Court: Use of ‘Dummy Code’ on Health Plan Claims Violated ERISA

The Fourth Circuit Court of Appeals has ruled that a claims administrator’s practice of encouraging the use of a “dummy” medical procedure code on health insurance claim forms to disguise ineligible administrative fees as legitimate health care expenses violated ERISA.

The plaintiff was covered under her husband’s self-funded group health plan. The health plan hired a claims administrator to process the plan’s claims, and the claims administrator subsequently entered into an agreement with a subcontractor that could provide chiropractic and physical therapy services for less money than the claims administrator. However, the claims administrator did not want to pay the subcontractor out of fees it received from the health plan. Instead, the claims administrator asked the subcontractor to secretly “bury” its fees within the claims submitted by the subcontractor’s

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downstream providers by using a “dummy” procedure code to reflect a “bundled rate,” consisting of the subcontractor’s administrative fee and the cost of the health care provider’s services. Under this arrangement, the self-funded health plan and its participants would effectively pay all or part of the subcontractor’s administrative fees.

When the plaintiff learned of this secret arrangement between the claims administrator and the subcontractor, she sued, alleging that the claims administrator and the subcontractor had breached their fiduciary duties under ERISA. A federal district court ruled that neither the claims administrator nor the subcontractor could be held liable under ERISA because they were not operating as fiduciaries under the terms of the health plan.

Here, the court noted that ERISA recognizes two types of fiduciaries: named and functional. A party that is designated in the relevant plan documents as a fiduciary is a “named fiduciary.” Although the appeals court agreed with the district court that the claims administrator was not a named fiduciary, it noted that a reasonable factfinder could conclude that the claims administrator was a “functional fiduciary” because it exercised control over plan assets and had responsibility in the administration of the plan.

Next, the court turned to the issue of the dummy procedure code and determined that, because the code did not represent covered medical services as required by the health plan’s summary plan description, a reasonable factfinder could conclude that the use of the code violated the terms of the plan. Further, the court noted, a reasonable factfinder could conclude that the claims administrator was unjustly enriched while avoiding payment of the subcontractor’s administrative fees, causing the plaintiff and the health plan to shoulder that expense. Both of these actions, the court noted, constituted breaches of fiduciary duty under ERISA.

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For these reasons, the appeals court reversed the district court's ruling on the fiduciary breach claims and remanded them for further proceedings consistent with this opinion.

Full text of Peters v. Aetna, Inc., 19-cv-2085 (4th Cir. June 22, 2021)

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