

# HOW TO HANDLE YOUR INSURANCE COMPANY

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When most people think about medical insurance they assume that, if they have it, everything necessary for the health care of their family will be taken covered. This is not necessarily so. Different insurance policies offer different levels of coverage. You cannot assume that, because your friend's policy covers a certain procedure or item, yours will too. Even Medicaid eligibility and benefits vary from state to state. It's not so much a question of what your medical coverage is, but how do you get the most out of your current carrier.

## **A. Getting the Most Out of Your Current Insurance Carrier**

**1. Request a case manager.** If you do not already have one, call your insurance company and request to have a *case manager* assigned to your child. A case manager will coordinate all claims and authorizations relating to your child's care. Having a case manager will also ensure that you will be able to speak to the same person each time you have a question. Having a single, regular contact at your insurance company will decrease the amount of time you spend on the phone, repeating your story to a new person and guarantees that you will not get conflicting information from different sources. This is probably the single most important thing you can do to help yourself deal with your insurance company.

**2. Know your plan.** Does your insurance carrier require that your family doctor/pediatrician (sometimes referred to as your *primary care physician*) supply *referrals* to all other specialists and therapists? If so, it is your responsibility to obtain these referrals. Do not assume that the doctor's office took care of it for you. If you need authorization for a procedure or a referral to a specialist, make sure to request it ahead of time. In situations where you are unable to get these referrals, such as after-hours emergencies, make sure to contact your case manager as soon as possible to notify them of the situation and to find out what else you need to do to ensure coverage. Failure to get necessary referrals and go through proper channels may cause you to incur charges that will not be covered by the insurance company and will have to be paid out-of-pocket. These charges may be very expensive, and will add up!

**3. Use "participating providers" whenever possible.** Most insurance plans offer a higher level of benefits when you use certain providers. These providers are called *participating providers* or *in-network providers*. Many plans allow you to go to other doctors and facilities (often referred to as *out-of-network providers*), but at a much higher cost to you. Some plans do **not** provide **any** benefits for out-of-network services at all. If yours is one of these plans, and you choose to use an out-of-network provider, you will be responsible for the full cost of the visit. It is your responsibility to make sure that all doctors, therapists, suppliers and treatment facilities that you are referred to accept your insurance. Even if you have an up-to-date listing that identifies a particular doctor or facility as a participating provider on your plan, it is a good idea to verify this at the time you make the appointment. Provider lists change constantly and, if the list you are using is outdated, you may be stuck paying a large bill out-of-pocket. If you do not have an up-to-date provider listing, call your insurance company and get one. If your family doctor refers you to a provider that is not on your plan, let them know who is on your plan and ask them to recommend one from that group.

In many cases, insurance coverage for *durable medical equipment* (DME) differs from coverage for office visits, hospital stays and other medical services. Often, an insurance company will contract with a single DME company for a particular region, and you must use the company assigned to the area you live in or you will be denied coverage. Make sure to call your case manager and get the name of the company or companies that supply your area.

**4. When in doubt, ask.** If you're not sure whether you need special authorization for an item or procedure, call your case manager. If you don't have a case manager or are unable to speak to him/her for some reason, be sure to get the full name of every person you speak with so that they can be held accountable for what they tell you.

**5. Don't be caught without the necessary information.** Treat your insurance card like you do your driver's license; never leave home without it. Program the contact number into your cell phone, just in case. Carry a copy of your participating provider list with you to all medical appointments – you never know when you will be referred to a new specialist and having the list of participating providers available will save you time and energy.

**6. Keep careful records.** Keep all of your benefits information in one place. Create one file just for manuals and provider directories. When you receive a new provider directory, throw the old one out – it is no longer accurate and can lead you to make mistakes. Make separate files for each family member. If you have a troublesome provider or one you have a lot of dealings with, make a separate file just for them. For claims that are processed and paid correctly, staple the insurance statement (also called an Explanation of Benefits or EOB) to the original bill and any related receipts you have and file them in the proper family member's folder. You may need them come tax-time (some out-of-pocket expenses are deductible). Keep a separate "Active" file for all claims that were not paid correctly (see Section C for information about denied claims). Keep all paperwork related to Active items in this folder, including logs of your phone calls, any letters or emails from the case manager and copies of all outgoing correspondence. If you have more than one Active item at a time, be sure to attach items related to each claim so that you will not need to sort the file each time you look into it.

**7. Read all of your Explanation of Benefits (EOB) forms carefully.** If you have private insurance (such as through an employer), you will get a statement from the insurance company every time a provider's office makes a claim. This statement is called an *Explanation of Benefits* (EOB). An EOB shows how much was billed, how much was paid and, if the full amount wasn't paid, why it was denied or adjusted. If several things are done at a single doctor's visit, you may get separate EOBs for each item (the office visit, lab work, x-rays, etc.) If you have Medicaid or other government benefits, you may not receive an EOB. This varies from state to state and program to program. If you are not receiving them, call your insurance company and find out why not. You have the right to know what is being billed and paid in your name so that you can spot erroneous billing and so that you know what your out-of-pocket cost is going to be.

**8. Make sure your information is up to date.** Whenever you change insurance companies or you receive an updated card from your current company, be sure to replace your old card in your wallet. Then call all of your providers and give them the new information as soon as possible.

## **B. Handling Your Provider**

In a perfect world, your doctor would write brilliant letters of medical necessity for your child's needs, respond quickly to questions about insurance filings, meet deadlines and help you get whatever equipment you wanted for your child without a problem. However, we don't live in a perfect world. There **are** good doctors out there. But even the best doctors are not familiar with every medical situation, and don't necessarily know everything there is to know about insurance companies. Unfortunately, you need to deal with your doctor since most insurance companies won't even consider paying for most items unless a physician prescribes them. You can't force your doctor to go the extra mile for you, but you **can** make him do what is required of him. Here's how:

**1. Don't take "No" for an answer.** Your doctor isn't your insurance company. Just because he doesn't think your insurance company will approve something doesn't mean that he can't prescribe the item or therapy. In some cases, the doctor assumes that because one company won't pay for an item that no company will. Even if the company that sent that *other* patient's denial is the same company that you use, individual policies vary. You should always make the attempt. Always. If you think that your doctor is going to argue with you, do a little research ahead of time. Call friends. Print articles. Anything you can do to support your request will help.

One SMA mom says: *"You know how they love to try and give you insurance advice. 'Your insurance probably won't pay for this...' thinking it'll shut you up. One neurologist here about a cough assist: 'Insurance won't pay for those.' You know, like it's gospel. Of course I said, 'Umm, yes they will. We got ours without appeal in October of 2004.' He says 'Oh, well I just had a patient who was denied.' So, apparently that means NO insurance companies pay and somehow there is no appeal process. And he was just saying that to me out of the blue not because I'd asked for anything."*

**2. Make sure they file your insurance properly.** Make sure that your insurance information on file is correct. If you received an updated card, make sure to give them a copy. Something as simple as sending the claim to the wrong post office box or the wrong department at the insurance company will lead to a denial. If you have more than one insurance plan, make sure that they file with your secondary carrier if your primary insurer denies coverage.

From an SMA mom: *"Here I was applying for nursing care and the provider calls me and says it was denied by Medicaid. So, I'm disappointed and asked the reason code. She says, 'You have other insurance?' Yes... and the problem is? They had 'forgotten' to apply through our private insurance and went straight to Medicaid. So, I suggest they apply to our insurance company, get a denial and reapply with Medicaid."*

NOTE: If you have private insurance and don't have secondary coverage, please read section G for information about Medicaid waivers and other programs.

## **C. When Claims Are Denied or Not Paid in Full**

**1. Check the EOB for errors.** Sometimes a misspelled name or incorrect diagnosis code is all it takes for a company to deny a claim. If you notice any errors, notify the company immediately.

**2. Call the insurance company!** There is no easy way to figure out why a claim was not paid properly without taking this step. No one likes calling their insurance company, but it is by far the easiest and fastest way to fix a problem. Many times, a problem can be cleared up in a single phone call.

Make sure to have the Explanation of Benefits with you so that you can refer to it easily. Also make sure to have a pen, paper, your insurance card and any other information (copy of the bill, pre-authorization number, etc) that will help the company identify the claim and help you get the information you need.

If you are unable to speak with your regular case manager, make sure to get the full name of the person you're speaking with. Ask for the spelling so that you know you have it written down correctly; you may need to track them down later.

One of three things will happen during this phone call. Be prepared for all three options:

a) The insurance representative may simply say "Oh, that was our mistake! I'll put this through again for you." Not everything will be a fight. If this is the case, put the paperwork aside where you can access it easily when the second EOB comes through. Check the total paid on both EOBs and make sure it's correct before you staple it all together and put it away.

b) You may actually owe the amount they claim. Some insurances have deductibles that you must meet before they'll pay a dime. Others only cover a percentage of the fee; you are responsible for the remainder. Many plans require you to pay co-payments. It is easy to forget this at times, but one call to the insurance company will remind you of the limitations of your coverage.

If you actually do owe some money, do NOT send payment until you are billed by the provider. The bill will contain information (account number, etc) that you should include on your check to help them locate and properly credit your account. Send a payment without this information and you run the risk of having payment incorrectly applied, which is a whole different headache. Once you are billed and submit payment, attach a copy of the bill along with payment information (date, check number, amount paid) to the bundle of papers relating to that claim and file it. Having the payment information together with the information about the original claim will make things easier if you intend to write off these expenses come tax time.

c) The insurance company will have another reason – for example, "the item is experimental" or "not medically necessary"– for denying the claim. If this is the case, you will need to gather information and make an appeal. Speak to your doctor's office first. Some physicians will gladly write a revised Letter of Medical Necessity (the letter that your doctor writes to the insurance company explaining why your child requires a particular item). Others will be happy to sign an appeal letter that you or someone else has written. There is no need for you to spend time away from your child to research and write an appeal if your doctor will do it for you.

Do **not** get off the phone without getting a clear answer from someone whose name you have written down! If the person you are speaking to is unable to answer your question, tell them that you really need to have the question answered clearly and ask to speak to a supervisor.

## **D. Appeals**

**1. Sending a prepared Letter of Medical Necessity (LMN).** If you are sending a revised LMN that was prepared by your doctor's office, make sure to enclose a short cover letter identifying the claim. Include the patient's name, the name and ID number of the insured party, group number (if applicable), item requested and claim number if one has been assigned. An example cover letter:

*Dear Mr./Ms. (Name):*

*In response to Your Insurance Company's denial of 4/8/05 (please see attached), regarding the following claim:*

*Patient: Jane Public*

*Insured: John Q. Public (father)*

*Insured ID: 123-45-6789*

*Group #: 12345*

*Item: Wheelchair (be specific – include the make and model name/number)*

*Claim number: 98765*

*I am enclosing the requested letter of medical necessity from Dr. Smith, MD, of the Orthopedic Medicine Department of (hospital name). Please contact me immediately at (512) 555-1234 if further information is required.*

*Thank you.*

*Sincerely,*

**2. Making an appeal on your own.** Some appeals will be simple. You'd be surprised at some of the seemingly silly – and easily fixable - things that an insurance company will deny a claim over. Other appeals will be harder. For example, proving that an item is medically necessary takes research, time and energy. Whether you take on the challenge of an appeal by yourself or you seek help with the appeal, you will need to know the proper process and follow it exactly. Before you expend any energy on the appeal, call your case manager and make sure you understand the precise reason for the denial and what you need to provide to get the appeal processed and approved.

Try not to think of this as a hassle – treat it as an opportunity to educate your case manager and the insurance company about SMA and the various therapies and equipment that your child needs. The effort you make now may prevent another family from having to repeat the process later. This attitude shift might seem impossible to make, but it will help you keep your cool while you're dealing with the company, and that is important. Facts and reason will win an appeal. Emotion will not.

From an SMA Support thread on the topic: *The most ineffective thing you can do is try to appeal to their emotions - the person you spoke to can't very well go to their superiors and say "well, I had to give it to her - she cried."*

Here are some basic steps to follow:

a) Before you can begin the appeals process, you need to determine exactly why your claim was denied. If you have not already done so, call your case manager for more detailed information about the denial. Have the EOB in front of you when you call and take down the exact reason for the denial.

b) Gather as much information about the original claim as you can. If your doctor's office provided the insurance company with a Letter of Medical Necessity (LMN) stating his/her exact reasoning for prescribing the equipment or therapy, try to get a copy. Knowing what the insurance company was already told can be helpful. If a formal LMN was not prepared, get the diagnosis code (also called an ICD-9 code) that was used to justify the application. Make sure that the item was coded correctly – if a single digit of this code is wrong, it may explain why the item was denied. If the ICD-9 code is wrong, call your doctor's office immediately and have them revise the claim.

c) Do research. Visit the manufacturer's website first. Many times their website will contain links to supportive journal articles; use these articles to persuade your insurance company to pay for the item. Search online medical journals for information about the item or procedure you are trying to get approved. If you don't have internet access, contact the manufacturer by phone. They are usually very helpful. If insurance doesn't cover their product, chances are it won't sell at all. Try to find other families who have had the item approved and find out how they got it; you may be able to use another family's LMN as the basis for yours.

d) Write the letter. This is a serious situation and merits a serious tone. Be as straightforward and businesslike as you can. Make sure to include all of the information about the original claim as possible – patient name, insured's name (this sometimes differs from the patient name – check the EOB to be sure), insured's ID number, date of claim, etc. If you have a case manager, address the letter directly to them and make sure to mail it to them directly. Write out all of your reasons why their denial was incorrect, but stick to the subject. If they denied a piece of equipment because it is not medically necessary, for example, make sure that by the end of your letter, you have given several pieces of proof that the equipment is a generally accepted form of treatment for your child's particular condition. It is also a good idea to point out what's in it for them. Explaining to them that spending \$1,000 on a preventative treatment now will save them \$10,000 in hospital costs down the line may help. Remember, insurance companies are in business for one reason and one reason only: to make money. Because what they do is so sensitive, we tend to forget that. It's nothing personal, but it can feel that way sometimes. Just keep it impersonal - stick to the facts - and they will have a harder time rejecting your appeal.

e) Back it up with copies of supporting articles. If you are unable to provide actual copies of the articles that you are citing, provide enough information about the article so that your case manager can find the article for him/herself. A proper citation includes a list of authors, article title, journal name, journal issue, and page numbers.

f) Use their own words against them. Comb through your policy documents for anything that supports your claim. If you do not have your policy documents, try the company's website. If your primary insurance is Medicaid or other state-funded insurance, try the homepage of the division of state government that administers the program (the name of this department varies from state to state).

g) If the insurance company sent a formal letter of denial, it wouldn't hurt to attach a copy of that as well. The less work the insurance company has to do, the quicker you'll get an answer. It helps to remember that there is a human being on the receiving end and think "what else can I do to make their job easier." It won't hurt to help them out by providing all the info they need and prevent them having to dig through files to find information.

An example LMN format:

*Date*

*To Whom It May Concern: (or, if you have a case manager, address it to them directly)*

*I am writing on behalf of my daughter, Jane A. Public, regarding An Insurance Company's denial of claim number 456 on 07/06/2006. A copy of the denial is attached for your convenience.*

*The basis of this denial was that Pediatric Vivonex is considered a dietary supplement and is therefore not covered on our plan. However, in Jane's case, Vivonex is a source food, not simply a supplement to a normal diet.*

*Jane suffers from Spinal Muscular Atrophy (SMA), a disorder of muscle and of fatty acid metabolism that requires a special diet to maintain optimal health. In addition to metabolic aberration associated with immobility, systemic illness, muscle denervation, and muscle atrophy, SMA patients have inborn metabolic abnormalities in mitochondrial fatty acid oxidation and carnitine metabolism that may increase the liver and kidney's production and excretion of dicarboxylic acids.*

*(lots of proof, cited from attached articles)*

*In light of the above evidence that Pediatric Vivonex will be used as a source food and not merely as supplemental nutrition in Jane's case, I am requesting a review of this claim. Thank you for your consideration of this matter.*

*Sincerely,*

*John Q. Public*

*Member name: John Q. Public*

*Member# 123-45-6789*

*Group# 987654321*

*(1) Properly numbered and cited list of articles and other attachments*

**3. Uncooperative doctor and no time to handle it alone?** If taking care of your child doesn't allow you the time to do the research required to handle an appeal on your own, and your doctor's office is not being helpful, there is other help available. SMA Support provides free, no-obligation insurance claim assistance for SMA families. Just visit their website at <http://www.smasupport.com> and click on the

“Contact Us” link on the left hand side of the page. Please include your name, email address, phone number and a brief description of the problem you’re having with your insurance company. Someone will get back to you as soon as possible.

## **F. A Note About Annual and Lifetime Maximums**

It is easy not to think about how much your insurance company is spending on your child’s behalf until they come back and tell you that you’ve reached your policy limits. Some plans have annual maximums, that is, there is a limit to the amount of money your company will spend per year on your child’s medical expenses. Some companies have overall limits, others limit the amount they will spend on a particular type of care or equipment (especially DME). Once you reach your annual limit, your company will not provide you with any further benefits until the next calendar year. Almost every insurance plan has a *lifetime maximum*. In other words, they will spend a certain amount of money on your child’s care, within the limits of your plan, over the course of his or her lifetime. If you exceed the lifetime maximum, you will receive no further benefits from that company.

Call your case manager or check your policy documents to see if you have annual limits on all or any part of your coverage (ask specifically about durable medical equipment, since this is an area where many companies place limits as well as one where your costs add up). Also ask about your lifetime maximum and whether that maximum applies per person or to your entire family together. Find out how close you are to reaching your maximums, both annual and lifetime. If you’re getting close to either limit, it’s time to look into secondary coverage and other resources (see Section G). It’s also a good idea to look at the way you’ve been spending your insurance money. See if all of your expenses make sense, and see where you can save money. For example, if you’re going to be renting a machine for a long time, find out if you can make it a rent-to-purchase contract. That way, once the rental fees that you have paid add up to the purchase price of the equipment, the equipment will become your property. One drawback to this is that, when the equipment becomes your property, it also becomes your responsibility. The DME company is no longer required to check on it or do maintenance or repairs on it. Some companies offer service contracts on purchased equipment, but think carefully before agreeing to one. The cost of the contract may greatly outweigh the cost of hiring someone to repair equipment if it breaks. Also, some insurance companies will not reimburse you for service contracts and the costs will come out of your own pocket.

One SMA parent sums it up nicely: *“You have to look at lifetime maximums; ours is one million, which sounds like a lot, but you have to look at your past and current situations. <Our daughter> also had several hospitalizations and air lifts, which were huge chunks out of that. I am starting to get stingy with our supplies and am cracking down on our home nurses to not toss things that are being replaced ‘just because it’s been a while.’ That is all money off of the one million maximum. I would hate for <my husband> to have to change jobs to get a new insurance policy.”*

## **G. Other Resources for Services and Supplies**

**1. Look into Medicaid and other state programs.** If you haven’t already done so, contact your state’s Medicaid office and make an appointment to speak with a social worker. Even if you think your family makes too much money to qualify for Medicaid, make the call and ask about waiver programs for the disabled. Most states have waiver programs that provide Medicaid coverage for children and adults with

disabilities. Each state has different rules and different programs, but chances are that you will qualify for one or more of them. While you're speaking to your social worker, ask about any other federal or state-run programs that you may qualify for. If you don't ask, you may never find out!

An SMA mom in Georgia wrote: *"We get the (amino acid diet, ed.) formula through the WIC program, not through insurance. All children in Georgia who have Medicaid (waiver or not) are eligible for WIC until the child is 5. I've found that few people know that... If we hadn't had a knowledgeable and creative nutritionist assigned to us through Babies Can't Wait, I'd never have known. Also loaner pools... we had a Tumble Forms TriStander from the Foundation for Medically Fragile Children.. There's an organization called FODAC here (Friends of Disabled Adults and Children, ed.) and they recondition DME and give (not loan) it to other families."*

**2. Use the grapevine.** One SMA mom said it so well that it needs no further elaboration:

*"I've found resources mostly by running my mouth all the time about what's going on with us. A PT, OT or Speech therapist will know about an organization (or program)... like the program through Medicaid called GAPP that provides private duty nursing for medically fragile kids... Then when I find an organization or program I tell everybody we come into contact with hoping it'll stick with somebody and they can share it with another family. At first his PT and OT thought I was a little lonely and probably a bit crazed BUT I think they understand my methods now. I'm always catching the social worker in the hall and telling her about resources I've heard about or used. Sometimes I think it pays to get involved in local organizations not related directly to SMA, exchange information with parents from other worlds, make some friends locally."*

**3. Apply for the Health Insurance Premium Payment Program (HIPP).** If your child qualifies for Medicaid as a secondary insurance, you may qualify for the HIPP Program (Health Insurance Premium Payment). Under this plan, you may qualify for reimbursement of your out-of-pocket expense for health insurance premiums, deductibles and coinsurance. While you're calling your state's Medicaid office to ask about their waiver programs, ask about HIPP too. of many insurance companies to get the answers you need about your coverage.

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*Andrea Smith is a writer and stay-at-home mom whose background includes college coursework towards a biology/chemistry degree, experience working as a database manager at Cornell Medical College in New York City and over six years of corporate accounting experience. After learning that a high school friend had lost a child to spinal muscular atrophy, Andrea got involved with SMA Support, providing help to families of children with SMA. She recently started working with FightSMA and has helped to raise funds for SMA research and is working on a manual to help parents with children with SMA.*

*If you have questions for Andrea about a particular insurance issue, you can e-mail her at [kpax@charter.net](mailto:kpax@charter.net) with a question. When you e-mail her, be sure to include information on your child's age and what type of spinal muscular atrophy they have; the name of your insurance company; the type of health insurance you have and the state you live in. Also, include any relevant information such as what you are trying to get coverage for and, if denied coverage, the reason for refusal. Finally, provide a phone number where you can be contacted.*

