

RECENT CASE HIGHLIGHTS THE IMPORTANCE OF CAREFUL ADHERENCE TO ERISA CLAIM PROCEDURES

Hodgson Russ Employee Benefits Newsletter
October 30, 2017

In a recent case involving a participant's precertification request for Applied Behavioral Analysis therapy ("ABA therapy"), a court held that a claim fiduciary's claim process failed to afford the participant meaningful access to the medical plan's claims procedure.

ERISA requires employee benefit plans to maintain a claims procedure that, in form and operation, complies with standards designed to ensure that aggrieved participants are afforded a reasonable opportunity for a full and fair review of an adverse benefit determination. If the plan maintains an ERISA compliant claims procedure, and the plan's claims fiduciary follows that procedure in denying a claim, two favorable consequences follow: 1) the participant cannot file suit until he or she exhausts the claims procedure (the "exhaustion requirement"); and 2) if the participant, at the conclusion of the claims process, chooses to file seeking a reversal of the adverse benefit determination, the reviewing court will uphold the claim fiduciary's decision unless the court finds that the fiduciary's decision was arbitrary and capricious (the "deferential review standard"). A court may excuse the exhaustion requirement and refuse to apply the deferential review standard if it finds that the claims fiduciary failed to follow the plan's claims process, including the requirement that the participant be afforded meaningful access to the administrative review process. A requirement that played a prominent role in this case is the requirement that when a claim for benefits is denied, either in whole or in part, the fiduciary must send the claimant a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary.

In this case, the defendant claims fiduciary moved to dismiss the complaint on the grounds that the plaintiff/participant did not submit a claim for precertification of ABA therapy; and second, that the plaintiff/participant did not exhaust his administrative remedies before filing suit. The court denied the motion to dismiss the complaint on the basis that the participant did, in fact, provide the information necessary to process his claim. To the extent the participant failed to provide the necessary information, the court held it was the claim fiduciary's obligation to advise him of this fact in a timely and precise fashion, which the claims fiduciary failed to do. Under ERISA rules governing the claims process, claims fiduciaries bear the burden of investigating claims and requesting any additional information they may need to decide the claim. Finding that the claims fiduciary failed to respond to the participant's communications in a meaningful way, the court ruled that the participant was excused from the requirement of administrative exhaustion, and further that it would not apply the deferential review standard, but would review the plaintiff's benefits claim "de novo". Under a de novo review standard, a court is free to substitute its judgment for that of the claim fiduciary.

This case highlights the importance of maintaining an ERISA-compliant claims procedure, communicating the procedure to participants, and adhering to the timeline, notice, and substantive requirements of the procedure. A failure to do so could expose the plan to litigation that might otherwise have been avoided and a greater likelihood that the claim fiduciary's decision will be reversed. *Coleman v. Alcatel-Lucent USA, Inc.* (N.D. Ala., September, 2017).