

How to Appeal Your Medication Device Claim

Step 1: Gather Information

If you do not already have a file and a notebook to document all correspondence, start one now. You should keep a record of all letters you receive and a log of all telephone calls you make or receive related to the denial. Over time you may forget people's names and dates.

This documentation will help you stay organized and focused on your goal. There are specific questions you need to ask once you are notified the procedure will not be covered through pre-authorization.

- When did you receive notice of the denial?
- How did you receive notification of the denial?
- Did your doctor notify you directly, or did the administrator or insurer notify you directly?
- Did you receive a letter or phone call from the insurance company?
- Did you receive a statement from your insurance company stating that your bills will not be paid?

First and foremost, **you need to get a copy of the denial letter.** Under the Employee Retirement and Income Security Act (ERISA), your denial letter should include a **specific reason** for the denial and a reference to your plan explaining the basis for the denial. For example, is your insurance company denying paying for your treatment because it considers it to be experimental? Or, do you belong to an HMO that does not have out-of-network benefits and you wish to go to an out-of-network provider? Place a call to the doctor's office and find out what information was submitted to the insurance company and ask for a copy of the information and the letter written by your doctor requesting payment authorization. If your requests are ignored, you should put them in writing to make a record of your attempts to obtain the information you need.

If you have received a denial for a procedure that has already taken place and there are bills that are unpaid, you need to begin to backtrack to find out why.

- Does your insurance company require procedures to be pre-authorized?
- If so, did your doctor's office pre-authorize the procedure?

This brings up the most important documents you have and need: your plan document and plan summary, or health insurance booklets. The plan document and plan summary are essentially a contract between you and the insurance company. You need to be sure that you have a current copy. If you do not have a copy, you must write to the plan administrator and request that a copy be sent to you. Under ERISA, these documents must be sent to you within thirty days of the written request or the company may be assessed penalties. **READ** your plan language. What does it say about your procedure and specific reason for denial? Under ERISA, a specific reason for denial must be stated in language that would be understandable to an employee. If the procedure was to be pre-authorized, do you or your doctor have a copy of the authorization or the approval from the insurance company? If no pre-authorization was required review specific exclusions listed in your plan. If your treatment is not identified as a specific exclusion, you need to begin your appeal.

- Who can you contact to discuss the denial?

You need specific names and numbers of contact people. The denial letter from the insurance company may contain this information. You may need to call the insurance company and ask for a contact person. Be sure to ask for that person's direct line. Ask the staff at your doctor's office who you can call to ask questions and get any letters or records you may need. If you will be receiving your treatment at a facility away from home, be sure to have the name and number of your treating doctor's nurse. You will likely need to get letters from the treating doctor as well. You also need to be sure that you have a written copy of the steps that you must take in order to appeal the denial. This information should be in your plan document. It may also be in the denial letter. You may need to request this information from the insurance company. Be sure you understand each step of the appeal process. It is your path to obtaining reimbursement.

By answering these questions and collecting these documents you have the initial information you need. You have your plan document, your denial letter and you have the names of the contact people at the insurance company and the doctor's office.

Now you must begin to educate yourself and continue to research the issue to achieve your goal of reimbursement. If you still do not understand your rights, or the appeal process is unclear, and the employer or insurer will not or cannot explain further, it may be helpful to contact an attorney.

When to Consult an Attorney

This is an important question and one that is asked frequently. There is no right or wrong answer. Many people feel more secure discussing their case with an attorney when they receive the denial. Others would rather appeal the decision on their own to see if they can overturn it without legal help and expense. For some it depends on the cost of the procedure which has been denied. It may make more sense to seek legal advice if the procedure costs \$100,000 than if the procedure costs \$1000. As previously mentioned, if you do not understand the appeal process or you are unable to get answers from your employer or insurance company, an attorney may be helpful to advise you of your rights and options. This is an individual decision. If you decide to seek legal advice you should consider the following:

- Select an attorney with experience in healthcare law.
- Discuss the legal fees up front and request a detailed billing.

- Determine at what point the attorney will take over the case.

Some patients will completely exhaust the administrative appeal process before they ask an attorney to take over the case. It is imperative that you make every effort to have an attorney involved in the case throughout the administrative appeal process in the event you wish to pursue the case later in court.

Others to Notify

Insurance and patient's rights are a hotly debated political issue. Patient's often ask if it is helpful to notify their state and local representatives of their insurance issues. In some cases it has been helpful. Other times patients get nothing more in return than a form letter stating there is nothing their legislator can do. You may choose to approach this question by asking yourself, "What do I have to lose?" You are already preparing your own appeal letter. You could easily send a copy of your denial letter and your appeal letter to your legislators asking for any assistance they can provide.

It may also be beneficial to notify your State Department of Insurance. The duties of the insurance commissioner and the Department of Insurance vary from state to state. One of the main objectives is to be sure the insurance company is following the patient's policy. The Department of Insurance may also be aware of any state laws that may come in to play in a specific case. Many states require that problems be reported by the patient in writing and may even require that their forms be filled out. It can be helpful to notify the Department of Insurance in your state when you receive the original denial. You can call them to request a copy of the necessary paperwork to submit your complaint.

In some rare instances it may be necessary to contact the media. This is recommended only if you have tried at length to resolve the problem and have enlisted the help of your legislators and the Department of Insurance with no resolution.

Expedited Review

If you have received a denial for a procedure that must be performed within a specific time frame, you and your doctor need to communicate that to the insurance company immediately. Most states have laws protecting patients in an emergency. That may be different if the procedure must be started in near future. Most insurance companies already have a plan in place for such occurrences and their guidelines will be different. If you do not feel that you are making progress toward your goal and time is short, you may choose to consult an attorney to advise you of your rights and options.

When to Contact the Patient Advocate Foundation

You may contact PAF at any point in the process for our advice, guidance, and support. The appeals process is very complicated. It requires you to gather information and write letters. You need to keep a notebook and a file for documentation. You need to remain courteous and polite when working with your insurance company, while you are dealing with the stress of an illness. You now know what steps to take to appeal your denial. Take this process one step at a time.

Take it one day at a time. The PAF would be happy to answer any questions you may have. To reach the Patient Advocate Foundation:

753 Thimble Shoals Blvd.
Suite B
Newport News, VA 23606
Phone: 1.800.532.5274 -or- 757.873.6668
Fax: 757.873.8999
Email: help@patientadvocate.org
INTERNET: www.patientadvocate.org

Step 2: Understanding the Illness and the Insurance

You need to understand your condition or your loved one's condition before you can discuss the case with the insurance company. It is very important that you understand exactly what the doctor wants to do and why it is necessary. Read any copies of the letters your doctor may have submitted to the insurance company. The initial letter typically discusses the patient's case in simple medical terms and then explains what the doctor proposes to do. This letter is often referred to as the "treatment plan" or "plan of care". You can also ask your doctor or nurse to explain it further. Often they may have written material that may be helpful, or they may be able to direct you in finding more information.

You need to be familiar with the type of insurance you have. If your insurance is through your employer or your spouse's employer, call the benefits manager and ask him or her to explain the coverage. For example, is the employer self insured and does the employer contract with a third party to administer the plan? Or does the employer contract with an outside company to administer the plan and pay the claims? It makes a difference because you may be able to get your denial overturned by working with the benefits manager or the designated representative of Human Resources. If the company is not self-insured, explaining the problem to the benefits manager, both verbally and in writing, may be very beneficial. The benefits manager can, in some situations, put enough pressure on the insurance company to get the denial overturned. Also, if the employer has had problems with the insurer they may choose not to renew the contract with that insurance company.

Step 3: Write the Appeal Letters

After you have gathered the preliminary information and have a basic understanding of the illness and the insurance policy, you are ready to start the appeal process. Some appeals are handled by the doctor's office or the clinic or the hospital. In this situation, the patient is usually put in contact with a case manager who has experience in the appeals process. In this case, the patient should understand the steps in the process and should "oversee" what is being done. It is suggested that the patient request copies of all letters and

correspondence to and from the insurer. The patient should also be in close contact with the case manager or person handling the appeal for them.

In other situations, the patient and family are informed of the denial and they must handle the appeal on their own. If this is the case, you must manage your appeal. Your appeal should include:

- An appeal letter
- A letter from your doctor and specialist addressing specifics of your case.
- Any pertinent information from your medical records.
- Any articles from peer-reviewed clinical journals that support your case that illustrate medical efficacy.

The Appeal Letter

The purpose of the appeal letter is to tell the insurance company that you disagree with their decision and why you believe they should cover the procedure. The letter should be factual and written in a firm but pleasant tone. When writing your appeal letter you should include:

- *Your identification.* This includes your policy number, group number, claim number, or other information used to identify your case.
- *The reason for the denial that they explained in the denial letter.*
- *A brief history of the illness and necessary treatment.* Typically this information will be included in the doctor's letter in detail but it can also be helpful to add a shorter and less complicated version in the patient's letter.
- *The correct information.* If you believe the decision was made because of an error, state the correct information, i.e. is the denied procedure different from the requested procedure? Maybe a coding error was made and the insurance company believes you will be receiving a different drug.
- *Why you believe the decision was wrong.* Specific information based on facts to show that the treatment should be provided, i.e. you may have to go out-of-network for a procedure but only because the procedure is medically necessary according to your doctor and there is no in-network provider for the treatment.
- *What you are asking the insurance company to do.* Typically you are asking that the insurer reconsider the denial and approve coverage for the procedure in a timely manner.

Sample Appeal Letter

The Sample Appeal Letters included in this guide are designed to be a general guide for your specific letter. Sample Appeal Letter A was written as though the denial was based on a question of medical necessity. Sample Appeal Letter B addresses the issue of a denial based on out of network benefits. Each patient and each denial are unique. It is recommended that you read each letter and then identify other important details that need to be added to your letter. You must also remain factual. It is very important that your denial letter be focused on the intended outcome.

[Sample Letter A](#)

Sample Appeals Letter A

(Date)

(Name)

(Insurance Company Name)

(Address)

(City, State ZIP)

Re: (Patient's Name)

(Type of Coverage)

(Group number/Policy number)

Dear (Name of contact person at insurance company),

Please accept this letter as (patient's name) appeal to (insurance company name) decision to deny coverage for (state the name of the specific procedure denied). It is my understanding based on your letter of denial dated (insert date) that this procedure has been denied because:

(Quote the specific reason for the denial stated in denial letter)

As you know, (patient's name) was diagnosed with (disease) on (date). Currently Dr. (name) believes that (patient's name) will significantly benefit from (state procedure name). Please see the enclosed letter from Dr. (name) that discusses (patient's name) medical history in more detail.

(Patient's name) believes that you did not have all the necessary information at the time of your initial review. (Patient's name) has also included with this letter, a letter from Dr. (name) from (name of treating facility). Dr. (name) is a specialist in (name of specialty). (His/Her) letter discusses the procedure in more detail. Also included are medical records, and several journal articles explaining the procedure and the results.

Based on this information, (patient's name) is asking that you reconsider your previous decision and allow coverage for the procedure Dr. (name) outlines in his letter. The treatment is scheduled to begin on (date). Should you require additional information, please do not hesitate to contact (patient's name) at (phone number). (Patient's name) will look forward to hearing from you in the near future.

Sincerely,
(Your name)

Sample Appeals Letter B

(Date)

(Name)
(Insurance Company Name)
(Address)
(City, State ZIP)

Re: (Patient's Name)
(Type of Coverage)
(Group number/Policy number)

Dear (Name of contact person at insurance company),

Please accept this letter as my appeal to (insurance company name) decision to deny coverage for (state the name of the specific procedure denied). It is my understanding based on your letter of denial dated (insert date) that this procedure has been denied because: (Quote the specific reason for the denial stated in denial letter)

I have been a member of your (state name of PPO, HMO, etc.) since (date). During that time I have participated within the network of physicians listed by the plan. However, my primary care physician, Dr. (name) believes that the best care for me at this time would be (state procedure name). At this time there is not a physician within the network who has extensive knowledge of this procedure. Dr. (name of primary care physician), a plan provider, has recommended that I have the procedure done outside the network by Dr. (name of specialist) at (name of treating facility).

I have enclosed a letter from Dr. (name of primary care physician) explaining why he recommends (name of procedure). I have also enclosed a letter from Dr. (name of specialist) explaining the procedure in detail, his qualifications and experience, and several articles that discuss the procedure.

Based on this information, I am asking that you reconsider your previous decision and allow me to go out of network to Dr. (name) for (name of specific procedure). The procedure is scheduled to begin on (date). Should you require additional information, please do not hesitate to contact me at (phone number). I look forward to hearing from you in the near future.

Sincerely,
(Your name)

Your Doctor's Appeal Letter

You should also ask your doctor and your specialist to write a letter discussing your specific case and why your treatment is medically necessary. The letter should be addressed to the person at the insurance company that sent you the denial letter, or directly to the medical director at the insurance company. It should include:

- Any information about your illness that your doctor feels is clinically important.
- The prescribed treatment plan.
- Why the treatment is medically necessary.

[Sample Physician's Letter](#)

Sample Physicians Letter

(Date)

(Name)
(Insurance Company Name)

(Address)
(City, State ZIP)

Re: (Patient's Name)
(Type of Coverage)
(Group number/Policy number)

Dear (Name of contact person at insurance company),

It is my understanding that (Patient's name) has received a denial for (name of procedure) because it is believed that the procedure is (state specific reason for the denial i.e., not medically necessary, experimental, etc.)

As you know, (patient's name) has been under my care since (date) for the treatment of (state disease). (Give a brief medical history emphasizing the most recent events that directly influence your decision to recommend the denied therapy.)

For this reason I am writing to provide you with information regarding (name of denied procedure). (Give a brief, yet specific description of the procedure and why you believe it should be approved.)

I have also included several journal articles supporting the use of (name of procedure) for (patient's name) (name of disease).

I ask that you reconsider your previous decision based on the information above. I believe therapy should begin on (date). Should you have any questions, please do not hesitate to call me at (phone number).

Sincerely,
(Doctor's Name)

Medical Records

Ask your doctor and specialist if there are any documents in your medical records that may be helpful in your appeal. For example, it may be helpful to send a pathology result documenting the specific cell type. In the case of certain cancers, the insurance company may need to see what chemotherapy drugs you have already received. In some cases the insurance company may ask to see specific documents from your medical records.

Articles from peer-reviewed clinical journals

Often an insurance company will deny a procedure because they believe there is not enough evidence that the procedure is helpful for a specific disease. If you and your doctor believe this is the basis for your denial, you need to submit documentation that the procedure is effective. This documentation should be in the form of articles that come from the professional journals or "magazines" that doctors use to keep up to date on the latest treatments. These journals have editorial boards of physicians who specialize in specific areas of medicine. That is what makes a journal "peer reviewed". This type of documentation has become very popular with the insurance companies and it is very common for them to request this type of documentation. Your physician and specialist have probably had such a request for information in the past and they can assist you in obtaining these articles.

These four pieces of information should be put together in a "packet" and be submitted to the insurance company by registered mail or some other form that you will be able to track and find out who signed for the information. This will alleviate the excuse that the information was "never received". You should keep a duplicate copy of all the information you are submitting and add it to your file. You may wish to call to confirm receipt of your materials.

After the denial has been received and your appeal has been submitted, the next thing to do is wait for a response. Waiting can be the hardest part. Your plan probably gives a length of time that the insurance company has to respond to your appeal. If it does not, you need to ask the benefits manager or the insurance company when you will be notified of the response. If you are unable to get a response, you may want to consider legal counsel. (see "When to Consult an Attorney Above")

Sample Appeal Letters

The Physician's Sample Appeal Letter is also a general guide for a specific letter. Most physicians have written appeal letters many times. Some are far removed from the appeal process and are unsure of the specifics of your denial. They may also be unsure of the amount of information necessary. It is important that you communicate the specific reason for the denial to your treating physician and ask that they write their appeal letter with enough information to address the denial specifically.

Step 4: Evaluate the Results

If you receive a phone call or a letter informing you that your denial has been overturned and the insurance company will cover the procedure, **Congratulations!** Before you celebrate you need to request a copy of the approval letter. You also need to be sure that you are aware of any conditions that are included. For example, you may get an approval to have the surgical procedure, but the insurance company may only cover it if it is performed by one of the doctors in their plan that you have never seen. If the conditions are unreasonable and unacceptable to you, discuss them with your doctor and insurance contact person. You may consider continuing with the appeal process. Most plans have several levels of appeal.

If your appeal has been denied, you also need a copy of the second denial letter. Like your original denial letter, this letter must also contain the specific reason for denial. Read the letter carefully. It may have a different reason for the denial. For example, the original denial letter states that a bone marrow transplant was denied because it was not effective for the disease, and was to be performed "out-of network". You submitted your appeal and all the appropriate documentation. The second denial letter rejects the procedure because "there was not enough evidence provided to show that the transplant is medically necessary". These are very different reasons for denying the same procedure.

Typically, the second level of appeal will be reviewed by a different group of people at the insurance company. Usually your second denial

letter will explain the reason for denial and may even ask that you submit specific information that was not received with your first appeal letter. Be sure to notify your doctor of the decision and the new information that is needed. This denial letter may instruct that if you are interested in appealing further that you send your letter and new information to a different person. If you decide to continue with the appeal process, you should submit another appeal packet with new information specifically addressing the current reason for denial. Again, keep copies of all information and send the packet registered mail, return receipt requested. If your appeal is again denied, you should request the third denial in writing and notify your doctor. If you believe your insurance company should cover the procedure and are willing to proceed with the appeal process, you should refer to your plan document for the next step.

At this point some insurance companies will offer you what they call an "external review". This means that the insurance company will send your appeal to a company that they contract with who will review the denial, the appeal, and any new information and make a recommendation to the insurance company about the procedure in question. The external review board is typically made up of nurses, attorneys, and doctors who specialize in the specific procedure you are asking the insurance company to cover. In some states the law allows the patient to request that your case be sent for an external review.

To date, the following states have external review boards:

Arizona	California	Connecticut
Florida	Hawaii	Illinois
Maryland	Minnesota	Missouri
New Jersey	New Mexico	New York
Ohio	Pennsylvania	Rhode Island
Tennessee	Texas	Vermont

If you live in a state that has an external review board, you can contact the state department of insurance for further information.

While external review can be very beneficial, it is important that the limitations are clear. The external review company can only act within specific parameters. They cannot override your policy. They can make decisions based on your policy guidelines. For example, you need to have surgery and want an out-of-network doctor miles from your town to perform the surgery but you have a policy with no out-of-network benefits. Your insurance company agrees that you need the surgery and has an in-network surgeon in your town. If the surgeon in your town is in-network and is qualified to perform the surgery the external review board would probably not be helpful because of the nature of your request. However, if you and your surgeon believe that the surgeon in your town is not qualified to perform the surgery for a specific reason and you can support this with the necessary documentation, the external review board may be able to substantiate your claim. That may result in the insurance company overturning your denial.

At this point, if you have exhausted all the levels of appeal and are not satisfied with the decision, your remaining alternative may be to pursue the issue in court.