Tennessee Medical Association

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ERISA Demand Letter
Response to Recoupment Demand

[Date]

[Employer Plan Administrator]
[Address]

RE: [Patient Name
Patient Address
Patient Phone Number
Patient DOB
Patient SSN/Health Plan ID
Group Policy Numbers]

To Whom it May Concern:
[Name of Practice or Physician] is in receipt of your letter dated xx/xx/xxxx demanding recoupment of claims previously paid based on a post-payment audit performed on behalf of your company. This constitutes an adverse benefit determination under the Employee Retirement Income Security Act of 1974 (ERISA). *Porter v. Anthem Health Plans of Kentucky, Inc.*, 2010 U.S. Dist. LEXIS 25791, *2 (E.D. KY March 18, 2010).
[Name of Practice or Physician] has taken valid assignment of benefits under ERISA for the subscriber patient claims on the dates of services included in the demand letter. Enclosed please find a copy of the patient signed Assignment of Benefits Form, authorizing me to act as the patient's representative in this appeal.

This is to notify you that [Name of Practice or Physician] disputes this determination and is appealing [them all/the following claims:] prior to any recoupment of benefits. You shall not, therefore, offset future claims or otherwise recoup or attempt to collect these funds by any means until a full and fair review has taken place and is final. I request a full and fair review of these claims and the adverse benefit determinations made by your company pursuant to ERISA regulations which require you to provide a proper means to appeal an adverse benefit determination "to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination." 29 CFR § 2560.503-1(h).
Failure to provide such full and fair review shall return the claim back to the status quo and remand back for re-adjudication. *Chionis v. Group Long Term Disability Plan for Edward Health Services Corp.*, 2006 U.S. Dist. LEXIS 49221 (N.D. Ill. July 7, 2006) citing *Hackett v. Xerox Corporation Long-Term Disability Income Plan*, 315 F.3d 771, 776 (7th Cir. 2003).
Pursuant to ERISA, I request that [Plan Administrator] provides the following information to my practice within [60 days if plan requires one level of appeal or 30 days if plan requires two levels of appeal]:

1. Specific reasons for denial,
    - Courts have held that a mere conclusory statement that service was not "medically necessary" (*Weiner v. Health Net of Connecticut*, 311 Fed.Appx. 438, 441 (2d Cir. 2009)) or that "the claims were processed incorrectly" (*Harlick v. BlueCross BlueShield of California*, 686 F.3d 699 (9th Cir. 2012); *Flinders v. Workforce…*, 491 F.3d 1180, 1191 (10th Cir. 2007) are insufficient reasons to demand a recoupment. As such, we demand a valid reason under ERISA for recouping this payment.
2. Reference to specific plan provisions on which determination was based,
3. A description of any additional material or information necessary for me to perfect the claim,
4. A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of my right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination,
5. Copy of internal rule or guideline of use in making denial or a statement that I may access them free of charge, and
6. Statement that explanation of scientific or clinical judgment used in making denial will be provided free of charge if denial was based on medical necessity. 29 CFR 2560.503-1(g).

The regulations further provide that a document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or
- In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination. 29 CFR § 2560.503-1(m)(i)-(iii).

If these requests are ignored, [Plan Administrator] may be liable for penalties and other relief as necessary. 29 CFR § 1132(c)(1). In addition, please note that federal law prohibits [Plan Administrator] from taking any retaliatory actions against me, my practice, or the above indicated patient. 29 USC §1140. If any such action is taken, the injured party reserves the right to file a complaint with the US Department of Labor and may be entitled to injunctive relief.

It is the hope of [Name of Practice or Physician] that [Plan Fiduciary or Contractor] will realize that these claims were paid correctly and withdraw the subject recoupment demands. In the alternative, we hereby pursue our request for a full and fair review of these claims.

Sincerely,

[Treating Physician]