

PAF Articles



DENIALS & APPEALS

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Where to Start if Insurance Has Denied Your Service and Will Not Pay

If your insurance plan refuses to approve or pay a medical claim, including tests, procedures or specific care ordered by your doctor, you have guaranteed rights to appeal. These rights were expanded as a result of the Affordable Care Act.

Review your denial letter carefully as it outlines your next steps for appealing their decision.

Your insurer must provide to you in writing:

- Information on your right to file an appeal
- The specific reason your claim or coverage request was denied
- Detailed instructions on submission requirements
- Key deadlines to submit your appeal
- The availability of a Consumer Assistance program, if available in your state

Reasons that your insurance may not approve a request or deny payment:

- Services are deemed not medically necessary
- Services are no longer appropriate in a specific health care setting or level of care
- The effectiveness of the medical treatment has not been proven
- You are not eligible for the benefit requested under your health plan
- Services are considered experimental or investigational for your condition
- The claim was not filed in a timely manner

Think of an appeal as a contract dispute over the interpretation of the plan coverage details. Your health plan language defines your contract.

It is important to remember, that prior authorization does not guarantee payment of the claim.

There are multiple levels of appeal. Even if the first appeal is denied, you have additional levels of appeals that will be outlined in your denial documents.

If you have overdue medical bills on services that have already been completed, work with your providers so the bill is not sent to collections while the appeals process takes place.

FAST FACT: Your health plan cannot drop your coverage or raise your rates because you ask them to reconsider a denial related to care.

Things to Include in Your Appeal Letter

Appealing to your insurance company can certainly seem intimidating. It doesn't have to be if you stay organized! One of the most important elements of your appeal packet, is a clear, concise letter detailing your counterargument addressing the original reason for denial and citing the terms of your policy. The letter can be addressed from you, an advocate, or a medical provider written on your behalf.

Elements of the letter:

- Patient name, policy number, and policy holder name
- Accurate contact information for patient and policy holder
- Date of denial letter, specifics on what was denied, and cited reason for denial
- Doctor or medical provider's name and contact information

Be sure to include your detailed case as to why the plan should cover the claim:

- State why you need the prescribed medical service and why you believe your insurance policy covers the treatment or service. Cite plan language where possible.
- Ask your medical provider to prepare a letter of medical necessity explaining your prior treatments as well as the reason the treatment is being ordered and necessary for your situation.
- Provide and reference published journal articles or treatment guidelines from an industry recognized group or institution that demonstrates outcome benefits and treatment success.
- Anything else that supports your request, including copies of pre-authorization if submitted, second opinions, etc.

Sending Your Submission:

- Track submission. If submitted by fax, keep the confirmation of successful transmission. If submitting by mail, send it by certified mail with a request of a return receipt.
- Keep a copy of the letter, all submitted materials, the delivery or submission receipt, and your record of all correspondence during your appeal in a safe and organized place.
- You should receive an official notice within 7-10 days that your appeal has been received. If you do not receive confirmation, contact your insurance company to make sure your appeal has been received and shows in their system.