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How to appeal health insurance claim denials

Overview: Insurance claim denials and appeals

By Ruth Susswein

Among perhaps the most acute of modern-day exasperations are health insurance claim denials. Insured patients follow their doctors' advice, only to have their claims denied by insurer functionaries. While health insurers cover the vast majority of medical claims, a denied claim can be costly, frightening and even risky to your health.

Approximately 17% of in-network medical insurance claims were denied in 2019 by HealthCare.gov issuers. These denials came from insurers offering individual Affordable Care Act (ACA) Marketplace plans and some group health plans. Last year, the Kaiser Family Foundation (KFF) analyzed data (*https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/*) released by the Centers for Medicare & Medicaid Services (CMS) showing that the denials hit those with catastrophic plans the hardest (18% denial rate). (Catastrophic plans cover all the preventive benefits required by ACA, but with very high deductibles.)

Sometimes insurance claims are denied because a treatment is deemed not "medically necessary" or a procedure is not covered by the insurance plan. More often, denial is based on a simple mistake in a medical code or claim number, or the claim may be missing key information. Of the more than 40 million HealthCare.gov claims that were denied in 2019, nearly one-fifth were rejected because the treatment was excluded from coverage; 9% were denied because they lacked a referral or prior authorization; and nearly 72% had unspecified reasons for denial.

Other denials

Denials of prior authorization requests also plagued some Medicare Advantage beneficiaries. A recent Inspector General's (IG) report (*https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf*) found that Medicare Advantage insurers denied access to some medical care and claims even when Medicare and Medicare Advantage rules were followed. (For more, see *Medicare Advantage claim and care denials*, following this story.)

Medicare Advantage is a private managed care health insurance alternative to original Medicare. Older Americans typically choose to sign up for original Medicare plus a supplemental "Medigap" policy to cover copays and some deductibles, or they choose a Medicare Advantage plan, which may offer broader, less expensive coverage from in-network providers. Costs vary depending on the type of health care you require. For help evaluating your options, see the Medicare Issue of *Consumer*

Action News (https://www.consumer-action.org/news/articles/medicare-issue-fall-2021).

Yet a separate study (https://www.fiercehealthcare.com/payer/health-affairs-study-medicare-coverage-denials-more-common-than-medicare-advantage) compared original Medicare denials to Aetna's Medicare Advantage denials from 2014 through 2019. Researchers concluded that Medicare rules were responsible for more denials than private insurers' Medicare Advantage policies. While reasons varied, three-quarters of the original Medicare denials were for tests/procedures and 60% of the Aetna Medicare Advantage denials were due to services that were deemed "experimental" or "investigative."

Appeals

Fortunately, everyone is entitled to appeal an insurance claim denial. When you file an appeal, you are asking Medicare or the insurance company to review and reconsider its decision to refuse your claims.

While everyone is entitled to appeal an insurance claim denial, consumers rarely, if ever, actually appeal these decisions. According to KFF, HealthCare.gov consumers appealed *less than two-tenths of 1%* of claims in 2019. Nearly two-thirds (60%) of those appeals failed (https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/). While CMS requires that denial and appeal data be publicly reported, it does not require insurers to break down the data (denials or appeals) based on treatment or diagnosis.

Every insurance plan—private, employer-sponsored or Medicare—is required to have an appeals process. (For more, see *Medicare and non-Medicare appeals processes*, on page 5.) The process is often time-consuming and may have multiple steps, but the odds of reversing a denial are good. KFF's analysis of Marketplace appeals to the insurer found that 40% of consumers were successful in getting their claims covered the second time around.

Make sure you understand why your claim was denied. Address the reason for denial, making your best argument for reversal. Ask your doctor for help by providing a letter defending the care on medical grounds. Filing a timely appeal can mean the difference between money in your pocket or the insurer's. There are also state-run ombudsman programs that can help with appeals. For advice on how to win an appeal with your insurer, see *Appealing a health insurance claim denial*, on page 3.

Medicare Advantage claim and care denials

By Ruth Susswein

Medicare Advantage—Medicare "managed care" provided by private health insurers—is a coverage choice that has been playing an increasingly important role in providing access to health care for older Americans. By next year, Medicare Advantage is expected to be the primary source of healthcare coverage for more than half of all Medicare beneficiaries.

A recent report (https://oig.hhs.gov/newsroom/videos/medicare-advantage-denials-of-care/) by the Inspector General (IG) for the Department of Health and Human Services (HHS) determined that Medicare Advantage beneficiaries have had medically necessary health care "denied or delayed" by the insurers that run the plans.

The IG concluded that many of the claims and coverage denials complied with Medicare rules, and likely would have been approved under original Medicare. According to the IG's report (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf), Medicare Advantage plans:

- requested unnecessary documentation,
- made human and system processing errors, and
- used clinical criteria not required by Medicare rules.

Although the vast majority of claims were approved, in 2019, about 1.5 million payments were denied (18%). Imaging services (MRIs and CT scans, for example), post-hospital stays in skilled nursing centers, and injections were three prominent areas of denial that the IG said met Medicare coverage rules.

Most Medicare Advantage enrollees are required to get preapproval—called prior authorization—for certain medical services. Federal investigators criticized some of Medicare Advantage's prior authorization denials, which often required other X-rays or imaging before more advanced tests would be approved. Some denials were related to insufficient documentation, even though the IG's office found otherwise.

Better Medicare Alliance (BMA), a coalition that promotes Medicare Advantage plans, refuted (https://bettermedicarealliance.org/blog-posts/a-deeper-dive-on-prior-authorization-in-medicare-advantage/) the IG's report and defended Medicare Advantage's coverage and cost savings,

countering that the IG drew broad conclusions based on a very small sample of denials. (Consumer Action is a Better Medicare Alliance member.)

BMA has advocated for ways to simplify (*https://bettermedicarealliance.org/blog-posts/a-deeper-dive-on-prior-authorization-in-medicare-advantage/*) the prior authorization process and supports the Improving Seniors' Timely Access to Care Act (HR 3173 [*https://www.congress.gov/bill/117th-congress/house-bill/3173?r=5&s=1*] and S 3018). The bills would create an electronic process for Medicare Advantage prior authorizations, improve approval response times and require Medicare Advantage plans to report on their rates of approval and denial.

The IG's office has recommended that the Centers for Medicare & Medicaid Services (CMS) clarify when extra steps are needed for specialized tests, such as MRIs. It also recommended better oversight to reduce human and system errors.

Medicare Advantage gains

Medicare Advantage, the private insurance managed care option that provides coverage for nearly 30 million older Americans and people with disabilities, caps enrollees' out-of-pocket expenses and is sometimes less costly than original Medicare. Medicare Advantage plans say they keep costs down by cutting back on expensive medical testing deemed unnecessary by the insurer and limiting coverage to certain hospitals and doctors. Some of the money saved is used to offset insurance premiums, which may be lower than original Medicare premiums.

Insurers that offer Medicare Advantage plans are paid a flat per-patient fee by the government, plus extra for certain conditions that qualify for a "risk adjustment," such as diabetes or heart disease. Under original Medicare (*https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage*), doctors and hospitals are paid based on a fee-for-service system.

BMA released a study (*https://bit.ly/3zxM3RU*) in April that says Medicare Advantage plan members pay nearly $2,000 less in premiums and out-of-pocket expenses than original Medicare recipients. Many people with original Medicare buy "supplemental" insurance policies that pay for the 20% of medical costs not covered by Medicare, which adds to the cost of original Medicare.

When comparing the health outcomes of high-need, high-cost Medicare Advantage and original Medicare patients, a 2020 BMA study (*https://bettermedicarealliance.org/wp-content/uploads/2020/12/BMA-High-Need-Report.pdf*) reported that Medicare Advantage enrollees had better outcomes than those with original (fee-for-service) Medicare, such as fewer avoidable hospitalizations and lower readmission rates.

To compare Medicare Advantage and original Medicare coverage and cost options, beneficiaries can turn to their State Health Insurance Assistance Program (SHIP). SHIP (*https://www.shiphelp.org/about-us*) counselors offer free, one-on-one guidance online (*https://www.shiphelp.org/about-medicare/regional-ship-location*) or by phone 877-839-2675.

Appealing a health insurance claim denial

By Monica Steinisch

If your health plan notifies you that it will not cover your claim, and you feel that the decision is unjustified, you have the right to appeal it. This is true whether your coverage is provided by the government, sponsored by your employer, or purchased through the ACA Marketplace or not.

Levels of appeal

The appeals process is based on the type of insurance you have. All insurers' processes have multiple levels of appeal.

For both original (*https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/medicareappealsprocess.pdf*) Medicare and Medicare Advantage (MA) plans (*https://www.medicare.gov/claims-appeals/file-an-appeal/appeals-if-you-have-a-medicare-health-plan*), there are five levels to the appeals process (*https://www.medicare.gov/claims-appeals/file-an-appeal/appeals-if-you-have-a-medicare-health-plan*). Each decision notice will include instructions for moving to the next level of appeal (*https://www.medicare.gov/Pubs/pdf/11525-Medicare-Appeals.pdf*).

For health plans purchased through the Affordable Care Act (ACA) Marketplace, there are typically two levels of appeal—internal appeal (*https://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals/*), in which you ask the insurer to reconsider its decision, and external review (*https://www.healthcare.gov/appeal-insurance-company-decision/external-review/*). Here, an independent third party reviews your claim and makes a decision.

Non-ACA health plans may have three levels—two internal appeals and one external review.

You can appeal denials for services already provided or

not yet provided (preauthorization).

Note: A rejected claim is not a denial. A rejection occurs before the claim is processed, and is usually the result of incorrect information in the claim—often a wrong billing code entered by your doctor's office. This doesn't warrant an appeal; you or your physician should contact the insurer to correct the information.

Decision notices should include information about the appeals process. If yours doesn't, contact your health insurer. In some cases—for example, if you're a Medicare beneficiary and are being discharged from the hospital—you're entitled to a fast appeal (*https://www.medicare.gov/claims-appeals/your-right-to-a-fast-appeal/getting-a-fast-appeal-in-a-hospital*) for further care.

Worth the effort?

Appealing an insurer's decision can be daunting, but the odds of success are favorable enough to make the effort worthwhile, especially if the insurer is saying you are liable for a hefty charge.

Consumers rarely appeal claim denials, according to a Kaiser Family Foundation (KFF) study (*https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/*) of 2019 ACA Marketplace insurance plan data. Yet, of those who did, about 40% of the appeals resulted in the denial being overturned, so challenging an insurer's decision is far from futile. The Inspector General for the U.S. Department of Health and Human Services reported (*https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf*) that Medicare Advantage plans overturned 75% of their own denials from 2014 to 2016.

Tips for a successful appeal

You can improve your odds of mounting a successful appeal by following these tips:

- Understand your insurer's appeals process. Include claim or policy number, date of service, date of birth, and other required information on all forms and letters. Submit everything on time; missing a deadline could disqualify your appeal.
- Address the specific reason(s) for the denial. If it is unclear why your claim was denied, contact your insurer for an explanation.
- Write a strong and detailed appeal letter (*https://content.naic.org/article/consumer-insight-health-insurance-claim-denied-how-appeal-denial*), but make your letter as concise as you can. The National Association of Insurance Commissioners (NAIC) says to give specific reasons why the procedure or medication is necessary or why your claim should be paid, and include evidence to support your position (medical records, lab results, a letter from your physician, etc.). The Washington State Insurance Department offers varied sample appeal letters (*https://www.insurance.wa.gov/common-reasons-denial-and-examples-appeal-letters*). Here's a template (*https://www.urmc.rochester.edu/encyclopedia/content.aspx?contenttypeid=34&contentid=20275-1*) for appealing a denial for treatment that is "Not a covered benefit."
- Reach out to professional societies or disease associations for more evidence about why a particular treatment is medically necessary (*https://www.insurance.com/health-insurance/coverage/appeal-a-health-insurance-claim-denial.html*).
- Make notes of every interaction with your health plan (date, name of representative, actions/outcomes, etc.) as well as when you should expect to hear back or follow up. Keep copies of all forms, letters, documentation and proof of your submissions.

If you need help

Many states have established Consumer Assistance Programs (CAPs), which can help you file an appeal. Check the online map (*https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants*) for CAPs and other resources.

For help filing a Medicare appeal, contact your State Health Insurance Assistance Program (SHIP) (*https://www.shiphelp.org/*). Medicare allows you to appoint (*https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf*) a representative—a friend, relative, physician, attorney, etc.—to handle (*https://www.medicare.gov/claims-appeals/file-an-appeal/can-someone-file-an-appeal-for-me*) the appeal for you. Or, you could hire a professional claims assistant (*https://www.claims.org/*).

Consumer Reports (*https://www.consumerreports.org/medical-billing/how-to-appeal-a-denied-health-insurance-claim-a6630761086/*) suggests considering getting legal help for any of the last three levels of a Medicare appeal (the very last of which is a hearing before a judge).

If you've exhausted the normal appeals process and still feel like the denial is unjustified, contact (*https://content.naic.org/state-insurance-departments*) your state's Insurance Department to find out if there are any next steps. If you have a private health plan covered by the Employee Retirement Income Security Act (ERISA) (*https://www.dol.gov/general/topic/health-plans*) and you've exhausted the appeals process, you could file an appeal in federal court.

If you feel your insurer is not cooperating with the appeals process, contact your state's Insurance Department (*https://content.naic.org/state-insurance-departments*).

Medicare and non-Medicare appeals processes

By Monica Steinisch

The process of appealing a denial of your medical claim varies, depending on your insurer or plan.

Original Medicare:

- You must file your appeal within **120 days** of receiving the Medicare Summary Notice (MSN) (*https://www.medicare.gov/basics/forms-publications-mailings/mailings/costs-and-coverage/medicare-summary-notice*) notifying you of the denial. If you miss the deadline, you may still be able to appeal if you have a good reason for filing late.
- You can file (*https://www.medicare.gov/claims-appeals/file-an-appeal/appeals-level-1-company-handling-medicare-claims-redetermination*) your appeal three ways: 1) Fill out a Redetermination Request Form (*https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS20027.pdf*); 2) Follow the instructions on the MSN; or 3) Send a written request. Send your appeal to the company that handles claims for Medicare (the address is listed in the "Appeals Information" section of the MSN).
- You'll typically get a decision, called a "Medicare Redetermination Notice," within 60 days. You can request an expedited—fast—appeal if your Medicare-covered services are ending soon. Follow the instructions in the notice or go online to learn more (*https://www.medicare.gov/claims-appeals/your-right-to-a-fast-appeal*).
- If you disagree with the decision, you have 180 days after you get the notice to request a reconsideration (*https://bit.ly/3veiP89*) by a Qualified Independent Contractor (QIC).
- The appeals (*https://go.cms.gov/3b2ZoZc*) process has five levels. If you disagree with the decision made at any level, you can generally go to the next level. The decision letter will provide instructions on how to move to the next level of appeal.

Medicare Advantage plans:

- You (or your physician or representative) must request a "reconsideration" within **60 days** of the notice of (full or partial) denial. Follow the instructions in the denial notice or in your health plan materials.
- Explain why you're appealing the plan's decision, include all claim information (service date, policy number, etc.), and include any supporting materials to make your case (medical records, doctor's letter, etc.).
- You should receive a decision within 30 days. If you or your doctor believe that such a wait would jeopardize your health, you can request an expedited appeal, which requires a response within 72 hours, unless the insurer determines that it needs more time (up to 14 days) to gather more information.
- There are five levels in the appeals process (*https://www.medicare.gov/claims-appeals/file-an-appeal/appeals-if-you-have-a-medicare-health-plan*). Follow the instructions in each decision notice to move to the next level.

ACA Marketplace plans:

- Follow the instructions from your plan to file an "internal appeal" (*https://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals/*)—the company's review of its initial decision—within **180 days** of receiving notice that your claim was denied. The internal appeal must be completed within 30 days for a service you haven't received yet (preauthorization) or within 60 days for a service you've already received.
- If your health plan still denies your claim, you have the right to request an "external review" (*https://www.healthcare.gov/appeal-insurance-company-decision/external-review/*) conducted by an independent third party. You have up to four months from denial of your internal appeal to request an external review (check the denial notice for the exact deadline). Follow the instructions in the denial notice or your health plan. Your state may offer 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 process.
- The decision should arrive no later than 45 days after your request was received. If your medical situation is urgent, you can request an external review at the same time as your internal appeal. You should receive a decision within 72 hours of receipt of your request.
- You also can appeal certain ACA Marketplace decisions, including those regarding eligibility to enroll or receive cost-sharing subsidies. You generally have 90 days from the date of your Eligibility Determination Notice to appeal. Learn more (*https://www.healthcare.gov/marketplace-appeals/*) at HealthCare.gov.

Non-Marketplace plans (including employer-sponsored):

- Follow the instructions in the denial notice or in your health plan to learn your plan's particular appeals process and timeline. Non-Marketplace plans will offer one or two internal appeals and an external review.

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