

Appealing a Reimbursement Decision

My Claim Was Denied – Now What?

It's a terrible feeling to open a letter from your insurer and find you owe more money than you thought. Maybe your insurer paid less for a procedure than you expected. Or, maybe they denied a payment entirely. What do you do now?

The first thing to do is talk to your insurer and find out why the claim was denied. It might have been a simple mistake. Maybe your healthcare provider used the wrong code for your treatment when submitting the claim. Or, maybe you got prior authorization like you were supposed to, but your insurer didn't realize it. If it was just an error, your provider may be able to help you clear up the confusion with your plan.

But, maybe it wasn't a mistake. The claim may have been denied because, for example, your insurer did not find the treatment medically necessary, considered it experimental, or doesn't cover the service at all. In that case, you have a legal right to appeal. That means that you can formally ask your plan to reconsider their decision.

(Keep in mind that if your claim is denied because your insurer doesn't cover that service – say, cosmetic dentistry – your appeal will most likely be denied, too, because that service is simply not part of your plan.)



How Do I Make an Appeal?

Different types of plans must meet different laws and regulations for appeals. So, you need to make sure you follow the appeals process that applies to *your* particular plan.

Your insurer's customer service representatives should be able to give you the detailed instructions on how to make an appeal. This information, as well as appeal forms, may also be available on your insurer's website or in your plan documents. Your Explanation of Benefits from your insurer may also include a statement about how to appeal a decision.

Keep in mind that at each level of appeal, different plans may have different timeframes and deadlines for submitting the appeal documents, so be sure to familiarize yourself with these dates.

How Does it Work?



The appeals process is structured so that you have more than one chance to get your decision reviewed. If your appeal is denied, you can go to the next level. But remember, some insurers may need to follow different rules and policies about appeals. You will need to make sure you know the appeals process for *your* particular plan.

Generally, the process works like this:

- **First-level appeal:** This is an “internal review” because the appeal goes directly to your insurer. To make sure the process is fair, people who were not involved in the original decision to deny or downgrade your claim will review your case.
- **Second-level appeal:** If your first appeal is denied, you can make a second request. This one generally also goes to your insurer. This time, your case will be reviewed by people who were not involved in the original decision *or in your first appeal*.
- **Third-level appeal (External Appeal):** If your claim is still denied after the internal appeals, most states allow you to begin an external appeal. To begin this appeal, you can contact your State Insurance Department, who may refer you to an independent outside organization that will handle this level of appeal. For instance, if you are appealing because your insurer did not think your service was medically necessary, the appeal will usually be reviewed by an independent organization that is approved by the state, or sometimes by a state insurance department or another governmental organization.

Remember: there are time limits to submit your appeal at each level, and your insurer is required to respond to you. For this reason, it's also a good idea to make sure that you have all of your paperwork ready when you file your appeals.

Where Can I Find More Information?

The first thing to do is check your plan booklet, your insurer's website, or call your insurer so you can be sure you understand how *your* plan's appeal process works.

If you get health coverage through your employer, your plan may have to follow regulations set by a law called ERISA (it stands for the Employee Retirement Income Security Act). ERISA has specific rules about the timelines for appeals, your rights, and the kind of information that your insurer must give to you. Your plan may have to follow certain state laws, too.

Many plans also have to follow new rules set by the health reform law as of September 23, 2010. You can find more information on those rules at the official healthcare reform site www.healthcare.gov.

Also be sure to visit Healthcare Resources section at www.fairhealthconsumer.org for organizations and resources that may be helpful for the appeals process. One such organization is Advocacy for Patients with Chronic Illness.



Your Action Plan: Be Informed

The easiest way to deal with a claim denial is to stop it from happening in the first place. Make sure you understand the services that your plan covers, and the rules that you need to follow.

Before you get treatment, ask:

- Is it covered? Check your plan documents or call your insurer to make sure the service you need is covered by your plan.
- Do you need pre-authorization? If so, make sure you get your authorization first. Keep a record of the approval number and any supporting documents.
- Are there any restrictions? Sometimes, plans will only cover a certain number of specialist visits. For instance, you may only get 12 physical therapy visits each year. If you need more, claims for those extra visits will be denied.
- Be sure to check out www.fairhealthconsumer.org for a list of helpful questions that you can ask your plan and provider to avoid any confusion over what is, and what is not, covered.

If a claim is denied:

- Talk to your insurer first to make sure it wasn't an error, like a wrong code or missing information.
- If it wasn't an error and you decide to appeal, read your plan's appeal policy carefully. Call and ask questions if there is anything you don't understand.
- Make sure you file your appeal within the time frame that your plan requires: you don't want your appeal to be denied because it's late. Take note of your plan's appeal deadline.
- Make sure your appeal form or letter is complete and that you include any supporting documents that your plan requires. Your doctor may be able to help you.
- It's a good idea to document all communications that you have with your plan on a claim you are appealing. This would include records of when, what was said and to whom you have spoken with at your plan, and keeping a copy of everything you have sent and received from your plan.

And most importantly – remember that you are your own best advocate. Speaking up and asking questions up front will help you get the information you need to avoid claim denials and high out-of-pocket costs.

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