TRIAGE CANCER . . . beyond diagnosis

Quick Guide to Appeals for Employer-Sponsored & Individual Health Insurance

At some point during cancer treatment, you may experience a denial of coverage from an insurance company, whether for an imaging scan, prescription drug, treatment, procedure, or genetic test. Most people take "no" for an answer. But those who don't accept the denial, and file an appeal, may actually win and get coverage for the care prescribed by their health care team up to 60% of the time! Note: if you have a self-funded employer plan the process may be different. For more: TriageCancer.org/Cancer-Finances-Appeals.

Internal vs. External Appeals
You generally have **two chances** to appeal a denial of coverage: an internal appeal and an external appeal.

Internal Appeals: When an insurance company has denied coverage for care, you can file an "internal appeal" within your insurance company. Each insurance company has their own internal appeals process, so contact your insurance company for details or look for instructions on how to file an appeal on your denial letter. There are time frames related to filing an internal appeal.

Type of Appeal	Reason for Appealing	When Patient Should Submit Appeal	Timeline for Decision from Insurer
Pre-Authorization Appeal	Denial before services rendered. Denial prevented patient from receiving care	Within 180 days	Within 30 days of initial appeal
Post-Treatment Appeal	Denial for payment of care received meaning patient is 100% responsible for any charges	Within 180 days	Within 60 days of appeal
Urgent Care (or Expedited) Appeal	Delay in treatment would seriously jeopardize life/overall health, affect your ability to regain maximum function, or subject you to severe and intolerable pain	Within 180 days But if urgent can ask for external review at same time as internal review	Within 72 hours of receiving appeal

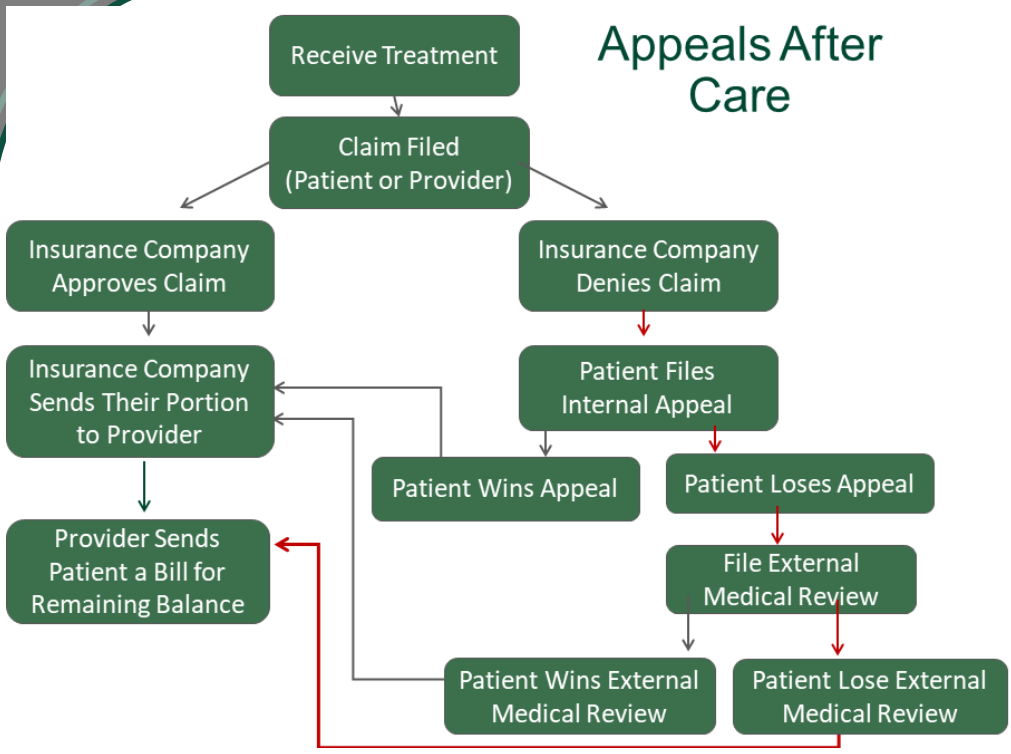
If your insurance company denies your internal appeal, you can request an external appeal. Under the Affordable Care Act, all states must have an external appeals process – this is also sometimes referred to as External Medical Review or Independent Medical Review.

External Appeals: Within four months of receiving your insurance company's denial of your internal appeal, you can file a written external appeal (note some states provide additional time). External appeals are completed within 45 days of filing and the decision is binding on the insurance company. If urgent, reviews can be expedited, filed at the same time as an internal appeal, and decided within 72 hours. State insurance agencies or the federal Dept. of Health & Human Services administer external appeals. Visit https://TriageCancer.org/StateLaws to find the process and contact information for your state. The HHS process is free, but states can't charge more than $25 for an external appeal.

Appeals Before Care vs. After Care
You can file appeals both before and after medical services are provided. The process for filing an appeal before care and after care are slightly different. An example of when you might get a denial of coverage before you even receive care, is when your insurance company requires a pre-authorization before getting care. If your insurance company denies pre-authorization, you can appeal that decision.

For more information:

- Triage Cancer Health Insurance Resources: https://TriageCancer.org/HealthInsurance
- Triage Cancer Webinar on Appeals: https://triagecancer.org/webinar-appeals



Key Steps to the Appeals Process

Step 1: Contact Your Insurance Company

- Contact the insurance company to ask for a detailed explanation of your denial and the company's internal appeals process.
- Keep track of the dates of contact with insurance company representatives, names of individuals you talk to, notes of conversations, and any written documentation you receive. Triage Cancer has an Appeals Tracking Form here: TriageCancer.org/AppealTrackingForm
- Ask family and friends to help you organize bills and insurance documents and take notes during calls with the insurance company.

Step 2: Understand Your Denial

There are several reasons why insurance companies may deny your claim, including:

- Mistakes: Errors can occur relaying patient identifying information, billing details, or CPT/HCPCS codes. Review your bills (don't be afraid to ask your provider for help), contact your provider and request they resubmit your claim with correct information, and explain the resubmission to your insurance company.
- Pre-Authorization: Insurance companies are not required to pay for care when it has not properly been pre-authorized, so it is very important to note what services require pre-authorization before you get care. If you haven't gotten a service pre-authorized, ask your insurance company to retroactively authorize it.
- "Experimental or Investigational:" Treatments deemed experimental or investigative by your insurance company may result in denials. Make sure to ask your provider to help when justifying these treatments.
- Service Not Covered: If your insurance company says your service is not covered, check your policy to see if the service is listed as "excluded." If not, contact your insurance company and ask for more information about the denial. They may claim the service was unnecessary. If so, call your provider and ask for help showing that the care is "medically necessary."
- Timely Submission: Claims submitted too long after services were provided may be denied. However, if your provider is within network, fixing this error usually only requires a phone call to your provider. As they are in charge of submitting claims, providers are usually held responsible for this mistake.
- Coordination of Benefits (COB): If you have both a primary and a secondary insurance policy, it's essential to complete and submit COB forms every year. Failing to complete these forms can result in claim denials.

Step 3: Gather Evidence

When gathering evidence for your appeal, make sure to pay attention to the deadlines and requirements for your insurance companies' internal appeals process. Evidence to support your appeal can include:

- Notes and/or letters of support from your healthcare providers
- Results of tests and procedures related to the care in question
- Relevant medical literature, professional journals, and studies showing the effectiveness of the care, especially when appealing denials of care for being experimental or investigational
- A brief and factual personal statement describing the need for the requested care