https://time.com/7014894/how-to-appeal-health-insurance-denial/?utm_source=beehiiv&utm_medium=email&utm_campaign=newsletter-health-matters&_bhlid=b3772f654f8a8264c7ec60b58b1408daaf2b7cde

What to Do When Health Insurance Denies Care You Really Need

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If there's anything worse than being sick, it's being sick while dealing with insurance issues. But unfortunately, that situation is all too common. Recent research from the Commonwealth Fund, a private foundation that researches health care issues, finds that 17% of U.S. adults have in the past year had their insurance company deny doctor-recommended care, with denials happening about as frequently for people on both commercial and government insurance plans.

Denials can occur either before you've gotten a test, procedure, or treatment—when a provider submits a request for prior authorization, for example—or after you've already received care. The insurer may argue the service isn't one it covers or is medically unnecessary for you, or it may deny care on logistical grounds, like a claim having incorrect information or coming from an out-of-network provider. Receiving a denial letter can be discouraging, but you can take certain steps to fight back. Here's what to do.

Read your denial letter in full

It's easy to let your eyes glaze over when faced with a letter full of jargon, but it's important to read it carefully, says Jeremy Gurewitz, CEO of Solace, a company that connects consumers with advocates who help them navigate the health care system. Your letter should spell out exactly why you were denied coverage—and that reason is important to know, Gurewitz says, because it determines your next steps. Your issue may have a fairly straightforward fix, like providing additional paperwork or re-submitting a claim with different information. Or, it may require putting together an appeal to argue that your doctor's treatment plan is, in fact, medically necessary. Gurewitz recommends starting with a call to your insurer's customer service line, as some issues can be worked out on the phone.

Insurance companies also make mistakes “all the time,” Gurewitz says, so don’t assume that your denial letter is correct and give up right away. Consult your policy documents to verify that what the insurer is claiming is true, and ask them to correct any errors you find.

Appeal

Even if your denial can’t be easily reversed—such as when the company argues a service isn’t medically necessary, or you accidentally saw an out-of-network provider—you still have options. “Never take ‘no’ as a final answer, ever,” says Wendell Potter, a former Cigna executive who became a whistleblower and advocate for health care reform after leaving the company in 2008. “Insurance companies are expecting the people enrolled in their health plans to just accept whatever they decide to do because [pushing back] is complicated. It’s a burden. It’s a chore.”

People who do take the time to appeal, however, often get good results. The Commonwealth Fund’s recent report found that half of people who challenged an insurance denial ultimately got at least partial approval, or approval for a similar service. (The same is true for medical bills, by the way. Recent researchsuggests more than 60% of people who try to negotiate their health bills successfully get a price adjustment.)

Putting together a good appeal does require doing some homework, though. First, refer back to your denial letter, which should include information about how to file an appeal and, potentially, specific instructions about what to include and in what format, Gurewitz says. This information should also be available on your insurer’s website.

If you've been denied on medical necessity grounds, your goal is to make a clear, compelling case for why you need a treatment, procedure, or medication. If you can, get your doctor involved, recommends Diane Spicer, supervising attorney at Community Health Advocates (CHA), a group that helps people in New York use the health care system. This can be tricky, as providers aren’t always willing or able to make the time, she says. But if your doctor makes a detailed argument for medical need, augmented by medical records and clinical notes, it significantly strengthens your case, she says.

A doctor may choose to write a letter themselves or they may provide you with a statement to include in your own letter. You’re also entitled to ask for the criteria your insurer used to make its decision, Spicer says. The best way to get this, as well as other records related to your case, is to ask for your “claim file.” You can compare the insurer’s decision-making criteria with national

standards of care for your condition; if your insurer is trying to enforce a more stringent standard than is typical, you can include that information in your appeal letter.

To find these national standards, Spicer recommends using a search term like, “Guidelines for the diagnosis, management, and treatment of [insert name of condition, being as specific as possible].” Search results will typically lead you to reports or guidelines from national health organizations. You can also search UpToDate, a database that compiles information about evidence-based health care practices, but that requires paying a fee.

If you've been denied because you were treated by an out-of-network provider, you may also be able to appeal, Spicer says. The No Surprises Act protects consumers in a variety of circumstances, such as if you're treated by an out-of-network clinician during an emergency or a provider is mistakenly listed as in-network on an insurer's database.

Insurers often ask for appeals to be submitted by mail. If so, it’s “super important” to send yours by certified mail so you can track delivery, Gurewitz says. “You need to have a paper trail,” he says.

Escalate

If your appeal is denied, that’s still not the end of the road. If the company continues standing by its original decision, you can request an external reviewin which a third party assesses the case. You also don’t have to stop at filing an appeal through official channels, Potter says. Consider alerting executives at the insurance company, regulatory boards, local politicians, or the media to turn up the pressure. This works best, Potter admits, if you have an especially sympathetic or dramatic story—if the company’s denial has forced you to delay critical care or caused significant financial hardship, for example. If you don’t want to go quite so nuclear, you can always call out the company on social media, Potter says.

“Being a squeaky wheel is important,” Potter says. When he worked at Cigna, he says, the company had a system for dealing with “high-profile” cases, like those that had attracted the attention of a journalist. “Before too long,” he says, “that denial would be overturned.”

Get help

If all of this sounds overwhelming, call in the experts. Health advocates can help put together a strong appeal, as they know the ins and outs of the system and what's worked with specific insurers in the past.

Consumers can work with health advocates, whose services are often free, through private companies like Solace, charities like the Patient Advocate Foundation, or state-specific organizations like CHA. Sometimes, employers even offer health advocacy services as an employee benefit. The soon-to-launch startup Claimable also promises to use artificial intelligence to sort through medical research, information about your insurance plan and health history, and data from past appeals to craft one with a better shot at working.

Whatever avenue you take, it's important to remember there are people who can help, Gurewitz says. "When you or your loved one is dealing with a serious illness," he says, "the last thing you want to be doing is scouring the paperwork."