Guardian Nurses Healthcare Advocates

DOL ERISA Advisory Council

Thursday, September 12, 2024

Who We Are

Guardian Nurses is a national, nurse-owned, nurse-led company with an award-winning care model.

- **Founded in 2003** in Philadelphia, PA; currently supporting clients **throughout the U.S.** both telephonically and in-person
- Our team is comprised of 54 full-time and 2 part-time employees. We have 50 RNs, each with a minimum of 10 years experience. (Overall, we have **more than 1,000 years of total nursing experience**!)
- Since 2003, we have been referred 6,194 insurance related cases, engaged 90%, and **'won' 93% of them**

What We See Systemically

- Unclear policy language
- Inconsistent application of medical necessity criteria
- Unnecessary (and sometimes intentional) delays in the appeals' process
- Decisions (either in the appeal or in the peer-to-peer review) made by clinicians who have little-to-no expertise in the medical condition related to the claim.
- Very little support of patients while they're going through the appeals' process

Our Support

1. **Reviewing Denial Letters and Policies:** We meticulously review the denial letters issued by insurance companies and cross-reference them with the patients' insurance policies. This process helps us understand the grounds for denial and identify any potential discrepancies or unjust denials.
2. **Gathering and Organizing Medical Evidence:** To support appeals, Guardian Nurses collect and organize medical records, doctors' notes, and other relevant documentation. This evidence is crucial in demonstrating the medical necessity of the denied treatment or service.
3. **Writing Appeal Letters:** Our team assists in drafting detailed and well-supported appeal letters to insurance companies. These letters address the reasons for denial, provide supporting evidence, and make a strong case for overturning the denial based on medical necessity, policy language, and regulatory requirements.
4. **Navigating the Appeals' Process:** We guide patients through the multi-step appeals' process, which often includes internal appeals and external reviews. Our goal is to ensure that patients are fully informed and supported at every stage.
5. **Providing Clinical and Emotional Support:** Beyond the technical aspects of an appeal, we offer clinical and emotional support to patients and their families. The stress and anxiety associated with healthcare denials can be overwhelming, and having a knowledgeable advocate can make a significant difference. Waiting for a decision can also have deleterious effects on the patients' clinical status, as well as (possibly) financial status.

Our Suggestions

1. **Enhance Transparency and Clarity in Insurance Policies:** Require insurers to write clearer and more accessible explanations of coverage and exclusions in policies to help patients understand their rights and benefits. Test the insurer's materials with 'average working people' and if they can't understand what's being written, require insurance companies to edit until they do.

2. **Standardize Medical Necessity Criteria:** Develop standardized criteria for determining medical necessity to ensure consistent decision-making across insurance companies. Require insurers to share the reasons for their decision based on the clinical indication, whether the test or procedure is appropriate and evidence-based. Studies have shown that up to 40-50% of health insurance denials are overturned on appeal. (This percentage can vary depending on the insurance company, the nature of the claim, and the persistence of the policyholder in pursuing the appeal.)

3. **Streamline the Appeals Process:** Simplify and expedite the appeals process to reduce delays and administrative burdens on patients and healthcare providers. Require that physicians who review the case have a clinical expertise in the case. Create a maximum time period that an appeal can go without a decision and establish stricter oversight and penalties for insurers who unnecessarily delay decision making.

4. **Create a Nurse-Led Department within the Department of Labor to support patient complaints.** This department would be staffed by experienced nurse case managers who understand the challenges for patients to receive necessary, appropriate care that is covered. Empowered by the Department of Labor, patients would be encouraged to utilize this department to investigate customer service problems when dealing with insurers and report unclear language in summary plan descriptions.

5. **Increase Accountability for Insurers:** Implement stricter oversight and financial penalties for insurance companies that routinely deny medically necessary care. Require insurance companies to post their stats regarding denials.

Lighting Patients' Way Through the Healthcare System

GuardianNurses.com