

Rejecting Denials

How to battle insurance companies for long-term nursing coverage

BY ORLY AVITZUR, M.D.

“I had been thrown into the maze of hospital corridors and insurance forms, with every procedure automatically denied by a grand vizier who lived unseen behind an 800 number. To this magistrate of maladies, my symptoms did not exist unless I died for them. So for now, since I was still very much alive, the tests were unnecessary and not covered.”

—Amy Tan
The Opposite of Fate

As Amy Tan chronicled in this 2003 memoir, the frustrations of dealing with insurance claim denials began as soon as she became ill. Two years earlier, while on a four-month book tour, the author of *The Joy Luck Club* was plagued with a persistent headache, a stiff neck and overwhelming exhaustion. She later began to have difficulty concentrating and even following conversations. For the author of several bestselling novels, writing became impossible.

It would take another two years and many doctor visits before she was finally diagnosed with Lyme disease. To make matters worse, her struggles with the monolithic insurance empire came at a time when, like for many patients suffering from neurological conditions, she was foggy-headed and lethargic, and least equipped to handle it.

When medical services are denied as unnecessary or uncovered, what can you do?

DO YOUR HOMEWORK

Catherine Wolf sought long-term skilled nursing care after amyotrophic lateral sclerosis (ALS) left her quadriplegic, and was told by her insurance company that her preferred provider plan did not cover the service. Even when the disease's progression left her dependent on a ventilator, her request for round-the-clock



nursing care was rejected. But when her lawyer requested her file, it proved that benefits were improperly denied.

“Demand as much documentation as you can get—it’s your right,” Wolf advises. “Be persistent. Insurance companies know that people will give up when a claim is denied.”

Twenty years as a neurologist has taught me that rejected claims often stem from clerical mistakes, office coding errors or incorrect insurance processing. If you get a denial, read your policy carefully to see what’s covered.

Wolf’s attorney, Mark Scherzer, who specializes in patient rights, says the key to dealing with denials is persistence. Make sure you understand the reason for the denial. “If there is a problem, get

expert help early,” Scherzer advises.

When Wolf retained Scherzer, she sent him a history of her illness as well as the correspondence with her insurance company. Document all phone conversations in detail. Follow up with a certified letter so a record trail is created.

FIND AN ADVOCATE

Amy Tan had to rely on help because Lyme disease, a tick-borne infection, left her unable to think clearly at times.

“You really need someone who understands health insurance and can speak for you,” says Tan, herself now a spokeswoman for the Lyme Disease Association. “It’s especially important to assign an advocate when cognitive abilities are impaired, as was the case in my situation.”

Scherzer recommends checking if your employer provides a healthcare advocate whose role includes fighting denials. Local legal assistance organizations and consumer advocacy will often provide a social worker or attorney for patients with insurance problems.

National and local organizations serving patients with specific neurological disorders also provide guidance. After Michael Harrington was denied coverage for the drug prescribed to treat his multiple sclerosis (MS), he turned to the National MS Society for help. Within six weeks, his denial was reversed. When his prescription for a drug to treat cognitive problems was denied, he successfully appealed again. “The National MS Society was wonderful,” says Harrington, who reports that one of its advocates guided him through the process and even made calls on his behalf.

ASK YOUR DOCTOR TO HELP

After the insurance company denied Wolf’s request for 24-hour nursing on the grounds that her ALS care was custodial, her doctor wrote directly to her insurance company’s medical director. When that didn’t work, he followed up by phone. He argued that ventilator failure or a life-threatening mucous plug could occur at any time and that her diminished ability to verbally communicate required the expertise of a nurse to assess her condition.

Patients, physicians and advocates should be polite and professional. State the facts, describe the potential medical consequences and the economic burden on the insurer should the patient fail to receive the requested services. Remember, documents are likely to be reviewed on appeal. Bruce Sigsbee, M.D., who teaches neurologists how to handle insurance problems in American Academy of Neurology courses, advises, “It

may be cathartic to write a ‘Dear Bozo’ letter, but it is rarely effective, and may come back to haunt you.”

FILE AN APPEAL

“Many insurance companies have discovered that they can save money through automatic denials because so few people appeal,” says Robert M. Hayes, president of the Medicare Rights Center, an advocacy organization that assists elderly and disabled individuals. “Their strategy—delay, delay, deny—turns out to be effective. But if you have representation, you are likely to win.”

About 70 percent of denied claims are overturned on appeal, says Jennifer Jaff, author of *Know Your Rights: A Handbook for Patients with Chronic Illness*. The former Connecticut assistant attorney general runs Advocacy for Patients with Chronic Illness, an organization that educates and advocates for patients’ rights. One of Jaff’s clients, Kathleen Crowley, found herself rapidly accruing \$17,000 interest on college loans when she was diagnosed with MS and lupus soon after graduation. Like so many patients with chronic illnesses, Crowley was in financial straits because she was unable to work. She turned to Jaff’s organization, whose fundraising efforts allow it to offer its services at no charge. It packaged her appeal—attorney-signed letters, medical records, published medical research, written support from treating physicians. Jaff credits that approach for her organization’s success rate of over 95 percent. “Jennifer gave me back hope,” says Crowley, who was forgiven her loans and was given a special bed to avoid pressure sores.

Roger Patterson was stunned when he was denied much-needed physical

Negotiating the maze of insurance bureaucracy takes expert advice and loads of persistence.

therapy last year after a stroke left him weak on his right side. “The \$12,500 bill came at a time when I was incapable of making decisions,” Patterson recalls. He won the appeal after Susan Dressler, president of the Alliance of Claims Professionals, sent all his rehab and physical

therapy notes along with doctors’ letters of medical necessity. Her organization serves as a referral service for industry experts familiar with the insurance business and available to serve as healthcare hired guns.

“In some situations, such as self-insured health plans, you get only one shot at an appeal,” warns Scherzer. “If you have gone through the process and then want to go to court, evidence may be limited to those records which the insurer examined.”

In those cases, it helps to seek advice from the start on which supportive documents to send in for review. Inadequate records end up working against you. Insurance rules—such as your right to appeal, to access documentation and to review clinical guidelines on medical necessity—vary both by payer and by state, says Scherzer.

In Wolf’s appeal, Scherzer argued that her ALS required skilled nursing according to state law, supporting his brief with past court cases. They won the appeal within six months. NN

Dr. Orly Avitzur is a neurologist in private practice who holds academic appointments at Yale University School of Medicine and New York Medical College.



For more information about insurance advocacy, see **RESOURCE CENTRAL** on page 46.