

WHAT TO DO WHEN YOU HAVE A DISPUTE WITH YOUR INSURANCE COMPANY

How to challenge your insurance company's decision
to deny the care you've requested.

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I. FAST FACTS about your health insurance plan:

General Information:

- When you purchase (or when your employer purchases for you) a health insurance plan, you are entering a contract.
- You, as a member, are agreeing to give your insurer the right to manage your medical care.
- This means your insurer has a right to decide which benefits are covered under the policy, which are excluded from coverage, any caps on the benefits covered, the criteria that must be met for coverage to kick in, any referral or pre-authorization requirements that must be met prior to care being covered and which providers (doctors, hospitals and other health care professionals and facilities) it wishes to contract with to provide care to members.

- Your insurer is agreeing to pay for medically necessary care for the benefits covered by the policy, subject to any exclusions, limitations, caps, criteria, referral and pre-authorization requirements and to provide you with a network of providers who can render the care needed.
- Your insurer has no legal obligation to pay for care beyond the benefits covered under the policy.

HMOs:

- If your plan is an HMO (health maintenance organization), you are also agreeing to seek care only from providers within the plan's network (known as "in-network providers") unless you can prove conclusively that there are no providers in the network offering the care that you are seeking.
- In most instances, the insurer has no legal obligation to pay for care not rendered by an "in-network provider."
- When you stay within your plan's network, your plan covers most of the costs associated with your care and has negotiated lower rates with its "in-network providers" that it can pass on to you.
- Your financial responsibility is generally smaller premiums, co-pays, deductibles, and/or co-insurance.

PPOs:

- If your plan is a PPO (preferred provider organization), you have the additional right to seek care from providers outside the plan's network (known as "out-of-network providers").
- In most instances, you pay a greater portion of the cost (higher monthly premium, co-pays, co-insurance, deductibles, and/or any amount that exceeds the reasonable and customary charge for that service).
- There are no negotiated rates so providers can determine the charges for their services.

II. HOW TO CHALLENGE your insurance company's decision to deny medically necessary care:

Don't get angry – get involved.

- Insurance companies want to keep costs down and do so by denying payment for care and treatment that they feel are not absolutely medically necessary.
- Don't take this personally.
- A denial-of-care notice, adverse determination letter, explanation of benefits (EOBs) notice denying payment or other official statement denying approval of the care you are seeking or denying payment of care that you've received is often just a simple business decision made by a computer or a cursory review by insurance company employees.

Hold on to your written records.

- Keep all correspondence and written documentation from your insurance company and your provider, (including but not limited to denial of care notices, adverse determination letters, approval and pre-authorization letters, EOBs, letters of medical necessity, medical records, bills).
- Keep a record of any dates of service/treatment, any payments/costs, and any conversations you may have had with insurance company personnel or customer service representatives (dates and names are critical).
- You will likely need these records to challenge your insurer's decision whether you do it on your own or you seek outside assistance.

Talk to your doctor(s).

- Clarify with your doctor(s) to determine if the denied care or treatment is absolutely necessary rather than something that may be helpful.
- If it is the latter, the insurer may deny it for a lack of medical necessity.
- If your doctor believes it is absolutely necessary ask him/her to write a "letter of medical necessity" supporting the critical need for the care requested.
- Get similar letters of support from your PCP and any specialists involved in your care.
- The more support you have the stronger your case will be.

- Ask your providers to supply you and the insurer with any medical records that support your need for the requested care.
- Insurers don't approve care or treatment because you want it or feel you need it.
- They need to see documented medical support for why the care is medically necessary.

Try to demonstrate "medical necessity."

- Most insurance plans approve treatment based on the concept of "medical necessity."
- Simply put, this means that without the care in question, your condition could get worse.
- It does not mean that you are entitled to the newest high-tech treatments, especially if they are not yet fully tested.

Do some research.

- Many medical organizations and associations have set up "practice guidelines" - suggested standards for basic care - which you will find on their websites.
- For instance, if coverage is denied for a drug that's widely prescribed after a heart attack, or you find that the treatment you are seeking is the standard of care for your illness, injury or condition, or you learn that a treatment or procedure has been approved by a medical association, you can use these facts to further your case.

Request an internal appeal.

- Call your insurance company and say “I am appealing my denial of care.” Then put it in writing.
- When you call in a complaint, it likely goes to a customer-service department, where there is no legal time constraint to respond.
- By initiating an appeal, the insurance company - generally by law or contract - has to begin a timely review of your case, which ultimately may be decided by a neutral outside panel.
- Follow up the call with a traceable letter in which you again use the word “appeal.”
- Send it by certified or registered mail, overnight delivery or fax and keep copies and any receipts for your records.
- If the care needed is urgent and your doctor can certify that without it you may suffer substantial harm, you may request an “expedited appeal” which is generally decided within 24 to 72 hours.

Notify your HR/Employee Benefits Department.

- Send a copy of your letter to the head of HR at work.
- Since this department actually purchases medical and other insurance on your behalf, the insurance company sees it, not you, as the customer.
- Often HR can put pressure on the insurance company to approve the care you need.