



It Matters

Empowerment Pathways



Tips for Appealing Insurance Denials

When you need medical care, the last thing you want to worry about is whether or not your health insurance will cover it. Your explanation of benefits document is an important source of information about coverage. For example, if you haven't met your annual deductible, what appears to be a denial may actually be your out-of-pocket responsibility. Insurance doesn't begin to pay its portion of the charges until you have met your deductible or paid your share of the cost. There are many reasons why medical services may be denied but you always have the right to appeal your insurer's decision. While it can be daunting to think of going through the process of an appeal, here are some tips to make it smoother and increase your chances of a favorable decision.

BEFORE YOU START YOUR APPEAL, INVESTIGATE WHAT HAPPENED

As a consumer you need to know the basic rules about your health insurance plan. For instance, what is covered under your plan? Do you need a referral to be seen by a physician or have testing completed? Is there a network facility that you are required to use and is prior authorization required? If you didn't follow the procedures your costs are likely higher, or sometimes a request for services is denied because of a simple data-entry error like a misspelled name, insurance ID number, or the wrong date of service. If it was an error on the part of your medical provider, ask them to correct the problem and resubmit the request or claim. If you still aren't sure why the claim was denied, call your plan and ask.

IDENTIFY THE "WHY" FOR THE DENIAL

Before you can begin a successful appeal, you need to know what was denied and why. If the denied care has not yet been provided, this would be a prior authorization denial; if the care has been completed, this would be a claims denial. Some of the common reasons for denials include: the treatment is considered not medically necessary, the drug or therapy is off-formulary, the care was provided by an out-of-network provider, the service is not a covered benefit under the plan language, the therapy did not adhere to step-treatment requirements, you have exceeded the benefit limits, or no pre-authorization was submitted.

JOIN FORCES WITH YOUR DOCTOR

Work together with the doctor's office staff to put together evidence to show that the care you are seeking is medically necessary. Also confirm that the prescribed care is covered by your health plan – this is available online through your health plan's member website. Relevant information about your medical history may help your request get approved. The denial letter or explanation of benefits you received should tell you how to appeal the decision, or you can call your insurance company directly and find out how to navigate the appeals process along with any timeline you must meet.

GATHER YOUR DOCUMENTS AND PLAN YOUR MESSAGE

As you prepare to write your appeal letter, be sure to clearly cite the service or therapy that you are seeking approval for and address the specific reason for the denial as stated by the insurer. The letter can be written by you, by a medical provider, or by an advocate on your behalf. Discuss your health problems, particularly the full history of the recent problem in question. Include any treatments or therapies you've tried and facts that offset the reason your claim was denied. Discuss what will happen to your condition without the treatment. Include supporting evidence, such as peer-reviewed journal articles or treatment guidelines from recognized organizations. Keep a copy of all information submitted to the insurance company. The most important thing to remember when appealing a denial is to not give up, especially if your health is on the line!

SEND IT BEFORE THE DEADLINE DATE

To have your insurer reconsider its decision, your appeal materials must be received within their timeline set for appeals. Each level of appeal has different submission deadlines established by the insurer, which are provided on your denial letter or explanation of benefits. If you are ever unsure of the deadlines, call your health plan directly and inquire. It is always a good idea to send your appeal package via certified mail or with a tracking receipt so that you have a documented record of submission should you need to reference it at a later point.

Many states offer assistance with managing medical insurance denials through its state Department of Insurance or Ombudsman programs. Free assistance from non-profit organizations may be available as well.

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