



Engaging with Insurers: Appealing a Denial

When you need medical care, the last thing you want to worry about is whether your health insurance will cover the services you've been prescribed. Receiving a denial from your insurance company related to care you need for your diagnosis or medical condition can be incredibly frustrating for patients, caregivers, and providers, and can lead to emotional or financial distress. It is important to remember that in most cases when you receive a denial, you have the right to appeal.

There are thousands of insurance companies and even more health plans in the United States. Each company and plan is different, and legally each company is allowed to make its own rules regarding what the appeals process is like for their plan. Within this document, we have outlined the process very generally to address most health qualified commercial plans on the market.

What does it mean to receive a health insurance denial?

Try thinking of your health insurance more like a business deal where you and your insurance company enter into a contract. Your policy language or "contract" lists the benefits you can receive, details are outlined in the insurance documents.

There are different reasons your insurance company may not pay for or denies the care you want to receive, these reasons are based on how the policy language is interpreted. A denial for care usually means that the health insurance plan is not going to pay anything or pays less than you expected towards the cost of an item or service.

When you file an appeal, you are making a contract dispute and asking your insurance company to reconsider their decision to deny payment. This allows you to provide additional information or medical records to fill in any gaps that may have existed when the original request was submitted. Appeals can be submitted by a patient, family member, caregiver, advocate, or by your healthcare provider.

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 that there may be situations where your insurance is not going to pay anything towards the cost of your care. If you already received the care, your explanation of benefits (EOB) is an important source of information about coverage. For example, if you have not met your annual deductible, the amount you are required to pay before the insurance company begins paying their portion, what appears to be a denial may simply be your cost-sharing responsibility.

There are other times where the **coinsurance**, the amount you pay after meeting your annual deductible, requires you to pay more out-of-pocket costs for a specific treatment or service. For example, an 80/20 coinsurance rate means the insurance company pays 80 percent and you pay the remaining 20 percent of the health plan's allowed amount. This is **NOT** a denial and therefore cannot be appealed. This is simply part of the design of your specific plan.

Sometimes a denial of payment could be related to something simple that can be fixed by correcting an error on the bill and resubmitting the claim. For example, if you receive a bill from your provider but there is no insurance payment noted, there is a chance this could be an easy fix. The provider's office may not have sent a claim to your insurer yet or the claim may not have been processed by your plan, so it appears you are responsible for 100% of the cost. Claims cannot be paid until errors are corrected.

Different Reasons for Denials

The “**why**” of the denial depends on **what** was denied. Lots of times, the reason for the denial depends on whether you are denied for a procedure, testing, or a medication.



Common denial reasons for procedures or testing:

- A procedure could be denied because it is **not a covered benefit** or a listed **exclusion**
- Your provider was **out-of-network** for your insurance plan and you do not have out-of-network benefits
- The services were considered **experimental or investigational** for your condition
- The treatment you were prescribed is **not considered medically necessary** by your health insurance plan
- Services are **no longer appropriate** in a specific health care setting or level of care
- The claim was **not filed timely**
- The treatment required **pre-approval that was not submitted**

Common denial reasons for medications:

- There is a **quantity limit** on the number of pills you can receive each month
- This could be related to an issue called **step therapy** where your health plan says you need to try cheaper medications before you can try the more expensive one your provider prescribed
- The drug plan only covers **generic medications**
- The medication is not listed on the health insurance plan drug list or is **off-formulary** and the health plan will not pay for the medication without requesting an exception
- The medication required **pre-approval that was not submitted**

The Formal Appeals Process

Now that we know what denials are and how to recognize them, along with why you might have one, the next step is to move into the formal appeals process. Before you begin an appeal, you need to know the reason why your claim was denied.

Investigate what happened. After you do some digging if you still aren't sure or don't understand why the claim was denied, call your health plan and ask for an explanation. You can typically reach your insurance company's customer service department by calling the number listed on the back of your identification card. Sometimes a denial is triggered by something as simple as a data-entry error like a misspelled name, incorrect insurance ID number, or your date of birth being keyed in wrong. If the information submitted by your provider's office doesn't match what your insurance company 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. If a denial involves incorrect billing codes or missing documentation, the health insurance plan will require resubmission of the claim. This may be handled in a simpler and faster manner by your provider's office and the claim will most likely be paid upon reprocessing.

Take notes. It is important that when you make phone calls to your insurance company or your provider's office to discuss the denial, that you write down the date, time, name of the person you spoke with, along with a summary of the call and any relevant information they gave. Be respectful when talking to the insurance company or your provider office. They are not your enemy but are required to follow their company rules. Insurance companies can give you a reference number for your call so you can refer to it in the future if necessary.

Calling the insurance company may not always be a positive experience, if you find that you are not getting your questions answered, ask to speak with a supervisor to see if they can better assist you.

When you are on the phone with your insurance company, the representative may ask you if you would like to file your first level appeal at that time. This is not always in your best interest, as it does not give you time to prepare your thoughts or speak with your provider about the denial. You may get better results if you wait and take the opportunity to do further research and prepare your appeal. You will want to provide any evidence you have that the services you are seeking access to or already received are covered by your health plan. Include relevant information from your medical history, this may help get your request approved or paid by your health plan.

After you have figured out the reason for denial, be sure you understand the process and timelines for appealing. This information should be on the denial letter or explanation of benefits document. It is important to remember that appeal timelines are plan specific.

Note: It's important that when you are figuring the time you have to submit an appeal, you need to use the date on the denial letter or EOB, and NOT the date of service or the date you received the letter.

Depending on the plan you have, there may be instances where appeals need to be submitted within 10 days, or you may have up to 180 days to submit your appeal.

Next, join forces with your provider. If you have already had the service that is being denied, you want to ask the provider's office to place your account on hold while you go through the appeals process, this will help make sure you don't end up paying charges that you may not owe. Many medical provider offices will complete the appeals process on behalf of the patient. So, you will want to double-check with your provider to see if they plan to file the appeal for you. It's best to coordinate so that one person, whether it be you or someone at the provider's office, will manage the appeal process.

The first thing you will need to determine is whether your medical provider is willing to participate in a **peer-to-peer conversation**. This option involves a discussion between your provider and a medical director that works at the insurance company. Typically, your provider shares your treatment history, details about your illness, and explains why they feel the prescribed treatment is the best course for your condition. Since your provider is having this conversation with a medical director, the denial can be overturned at this stage. That way, you will not have to continue with the formal appeals process and the care in question can be paid or you will be able to receive the care you were prescribed.



Has a peer to peer review been scheduled or completed? If so, what was the result?

- Peer-to-Peer review involves a discussion between the prescribing provider and a medical director at the insurance company
- Your provider shares medical and treatment history, details about diagnosis or condition, and explains why they feel the prescribed treatment is the best course for the patient
- Medical directors can use their own judgment and overturn the denial at this stage so the patient can proceed with treatment
- Coordinate with the provider office and/or insurance company to schedule a time for the call, and then follow up with the provider office to learn the result of the call

Is it necessary for you to proceed with a formal appeal?

If your provider's office is not filing the appeal on your behalf, you still need to work with the staff to gather evidence supporting the fact that the care you are seeking or received should be covered. You want to get medical records that include recent test results and doctor's notes from your office visits. Also, you should request a **Letter of Medical Necessity**. This letter allows your provider to put in his or her own words why the prescribed care is the best course of treatment for you and why other medications, treatments, etc. would not be as effective for you as the one that was denied. This letter should include your specific diagnosis and medical history, and treatments you have tried both medically and holistically.

You should also talk with your provider to see if they have suggestions for medical journals or articles that support the treatment plan. Often there has been research done by medical professionals that shows the effectiveness of the treatment for your specific condition or illness. You can also try to research on your own articles at <https://pubmed.ncbi.nlm.nih.gov/> or by searching the internet on sites such as Google Scholar.

If the treatment or medication you were prescribed is considered urgent by your medical provider, your insurance company has a process in place for handling **expedited appeals**. You have the option to file for an urgent or expedited appeal if your doctor agrees that the timeline for the standard appeal process would jeopardize your life or potentially cause you serious pain or harm. Insurance companies have 72 hours to review and make a decision on urgent appeals.

There is not a standard time frame for when you will receive a decision, but this information should be listed in your insurance policy documents. Generally, pre-service (before the care is received) appeals initial decisions should be completed within 30 days, however, the initial decision for post-service (after the care was received) appeals should not take longer than 60 days. If your insurance company is going to take longer than this to make a decision, you should receive a letter explaining any delay.

You should receive a notice from your insurance company that your appeal has been received within 10-14 days after submission. If you don't hear anything from your insurance company, call them to ensure your appeal was received and is being processed. You can ask them for a status update and when a decision is expected to be made. Be sure you document who you talk to, include the date and time and details, and mark your calendar so you can follow-up with the insurance company if you do not hear anything at the end of the time frame.

After a decision is made by your insurance company, you will receive a letter telling you the decision and the medical reason or section of your health plan that was used to come to that decision. If the decision is to overturn the denial, congratulations! If the denial was upheld, the denial letter will provide details on the next steps you can pursue along with any timeline you must meet.

Two Types of Health Insurance Appeals

The appeal process gives you two options for appealing a denial: an internal appeal and an external appeal. An **internal appeal** is an effort to get the insurance plan to change their mind and approve your request, this may require that you provide additional information. This process has multiple steps if care has not yet been provided. Most plans will offer at least two levels of internal appeal. 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 to a medical director from the insurance company, during their discussion your provider can share your treatment history, details about your diagnosis, and explain why they feel the prescribed treatment is the best course for you. By providing additional information you may be able to get the medical director to use their clinical judgment and approve the care you are requesting.

If your appeal is for care that was already provided, you will not have the option for a peer-to-peer review, and generally have the right to seek one internal appeal and one external appeal.

If you were not able to get a favorable decision after completing the internal appeal process you may have the right to request an **external appeal** usually within 4 months from the final internal appeal denial. You typically can only file for an external review once you have exhausted the internal appeals process. However, in medically urgent situations, you can request an external review even if you haven't completed all the available internal appeals. In both situations, the appeal must meet the insurance company's criteria for an urgent appeal and if so, a decision will be made within 72 hours.

Your Explanation of Benefits or the final internal denial letter will give you the contact information for the Independent Review Organization that will handle your external review. To proceed, you will need to file a written request, most states have a form to complete. External appeals are generally reserved for situations where you or your provider disagree with the insurance company based on medical judgment or if the insurance company claims the treatment prescribed is experimental or investigational and you or your provider are arguing it is not.

An **external appeal** is when an outside physician group referred to as a third-party or an Independent Review Organization (IRO), not connected with the insurance company, reviews all of the documents previously submitted, denial letters, and any additional information that supports your request, and makes an impartial decision. The external reviewer can uphold the insurance company's decision or may find in your favor and approve the care. Your health insurance company is required to accept the decision made by the IRO. The average external review does not take longer than 60 days.

You may have access to a Consumer Assistance Program through your state Department of Insurance that can answer questions and walk you through the appeals process. If your insurance comes through an employer plan contact your human resources department for advice on how to proceed. You may also be able to undergo a state or federal external review process depending on your situation.

Many states help with managing medical insurance denials through their state Department of Insurance or Consumer Assistance Program (CAP). In addition, you have the option to reach out to your state legislators and request help.

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 assistance from your State Health Insurance Assistance Program (SHIP), which offers free services to help people who have Medicare questions or concerns. For information on Medicare appeals refer to chapter 7 of PAF’s publication, *A Clear View to Medicare* for more details.

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.

What if you are denied:

Don’t give up. The denial letter from your appeal will provide you with details about your next steps. Time frames for secondary appeals are not always the same as the initial appeal so be sure that you are keeping track of the date when you must submit the documents.

Regroup. Were there missing pieces in your first appeal? Have you experienced any new symptoms or changes in your condition since your initial appeal submission? Or have you tried and failed any new therapies to treat your condition? If so, be sure to include this information in the next level of appeal as these facts can become good support for your request.

Try not to get discouraged. It is easy for this process to get you down and it can feel like one hurdle after the next but try your best not to get frustrated. Just remember that moving through the appeals process is part of advocating for yourself so you can receive 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 the benefits, your employer has the right to make or overturn decisions about 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 employee insurance plans. This law does not apply to government-sponsored plans or churches. Among other things, the law outlines your protections when a claim is denied and provides a description of your rights to seek legal action if you don’t agree with the plan’s decision.



Putting It All Together - Your Appeal Packet

Keep copies of all information that applies to your claim and denial that you send to the insurance company in one place. This may include:

- A copy of the denial letter or Explanation of Benefits
- A copy of any appeal form you were required to send to your insurance company
- Your appeal letter – be factual, not emotional when writing the letter. Be sure it is based on the actual insurance company denial reason
- Give a brief history of your medical condition and your understanding of why your medical provider is ordering this treatment
- Prepare a list of previous therapies and outcomes (i.e. did it help, if not, include why not). Any additional medical information from your provider such as a Letter of Medical Necessity, relevant medical records, and a copy of any medical journal articles supporting the treatment
- Be specific in your ask to the insurance company asking them to reconsider their decision to deny your request
- A copy of a second opinion or specialist report that supports the treatment being recommended if available

The denial letter or EOB should give you the address and/or fax number of where your appeal should be sent. Some insurance companies want you to upload your appeal to the insurance company's member portal. It's a good idea if you are sending your appeal package by mail to send it certified or with tracking, so you know it was received. Always follow up to confirm receipt.

Your letter is an important piece of your appeal, this allows you to educate the insurance company on your situation. We provided suggestions on different documents you may want to include in your appeal packet. Now we want to give you tips on what to include in your letter based on the reason the insurance company provided for denying your request or claim.

DENIAL FOR NOT MEDICALLY NECESSARY

- Review the definition of medical necessity in your member handbook and show that the drug or treatment being requested meets the health plan's definition
- Request a letter of medical necessity from your treating provider (if you have a second opinion or specialist report that supports the treatment include that as well) stating why the drug or procedure is being recommended
- Prepare a detailed history that highlights previous treatments or therapy attempted as well as the results, did it work or not
- Search online in professional societies or disease associations for information about when the specific type of treatment being recommended is the best practice for your condition. Ideally, ask your prescribing provider's office to provide some guidance
- If this is for medication, verify that the drug is included on the insurance plan drug formulary. Depending on the denial reason, check to see if the drug is approved by the Food and Drug Administration (FDA) for your condition

DENIAL FOR EXPERIMENTAL OR INVESTIGATIONAL TREATMENT

- Provide proof that the drug or treatment being requested is considered standard of care for your diagnosis or situation. When possible include the package insert from the medication or FDA approval letter with your appeal
- Obtain a letter from your treating provider that explains why a drug or treatment is being ordered as well as describing other treatments you have tried, and results of that treatment
- Search online professional societies or disease associations for information supporting the treatment being recommended is an accepted treatment for your condition. Ideally, ask the prescribing provider's office to provide the articles for you

DENIAL FOR OUT-OF-NETWORK PROVIDER OR FACILITY

- If the denied charges occurred while you were receiving care from network providers (e.g. radiology, laboratory, or anesthesia charges) before writing a letter, contact the insurance company by phone and explain the situation and ask them to reconsider paying the charges at an in-network rate
- If care is a result of an emergency, provide documentation that will allow the insurance company to reconsider paying the charges at an in-network rate
- If this was a scheduled procedure you need to prove that no one currently listed in the insurance provider network has the training or experience necessary to treat your condition. You may be able to demonstrate that:
 - There are no network providers board-certified in the necessary specialty, or that they do not have the expertise to treat your specific condition
 - Establish that there was no similar service available within the approved network



DENIAL FOR LACK OF PRIOR AUTHORIZATION

- Contact the provider office to inquire if a prior authorization was submitted along with details they can provide – e.g. if one was submitted what was the decision? Was the insurance company contacted and the provider was told that prior authorization was not required? If so, you'll want to get the date, time and name of the insurance company representative that provided the information
- Contact the insurance company and request that the denial be reconsidered for medical necessity. It is important to know some insurance companies will not issue what they call a retroactive authorization (after the services have been provided)
- Give the reason why prior authorization was not obtained, provide supporting documents that show the services were medically necessary. Your objective is to show with any documentation that if prior authorization had been requested, you would have been approved

As a consumer, contact your insurance company any time you are being scheduled for a procedure, it is your responsibility to notify your insurance company and verify if this is a covered service and if prior authorization is required. Keep good records of all communication.

DENIAL FOR SERVICES OR PROCEDURES NOT COVERED BY YOUR POLICY OR EXCEED POLICY LIMITATIONS

- Refer to your policy booklet or the online policy under covered services or non-covered benefits (how it is referenced changes from policy to policy) to verify if the service, procedure, or treatment being requested is specifically listed as an exclusion under the policy. You will want to quote from the handbook and provide evidence of coverage in your letter, including the page and section
- Check the fine print at the bottom of the page that lists exceptions to see if they may apply in your specific circumstance. For example, if there is a limit on physical therapy visits listed in the handbook, there may be an option to request additional visits if you can show improvement and ongoing medical necessity
- Check with your state insurance department (if an individual or marketplace plan) to see if there are state-specific consumer protections that may apply

Have a denial?



You have been denied. Determine the reason



Pay attention to timelines for submission



Contact doctor for support. Write an appeal letter



Send appeal letter and supportive documentation



Verify insurance company received appeal and it is being processed



Insurance company's decision letter is received



1. If approved—congrats!
Move forward with treatment

2. If denied, consult denial letter
to start next level of appeal

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:

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, [patient name] has been under treatment for [disease name] since [date of onset]. Dr. [name] believes that [patient name] will benefit from [procedure/treatment/medication], see the enclosed letter for [patient name] a detailed medical history.

Specifically [patient name] has [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 my patient 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]
- [If applicable, Journal articles supporting the treatment]

Thank you for your prompt response to this request. 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 [patient name] at [phone number]. I look forward to hearing from you soon.

Sincerely,

Your Name



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