

Obtaining Insurance Benefits for Your Client's Care

National Association of Professional Geriatric Care Managers

2011 Western Region Chapter Conference

Las Vegas, NV

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Overview

- The nature of long term care insurance
- The types of policies sold to insureds
- Tips for a successful claim process
- Why claims are denied (and how to avoid common pitfalls)

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Why is LTC Important/Popular?

- About 60 percent of individuals over age 65 will require at least some type of long-term care services during their lifetime.
- Medicare only pays a limited amount for “Skilled Care.”
- Without LTC insurance, the cost of providing needed services may quickly deplete the savings of the individual and/or their family.
- LTC pays a HUGE percentage of the first year’s premium to the sales agent, so it gets sold VERY aggressively.

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What Is Long Term Care Insurance?

- Long Term Care Insurance (LTC) covers costs incurred for home health care, assisted living, nursing homes and other “non-skilled” care.
- Individuals who require long term care are generally not sick in the traditional sense, but instead, are unable to perform the basic activities of daily living (ADLs); eating, bathing, dressing, ambulating, transferring, toileting and continence.
- LTC insurance is “the fastest growing type of health insurance sold in recent years.”

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Do Not Assume all LTC Policies Are The Same

- Older policies have more restrictive coverage
 - Nursing Home Only Policies
 - Home Health Care Policies
- Newer policies typically provide comprehensive coverage for both facility care and home health care.
- Regardless of the title of the policy, it should be closely examined to determine the type of benefits provided.

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Threshold Requirements for Benefit Eligibility

- Older contracts may be predicated on “medical necessity.”
- Current policies are triggered by an inability to perform 2 or more activities of daily living without “hands on” or “stand by” assistance. “Stand by” assistance is within an arm’s length.
- Insured may meet policy criteria if he or she is “cognitively impaired” to the extent that “substantial supervision” is required.

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Impairment in Two or More Activities of Daily Living

- Eating (feeding oneself)
- Bathing (washing and maneuvering into tub or shower)
- Continence (maintaining control and personal hygiene)
- Dressing (putting on and taking off clothing)
- Toileting (to and from toilet)
- Transferring (in and out of bed or wheelchair)

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Threshold Requirements for Benefit Eligibility (cont’d)

- The insured must be certified as requiring the recommended care.
- Care must be provided by an eligible facility or care provider.

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Home Health Care Policies

- Older policies (usually pre 1990) may have “gatekeeper” provisions, requiring a prior hospitalization confinement or nursing home stay (or both).
- Later policies (usually issued after 1990) may not require confinement in an institution prior to receipt of home health care benefits.

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Benefits that are Available Under Home Health Care Policies

- “Certified” for daily and hourly care up to the Daily Maximum Benefit.
- Benefits are also available for respite care.
- Once benefits are approved for inability to perform ADL’s; benefits are often available for “personal care.”

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The “Comprehensive” Long Term Care Policy

- Generally, under current law, a policy that does not provide both facility and home health care cannot be called a “comprehensive” or a “long term care” policy.
- A comprehensive or long term care policy provides for both home health care and facility care.

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Benefits that are Available Under Home Health Care Policies

- Older policies limit benefits to confinement in a “skilled” or “intermediate” care facility.
- Such policies may also require that the facility be under the direction or supervision of a physician or a nurse.
- The facility may be defined by the scope of its license. Or, the facility may only be required to be “licensed.”
- Newer policies may be required to provide for some care in Assisted Living Facilities.

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Conservation of the Benefits

- “Pool of Money” policies only provide a maximum amount of benefits for the lifetime of the policy. This type of policy may be “stretched” to provide greater benefits over a longer period of time.
- Time Period policies provide for a maximum amount of time in which the insured may receive benefits.
- Be careful of modifications to the policy. Due to premium increases, many insurers have negotiated for a reduction in benefits in exchange for keeping the premium level the same.

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The Claim Process

- No preauthorization.
- The insured's physician must certify a "plan of care" and an inability to perform two or more activities of daily living.
- An eligible provider must provide the services.

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What to Submit With a Claim

- Review the claim forms carefully.
- Attending Physician Certification of Necessity of Treatment and/or Plan of Care.
- Trap for the Unwary
 - Home Health Care Provider "Daily Care" Notes/Diary
 - Policies may not require in writing, but carriers often will not pay w/o adequate documentation by care-givers.

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Submitting a Claim

- What are the terms of the policy?
 - Nursing Home vs. Home Health Care
 - Elimination Period
- What evidence does the policy require, and what else should be included?
- How best to communicate with the insurance company?

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An Assessment by the Insurer

- An insurer may conduct an in person assessment of the insured to establish the need for care.
- A family member or knowledgeable caregiver should be present at the assessment to ensure that accurate information is obtained.
- Policies issued after 2000 mandate that benefits cannot be denied without giving the insured an in person assessment by an independent licensed health care provider.

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The Facility Certification

- The Facility must complete forms demonstrating that it qualifies as an eligible provider under the Policy.
- Typical eligibility requirements include licensing, a nurse or physician on staff and maintenance of daily care notes.
- The Facility will also provide an assessment of the insured to determine his or her needs.

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Do Not Assume that the Claim Representative is Familiar with the Claim

- Once the insured is deemed eligible and that the caregiver is an eligible provider, there is ongoing certification, every 6 months or annually.
- Ongoing claims may be adjusted by different representative who do not know the history of the claim.

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How to Communicate with the Insurance Company

- When communicating by phone, obtain identifying information of the carrier's representative.
- Document the conversation in writing.
- Send everything in writing, by certified mail, return receipt requested.
 - Keep copies of EVERYTHING sent and received
- Email and FAX are the next best options.
- Keep a journal.

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The Oxymoron of "Customer Service"

- Many companies do not let you speak to a claim representative.
- Customer Service is not familiar with your claim. They may not know about or understand the claim denial.
- "Escalate" the claim to be put in touch with a supervisor.
- Document everything in writing or advise your client's family to do the same.

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Why Do Claims Get Denied?

- Companies acting in good faith typically pay legitimate claims on a timely basis:
 - However, as shown many companies are prone to stonewalling claimants in hope claimant either go away, or die
 - Remember nature of long term care claimant
 - Elderly, infirm, cognitively impaired?
- Companies:
 - Interpret plan terms to advance their own interests
 - Deny receipt of necessary documents
 - Utilize biased doctors and nurses to justify denial of claims
 - Ignore, or fail to advise insureds about benefits to which they are entitled

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Claim Denied: “The Care is Being Provided by an Ineligible Caregiver.”

- The Care Giver Who is Providing Services in the Insured’s Home is Not Appropriately Licensed.
 - In California, a Home Health Aide does not have to be licensed.

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Claim Denied: “The Care is Being Provided in An Ineligible Facility.”

- An ineligible facility.
 - The facility does not have the correct license.
 - The facility does not have appropriate medical personnel on staff.

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Claim Denied: Older Policies Were Written Before the Popularity of Assisted Living Facilities

- The insured lives in an Assisted Living Facility and receives care giver services in his or her “home.” The insurer denies benefits on the basis that the insured is not receiving services in a “residence.”

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Claim Denied: Failure to Pay Premiums Due to Cognitive Impairment

- State law requires that the insured be given the option of designating a third party to receive lapse notices.
- The policy has lapsed due to failure to pay premiums. Premiums were not paid due to a cognitive impairment of the insured. Despite policy provisions that protect against such a lapse, the insurance company refuses to reinstate the policy.

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Claim Denied: An “Alternate Plan of Care” is Not Approved

- The policy has an “Alternative Plan of Care” provision that provides for flexibility of benefits. Despite this provision, a carrier may refuse to provide flexible benefits.
 - An “Alternate Plan of Care” must be agreed to by the carrier, the insured and the attending physician.Usually only used for accommodations.

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Claim Denied: Failure to Adequately Document the Type of Care Provided

- The insured does not require the caregiving assistance provided by the home health aide.
 - Often because the care provided is not adequately documented.

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Claim Denied: Failure to Meet the “Gatekeeper” Prerequisites

- The Insured was not “Hospitalized” prior to the receipt of care.
 - Prior hospitalization was often required in policies issued prior to 1990.
 - Newer policies may not include a prior hospitalization requirement.

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Claim Denied: Policy Maximum Benefits Have Been Exhausted

- The Insured has met his or her “per occurrence” maximum under the policy and is not entitled to further benefits for this condition.
 - A “second occurrence” may trigger a new benefit period.

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Claim Denied: Miscellaneous

- Catch-all reasons which have no basis in the policy for denial; such as the insurer will not pay benefits until the client first pays for the services; the “nursing notes are inadequate,” or there is no proper “plan of care” in place, etc.

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Claim Denied: Inappropriate Medical Supervision

- The insured is not receiving a weekly “RN Visit.”
 - Newer policies may not impose this requirement.
- The facility is not appropriately staffed with a physician or a RN.
 - Check policy to see if there is an hourly requirement.

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