# The Non-Subscriber Case Law Update

A Bi-Monthly Publication Dedicated to Detailing Recent Cases Pertaining to Non-Subscription Issues.

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## Recent ERISA Case

It is unusual that I come across an ERISA case that I feel is particularly noteworthy. Since most Non-subscribers have ERISA benefit plans which provide medical benefits and wage indemnity for employees injured while at work, non-subscribing employers must have some knowledge about ERISA.

In LaFleur v. Louisiana Health Service and Indemnity Co., 563 F.3d 148 (5th Cir. 2009), the district court granted summary judgment to the health insurance company (Blue Cross Blue Shield for Louisiana). The court of appeals reversed and remanded the case back to the trial court. What are noteworthy are the reasons for reversal. Mr. LaFleur was denied benefits for nursing home care after he failed to regain consciousness following a heart bypass operation. Blue Cross denied the care because the care was not skilled nursing (which was covered under the plan) but instead considered custodial care (which was not covered under the plan). Custodial care was defined as care which could be rendered safely and effectively by someone without medical training. Dr. William Weldon, Blue Cross's in house medical director, consulted with Dr. Dwight Brower about whether continuous bladder irrigation (CBI) was a skilled nursing procedure and whether there were alternatives to this type of care. Dr. Brower, in turn, consulted with an unnamed board certified urologist. Based upon Dr. Brower's consultation with the urologist, Blue Cross denied the claim by stating, "Contractual Exclusion for Custodial Care per Medical Director. Notes in the file indicated that Dr. Weldon felt there were alternatives to the CBI. The employee appealed and Dr. Brower responded to the level one appeal. The Level two appeal was done by the Review Committee. Dr. Brower did not consult with other health care professionals in upholding the denial at the level one appeal stage. The level two appeals committee only consulted with Dr. Brower in upholding the denial.

The 5th Circuit Court of Appeals reversed based upon Section 1133 of ERISA which requires a full and fair review and cited to the Department of Labor (DOL) regulations which require that when the denial is based upon medical judgments, the plan is required to consult with a healthcare professional who has appropriate training and experience in the medical field involved in the medical judgment. The court found that neither Dr. Weldon nor Dr. Brower were qualified as neither was a urologist. The fact that they consulted a urologist was not sufficient because they failed to identify him in any of the denial letters or even in the claim file notes. The court also found that the level one and level two appeal were not proper as they relied too heavily on Dr. Broward's opinion or, in the case of the level one appeal, it was performed by Dr. Broward. With regard to an appeal of an initial denial, the DOL regulations require someone other than the person making the initial determination is to review and make the decision on appeal. The appeal is to give no deference to the prior determination. The court did allow for participation by the same doctor in the second appeal; however, the persons making the determination on appeal cannot rely heavily on the first doctor in making their determination and should likely consult with a different doctor with proper qualifications.

You would expect that after all the missteps by Blue Cross that the employee would at least prevail and receive his medical benefits. Wrong. The 5th Circuit ordered the trial court to remand the claim back to the plan administrator (Blue Cross) so they could perform a full and fair review. In essence, Blue Cross was given an opportunity to correct the review process. The employee argued that he should be awarded benefits but the court stated that a retroactive award of benefits for violation of the full and fair review provisions is only granted when the violation is flagrant.

*Comment:*

*This opinion has certainly added to the complexity of denying claims. What this requires the administrator of the plan to determine when considering a claim is whether in accepting or denying the claim is there a medical judgment being made. If so, then they should consult with a person who has the appropriate medical background. If there is an appeal, then the 5th Circuit seems to require that a second doctor, with proper credentials, be consulted. The days of having a nurse on staff to make medical determinations and feeling absolutely comfortable with regard to the process meeting ERISA's fair and full review may be over. Conceivably, a nurse with the proper background may be sufficient but it is still risky due to their lack of doctoral degree. In making decisions in this tight business economy, what cannot be ignored is the remedy for the failure to provide a full and fair review: send the claim back to the plan administrator and do it right this time. This really does not serve any deterrent purpose. Effectively, non-subscribing employers may want to save costs and not consult with a medical provider since 95%+ of plan denials do not lead to an ERISA appeal or lawsuit. If anything, a denial usually leads to a personal injury claim.*

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