Doctors can be passionate patient advocates. But, typically, busy physicians have neither the time nor the economic incentive to appeal health plan coverage decisions.

"Doctors aren't reimbursed one darn cent for the time they spend going to bat for patients," says Scottsdale, AZ, gastroenterologist Joel Brill, who's worked as a reviewer for both health plans and an IPA. "As a result, the number of doctors who get deeply involved in the process is exceedingly small."

FP Gil Solomon, a medical director at Blue Shield of California, agrees. "It's rare for a physician to be involved in an appeal," he says. "It's usually the patient who initiates one and sees it through."

Still, there are things physicians can—and, in some cases, should—do to help patients. We talked to practicing doctors, as well as current and former health plan medical directors, to find out just what those things are and how much effort they'll take. Click here and you'll find a clip-and-copy instruction sheet that you can give patients so they can more easily help themselves.

**Simple steps to make things run smoother**

From their own experience, doctors know that most health plan denials don't require an appeal. Over the years, doctors have developed a range of "informal" techniques for dealing with UR rejections. Share them with your patients.

Steven D. Kamajian, an FP in Montrose, CA, instructs his patients who work for self-insured companies to contact their benefits managers. "A call from someone paying the premiums for 500 employees has far more impact than anything I can say," says Kamajian.

Richard J. Sagall, a Philadelphia FP, takes matters into his own hands. When dealing with a reviewer who refuses to budge, he first asks for a name and phone number. "I then tell the reviewer that I'm including this information in the patient's chart, along with details of our discussion and a note outlining my continuing belief that the referral or treatment is medically necessary," Sagall says. "The prospect of having the reviewer's name and contact information in the chart changes a lot
of their minds."

But what if your authorization request is still denied—despite your best efforts?

At this point, laws in all 50 states give you and your patient the right to appeal the health plan's decision to an in-house panel. (Standards for internal review vary significantly among the states, although most make allowances for expedited appeals in emergencies. For more on the internal appeal process, see "What to say in your letter").

Before initiating an appeal, doctors and their patients can save time while increasing their odds of success by following two simple initial steps:

1. **Look closely at the benefit.** Just because you're convinced a specific treatment or regimen will help your patient's medical problem doesn't mean it's a covered benefit.

   "To take a far-fetched example, consider the woman with arthritis who's told by her doctors that she should swim in a heated pool, and she asks her health plan to build her one," says Abbie Leibowitz, former chief medical officer of Aetna US Healthcare and one of the founding partners of Health Advocate, a patient advocacy company in Pennsylvania. "Building a heated pool is certainly not a covered benefit. But there may be some form of reimbursement or discount for an exercise program."

   In most physician practices, the first line of defense in such cases is the practice's benefits or insurance coordinator. If she isn't convinced a specific benefit actually exists, it probably doesn't.

2. **Find support for the procedure.** Everyone knows that plans generally don't cover experimental treatments, but doctors don't always realize that plans might not cover "nonstandard application of an established procedure," says Leibowitz. So, for doctors and patients contemplating an appeal, it's crucial to find proper support for the treatment in question. "Most plans will listen if there's support for a procedure in the peer-reviewed medical literature—even if it's a cutting edge use of an existing technology or an off-label use of a recognized drug," Leibowitz says.

A case brought to his own patient advocacy company illustrates the point. Doctors wanted to treat a patient suffering from myasthenia gravis with a drug that's typically been used to prevent rejections during organ transplant surgeries. But doctors had also read about its efficacy in treating MG and possibly other autoimmune diseases.

"The plan said that the drug wasn't covered because the proposed treatment was an off-label use of the medication, although that shouldn't have been an automatic disqualifier," says Leibowitz. "We talked to the expert on the subject at Johns Hopkins who'd written an article in Neurology. He said the drug has become the standard of care for this kind of patient. Based on his opinion and similar evidence, we were able to make the case that got the treatment approved."

**Don't write the wrong letter**

If the referral, treatment, or test you're recommending is both a covered benefit and supported by expert opinion, you have to convey that information to the health plan.

Unfortunately, doctors often end up writing the
wrong letter. "The doctor may write that it's medically necessary to treat this patient," says Leibowitz. "But often the plan isn't questioning medical necessity per se. It's questioning the necessity of treating the patient in this fashion. Doctors must be sure to address the question that the plan is basing its decision on."

Pediatrician Alberto Kriger of Pembroke Pines, FL, learned this lesson the hard way. "I'd write a letter, and it would be rejected," says Kriger. "Then I'd write another letter and something else was missing, and it went on like this."

Now Kriger does his homework beforehand. "If parents who've been denied a service tell me they want to appeal, I tell them to contact someone accountable in the health plan and find out exactly what needs to go into the letter," he says. "Often, I'll tell the parents to write a first draft, which I then revise, adding the appropriate medical terminology and whatever additional documentation is necessary."

Kriger will take more of the burden on himself for parents he thinks are "incapable of effectively advocating for their children." But if an otherwise capable parent isn't willing to participate fully in the process, he's "more reluctant to spend the time."

Sometimes a phone call prior to any written communications can work wonders. But it's crucial for busy doctors not to "get sucked into the bureaucracy of the plan," says Leibowitz. "The best thing for a doctor who wants to get a clinical issue addressed is to speak to one of the plan's medical directors. Virtually every medical director in every plan will speak with a physician if he's persistent enough."

That's certainly been the experience of FP Jeffry C. Hatcher of Paris, IL. "Medical directors are very receptive to this kind of contact," he says. "Physicians don't take the time to call, but it's a very effective way of getting problems resolved."

Of course, even the medical director won't necessarily resolve things in your favor.

Dermatologist Stephanie A. Mackey of Lancaster, PA, found that out when she appealed her plan's referral policy. "Primary care doctors would refer some high-risk patients to me, and those referrals would routinely be denied by a local HMO," Mackey says. "The plan's position was that the PCPs could check their own patients' skin. So I met with the medical director and showed him a list of patients I'd seen whose problems had been misdiagnosed or treated improperly. He stuck to his guns anyway."

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**What to say in your letter**

Physicians have a legal obligation to advocate on their patients' behalf. Most malpractice insurers provide a sample letter to protest a plan's authorization denials. You can ask your insurer for one, or use the language below.

Address your letter to the plan's medical director or the chairman of its utilization review committee:

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**On (date), I recommended (test, medication, procedure) for (patient). On (date), your plan refused to authorize payment. I find that I must take issue with your determination for the following reasons: (list them).**

In my medical judgment, this (test, medication, procedure) is a very important part of my overall care for this patient. He suffers from (diagnosis). The (test, medication, procedure) is necessary to (give its purpose). Failure to administer it could result in the following problems: (list them).

For these reasons, I urge you to reconsider your refusal to authorize payment. By copy of this letter to (patient), I am reiterating my suggestion that, for reasons set forth in this letter and in prior discussions, the patient obtains the (test, medication, procedure) despite your refusal to authorize payment.

Sincerely,

If the patient declines to follow your treatment advice after a health plan denies coverage, there's one other letter you should send. It's to the patient, and it's necessary to protect yourself:

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**On (date), I prescribed (test, medication, procedure). On (date), your health plan refused to authorize payment. Because of the refusal, you informed me of your decision to forgo the treatment I'd prescribed. I expressed my concerns regarding your decision during our discussion on (date) about the potential ramifications of your choice.**

The purpose of this letter is to recommend that you appeal the plan's denial of benefits, and reconsider your decision in light of the potential consequences. This office will be happy to assist in your appeal process as far as we are able.

Should you wish to discuss this further, please do not hesitate to contact me.

Sincerely,
In the end, Mackey withdrew from participation in the plan, in part because of liability concerns. "I'll accept liability when I'm seeing a patient all along, but if I see a patient once or twice and then future referrals are denied, then I have a problem."

But despite the inevitable setbacks, persistence more often than not pays off. Says former medical director Leibowitz: "You have to persevere and not take a lack of a response as an answer."

Help patients navigate external appeals
In 43 states and the District of Columbia, denials by health plans can also be appealed to an external or independent review panel.* All but one of these states require patients to have exhausted their health plan's internal appeals process before taking their case outside the plan, according to the Health Policy Tracking Service of the National Conference of State Legislatures. The one exception is Missouri, although even here patients as a practical matter are likely to follow the typical pattern.

Patients who appeal plan decisions find relief about half the time, according to studies by both the managed care industry and independent groups. Despite this, a study released last March by The Henry J. Kaiser Family Foundation reported that the external review option is used "infrequently" (it's estimated that only 4,000 appeals are filed annually).

Among the factors cited for the low turnout are the policy of requiring patients to exhaust the internal review process before moving on, the difficulty many patients have navigating the multilevel review process, state policies that permit belated notices of external review rights, and overly strict eligibility requirements.

To offset these problems, doctors should advise eligible patients of the resources available to them. These include:

➤ A Consumer Guide to Handling Disputes with Your Employer or Private Health Plan, (2003 Update). A joint project of The Henry J. Kaiser Family Foundation and Consumers Union, this free guide gives patients tips on determining their coverage, and on initiating and filing an internal appeal. There's also a state-by-state breakdown of external review programs, eligibility requirements, and contact information. Copies of the guide are available at either www.kff.org/content/2003/20030123a or www.consumersunion.org/health/hmo-review or by calling the Kaiser Foundation's publication request line at 800-656-4533.

➤ Patient Advocate Foundation, Newport News, VA. One goal of this organization is to mediate disputes between patients and their insurers. Contact the foundation at help@patientadvocate.org or by calling 800-532-5274.

➤ Disease-related groups and associations, including the American Cancer Society, the Arthritis Foundation, the American Diabetes Association, the Epilepsy Foundation, and the Lupus Foundation of America. Each of these groups can lend their expertise during an external appeal.

➤ Employer patient advocacy programs. An increasing number of employers have contracted with companies like Health Advocate to advise and, when appropriate, go to bat for their employees. Health Advocate (www.healthadvocate.net) now has about 135 clients, covering 200,000 employees. Other companies providing similar services include Patient Care, a service of New Orleans-based Labyrinth HealthCare Group, and CareCounsel, in San Rafael, CA.

Resources like these can help your patients—without taking you away from your practice.