What if I am Denied Coverage? Appeals and Grievances

Dealing with insurance companies can be complicated and frustrating, especially if you have a chronic illness, such as hemophilia or von Willebrand disease. Medications needed to manage your health can be overly burdensome, but are manageable. However, should your insurance plan deny coverage of a medically necessary prescription drug, you could be left in an anxious situation not knowing how you will get your next dose. Fortunately, there are now options that allow you to appeal your insurance company's decision.

Your rights when you are denied coverage: 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." Under the new rules:

- When your plan denies a claim, the plan must 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).

- If English is not your first language, 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. Under the rule, the plan or insurer must defer to the attending provider in determining whether a claim is urgent or not. (If your appeals 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 nonurgent care you have 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 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.

- How much these new 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're allowed to submit a request for an external review. However, all levels of the internal appeals process must be completed within the timeframes above.

How to file an internal 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. It should inform you of the deadline to send any additional information requested. If a deadline is not given, call your insurer using the number on the back of your ID card. Remember, you should receive the denial in writing. Be proactive and call your insurance company if you do not.

Steps in the Appeal Process:

1) Contact your prescribing/treating physician and ask him/her to contact your insurer's medical management area or medical director to request a peer-to-peer review to discuss the specific reason why you need this type of medication.

2) If your physician has already had the peer-to-peer review with the medical management staff, 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. Be sure to write a clear and simple letter providing:

   a) Pertinent clinical information regarding your health and medication history:

      i) 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 medications (over the counter or prescribed), or generic equivalents that were not effective.

   c) If your insurer requires the prescribing physician to complete a drug authorization form, you should make sure this has been done.

   d) If you received a letter of denial for the medication, ensure that the information provided directly addresses the reasons for the denial.

e) If the dispute is over the medical necessity of the service, 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 any one of the three standards below:

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

ii) 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.

iii) 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.

f) The letter should assert that the prescribed drug is medically necessary and:

i) Any drug on the formulary would not be as effective and/or would be harmful to you.

ii) 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.

g) After submitting your request, contact your insurer to make sure it was received.

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.