Fast Facts

Appeals and Medical Necessuty

Appeals– *from healthcare.gov*

If your health insurer refuses to pay a claim or ends your coverage, you have the right to appeal the decision and have it reviewed by a third party.

You can ask that your insurance company reconsider its decision. Insurers have to tell you why they've denied your claim or ended your coverage. And they have to let you know how you can dispute their decisions.

Types of Appeals

Internal appeal: If your claim is denied or your health insurance coverage canceled, you have the right to an internal appeal. You may ask your insurance company to conduct a full and fair review of its decision. If the case is urgent, your insurance company must speed up this process.

There are 3 steps in the internal appeals process:

You file a claim: A claim is a request for coverage. You or a health care provider will usually file a claim to be reimbursed for the costs of treatment or services.

Your health plan denies the claim: Your insurer must notify you in writing and explain why:

- Within 15 days if you're seeking prior authorization for a treatment
- Within 30 days for medical services already received
- Within 72 hours for urgent care cases

You file an internal appeal: To file an internal appeal, you need to: Complete all forms required by your health insurer. Or you can write to your insurer with your name, claim number, and health insurance ID number. Submit any additional information that you want the insurer to consider, such as a letter from the doctor.

The Consumer Assistance Program in your area can file an appeal for you.

You must file your internal appeal within 180 days (6 months) of receiving notice that your claim was denied. If you have an urgent health situation, you can ask for an external review at the same time as your internal appeal.

If your insurance company still denies your claim, you can file for an external review.

What papers do I need?

Keep copies of all information related to your claim and the denial. This includes information your insurance company provides to you and information you provide to your insurance company like:

- The Explanation of Benefits forms or letters showing what payment or services were denied
- A copy of the request for an internal appeal that you sent to your insurance company
- Any documents with additional information you sent to the insurance company (like a letter or other information from your doctor)
- A copy of any letter or form you're required to sign, if you choose to have your doctor or anyone else file an appeal for you.
- Notes and dates from any phone conversations you have with your insurance company or your doctor that relate to your appeal. Include the day, time, name, and title of the person you talked to and details about the conversation.
- Keep your original documents and submit copies to your insurance company. You'll need to send your insurance company the original request for an internal appeal and your request to have a third party (like your doctor) file your internal appeal for you. Make sure to you keep your own copies of these documents.

Internal Appelas contd'

What kinds of denials can be appealed?

You can file an internal appeal if your health plan won't provide or pay some or all of the cost for health care services you believe should be covered. The plan might issue a denial because:

- The benefit isn't offered under your health plan
- Your medical problem began before you joined the plan
- You received health services from a health provider or facility that isn't in your plan's approved network
- The requested service or treatment is "not medically necessary"
- The requested service or treatment is an "experimental" or "investigative" treatment
- You're no longer enrolled or eligible to be enrolled in the health plan

It is revoking or canceling your coverage going back to the date you enrolled because the insurance company claims that you gave false or incomplete information when you applied for coverage

How long does an internal appeal take?

- Your internal appeal must be completed within 30 days if your appeal is for a service you haven't received yet.
- Your internal appeals must be completed within 60 days if your appeal is for a service you've already received.

At the end of the internal appeals process, your insurance company must provide you with a written decision. If your insurance company still denies you the service or payment for a service, you can ask for an external review. The insurance company's final determination must tell you how to ask for an external review.

What if my care is urgent and I need a faster decision?

In urgent situations, you can request an external review even if you haven't completed all of the health plan's internal appeals processes. You can file an expedited appeal if the timeline for the standard appeal process would seriously jeopardize your life or your ability to regain maximum function. You may file an internal appeal and an external review request at the same time.

A final decision about your appeal must come as quickly as your medical condition requires, and at least within 4 business days after your request is received. This final decision can be delivered verbally, but must be followed by a written notice within 48 hours.

External review: You have the right to take your appeal to an independent third party for review. This is called external review. External review means that the insurance company no longer gets the final say over whether to pay a claim.

There are 2 steps in the external review process:

You file an external review: You must file a written request for an external review within 60 days of the date your insurer sent you a final decision. Some plans may allow you more than 60 days to file your request. The notice sent to you by your health insurance issuer or health plan should tell you the timeframe in which you must make your request.

External reviewer issues a final decision: An external review either upholds your insurer's decision or decides in your favor. Your insurer is required by law to accept the external reviewer's decision.

Types of denials that can go to external review

- Any denial that involves medical judgment where you or your provider may disagree with the health insurance plan
- Any denial that involves a determination that a treatment is experimental or investigational

Cancellation of coverage based on your insurer's claim that you gave false or incomplete information when you applied for coverage

What are my rights in an external review?

Insurance companies in all states must participate in an external review process that meets the consumer protection standards of the health care law.

State: Your state may have an external review process that meets or goes beyond these standards. If so, insurance companies in your state will follow your state's external review processes. You'll get all the protections outlined in that process.

Federal: If your state doesn't have an external review process that meets the minimum consumer protection standards, the federal government's Department of Health and Human Services (HHS) will oversee an external review process for health insurance companies in your state.

Depending on your plan and where you live, the following may apply to you:

- Insurance companies may choose to participate in an HHS-administered process or contract with independent review organizations in states where the federal government oversees the process.
- If you're in an employer-sponsored health plan, you may not be eligible to participate in a state-run external review process.

If your plan doesn't participate in a state or HHS-administered external review process, your health plan must contract with an independent review organization.

How do I learn more about my state's external review?

- Look at the information on your Explanation of Benefits (EOB) or on the final denial of the internal appeal by your health plan.

It'll give you the contact information for the organization that will handle your external review.

How long does external review take?

Standard external reviews are decided as soon as possible - no later than 60 days after the request was received.

External Review Contd'

If my health insurance company participates in the HHS-administered external review process, how do I request an external appeal?

- Call toll free: 1-888-866-6205 to request an external review request form. Then fax an external review request to: 1-888-866-6190.
- Mail an external review request form to: MAXIMUS Federal Services 3750 Monroe Avenue, Suite 705 Pittsford, NY 14534

Submit a request via email: is ferp@maximus.com

Visit www.externalappeal.com. In the future, you'll be able to file a request using a secure website.

Can someone file an external review for me?

You may appoint a representative (like your doctor or another medical professional) who knows about your medical condition to file an external review on your behalf. An authorized representative form is available at: www.externalappeal.com

How much does an external review cost?

If your health insurance company is using the HHS-administered external review process, there's no charge. If your issuer has contracted with an independent review organization, or is using a state external review process, you may be charged. If so, the charge can't be more than $25 per external review.

Where can I get help filing an appeal?

If you need help filing an internal appeal or external review, your state's Consumer Assistance Program (CAP) or Department of Insurance may be able to help you. Contact Us for more information.

Appeals and Medicaid– *from Colorado.gov site*

How do I file an appeal? If your case involves the denial, termination or reduction of a benefit such as Health First Colorado (Medicaid), Food Assistance or Colorado Works:

Complete the Request for State Level Hearing Form or you may write us a letter with the following information:

- Your name, address and telephone number
- The county that denied the benefit
- The benefit that was denied
- Whether you will have another person represent you and if so their contact information (name, address and telephone number)
- A brief explanation of why you are appealing the decision
- Copies of any denial/termination notice you received.

Please make sure to sign the letter or form and either mail it to the Denver Office of the OAC or fax it to 303-866-5909. If you wish your benefits to continue while you are appealing, make sure you state that in your appeal as well as notifying the county that you have appealed the decision.

In many cases involving denial, termination or reduction of a benefit (food assistance or Health First Colorado (Medicaid) for example), you can be represented by someone who is not an attorney. However, the person representing you MUST have your written authorization to do so. This written authorization can take several forms:

- General Power of Attorney appointing your representative to act on your behalf (in most cases a Medical Power of Attorney is not sufficient)
- Order of Guardianship, wherein the representative is appointed the legal guardian.
- A letter signed by the benefit recipient specifically naming the representative. This letter must be signed by the recipient.
- In a Medicaid case a fully executed Non-Attorney Representative form must also be completed.
- In a non-Medicaid case a fully executed Representative Authorization form.

If you are filing an appeal on behalf of your minor child, state this in your appeal letter and indicate your child's date of birth. If you are filing on behalf of a minor foster child, you will need to include a copy of the Order granting you legal guardianship.

How long will it take to get a hearing? The rules relating to when your hearing will be scheduled are governed by the rules pertaining to the case type. As a general rule, your hearings will usually be scheduled for 6 to 8 weeks from the receipt of your appeal.

COLORADO
Department of Health Care
Policy & Financing

Letter of Medical Necessity- - *Sharecare.com*

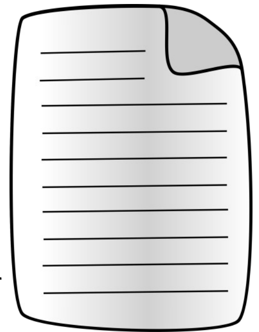
A letter of medical necessity (aka LOMN) is an essential part of a request for services, and can be used in a wide range of issues. Maybe a physician has ordered a new medication for a patient and the insurance company denies paying for the medication. Or, a patient is hospitalized and his physician wants him to go to an acute rehab facility post discharge but the insurance company denies the request. Or, maybe a physician orders a piece of assistive technology (wheelchair, hearing aid, et al) and the insurance company decides they're not going to pay for it.

A letter of medical necessity, whether being submitted to a private insurance company or other funding source, or a governmental agency like the Dept. of Human Services, should contain the information needed to convince the reader that the requested service is necessary to meet the medical needs of the person for whom the service is being requested.

In order to be effective, the letter of medical necessity should be written by a healthcare professional familiar with the requesting party's medical condition. The professional should briefly describe their credentials and relationship to the requesting party. This professional may be a physician, a nurse, a physical therapist, an occupational therapist or other medical professional. However, note that most funding sources (aka insurance companies) require a physician's prescription as part of the funding request. Therefore, letters of medical necessity not written by a physician should be endorsed by a physician or accompanied by a physician's prescription.

When an LOMN has been written, but services are still being denied, do yourself a favor and track it down so that you can make sure that the important parts are included. Most LOMN are not that well written or compelling so insurance companies can easily deny the service.

Writing a Letter of Medical Necessity



1. Name of child, names of parents (parents and child may have different names)
2. Date of birth of child
3. Insurance plan name (there may be more than one plan)
4. Relevant diagnoses (codes are helpful only if they are accurate!)
5. Item/service requested
6. Why item/service is medically necessary (refer to the plans' definition)
7. What positive/negative impacts the item/service will result on (include financial) scope and duration of treatment
8. Supplemental documents (letters from other providers, research articles, product information, PAR)
9. Include funding streams NOT able to help (denial letters help)

Terms to use; *medically necessary, clinically based, promoting independence, preventing secondary disability, cost-effective, safety.*
Terms to avoid; *custodial, rehabilitate, developmental delay/disability, speech delay (without a diagnosis such as aphasia), Caregiver convenience.*

Ask if your Letter of Medical Necessity answers the following:

- Is there a licensed provider stating in writing the item/service is medically necessary?
- Is this item/service not for care giver convenience?
- Is this item/service costs effective and if so have you explained how?
- Is this item/service considered standard medical practice?
- Have you explained how long and how often the item/service will be used.
- Is this item/service right for the need of individual

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