Cancer Legal Resource Center
A DRLC PROGRAM

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A CONSUMER'S STEP-BY-STEP GUIDE TO NAVIGATING HEALTH INSURANCE APPEALS

I. INTRODUCTION

This handout is a step-by-step guide to the internal and external appeals processes for health insurance for individuals with cancer whose insurance companies have denied a particular treatment based on medical necessity or experimental treatment.

Before beginning the process of appealing to an insurance company, it is important for individuals to remember that they have the following rights:

(1) A right to information about why a claim or coverage has been denied;
(2) A right to see and respond to all information used in the internal appeal decision; and
(3) A right to an independent review (also called an external appeal).

It is also important to remember that a consumer's rights regarding how to proceed with an internal and external appeal depend on the specific policies of the insurance company, and the laws of the state where the consumer lives. This guide will focus on information regarding the federal standards given under the Affordable Care Act (ACA), otherwise known as healthcare reform. **Note:** The ACA is the minimum standard that non-grandfathered insurance companies and states must meet, however, each state can have more protective laws. Check your state law to see what processes it has in place for internal and external appeals

II. HEALTH INSURANCE APPEALS

Before You Begin: Familiarize yourself with the following health insurance definitions:

- Health plan: The commonly used term for all types of health insurance and health plans (i.e. HMO, PPO, and POS plans).
- HMO (health maintenance organization): Requires that all of a patient's care be arranged through the patient's primary-care physician (PCP), who will refer the patient to specialists, therapists, etc. that are part of that HMO's network.
- PPO (preferred provider organization) plan: Allows the patient to use any providers (hospitals, doctors, and therapists) they choose, but the patient will pay less for services provided by health care providers that are part of that PPO network.

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- POS (point-of-service) plan: An HMO that allows patients to obtain services from health care providers who are not part of the HMO network, but the patient will pay less for services from providers within the network.
- Employer-sponsored health plan: A health plan that an individual enrolls in through their work. The employer generally makes a contribution toward the cost of coverage, and the employee pays for the remainder of the cost of coverage.
- Individually purchased health coverage: A health plan that an individual purchases on their own directly from a health plan, such as through a health insurance exchange. The individual is responsible for paying the entire premium on their own. State law governs both the internal and external appeals process for individually purchased health coverage.
- *Self-funded* employer-sponsored health plan: When an employer pays for health care costs of employees directly rather than purchasing insurance from an insuring organization. Often, self-funded plans process employee claims through a health insurance company, which acts as a "third-party administrator" for the employer's self-funded plan. The best way to find out if your plan is self-funded is to ask the person who administers the benefits where you work. **Internal appeals to self-funded plans are governed solely by federal ERISA regulations (see below) and individuals may not be able to use their state's external review process.**
- *Insured* employer-sponsored health plan: When an employer purchases health coverage from an insuring organization such as a commercial insurer, a Blue Cross or Blue Shield plan, or an HMO. **Internal appeals to insured health plans are governed by both federal ERISA regulations and state law, as long as the state external review law does not conflict with federal law.**
- ERISA (Employee Retirement Income Security Act): A complicated federal law, which governs the internal appeal process for employer-sponsored health plans and disability insurance programs provided as an employee benefit. For both insured and self-funded employer-sponsored health plans, ERISA regulations establish procedures and timelines for disputes involving claims for treatment coverage. ERISA requires that employer-sponsored health plans let the individual see all documents used by the health in its determination to deny coverage, prohibits more than two levels of internal review, and prohibits the health plan from charging a fee for the review.
- Internal Appeal: The review of denials that are conducted by the health plan.
- External Review (also called an Independent Review): The reconsideration of a health plan's denial of coverage by an outside, independent organization. Effective January 1, 2012, all 50 states require that health plans must provide an external review process. This review is conducted by an Independent Review Organization (IRO) (i.e. MAXIMUS is the IRO for the HHS Federal External Review Process).

Grandfathered Plan: A 'grandfathered' plan is one that existed on March 23, 2010 and has covered at least one person continuously from that day forward. The plan would be grandfathered whether it is an individual health insurance policy or a job-based health plan that an employer established before

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March 23, 2010 and the individual enrolled in that job-based plan sometime later. A grandfathered plan does not have to comply with the ACA appeals standards unless it significantly cuts benefits, substantially increases cost-sharing or deductibles, or decreases the amount it pays towards premiums by more than five percent. These plans may still fall under state law.

The Step-by-Step Internal Appeals Process: If you disagree with your health insurance company's decision, the first step is to appeal directly to your health plan. In most states, you must first exhaust your health plan's internal appeals process before requesting an external independent medical review of the insurance company's decision. **If you have an urgent medical condition, you can file for an expedited review and file both the internal and external appeals at the same time.**

Step #1: Collect All Relevant Data**:**

- Learn the details of your health plan:
  - Read your policy, contract, or Summary Plan Description.
  - Speak to your employer's Human Resources representative if it is a group plan.
  - Collect information on the type of plan, which services your plan covers, whether the plan is self-funded (for employer-sponsored plans), and the internal review processes of the plan.
- You have a right to information about why claims are denied. Get the reason in writing from your insurance company.
- Find your plan's coverage language, and figure out why the procedure you are seeking fits into a category of care that the insurer has promised to pay for.
- If you request it, your insurer must provide the name, title, and credentials of the person who made the decision, experts consulted, the medical review criteria used (or instructions for obtaining this info), and contact information and instructions for obtaining additional assistance.
- Start a file for paperwork such as medical bills and "Explanation of Benefits" letters from your health plan.
  - Record notes for every conversation you have with your insurance company. Keep a log of the date of the conversation and the name and contact number of the person you spoke to.
- Gather objective medical evidence to support your appeal that demonstrates why the insurance company should cover your claim. This may include copies of relevant medical records, a letter from your doctor, or even independent research on the treatment or procedure.
  - **Note**: It is not necessary to have this information to appeal, so don't delay filing if you cannot get this information! However, in some cases it can be helpful to have.
- Time limitations: If the insurance company plans to deny all or part of your claim, they must notify you in writing, within 15 days for prior authorizations; within 30 days for medical services already received; within 72 hours for urgent cases.

Step #2: Try to resolve the issue informally:

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- Contact your health insurance company over the phone to try to resolve the issue quickly. Keep track of who you spoke to and what was said. Hopefully the problem can be solved quickly. If not, follow-up in writing to formally begin the internal appeals process.

Step #3: Learn the appeals process requirements for your particular insurance company**:**

- Each insurance company has different internal appeals procedures. Make sure to follow these procedures closely.
- Know the time limitations your company has for the internal appeal and file your appeal within the time limits! Failure to observe the time limitations for an internal appeal may result in the loss of the opportunity for an internal *and* external review.
- Your doctor or the insurance coordinator at your doctor's office or hospital may be able to assist you with the appeals process by contacting the insurance company directly on your behalf, or providing advice about what has helped patients in the past who have gone through the appeals process for similar services or treatments.

Step #4: Write an effective appeals letter to your insurance company**:**

- Verbal appeals are often possible, but it is best to send the insurance company a letter requesting an appeal, along with supporting evidence if you have any. It is also important to send this letter via certified mail, so that you will be able to track the letter and confirm that your insurance company has received your request for an appeal.
- Time limitations: Federal ERISA regulations require that employer-sponsored health plans (both insured and self-funded) must give the individual at least 180 days after receiving notice that their claim was denied, to file an appeal. But, be sure to review your specific plan's time limits for each stage of the appeal process.
- In the letter, begin with the following identifying information: your name, policy number, group number, claim number, and clearly state that you are appealing the insurer's denial.
- It is important to include the reason for the denial that they explained in the denial letter; a brief history of the illness and necessary treatment; why you believe the decision was wrong; what you are asking the health plan to do (i.e., pay for the requested medical treatment); and a request for the insurer's file on the claim.
- Submit additional information, for example, a letter from your doctor, additional medical records, etc, if you have them available.
- Use the CLRC sample insurance letters for assistance.

Step #5: Keep a record of all correspondence and all conversations you have with your insurance company.

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- Be sure to include the dates and times of each contact, the name and title of every person you speak to, make copies of all correspondence, and send all correspondence via certified mail.
- Under new regulations established by the Affordable Care Act (i.e. Healthcare Reform), all health plans are now required to provide consumers with information regarding the plan's internal and external appeals processes, as well as provide notice about the availability of any applicable state office of health insurance consumer assistance or state insurance ombudsman. These resources in your state may be able to provide assistance or answer questions about your individual appeal.

Step #6: Follow up and be persistent:

- Your insurer must make a decision on the appeal within 30 days for prior authorization, within 60 days for medical services already received, and within 72 hours in urgent cases.
- Call your insurance company to ask about the status of the review and follow up until you receive an official, final response to your request for an appeal, in writing from your insurance company.
- Show your insurance company that you are proactive and persistent, and are willing to pursue the appeal process until you receive a favorable outcome. Some insurance companies intentionally make their appeals process confusing and tedious, so consumers will be deterred from appealing. Simply beginning the internal appeals process will show your insurance company that you will not back down until you receive your medical treatment.

The Step-by-Step External Appeals Process: Your Right to an Independent Opinion

If the insurer continues to deny your claim, you may have the right to appeal to an independent third-party for review (external review) of the insurer's decision. This means that the insurance company no longer gets the final say over many benefit decisions. The external review is conducted by an impartial expert who is not a direct employee of or related to your health insurer.

Time limitations: You must file a written request for an external appeal within 60 days of the date your health insurer sent you a final decision denying your services or your claim for payment. Some states or plans may allow you more than 60 days to file your request. The notice sent to you by your health insurer should specify the timeframe in which you must make your request. **If your health issue is urgent, you may file an external review request at the same time you file for an internal appeal**.

Effective January 1, 2012, health insurance issuers in every state must participate in an external review process that meets minimum consumer protection standards outlined in the Affordable Care Act (i.e. Healthcare Reform). Some states have external review processes that go beyond these standards, and all insurance companies in that state are required to follow the state's guidelines for an external appeal.

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Step #1: Find out if health issuers in your state follow a state-run external review process or participate in the Health and Human Services (HHS)-administered federal external review process**.**

- This information can be found on the final denial of the internal appeal letter from your insurance company, or at: https://www.cms.gov/CCIIO/Resources/Files/external_appeals.html.

Step #2: If your insurance company participates in the HHS-administered process, then you may request an external appeal in one of the following ways**:**

- Call toll free: 1-888-866-6205 to request an external review request form or download the form at http://www.externalappeal.com/Portals/8/Forms/ExtReviewReqInfoForm_28Jun12-AC3.pdf.
- Then fax an external review request to: 1-888-866-6190; or mail an external review request form to: MAXIMUS Federal Services 3750 Monroe Avenue, Suite 705 Pittsford, NY 14534; or submit a request via email: is ferp@maximus.com.
- Note: If you are in an employer-sponsored health plan, you may not be eligible to participate in a State run external review process, due to Federal ERISA regulations. Additionally, grandfathered plans do not have to comply with ACA appeals rules.

Step #3: Under the Affordable Care Act, if your insurance plan does not participate in a state or HHS-administered external review process, the insurer must contract with an accredited independent review organization to conduct external reviews**.**

- Your health plan is required to tell you how to request an external appeal, and must provide these instructions when your final internal appeal is denied. Some states require that you begin the external appeal process by contacting your health plan directly once again. Other states require that you contact your state's department of insurance or other state agency to begin the external appeal process.
- Possible assistance filing an external appeal is available through your state's Department of Insurance. To find contact information for your state's Department of Insurance, please visit: http://www.naic.org/state_web_map.htm.

Step #4: Your external appeal will be reviewed by an Independent Review Organization (IRO):

- The members of the IRO must also be individuals who are qualified to conduct the external review based on the nature of the health care service in dispute and must have no conflicts of interest that may influence their decision. IROs are typically comprised of lawyers, doctors, nurses, or other consultants in that particular area.

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- Consumers must be allowed to submit additional evidence in writing to the IRO that the IRO must consider when conducting the external review, and the claimant must be notified of the right to submit additional information to the IRO.
- For standard external review, the IRO must provide written notice to the health plan and the consumer of its decision to uphold or reverse the adverse benefit determination within no more than 45 days after the receipt of the request for external review. This decision is binding on both the individual and the health plan. Health plans must also provide an expedited external review process for urgent circumstances and, in such cases, provide notice of the decision no later than 72 hours after receipt of the request for external review.
- If you are not satisfied with the result of the external review, you may be able to file a lawsuit in court at this point.

III. INSTRUCTIONS

The following sample letter is designed for individuals who are appealing an insurance company denial. The purpose of this letter is to provide such a person with an internal appeals request. Please note this sample letter is not intended to be legal advice or a substitute for professional services. It does not establish an attorney-client relationship.

Please read the following before filling out the sample letter:

Replace the sample text in parentheses with your own information.

Either the first or the second paragraph should be included, but not both. The first should be used if you have already received the service or treatment, but the insurance company denied payment. The second should be used if the insurance company has denied a pre-authorization request.

Delete any text that is in *italics* as this is meant to be instruction for you and is not meant to be included in the letter.

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[Date]

Customer Service Department

[Health Plan Name]
[Address] [City, State, Zip Code]

Re: Appeal for [your name]
[Group/Policy Number]

Dear Customer Service Department:

[Paragraph 1] I am writing to seek coverage from [health plan name] for a bill I received for [type of service or procedure]. [Name of provider/doctor] provided this service on [date] for [state reason for treatment – i.e. for treatment of [medical condition]]. I have been billed for [dollar amount of bill], however I believe [health plan name] should cover this procedure. At the time of service, I was covered by your health plan and the care received was a covered service. Included with this letter is a copy of my insurance card with the effective date. *[Attach a photocopy of your card]*

[Paragraph 2] I am writing to seek pre-authorization from [health plan name] for [type of service or procedure]. [Name of provider/doctor] intends to provide this service on [date] for [state reason for treatment – i.e. for treatment of [medical condition]]. [Health plan name] has denied a pre-authorization for this procedure, however I believe it should be covered. I am currently covered by your health plan and this is a covered services. Included with this letter is a copy of my insurance card with the effective date. *[Attach a photocopy of your card]*

On [date] I called [health plan name] and spoke with [name of representative] regarding this issue, but the problem has not yet been resolved.

[If you wish you can include a paragraph with information about why you think the service should be covered, such as it is a covered service under my health plan, I was referred by a primary care physician, the services were/are medically necessary, or the service is a required coverage under state or federal law [cite to specific law]. This information is not necessary for an appeal. Note - if the insurance company denies you, they must provide you the reason for the denial in writing.]

Thank you for your prompt response to this request. As you know, [health plan name] is required to provide me, in writing, with your final answer. Additionally, if it is a denial, you must provide me with

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the specific reason for denial. If this issue is not adequately resolved through [health plan name], I intend to appeal the decision through the state's external appeal system.

Sincerely,

[Name]

[Address]

Cc: _____ [anyone else you are sending this letter to]

[some possible individuals to send the letter to are your primary care physician, the provider who is billing you, your employer or your medical group, and the health plan.]

Enclosures:

[Copy of bill]

[You can also put in other materials or documentation such as copies of portions of your policy, copy of a letter from your doctor, medical records, or medical journal articles supporting medical necessity of care. However, this documentation is not required for an appeal.]

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Below is a sample of a completed letter appealing an insurance company's decision:

January 1, 2016

Customer Service Department
ABC Health Care Insurance Company
100 Main Street
Big City, CA 90000

Re: Jane Smith, PPO, Group 123 / Policy Number ABC456

Dear Mr. Health Care Representative:

I am writing to seek coverage from ABC Health Care Insurance Company for a bill I received for a colonoscopy. Dr. Healthy provided this service on October 26, 2015 as part of my treatment for colon cancer. I have been billed for $2010, however I believe ABC Health Care Insurance Company should cover this procedure. At the time of service, I was covered by your health plan and the care received was a covered service. Included with this letter is a copy of my insurance card with the effective date.

On December 29, 2015 I called ABC Health Care Insurance Company and spoke with Joe Worker regarding this issue, but the problem has not yet been resolved.

Thank you for your prompt response to this request. As you know, ABC Health Care Insurance Company is required to provide me, in writing, with your final answer. Additionally, if it is a denial, you must provide me with the specific reason for denial. If this issue is not adequately resolved through ABC Health Care Insurance Company, I intend to appeal the decision through the state's external appeal system.

Sincerely,

Jane Smith
Cc: Dr. Robert Healthy
Enclosures