OFFICE of the INSURANCE COMMISSIONER WASHINGTON STATE

How to appeal a health care insurance decision

A guide for consumers in Washington state

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OFFICE of the INSURANCE COMMISSIONER WASHINGTON STATE

Table of contents

Introduction 1
Where to start 2

SECTION A: Information about appeals

STEP 1: Identify your plan and status
- **1.1 Identify your type of insurance coverage** 3
- **1.2 Identify if your issue is "pre-service" or "post-service"** 4
- **1.3 Is your issue urgent?** 4
- **1.4 Accidental billing error or intentional denial?** 5
- **1.5 What does your plan cover?** 7

STEP 2: Learn who regulates your health plan and what to do once you've decided to appeal
- **2.1 Different plans have different regulators** 8
- **2.2 Chart: Which law does your plan follow?** 9
- **2.3 Where to find appeals information for plans not subject to state and federal requirements?** 10
- **2.4 What do do before you file your appeal** 12
- **2.5 Gather all necessary documents** 13

STEP 3: The appeals process for grandfathered & non-grandfathered ("other") plans
- **3.1 Information about filing your appeal** 14
- **3.2 Overview of the appeal process for grandfathered plans** 15
- **3.3 Overview of the appeal process for non-grandfathered ("other") plans** 16

STEP 4: Increase your chances of winning your appeal
4.1 Tips for drafting your appeal 18
4.2 Things to avoid when drafting your appeal 20
4.3 Summary of recommended best practices and tips - for all types of health coverage 22
4.4 Tips for writing a good appeal letter 26
Sample templates and letters 27-35

SECTION B: Additional resources 36
Appeals tracks 1-6 37-41
"Keeping track of your communications" log 42
Your "Important information" worksheet 43
FAQ about Washington state laws 45
Glossary of terms 46
List of additional agencies, websites and places for you to use as a resource 55

Information provided in this guide is intended as general summary information for the public. It's not intended to take the place of any applicable law or regulations.

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Dear Washington state resident:

Federal health care reform impacts nearly everyone in our state. The Patient Protection and Affordable Care Act changes how health care is purchased and provided.

One of my responsibilities as insurance commissioner is to advocate for Washington consumers and help you get the information you need to make insurance decisions.

This guide is designed to help you understand your appeal rights under current law, determine what rights you have under the Affordable Care Act, and learn where to go for more information.

If you have any questions about the guide or an insurance issue, please call our Insurance Consumer Hotline toll-free at 1-800-562-6900 or e-mail me at AskMike@oic.wa.gov.

We're here to help you.

Sincerely,

Mike Kreidler
Washington State Insurance Commissioner

Introduction

This guide provides you with information about how to appeal a health care decision your health plan made.

Specifically, it provides:

- Information about what can be expected throughout the process.
- Tips on how you can increase your chance of winning your appeal.
- Information about how the appeals process will evolve with health care reform.
- Additional resources for information not found in this guide.

This guide will help you learn what options you have when you receive a denial from your health plan and will recommend best practices for your appeal.

To file an actual appeal, you or your authorized representative will need to follow the process established by your health plan.

The Patient Protection and Affordable Care Act & Grandfathered plans

With the passing of the Patient Protection and Affordable Care Act (PPACA, or ACA) often called "health care reform," on March 23, 2010, the new appeal rights were granted to consumers in certain kinds of plans.

The plans that are expected to comply with the new law are either:

- Plans that came into existence after the law was signed; OR
- Plans that were in existence before the law was signed that have made certain changes resulting in reduced benefits, higher costs to consumers, or both.*

Plans not expected to comply with the new law are those that existed before March 23, 2010, and have not made significant changes to the benefits or costs paid by the consumer. These plans are known as *grandfathered plans*.

Because of this distinction, it's important for someone appealing a health care decision to know whether his or her plan is a grandfathered plan, or if it's considered an "other" kind of plan. (Discussed in greater detail in Step 3.1, on page 17.)

By law, carriers must notify plan participants in writing if they are maintaining grandfathered status. Most likely, it will be in the benefits booklet sent out at the start of every plan year.
*"Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans:" www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/keeping-the-health-plan-you have-grandfathered.html.

Where to start

Appeals are generally made up of the same three phases:

Phase 1 —> Denial of request for service, payment, or coverage
Phase 2 —> Internal appeal to your health plan or carrier
Phase 3 —> External appeal to an independent review organization (if applicable)

Depending on which phase you're in, you might want to read the whole guide, or you might want to read specific sections. The table of contents will help you navigate around the guide if you choose to read specific sections.

If, at any point, you need help understanding the contents of this guide or you have a question that isn't answered here, please call our Insurance Consumer Hotline at 1-800-562-6900. Our Consumer Protection Division is currently designated by the U.S. Department of Health and Human Services as the official ombudsman in the State of Washington for consumers who have questions or complaints about health care appeals.

Recommended best practice

When in doubt, ask your health plan to re-evaluate the denial

Your health plan CANNOT drop your coverage or raise your rates because you ask them to reconsider a denial. You're allowed to ask for an appeal – it's your right.

SECTION A: Information about appeals

STEP 1: Identify your plan and status

1.1 Identify your type of insurance coverage

Find your source of coverage	→ Type of Plan
Are you or your family signed up for a plan that your employer offers to the employees at your workplace, or that you buy through an association?	If yes, then you have a group plan
Do you have insurance through a public program? For example: Medicare, Apple Health or another kind of state or federally-sponsored program?	If yes, then you have a government-sponsored plan
Do you have a policy that you or a family member bought directly from an insurance company?	If yes, then you have an individual plan

If you have any of the policies listed below, you'll need to contact the provider of the policy to learn what appeal process might be available to you since these policies are not recognized as health plans by Washington state law.*

• Long-term care insurance • Medicare supplemental coverage • Limited health care services • Disability income insurance • Coverage provided from an auto or homeowner's personal injury claim • Worker's compensation coverage	• Accident only • Fixed payment indemnity or "mini-med" insurance • Critical illness coverage (a policy for serious illness, like cancer) • Dental or vision only coverage • Short-term limited purpose insurance (for example, student coverage)

* RCW 48.43.005(26)(a-l)

1.2 Identify your type of insurance coverage

Chances are you received a denial from your health plan based on one of the following:

- It refused to pay your medical provider for all or some of the care you've already received, which is known as a **"post-service"** determination, or
- It denied approval for treatment you're currently receiving – or for future treatment your medical provider recommends – which is known as a "pre-service" determination.
    - If you have a pre-service issue, and it's an urgent medical situation, you may qualify for a shorter turnaround time on your appeal. For more information, see Step 1.3 below.

If you have another type of issue (such as an eligibility issue), contact us at 1-800-562-6900 and ask if your issue qualifies for an appeal.

1.3 Is your issue urgent?

If your situation's urgent, your health plan will decide your appeal faster than if it's a non-urgent issue. This is called an **expedited appeal.**

You can file an expedited appeal if you:

- Are currently receiving or you were prescribed to receive treatment; and
- Have an "urgent" situation. Urgent means a medical provider believes a delay in treatment could seriously jeopardize your life or overall health, affect your ability to regain maximum function, or subject you to severe and intolerable pain.
  -OR-
- Have an issue related to admission, availability of care, continued stay, or health care services received on an emergency basis and have not been discharged.

You cannot file an expedited appeal if:

- You already received the treatment and are disputing the denied claim, or
- Your situation is **not urgent**.

Who decides if your situation is urgent?

A medical provider with knowledge of your medical condition or the medical director of your insurer.*

How do you file an urgent appeal?

You, or your authorized representative, may file your expedited appeal with your health plan verbally.

As of Jan. 1, 2012, your health plan must respond as soon as possible, preferably within 24 hours, but in no case longer than 72 hours. They may deliver the response verbally, but must issue it in writing no later than 72 hours after the decision.

*RCW 48.43.530(5)(c)
**WAC 284-43-3170

If you need to file an urgent appeal, we suggest you, or your authorized representative, call your health plan immediately.

1.4 Accidental billing error or intentional denial?

If your claim was denied, first rule out the possibility of a billing error. Re-read the material your health plan sent you, most likely an Explanation of Benefits (EOB) statement, and confirm that:

- You (or a covered family member) made the visit to a medical provider
- The correct groups are represented (you, the provider and the health plan)
- Your medical provider billed your health plan for the correct:
  - Charges
  - Date of service
  - Current medical codes, and listed services you received in the correct order

If any of these details are not correct, or you have questions on what certain codes mean, call your medical provider's office and ask them.

If they tell you everything was billed correctly, and you believe your insurer should have paid the bill, we recommend you continue reading this guide. You may also call our Insurance Consumer Hotline at 1-800-562-6900 and we'll help you decide if you need to file a complaint with our office, or file an appeal with your health plan, or both.

Recommended best practice

Keep detailed records

Before you contact anyone, create a record log to document what:

- Type of contact you made (phone, email, in-person conversation, letter, etc.)
- The date
- Who you talked to
- What was said

Check out the communications log in Section B to see one example of how to keep track of your contacts.

One reason to keep detailed records is that insurance companies will often honor any mistakes they make.

For instance, if you received incorrect information from an insurance company's customer service representative, the company will verify that information was given to you and they will generally honor that mistake in your favor – but only on past denials. They will not make the same decisions in the future once they provide the correct information.

Recommended best practice

Billing errors

If you think a billing error occurred, ask your doctor's office (or search online) for a detailed description about what the Current Procedural Terminology (CPT), or treatment code means. Sometimes valid disputes occur about treatment coding. Current CPT coding is a shorthand method to transmit claim information from medical providers to health insurance plans. Generally, health plan coverage and exclusions don't refer to CPT codes, or how they should be applied. They only refer to specific treatments.

If you think the codes don't fairly represent the treatment you received, you can ask your doctor to send your chart notes to the company. Your health plan may use those chart notes to determine if the treatment you received is covered or not, and make adjustments to the original claim.

1.5 What does your plan cover?

Your insurance policy should explain the following (or explain where to find this information):

- Your health care benefits and any limits on the number of times you can use a specific benefit (i.e., some plans only cover 10 chiropractic visits per person, per year)
- Details about co-pays – that is, cost-sharing with your insurance company (i.e., you may have a co-pay of $20 each time you visit the doctor)
- The deductible, if any, you must meet before the plan will start to pay for medical care you received
- The exclusions or limitations to the policy (what your plan does not cover)
- How the policy defines medical necessity and experimental treatment
- The benefits that require advance permission from your health plan, and how to get that approval
- How to appeal decisions made by your health plan
- The medical providers you can use

Before you decide to file an appeal, read:

- Your covered benefits in your plan's benefits booklet
- What your health plan will not cover – this is in the exclusions and limitations section (for some plans you may need to contact your health plan directly for this information).

Recommended best practice

Information about your benefits

Make sure you have the most recent copy of your plan's benefits booklet, which should include the specific exclusions and limitations to your plan.

Next step:

Learn who regulates your health plan and what to do once you've decided to appeal.

STEP 2: Learn who regulates your health plan and what to do once you've decided to appeal

2.1 Different plans have different regulators

In Step 1, you identified what kind of plan you have. Now we're going to identify who regulates that plan, which will determine your appeals process.

Your plan's appeal process is regulated by one of the following:

- Federal laws (such as ERISA, COBRA, and HIPAA*); and/or
- Washington state law (RCWs and WACs); or
- Neither – your plan may be allowed to establish its own process because it isn't subject to the federal or state laws listed above.

* For definitions, please refer to the "Glossary of common health insurance terms" in Section B, The chart in 2.2 (on the next page) will help you figure out which laws your plan's appeal process follows.

2.2 Chart: Which law does your plan follow?

Use the chart below to find out who regulates your plan. If your plan's "x" is in one of the first two columns, **and** it's not a grandfathered plan, then it's subject to the Affordable Care Act.

Type of health insurance	Plan is regulated by:		
	WA state	**Federal**	**Plan Specific**
	Subject to ACA (non-grandfathered)		**ACA Exempt**
INDIVIDUAL PLAN			
Insured policies purchased from an insurance company	x		
Washington State Health Insurance Pool (WSHIP)			x
GROUP PLAN (Purchased from work or association)*			
Self-funded		x	
Exempt self-funded or Non-ERISA			x
Fully Insured	x		
Other Plans including **GOVERNMENT SPONSORED**			
Original Medicare (Parts A&B) & Medicare Rx Drug (Part D)			x
Medicare Advantage			x
Apple Health for kids and adults (Medicaid)			x
DSHS and Health Services Medicaid (Provider One)	x		

*While your benefits booklet and possibly your insurance card might tell you which type of policy your group plan is, we recommend you ask your Human Resources department for clarification. They can provide you with the most accurate answer.

2.3 Chart: Where to find appeals information for plans not subject to state and federal requirements?

- Medicare
- Washington State Health Insurance Pool (WSHIP)
- Apple Health (for kids and adults)
- Exempt Self-Funded (for example, TRICARE or Uniform Medical Plan)

Medicare plans

Plan	Where to look for appeal information If you don't have these documents on hand, go to www.medicare.gov and type in the name of your publication in the search bar located in the upper-right corner of the page.
Original Medicare	1. On the back of your Medicare Summary Notice 2. Medicare Appeals and Grievances website 3. In Section 2 of Medicare's PDF publication *Your Medicare Rights and Protections* 4. The current PDF version of Medicare's publication *Medicare & You*.
Medicare Advantage	1. On your plan's materials 2. By calling your plan 3. In Section 3 of Medicare's PDF publication *Your Medicare Rights and Protections* 4. Medicare Advantage Plans and Medicare Cost Plans: "How to File a Complaint (Grievance or Appeal)" website 5. The current version of Medicare's PDF publication *Medicare & You*
Medicare Prescription Drug (Part D)	1. On your plan's materials 2. By calling your plan 3. In Section 4 of Medicare's publication *Your Medicare Rights and Protections* 4. The current version of Medicare's publication *Medicare & You*

Some Medicare-related issues are actually decided by the Social Security Administration (SSA). SSA determines:

- Your Medicare eligibility and effective dates
- Any Medicare late-enrollment penalties
- Your Medicare premiums
- Your eligibility for Extra Help with Medicare Prescription Drug coverage (Part D)

SSA also determines whether you qualify for financial disability benefits, including:

- Social Security Disability Insurance (SSDI)
- Supplemental Security Income (SSI)

You have appeal rights to SSA decisions. For more information:

- Go to your local SSA office
- Phone: 1-800-772-1213
- Web: www.ssa.gov/pubs/10041.html

If you've tried to work directly with Medicare or your plan, and still need help, call our Insurance Consumer Hotline at 1-800-562-6900.

Washington State Health Insurance Pool (WSHIP)

Web: wship.org – find the WSHIP Complaints & Appeals Policy located under the "Benefit Plans" tab on the left-side navigation column.

Customer service: 1-800-877-5187, 8 a.m. - 5 p.m. (PST), Monday-Friday

Apple Health (for kids and adults)

Includes these three programs:

- State Children's Health Insurance Program (SCHIP)
- Children's Health Program (CHP)
- Medicaid for kids
- Expanded Medicaid for adults under the ACA

Call 1-800-562-3022 or contact your specific program for more information about appeals.

Exempt self-funded

This category includes several different kinds of health plans. Some are exempt from the federal ERISA law (www.dol.gov/ebsa/compliance_assistance.html), such as TRICARE.

Military personnel with TRICARE should review:

- Web: www.tricare.mil/ContactUs/FileComplaint
- Phone: Call the appropriate Tricare contact number for your service area listed on their website at: www.tricare.mil/ContactUs/CallUs.aspx

Others are exempt from ERISA, but have appeals processes that are subject to the same set of laws as all state-regulated plans, such as the Uniform Medical Plan.

Uniform Medical Plan - is a health plan offered to Washington state public employees (active and retired) and their dependents. Washington State's Patient Bill of Rights. This means that while it has a plan-specific appeal process, many of the rights available to consumers in state-regulated plans (such as external reviews) will also be available to consumers with this coverage.

Web: www.hca.wa.gov/ump/Pages/index.aspx (type "appeal" into the search bar at the top right of the page)

If you have a different kind of exempt self-funded plan, please contact your plan's administrator and ask for information about the appeals process they use.

2.4 What to do before you file your appeal

Talk with your medical provider's office to let them know you plan to appeal the denial. Work with them to handle any outstanding bills.

If a bill is due, you have three options. You can:

- Delay paying it until you know the outcome of your appeal. Ask your medical provider's office to not send the bill to collections (which they may or may not do); or
- Set up a payment plan, and try to negotiate the amount you owe (to avoid having the bill sent to collections); or
- Pay the bill and get reimbursed by your health plan if you win your appeal.

We cannot recommend one of these options over the other two. You must decide what is best for your situation.

2.5 Gather all necessary documents

For your convenience, you can use the "Your Important Information" worksheet (see Section B) to gather information in case you need it later:

- Your contact information (name, mailing address, phone number)
- Contact information for the person representing you, if applicable (such as an attorney, parent or guardian, provider, or person who is acting as your attorney)
- Name of the company or group providing the health plan
- Policy number and - if it applies - claim numbers
- If your plan is through your employer, the name and location of your employer
- Names of doctors or providers who provided care or who gave an opinion or recommendation

Documents you may need to gather to help you with your appeal:

- Your most current benefits booklet
- Your insurance card
- All documents related to the situation you are appealing
- Any explanation of treatment or services from your medical provider's office
- Any denials (also known by your health plan as adverse benefit determinations)
- Any research to support your opinion that the denial should be overturned

Recommended best practice

Getting your documents

Gather all medical records and other supporting documents early on in the appeals process.

Next step: The appeals process and health care reform.

STEP 3: The appeal process – for grandfathered or non-grandfathered ("other") plans

3.1 Information about the appeals process

As was mentioned earlier, this guide will help you know what to expect from your health plan's appeal process. If you see any information in this guide that differs from what your carrier tells you, please keep in mind this is general information. Call our Insurance Consumer Hotline at 1-800-562-6900 with any specific questions you may have.

To actually file an appeal, you'll need to contact your health plan.

In the following steps, you'll find information about:

- The appeals process before the Affordable Care Act (ACA) became law – which will continue to be the process for grandfathered plans; and
- The appeals process for the "other" plans, effective Jan. 1, 2012.

Review: the difference between grandfathered and "other" plans

Grandfathered plans

- A health insurance policy that was in place before the ACA was signed on March 23, 2010.
- They aren't required to comply with the new requirements until they've made certain changes that cause them to lose their grandfathered status.*
- If you have a grandfathered plan, your carrier is required to tell you it is grandfathered in your benefits booklet.

"Other" plans

- Plans that are either:
  - New plans with effective dates after the ACA was signed, or
  - Plans in existence before the ACA that lost their grandfathered status at renewal.
- These plans are required to offer an appeals process that complies with the ACA.

If you're unsure which kind of plan you have, we recommend calling your carrier (with your insurance card on hand to reference your policy number), and asking them.

As rulemaking and companion legislation continue to evolve, we recommend you check our website on a regular basis for the latest information.

*"Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans:" www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/keeping-the-health-plan-you-have-grandfathered.html

3.2 Overview of the appeal process for grandfathered plans

Generally, the appeals process for grandfathered plans looks like this:

a. You file your appeal with your health plan (your health plan may provide a form for written appeals) within the timeframe your plan requires. The timeframe will be listed on either the adverse determination or in your plan summary.
b. Your plan's decision could come back in:

- 72 hours or less if it's urgent*;
- 14-30 days if it's a pre-service denial; or
- 14-60 days if it's a post-service denial.

c. If you lose this first level, you may have more internal levels to complete before you get a plan's final decision on your internal appeal.
d. Once you've completed all the internal levels, you might be able to request an external review if your plan is fully-insured. If this is the case, your health plan will assign an Independent Review Organization (IRO) to review your appeal.

- The IRO must notify you and your health plan of a decision within the timeframe allowed.**
- If the IRO overturns the denial, the decision is binding to the health plan. If it upholds the denial, your only option at this point is to pursue legal action.

All plans allow their participants at least one opportunity to request that the insurer reconsider the denial, and some allow for more opportunities. However, if you have a grandfathered plan, you may or may not have the option to request an external review by a certified independent reviewer. Your plan is required to tell you if this option is available to you.

If you've gone through your plan's appeal process in its entirety and the original denial was upheld, your only option at this point is to seek legal counsel and see if a judicial review is available to you.

Before you file your appeal, we encourage you to read on about how to increase your chances of winning in Step 4.

* RCW 48.43.530(5)(c)
** WAC 284-43A-070 (3)(a)(i) & (ii)

3.3 Overview of the appeal process for non-grandfathered ("other") plans

Effective Jan. 1, 2012, plans that do not have grandfathered status are required to implement the new appeal requirements of The Affordable Care Act.

Here a few things you can expect if you have a non-grandfathered plan:

Transparency – You'll have the right to:

- Know the actual reason for the denial and receive it in writing
- Access your file and see the criteria used to make the decision to deny the claim
- Present evidence as part of your appeal

Representation – You will be able to authorize someone else to appeal on your behalf.

Objectivity –

- You will have the right to an external appeal by an independent reviewer, no matter whether your plan is regulated by state or federal law.
- Appeals may not be reviewed by any person who was involved with the original denial.

Timeliness – If you have an urgent appeal, you'll get a decision on your appeal(s) faster and have the option of a concurrent review.

Generally, the appeals process for non-grandfathered ("other") plans looks like this:

a. You file your appeal with your health plan (your health plan may provide a form for written appeals) within the timeframe your plan requires. The timeframe will be listed on either the adverse determination or in your plan summary.
b. Your plan's decision could come back in:

    - Preferably 24 hours or less, but no more than 72 hours if it's urgent*;
    - 14-30 days if it's a pre-service denial; or
    - 14-60 days if it's a post-service denial.

c. If you lose this first level of internal appeal, and have an individual plan, you may request an external review. If you have a group plan, your plan will notify you on what you can do if you would like to continue appealing. Some plans will offer another round of internal review, some will tell you how to file an external review, and for others it might mean pursuing legal action.**

d. You can request an external review of the determination from your health plan once:

- You've completed the internal review, or
- Your plan fails to return its decision by the time allowed, or
- You have an extremely urgent issue and you request to have an external review at the same time as the internal review.

e. Your health plan will assign an Independent Review Organization (IRO) to review your appeal.

- It will notify you which IRO is reviewing your appeal, and give you five days to provide any missing information or additional evidence.
- The IRO must notify you and your health plan of a decision within the timeframe allowed:

  1. 72 hours if it's urgent
  2. 15 days after receiving all necessary information, or 20 days after receiving the referral (whichever is earlier) for fully-insured plans***
  3. 45 days for self-insured plans

- If the IRO overturns the denial, the decision is binding to the health plan. If it upholds the denial, your only option at this point is to seek legal counsel.

You can find more information about your specific appeals track in Section B.

Recommended best practice

Review IRO appeal decisions

Visit our office's online database to search and review IRO decisions for appeals involving your health plan, diagnosis, and treatment. This database contains decisions issued by IROs as of 2016: fortress.wa.gov/consumertoolkit/Search.aspx

Next step: Increase your chances of winning your appeal

*WAC 284-43-3170 (4)
**WAC 284-43-3130(1)
***WAC 284-43A-070 (3)(a)(i) & (ii)

STEP 4: Increase your chances of winning your appeal

4.1 Tips for drafting your appeal

To increase your chances of winning your appeal, consider following these guidelines for your appeal:

Appeals are more likely to go in your favor if they:

- ✓ Contain easy-to-prove facts
- ✓ Are to the point, and contain only necessary information
- ✓ Are complete
- ✓ Are submitted within the time allowed by your plan
- ✓ Show you were proactive and persistent in your interactions with your health plan and your medical provider
- ✓ Are specific in the outcome you expect

If your health plan listed one of the common reasons below for denying your claim, consider using the recommended approaches for your appeal.

These have worked for consumers in similar situations.

NOT MEDICALLY NECESSARY

- You have to prove the medical provider thinks the recommended treatment is or was medically necessary. Have your doctor (and possibly other medical experts) provide written documentation to explain his or her criteria. (See sample letter #1)
  - » If you have any information from your plan on the criteria the plan used, give it to your provider before his or her letter of support is written so that the letter can address the specific reason why your claim was denied.

EXPERIMENTAL

Your health plan may cover treatment ruled as experimental if you or your medical provider can prove it is one of the following:

- Medically necessary
- The only treatment that will work (document what hasn't worked before)
- Less expensive than the "standard" treatment
- Considered "standard" treatment by the medical community
- A treatment your health plan has paid for in the past, for people who have the same medical condition as you - something your provider might know. (See sample letter #5 in Section 4.4, on page 38)

NETWORK

If your claim was denied because the provider was out-of-network, you'll have a greater chance to win your appeal if you can prove the plan had:

- No providers with the specialty you needed in network (see sample letter # 3 in Section 4.4, on page 36)
- Very long wait times for in-network providers

OTHER POSSIBLE REASON FOR A DENIAL – MISTAKE BY YOUR PLAN

- Prove you or your medical provider followed the rules under your health plan.
- Show how the denied treatment falls within a gray area of the plan's covered services. If it's not explicitly excluded, you could reason your plan should pay for it.

And if all else fails, sometimes just asking your health plan for an exception can help your case! (See sample letter #2, on page 35)

4.2 Things to avoid when drafting your appeal

Appeals are less likely to go in your favor if they are:

- Submitted past the deadline
- Hard to read/not organized well
- Excessively long and include unnecessary details
- Highly emotional and include feelings of frustration, pain, or anger rather than facts
- Incomplete
- Unreadable due to bad handwriting

One way to prevent many of these issues is to have someone else proofread your appeal before you send it.

Common reasons why consumers lose their appeals:

MISSING INFORMATION

If you don't:

- Have a letter from your medical provider detailing why a procedure is medically necessary.
- Have letters that specifically address:
    - Your medical issues
    - The reason your plan rejected the claim
    - Why your plan should cover your claim
- Provide the history of treatments you tried prior to the treatment your medical provider is currently prescribing.
- Provide relevant information about something the health plan considers relevant and wants to investigate (for example, notes from previous visits to a medical provider).
- Include evidence that shows how that the medical community considers your provider's prescribed treatment as standard practice.

YOUR CARRIER BELIEVES YOUR REQUEST IS OUTSIDE ITS CONTRACTUAL RESPONSIBILITY

- You were prescribed or received treatment, or a prescription, that's not covered by the plan.
- You didn't pay your premium on time, and your policy was cancelled. Claims reflecting the use of benefits after the policy was canceled will not be paid by the health plan.
- You disputed the contracted amount the health plan paid to your provider. Consumers cannot request the plan to pay higher or lower amounts to a provider than what the provider and the plan have contractually agreed to for a service.
- You requested a formal decision on a hypothetical situation. Unless your provider is required to get prior authorization for a treatment they determine to be medically necessary, the health plan isn't required to tell you how they would process a claim in advance.
- Your medical provider's billing mistakes. Your health plan can only respond to information provided by your doctor. If your doctor used the wrong CPT code, or didn't get prior authorization as the plan requires, then your provider may be held responsible for his or her mistakes.

ISSUE IS BETWEEN THE EMPLOYER AND AN EMPLOYEE

- **Eligibility issues** – For example, when an employer tells the group health plan provider that a worker no longer qualifies for coverage as of a certain date, and the health plan denied any claims that came in for that worker after that effective date.
  - » This happens often when employees are required to work a certain number of hours to be eligible for the group health plan.

- **Late premium payment** – When an employer fails to pay its portion of the premium to the health plan and the health plan cancels coverage for all the employees on the plan.

You cannot fix these last two issues by filing an appeal. Instead, as an employee, consider file a complaint with:

United States Department of Labor - Employee Benefits Security Administration
Phone: 1-866-444-EBSA (3272)

4.3 Summary of recommended best practices and tips – for all types of health coverage

WHEN YOU THINK YOUR PLAN SHOULD PAY FOR COVERAGE – APPEAL.
If you don't win at the first level, keep appealing to the next level until you've exhausted all your options.

For your interactions with your medical provider or your health plan:

- Keeping detailed records will increase your chances of winning an appeal. Most appeals require you to prove something, and it can be a lot easier to do that if you have good records. Document everything.

- Continue to be proactive with all your conversations and written documentation.
  - Stick to the facts and emphasize objective medical information over discussing your emotions.
  - If someone told you they'd get back to you by a certain day and they didn't, pick up the phone and contact him or her.

- If something is not clear to you, ask questions until you understand it.

- When you need to send documents to your provider or your health plan:
  - Send **copies** instead of the originals.
  - Send documents as certified mail, so you'll know when they are delivered. (Certified mail means someone has to sign for it, and you can see who signed for it and when.)

- Know that you may choose an authorized person, or your medical provider to act on your behalf.

- Your portion of the cost of medical care is usually negotiable.
  - Ask your health care provider to accept the amount your health plan will pay for a procedure as full payment.
  - If a health plan won't pay at all, try to settle on a price for you to pay out of pocket.
  - Ask your medical provider to change your prescription if it's not covered by your plan.

For a denied claim

- Rule out the possibility of a billing error.
- Call your medical provider's office first (document the call on your records log).
- Tell them you received notice of a denied payment from your health plan.
- Ask them why your health plan denied payment for a visit to their office. They'll tell you it's either a billing error or a claims processing error - both of which should be cleared up by your provider's office. If it's not a billing or processing error, you'll need to appeal to overturn the denial.

Check to make sure you have a copy of the most current plan summary and the plan's exclusions and limitations (if separate from the plan summary). You may need to call your health plan to find out where you can find this information on its website, or have them mail it to you.

Read the denial to learn:

- The specific reason for the denial
- The plan provision that supports the decision
- What the plan needs to have so that it will reverse its initial ruling
- What your plan's appeals and grievance process is and the associated timeline
- Where to send a formal appeal

Consider filing a complaint with our office. Call our Insurance Consumer Hotline at 1-800-562-6900 to discuss your case with an insurance expert and find out how we can help you.

Ask your plan for a copy of everything they used in their denial

- Search for any missing information in your file to support authorizing or paying the benefit.
- Ensure any clinical research you use is current. Ask your doctor for guidance and do your own research at www.pubmed.gov, a website run by the National Institute of Health.

Stay in contact with your medical provider. If you're appealing the denial, call your health care provider's office, and ask them not to send your bill to collections. They may or may not honor that request.

If they require payment, you can:

- Delay paying it;
- Pay it in full; or
- Set up a payment plan. You will most likely be reimbursed if you win your appeal by your health plan.

If you'll need a letter from the medical provider, confirm that he or she will be available to write it (and will not be away from the office).

Provide your medical provider with a copy of the contract provision the health plan is using for the denial. You should also give your medical provider(s) any documents (such as letters, memos, or notes) the company sent you about denying the claim. This helps providers to focus their statements on issues related to your appeal.

- If time allows, ask to proofread the letter your medical provider writes on your behalf. Make sure the letter addresses the reasons your health plan is denying the claim. Some letters aren't specific enough, or sometimes contain errors. Successful appeals have persuasive letters from medical providers.
- Gather and organize all medical records and other supporting documents early in the process. Some turnaround times for appeals are very short and you will need to be prepared to quickly produce your documentation.

If your health plan requests more time to consider your claim, you don't have to grant it. If it doesn't return a final decision to you in the time allowed, you can usually move on to the next level of appeal.

If your health plan voluntarily waives its right to review your appeal or fails to return its decision to you by the date required - you are entitled to an external review.

For continued care in an urgent situation

- A health plan must provide continued coverage pending the outcome of an appeal. It cannot reduce or stop benefits for an ongoing course of treatment without providing you with an advance notice and an opportunity for advance review. [RCW 48.43.535(9)]
    - Note: If you lose the appeal, you may be responsible for the cost of coverage you received while the appeal was being decided.

For rescinded or cancelled coverage

Rescinded coverage:

- Carriers must provide you with written notice at least 30 calendar days before they can rescind* your health coverage.
    - ***Note:*** Rescission is when an insurer withdraws their original approval of an application for coverage and any payment for benefits used. This usually happens when the insurer learns you did not fill out the application accurately. Under health

care reform, insurers can only rescind policies in instances where someone intentionally lied on the application.

Cancelled coverage:

- **Avoid making late premium payments.** If you fail to pay your insurance premiums, your health plan *might* tolerate one late premium payment (see sample letter #2). Be aware it typically will not allow a second late payment and will cancel your policy.

Cancelled COBRA www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra**:**

- Your employer can cancel your COBRA coverage if you don't make your premium payments. Federal COBRA law doesn't require your employer to notify you that it's cancelled your coverage. However, the federal HIPAA law does require a Certificate of Creditable Coverage be issued to the subscriber by the employer when coverage has ended.
    - If you think a former employer cancelled your COBRA coverage in error, contact the U.S. Department of Labor (DOL) who oversees COBRA issues at 1-866-444-3272.

For individual health plans

Number of allowed appeals

- As of Jan. 1, 2012, your individual health plan will be allowed only one level of internal appeal to make its decision. After that internal appeal, you may ask for an external review if necessary.

Next step: Tips for writing a good appeal letter

4.4 Tips for writing a good appeal letter

A well-written, fact-based letter is critical to your chances for winning an appeal. But before you write your letter, make sure you know what:

- Deadlines you must meet in filing an appeal.
- Specific department/person to whom you need to address your correspondence.
- Specific information the plan needs from you to overturn the original decision.

Here are some tips we recommend when you write your appeal letter – include:

1. Identifying information about you, your plan, and the claim (or treatment) that has been denied. If possible, include a photocopy of your insurance card with your appeal.
   - If you're writing on behalf of someone else as his or her authorized representative, be sure to include your contact information and establish your legal right to act as a representative.
2. A clear statement identifying the decision(s) you're appealing.
3. A description of where you are in the appeals process.
4. A clear statement of what you are hoping to achieve with the appeal.
5. A sincere statement of why you are appealing the decision. Customize this part of the letter to your situation. Be sure to include all relevant facts, and any persuasive details.
6. A description of any supporting information you've included for the review board to take into consideration.
7. A table of contents, if you have included more than a couple documents, to tell the reader where he or she can find specific items.
8. A courteous, closing statement after stating your case, and indicate that you look forward to hearing their decision.

Tips for once you're done writing the letter:

1. Proofread your appeal letter.
   - For starters, take some time away from it, and come back to it with fresh eyes. Ask yourself if the letter says everything you want it to say and make edits if it doesn't.
   - Once you're happy with it, ask someone else to read it and let you know if he or she finds anything that makes it hard to read – such as spelling mistakes or grammatical errors. You might also want to ask your proofreader to look for details that are not relevant.
2. Once you finalize the letter, print out two copies:
   - Put one copy with your appeal and send it to the insurance company via certified mail.
   - Keep the second copy for your records and be sure to note on it when you mailed the other copy and when the insurance company received it.
3. To see how you might incorporate these tips, take a look at the sample templates and examples of letters written for specific scenarios on pages 31-38.

SAMPLE TEMPLATES:

1. Requesting an internal appeal
2. Requesting an external appeal
3. Requesting documents to help a consumer prepare for an appeal

SAMPLE LETTERS:

1. Letter appealing a post-service denial deemed not medically necessary
2. Letter requesting policy be reinstated after premium wasn't paid
3. Letter requesting a second opinion from someone outside of network
4. Letter requesting state-regulated health plan pay for in-home health care of sick child
5. Letter appealing a post-service denial deemed 'experimental'

SAMPLE LETTER TEMPLATE TO REQUEST A FIRST-LEVEL (INTERNAL) REVIEW

[*Your name*]
[*Your address*]

[*Date*]
[*Address of your health plan's appeal department*]
RE: [*Name of the Insured*]
Plan ID #: [*123*]
Claim #: [*456*]

To Whom It May Concern:

I'm requesting a review of your denial of [*coverage, pre-authorization, or other*] of the treatment prescribed by my medical provider [*Dr.* _] on [*date*].

The reason for the denial was listed as [____], but in reviewing the most current version of my plan summary, my provider and I believe [___] should be covered.

> *At this point in your letter, you should customize the message to your particular situation and include only relevant facts. This is your opportunity to tell them a little about "what" happened, and a lot of "why" you think it should be covered. Short factual statements are more likely to win your appeal than letters that are long and full of emotion or commentary not relevant to the issue/claim.*
>
> *If you're providing a lot of documents, tell them in this letter what is included, and in what order you've arranged the items. If appropriate, use a table of contents.*
>
> *Once you've stated your case, let them know where you can be reached should they want additional information.*

I look forward to your direct response as soon as possible.

Sincerely,
[Your name]
[Contact Info]

SAMPLE LETTER TEMPLATE TO REQUEST AN EXTERNAL REVIEW

[*Your name*]
[*Your address*]

[Date]
[Address of your health plan's appeal department] RE: [Name of the Insured]
Plan ID #: [123]
Claim #: [456]

To Whom It May Concern:

I'm requesting an external review by an independent review organization (IRO) of the final internal adverse benefit determination I received on [date], which is included with this appeal.

I filed my internal appeal on [date], in response to [*for example, a procedure I had done by the advice of my primary care physician, which was not considered to be medically necessary*]. Your review board returned their ruling, upholding the original decision.

> [*After requesting the external review, this place in the letter is usually a good point to include anything that has come to your attention since you filed your first appeal. For example, "In the process of filing an internal appeal, I learned that my primary physician was granted prior approval for my procedure as documented in the notes included in this appeal." Again, keep it fact-based, and to the point.*]

I look forward to your direct response as soon as possible.

Sincerely,
[Your name]
Contact info

SAMPLE LETTER TEMPLATE TO REQUEST DOCUMENTS USED BY THE HEALTH PLAN IN THEIR DECISION

[*Your name*]
[*Your address*]

[Date]
[Address of your health plan's appeal department] RE: [Name of the Insured]
Plan ID #: [123]
Claim #: [456]

To Whom It May Concern:

I'd like to request you send all of the following to me [*ask for only what you don't already have*]:

1) A detailed description of why my claim was denied
2) A written statement of the clinical rationale for the decision
3) Instructions for how to obtain the clinical review criteria used to make the determination
4) All notes your company made in my file
5) A description of what you need to overturn the denial

My provider and I will need these as we prepare to appeal your determination on the claim referenced above.

I look forward to your direct response as soon as possible.

Sincerely,
[Your name]
Contact info

SAMPLE LETTER #1: APPEALING A DENIAL BASED ON LACK OF MEDICAL NECESSITY

Situation:

A medical provider billed the consumer for a denied post-service claim. The consumer wants to appeal the denied claim since he asked how much it would cost before receiving the services and the doctor who is contracted by the plan told him the plan would cover the ultrasound after he made a $30 co-pay.

Sample letter for the consumer might look something like this:

Consumer's Name, Address, Policy #
June 1, 2011
Appeals Dept. Info

To Whom It May Concern:

I am appealing your company's decision to deny payment to Dr. Wilson for the ultrasound I received on 3/14/11 – Claim number 2596BG. The reason listed on the denial is "not medically necessary."

In addition to the inclusion of a letter from Dr. Wilson, who thought it was medically necessary, I asked Dr. Wilson's office, which is a contracted provider, how much would I have to pay out of pocket for the ultrasound. His office said I would be responsible for only a $30 co-pay.

Attached you'll find the letter from my doctor describing:

- Why he found it necessary to perform the ultrasound
- The chart notes from my office visit
- The recommendation I have this ultrasound
- A recent article explaining how standard ultrasounds are for situations like mine (high enzyme count in the liver)

Please let me know if you need any other information from me to review my case (via phone: 253-555-7890).

I look forward to rectifying this outstanding bill in a timely manner.

Sincerely,
John Williams
253-555-1111

SAMPLE LETTER #2: APPEALING A CANCELATION OF A POLICY FOR LACK OF PAYMENT

Situation:

A consumer wasn't able to pay his health insurance premium due to an error made by his payroll department.

Sample letter for the consumer might look something like this:

Consumer's Name, Address, Policy #
June 15, 2011
Appeals Dept. Info

To Whom It May Concern:

I'm appealing your company's decision to cancel my individual policy effective June 1, which had been in force for three years. I'm kindly asking that you reinstated it.

While I understand your requirement that coverage is contingent upon timely payment of premiums, I ask that you grant an exception in this case. My employer's payroll department made an error that left me and my 29 co-workers without our direct deposit paycheck for four days. Since my health insurance premium is scheduled to be deducted from my checking account two days after I'm normally paid, there wasn't enough money in there to cover the $624 bill.

Please note this has never happened before. I have a letter from my company's Human Resources Director certifying this payroll error did occur and that it took four days to correct.

I look forward to hearing your decision to my request for reinstatement as soon as possible, and would be grateful for any room you could give this first-time error.

Sincerely,

Charles Johnson
Contact/phone info.

SAMPLE LETTER #3: REQUESTING A VISIT WITH AN OUT-OF-NETWORK PROVIDER

Situation:

A consumer would like a second opinion from a provider not in her health plan's network.

Sample letter for the consumer might look something like this:

Consumer's Name, Address, Policy #
June 5, 2011
Appeals Dept. Info

To Whom It May Concern:

I'm appealing your company's decision to deny my request for a second opinion from a provider outside of your network.

I understand my current policy is not obligated to pay for this, but I would like to request an exception. Before I begin any treatment, I would like to be confident that:

1. The type of cancer was correctly identified in my first diagnosis.
2. The course of treatment recommended will be effective in treating my cancer.
3. There is no other kind of treatment out there that is less invasive and therefore preferred.

I would like to obtain an opinion from Dr. Miller – a renowned specialist in this type of cancer who is located in Seattle and isn't in my plan's network.

When I requested a second opinion on June 2, your account manager Dawn Jones, told me my plan would authorize a second opinion from a provider within my covered network only. I do not believe this will be adequate since I live in Spokane, and I have already seen the one provider in the area who has experience treating this rare cancer. To consult with a second specialist will require a visit out of network.

I understand that my health plan will pay for treatment administered by my in-network provider only. This is a request for authorization to obtain only a second opinion from an out-of-network provider.

Thank you for your consideration of this request for an exception.

Sincerely,
Alexis Tate
Contact/phone info

SAMPLE LETTER #4: APPEALING A DENIAL BASED ON HEALTH CARE SETTING

Situation:

A consumer with a state-regulated plan is trying to get her insurance company to pay for the home health care of her sick child. The insurance company is claiming care is not medically necessary or that policy limitations for care have already been met.

Sample letter for the consumer might look something like this:

Consumer's Name, Address, Policy #
May 8, 2011
Appeals Dept. Info

To Whom It May Concern:

I am appealing your company's decision to deny my request for in-home health care of my daughter. Not only does her doctor believe this is the best treatment option for her, but more importantly, this treatment is also a right guaranteed to her by the Washington Administrative Code.

Included in this appeal, you'll find:

1. The written treatment plan from my daughter's attending physician;
2. A supporting letter from the same physician analyzing the costs of hospitalization verses in-home health care; and
3. A copy of WAC 284-96-500, the regulation requiring coverage for in-home health care.

Please review this appeal and let me know if you need any more information. I look forward to hearing from you.

Sincerely,
Margaret Smythe
Contact/phone info

SAMPLE LETTER #5: APPEALING A DENIAL FOR EXPERIMENTAL TREATMENT

Situation: A consumer would like the insurer to pay for the arthroscopic surgery she had to treat a bone spur on her hip, which was denied for being experimental.

Sample letter for the consumer might look something like this:

Consumer's Name, Address, Policy #
May 8, 2011
Appeals Dept. Info

To Whom It May Concern:

I'm appealing your company's decision to deny payment for the arthroscopic surgery I had on March 28, 2011, which was performed by one of your contracted surgeons, Dr. Andrew Shah.

Upon receiving the Explanation of Benefits in the mail on April 19, 2011, I called the customer service number and spoke with Ruth C. who told me this was denied it because the only approved treatment for my diagnosis was open hip surgery. Hearing this, I called my provider who assured me the arthroscopic surgery is a safer and less-expensive treatment than open surgery. He also said he's had no problem receiving payment for nine other patients insured by your company.

If you've paid for this less invasive and less expensive procedure nine other times, I would ask you to continue with this precedent and pay for mine as well.

Included in this appeal is:

- A letter from Dr. Shah explaining why he chose this treatment over the open hip surgery. He also cites several publications establishing this treatment as the current accepted procedure.
- A letter from my physical therapist explaining how my recovery time was significantly less than those of other patients who had the open hip surgery.
- A copy of my file with your company, where it appears you authorized this surgery for Dr. Shah on March 16.

Please review this appeal and let me know if you need anything else to consider this request. I look forward to hearing from you directly as soon as possible.

Sincerely,
Robin Brown
Email: robin.brown@abc.com

SECTION B

What kind of appeal to you have?

Four questions to help you figure out the answer:

1. Is your plan a grandfathered plan or an "other" plan? (See the Introduction or Section A, Step 3.1 on page 17.)
   - If it's a grandfathered plan, your general appeals process is explained in Section A, Step 3.2.
   - If it's not a grandfathered plan, your general appeals process is explained in Section A, Step 3.3. You can review the next three questions and choose the appropriate appeals track below for specifics on your process starting Jan. 1, 2012.

2. What kind of insurance do you have? (See Section A, Step 1.1)

3. Is your denial a "pre-service" or a "post-service" issue? (See Section A, Step 1.2)

4. If it's a pre-service issue, is it urgent? (See Section A, Step 1.3)

If you don't know the answer to any of these questions, review the step in parenthesis.

However, if you know the answers, choose the appropriate appeals track for specific information about your appeal.

	Urgent	Non-urgent pre-service	Post-service
Individual	Track #1	Track #2	Track #3
Group, Fully-Insured	Track #1	Track #2	Track #3
Group, Self-Insured	Track #4	Track #5	Track #6

If you have a question about your appeals process, please call our Insurance Consumer Hotline at 1-800-562-6900 from 8 a.m. – 5 p.m. (PST), Monday through Friday to speak with an insurance expert.

Appeal Track 1: *Urgent "Pre-Service" Benefit Denial from an Individual or Fully- Insured Group Plan (effective 1/01/12)*

Situation: You're denied approval for medical treatment your doctor believes is medically necessary. Your medical provider believes your situation is urgent.

1. You and your provider* want to ask your insurance carrier for either:
   a. An expedited internal appeal (possibly followed by an expedited external), or
   b. A concurrent expedited internal and external appeal (see #4).
2. The carrier will review your request. They will seek to ensure they have enough information to consider your appeal.
   a. If they do not have enough information, they will ask you or your provider to produce the information.
   b. If they have enough information, they will make a decision within 72 hours or sooner of receiving your appeal.
3. Your carrier will make its determination.
   a. If they overturn the denial, they will cover the treatment you need.
   b. If they uphold the denial or do not return a decision within 72 hours, you can file an external appeal or you can accept the denial.
4. You file an expedited external appeal (or a concurrent internal and external review).
5. Your carrier will immediately forward your request to an independent review organization (IRO) as well as all the information they used to make their original determination.
   a. They will tell you which IRO is reviewing your appeal, so that you or your provider can provide any additional information for consideration by the reviewers.
6. The IRO reviewers will make their decision based on the information you and your carrier provided within 72 hours.
   a. If the IRO disagrees with the original determination, you win the appeal and your carrier must provide the medical treatment your provider recommends.
   b. If the IRO agrees with the original determination and upholds the decision, your only recourse at this point is to file a lawsuit.

***You are not entitled to an expedited appeal unless a medical provider believes it is necessary.**

Appeal Track 2: *Non-Urgent "Pre-Service" Benefit Denial from an Individual or Fully-Insured Group Plan (in effect on 01/01/12)*

Situation: You receive a denial for treatment prescribed by a provider, who has determined your condition is not urgent.

1. You file a standard appeal.
2. Your carrier reviews your appeal.
   a. If they are missing information, they will ask you for supporting data.
   b. If your appeal is complete, your carrier has 14 days to make a decision. They can take up to 30 days if they notify you by the 14th day that they need more time.
3. Your carrier issues their decision.
   a. If they overturn the denial, your plan must pay for the medical treatment.
   b. If they uphold the denial or do not provide a decision within legal time limits, you are allowed to appeal to the next level or accept the denial. (For individual plans, the next level is the external level. For fully-insured group plans, the next level might be an additional internal level.)
4. You file a standard external appeal.
5. Your carrier will immediately forward your request to an independent review organization (IRO) as well as all the information they used to make their original determination.
   a. They will tell you which IRO is reviewing your appeal, and will give you the opportunity to present additional evidence to the reviewers (within five days).
6. The IRO will make their decision based off the information you and your carrier provided within 15-20 days (or 25 days in some cases).
   a. If the IRO disagrees with the original determination, you win the appeal and your carrier must provide the medical treatment your provider recommends.
   b. If the IRO agrees with the carrier's original determination and upholds the decision, your only recourse at this point is to file a lawsuit.

Appeal Track 4: *Urgent "Pre-Service" Benefit Denial from a Self-Insured Group Plan (in effect on 01/01/12)*

Situation: You are denied medical treatment your doctor believes is medically necessary. Your doctor also believes your situation is urgent.

1. You would like to ask your health plan for either:
   a. An expedited internal appeal (possibly followed by an expedited external), or
   b. A concurrent expedited internal and external appeal (See #5).
2. You file an expedited internal appeal.
3. The plan will review your request. They will seek to ensure they have enough information to consider your appeal.
   a. If they do not have enough information, they will ask you to provide the data within 24 hours. If you do not provide them with missing data, they will deny your appeal.
   b. If they have enough information, they will make a decision on your request within 72 hours.
4. Your plan will make its determination.
   a. If they overturn the denial, you win your appeal.
   b. If they uphold the denial or do not return a decision within 72 hours, you are allowed to file an external appeal or you can accept the denial.
5. You file an expedited external appeal (or file for a concurrent internal and external review).
6. Your plan will immediately forward your request to an independent review organization (IRO) as well as all the information they used in making their original determination.
   a. They will tell you which IRO is reviewing your appeal, and give you the opportunity to present additional evidence to the reviewers.
7. The IRO reviewers will make their decision based off the information you and your plan provided within 72 hours.
   a. If the IRO disagrees with the original determination, you win the appeal and your carrier has to provide the medical treatment your provider recommends.
   b. If the IRO agrees with the original determination and upholds the decision, your only recourse at this point is to pursue legal counsel.

Appeal Track 5: *Non-Urgent "Pre-Service" Benefit Denial from a Self-Insured Plan (in effect on 01/01/12)*

1. You receive a denial for treatment prescribed by your medical provider, who rules your condition is not urgent.
2. You file a standard appeal within 180 days of receiving the denied authorization for service.
3. Your health plan now has 30 calendar days to review and make a decision on your appeal. They can:
   a. Overturn the denial and you win the appeal.
   b. Uphold the denial.
   c. Not return a decision within the time allowed (30 days).
4. If they didn't rule in your favor, you can file a standard external appeal.
5. Your health plan has five business days to forward your appeal to an independent review organization.
   a. You will have five days after being notified of which IRO is handling your case to submit any additional evidence you would like them to consider.
6. The IRO must make their decision within 45 days and notify you and your plan.
   a. If the IRO disagrees with your plan, you win.
   b. If the IRO upholds the decision, your only alternative is to file a lawsuit.

Appeal Track 6: *"Post-Service" Benefit Denial from a Self-Insured Plan (in effect on 01/01/12)*

1. You receive a denial from your health plan.
2. Verify it's not a billing error. Call your medical provider to verify this. If it's not a billing error, file your appeal.
3. You must file a standard appeal within 180 days of receiving the denial in writing.
4. Your health plan has 60 days to review the appeal and make a decision. They can:
   a. Overturn the denial and rule in your favor.
   b. Uphold the denial. You can accept or file an appeal at the next level. See #5.
   c. Not respond in time. If they do not respond within 60 days, you can file a standard external appeal. See #5.
5. File a standard external appeal with your health plan.
6. Health plan has five business days to review your appeal and forward on to an independent review organization (IRO).
   a. You will have five days after being notified of which IRO is handling your case to submit any additional evidence you would like them to consider.
7. The IRO must make their decision within 45 days and notify you and your plan.
   a. If the IRO disagrees with your plan, you win.
   b. If the IRO upholds the decision, your only alternative is to file a lawsuit.

Keeping Track of Communication

Keeping a written record of every single letter, phone call, email, and in-person conversation related to your appeal is very important. Try to write about each contact immediately after they happen while they are fresh in your memory.

Here you can see the example that shows the date of the communication, what format it was in, who initiated the contact, and what was communicated.

FOR EXAMPLE:

Date	***Type of Contact***	***From:***	***To:***	***Summary:***	***Follow Up Required?***
3/04/2011	Letter	My health plan	Me	Claim for my MRI has been denied (medically unnecessary)	
3/07/2011 (10 AM)	Phone Call 206-626-1234	Me	Dr. Wilson's office. Spoke with Carol T.	Called to ask if claim was billed properly. It was. Notified Dr. Wilson I would be appealing the denied payment. Was told to check back in before I filed the appeal to get a letter from Dr. Wilson stating why it was necessary.	Yes. Before I file the appeal
3/08/2011	Phone Call 425-555-1234	Me	My health plan. Spoke with Ruth Johnson	I asked for clarification on how long I would have to file an appeal. Was told 180 days (mid-August). I asked who I should send an appeal to, and was told the address is on the first letter I received.	
3/18/2011	Phone Call 800-562-6900	Me	Office of Insurance Commissioner. Spoke with Jane P.	Was told to file my appeal with my health plan, and that I could file an additional appeal after that if my first one was denied.	

Date	Type of Contact	From:	To:	Summary:	Follow Up Required?

Your important information for an appeal

1. **Information about your plan:**
   a. Type – (individual, group, or other)_____
   b. Insurance provider _____
   c. Policy number (if applicable) _____
   d. Group number (if applicable)-_____
   e. If it's a group policy, is it fully-insured, self-funded, or exempt?_____
   f. ID number-_____
   g. Is it a new (non-grandfathered) or old (grandfathered) plan? _____
   h. Who regulates it? _____
   i. Is coverage still effective, or has it terminated?_____
   j. Is the health plan an HMO, PPO or traditional indemnity (fee-for-service plan)?_____
   k. Based on the information above, can one see out-of-network providers and if so, how much is the coinsurance, copay or deductible?_____
   l. Do you need a referral from a primary-care provider for a specialist and if so, are there restrictions to which specialists that you can see (i.e., in- vs. out-of-network)?_____

2. **Information about your denial:**
   a. Is it a pre-service or a post-service claim?_____
   b. If it's pre-service, is it urgent?_____
   c. What is the date of the denial?_____
   d. How long do you have from this date to appeal?_____
   e. What is your claim number?_____
   f. Do you know the diagnostic code used?_____
   g. What is the treatment or service that needs to be covered?_____
   h. Do you have evidence to prove that it should be covered? (e.g. page # of EOC, doctor's recommendation notes, notes documenting prior health history)
   _____
   i. Research that shows how treatment is necessary or cost-effective in the long run?
   _____
   j. Contact information for the recipient of the appeal and the expected timeline for the various stages of the appeal (e.g. list dates when one should expect a response from company)._____
   k. Is your issue one listed in the list of exclusions and limitations (Evidence of Coverage) that the health plan will not cover?_____

3. Information about your provider:

a. What is the name of your medical provider?_____

b. What is the address of where you received the medical service or treatment?

_____

c. What is your provider's phone number?_____

NOTES:

FAQs about state and federal laws

1. ***What do RCW and WAC stand for, and what's the difference between the two?***

   RCW stands for Revised Code of Washington. These are state laws that are the result of legislation passed by the House and Senate, and signed by the Governor. They are updated online twice a year.

   WAC stands for Washington Administrative Code. These are the regulations (or rules) adopted by executive branch agencies to enact the legislation and RCWs. These are updated online twice a month.

2. ***When would there be a difference between state and federal law?***

   States have the option to enact laws and rules that differ from federal law, but only if they enhance protection of the state's consumers and residents.

3. ***How do I look up RCWs and WACs on a particular topic?***

   The Washington State Legislature maintains a website that allows you to search the RCWs, WACs, or both. You can go to search.leg.wa.gov/search.aspx#document and follow the instructions on the site. If you already know the RCW or WAC and want to see what it says, we suggest typing it into a search engine (like Google, or Bing).

   However, before you spend any length of time trying to understand a law or regulation on a specific life or health topic, please call or email us for help. This kind of research can be very complicated, and we would like to help save you time if possible.

Glossary of common health insurance terms

A

Administrative Services Only (ASO) — When a Third-Party Administrator (see term Third-Party Administrator) provides services, such as processing and paying health insurance claims for an employer.

Adverse benefit determination — Adverse benefit determination - This means that for some reason, the health plan has decided that it's not going to pay a claim, or it's not going to pay the dollar amount that the consumer wanted. The denial can be for many reasons. For example, the:

- Health plan simply doesn't cover the procedure;
- Consumer's employer tells the health plan that, at the time the consumer received the service, the consumer wasn't eligible to participate in the plan; or
- Health plan defines the service as "experimental or investigational" or "not medically necessary."

When consumers receive adverse benefit determinations from their health plans, consumers can file an appeal, and this manual provides tips for filing appeals.

Agent — Someone who sells and services insurance policies. In Washington state, all insurance agents must be licensed by the Office of the Insurance Commissioner – who refers to them as producers.

Annual Limit — Many health insurance plans place limits on how much money they'll pay for specific benefits over the course of a plan year. Health care reform bans annual limits for essential benefits for plan years starting after Sept. 23, 2010.

Appeal — A request for reconsideration of a decision by a health plan, usually from a denial.

C

Carrier — A company that sells insurance (also called an insurer).

Claim — When you or your doctor request payment of benefits from your insurance plan after you've received treatment or services (reimbursement).

COBRA — Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. COBRA provides temporary continuation of health coverage at group rates. The law generally covers health plans maintained by private-sector employers with 20 or more employees, employee organizations, or state or local governments. Many states have "mini-COBRA" laws that apply to the employees of employers with less than 20 employees.

Coinsurance — A percentage of a health care provider's charge for which the patient is financially responsible under the terms of the policy. Also known as a "co-payment" or "co-pay."

Coordination of Benefits (COB) — When you're covered by two or more insurance plans, this determines how much each insurer will pay for a benefit. Total reimbursement should not exceed 100 percent of the cost of care. This is common when two people in a household have separate insurance plans.

Copayment — A copayment is a patient's share of a health care bill. It usually is a small, flat-dollar amount, such as $10 or $25 for an office visit.

Coverage — The scope of protection provided to the insured person under an insurance contract. When used to refer to a health plan, it means the benefits available.

Creditable — Any previous health coverage a new plan will allow a person to use to shorten his or her pre-existing condition waiting period.

Current Procedural Terminology (CPT or treatment code) – These are five-digit codes developed by the American Medical Association that doctors use to communicate with health plans about the tasks and services they provided to a patient. Medicare refers to these as Healthcare Common Procedure Coding System (or HCPCS) codes.

D

Deductible — The dollar amount you pay for covered charges during a calendar year before the plan starts paying claims.

Drug Formulary — See Formulary.

E

Eligibility – Whether a person qualifies for coverage or not. If you were eligible, and then lost eligibility, health plans may cancel your coverage and deny any claims incurred after eligibility was lost. Should this happen, you may be able to appeal the decision to the health plan under the ACA.

Employee Retirement Income Security Act (ERISA) — The Employee Retirement Income Security Act of 1974 (ERISA) is a complex statute that federalizes the law of employee benefits. ERISA applies to most kinds of employee benefit plans. ERISA was later amended by COBRA and HIPAA.

Essential Benefit— Basic benefits that include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

Exclusions — Clauses in a health insurance contract that deny coverage for specific medical treatments and supplies. Examples of commonly excluded "events" include elected cosmetic surgery, gastric bypass surgery, treatment in clinical trials, gender reassignment surgery, or treatment that is deemed experimental.

Explanation of Benefits (EOB) — This is a notification sent to you from your insurance company after they've processed a claim. It should explain what services the provider claimed to have provided, what the insurance company paid, and what amount was not paid. Many of these EOB's contain fine legal language regarding coverage.

External Review — Review of plan or issuer's denial of coverage or services by an Independent Review Organization (IRO). This review happens after the internal review process has been exhausted, or when circumstances qualify the appeal as being urgent and the IRO's decision is needed for a quick response – both of which are changing with implementation of the ACA. The insurance company is bound to the decision reached in the external review. Health care reform requires all new health plans to provide an external review process that meets specific standards.

F

Fee Disclosure — This is when medical providers and caregivers disclose their fees upfront with patients before treatment.

Final Adverse Benefit Determination — An adverse benefit determination that has been upheld by a health plan at the completion of the internal appeals process. If a consumer wants to appeal a final adverse benefit determination, he or she would request an external review from his or her health plan.

Formulary — A list of prescription drugs a health care plan covers; coverage amount varies by tiers.

G

Grandfathered Plan — (Also sometimes referred to as an "old" plan) A plan that is exempt from most of the changes required by health care reform because it was in existence before March 23, 2010 and hasn't made significant changes to the plan design. If a plan is grandfathered, it must disclose this status. New people and their dependents can be added to a grandfathered plan.

Group Contract — An insurance contract between an insurance company and an employer or other entity to cover employees or group members. Eligibility for coverage is defined in the contract. For example, an eligible employee might be defined as "employees working over 30 hours per week for the employer." These contracts are popular with workers because they are usually less costly than if the workers tried to buy the same kind of coverage as individuals. Often the contracts are referred to as policies.

Group Insurance — A health insurance policy or a health care services contract (HCSC) that covers a group of employees and often their dependents. Health care coverage occurs under a master policy issued to the employer or other group.
Guaranteed Issue — A requirement that health insurers not screen applicants with medical underwriting and accept anyone to whom the plan is offered (in the case of group insurance) or is made available (in the case of individual insurance), and not discriminate on the basis of age, health condition, ethnicity, etc. Health care reform requires all health insurance be sold on a guaranteed-issue basis as of 2014.

H

Health Care Service Contractor — A type of carrier that enters into contracts with health care providers such as doctors, clinics and hospitals to provide care to its customers (usually called "members" or "enrollees"). For example, in Washington state, Premera and Regence are Health Care Service Contractors.
Health Insurance — A policy or product that provides coverage to someone for doctor, hospital, and other medical expenses for prevention and treatment of illness or injury. It can be issued as an individual or a group policy.
Health Maintenance Organization (HMO) — A type of health carrier that requires subscribers to get all their care from a group of providers (except for some emergency care). The plan may require the subscriber's primary care doctor to provide them with a referral before they can see a specialist or go to the hospital. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan.
Health Plan Provider — The company or group that provides your health plan to you.
High Risk Pool — Washington State Health Insurance Pool (WSHIP is the high-risk health insurance pool for the state of Washington. It serves as a safety net for individuals who can't get comprehensive coverage in the regular insurance market and also provides supplemental coverage to individuals enrolled in Medicare can't get comprehensive supplemental coverage.
HIPAA (Health Insurance Portability and Accountability Act of 1996) — A federal law enacted in 1996. The law makes it easier for people to change jobs without the risk of being unable to obtain health insurance or having to wait for coverage due to pre-existing medical conditions. The law also creates standards that deal with the privacy of health information, which helps stop improper use your medical records.
Hospital Benefits — Benefits a health plan pays when you're hospitalized. They can include reimbursement for both inpatient and outpatient medical care expenses. Inpatient benefits include charges for room and board, necessary services, and supplies. Outpatient benefits may include surgical procedures, radiology services, and rehabilitation therapy.

I

Independent Review Organization (IRO) — An independent and unbiased group or entity that conducts external reviews of final adverse determinations made by insurance companies; the reviews are at the request of the insured. The cost of such a review falls on the insurance company to pay, and their determination is final and binding on the insurance company.

Individual Market — This market consists of individuals and their dependents who buy health insurance coverage directly from an insurer. People usually buy their own coverage because they don't qualify for government (such as Medicare or Medicaid) or employer-sponsored coverage.

In-Network Provider — A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an HMO or PPO). The provider agrees to the managed care organization's rules and fee schedules and agrees not to bill patients for amounts beyond the agreed upon fee.

Insurance — A contract to transfer risk from individuals to an insurance company. In exchange for a payment called a premium, the insurance company agrees to pay for losses covered under the terms of the policy.

Insurance Commissioner — The elected state official in Washington state who enforces the state's insurance laws, and makes reasonable rules and regulations to implement provisions of these laws. The Insurance Commissioner also conducts investigations, examinations, and hearings related to enforcement activities. The role of the Office of the Insurance Commissioner is to also provide information to consumers about insurance matters, listen to their complaints, and advocate for consumers when appropriate.

Insured — When you're covered by insurance, you're the insured.

Internal Appeal — This is the first stage of an appeal when you (or an authorized representative) ask a health plan to reconsider a decision it has made about your benefits (an "adverse determination"). The plan will review your appeal, and will notify you of whether or not it thinks their initial decision was decided correctly. Some internal appeals have multiple levels.

L

Lapse — When an insurance company ends a policy because the insured person fails to pay the premium.

Lifetime Limit—A lifetime limit is a dollar limit on what a health plan would spend for your covered benefits during the entire time you were enrolled in that plan. Before health care reform passed, you were required to pay the cost of all care exceeding those limits. Under health care reform, lifetime limits on most benefits are banned in any health plan or insurance policy issued or renewed on or after Sept. 23, 2010.

Limitations — These are exclusions, exceptions, or reductions of coverage in an insurance policy.

M

(Major) Medical Insurance — Health insurance to cover medical expenses over and above that of a basic health insurance policy. Major medical policies pay expenses both in and out of the hospital.

Managed Care Plan — A health plan that coordinates covered health care services for a covered person using a primary care provider and a network. Examples include Health Maintenance Organizations (HMOs) and some network plans.

Mandated Benefits — Washington state law requires insurance companies to offer or include certain benefits in specific health plans. Mandates may include mammograms, automatic coverage of newborn or adopted children, and home and hospice treatment options.

Medicaid — A federal and state-funded program that provides health care coverage to eligible categories of low-income people who meet certain criteria.

Medically Necessary — Covered health care services required to maintain the health of a patient in line with the geographical area's standards of medical practice. These are often defined in the policy.

Medicare — A federally funded insurance plan that provides hospital and medical coverage for people age 65 and older, for people with certain disabilities who are under age 65, and for people of all ages with End-Stage Renal Disease (permanent kidney failure) or Amyotrophic Lateral Sclerosis (Lou Gehrig's disease).

Medicare Advantage Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan.

Medicare Supplement (aka Medigap) — Voluntary private insurance coverage Medicare enrollees buy to cover the cost of services not reimbursed by Medicare. These policies are not classified as a health plan, and they are not subject to state appeal processes.

N

Non-grandfathered plan – (Also known as an "other" type plan) A plan that's required to implement the changes required by health care reform because it either came into existence after the law was passed (March 23, 2010), or was in existence before the law but made significant changes causing it to lose its grandfathered status.

O

Out-of-Network Provider — A health care provider (such as a hospital or doctor) that is not contracted to be part of an organization's network (such as an HMO or PPO). Depending on the managed care organization's rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network provider.

Out-of-Pocket Limit — The maximum coinsurance a health care plan requires a person to pay for covered charges, after which the insurer will pay 100 percent of covered expenses up to the policy limit.

Outpatient Services — Health care services provided to a patient in or out of a hospital facility, when medical or surgical care does not include an overnight hospital stay.

P

Patient Protection and Affordable Care Act (PPACA or ACA) – The comprehensive federal legislation signed into law on March 23, 2010 also known as health care reform. The major provisions of the bill will take effect during the five years that follow.

Post-Service Claim – Claims that get submitted by you or your doctor after you've received medical services, such as requests for reimbursement or payment for services provided. Most claims for group health benefits are post-service claims.

Preauthorization— This is a procedure managed care plans use to control plan members' use of health care services through pre-approval. See also term "prior authorization."

Pre-Existing Condition — A health problem you had before your new health insurance plan starts. Coverage for a pre-existing condition depends on the health insurance plan. Determining a pre-existing condition sometimes relies on a previous diagnosis, or treatment that was recommended for symptoms related to your condition.

Pre-Service Claim – A request for authorization from your health plan before you get medical care or treatment. For example, if you (or your provider) have to get your plan's authorization before having a procedure in order for the plan to pay for it, that request is known as a pre-service claim. If your plan denies authorization, that is known as a pre-service denial.

Preferred Provider Organization (PPO) — This is a network of health care providers who work with health insurance plans. A health insurance plan often pays more if members get their care from doctors or hospitals that contract with a PPO. The providers and hospitals are called "network" providers. Members pay more if they go to a doctor or hospital not listed in the plan's network. The providers in this PPO have agreed to accept negotiated fees for their services.

Premium — The dollar amount you pay for insurance coverage. For the policy to remain in place, you (and if applicable, your employer) must pay the premium on time.

Preventive Benefits — Covered services that are intended to prevent disease or identify disease while it is more easily treatable. Health care reform requires insurers to provide coverage for preventive benefits without deductibles, co-payments or co-insurance.
Prior Authorization — This is a managed care procedure to control your use of health care services through review and pre–approval. See also preauthorization.
Providers — Institutions and individuals licensed to provide health care services, such as hospitals, doctors, naturopaths, medical health clinicians, pharmacists, etc.

R

Rescission —When an insurer withdraws their original approval of a policyholder's application for coverage and any payment for any benefits he or she used. This usually happens when the insurer learns the policyholder did not fill out the application accurately. Under health care reform, policies can only be rescinded in instances where the policyholder intentionally lied on the application.
Rider — An attachment to a policy that modifies the conditions of the policy by expanding or decreasing its benefits, or excluding certain conditions from coverage.

S

Self-funded (aka self-insured) — When an employer or organization assumes responsibility for the covered health care expenses of its employees. Usually the employer sets up and contributes money to an account solely to pay claims. Sometimes the company handles the claims internally, but often an independent organization, such as a third-party administrator (TPA), processes employee claims and makes claim payments out of the employer's self-funded plan account. Some plans are not subject to state insurance laws; most self-funded plans are regulated under federal law by the U.S. Department of Labor.

T

Third-Party Administrator (TPA) — For health insurance, it's a person or company hired by an employer to manage health care claims processing, and pay providers. The TPA is not the policyholder or the insurer.

U

Urgent Care Claims – This is an expedited claim you can make if withholding medical care endangers your life or causes you prolonged pain or discomfort. Your medical provider with knowledge of your situation will decide if your condition is urgent or not.
Utilization Review— A health insurance company's review to determine if the health care services a provider or facility gives to a member or group of members is necessary and appropriate.

W

Waiting Period — For health insurance, it's the length of time you must wait from the date of hire until the date your health care coverage starts. This term may also refer to the total time you must be covered on a health plan before the plan will cover pre-existing conditions.

Additional resources

These resources will help you find additional information about health plan appeals.
We only manage the content on our own website. The appearance of a private website on this list is not an endorsement by our office.

RESEARCH

Washington State Office of the Insurance Commissioner
www.insurance.wa.gov/

U.S. Healthcare
www.healthcare.gov/appeal-insurance-company-decision/appeals/

U.S. Department of Health & Human Services, Appealing Health Plan Decisions
www.hhs.gov/healthcare/about-the-law/cancellations-and-appeals/appealing-health-plan-decisions/index.html

U.S. Department of Labor
www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/filing-a-claim-for-your-health-or-disability-benefits

U. S. National Library of Medicine
http://www.ncbi.nlm.nih.gov/pubmed/

MEDICARE

Medicare Appeals and Grievances
www.medicare.gov/claims-and-appeals/file-an-appeal/appeals.html

Your Medicare Rights
www.medicare.gov/claims-and-appeals/medicare-rights/medicare-rights-overview.html

Multiple Sclerosis - Health Insurance Appeals and Exception Requests
www.nationalmssociety.org/Resources-Support/Insurance-and-Financial-Information/Health-Insurance/Appeals

WSHIP – WASHINGTON STATE HEALTH INSURANCE POOL
www.wship.org

WSHIP Complaints & Appeals Policy
wship.org/appeals.asp

LEGAL RESOURCES

The CLEAR free legal help program
nwjustice.org/get-legal-help

ADDITIONAL ARTICLES

"New Rules Guarantee Patients' Right To Appeal Insurance Claim Denials," Kaiser Health News, (07/22/2010)
khn.org/news/insurance-denials-2/

"Fighting Denied Claims Requires Perseverance," *The New York Times,* (02/2010)
www.nytimes.com/2010/02/06/health/06patient.html?_r=2&hpw

"How to fight a bogus bill," from *The Wall Street Journal*, (02/19/2011):
www.wsj.com/articles/SB10001424052748703312904576146371931841968

"Working the System: One Cancer Patient's Story," The Wall Street Journal (12/29/2009)
www.wsj.com/articles/SB10001424052748704718204574616181790811124

How to get your health insurer to pay for your weight-loss surgery (4/29/2010)
www.insure.com/health-insurance/weight-loss-surgery.html