



How to Handle Insurance Disputes



By responding appropriately, patients often can get their insurance claim denials overturned in their favor.

By Jennifer C. Jaff, Esq.

Individuals who have health insurance often face obstacles to obtaining the healthcare they need. Unfortunately, those obstacles increase for patients with a chronic illness. In fact, it is a rare occasion when patients with a chronic illness do not have to fight with their insurance company over something such as a medication, hospitalization or a diagnostic test. And, while most patients don't know where to begin when faced with an insurer's non-coverage decision, responding appropriately will help to ensure the outcome is in their favor.

What Not to Do

Patients should understand that there are some hard-and-fast don't-do rules. First, patients should never call an insurance company to appeal a denial of coverage. If insurance company representatives review what is already on file, it is highly unlikely that their opinion will change. To change their decision, something new has to be submitted.

Nor should patients hastily submit a letter that says, "But my doctor says I need this." The insurance company denied coverage after the doctor ordered the item or service in question. Therefore, they already know the doctor thinks the patient needs it; they disagree.

So, prior to responding to the insurance company's denial, patients need to determine why coverage was denied. This, then, will determine how they should respond.

Countering Claim Denials

If a claim denial is due to an alleged lack of medical necessity, patients must prove that the item in question is medically necessary. This will require patients to compile medical records, and send them with a detailed letter to the insurance company, that establishes the diagnosis, lists

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the treatments that have been tried and failed, and outlines the reasons their doctor believes this item is medically necessary. Medical necessity is best established with a short letter from the doctor, which should accompany the patient's letter and records.

If a denial is due to the insurer's belief that the item or service is experimental or investigational, patients will need to take one additional step to prove that, in addition



to being medically necessary, the item or service has been tried, tested and vetted in published medical journal articles. If possible, patients should try to get their doctor to help with this, as it can be hard to obtain copies of medical journal articles without going to a medical school library. Another option is to locate summaries of articles on the Internet at websites like PubMed (www.ncbi.nlm.nih.gov/sites/entrez?db=pubmed) or search engines like Google Scholar (scholar.google.com).

There also can be countless other reasons why insurance coverage is denied, and for each reason, patients need to tailor their response to effectively counter the insurance company's reasoning. For example, in some instances, doctors' offices make coding errors, which need to be corrected with the individual in charge of billing. In other instances, insurers receive bills without any supporting documentation, and patients will need to provide those documents. Whatever the reason, patients' appeals should respond to the specific reason for denial.

Insurance denial also may be a result of whether the request for coverage comes prior to or after treatment. These days, patients must get prior authorization from their insurance company for most expensive tests and treatments. If an insurer denies prior authorization, patients must appeal and obtain a favorable decision prior to having the test or treatment. If they don't, failure to get prior authorization is itself a reason for denying coverage.

Filing an Appeal

When filing an appeal, patients must ensure that they meet the deadline. Most insurance policies require the first-level appeal be submitted within 180 days of the date of the denial letter. Subsequent levels of appeal typically are required to be filed in an even shorter time frame. If appeal deadlines are missed, in most cases, patients have no recourse at all.

Depending on the type of insurance, it may be possible to file an appeal with an external reviewer after exhausting appeals to the insurance company. There are two types of insurance: fully-funded and self-funded. All individual health insurance plans, most small group plans and many large group plans are fully-funded plans, which means the individual or their employer pays a premium and the insurance company pays for the healthcare. However, some large group plans are self-funded plans, in which the employer pays a third-party administrator (TPA) to administer the plan and the employer pays for the healthcare. Self-funded plans are governed by the federal law known as ERISA, the Employee Retirement Income Security Act.

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Most states have enacted laws that provide for a review of insurance company denials of coverage by an external reviewer independent of the insurance company. As a result, after exhausting appeals to the insurance company, patients have the right to one more appeal, usually through their state insurance department. However, because these “external appeals” are created by state law, they do not exist for self-funded plans — unless the plan itself requires it, and some do. For example, in a large corporation like General Motors, although the insurance plan is self-funded, it provides for external, independent reviews of insurance company decisions. The same is true of the federal employee plans, which allow an

independent review by the United States Office of Policy Management.

External appeals — whether the plan is fully-funded or self-funded — are the most important consumer protection to have been developed in the insurance arena. It's not uncommon for insurance companies' denials of coverage to be overturned following an external appeal. Indeed, some insurance companies' decisions are regularly overturned after an external appeal.

Going to court is the sole recourse for patients who are in self-funded plans that do not provide for an independent review. In fact, if patients receive a denial letter specifying they have a right to file a civil action under section 502(a) of ERISA, that means their efforts to resolve the dispute without going to court have been exhausted. Therefore, to pursue the matter further, they will need to hire an attorney who handles ERISA cases.

However, going to court is not a good option in most instances. In fact, it's rare to find an attorney who will take an insurance claims case on a contingency basis, which means one-third of what the patient ultimately wins will go to legal fees. This is because most insurance claims — even high-dollar ones — do not result in large enough settlements to cover the lawyer's time and expense (unless the settlement is greater than \$50,000). Therefore, in most cases involving health insurance claims, patients will have to pay a lawyer on an hourly basis.

Going to court in an ERISA case also is particularly difficult. In ERISA cases, courts give deference to insurance company decisions unless there has been a serious procedural irregularity or conflict of interest. In addition, no new evidence can be presented in court; the evidence is limited to what has been submitted to the insurance company — all the more reason to take the initial insurance appeals seriously.

You Can Win

Thankfully, though, most of the time, patients don't need a lawyer to win an insurance dispute. They just have to take it seriously, take their time, gather medical records and other materials, and address the reasons why their claim was denied. ■

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