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PATIENT MONEY

## Fighting Denied Claims Requires Perseverance

By WALECIA KONRAD

Maria Carr, a 43-year-old school administrator from Tulare, Calif., could not believe it when her insurer, UnitedHealth, denied coverage for arthroscopic surgery she underwent last year to treat a bone spur on her hip.

Her doctor told Ms. Carr he had successfully performed this procedure for eight other United Health patients suffering from the same ailment in the same year. To Ms. Carr's mind, [arthroscopy](#) seemed a much less invasive and cheaper way to treat the problem than open hip surgery, the traditional treatment for bone spurs.

"When the denial came I was shocked," Ms. Carr said, "but I figured I'd just have to find a way to pay." The total bill for the hospital and surgeon fee was \$21,225.

Ms. Carr's form of shock is all too common. The Department of Labor estimates that each year about 1.4 billion claims are filed with the employer-based health plans the department oversees.

Of those, according to data collected from [health insurance](#) industry sources, 100 million are initially denied. In simpler numbers, that is one of every 14 claims.

But Ms. Carr, whose [hip pain](#) ceased after the arthroscopic surgery, did not give up on the reimbursement. And neither should you. When Ms. Carr, a special education administrator at a local [charter school](#), read her explanation of benefits statement more carefully, she spotted some instructions on how patients can appeal denied claims.

"I decided I would fight," she said. "After all, what did I have to lose?"

Ms. Carr researched medical journals and other publications to find proof that her procedure was a bona fide and safe treatment. She then wrote a formal letter to her insurer making her case and including copies of the research she had found. Her doctor backed her up with a thorough letter of his own.

The appeal was initially denied, but Ms. Carr kept fighting. She took her case to her insurer's external review board, where an impartial medical expert weighed the evidence.

The expert agreed with Ms. Carr, saying UnitedHealth had to pay the claim. "The expert felt UnitedHealth couldn't call the procedure experimental if it paid for other patients to have it," Ms. Carr said.

UnitedHealth ended up paying \$12,282 for Ms. Carr's claim — at a rate the insurer negotiated with the doctor and hospital. Ms. Carr's share was about \$500.

"That's what the appeals process is there for," said Cheryl Randolph, a spokeswoman for the insurer. "We're glad it worked for her, and we encourage members to exercise their right to appeal whenever they need to."

Not that UnitedHealth now happily pays all such claims. Soon after Ms. Carr's successful appeal, the insurer revised its policy to stipulate that it did not cover that type of hip procedure — although Ms. Randolph says the

company now rethinking things once again because of "the changing landscape of medical literature" about the procedure.

Whatever the treatment or procedure a patient receives or is contemplating, a variety of things can prompt a claims denial. It might be a simple clerical error, like an incorrect address, or a doctor's use of the wrong diagnostic or treatment code for your treatment.

Then there are the more serious causes — as when a treatment is specifically excluded from your policy, for example, or, as in Ms. Carr's case, when the insurer deems a procedure experimental and therefore ineligible for reimbursement.

Other frequently denied claims involve emergency room visits, especially those at out-of-network [hospitals](#) and clinics.

Another big category involves chronically ill patients, who often must try several medicines and treatments to find the one that works best for them. Such patients can become all too familiar with [insurance](#) denials, says Jennifer C. Jaff, founder of Advocacy for Patients with Chronic Illness.

But as Ms. Carr discovered, if you are denied coverage you have a right to appeal. And in most cases, experts advise you to do just that. Approximately half of all appeals are successful, according to anecdotal evidence from patient advocacy groups and data from individual states.

"About 53 percent of appeals work in our state," said the Kansas insurance commissioner, Sandy Praeger. "That demonstrates that the process works."

Use the following advice to increase your chances of success in appealing a health insurance denial. As you'll see below, expert help may be available. And if you feel in over your head, and a significant amount of money at stake, it may even be worth hiring a type of specialist known as a billing advocate.

**READ YOUR POLICY** Always check your policy carefully before you undergo treatment.

Many denials are made because the policy specifically excludes coverage of a certain treatment, procedure or medicine, Ms. Praeger said. When it is spelled out that something specific is not covered, an appeal will not work.

**TAKE YOUR TIME** When you decide to appeal, do not act in haste, advises Ms. Jaff, of the patient advocacy group.

Most insurers allow a certain amount of time to file for an appeal, usually 60, 90 or 180 days. If you call and say I want to appeal, an insurer may consider that the appeal itself. So you want to take advantage of the time you have (without missing the deadline) to build your case.

Before you file, make sure you have all the information you need from your insurer to start your appeal in earnest. Your explanation of benefits should provide a code for the reason for the denial, and that code should be translated somewhere on the statement. If it is not or if you still have questions, contact your insurer.

Make it clear in your phone call or letter that you are not officially starting the appeal process. You simply have questions. If it is not already clear, you should also ask exactly to whom the appeal should be sent. (You do not want precious time wasted because your appeal was shuffled from desk to desk. )

Whenever you call your insurer, be sure to make a note of the time and date and the person you talked to. If you send a letter, send it registered mail with return receipt, and keep your own copy.

**DO RESEARCH** Once you learn why your claim was denied, customize your appeal to argue specifically against that reason. A clerical or coding error is fairly straightforward, but just to be sure, enlist the help of your doctor's or hospital's billing specialist to back you up with a letter explaining how the mistake was made.

Something more complicated, like an out-of-network emergency claim, will require proof that the situation was indeed a medical emergency and that no in-network provider was available. Obtaining your medical records can help support your argument, so can letters from the doctors who treated you.

Fighting a denial for something your insurer deems experimental can be the trickiest appeal. In addition to support from your doctor, you will need to find articles from established medical journals for evidence that the treatment is not only effective but safe.

You can find abstracts of many articles free on [pubmed.gov](http://pubmed.gov), the library of the [National Institutes of Health](http://www.nih.gov). Often the abstracts are enough to make your point. If you need the full article, which can be expensive, ask your doctor's office for help or check with a local medical school library.

Any proof you can show that other insurers in your area cover the treatments in question can be valuable. Most big insurers list medical policies concerning treatments on their Web sites. Your doctor's office can probably help with this, too.

You also must prove the medical necessity of a treatment, especially if it is considered experimental.

Ms. Jaff, for instance, learned this when she was denied coverage for a certain drug her doctor prescribed for [Crohn's disease](#). Her insurer argued that other, more established drugs could treat the problem. True enough, but Ms. Jaff had already tried those drugs without success.

For her appeal, Ms. Jaff collected her medical records that showed when she had tried each drug and how each had failed. The strategy worked, and her claim was ultimately paid.

Be sure to stick to the facts in any argument you make. Emotional or angry arguments, as much as they may feel warranted, will not help your case, said Erin Moaratty, who heads special projects for a group called the Patient Advocate Foundation.

**GO THE DISTANCE** Even if your well-researched and thorough appeal is denied, do not give up. You still have options, depending on the type of insurance you have.

If you receive coverage directly from an insurance company, say through a private policy or from your small or midsize employer, your insurer is regulated by your state's insurance department. All but five states, Alabama, Mississippi, Nebraska, South Dakota and Wyoming, allow patients to have their appeals considered by an independent external review board, usually after all internal appeals have been exhausted.

In most cases the board consists of doctors and other professionals with an expertise in your condition. For more information on your state's rules contact its department of insurance. To find yours, go to the National Insurance Commission's Web site and [click on your state](#).

Large employers that self-insure — meaning that they pay medical claims themselves, not through an insurance company — are not subject to state insurance laws. But most have provisions for external appeal reviews. Check your plan summary, the large booklet you received when you signed up for health care, for details.

**GET HELP** Your state insurance department can help answer questions and start an appeal. In addition, groups such as [Advocacy for Patients with Chronic Illness](#) and the [Patient Advocate Foundation](#) help seriously ill

patients file appeals free.

Be sure to check the advocacy organizations for the illness you have. Many offer free advice on dealing with health insurance disputes with specific information related to your condition.

You may also want to seek help from a medical billing advocate ([see our earlier column](#) "A Guide through the Medical Wilderness"). Depending on the case, these professionals charge an hourly fee or a percentage of any recovered claim.

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