Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
November 2022

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Health insurance bad faith for prosthetic denials

THE BASIC THINGS TO LOOK FOR IN EVALUATING BAD-FAITH CLAIMS FOR IMPROPER DENIAL OF COVERAGE FOR PROSTHESES

When is an artificial limb *not* a medical necessity?

This might seem like a trick question at first. Common sense seems to suggest that it would always be a necessity for someone missing a limb to have an artificial limb in its place to meet their medical needs. Insurers, however, sometimes try to disclaim coverage for more costly types of prostheses on the basis that they are not medically necessary – despite the recommendations of the patient's physicians and certified prosthetists.

The improper denial of coverage for prosthetic devices is an important issue in the amputee community. Amputees are often in a particularly vulnerable condition when they receive denial letters from insurers. Some amputees may take the claim denial letters from the insurer at face value, not realizing that legal options even exist outside the carrier's internal appeal process. Other amputees may be confused whether it is worth re-submitting the claim, or if other, less expensive devices would be covered by their plan.

Amputees may also get discouraged by the delay in coverage, and the further delay caused by challenging the denial; they may thus end up settling for a device that does not meet their medical or functional needs. Delay in coverage is especially detrimental to the health and safety of first-time amputees, who need to

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make early and regular progress if they are to learn how to walk using an artificial limb.

In this article, we set out some of the basic things to look for in evaluating "bad faith" claims for improper denial of coverage for prostheses. We also provide a few examples of successful actions that we have brought against insurers, and times we have been able to get insurers to change restrictive policies governing prosthesis coverage. This is only an overview of an intricate and nuanced legal area, however; amputees should always seek out experienced legal advice that is tailored to their specific situation.

Potential claims

As noted below, the specific causes of action against an insurer who wrongfully denies prosthetic coverage will vary depending on the facts, and depending on such factors as whether the health plan is governed by state or federal law (ERISA), and whether the case involves a third-party administrator or not. By way of example only, though, if the health plan is governed by state law, causes of action might include claims for breach of contract, breach of the covenant of good faith and fair dealing, and unfair, unlawful, or fraudulent business practices, including unfair competition (which provides for recovery of attorney fees). (See, e.g., Bus. and Prof. Code, §§ 17200 and 17500.)

State-law claims for damages for bad faith permit recovery of damages beyond the amount of the disputed claim, and can include components for such things as the emotional distress experienced by an amputee due to the delay in receiving a prosthesis, as well as attorney fees. Depending on the egregiousness of the conduct of the insurer (and on factors such as whether the insurer is a "repeat player" in defending such claims), punitive damages may be sought. If the plan is governed by federal law (i.e., ERISA), claims may be made for such things as claim benefits, determination of rights, and breach of fiduciary duty (as well as possible attorney fees).

Insurer rationales for denying coverage

Some insurers try to avoid paying for prosthetic claims by restricting the scope of "medical necessity" by definition in health plans, or by referring to restrictive medical policies that are not contained in the plans themselves. Other insurers may try to rely on outdated medical policies and studies to claim that a prosthetic technology that is standard and well-established is still "experimental and investigational," and thus not covered.

Carriers may also seek to contain costs by drafting contractual provisions stating that prostheses will not be covered if they exceed the minimum specifications for the needs of the insured; these carriers will then deny claims outright on that basis, without providing any information about what less expensive devices or components the plan might cover. This practice leaves the amputee in the dark and delays vital treatment while he and his providers attempt to re-submit the claim using a configuration of less expensive components, to try to meet his medical needs.

Some insurers will claim that prosthetic technology such as the microprocessor knee is only required by amputees who are engaging in specialty pursuits, even though it is actually important for the health and safety of a wide variety of amputees. Insurers may argue, for example, that prostheses with microprocessors are not necessary unless the patient needs to ambulate quickly (while participating in sports, for example) or over difficult terrain. Microprocessor knees, however, are not just needed by elite athletes and the like; the technology may also be needed by amputees for day-to-day activities, to reduce falls through added stability – regardless of the speed of ambulation.

First steps in evaluating prosthetic bad-faith cases

In order to evaluate a potential "bad faith" case based on the denial of coverage for prosthetic limbs, counsel should first ask the client to send these materials:

(1) the complete insurance contract (this is usually called either the "Evidence of Coverage" (EOC) or the "Summary Plan Description" (SPD));

(2) the prosthetist's file for the patient (including the medical records related to the amputation and all the materials submitted to the insurer by the prosthetist in support of the claim for coverage for the prosthesis);

(3) all correspondence with the insurer regarding the claim (including claim denial letters, and decisions on any appeals that have been taken).

The potential client can get the insurance contract (i.e., the Evidence of Coverage of Summary Plan Description) either by contacting the insurer directly, or by requesting it from the Human Resources department at his workplace. Sometimes an insurer or employer will only send a two-page summary of coverage; counsel, however, must review the complete contract (usually a document of between 75 and 100 pages) in order to analyze the contract language that specifically covers prostheses (or "artificial limbs" or "durable medical equipment," etc.), and see whether the contract contains any exclusions for specific types of prostheses.

Counsel should then compare the client's claims for his need for the requested device against the definitions in the EOC or SPD for the terms used in the denial (e.g., "medical necessity"; "experimental and investigational") to see if there is a viable exclusion based on those definitions.

Usually, the provisions in the EOC or SPD covering prostheses or artificial limbs will be drafted in broad and general terms without specific exclusions. If the EOC or SPD lacks a specific exclusion that applies to the requested device, counsel should then review the claim denial letters (and any appeal denial letters) from the insurer to find the purported rationale for the denial.

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Rather than base a denial on the plan language, the insurer will often refer to its own specific medical policy in the claim denial letter in support of the denial. The next step is therefore to download a copy of the version of the numbered policy in effect at the time of the denial from the insurer's website, to see if it applies on its face. Even if the policy does seem to apply, it is important to remember that, if the specific medical policy referred to in the demand letter is not included within the "four corners" of the EOC or SPD itself (and it almost never is), then that policy is not binding on the insured, and can still be challenged as unreasonable. And it often is unreasonable or not based on prevailing medical standards.

ERISA cases

Counsel must also make a threshold determination whether the insurance contract (i.e., the EOC or SBD) is governed by the federal Employee Retirement Income Security Act of 1974 (ERISA). (See 29 U.S.C. § 1001 et seq.) ERISA generally applies to group life, health, or disability employee benefit plans (i.e., not "individual" plans), unless the employer is a governmental entity or church. (See *Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 44-47.) ERISA preempts all state insurance bad faith laws. (See 29 U.S.C. § 1144(a); *Pilot Life*, *supra*, 481 U.S. at p. 41.)

ERISA is less favorable to insureds than state law in several respects. In an ERISA case, for example, recovery of damages for emotional distress and "bad faith" (i.e., breach of the implied covenant of good faith and fair dealing) is unavailable – as is the recovery of punitive damages (although attorney fees may be available). (See 29 U.S.C. § 1144(a); *Pilot Life*, *supra*, 481 U.S. at p. 41.)

Thus, for an insurer, the only downside to defending ERISA claims may be paying the amount of the denied claim itself. (See *ibid*.) Discovery is very limited in ERISA cases, and there is no right to a jury trial. (See *Kearney v. Stan. Ins. Co*. (9th Cir. 1999) 175 F.3d 1084, 1090; *Thomas v. Oregon Fruit Prod. Co*. (9th Cir. 2000) 228 F.3d 991, 995-97.) The statute of limitations for a cause of action may be set by contracts governed by ERISA (as long as the period is reasonable), and the court may apply a deferential standard in reviewing the decision to deny the claim (if the benefit plan gives the administrator authority to determine eligibility for benefits, or to construe the terms of the plan). (See *Heimeshoff v. Hartford Life & Acc. Ins. Co.* (2013) 134 S. Ct. 604, 610; *Wetzel v. Lou Ehlers Cadillac Grp. Long Term Dis. Ins. Prog*. (9th Cir. 2000) 222 F.3d 643, 646-47; *Firestone Tire & Rubber Co. v. Bruch* (1989) 489 U.S. 101, 114.)

Despite these limitations, however, our firm (working with the firm of Gianelli & Morris) has still been able to bring several successful ERISA class actions against insurers on behalf of amputees who were wrongfully denied prosthetic coverage. In *Atzin, et al. v. Anthem, Inc., et al*., Case No.: 2:17-cv-6816 ODW (PLAx), for example, a class of amputees sued Anthem, Inc., and Anthem Utilization Management Services, Inc., in the United States District Court for the Central District of California, for Anthem's practice of improperly denying coverage for microprocessor-controlled lower limb prostheses.

In *Atzin*, we were able to get Anthem to change two of its restrictive prosthetic policies and get an injunction requiring Anthem to re-process the class members' claims it had denied, using the new coverage criteria. Anthem thus agreed to remove the "investigational" bar to coverage from its medical policy on microprocessor-controlled foot-ankle devices. Anthem also agreed to adopt new "medical necessity" coverage criteria for microprocessor-knee devices and foot-ankle devices, so that the criteria fell within current generally accepted standards of medical practice. Thus, for example, Anthem removed its restrictive criteria for 'walking speed' and 'continuous walking distance,' as well as restrictions on a patient's ability to establish need using evidence of activities in the home, office, or community.

In 2017, Doyle Law and Gianelli & Morris also brought a national class action on behalf of amputees against United HealthCare Services, Inc., and UnitedHealthCare Insurance Co., for benefits, determination of rights, and breach of fiduciary duty under ERISA. (See *Trujillo and Harden v. Unitedhealth Grp. Inc., et al*., Case No. SACV 17-2547-JFW (KKx) (C.D. Cal. 2019).) United had been wrongfully denying claims for prostheses based on a "minimum specifications" provision in its insurance contracts. That provision stated that the plans would only cover the "most basic" device that met the member's needs. In agreeing to settle the action, United agreed to make significant changes to its business processes to ensure that claims for prosthetic devices were not wrongfully delayed or denied. United also agreed to re-process past claims denials under the new standard.

Changing the policy

Even if a case is not brought on behalf of a class of amputees, litigation for "bad faith" denial of individual prosthetic claims can bring about important changes to the prosthetics policies used by insurers. Even if the case is brought on behalf of an individual plaintiff, counsel may be able to negotiate with the insurer to institute policy changes that will benefit all future amputees bringing similar claims.

For example, our firm recently sued Anthem for the wrongful denial of a claim for a partial-hand myoelectric prosthesis. Anthem based its denial on its medical policy ("Partial-Hand Myoelectric Prosthesis" (OR-PR.00004)). That policy essentially barred any coverage for the device, stating that partial-hand myoelectric prostheses were considered "investigational and not medically necessary under all circumstances."

While Anthem claimed there was insufficient peer-reviewed literature to support the use of the device, Anthem's policy was out of date. The policy ignored

the wealth of more recent studies from around the world establishing the utility of myoelectric digits. Anthem also ignored the fact that the partial-hand myoelectric technology had existed for decades; had been considered the standard of care in the industry for over a decade; was considered medically necessary for some indications by Medicare; and had been approved by the FDA. Anthem ultimately changed the outdated policy voluntarily when we demonstrated that it was obsolete.

Conclusion

Amputees may not be aware of their possible legal options when their insurer denies coverage for a prosthesis recommended by their physician and certified prosthetist. Counsel, however, may find that the denial of coverage was unreasonable, after examining, e.g., the plan language providing for prostheses; the purported rationale for the denial (and any referenced medical policy); peer-reviewed studies showing the benefits of the device; and prosthetics industry standards. If these cases are brought in state court, they may permit recovery for extra-contractual damages (including damages for breach of the duty of good faith and fair dealing), as well as possible recovery for unfair business practices (which also provides for attorney fees and costs), and punitive damages. Depending on the nature of the health care plan, one might also be able to bring an ERISA case in federal court (although the damages recovered per claimant would then not include damages for "bad faith").

Wherever good cases are brought, they can help amputees ensure that insurers are not denying claims for artificial limbs that have been determined to be medically necessary, based only on cost. These cases may also lead to changes in the prosthetic policies used by insurers, which will also help future amputee claimants meet their medical needs. Cost savings for insurers should not come at the expense of the stability, health, or safety of amputees.

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