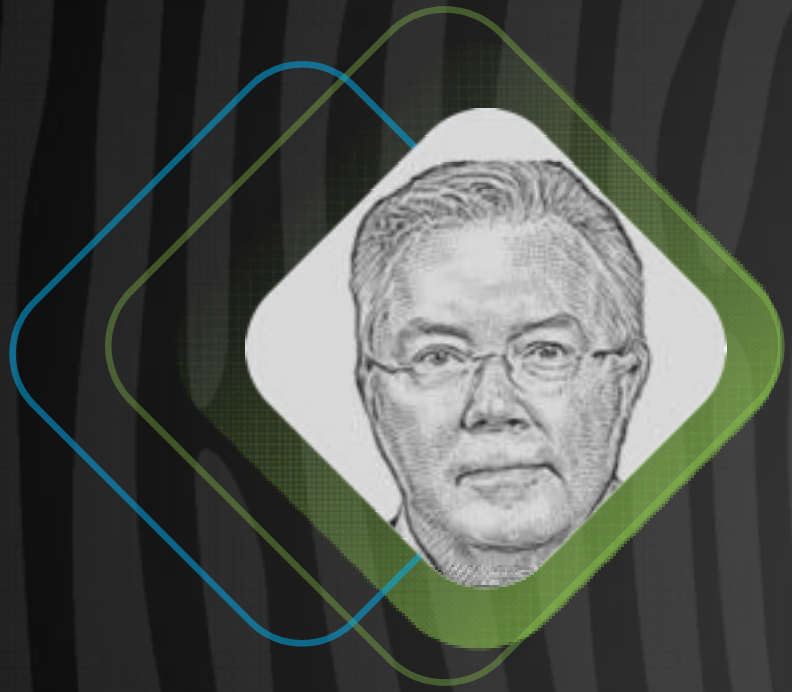
How to

APPEAL

Health Insurance Company **Denials**



TOM WILSON

Leader, Wisconsin
Neuroendocrine Cancer
Connection group

NEUROENDOCRINE CANCER

Recognition of Laurie Todd,
The Insurance Warrior

1. Laurie Todd wrote the book **Fight Your Health Insurer and Win** and **Approved. Win Your Appeal in 5 Days.**

2. Before I embarked on getting what we deserved from our insurance companies, I read her book cover to cover and followed her letters, using them as templates.

3. Along the way, I have built on her key points and added few key learnings of my own.

Key Topics


Background
Appeal process
Three D'S
Denial terminology
Medical terminology
Appeal process – our experience
Why we prevailed
What is it like to attend a grievance hearing?
What to appeal
End of year issues
What to do when a test is denied
Words & phrases used in an appeal
Traditional Medicare vs Medicare Advantage
Surprise Billing & Balance Billing

Obsessive Brute Persistence

Remember this phrase, because without it, **nothing will happen**

1. Insurance companies count on consumers giving up (lack the energy or knowledge)

2. Be like a dog with a bone; be nice, but firm.

3. Tenacity, persistence, determination, steadfastness, diligence, insistence, perseverance, firmness, courage. **Be your own advocate.** Don't rely on medical professionals to gain approval. They can help, but don't count on them as your sole source of change.

4. Most NETs patients/caregivers are well informed, knowledgeable and determined advocates

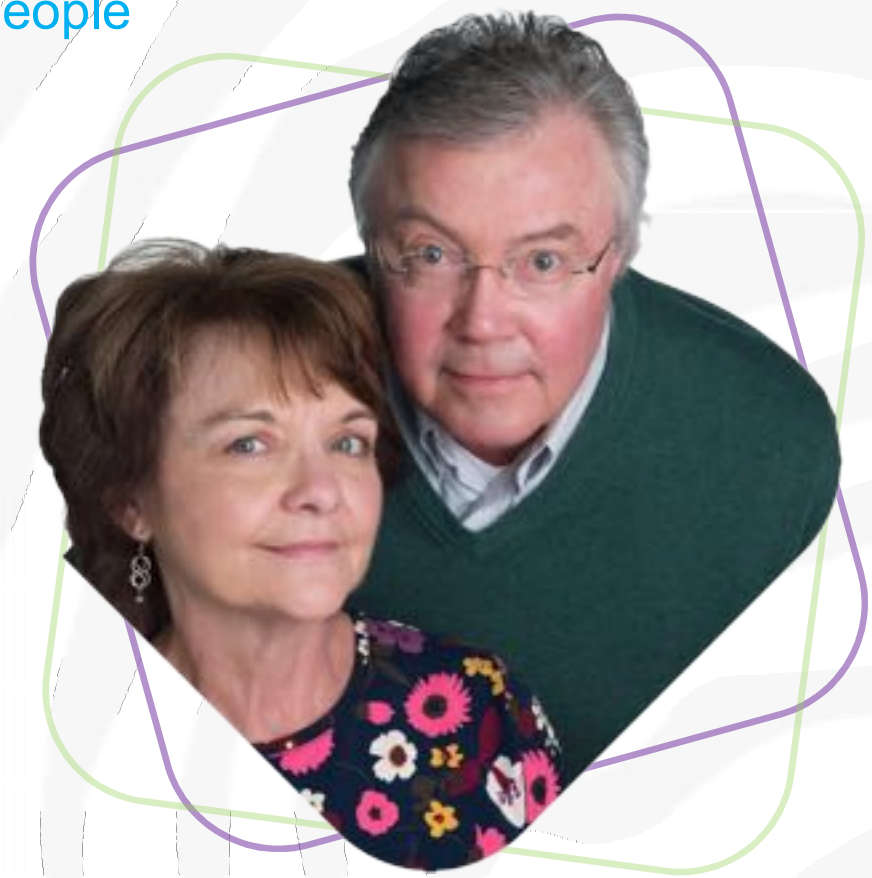
"When I use a word,"

Humpty Dumpty said to Alice in Wonderland, in rather a scornful tone,

"it means just what I choose it to mean - neither more nor less."

Background

I am not an expert, but I've helped quite a few people



Cancer is a very complex health care situation

- Mid-gut with METs to liver + carcinoid heart disease
- NETs DX April 2015, two surgeries and $2.5+ million of medical bills
- Seen at Mayo, Rochester, MN
- Carcinoid Heart Disease DX spring 2021

Background con't

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insurance providers from 2015 to today

Entrepreneurs with private insurance

8

The Three D's:

Deny, Delay, Defend

Whether it's insurance for your car, house or health, insurance companies are noted for the 3 D's - deny, delay and defend.

Denial Terminology

- Grievance and Grievance Panel Review
- Expedited Urgent Request - 7-day response vs 30 days
- Adverse selection - ‘if you have anything wrong, we don’t want to insure you’
- Pre-Auth or pre-authorization, pre-approval, prior approval
- Convenience (its for your convenience and therefore we won’t approve it)
- Not medically necessary or medical necessity
- Above usual and customary; what is usual and customary and who defines it?
- Experimental or investigational - if it were experimental, you would be required to sign a release form

Denial Terminology

Not standard of care

Not clinically appropriate (in terms of type, frequency, extent, site, and duration)

Criteria words

A set of rules for assessing or categorizing a thing. A listing of the signs and symptoms of a disease.
A standard or attribute for judging a condition or establishing a diagnosis

Contract exclusions

These are buried deep inside your insurance policy

Revisions or Conversions

A ‘do over’ of a surgery or procedure (see next slide)...

Denial Terminology

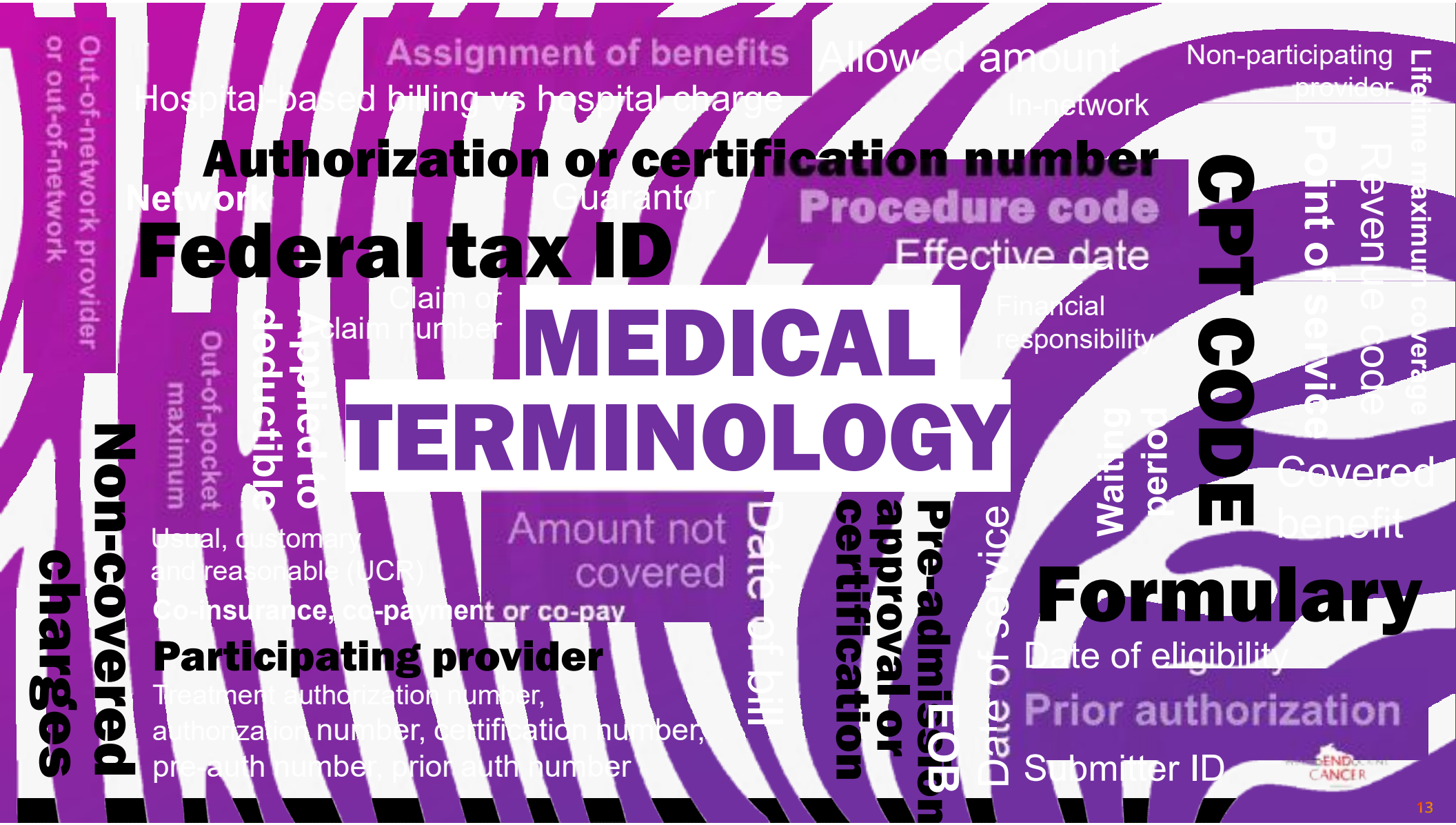
Coverage may be denied if something needs to be ‘fixed’. **Insurers may claim that:**

- The patient was not in compliance with a follow-up program
- Only one surgery per lifetime is covered
- There is no technical proof that the first procedure needs to be corrected or replaced
- The patient no longer meets the requirement for the surgery

Miscoding denials - ICD 10 codes, CPT codes, HCPCS (pronounced hic-pic)

Office visit
99201, 99202, 99203, 99204, 99205

New patient?
Work Up, Examination, Complexity & Decision Making, Amount of Time Spent


MEDICAL TERMINOLOGY
Assignment of benefits
Allowed amount
Non-participating provider
Hospital-based billing vs hospital charge
In-network
Authorization or certification number
Network
Guarantor
Federal tax ID
Procedure code
Effective date
CPT CODE
Out-of-network provider or out-of-network
Claim or claim number
Financial responsibility
Lifetime maximum coverage
Revenue code
Point of service
Out-of-pocket maximum
Applied to deductible
Usual, customary and reasonable (UCR)
Amount not covered
Covered benefit
Co-insurance, co-payment or co-pay
Pre-admission approval or certification
Formulary
Non-covered charges
Participating provider
Date of eligibility
Treatment authorization number, authorization number, certification number, pre-auth number, prior auth number
Prior authorization
Submitter ID

Formal Appeal Process

Wisconsin

Grievance hearing
fill out form

2nd Grievance hearing
fill out form

Arbitration

We have filed three grievances with two different insurance companies and arbitration

Attended each 'grievance hearing' in person

Filed for binding arbitration and prevailed

NEUROENDOCRINE CANCER

Our Formal Appeal Process

May vary by State

After two denials from the Chief Medical Officer (and CEO), in March 2017 we filed a formal grievance (there is a form for this). The process is as follows:

You submit any additional information you would like them to consider. We had previously submitted 50 pages of background and medical, surgical and office visit reports.

Drafted 3 ‘letters of medical necessity’

“There is now evidence to suggest that patients with neuroendocrine cancer receiving care at neuroendocrine centers of excellence may have superior outcomes to those treated at centers with lower volumes of neuroendocrine tumors and with less experience.”

Our Formal Appeal Process

May vary by State

1. Along with these letters, we submitted a two-page cover letter recapping the background and why the University of Wisconsin (UW Health), an in-network clinic wasn't considered a center of NETs excellence based on quantitative evidence.

2. WPS or Wisconsin Physician Services, my wife Lynn's health insurer returned a confirmatory letter of the appeal.

3. Lynn's case history was sent to an outside medical review company in Portland, Oregon who sent it to an outsourced Oncologist with no NETs training who made the determination.

What is it Like to Attend a Grievance Hearing?

1. Enter building and wait in the lobby.
2. Escorted to a conference room.
3. About a dozen mid-level administrators with no medical training and perhaps one nurse sitting in a conference room
4. Grim faces, very daunting
5. They likely don't know your background or history and they probably didn't read the summary that you may have provided to them in advance.

Our Formal Appeal Process

May vary by State

Set up in-person meeting or you can Zoom/phone in

Due diligence regarding the outside contractors

Discredited insurers third party outside review contractors

Our Formal Appeal Process

May vary by State

May 9, 2017

'Grievance Panel' in person where I Delivered our 8-minutes of commentary

May 12, 2017

The grievance panel manager called to say they needed a little more time to make a determination.

May 15, 2017

The company's Grievance Manager phoned Lynn to say they would consider her May 26, 2017, visit to Mayo including blood work, scanning as 'in-network'.

Any **future visits** would require a pre-auth.

Why did we Prevail?

We presented a fact-based case

Researched medical codes and provided a comparison of cost between U.W. Health and Mayo

Had conversations with employees in several departments within U.W. Health to gather facts.

We discredited their expert consultant based on his embarrassing lack of due diligence

We prevailed because:

Obsessive Brute Persistence

Obtained ‘Letters of Medical Necessity’ from three NET experts.

We were straightforward and pleasant; not antagonistic.

We prepared and mailed over 50 pages of documentation in preparation for the review. The insurance company filed over 200 pages.

What to Appeal?

Appeal anything that is:

- Denied (Examples - Asst. Surgeon; private room charge)
- That you feel should be covered as part of your policy
- Is being overcharged in your opinion
- A ‘surprise’ bill or being ‘balance billed’

Everything is negotiable because there are no price lists in medicine and certainly no pricing transparency.

Click here for NPR series called **Bill of the Month.**

Two negotiating strategies:

- Agree to pay what Medicare pays
- Use the Healthcare Bluebook
- Contest the bill in writing and via a phone call (they are recorded, and transcripts kept).

What to DO when a Test is Denied

When a test or treatment is denied… a typical insurer cost savings measure:

1. Tell the insurer you want to speak with the HIPAA Compliance/Privacy Officer. By law, they must have one.

2. Request names and credentials of each person having access to your records that were included in the denial decision. By law, you have a right to that information.

3. They will almost always reverse the decision rather than admit that the staff who made the decision aren't qualified. They are merely looking for 'criteria words'. In a case where it is made by a medical person, check their credentials as part of the due diligence process

4. What is the specific reason X service was denied.

5. Has Y insurance company ever denied X before and if so, under what circumstances?

6. Has Y insurance company ever approved X before?

Words & Phrases Used in an Appeal

Medical necessity - to maintain, preserve or restore your health

Incurable disease (Stage 4)

'Life saving' (this treatment or procedure could be life saving by being able to better detect… or aggressive surgery to remove tumor load from my liver….)

You could become 'injured' if the proper plan isn't followed; you are seeking a good outcome

The in-network person they say you must see is not a qualified NETs expert

URGENT EXPEDITED REQUEST

get around the insurer's 'delay' tactic - Insurance companies have 30 days to respond - unless you send them an Urgent Expedited Request for approval, then its 72 hours or so.

If it comes from your doctor, it may speed it up. Draft the letter for him or her.

Send it FEDEX overnight to your insurance company and fax it as well.

Indicate URGENT EXPEDITED REQUEST on the letter/fax.

The insurer may delay even an urgent expedited request by up to 14 days by asking for additional information.

Words & Phrases Used in an Appeal

‘Tantamount to malpractice’ - due to lack of experience; being encouraged to seek medical care at a facility or from a physician without the necessary medical expertise, tools or training with NETs is “tantamount malpractice”.

A ‘gap exception’ or ‘clinical gap exception’ where you request an out of network doctor/facility to be included as in-network because “no doctor in the network is qualified to offer curative treatment.”

‘Require life saving surgery’ if you are trying to get a surgery approved

‘Rare form of cancer’; most doctors may see one case of NETs in their career. I asked for a show of hands among the 12 to 14 Arise Health Plan employees how many had heard of neuroendocrine tumors. Only one raised her hand, a nurse.

Peer reviewed articles - reference peer reviewed studies by experts published on PubMed or NIH site that pertain to your unique situation. If you attend a hearing, leave a copy. Otherwise fax it to them ahead of a grievance hearing. Always plan to attend a grievance hearing in-person or by teleconference.

Words & Phrases Used in an Appeal

Has **(name of insurer)** ever allowed any policy holder to be seen at an out-of-network facility at in-network rates because there were no qualified doctors to treat them for a specific disease?

Concluding remarks: "All I ask from you is the same fine treatment that you would provide to any **other (name of health plan)** member with a more common cancer where it would be considered appropriate to be seen at **(name of facility).** It is time to do the right and reasonable thing, adjust the policy for treating this rare form of cancer and let me be seen at a qualified facility by a recognized neuroendocrine tumor specialist.

There is no doctor at **(facility)** who is considered a NET specialist

End of Year Issues

You are in the hospital at the end of the year which will carry over into the new years and you are switching insurance carriers.

Insurance company 'A' (the old insurance company) won't pay for the new year expenses, so they deny everything.

Insurance company 'B' (the new insurance company) won't pay for the previous year's expenses, so they deny everything.

The hospital bills you for the entire bill.

26

Traditional Medicare

Have NETs?
Traditional Medicare + supplement + Part D is best option.

$2.5 million
expense over 7 years; >$500,000 annually now

Limitations of of Part D; $40,000 per month x 5%
= $2k/m

VS

Medicare Advantage

42%
choose a Medicare Advantage plan (lower perceived cost and benefits)

Limited coverage, high deductibles, copays, pre-approvals

Copays

Once you choose a M.A. plan, you can't change to traditional Medicare (if you have issues)

?

Surprise Medical Billing or Balance Billing

Surprise bills occur when a patient goes to a hospital in his/her insurance network but receives treatment from a doctor that does not participate in the network.

Effective January 1, 2022, this practice has ended.

New billing protections when getting emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers.

Those on Medicare already enjoy these protections.

What's a surprise medial bill?

Let's say you have broken a bone and need an x-ray

You do your homework and go to a hospital that's covered by your insurance. Great!

But the doctor who reads the x-ray & who you never meet isn't in your network…

As a result, your get a huge medical bill. **Surprise!**


Thank
YOU