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Maximizing Your Chances of Getting an Insurance Approval the First Time

Walter Lindstrom, Jr.

Attorney At Law, Obesity Law & Advocacy Center - San Diego, California, USA

Background: Support staffs for any bariatric surgeon are confronted with daily requests for information, rejections and non responses. Although we are only in control of one-half of the process (with the insurer holding the other cards), there are specific things which can be done to minimize the amount of time spent on each individual claim and maximize your chances of getting it done the first time.

Methods: This paper explores an attorney/obesity rights advocate's various approaches which successfully lead to the overturning of denials by an insurance company or HMO. Implementing such techniques by the surgeon's office *may* assist some patients in getting approved without having to hire counsel.

Results: By standardizing certain repetitively sought information, utilizing existing technology and creating comprehensive checklists, providers can comprehensively process patient claims with an eye toward providing all necessary information from the start. In addition, 'local knowledge' of the propensities of particular insurers must be documented and kept in mind so that inevitable requests for additional information can be minimized. Lastly, a 'crash course' in insurance law may assist your patients' chances to get approved.

Conclusions: Some denials will not be overturned without the assistance of qualified counsel. However, some potential denials can be defeated before they start by carefully documenting files, using technology to provide ample information for the insurance company decision makers, knowing some basic insurance law and by actively seeking your patient's involvement in their claims.

Key words: Insurance approval, insurance claim, litigation, obesity, obesity surgery.

Introduction

There is not a bariatric surgical provider in this country who needs to be told that health insurers and health maintenance organizations (HMOs) have become increasingly hostile in their response to claims for surgery. Their answers range from a firm and unequivocal "No" to the endless (and often unanswerable) requests for 'additional information'. This paper attempts to provide some guidance and insight with respect to strategies which can easily be implemented to maximize the chance of getting that "Yes" the first time around [1].

Countering the virtually limitless resources of the insurance industry is no easy task. However, the rewards to the provider and his or her staff in giving patients access to a surgical tool with which they can potentially change their lives are so great that it is a job which must be embraced with passion and tenacity.

Step One: Attention To Details

In my experience in handling appeals of surgical denials, one of the most prevalent reasons for denying surgery can be summarized as a failure to document or demonstrate 'medical necessity'.

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[1] To best implement many of the concepts of this paper, a review of the author's paper 'Believe It Or Not, *Sometimes* Lawyers Are the Good Guys!' (Obesity Surgery; August 1996) (also available on-line at www.obesitylaw.com) is strongly recommended. That paper sets forth a basic primer on health insurance concepts and the rationale behind many insurers decisions to deny bariatric surgical claims.

We are all familiar with the concept of 'criteria' used by insurers and their agents to deny access to this treatment. Access to this criteria is often guarded by the insurer better than secrets impacting national security. Therefore, while it is easily stated that obtaining the criteria should be done in every case, the reality is that it often takes someone other than the patient or provider (like a lawyer or employee advocate) to get those criteria. Even in that instance, the criteria are not always provided [2].

Notwithstanding, requests for criteria to all insurers and HMOs should be included with all communications to underscore the importance to you as a provider that you have all necessary information to allow them to process the claim expeditiously. In those instances where you are successful in obtaining criteria, make sure that there is a dedicated notebook or other location where that criteria is kept and can be used for subsequent patients.

Attention to details also means submitting to the insurer any available information which may support the surgical request. For instance, my experience has been that a one page letter requesting pre-authorization or certification is often the only material sent in by the surgeon's office. This may be enough in some cases, but it rarely achieves the stated goal of getting the approval. There have been several cases where I have successfully turned denials around simply by providing consultation reports or medical records **which already were in existence at the time pre-certification was sought.**

It is highly recommended that you make your prospective patients active participants in the approval process. One way of doing this is to have them gather records and recommendations from their other doctors which are supportive of the procedure. Letters and/or reports from internists/PCPs, cardiologists, pulmonary specialists (especially with documented sleep apnea or related disorders), psychologists/psychiatrists, orthopedics, etc., can only help your chances of getting the approvals the first time [3]. Many of these materials already exist and are resources often untapped or unexplored by bariatric providers.

Step Two: Use Your Technology

With computers comes a wonderful 'evening up of the playing field'. While it is doubtful (and probably not even desirable) that the patient approval process be fully automated, there are tools which any office can utilize in order to get to the "Yes". For instance, every office is very experienced in dealing with patients who suffer not only from clinically severe obesity, but a host of related co-morbidities which make the patient's life a difficult one. Often the existence of these co-morbidities and the demonstration that bariatric surgery reduces or ameliorates many or all of these conditions is a crucial factor in getting a recalcitrant insurer to say "Yes".

It is critical that each and every one of these co-morbidities be fully addressed in the initial request for authorization. One easy method of doing this is to create a word processing template or macro for each of the major co-morbid conditions you see on a daily basis. In other words, work with your surgeons and other staff professionals to develop a one or two page explanation of the relationship between obesity and:

- hypertension;
- diabetes;
- sleep apnea/obesity hypoventilation syndrome;
- cardiovascular disease;
- osteoarthritis;
- gastro-esophageal reflux;
- dyslipidemia;

[2] For instance, California Health and Safety Code section 1363.5 mandates access to these criteria including identification of the authors of the criteria, the clinical principles utilized to develop the criteria, the last time it was reviewed and updated, etc. Despite being subject to this Code section, some insurers and HMOs still blatantly refuse to provide access to this material, even when denials are based on failures to meet 'criteria'. Query how anyone can successfully challenge such a denial without access to the criteria and background information upon which it is based.

[3] Many of you will read this and say "but our patients simply don't want to go through obtaining all of these materials and we don't have the staff or other resources available to spend the time getting them ourselves". These are very legitimate concerns. Having the patient be proactive in getting the records answers the 'lack of resources' issue. If the patient is unable or unwilling to obtain these records to assist in getting this potentially life-saving procedure, one must naturally wonder whether they should be a surgical candidate in the first instance. Keep in mind the critical language found in the 'Patient Selection' section of the National Institutes of Health Consensus Statement of 1991, upon which we all so heavily rely: "A gastric restrictive or bypass procedure should be considered **only for well-informed and motivated patients** with acceptable operative risks." [Emphasis added]. If your patient isn't motivated enough to actively work, and work hard, toward getting his or her approval, maybe they don't fit the criteria in the first instance.

- idiopathic intracranial hypertension;
- infertility;
- urinary stress incontinence;
- lower extremity venous stasis disease.

Each time you have a patient demonstrating one or more of these associated conditions, you will then be able to simply pull up and print out an explanatory page or two of critical information which explains why the procedure acts not only to control the clinically severe obesity, but also reduces or eliminates the condition in question. You are able to make these pre-printed (dare I say 'boilerplate') information sheets all the more impressive if you list out a bibliography at the end of each of them giving current literature and journal articles demonstrating the efficacy of bariatric surgery in treating these conditions. This enables a medical director or other reviewer to actually look up source data in support of your procedure [4].

Technology can also be used by automating references to repetitive information which should *always* be submitted with every claim. The 1991 Consensus Statement by the National Institutes of Health should always be referenced in each pre-authorization package. There are abundant statements in that document which should be quoted to demonstrate the acceptance of this form of treatment. More recently, the American Obesity Association (AOA) and Dr C. Everett Koop's 'Shape Up America' (SUA) programs jointly issued the 'Guidance For Treatment Of Adult Obesity'. That document endorses surgical intervention along similar lines to the NIH Consensus Statement [5].

Documents such as the NIH statement or the Guidance are important because, unlike those of us who have devoted all or a substantial portion of our lives and professions to obesity-related issues, many insurance companies and medical reviewers continue to view obesity as a character defect rather than a serious medical condition. Accordingly, it is important to demonstrate to your audience, the person(s) with the power to say "Yes" or "No", that they are dealing with a routinely acceptable treatment for severe obesity. Keep in mind that many people in the opposition are still in the mind set that obesity surgery kills rather than saves lives. Part of your job is to change that mind set. Such preconceived notions are a major reason why there is a knee-jerk reaction by insurers to deny these procedures. Unfortunately, only time and education will change that. You are part of that educational process.

Step Three: The 'Dreaded' Diet History

There remains one tool utilized by most, if not all bariatric surgical offices which, in my opinion, is misunderstood by patients and can often adversely impact the approval process. That tool is the 'diet history'.

I use the word 'dreaded' speaking now as a surgical patient [RYGBP 3 years ago]. From the patient/obesity advocate perspective, I believe that many providers, regardless of their heightened levels of sensitivity when dealing with persons of size, underestimate the profound effects that filling out the diet history has on your patients. This portion of the paper attempts to detail in some small way your patient's perspective when it comes to filling out that history. By improving your patient's attitude toward these necessary surveys [6] you may be able to get better use out of them, thereby maximizing your chance at that elusive "Yes".

Most providers hand out these survey sheets in a business-like manner, asking the patient to list out their various prior attempts at weight loss. What many providers fail to realize or appreciate

[4] Another interesting benefit to providing the insurer with such a bibliography is how their use or nonuse of that information can be exploited by experienced counsel in the event of a claims denial. For instance, should you provide an insurer with such information and they fail or refuse to review it as part of their claims handling process and your patient ultimately is compelled to litigate the denial, that failure or refusal to look at information made available to them can be used to demonstrate that the insurer or benefit plan acted 'unreasonably', 'capriciously', 'arbitrarily' or 'without proper cause'. These standards of conduct are critical to succeeding with claims for benefits under the Employee Retirement Income Security Act of 1974 (ERISA) or for claims of 'bad faith' under applicable state insurance law.

[5] Pages 68–70 of the Guidance specifically address surgical intervention. Copies of the Guidance can be obtained for a nominal charge ($3.00) from Shape Up America located at 6707 Democracy Blvd., Suite 107, Bethesda, MD 20817 or obtained via the Internet at http://www.shapeup.org/sua

[6] I say 'necessary' because most treatment guidelines, including the NIH criteria, do not advocate surgical intervention in the first instance. Accordingly, providers and patients have been required to demonstrate a history of 'less drastic attempts' at weight loss prior to being considered an acceptable candidate. These prior attempts are generally documented in a patient questionnaire which I call the 'diet history'.

is how their patients actually feel when they are confronted by these questionnaires. Identifying and addressing those feelings as part of the initial consultation is critical to helping your patients help themselves.

From your patient's perspective, when you give out your diet history questionnaires, please understand that you are *really asking* your patients to answer the following:

Please set forth in as much detail as possible each and every failure you have had over the past 'x' number of years in attempting to achieve perhaps the single most important goal of your life!

The devastating impact of that question when your patients are confronted by these questionnaires cannot, and must not, be minimized by the bariatric surgeon and his/her staff. No person, regardless of size, likes having to confront failure in their lives. Compound that natural human instinct with the mind set of the person of size. Persons suffering from clinically severe obesity generally come to your offices filled with a self-loathing or self-doubt inspired by prevalent societal attitudes that their size is 'their fault'. In other words, your patients still generally believe that if they were 'better people,' they wouldn't be having a surgical consultation to help them with their character flaw. These are people often desperately seeking, from you and the surgeon, success at what has become the single most important or dominant thing in their lives. Losing weight, for some, is more important than their jobs or their families; and all your patients know is that they have never been able to do it. You know that your patients are not 'flawed'. Once again, part of your job and part of getting to the "Yes", is to educate your patients about the nature of their condition. Part of that patient educational process comes with you treating the diet history differently.

Many patients will often dutifully attempt to fill them out completely. However, the process is painful beyond imagination for most. Other patients will gloss over many attempts, consciously or unconsciously avoiding confrontation with the pain of what they perceive as ultimate failure. You can change the reaction of both types of patients by counseling them ahead of time that the purpose of the questionnaire is not to make the patient feel badly about themselves, but rather, to demonstrate to their insurer that they actually do suffer from a medical condition and that part of showing that medical condition is simply a fundamental inability to maintain weight loss by nonsurgical means.

Of course, patients are individuals, and this approach will not necessarily take the sting out of this sometimes painful process for some. However, getting the patients to understand the questionnaire and its role is a major step in getting them to recognize that they are not flawed as people and may assist them in developing a needed sense of righteous indignation and urgency with respect to obtaining this necessary treatment. This educational process will often create an alliance between patient and provider which empowers the patient with a strength of purpose and the tenacity to actively participate in the approval process.

Once you have the 'new and improved' diet history questionnaire, you can review it with your patients to ferret out critical information which may lead to the patient getting that "Yes". If there are physician-supervised weight loss attempts, encourage the patient to get medical records or a report from the physician involved. If there are commercial efforts documented, encourage the patient to get copies of their records from the organization, including records of attendance, weight loss, etc. Providing all of this information and any supporting data which may be available can greatly assist in getting the "Yes".

While the efficacy of nonsurgical treatment options is minimal according to medical literature, we are unfortunately confronted with a mind set and an insurance industry which believes, rightly or wrongly, that such documentation of prior failures is necessary before an approval can be given [7]. This makes approvals all the more problematic in cases where there is no supporting data or the patient is unable to document prior efforts.

In those instances, it may be helpful to include some reference materials demonstrating that there is no correlation between a certain number of years of physician-supervised programs and success through surgical intervention. In other words, you can anticipate the insurer's objection that

[7] It is important to not overlook that a critical aspect of the NIH Consensus Statement of 1991 specifically says with respect to Patient Selection: "Those patients **judged by experienced clinicians** to have a low probability of success with non surgical measures, as demonstrated for example by failures in established weight control programs or reluctance by the patient to enter such a program, **may be considered for surgery**."

'Patient A does not document any prior supervised weight loss attempts' by countering with the fact that there is no data to support such a requirement. Again, this can be a standard one or two page sheet which can be created once and then included with all materials sent in support of the procedure [8].

In summary, changing the patient's attitudes about the dreaded diet history and then utilizing the information uncovered by that history (with your patient's enthusiastic assistance) can only lead to a better chance at the "Yes".

Step Four: Proceed With Passion And Resilience

The final hint this paper can offer is that 'attitude is everything'. You are the caretakers of a person's dream – a dream 'to be just like everybody else'. The frustration of dealing with insurance companies who are designed and trained to say "No" and often dealing with patients who are sometimes less than enthusiastic about assisting in obtaining their own treatment can sometimes be overwhelming. However, you must fight the impulse to give up the fight for that one more approval.

Implementing much or all of what this paper suggests will not assure an approval each and every time. There will be the inevitable denials for no good reason other than the prevailing societal attitude that we serve a population who should simply push themselves away from the table and walk around the block. We advocate a procedure which is condemned by many ignorant persons, both within and outside of the medical and insurance establishment, as doing more harm than good. We have a lot of educating to do before obesity surgery is acceptable as a treatment modality without apology or explanation.

However, setting that aside, remember that your success in obtaining a "Yes" gives your patients access to a tool they can use to change their lives. They may be able to change their interpersonal relationships for the better; they may enhance their economic well-being; they may simply be able to live out their lives without being stared or laughed at. As a patient, I can tell you that nothing is more important than the work that you do. Furthermore, if these hints produce just one more approval in your office, as I have said before, something glorious has occurred!

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[8] For example, one major California insurance company recently eliminated its prior requirement that 'Non-surgical methods of accomplishing weight reduction must have been attempted under physician supervision for at least three years'. That insurer's revised criteria concluded: '**There is *no convincing rationale* for requiring that non-surgical methods of accomplishing weight reduction must have been attempted under physician supervision for at least three years before undertaking these surgeries**'.