Guide to Appeals

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This guide was made possible by funding from the Commonwealth Health Insurance Connector Authority. HLA is a public interest law firm dedicated to providing *pro bono* legal representation to low-income residents experiencing difficulty accessing or paying for needed medical services.

Please note: this information is not legal advice. The contents are intended for general purposes only.

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Introduction

What is an insurance denial?

When you receive medical services or treatment, your doctor or other health care provider (provider) will submit a request for payment to your insurance company. These requests are often submitted before you receive the treatment or service but sometimes they are submitted after. Usually, payment will be sent to the provider and you will receive an Explanation of Benefits (EOB) that includes the treatment, date of service, what is covered, and what the provider may bill you for (for example, if a co-payment, co-insurance, or deductible applies).

However, if there is disagreement about the treatment your doctor provided or recommends, you will receive an EOB or a letter that says insurance coverage is not authorized. This is an insurance denial. Information about how to appeal the denial or ask the insurance company to reconsider the decision will be included with the EOB or denial notice. Under the Affordable Care Act, you can submit an appeal of a denial when your insurance company decides:

- that you are not eligible to enroll in the health plan
- to not pay for a service that is a benefit under your plan
- to reduce or terminate a covered service that you have been receiving under your health insurance
- that care is not medically necessary
- that you are not eligible for a particular benefit
- that the treatment is experimental or investigational to cancel your coverage

What is not an insurance denial?

If you have questions about your insurance, such as, what you pay for your premium, your deductible amount, or whether your doctor is in-network, these are not considered insurance denials. A denial involves a decision by the insurance company regarding whether a particular medical service should be paid for under your plan. If you have a complaint about your health plan that does not involve a specific treatment denial, you may still file a complaint or grievance with your insurance

company. For example, if your insurer says it will not pay for a service because of other health insurance you have, you may be able to submit a grievance. You should check your health plan or call the number on your insurance card to learn more about its grievance process.

Your Appeal

Step 1 – Getting Organized

Get organized and keep everything in one place. Have a notebook or file to help keep track of all of the documents, because it is likely there will be many. Keep good records and save all correspondence from your insurance company. Ask for a name and/or confirmation number each time you call your health insurer and keep complete notes. If you receive conflicting or confusing information, follow up with your health insurer in writing.

Step 2 – Do Your Homework

You can appeal to your health plan when there has been a decision by the health plan to deny, reduce, or suspend a health insurance benefit, or a decision to terminate or rescind your health insurance coverage. This is commonly called a denial, but is also referred to as an "adverse benefit determination."

You should review the denial letter from your insurer carefully so you know what is being denied, and why. If you do not understand the denial, request a copy of the insurer's standards and records relating to the denial. This information should be provided free of charge by your insurance company. Determine what these documents say about appealing the decision, including when appeals must be submitted.

Step 3 – Understanding your Insurance Plan

While most people have never reviewed their insurance plan documents, it is important to read them now because knowing what your plan covers will help you develop the basis for your appeal. Your plan may be on the insurer's website. If not, you should call your insurance company and request a complete copy of your plan and any riders that apply because they change your benefits. Be sure to ask for the entire plan and not a summary (it may be called the Member Handbook, Benefits

Handbook, or Evidence of Coverage). You are looking for the most comprehensive information that is available.

Also, be sure to request and review the plan that was in effect at the time your treatment or service was requested. If, for example, your plan year is from January 1 through December 31, and your service was requested and the denial was issued in December 2012, you need the 2012 plan. If, on the other hand, the service was requested and denied in January 2013, make sure you request and review the plan in effect for 2013.

If you have insurance through an employer, you should request the plan from your employer. If you have trouble obtaining a copy of the plan, you may want to call the U.S. Department of Labor's Employee Benefits Advisors at 866-444-EBSA. If you are having trouble getting a copy of the plan and it is an individual (also known as a non-group) health plan, you may want to call the Massachusetts Division of Insurance at 617-521-7794.

When reviewing your plan, you should pay particular attention to:

1. what kind of plan it is, fully-insured or self-insured;
2. all of the terms that appear in your denial and the plan's definition of them, such as "medically necessary," "excluded" or "exclusion," "experimental," "unproven," "uncovered," etc.;
3. the sections relating to the denied service; for example, if you were denied mental health treatment, be sure to review the plan's mental health services section;
4. how to request the standards that applied to your service and other records relating to the denial, which should be available at no charge;
5. what the plan says about your right to appeal both internally and externally, including the deadline(s) for filing, and where appeals should be sent; and
6. the options available to you if your appeals are unsuccessful.

After reviewing your plan, one question you should be able to answer is whether you have a full-insured or self-insured plan. In a fully-insured employer-based health plan, the employer purchases a health plan from a health insurance carrier and the health insurance carrier bears the financial responsibility for paying out the cost of the employee health benefits under the terms of the plan.

In a self-insured (or self-funded) health plan, the employer acts as its own insurer. Though the employer may contract with a health insurance carrier to act as a claim

administrator, the employer is financially responsible for paying out the employee health benefits and bearing the total cost. Very large companies are more likely to offer employees a self-insured health plan.

To find out what kind of plan you have, it is best to call your insurance company, employer's human resources office, or your insurance broker. If you have been enrolled in a plan since March 23, 2010, you may have what is known as a "grandfathered plan" and the Affordable Care Act's appeal protections do not apply. It is still best to call and find out what you have.

If you receive your insurance through the Massachusetts Group Insurance Commission, you can find out information about your plan and member appeal rights on the GIC's website at www.mass.gov/gic.

If you purchase a Commonwealth Choice or Business Express health plan through the Health Connector, or purchase an individual health insurance plan through a broker or directly from a health insurance company in Massachusetts, you likely have a fully-insured health insurance plan. But, if you are unsure of what type of plan you have, ask your insurance company or broker.

You should understand why your health insurer denied the service. For example, does the insurer consider it not medically necessary or unproven given your medical condition? Before you can lay the foundation for reversing a denial, you need to understand the criteria that are being applied. More information on how to request the standard and other documents, the "claim file," from your insurer is on page 5.

Another section of the plan that is important is the information about appeals. If your health plan sends you a denial or an adverse benefit determination with respect to your medical treatment, it must include information on your right to appeal and describe the appeal process. There are two types of appeals; an internal appeal that is reviewed by the insurance company itself, and an external appeal that is reviewed by an independent organization. External reviews are generally allowed only for questions regarding whether a service is medically necessary.

You may be required to file two internal appeals before filing an external appeal. But when there is an urgent medical need, you may be able to file both an internal appeal and an external appeal at the same time. An internal appeal to the health plan must be submitted within 180 days from the date you receive notice of a denial or other adverse benefit determination. Appeals can be submitted either over the phone (orally) or in writing, but HLA strongly encourages you to submit any appeals in writing and to keep a complete copy of what you send.

If your health or life is in jeopardy, you may be entitled to an expedited or urgent appeal. Your doctor may need to authorize your request for an urgent appeal. If an internal appeal is urgent, the insurer must respond within 72 hours of receipt. For an expedited external review, a decision must be issued within 4 days of receipt by the reviewing organization. You should check the appeals section of your plan very carefully and if you have questions, call the number on your insurance card.

Step 4 – Requesting the Claim File

In order to make a successful appeal, you must first understand the basis for the health insurer's denial and be able to provide support for why you meet the standard that is being applied by your insurer. If you and/or your doctor do not understand the reason for the denial, you should request a copy of your "claim file" from the insurance company. Your claim file includes a copy of the criteria or standards that were used and all of the documents related to your claim.

The denial letter or notice from your insurance company should explain how to request a copy of the claim file at no charge. The notice should provide information on how to request the information from the insurer. If there is no information in the denial about how to do so, call your insurance company and ask about it.

It is important to submit your request for the claim file in writing and keep a copy so that you can keep track of when it was submitted. You should:

1. include a disclaimer that "this is not an appeal," because sometimes a claim file request is mistaken as an appeal;
2. include your name, address and phone number;
3. send it by certified mail, return receipt requested;
4. include the date you are sending it;
5. confirm the fax number or address where the request should be sent;
6. include the patient's name, the subscriber name (if different), identification number, the service that was denied, the date of the denial, and the doctor's name;
7. state the reason for the letter as a request for all information relative to the denial;
8. include a copy of the denial letter (do not send the original);
9. provide the address where the requested documents should be sent;

10. include your phone number, should there be any questions; and
11. refer to the enclosed document (the denial letter).

*Each numbered step corresponds to a section in the sample claim file request letter found on page 13 of this guide.

If you have insurance through your employer and do not receive a response to your claim file request within 30 days, you may want to call the United States Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA.

If you have trouble obtaining the claim file from an individual (non-group) health plan, you may want to call the Massachusetts Division of Insurance Consumer Hotline at 617-521-7794.

Step 5 – Talk to Your Doctor

Talk to your doctor(s) or someone in your doctor's office about the denial and provide a copy of the denial notice if they have not received it. Ask for any information and copies of all medical records that would support your appeal. Decide whether you want to ask your doctor to submit an appeal on your behalf. If your doctor agrees to do so, make sure s/he understands what is required.

HLA's Suggestions for Providers, found on pages 14-17, is intended to help your provider submit an appeal on your behalf or to write a letter of support to be included in your appeal.

Step 6 – Writing Your Appeal

Though an appeal may be submitted to your health insurer orally (over the phone), we strongly suggest that you submit your appeal in writing. Your appeal should identify the insurance company's decision you are appealing and clearly explain the reasons why it should be reversed with as much medical support and documentation as possible.

After you have reviewed the denial and your plan, understand your appeal rights, obtained the claim file, talked to your doctor, and collected your medical records and letters of support from your providers, it is time to start writing your appeal. You may want to include a personal statement, but otherwise, it is best to stick to the facts. For help with a personal statement, see page 18.

In your appeal letter, be sure to:

1. Include your name, address and phone number.
2. Send it by certified mail, return receipt requested.
3. Include the date you are sending the appeal.
4. Make sure you are sending the appeal to the right place. This information should be in the denial letter. If not, call your insurer and confirm.
5. Include the member's name (if it is not you), the identification number, group name (if you receive insurance through your employer or another group), the type of plan you have, the provider name and treatment.
6. Start with exact language of the denial, the date, and the service
7. Quoting directly from the denial, state the criteria that the health plan applied.
8. Include a copy of the denial (be sure not to include the original).
9. List the reasons why you meet the criteria. Make sure you address each requirement separately. Try to be as clear as you can and provide references to your medical records and/or a doctor's letter of support.
10. Include a doctor's letter of support.
11. Provide copies of all pertinent medical records.
12. Include a personal statement about what this treatment means to you, your medical condition, impact on your day-to-day living, etc.,
13. Reference that you are including documents with your appeal.

*The numbered steps correspond to the sections in the sample appeal letter, found on pages 19-20 of this guide.

Once you have finished writing, get some feedback. Ask someone you know, like a family member, close friend, or your doctor, to read your appeal. Find out which parts of the appeal are most persuasive, whether you convinced them that you met the criteria, or, if not, if they have suggestions for how to improve it.

Before sending your appeal, make a copy of it and all of the documents enclosed. Be sure to send it certified with proof of receipt so you will know when it was received.

If you decide you would rather have someone else submit your appeal, you can authorize a representative to assist you in the appeal process. You will need to submit a signed authorization form to your health insurer that will authorize

communication with your representative on your behalf. This authorization is required when a family member, even a parent or spouse, is helping you. You can often find these forms on your health plan's website or by calling the customer service phone number on your member identification card. A sample authorization form is provided on page 21, but it is best to check with the health insurer in case it has an authorization form for this purpose.

If you live in Massachusetts and need assistance submitting an appeal, you may call Health Law Advocates at 617-338-5241. HLA staff can answer your general questions about the appeal process and will talk with you to determine if we can provide assistance with your appeal. If you live in another state, you can find out about the resources that are available to help you with your health insurance appeal questions at www.healthcare.gov.

Step 7 – After the Appeal, What Happens Next?

If you are appealing a denial of coverage for services you have not yet received, the health plan must issue a decision within 30 days. For a denial of treatment you have already received, the health insurer must issue an internal appeal decision within 60 days. 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. If your appeal pertains to urgent medical care, you may be able to obtain internal and external reviews at the same time.

If your internal appeal was denied, you may be eligible to have a review of this decision by an independent review organization, or IRO, that is not associated with the health plan. Almost all health insurers are required to offer an external review process to members who have exhausted the internal appeal process, but still disagree with the health plan's decision. An external review decision must be issued within 60 days. However, for an urgent medical need, you may be eligible for expedited external review.

Your denial letter should indicate whether you have received the insurance company's final decision on your appeal and whether you are eligible for an external review. An external review is typically only available for health plan decisions that are based on whether a requested service or treatment is medically necessary. You should keep in mind that you may (and it is a good idea to) submit additional relevant information in any other appeal you file. You also may want to contact your provider(s) and obtain additional medical records and/or letters of support for your next appeal.

If you are covered under a fully-insured health plan in Massachusetts, you must request an external review through the Office of Patient Protection (OPP). You can find out more about external appeals on the OPP website at www.mass.gov/dph/opp or by calling 800-436-7757.

If you have a self-insured or self-funded health plan and it was not in existence on or before March 23, 2010, your health insurer must provide an external review process that is compliant with federal rules. You should refer to your denial letter and specific health plan documents for information on the availability of an external review. If you have trouble finding information about your external review rights, you can call the United States Department of Labor's Employee Benefits Security Administration at 866-444-EBSA.

Conclusion

It is true that appealing an insurance denial can be overwhelming and it is impossible to predict whether your appeal will be successful. By their very nature, insurance appeals are tremendously fact-specific. They relate to your medical history and current condition, the particulars of your insurance plan (which you often do not control), and the specific type of medical service that is being recommended. But there is another truth: you will never know unless you try.

> *"Never doubt that a small group of thoughtful committed citizens can change the world. In fact, it's the only thing that ever has."*
>
> Margaret Mead

We hope that we have helped change your world.

Glossary

Adverse benefit determination—a decision by your insurance company to deny or reduce payment for a particular medical service, or terminate your health insurance coverage.

Affordable Care Act—the national health care reform law signed by President Obama in 2010.

Claim file—all of the information and documents involved in an insurer's review of a requested treatment or service which should be provided at no cost to you.

Co-insurance—a percentage of your medical care costs that you are required to pay under your health plan for a particular type of care.

Coordination of Benefits—when an individual is covered by two or more insurance plans, this determines how much of a treatment or service each plan covers.

Co-payment—what you are required to pay each time you obtain a particular type of medical service, such as office visits or prescription drugs.

Deductible—the total amount you must pay for medical treatment before your health plan will start covering the cost of your medical care for you and/or your dependents.

Denial—a decision by an insurance company not to pay for treatment either before it is delivered or after you have already received it.

Eligibility—whether a person has the right to coverage. Eligibility can vary based on the particular health plan, the provider, service area, or the treatment/service sought.

Exclusion—a service or treatment that is not covered by your plan.

Explanation of benefits or EOB—this is the notification the insurance company sends after processing a claim. It should include the treatment, date of service, what is covered, and what the patient should pay (for example, if a co-payment, co-insurance, or deductible applies).

External appeal or external review—an appeal that is not reviewed by your insurance company, but is sent to an independent review organization for a decision.

Fully-insured plan—a health plan in which the insurance carrier bears the financial responsibility for paying out the cost of health benefits under the terms of the plan. A fully-insured plan may be an individual or group plan that is offered through your employer.

Grandfathered plan—a health plan that was in effect on March 23, 2010 and which has not changed substantially since that date. The appeal protections in the Affordable Care Act do not apply to grandfathered plans.

Independent Review Organization or IRO—an entity that conducts reviews of an insurance company's final decision not to cover a service or treatment. The IRO's decision is final.

Internal appeal—an appeal for a denial of medical treatment or cancellation of coverage that is submitted to and reviewed by your insurance company. A plan may require one or two internal appeals.

Medically necessary or medical necessity—a standard used by an insurance company to determine whether treatment or services are appropriate and effective given a patient's health needs. Frequently a health plan will include a list of requirements that must be met in making this determination.

Out-of-Network Provider—a medical provider (such as a doctor or treatment center) that has not contracted with your insurance plan to provide medical services at a negotiated rate. The patient may be responsible for all charges depending on what the specific health plan covers.

Out-of-pocket maximum—the total amount you will pay for medical care that includes your co-insurance and deductible amounts, but usually not co-payments. Once your out-of-pocket maximum is reached, your health plan covers all of your medical expenses.

Preauthorization or prior authorization—a request by your provider to have a particular service or treatment approved by your insurance company.

Provider—a doctor or someone else who is qualified to deliver medical services.

Rider—a condition or additional provision that is added to a policy that changes the benefits provided.

Self-insured plan—a health plan in which the employer pays for the actual cost of the health benefits provided to employees. A self-insured plan is usually purchased by a large employer or union but which can be administered by a third party.

Urgent appeal—an expedited appeal you can make if withholding medical care places your life or health in jeopardy.

Additional Documents

Sample Claim File Request Letter

(1) PLEASE NOTE: THIS IS NOT AN APPEAL

(2) Sent By Certified Mail
Return Receipt Requested

(3) [Date]

(4) [Insurance Company]
[Address or Fax Number]

(5) Patient Name:
Member Name:
Member ID#:
Service Denied:
Date of Denial:
Provider's Name:

To Whom It May Concern:

(6) I am writing to request a copy of all standards, policies, criteria and/or any other documents involved in issuing the denial referenced above.

(7) I have enclosed a copy of the denial letter.

(8) Please send the requested documents to me at [insert your address].

(9) If you have any questions about this request, please call me at [insert your phone number].

Sincerely,

Your Name

(10) Enclosure

Health Law Advocates' Suggestions for Providers

Appeal

Health Law Advocates is a nonprofit law firm dedicated to assisting individuals with medical debt or when they have difficulty obtaining medical services. This information is meant to offer suggestions to you, as a provider, if your patient's health insurance company has denied the medical service or treatment you recommended.

In general, a health insurer must cover a service when it is a covered benefit under the health plan and the patient's need for the service meets the health plan's medical necessity criteria.

In submitting an appeal of a denial, it is important to provide information and documentation that supports how this service addresses the patient's specific medical needs. Before agreeing to submit an appeal on your patient's behalf, please consider the importance of taking this step because it may be the patient's only opportunity to obtain coverage for this service.

Before drafting your patient's appeal, you should:

1) review the insurance company's denial to understand why coverage for this service was denied. If you do not understand it, please call the insurance company to get more information and request the criteria that was used; and

2) review the medical records to ensure there is supporting information and documentation for the treatment you are recommending.

If you would prefer that the patient obtain this information, please let him/her know as soon as possible because appeals are time-sensitive.

In the appeal, be sure to:

1) include the date and reason for the original denial and include a copy with your appeal;

2) state your expertise in recommending and/or providing this treatment (e.g., your particular training, education, specialized experience);

3) describe the patient's unique circumstances (e.g., when first diagnosed, other unsuccessful treatments, how this condition is unique);

4) describe how your patient's medical condition specifically meets the criteria used by the insurer using as much detail as possible;

5) refer as much as you can to the patient's medical records, preferably with specific cites to particular medical visits and diagnostic results;

6) explain unsuccessful treatments and how and why this service is expected to improve the patient's condition;

7) detail why this service is the most appropriate and cost-effective for this patient;

8) provide any peer-reviewed medical literature that supports this service if it is unique or considered experimental or unproven; and

9) include a copy of all medical records or other documents you reference.

You should keep a copy of the appeal and all of the medical records that are included and send a complete copy to the patient. If this appeal is denied again, the patient may be entitled to another internal or an external appeal. In order to do so effectively, however, the patient will need a copy of everything that you submitted.

Appealing a denial by a health insurance company can be a time-consuming process. Please understand that you and your staff play a very important role in this process and can make a huge difference in the outcome of a patient's appeal.

If you are unable to submit the appeal on the patient's behalf, you can still help by writing a letter of support that can be included in your patient's appeal.

Health Law Advocates' Suggestions for Providers

Letter of Support

Health Law Advocates is a nonprofit law firm dedicated to assisting individuals with medical debt or when they have difficulty obtaining medical services. This information is meant to offer suggestions to you, as a provider, if your patient's health insurance company has denied the medical service or treatment you recommended.

Keep in mind that a patient has limited opportunities to appeal a denial issued by an insurance carrier. A provider's letter of support can mean the difference between whether an appeal is successful or not. In general, when drafting a letter of support, you should include as much detail as possible concerning the patient's particular medical needs, how the insurance plan's standards or criteria are met, and copies of all medical records that support your statements. If you do not have sufficient information or knowledge to draft such a letter, you should tell the patient so s/he can locate another provider to assist with the appeal.

Here are some suggestions to keep in mind before you begin drafting the letter:

1. Review the denial. If you do not understand the criteria being applied, ask the insurance company to send you a full copy of their coverage guidelines.

2. Review the patient's medical history to make sure you can support the position that the patient's medical needs meet the insurance plan's criteria.

3. Identify those test results, pictures, and/or medical records that support the requested treatment or service and make copies.

4. If the treatment is considered experimental, investigational or unproven, gather the citations for studies, medical journals and articles that support the treatment.

Drafting the letter:

1. Identify yourself and provide background information (e.g., how long you have known the patient, why the patient came to you, and your particular expertise that qualifies you to make this recommendation).

2. Provide the insurance plan's criteria and reason for the denial.

3. Articulate the reasons the denial should be overturned, including any information in the medical records that supports those reasons. Remember to link the patient's medical needs as closely as possible to the criteria that is being applied and address each criterion individually with supporting documents.

4. Describe how other treatments have been unsuccessful, using references to medical records if applicable.

5. Provide a clear explanation for why this is the most appropriate and cost-effective treatment given the patient's medical condition.

6. Describe the expected positive effects of this treatment for your patient.

Be sure to include a copy of all of the medical records you reference when you give the letter to your patient.

Personal Statement Considerations

Some feel that they are profoundly affected by their insurance plan's denial of a service or treatment. If this is the case for you, consider whether you would like to put this in writing in a separate document, so you can keep the rest of your appeal as fact-specific as possible.

Here are some questions for you to consider when thinking about writing a personal statement:

1. How long have you had this medical condition?
2. What does this medical condition mean for you?
3. How has your personal life been altered by this denial?
4. How has your work life been affected?
5. Are there other effects that you have noticed?
6. What are the short- and long-term effects of this denial?
7. What other treatments have you tried unsuccessfully?
8. What were you told by your provider concerning this treatment?

Sample Appeal Letter

(1) [Your Name]
[Address]
[Phone Number]

(2) Sent by Certified Mail
Return Receipt Requested

(3) [Date]

(4) [Insurer Name/Address]

(5) Patient Name:
Member Name (if different):
ID#:
Group (if through an employer or group):
Plan:
Provider:
Treatment:
Treatment Date:

To Whom It May Concern:

(6) I am appealing the denial of [name of treatment] dated [date of denial] for service provided/requested on [date of service or authorization submission].

(7) The standard that is being applied to this treatment is [include the exact language from the denial notice].

(8) I have included a copy of the denial.

(9) I believe this denial should be overturned for the following reasons [list each of the reasons you meet the criteria, including, e.g., your medical needs, prior unsuccessful treatments, expected result].

(10) I have enclosed a letter of support from my doctor that states [summarize the information in the doctor's letter].

(11) I have included the following medical records [list the copies of documents (not originals) you are including].

(12) I have included a personal statement [if you are and briefly summarize it].

For the reasons outlined above, I request that the denial be reversed. Please do not hesitate to call me if you require additional information or have any questions.

Sincerely,

Your Name

(13) Enclosures

Sample Representative Authorization Letter

[Insurer Name/Address]

To Whom It May Concern:

I, [insert your name], freely and willingly consent to allow [name of authorized individual, medical or legal entity], to obtain and review my medical records and discuss my health information concerning [describe the denial] with [insert the name of the insurer].

I also consent to allow [name of authorized individual, medical or legal entity] to represent me in this dispute with [insert the name of the insurer] concerning my appeal.

I understand that I may revoke this consent at any time and will provide written notice to do so.

_____
Signature

_____
Address

_____
Phone Number

_____
Subscriber ID#

_____
Date