

## Strategy for Appealing Health Plan Decisions

If you choose to appeal a decision of your health insurance provider, it is important that you understand the appeal process and give the health insurance provider as much information as possible to support your claim.

### Next steps to take when your request is denied

When given a denial over the phone, don't accept a simple "no." Always request the denial in writing. Once you have been denied, there are a number of "next steps" that you can take to pursue payment, including filing an appeal, collecting supportive documentation, writing a letter, and requesting an external appeal in some circumstances.

### Obtain a copy of the appeal process

The appeal process for your insurance provider should be explained in your benefit plan or certificate of coverage. You may also contact your insurance provider and ask for a written copy of the appeal process.

### Know your coverage and the health plan's position

If you ask for the denial in writing, your insurance provider must send you a letter that explains why your request was denied. Read the reasons carefully. Refer to your benefit plan contract to determine if those reasons comply with the plan and to find definitions of any terms used in the letter.

Denials can fall into several categories. The most common categories are a coding error, or a procedure/treatment not being deemed medically necessary, or experimental.

- **Coding errors:** Sometimes these are simple mistakes that may be fixed by contacting your doctor's office. Ask them to review the services received, and make sure everything was coded correctly.
- **Not Medically Necessary:** These denials benefit from supportive documentation from the physician recommending the procedure/treatment, explaining why the treatment is medically necessary.
- **Experimental/not scientifically proven:** Again, medical documentation coming from the physician is going to be the strongest argument you can put forth, especially if it includes studies that support his/her recommendations.

### Write a letter

In most cases, in order to start the appeal process you must submit the appeal in writing. Use these guidelines to organize your letter:

- **Purpose:** State your purpose for writing
- **Diagnosis:** Explain your child's diagnosis and how it affects your child
- **Reasons:** Give specific reasons why your child needs the service
- **Documentation:** Mention the supporting documentation you are including
- **Action:** Close by requesting a written reply

Make sure your letter directly addresses the specific reason given by the insurance company for the denial.

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## **Personalize your request**

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- Ask for letters of support from one or more doctors familiar with your child’s case.

## **Keep records of phone conversations**

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For all phone conversations, keep a written record of the following:

- The date and time of your call
- The name of the person you spoke with on the phone
- What was discussed during the call

## **Create a paper trail**

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Create a paper trail by organizing the following:

- Your insurance policy
- Copies of denial letters
- Copies of any correspondence with your health insurance provider
- Detailed notes of conversations
- Copies of any correspondence between your doctor and the insurance provider concerning your problem

## **Send copies**

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Send copies of all correspondence with your plan to all interested persons. For example, you may send copies to your physician, your employer’s benefits manager or human resources director, the commissioner responsible for regulating the Health Maintenance Organization (HMO) or insurance company, the head of the agency you are seeking services from (for example, the hospital administrator), and anyone else you have contacted regarding your situation. Indicate that you have sent copies by noting each name at the bottom of the letter under the notation “cc:”

## **Know your rights**

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Under the Affordable Care Act all insurance policies have new consumer rights, including:

1. You must be told of your right to appeal.
2. The right for an expedited appeal if your health is deteriorating and the usual timelines may result in worsening of your condition.
3. The right to an interpreter if you don’t speak English (for plans after 1/1/12).
4. The right to have an authorized representative assist you. Your insurance company must offer you the chance to have someone help you with your appeal.
5. Your right to an internal review, which may take place at a couple of levels, depending on the policy and the state that you live in.
6. If the issue isn’t satisfactorily resolved through internal appeals, you have the right to an external review by a third party.

**Note:** These appeal rights do not apply to policies “grandfathered-in”, after the Affordable Care Act. If you have had the same policy since 2010, or are not sure if your plan was “grandfathered-in,” you can check with your insurance company.