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Pushing Back When Insurers Deny Coverage for Treatment

By ANNA WILDE MATHEWS

Battling a health insurer when it refuses to cover certain treatments can be aggravating and time-consuming. But if you choose to join the growing number of people who are appealing coverage denials, there are several strategies that can bolster your case.

Some health-coverage problems -- such as when your doctor enters a wrong code on a claim form -- can be resolved with a phone call. But other issues can be more difficult, because they center on complex medical questions like whether a certain cancer treatment is appropriate for you. Faced with such a situation, you may need to enlist help from your doctor, and even do some scientific research of your own. As a last resort, most states will consider appeals that have been denied by private insurers.

Insurance companies generally don't disclose how many appeals they receive. But state regulators keep data on the frequency of cases filed with them, and the trend is up -- 12% growth between 2004 and 2006, according to a survey by America's Health Insurance Plans, an industry group, which says such appeals represented less than one out of every 10,000 insured people. That's a small share of the total, though, since most appeals never get to the state bodies.

New York's regulator, the state Insurance Department, is one of the few agencies that also keeps track of how many people in its state file appeals with health insurers. In 2007, the number was 33,355, up 18% since 2004.

Why the increase in appeals? Patient advocates and state officials say the weak economy and ever-rising health-care costs put pressure on insurers to squeeze expenses by denying claims, and leave consumers watching their spending more closely. But the insurance-industry group says the growth is likely fueled by insurers' efforts to educate consumers about their rights. Several companies say they are working to make the process easier, but many aspects are mandated by state regulators.

In any case, appealing an insurer's decision is often complex and tricky, and the

deck can seem stacked against you. It is often hard for consumers to know what is covered and what isn't in an insurance plan. Indeed, insurers have been winning a majority of the cases reviewed by state regulators in recent years, with victories for insurers at 59% in 2006.

Here are some ways you may be able to better your odds.

Getting Started

First, figure out what led to the denial of coverage and learn your insurer's procedure for appeals. When you call your health plan to get the information, take notes and get names. If the problem can't be readily resolved, you should ask the insurer for some key documents to reconstruct what led to the rejection.

You will need the denial letter. You should also get a copy of your plan's full benefits language, sometimes called the "Evidence of Coverage," as well as the detailed guidelines that explain what the company considers medically necessary. Some companies, such as Cigna Inc. and Aetna Inc., post their medical policies online.

Sometimes the appeal is straightforward. Murielle Curcio, 51 years old, of San Jose, Calif., was told by Blue Shield of California last October that it wouldn't pay for a genetic test to gauge her risk of breast cancer. The letter said the test hadn't been preauthorized by the company or performed by her primary-care physician. With more than $3,000 at stake, Ms. Curcio enlisted the help of Health Advocate Inc., a firm that works under contract with her employer.

Ms. Curcio filed an appeal in January. She says she got a letter from the testing lab confirming that her physician had ordered the test and that his office had been told by the insurer that it would be covered. In her appeal, Ms. Curcio also cited the insurer's policies to argue that such tests were covered by her plan, and that she was a medically appropriate candidate. A few weeks later, Blue Shield paid for the test.

A Blue Shield of California official said he couldn't comment specifically on Ms. Curcio's case because the insurer hadn't received a release form from her. But the official said appeals often stem from a lack of complete information, and "the most common reason for overturning a decision is, we get information we didn't get at the outset."

Building a Case

After you gather the facts, set a strategy. Your appeal may hinge on proving that your treatment qualifies for coverage under your plan's benefits and rules. Tom Bridenstine, managed-care ombudsman for the state of Virginia, says he once worked with a consumer whose insurer refused to pay for bariatric surgery

because such obesity treatments weren't allowed benefits. Mr. Bridenstine says he helped win a reversal by showing that the woman's weight issue was actually a symptom of a rare disease.

Many appeals focus on demonstrating that a treatment is scientifically proven and medically necessary. Your doctor should be able to write a detailed letter on your behalf. You also may be able to bolster your case by researching the scientific evidence online on sites like pubmed.gov, sponsored by the National Library of Medicine.

David Foglesong, a history professor from Montgomery Township, N.J., began searching medical databases soon after Horizon Blue Cross Blue Shield of New Jersey declined to pay for a targeted chemotherapy treatment for his wife, RoseMary. During one library visit, he found a new study that showed the treatment had helped patients with conditions similar to his wife's disease, advanced sarcoma that had spread to her liver.

The couple, advised by Patient Advocate Foundation, a nonprofit group, solicited new letters from Ms. Foglesong's doctors, and her primary oncologist argued on her behalf in a conference call with the insurance company's reviewers in June. The company reversed its earlier decision, and Ms. Foglesong, 49, got the treatment in July.

Horizon officials say the procedure was initially denied because it was deemed experimental and not the standard for Ms. Foglesong's condition. The company said a review committee reversed that decision because of the "whole totality of her case," including the medical literature.

Last Resort

Even if your insurer rejects your appeal, you still have other options. If your employer has a self-funded health plan, which might be administered by a private insurer but is backed by the employer, your next step is often to sue in federal court, a tough and expensive proposition.

But if your coverage is with an insurance company, either through your employer or an individual policy, you can opt for your state's appeals process. Check with the agency, because the 44 states that offer independent reviews won't handle all kinds of issues, and each has its own rules.

Sharon Hines, 52, of Middletown, Conn., appealed to the state after her insurer refused to pay for Avastin, an expensive biotech drug that has drawn debate over what uses are justified. Ms. Hines, an oncology nurse practitioner, says she and her husband, a truck driver, couldn't afford the roughly $100,000 a year cost of the treatment.

Ms. Hines said her insurer, ConnectiCare Inc., a subsidiary of Health Insurance Plan of Greater New York, had raised various objections to Avastin, including that there wasn't evidence the treatment would work for someone, like her, who had previously taken Tarceva, another cancer drug. In August, the state's reviewer ruled that Avastin was medically necessary because Ms. Hines would be getting it with first-line chemotherapy, its approved use. "It was such a sense of relief," she says.

In a statement, a ConnectiCare official said the independent oncologist who reviewed Ms. Hines's appeal for the company "did not agree with the use of Avastin" and the insurer followed his recommendation. When the insurer got the state review's decision "we immediately covered the drug for her....We wish her well with her courageous battle."

Medicare Appeals

For Medicare beneficiaries, there is a separate, federal appeals-review process. That is what Ellen and Paul Hoppe used after Health Net of California, the Health Net Inc. unit that provided Mr. Hoppe's Medicare Advantage plan, declined to pay for proton-beam radiation for his prostate cancer. The denial document said there was no evidence that Mr. Hoppe, 67, would get any added advantage from proton-beam therapy, which is significantly more expensive than conventional X-ray radiation.

But the Hoppes, phone-company retirees in California, were convinced that proton-beam therapy carried a lower risk of side effects such as incontinence. They got backing from Mr. Hoppe's doctor at Loma Linda University Medical Center, who wrote a six-page letter, including two pages of research citations. In June, Medicare's appeals contractor sided with the Hoppes, saying the proton-beam therapy qualified for the federal standard of "reasonable and necessary" treatment.

Health Net said in a statement that it couldn't comment on Mr. Hoppe's case because it hadn't received a release from him. But it said, "Any single portrayal of a less-than-satisfactory customer service experience does not represent the overall experience of our customers." A Health Net spokesman added that medical coverage decisions aren't affected by the cost of treatment.

Navigating the health-care maze is tough, and we are increasingly asked to make our own choices. In the new biweekly column Healthy Consumer, Anna Wilde Mathews explores costs and values, and how to be a smart health-care consumer.

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