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Alerts

# ERISA Exhaustion Requirement Not Satisfied by Verbal Appeal When Plan Required Written Appeal

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*The LHD/ERISA Advisor*

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In *Ligotti v. United Healthcare Services*, 2021 U.S. Dist. LEXIS 106992 (S.D. Fla., June 8, 2021), a Florida district court held that a health care provider challenging claim denials on behalf of his patients cannot satisfy ERISA's exhaustion requirement by verbally appealing adverse benefits determinations when the underlying plan requires written appeals.

Michael Ligotti, a physician owner of a substance abuse clinic, sought reimbursement for treatment he provided to hundreds of patients who were participants in various ERISA employee benefit plans administered by Defendants United Healthcare Services, Inc. and United Healthcare of Florida, Inc. (collectively "Defendants"). The patients had assigned their claims to Ligotti. Defendant's denied the claims because of questions involving the status of Ligotti's medical license.

Ligotti and his clinic ("Plaintiffs") sued Defendants in a Florida federal court under ERISA. Defendants filed a motion for summary judgment on several grounds, including that several of the underlying plans contained anti-assignment provisions and that Plaintiffs had failed to exhaust their administrative remedies. On the first issue, the court sided with Defendants and dismissed all patient claims for which the governing ERISA plan had an anti-assignment clause.

With respect to exhaustion, the court denied Defendants' motion *without prejudice* to allow for additional discovery on the remaining 536 patient claims to determine whether Plaintiffs had exhausted their administrative appeals. The court held that Defendants could renew their motion for summary judgment after the discovery process, which is exactly what Defendants did.

In opposition to the renewed motion, Plaintiffs submitted hundreds of documents produced in discovery that they claimed demonstrated viable appeals. Plaintiffs also argued in the alternative that they made phone calls to Defendants that qualified as appeals. Defendants disagreed that any of the documents constituted proper written appeals and filed multiple plan documents that set forth the requirements for written appeal.

## Attorneys

Peter J. Felsenfeld

## Service Areas

Life, Health, Disability & ERISA Litigation

The court found Plaintiffs' exhaustion argument to be unpersuasive. Specifically, the court stated that none of the documents Plaintiffs produced in discovery constituted appeals; they were mostly claims submissions made before the initial denials, as well as miscellaneous faxes, post-it notes and other documents that included no requests for appeal. Regarding the purported phone calls, the court held that the parties were bound by the unambiguous language in the subject plans requiring written appeals.

ERISA does contain a potential exception to the exhaustion requirement where a plan contains ambiguous or contradictory terms. *See Watts v. BellSouth Telcomms., Inc.*, 316 F.3d 1203, 1204-06 (11th Cir. 2003). However, the court noted Plaintiffs declined to invoke this exception, and it would not have applied anyway because of the clear terms in the plans.

> "The ERISA plans that governed those . . . claims unambiguously required the claimants to appeal adverse benefits determinations before filing their federal lawsuits. But the Plaintiffs (as proxies for their patients) didn't appeal those denials—or, at least, they don't submit any evidence that they did."

Accordingly, the court dismissed 493 patient claims where the exhaustion requirement had not been met. The remaining 43 claims remain in active litigation.

>> Return to the October 2021 edition of The LHD/ERISA Advisor