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SPECIAL NEEDS RESOURCE PROJECT e-newsletter

Things to Think About!

By Brandan Atkin

Attention Providers and Vendors

Be sure to check if your state has a Provider's Manual. Many states provide a manual specifically for you. These manuals, most often found on a stat's Health and Human Services website, will give you all the information you need regarding services, medical supplies, equipment, policies, list amounts, codes and other needed criteria. Can't find a manual? Call your state office and ask.

Utah's Provider Manual can be found in the right hand menu here: http://www.health.utah.gov/medicaid

If there is anything that is not discussed in our newsletters and you would like to see it discussed, or you would like to be added to our newsletter mailing list, please contact us at snrproject@hotmail.com

"How To" File an Appeal

By Linda Jorgensen

Recently I had a telephone conversation with one of the managers of our state's Bureau of Coverage and Reimbursement for Medicaid. That office is responsible for reviewing all appeals for denied Medicaid medical claims in the state. ***The most common mistake people make when receiving a denial of benefits is failing to file an appeal!*** In our state the vast majority of appeals are approved, provided they have been submitted properly and provide necessary information proving medical necessity.

A denial often means the insurance provider needs more information than they have been given.

Medical claims are denied for a wide variety of reasons with the most common being *failure to provide enough information regarding the requested benefit to prove medical necessity.* This is especially the case with high dollar medical equipment, palliative care, and other treatments specifically identified by the insurance company. It is important to remember you are dealing with individuals who don't know you, don't know your child and most likely don't have enough information regarding an individual's medical condition and status, why the item(s), treatments, cares, etc. are medically necessary and what possible outcomes may be expected if the individual does not receive the requested benefit.

By following the approved appeals process many individuals will obtain approval for the services or equipment they need. **Always appeal a denial.**

It is important for you to be familiar with the appeal process required by your insurance company. Not all companies follow the same appeal process. Most companies include a section in their beneficiary manual on "How to File an Appeal". Many companies also include that information on the back of their Explanation of Benefits (EOB), or in the fine print of any claim summaries you may receive. If you cannot find appeal instructions call the insurance provider's Customer Service number and specifically request information on how to file an appeal.

There are seven basic steps in filing an appeal. Each step is important and should be followed in order. Generally, the vendor who will provide the equipment or service will also be assisting you in the appeal process.

• **Step One: Review your Benefits and Policy Manual**. The first step in launching a denial appeal is the same as filing the claim in the first place. Was there something there that you missed? Did you read the fine print? Are you sure of the detail? Did you need a preauthorization and fail to get one? Having a firm understanding of your policy will help you know what questions need to be asked.

• **Step Two: Contact your Insurance Provider.** If your claim has been denied be certain it was denied by the appropriate person. Often times insurance company personnel will tell you "no" when in reality they do not have the authority to do so. Be sure the decision came from the right office. **Don't take "No" from someone who isn't authorized to say, "Yes".** When you call to verify information be sure to document all pertinent information you discuss. I recommend using an SNRP Call Form. Be sure to document all of the following on your call form or in your notes if you are not using a call form:

- Company name.
- Date and time the conversation took place.
- Name and title of the person you talked to. Be sure to note any other individuals you may talk to during your call.
- Account number and any questions you may have regarding the claim in question.
- Write a detailed summary of what was discussed and any instructions or information you were given.
- Obtain a confirmation number for the call, if your company provides one, once the call is completed. This will be used as a reference by case management in future follow up action.
- Write a short summary of any decisions or agreements reached.
- Be sure to add your signature to the bottom of the page. This could always be used as a legal document later, if needed. Information on this document may be used as part of the documentation packet submitted with your appeal letter. Remember. ***"If it isn't on paper, it didn't happen".***

• **Step Three: Ask for help.** Once you have contacted your insurance provider and identified the process to follow you may need further assistance in proving your case. If so, get help. Contact your Primary Care Physician and any other related specialists. Specialists may include therapists, school staff, home health nurses, lab reports, second opinions from other physicians, etc. Tell him/her you are appealing a claim denial and need assistance. Ask for a detailed letter of medical recommendation, medical necessity, medical records, care notes or any other information requested by the insurance company that may aide you in stating your case.

Still need help? Contact your company Human Resources Office and ask for assistance in mediating an insurance claim denial. Many companies have an insurance mediator assigned to assist employees with difficult medical claims. They are also good at reading the fine print.

• **Step Four: Write your letter of appeal.** Be sure to be clear and concise. State you are requesting an appeal, and why. Attach any new information, treatment records or detailed letters from your physician or other providers regarding the request. Many times important detail has been left out of the first authorization request and more detail is needed. This is the time to use the documentation you've been keeping. Copies of phone conversations (completed call forms), letters you may have sent, bills, EOB's, letters of denial, etc. can all be used in the appeal process. Be sure to outline the steps you have taken and list the documents you are attaching for review.

• **Step Five: Submit your appeal.** Once you have gathered all your supporting documentation, asked for help and written your letter it is time to submit your appeal packet. Make copies of all documents in your appeal package. If sending by US Post, send the packet with a Delivery Confirmation slip and tracking number. Be sure to file this information with your copy of the packet. If you are faxing your information be sure to retain your fax confirmation sheet.

• **Step Six: Track your appeal!** Be persistent in keeping track of where in the process your paperwork is. Many companies will assign an individual case manager to appeal cases. Be sure to stay in touch with your contact person. Don't lose your appeal by letting it "fade into the paperwork pile" on someone's desk.

With many large companies an appeal could take a few weeks or even a few months. Most folks think, "No news is good news". No news could mean trouble. Ask your case manager if there is a time limit. If a deadline is approaching and you still haven't heard anything, call and ask for a status, or progress, report on your appeal. The biggest majority of folks who lose out on benefits don't lose them because they are denied it's because they fail to follow through. If you want that medical equipment paid for appropriately you're going to have to follow through until you have that determination letter in your hand.

• **Step Seven: Document the outcome.** Once an *appeal* has been denied it becomes your responsibility to find alternate resources for funding. Every time you receive a denial from someone, KEEP IT! A denial for a medical claim will give you extra leverage when filing for other assistance programs and justification for financial assistance programs. DENIALS ARE GOOD! They are the evidence which proves that you really have tried other avenues and really do need assistance from other sources. Without them you only have your word that you tried your insurance provider first.

I know, I can hear parents groaning about paperwork and bureaucracy but it is often imperative to go through the denial process in order to get other services available. If you want the services you need you have to fight for them. Unfortunately paperwork is a part of the system we have to deal with. If, at first, you don't succeed, file an appeal. Don't wait, just do it.