
# Never Give In – Never Give Up

*by Marc Rohner*

In October 2003, I learned that I had a large bone tumor within my right distal femur. Although it was originally diagnosed as benign and relatively easy to deal with, the tumor returned four times, mutating and becoming more aggressive each time. Within three years I had undergone five surgeries. With the last recurrence, my physician stated he would no longer be able to remove the tumor and reconstruct the bone and muscle attachments. So on October 4, 2006 my right leg was amputated above the knee.

The following month, I met with my prosthesist for the first time. He gave me literature about the different types of lower-limb prostheses available. After reading through the information and discussing it with my doctor we decided upon a leg with a microprocessor knee.

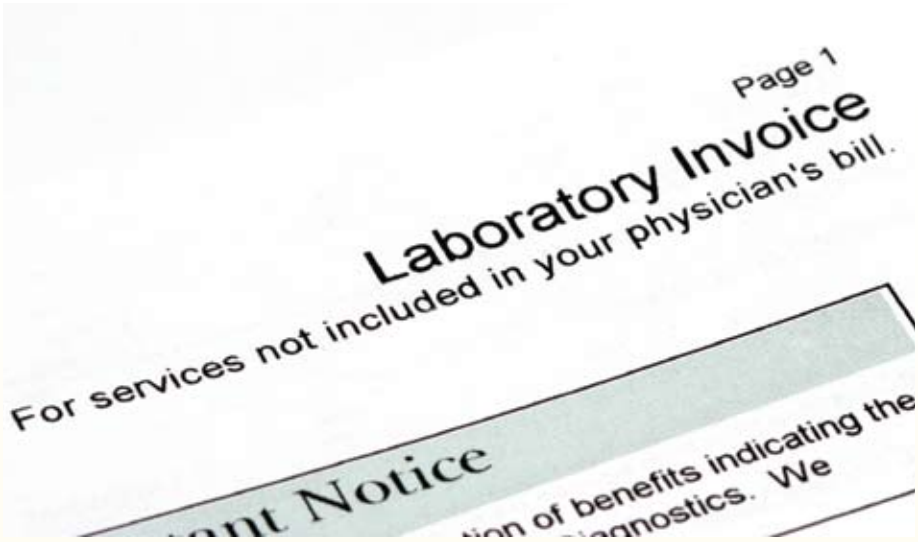
This was the best leg for many reasons. It offered the ability to program the limb and set it into different modes, depending upon the activity being performed. It had proven ability to walk on uneven terrain. Most importantly this leg would allow me to have a lifestyle as close as possible to what I had before my amputation.

I submitted a claim to my insurance carrier for pre-approval/pre-certification. On November 21, my prosthetist was informed that my claim had been denied for reasons stated as "not medically necessary and experimental." I learned that it is not uncommon for an insurance company to deny a claim for prosthetics with microprocessor technology, especially based upon those reasons.

The insurance company said that my doctor was allowed a physician-to-physician verbal appeal, but it had to be done within 24 hours. At the time, my doctor was away on vacation for the Thanksgiving holiday. I managed to contact him and asked if he could make the appeal. On November 22, within the 24-hour window, my doctor called the number provided by the insurance company and reached a voicemail recording. A message was left with his contact number but it wasn't returned – because the next day was Thanksgiving.

The following Monday, I called the insurance company and was told that the 24-hour period had expired and that I now needed to file a written appeal. My doctor and I wrote separate letters addressing the issue of experimental and medical necessity. I also submitted a written request for the guidelines that were used in making the decision.

About 20 days later, I received a letter stating that my appeal had been denied. The reason cited this time was "not in general enough use." Again, my doctor and I wrote appeal letters; this time, my prosthetist wrote a letter as well. Before submitting the appeal letters, I repeated my request for the guideline information used by the reviewing physician. I also asked how many limbs needed to be in use before it is considered "in general use."




This appeal was denied as well. This time, the letter of explanation stated that while the company recognized the potential benefits of microprocessor technology, the benefits did not justify the price. Paradoxically, the letter included a disclaimer stating that the decision to deny was based on medical necessity, not cost. These two statements contradicted each other.

I had exhausted my appeals within the guidelines of my insurance company's policy and had to pursue litigation. After speaking with various people within the amputee community, it was suggested that I first file a formal complaint with the insurance commissioner of Ohio. An investigation would take about 45 days, but it would cost nothing out of my pocket. If the commissioner found that the insurance company had failed to follow the policy as contracted, it would not only pay for the limb but also have fines or penalties placed upon it. Unfortunately, pursuing litigation could take over a year.

While I organized and collected information to submit with my complaint to the insurance commissioner, I again asked for the guidelines used to determine what is and is not approved in regard to prosthetics. Still getting nowhere, I contacted the human resources department at work to see if they might be more successful in getting the information. After about a month of this, I called the CEO and vice president of my company to complain about the treatment I was receiving from the insurance company.

This proved to be a very good move on my part. Less than four hours later, the insurance company e-mailed me the guidelines and apologized repeatedly for not sending it to me earlier. Within 48 hours, I was contacted by the director of compensation at work who was interested in hearing about my plight. Our lengthy talk resulted in the insurance company granting me another physician-to-physician verbal appeal. Five days later, I was approved for the computerized leg.

I came away from this experience having learned a few things. First and foremost, never give up. Next, contact the insurance company and find out what limitations exist. Before choosing a limb, find out if coverage is restricted to a one-time purchase, if there is a maximum co-insurance amount, and if there is a lifetime limit amount.

If you have financial limits within your policy, as well as personal financial limits, carefully choose a limb within your means. You may try to raise money through donations or apply for grants through various nonprofit organizations. Explore types of payment arrangements with your prosthetist, ask your physician to write a prescription for the exact prosthesis required, and submit these to the insurance company for approval. If the request is denied, find out the appeal process within the policy guidelines and if you are allowed verbal appeals.

I recommend going to the prosthetic manufacturer's Web site; it should have a link dedicated to helping patients, physicians, and prosthetists in writing appeals and addressing denial claims. Have your doctor and prosthetist write a letter. Write a letter yourself, but avoid citing any cosmetic or emotional needs; these are not medically justifiable and can only hurt your case. If you can show a need based on employment reasons, have your human resources department write a letter as well, including a brief job description.

If you're denied again, re-appeal until you have exhausted the appeal process. Once that has been done, and you still haven't been approved, I recommend filing a complaint with the state insurance commissioner. Write a letter and submit it along with copies of everything previously sent to your insurance company as well as copies of everything you have received from your insurance company.

*Editor's Note:* During the lengthy appeal process, Marc fell and fractured the femur in his residual limb in January 2007. Although he's recovered from this injury, he notes that it could have been avoided if he had been using a prosthesis at the time. ■

*The views represented in this article do not necessarily represent the views of the CDC.*