Excerpt 12: Treatment of Choice - - Focus on Your Objective

Previous Excerpt 11 "Cover Letter -- Opening Salvo"

The treatment that I will focus on in this sample appeal is the treatment that I know the best—cytoreductive surgery and heated intraperitoneal chemotherapy (HIPEC).

If you happen to have an abdominal cancer, and you are appealing for this treatment, the content of the sample appeal will apply directly to you.

If not ... I believe that seeing why, how, and in what order I present this material will be useful and applicable to any patient or medical provider requesting any treatment.

This is not an "appeal template." Insurance companies scoff at appeal templates.They do not work. What I give you in this sample appeal is an inside look at how I prepare, write, and fight an appeal. What goes into it, how to deliver it.

This is not about content. Think of this sample appeal as a bus. I am an expert professional driver, guiding you down the freeway. You may be driving a different vehicle than I—a Toyota perhaps, or a motorcycle. You are definitely not driving a bus.

No matter. You will follow me, and you will get to the destination just the same.

Purpose

No matter what your requested treatment, the first job of your appeal is to teach Acme Insurance about it. Assume that they know nothing.

Remember ... when the appeals department receives your appeal, they are notgoing to jump on the Internet, and start researching your treatment-of-choice. All they is going to do is pull a copy of Acme's Medical Policy Statement, and see if it says "yes," or "no."

Let's look at this section of the sample appeal, and learn how to teach your new friends at Acme about your requested treatment.

CYTOREDUCTIVE SURGERY AND HIPEC: THE TREATMENT

On 4/19/09, Dr. Jeffrey Hart performed a debulking surgery on me for appendix cancer.

Debulking Surgery

"Debulking" means taking out the large (bulky) tumors, and leaving the rest. Dr.Hart explained to me prior to this surgery that this was not an attempt to remove all tumor, just to reduce the amount of tumor and ascites.

Cytoreductive Surgery

"Cytoreductive surgery" is a sugery performed with curative intent, the goal being to remove all visible (macroscopic) disease. My surgery was not an "optimal debulking"—it was a sub-optimal cytoreduction.

Cytoreductive surgery, with intent to remove all visible disease, is like ten abdominal surgeries rolled into one. Consider the following description of a basic, bare bones, no special circumstances cytoreductive surgery. This description comes from the Anthem Blue Cross Blue Shield Medical Policy Statement that declares that this treatment is now standard of care for peritoneal malignancies of gastrointestinal origin.

Cytoreduction initially involves mobilization of the liver, exploration of the diaphragm, mobilization of the stomach and lesser sac, exploration of the bilateral abdominal gutters, pelvic recesses, and mobilization of the large and small bowel with examination for tumor deposits along their entire length. Surgical resection can be extensive, depending on the extent of disease, but may include partial gastrectomy, splenectomy, and resection of the tail of the pancreas, omentectomy, multiple small bowel resections, ileocecal resection, rectosigmoid resection, uterine resection, and multiple peritonectomy procedures. The surgical procedure is followed intraoperatively by the infusion of hyperthermic chemotherapy, most commonly mitomycin C. Inflow and outflow catheters are placed in the abdominal cavity, along with temperature probes to monitor the temperature. The skin is then temporarily closed during the chemotherapy perfusion, which typically runs for 1 to 2 hours.

Without the peritonectomy procedures, there is no complete cytoreduction.

Without a complete cytoreduction, recurrence is nearly 100% guaranteed.

CYTOREDUCTIVE SURGERY AND HIPEC:

THE OUTCOMES

Dr. Sugarbaker's Outcomes

Dr. Sugarbaker has performed over 1500 of these cytoreductive surgeries with HIPEC. He has exhaustively documented his approach, techniques and outcomes in 452 peer-reviewed medical journal articles and studies.

In terms of outcomes, is the Sugarbaker approach to this surgery worthwhile?

Appendiceal mucinous neoplasms somtimes present with peritoneal dissemination, which was previously a lethal condition with a median survival of about three years. Traditionally, surgical treatment consisted of debulking that was repeated until no further benefit could be achieved; systemic chemotherapy was sometimes used as a palliative option. Now, visible disease is removed through visceral resections and peritonectomy.

To avoid entrapment of tumour cells at operative sites and to destroy small residual mucinous tumour nodules, cytoreductive surgery is conbined with intraperitoneal chemotherapy with mitomycin at 42° C. Fluoracil is then given postoperatively for five days.

If the mucinous neoplasm is minimally invasive and cytoreduction complete, these treatments result in a 20-year survival of 70%. In the absence of a phase III study, this new combined treatment should be regarded as standard of care for epithelial appendiceal neoplasms and pseudomyxoma peritonei.

(Sugarbaker PH. New standard of care for appendiceal epithelial neoplasms and pseudomyxoma peritonei? The Lancet Oncology 2006; Vol. 7: 69-75.)

Outcomes Depend on Experience

After studying 323 cytoreductive procedures, Dr. RM Smeenk et al, Department of Surgery, Netherlands Cancer Institute conclude:

The peak of the learning curve, graded by the percentage of complete cytoreductions, was reached after approximately 130 procedures.

Conclusion: The learning curve of combined modality treatment for peritoneal surface disease is long, and reflects patient selection and treatment expertise."

(Smeenk RM et al. Learning curve of combined modality treatment in peritoneal surface disease. Br J Surg 2007 Nov; 94(11):1408-14.)

And this from Dr. Sugarbaker:

It is likely that surgical skill is a more important determinant of prognosis than the aggressive nature of the cancer, or its stage at diagnosis.
(It's what the surgeon doesn't see that kills the patient, PH Sugarbaker*.)*

CYTOREDUCTIVE SURGERY AND HIPEC: THE SCIENTIFIC EVIDENCE

Excellent outcomes reported by leading cancer centers

1. This from Dr. David L. Bartlett and his team, Division of Surgical Oncology, University of Pittsburgh Medical Center:

The most favorable diagnosis was appendiceal cancer, for which two-year survival was 66.7%, with lower-grade histologic subtypes of appendiceal reaching 85.7% two-year survival.
And this regarding the safety of this treatment:

In a high-volume center with extensive experience treating peritoneal malignancies, perioperative mortality can be lowered to nearly zero.

(Bartlett DL et al. Aggressive surgical management of peritoneal carcinomatosis with low mortality in a high-volume tertiary cancer center. Ann Surg Oncol 2008 Mar; 15(3): 754-63.)

2. Dr. Brendan J. Moran, M.Ch, Pseudomyxoma Peritonei Centre, Colorectal Research Unit, Basingstoke, United Kingdom comes to the following conclusion in his peer-reviewed medical journal article "Early results of surgery in 123 patients with pseudomyxoma peritonei form a perforated appendiceal neoplasm (Dis Colon Rectum 2006; 50:37-42.):

Within the last fifteen years, the unique features of epithelial neoplasms of the appendix have led to the development of a novel treatment strategy. This involves cytoreductive surgery for macroscopic tumor removal, involving multiple peritonectomy procedures and visceral resections combined with heated intraoperative and early postoperative intraperitoneal chemotherapy. A number of centers have achieved five-year overall survival rates of 50% to 96% in selected cases.

(Sugarbaker PH, Chang D. Results of treatment of 385 patients with peritoneal surface spread of appendiceal malignancy. *Ann Surg Oncol* 1999;6:727-31.)

(Witkamp AF, de Bree E, Kaag MM, et al. Extensive cytoreductive surgery followed by intraoperative hyperthermic intraperitoneal chemotherapy with mitomycin-C in patients with peritoneal carcinomatosis of colorectal origin. *Eur J Cancer* 2001;37:979-84.)

(Deraco M, Baratti D, Inglese MG, et al. Peritonectomy and intraperitoneal hyperthermic perfusion: A strategy that has confirmed its efficacy in patients with pseudomyxoma peritonei.
Ann Surg Oncol 2004;11:393-8.)

(Shen P, Hawksworth J, Lovato J, et al. Cytoreductive surgery and intraperitoneal hyperthermic

chemotherapy with mitomycin C for peritoneal carcinomatosis from nonappendiceal colorectal carcinomatosis. *Ann Surg Oncol* 2004;11:178-86.)

(Guner Z, Schmidt U, Dahlke MH, Schlitt HJ. Cytoreductive surgery abnd intraperitoneal chemotherapy for pseudomyxoma peritonei. Int J. Colorectal Dis 2005;20:155-60.)

(Moran BJ, Mukherjee A, Sexton R. Operability and early outcome in 100 consecutive laparotomies for peritoneal malignancy. Br J Surg 2006;93:100-4.)

CYTOREDUCTIVE SURGERY AND HIPEC:
THE SCIENTIFIC EVIDENCE

Need I belabor the point? Dr. Sugarbaker pioneered this combined treatment modality of cytoreductive surgery and HIPEC. He has performed over 1500 of these surgeries, with excellent documented outcomes in patients who come to him with peritoneal carcinomatosis—a condition which, before this treatment, was universally fatal.

Leading cancer centers—in the United States and all over the world—have developed programs based on Dr. Sugarbaker's surgical techniques and protocols, and achieved similar outcomes.

There is no question in the professional ranks of surgical oncologists that cytoreductive surgery and HIPEC are standard of care for peritoneal carcinomatosis of all types, with spectactular results with my less aggressive form, pseudomyxoma peritonei.

Compare and Contrast

On page 50 ("Cytoreduction and HIPEC: The treatment"), I take one page to compare and contrast the treatment that I have received in-network, and the treatment that I am requesting.

Make it short, and powerful. I received a debulking surgery. Debulking is palliative, debulking didn't work.

Cytoreductive surgery plus HIPEC is curative. I list the surgical procedures involved in it, to show how much more sophisticated and thorough it is than standard debulking surgery.

Notice a clever twist: My description of my treatment-of-choice comes from a Medical Policy Statement of Anthem Blue Cross Blue Shield, which declares this treatment to be standard of care for my disease.

Might as well kill two birds with one stone, yes?

Compare the ineffective treatment that you have already received (or will be receiving), with the definitive, curative treatment that you are requesting.

Talk about Outcomes

Acme Insurance is supposed to be concerned about your "outcome." Outcome is the magic word, which invokes all of the so-called scientific evidence in Acme's medical policy statements.

If your treatment is not routinely offered by your health insurer, it is the medical policy statement that determines whether they consider it to be "standard of care," "experimental/investigational," "medically necessary," or "not medically necessary."

Find a copy of the medical policy for your requested treatment, if there is one. You will find the med policies on the insurer's website. Or, simply call Acme Insurance, and tell them to fax you a

copy—today.

The whole point of the medical policy statement is to "prove" that your requested treatment is neither safe, nor effective.

Look closely at any of these med policies, and you will find that their "proof" is feeble at best, laughable at worst.

You must address the issue of outcomes. Dig up a page or two of recent peer-reviewed medical journal articles, and you will have more proof than they do.

Scientific Articles: Where to find them

Please don't go trolling all over the Internet, trying to find peer-reviewed medical journal articles to support your appeal.

Why not go where the doctors go, when they want to read up on a treatment? The place where all of the medical journal articles and studies are gathered together in one place?

Begin your search at the database of the National Institutes of Health:http://www.ncbi.nlm.nih.gov/entrez. You can search by topics, authors, or journals.

Let's say that your requested treatment is chemoembolization of the liver. Search for "chemoembolization," or other word combinations that are used to describe your treatment.

Hundreds of abstracts will come up. You will find abstracts only, no full-text articles on Entrez Pub Med. Before I had access to full-text articles, I simply used the abstracts to support my appeals. The conclusions are stated in the abstract, and often that is sufficient for my purposes.

Entrez Pub Med is also useful at the beginning of your process, before you think about writing an appeal.

Learn about the most state-of-the-art treatments—by searching by topic, and typing in the name of your disease or condition.

Find out who the experts are—by searching by topic, and typing in the name of your disease or condition. Then, browse through the titles and abstracts. Who has the most articles and studies?

Let's say that you have a rare disease: splenic marginal zone lymphoma. Look for titles like "Study of 482 patients with splenic marginal zone lymphoma." The author of that study is an expert on your disease.

Why not write him a letter, and see if he has some advice to offer you about your treatment? If you are a candidate, this world's expert may even agree to treat you.

Of course, he will be out of network for your insurance, and your insurer may deny the treatment, calling it "experimental."

So what? You are going to write a powerful appeal, and make Acme Insurance pay.

Scientific Articles: What to do with them

First, I will tell you what NOT to do with scientific articles and studies. Do not attach articles—or lists of articles—to your appeal.

Most people think they are being pretty sophisticated if they manage to find several peer-reviewed medical journal articles, and attach them to their appeal. I followed along in this tradition during my

first three years of appeal writing.

I used to believe that scientific articles impressed insurance companies. Further, I believed that an appeal had to intimidate by the very weight of its pages—the longer, the better.

I won forty-three appeals with this approach. Then I lost one appeal, and updated my approach.

You have found the perfect abstracts to show good outcomes from your requested treatments. You obtained full-text articles by googling around, visiting your local medical library, or calling your expert doctor-of-choice and requesting copies from his office.

You have a stack of a half-dozen wonderful articles about your treatment. What should you do with them?

READ THE ARTICLES. Get out your pencil or highlighter, and read the articles. Read them to learn about your treatment, and read them to find the perfect quotes (gold nuggets) for your appeal.

The bean counters at Acme Insurance are not going to read one word of any article that you attach to your appeal. Articles attached to appeals are just dead weight. You have to read the articles for them—predigest the material, as it were.

When I tried this approach with my forty-fourth appeal, I discovered an unexpected benefit from actually reading the articles, rather than simply attaching them to my appeal.

When I read the articles, I absorbed the scientific information in them, and began to sound like an expert, as I wrote the appeal.

The entire purpose of an appeal is INTIMIDATION. We want them to think that we might be some kind of powerful, dangerous, scary insider.

Before I read the scientific articles, I sounded like a lawyer. After I read the articles, I sounded like a lawyer, a doctor, and a medical researcher.

If you want to intimidate with your mighty knowledge, read the articles, and do not attach them to your appeal.

Scientific Articles: How to showcase them in your appeal

On pages 51-52, see how I deploy the quotes from medical journal articles in my appeal.

I introduce the quote with a short summary of what it says. Then, I drop in the quote.

I showcase the quote by changing the typestyle to 10-point Arial. I double-space between the summary and the quote. If the quotation includes more than one paragraph, I put a half-line (6 pts) between each paragraph of the quote. Finally, I indent the entire quote:

(quote from page 52)

After studying 323 cytoreductive procedures, Dr. RM Smeenk et al, Department of Surgery, Netherlands Cancer Institute conclude:

The peak of the learning curve, graded by the percentage of complete cytoreductions, was reached after approximately 130 procedures.

Conclusion: The learning curve of combined modality treatment for peritoneal surface disease is long, and reflects patient selection and treatment expertise."

(Smeenk RM et al. Learning curve of combined modality treatment in peritoneal surface disease. *Br J Surg* 2007 Nov; 94(11):1408-14.)

When it comes to quotations from medical journal articles, I set aside my "nounderline" rule. Every quote from a scientific article contains one sentence—onegold nugget—that is meant to blow them away, move them, change their mind.

I am going to do everything in my power to make them read that quote, notice thegold nugget, and move one step closer to approving the appeal.

More about Outcomes

On page 50, I compare the palliative in-network treatment with the curative out-of- network treatment.

On page 51, I reveal and showcase the outcomes of my expert-of-choice.

On pages 52-53, I show the outcomes of other experts and groups of experts. I have learned that, if I only include proof and outcomes from my requested out-of-network doctor, Acme Insurance spits in my eye, "He is probably the only one in the world who performs this crazy treatment."

Include plenty of proof from sources other than your expert-of-choice.

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Read the articles yourself, and quote them in your appeal.

Teach them about your treatment. Then, prove with facts that your in-network treatment will not yield a good outcome, and your requested treatment is likely to yield a good outcome. Finally, prove with quotations from peer-reviewed studies and articles that your treatment-of-choice is standard of care for your disease—both according to your expert, and according to other experts.

Your appeal is a teaching exercise, an exercise in persuasion. There is a purpose and direction to your argument. Your argument needs to guide them, lead them, nudge them along. Until they arrive at the point where all they can do is say,
"Yes."

Next Excerpt 13 "Insurance Law -- Powerful Ammo"
Return to main Insurance Warrior page.

To purchase Laurie’s book and CD, click here: http://theinsurancewarrior.com/thebookandthecd.html

Source URL: http://www.carcinoid.org/content/excerpt-12-treatment-choice-focus-your-objective