Filing Health
INSURANCE APPEALS

Has your insurance company denied your medical claim or failed to pay your claim the way you think it should? You may be able to resolve the issue by filing an appeal.

pennsylvania
INSURANCE DEPARTMENT

Some of the language used in this guide may be unfamiliar, so we've included definitions for bolded terms at the end of this guide.

The appeals process is used when your insurance company denies a benefit or does not make full payment on a benefit that you and your doctor believe you need.

By law, health insurance companies are required to have procedures in place to address concerns from policyholders. The appeals process is used if you receive an **adverse benefit determination,** that is, when your insurance company denies a benefit or does not make full payment on a benefit that you and your doctor believe you need. This can happen for many reasons, including:

- The benefit isn't covered by your health insurance plan;
- You received the service(s) from an out-of-network health provider or facility;
- The service is not medically necessary;
- The service is specifically excluded from your policy;
- The service is a covered service at an in-network provider, but you and your insurer disagree about how much you should pay; or
- You are no longer eligible for coverage under that health insurance plan.

If you believe you've received an adverse benefit determination that you don't think is right, make sure to read your **explanation of benefits** before contacting your health insurance plan. You will receive an explanation of benefits every time your insurance company receives a bill for you, and it lists the services you received and how much the insurance company will pay on your behalf for those services. This document may help you understand why you are receiving a charge or why a certain service wasn't covered. It will also explain how to file an appeal with the company.

If your insurance company denies your request for a service that you and your doctor believe you need, you may appeal this adverse benefit determination. Adverse benefit determinations can be reviewed by a health insurance company in an **internal appeal** process. If you are still unsatisfied with the results after completing the internal appeal, you may appeal for an **external review** performed by an independent party. If you are unable to request the review or need assistance, you have the right to appoint a representative, such as a family member or your health care provider.

How exactly does the appeal process work? Let's look a little closer.

Internal Appeal Process

You may file an appeal with your health insurance plan if you feel that you wrongfully received an adverse benefit determination.

Insurance companies must make their initial decision regarding whether or not a service you received or seek to receive is covered within:

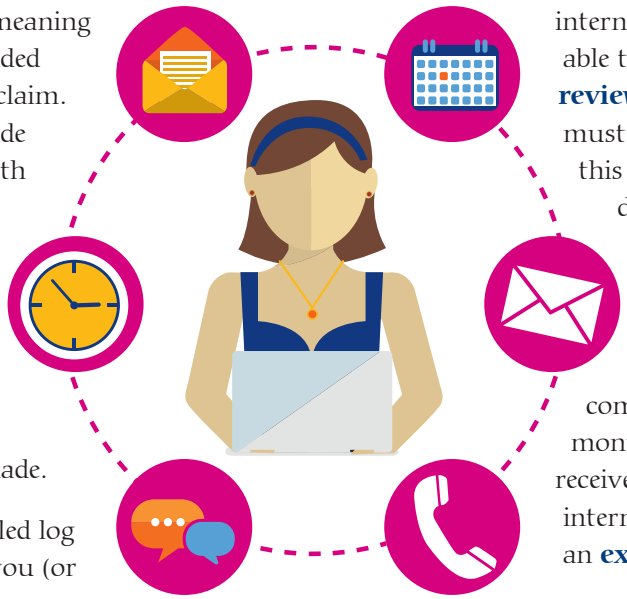
- 15 days of the request for a service requiring pre-authorization;
- 30 days for a service that was already received;
- 72 hours for urgent cases, or sooner if medically necessary.

From there, if the company makes an initial decision to deny coverage on a medically necessary health care service or to deny access to a service that requires pre-authorization, determines that a service wasn't medically necessary, or determines that you are not eligible to receive coverage by the plan, you may want to consider filing an internal appeal.

An appeal must be filed within six months of receiving an adverse benefit determination. Health insurance companies must make accommodations if you have a disability or language barrier.

Make sure to maintain a detailed log of communications between you and your insurance company throughout the claims and appeal process.

The insurance company must give each appeal a full and fair review, meaning you can submit new or expanded information to support your claim. The company must also provide you or your representative with copies of everything it has related to your claim. Your insurance company must give you and/or your representative(s) proper time to review and respond to the company's supporting evidence before a decision is made.



Make sure to maintain a detailed log of communications between you (or your representative) and your insurance company throughout the claims and appeal process, including the date, time, the name of the person you spoke with, and the content of the conversation. Keep original documents and send copies if you are providing the company with supporting documents. If you have questions about how to file or what to include with your appeal, you may contact the Pennsylvania Insurance Department.

Insurance companies must reach a decision on an appeal within a certain time frame. Generally, if you are appealing a pre-service claim (for example, you were denied pre-authorization), the appeal must be completed within 30 days. If you have already received the treatment, the internal appeal must be completed within 60 days. If your medical situation is urgent, you will be able to get a decision sooner. We'll discuss these expedited appeals a little later in this guide.

After your insurance company completes your internal appeal, you will receive a written determination explaining the company's reasons for the decision. If you are unsatisfied with the outcome, you may request an external review performed by an independent party, although some companies may require a second internal appeal before you are able to request an **external review.** Your insurance company must explain how to begin this process in their written determination of your internal appeal.

External Review Process

Your health insurance company must give you four months from the date you received the decision on your internal appeal to file a request for an **external review.** External

review is not available for all adverse benefit determinations. External review is available for adverse benefit determinations such as whether your care is **medically necessary,** where you receive care, what types of care are available to you, and **rescissions of coverage.** If your issue involves something else, external review is not available to you.

> The decision of the IRO (independent review organization) is **final and binding** against both you and the insurance company.

External reviews are assigned to an **independent review organization (IRO).** Health insurance companies are required to contract with at least three IROs and assign them to cases on a random or rotating basis. IROs are independent, do not work for your insurance company, and cannot receive financial incentives to side with one party over another.

You have 10 business days to submit supporting documents to the IRO. Like other stages in the review process, it is very important to include documentation from your health care provider so the IRO may gain an understanding of why the particular service was recommended. If any documents are submitted late, the IRO may accept the information, but it isn't required to do so. Your insurance company will submit to the IRO information it considered when making the adverse benefit determination.

During the external review, the IRO will review the claim from the beginning and has no obligation to uphold your insurance company's previous decisions. IROs employ legal and medical experts to consider documents submitted by you and your insurance company as well as your medical records, recommendations from your health care provider, reports from independent health care providers in a similar field, the terms of your insurance policy, medical practice guidelines, and clinical review criteria developed by your insurance company, if applicable.

The IRO will reach a decision and provide written notice to you and your insurance company within 45 days of receiving the request for external review, unless the review is expedited. This decision will include an explanation of what the IRO decided, as well as references to evidence that supports the final outcome. If the IRO decides in your favor, your insurance company is obligated to pay for the services in question. The decision of the IRO is final and binding against both you and the insurance company.

Expedited Review Processes

In certain circumstances, both internal appeals and external reviews can be completed on a much shorter timeline. Those circumstances are when a covered individual's life, health, or ability to return to maximum function would be jeopardized by the timeline of the standard review process. You may also request an expedited external review in cases where your insurance company refuses coverage for admission to or continued stay at a health care facility if you have not yet been discharged.

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 may file an internal appeal and an external review request at the same time.

Aside from the timeframe, the expedited review process follows most of the same procedural requirements as a standard review. If you or your representative cannot appear in person given the timeline, the review will take place over the phone. You or your representative should be ready to present as much information as possible given the abbreviated timeline.

Expedited reviews must be completed within 72 hours of the request but can be completed more quickly if the medical condition requires more immediate action. This final decision can be delivered verbally but must be followed by a written notice within 48 hours.

If You Need Help

The Pennsylvania Insurance Department understands that the appeal processes may be confusing for consumers, but the department is here to help.

Questions can be submitted at www.insurance.pa.gov at the "Ask a Question or File a Complaint" link on our homepage.

After you submit your question, a representative from our Consumer Services Bureau will be in touch to help. Consumers can also reach the department by phone at 1-877-881-6388.

Defined Terms

Adverse Benefit Determination

A determination by a health insurance company that includes a denial, reduction, termination, or failure to make either full or partial payment for a benefit, regardless of the reason for the determination.

Explanation of Benefits

A statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf. The **EOB** may be attached to a check or statement of electronic payment.

External Review

A review by an IRO of a plan's decision to deny coverage for or payment of a service. If the plan denies an internal appeal, an external review can be requested. An external review either upholds the plan's decision or overturns all or some of the plan's decision. The plan and covered person must accept this decision.

Independent Review Organization

An organization that determines whether a health insurance company was correct to refuse to pay for health care services for a covered individual based on the coverage provided by the policy and the medical judgment of health care professionals. **IROs** do not work for the insurance companies and can fairly decide whether the insurance company or the covered individual is correct.

Internal Appeal

A review by an insurance company of its own adverse benefit determination, triggered by a covered individual who believes that their claim should have been paid in whole or in part.

Medical Necessity/Medically Necessary

Generally speaking, services or supplies your health are provider determines are needed for prevention, diagnosis or treatment of a patient's illness or injury or other medical condition that meet generally accepted medical standards and are clinically appropriate for the patient. Your health plan may have a more specific definition.

Rescission of Coverage

Rescission of Coverage is the retroactive cancellation of a health insurance policy. Rescission of Coverage is prohibited except in cases of fraud or intentional misrepresentation of a fact relevant to the individual's enrollment.

Sample letter to request an internal appeal

Your Name
Your Address

Date

Address of the Health Plan's Appeal Department

Re: Name of Insured
Plan ID#:
Claim #:

To Whom It May Concern:

I am writing to request a review of your denial of the claim for treatment or services provided by *name of provider* on *date provided.*

The reason for denial was listed as (reason listed for denial), but I have reviewed my policy and believe *treatment or service* should be covered.

> *Here is where you may provide more detailed information about the situation. Write short, factual statements. Do not include emotional wording.*
>
> *If you are including documents, include a list of what you are sending here.*

If you need additional information, I can be reached at *telephone number and/or e-mail address.*

I look forward to receiving your response as soon as possible.

Sincerely,

Signature

Typed Name

Sample letter to request an external review

Your Name
Your Address

Date

Address of the Health Plan's Appeal Department

Re: Name of Insured
Plan ID#:
Claim #:

To Whom It May Concern:

I am writing to request an external review by an independent review organization (IRO) of the final internal adverse benefit determination I received on *date*. I have included a copy of that determination with this request.

I filed my request for an internal appeal on *date* in response to the denial of coverage for *treatment or service* provided by *name of provider* on *date provided*. The medical review upheld the original decision.

> *Here is where you may provide more detailed information about the situation. Write short, factual statements. Do not include emotional wording.*
>
> *If you are including documents, include a list of what you are sending here.*

If you need additional information, I can be reached at *telephone number and/or e-mail address*.

I look forward to receiving your response as soon as possible.

Sincerely,

Signature

Typed Name

Questions?
For more information on
auto insurance, visit:

www.insurance.pa.gov
and click “Health”
under Coverage

or
call the department at
1-877-881-6388

Follow and Like Us!
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Facebook.com/
PAInsuranceDepartment

pennsylvania
INSURANCE DEPARTMENT

PA pennsylvania

Insurance Benefit Administrators I Attn: Claim Reviews I PO Box 2917 I Shawnee Mission, KS 66201-1317

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