashed by the Participant's estranged wife. Court said that plan would have to pay Participant again, thereby having to pay twice. The only course open to the plan was to seek recovery from his estranged spouse.

Plan paid money to provider in error. Provider refunded the overpayment error. Estate, representing the deceased participant, sued the plan for such error and overpayment. Their argument was that the plan's inexcusable error constituted a waiver of its rights to the denial due to pre-existing; their interest in the matter arose from the fact that if the plan did not pay, it would have to pay. Court held that the principles of waiver and estoppel may not be applied to expand the plan's benefits. The estate may not be unjustly enriched by the plan's error.

Plan, in error, paid a hospital for a pre-existing condition. Upon discovery, hospital refunded the money and sought payment from the participant. Participant sued claiming that plan's payment constituted a waiver of its known right which would estop it from denying liability. Court held otherwise stating that plan's benefits could not be expended nor could it permit the participant to be unjustly enriched.

Plan, in error, overpaid a hospital. Hospital refused to refund the overpayment claiming that the one causing the loss must bear the loss. Offsetting this rule is the rule against unjust enrichment.

Several questions need to be addressed:

- Did the hospital materially change its position as a result of the overpayment? That is, did the overpayment cause hospital to act in any manner differently than it otherwise might have? If so restitutions by the plan would be denied.
- Did the mistake occur 100% at the hand of the insurer? If so restitution may be denied.

The court held against restitution.

Any overpayments will be deducted from future benefits.

Recovery Of Overpayments

Introduction

When an overpayment is discovered, restitution is required – if possible.

Overpayment to Claimant. A letter requesting repayment should be sent to the claimant. No further payments should be made pending recovery. If repayment is refused, any of these courses of action are possible:

- Ask participant to assign any future benefits to the Plan
- Write the overpayment off as a bad debt.

The facts/circumstances of each case will determine the appropriate course of action.

Overpayment to a Provider. Normally, a provider will refund an overpayment as a routine business matter.

Hospital Bill Recovery Firms

These firms are hired by hospitals to audit such hospital's bills and find lost (never billed or under-billed) charges and then re-bill insurers, plans, or patients for the under-billed portion. There are currently estimated to be 35 of such hospital revenue recovery firms around the country, mostly small and local. They have no Federal or state oversight or regulation, though the U.S. Senate Permanent Subcommittee on Investigations is looking into the possibility for abuse in the new industry.

The revenue recovery firms are paid on a contingency basis, splitting the recovery either the hospital, (the large firm in the example, above, earned \$23 million in annual revenues). There is an incentive for the revenue recovery firms to inflate the amount of billable undercharges discovered, or have informal quotas as which auditors (mostly nurses and former hospital records personnel) are expected to uncover and bill. Also, Some firms apparently send their extra billing on hospital stationery and do not disclose their own identity or involvement.

The growth pressure on this industry comes from two major sources. First, hospitals have seen their profit margins squeezed in recent years by Medicare and other cutbacks. Second, the increasing use by insurers of hospital audits to discover over-billings showed that the reverse was possible.

Medical Records

Introduction

Physicians become irate when they are asked to dig up records for claims/underwriting purposes. Since medical records are the property of the patient, the physician is obligated, with a proper release, to provide such records. However, under medical code of ethics, the physician may charge for them. When the physician is expected to give up the records *for free*, the physician *sees red*.

Response of the Irate Physician

Consider two examples:

- Letter No. 1

I am returning your request for medical information about one of my patients. We give patients *Superbills* at the time of service. They contain all the information needed for any claim. When a plan wants further information, I charge for the time it takes me and my staff to prepare the response.

The charges are:

- \$15- if the plan is courteous enough to send a blank check or offer to pay for my services.
- \$20- the plan does not offer to pay but sends a self-addressed stamped envelope.
- \$25- if the plan neither offers to pay nor sends a stamped return envelope with its request.

In your case, the charge is \$ _____.

If you still desire the information you've requested, return your request with a check, envelope, and signed authorization from the patient to release the information.

- Letter No. 2

Your plan has asked me to send it a copy of your child's medical records. I'm sure it wants this to help it decide whether or not to pay you for a claim you have made. I must furnish this information or the plan will automatically deny any payment you are due.

Most ethical plans pay doctors a small fee to cover the expense of doing this, but your particular plan refuses to do so.

A plan that cuts corners like this usually looks for any loophole it can find to deny payments to you. So use caution in your dealings with it.

I don't charge parents for such records, so I am sending the requested copies to you. I suggest that you send this letter along with the copies to plan sponsor.

Self-Funded Plan's Reaction to this Physician Attitude

Basically the Plan Supervisor can ignore it or respond to it. There are compelling reasons as to why the TPA should respond to it:

- With the family of court cases making the provider-assignee a beneficiary, the need for the physician and the Plan Supervisors to be non-adversarial is of added importance.
- As managed care develops Plan Supervisor become most useful.
- Because of the community closeness between the employer and the physicians, needless *noise* should be avoided.

How Should the Plan Supervisor Act? This suggestion is offered: Write a nicely- worded hat-in-the-hand request with a postscript stating that a \$X check is enclosed to help defray the physician's cost of providing the record. The participant should be copied. Over the long run it should cost somewhat more because the \$X is needless in many instances but a bill for a larger amount will be avoided in other instances. On balance, the good physician relations should be scarcely noticeable when billed back to the employer.

Staffing And Training

In General

Much of the success of the Plan Supervisor's benefit administration rests on the quality of the staffing and training.

A very important point needs to be made:

While benefit administration is complex, it won't work to reason that only *highly trained and well educated* and *keen minds are needed*. Rather it is the goal of the Plan Supervisor to reduce the complexities to such *small bit-like chores* that people of average training and intellect and education can do the work. In brief, two ingredients are essential:

- Reduce work to simple steps
- Train people of average intellect by on-the-job and classroom methods.

Staffing

In benefit administration staffing, the following guidelines will prove to be helpful.

- Expect a trained examiner being able to handle approximately 1800 employee participants representing approximately 15 plans of similar complexity. Untrained examiners will do less; plans with varying benefits/provisions add to work time.
- Expect one supervisor for each three examiners; each trained examiner should be paired with a junior or untrained examiner where practicable.
- Clerical support will provide these functions:
 1. Confirmation of benefits and coverage
 2. Mail receipt, sorting, matched with files and give to examiners for processing.
 3. Maintaining pending files
 4. Mailing correspondence, claim checks, etc.

One clerical person is needed to support each three examiners.

- The supervisor should be able to perform these functions:
 1. Check the work of three examiners
 2. Do the excess loss claim filing of plans supervised
 3. Assist with larger or difficult benefits
 4. Do the late applicant underwriting.

The expectations set forth above presuppose that only a few of the plans have either dental or disability, are relatively standard as to benefits and provisions, have a few of the basic cost containment programs (second opinions, ambulatory surgery and preadmission constraints, e.g.) and are processed by use of hand-prepared worksheets.

Where available, persons with some medical background are preferred (nursing school graduates or persons with work experience in hospitals and clinics are examples). Such persons are readily

promotable. The Plan Supervisor should arrange the staffing so that persons of intelligence, without prior medical experience, can learn the work quickly.

Training

Even with an experience examiner, training is needed.

- With an experienced examiner, the time to train will be dramatically reduced – but offset by the need to *untrain* some past errors, etc.
- With a trainee knowledgeable in medical administration, the time to train will be shortened.
- Any person, with good sense and education level who demonstrates the ability to learn should be trainable as an examiner within several months. That is, function as junior examiner paying 25-35 claims per day with a tolerable number of errors, found by senior examiner review.
- In training a person to be an examiner, a Training Guide is an excellent training tool.

Work Discipline

There are several work disciplines which may be considered by the Plan Supervisor regarding the examiner.

Mother's Hours. The examiner comes in at 9:00 a.m., e.g. and leaves at 2:30 p.m. with a short (15 minute) lunch break.

Flex-Time. The examiner comes in at 7:30 a.m. (as opposed to 8:30 a.m.) and leaves at 3:45 p.m. (as opposed to 5:00 p.m.) with a short (30 minute) lunch break.

Cottage Work. The examiner comes in Tuesday a.m. and picks up a box of work which is taken home and done. The box is returned with all worksheets prepared by Thursday p.m.

Reduced pay to the examiner results with the mother's hours and cottage work but an obvious increased quality in life for the examiner.

Examiner functions are restricted with cottage work because of inability to communicate with the providers and covered persons while at home. The examiner doing cottage work will have some, but not all of the reference books. An occasional telephone call because of lack of all of the books and an occasional trip to the office to get more facts, forms etc, may be expected.

Status Communications

When a claim is delayed for any reason (pre-existing, subrogation, late applicant underwriting, review by senior examiner coordination of benefits, etc.) it is good claim handling practice to notify the participant and the assignee-provider of such delay. Such notification eases the tension for the employee, the provider, the employer and, of course, the plan supervisor.

Work Tools

The following are the examiner's tools needed to process health claims.

Required

- **Supportive Texts**

1. Self-funding of Health Care Benefits
2. Physicians Fee Reference (UCR charge guidelines)
3. Dental Fee Reference (UCR charge guidelines)
4. Late Applicant Underwriting Guide
5. Medical Terminology Guide
6. Claims Examiner Training Guide

- Reference Books

Either one or all of these books:

1. Medical Dictionary (26th Edition)
W.B. Saunders Company
Philadelphia, Pennsylvania
 2. Taber's Cyclopedic Medical Dictionary (9th Edition)
F.A. Davis Company
Philadelphia, Pennsylvania
 3. The Merck Manual (15th Edition)
Merck, Sharpe & Dohme Research Laboratories
Rahway, New Jersey
- International classification of Diseases (9th Revision)
Volumes 1,2, and 3, ICD-9-CM
Post Office Box 971
Ann Arbor, Michigan
 - Current Procedure Terminology (4th Edition)
Referred to as CPT-4
American Medical Association
Post Office Box 10946
Chicago, Illinois 60610-0946

Other Optional Books of Help And Value

- Dentistry and Dental Claims
International Claims Association
C/o Life Office Management Association
5770 Powers Ferry Road
Atlanta, Georgia 30327

- *Physicians' Desk Reference*
Medical Economics Company, Inc.
Oradell, New Jersey 07649
- *Nurse Review*
Spring House Corporation
Springhouse, Pennsylvania 19477
- *The Human Body*
International Claims Association
c/o Life Office Management association
5770 Powers Ferry Road
Atlanta, Georgia 30327
- *Length of Stay by Diagnosis and Operation*
Committee on Professional and Hospital Activities
Post Office Box 1809
Ann Arbor, Michigan 48106

Waiver Of Deductible By Provider

In General. The issue is this: is it proper that the provider waive the copayment and deductible thereby accepting the plan benefit as full payment with an assignment? The provider would argue that the practice is sound and proper in that the end result is in the public good. The response is that this billing practice is fraudulent unless such is fully disclosed to all parties concerned. Numerous court decisions support the condemnation of the practice as fraudulent. As medical practice becomes more competitive, the fraudulent practice of waiving the copayment and deductible will increase in significance. Some providers are even advertising that they will do a waiver as an inducement to increase their practices; they also refer to it as *free* coverage.

In view of the consistent and stern court responses, the plans should increase their efforts to identify such waiver practices and respond accordingly. The response, of course, is that where such practice is found, no plan benefits are payable.

Proper Claim Handling. Presume that the provider agrees to waive the deductible and copayment, and accordingly submits a bill for \$100; the deductible of \$20 will be waived. This establishes that the adjusted eligible charges are \$80. Since the 20% of \$16 is waived, the adjusted eligible charges become \$64. This logic is carved down to where the plan owes nothing. This is an unexpected result to the provider but entirely consistent with the existing court decisions and plan language.

Legal Background. As cited earlier, numerous courts have held that the waiver practice is a fraudulent and deceptive practice. The anti-waiver practice does not constitute restraint of trade or price fixing. Where advertised and where postal service is used, such practice may well constitute a violation of the RICO (racketeering) statute. Several states have stated by law, that such practice is illegal. Further, several states have attorney general opinions which forbid such waiver practices. The American Dental Association has addressed the waiver issue and found it to be in violation of their Principals of Ethics and Code of Professional Conduct.

ERISA-Related

In General

Most participants have no real involvement with ERISA rules until they file a claim. Such involvement must be handled skillfully. When congress enacted ERISA, it carefully dealt with the matter of claims denial. The Regulations for detailed procedures are set forth in the last section of this Chapter.

ERISA claims procedures are, for the most part, a blessing to Plan Supervisor and the employer. The reason is that it clearly states that the claims process is a fiduciary one and that disputes are to follow a denial procedure which reduces state insurance department complaints, filings in state courts and punitive damage awards.

Fiduciary Responsibility

As used in herein, fiduciary means the Plan Supervisor and employer (or plan sponsor) and represented by the plan administrator as equal or co-fiduciaries. The Plan Supervisor is also an extension of and substitute for the plan administrator.

In General

ERISA not only regulates the handling and disposition of claims, but also brings the handling of claims within the scope of fiduciary conduct. Congress intended the plan fiduciary to have principal responsibility for claims processing.

Implicit in the standard for fiduciary responsibilities set forth under ERISA is the duty of fiduciaries to take the initiative to cause reasonably available evidence bearing on a participant's claim to be developed and considered in the decision-making process. Failure to develop available evidence regarding a claim, aside from undermining the actual claim decision, may also be a breach of fiduciary duty. In addition, the absence of a clear record for a claim denial subjects any claim denial to the charge that the decision was arbitrary and capricious – the standard by which the courts review the benefit eligibility determinations of plan fiduciaries. Thus, Plan Supervisors of plan covered by ERISA – if they are fiduciaries – must comply with the procedural requirements of the statute and the regulations for handling ERISA claims.

The Law – ERISA

The statutory provisions dealing with claims procedures focus on claim denial. ERISA provides that every employee benefit plan, in accordance with regulations prescribed by the Secretary of Labor, must satisfy the following requirements:

1. Provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant.

2. Afford a reasonable opportunity to any participant whose claim for benefits has been denied for a fully and fair review by the appropriate named fiduciary of the decision denying the claim.

Regulations

Under the regulations contained in this Chapter, the principal test of a claims procedure is that it must be *reasonable*. Whether a plan's claims procedure is *reasonable* is determined by its satisfaction of the requirements set out in the regulations. Under the regulations, a claims procedure may neither contain any provision, nor be administered in any way, that unduly inhibits or hampers the initiation or processing of a claim. The regulations also require that the participant be notified of the claims procedure at a minimum through the plan booklet.

In addition to these basic requirements, the essential elements of a reasonable claims procedure include provision dealing with claim filing, claim processing, and claim denial, as well as review of claim denial.

Claim Filing. The regulations permit a plan to establish any reasonable requirements for filing a claim. Therefore, it often is the plan administrators normal procedures that determine the specifics of the initial claim filing. However, two elements are critical. The claim filing procedure should require first that all claims be in writing and second that they be filed with a definite person or office. If the claims procedure does not contain these filing requirements, the regulations provide that a claim will be deemed filed under circumstances that may never bring the claim to the attention of the responsible persons. A claim will be deemed filed when a written or oral communication is made by the participant or his authorized representative that is reasonably calculated to bring the claim to the attention of the customary organizational unit or any officer of the *plan administrator* or the Plan Supervisor.

Claims Processing. In the area of claims processing, the regulations also do not provide substantive restrictions on the procedures adopted by the *plan administrator*. Thus, the procedures can be designed to best suit the *plan administrator's* operations. These procedures should have two major purposes.

- I. The claim processing procedures should ensure that the persons deciding the claim have and consider all relevant information concerning (a) the terms of the plan, (b) the facts of the particular case, and (c) the manner in which similar claims were resolved. It should be noted, however, that the *plan administrator* is not necessarily required to disclose to a participant information concerning other participants' claims or benefits.
- II. The procedures should ensure that a written record is established that later can be presented to demonstrate that, from a procedural standpoint, the claim was handled fairly. While it is impossible to state at what point failure to follow procedures begins to undermine the substantive decision, if litigation should arise over a claim, a court's discretionary decision on the substantive merits of a claim is likely to be influenced by glaring failures to accord a claim fair procedural treatment.

Claim Denial. The regulations do provide detailed requirements where a claim is denied. Under the regulations, a claim is considered denied if all or any part of the claim is not granted. The regulations require that a participant receive a written notice of the whole or partial denial within 90 days (subject to extension where prior written notice is given) after the claim is received. In understandable language, the denial must state (a) the specific reasons for the denial, (b) the plan provisions on which the denial is based, (c) a description of

anything necessary to perfect the claim and an explanation of why it is necessary and (d) information necessary to have the claim denial reviewed.

Review of Denial. The written denial of any claim must also inform the participant of the plan's review procedure for denied claims. Under the regulations, the participant must have at least 60 days to file for review. In addition, the participant must be allowed to review pertinent documents and to submit a statement containing the issues and the participant's comments on those issues. The regulations do not require, however, that a participant or his representative be permitted to appear personally before the reviewer. The regulations provide that within 60 days of the receipt of a request for review (subject to extension in certain circumstances), the participant must be given a written decision of the review of the claim. The decision must (a) be written in an understandable manner, (b) give reasons for the decision, and (c) refer to the plan provisions on which the decision is based. Failure to render a decision within the appropriate time period will be deemed a denial of the claim.

Legal Action

In General. ERISA does not expressly require a participant to exhaust his remedies before filing legal action. ERISA gives a participant the right to file a legal action to enforce the provisions of the plan without mentioning any exhaustion requirements.

The federal courts have generally held that ERISA requires the exhaustion of plan administrative grievance procedures before a participant files a judicial action for benefits under the terms of a plan. The exhaustion requirement dovetails with the arbitrary and capricious standard by which courts review the benefit eligibility determinations of plan fiduciaries. Under this standard, a plan administrator's interpretation and application of a plan must be sustained unless it is arbitrary, capricious, or in bad faith. Such a determination requires a review both of the evidence before the plan administrator and the plan administrator's handling of the claim. Thus, without exhaustion, there would be nothing for a court to review.

Exceptions to Exhaustion Rule. There are some exceptions to the exhaustion rule.

- III. For instance, if a participant is denied meaningful access to the claims procedure, exhaustion will not be required.
- IV. A participant will not be required to exhaust his plan remedies, if he can show that it would be futile to use the claims procedures.
- V. Another justification for not using the exhaustion rules is a showing by a participant that he will suffer irreparable harm that either is job-related or will affect the exercise of employee rights under ERISA.
- VI. Inadequacies in the claims procedures themselves may not excuse exhaustion.
- VII. Exhaustion was excused due to procedural inadequacies in a case where a participant received improper notice.

Protected Rights. Must a participant first exhaust his administrative remedies when filing an action under ERISA that alleges interference with so-called protected rights? ERISA provides that it shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan. On this issue there is no clear answer as yet.

ERISA Appeal Procedures

ERISA Denial

A benefit denial is appropriate where the possibility exists that the covered person will believe such benefit is payable. Normal applications of deductions, out-of-pocket limitations, maximums and coordination of benefits will not normally be deemed a denial; application of rules relative preexisting, definition, exclusions and covered expenses will normally be deemed a denial. Best rule is - if in doubt, do a denial letter.

The examiner should follow these rules before beginning the ERISA denial procedure:

- Be certain all sources of evidence and documentation having a bearing on the benefit have been exhausted.
- Do whatever investigation and examination is needed to properly evaluate the benefit.
- Deal with written evidence (affidavits are particularly helpful) and not oral opinions.
- Be sure of complete proof and evidence.
- Be sure to follow plan supervisors' rules regarding reviews by supervisor, medical doctor or attorney.
- Always anticipate a complaint, a response or possibly a lawsuit.

ERISA Appeal

ERISA sets forth specific benefit appeal procedures. Examiners should be familiar with these.

Appendix

ERISA requires that specific reasons be provided to the participant in writing when a claim is wholly or partially denied. Reference must be made to the specific plan provision upon which the denial is based. An explanation must be included in any additional information which would, if available, to allow reconsideration of the claim. The denial must state the method by which the employee may request a review of the denial. A participant must request such review in writing within sixty (60) days of the date the denial is received. The participant has the right to review pertinent plan documents and submit issues and comments in writing.

Defensive Benefit Administration

Defensive benefit administration, as with defensive driving is the *only way to go*. A simple checklist of defensive benefit administration follows:

1. Identify the potential problem
Staff absences or turnover
Changes in systems
Rapid growth.
2. Evaluate the problem
Consider the potential for errors with untrained staff, new systems and trying to do too much.
3. Implement Controls
Be somewhat overstaffed, require work of service people to be checked, say not to a new plan, phase in new systems as slowly as possible.
4. Monitor Results
Follow up with Plan Supervisor-initiated internal audits.

Some specific examples of defensive administration are as follows:

- Written transcript of telephone calls
- Discipline against special exceptions; keep the plan as standard as possible
- Records kept of employment and coverage verification
- Restricting payment authority of junior examiners
- Take time for staff training
- No exceptions without specific management approval in writing
- Make work as structured as possible; keep adequate staff – especially at entry level
- Seek legal advice frequently – not rarely.

Assessment Of Claims Administrator's Exposure To Errors

The assessment process consists of these steps:

- Identification of Potential Exposure

What is time lag from when participant terminates for coverage and is known as so-terminated by the examiner? Are accurate records kept of persons on leave or disabled (i.e., not actively at work) but show on the Plan Supervisor's records as an active participant? Are COBRA paid-to-dates being accurately reflected? When Plan Supervisor has personnel or system changes, will anything *fall between the cracks*? Is the Plan Supervisor growing too rapidly to efficiently and carefully maintain high standards?

- Evaluate the Expenses

The Plan Supervisor should think creatively so as *price out* the expenses. A correction may be more trouble than it is worth.

- Implementation

To the extent possible or practical, the Plan Supervisor should attempt to correct the problems, if any, to reduce exposure.

There are several practical examples which may be reviewed:

- Improve on documentation – telephone calls, e.g.
- Be honest, accurate, fearless in telling employees of their risks and obligations.
- Be careful to verify benefits accurately and keep a telephone log. Some Plan Supervisor's make this a special function.
- Satisfy authority level for claims. Newer examiners have lower authority limits, e.g.
- Take the time and effort and do staff training.
- Review the Plan Supervisor's security measures: Theft, fire, computer breakdown, power failure, loss of personnel, e.g.
- Always be slightly *overstaffed* and *not* slightly *understaffed*.
- Have access to competent legal advice. Those Plan Supervisor's with an on-site attorney have a competitive edge over those which do not.

Benefit Administration Philosophy

The examiner is to pay promptly those benefits clearly due; reject promptly but courteously those not due; investigate thoroughly those which are marginal being fair to the participant, the employer and the provider as possible.

The following principles of benefit administration should be followed:

Any individual who has, or believes he or she has, a benefit is entitled to courteous, fair, and just treatment; and shall receive with reasonable promptness, an acknowledgement of any communications with respect to his claim.

Every participant is entitled to prompt investigation of all pertinent facts, an objective evaluation, and the fair and equitable settlement of his benefit as soon as liability has become reasonably clear.

Participants are to be treated equally and without considerations other than those dictated by the provisions of their plans.

Participants shall not be compelled to institute unnecessary litigation in order to recover amounts due, nor shall the failure to settle a benefit under one plan or portion of a plan be used to influence settlement under another plan or portion of a plan.

Recognizing the obligation to pay promptly all just benefits, there is an equal obligation to protect the plan from increased costs due to fraudulent or nonmeritorious benefits.

Procedures and practices shall be established to prevent misrepresentation of pertinent facts or plan provisions to avoid unfair advantage by reason of superior knowledge, and to maintain accurate records as privileged and confidential.

Reasonable standards shall be implemented to provide for adequate personnel, systems and procedures to effectively service benefits. These standards shall be such as to eliminate unnecessary delays or requirements, and excessive appraisals or examinations. Benefit personnel shall be encouraged and assisted in further developing their knowledge, expertise, and professionalism in the field of benefit administration.

Claim Practices To Avoid

The following outline sets forth a broad range of claims practices which by both case and statutory law as well as general concerns are deemed to be unacceptable.

I. Assisting the Beneficiary

A. Communications in general

1. Failing to make an appropriate reply to all pertinent communications which reasonably suggest that a response is expected, within ten working days.
2. Failing to provide the beneficiary with a toll-free or collect telephone number of the plan supervisor handling the benefit
3. Failing to write in easy-to-read and understandable terms

B. Acknowledging notice of claim

1. Failing to acknowledge receipt of notification of a benefit within ten working days, unless payment is made within the period of time

C. Notification of need for more time

1. If more than ten working days is needed to determine whether a benefit should be accepted or denied, failing to notify the beneficiary within ten working days after receipt of the proofs of loss giving the reasons more time is needed, and failing to continue to provide letters every 30 working days setting forth the reasons additional time is needed for the investigation
2. Failing to send the beneficiary written notice by the end of 30 calendar days, if the benefit has not been paid, stating the reasons additional time is needed

D. Limitations of actions

1. Misleading a beneficiary as to the applicable statutes of limitations

E. Assisting beneficiary with documents

1. Upon receiving notification of benefit, failing to provide necessary forms, instructions and reasonable assistance within ten working days, so that first party beneficiaries can comply with the policy conditions and the plan supervisor's reasonable requirements
2. When a beneficiary does not submit sufficient information to establish entitlement, failing to provide the beneficiary with a general description of the information and documentation needed to establish entitlement to the benefits claimed
3. When it is apparent that additional benefits would be payable upon receipt of additional proof of loss, failing to communicate to and cooperate with the participant determining the extent of liability

F. Requiring improper documentation

1. Delaying the investigation or payments of benefits by requiring a participant, beneficiary or the provider of either to submit a preliminary benefit report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information

2. Requiring additional physicians' reports to substantiate disability which has already been established by a prior report
3. Demanding information which would not affect the payment of the benefits

G. Imposing improper time limits on submission of documents

1. In the absence of a time limit specified in the plan documents making statements, written or otherwise, which require a beneficiary to give written notice or proof of loss within a specified time limit is not complied with unless the failure to comply with such time limits prejudices the employer's rights
2. Making any statement requiring the beneficiary to give written notice of loss within a specified time so that the employer is relieved of its obligations thereunder if such time limit is not complied with, unless the statement is made after the plan supervisor's unreasonable failure to give written notice

II. Investigation

- A. Refusing to pay benefits without conducting a reasonable investigation based upon all available information
- B. Failing to begin investigation of a benefit within five working days of receipt of notification of such benefit
- C. Failing to complete investigation of a benefit within 30 days after notification thereof unless the investigation cannot reasonably be completed within that time
- D. Denying or compromising a benefit based on any exclusion, reduction or limitation if documentation of facts rendering the exclusion, reduction or limitation operative cannot be obtained
- E. Failing to give greater weight to the opinion of a physician who has examined the patient than to the opinion of a physician who has not examined the patient and whose opinion is based solely on a review of the examining physician's notes or reports
- F. Requiring a polygraph or similar type examination as a condition precedent to payment of a benefit. The use of examinations under oath, sworn statements or similar procedures shall not be restricted.

III. Payment or Denial

- A. Making decision and notifying beneficiary promptly
 1. Failing to affirm or deny coverage within a reasonable time after proof of loss statements have been completed
 2. Failing to advise the first party of the acceptance or denial of the benefit or of the need for more time within ten working days after receipt by the benefit of properly executed proofs of loss

3. Failing to advise the beneficiary of the acceptance or denial of the benefit within 60 business days after receipt of a properly executed proof of loss
4. Failing to inform the beneficiary in writing as soon as it is determined that there was no policy in force
5. Failing to inform the beneficiary in writing as soon as it is determined that the employer is disclaiming liability because of a breach of policy provisions by any plan fiduciary
- B. Paying where payment is due
 1. Not attempting in good faith to effectuate prompt, fair and equitable settlements of benefits in which liability has become reasonably clear
 2. Failing to pay a benefit or delaying payment of a benefit without just cause
 3. Failing to pay any amount finally agreed upon in settlement within five working days from the receipt of the agreement by the plan supervisor or from the date of performance by the beneficiary of any condition set by the agreement, whichever is later
 4. Settling a benefit involving both a covered and noncovered condition, on a percentage basis of contribution to the loss, unless the percentage is reasonable
 5. Excluding or limiting benefits for a particular condition where the medical records indicate a reasonable basis for, and the plan permits, distinguishing between the eligible condition which necessitated the treatment and a concurrently noneligible condition which did not contribute to the need for the treatment or contribute to the disability
 6. Settling benefits for a fraction of an indemnity period on other than a pro rata basis, unless the plan specifically excludes pro rata payments
- C. Misleading or coercing beneficiary
 1. Misrepresenting pertinent facts or provisions relating to coverages
 2. Advising a beneficiary not to obtain the services of an attorney, or representing that payment will be delayed if the beneficiary retains an attorney
 3. Advising a beneficiary concerning legal rights
 4. Attempting to pay for less than the amount to which a reasonable person would have believed himself entitled to by reference to written or printed advertising material accompanying or made part of an application
 5. Compelling beneficiary to institute litigation to recover amounts due by offering substantially less than the amount ultimately recovered in actions brought by such beneficiary

6. Offering to settle for an amount less than the amount otherwise reasonably due based upon the possibility that the beneficiary would be required to incur attorney fees to recover that amount
7. Making known a policy of appealing from arbitration awards in favor of the beneficiary for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration
8. Invoking or threatening to invoke defenses for the primary purpose of discouraging or reducing a benefit

9. Failing to allow initial offer of settlement to remain open for a reasonable period of time
10. Failing to settle benefit promptly, where liability has become reasonably clear, under one portion of the plan's coverage in order to influence settlements under other portions of the plan's coverage
11. Failing, in any case where there is no dispute as to one or more elements of a benefit, to pay such element notwithstanding the existence of disputes as to other elements of the benefit where such payment can be made without prejudice to either party
12. Withholding any portion of any benefit as an adjustment or overpayment made on a benefit arising under the same plan unless: The plan supervisor has in its files clear, documented evidence of an overpayment and written authorization from the beneficiary permitting the withholding, or the plan supervisor has within its files clear, documented evidence that the overpayment was clearly erroneous under the provisions of the plan and the error was not a mistake of law; and the plan supervisor gives notice, clearly stating the nature of the error and the amount of the overpayment within six months after the day on which the erroneous draft for benefits was issued, except that, if the error was prompted by representations or nondisclosures of beneficiaries or third parties, the notification may be made within 15 working days after the date of which clear, documented evidence of discovery of such error is included in the plan supervisor's file; and the benefit used to adjust the first overpayment is made no later than three years after the day on which the erroneous draft for benefits was issued
13. Using any inducements to encourage beneficiary to accept or reject a benefit offer, payment or compromise settlement
14. Attempting to settle on the basis of an enrollment form which was altered without notice to or knowledge or consent of the participant
15. Undertaking any activity that has the effect of coercing the insured to settle a disability on a lump sum basis

D. Releases

1. Requesting a beneficiary to sign a release that extends beyond the subject matter that gives rise to the benefit payment
2. Indicating on a payment draft, on a check, or in any accompanying cover letter, that the payment is *final* if additional benefits relating to the benefit for which amounts are being paid are payable under the plan

E. Assignments

1. Failing to honor an assignment of benefits, even though the benefits may have been erroneously paid to the participant if the contract does not prohibit assignments and a proper assignment (including notice before payment of the benefit) has been made

2. Failing, upon assignment of benefits to a hospital or other health care agency, to pay the assignee within 30 days of receipt of the final bill, provided the plan sponsor has received the information necessary to determine the extent of liability
3. Failing, upon assignment of benefits to a hospital or other health care agency, to request within 1.5 days after receipt of claim the information required for payment of the assigned benefits

F. Rescission

1. Rescinding coverage other than at the time the plan supervisor receives the information justifying rescission
2. Rescinding coverage or denying a benefit during the contestable period based on omission of material information if the information is not specifically requested on the enrollment form
3. Rescinding coverage due to misrepresentation in an enrollment form without having resolved patently conflicting or incomplete statements in the enrollment form
4. When an enrollment form contains only one medical question or a declaration as to the general status of the participant's health, such as "are you now in good health," rescinding or denying a benefit during the contestable period on the basis of material misrepresentation by the participant if, based on the totality of circumstances, the participant responded to the best of his or her knowledge and belief that the general status of his or her health was satisfactory

G. Preexisting condition

1. Denying a benefit on the basis of a preexisting condition defense if the condition was disclosed in the enrollment form and the condition is not excluded from coverage by name or specific description
2. Denying a benefit on the basis of a preexisting condition defense with respect to a loss incurred or disability beginning 12 months or more from the date of coverage, if the enrollment form does not ask about health history, and if the condition is not excluded from coverage by name or specific description
3. Denying a benefit on the basis of a preexisting condition defense without having resolved patently conflicting or incomplete statements in the enrollment form and without having duly considered the material the plan supervisor would have obtained through a reasonable inquiry following consideration of such statements
4. Denying a benefit on the basis of a preexisting condition defense without evidence that the condition manifested itself before the date of coverage

H. Communicating with beneficiary concerning payment or denial

1. Failing to include with benefit payments a statement setting forth the coverage under which payment is made and explaining how the benefit payment was calculated
2. Failing to give the beneficiary a written explanation of a settlement involving both a covered and an uncovered condition which is made on a percentage basis of contribution to the loss
3. Failing to give the denial to the beneficiary in writing
4. Failing to provide promptly a reasonable explanation of the basis in the plan in relation to the facts or applicable law for denial of a benefit or for the offer of a compromise settlement

5. Denying a benefit on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition or exclusion is included in the denial
6. Denying a benefit without including the following information: the basis for denial; the name, address and telephone number of the plan supervisor to whom the beneficiary may take any questions or complaints about the denial; and the plan number of the participant
7. Denying a benefit without including notice of the availability of assistance by the Department of Labor
8. Denying a benefit due to the lack of medical necessity, or due to preexisting condition, without offering in the denial letter an opportunity for review
9. Failing to make any lump-sum disability settlement in writing with an explanation of the basis of the settlement including a comparison of the different modes of settlement

IV. Benefit Files

- A. Failing to maintain in benefit files all notes and work papers pertaining to the benefit in such detail that pertinent events and the dates of such events can be reconstructed
- B. Failing to make a notation of the acknowledgment of a benefit in the benefit file which includes at least the following information if the acknowledgment was made by telephone or other oral contact:
the telephone number called, if any; the name of the person making the telephone call or oral contact; the name of the person who actually received the telephone call or oral contact; and the date and time of the telephone call or oral contact
- C. Failing to maintain a copy of the denial in the benefit file
- D. Upon denying a benefit by means other than writing, for reasons other than on the grounds of a specific policy provision, condition, or exclusion, failing to make an appropriate notation in the benefit file
- E. Denying a benefit upon information obtained in a telephone conversation or personal interview with any source without documenting the conversation or interview in the benefit file
- F. Failing to place in the benefit file a written notation explaining how to obtain documentation of facts rendering operative the exclusion, reduction or limitation on which a denial or compromise is based
- G. Failing to maintain in the benefit file the basis for a settlement involving both a covered and noncovered condition which is made on a percent basis of contributing loss
- H. Failing to date, in the benefit file, all communications and transactions, whether written or oral

V. Procedures

- A. Failing to make provision for adequate benefit handling personnel, systems and procedures to service benefits effectively

B. Failing to adopt and implement reasonable standards for the prompt investigation of benefits

- C. Failing to adopt and implement reasonable standards for the processing and payment of benefits once the obligation to pay has been established
- D. Failing to distribute copies of the regulation to every person directly responsible for the handling and settlement of benefits subject to the regulation, and failing to satisfy oneself that all such persons are thoroughly conversant with the regulation and are complying with the regulation

VI. ERISA Fiduciary Considerations

- A. Acting in an arbitrary and capricious manner on benefit adjudication and processing
- B. Willfully and intentionally ignoring the plan's documents
- C. Failing to process claims in good faith; being vindictive and not helpful
- D. Being lax in benefit investigations
- E. Failure to follow denial of benefit procedures set forth by the Department of Labor

VII. Miscellaneous

- A. Engaging in activity which results in a disproportionate number of meritorious complaints or lawsuits
- B. Failing, where appropriate, to make use of arbitration procedures authorized by the plan
- C. Paying a judgment or settlement of a benefit with an instrument other than a negotiable bank check payable on demand and bearing even date with the date of writing
- D. Terminating disability benefits based solely on lack of regular medical attendance if the disability has been verified by a physician and can reasonably be expected to continue beyond the date through which benefits have been paid, unless otherwise provided by the plan

Operational Guidelines

Each benefits administration unit is managed differently – this Guide does not address how any particular unit is structured. There are, however, several time-tested and valuable rules which must be stressed.

1. Typically one examiner can be responsible for 1,500-2,000 participants; 3-4 examiners require one supervisor.
2. Levels of payment authority should be upgraded with the experience of the examiner; each examiner should be audited on a systematic and frequent basis.
3. Instances where the examiner should refer the facts to the supervisor for review include:
 - Denials, pre-existing, e.g.
 - Subrogation
 - Large or troublesome claims
 - Possible litigation or lawyer involvement
 - Involving an excess loss or reinsurance benefit
 - Requiring medical consultation
 - Late benefit submission.
4. There must be a program devoted to achieving and maintaining both quality and currency of benefit administration.