Healthwise Publications

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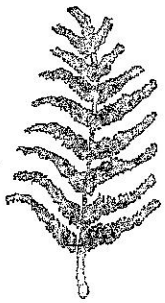

Where do I start?

Appeals are not just for denials. Appeals are for network issues. You can appeal an out-of-network approval—and transform it to in-network. If your out-of-network deductible is $30,000, isn't it worth it?

1. Find out if you have a self-funded employer plan. In a self-funded plan, the employer—not the insurer—decides on medical treatments. You need to know.

2. Get your plan document. The plan document is your insurance contract. Appeals are contractual disputes. You need to know what it says about your issue.

3. Study your appeals procedures. The appeals procedures are in your plan document. They tell how many appeals you get, how long the insurer gets to decide them.

4. Build your Addressee List. The most important part of an appeal is not what you say—it's who you send it to.

5. Focus on the stated reason for denial. If the denial letter says that they denied the treatment as "experimental"—then your job is to prove that it isn't.

6. Examine the medical policy. Find it on the insurer's website or ask them for it. The medical policy is where the insurer explains why they won't pay for your treatment.

7. Zero in on the definitions. "Experimental" or "medically necessary" mean what the insurer says they mean. You must refute their definitions in your appeal.

8. Seek outside eyes. You need outside eyes to keep them honest. A carefully-chosen politician or member of their board of directors can make all the difference.

9. Prepare to phone. Delivering the appeal copies is just the first step. If you don't execute a masterful telephone attack—you just lost your appeal.

10. Own your power. If you are seeking a legitimate, clincally-appropriate treatment, you should always appeal—and you can always win.

All things are possible.