U.S. Department of Labor **Employee Benefits Security Administration**
Washington, D.C. 20210

June 10, 2005

Dr. Gary W. Conant, D.C.
Conant Chiropractic Clinic
15364 S. Telegraph Road
Monroe, MI 48161-4070

2005-16A
ERISA SEC.
503

Dear Dr. Conant:

This is in response to your request for an advisory opinion from the Department of Labor (Department) regarding the claims procedure regulation under Title I of the Employee Retirement Income Security Act of 1974 (ERISA). Your inquiry concerned the requirement in 29 C.F.R. § 2560.503-1(h)(3)(iii) that a named fiduciary deciding an appeal of a health benefits claim that was denied, in whole or in part, based on medical judgment must consult with a "health care professional" who has appropriate training and experience in the field of medicine involved in the medical judgment. You asked in particular for the view of the Department on whether the definition of "health care professional" in 29 C.F.R. § 2560.503-1(m)(7) requires the physician or other health care professional to be licensed either in the State where the claimant received the health benefit services or in the State where the claimant resides in order to perform the consultation.

Your correspondence includes the following facts and representations. You are a chiropractor whose practice is in Michigan. Several of your patients are participants in a self-funded group health plan sponsored by their employer in Michigan. Post-service claims for the chiropractic services were submitted to the plan's third-party claims administrator (TPA) located in Texas. The claims were denied in whole or in part by the plan. The adverse benefit determinations were appealed in accordance with the plan's claims procedures and the denials of the claims were upheld on appeal. You requested, and the plan's TPA provided, the names of the chiropractors that were consulted as part of the appeals process. You represent that the chiropractors that performed the medical reviews were not licensed in the State of Michigan.

Pursuant to section 503 of ERISA, employee benefit plans covered by Title I must establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations. The Department issued a final regulation on November 21, 2000, that amended and updated the minimum requirements for employee benefit plan claims procedures under section 503 of ERISA.[1] The final regulation established special rules for group

[1] The final rule is effective with respect to benefit claims filed on or after January 1, 2002, under all plans other than group health plans. For claims filed under a group health plan, the final rule is effective

health plans and plans providing disability benefits. Of particular relevance to your inquiry, subsection 2560.503-1 (h)(3)(iii) of the regulation establishes a special rule for appeals of adverse benefit determinations involving medical issues. Specifically, in the case of group health plans, the appropriate named fiduciary deciding an appeal of an adverse benefit determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, must consult with a "health care professional" who has appropriate training and experience in the field of medicine involved in the medical judgment.

"Health care professionals" that may be engaged to provide the required medical consultation are defined in subsection 2560.503-1(m)(7) of the claims procedure regulation as a "physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law." Subsection 2560.503-1(h)(3)(v) further provides that the health care professional engaged for purposes of such consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.[2] This requirement of consultation is intended to ensure that the fiduciary deciding a claim involving medical issues is adequately informed as to those issues.

You indicated that the chiropractors consulted by the plan were not licensed, accredited, or certified to perform chiropractic services in Michigan. We will assume for purposes of this opinion that each chiropractor was licensed, accredited, or certified to perform chiropractic services in another State.[3] We will also assume that the plan in question is an "employee welfare benefit plan" covered by ERISA and that the adverse benefit determinations in issue are group health claims.

As a general matter, Title I of ERISA affords plans substantial discretion in structuring and administering their benefit plans so long as ERISA's statutory and regulatory requirements are met. It is the view of the Department that nothing in 29 C.F.R. § 2560.503-1(h)(3)(iii) requires that the health care professional consulted by the plan's named fiduciary in deciding an appeal of a health claim that was denied based on a medical judgment be licensed, accredited, or certified in the State where the services

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beginning on the first day of the first plan year that begins on or after July 1, 2002, but in no event later than January 1, 2003.

[2] The regulation also requires that the claims procedures for group health plans must provide for the identification, when requested by a claimant in connection with an adverse benefit determination, of any medical or vocational experts whose advice was obtained on behalf of the plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the determination. *See* 29 C.F.R. § 2560.503-1(h)(3) (iv).

[3] Section 3(10) of ERISA defines the term "State" for purposes of Title I to include the fifty States, the District of Columbia, and certain territories of the United States.

were rendered or in the State where the claimant resides. Rather, in the Department's view, the regulation's condition is satisfied if the person so consulted by the named fiduciary is a physician or other health care professional with appropriate training and experience in the field of medicine involved in the medical judgment, and that person is licensed, accredited or certified to perform specified health services in any State.

We note that 29 C.F.R. § 2560.503-1 establishes minimum requirements for benefit claims procedures of employee benefit plans covered under Title I of ERISA. This letter should not be read as expressing any view on any issues that might arise from state law requirements applicable to an insurance company or other organization providing benefits under an ERISA-covered plan pursuant to an insurance contract or policy. In that regard, subsection (k) of 29 C.F.R. § 2560.503-1 states that "[n]othing in [the claims procedure regulation] shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section."

This letter constitutes an advisory opinion under ERISA Procedure 76-1 and, accordingly, it is issued subject to the provisions of that procedure, including section 10 thereof relating to the effect of advisory opinions.

Sincerely,

John J. Canary
Chief, Division of Coverage, Reporting and Disclosure
Office of Regulations and Interpretations