



ERISA: Finding the Hidden
Gold in Your Revenue Cycle

ERISA Knowledge = Revenue Generation



What is ERISA?

ERISA was signed into law September 2, 1974

The Final Rule / Federal Register was effective January 1, 2003 which allows recovery back to that date.

ERISA applies to both self funded and fully funded plans under US Code Title 29 §1002 (1)(A)

(1) The terms “employee welfare benefit plan” and “welfare plan” mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise,

(A) medical, surgical, or hospital care or benefits...” (emphasis added)

ERISA denial reasons

- Usual Customary and Reasonable
- Medical Necessity
- Preauthorization/Precertification - both ER and regular admissions
- Excluded/Not Covered Service
- Past 180 day appeal filing limit
- Maximum allowable exceeded
- Experimental/Investigational
- Appeal rights have been exhausted
- Reduction in payment due to plan procedures not being followed
- ER/Urgent care charges not qualified (different form of medical necessity)

Exceptions to ERISA law appeals

- Medicare
- Medicaid
- Military Plans
- Workers Compensation
- School Plans (prior to 2010)
- Church Plans (per 6/5/17 US Supreme Court Ruling church affiliated employers now exempt previously fell under ERISA)
- Government Plans (prior to 2010)
- Individual Plans (prior to 2010)
- Contractual allowances when no ERISA denial is present

Traditional appeal vs. ERISA appeal

Traditional

Focuses on contract between provider and payer

Favors the Payer

Appeals based on contract only

State law presides

ERISA

Focuses on contract between employer and employee known as the Summary Plan Description

Favors the provider

Appeals based on ERISA law, DOL guidelines and supporting case rulings.

ERISA as a federal law will always supersede state law

In Network ERISA Examples

In network paid per contract, no ERISA appeal

Billed Charges	\$100,000
Contract Rate	\$60,000
Insurance Paid	\$60,000
ERISA Denial Amt.	\$0

In network ERISA denial reason recovery on contract difference only

Billed Charges	\$100,000
Contract Rate	\$60,000
Insurance Paid (ERISA denial reason)	\$40,000
ERISA Denial Amt.	\$20,000

Out of Network ERISA Examples

Out of network paid per patient's plan, no ERISA appeal

Billed Charges	\$100,000
Allowed Charges	\$100,000
Plan Pays 80%	\$80,000
ERISA Denial Amt.	\$0

Out of network ERISA denial reason recovery potential

Billed Charges	\$100,000
Allowed Charges	\$60,000
Plan Pays 80%	\$48,000
ERISA Denial Amt.	\$40,000

Fake/Silent PPO

- Fake PPO – When a payer takes a discount on an out of network provider's charges as if a contract existed when no contract ever existed but still pays the provider out of network rates.
- Silent PPO – When a payer “leases or borrows” an existing contractual discount that the provider has with a different payer but still pays the provider out of network rates.
- Both practices are against judicial estoppel. In laymen's terms you can't have your cake and eat it too. If taking an in network discount then you have to pay in network rates.
- In the case of the Silent PPO unless the existing contract specifically lists the payer involved is an affiliate that is entitled to the discount they cannot take it.
- **CAUTION** – some contracts state that the contracted payer can lease the PPO out to other payers without approval from the provider and pay as out of network. Know your contract language before signing!!!!

Why you don't waive patient responsibility

- OXFORD HEALTH INSURANCE V. JOSEPHSON NY 2010
- CIGNA V. BAY AREA SURGICAL MGMT. (BASM) CA 2013
- AETNA V. HUMBLE SURGICAL HOSPITAL TX 2014
- CIGNA V. Elite Center for Minimally Invasive Surgery, TX 2017
- Houston Metro Ortho and Spine Surgery Center

1. COLLECT OR ATTEMPT TO COLLECT ALL PATIENT RESPONSIBILITY BASED ON BILLED CHARGES OR CONTRACTED PAYMENT AMOUNTS.
2. INFORM THE PATIENT THAT YOU ARE OUT OF NETWORK, HAVE NOTIFICATION FORM SIGNED AND DO NOT STATE YOU WILL TAKE ANY TYPE OF IN NETWORK RATE AS PAYMENT IN FULL.
3. ASSESS PATIENT ASSISTANCE BASED ON FINANCIAL HARDSHIP WITH PAPERWORK FOR DOCUMENTATION ALONG WITH SIGNED FORM.

CEASE WAIVING PATIENT RESPONSIBILITY AS STANDARD PRACTICE IMMEDIATELY!

Overpayment Recoupments

- Most states have their own restrictions on how far back a payer can go to recoup.
- The U.S. Supreme Court ruling handed down on January 20, 2016 states that when a settlement (payment) is dissipated on non-traceable items the fiduciary cannot bring suit to attach the participant's (provider's) general assets under §502(a)(3) (ERISA) because the suit is not one for "appropriate equitable relief". In laymen's terms, the payer can only enforce an equitable lien only against specifically identified funds that remain in the provider's possession. If the provider paid numerous operational expenses out of a general operating fund they would have no way of identifying what specific reimbursement for what specific patient was used to pay those expenses. The reimbursements were all comingled into a general operational fund.
- If the payer has already recouped the money from another payment and if that payment is on a completely different plan than the original plan this is illegal forfeiture. The U.S. District Court of Minnesota ruling on January 15, 2019 and the more recent U.S. Court of Appeals Eighth Circuit ruling which upholds the Minnesota rulings state you cannot recover from a different plan than that of the one making the original payment. Example: If the original payment was made on an AT&T plan but the payer recouped the supposed overpayment on a payment to be made from Wells Fargo this is illegal forfeiture. The same plan was not involved for both transactions.

DOL FAQ B-2 vs. B-3 Assignment of Benefits

A DOL FAQ B-2 assignment gives the right to receive payment directly instead of the patient receiving the payment. It gives the provider no derivative standing in the appeals process.

A DOL FAQ B-3 assignment gives the provider the same rights as the patient in the appeals process including direct payment. This is also guaranteed under ERISA (b)(4).

Components necessary for effective appeals

- ALWAYS get detailed employer information either on intake form or by copy of insurance card, preferably both
- Modify intake form to include DOL B-3 and ERISA (b)(4) language making the provider a duly designated and authorized representative of the patient.
- If you have 835/837 files use the list of ANSI codes to assess potential recovery and reimbursement issues. If not, take your COMMERCIAL claims total billed times 1.59% and that will give an estimate as to the recovery potential.
- Have software in place or knowledgeable staff capable of completing the calculation of the expected payment amount per contract. KNOW YOUR EXPECTED PAYMENT!!!
- Have follow up procedures in place (utilizing all available tools) to ensure complete and accurate payment. Contractual disputes must be monitored and appealed within contract constraints.
- Make sure all contracts are cataloged and filed correctly in date order from oldest to newest for each payer.



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E: lfowler@titan-health.com

P: (602) 584-8264

Titan-Health.com

