Autism Insurance Resource Center

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Insurance Denials and Appeals

What is an insurance denial?

A denial is when your insurance company refuses to pay or denies responsibility to pay for medical services or treatment that has been provided to you or a family member. The denial can apply to a service that has already been received or to one that has not yet been delivered, such as when an ABA provider requests authorization to deliver services under a treatment plan that includes a certain number of hours. Typically, when you or a family member receives medical services or treatment, your health care provider submits a request for payment to your insurance company, the insurance company pays the provider, and you receive an Explanation of Benefits (EOB) from the insurance company that includes the treatment, date of service, what is covered and what the provider may bill you for (co-pays, co-insurance or deductible). If the insurance company questions its responsibility to pay for the treatment or service, it sends you an EOB letter explaining why it is refusing to pay (or fully pay) for the services or treatment billed or proposed to be provided by your health care provider.

What are my options if I receive a denial?

You must review the denial carefully so that you understand what is being denied and why. If you do not understand the reason for the denial, request a copy of your claim file and any records relating to the denial. Your insurer is required to provide this information to you free of charge.

In the case of ABA services, what if the insurer only authorizes a portion of the requested hours?

A partial authorization is the same as a partial denial. In some cases, the insurer may "negotiate" with the provider to approve reduced hours from what the provider requests. This is appealable, but it may require the provider or the family to request that the insurer issue a denial in order to appeal the reduced hours. If you appeal a partial denial, the provider can continue to service your child for the number of hours authorized from the previous treatment plan. For example, if your child has been receiving 10 hours of ABA/week, but the insurer only approved 6 hours/week in the new plan, the provider can continue with 10 hours/week during the appeal process.

The provider needs to tell the insurer that they are appealing the denial and expect services to be covered under Continuity of Care while the appeal is proceeding.

What is medical necessity and how does it relate to a service denial?
Medical necessity is a standard used by an insurance company to determine whether treatment or services are appropriate and effective given a patient's health needs. Every insurer or health plan will include a list of requirements that must be met in making this determination. If an insurer issues a partial or full denial, it is usually due to "lack of medical necessity." After you understand the reason for the denial, you can either pay the out-of-pocket cost directly to the provider or file an appeal.

What should I do first if I decide to file an appeal?
First, you should ask your insurance company for a copy of your "claim file." You should make this request in writing, rather than by phone. Your claim file includes a copy of the criteria or standards that the insurer used to evaluate the claim and all documents related to the claim.

When will I receive a copy of my claim file?
Your insurer has 30 days to comply with your request.

What do I do after I receive my claim file?
Talk to your provider about the denial and provide a copy of the denial notice if they have not received it. Ask for any information, including medical records that would support your appeal. Request a letter of support from your provider to be included in your appeal. Note: The denial letter may be sent directly to the provider.

Should my appeal be in writing or can I appeal over the phone?
It is important that your appeal be in writing to ensure that your position is not misunderstood or misrepresented.

What information do I need to include in my appeal letter?
You should include all member and insurance plan information, including a copy of the denial letter, the date of the service denied, and the provider name and treatment. Quote directly from the denial document, restating the criteria that the health plan applied in denying your claim (for example, that the service or treatment was not "medically necessary"). List the reasons why you believe the services or treatments do, in fact, meet the criteria. Make sure to address each requirement separately. Try to be as clear as you can and provide references to your medical records. Include a doctor's letter of support, copies of all medical records, and a personal statement about what

this treatment or service means to you or your loved one (impact on your day-to-day living, for example).

How long will it take before my insurer makes a decision on my appeal?
If the service has not yet been received, the insurer must issue a decision within 30 days. For denial of a treatment you have already received, the decision must be made within 60 days.

How many times can I appeal a denial?
Most insurers allow two internal appeals before you can request an external review of your denial.

What if my insurer offers an expedited appeal?
It is not recommended you accept the offer. An expedited appeal does not give you enough time to obtain copies of medical records, and it does not give your provider enough time to address the reason(s) for the denial.

What is an external review?
This is a review of your denial by an independent review organization (IRO) not associated with the insurer. An external review is typically only available when the reason for denial is that the requested service or treatment has been deemed not medically necessary.

Can I appeal Speech/OT/PT annual plan limits?
Yes. Follow the instructions listed above. Your appeal will be based on Federal Mental Health Parity law, which says that your health plan cannot impose a stricter standard for mental health benefits than it does for medical/surgical benefits. If the Speech, OT/PT therapies are related to autism, they are accessed via the mental health benefits. Contact our Center for information on the Mental Health Parity Law.

Is there a different external appeal process if I have a fully insured vs. a self-funded plan?
Yes. **Depending on your plan, here is the process:**

- Fully insured health plan: A request for an external review must be submitted to the Massachusetts Office of Patient Protection (OPP) website (https://www.mass.gov/orgs/office-of-patient-protection) or call 800.436.7757 for more information.
- Self-funded health plan: A request for an external review must be submitted to the U.S. Department of Labor. You can access their online complaint intake portal (https://www.askebsa.dol.gov/WebIntake/Home.aspx) or you can call

866-444-3272 to talk with a benefits advisor. You can also file the request with the local Massachusetts office: Department of Labor, Employee Benefit Security Administration JFK Federal Bldg., 25 New Sudbury Street, Room 525-A, Boston, MA 02203.

- Under either form of insurance (fully insured or self-funded):
  - You must file your request for an external review within four months of the internal review denial.
  - Federal law requires that your health insurer provide for an external review by an independent review organization (IRO) at no cost to you.

Where can I obtain examples of a claim file request letter and an appeal letter?
Health Law Advocates (HLA) has a Guide to Appeals that is available for free. This guide includes sample letters for you and your provider to use to help with your appeal. Download the Guide to Appeals (https://www.healthlawadvocates.org/get-legal-help/resources/hla-guide-to-appeals) or call 1.617.338.5241.

*Guide to Appeals, Health Insurance Policy, Health Law Advocates/HLA

For further information, contact an information specialist at 774-455-4056 or email us at info@disabilityinfo.org. The current version of this fact sheet and other important information is available on our website, massairc.org.

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