

Prepared to

APPEAL

How Readiness Is Next to Healthiness

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"Let our advance worrying become advance thinking and planning."

—Winston Churchill

When an insurance provider decides not to pay for a doctor-recommended procedure, a denial has occurred. The procedure may have already happened, or you may be at the preauthorization stage. Regardless—payment has been denied. End of story? Not necessarily. Patients have the right to appeal. And patients should flex this right—especially when a doctor's recommended course of treatment is the best course of action.

But that doesn't mean it's going to be easy. Just the thought of an appeal can be stress-inducing, let alone actually doing it. But there are ways to manage the process logically to minimize stress. What helps most is being ready. And for patients in the IG community, this means being prepared for an appeal, even if you aren't currently having access or reimbursement issues. Think best-defense cliché. What, then, is a good offense? To answer that, we must first go to the beginning of the story.

First Things First

If you don't have a current copy of your plan's benefits, call your insurance company and request one. If you do have one, it's still not a bad idea to call to ask if you have the most recent copy. Once you have it, read it. Pay close attention to two things. First, you have to know what your plan says about your condition (this is important, as the medical knowledge on which an insurer bases a denial may be lacking or out of date). Second, you need to know what treatment your plan allows. Without this knowledge, moving forward will be difficult.

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Once you have taken care of this, the following steps are also necessary for a good offense:

- Start a file now: It's wisest for everyone to already have documents on hand in case treatment is unexpectedly interrupted. This includes lab reports, radiology reports and letters from treating physicians used in requesting authorization for treatment. (Many use a binder for this.)
- Stay in the loop: If your doctor has recently requested preauthorization, an appeal may be happening without your knowledge; ask to be kept in the loop from the get-go. Ask for copies of all tests or lab work done, as well as copies of communication between your doctor and the insurance provider. (Note: Many insurers now have a standard preauthorization form. Find out if yours does by calling or looking on their website. Given varying insurers' requirements and forms, don't expect your doctor to be aware of this.)
- Be armed with medical knowledge: Having relevant medical studies to bolster your case can be vital.

This may sound like a lot to do. And it is. But if a denial happens, and you receive the dreaded letter, you will be ready when it matters most.

To the Letter

A denial letter must include a reason. Knowing this reason is key because this is what your appeal must address. One of the most common reasons is that a procedure or treatment is considered "not medically necessary." On its face, this seems simple enough. But really, the rationale behind it can be nuanced, which these following examples demonstrate.

Example One:

One man was denied IVIG treatment based on his policy's requirement that a patient with multifocal motor neuropathy (MMN) have anti-GM1 antibodies and positive nerve-conduction block studies. Though the patient did have the positive nerve-conduction tests, he did not have the anti-GM1 antibodies. In appealing the decision, this patient provided documentation that showed it is not uncommon for patients with MMN to not have anti-GM1 antibodies. In addition, he was able to show that treatment with IVIG is a standard of care. As a result, he was able to attain a trial of IVIG to help establish whether it would be a good treatment.

Example Two:

A similar case illustrates another important note: Maybe you just need a second opinion. In this case, a patient was denied IVIG based on negative nerve-conduction studies and his lack of anti-GM1 antibodies. The denial letter stated that he "...does not meet the medical necessity criteria. There's no indication this member is having anti-GM1 antibodies and conduction block. This information is unavailable despite specific requests from our nurse manager." The patient was referred to another neurologist who was able to find the nerve-conduction blocks. His case was sent for authorization based on the new studies. Further, he also sent documentation showing that anti-GM1 antibodies are not found in many patients with MMN.

Example Three:

This appeal involves a man who has myasthenia gravis (MG). After a year of IVIG treatment, he was denied reauthorization for IVIG based on a policy of only providing IVIG for MG patients in a myasthenic crisis. Given that his condition had stabilized, he no longer qualified ➤

for treatment. The insurer wanted him to switch to covered maintenance treatments, which include prednisone and Mestinon®. Gathering articles on the use of IVIG in myasthenia gravis patients, as well as physician notes that documented the adverse effects he was having to prednisone and Mestinon—the man wrote an appeal to the independent review board. In his letter, he stated that he felt the insurance company's policy of covering only, in his case, the prednisone and Mestinon was adding to his disability. He also questioned whether that carried a liability issue. Before the case could be reviewed, the insurance company stated that based on the failure of traditional treatment, it would make a single case exception for treatment with IVIG for one more year: "Based on our review of the above information, we are reversing our previous benefit decision and will now allow coverage for continued IVIG therapy for a period of one year. The basis for this determination is that you have been tried on and failed standard therapies and have failed Mestinon for symptomatic therapy."

How to Track Communication During an Appeal

- Stay within the time frame given for an appeal.
- Keep a log of whom you talk with regarding your appeal and when (both insurance representatives and medical providers). This includes date and time, name of the person you spoke to, his or her title, phone number, and conversation details.
- If employees of the health plan say that they'll call back, make note of this too. If they don't, contact a supervisor. And don't hesitate to escalate the issue to a regional director or manager.¹
- If a promise is made over the phone, ask for it in writing; if dealing with an HMO, ask that your conversation be recorded.²
- Save phone bills that show the calls.³
- After each call, send a letter summarizing the conversation and ask to hear back in 30 days.³
- Send letters by registered mail.³ Send your appeal letter and supporting documents all in one packet. Don't be afraid to send a copy to your representative and/or state insurance commissioner.
- This tip comes from the Immune Deficiency Foundation: Save the envelopes of important letters, such as denials that come from the insurance companies. The letters inside are frequently dated a week before the letter actually arrives. If the appeals time frame gets tight, those envelopes are documentation that proves when you actually received notification.

Other Potential Issues

On a less-complicated note, billing issues or administrative errors (an incorrect diagnostic code or procedural code) may also have caused the denial. In one situation, a doctor used a diagnostic code for a condition for which IVIG was no longer covered. Once the proper diagnostic code was given, the issue was resolved.

Inadequate documentation can also lead to a denial. One woman's denial letter stated that "the diagnosis of chronic sinusitis is not adequately documented." The insurance company had not received records because the infectious disease doctor, the one ordering the IG, had not received them either. The patient, of course, didn't realize this. Neither did the infectious disease doctor. According to this patient, "most

¹ *Research and Appeal a Claim Denial*, www.healthsymphony.com/healthinsurance.htm.

² *State of Wisconsin Consumer Guide to Health Care*, <http://dhfs.wisconsin.gov/guide/spec/probins.htm>.

³ Shomon M, Kline W, M.D. *Your Guide to Thyroid Disease. When Your Insurance Company Won't Pay*, <http://thyroid.about.com/cs/newsresearch/a/insurancepay.htm>.

of the records hadn't gotten to the infectious disease doctor, who was the one ordering the IG." In turn, the insurance company did not have any culture reports, hospitalization records, or records of IV antibiotic use—only a report from a doctor stating that these records existed. She determined this by asking for copies for herself of all the relevant medical records. Once she identified what records were missing, she was able to return to the proper source to obtain them.

As the previous cases show, to appeal successfully, you must address the exact reason given for a denial. And as the previous examples also show, getting to the bottom of that reason can be arduous. However, being prepared will not only help immensely, it also may save precious time. Clichés exist for a reason, and when that reason is your well-being—a good offense is vital. ■

The Nuts and Bolts of an Appeal

The following is a synopsis of a full-length publication, "Your Guide to the Appeals Process," which was written, produced and copyrighted by the Patient Advocate Foundation. This publication lists the four necessary steps to submit an appeal, as well as sample appeal letters. The complete guide is available for download at www.patientadvocate.org/requests/publications/Guide-Appeals-Process.pdf or can be requested by patients free of charge by calling 800-532-5274.



Step 1: Gather Preliminary Information

To begin, start a file to document all correspondence. Keep a record of all letters and a log of all calls, including when and how you received notice of the denial, as well as who notified you. You also need a copy of the denial letter from the insurer as well as copies of the information your doctor submitted and the authorization request. If your requests are ignored, make a record of your attempts to obtain this information.

If you've received a denial for a procedure that has already taken place and there are bills unpaid, you need to find out why. For example, does your insurance company require procedures to be preauthorized? If so, did your doctor's office preauthorize the procedure?

The most important documents you need are your plan document and plan summary. If you do not have current copies, write the administrator to request one. Read your plan to learn what it says about your procedure and the specific reason for denial. If the condition was to be preauthorized, do you or does your doctor have a copy of the authorization or the approval ➤

from the insurance company? If no preauthorization was required, review your plan's specific exclusions. If your treatment is not identified as such, you need to begin your appeal.

If the denial letter does not say whom to contact about your appeal, call your insurer and ask. Ask your insurer for a written copy of the steps you must take to appeal the denial. Also, ask your doctor's staff whom to call to ask for letters or records you might need.

Step 2: Understand the Illness and the Insurance

Support from your treating physician and specialist is critical. You must understand what the doctor wants to do and why. Read any letters your doctor may have submitted to the insurance company. You also need to be familiar with your insurance. If your coverage is through an employer, call the benefits manager and ask to have the coverage explained. A benefits manager might be able to work with you to get the denial overturned.

Step 3: Write the Appeal Letters

Some appeals are handled by the doctor's office, the clinic or the hospital. In this situation, a patient will work with a case manager to oversee the process; make sure to ask for copies of all letters and correspondence to and from the insurer.

In other situations, the patient handles the process. Your appeal packet will include an appeal letter; a letter from your doctor and specialist addressing specifics of the case; pertinent information from the medical records; and articles from peer-reviewed clinical journals that support your case by illustrating medical efficacy.

Your appeal letter, which should be factual and written in a firm but pleasant tone, must express why you think the procedure should be covered. In your letter, include identification (policy number, group number, claim number, or other information used to identify the case); the reason given for the denial; a synopsis of the illness and the treatment; the correct information (in cases where, for example, a wrong diagnostic code was used); why you believe the decision was wrong (specific information based on facts to show that the treatment should be provided); what

you are asking the insurance company to do (typically, this is to reconsider the denial and approve coverage in a timely manner).

Your doctor's appeal letter should be addressed to the person at the insurance company who sent the denial letter, or to the medical director at the insurance company.



It should include: 1) important information about your illness; 2) the prescribed treatment plan; and 3) why the treatment is medically necessary. Ask your doctor if there are any medical records that might help your appeal; if so, include these (for example, lab results or certain tests).

Often an insurer will deny a procedure if there's not enough evidence that the procedure can help a specific disease. If this is the case, then submit documentation that the treatment is effective from peer-reviewed medical journals.

This information should be submitted in a packet by registered mail. You should keep copies for yourself, too.

Step 4: Evaluate the Result

If you receive a letter stating that the denial has been overturned, congratulations! But before you celebrate, you need a copy of the approval letter. Also, be aware of any terms, such as a requirement that a specific practitioner perform a surgery. If the requirements are not acceptable, discuss them with your insurance contact and your doctor; you might want to continue the appeal.

If your appeal was denied, you'll need a copy of the second letter, which must also include a reason (which may be different). If this letter asks for more information, notify your doctor. Another contact may be listed in case you continue your appeal. Again, keep copies of the new packet and submit it by registered mail. If your appeal is again denied, you should request the third denial in writing and notify your doctor. If you believe your insurance company should cover the procedure and are willing to proceed with the appeal, refer to the plan document for the next step.

At this point, some insurers will offer an external review, in which case they send your appeal to a company to review the denial, the appeal, and any new information. The review board, which will make a recommendation to the insurance company about the procedure, typically comprises nurses, attorneys and doctors who specialize in the procedure.

If you have exhausted all levels and are still not satisfied, your remaining alternative may be to pursue the issue in court.

When to Consult an Attorney

This important question has no easy answer. If you do not understand the appeal process and are unable to get answers from your employer or insurance company, an attorney may be helpful to advise you of your rights and options. If you do seek legal advice, you should select an attorney with experience in healthcare law. Also, you should discuss legal fees upfront, request detailed billing, and determine at what point the attorney will take over the case.

Some patients will completely exhaust the administrative appeal process before involving an attorney. It is very important that you make every effort to have an attorney during the administrative appeal process in the event you wish to pursue the case later in court.

Others to Notify

In some cases, notifying state and local representatives about insurance issues helps patients. You can send a copy of your denial and appeal letter to your legislators asking for any assistance they can provide. A list of legislators is available by state on the PAF website at www.npaf.org. ■