MARTIN & JONES PLLC

Attorneys at Law

Remember the days when you purchased a health insurance plan from a health insurer, and you brought that health plan to the doctor when you were sick? You met with your doctor, the doctor prescribed treatment that you needed, and your health plan paid its portion of the doctor's bill for that treatment? Me neither.

The world of "health insurance" has been largely transformed these days into a shiny term that is typically referred to as "managed care." These days, "managed care" is a fancy word, often hidden behind the mysterious benefit of "cost savings," for certain groups coming in between you and your doctor to prevent, screen or otherwise prohibit treatment that your doctor prescribes.

Many health plans under the "managed care" philosophy essentially work like this: your doctor has prescribed a certain treatment plan for you, let's say radiation therapy to help treat an illness. Your health plan does not exclude radiation therapy under the terms of the plan. But in a managed care atmosphere, the health plan takes your doctor's recommendation for treatment and has it "reviewed" by a third party that, in many cases, looks for reasons to deny covering the treatment. The most common way the managed care plan denies treatment your doctor or physician prescribes is under what is called a "medical necessity" justification. This means that despite the fact that a physician has treated you in person, examined you and determined the type of treatment you need, some person who has never seen you, treated you, or evaluated you can make a determination that in fact that treatment is "not necessary." Often times the managed care plans will tell patients that the treatment is experimental for that type of illness, or there is not enough medical literature to justify the treatment.

Ultimately, the end result is a denial of the claim, and the plan's refusal to pay the portion of the treatment that you bargained for when you purchased the health plan.

Cases brought against managed care companies around the country have shown that many denials are almost entirely based on saving money and internal "quotas." Some cases have even shown denials based on the fact that employees tasked with reviewing these denials receive bonuses based on the amount of denials that they have administered in a given year.

In small cases where a patient can still afford to pay out of pocket for certain treatments, this practice usually goes unnoticed, or at least without much economic hardship if paying out of pocket for the treatment. However, this abuse can be absolutely devastating in cases of catastrophic and chronic illness. Instances where managed care providers deny care for life saving procedures such as cancer treatment, surgical procedures for rare illnesses, and the treatment of severe injuries such as traumatic brain injuries, can certainly mean the difference between life and death or economic ruin for the patient.

It is important to know your rights when you have suffered the denial of significant treatment by a managed care plan. Specifically in North Carolina, there are certain requirements when challenging a health insurer's denial of payment under the "medical necessity" exclusion of the managed care plan. This includes in many cases the requirement that the patient or beneficiary make certain internal appeals under the health plan to contest the decision to deny care. In North Carolina, this usually requires at least two internal appeals through the health plan itself before an outside "neutral" third party is allowed to review the decision to deny care. It is only until these appeals are exhausted in many cases that a patient may bring an action in court against the plan to enforce their contractual rights.

In cases where serious and chronic illness treatments are denied, it may be important to consult an attorney early on so that you are advised of all the appropriate appeals necessary to preserve a claim should you need to bring a lawsuit or involve the courts. Many of the appeals that a patient must make have time limits, which means if they are not brought, your right to proceed against the plan for a wrongful denial of benefits may be forfeited. Similar cases brought around the country have involved not only claims of breach of the health insurance contract, but include other more serious claims such as bad faith insurance practices.

Victims of managed care abuse can potentially face terrible economic harm, as well as a loss of lifesaving medical care. If you or a family member has suffered the denial of serious lifesaving treatment by a managed care plan under the "medical necessity" or similar exclusions, you should seek legal advice immediately to understand your rights under the plan and all applicable state and federal laws.

© 2024 Martin & Jones, PLLC.