4 Tips for Successful Insurance Appeals

In the mysterious world of insurance appeals, final determinations are based on the merit of your grievance, your insurer's policy and your plan benefits. Following these tips may lead to better outcomes.

1. Know the Facts

Providers should be initiating the vase majority of appeals. They have the medical, coding, and technical knowledge to do so. If they refuse, or are unable to do so, you should, at a minimum, receive all relevant supportive documentation.

If a claim was rejected for billing errors (incorrect codes, diagnosis ID, etc), filing an appeal is a waste of time as only a processed and paid claim can be appealed. Your doctor's billing person should resubmit corrected charges, or provide your insurer with any requested documentation.

If a charge is rejected as "non-covered, not a benefit of the plan, not reimbursable under the insurance guidelines, experimental, off-label, not medically necessary or out of network", a talk with the office manager at your office is in order. Was this info known to the office but not communicated? Were your benefits verified before services were rendered? Is it a simple clerical error?

Answers will determine whether this is now appeal material, an financial issue between you and the provider, a third party responsibility (i.e. an incorrect dx given to the lab whose claim was rejected) or your own error (i.e. you did not share your new ID card).

2. Who should appeal?

If the office is responsible, it should take immediate corrective steps, send records, or update information.

Billing mistakes made by secondary providers (labs, imaging centers) are common. Call them to give your new insurance ID or address. Many denials occur when invalid or non-payable diagnosis codes are forwarded with the order or prescription. Your MD cannot be expected to know each payable dx for every outside service. Updating the order in your chart must be completed before the appropriate biller can resubmit the charges with a payable code.

If information was withheld from you, either deliberately or by ignorance, insist the office appeal to your insurer with comprehensive explanations and detailed clinical justification from accepted sources. Best undertaken by both the patient and the provider, this process calls for payment due to "medical necessity".

If you had no choice or option, and are being billed for services considered "out of network" or "non covered", do file an appeal, especially if these were rendered under emergency conditions.

When in doubt, go ahead and file. You are within your rights to ask that your claims be reviewed, and your financial responsibility confirmed.

3. Be Clear and precise

Why you are requesting the review of a charge? Asking your insurer to reprocess a claim just "because they did not pay or not enough" almost guarantees a denial of your request. Computers process claims, not people. They seldom make mistakes (computers not people!). As an actual person will review your appeal letter, the exact reason(s) of your request should be clear.

Invoke your right to a "continuation of care" level of coverage if your Dr cancelled his/her contract in the middle of treatment and claims were paid "out of network". Demand payment of non-contracted charges based on your emergency hospitalization as the law states. Demonstrate that "medical necessity" was met for a prescribed treatment or procedure by using your medical records, and supportive industry or Medicare

guidelines. Ask for a reversal of a denial based on specific and unusual circumstances. Brand drug manufacturers offer ready-made sample letters to appeal coverage of their products.

4. Attach relevant documentation

Documentation is essential to any appeal. No or little documentation = not much hope of success.
While I would not recommend sending truckloads of papers to the reviewer, ask the staff to provide the most appropriate clinical records to make your case. Ask them to direct you to related websites, significant studies, important links and online resources to add supportive documentation.
You may need to request records from a third party, usually the physician who ordered a specific lab, test or imaging service, in order to get medical justification and prove medical necessity. Remember to include the original order or prescription with your attachments.

Mail a copy of the appeal to the related provider, and ask for the financial responsibility to be shifted back to the insurance during this process. If the provider refuses, make small monthly payments to keep your account current, show good faith and avoid collection action.