



Bucks

Making the Most of Your Money

7 Steps in Appealing a Health Insurance Denial

By ANN CARRNS | July 11, 2011

It's unsettling to receive a letter from your insurance company telling you that your request for medical care, or for payment of care you've already received, has been denied. But there are some steps you can take to help boost the odds of filing a successful appeal.

Martin Rosen, a co-founder of Health Advocate, Inc., a business that helps people who get their insurance through their employer navigate dealings with their insurance company, says the key to avoiding a denial in the first place is knowing the details of your insurance policy before you seek treatment. **(The company also offers advocacy services, for a fee, through Health Proponent, for those who buy insurance on their own.)** But if you do receive a letter denying coverage, and you and your doctor believe you have a strong case to fight the denial, **Mr. Rosen offers these tips:**

Check the details of your insurer's appeals process. In the coverage documents and summary of benefits, insurance companies are required to give all the tools needed to properly make an appeal. There are often deadlines to meet, so act quickly.

Have your paperwork in order. Keep records of everything: the bills from your provider, your explanation of benefits, copies of denial letters, medical records, letters from your provider of care, etc.

Call your human resources department if you receive coverage through your employer. The department may provide direction, advocate on your behalf and help to translate the fine print of the policy.

Enlist the help of your doctor. Check the medical policy and ask your doctor to review it to prepare something called a letter of medical necessity to support your case.

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Take detailed notes when you speak to the insurance company. Write down the time and date, length of the call, the name and title of the person you speak with and all the details of the conversation. Make note of any follow-up activities and next steps by all parties.

Write down your argument. Make notes of exactly what happened, when and why. If you are seeking approval for treatment, note any supporting science, clinical evidence, expected benefits, etc. Be clear, firm and concise. Make it clear that you plan to pursue the appeal until it is resolved, the claim is paid or care is approved.

Follow up with your insurance company. Many appeals take weeks, even months, so call often to check the status and take notes of each call.

Most insurance companies have at least a three-level appeals process. Appeals at the first level are usually processed by the company's appeals staff or by the company's medical director responsible for the denial. Second-level appeals are reviewed by a medical director not involved in the original claim decision. And the third level usually involves an independent, third-party reviewer, along with a doctor who is board-certified in the same specialty as the patient's doctor.

If your appeal is elevated to the third level and the insurance company continues to deny the claim, you can then take the appeal to the state level. Processes vary by state; you can contact your state's insurance department for details.

If you feel too frail or overwhelmed to pursue an appeal yourself, nonprofit groups like the Patient Advocate Foundation can provide guidance for free. **Fee-based services like Health Proponent are also an option.** The service has been experimenting with different fee structures and is joining with affinity groups, like alumni associations and the American Automobile Association, to broaden its membership.

Health Proponent charges \$29.95 a year for individuals and their families to join and charges additional fees, depending on the type of service it provides. If you have a claim denied, for instance, it will research the problem for a flat fee of \$99. (That means using the service for claims of less than that amount doesn't make sense.)

If you have uncovered medical bills totaling at least \$400, the company will attempt to negotiate a reduced bill (there's no upfront charge for the service, beyond the annual membership fee). **The service previously charged an hourly rate for this service, Mr. Rosen said, but has switched to a percentage fee.** If the company can't negotiate any savings, you pay nothing to Health Proponent; if it does get the bill reduced, you pay 25 percent of the savings as a fee. (Say you are billed \$10,000 which is not covered by your insurance, and the company negotiates the amount down to \$5,000 — half the total. You pay \$5,000 to the provider, plus a fee of \$1,250 to Health Proponent. So you pay a total of \$6,250, a savings of about 38 percent.)