Health Insurance Education Series: Appeals

MAY 2023

Division of Specialized
Care for Children

About the Presenters

DSCC Benefits Management & Research Team

Works with the DSCC care coordination teams to help solve insurance problems.

Presenters

- Brittani Provost
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Housekeeping

Captioning is available for this presentation.

ASL interpretation is also available.

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The chat has been turned off.

Housekeeping

We are recording this presentation. The recording will be posted on the website.

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Agenda

DSCC Overview

What is an appeal

The steps for an appeal

How to write an appeal letter

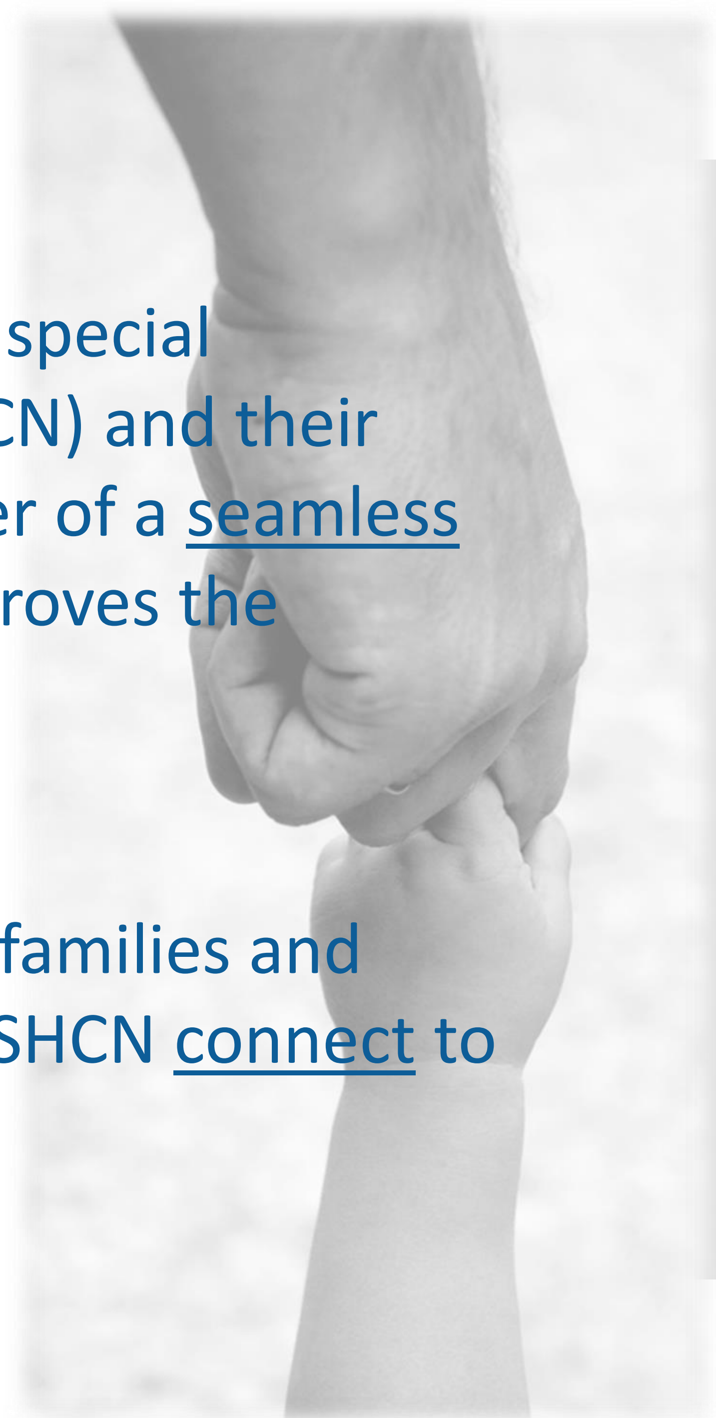
Our Vision and Mission

Vision

- Children and youth with special healthcare needs (CYSHCN) and their families will be the center of a seamless support system that improves the quality of their lives.

Mission

- We partner with Illinois families and communities to help CYSHCN connect to services and resources.



Who We Serve

DSCC provides care coordination services through four programs:

- **Core Program** – Ages birth to 21 with medically eligible conditions.
- **Connect Care Program** – Ages birth to 21 with special healthcare needs who are enrolled in a Medicaid Health*Choice* Illinois plan that has contracted with DSCC for care coordination.

Who We Serve

DSCC provides care coordination services through four programs (continued):

- **Home Care Program** – Children or youth in need of in-home shift nursing.
- **Interim Relief Program** – Children with eligible mental health or behavioral disorders.

What is an Appeal?

An appeal is when you ask your health insurance company to reconsider their decision. Health insurance plans are required to tell you why they did not cover services.

You may get a letter from your insurance plan denying coverage for services.

You have the right to file an appeal with your insurance company.

Appeal Process

STEP 1: Know your insurance plan

STEP 2: Understand the denial

STEP 3: Know your rights to appeal

STEP 4: Gather documentation

STEP 5: Write an appeal letter

STEP 6: Submit the appeal

Why should you appeal?

It is your right. When a service or supply is medically necessary, do not accept “no” for an answer.

An appeal can help you get an approval for a needed service.

Who can help with an appeal?

Your health insurance plan

Your doctors and providers

Social worker

DSCC care coordinator

Illinois Department of Insurance

Illinois Attorney General

Example Case

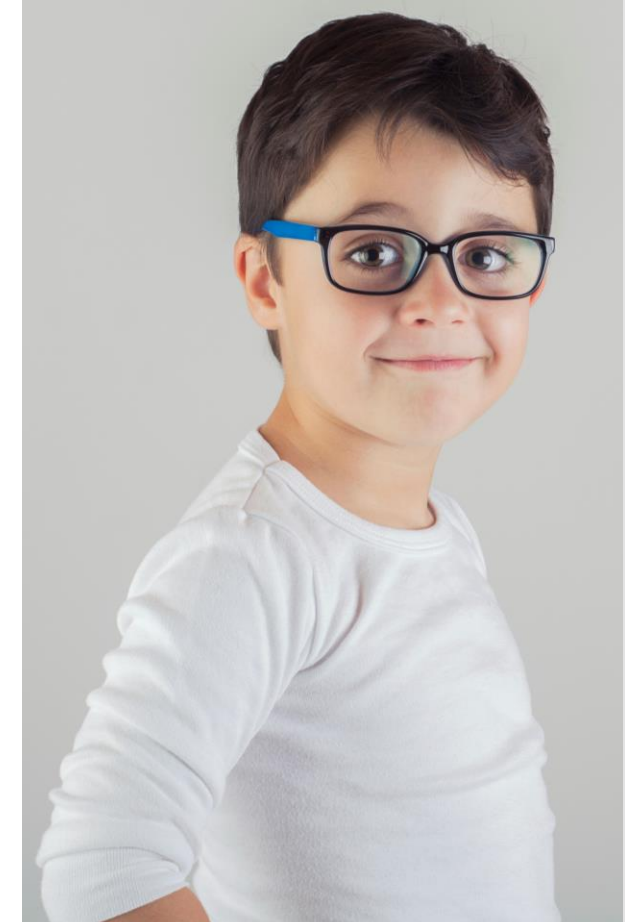
Patrick James, age 5

Has an autism diagnosis

Needs applied behavior analysis (ABA) therapy

Has private Aetna plan through mom's job

- The plan is a Health Maintenance Organization (HMO)



Step 1: Know Your Insurance Plan

Know the name of your insurance and what type of plan you have

Review the health benefit handbook to understand your benefits. This is usually called a “member handbook”

Talk with your doctor or provider about the needed service

- Other options might need to be tried first
- The doctor might have more information on how to get the service approved before an appeal is needed

Step 1: Know Your Insurance Plan

Getting a referral when required

- A referral is when your primary care doctor works with your health insurance to get permission for you to see a specialist or for you to receive care.

Getting a prior authorization when required

- A prior authorization is when your insurance company reviews the services needed and gives approval before they will pay for services.

Using in-network doctors

- An in-network provider is a provider who your insurance plan has made an agreement with to provide services to anyone with that insurance plan for a less expensive rate.
- You may have out-of-network benefits available too, but you will need to know how your plan works

Your Costs

Premium: The amount you pay for your health insurance every month.

Deductible: The amount you pay for covered services before your insurance plan starts to pay.

Co-insurance: A percentage amount you pay for a covered healthcare service.

- Example: Durable medical equipment is covered at 80 percent so you have a 20 percent co-insurance per service. If you need a piece of equipment that is billed at $100, your insurance pays $80 and you pay $20.

Your Costs

Co-pay: A set amount you pay for a covered healthcare service.

- Example: $20 to be seen at your regular office visit or $30 to be seen at a specialist visit.

Out-of-Pocket Maximum: The most you must pay for covered services in a plan year.

What is a Bill?

----- MAKE CHECKS PAYABLE TO -----

Best Main Hospital
123 Space Way
Nowhere, IL, 60202

FOR BILLING IINQUIRES CALL: 800-555-1212

Alex Smith
808 First Avenue
Town, IL, 60204

Best Main Hospital
123 Space Way
Nowhere, IL, 60202

STATEMENT

DATE OF SERVICE	CODE	DESCRIPTION OF SERVICE	CHARGES	INSURANCE PAYMENTS	BALANCE
03/04/2021	01234	Surgery	$45,000	$40,000	$5,000
03/04/2021	99999	Other charges	$5,000	$4,000	$1,000
			$50,000	$44,000	$6,000

Understanding an Explanation of Benefits (EOB)

Source: go.cms.gov/c2c

1. Phone Numbers
You can call your health plan if you have questions about finding a provider or what your coverage includes.

2. Payee is the person who will receive any reimbursement for over-paying the claim.

EXPLANATION OF BENEFITS

(1) **Customer Service Number:** 1-800-123-4567

Statement Date: XXXXXX
Document Number: XXXXXXXXXX

Member Name:
Address:
City, State, Zip:

THIS IS NOT A BILL

Subscriber Number: XXXXXXXXXX **ID:** XXXXXXX **Group:** ABCDE **Group Number:** XXXXX

Patient Name: XXXXXX **Provider:** **Claim Number:** XXXXXXXX
Date Received: XXXXXXXXXX **Payee:** (2) **Date Paid:** XXXXXXXX

3. Service Description
shows the health services you received, like a medical visit, lab test, or screening.

4. Provider Charges
is the amount your provider bills for your visit.

5. Allowed Charges
is the amount your provider will be paid; this may not be the same as the Provider Charges.

Claim Detail				What your Provider Can Charge You		Your Responsibility			Total Claim Cost		
Line No.	Date of Service	(3) Service Descrip-tion	Claim Status	(4) Provider Charges	(5) Allowed Charges	Co Pay	Deduct-ible	Coinsurance	(6) Paid by Insurer	(7) What You Owe	(8) Remark Code
1	3/20/22-3/20/22	Medical care	Paid	$31.60	$2.15	$0.00	$0.00	$0.00	$2.15	$0.00	PDC
2	3/20/22-3/20/22	Medical care	Paid	$375.00	$118.12	$35.00	$0.00	$0.00	$83.12	$35.00	PDC
			Total	$406.60	$120.27	$35.00	$0.00	$0.00	$85.27	$35.00	PDC

Remark Code: PDC—Billed amount is higher than the maximum payment insurance allows. The payment is for the allowed amount.

6. Paid by Insurer
is the amount your health plan will pay to your provider.

7. What You Owe is the amount you owe after your insurer has paid everything else. You may have already paid part of this amount. Payments made directly to your provider may not be subtracted from this amount.

8. Remark Code
is a note from the health plan that explains more about the costs, charges, and paid amounts for your visit.

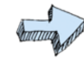
Step 2: Understand the Denial

An important step before the appeal is to understand why your health insurance plan said “no” to a service.

Your health insurance plan will usually send you a letter that says why the service was denied. This can happen before or after a service is received.

You may also look at an Explanation of Benefits (EOB) to see information about a denied service. These are sent after a service has been provided.

Common Denial Reasons

 Mistake or error

Pre-authorization was required

Treatment is not medically necessary

Drug or therapy is off-formulary

The care is out-of-network

Service Not Covered

Example Denial Letter

Image Source: https://portal.ct.gov/OHA/Health-Insurance-101/Appeals/Youve-been-deniedwhat-now

Member Name: Patrick James
Member ID: 12345682123
Date of Birth: 8/10/2017
Case Number: 456787
Plan Sponsor: Alicia James
Plan Sponsor Account Number: 12345688753

Dear Member and Healthcare Provider(s) of Record

After review, we have made a decision about coverage for the following health care services for the member named above. We use nationally recognized clinical guidelines and resources, such as Level of Care Assessment Tool (LOCAT), American Society of Addiction Medicine's Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition Revised (ASAM PPC-2R), Applied Behavioral Analysis (ABA) Guidelines for the treatment of Autism Spectrum Disorders, and Clinical Policy Bulletins available at http://www.aetna.com/cpb/cpb_menu.html, as well as plan benefit documents to support these coverage decisions.

Coverage Decisions For Denied Services:

Service Dates:	Procedure Code:	Service Description:	Number:	Type of Service:
05/012023 – 11/01/2023	H2019	THERAPEUTIC BEHAVIORAL SERVICES, PER 15 MINUTES	6	Month(s)

Coverage for this service has been denied for the following reason(s):

Coverage for the requested services has been denied because we have not been able to obtain any requested clinical information from the provider to determine whether or not the services are considered medically necessary under the terms of the plan.

(No Clinical Information Denial) This coverage denial was based on the terms of the member's benefit plan document (such as the Certificate of Coverage or benefit plan booklet/handbook, including any amendments or riders). The plan has a requirement to receive enough information to determine if services are covered. Please see the Reports and Records section of the benefit plan document or the section of the plan document that talks about reporting claims or claim procedures.

(No Clinical Information Denial) This coverage denial was based on the terms of the member's

F00505400000300000001000J1VCEX13840F

Step 3: Know Your Rights to An Appeal

Understand the appeal timeline and the deadline to file your appeal

- The timelines for filing an appeal can be found in your Member Handbook
- You can call your health plan to get this information

If an Explanation of Benefits was received in the mail or electronically, it should tell you the appeal process. The notice usually tells you the deadline to file an appeal for the claim

Know how to contact your health plan to start the appeal process

Types of Appeals

There are three different types of appeals you can file.

These are based on the time, outcome, and medical need of the denied service or supply.

- **Pre-service Appeals** are before the service happens.
- **Post-service Appeals** are for services already received that were denied.
- **Expedited Appeals** can be used if a regular appeal could seriously risk the life or long-term health of a person. This is if you need the health plan to decide quickly.

Document During the Process

You will want to keep detailed documentation throughout every step. Documentation is very important in the appeal process.

Keep a calendar to track dates

Keep a contact log to track when you talked to different people

- Doctors, the health plan, or others

Keep a folder for supporting documents

- Medical records or letters from the doctor
- Letters from you
- Letters or documents from the health insurance plan

Document Tools to Use

Insurance Appeals Calendar

Documentation is very important when appealing a decision made by your health insurance plan. There are many tools that can be used to stay organized.

This calendar can be used for the appeals process to keep track of:

- Important deadlines or dates
- Dates documents or calls were received from the health plan
- Dates phone calls were made to the health plan or documentations was sent to the health plan

MONTH:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

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Document Tools to Use

Insurance Appeals Communication Log

Documentation is very important when appealing a decision made by the health insurance plan. There are many tools that can be used to stay organized.

This communication log can be used for the appeals process. You can keep track of when you talk to people and what you talked about. Here are some examples of what to keep track of:

- When you call the doctor to ask for supporting letters
- When you call the health plan to ask questions
- When you mail the appeal letter

Date	Name	Role	Contact Information	Notes

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Step 4: Get Supporting Documents

You will write a letter to your health plan. It is also important to have supporting letters or documents from your doctor or providers.

A letter from your doctor or medical provider

- The letter should say why the doctor supports your decision to appeal the denial.

Any other information you have that may be helpful

- This could be calls with your insurance company where you were provided information
- Other medical reports that support the need for the service

Step 5: Write the Letter

You will have to write a letter telling your health insurance plan that you are appealing a decision.

- The letter should be to the point and specific.
- Tell them that you disagree with their decision and why you disagree.
- Tell them what result you want
- Put a brief summary of the other documents that you are including in your packet.

There are many important details that you should include in the letter. We will review those together.

Example Letter Template

Health Insurance Appeals

An appeal is when you ask your health insurance company to reconsider their decision. Health insurance plans must tell you why they did not cover services.

Steps for the Appeal

Step 1	• Know Your Insurance Plan
Step 2	• Understand the Denial
Step 3	• Know Your Appeal Rights
Step 4	• Gather Documents
Step 5	• Write an Appeal Letter
Step 6	• Submit Your Appeal

Tips for the Appeal

- Pay attention to appeal deadlines for when the appeal is due. Mail your letter certified. This step will give you proof that you sent the letter before the deadline.
- Stay organized with a calendar or contact log. You should document your communications and important dates.
- Make copies of your appeal packet.
- You can request an expedited review of your appeal if you or your child need a treatment or procedure right away.

Sample Appeal Letter

The next page has a sample letter that you can use when you need to file an appeal to your health insurance plan. You will need to include your own information.

[Date]

[Health Insurance Plan Name]
[Appeals and Grievances Department]
[123 Street Address]
[Town/City, IL, 12345]

RE: **[Patient's Name]**
[MEMBER ID Number]
[Reference Number on Explanation of Benefits]
[Date of Birth]

RE: **[Policy Holder's Name]**
[MEMBER ID Number]
[Reference Number on Explanation of Benefits]
[Date of Birth]

To Whom it May Concern at **[Insurance Company Name]**:

My name is **[your name]**, and I am a policyholder of **[insurance company]**. My child's name is **[child name]**. I wish to file an appeal to **[health plan name]** for the denial of **[procedure or service description]** for my child. I received an Explanation of Benefits dated **[date]** stating **[provide denial reason directly from letter]**.

My child was diagnosed with **[diagnosis]** on **[date]**. **[Here include a brief description of the condition and how it impacts your child's life. This should relate to the services that you are appealing]**. My child is seen by **[doctor name]** at **[provider/facility name]**. In the Letter of Medical Necessity, which is included, **[doctor name]** explained why **[service or treatment]** is necessary for my child. I have also

What to Put in the Letter

You and your child’s information.

- Your health plan information such as your member ID, policy holder, group number.
- The policy holder’s name and the child’s name and date of birth.

Claims information if services were already received.

- This includes the claim number and date of services.
- This can be found on the Explanation of Benefits or by calling your health plan.

The provider's name and your doctor’s name.

Example Letter

May 5, 2023

Aetna
Appeals and Grievances Department
PO Box 14463
Lexington, KY 40512

Member: Patrick James
Member ID: 12345682123
Date of Birth: 08/10/2017

Policy Holder: Alicia James
Member ID: 12345688753
Date of Birth: 01/23/1990

To Whom it May Concern at Aetna:

What to Put in the Letter

The denial reason

- You should try to word this exactly how they put it in the denial letter.

History of your child's illness and the necessary treatment

- Your doctor will probably explain this but it is important to include a short explanation in your letter
- It is important to include what will happen if your child's services do not get approved.

What decision you are appealing and you believe the decision was wrong.

What result you want from the insurance company.

Example Letter

To Whom it May Concern at Aetna:

My name is Alicia James, and I am a policyholder of Aetna. My child's name is Patrick James. I wish to file an appeal to Aetna for the denial of Applied Behavior Analysis Therapy, Procedure Code H2019 for my child. I received a denial letter dated 4/15/2023 stating coverage for the requested services has been denied because Aetna was not able to obtain any requested clinical information from the provider to determine whether or not the services are considered medically necessary under the terms of the plan.

My child was diagnosed with Autism in September 2020. Autism is a severe, chronic developmental disorder. Applied Behavior Analysis Therapy can promote social and language development. This can help minimize behaviors that interfere with functioning and learning. ABA is considered by many researchers and clinicians to be the most effective evidence-based therapeutic approach for children with autism.

Example Letter

Patrick is seen by Dr. Fisher at Good Family Pediatrics. Dr. Fisher has referred Patrick for Applied Behavior Therapy at Best Therapy Center. The therapist he sees is Jackie Smith. In the Letter of Medical Necessity, which is included, Dr. Fisher explained why Applied Behavior Analysis Therapy is necessary for my child. I have also included other documents including medical reports and evaluations that Patrick has had done that explain why this care is needed for my child. This is the only therapy of its kind. Patrick has been in occupational, developmental, speech, and physical therapy since he was 6 months old. He needs additional support with ABA Therapy.

Please review the included documents and reconsider the previous denial decision to allow coverage of ABA Therapy as this treatment is necessary to my child's health.

If there is any other supporting information you need to approve these services, please do not hesitate to contact me at 123-456-7891 or Dr. Fisher at 800-123-4567.

Example Letter

Thank you for your attention in this matter. Your prompt consideration to this appeal is appreciated.

Sincerely,

Alicia James
123 Main Street
Anytown, IL, 12345

Enclosures:

1. Denial Letter dated 4/15/2023
2. Doctor's Letter of Medical Necessity
3. Medical Records
4. Documents explaining procedure

Things Not to Do

Do not talk about what would make it easier for the patient or caregiver.

Do not be vague. It is important to be specific and clear.

Do not miss timelines when filing an appeal. Submit an appeal letter within the deadline for your health insurance plan.

Do not forget to include plan identification number(s). If the plan and plan member cannot be found, the appeal will not be processed.

Step 6: Send the Appeal Letter

Submit the appeal letter and all other documents on time. Pay attention to the deadline.

Mail your letter certified. This will give you proof that you sent the letter before the deadline.

Make copies of your appeal packet.

You can request an expedited review of your appeal if a treatment or procedure is needed right away.

If you get your insurance through your job, you may also be able to get help from your employer's human resources or benefits department.

Follow up and External Review

It is important to continue to follow up with the health insurance plan until the decision has been made. You should continue to keep documenting when you call to check on the appeal.

If the appeal is denied, you can file a second appeal and include additional information not included in the first appeal or you can ask for an external review.

External Review

An external review is an appeal that is completed by someone outside the health plan.

- This appeal can be done if the internal appeal is denied by the health insurance plan.
- Done with a physician who is board-certified in the same specialty as the patient's physician.

The health plan will give you the choice of two independent reviewers.

- They do not work for the health plan.
- The reviewers are from the Illinois Department of Insurance.
- You and your provider can choose which one will do the independent review.

What happens if the external appeal is approved?

If the external appeal was a post-service appeal and is won, the health plan will be told, and the treatment/claim will be processed as approved.

If the external appeal was a pre-service appeal and is approved, the health plan will be told, and an approval will be given for treatment.

What happens if the external appeal is denied?

If the external appeal request is denied, you can appeal the decision of the independent reviewer with the Illinois Department of Insurance.

If the Illinois Department of Insurance changes the independent reviewer’s decision, they will require the insurance to pay for the treatment/claim.

- The health plan can appeal the Department of Insurance decision and a new independent reviewer will be assigned to review the case.
- The decision of the independent reviewer can be appealed.

The complaint will be sent to the health plan. Illinois law allows 21 days for the health plan to respond.

Resources

First work with your providers and health insurance plan.

Contact the Illinois Department of Insurance or the Illinois Attorney General to get more help.

Department of Insurance Contact Information:

- http://www.insurance.illinois.gov/
- Consumer Complaints Number 312-814-2427

Illinois Attorney General Contact Information:

- http://www.illinoisattorneygeneral.gov/consumers/index.html
- Hotline Telephone Number 877-305-5145

Resource Links

[Appeals Article from Healthcare.gov]

[Glossary of Words from Healthcare.gov]

[Navigating the Insurance Appeals Process Guide from Patient Advocate Foundation]

[Guide to Appeals from Health Law Advocates]

[Sample Insurance Appeal Letter Template]

Summary

Appeals can result in a changed decision – this can benefit you and/or your child greatly!

It is important for you to keep detailed documentation during all the steps of the appeals process.

It is important to keep track of deadlines for the appeal.

You should work with providers or others that can help to get all the right information for the appeal

If an appeal is denied, you have other options.

Questions

We have saved some time for questions.

Please use the **Q&A button** box if you have questions. You can also use the **Raise Hand** button and we will unmute you.

Thank you!

Survey

Thank you for participating in our training today. We hope you found it helpful!

We will email the slides to you. They will be posted at https://dscc.uic.edu/family-education-webinars/

The recording for this training will also be posted on the website.

Please complete the survey at the end of the training. Your thoughts are very helpful and important.

We also would like to know any other topics you would like more training on.

Other Webinars

This training is part of a series of trainings called “Health Insurance Education”

You can review this recording and materials for the other two trainings on our website.

- March: Understanding Your Insurance
- April: Medicaid Eligibility and Coverage
- May: Insurance Appeals

Visit https://dscc.uic.edu/family-education-webinars/

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UIC Division of Specialized Care for Children