Excerpt 19: Not Medically Necessary - - Use Their Weapons

Previous Excerpt 18 "Experimental -- Seize Their Weapons"

Insurance companies always deny treatments for the same three reasons:

1. It's Experimental/Investigational
2. It's out of network.
3. It's Not Medically Necessary

"Not medically necessary" used to be the insurers' favorite reason for denial. Why? Because nobody had any idea what it meant. We think we know what "Experimental" means. However—when it comes to Medical Necessity—your average insured person is completely stumped.

It also sounds official, and has the feel of ultimate authority: "My insurer said that it was not medically necessary." 99% of people would knuckle under right there, not suspecting that "medical necessity" is not a medical term, but a legal term.

The phrase "medical necessity" did not exist before the invention of managed ca rein the early 1970s. It is a brilliant phrase, because it implies authority, medical knowledge and control—all in two words.

When I ask people, "What does 'medically necessary' mean?" they say, "Needed for quality of life, needed to keep me alive, needed to treat my condition."

No, no, and no. "Not medically necessary" means that they don't want to pay for it.
People, please. Acme Insurance didn't do a ton of research to find out if you
needed this treatment or not. What you need medically is not at issue here.

Your insurer pulled a copy of their medical policy statement for your requested treatment. If it said "pay," they paid. If it said "experimental," or "not medically necessary," they denied. Period.

Just like "experimental," "medical necessity" means whatever your insurer says it means. Let's look at the sample pages and see how I dispose of the medical necessity objection.

THIS TREATMENT IS MEDICALLY NECESSARY BY ACME'S OWN DEFINITION

This treatment meets every condition of Medical Necessity as defined by the Acme Insurance Evidence of Coverage Summary.

Per Acme, a treatment is considered medically necessary if it is ...

For Diagnosis or Treatment

1. *“necessary for the symptoms and diagnosis or treatment of the condition, illness, or injury”*

There are only three treatment options for appendix cancer. The first is to do nothing. This has shown to be fatal—100% fatal in all the medical literature. Appendix patients with gross residual disease have virtually no chance of survival.

The second option is serial debulking surgeries, in which the mucin is removed, along with the larger and more easily-removed tumors. This treatment is palliative only, and has a uniformly predictable

outcome, found in all the literature about appendix cancer. Further, this fatal prognosis is supported by all three appendix cancer specialists with whom I consulted.

Organs are removed, scar tissue and adhesions increase with each surgery—making it more and more difficult to operate with each surgery. Cancer cells are left in the peritoneal cavity, so the tumors continue to multiply. The surgeries come at shorter and shorter intervals—two years, one-and-a-half years, one year, six months. Eventually, you end up in a nursing home with no stomach, no colon, a feeding tube, and a permanent ostomy. As stated in “New standard of care for appendiceal neoplasms” by Dr. Paul Sugarbaker (The Lancet/Oncology, Vol. 7, 1/2006), “This approach resulted in a median survival of 2.5 years, with few patients being alive after five years.”

The third option is cytoreductive surgery, combined with heated intraperitoneal chemotherapy with an appendix cancer specialist surgeon. This treatment was developed by Dr. Sugarbaker in the 1980s, and is now being used at thirty-eight leading cancer centers in the United States and around the world that treat appendiceal cancer on a regular basis.

The prognosis with this precise, meticulous treatment? I quote again from Dr. Sugarbaker’s article, “New standard of care for appendiceal epithelial neoplasms”:

“If the mucinous neoplasm is minimally invasive and cytoreduction complete, these treatments result in a 20-year survival of 70%.”

THIS TREATMENT IS MEDICALLY NECESSARY
BY ACME'S OWN DEFINITION

For Diagnosis or Treatment of Condition in Question

1. *provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury*

Surely, it is obvious that cytoreductive surgery and intraperitoneal chemotherapy are for the direct care and treatment of appendix cancer.

Generally Accepted

1. *in accordance with generally accepted medical practice*

Surgical oncologists are the experts on disseminated abdominal cancers.. In January 2006, surgical oncologists from all over the world met at the first International Symposium on Regional Cancer Therapies Snowmass, Colorado.

It was at this conference that the surgical oncologists began the process of standardizing their methods of patient selection, surgical approach, and delivery of HIPEC. By June of 2006, the experts had come together to make an official statement about this treatment:

(Esquivel J, Sticca R et al. Cytoreductive surgery and hyperthermic intraperitoneal chemotherapy in the management of surface malignancies: a consensus statement. *Ann of Surg Oncol* Jan 2007;14(1):128-33.)

The paper covers Materials and methods, Rigorous diagnostic work-up, Variables associated with increased chances of having a complete cytoreduction. The experts estimate the number of patients who could be helped by this treatment:

"In the United States an estimated 50,000 patients annually will present with or develop peritoneal carcinomatosis from primary colorectal cancer, gastric cancer, appendiceal cancer and ovarian

cancer."

The following institutions participated in the Consensus Statement:

Akademiska University Hospital, Uppsala, Sweden
Altru Hospital, University of North Dakota, Grand Forks, ND, USA
Baltimore-Washington Medical
Baylor University Medical Center, Dallas, TX, USA
Beebe Medical/Christiana Care, Lewes, DE, USA
Charite Hospital Campus Mitte, Berlin, Germany
Creighton University Medical School, Omaha, NE, USA
Dekalb Medical Center, Decatur, GA, USA
Dorothy E. Schneider Cancer Center, San Mateo, CA, USA
Fairview University Medical Center, Minneapolis, MN, USA
H Lee Moffitt Cancer Center, Tampa, FL, USA
Helen F. Graham Cancer Center, Newark, DE, USA
Hospital General Universitario Gregorio Maranan, Madrid, Spain
Hospital San Jaime, Torrevieja, Spain
Hospital medica Sur, Tlalpan, Mexico
Hospital de San Pablo, Barcelona, Spain
Hospital Virgen de la Nieves, Granada, Spain
Hospital Torrecardenas, America, Spain
Institut Gustave Roussy, Villjuif, France
Instituto Nacional De Cancerlogia, Distrito Federal, Mexico
Johns Hopkins Hospital, Baltimore, MD, USA
Lousiana State University, Shreveport, LA, USA
Maine Medical Center, Portland, ME, USA
Mills-Peninsula Health Services, Burlingame, CA, USA
Medical School of Crete University Hospital, Herakleion, Greece
Miami Valley Hospital, Xenia, OH, USA
MD Anderson Espana, Madrid, Spain
Mercy Medical Center, Baltimore, MD, USA
National Cancer Institute of Milan, Milan, Italy
National Cancer Institute of USA, Bethesda, MD, USA
Netherlands Cancer Institute, Amsterdam, Holland
North Hampshire Hospital, Basinstoke, United Kingdom
Ospedale San Giovanni, Bellinzona, Switzerland
Ospedale S. Camillo-Forlanini, Rome, Italy
Policlinica San Jose, Vitoria, Spain
Roswell Park Cancer Center, Buffalo, NY, USA
St. Agnes Hospital, Baltimore, MD, USA
St. George Hospital, Sydney, Australia
St. Luke's Hospital, Bethlehem, PA, USA
Sharp Healthcare Hospital, San Diego, CA USA
Soroka University Medical Center, Beer Sheva, Israel
Surgical Departement Kantonsspital, St. Gallen, Switzerland
Surgical Oncology Associates, Newport News, VA, USA
Tel-Aviv Sourasky Medical Center, Tel-Aviv, Israel
University of Iowa, Iowa City, IA, USA
University of Louisville, Louisville, KY, USA
University of Lyon, Lyon, France
University of Maryland, Baltimore, MD, USA
University of Medicine Dentistry of New Jersey, Newark, NJ, USA
University of Pittsburgh Medical Center, Pittsburgh, PA, USA
University of Regensburg, Regensburg, Germany
University of Washington, Seattle, WA, USA
Wake Forest University, Winston-Salem, NC, USA
Walnut Creek Kaiser Permanente, Walnut Creek, CA USA
Walter Reed Army Medical Center, Washington, DC, USA

Washington Hospital Hospital Center, Washington, DC, USA

The overwhelming consensus among expert surgical oncologists is that complete cytoreduction—including peritonectomy procedures, and combined with heated intraperitoneal chemotherapy is now Standard of Care for disseminated abdominal cancers. This treatment should be offered to carefully selected patients whose disease is confined to the abdomen, and according to Dr. Sugarbaker's Prior Surgery Score (PSS), and his Peritoneal Cancer Index (PCI).

This treatment meets and exceeds "generally accepted medical standards."

Not for convenience

d) not for a member's convenience

It is in no way convenient for me to have this surgery performed at Washington Hospital's Washington Cancer Institute. I am a Colorado resident, and I will incur considerable added personal expenses in order to have this treatment in Washington, DC, as opposed to closer to my home in Colorado. I am prepared to undergo this great inconvenience for my best chance at a good outcome.

Appropriate level of care

1. *the most appropriate level of medical care that a member needs*

As we proved in Section A ("Necessary for the symptoms and diagnosis and treatment of the condition, Illness, or Injury"), the established procedures for appendix cancer—no care at all, and serial debulkings—are universally fatal.

Cytoreduction and HIPEC (heated intraperitoneal chemotherapy), pioneered by Dr. Sugarbaker and practiced successfully for over thirty years by him, can offer a 70% chance of non-recurrence over twenty years.

Anything less than complete cytoreduction by an expert is so much LESS beneficial as to be tantamount to malpractice.

Generally accepted—again

f) *furnished within the framework of generally accepted methods of medical management currently used in the United States*

This section is redundant. We have already proved this point in Section C, ("In accordance with generally accepted medical practice, where we cite:

(Esquivel J, Sticca R et al. Cytoreductive surgery and hyperthermic intraperitoneal chemotherapy in the management of surface malignancies: a consensus statement. *Ann of Surg Oncol* Jan 2007; 14(1):128-33.)

Washington Hospital Center is in the United States, and is networked with Acme. Dr. Sugarbaker has performed cytoreductive surgery and HIPEC there for appendix cancer for twenty-seven years. The same treatment is routinely performed at thirty-eight leading cancer centers throughout the United States (Att. x). All of the major insurers in the United States have been routinely funding this treatment for years, even when the policy-holders have no out-of-network benefit. BC/BS of California has deemed this treatment Standard of Care for appendiceal malignancies. This method of medical management is therefore generally accepted, and currently used, in the United States.

We take a similar approach to all insurance company definitions. It doesn't matter whether the definition is "experimental," or "not medically necessary." Simply break down the lengthy definition into sections, then refute each section in your appeal.

These definitions are meant to be exceedingly vague—so that Acme Insurance can apply them to any and all situations, and use them to deny any expensive treatment, no matter what the merits of that treatment.

For us, this vagueness is a beautiful thing. It makes it easy for us to take that vague language, and use it to prove our points.

Back when I was writing my own appeal in 2005, I spent three days in the public library trying to find out what "generally accepted medical practice in the State of Washington" was. I sat on the floor in front of the shelves, poring over the Revised Code of Washington. I corresponded with the president of my state's medical society. I scrounged free advice from a malpractice lawyer.

It was a major "Aha" moment when I realized that—THERE ARE NO GENERALLY ACCEPTED MEDICAL PRACTICES.

It's all smoke and mirrors. There is no substance behind an insurance company definition, and there is no substance behind an insurance company denial.

If there is no such thing as "generally accepted medical practices"—you get to make up your own definition of it, then prove that your requested treatment meets and exceeds the standards which you have set.

It's a bluff. Their bluff is feeble. Make your bluff better than their bluff, and you will win your appeal.

For Diagnosis and Treatment

In order to address Acme's definition, I have to prove that my treatment-of-choice is for "diagnosis or treatment of a condition, illness, or injury".

On the fact of it, this is a ridiculous statement. How many people go through the major work of preparing an appeal for a treatment that is NOT for treatment of a condition, illness, or injury?

Answering this requirement allow me to discuss the three treatment options for appendix cancer—do nothing ("watchful waiting"), repeated debulking surgeries, and cytoreductive surgeries.

I take the opportunity to point out for the umpteenth time that the first two options are universally fatal, and the third—my requested treatment—can result in a 70% rate of non-recurrence.

For diagnosis and treatment of the condition in question

Who writes these insurance company definitions, anyhow? I am supposed to prove that my treatment-of-choice is "provided for the treatment of the condition, illness or injury (in question)."

I have appendix cancer. Do they think that I am going to request treatment for other types of illnesses or conditions?

In accordance with generally accepted medical practice

Here we go again ...

"generally accepted medical practice"
"prevailing opinion among experts"
"in accordance with accepted standards"

As we learned when we attacked the definition of "Experimental"—there is no such thing as "generally accepted medical practice." The insurance company knows that you will never find these shadowy standards, because they do not exist.

So, you answer this objection as best you can. Yes, my requested treatment is "generally accepted." Now, how do I prove it?

In this case, I happened to have the powerful consensus statement about the requested treatment—signed by fifty-six of the most well-known surgical oncologists from the most respected institutions all over the world.

If you can find a consensus statement—either by searching online, or by asking your doctor's office—that would be the best solution.

What if you can't find a ready-made consensus of experts?

1. Find the top ten experts on your treatment, find a published medical journal article from each, pull out the best quote endorsing this treatment, and put it in your appeal.

2. Find a list of leading medical centers where this treatment is performed, and include the list in the body of your appeal.

3. Go to the NIH database of medical journals, http://www.ncbi.nml.nkh.gov, and compile a list of three hundred articles describing and endorsing this treatment.
Do not attach your list, if you want Acme Insurance to look at it. Type it into the body of your appeal.

Once again, we always find a way. We don't complain about what we don't have—we work with what we have.

Not for convenience

Right. Like anyone would fight the Clash of the Titans with their insurance company to get a treatment that was "just for convenience."

I allow myself the tiniest bit of snarkiness when I answer an idiotic objection like this:

It is in no way convenient for me to have this surgery performed at Washington Hospital's Washington Cancer Institute. I am a Colorado resident, and I will incur considerable added personal expenses in order to have this treatment in Washington, DC, as opposed to closer to my home in Colorado. I am prepared to undergo this great inconvenience for my best chance at a good outcome. However, no matter how idiotic it is, every paragraph of their definition must be addressed, and every objection overcome.

This is their stated reason for denying. It must be completely demolished, destroyed, dismantled.

Appropriate level of care

You are requesting life-saving treatment. This is another opportunity to point out to Acme Insurance that there is no alternative treatment for you. If you don't get it, you die. Or go blind, or wind up in a wheelchair—or whatever the dire consequences if you don't get your requested treatment.

Another silly provision, easily overcome.

Generally accepted

Whoever wrote this definition must have been asleep when they wrote this section. It is an exact repeat of "in accordance with generally accepted medical practice." Now, they are asking that the treatment be "within the framework of generally accepted methods of medical management."

I point out that this is redundant, and remind them of the consensus statement.

Then, I summarize the rest of my proof for the umpteenth time:

Washington Hospital Center is in the United States, and is networked with Acme. Dr. Sugarbaker has performed cytoreductive surgery and HIPEC there for appendix cancer for twenty-seven years. The same treatment is routinely
performed at thirty-eight leading cancer centers throughout the United States (Att. x).
All of the major insurers in the United States have been routinely funding this treatment for years, even when the policy-holders have no out-of-network benefit.
BC/BS of California has deemed this treatment Standard of Care for appendiceal malignancies. This method of medical management is therefore generally accepted, and currently used, in the United States.

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"Not medically necessary" used to be the most common stated reason for insurance denials. It is not used very much these days. Why? Because there have been too many legal challenges to the concept of "Medical Necessity" over the years. The phrase "medical necessity" has a perfectly real, urgent clinical meaning. It means that you need a treatment to heal from your illness or injury, or to save your life.

I believe that the health insurers went too far—legally speaking—when they took a legitimate clinical term, and used it to control access to treatments. By "medically necessary," the insurers meant "medically necessary according to the Medical Director of Acme Insurance.

This opens the insurance company up to serious legal challenges. The insurance company is not your doctor. They have not examined you, they have not treated you, and they are not doctors who regularly treat your disease/condition. How could they possibly know what is medically necessary to treat you?

Acme Insurance counts on you being intimidated by this phrase, because it implies that they know better than your doctor, and they get to say what is needed for your medical care.

If Acme Insurance denies your treatment as "not medically necessary," just know that they are on very shaky legal ground. They don't expect you to have the nerve to refute their own definition. If you do, you will be one step closer to winning your appeal.

Next Excerpt 20 "Rationale for Denial -- Mop up All Resistance"
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