

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 (VWD). Medications and treatments 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 or other treatment or service, you could be left in an anxious situation not knowing how and when you will get the care you need. 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 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."

Note that these ACA rules apply only to new (non-grandfathered) plans. Grandfathered plans do not have to comply with the new rules. However, over time all plans will lose that status and have to comply.

The ACA rules are:

- When your plan denies a claim, the plan must notify you of the following: the reason the claim was denied, your right to request an internal appeal of the denial, your right to 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.
- You can request an internal appeal up to 6 months from the date of your denial of coverage or payment for a specific service. 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 concern 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.
- 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. You may be able to get help with this request from your state insurance department, or, in some states, a Consumer Assistance Program(CAP). If the external reviewer overturns your insurer's denial, your insurer must give you the payments or services requested in your claim.
- How much these new rules will change your 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 stated above.

Your rights when you are unable to obtain coverage of a prescription drug prescribed for you: You can request coverage of a prescribed drug when it's not covered on your plan's formulary or appeal the denial of a covered drug based on "medical necessity."

Requesting coverage of a non-formulary drug: Federal law requires health plans to have a process for requesting a non-formulary drug. In some states, there may be an exceptions process that is separate from the internal appeals and external review process described above. In other states, requests for non-formulary drugs are treated like all other denials of "medically necessary" health care treatments and services and the internal appeals/external review process discussed above will apply.



Your plan documents will tell you whether to use an exceptions process or the internal appeal and external review process to request coverage of a non-formulary drug. You can also contact your state's insurance department to find out what rights you have under state law. But, it's important to keep in mind that federal law requires exceptions processes to:

- provide consumers a decision within 72 hours of the request for coverage (and within 24 hours if it's an urgent case), and
- provide access to an independent, external review if your plan denies your exceptions request.

Requesting coverage of a formulary drug that has been denied for you: In some cases, you may need a drug that is covered on your plan's formulary, but is denied to you based on "medical necessity" or comes with limits that your prescribing physician has said would be ineffective or inappropriate for you. In this case, you'll use the internal appeal/external review process discussed above.

Tips for advocating for coverage of the health care services and treatments you need

When you request an internal appeal of a plan denial, or coverage of a non-formulary drug, your insurance company may ask your provider for more information in order to make a decision about the claim. Your insurance company should inform you of the deadline to send any additional information requested. If a deadline is not given, call your insurer using the number provided on the back of your ID card. Remember, you should also receive the denial in writing. Be proactive and call your insurance company if you do not.

Where to start: You may want to start by contacting 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 or treatment/service. This may resolve your issue without having to go through a more formal internal appeal or exceptions request process.

However, do keep in mind that you have 6 months from the date of your coverage denial to request an internal appeal. The deadlines for your plan to respond to your request may not be triggered without a more formal internal appeal or exceptions request.

If your physician has already had the peer-to-peer review with the medical management staff, and the request continues to be denied, you have the right to appeal this decision in writing to the appropriate department or to more formally request an exception to the formulary. You can find information on how to request an internal review or an exception in your coverage documents, or by contacting your insurer using the member services telephone number on your ID card. You can also find information on your internal appeal rights in your Explanation of Benefits or denial letter, as well as in your plan's **Summary of Benefits and Coverage**.

When you request an internal appeal or exception, be sure to write a clear and simple letter providing the following:

- Pertinent clinical information regarding your health and medication history, including any medical records documenting your health history. If you're requesting a medication, include:
 - Information on other drugs or drug dosages you may have tried or considered but were or would have been ineffective or cause harm, or, based on sound clinical evidence and knowledge of the patient, are likely to be ineffective or cause harm.
 - 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.
 - Your treating physician should have copies of these.

Keep the following in mind:

- If your insurer requires the prescribing physician to complete a drug authorization form, you should make sure this has been done in compliance.
- If you received a letter of denial for the medication, ensure that the information provided explicitly addresses the reasons for the denial.
- If the dispute is over the "medical necessity" of the service, your physician's support in the form of a letter, including any relevant studies supporting the benefit of the treatment in question could be invaluable. Request that your physician write a letter of "medical necessity." Your insurer may have its own definition of medical necessity, but generally, 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.
- **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.

