

Medical Appeals Tool Kit

The Medical Appeals Tool Kit provides information and resources to help consumers file an appeal with their health insurance company. Consumers may believe that the service they received from their provider is covered; and are surprised when they receive a denial of coverage notice from their health insurance company. Not only is the denial a surprise, it can often create a high level of anxiety and financial burden for the consumer.

Health insurance companies can deny prior approval authorizations (pre-service) or (post-service) claims for a variety of reasons. The good news is that consumers have appeal rights and your insurance company must notify consumers with the process for appealing the decision.

This tool kit provides the following information and resources to assist you with the Appeals Process:

What is an Appeal?

How to File an Internal Appeal

Sample Appeal Letters

- **Sample Letter to requesting documentation from the health insurance company about your denial.**
- **Sample Letter for a “not medically necessary” denial.**
- **Sample Letter for a “not medically necessary” and “investigational” denial.**
- **Sample Letter to appeal denial based on health care *setting*.**

After you review this information, if you have questions or need assistance, please contact the Smart NC Program at 855-408-1212 (Toll-free). We are here to help you!

What is an Appeal?

If your insurance company receives a claim for a healthcare service that you received, or is asked to approve treatment that has not yet been provided, the company will likely evaluate whether the services are medically necessary for

your specific medical condition. If the company determines that the services or service setting requested is not medically necessary (including experimental and cosmetic services), the company will issue a “noncertification” decision. The noncertification means that the service or setting has not been certified, or approved. When this occurs, the company must notify you of your rights to appeal the decision.

What is an appeal? An appeal is another review of your case by someone within the insurance company who was not part of the original decision to deny your claim and will take a second look at your case and determine if the denial was proper. Some plans provide one level of appeal, but some plans provide two levels of internal appeal. The second-level is referred to as a second level grievance review.

If your insurance company denies a claim, you will receive an explanation of benefits (EOB) letter that will explain your right to file an internal appeal.

*If you have questions and don't understand the denial from your insurance company, call **Smart NC at 855-408-1212 (toll-free)** and discuss your case with an insurance specialist.*

How to File an Internal Appeal

Step 1 - Know Your Deadline for Filing an Internal Appeal

You only have a certain amount of time to file an internal appeal. The insurance company denial letter or EOB will specify the amount of time you have to file. Some companies require that the internal appeal be filed within 180 days of the Date of Notice sent to you. For other insurance companies, the time may be less. It is important to check your policy and know your rights. If information about how to file an internal appeal is not in the denial letter, check your policy, or call your insurance company's customer service line.

Step 2 – DO NOT WAIT until you are close to the deadline to start working on your appeal. It may take several weeks to collect all of the information needed to submit a strong appeal. This includes obtaining information from the insurer such as the corporate medical policy specific to the denied service and criteria the insurance company used to make their decision, letter of medical necessity from the provider, medical records, research and preparing the appeal letter. Once you are ready to submit your information, send it certified mail or some other trackable means (i.e. FedEx, UPS) whereby the insurance company is required to

sign in order to receive the information. It is in your best interest to start early and appeal your decision as soon as possible to resolve the matter.

Step 3 – If Necessary, Appoint an Authorized Representative

You have the right to ask for an appeal. You also have the right to appoint an authorized representative to file an internal appeal on your behalf. In appointing an authorized representative, you are giving permission for someone else to ask for the appeal for you. Sometimes your medical provider will be willing to act as your authorized representative; you can also appoint a trusted friend or family member.

Some health insurance companies have a “Member Appeal Representation” authorization form. Other companies include the naming of the authorized representative on their Appeal Request form. You can obtain the form used by your health insurance company by calling their Customer Service number to request the form or obtain the form from the insurance company’s website. **The insurance company must have the signed form from you on record so that your designee can act for you.**

Step 4 – Read the Denial Notice

Read the denial notice to learn the following:

- The specific reason for the denial.
- The plan language used to deny the service.
- What the plan needs in order to reverse its initial denial.
- What your plan’s appeals and grievance process is and the deadline to submit your appeal.
- Where to send a formal appeal.

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Step 5 – Gather Supporting Documents

All appeals must be in writing. To help increase the possibility of overturning the adverse determination, it is in your best interest to collect additional information to support and prepare your appeal.

From your insurance company

Ask for a copy of all information used for the denial decision. This is provided at no charge to you. This could include:

- Copies of all records about your case;
- Copies of the medical review criteria, corporate medical policies, or any other clinical guidelines used to make the decision for the requested treatment or service; and
- Determination notice from your insurance company.

Review the insurer's information and search for any missing information in your file that supports paying the benefit or approval of service. Review the medical criteria and corporate medical policy which outlines the requirements to be met in order for the service or treatment to be approved.

From your provider

The type of information that will be helpful to your case depends on the reason for the denial. Here are some examples:

- If your claim or pre-service request was denied as being ***not medically necessary***, ask your medical provider(s) for a copy of your medical records; and to write a letter explaining why the denied treatment or pre-service request was prescribed, how the insurer's medical criteria for treatment or service has been met and why other forms of treatment were not appropriate.
- If your claim or pre-service request was denied as being "**experimental or investigational**," ask your medical provider for a copy of your medical records, current scientific clinical research articles which shows evidence that the medical community considers the treatment for your condition to be the standard of care, and a letter explaining these studies and the treatment rationale.
- If your claim was denied as **not covered under your policy**, you should review the policy and find the language that supports payment of your claim and your argument.

General Information

Include current scientific clinical research articles that shows evidence that the medical community considers the treatment for your condition to be the standard of care. Ask your provider for guidance. Do your own research at

www.pubmed.gov

Step 6 – Writing the Appeal Letter

Write a persuasive letter to the insurance company. The letter should explicitly request a first-level appeal or second-level grievance review of your denied claim or pre-service request (prior approval). At the top of the letter, include the following:

The date you are writing the appeal

The address indicated in the denial letter as the place to send an internal appeal

Your name as the patient's name

Your date of birth

Your primary insured's name (if you are a spouse or dependent on the policy)

Your medical policy identification number

The denied claim number

The date you received the service that was denied, or date on the letter of denial for prior approval of the service requested.

Once you have included all of the above information, you are ready to write the letter. The first sentence should state, "I am writing to request a (first-level appeal) (second-level grievance review) of the denied claim referenced above."

Explain why you believe the claim should be covered. Include as much detail as possible, referencing the insurer's corporate medical policy and clinical review criteria and how you and your provider believe you have met the criteria. Reference the scientific research and standard of care for treating this condition. Be sure to include all supporting documents with your appeal. If you have an Authorized Representative, be sure to include the contact information for that individual in your letter.

When you are ready to send your appeal letter and supporting documentation, send the correspondence via a trackable means whereby a recipient of the organization must sign that they have received the correspondence. Examples include Certified US Mail (return receipt), FedEx, UPS and other similar carriers that provide confirmation of delivery.

If you fail to win your appeal

If you failed to win your appeal – you may be eligible for an External Review. External Review is the independent medical review of a health plan denial

(noncertification) and offers another option for resolving coverage disputes between a covered person and their insurer. A noncertification is a decision made by a health plan that a requested service or treatment is not medically necessary, cosmetic or experimental/investigational for the person's condition.

*For more information about requesting an external review, please call **Smart NC at 855-408-1212 (toll-free)** to discuss your case or click on the external review link [http://www.ncdoi.com/Smart/External_Review - Request.aspx](http://www.ncdoi.com/Smart/External_Review_-_Request.aspx) .*