
ERISA or PPO?

Managed Care Slavery or ERISA Superhero

MAXIMAL REIMBURSEMENT THROUGH COMPLIANCE



Claims Recovery Company

One of the most misguided and financial suicidal concept in healthcare reimbursement is that health care providers are historically and fundamentally as well as legally taught and convinced that any and all denials or reductions of your claims with or through managed care entity are a PPO discount, a consensual compromise or defeat, instead of ERISA benefits denial, in whole or in part, based on relevant plan benefits provisions governed under ERISA, the federal as a public policy, even though every managed care contract, managed care network medical policy, managed care provider manuals have specifically and unambiguously disclaimed and instructed that provider contracts are for provider voluntary reduction from the total amount that each members benefit plan has already approved as benefits reimbursement, specifically based on each individual patient/member benefits plan provisions, Summary Plan Description (SPD), [governed by federal law ERISA, for any ERISA regulated employer sponsored health benefits plan in private sector.](#)

ERISA is a federal law, governing ERISA plans, health insurance/benefits through employment in private sectors. The simplest way to understand and identify an ERISA plan is if your patient obtained health insurance from employment in private sector, from both self-insured and fully insured (through purchase of insurance) benefits plans.

SPD (Summary Plan Description) is ERISA version of insurance policy, SPD controls insurance/benefits coverage, limitation, and conditions for

reimbursement. Each individual patient eligibility, qualification, coverage, limitation, and circumstances for disqualification are specifically determined by the terms and conditions of each individual plan SPD. Any managed care contract, PPO, POS, EPO, P4P and HMO, may not be intended, or shall not be construed, to supercede, alter or limit the rights or remedies otherwise available to any Person under [§ 502\(a\) of ERISA or to supercede in any respect the claims procedures of § 503 of ERISA](#).

Managed care contract between healthcare providers and manage care entities or organizations, or even directly with ERISA plans or insurers, are legally a third-party business contract, independently and separately from an ERISA plan. A managed care contract is primarily used to solicit or offer provider discount in exchange of wholesale referral (network access) and prompt reimbursement.

Any claim denials or delays for plan coverage, limitation, medical necessity, UCR, network provider access, coordination of benefits, pre-existing condition, eligibility determination, anything about money and rights for any participant and beneficiary, except for pure PPO discount, are governed by ERISA, as a public policy, and determined based on each individual benefits plan provisions, however if all of the above are not in dispute, or moot, but there is a pure PPO or managed care discount, that would be a provider PPO dispute, determined by each individual manage care contract, governed by specific individual state laws where contract was entered and choice of law was agreed by parties of such contract.

Therefore, any PPO discount or dispute is not triggered unless or until ERISA benefits questions or disputes are resolved or moot.

[As a national insanity or stupidity in US health care crisis](#), managed care contracting has been used to hijack, interfere, substitute, replace and discount or deceit the compliance and enforcement of ERISA, a federal law as public policy.

[Even as 950,000 physician class-action lawsuit settled with](#) almost every insurance company and MCO's with following captioned final agreement and clarification for most of all managed care contracting:

[AETNA SETTLEMENT AGREEMENT \(pdf, 97 pages\)](#), dated as of May 21, 2003 by and among AETNA INC., THE REPRESENTATIVE PLAINTIFFS, THE SIGNATORY MEDICAL SOCIETIES AND CLASS COUNSEL

"7.10. New Dispute Resolution Process for **Physician Billing Disputes**.

a.".....Nothing contained in this § 7.10 is intended, or shall be construed, to supercede, alter or limit the rights or remedies otherwise available to any Person under [§ 502\(a\) of ERISA or to supercede in any respect the claims procedures of § 503 of ERISA](#)." [page 25]

Healthcare providers have continued to engage voluntary and consensual financial suicide, by thinking and saying:

"What ERISA? but we have signed a contract, it is our choice, we have no right"

In order to obtain maximum reimbursement for what a provider is legally entitled to under applicable federal and state laws, a provider must understand that your managed care contracting is only good for pure PPO discount, ERISA, not your managed care contract, governs, controls and determines the policy coverage, medical necessity, experimental and investigational, UCR, pre-existing condition, coordination of benefits, provider and network access-choice of providers, urgent care, and everything has the your patient rights under the plan and "denial of benefits".

Every healthcare provider must understand ERISA in order to avoid financial suicide or crisis in voluntary consensual fashion through managed care contracting.

[**US SUPREME COURT UNANIMOUSLY CONCLUDED THAT ERISA Governs and Controls All of Your Money Dispute, Preempts and Invalidates or Supersedes 100 Percent of Your State Laws and Managed Care Contracting, if inconsistent or contrary to ERISA and SPD**](#)

[Aetna Health Inc. v. Davila](#)

06/21/04

Opinion of the US Supreme Court

"Held: Respondents' state causes of action fall within ERISA §502(a)(1)(B), and are therefore completely pre-empted by ERISA §502 and removable to federal court. Pp. 4–20."

"We hold that respondents' causes of action, brought to remedy only the denial of benefits under ERISA-regulated benefit plans, fall within the scope of, and are completely pre-empted by, ERISA §502(a)(1)(B),....."

Egelhoff v. Egelhoff

"Held: The state statute has a connection with ERISA plans and is therefore expressly pre-empted. Pp. 4-10.

(a) ERISA's pre-emption section, 29 U. S. C. §1144(a), states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. A state law relates to an ERISA plan "if it has a connection with or reference to such a plan." Shaw v. Delta Air Lines, Inc., 463 U. S. 85, 97."

"To determine whether there is a forbidden connection, the Court looks both to ERISA's objectives as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the state law's effect on ERISA plans. California Div. of Labor Standards Enforcement v. Dillingham Constr., N. A., Inc., 519 U. S. 316, 325. Applying this framework, the state statute has an impermissible connection with ERISA plans, as it binds plan administrators to a particular choice of rules for determining beneficiary status."

To decide or determine if your dispute is common-law PPO or ERISA dispute, in PERALTA V HISPANIC BUSINESS, The Ninth Circuit has explained that common law claims do not "relate to" an ERISA plan when:

1. "the "adjudication of the claim required no interpretation of the plan"
2. "no distribution of benefits", and
3. "no dispute regarding any benefits previously paid".

EVERY MANAGED CARE CONTRACT IS SUBJECT TO ERISA AND PLAN SPD FOR REIMBURSEMENT FROM AN ERISA PLAN.

SMS Fresno Community Hospital and Medical Center

v.

John Souza

EASTERN DISTRICT OF CALIFORNIA

July 3, 2007

“ALLEGATIONS AND CAUSES OF ACTION

According to the complaint, UMC entered into a contract with Blue Cross of California (the “Blue Cross Contract”) pursuant to which it agreed to provide medically necessary services, equipment and supplies to individual enrollees of health plans registered with Blue Cross as “Payor” signatories to the Blue Cross Contract. Teamsters was a Payor signatory to the Blue Cross Contract. In exchange, Teamsters agreed to pay UMC for the medically necessary services, equipment and supplies rendered to the individual enrollees in Teamsters’ health plan. The negotiated rates under the Blue Cross Contract provided for such services to be paid at a ten percent discount. UMC agreed to submit bills to Teamsters and/or Teamsters’ agent reflecting the ordinary total billed charges for services rendered to the individual enrollees of Teamsters’ health plan on a claim form, and Teamsters would then process and pay each claim at the ten percent discounted rate. Complaint, ¶¶ 9-12. Delta Health Systems was the third party administrator for the Teamsters’ plan.”

“The complaint alleges that Teamsters failed to pay for medical treatment provided to two patients enrolled in Teamsters’ health plan. UMC alleges that Teamsters verified that these patients were enrolled in their health plan yet failed to pay the final bills. After application of the discount, UMC alleges that it is owed a total of \$38,952.93 (\$43,281.03 prior to discount).”

"UMC alleges causes of action for breach of contract, quantum meruit and negligent misrepresentation against Teamsters. It alleges intentional interference with contractual relations against Delta Health Systems based on the allegation that Delta convinced Teamsters to withhold payment on the pretext that they could do so pending the completion and delivery of certain forms."

"In [PERALTA V HISPANIC BUSINESS](#), [The Ninth Circuit has explained that common law claims do not “relate to” an ERISA plan when:](#)

1. “the “adjudication of the claim required no interpretation of the plan”,
2. “no distribution of benefits”, and
3. “no dispute regarding any benefits previously paid”.

"Section 6.14 of the **Blue Cross Contract** provides as follows:

BLUE CROSS agrees to verify to HOSPITAL a person's BLUE CROSS membership and to identify for HOSPITAL, based upon information provided by HOSPITAL, waived conditions, current balance of lifetime maximum and any dollar limits applicable under the relevant Benefit Agreement. . . . A guarantee of eligibility is not a guarantee of payment. If HOSPITAL is notified that the member is eligible, HOSPITAL is entitled to payments for services rendered, covered under, and **subject to the exclusions and limitations of the relevant Benefit Agreement.**”

[Benefit Agreement = Summary Plan Description, SPD - by ERISAclaim.com]

“CONCLUSION

Based on the above, the Court finds that the First, Second and Third Causes of Action are preempted by ERISA. UMC’s motion to remand is therefore DENIED.”

PPO Contract with Insurance Verification and Precertification = PPO or ERISA?
= ERISA!

EVERY MANAGED-CARE CONTRACT DISPUTE, CLASS-ACTION LAWSUIT, SETTLED WITH CONCLUSION THAT ERISA AND SPD CONTROL YOUR PPO.

- A. [AETNA SETTLEMENT AGREEMENT \(pdf, 97 pages\)](#), dated as of May 21, 2003 by and among AETNA INC., THE REPRESENTATIVE PLAINTIFFS, THE SIGNATORY MEDICAL SOCIETIES AND CLASS COUNSEL

"7.10. New Dispute Resolution Process for **Physician Billing Disputes**.

a.".....Nothing contained in this § 7.10 is intended, or shall be construed, to supercede, alter or limit the rights or remedies otherwise available to any Person under § 502(a) of ERISA or to supercede in any respect the claims procedures of § 503 of ERISA." [page 25]

7.11. **Medical Necessity** External Review Process.

"(c) Notwithstanding the provisions of § 7.11(a), **Physicians may not seek review of any claim for which the Plan Member (or his or her representative) has filed suit under § 502(a) of ERISA.** In that event, or if such a suit is subsequently initiated, the Plan Member's lawsuit shall go forward and the **Physician's claims shall be dismissed and may not be brought by or on behalf of the Physician in any forum;** provided that such dismissal shall be without prejudice to any Physician seeking to establish that the rights sought to be vindicated in such lawsuit belong to such Physician and not to such Plan Member.

(d) **Nothing contained in this § 7.11 is intended, or shall be construed, to supercede, alter or limit the rights or remedies otherwise available to any Person under § 502(a) of ERISA or to supersede in any respect the claims procedures under § 503 of ERISA.**

e. Company shall maintain an **internal appeals process for medical necessity denials** and shall disclose such process on the Public Website. Company shall adjudicate all such appeals of medical necessity denials on the timeframes that are applicable to Plans subject to ERISA, regardless of whether such Plans are actually subject to ERISA....." [page 30]

[Aetna Settlement Claim Form \(pdf\)](#)

B. **CIGNA SETTLEMENT (pdf, 150 pages) (doc)**

"7.10 Dispute Resolution Process for Physician Billing Disputes.

a. CIGNA HealthCare shall implement an independent, external billing dispute review process (the "Billing Dispute External Review Process") for resolving disputes with Class Members concerning the application of CIGNA HealthCare's coding and payment rules and methodologies to (i) patient specific factual situations, including without limitation the appropriate payment amount when two or more CPT® Codes are billed together, or whether the Class Member's use of modifiers is appropriate, or (ii) any Retained Claims, so long as such Retained Claims are submitted by the Physician to the Billing Dispute External Review Process prior to the later to occur of either ninety (90) days after Final Approval **or thirty (30) days after exhaustion of CIGNA HealthCare's internal appeals process.** Each such matter shall be a "Billing Dispute." The Reviewer (as defined below) shall not have jurisdiction over any disputes that are not patient specific application of Claim Coding and Bundling Edits, including without limitation those disputes that fall within the scope of the Medical Necessity External Review Process set forth in Section 7.11 of this Agreement, disputes about the submission of Clinical Information that fall within the scope of Section 7.12, Compliance Disputes and disputes concerning the scope of Covered Services. **Nothing contained in this Section 7.10 is intended, or shall be construed, to supersede, alter or limit the rights or remedies otherwise available to any Person under § 502(a) of ERISA or to supersede in any respect the claims procedures of § 503 of ERISA.**

"(3) *Time Limits for Completing Internal Appeals.*

All internal appeals shall be completed within the time limits required by regulations issued by the Department of Labor, **even those internal appeals for which ERISA is not applicable.** [page 50]

(3) Notwithstanding the provisions of this Section 7.11, Class Members may not seek review of any claim for which the CIGNA HealthCare Member (or his or her representative) has filed suit under § 502(a) of ERISA or other suit for the denial of health care services or supplies on Medical Necessity grounds. In that event, or if such a suit is subsequently initiated, the CIGNA HealthCare Member's lawsuit shall

go forward and the Class Member's claims shall be dismissed and may not be brought by or on behalf of the Class Member in any forum; provided that such dismissal shall be without prejudice to any Class Member seeking to establish that the rights sought to be vindicated in such lawsuit belong to such Class Member and not to such CIGNA HealthCare Member. [page 52]

"(4) Nothing contained in this Section 7.11 is intended, or shall be construed, to supersede, alter or limit the rights or remedies otherwise available to any Person under § 502(a) of ERISA or to supersede in any respect the claims procedures under § 503 of ERISA." [page 53]

[Anti-balance Billing Instruction to Non-participating Physicians \(page 80-81\)](#)

"p. Participating Physician Status Dependent Upon Existence of Contracts; Limitations on Obligations of Non-Participating Physician.

CIGNA HealthCare agrees that it will treat a Class Member as a Participating Physician only in those circumstances in which the Class Member is a party to a written contract with CIGNA HealthCare or with an intermediary with which CIGNA HealthCare has a written contract. CIGNA HealthCare further agrees that at least through the Termination Date, it will not rent its networks to any other managed care company or health insurer for the purpose of providing health care services or supplies to any person who is not a CIGNA HealthCare Member; provided that nothing in this sentence shall prevent CIGNA HealthCare from making its networks available among the various current and future Subsidiaries of CIGNA Corporation; and provided, further, that nothing in this sentence shall be held to apply to a situation in which a CIGNA HealthCare customer elects to make payments on claims in respect to provisions of health care services or supplies to a CIGNA HealthCare Member through a third party administrator or where CIGNA Behavioral Health provides mental health services for another health insurance company or other entity. No affirmative obligation that this Section 7 imposes on a Participating Physician shall apply to Non-Participating Physicians unless and until, and then only to the extent that, with regard to each individual claim, such Non-Participating Physician submits or transmits to CIGNA

HealthCare a claim for payment which designates therein that the Non-Participating Physician has accepted an Assignment of the CIGNA HealthCare Member's benefits as payment for that individual claim.

q. Effect of Assignment of Benefits.

The existence of an Assignment of Benefits authorization, whether or not submitted by the Non-Participating Physician to CIGNA HealthCare, **does not constitute in and of itself full or partial payment of the Non-Participating Physician's fee (unless so agreed between the Non-Participating Physician and the CIGNA HealthCare Member), does not create an implied contract between the Non-Participating Physician and CIGNA HealthCare, and does not limit the Non-Participating Physician's fee to any fee schedule. The Non-Participating Physician retains the right to elect either to collect the Non-Participating Physician's full fee from the CIGNA HealthCare Member or collect partial payment from CIGNA HealthCare and the balance from the CIGNA HealthCare Member ("balance bill")."**

EVERY MANAGED CARE CONTRACT AND MANAGE CARE MEDICAL POLICY HAVE TOLD YOU ERISA & SPD CONTROLS YOUR PPO OR HMO.

[Aetna Clinical Policy Bulletins](#)

[Agree to terms and conditions](#)

"Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the **member's benefit plan to determine** if there are any exclusions or other benefit limitations applicable to this service or supply."

"The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Aetna) for a particular member. **The member's benefit plan determines coverage.** Some plans exclude coverage for services or supplies that Aetna considers medically necessary. **If there is a discrepancy between a Clinical Policy Bulletin (CPB) and a member's plan of benefits, the benefits plan will govern."**

CIGNA - Coverage Positions/Criteria

"The terms of a participant's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, **Summary Plan Description (SPD)** or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Positions are based. **If these Coverage Positions are inconsistent with the terms of the member's specific benefit plan, then the terms of the member's specific benefit plan always control."**

UnitedHealthcare Medical Policies

"By clicking "I agree," you agree to be bound by the terms and conditions expressed below, in addition to our Site Use Agreement.

UnitedHealthcare medical policies have been made available to you as a general reference resource. When reading these policies you agree that:

Our Medical Policy is not your patient's Benefit Plan.

Your patient's medical benefits are governed and determined by a benefit document, either a Certificate of Coverage or a **Summary Plan Description**. You should not rely on the information contained in this Web site section to determine your patient's medical benefits.

- a. Federal and state mandates and the patient's benefit document take precedence over these policies.
- b. The patient's benefit document lists the specific services that have coverage limits or exclusions.

Our Medical Policy does not address every situation and individuals should always consult their physician before making any decisions on medical care."

MORE THAN 60% OF CLAIM DENIALS ARE NOT PPO DISCOUNT BUT ERISA AND SPD GOVERNED POLICY EXCLUSION, MEDICAL NECESSITY, NETWORK ACCESS (CHOICE OF PROVIDERS),

ALTHOUGH MOST EOB's (EXCLAMATION OF BENEFITS) MAY LABEL THESE BENEFITS DENIAL AS PPO DISCOUNTS.

The latest and updated RAND/Harvard Study, funded by the U.S. Department of Labor (DOL) and requested by Congress, examines the outcomes of nearly a half-million coverage requests in two large medical groups and revealed the following:

Reasons for Denial Prospectively (RAND/Harvard Study Fund by DOL)	
Not a Contractually Covered Services (Policy Exclusion)	42%
Not medically necessary	29%
Provider Choice (Out Of Network)	22%
Other/unknown	7%
<ol style="list-style-type: none"> 1. <u>"Prospective denials of coverage on grounds of medical necessity are only a small part of the overall picture."</u> 2. <u>"Retrospective requests were nearly four times more likely than prospective ones were to be denied"</u> 3. <u>"Denials made on contractual grounds—the largest share of denials—may call for both clinical and contractual expertise. Hence, they should ideally be made by personnel who are versant in both areas"</u>. 	

The Latest AMA (PSA) Managed Care Hassles Survey through nationwide state medical associations and national medical specialty societies identified the most popular and important managed-care claim denials and delays.

Top Seven Issues through National Medical Specialty Societies		
Rank	Problems Reported By Popularity Rank	%
1	Bundling	67%
2	Medical Necessity Decision Denials	43%
3	<u>Prompt Payment</u>	43%
4	Administrative Hassles	33%
5	Coding Issues	24%
6	Downcoding	19%
7	Bargaining Lack of Negotiation Power	14%

Top Eight Most Importantly & Frequently Listed Issues through State Medical Associations	
Rank	Problems Reported By Importance Rank
1	Downcoding & Bundling
2	Prompt Payment
3	Lack of Budgeting Power
4	Medical Necessity Denials
5	Prior Authorization of Med. Services
6	Health Plan Credentialing
7	Drug Formularies
8	Other

EVEN IF YOUR PROBLEMS ARE TRULY PPO DISCOUNT, HEALTH PLANS AND INSURANCE COMPANIES MAY STILL ASSERT ERISA DEFENSE BECAUSE ERISA PREEMPTION KILLS YOUR PPO ARGUMENT AND STATE LAW PROTECTIONS.

[**PASCACK VALLEY HOSPITAL, INC. v LOCAL 464A UFCW WELFARE REIMBURSEMENT PLAN**](#) (3rd Cir. 11/01/2004)

[**Northeast Hosp. Authority v. Aetna Health Inc.**](#) (October 17, 2007)

"As in Pascack Valley Hospital and Anesthesia Care Associates, the crux of the parties' dispute in this case arises from the terms of a contract-the Hospital Agreement-that is independent of the ERISA patients' plans; the ERISA patients are not parties to the Hospital Agreement; and parties dispute the level, rate, or amount of payment, not the right to payment. Northeast does not challenge Aetna's benefits determinations under the patients' ERISA plans. Nor does Northeast challenge the scope of the plans' coverage."

"Courts applying Davila have found that no there is no ERISA preemption when a health-care provider sues an insurance company to assert contract claims that exist independently of ERISA. The Third Circuit, for example, found no

preemption in *Pascack Valley Hospital, Inc. v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393 (3d Cir.2004)."

EVEN FOR SILENT OR PASSIVE PPOs, ERISA LAW GOVERNS YOUR MONEY PAYMENT IF THE PAYOR IS AN ERISA PLAN

Hahnemann Univ Hosp v. All Shore Inc

3RD Cir., 01/29/2008

"Upon receiving Hahnemann's claim for benefits, BCI sought to determine whether a preferred provider organization ("PPO") option applied to the claim. As a third-party claims administrator, BCI entered into contracts with various PPOs which allowed a health benefit plan access to the PPOs' price discounts, even though there might not have been an agreement between the health benefit plan and the PPO itself. These are called **passive PPOs**. Upon analyzing Hahnemann's claim for benefits, BCI determined that a 10 % discount might apply to Hahnemann's claim based upon a PPO established by MultiPlan, Inc. ("**MultiPlan**").

Hahnemann did not receive a check for the amount it requested, or even an amount applying a 10 % discount. Instead, the managing general underwriter concluded that a 40 % discount was applicable to Hahnemann's charges through a different PPO. Specifically, the underwriter determined that the National Preferred Provider Network ("NPPN") PPO applied. Thus, Hahnemann only received 60 % (or approximately \$150,000) of the charges it originally submitted. Hahnemann received this payment in September 1999."

IF YOU DO PPO DISCOUNT AND PREVIEW YOUR PROVIDER GRIEVANCE, YOUR HALLUCINATED OR PERCEIVED VICTORY IS ALSO PERSUASIVELY PREEMPTED BY ERISA, AS CLEARLY EXPLAINED TO YOU BEFORE YOU START YOUR SILLY PPO APPEALS FOR ERISA PROBLEMS.

"PROVIDER DISPUTE RESOLUTION:

If you disagree with a Blue Cross claim or billing determination, or Blue Cross' request for reimbursement of an overpayment, or if you have a contract dispute. **you may submit a provider dispute** by mailing written notice to us Disputes involving a claim, billing or overpayment must also include the service

'From/To" date. State dispute resolution requirements are preempted by Federal laws."

All Non-ERISA Provider Appeals Under State Laws Are Pre-empted by Federal laws – ERISA.

SO, WHAT AM I SUPPOSED TO DO? MANAGED-CARE SLAVERY OR ERISA SUPERHERO?

1. Understand ERISA and your managed care contracting
2. Become an authorized representative under ERISA
3. Appeal ERISA claim denial and delays first
4. Appeal PPO discount if and after all of the ERISA issues disputes are resolved or moot.