3 Hints

TO HELP YOU NAVIGATE THE APPEALS PROCESS

Navigating the health insurance appeals process for children with genetic conditions can be overwhelming. Here are three helpful hints for getting you through it.

1

Work Collaboratively

Partner with your medical provider early in the process. Insurance companies frequently request additional medical information to process your claim. Your provider can be there to help you.

2

Documentation is key

Keep records of all phone conversations and e-mail exchanges you have with the insurance company and your provider.

3

It's never too early to advocate

Elevate your issue as soon as you begin the appeals process by requesting to work with a supervisor at your insurance company. It will likely save you time and energy.

Navigating the Health Insurance Appeals Process for Children with Genetic Conditions

A Parent Guide

NEW ENGLAND GENETICS COLLABORATIVE

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Healthcare Access & Finance Work Group

Step One: Internal Appeal Process

My health insurance company denied my claim. What can I do?

If your health insurance company will not pay for a service or part of a service that you believe is covered by your plan, you have the right to file an appeal. Information on how to submit your appeal is included in the denial letter you received from your insurance company. Key information to look for is the reason for denial and the appeal deadline. If the appeal deadline is not in the denial letter, call the insurance company's customer service number provided and find out. You can also request that all information and documents related to your denial be shared with you.

Check your insurance plan contract to understand exactly what is covered under your policy so that you can determine whether you have grounds for an appeal. If you have questions about the service, contact your provider.

What information should I include in my appeal letter?

Include identifying information, such as your name, claim number, and health insurance ID number, along with any information that will help strengthen your case. For example, you may include a letter of support from the doctor who treated your child, which states why the services received were medically necessary and appropriate. Relevant case studies and clinical trials may be helpful, too. Work collaboratively with your provider to build your case.

Tell the provider's billing office that you are aware your claim has not been paid and that you're actively working to resolve it. It may help them decide to waive late fees.

What are some tips to writing an appeal letter?

Be clear and concise. Show how the condition has affected your child and your family, but avoid ranting. Use data-driven information.

Stay as organized as possible. Keep records of all phone conversations and e-mail exchanges you have with the insurance company and your provider.

PRIOR APPROVAL / AUTHORIZATION

A DECISION BY YOUR HEALTH INSURER OR PLAN THAT A REQUESTED SERVICE, TREATMENT, PRESCRIPTION DRUG OR DURABLE MEDICAL EQUIPMENT IS MEDICALLY NECESSARY.

CLAIM

A CLAIM IS A FORMAL REQUEST TO AN INSURANCE COMPANY TO PAY FOR A HEALTH CARE SERVICE THAT YOU RECEIVED.

APPEAL

AN APPEAL IS A REQUEST FOR A DECISION TO BE REVERSED. IN THIS CASE, YOU ARE ASKING FOR AN INSURANCE COMPANY TO REVERSE ITS DECISION AND PAY YOUR SUBMITTED CLAIM.

INTERNAL APPEAL

YOUR INSURANCE COMPANY REVIEWS ITS INITIAL DECISION OF YOUR CLAIM.

Step Two: External Appeal Process

My insurance company denied my claim again. Now what?

Your insurance company is required to notify you of the next step in the appeal process. All insurance companies are required to offer at least one level of appeal; some offer two levels. If you still do not receive a satisfactory resolution to your case, you may have the right to request an external appeal. External appeals are administered by your state insurance bureau, and they available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, and level of care or effectiveness.

EXTERNAL APPEAL

YOUR STATE INSURANCE BUREAU REVIEWS YOUR CLAIM AND DECIDES IF YOUR INSURANCE COMPANY MUST PAY IT.

Is everyone eligible for an external appeal?

No. Standard requirements for external appeal eligibility include (1) having a fully-insured health plan; (2) completed the insurer's internal appeal process; (3) received a final denial of services from the insurer; (4) completed and submitted state-specific, required documentation and application for the external appeal.

Deadlines for filing external appeals are state-specific. You can find this information by visiting your state insurance bureau website or calling its customer service number.

Who makes the external appeal decision?

If you are eligible for an external appeal, your case will be assigned to an independent reviewer; in other words, one that is not associated with your insurance company. The independent reviewer will hire a health care provider that is an expert on the medical issue being decided and who will be responsible for making the decision on your appeal.

In many cases, families can designate an individual to represent them for the external appeal. It can be helpful to assign your provider as the representative in order to ensure the medical case for the appeal is clearly stated.

What are the potential outcomes of the external appeal?

There are two potential outcomes of the external appeal. The decision will either (1) support the insurance company's denial, in which case you must pay your claim; or (2) support you, in which case your insurance company must pay your claim. By law, your insurance company must accept the decision of the external review.

Some states require you to pay a fee for an external appeal. If the external appeal decision is in your favor and requires the insurance company to pay your claim, the fee for the external appeal is waived.

Expedited Appeals

EXPEDITED APPEAL

AN APPEAL THAT CAN BE REQUESTED IF IT IS BELIEVED THAT WAITING FOR A DECISION UNDER THE STANDARD TIMEFRAME COULD JEOPARDIZE THE LIFE OR HEALTH OF AN INDIVIDUAL

How do I qualify for an expedited appeal?

To qualify for an expedited appeal, your child's life, health, or ability to function must be in serious jeopardy. If your provider believes that your child needs the medical care in question sooner than it takes to go through the standard appeals process, you or your provider can request the appeal be expedited.

How long will it take to receive a response for an expedited appeal?

The appeal decision will be provided as quickly as required by your child's condition, but no more than 72 hours after the review is initiated.

What happens if my expedited appeal is denied?

You may immediately request an expedited external appeal by contacting your Bureau of Insurance. Typically, these requests are completed within 72 hours.

Tips for Navigating the Appeals Process

- Work collaboratively with your medical provider as early in the appeals process as possible. Insurance companies frequently request additional medical information to process your claim.

- Special conditions are frequently denied by insurance companies, and many families do not pursue the appeals process. Because these denials are almost routine, families with children with special conditions always need to be one step ahead.

- Documentation is key. Keep track of all communication with the insurance company, including names, dates and times of conversations, duration of conversations, how many times you were transferred, etc. If you are told that you will receive a call back, ask from whom and on what date.

- Don't be afraid to elevate your issue. Request to work with a supervisor at your insurance company early in the process. It will likely save you time and energy.

- Every state has a Family-to-Family Health Information Center (often paired with Family Voices) which helps families navigate the system.

Below are agencies you may contact in the appeal process. Family organizations are included because they can help you navigate the system, especially since every state is a little bit different!*

Connecticut

Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
(866) 466-4446
Healthcare.advocate@ct.gov
www.ct.gov/oha

Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142
Consumer Affairs Unit – (800) 203-3447
cid.ca@ct.gov
www.ct.gov/cid

*PATH Parent to Parent/Family Voices of CT
P.O. Box 117
Northford, CT 06472
(203) 234-9554
www.pathct.org

Maine

Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333
(207)624-8475
www.maine.gov/insurance

Maine Bureau of Insurance - Appeals
http://www.maine.gov/pfr/insurance/consumer/individuals_families/health/complaints_appeals_externalreviews/appeals.html

*New Directions for Maine Families
P.O. Box 18
Lincolnville, ME 04849
(207) 358-9005
www.nd4me.org

*Maine Parent Federation
PO Box 2067
Augusta, ME 04338
(207) 588-1933
www.mpf.org

Massachusetts

Office of Patient Protection
(800)436-7757
HPC-OPP@state.ma.us

Massachusetts Ins. Dept. – Appeals
http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/patient-protection/appeal-a-health-insurance-claim-denial.html

*Mass Family Voices at Federation for Children with Special Needs
The Schrafft Center / 529 Main Street, Suite 1M3
Boston, MA 02129
(617) 236-7210
www.fcsn.org

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New Hampshire

New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301
(603)271-2261

New Hampshire Ins. Dept. – Appeals
(800) 852-3416
http://www.nh.gov/insurance/consumers/appeals.htm

*New Hampshire Family Voices
129 Pleasant St
Concord, NH 03301
(603) 271-4525
www.nhfv.org

Rhode Island

Office of the Health Insurance Commissioner (OHIC)
(401)462-9517
www.ohic.ri.gov

*Rhode Island Parent Information Network (RIPIN)
1210 Pontiac Avenue
Cranston, RI 02920
Phone: (401) 270-0101
www.ripin.org

*RIREACH (part of RIPIN)
(855) 747-3224
www.rireach.org

Vermont

Department of Financial Regulation Consumer Services
89 Main Street
Montpelier, VT 05620-3101
(800) 965-1784
dfr.insurancein@vermont.gov

http://www.dfr.vermont.gov/insurance/insurance-consumer/file-insurance-complaint

Vermont Legal Aid Health Care Advocate HelpLine
(800) 917-7787
www.vtlawhelp.org/health

*Vermont Family Network
600 Blair Park Road Suite 240 ·
Williston, VT 05495-7549
(802) 876-5315