



When a Carrier Just Says No: Helping Patients Appeal Denials of Care

Christin Engelhardt, Outreach and Publications, Health Assistance Partnership

Mike Klug, Volunteer Program Development Consultant, Health Assistance Partnership;
Consultant, National SHIP (State Health Insurance Assistance Program) Resource Center;
Consultant, Caregiver Training and Support Program

Jane Smith, Retired Benefits Specialist, Department of Labor; Volunteer, Health Assistance Partnership

Basics of an Appeal After a Consumer Is Denied Care

All consumers—whether insured by Medicare, Medicaid, or private insurance—can appeal denials of care, yet there are different rules and processes, depending upon the type of insurance and the state. Federal law covers some aspects of private insurance appeals, state laws other aspects. Sometimes states give you additional rights and protections, but not always. For those insured by a group plan, the appeal process varies further, depending upon whether the plan is self-insured or not. Despite these differences, there are many commonalities to appeals that are outlined here.

Note: Remember to document all actions in one file: record dates and times of conversations with all parties (including your health care professionals and customer service representatives at the insurance carrier); summarize all conversations; and keep all correspondence received and copies of all correspondence sent.

1. You are notified of a denial of care. (If the denial is not given in writing, request that the denial be put in writing.)
Note: If you have already received the care, re-submit the claim with more information on the necessity of the treatment.
2. Examine the reason for the denial against your specific plan benefits and determine if the denial is based on medical grounds or on plan rules. (Plan rules include limitations and exclusions and are stated in the summary plan document which you get each year from the employer—if insured through an employer—or plan—if self-insured. If you have lost yours, immediately request a new copy from your human resources department or from the plan.)
 - a. Unsupported therapy?
 - b. Experimental therapy?
 - c. Not a covered service? (e.g., the plan does not cover durable medical equipment)
3. Ask your health care provider to speak informally, on your behalf, to the medical director or other appropriate personnel at the carrier responsible for the denial.
 - a. If your plan is self-insured, speak to the benefits administrator (who must protect patient confidentiality) and/or ask your health care provider and/or other



- advocates to speak to the administrator. The administrator can help reverse a denial, especially after considering indirect costs to the employer (such as longer sick leave, replacement costs, etc.).
- b. If your plan is not self-insured but is provided through your employer, your employer may still be able to help. Speak to the human resources director and ask him/her to contact the plan on your behalf. He/She may be able to persuade the plan, which views the company as a customer, to reverse the denial.
 4. If the informal routes fail, begin the formal process of appealing. First and foremost, understand the appeal process, including timelines (e.g., 30 days for a first appeal to be filed in writing) and what rights you have under it.
 5. Get letters of support from your providers (physicians, nurse practitioners, psychologists, physical therapists, and others involved in your care) that also, if necessary, address any risks of the therapy. The stronger the letter, the better and, further, the more letters, the better. Letters from practitioners who do not benefit financially from the requested treatment are particularly helpful.
 6. Formulate your argument in response to the reason for the denial. You must make a solid and focused case, based on medical necessity and/or plan rules, for why your insurance company should cover this care.
 7. Research your position and compile evidence to support your argument (if there is an organization for your condition, that group may be able to help prepare your medical-necessity argument). Put your strongest arguments first, and, without overwhelming the reviewers, use the following if they support your case:
 - a. plan benefits and plan rules,
 - b. your medical records (remember that the Health Insurance Portability and Accountability Act or HIPAA gives patients a right to review and to make changes to them),
 - c. standards of care/guidelines/options (sometimes called practice parameters or practice guidelines) or consensus statements from professional societies,
 - d. position statements or guidelines or educational material from patient organizations (although these do not carry as much weight as positions from professional societies),
 - e. statements or publications from the National Institutes of Health (which are viewed as authoritative but are often slow to be issued)
 - f. approvals from the Food and Drug Administration and accompanying approved labeling text (e.g., indications and usage, contraindications, precautions, adverse reactions),
 - g. articles published in peer-reviewed scientific journals (read the full article, not just the abstract and be mindful of the date as older articles *may* be disregarded),
 - h. Medicare coverage,
 - i. accepted off-label use as noted in certain publications, and
 - j. the cost-benefit ratio of the treatment.
 8. Address any risks (such as high blood pressure) or other disadvantages to the care desired: explain, if possible, that these are minimal risks or irrelevant, given your medical history.



9. Simultaneously understand the insurance company's opposing argument so that you can argue against it.
10. In a professional manner, write your own statement of appeal: reference the plan rules plus the science, the clinical evidence on the expected benefits, etc. while you make your argument clear and concise. Use a firm tone that indicates you plan to pursue your care until you succeed. (Copying elected officials and government employees of relevant agencies, such as the state insurance commissioner's office, can be helpful. You may also consider cc'ing representatives of the media, but only if you are certain that you want your fight to be public.)
11. Submit all of the information in the required timeframe (preferably in a way that provides you with a confirmation of receipt such as certified mail), and make sure the insurance carrier responds within the appropriate timeframe.
12. If your appeal is successful, notify your health care professionals. If unsuccessful, take the next allowable step (which may be a face-to-face appearance before a panel of individuals chosen by the carrier).
13. Address any issues raised in denial of appeal; if allowed in the claims procedure, submit second appeal according to the timelines. If possible, submit any new information omitted in the original appeal.
14. If your appeal is successful, notify your health care professionals. If unsuccessful, take the next allowable step (which may be to a third party such as a state's insurance department).

Not all appeals are successful, but many are. If you do not succeed and after you have exhausted all of the appeal channels, depending on the type of insurance and the state where you live, you may be able to sue. If you reach this point, seek legal advice.