

What if I am Denied Coverage? Appeals and Grievances

Overview of Appeals Process

Dealing with insurance companies can be a complicated and frustrating endeavor and even more so when dealing with a chronic illness, such as chronic obstructive pulmonary disease (COPD). Medications needed to manage your health can be overly burdensome, but manageable. However, should your insurance plan deny coverage of a medically necessary prescription drug, you could be left in a precarious situation not knowing how you will get your next dosage. Fortunately, there are options available to you that will allow you to appeal your insurance company's decision.

Your Rights

The Affordable Care Act (ACA) includes new rules that spell out how your plan must handle your appeal (usually called an "internal appeal"). If your plan still denies payment after considering your appeal, the ACA permits you to have an independent review organization decide whether to uphold or overturn the plan's decision. This final check is often referred to as an "external review."

ACA rules

When your plan denies a claim, it is required to notify you of:

- The reason the claim was denied
- Your right to file an internal appeal
- Your right to request an external review if your internal appeal was successful
- The availability of a Consumer Assistance Program (CAP) that can help you file an appeal or request a review (if your state has such a program)

If you don't speak English, you may be entitled to receive appeals information in your native language upon request.

When you request an internal appeal, your plan must give you its decision within:

- 72 hours after receiving your request when you're appealing the denial of a claim for urgent care. (If your appeal concerns urgent care, you may be able to have the internal appeal and external review take place at the same time)
- 30 days for denials of non-urgent care not yet received
- 60 days for denials of services you have already received

If after an internal appeal the plan still denies your request for payment or services, you can ask for an independent external review. Your plan must include information on your denial notice about how to request this review. A CAP program can help with this request. If the external reviewer overturns your insurer's denial, your insurer must give you the payments or services requested in your claim.

These new rules apply only to new plans (purchased or created after March 23, 2010). Grandfathered plans do not have to comply with the new rules.

Overview of Filing Internal Appeals

When you request an internal appeal, your insurance company may ask your provider for more information in order to make a decision about the claim. The insurer should inform you of the deadline of the requested additional information. If a deadline is not given, call your insurer at the number found on the back of your ID card. Be sure to receive the denial in writing. If you have not received a written denial but have been denied coverage, call your insurer at the number found on the back of your ID card and request a written denial.

Steps in the Appeal Process

Step 1

Contact your prescribing physician and ask them to contact your insurer's medical management area or its Medical Director directly in order to request a peer-to-peer review to discuss the specific reason why this type of medication is needed by you.

Step 2

If your physician has already had the peer-to-peer review with the medical management area, and the request for medication continues to be denied, you have the right to appeal this decision in writing to the appropriate department. You can find the address to submit appeals in the denial letter, your coverage documents or by contacting your insurer using the member services telephone number on your ID card. Provide:

- 1) Pertinent clinical information regarding your health and medication history;
- 2) Your medical records documenting past drug trials and health history. Your prescribing physician should have these.
- 3) History of any adverse reactions or side effects you have had to similar medications (over-the-counter or prescribed) or generic equivalents that were not effective;
- 4) If your insurer requires a drug authorization form, have your prescribing physician complete the drug authorization form;
- 5) If you received a letter of denial for the medication, ensure that the information provided directly addresses the reasons for the denial.
- 6) If the dispute is over necessity, your physician's support in the form of a letter including studies supporting the benefit of the treatment in question could be invaluable. Request that your physician write a letter of medical necessity. A service is medically necessary if it meets one of the three standards below:

- a) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
 - b) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition or disability.
 - c) The service or benefit will assist the individual to achieve or maintain maximum functional capacity in performing daily activities taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.
- 7) The letter should assert that the prescribed drug is medically necessary and:
- a) Any drug on the formulary would not be as effective and/or would be harmful to you.
 - b) All other drug or dosage alternatives on the plan's formulary have been ineffective or caused harm, or based on sound clinical evidence and knowledge of the patient, are likely to be ineffective or cause harm.
- 8) Contact your insurer after submitting your request to make sure they have received it.

Step 3

Follow up. If your appeal is denied, go to the next level of appeal. Do not assume this happens automatically – make sure you communicate your desire for a second-level or independent external review. This will be a reconsideration of your original claim by professionals with no connection to your insurance plan. If the independent reviewers think your plan should cover your claim, your health plan must cover it.

Adapted from the Immune Deficiency Foundation Insurance Toolkit and the Personal Health Insurance Toolkit produced by the American Plasma Users Coalition's (A-PLUS) State Exchange Project. Special thanks to the following organizations for their assistance with content development: Alpha-1 Association, Immune Deficiency Foundation, Georgetown Health Policy Institute, National Hemophilia Foundation and Patient Services, Inc.