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Best Practices in Administering Benefit Claims #4 – Know (and Understand) the Law: Full and Fair Review

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This week in our blog series on best practices in administering benefit claims, we discuss the importance of knowing and, importantly, understanding the laws governing benefit claim administration.

Section 503 of ERISA sets forth the general guidelines for a plan's claims and appeal procedures. It requires that a plan provide adequate written notice of the denial of a claim by a participant or beneficiary (or authorized representative). The notice has to set forth the specific reasons for the denial and be "written in a manner calculated to be understood by the participant." ERISA also requires that a plan provide a participant whose claim has been denied the opportunity for a "full and fair review by the appropriate named fiduciary." The U.S. Department of Labor's implementing regulations elaborate on the ERISA claims procedures requirements in much more detail and, in particular, concern the time, notification, and content requirements for each phase of the claims process.

- *What is the timing for an initial claim decision?* The regulations provide specific timing requirements for deciding an initial claim; generally speaking, a decision regarding a claim must be rendered within 90 days of receipt of the claim regardless of whether the claim was complete. That period can be extended in the case of "special circumstances" provided the claimant is notified of the extension before the expiration of the initial period. In some cases (*g.*, urgent care, pre-service, and post-service claims under a group health plan), the period may be shorter than 90 days.
- *What information must an adverse claim decision include?* If the claims fiduciary determines that the claim should be denied (in whole or in part), that adverse determination has to include the specific reasons for determination, information needed to perfect the claim, references to relevant plan provisions, a statement of the claimant's right to relevant documents, a description of the plan's appeal

procedures and time limits, and a statement of the claimant's right to bring suit under ERISA following an adverse benefit determination on appeal. Additional information may be required when dealing with a group health plan or a plan providing disability benefits.

- *What is the timing for decision on appeal?* A claimant should be given at least 60 days (or 180 days for group health plans) to appeal following receipt of an adverse benefit determination notice. In connection with their appeals, claimants should be given the opportunity to submit comments and other documentation related to the claim, and to request any documents, records, and information relevant to the claim.
- *Who decides the appeal and what information must an adverse appeal decision include?* The same person or group may generally decide the claim and appeal other than for group health plans where the decision-maker on the appeal must be different from the decision-maker on the claim. In all cases, the fiduciary responsible for the decision on appeal may not give deference to the initial claim decision and should take into account everything submitted in connection with appeal to make its own decision. If there is an adverse benefit determination on appeal, the notice must contain much of the same information as the initial adverse claim decision.
- *Special rules for group health plans.* There are a number of special rules for group health plans, including those noted above and, in certain instances, an external review requirement. These requirements go well-beyond the scope of this blog.

ERISA's claims regulations weave a complex web of rules for a plan's claims and appeal procedures. Care should be taken to (1) review and understand the regulations, and (2) properly document the claims procedures in the plan document and summary plan description.

Next week, we'll discuss the importance of a good claims process and a participant's obligation to exhaust the claims procedures before commencing an action for benefits.

You can find our previously published best practices here:

- #1 – Know (and Read) Your Plan Document
- #2 – Know (and Read) Your SPD
- #3 – Dealing with Benefit Assignments

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