THE
NATIONAL LAW REVIEW

District Court in California Denies Motion to Dismiss, Finds an Independent Review Organization to Be a Functional Fiduciary Under ERISA

Friday, June 14, 2019

In *Josef K. v. California Physicians' Service*, No. 18-cv-06385-YGR (U.S. District Court for the Northern District of California, June 3, 2019), Judge Yvonne Gonzalez Rogers concluded that an independent medical review (IMR) organization can be subject to a claim under the Employee Retirement Income Security Act of 1974 (ERISA) as amended, 29 U.S.C. 1132(a)(3), for breach of fiduciary duties based on the review of a medical necessity appeal under an ERISA-governed employee welfare benefit plan.

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Pertinent Facts

The case involved a straight-forward denial of a mental health benefit based on medical necessity. The plaintiff, E.K., is the plaintiff Josef K.'s daughter and was a plan beneficiary. The plaintiffs submitted a claim for benefits under an ERISA employee welfare benefit plan for treatment that E.K. received at two mental health treatment programs. The plan, through Blue Shield and/or its contracted third-party administrator, denied the claim and the appeal of the denial. The plaintiffs then requested an IMR. Maximus Federal Services, Inc. was selected to perform the review. Maximus concluded that E.K.'s treatment was not medically necessary, upholding Blue Shield's denial of the claim. The plaintiffs contended that Maximus failed to consider the evidence submitted in support of the IMR, mischaracterized E.K.'s condition and medical history, and conducted an insufficient review.

Legal Analysis

ERISA Preemption

The court first concluded that the plaintiffs' claim for interference with contract was preempted by ERISA because it was "inextricably tied to the denial of benefits under the ERISA plan."

Breach of Fiduciary Duties

The more interesting part of the opinion is the court's conclusion that Maximus was a "fiduciary" as defined by ERISA and, therefore, subject to allegations of liability under ERISA for breach of fiduciary duty while performing its duties as an IMR organization. Judge Rogers found that a party not named in a plan becomes a fiduciary if (i) the party "exercises any discretionary authority or discretionary control respecting management of such plan or exercises any control respecting management or disposition of its assets," (ii) the party "renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so," or (iii) the party has "any discretionary authority or discretionary responsibility in the administration of such plan."

The court then acknowledged the distinction between a named fiduciary and a functional fiduciary. The parties agreed that Maximus was not a named fiduciary. In fact, plans often have several IMR organizations that are randomly assigned appeals. The only avenue for possible exposure at the pleading stage was if Maximus was a functional fiduciary based on the facts alleged by the plaintiffs.

In explaining the role of a functional fiduciary, Judge Rogers quoted a Ninth Circuit Court of Appeals decision, stating that "merely perform[ing] ministerial duties or process[ing] claims" does not make an entity a functional fiduciary. Rather, a functional fiduciary "has the authority to grant, deny, or review denied claims." According to the judge, "[t]he central inquiry when determining whether a party is a functional fiduciary is whether it was acting as an ERISA fiduciary 'when taking the action subject to complaint.'"

Based on the facts alleged, Judge Rogers concluded that Maximus acted as a functional fiduciary. These alleged facts included that Maximus's role was to decide the medical necessity of treatment. The plan guaranteed coverage for medically necessary treatment, but it did not define "medical necessity." According to Blue Shield, "medically necessary treatment" was defined in its evidence of coverage as treatment that "had been established as safe and effective," was "furnished under generally accepted professional standards," and was determined by Blue Shield to be "[c]onsistent with Blue Shield of California's medical policy," "[c]onsistent with the symptoms and diagnosis," "[f]urnished at the most appropriate level," and not "furnished primarily for [] convenience." The court concluded that "[a] reasonable reading of these allegations is that Maximus exercised significant discretion in reaching its determination regarding medical necessity, including in construing terms like 'safe,' 'effective,' and 'appropriate.'" The plaintiffs alleged that Maximus "'had the authority to interpret level of care guidelines and apply a definition of Medical Necessity' in reaching its conclusions." Because of this discretionary authority, the allegations were sufficient to establish that Maximus was a fiduciary under ERISA.

The court also concluded that Maximus had control over plan assets because, if Maximus concluded the treatment was medically necessary, the claim would be paid or the services provided. If the treatment was found by Maximus not to be medically necessary, the claim denial would be upheld. The court held that "[s]uch allegations indicate that Maximus exercised at least some control over the disposition of the Plan's assets to cover E.K.'s treatment, which is plausibly sufficient to establish functional fiduciary status." This provided an alternative basis for the court to conclude that the allegations were sufficient to establish that Maximus was a fiduciary.

With regard to relief under 29 U.S.C. 1132(a)(3), the plaintiffs sought an order requiring Maximus to make specific modifications to its IMR process. Judge Rogers rejected this claim, recognizing that injunctive relief under 1132(a)(3) must be to enjoin any act or practice that violates ERISA or the terms of the plan. The court concluded: "Insofar as plaintiffs also seek this form of relief under section 1132(a)(3), the Court finds such relief is not available" because the complaint is "devoid of allegations regarding Maximus' review process generally, or how Maximus' conduct may have injured the Plan or all Plan participants." Maximus's alleged breach of fiduciary duties arose out of the review of E.K.'s claim only, and the alleged breach harmed the plaintiffs specifically.

The court did, however, allow the plaintiffs to pursue an equitable surcharge claim under section 1132(a)(3). The plaintiffs argued that they could recover "costs incurred in connection with the investigation of E.K.'s benefits claim." The court also found that the plaintiffs could pursue a clam for "individualized disgorgement of profits, relating to revenue earned by Maximus in the course of reviewing E.K.'s claim denial only."

Key Takeaways

It is important to remember that this matter involved a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6), in which the court must accept as true all of the facts alleged in the complaint. How the allegations fare once the actual facts are established remains to be seen.

In a typical IMR, the company is assigned the claim randomly, and most plans use more than one independent reviewer. The company assigned the claim refers it to a medical specialist, typically a board-certified physician, who makes a determination of whether the services at issue are medically necessary. The plan itself ultimately decides if the claim is payable. It is hard to imagine evidence through which participants can establish that a board-certified physician making a medical necessity decision is a functional fiduciary under an ERISA plan. Nonetheless, it may be wise for plan administrators to step into the process and make the claim decision based on all of the evidence in the administrative record, including the review by the IMR.