What If I Am Denied Coverage?
Appeals and Grievances

Dealing with insurance companies can be a complicated and frustrating endeavor and even more so when dealing with a chronic illness, such as a primary immunodeficiency disease. Should your insurance plan deny coverage of a medically necessary treatment, you could be left in an anxious 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. In addition to filing an appeal, you may also wish to speak with an insurance case manager, should your plan provide one, as a resource regarding your grievance.

Guarantees of the Affordable Care Act
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 appeal.”

When your plan denies a claim, it is required they 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 unsuccessful, and 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).

How to File an Appeal
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. They should inform you of the deadline to send additional information and if a deadline is not given, call your insurer at the number on the back of your ID card. Remember, you should receive the denial in writing. Be proactive and call your insurance company. Also, keep notes on every conversation you may have with your insurance company.

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

- 72 hours after receiving your request when you are 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 you have not yet received.
- 60 days for denials of services you have already received.

Steps in the Appeal Process
1. 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. Write a clear and simple letter providing:
   a) Pertinent clinical information regarding your health history and treatment history as well as your medical records documenting past drug trials and health history. Your prescribing physician should have these
   b) History of any adverse reactions or side effects, you have had to similar treatments
   c) If your insurer requires the prescribing physician to complete a drug authorization form, you should make sure this has been done; and,
   d) If you received a letter of denial for the treatment, ensure that the information provided directly addresses the reasons for the denial.
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e) If the dispute is over the medical necessity of your treatment, your physician’s support in the form of a letter including studies supporting the benefit of the treatment in question is invaluable. Request that your physician write a letter of medical necessity. A service is medically necessary if it meets any one of the three standards below:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness condition, or disability.
- 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.
- 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.

The letter should assert that the prescribed treatment is medically necessary and:

- Any product on the formulary would not be as effective and/or would be harmful to you.
- All other product 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.

f) Contact your insurer after submitting your request to make sure they have received it.

2. Your physician can also request a peer-to-peer review to discuss the specific reason why this type of treatment is needed for you if the initial appeal is unsuccessful.

3. If after internal appeal the plan still denies your request for payment or services, you can ask for an Independent External Review. This will be a reconsideration of your original claim by professionals with no connection to your insurance plan. Your plan must include information on your denial notice about how to request this review, do not assume this happens automatically. If the independent reviewers think your plan should cover your claim, your health plan must cover it.

How much these new ACA rules will change your current appeal rights depends on the state you live in and the type of plan you have. Some group plans may require more than one level of internal appeal before you are allowed to submit a request for an external review. However, all levels of the internal appeals process must be completed within the timeframes above.

These new rules apply only to new plans (purchased or created after 3/23/2010). Grandfathered plans do not have to comply with the new rules. However, over time all plans will lose that status and have to comply.