

Arizona Center for Disability Law

Protection and Advocacy System for Arizona

HOW TO GET THE SERVICES YOU NEED WHEN YOUR PRIVATE HEALTH PLAN TELLS YOU “NO”

Arizona Center for Disability Law

3839 North Third Street
Suite 209
Phoenix, Arizona 85012

100 North Stone Avenue
Suite 305
Tucson, Arizona 85701

(602) 274-6287 (Voice/TTY) (520) 327-9547 (Voice/TTY)
1-800-927-2260 (toll free) 1-800-922-1447 (toll free)
(602) 274-6779 (Fax) (520) 884-0992 (Fax)

www.acdl.com
center@acdl.com

Getting services from your private health insurance company can be frustrating. This guide will tell you what to do if your private health plan says “no” to providing for or paying for a health care service. It will explain in easy steps the process to follow to get what you need. This guide is for you if you have individual health insurance or group health insurance through your employer. If you are on AHCCCS, ask for the guide “How to Get the Services You Need When Your AHCCCS Health Plan Tells You ‘No’.”

It is important to know that there are two types of denials from your health plan: denial of a service and denial of a claim. A “denied service” is when your health plan will not authorize a service that you have not yet received. A “denied claim” is when you have already received the service and the health plan refuses to pay the provider.

There are several ways that your health plan may say “no”. You may get an Explanation of Benefits (EOB) statement or a written letter denying the service or claim. An employee of your health plan may tell you “no” on the phone or your health plan may simply just ignore your request. In all these cases, here’s what you can do:

STEP 1: ASK FOR AN INFORMAL RECONSIDERATION

The first step is to ask the health plan for an informal reconsideration of their denial. You have **2 years** from the health plan’s denial to ask for an informal reconsideration. You can do this by calling, writing or faxing the health plan. It is better to ask in writing so your request does not get lost. If you make your request by phone, write down the date and who took your request. The health plan must send you a letter stating that they received your request for informal reconsideration within 5 days. You should tell the health plan why you disagree with their denial. If the reason for denial is that the service is not “medically necessary”, then you should ask your doctor to write a letter of medical necessity. Include this letter and any medical records that make your point with your informal reconsideration letter.

Letters of Medical Necessity

The most common reason a health plan will deny a service is that it does not have enough information about you and the service you need. To avoid this problem, ask your doctor or health care provider to write a letter of medical necessity and send it with the request for service. The letter should have:

- ✓ Your medical condition with exact diagnosis.
- ✓ How long your condition will last.
- ✓ Why you need the service and a description of the service.
- ✓ What health problems will occur if you do not get the service.
- ✓ What other treatments or services were tried, if any, and why they did not work.

The doctor can ask the health plan to call him or her with any questions about the letter. You can get letters from any health provider or other professional who knows about your condition, the service and why you need the service. For a sample letter to send to your doctor asking for a letter of medical necessity and a sample letter of medical necessity, go to the Center's website or contact us directly.

Tip: For requests to your health plan:

- Always do it in writing.
- Keep a copy for your records.
- Keep proof of when and where you sent your request. Send important documents by certified mail, return receipt or by fax with a confirmation sheet.

STEP 2: READ THE RECONSIDERATION DECISION

Your health plan must mail you and your doctor a written answer within 30 days. The letter will state whether the health plan said “yes” or “no” to the service or claim and the clinical reason for the decision. If you do not hear from your health plan, you can call them to see if a letter was sent. If the health plan does not mail you an answer within 30 days, you can consider their answer to be “no” and go to Step 3.

STEP 3: SEND IN A WRITTEN APPEAL

If your health plan said “no” after informal reconsideration, you can send a written letter to appeal their decision. This appeal must be in writing. For denial of a service, you must mail a written appeal to your health plan within **60 days** after you received the denial on reconsideration. For denial of a claim, you have **2 years** to mail in your appeal letter. Don't wait too long to appeal a claim. The longer you wait, the harder it is to gather all the necessary information.

Your appeal letter should directly respond to the reason for denial. Include any additional information not included in the informal reconsideration letter. If you have not already done so, ask your doctor to write a letter of medical necessity. (See “Letters of Medical Necessity” under Step 1).

STEP 4: READ THE APPEAL DECISION

For an appeal of a service denial, the health plan has 30 days to mail you a decision. For an appeal of a claim denial, the health plan has 60 days. The health plan's decision should tell you the criteria used and the medical reason for the decision. It will also tell you about your right to ask for an external independent review or another appeal process. If you disagree with the decision, go to Step 5.

STEP 5: ASK FOR EXTERNAL INDEPENDENT REVIEW

This step will depend on your health insurance. Your health plan or employer can tell you your type of insurance and where to go next after an appeal is denied. Many employers buy health insurance for their employees. If your employer bought health insurance through an insurance company or you bought health insurance for yourself, you have the right to an external independent review of a denied service or claim.

An “external independent review” means someone who does not work for the health plan will look at all the information and make his or her own decision. You must ask for this independent review within **30 days** after the health plan sends your appeal denial. You mail your request directly to your health plan. Your health plan will send your information to the Arizona Department of Insurance. You do not pay for an external independent review.

QUESTIONS OF MEDICAL NECESSITY VERSUS QUESTIONS OF COVERAGE

Who will review your case depends on whether you have a question of medical necessity or a question of coverage. A question of medical necessity means that the health plan does not believe that the health service is necessary to treat your medical condition. In this case, a doctor who knows about treating your medical condition will review all the information. A question of coverage means the health plan believes that the health service is not covered under the terms of your health insurance policy. An employee of the Arizona Department of Insurance reviews questions of coverage.

Since the doctor will review only written information, it is important that you have in writing all the reasons why the denial of your service or claim is wrong. Letters of medical necessity from your treating doctor and any other health care providers are key for the independent doctor to review along with your medical records. You can call the Department of Insurance directly to make sure they have all your information.

ERISA Complaints: Some employers who “self-insure” do not buy insurance from an insurance company. Instead, they self-fund meaning that they provide their own insurance and bear their own risk. These employers must follow a federal law, the Employee Retirement Income Security Act, known as ERISA. If your employer has self-insured health insurance, you cannot ask for an external independent review through the Arizona Department of Insurance. If your appeal was denied, you may be able to file a complaint with the U. S. Department of Justice. You can contact them at 1-666-444-3272 or visit their website at www.dol.gov/ebsa for information on how to file a complaint.

STEP 6: EXTERNAL INDEPENDENT REVIEW DECISION

For questions of medical necessity, the independent doctor who reviews your case has 21 days to tell the Department of Insurance of his or her decision. The Department of Insurance will send you the decision 5 days later. For questions of coverage, the Department of Insurance will usually mail you a decision within 15 days.

The external independent review decision is legally binding on the health plan and you. On questions of medical necessity, if you disagree with the independent review, the next step would be to go to court. On questions of coverage, you or the health plan can ask for a fair hearing with the Office of Administrative Hearings. You have 30 days to request a fair hearing. Information sent with the independent review decision will explain how to ask for a fair hearing.

WHAT IF I NEED A SERVICE URGENTLY AND MY HEALTH PLAN SAYS NO?

If your health plan denies a service that you need urgently, you can ask for what is called an Expedited Medical Review. The purpose of an Expedited Medical Review is to force the health plan to make a quick decision since your health is at risk. Your doctor must certify in writing that delaying this service could cause a significant negative change in your medical condition. The health plan cannot dispute your doctor's certification. It must make a decision 1 business day after receiving the certification and other supporting information. If the health plan still denies the service, you can appeal and eventually ask for an external independent review. The time period for the health plan to respond at each level is very short. The Arizona Department of Insurance has a packet of information on Expedited Medical Review that has the forms and information you need. You can contact them at 1-800-325-2548 or www.id.state.az.us.

PRIVATE HEALTH PLAN APPEALS PROCESS

1. ASK FOR INFORMAL RECONSIDERATION	You have 2 years from health plan denial
2. READ THE RECONSIDERATION DECISION	Health plan has 30 days to make a decision
3. SEND IN WRITTEN APPEAL	You have 60 days for denial of a service and 2 years for denial of a claim
4. READ THE APPEAL DECISION	Health plan has 30 days for denial of a service and 60 days for a denial of a claim
5. ASK FOR EXTERNAL INDEPENDENT REVIEW	You have 30 days to ask for review
6. EXTERNAL INDEPENDENT REVIEW DECISION	