Advanced Bionics
Bionic Ear Association
Web Class Series
For Candidates and Users of Cochlear Implants
www.BionicEar.com

Course Title:

Insurance Advocacy: Support for Negotiating through the Cochlear Implant Insurance Process

Published: 9-29-2006

This presentation will help demystify the health insurance appeals process and provide clear and concise guidelines on developing a viable insurance appeal.

Presenter:
Sheri Byrne-Haber, B.Sc., J.D., Let Them Hear Foundation

On Line Web Class Link (for slides and audio):
http://www.audiologyonline.com/ceus/recordedcoursedetails.asp?pid=5&class_id=7072

Class transcripts follow

Transcription by: Caption First, Inc. 800-825-5234 www.captionfirst.com
This text is being provided in a rough draft format. Communication Access Realtime Translation (CART) is provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings.

Captioning Provided By: Caption First, Inc.
10 E. 22nd Street
Suite 304
Lombard, IL 60148
800-825-5234

***

This text is being provided in a rough draft format. Communication Access Realtime Translation (CART) is provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings.

***

>> All right. Well, I would like to welcome you all to the Advanced Bionics web class on Combatting Insurance Denials. My name is Carrisa Mogenberg and I'm one of the education

specialists with Advanced Bionics. And we have a guest speaker with us today. Her name is Sheri Byrne-Haber and she's from the Let Them Hear Foundation. I'm going to do a formal introduction in just a minute. But first I would just like to review a few housekeeping items.

For those of you who may be new to our web classes, I want to just kind of orientate you to this screen you have in front of you. The slide with all the information you are viewing will show up in the center. Along the right-hand column, you have a list of participants. You have the option to do a few things. You can send the moderator and/or the participants notes. If you right click on your hedge, you will notice that there's an option that says "Send Note." Simply type in your note and you can communicate with the moderator and the event participants that way.

You also can send a note towards the top of the screen. When you do so, it goes to both the co-moderator and the event moderator. So it goes to both Sheri and myself. You have the option of raising your hand. And that allows you to request the right to speak. In order to request the right to speak you need to have a built in microphone that's in your computer and working or you need to be using a headset.

So first of all, I want to welcome you all again to our web class today. And thank you for your participation. Just as a reminder, this web class will be recorded. So that in the event you would want to view the class again, you can easily do so by visiting our web site at www.bionicear.com. Additionally, you may have colleagues that weren't able to attend today's session and you can easily refer them to our web site, as well. We would like to ask that you save questions for the end of class. At the end of class you will be given the option to either write your question down in the form of a note or request the right to speak.

If you did not receive a handout to today's class, please feel free to e-mail me after this event at carissam@advancedbionics.com and I'll be more than happy to send you a handout. For those of you interested in continuing education units, we will be offering AAA units for this live session and also our recorded version.

On that note I would like to introduce our guest speaker today. Sheri Byrne-Haber joined the Let Them Hear Foundation in 2004. She is currently the director of the Insurance Advocacy Program. She has been champion -- campaigning the cause of overcoming insurance denials for hearing impaired individuals since 1997 assisting in almost 400 individuals in appealing their insurance denials.

She has an undergraduate degree in computer science and a law degree from the University of San Francisco.

She passed her bar exam in California in July of 1997 and is currently completing an MBA in healthcare from George Washington University. Additionally, Sheri has three daughters, one of whom is hearing impaired.

So on that note, I would like to turn it over to Sheri so that she can provide us with her wealth of information and experience on combatting insurance denials.

>> Thank you, Carrisa. I just want to thank everybody for joining us today so that I can share what I think is important information with you as both parents and providers in how to deal with insurance denials for hearing impairment related issues.

So we're going to focus this talk today on two things. One is to discuss the tactics and to a certain extent some of the reasoning used by insurers when they are issuing these denials and attempting to avoid paying for what the patient is obviously saying is a legitimately requested survey. And secondly, to understand what questions you need to ask yourself and answer yourself to determine the best approach in handling the appeal.

Because one technique that will work in one state with one insurance plan may totally not work with another insurance plan in a different state. So there's a lot of different paths that you can go down and kind of decision tree analysis that has to be done to figure out how to bet get your denial overturned.

Here we go. So initially I'm going to do a little bit of what might be considered basic introduction just in some of the insurance terms that we're going to be using. I apologize if this is old hat for some of you. But we need to make sure that everybody understands all of these terms or the rest for the presentation might be in Martian.

First of all, there are four different types of health insurance that we have in the United States. There's group insurance. And group insurance can either come from an employer or from your involvement or membership within a group. For example, a union or an AARP, for example. In those cases your agreement is not directly with the insurance company but it's with the group. And the group holds the contract with the insurance company.

There's individual insurance. And individual insurance is where you're contracting directly with the insurance company to provide you with information.

There's government insurance. And government insurance typically falls under the category of things like Medicare for people who are disabled or over 65. Medicaid, which is on a state-by-state basis. Tricare, which is for military insurance or some type of program for Federal

employees. The one that I most frequently see is Blue Cross-Blue Shield for Federal employees.

And then finally a variant of group insurance is known as COBRA. When you are a member of a group and you have group insurance, when you lose your qualifications to belong to that group, you can get extended benefits for up to 18 months through COBRA which means that you take over payment for the premiums. And COBRA is just the name of the Federal law that mandates that coverage for 18 months.

Most of the time it happens when somebody either quits their job and doesn't qualify for insurance and/or a new job or -- doesn't get a new job right away. Or if you are the spouse of somebody who is employed and is divorced, when the divorce is final, you lose your rights to that insurance coverage. And so those are the most frequently used instances for COBRA qualification.

So insurance terminology. Most of you are probably familiar with the term in network and out of network. Sometimes in network is referred to as preferred provider. It implies that there are a certain number of providers in your area that your insurance company has a special contract with. And that if you go to one of those providers, you're going to get a special rate. Perhaps a better reimbursement percentage. Or it won't even be based on a percentage. You just make a co-pay and you're done.

Out of network means it's somebody that's not part of that network, not contracted to the insurance company. Reasonable and customary has to do with the fees where what the doctor is billing isn't necessarily what the insurance pays. So reasonable and customary is sometimes also referred to as the contracted rate. And that has to do with the arrangement between the insurance company and the provider for how much they are going to get for providing a particular service.

Utilization review is a process that ensures you typically -- typically they reserve it for expensive procedures -- which means cochlear implants come under what would be considered to be an expensive procedure by most insurance company's standards -- where a committee will get together and actually review the request, review the case file, make sure that the service that is being requested is appropriate for the patient and being provided in the most cost effective manner possible under the obligations of the insurance plan.

And finally, preauthorization versus predetermination. It may surprise people who are listening to me today. But preauthorizations typically are not legally binding. The preauthorization is usually the process that you go through where your surgery coordinator at your implant center submits the request and says, "So-and-so needs a cochlear

implant. Here's their audiogram. Here is the medical recommendation." And the insurance company will come back and say, "Yes, this is preauthorized."

Typically at the end of the letter there will be what I like to refer to sometimes as the weasel language that says, "Subject to the terms in effect at the time the service is rendered" or something to that general effect. Which means that if the preauthorization was issued in mistake, they can actually revoke the preauthorization before the surgery or they can actually refuse to pay after the surgery.

And it doesn't happen frequently. But 5 of the 175 cases that I'm handling right now have to do with families who appropriately preauthorized the surgery and then were told after the surgery that the insurance company wasn't going to be paying for it.

Predetermination on the other side are contractually binding and they are a commitment by the insurance company to pay a particular amount of money for these particular services that are being rendered. Insurance companies don't like to issue predeterminations obviously because this really boxes them into a corner that's much more difficult for them to get out of at a later date. And some insurance companies will do predeterminations. Others will not.

Okay. The other kind of threshold information that you need to understand to get started is what is a self-insured plan. There are two different kinds of insurance. There's what we call traditional insurance, also sometimes referred to as fully insured, and there's self-insured plans.

When you have traditional insurance, what that means is you or your employer is paying a premium to the health insurance company. The risk is entirely on the health insurance company. If there is money left over at the end of the year because the premiums exceed what they've paid out, the insurance company gets to keep that money. If it turns out that they've substantially underestimated the amount that needs to be paid, the insurance company is the one who is on the hook for paying that money.

So self-insured and fully insured has to do with who has the risk. Fully insured, the insurance company has the risk. Self insured is where the employer actually has the risk. Typically we see self-insured plans when there's more than 500 employees or if it's a School District, a hospital, a union, a sheriff's department, some type of quasi governmental organization.

And what that actually means is that the name of the company on your insurance card is not your insurer. Your employer is actually your insurer. What the employer is doing is instead of paying premiums to a health insurance company,

they are putting money in a pot. And they are paying an insurance company such as United Healthcare or Blue Cross to act as what we refer to as a third-party claims administrator and to pay money out of that pot processing claims based on the rules that the employer, who is your insurer, has defined.

So you might be looking at your card and thinking "Well, ra ra ra Blue Cross ra ra won't pay for my mapping sessions." But if you work for IBM or you work for -- I'm just picking random company names here out of a hat. I'm not intending to capture aversions on any insurance company or any employer -- IBM is typically your insurer under those circumstances, not Blue Cross.

The reason why it's really, really important to delineate up front as soon as you get a denial whether or not your plan is self insured is because the path that you go down and options that you have available to you entirely depend on whether your plan is self insured. If your plan is self insured, Federal law, which is known as ERISA, only applies to your insurance plan. You may not avail yourself of the Insurance Commissioner of your state.
You may not utilize any of the insurance law in your state. So if you live in a state that says that speech therapy has to be covered, since you're in a self-insured plan, self-insured plans don't have to abide by that state law because only Federal law governs the self-insured plan.

There's two different strategies in order to handle appeals once you've been denied a particular service by an insurance company related to hearing imparity. We are only going to address here the second strategy, which is the legal strategy, which is the strategy that the Let Them Hear Foundation uses. The reimbursement/billing strategy is more of a strategy where non-legal people are used to try to convince the insurers to pay for something or to try to get them to pay more for something than they've paid.

I don't consider that to be a particularly successful strategy probably because I'm a lawyer. I'm somewhat biased in this matter. The legal strategy takes a different approach which explains to the insurance company what their contractual obligations are to the member, how they are failing to meet those contractual obligations and what liability that they are exposing themselves to financially by failing to meet their legal obligation through their contracted members.

And so that's the approach that the Let Them Hear Foundation takes. In the end it's all about convincing the insurance company that it's going to cost them more to fight providing the service than it's going to cost them to provide the service.

Okay. Why do insurance companies refuse to pay

for certain things? Well, they profit from attrition, uncontested mistakes, illegal denials, missed deadlines and the fact that at the end of the day, in the Insurance Commission's process, there's no denial-related penalties or legal fees if they are obligated to pay. So when we win an appeal for somebody, what we've won for them is that service and the obligation of the insurance company to pay for the service.

If the insurance company has turned down that service 20 times and the Insurance Commissioner has told the insurance company 20 times "No. Sorry. You have to pay for this," nothing is stopping them from turning it down the 21st time. And the reason why they do that is because there are probably sometimes up to five or six different levels of appeal that a person can undertake when the service has been denied. If you consider 5 to 10% of the people drop out at every single level, by the end, even if you know you're going to have to pay every time there's no penalty for having turned them down, you aren't going to have to pay their legal fees if they've incurred any legal fees. And 50% of the people have dropped out along the way. And so that's 50% fewer of whatever it is -- and I'll use bilateral cochlear implants as an example -- that the insurance company ends up paying for.

Furthermore, they've been able to earn the interest on the money that they haven't paid out for that six months that they've dragged out the appeals process. And that's kind of an extreme example. But we have had certain types of appeals do take sometimes six to nine months to resolve. And when you look at that happened with one person, that doesn't seem like a lot of money. But when you think about it times the number of people across the United States that this is happening to, you start talking about some pretty real money pretty quickly.

So I want to go over now the level of appeals and what a typical appeals process looks like. The first number of bulleted items under internal to insurer typically happens with almost every insurance company.

(Brief interruption.).

>> Sorry. I don't know how to turn that off. I'll turn the volume down, if nothing else.

Okay. So internal requests would be -- sorry. Initial request is your attempt to get that covered from your surgeon. The first internal appeal would be your first request after it's been denied.

Second internal appeal would be your second request to get it covered after the first internal appeal is denied. Then there's a number of external reviews that you can look at.

Some insurers have something that we call

voluntary review panels. And what a voluntary review panel is, it's a group of people usually consisting of a couple of doctors, maybe a couple of insurance company employees, usually some consumer individuals. Just, you know, regular people off the street.

And the insurers will have these panels. And they will send a case over to the voluntary review panel and say, "Hey, do you think we should pay for this or not? " The issue with voluntary review panels, because it's voluntary and because the insurance company is doing it on their own, the voluntary review panel's decision is not binding on the insurer.

So the voluntary review panel can say, "Yeah, we think you should pay for this insurer" and the insurer can say, "You know what? We're still not paying for it."

External reviews are a little bit more structured. And external reviews are where the insurer contracts with an external review company. And there's a couple dozen of these companies, large ones, in the United States and probably many, many, many more small ones. Where they will have a board certified physician review the case and make a professional recommendation about whether or not the service will be covered. The big problem that I have with external reviews is there's nothing in the law that requires an insurance company to use an expert through the external review company that's board certified in otolaryngology or otology or who has ever even done a cochlear implant.

I have received external reviews recommending that cochlear implants not be covered from gerontologists, who are people who specialize in elder care that happen to be for a cochlear implant for a five-year-old.

I've received reviews from osteopaths who are not surgeons. I've received them from dermatologists who are, you know, acne experts rendering their quote, unquote "professional opinion" about whether or not somebody should receive a cochlear implant.

So you can probably tell by the tone of my voice that that really ticks me off. And it's important that if you are working with an insurance company and your insurance company says, "Okay. We're going to send this out to external review," you want to send them a written letter saying, "I expect you to send this to somebody who is board certified in otology or otolaryngology. Those are the only people who are qualified to render an opinion in this matter."

Independent medical review is kind of an overall catch phrase for the Insurance Commission process. 43 out of 50 states in the United States have a normal structured independent medical review process where they either have physicians on staff who review cases and render opinions or they have agreements with external review companies and they send it out

for external review. And external review companies render opinions in the cases.

The state Insurance Commissioners are much better than the insurers about making sure that the external reviewers have the correct qualifications. I've never had a state Insurance Commissioner send something out to a dermatologist for external review, for example.

Independent medical review and ERISA arbitration is an or situation. If you're fully insured, you're going to come under independent medical review. If you're self insured, you'll come under ERISA arbitration. If you've exhausted all of your insurance appeals internally with the third-party administrator, then there are occasionally, depending on your personal situation, steps that you can take prior to filing a lawsuit against your employer to try to get the denial overturned.

And then finally, EEOC and ADA complaints. Those are primarily for individuals who have insurance plans that completely exclude cochlear implants or the insurance plan is being provided through a job. And I will go through in more detail in a few slides about how we utilize the EEOC and the ADA complaint process to leverage getting approvals for those particular cases.

About 12% of the appeals that we are currently seeing involve just absolute outright cochlear implant exclusion. And we've been able to get 20 out of 20 of those overturned at this point through our advocacy program. So it is possible to get coverage for things that are completely excluded in your health insurance plan.

Okay. So we've already gone over this a little bit. Preauthorization versus predetermination. Preauthorizations are not legally binding. Predeterminations are a contractual commitment to pay a certain amount of money for a list of procedure codes on a specific date for a specific patient. And they are more binding than a preauthorization.

Refusals to preauthorize is not a denial. What does that mean? Okay. Certain insurers, Medicare being one of them and Blue Cross-Blue Shield for Federal employees being another, have a policy saying either A, they either never, ever preauthorize surgery in the case of Medicare or B, that they refuse to preauthorize surgeries that are being done by an in network physician that do not require an overnight stay.

So your implant center makes the surgery request. And the -- you know, they say, "Please preauthorize this." And the insurance company comes back and says, "Sorry. We don't preauthorize under these circumstances."

The reason why that's a problem is because if the insurer determines after you've had the surgery for whatever

reason that they feel the surgery wasn't medically necessary, they won't pay for it. At that point your appeal is no longer preservice because you've already had the surgery. The appeal becomes a post service appeal. And there's a lot of difference between doing a preservice appeal and a post service appeal. And we'll discuss that in more detail in a few slides.

There is almost no state insurance law protections for these cases. Insurance Commissioner's mandates are written up very strictly. And most of them say that they will only review denials and refusals to pay. A refusal to preauthorize is not a denial. And it's not a refusal to pay. Therefore, it's difficult to get a state Insurance Commissioner to review it. And there's also -- there's no ERISA protection whatsoever if you are in a self-insured plan.

So if you are in a situation where you get a refusal to preauthorize, that is something that typically cannot be handled in the appeals process until after you've actually had the surgery. And then, you know, maybe they pay for it and maybe they don't. And if they don't, then you can trigger your right under the appeals process.

Okay. One -- the No. 1 rule that I tell everybody for dealing with insurance companies in any aspect is that if it's not in writing, it didn't happen. We have one particular insurer, I won't name their name since I'm casting expressions, that nearly one-third of the paperwork we send them gets quote, unquote "lost" or quote, unquote "not received."

As such, we send every single piece of paper that comes out of the advocacy program goes to insuring companies by certified mail with return receipt requested. And the other important thing to know with insurance companies, and especially if you're self insured, if you have a telephone conversation with the insurance company where the insurance company represents something that affects your appeal or something that is -- pertains to your rights under the insurance contracts, what you want to do is you want to summarize that phone call in writing, send it to the insurance company, once again, certified mail, return receipt requested, and tell them that they have ten days to dispute what you're saying.

The reason why that's important is because there are certain parts of the ERISA process with the self-insured plans where you can't introduce new evidence. Decisions are made based on what is quote, unquote "on the record." And by summarizing the telephone conversation and submitting it back to the Insurance Company, you're getting that included in your patient file and it becomes on the record. Where a telephone conversation that you had where you could testify to the telephone conversation, that might be considered the introduction of new evidence. And it's much harder for that to

get accepted. So that's definitely something that you need to be aware of.

Okay. Prospective versus retrospective appeals or preservice versus post service appeals. It's kind of two different sets of terminology that means the same thing. Although the process is very much the same for appeals whether you're doing it preservice or post service, the timelines and the outcomes are very different. On an industry average -- and when I say "industry average," I mean all health insurance claims, not just hearing impairment related claims, 80% of preservice denials are eventually overturned but only 36% of post service denials are overturned.

And the reasoning from my perspective is purely psychological. When you're arguing a preservice appeal, you have a health condition that your insurance company is refusing to treat. And so you're in a situation where you're not getting treatment for a health condition. Basically that you're going to be forced to live with that condition if the denial isn't overturned.

When it's post service, you've had the service. You've had the treatment. Hopefully your treatment was successful. The argument at that point is solely about who is going to pay for it. And the insurance company's opening line will be "But we told you we weren't going to pay for this in the first place." And then you have to overcome that presumption. So that's my explanation for the huge difference between preservice denials and post service denials and getting them overturned.

Okay. So which law applies to your particular case? As I mentioned, there are state laws and there's Federal law. Federal law only applies to self-insured plans. State law applies to fully insured plans. And where the state law applies, you may apply both the law of the state you reside in and the law of the state the insurance company resides in.

So let's say you live in California but you work for Advanced Bionics. Blue Cross-Blue Shield of Massachusetts is your insurer. So what that means is the law of Massachusetts actually applies to your case, even though you happen to reside in California. So it's very important to know up front that some states allow you to apply the law of both states, so the law that you reside in and the law that the insurance company resides in.

Unfortunately, California is not one of them. So anybody who lives in California who works for Advanced Bionics would only have the Massachusetts Insurance Commissioner, whose rules are very different than the California Insurance Commissioner, in order to get their case resolved. So that's another important piece of information to know up front when

you're figuring out what your appeals strategy is and what your timelines are for getting these things resolved.

The No. 1 question I get asked is "Well, who are the good states and who are the bad states and who are the good insurers and who are the bad insurers?" This is just my personal take having done this for a while about what states are easier to work in and what states are difficult to work in.

There are no states that currently mandate coverage for cochlear implant.s however, there are several states that mandate coverage for things that are peripherally related to cochlear implants. Congenital defects is one. Hearing aids is one. And speech therapy is one.

So what you can do is you can make the argument, especially for children who are identified in newborn hearing screenings or even adults who are later identified with a genetic syndrome that was the source of their hearing loss, that it was a congenital defect and as such, if you have a law thing that the insurance company has to treat congenital defects, that they have to provide coverage for your cochlear implant.

Hearing aids and speech therapy, the arguments I use there are that the intent of the legislature in passing those laws would be that the individuals residing in that state have access to sound and have access to therapy that will improve their speech. And without a cochlear implant, somebody who is profoundly hearing impaired is not going to have that access to sound and is not going to have that access to speech therapy or developing better speech.

And so what you're doing is you're making an indirect argument saying that the intent of the legislature would apply also to cochlear implants, as well. So you can see the list of states here that have laws that have one or more of these three things included in their laws. And these are states that are typically easier or better to do appeals in.

The bad states -- well, the No. 1 group of bad states are the states that don't have a formal Insurance Commission review process or formal IMR process. They tend to be states with lower populations. As we can see Idaho, Nebraska, Wyoming, states like that.

They all have some sort of process where you can make a complaint with a particular government agency and a government agency will investigate it. Idaho, for example, has an arbitration system. But these are a lot more difficult to deal with and a lot more erratic in terms of the results that you're going to get than having a structured standardized Insurance Commission which is doing the same type of IMR process for everybody in the state for denied insurance claims.

States that have a single insurer that has a majority of the business in that state are also difficult states

to appeal in. Utah and Tennessee are examples of this. For example, Blue Cross has I think 65% of the business insurance in Tennessee. And Utah, there were two insurers combined in Utah that had 80% of the private insurance business in Utah between those two insurers. Those can be more difficult types of appeals and take longer to accomplish.

Okay. The next question that always comes after that is "Well, who are the good insurers and who are the bad insurers?" And the bad news is it differs on a state-by-state basis. And it even differs within regions within a state.

So for cochlear implants, for example, Blue Cross-Blue Shield of southern California was much easier to deal with than Blue Cross-Blue Shield of northern California. And it was strictly because of different medical directors and different personnel.

That also changes over time. Over the last 18 months or so I've always told people that United Healthcare in my personal opinion was one of the better insurers to deal with. They actually frequently preauthorize cochlear implant surgery without -- bilateral cochlear implant surgery without even requiring an appeal.

Well, all of a sudden last month United Healthcare issued a memo that they are going to stop approving bilateral cochlear implants on October 10th of this year. So that's moved one from good insurer to bad insurer just with the issuance of one memo.

So it does frequently change. It changes based on personnel. It changes based on state. It depends on a lot of different things.

These are the appeals. PPOs are easiest to appeal. Open HMOs, meaning that you can go to different facilities as long as you stay within the HMO network, are slightly harder but still not too difficult. Closed HMOs start to be where it gets a little bit trickier.

By closed HMO I mean something like a Kaiser where you would have to go to a specific facility and use only the doctors in that building or you get no coverage whatsoever. Public insurance is definitely the hardest. And it's the hardest not because we don't get good outcomes. We get very good outcomes with our appeals. Just because the appeals take so much longer in the Medicare and Medicaid system in particular than private insurance appeals.

Private insurance appeals might average four months with an outlier maybe taking nine months. Public insurance appeals frequently take upwards of a year. We've had a couple go over a year. So it is a very long drawn-out process if you have public insurance.

All right. So now we're going to look at the

five different types of denials that are our program most commonly sees, specifically when refusing to pay for bilateral cochlear implantation. The first four we'll talk about in some detail. The fifth one, pre-existing conditions, we're really not going to talk about.

There's only two situations when you're going to end up with a denial based on a pre-existing condition. One is if you've got an individual plan where you waived the right for treatment through a pre-existing condition as a condition for being accepted on that plan. And that type of denial is not appealable because you voluntarily gave up your rights to receive coverage for treatment for your hearing impairment to get that insurance.

The other time you'll get a pre-existing condition denial is let's say your in it for a year. You take off for six months. You go join, you know, medicine (inaudible) or you go to Europe for six months and you say, "Okay. I'm just not going to carry my insurance while I'm gone for these six months." And then you come back and you get another job.

If you have a gap of more than 63 days -- and I don't know how that number got picked -- between your two group insurance plans, your new plan can exclude pre-existing conditions for a set period of time. The set period of time is -- it depends on somewhat how long the gap was between your two insurance policies. I think the maximum that they can exclude under those circumstances is 18 months.

So what that means is that if you stay with the new plan, eventually you will be covered. But you won't be covered for a particular period of time.

Neither of those cases that we just discussed, the individual plan or the gaps between group plans, is appealable. And so the Let Them Hear Foundation doesn't undertake appeals for those particular situations.

Okay. It's really important to read your denial letter carefully and make sure that your arguments in your appeals are targeted for the reason why they are denying something. If the insurance company is arguing that a particular treatment is not medically necessary, you don't want to include ten pages on how bilateral cochlear implants aren't experimental and aren't investigational because that's not why they are denying it. They are denying it saying it's not medically necessary. So your argument needs to focus on why it's medically necessary for you.

The fact that you meet the FDA guidelines for cochlear implantation is going to be important. Objective test results are a key component to getting those denials overturned. So things like your tent test results, how you do with discriminating speech and noise, what your open set sentence

recognition is. Subjective data can support that.

In the case of a child, you have a letter from a teacher saying, "Look. This child is really doing poorly in class and group situations because they can't deal with the background noise" or a letter from your employer saying, "We couldn't promote somebody to a particular position because it required a certain level of hearing and they didn't have that level of hearing." Those types of subjective data can support.

Obviously safety is going to be a big component. If you can't hear out of one side, you can't localize sound, that's going to be a significant note. And the arguments can and should include psychological impact, if it's applicable to your particular case.

If you have a child, for example, who is exhibiting signs of ADHD that may be linked to their inability to hear out of one side, you want to bring that up. Because the reason being is that treating ADHD for a lifetime on this insurance plan or even for five or ten years is actually going to end up being more expensive to the insurance company than covering the cochlear implant in the first place.

Same argument goes for clinical depression. You know, people who have unresolved hearing impairments are more -- typically more socially withdrawn and do have a much higher incidence of accessing mental health services than people with normal hearing. So that's something that you really want to bring to the attention of the insurance company to make sure that they clearly understand that there's an expense to not approving the surgery in addition to an expense of approving the surgery.

Denials for out of network service providers. So let's say the insurance company says, "Yes, we will pay for this. But only if you go to Provider A" and you want to have the surgery with Provider B. Insurance companies are obligated to provide you with a competent medical provider. They are not obligated to provide you with the best medical provider.

And so what that means is that in order to make the argument that they should pay for Provider B, you need to argue why Provider A is not competent to provide your medical services. Now, it may be that Provider A has only done five bilateral cochlear implants, for example. Where Provider B does 50 a year. That would be something that you would want to highlight.

It may be that Provider A has had malpractice claims filed against them. It may be that Provider A doesn't have his own audiology staff; that he sends people out to mapping clinics that slow down troubleshooting and adaptation time.

What you need to do is you need to identify

factual reasons why Provider A is not competent to provide your medical treatment and why Provider B is competent to provide your medical treatment. So there you are not arguing about whether or not the treatment is medically necessary. You are only arguing about who is the person who is going to be providing the medical treatment to you.

About 12% of the cases that we get, as I mentioned before, are blanket exclusions of cochlear implants. And what I mean by that is there is a line somewhere in the insurance contract that says, "We don't pay for cochlear implants ever. Period." It's the position of the Let Them Hear Insurance Advocacy Program that these blanket exclusions when they are in employer provided group insurance are illegal under the EEOC and ADA.

And the EEOC is the Equal Employment Opportunities Commission. The ADA is the Americans with Disabilities Act. The EEOC actually reviews benefits and looks for signs of discrimination.

If you take a category of people, meaning an entire category of profoundly hearing impaired people who qualify for cochlear implants under FDA guidelines, and you single out that group of people and say, "We're not going to treat your disabling condition" -- and please bear with me. The Federal government has actually defined the inability to hear as a disabling condition.

You may or may not personally consider yourself disabled. But for the purposes of this particular argument, the government does consider you as having a disabling condition.

And you can't meet what we refer to in the legal community the disability based distinction, you can't single out one group of people based on one particular disabling condition and say, "You know what? We're not going to treat that condition." And so that's our argument. And as I mentioned, we've been very successful in getting multiple Fortune 500 companies and schools and unions and hospitals to drop these types of exclusions.

And this argument applies to whether or not the company is self insured. So this Federal law applies to both self-insured plans and traditionally insured plans.

In actuality, 19 out of the 20 cases that we've completed that have involved contract exclusions were self-insured plans. This is something that employers typically do to try to save money. It's not something that is common to find in a traditionally insured plan.

The No. 1 reason for denial that we currently see for bilateral cochlear implants is that they are experimental and investigational. So the arguments need to focus on the following: They need to focus on the research papers that say

that bilateral cochlear implantation is not experimental. Is not investigational. Is medically necessary.

Most of those papers focus on three different reasonings behind that. The fact that people with bilateral cochlear implants have much better speech recognition in noise environments. The fact that people with bilateral cochlear implants frequently can localize sounds after receiving the second implant. And the safety concerns involving not being able to hear out of one side.

It is very appropriate in these cases to highlight any other medical conditions that you may have that are exacerbating these safety problems. Approximately 40% of hearing impaired people have some other medical condition, be it vestibular problems, sensory integration issues, motor skill related problems or visual deficits that may defeat the issue to be able to localize sound and get out of the way of the source of a dangerous noise even more crucial. So it is appropriate and useful to highlight those other medical conditions under these circumstances.

The other thing that's really important to do is under Federal law the insurance companies must provide you with copies of all the information that they used to issue the denial. If they received a report from somebody or if they subscribed to a service that said, you know, "Bilateral cochlear implants are experimental and investigational," they have to provide you with all of that information. Once you get that information, you will typically discover or at least we have frequently discovered that the information is either out of date or it's set for an inappropriate audience.

So for example, until Blue Cross changed its policy on bilateral cochlear implants last July -- so July of 2006 -- the most recent information that they had in their particular research tool they were using to deny implants was from 2004. And there were actually 16 articles that came out subsequent to their review date. And they were ignoring all 16 of those articles. So that's something that's really important to look at.

Another thing that's really important to look at is list who the audience is in those papers. Insurers were heavily relying in the past on a couple of early studies that focused primarily on the elderly community and their reactions to bilateral cochlear implants which are obviously not as favorable as implanting children or post lingually deafened adults when the implantation is soon after their hearing impairment as opposed to having an age related hearing loss.

And so it is absolutely appropriate to say, "Hey, you know, my son is 5 and you're relying on a study that says 75-year-olds don't do well with bilateral cochlear implants.

That's not appropriate. You need to look at all of these studies over here that say unequivocally that children under the age of 5 do great with bilateral cochlear implants." "

Okay. How long does this process take? Our appeals are all over the map. We've had some take as short as two days. We've had some take as long as 14 months. The average appeal -- and "average" meaning that we resolve two-thirds of them -- is about 11 weeks. 11 weeks to kind of the 3 to 4-month range.

Now, many parents -- and believe me. I understand the situation. The process that I started with my daughter took seven months before we got approval for her surgery. And during those seven months, you know, we couldn't communicate with her. She was five. She had a progressive hearing loss that progressed suddenly. And it was absolutely the worst seven months of my entire life. Because I was sitting there and there was nothing I could do because I couldn't get the insurance company to approve it.

Unfortunately, requesting expedited appeals are typically only available for meningitis and explant cases, meaning device failures that have to be replaced. You need to be able to get a letter from a doctor saying that the -- that your medical condition or the child's medical condition is going to deteriorate if a decision isn't rendered in a short period of time. And those are really the only two situations I see where those types of letters can legitimately be written. In the case that you do qualify for an expedited appeal, usually they only take two or three weeks from the date of the initial request until the date of the final determination.

So now I'm going to talk a little bit more specifically about how the Let The Hear Foundation appeals process works. What I talked about up until now is more broadly about how to do an appeal in general. We have an online application process. Our URL is advocacy.let them hear.org. And it's at the end of this presentation, as well, written down so you can see it.

Application is a bit of a misnomer. We actually accept 96% of our applications. It's not like we'll say, "Oh, we'll take you and we won't take you." It's more of a centralized data gathering device where we get all of the information that we need to be able to categorically decide on the spot what kind of appeal you've got. What kind of approach to take. And which among those ten interns that I have and the other two attorneys would be the best person to work on your case.

Because we have particular individuals who somewhat subspecialize in various different areas. I've got one, for example, whose been extremely successful with cases

against Aetna. So since we don't believe in tempting fate, we assign all of the new Aetna cases to her.

We have an intake interview process where we gather additional information we need that's not in the application process. We request the materials from the insurer that the denial is based on. If there was an external reviewer involved, we would do a letter to the external reviewer. I would say that's the exception rather than the rule, especially if you're just coming with an initial denial and you haven't had three or four denials before you contact us.

We draft, review and submit the appeal and repeat that process, you know, as many as allowed or until it gets approved, whichever comes first. If we exhaust all of our appeals processes and we still don't have a favorable determination, then we proceed for the Insurance Commissioner's hearing or necessary arbitration or in some extreme cases filing lawsuits in order to resolve the case.

We spend a lot of time watching the mailbox. For the 11-week period that I mentioned that these appeals take, pretty much only two weeks of that is going to be you interacting with the foundation in drafting and getting your appeal out the door. The remaining nine weeks is the amount of time the insurance company has to review things before they have to get back to you.

In some cases with self-insured plans, they have up to 90 days to review particular requests. Some states for traditionally insured plans limit that to 30 days. Some states are actually good enough to say that if the insurance company hasn't given you an answer in 30 days, it's been deemed to be approved. But that doesn't happen very often.

So a little bit more detail about our program. We were officially founded two years ago in 2004. We ran a 14-month pilot program where it was just me. And during that 14-month period of time we completed 53 cases and won all 53 cases, which included 18 bilateral cochlear implants. So at the end of the pilot program we said, "Okay. You know what? We see a theme here. And the theme is that with the right representation and the right arguments, these things are getting approved. And so we should expand this program to go nationwide."

So initially we expanded to go nationwide with five additional law student interns working with me. We just expanded again. We just hired three more interns, who will be starting this week. So we have -- let me see. I think that makes eight interns, two attorneys. And I'll have a full-time program administrator starting on Friday.

We completed 196 cases since Christmas. We've still won every single case that we've completed including 108 bilateral cochlear implants. So bilateral cochlear implants

represent about 60% of the appeals we're doing right now. And the wins since Christmas has resulted in about 8 million dollars in services and equipment being provided to the patients.

As I mentioned, 12% of the appeals are for denials that were illegal. Either under Federal or state law. 60% have been overturned on the initial appeal. 18% get overturned on the second appeal. 7% require some extra step, external review, IMR, arbitration or as far as filing a lawsuit.

And you may be adding up those numbers and going "Okay. 60 plus 18 plus 7 is, you know, 85%. What happened to the other 15%? "

The process is so drawn out that 15% of the time patients drop out of the appeals process before the approval happens. Either something happens where their insurance changes, their job changes, they have to move, some other intervening medical condition has taken place that decided to happen since the cochlear implant to put it on the back burner, divorces, all kinds of stuff have happened that has caused some kind of intervening issue that's caused them to drop out of the program.

We've had a number of significant wins with Insurance Commissioners in the last three months. California, Georgia, New York, Rhode Island, Kansas, Iowa, North Carolina. Now, what does that mean? That means that if you have Blue Cross-Blue Shield of North Carolina, are they going to still be able to deny you a bilateral cochlear implant despite the fact that we've gotten new rulings from the North Carolina Insurance Commissioner?

The answer is yes, they can still deny it. However, they have a very difficult case in order to keep that denial upheld. Because the North Carolina Insurance Commissioner has already said on a previous occasion "We don't think bilateral cochlear implants are experimental or investigational."

We've had a number of big wins with contract exclusions. We had a couple of cases in Utah. In Utah up until June of this year, 80% of the people in Utah couldn't even get one cochlear implant because the two largest insurance companies in Utah refused to provide any cochlear implant coverage whatsoever.

We had a number of self insured companies, Apple, UPA, Harrah's, Conway T Mobile, Verizon. You can say the Aunt Jan Rule applying my Aunt Jan has heard of most of these companies. They all had cochlear implant exclusions. We got them to drop their exclusions for part of their appeals process for one of their employees.

External reviews. I don't expect you to recognize the names of any of these companies. But these are

companies who are professionally external review organizations who have issued rulings in favor of bilateral cochlear implantation. So if you're in a situation where your insurance company says, "We'll send this out to external review. Here is a list of companies. Who do you want?" you might want to cross check that list against this list. And if you see any that intersect, you might want to pick out one that you know has already issued a ruling in favor of bilateral cochlear implants before.

Finally, we've been able to effect a number of good positive policy changes recently. The first two, Wellpoint and HCSC representing Blue Cross And Blue Shield in 18 states covering 45 million individuals now cover bilateral cochlear implant. It's actually stated in their policy that it's a covered benefit. Kaiser of northern California with a closed HMO recently decided to cover bilateral cochlear implants. So that was a significant one, as well.

Why does our program work better than say your doctor's office appealing this or you appealing this on your own? We're a third party non-profit. We're not directly connected to the case. We're not financially connected to the case.

We don't charge you so we don't get paid. We're not the manufacturer so we're not making money off the device. So we're not the surgeons so we're not making money off the surgery.

We have a significant amount of credibility because we focus entirely on hearing impairment. That's all we do. We have this stat of wins that I think you should be fairly impressed with, which would beg the insurance company to ask the question "Why am I special? Why should this be approved 108 times in a row and I don't have to pay for it?"

We're continually updating our research. And finally, it helps that somebody that's an attorney is signing the paperwork. Because insurance companies are far more scared of attorneys than they are of medical providers.

The types of reviews we do are sequential and simultaneous. Bilateral cochlear implants. Unilateral cochlear implants. Where there are contract exclusions, any Baha device, atresia repair and microtia reconstruction.

We're going to be doing processor upgrade appeals starting December 4th of this year. We're not doing them yet. But that's one of the reasons why we hired the new staff to get going on that.

I'll just list through this because I know we're running out of time and I know you guys want to ask some questions probably. So start putting those questions in if you would like.

Here is some useful sites if you want to get information about the appeals process, law that applies to the appeals process, how to get media outlet coverage. If you want to get some kind of story on television, insurance companies hate bad publicity. So if you're that kind of family, that might be something that works for you.

Pubmed is where most of the white paper research is published concerning cochlear implantation. All of Dr. Peters, for example, and Dr. Litofky's papers are published here.

How to access the program. Here that URL I promised you. Advocacy.letthemhear.org. My e-mail: Advocacy@letthemhear.org.

And there's an online application. You just click on the online application. Have all of your insurance information with you. Fill it all out. And we review the cases twice a week. And somebody will be calling for you.

Question: What do you charge for this service? Answer: Nothing. We are a non-profit. We definitely appreciate donations at the end of the process. But there's absolutely no charge for us to undertake a case for you. So hopefully that's an answer you like.

That was the only question I've had submitted so far. So I will hang out for a few minutes in case people want to ask other questions. Or if you want to discuss a private situation that you have with your particular insurance, you can e-mail the address that I mentioned.

Okay. Carrisa, I just added you back in.

>> Thanks, Sheri. Again, if anybody has any questions, please feel free to send Sheri a note and she would be happy to answer them. Also, if you would like to speak with her afterwards, again take her up on her offer and e-mail her at the address listed above or give her a call. And for those of you who need to get back to your clinics or other events in your life, please feel free to log off at this time.

>> Question: Can you help for coverage with hearing aids? The answer is yeah, we just started within the last six weeks doing hearing aid appeals. We're still undertaking them slowly as we're getting our templates together and our -- you know, our arguments adjusted for a different type of appeal.

We're running about a one-month backlog right now on handling applications for covering -- for denials for hearing aids. But absolutely we will assist you with those, as well.

All right. Another question: Can we get a copy of this presentation? I don't know the answer to that question, Carrisa. I know it's going to be recorded and online. But is there somewhere where they can actually download the power points?

>> Yeah. Actually if you e-mail me at carrisam@advancedbionics.com, I'll be happy to send you a PDF of today's presentation.

>> Comment from Debra saying thanks and it's been helpful. Yes, definitely pass the information on to your patients. We will talk to the clinics. If the clinics have, you know, general questions. But we only accept applications from families directly. So the request for assistance has to come from the family, not the clinic. But if you want to call me and say, "Hey, what should I tell this family that has Situation X, Y and Z?" I can give you that information and you can pass it on to the family so that they can act on it.

>> Okay. If there aren't any more questions, I would like to thank you all for your participation today and we look forward to seeing you at another Bionics web class. Thank you.

***

This text is being provided in a rough draft format. Communication Access Realtime Translation (CART) is provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings.

***