

When Your Insurance Claim Is Denied

by David McGill, Esq.

Imagine the surprise of the 26-year-old above-elbow amputee who learned, courtesy of her insurance company, that her claim for a new myoelectric prosthesis had been denied because she had “a fully functional contralateral extremity.” Or the consternation of the 63-year-old whose insurer refused to pay for her microprocessor-controlled knee because its “national policy” (as announced on its Web site) prohibited reimbursement for the device. Or the anger of the 41-year-old bilateral amputee whose insurance company kept changing the basis for its refusal to pay for her prostheses, even as she systematically undercut the validity of each ground for denial.

Working closely with each of these individuals, I, as an above-knee amputee myself, experienced their feelings of disbelief, worry, helplessness and rage in a very personal way. Their insurers were refusing to pay for necessary technology that they would use every day! I, therefore, experienced equally intense feelings of elation when we successfully appealed each of these denials.

Insurance appeals are not inherently unmanageable, nor are they necessarily complicated. In fact, a successful appeal hinges on setting forth the relevant facts in as simple and straightforward a manner as possible.

But appeals also require tenacity, organization, and a modicum of sophistication in “things insurance,” all of which insurance companies assume (often correctly) that their insureds lack. In fact, after receiving a negative determination by their insurance company, most people do not even bother to file an appeal, concluding that the process is too complex, the insurer too powerful, and their own skills too insufficient to effect any change. Appeals can be won, however, and when done correctly, they often are. But the prerequisite to winning an appeal is



filing it in an intelligent and articulate way.

Preliminary Issues

Your insurance company sends you a tersely worded document informing you that it will not pay for your prosthesis. What do you do next? Consider these suggestions.

1. Become a collector of paper

Save everything your insurance company ever sends you, including the envelopes in which the correspondence comes. Insurers sometimes draft and date denial letters weeks (and sometimes months) in advance before sending them to you. When you retain the letter dated January 1 but throw out the envelope bearing a May 15 postmark, you risk a successful argument by the insurer that your June 13 appeal was not filed within the time period required by the policy.

Some companies now communicate with insureds via e-mail in an attempt to reduce paperwork. You should print out every piece of e-mail as you receive it, storing it just as you would snail mail. You should also set up an insurance file that contains a chronological history of all correspondence between you and the company.

2. Determine why your claim was denied

When an insurer denies a claim, it must specify the reason. Because the policy is a contract, the refusal to approve the recommended prosthesis must arise out of specific contractual language in the policy. Generally

speaking, insurers base their denials on one of three grounds.

First, the recommended prosthesis or prosthetic component must be medically necessary. This means your prosthetist and doctor must establish the importance of the recommended technology. If they fail to lay the groundwork unequivocally demonstrating why you need the prosthesis, or if the insurance company believes that the recommended item will merely improve your already-adequate ability to function, the insurer may deny your claim. Quality of life enhancements, in an insurer's view, are not essential (i.e., “medically necessary”).

Second, insurers will not reimburse devices that are “experimental or investigational.” Unfortunately, insurance companies sometimes use this ground as a false pretext for denying new items that have a significantly higher cost (e.g., microprocessor-controlled knees, myoelectric arms).

Finally, insurers can deny coverage on the ground that the contract simply does not cover the recommended technologies. An example of this would be a policy containing a specific exclusion precluding coverage for a particular type of component.

Identifying which of these three grounds your denial is based upon is essential.

3. Determine when and where you must send the appeal

Always read every sentence in every piece of correspondence your insurance company

sends you, including the small print and the form language on the back. Most denial letters contain not only the basis for the insurer's decision, but the steps necessary to appeal the claim (i.e., where to send the papers and how much time you have to do so).

You cannot win an appeal if you do not know where it must go and when it must get there. If the denial letter does not answer the where and when questions, immediately contact your insurer to find out the answers, as some policies give you as little as 30 days to appeal. When speaking on the phone with the company, record the date and time and the name of the person you speak with.

Take notice of the time you have to appeal. An appeal sent in a timely fashion, even if it is addressed to the wrong department of the company, will usually be viewed as adequate notice to the insurer and will permit the appeal to be heard. In contrast, an appeal sent to the correct address three days too late will be denied, based upon your failure to comply with the policy's terms and conditions.

Constructing a Successful Appeal

Now comes the hard part – the actual guts of the appeal.

I would like to tell you that this is the magic part of the article where I arm you with the silver bullet that proves fatal to all insurers. However, the inherently fact-specific nature of each denial and the information provided to the insurer by your prosthetist and doctor mean that each appeal has unique characteristics. With that in mind, I focus on general strategies that you can use in any appeal.

1. Paper vs. person

Some insurance companies give you the choice of appealing on paper, in person or via telephone. While I am reluctant to recommend a hard-and-fast rule, my personal preference is to put everything in writing. In my view, the risks of a "personal appeal" outweigh its benefits.

Most people, for example, would be uncomfortable speaking in front of an insurance panel, whether in person or by phone, and this discomfort could manifest itself in an inability to present thoughts clearly and concisely. The insurer would then have a chance to ask you questions, placing you on

the defensive.

In contrast, taking the time to present your case on paper with supporting information from your prosthetist and doctor gives the insurance company something tangible that it has to respond to. In addition, if the insurance company stands by its denial and you have the opportunity to appeal to an external agency, a document (or set of documents) will be of inestimable value, particularly when, as happens in some instances, the insurer has no documentation supporting its position.

2. Find a friend!

Enlist a friend or acquaintance to review your appeal. (Even better if that person has legal training, an insurance background, or some other trait that gives him or her unique insight or abilities.) Getting an objective opinion is vitally important because the insurer's denial often results in a highly emotional reaction, depriving you of the objectivity and rationality needed to construct an effective appeal.

Encourage your reviewer to be honest. Asking someone to critique your appeal but expecting (or getting) only positive feedback will do wonders for your ego – until the insurer shoots it down with a precise, well-thought-out denial.

What about the role your prosthetist plays in this process? I have heard at least one prominent prosthetist at a national conference advise patients that they must take sole responsibility for all of their insurance matters (presumably appeals too), because prosthetists "don't have the time or resources to do so." This may represent the traditional model of a prosthetic facility, but should it? Should patients demand that prosthetists also provide assistance with appeals and other insurance issues? These are issues that you should think about, not only when faced with an appeal, but when analyzing the role your prosthetist plays in your care and treatment.

3. Simplicity, simplicity, simplicity

The insurance company is not relying on voodoo or sorcery to deny your claim. Either the technology was judged not medically necessary, experimental or investigational, or outside the scope of the policy. Your job is to demonstrate: (1) that the technology was medically necessary; (2) that it was not experimental or

investigational; or (3) that the contract does cover it. The only complexity is how to say this in a powerful, concise manner.

How do you maximize your chance of achieving this goal? The same way you learn how to use your prosthesis: invest a significant amount of time, energy and passion in the endeavor. When working on appeals – a task I was trained to do professionally – I typically need to set aside two or three full days in order to craft a finished product. (Day 1 and Day 2 are mainly spent researching the issues, brainstorming and outlining. Late Day 2 and Day 3 involve drafting the appeal a minimum of two times, and frequently a third.) Sorry – the only way to do it is through hard work!

Conclusion: Reverse the Mindset!

When insurance companies say, "You can't have this," we all-too-often respond affirmatively in a dull monotone, "We can't have this."

How absurd is this response?

Consider this:

1. You pay your insurer money (premiums) to obtain healthcare benefits,
2. As an amputee, you regularly require necessary prosthetic treatment to live your life, and
3. Your insurer unilaterally drafts and interprets your policy.

Under these circumstances, the real insanity is failing to take action when the insurer informs you that you cannot have what you need, and you have already paid the company for it!

Always remember: The insurance contract entitles you to certain benefits; you pay the insurance company good money to get those benefits; and the company has a contractual obligation to you. Remind them of that obligation: File the appeal! ■



About the Author

David McGill is an attorney who has represented insurers on a national basis. He is now the executive director of a prosthetics facility, where he regularly coordinates and drafts appeals. He is also a member of the ACA Board of Directors.