Advocacy for Patients Through ERISA Pre-Service Letters

Many managed care networks are requiring doctors to provide patient information on company-specific forms. Some companies expect their forms submitted immediately after the initial exam or re-exam, and some require them more frequently. When the doctor's plan for treatment is restricted or denied based on information provided to the managed care company, it can be beneficial to advocate on behalf of the patient by writing an explanation of the situation to the employer or fiduciary of the patient's plan.

Typically, ERISA legal remedies are used *after* care has been delivered and claims have been denied. There is a formal claims process for this type of use of ERISA legislation and this document does not address post-treatment appeals for adverse determinations.

This information sheet describes a different type of initiative: to correspond with the employer/fiduciary to make them aware that the benefit purchased for their employees may be being withheld.

What you can do:

1. Obtain a signed authorization from the patient allowing you to act on their behalf.
2. Personalize the template letter with the patient's information as indicated.
3. Address the letter to the patient's employer/fiduciary and mail with the original authorization form, plan of care, and copy of denial/restriction of proposed care.
4. Send a copy of all of the above documents to the patient and to the Employee Benefits Security Administration (EBSA) local office.
5. Keep a copy of all documents for patient's file.

Important Facts to Remember:

- ERISA benefits belong to the PATIENT. <u>You cannot act on their behalf without their authorization.</u>
- The employer/fiduciary is responsible for assuring the appropriate management of their benefit plan. When your letter is received, the employer may send you the plan description and request that you complete forms to file a formal claim. You should comply with their requirements so that an investigation may occur.
- The goal in sending this letter is to raise awareness on the part of the employers/fiduciaries regarding the management of chiropractic benefits so they can look into inappropriate restrictions/denials of care.

Note: On the Department of Labor website, in their question and answer section, (http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html) question A-5 states:

> "The regulation does not govern casual inquiries about benefits or the circumstances under which benefits might be paid under the terms of a plan. <u>*On the other hand, a group health plan that requires the submission of pre-service claims, such as requests for preauthorization, is not entirely free to ignore pre-service inquiries where there is a basis for concluding that the inquirer is attempting to file or further a claim for benefits,*</u> although not acting in compliance with the plan's claim filing procedures. In such a case, the regulation requires the plan to inform the individual of his or her failure to file a claim and the proper procedures to be followed. Specifically, this type of notification is required where there is a communication by a claimant or authorized representative (e.g., attending physician) that is received by a person or organizational unit customarily responsible for handling benefit matters (e.g., personnel office) and that communication names the specific claimant, specific medical condition or symptom and a specific treatment, service, or product for which approval is requested. Under the regulation, notice must be furnished as soon as possible, but not later than 24 hours in the case of urgent care claims or 5 days in the case of non-urgent claims. Notice may be oral, unless a written notification is requested. See § 2560.503-1(c)(1)."