MAINE BUREAU OF INSURANCE

CONSUMER GUIDE TO HEALTH INSURANCE APPEALS

WHAT IS AN APPEAL?

An appeal is a request to have the insurance company take a new look at a denial of benefits. You may appeal a denial of benefits for services already received, called retrospective denials, or for future benefits, such as an upcoming surgery. You may appeal medical denials (i.e., health care treatment denials based on diagnosis, care, or treatment) and non-medical denials (e.g., coverage was not effective at the time you received treatment).

If your insurance company has denied benefits for something which you think is covered by your policy, the first step is to contact your insurance company (the customer service number should be listed on the back of your insurance card). It is possible that your denial was in error and could be corrected over the phone.

If the issue is not resolved by contacting the company, and you still believe that your claim should be covered, you can appeal the decision. The denial letter provided by your insurance company should include information describing the specific reason for the denial, the appeals process, and to whom you should send your appeal. Your policy or summary of benefits should also spell out your insurance company's appeals process.

WHAT ARE THE STEPS IN THE APPEAL PROCESS?

- Reconsideration Request
- First Level Appeal
- Second Level Appeal
- Independent External Review

The basic appeals process is explained in this brochure; however, if you have specific questions, you can always contact the Bureau of Insurance for assistance.

PROVIDER RECONSIDERATION REQUEST

If the denial is for a medical reason, your health care provider (e.g., your doctor) may contact your insurance company and request a reconsideration. Your provider may call this a provider appeal, a reconsideration, or a peer to peer review. A reconsideration request must be completed by the insurance company within one working day after the request is received.

If your health care provider does not request a reconsideration, or if it is not successful, you have the right to two levels of appeal and possibly a third level (called an Independent External Review). If a medical opinion regarding a health condition is a critical issue in your appeal, under Maine law, you may be entitled to an independent 2nd opinion, paid for by your insurance company.

First Level Appeal

A first level appeal involves a review of your denial by one or more insurance company personnel. Most insurance companies request that you file your appeal in writing within 180 days of the denial unless you have a good reason for the delay. If your insurance company states that your appeal is too late, contact the Bureau of Insurance.

Your insurance company has 30 days from the date it receives your appeal to send you a decision letter. As a part of the appeal, you have the right to:

- Review your claim file
- Present evidence as a part of the appeals process
- Receive, free of charge, any new or additional evidence used by the insurance company in connection with your claim

Second Level Appeal

A second level appeal involves the review of your denial by a panel of insurance company personnel. You may ask for a hearing as a part of the second level appeal, and you may appear in person or participate by telephone. It can be very helpful to have your doctor participate in the hearing as well, either in person, by telephone, or by providing a letter in support of your appeal.

If there is a hearing, your insurance company has 45 days to schedule the hearing. Once the hearing has taken place, the panel has five working days to issue their decision. If there is no hearing, the company has 30 days to notify you of its decision.

Expedited Appeals

If your health care provider believes that you need the medical care in question sooner than it takes to go through the regular appeals process, you or your provider can request an expedited appeal. The expedited appeal decision will be provided as quickly as required by your condition, but not more than 72 hours after the review is initiated. To qualify for an expedited appeal, your life, health, or ability to function must be in serious jeopardy. Expedited appeals are **not** available for retrospective denials.

If the expedited appeal decision is not satisfactory, you can immediately request an expedited external review by contacting the Bureau of Insurance. The expedited external review will be completed within 72 hours if it does not involve a conference call.

Independent External Review

If your denial is medical, you may request an external review, which is administered by the Bureau. If you have a group plan (e.g., you receive health insurance through your employer), you must complete your insurance company's appeals process before you are eligible for external review (usually two levels of review). If you have an individual policy, you may request an external review after your first appeal is denied.

If you are eligible for an external review, the Bureau assigns your case to an independent reviewer (not associated with the insurance company). The independent reviewer hires a health care provider that is an expert on the medical issue being decided. You have the right to a conference call with the reviewing expert, and you may have your own health care provider take part in the call as well. The external review process usually takes 30 days to complete.

Filing A Complaint

You may file a complaint with the Bureau of Insurance at any time. The Bureau's investigation and your company appeals are separate; however, we will monitor the process to make sure that the insurance company is handling your appeals properly. A complaint investigation and an appeal can take place at the same time. If you would like to file a complaint, please contact the Bureau at the number or address below.

GENERAL TIPS FOR HEALTH INSURANCE APPEALS

Read your denial letter carefully. Under Maine law, the insurer's denial letter must provide you with specific denial information and deadlines (including, as applicable, references to the specific plan provisions on which the denial was based, what documentation might be needed to approve the claim, instructions and time limits for filing an appeal, etc.). These details will be essential to conducting a successful appeal.

Keep records. Keep records of everything: the bills from your provider, your explanation of benefits, copies of denial letters, medical records, letters from your provider of care, etc.

Talk to your doctor. Ask your doctor to review your denial and if he or she will assist you with your appeal. Your doctor may be willing to appear at the hearing or prepare a letter explaining the necessity of your treatment to support your case.

Outline your appeal. Write out notes explaining your position, the basis for your appeal, and what evidence you have to support your position. It is important to be clear and organized when communicating with your insurance company.

Take detailed notes. When you speak to the insurance company, write down the time and date, the name you speak with, and all the details of the conversation. If the company is going to be providing you with additional information or a follow-up call, ask for an approximate timeframe to expect the follow-up.

Be proactive. The appeals process can take months to complete, but it is important to make sure that the process is moving forward with reasonable follow-up with the insurance company.

Ask for help. The Bureau of Insurance is always available if you need assistance. In addition, you can get free health assistance with appeals from Consumers for Affordable Health Care at 800-965-7476.

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