Get More Cash Back on Your Health Claims

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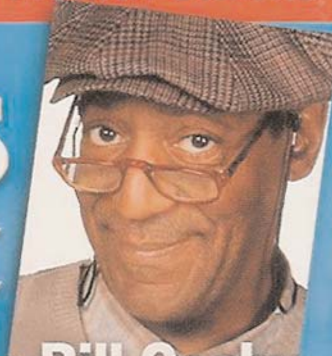

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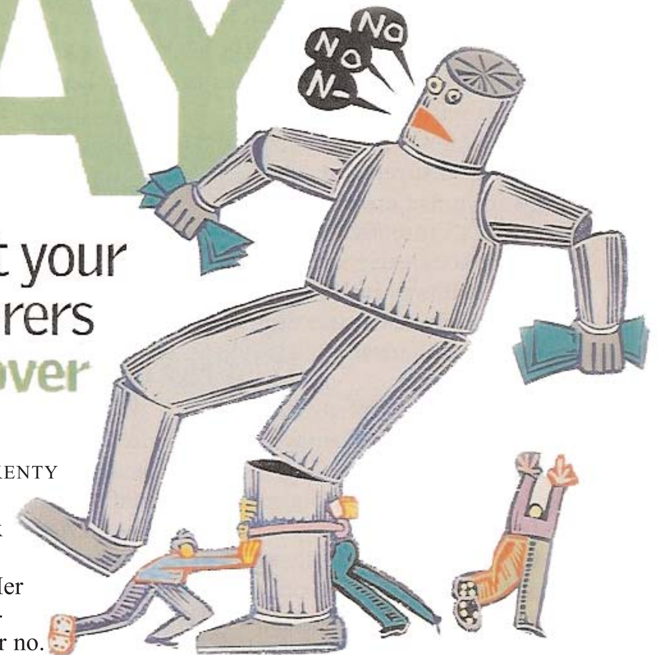


ELIZABETH MCKENTY wanted a new treatment to fix her congenital heart defect. Her insurer said no. She appealed – and got another no.

For most people, that would have been the end. But McKenty, 44, a librarian in Philadelphia, appealed again. With the help of **Health Advocate,** a company that fights denials, she marshaled medical literature showing why the treatment – implanting a device to help block leakage between the heart's two chambers – would give her better odds than open-heart surgery. This time she won.

BY PETER LANDERS AND AMY DOCKSER MARCUS

FROM THE WALL STREET JOURNAL

Most people take it as a maddening fact of life that health insurance companies are programmed to say no, and that appealing only brings headaches and another no. But for all their image as heartless Goliaths, insurance companies aren't invincible. Increasingly, it's possible to challenge a health plan's verdict and prevail.

New channels of appeal are making it easier for patients to press their cases. A backlash against health insurers has prompted many states to pass laws setting up external review panels and requiring insurers to adopt in-house appeal procedures. Currently, 41 states and the District of Columbia have independent review boards, most with the power to overrule insurers.

Those who appealed won on average 48% of the time.

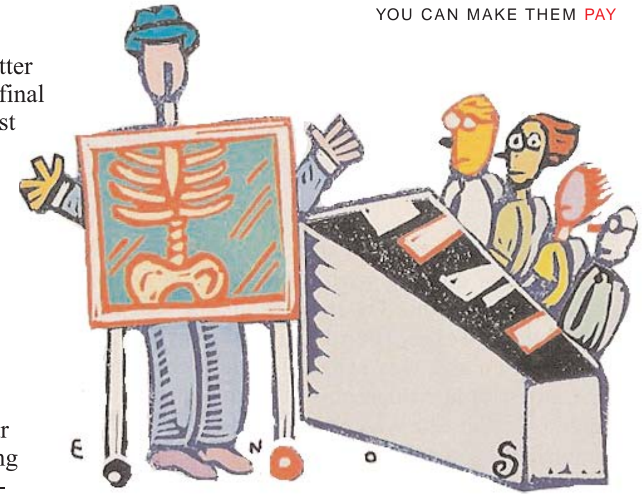
Yet only a handful of people are taking advantage of their appeal rights, and many still pay bills they don't have to. The biggest problem is the time and energy it takes to pursue complaints. "A certain percentage of appeals drop off because people are tired, confused and dealing with a health crisis that doesn't give them the wherewithal to figure this out," says Gerry Martens, a Connecticut state official who represents consumers in insurance disputes.

The chances of winning an appeal, however, are surprisingly good. Nationwide figures aren't available, but a Kaiser Family Foundation review of recent data from New Jersey, Pennsylvania, Arizona and Rhode Island indicated that patients had, on average, a 48 percent chance of winning their first in-house appeal. Those who appealed again wound at least 50 percent of the time. Data from 42 states show patients who took the next step – using independent state review boards – won cases an average of 45 percent of the time.

How can you successfully take on your health insurer? Knowing how to navigate the bureaucracy is key. Let's say your insurer has turned down your claim. Most plans have an 800 number for queries, but Rhonda Orin, an attorney at Anderson Kill & Olick who specializes in battling insurance companies, says don't call. Instead, write a letter immediately, acknowledging receipt of the denial and stating the grounds as you understand them. Attach medical records, and don't sound angry. Draft a reasoned argument, backed up by evidence as to why the procedure is medically necessary.

If you get a second no, your insurer will likely focus on its key reason for refusing coverage. Reappeal, homing in on that reason. Get a letter from your doctor – and a second opinion from another physician. Look for articles on the Internet showing the procedure is a recognized treatment.

If you get a third denial, chances are you'll receive a letter stating, "This is your final appeal." By now, most people will have given up. But if the dollars involved are big enough, it's worth another step. Write another letter, asking if there's anyone else in the company you should talk to. The letter shows you've exhausted your internal options, paving the way for going outside to litigation or a state board.



The Supreme Court ruled recently that consumers have the right to have health plan disputes reviewed by state boards. But most patients are unaware the boards even exist; only about 4,000 people use them each year.

The boards are made up of specialists in the area of medicine under dispute. They review medical literature and records from the case, but rarely call witnesses. A decision should come within 60 days or less, depending on the state – much faster if you have an emergency case. The appeal is either free or costs a nominal filing fee. (In many states, the insurer pays for the review, while in others, the state covers the cost.) Most states give information about the process on their websites.

People who work at companies that have "self-insured" health plans, in which the company directly pays all employee medical costs, aren't eligible to apply to state boards, but they have other protections. (The federal government regulates self-insured plans. The other type of employer-sponsored plan is one in which the employer buys health insurance from an insurance company.) Federal rules require insurers' in-house appeal boards to give judgments in 30 to 60 days; in urgent cases, within 72 hours.

It's also worth checking how Medicare, the government insurance program for the elderly, treats similar cases. Medicare hires private insurance companies to process claims. Its rules influence how insurers act even in non-Medicare cases. Your doctor's billing staff may be able to help gather this information.

David Stone, an executive at a Nashville, Tenn., company that handles billing services for doctors, recalls a case in which a woman received two

kinds of ultrasound on the same day.

The insurer refused to pay for both, but Stone got the decision reversed by showing that Medicare would have covered the two ultrasounds.

IT'S IMPORTANT to start early when dealing with your insurer. Cathie Owen of Kaufman, Texas, found that out when she was scheduled to give birth to her third child by cesarean section. She wanted a tubal ligation at the same time, but a few days before she went to the hospital, her insurer rejected payment for the ligation, reasoning it was an incidental add-on, known a bundling. Owen, unwilling to foot the $500 bill or undergo additional surgery, kept her tubes untied.

If Owen could do it again, she'd insist on getting an answer months before her child was due so she could appeal. She could have explained that the procedure would prevent unwanted pregnancies – and therefore additional expenses.

Bundling is a common source of disputed. Many insurers use software that automatically chops off some claims for procedures performed on the same day.

For example, if a woman visits her gynecologist and gets a regular checkup plus a biopsy, the computer program will allow payment for the biopsy but reject the checkup. The rationale is that a biopsy includes a bit of looking around, so the checkup shouldn't be billed separately.

Many doctors fight back by refusing to perform multiple procedures on the same day, instead making patients return on a later date. Doctors are afraid they won't get reimbursed. So if you're on the hook for charges insurance might not cover, the doctor's precaution might save you money too.

GRATITUDE, SHMATITUTDE

Sitting down to supper one night, myolder sister complained about having to eat leftovers. Our father decided she should say grace to show her appreciation.

Karen bowed her head and then prayed, "Thank you for this food…again."

HEATHER MARSHALL

LAUGHTER MAKES THE HEART GROW SOMBER

When my oldest son was in high school, he occasionally earned extra money making balloon animals. Since he is quite funny and charming, I suggested he might make even more money if he became a clown. He absolutely refused to consider it. "Buy why?" I asked.

"Because then everyone would laugh at me."

NANCY GALLETS