



How to manage an appeals process



Continue treatment during the appeals process.

Appeals can take weeks or months to complete, and health professionals and facilities that treat eating disorders advise that it's very important for the patient's well being to stay in treatment if at all possible to maintain progress in recovery.

Clarify with the insurer the reasons for the denial of coverage.

Most insurers send the denial in writing. Claims advocates at treatment centers advise patients and families to make sure they understand the reasons for the denial and ask the insurance company for the reason in writing if a written response has not been received.

Send copies of the letter of denial to all concerned parties with documentation of the patient's need.

Claims advocates at treatment centers state that sending documentation of an appeals request to the medical director, the human resources director of the company where the patient works (or has insurance under), if applicable can help bring attention to the situation. Presenting a professional-looking and organized appeal with appropriate documentation, including an evidence-based care plan makes the strongest case possible. Initial denials are often overturned at higher appeal levels, because higher-level appeals are often reviewed by a doctor who may have a better understanding than the initial claims reviewer of the clinical information provided, especially well-organized, evidence-based documentation.

Ask the insurer what evidence-based outcome measures it uses to assess patient health and eligibility for benefits.

Some insurance companies may use body mass index (BMI) as a criterion for inpatient admission or discharge from treatment for bulimia nervosa, for example, which may not be a valid outcome measure. This is because patients with bulimia nervosa can have close-to-ideal BMIs, when in fact, they may be very sick. Thus, BMI does not correlate well with good health in a patient with bulimia nervosa. For example, if a patient with bulimia nervosa was previously overweight or obese and lost significant weight in a short timeframe, the patient's weight might approach the norm for BMI. Yet, a sudden and large weight loss in such a person could adversely affect his or her blood chemistry and indicate a need for intensive treatment or even hospitalization.

Ask that medical benefits, rather than mental health benefits, be used to cover hospitalization costs for bulimia nervosa-related medical problems.

Claims advocates advise that sometimes claims for physical problems such as those arising from excessive fasting or purging, for example, are filed under the wrong arm of the insurance benefit plan—they are filed under mental health instead of medical benefits. They say it's worth checking with the insurance company to ensure this hasn't happened. That way, mental health benefits can be reserved for the patient's nonmedical treatment needs like psychotherapy. Various diagnostic laboratory tests can identify the medical conditions that need to be treated in a patient with eating disorders. Also, if a patient has a diagnosis of two mental disorders (also called a dual diagnosis), and if that diagnosis is considered by the insurance company to be more "severe" than an eating disorder, the patient may be eligible for more days of treatment.



Ask the insurer whether they will “flex the benefit.”

Flexing benefits means that the insurer applies one type of benefit for a different use. For example, medical benefits might be “flexed” to cover some aspect of mental health treatment—usually inpatient treatment. Also, inpatient benefits might be flexed (traded) to substitute intensive outpatient care for inpatient care—for example, 30 inpatient days for 60 intensive outpatient benefit days. Substance abuse (also called chemical dependency) benefits might be traded for additional benefits to treat the eating disorder if the beneficiary thinks he/she will never need the substance abuse benefits available under his/her coverage. There is a clinical rationale for doing this: if the eating disorder is not treated appropriately from the outset, the insurer risks incurring additional and higher costs for patient care in the future because further hospitalization and treatment may be needed. By flexing inpatient medical benefits or trading inpatient days for outpatient days to obtain more days of mental health treatment, future and possibly higher healthcare expenses might be avoided. While insurers are not obligated to do flex benefits, they may respond to a sound, logical argument to do so if it makes good sense from both a business and patient care perspective in the longer term. If you can support this argument with your doctors’ recommended treatment plan and clinical evidence from practice guidelines and an evidence report, the insurer may agree.

If the patient is employed or in a union, consider asking the employer (or its human resources manager) or union representative to negotiate with the insurer about aspects of the coverage policy that seem open to interpretation. As a client of the insurance company, the employer is likely paying a lot of money to provide benefits to employees (even when employees pay part of the insurance premiums). Because insurance companies want to maintain good business relationships with their clients, the employer may have more influence than the patient alone when negotiating for reimbursement. Many patients or families of patients are afraid or embarrassed to discuss bulimia or anorexia with an employer. Remember that legally, a person cannot be fired and insurance cannot be dropped solely because of having an eating disorder (or any other health condition).

Negotiate with the treatment center about the cost of treatment.

Our survey of treatment centers indicates that some treatment centers have a sliding fee scale and may adjust the treatment charges or set up a payment plan for the patient’s out-of-pocket costs.

Discuss with the insurer how existing laws and clinical practice standards affect your situation.

Educate yourself about how the state’s mental health parity laws and mandates apply to the patient’s insurance coverage. Also ask the insurer if it is aware of evidence reports on treatment for eating disorders and guidelines like the American Psychiatric Association’s clinical guidelines for treating eating disorders: www.psych.org. Ask what role the evidence plays in the decision about benefits. As a last resort, some patients or their advocates may also contact the state insurance commissioner, state consumer’s rights commission, an attorney, the media, or legislators to bring attention to the issue of access to care for patients with eating disorders.