Addendum A: How to Appeal a Denied Claim

Step 1: Get organized

- Create a communication log
- Use it to keep track all communication - dates and types of correspondence (letters, phone calls, emails, faxes), names of people you speak with, summaries of your conversations, dates of packages sent and received
- Keep a paper and electronic file of original documents (e.g. letters, forms, medical records, insurance documents, medical journal articles).
- Assign a representative(s) to help you with the process. You may need to do a lot of follow-up and it will help to have one or two advocates to help you.

Step 2: Request claim denial details

- Contact the insurer and request additional details if the reason for the denial is unclear.
- Send a letter identifying the representatives who can communicate with the insurer on your behalf.
- Be persistent – the response you receive after your first call may still be unclear or incomplete. You may need to make a second or third call. Calling a few minutes later or the next day may get you a different person who can provide better information.
- Escalate when needed - If you still find that after a couple of phone calls, the people who you talk to are not helpful or knowledgeable ask to speak to their supervisor.
- Always remember you can contact your state department of insurance to report problems you are having with getting information.

Step 3: Get claim related information from provider

- Contact the provider of the denied service (doctor's office, hospital, lab)
- Request your records for the date of service.
- Confirm the date that the claim was submitted by the provider. If the denial was due to an error by the provider, ask them both verbally and in writing to resubmit the claim with the correct and complete information.
- Follow up at least three days letter after to get confirmation that the claim was re-submitted

Step 4: Request an internal appeal

- Submit your appeal to your insurer in writing.
- Include your name, claim number and health insurance ID number.
- Send the letter and supporting documents by certified mail and ask for a return receipt.
- If you send documents by email, this may speed up the process. But you should still send a copy by certified mail as proof of receipt.
- Keep copies of everything you submit, as well as the delivery receipt from the post office. **Never mail originals of important documents.**

Sample List of Documents for an Appeal

- A letter requesting the appeal with a description of the need for the requested service.. It's important that the top of the letter clearly states it is an appeal.

- A letter from your health care provider stating the medical reasons that the service, procedure or medication should be approved.
- Related medical records or treatment plan from your physician.
- Results of tests or procedures related to the requested service or procedure.
- Peer-reviewed articles or studies that show the medical effectiveness of the treatment or product.
- Documents that show the technical error, e.g., late claim submission by provider, incorrect diagnosis code.

Timing

An internal appeal must be submitted within 180 days from the date you receive notice of a denial or other adverse determination. The insurer is required to acknowledge your appeal letter. If you do not receive a notice within 30 days that your appeal information has been received, call customer service.

Expedited Internal Appeal

If your situation is urgent, you can file an expedited appeal request.

- Clearly label the communication as an expedited appeal. (For urgent problems, you can request an external appeal (see below) at the same time that you request an internal review).
- Your insurer must make a decision within four business days from receipt of an expedited appeal.

Examples of urgent situation include:

- You are receiving or are prescribed treatment and your provider believes a delay in treatment could seriously jeopardize your life or overall health, affect your ability to regain maximum function, or cause you severe and intolerable pain.
- Your issue is related to a hospital admission or a continued in-patient stay and you are still in the hospital.

A medical provider with knowledge of your medical condition or the medical director of your insurer determines if your situation is urgent. You can't request an expedited review request if you have already received the treatment and disagree with a claim denial.

Step 5: Request an external review.

If the plan denies your appeal after internal review (an adverse determination), you can request an external review. While some insurance plans require only one internal appeal, others require you to complete a second internal appeal before you have a right to an external review.

Three types of denials qualify for external review:

- Medical judgment - you or your provider disagree with the insurer
- Experimental treatment – the insurer believes a treatment is investigational
- Canceled coverage - the insurer claims that you gave false or incomplete information when you applied for coverage

Who Handles External Review

An independent review organization (IRO), working with physicians who are the same type of specialist as your physician, will decide whether to uphold or overturn the plan's decision. You have a right to review the evidence your insurer has given to the IRO, provide new evidence or comments, and look at

the credentials of the reviewers. You have the right to request an expedited external review for the same reasons outlined above for requesting an expedited internal review.

Timing

Most health plans require that you file a request for an external review within four months after you have received the final adverse determination (but check with your particular plan for deadlines).

Possible Outcomes

All decisions of the IRO are binding on you and the insurer. However, any rights that you may have under state law are still available.

Step 6: File appeal with Department of Insurance.

Once you have received a final adverse determination, you can choose to file an appeal directly to your Department of Insurance in some states instead of requesting an external review.

- Check which state your health plan originates from so you know which Department of Insurance you should file the appeal with. For example: if you are working for a company that is headquartered in a different state from where you live, your appeal will have to be filed in that state. In some states, the external review may be handled by the Department of Insurance.
- Read the denial letter from your insurer carefully. With some insurance plans, if you chose to file multiple appeals with your insurer, you may lose the right to appeal to the state Department of Insurance, depending on where you live and the type of insurance plan you have.

If you have exhausted all these appeal options and are still not satisfied with the decision, then you may choose to pursue the issue in court. You can search for attorneys that specialize in healthcare at www.martindale.com.

Click on these links for more information about appealing health plan decisions and internal appeals.

Addendum B: Sample Appeal Letter for Services Denied as 'Not a Covered Benefit'

You can use this letter as a model for an efficient, effective appeal letter. You may also need to get help from a legal professional. Make sure your healthcare provider knows any issues you have with insurance. Your provider may be able to help you. [Letter should be addressed to the name of the Appeals Analyst referenced in the Denial Letter. It should be sent certified mail, return receipt requested. If you are requesting an expedited review, it should also be faxed or hand-delivered.]

Dear [Appeals Analyst]:

I am writing, on behalf of [name of Plan member if other than yourself], to appeal the [name of Health Plan] decision to deny [name of service, procedure, or treatment sought] for [name of Plan member if other than yourself].

It is our understanding that [name of Health Plan] is denying coverage on the basis that "[cite Health Plan's language in the denial letter]." [Attach denial letter.] We believe that [name of service, procedure, or treatment sought] is medically necessary to treat [name of Plan member if other than yourself]'s medical condition and that [name of service, procedure, or treatment sought] is a covered plan benefit.

[Name of Health Plan] covers medically necessary services that are not expressly excluded, which are described in the Evidence of Coverage and which are authorized by the member's PCP and in some cases approved by an Authorized Reviewer. [Attach relevant section from Evidence of Coverage.]

The entire treatment team has recommended that [name of service, procedure, or treatment sought] is medically necessary. [Attach supporting medical letter.]

Contrary to your letter, [name of service, procedure, or treatment sought] is a covered service. [Name of service, procedure, or treatment sought] is stated as a covered benefit in your HMO Member Handbook, is implicitly covered in the Evidence of Coverage, and is not expressly excluded as a covered service in the Evidence of Coverage. [Quote from Member Handbook and Evidence of Coverage to establish that the service, procedure, or treatment is a covered benefit and not expressly excluded.] [Cite your state's mandated benefit laws requiring that the health plan provide this coverage.]

[Describe member's health condition, and why the service, procedure, or treatment would benefit the member and the consequences if the patient does not receive this treatment.]

[If the treatment is out-of-network, establish that there are no comparable services offered within the network.]

[Finally, if you feel they won't cover the service because of the precedent, ask them to consider covering it as an extra-contractual benefit, and to pay for the service, procedure, or treatment out of the Health Plan's catastrophic payment pool.]

[If the member requires immediate treatment for the condition, request an expedited hearing – request that they respond within 72 hours of mailing of the letter. Note that ACA now requires a 72-hour expedited internal review for urgent care. This time frame is required for plan years or policy years beginning on July 1, 2012.]

[Attach a letter from your treating physician describing the person's condition.]

Thank you for your immediate attention to this matter.

Sincerely,

[Your name]

cc: [Possible people to whom you should consider sending copies of your letter]

[Health Plan Medical Director]

[Medical Group Medical Director]

[Your primary care or treating physician]