Claims Procedures

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I. Overview

In November 2000, the Department of Labor (DOL) finalized proposed claims regulations that significantly changed the claims procedure requirements for group health plans and plans providing disability benefits, and also made some changes in the requirements for other types of plans.[1] While the claims procedures for pension plans are substantially similar, the provisions for health and disability plans are considerably more detailed and fundamentally different. The new regulations, referred to herein as the "2000 claims regulations" or the "2000 regulations" to distinguish them from the previous 1977 claims procedure regulations, became effective as to claims filed on or after January 1, 2002 for non-health plans. For group health plans, the 2000 regulations become effective on or after the first day of the first plan year beginning on or after July 1 2002, but in no event later than January 1, 2003.[2] The provisions of the 2000 regulations are described in overview under subheadings II.B., II.C., II.D., and III.B.[3] In addition, Chapter 11, at VII.A. (which covers preemption issues relating to benefit denials and claims processing), discusses certain provisions of the 2000 regulations that give interpretive guidance on the relationship between those regulations and state laws pertaining to claims.[4]

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[1]29 C.F.R. §2560.503-1, 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[2]29 C.F.R. §2560.503-1(o), 65 Fed. Reg. 70,246 (Nov. 21, 2000), as amended by the DOL under 66 Fed. Reg. 35,886 (July 9, 2001). As amended, the regulations are effective for group health claims filed on the first day of the first plan year beginning on or after July 1, 2002, but in no event is the effective date for any group health plan later January 1, 2003.

[3]See *infra* II. In the preamble to the regulations (65 Fed. Reg. 70,255 n.39), the Department expressed the view that the claims procedure requirements of §503 and the regulations thereunder do not govern the determination of the qualified status of domestic relations orders and medical child support orders, but that such determinations are governed by the provisions of ERISA that specifically apply to such orders. See ERISA §§206(d)(3) and 609(a)(5).

[4]*See* 29 C.F.R. §2560.503-1(k), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

II. Claims Procedures

B. Reasonable Claims Procedures

The DOL's final 2000 claims regulations contain provisions applicable to all plans, as well as additional provisions applicable only to group health plans and disability plans. For all plans, the regulations provide that claims procedures will be deemed "reasonable" only if five conditions are satisfied:

1. the claims procedures must meet all applicable requirements of the Department's claims regulations;[5]
2. the summary plan description (SPD) must contain a description of all claims procedures (including preauthorization and utilization review procedures) and a description of all applicable time frames;[6]
3. the claims procedures may not contain any provision or be administered in a way that unduly inhibits or hampers the filing or processing of claims;[7]
4. the claims procedures must allow an authorized representative (including a health care professional with knowledge of the claimant's medical condition) to act on the claimant's behalf;[8] and
5. the claims procedures must contain safeguards to ensure that claim determinations are made in accord with plan documents and that plan provisions are applied consistently.[9]

Of the conditions listed, items (1), (2), and (3) are similar to requirements in the 1977 regulations, except for the new explicit requirement that preauthorization and utilization review procedures be included in the SPD disclosure. Item (4) was not explicitly included in the provisions

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[5]29 C.F.R. §2560.503-1(b)(1), 65 Fed. Reg. 70,246 (Nov. 21, 2000). However, like the 1977 regulations, the 2000 regulations provide that single employer plans established and maintained pursuant to a collective bargaining agreement may be deemed to comply with portions of the regulations, provided the collective bargaining agreement contains certain claims provisions. *See* 29 C.F.R. §2560.503-1(b)(6).

[6]29 C.F.R. §2560.503-1(b)(2), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[7]29 C.F.R. §2560.503-1(b)(3), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[8]29 C.F.R. §2560.503-1(b)(4), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[9]29 C.F.R. §2560.503-1(b)(5), 65 Fed. Reg. 70,246 (Nov. 21, 2000). Specific documents and information showing compliance with this fifth requirement are producible under other provisions of the regulations. *See* 29 C.F.R. §2560.503-1(m)(8)(iii), 65 Fed. Reg. 70,246 (Nov. 21, 2000) (defining "relevant" for purposes of the disclosure requirements of the regulations) and discussion *infra* at II.D. (on duty to produce relevant information).

of the 1977 regulations requiring establishment of a reasonable claims procedure, although a similar concept existed in other provisions of the 1977 regulations.[10] Item (5) was not explicitly included in the 1977 regulations, although the DOL expressed the view that item (5) merely formalizes a requirement that courts had already held was inherent in the basic fiduciary standards of the Act.[11] For group health plans[12] and plans providing disability benefits,[13] the regulations further provide that claims procedures will be deemed "reasonable" only if four additional, new conditions are also satisfied:

6. the claimant must not be required to file more than two appeals before bringing civil suit;[14]

7. if additional voluntary levels of appeal are available, the claims procedures must satisfy certain other requirements that help to ensure that any decision of the claimant to use these appeal levels is voluntary;[15] and

8. the procedures must not require mandatory arbitration unless it is one of the two levels of review and meets certain other requirements.[16]

Group health plans also are required to meet one additional requirement:

9. the claimant must be notified within specified time frames if he or she did not follow the proper procedures for filing a pre-service claim.[17]

In the case law under the prior claims procedure regulations,[18] the courts continue to address

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[10]Specifically, the provisions of the 1977 regulations dealing with full and fair review required that a duly authorized representative of the claimant be allowed to appeal a denied claim.

[11]Preamble to final regulations, 65 Fed. Reg. 70,252 n.26 (Nov. 21, 2000).

[12]29 C.F.R. §2560.503-1(c), 65 Fed. Reg. 70,246 (Nov. 21, 2000)

[13]29 C.F.R. §2560.503-1(d), 65 Fed. Reg. 70,246 (Nov. 21, 2000)

[14]29 C.F.R. §2560.503-1(c)(2), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[15]29 C.F.R. §2560.503-1(c)(3), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[16]29 C.F.R. §2560.503-1(c)(4), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[17]29 C.F.R. §2560.503-1(c)(1), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[18]A Fifth Circuit decision, while not directly discussing the reasonableness requirement in the DOL regulations, suggests some of the elements of a reasonable claims procedure. *See* Schadler v. Anthem Life Ins. Co., 147 F.3d 388, 395 (5th Cir. 1998) (stating that "the end product of a claims review process wherein §1133 and its regulations have been followed faithfully is a benefits decision that is

the issue of whether a particular plan's claims procedures are reasonable.[19] In *Terry v. Bayer Corp.*,[20] the First Circuit upheld the enforcement of a plan provision that required appeals to be filed within 60 days.

C. Adequate Notice of Claim Denial

The DOL's final 2000 claims regulations contain provisions regarding the manner and content of the "notification of benefit determination." This notification corresponds to the notice of claim denial in the 1977 regulations.[21] Certain requirements for the notification of benefit determination apply to all plans, whereas others apply only to group health plans and disability plans.

For all plans, the notification of benefit determination must include several items. In keeping with the prior regulations, all plans must give the claimant a statement of the specific reasons for the denial, a reference to specific plan provisions on which the denial is based, and a description of any additional information that is necessary to complete the claim.[22] The new regulations also contain a general requirement, similar to that in the prior regulations, that information be provided on how to obtain review.[23] However, there is now also a more specific requirement that the initial decision

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thoroughly informed by the relevant facts and the terms of the plan and, if benefits are denied, includes an explanation of the denial that is adequate to insure meaningful review of that denial").

[19]Sanford v. Harvard Indus. 262 f.3d 590, 26 EB Cases 2071 (D.C. Cir. 2001) (finding a failure to follow reasonable claims procedures when employer, rather than Board of Administration, denied claim after initial grant, because the Board had not specifically been designated this responsibility). Wheeless v. Wal-Mart Stores Assoc's. Health & Welfare Plan, 39 F. Supp. 2d 577, 579–80 (E.D.N.C. 1998) (finding claims procedure that complied with DOL regulations was reasonable even though it did not give the claimant an opportunity to request an extension of time for appeal to gather supporting documents). Chappel v. Laboratory Corp. of Amer., 232 F.3d 719 (9th Cir. 2000) (holding that an express and known plan requirement that the participant submit to binding arbitration after exhausting internal appeals was "reasonable," although the court may still review the arbitration award under the abuse of discretion standard).

[20]145 F.3d 28, 40–41 (1st Cir. 1998) (affirming administrator's decision denying claim of participant who had not filed his appeal within requisite period). *Compare*, Gugin v. J.C. Penney Co., 2000 WL 1728303 (8th Cir. 2000) (unpublished) (holding that it was unreasonable for the Plan Administrator not to extend the deadline for appeal).

[21]However, in contrast to the previously required notice of denial, the notification of benefit determination must be given in some circumstances where benefits are granted (specifically, in the case of urgent care and pre-service claims). 29 C.F.R. §2560.503-1(f)(2)(i), (ii)(B), and (iii)(A), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[22]29 C.F.R. §2560.503-1(g)(1)(i)–(iii), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[23]29 C.F.R. §2560.503-1(g)(1)(iv), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

contain a statement of the claimant's right to sue following an adverse determination on review.[24]

In the case of group health plans and plans providing disability benefits, the notification of benefit determination must supply "any internal rule, guideline, protocol, or other similar criterion" that the plan relied on (or alternatively, a statement that such information will be provided on request).[25] If the denial is based on a medical necessity or experimental treatment exclusion or a similar exclusion or limit, additional explanation is required (or a statement that such an additional explanation is available on request).[26] For urgent care cases, a description must be included of the expedited review process that applies; in addition, the notification of benefit determination for urgent care cases may be provided orally in the first instance.[27]

The 2000 claims regulations contain detailed provisions regarding the time frames that apply to the notification of benefit determination. The general rule, which is consistent with the 1977 regulations, is that notification must be given within 90 days.[28] However, for claims under group health care plans, the notification of benefit determination must be provided within 30 days if the claim is "post-service," as that term is defined in the regulation.[29] If a "pre-service claim" is involved, the time allowed is 15 days.[30] In the case of an urgent care claim, generally only 72 hours are allowed,[31] or 24 hours if the claim is a request for the extension of a course of treatment.[32] The

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[24] *Id.*

[25] 29 C.F.R. §2560.503-1(g)(1)(v)(A), 65 Fed. Reg. 70,246 (Nov. 21, 2000). In a footnote to the preamble to the regulation, the DOL takes the position that such rules, guidelines, protocols, etc., must also be provided to participants and beneficiaries on written request under ERISA §104(b).

[26] 29 C.F.R. §2560.503-1(g)(1)(v)(B), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[27] 29 C.F.R. §2560.503-1(g)(1)(vi) and §2560.503-1(g)(2), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[28] 29 C.F.R. §2560.503-1(f)(1), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[29] 29 C.F.R. §2560.503-1(f)(2)(iii)(B), 65 Fed. Reg. 70,246 (Nov. 21, 2000). Under the regulations, a "post service claim" is any claim that is not a pre-service claim; a pre-service claim is one for benefits that are payable only if plan approval is obtained before care is provided. 29 C.F.R. §2560.503-1(m)(2) and (3), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[30] 29 C.F.R. §2560.503-1(f)(2)(iii)(A), 65 Fed. Reg. 70,246 (Nov. 21, 2000). The definitions of "pre-service claim" and "post-service claim" are found in 29 C.F.R. §2560.503-1(m)(2) and (3).

[31] 29 C.F.R. §2560.503-1(f)(2)(i), 65 Fed. Reg. 70,246 (Nov. 21, 2000). An exception is made if the claimant fails to provide sufficient information. In such a case, the plan must notify the claimant within 24 hours of the information necessary to complete the claim; the claimant is given 48 hours to provide the information; and a decision is required 48 hours after the plan receives the claimant's information or the time for providing the information runs out. *Id.*

[32] 29 C.F.R. §2560.503-1(f)(2)(ii)(B), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

time provided for the notification of benefit determination in disability cases is 45 days.[33] Allowance is made for extensions of all of these time frames in circumstances such as the need for additional documents or information or because of matters beyond the control of the plan.[34]

Under a group health plan, if a course of treatment is being provided over a period of time or in a number of treatments, reduction or termination of the treatment is deemed an adverse determination of a benefit claim.[35] In such circumstances, notification of the adverse determination must be given sufficiently in advance to allow the claimant an opportunity to appeal the decision and obtain a decision on appeal before the termination or reduction takes place.[36]

Several circuit courts have addressed the issues of what constitutes a notice of claim denial[37] and what a notice must state to satisfy the claims procedure requirements of ERISA and the 1977 claims regulations.[38]

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[33]29 C.F.R. §2560.503-1(f)(3), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[34]29 C.F.R. §2560.503-1(f)(2), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[35]29 C.F.R. §2560.503-1(f)(2)(ii)(A), 65 Fed. Reg. 70,246 (Nov. 21, 2000). Such decisions are called "concurrent care decisions."

[36]29 C.F.R. §2560.503-1(f)(ii)(B), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[37]Robyns v. Reliance Standard Life Ins. Co., 130 F.3d 1231, 1236–37 (7th Cir. 1997) (holding that letter sent to participant advising him, inter alia, that his benefits were being suspended did not constitute claim denial and therefore did not trigger the procedural protections of the statute); White v. Aetna Life Insurance Company, 210 F.3d 412, 24 EB Cases 1801 (D.C. Cir. 2000) (holding that although the plan orally and in writing gave three different reasons for denying the claim, in reality it relied on a fourth reason not given; the notice was deemed not to be in substantial compliance with the statute). Regula v. Delta Family-Care Dis. Surv. Plan, 266 F.3d 1130, 26 EB Cases 2351 (9th Cir. 2001) (finding that claim denial citing to specific plan provisions and relevant physicians' reports as basis for denial is sufficient). Renaldi v. Sears, Roebuck, 26 EB Cases 1672 (N.D. Ill. 2001) (finding that substantial compliance with established claims procedures is sufficient, despite certain procedural violations, where claimant had opportunity to present evidence and, at trial, could not identify additional evidence he could have submitted which would have changed outcome of determination).

[38]Friedrich v. Intel Corp., 181 F.3d 1105, 1108 (9th Cir. 1999) (finding notice of denial insufficient where plan failed to advise the claimant of his right to submit medical evidence and of the criteria used by the plan administrator in making claim determinations); Schleibaum v. K-Mart Corp., 153 F.3d 496, 499–500, 22 EB Cases 1649 (7th Cir. 1998) (holding that there was not actual or even substantial compliance with requirements of ERISA where the denial letter failed to specify—at a time when he could have done something about it—the materials the claimant could submit to perfect his claim), *cert. denied*, 525 U.S. 1105,119 S. Ct. 872, 22 EB Cases 2912 (1999); Lee v. California Butchers' Pension Trust Fund, 154 F.3d 1075, 1079–80, 22 EB Cases 1954 (9th Cir. 1998) (finding a plan violated ERISA's claims procedure requirements where the initial denial letter was late, did not cite specific reasons for denying the claim, did not refer to specific plan provisions on which the denial was based, used conclusory statements, and was not written in manner calculated to be

D. Full and Fair Review and Access to Pertinent Documents

Like the 1977 regulations, the DOL's 2000 claims regulations require that all plans afford the claimant a reasonable opportunity to appeal a denial to an appropriate named fiduciary.[39] Also like the 1977 regulations, the 2000 regulations also require that the review of the claim be "full and fair."[40] Unlike the prior regulations, the 2000 regulations set forth specific requirements for a full and fair review that apply to all plans[41] and additional requirements for a full and fair review that apply only to group health plans and plans providing disability benefits.[42]

For all plans, full and fair review requires satisfaction of four basic requirements. First, the claimant must have an opportunity to submit comments, records, and other information.[43] Second, the claimant must be given access to documents, records, and other information "relevant to the

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understood by a lay person); Kinkead v. Southwestern Bell Corp. Sickness & Accident Disability Benefit Plan, 111 F.3d 67, 68–69, 20 EB Cases 2704 (8th Cir. 1997) (finding that letter complied with ERISA where it advised participant of her right to review and her right to examine the file and explained where and when to submit a request for review); Booton v. Lockheed Med. Benefit Plan, 110 F.3d 1461, 1463–64 (9th Cir. 1997) (holding that plan administrator did not comply with the "common sense standard" set forth in the DOL regulations when administrator denied claim without obtaining relevant information or providing explanation); Houston v. Ameritech Sickness and Accid. Dis. Benefit Plan, 1999 U.S. Dist. LEXIS 4640, 23 EB Cases 1638 (N.D. Ill. 1999) (finding reliance on pre-MRI report by insurer to be unreasonable, even where claimant failed to provide copy of MRI to insurer, to insurer, citing Johnson v. Ameritech Sickness & Accident Disability Benefit Plan, No. 97 C 0990, 1999 U.S. Dist. LEXIS 4640, 23 EB Cases 1638 (N.D. Ill. Apr. 2, 1999) (finding that where claimant provided documents from treating physician and plan responded with statement that benefits were denied for lack of medical documentation, plan did not satisfy requirements that notice of denial give specific reasons for denial and describe additional material needed).

[39]29 C.F.R. §2560.503-1(h)(1), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[40]29 C.F.R. §2560.503-1(h), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[41]29 C.F.R. §2560.503-1(h)(2), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[42]Reg. 29 C.F.R. §2560.503-1(h)(3) (group health plans) and (h)(4) (plans providing disability benefits), 65 Fed. Reg. 70,246 (Nov. 21, 2000). In addition to these requirements, the provisions of the 2000 regulations on maintaining a "reasonable claims procedure" also impose certain limitations on the review process. See *supra* II.B. (discussing the requirements that a reasonable claims procedure include no more than two levels of mandatory appeal and that binding arbitration be used only under specified conditions). Also, the case law construing the reasonable claims procedure requirement under the statute and the prior regulations often addresses questions about the review process. See *supra* II.B. (noting decisions in *Wheeless* and *Terry* concerning time for appeal).

[43]29 C.F.R. §2560.503-1(h)(2)(ii), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

claim."[44] Third, the information submitted by the claimant must be taken into account, regardless of whether it was submitted or considered at the time of the initial benefit determination.[45] And fourth, for all plans other than group health plans, at least 60 days must be allowed for filing the appeal.[46] These requirements are similar to those in the 1977 regulations, with two distinctions. First, the requirement in the 1977 regulations that review be allowed of "pertinent" documents has been replaced with a requirement that access be given to "relevant" documents and information, and a very detailed definition is given of the term "relevant."[47] Second, an explicit requirement has been added that information submitted by the claimant be taken into account, regardless of whether it was submitted or considered at the time of the initial benefit determination.

For group health plans and plans providing disability benefits, the following additional, new requirements apply under the 2000 regulations. Full and fair review must not accord deference to the initial determination.[48] The appropriate named fiduciary who reviews the claim must not be the party who made the initial decision, nor be a subordinate of that party.[49] The review of any determination based on a medical judgment (including determinations of whether a treatment or drug is experimental, investigational, medically necessary, or appropriate) must be conducted in consultation with an independent health care professional who has appropriate experience in the field of medicine involved in the medical judgment.[50] Provision must be made for identifying any medical or vocational experts whose advice the plan obtained in making the benefit determination.[51] Finally, a minimum of 180 days must be allowed for filing an appeal.[52] Full and fair review of urgent care claims is subject to special requirements under the 2000 regulations intended to allow review on an expedited basis (using telephone, facsimile, etc.).[53]

The decision on review, like the initial decision, is subject to certain requirements with

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[44] 29 C.F.R. §2560.503-1(h)(2)(iii), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[45] 29 C.F.R. §2560.503-1(h)(2)(iv), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[46] 29 C.F.R. §2560.503-1(h)(2)(i), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[47] 29 C.F.R. §2560.503-1(m)(8), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[48] 29 C.F.R. §§2560.503-1(h)(3)(ii) and 2560.503-1(h)(4), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[49] *Id.*

[50] 29 C.F.R. §2560.503-1(h)(3)(iii) and (v), and 29 C.F.R. §2560.503-1(h)(4), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[51] 29 C.F.R. §§2560.503-1(h)(3)(iv) and 2560.503-1(h)(4), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[52] 29 C.F.R. §2560.503-1(h)(3)(i) and 2560.503-1(h)(4), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[53] 29 C.F.R. §2560.503-1(h)(3)(vi), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

respect to the manner and content of notification.[54] Again, some of the requirements apply to all plans, and some apply only to group health plans and plans providing disability benefits. For all plans, the "notification of benefit determination on review" must provide the specific reasons for the denial, a reference to specific plan provisions on which the denial is based, and a statement that the claimant may receive documents, records, and other information "relevant to the claim." The notice must also describe any voluntary appeals procedures. For group health plans and plans providing disability benefits, the 2000 regulations provide that the notice of determination on review must include certain additional statements that are similar in part to those required for the initial notice of determination.[55] Specifically, the notice must provide "any internal rule, guideline, protocol, or other similar criterion" that was relied on (or alternatively, a statement that such information will be provided on request).[56] Also, if the determination is based on an exclusion such as "medical necessity, or experimental treatment, or a similar exclusion or limit," additional explanation is required (or a statement that such an additional explanation will be provided on request).[57] Finally, the notice must provide a statement concerning voluntary alternative dispute resolution options and where to get information about them.[58]

The 2000 regulations require that the notification of the decision on review must be provided within certain time frames. The general rule is that the notification must be given within a reasonable period of time not to exceed 60 days,[59] which is the period of time allowed for the decision on review under the 1977 regulations. The same period generally applies to group health care plan claims, provided they are post-service claims;[60] however, if a plan's procedures provides for two levels of appeal, each must be decided within 30 days.[61] If a pre-service claim is involved, the time allowed is 30 days, provided, however, that if the plan's procedures require two levels of appeal, the determination must be made, on each level, within 15 days of the date the plan received the claimant's appeal.[62] In the case of an urgent care claim, a maximum of 72 hours is generally allowed.[63] The time provided for the notice of benefit determination in disability cases is generally

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[54]See *supra* II.C., concerning the notice requirements that apply to the initial decision.

[55]*See* 29 C.F.R. §2560.503-1(g)(1)(v)(A) and (B), discussed *supra* II.C.

[56]29 C.F.R. §2560.503-1(j)(5)(i), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[57]29 C.F.R. §2560.503-1(j)(5)(ii), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[58]29 C.F.R. §2560.503-1(j)(5)(iii), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[59]29 C.F.R. §2560.503-1(i), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[60]29 C.F.R. §2560.503-1(i)(2)(iii), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[61]*Id.*

[62]29 C.F.R. §2560.503-1(i)(2)(ii), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[63]29 C.F.R. §2560.503-1(i)(2)(i), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

45 days, and this time period is allotted for both levels of appeal.[64] All plans except group health plans may extend for 60 days (45 days for plans providing disability benefits) their time to respond to an appeal.[65]

There are special rules relating to the timing of notification that apply to multi-employer plans where the claims fiduciary is a board or committee that meets at least quarterly. These exceptions do not apply to urgent care claims or pre-service claims.[66]

Courts continue to address ERISA's requirement that a claimant be given a reasonable opportunity for a full and fair review of a claims denial. The provision of the 1977 regulations that gives claimants the right to review "pertinent documents"[67] was at issue in several of these cases.[68] Another case dealt with a plan that appeared to have no formal review procedure.[69]

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[64]29 C.F.R. §2560.503-1(i)(3), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[65]29 C.F.R. §2560.503-1(i)(1)(i) and (i)(3), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[66]29 C.F.R. §2560.503-1(i)(1)(ii), (i)(2)(iii)(B) and (i)(3)(ii), 65 Fed. Reg. 70,246 (Nov. 21, 2000).

[67]29 C.F.R. §2560.503(g)(1)(ii) (1977 regulations). See also *supra* II.D., discussing comparable provisions in the 2000 regulations. Participants seeking review of "pertinent documents" under the 1977 regulations have often alleged that the documents are disclosable not only under ERISA §503 but also under ERISA §104(b)(4). For a discussion of documents that are disclosable under ERISA §104(b)(4). See also Employee Benefits Law (BNA), Chapter 12, at II.A.1. and II.A.5., on claims for relief and remedies for failure to produce documents (including failure to produce documents required under §§503 and 104(b)(4)).

[68]Hernandez v. Prudential Ins., 26 EB Cases 1423 (D. Utah 2001) (finding that insurer had discretionary authority under plan, even though not the "named fiduciary" and, as a result, was obligated to respond to plaintiff's request for mental health care review criteria, which court deemed "essential" for plaintiff to determine his rights). *Compare* Am. Med. Ass'n v. United Healthcare Corp., 26 EB Cases 1897) (S.D.N.Y. 2001) (finding that ERISA's disclosure duty is imposed upon "employee benefit plans" and not on insurers. Doe v. Travelers Ins. Co., 167 F.3d 53, 60, 22 EB Cases 2433 (1st Cir. 1999) (holding that this provision of the regulations did not require production of medical health guidelines used by an insurance company to determine medical necessity, because claimant had only requested "the medical reviewers' report"); Teen Help v. Operating Eng'rs Health & Welfare Trust Fund, 1999 U.S. Dist. LEXIS 21989, 24 EB Cases 1773, 1778 (N.D. Cal. 1999) (ruling that regulations' requirement that pertinent documents be produced compelled production, on request, of medical review officer's rationale in denying the claim as well as review officer's credentials and the utilization review criteria); Runyon v. Unum Life Ins. Co., No. 98-0174-A, 1999 U.S. Dist. LEXIS 8633, 1999 WL 386953 (W.D. Va. Apr. 13, 1999) (finding that DOL regulations supported the conclusion that a plan could not base a claim denial on conversations with plan's reviewing physician that had not been reduced to writing, because the conversations could not be disclosed to the participant as "pertinent documents").

[69]Adams v. Cyprus Amax Mineral Co., 44 F. Supp. 2d 1126, 1135–37, 23 EB Cases 1839 (D.Colo. 1999) (finding questions of fact as to (1) whether plan provided reasonable opportunity for review where administrator testified plan had no claims procedure, and (2) whether this deficiency was cured

In keeping with previous case law, a number of recent decisions dealing with full and fair review have considered whether the quantity and quality of evidence considered by the plan administrator was adequate to satisfy the requirement of full and fair review.[70] Several courts found that there was no full and fair review where evidence was proffered but not accepted.[71] Consistent with earlier decisions, several courts concluded that for full and fair review to occur, the participant must have been given adequate information about the basis for the initial claims denial.[72]

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when participant was sent a summary report of claim during settlement negotiations 2 years after the benefits request).

[70]Meditrust Fin. Servs. Corp. v. Sterling Chems., 168 F.3d 211, 215, 22 EB Cases 2881 (5th Cir. 1999) (holding plan conducted full and fair review when it reviewed medical records six times and relied on opinion of qualified general practitioner instead of obtaining opinions from medical specialists); Crocco v. Xerox Corp., 137 F.3d 105, 108 (2d Cir. 1998) (affirming district court's ruling that there was no full and fair review where plan administrator merely relied on denial decision of outside medical review group without exercising independent judgment).

[71]Killian v. HealthSource Provident Adm'rs, 152 F.3d 514, 519–22, 22 EB Cases 1499 (6th Cir. 1998) (affirming, under an arbitrary and capricious analysis, district court's ruling that there had been no full and fair review of a preauthorization denial where plan—which had no appeal procedure for preauthorization decisions—refused to consider new evidence pertinent to its decision; in support of its holding, court emphasized the nature of preauthorization denials, where there is a dynamic situation with constantly evolving considerations, and implied that it is especially important in that context to allow additional information to be submitted); Lee v. California Butchers' Pension Trust Fund, 154 F.3d 1075, 1079–80, 22 EB Cases 1954 (9th Cir. 1998) (finding that claimant had not been given a fair opportunity for review, in part because plan had refused to proceed at a belated hearing when the claimant did not appear in person); Williams v. International Paper, 227 F.3d 706 (6th Cir. 2000) (holding that plan failed to conduct a full and fair review when it denied the claimant an opportunity to introduce new medical reports for a independent medical review, where the reports provided ample evidence of disability); Mizzell v. The Paul Revere Life Ins. Co., 118 F. Supp. 2d 1016 (C.D. Cal. 2000) (finding that plan did not give a full and fair review where it only considered the appeal letter from the claimant's physician as the appeal, and did not consider the appeal presented by the claimant's legal representative).

[72]*Lee,* 154 F.3d at 1079–80 (finding that claimant had not been given a fair opportunity for review, in part because plan's initial denial letter was inadequate) (see *supra* II.C.); Teen Help v. Operating Eng'rs Health & Welfare Trust Fund, 1999 WL 1069756, 24 EB Cases 1773, 1778 (N.D. Cal. Aug. 24, 1999) (requiring disclosure of medical reviewer's rationale, noting that without this information "the claimant is left to shoot at a cloaked target and cannot deploy her arguments and evidence in a fashion that will meaningfully address the administrator's concerns"); Johnson v. Ameritech Sickness & Accident Disability Benefit Plan, No. 97 C 0990, 1999 U.S. Dist. LEXIS 4640, 23 EB Cases 1638 (N.D. Ill. 1999) (finding that adequate reasons for denial were not given, and this could prevent a claimant from addressing the determinative issues and having a fair chance to present his case on appeal) (see *supra* II.C.).

Courts also continue to address the issue of whether a party may urge a theory in court that was not presented or considered during administrative review of the claim.[73]

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[73]Yochum v Barnett Banks, Inc. Sev. Pay Plan, 234 F.3d 541, 547, 25 EB Cases 1449 (11th Cir. 2000) (holding that plaintiff could present additional theories to the district court because defendant denied him the opportunity to appeal); Stafford v. First Tennessee National Bank, 25 EB Cases 1555) (6th Cir 2000) (holding that a participant may rely in court on a plan provision not cited during the administrative review); *Schadler*, 147 F.3d at 398 (remanding newly raised issue to plan administrator while acknowledging that in some cases, such as where the administrator repeatedly refuses to rule or delays ruling, trial court may consider new theory under de novo review); Marolt v. Alliant Techsystems, 146 F.3d 617, 620 (8th Cir. 1998) (rejecting plan's construction of SPD because that construction was not mentioned at time of the initial claim denial or during the administrative review process); Peruzzi v. Summa Med. Plan, 137 F.3d 431, 435 (6th Cir. 1998) (stating, where claimant urged new theory in court, that "[w]e are doubtful that Peruzzi may properly raise this argument now because it is unclear that he presented it to the plan administrator"); Mitchell v. First Unum Life Ins. Co., 65 F. Supp. 2d 686, 696–97, 22 EB Cases 2636 (S.D. Ohio 1998) (remanding for administrative review new issues that were raised by defendant at trial but not included in its letters denying benefits); Juliano v. HMO of New Jersey, Inc., 221 F.3d 279, 25 EB Cases 1493(2d Cir. 2000) (holding that although it would not allow participants to be "sandbagged by after-the-fact plan interpretations devised for purposes of litigation," the remedy for plan's failure to raise argument that services were not "medically necessary" was to allow the district court to hear evidence on the issue from plaintiff).; Univ. Hosp. of Cleveland v. Emerson Elec., 202 F.3d 839, 23 EB Cases 2689 (6th Cir. 2000) (holding that one administrative committee member's testimony as to rationale for denial cannot be used to "shore up" an inadequate denial letter). See also *infra* IV.D. (discussing cases where court was asked to consider evidence not submitted previously to the plan).