Excerpt 6: Where Are the First Three Places to Go When Your Insurance Company Denies?

Previous Excerpt 5 "Before the Battle -- First Three Things to Do"

1. Medical Policy Statements
2. Insurance company definitions
3. Appeals procedures

Find the Medical Policy Statement

You may believe that your complete contract with your health insurer is covered in your benefits booklet. Not true.

Your contract with Acme Insurance consists of the following:

1. Benefits booklet
2. Insurance company definitions
3. Medical Policy Statements

Definitions are not in your benefits booklet to clarify or define words. Definitions and Medical Policy Statements spell out all the situations in which the items covered in your benefits booklet will NOT be paid for.

As a matter of fact, definitions and Medical Policies trump the benefits every time.

For example, let's say that your benefits booklet state that Acme Insurance will pay for a certain percentage of out-of-network treatment, hospitalization, etc. Acme has to pay for your treatment, yes?

No. All they have to do in order to not pay is to call your treatment "Experimental" (a definition). What is their justification for calling it experimental? The Medical Policy Statement.

Sound like all roads lead back to the insurance company? Sound like they hold all the cards?

Do you really think that, every time that a doctor or patient requests a treatment that is not routinely offered, the insurance company thoroughly researches that treatment, thinks long and hard about it, considers the ethical issues, etc.?

I'll tell you what they do. They pull the Medical Policy Statement. If the med policy says "pay," they pay. If the med policy says, "Experimental/Investigational," or "Not Medically Necessary," they don't pay. Period. Their entire justification for paying or not paying is in the med policy (sometimes known as "treatment guidelines."

If you request a treatment, and it is denied ... the first thing to do is to find and study the Medical Policy Statement.

First, let's see where to find the Med Policies. Then, we will look at one together.

Disclaimer: If you are not computer-savvy, call your insurance company, and ask them to fax you a copy of their medical policy statement for your treatment—today.

The insurance company's medical policy statements should be on their website. In order to find

them, you will pretend to be a doctor. Go to the part of the website called "For Providers."

If the website has a search function, search for "medical policies," and/or "treatment guidelines"—finding the Med Policy for your treatment-of-choice may be as easy as that.

If you don't find the med policy by the search feature, wander around the Providers section. Look for choices like "Resources," "Publications for physicians," "Policies," "Guidelines," "Coverage."

You will find a body of hundreds of medical policy statements for all types of treatments.

Study the Medical Policy Statement

I have included a medical policy statement for us to consider. I have included it as a separate PDF file: "Med Policy Example." Print the file now, and read along with me.

Medical policy statements are designed to strike fear into the hearts of insured people—if they ever manage to find them. They are many pages long, and they are full of legal and medical language. Plus, they include impressive lists of scientific articles, and consensus statements from professional organizations.

If there is a medical policy for your treatment ... you need to put on your big boy pants, dig right in, and prepare to find out what is wrong with it.

I have read and studied scores of med policies, from dozens of insurance companies. I am here to tell you that most of them are all bluff and bluster, signifying nothing. They are out of date, out of line, and many of the articles that they cite do not prove their point.

Are you willing to drill down into the dark heart of your insurance denial? You will find it in the med policy. Read your denial letter. They quote directly from the medical policy statement. There entire denial rests on this document. If you can find and refute it, they will think that you are an insurance company insider, and your appeal will be on the fast track to approval.

I have even seen a few cases where insurance companies have denied a treatment, and not bothered to look at their own medical policy. The denial stated that the treatment was "Experimental," and the med policy stated that the treatment was "Medically Necessary." Case won.

Don't be afraid. Let's take a look at the sample medical policy from Priority Health. (Print the PDF file "Med Policy Example.") This example happens to be a guideline for using intraperitoneal hyperthermic chemotherapy.

Discredit the Medical Policy Statement Section

I gives a description of the treatment. In section II, we find a list of the diseases for which Priority Health will provide this treatment. They go on to describe what stage the disease must be in, and what conditions must be in place for an insured person to get this treatment.

Section III shows if a "medical necessity review" is required or not. In this instance, it is not required. If it were required, I would look up Priority Health's definition of "Medical Necessity," and prove in my appeal that the treatment met and exceeded all of their requirements. I've prove it, no "medical necessity review" needed.

Section IV lists specific policy limitations.

Section V lists the ICD-9 Codes to be used when billing for this treatment. Codes can become very important in getting your treatment paid for—especially after the fact.

When treatments are denied, we have had insurers say "there are no procedure codes for it," when

the codes are right there in the medical policy statement. After the fact, the insurer will attempt to reduce their payment by deleting codes, saying, "That is not a legitimate charge." If you have the med policy in your hand, stating that each code is part of the treatment, they will have to pay for that item.

On to Section V, the list of "scientific proof." It is here that you will find the fatal flaws of a medical policy statement.

Don't worry, you don't have to read every medical journal article listed as a reference. Just scan the titles and dates. You just need to find a few weak points to prove that their med policy is worthless as proof.

I have seen med policies that state that a drug or piece of equipment is not FDA approved. I checked the FDA website, and the equipment had been approved five years ago. I have seen medical policies that said that the American Cancer Society or the National Cancer Institute or the National Institutes of Health did not endorse the treatment in question. I checked the ACS, NCI, and NIH websites, and this was not true.

Are they using a study from fifteen years ago to justify their denial? Point this out in your appeal, naming the article. Then, find a more recent article that proves your point.

When I read this med policy, my eye zeroed in on the last item: "Hayes Directory." Most people would probably skim right over it, believing that—since the insurance company relies on it—this must be some type of authoritative source.

I became a little obsessed with this Hayes Directory of Medical Technology, as it was used in many med policies to deny intraperitoneal hyperthermic chemotherapy. It took me two months to obtain a copy of it.

Guess what? When I had a doctor request a copy of Hayes' assessment of this treatment, they replied in an official letter on their stationery: "We no longer offer this assessment for sale, as it was last reviewed in 2006, and portions of it may be out of date."

When I finally got my hands on this Hayes assessment, what I found was ... a fifty-five page joke. They relied on articles dating back to 1980 to assess this treatment. They said that a machine used to heat the chemotherapeutic agent was not approved by the FDA—the machine was approved fifteen years ago.

And so on. I spent an hour gathering up five embarrassing inadequacies of the medical policy statement, and put it all in the appeal.

That was appeal number forty-four, which I won.

Use the Definitions

Treatments are denied with words, and denials are overturned with words. Insurance companies always use the same three phrases to deny treatments: "Experimental," "Not Medically Necessary," and "Out of Network."

When a treatment is denied as "experimental/investigational," or "not medically necessary," people assume that this judgment came down to Moses on the mountaintop.

Surely some objective authority somewhere decreed that the treatment that you have requested is "experimental," yes? The insurance company has a magical "experimental" list, yes? There is some kind of universal agreement on what "experimental" means, yes?

No, no, and no. What does "Experimental" mean? It means that the insurer doesn't want to pay for it, and they have come up with some language to make it sound official.

Look at your denial letter—what word did they use to deny? You will find the definitions either on the insurer's website, or in your benefits booklet. If you don't find it either of those two places, call the insurance company, and ask that they fax a copy of the definition to you—today.

In our discussion of the Sample Appeal, we will pick apart the definitions of both "experimental," and "not medically necessary," and turn them to our advantage.

Understand the Appeals Procedure

People often call me, asking questions about appeals procedures:

"My appeal was denied. What comes next?"
"How long do they have to decide my case?"
"My appeal failed twice, do I have any more chances?"
"What do I do to get an expedited appeal?"

Appeals procedure is different for every insurance company. You need to familiarize yourself with every step of your insurer's appeals process—from the day that you request your appeal.

If your treatment has been denied twice, and you still haven't studied your insurer's appeals procedures—wake up and smell the coffee! It's time to find out exactly where you stand, exactly what to do. And to start writing your own appeals.

Need I say it again? Write your own appeal.

- **"What comes next?"**

Most insurers offer two or three in-house appeal steps before they wash their hands of you. If there is a third step, it is often an in-person hearing.

In forty-one states, when you have exhausted your appeals within the insurance company, they hand you off to the "Independent Review." Although it sounds pretty good on the face, the independent review is the one place you do not want to go. We will discuss the independent review in the section "After the Appeal." My advice to you? Win your appeal on the first go-round, just don't let it out of the hands of the insurance company.

- **"How long do they have to decide my case?"**

Your insurer gets to decide how long they take to reach a determination. A standard appeal takes from thirty to forty-five days.

Of course, you don't want to wait that long. You will request an "Urgent, Expedited Appeal." If you have cancer or some other life-threatening condition, they will agree to expedite. Even if you don't have a life-threatening condition, ask for an expedited appeal anyway. Why not?

By the way, don't assume that the appeal time period automatically starts ticking from the day you send your appeal. You will be amazed at the many ways that Acme Insurance will find to extend their time limit. Weekends, emptying the post office box only once a week, pretending that they didn't receive it—the possibilities are endless.

- **"Do I have any more chances?"**

Go to your benefits booklet, and study the appeals procedure.

Even if you do not officially have "any more chances" ... if you have not written a proper and powerful appeal yet, I would go ahead, write one, and send it to all of the correct decision-makers at your insurance company.

I have had cases where the people didn't find me until they had supposedly exhausted all of their appeal options. I wrote a blockbuster appeal, and got it to all of the decision-makers who had never seen it before. The insurance reconsidered, and reversed their denial in every case.

People, I am asking for a paradigm shift. Every insurance company "NO" is just one step closer to a "YES." Never stop, never give up, never back down.

Once your life starts being on the line ... never believe what any professional or bureaucrat says to you, without checking it out yourself.

When it comes to health insurance—Everything. Is. Negotiable.

But only if you negotiate, from a position of knowledge, confidence, and strength.

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People often call me, saying, "My appeal failed. What should I do?" I ask, "What was in the first appeal?" They invariably say, "I don't know. My doctor wrote my appeal."

Don't waste one precious step of the appeals process letting your doctor write an appeal. Your in-network doctor is contracted with the insurance company; therefore, he is not ideally positioned to fight the insurance company. Your out-of-network expert has no influence whatsoever on your insurance company.

If you think that doctors have great influence with your health insurer, you are about forty years out of date. YOU are the insured person, you are the one with the contract. You are the only one who has any traction with your insurance company.

Letting your doctor or your case manager or your insurance broker handle your appeal is like letting go of the wheel, while your car is barreling down the freeway.

This is your hero's journey. Your life is on the line.

Keep your hands on the wheel.

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