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An insider explains what you can do to ensure that the services you provide are actually covered by your patients' insurance.

WORKING WITH INSURERS: A View From the Dark Side

Back when I was a practicing physician, I never thought I would participate in medical care delivery from the payer side. Time and events conspired against me, however, and here I sit making insurance coverage decisions. I hope that my experience from the trenches has influenced the way I do my current job. The same generally can be said for my colleagues in this much-maligned business.

This article gives an overview of how insurance companies make their coverage decisions. It also offers some simple strategies for obtaining favorable medical coverage decisions with the least amount of effort and the most effective results. ➤

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How coverage decisions get made

Insurance coverage decisions are made based on a hierarchy of rules:

1. Mandates from the federal and state governments are the first priority in making medical coverage decisions, assuming they have weighed in on the issues at hand. While these mandates appear to be absolute, their applicability might actually depend on the patient's insurance plan funding. Plans covered by the Employee Retirement Income Security Act of 1974 (ERISA) are more likely to be subject to government mandates than non-ERISA plans.

2. The next highest decision-making priority is the patient's benefit plan criteria. In short, employers make decisions regarding what type and level of medical services are going to be covered in the plans they offer to employees. If an employer elects to exclude coverage for a specific treatment, medication or procedure, then whether the service is medically necessary is a moot point. A medical benefit plan is essentially a contractual agreement; if a service is not a covered benefit under the plan, then the service cannot be reimbursed.

3. The third priority for medical directors in their decision making is medical necessity. They determine medical necessity either by reviewing external guidelines (such as those developed and sold by Milliman or InterQual) or by referring to the insurance company's internal guidelines. External guidelines are generally evidence based and relatively fluid; they are modified periodically or when new research comes to light. Still, there can be considerable lag time between when a test or treatment comes into common use and when it is incorporated into these guidelines. Insurance companies who rely on internal medical necessity guidelines also revise their guidelines based on new treatments and research, but they are not typically early adopters. On the contrary, insurers are generally slow to approve new services or treatments until there is a substantial body of evidence to support them.

Insurers base their coverage decisions on a strict hierarchy, with mandates from the federal and state governments given top priority.

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Certain services require review (prior authorization or pre-determination) before they will be covered. Although the responsibility for deciding which services require review falls occasionally to the employer, most of the time the insurance company makes the decision. They consider three main factors:

- The cost of the service;
- The frequency of requests for the service;
- The potential for inappropriate use of the service.

The review process can be complicated and expensive and involves extensive information gathering. Services are often separated into two categories: those that are likely to be approved and those that will need further scrutiny. This allows the first group to proceed through the review process more quickly, helping to ensure that appropriate coverage decisions are made at the earliest possible stage in the process.

By the time a request for a service reaches the medical director, there have been multiple levels of review within the insurance company. The first-line review is generally an automated process that identifies services and procedures where the insurer feels an impact can be made on the cost and provision of care. Nonclinical associates and nurses often provide the next level of internal analysis and review any request that did not initially meet approval criteria. After this information gathering, requests are either approved or referred for further review by a medical director. These cases are the exception. For every one case reviewed by a medical director, hundreds to thousands of claims are paid without the need for review.

If a service is denied, further consideration can be made through peer-to-peer discussions (usually an informal discussion involving the requesting physician and a physician at the health plan who, depending on state regulations, is not of the same specialty).

About the Author

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Various levels of appeal are also available, but describing them is beyond the scope of this article. Denied requests must be reviewed by a licensed physician in virtually every case (a notable exception being services that are administratively denied because they are not covered benefits in the patient's plan).

How to avoid payment hassles

Despite what some physicians believe, medical practices can take steps to minimize the hassle of having claims denied, and payments withheld, because of noncovered services.

Pearl No. 1: Verify more than just coverage. Although the need to verify patients' coverage is common knowledge in medical offices, it includes a major caveat that is not as widely known: Even if coverage is verified by the insurance carrier, the service may still require medical necessity review. In insurance company lingo, "The availability of benefits is not a guarantee of payment." Take care to verify not only that the procedure is eligible for coverage but also whether further information will be needed to assure that the procedure is approved and will be reimbursed. This includes verifying ahead of time whether a service requires preservice approval. While mechanisms for getting approvals after the fact do exist, this process is considerably more cumbersome and inefficient than preservice approval. Retrospective reviews are limited because the book has already been closed on preservice treatment, testing and documentation. For example, the medical necessity criteria for a lumbar MRI for the evaluation of uncomplicated chronic back pain require documentation of a six-week trial of failed conservative therapy. If the patient had an MRI performed prior to an adequate trial of conservative therapy, then the physician may have difficulty obtaining coverage retrospectively.

Pearl No. 2: Make sure your staff relays all relevant information to the insurer. This includes describing prior treatments that have failed, results of physical exams and previous evaluations, and the impact the service will have on the patient or treatment plan. The vast majority of services that I overturn as a medical director have one thing in common: The initial information provided by the medical practice is minimal to nonexistent. When a requesting physician gets involved to address the issue, many cases are easily given approval because the clinical information presented confirms that the requested service is necessary and appropriate. A smoothly functioning process, though, should allow for the exchange of information to occur well before a practicing physician and medical director invest their time and energy on a case. Fully instructing administrative staff on what information should be provided to the insurance company will reduce the chance that a physician will need to get involved. If the information required for approval is not clearly stated, it is better to err on the side of providing too much information.

Pearl No. 3: Familiarize yourself with medical necessity criteria. This will significantly improve your chances of getting a service approved. For instance, if removal of a skin tag is considered medically necessary and if there is documentation of symptoms related to the tag (itching, bleeding or pain), then the physician can appropriately advise the patient as to whether the removal will be covered by insurance. Insurers are required to make approval criteria available to physicians, and although the insurance and medical industries have been slow to adopt technology, many companies now post this information online. Naturally, there are unique or unusual cases that do not fit into standard medical necessity criteria, but the majority of cases that are not approved do not fit into this category.

Pearl No. 4: Don't give up if you receive a denial letter. Instead, read the denial letter closely to figure out what is needed to get a service approved. Medical reviewers are required to specify the reasons for not approving a service. As the requesting physician, you should use the denial letter to develop an appropriate response to get the service approved. For instance, if the reason for denial is a lack of documentation of a course of conservative therapy, then the appropriate response would

Denied coverage requests must typically be reviewed on the insurer's end by a licensed physician.

Common reasons for denied claims include failure to verify coverage requirements and failure to provide supporting information.

Growing numbers of insurers are posting their approval criteria on their Web sites.

be to relay the details of conservative therapy treatment that has been undertaken. There is generally no need to submit X-ray reports, emergency department records or other information not germane to the denial reason.

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Denials can cause stress and frustration, but try to be calm and professional in your discussions with insurers.

Pearl No. 5: Don't lose your cool. Understandably, denials can cause physicians to feel stressed and frustrated. However, entering into a verbal appeal or peer-to-peer discussion with these emotions raging can set the stage for a contentious or negative interaction. The chances of a successful appeal are greatly enhanced if the discussion is carried out in a courteous and collegial fashion. If a physician really desires approval of a denied service, then demeaning the medical director or impugning his or her professional competence or work ethic is not likely to improve the chances of an approval. Similarly, threatening to file a lawsuit or to report the medical director to the insurance commissioner might help the requesting physician vent his or her frustration, but it most likely will not lead to a favorable determination.

The quality and tenor of a peer-to-peer interaction can have a significant influence on the outcome of a discussion. The fact that a physician is calling the medical director means that he or she cares enough about the patient to take the time to do so. A professional interaction gives the physician an advantage in having the appeal reviewed, makes hard-copy documentation less critical and helps the physician convey unique circumstances more easily.

Help yourself help your patients

Understanding how the medical review process is conducted by insurance companies can help physicians receive approval for the services they request on behalf of their patients with the least amount of personal effort and the highest chance of success. Systems and processes can be designed to achieve the desired results. When physicians do need to get personally involved, the knowledge of what information to provide will create the best opportunity for an approval. FPM

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