Engaging with Insurers: Appealing a Denial

paf
Patient Advocate Foundation

When you need medical care, the last thing you want to worry about is whether your health insurance will pay for it. It can be frustrating for you, your family, and your medical providers when your health plan denies payment for care you need. This can cause a lot of stress and even financial problems. The good news is that, most of the time, you have the right to fight back and appeal.

There are many different health insurance companies and even more health plans in the United States. Each one has its own rules about how their appeal process works. This document gives a general overview of the appeal process for most commercial health plans.

What Does 'Health Insurance Denial' Mean?

Think of your health insurance as a business deal between you and the insurance company. Your insurance policy is like a contract. It spells out what your insurance will cover.

Sometimes, your insurance company might not pay for the care you want or need. This is called a "denial." A denial means your health insurance plan will either pay nothing or pay less than you expected for a medical service or item.

When you file an appeal, you're basically saying that you disagree with the insurance company's decision. You're asking them to look at their decision again. You can give them more information or medical records that might change their mind. You, a family member, a caregiver, someone helping you, or your doctor can file an appeal.

In instances where someone other than you submit an appeal on your behalf, you need to complete and file a form called an authorized representative form with your insurance company. By signing this document, you allow a family member, caregiver, advocate, or provider's office to manage the appeal process on your behalf.

Is it really a denial?

It's important to understand there may be times when your health plan does not pay anything toward the cost of your care. There are some situations where your insurance isn't denying coverage; it's just how your plan works.

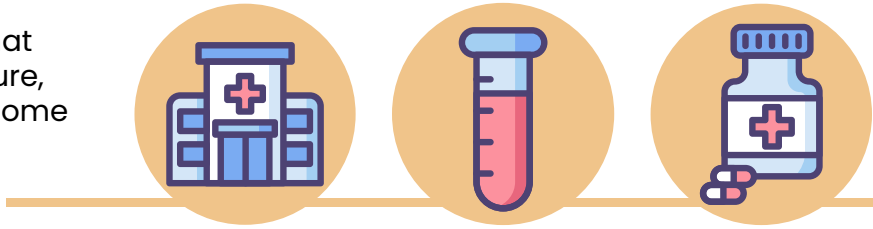
- **Deductibles:** For example, you might have to pay a certain amount of money (a "deductible") each year before your insurance starts paying. If you haven't met your deductible, it might look like your claim was denied, but it just means you owe that amount first.

- **Coinsurance:** Another example is "coinsurance." This is the amount you pay after you've met your deductible. For instance, if your coinsurance is 20%, the insurance company pays 80%, and you pay 20%. This isn't a denial, it's just how your plan splits the cost.

Sometimes, a denial is simply caused by a mistake that can be easily fixed. For instance, if there's a mistake on the bill, like a misspelled name, an incorrect birthday, or wrong ID number, the insurance company won't pay until it's corrected. If the information submitted by your provider's office doesn't match what your health plan has on file, your claim will be denied. If you find that the error was on the part of your provider, you can ask them to correct the problem and resubmit the request or claim.

Different Reasons for Denials

The reason for a denial depends on what kind of care was denied (like a procedure, a testing, or a medication.) Below are some common denial reasons.



Common Denial Reasons for Procedures or Testing:

- The procedure isn't covered by your plan, or it's **specifically excluded.**
- You went to a provider or hospital that's **not in your insurance network**, and your plan doesn't cover out-of-network care.
- The service is considered **experimental** or **investigational.**
- Your insurance company doesn't think the treatment is **medically necessary.**
- The service is **no longer appropriate** for your current health situation.
- The claim was **not filed on time**.
- There was **no prior authorization** for the treatment.

Common Denial Reasons for Medications:

- There's a **limit** on how much of the medication you can get each month.
- Your plan uses **step therapy**, meaning you have to try cheaper drugs first.
- Your plan **only covers generic drugs**.
- The **medication isn't on your plan's formulary** (list of covered drugs), and the plan won't pay for it without a special request.
- The medication **required pre-approval** that was not submitted.

What to Do if You Get a Denial

Now that you know what denials are, how to spot them, and why they happen, here's what to do next:

1. Find Out Why: The first thing to do is figure out exactly why your claim was denied. Check the Explanation of Benefits (EOB) or your denial letter. **(Learn more about Explanation of Benefits here!)** If you're not sure, call your health plan and ask them to explain it clearly. The phone number is usually on the back of your insurance card.

- **Take Notes:** When you talk to your insurance company or your doctor's office, write down the date, time, the person's name, what you talked about, and any important information. Be polite – the people you're talking to are just doing their job. Ask for a reference number for your call, so you can use it later if needed.

- **Be Organized:** Keep good records. If someone at the insurance company gives you wrong information, you can use that to support your appeal. If you're not getting clear answers, ask to speak to a supervisor.

- **Think Before You Appeal:** The insurance company might ask if you want to file an appeal right away. It's often better to wait, so you have time to gather your thoughts and talk to your provider. You'll want to collect any evidence that shows the services are covered by your plan.

What to Do if You Get a Denial (Continued)

2. Pay attention to deadlines: Make sure you understand the deadlines for filing an appeal. This information should be in the denial letter or Explanation of Benefits document. Appeal timelines vary by plan, so pay close attention! The deadline you will need to stick to is based on the date on the denial letter, not the date you received the service.

> **NOTE:** If your doctor says your treatment is urgent, you can file an "expedited" appeal. In this case, the insurance company must make a decision within 72 hours. This is for situations where waiting for the normal appeal process could seriously harm your health.

3. Work with your provider: Contact your provider's office. If you've already had the service that was denied, ask your provider's office to put your bill on hold while you appeal. Many providers' offices will help you with the appeal process, so check with them to see if they will file the appeal for you. It's best to coordinate with them first, so only one person manages the appeal.

- **Peer-to-Peer Review:** See if your provider is willing to talk directly to a Medical Director at the health plan. This is called a "peer-to-peer review." Your doctor can explain why the treatment is necessary, and sometimes, the denial can be overturned at this stage.

4. Gather evidence and use our template on page 8 to write your appeal letter. If your provider's office isn't filing the appeal on your behalf, you'll need to work with them to get the right paperwork. This includes:

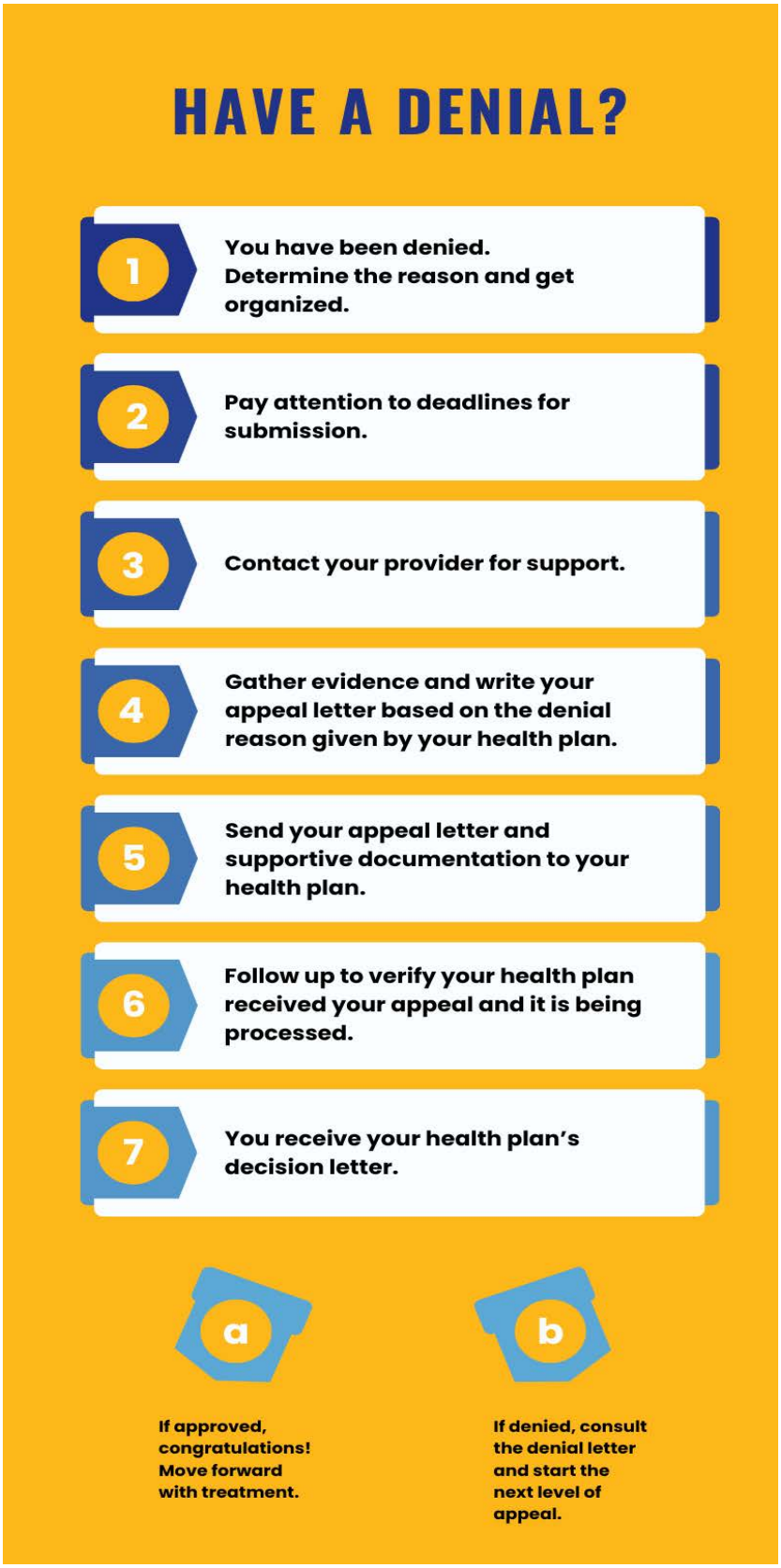
- Medical records, including recent test results and doctor's notes.
- A "Letter of Medical Necessity" from your provider. This letter explains in detail your relevant medical history, why the prescribed treatment is the best option for you, and why other treatments wouldn't work as well.
- Medical journal articles or research that support your treatment plan. Your provider may have suggestions for you to include, and you can also try searching online (like at **PubMed** or **Google Scholar**).

5. Send your appeal package to your health plan. Make sure to use their preferred method of submission. Your health plan may request your appeal sent via mail, fax, or uploaded to their member portal.

6. Follow up: You should get a notice from your health plan within 10-14 days that they've received your appeal package. If you don't hear from them, call them at the member services number listed on your insurance card to make sure they got it and find out when you can expect a decision. Make sure you take note of who you spoke with, as well as the date, time, and details of the call. It's also a good idea to mark your calendar so you can follow up with the health plan if you don't hear anything by their provided decision date.

7. Decision time: While there is no standard timeframe for an appeal decision, it should be outlined in your insurance policy document. Generally, for appeals taking place before you receive care, you should hear back within 30 days. For appeals taking place after you've received care, you will generally get a decision within 60 days. If it's going to take them longer to process your appeal, your health plan should send you a letter explaining the delay.

8. The Decision: You'll get a letter with the your health plan's decision. If they approve your appeal, great! If they deny it again, the letter you receive will explain any potential next steps as well as provide a timeline.



Two Ways to Appeal

The appeals process gives you two options for appealing a denial:

Internal Appeal

An internal appeal is an effort to get your health plan to change its mind and approve your request. This may require you to provide additional information. If care has not yet been provided, this process typically has multiple steps. Most plans offer at least two levels of internal appeal, during which your request is reviewed by different physicians within the insurance company. One option to consider is a peer-to-peer review, where your medical provider can speak directly to a medical director from the insurance company.

If the denied care has not yet been provided, the internal appeal process usually involves multiple steps or levels of review. This means your appeal won't just be looked at once. Instead, it will likely be reviewed by different individuals or departments within the insurance company. This multi-tiered approach is intended to ensure a thorough reconsideration of the initial decision. Often, these additional reviews are conducted by physicians who were not involved in the original denial.

If your appeal concerns care that has already been provided and you are seeking reimbursement, the process is often different. In these cases, a peer-to-peer review is typically not an option. Generally, you have the right to pursue one level of internal appeal to try and get the insurance company to reconsider their decision to deny payment.

External Appeal

If your internal appeal doesn't result in the approval you need, you generally have the right to request an external appeal. This request usually must be made within 4 months of the final internal appeal denial.

As a rule, you can only file for an external review after you've gone through all the steps of the internal appeal process. However, if your situation is medically urgent, you might be able to request an external review sooner, even if you haven't completed all the internal appeals. In either case involving urgency, the appeal must meet the insurance company's specific requirements for urgent appeals, and if it does, a decision will be made within 72 hours.

An external appeal is conducted by an independent group of doctors, known as a third party or an Independent Review Organization (IRO), which has no connection to your health plan. This group will review all the documents you've already submitted, the denial letters, and any extra information that supports your case. They will then make an unbiased decision. The external reviewer can either agree with the health plan's decision or rule in your favor and approve the requested care. Your health insurance company is legally bound to accept the IRO's decision. Typically, an external review takes no longer than 60 days.

You can find the contact information for the IRO that will handle your external review on your Explanation of Benefits (EOB) or the final internal denial letter. To start the external appeal, you'll need to submit a written request, and most states provide a specific form for this.

Tips for Assembling Your Appeal Packet

It's crucial to be organized. Keep copies of everything you send to your health plan. The denial letter or EOB should tell you where and how to send your appeal. If you're mailing it, send it certified or with tracking, so you know it was received. Always follow up to confirm they got it.

Putting Together Your Appeal Packet

- [ ] A copy of the denial letter or EOB
- [ ] A copy of any appeal forms from your health plan
- [ ] Your appeal letter
- [ ] A brief history of your medical condition
- [ ] A list of previous treatments and whether they worked
- [ ] Any additional medical information from your provider, like a Letter of Medical Necessity, medical records, and relevant medical journal articles
- [ ] A clear statement asking the health plan to reconsider their decision
- [ ] A copy of a second opinion or specialist report, if you have one

Where to Get Help

Your state's Department of Insurance or a Consumer Assistance Program (CAP) may be able to help you with the appeals process. If your insurance is through your job, your human resources department may also be a good resource. You can also contact your state legislators for assistance.

Important Notes for Specific Types of Insurance

If you have traditional Medicare: The process for appealing is very similar to that of the commercial plans, although the wording is different. The appeals process is different for each part of Medicare, Part A (hospital insurance), B (medical/outpatient insurance), C (Medicare Advantage Plan), or D (Prescription drug plan). If you need it, you can get free assistance from your State Health Insurance Assistance Program (SHIP), which offers free services to help people who have Medicare questions or concerns.

If you have Medicaid: State Medicaid programs are required to have a process for their members to appeal. Appeal rights are established federally, however, each state makes individual rules for processing the appeals. As well, states are required to offer a fair hearing to its members. For more information about how your state handles appeals, visit your state's Medicaid website or your local Department of Human Services.

Don’t Give Up!

If your appeal is denied, don't lose hope. The denial letter will tell you about the next steps. Deadlines for the next level of appeal might be different, so keep careful track of them.

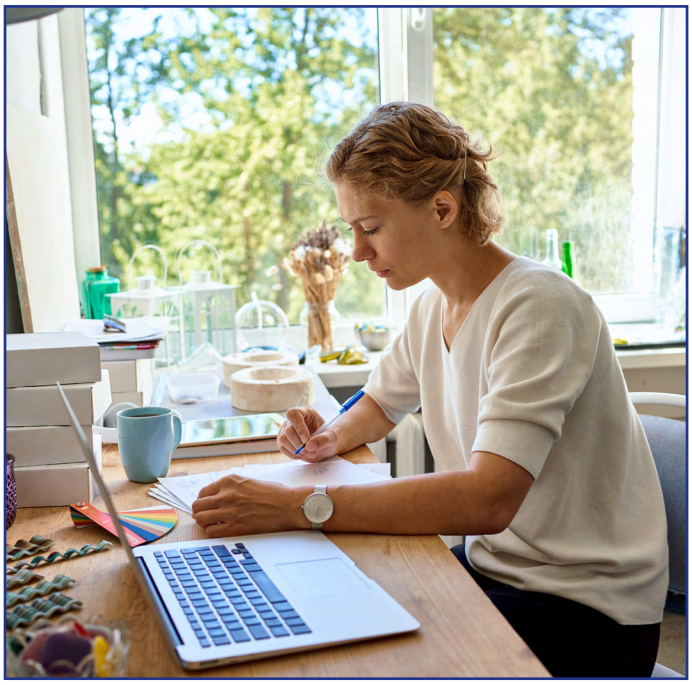
- **Regroup:** Think about what might have been missing from your first appeal. Have you had any new symptoms or changes in your condition? Have you tried any new treatments? If so, include this information in your next appeal.

- **Stay Positive:** It can be a frustrating process but try not to get discouraged. Remember that you're fighting for the healthcare you deserve.

If you have exhausted the formal appeal process, there may be other steps you can explore.

If your health plan is sponsored by an employer, they may “self-fund” their health insurance benefits for employees. This means the employer can influence the final decisions made on the payment of medical claims and other health care decisions related to your benefits. Although the employer has hired a health insurance company to administer these benefits, your employer retains the right to make or overturn decisions about the benefits provided by the insurance company. If you feel comfortable sharing your health information with your employer, you may consider making a **compassionate appeal** directly to the top executives within your company for them to make the final decision.

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal regulation that applies to participants in most employee insurance plans. This law does not apply to government-sponsored plans or those sponsored by churches. Among other things, the law outlines your protections when a claim is denied and describes your rights to seek legal action if you don’t agree with the plan’s decision.



Date

Attn: Appeals Department
Insurance company name
Address
City, State Zip

Re: Appeal for [Patient Name]
Member ID#: [Patient ID number]
Date of Birth: [Patient date of birth]
Group/Policy Number:

HELPFUL TIPS

Make copies of everything you send with your appeal for your records. If you are sending your appeal by mail, ensure you send it with tracking. If faxing, be certain to verify successful transmission of the fax.

Dear [Insurance contact name]:

Please accept this letter as [patient name] appeal for reconsideration of coverage of [state the name of specific procedure or drug name]. It is my understanding that this [procedure/treatment/medication] has been denied [insert date] because [enter the specific reason for the denial as stated in the denial letter].

As you know, I have been under treatment for [disease name] since [date of onset]. [Provider name] believes that I will benefit from [procedure/treatment/medication]. Please see the enclosed letter for a detailed medical history.

Specifically I have [tried and failed] the following therapies:

- [List therapy, length of therapy, and outcome (ie., specify reason(s) for unsuccessful results)]

[Drug Name or procedure] is medically appropriate for me for the following reasons:

- [Insert treatment rationale as to why (drug name or procedure) is medically appropriate]

To support this appeal, I have included the following documentation for your review:

- [Patient's progress notes outlining diagnosis of disease]
- [Documentation of treatment history, past therapies prescribed, and outcomes]
- [Rationale as to why the patient is appropriate for procedure or drug]
- [Denial letter from prior authorization request or claim]
- [Journal articles supporting the treatment]

I am asking you to reconsider your previous decision and allow coverage for the [procedure, treatment, medication] as outlined in this letter. Should you require additional information, please do not hesitate to contact me at [phone number]. I look forward to hearing from you soon.

Sincerely,
Your Name

Enclosures:
1. Denial Letter From Plan
2. Doctor's Letter of Medical Necessity
3. Medical Records
4. Supportive Journal Articles

CC: [Name of Treating Provider]

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Funding for this publication provided in part by the Patient Action Council