Insurance

COMMON REASONS FOR DENYING INSURANCE BENEFITS

- Weight – typically, that it's not low enough
- Treatment history
    - Patient has not tried a lower level of care prior to requesting a higher level of care
    - Patient's condition is chronic and past treatments at the requested level of care have been ineffective
- Lack of progress in treatment
    - Patient is not restoring weight
    - No reduction in behaviors
    - Lack of motivation in treatment
    - Inconsistent attendance
- Absence of behaviors – treatment is going well, and it may be appropriate to step down in level of care
- No medical complications

Here are some tips to help you obtain the insurance benefits your loved one needs and deserves so that they have the best chance possible to recover from an eating disorder.

EDUCATE YOURSELF

Read NEDA's resources to learn about eating disorders, treatment, and current clinical practice guidelines, and have them in hand when speaking to your health plan about benefits. Be prepared to ask your health plan for the evidence-based information they use to create their coverage policy for eating disorders.

READ YOUR PLAN

Obtain a copy of the full plan description from the health plan's member's website, the insurer, or, if the insurance plan is through work, the employer's human resources department. This document may be longer than 100 pages. Do not rely on general pamphlets or policy highlights. Read the detailed description of the benefits contract to find out what is covered and for how long. If you can't understand the information, try talking with the human resources staff at the company that the insurance policy comes through, with an insurance plan representative (the number is on the back of your insurance identification card), or with a billing/claims staff person at facilities where you are considering obtaining treatment.

If hospital emergency care is not needed, make an appointment with a physician you trust to get a referral or directly contact eating disorder treatment centers to find out how to get a full assessment and diagnosis. The assessment should consider all related physical and psychological problems. The four main reasons for doing this are:

- To obtain as complete a picture as possible about everything that is wrong
- To develop the best plan for treatment
- To obtain cost estimates before starting treatment
- To obtain the benefits the patient is entitled to under his/her contract for the type of care needed. For example, many insurers provide more coverage benefits for severe mental disorder diagnoses. Some insurers categorize anorexia and bulimia nervosa as severe disorders that qualify for extensive inpatient and outpatient benefits, while others may not.

Medical benefits coverage also often comes into play when treating eating disorder-associated medical conditions, so diagnosing all physical illnesses present is important. Other mental conditions often coexist with an eating disorder and should be considered during the assessment, including depression, trauma, obsessive compulsive disorder, anxiety, social phobias, and chemical dependence. These coexisting conditions can affect eligibility for various benefits (and often can mean more benefits can be accessed) and eligibility for treatment centers.

DOCUMENT EVERYTHING

If you don't document it, it didn't happen. It's a saying frequently used in the legal and insurance fields alike. Insurance attorneys recommend documenting every single contact you have with your loved one's insurer, including the time and date of the call, the name of the person with whom you spoke and their contact information, and what was discussed during the conversation. Experts also recommend keeping copies of all written communication you receive from your insurance companies, such as denial or approval letters, explanations of benefits, and more. Some loved ones have found it useful to organize everything in a folder, a binder, or electronically. If you decide to tape record any conversation, you must first inform and ask the permission of the person with whom you are speaking.

Confirm with the insurer that the patient has benefits for treatment. Also, ask about "in-network" and "out-of-network" benefits and which eating disorder facilities have contracts with the patient's insurance company, because this affects how much of the costs the patient is responsible for. If the insurer has no contract with certain treatment facilities, benefits may still be available but may be considered out-of-network. In this case, the claims will be paid at a lower rate and the patient will have a larger share of the bill.

You may also want to consider having an attorney in case you need to consult someone if roadblocks appear; however, avoid an adversarial attitude at the beginning. Remember to keep complete written records of all communications with every contact at your insurance company. Other things to remember:

- Thank and compliment anyone who has assisted you.
- You're more likely to receive friendly service when you are polite while being persistent.
- Send important letters via certified mail to ensure they can be tracked and signed for at the recipient location.
- Set a timeframe and communicate when you would like an answer. Make follow-up phone calls if you have not received a response within that timeframe.

- Don't assume one department knows what the other department is doing. Copy communications to all the departments, including health, mental health, enrollment, and other related departments.
- Don't panic when and if you receive the first denial. Typically, a denial is an automatic computer-generated response that requires a "human override." Often you need to go up at least one level, and perhaps two levels, to reach the decision maker with authority to override the automated denial.
- Your insurance company only knows what you and the treating professionals tell them. Make sure they have all information necessary to make decisions that will be most beneficial to you or your loved one.
- Make no assumptions. Your insurance company is not the enemy – but may be uninformed about your case. Treat each person as though they have a tough job to do.
- Be aware that if the patient is a college student who had to drop out of school to seek treatment and was covered by school insurance or a parent's insurance policy, the student may no longer be covered if not a full-time student. While many people will continue working or attending school, some cannot. If this is the case, it's important to understand what happens with insurance. Most insurance policies cover students as long as they are enrolled in 12 credit hours per semester and attend classes. Experts in handling insurance issues for patients with eating disorders caution that patients who have dropped out of school should avoid trying to cover up that fact to maintain benefits, because insurance companies will usually find out and then expect the patient to repay any benefits that were paid out.

If coverage has been lost, the student may be eligible to enroll in a Consolidated Omnibus Budget Reconciliation Act (COBRA) insurance program. COBRA is an Act of Congress that allows people who have lost insurance benefits to continue those benefits as long as they pay the full premium and qualify for the program. See www.cobrainsurance.com for more information. A person eligible for COBRA has only 30 days from the time of loss of benefits to enroll in a COBRA plan or that option is lost. Be sure to get written confirmation of COBRA enrollment from the plan. If the student is not eligible for COBRA, an insurance company may offer a "conversion" plan for individual coverage.

OBTAIN A CASE MANAGER

A case manager is a single person at your insurance company who handles your loved one's case. This can make it easier to contact your insurance company with questions and other issues, since you only have to make one phone call. This individual will become familiar with your loved one's case, facilitating decision making.

**These statistics have been taken from www.nationaleatingdisorder.org