



Consumers for
**Affordable
Health Care**

Advocating the right to quality affordable
health care for every person in Maine.

Do it yourself health insurance appeal:

A step by step guide to exercising your rights

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About This Guide

Perhaps you owe a health care bill and your health insurance company says they will not pay for it. Or maybe your insurance company won't agree to cover a health care service you need. What do you do?

Think about asking for an appeal. Insurance companies sometimes make mistakes or just don't have enough information to understand your health needs. About half of people who complete the appeals process win and have their medical bills paid. Filing an appeal can be worth it.

This Guide is for people in Maine with **private** health insurance plans. It explains the steps needed to challenge your health insurance company's decision.

Private plans include:

- Insurance plans offered through an employer.
- Plans from an insurance company like Anthem, Aetna, Cigna, Community Health Options, Harvard Pilgrim, or United Health Care
- Plans from the Marketplace found online at www.Healthcare.gov also known as "Obamacare."

If you have been denied by a **public** plan, like the ones listed below, your appeal will be different than what we talk about in this Guide. You can find out about your appeal rights by calling our Consumer Assistance HelpLine at 1-800-965-7476, or the groups listed below:

- **MaineCare or Medicaid:** Maine Equal Justice Partners, 1-866-626-7059
- **Veteran's Coverage or Tricare:** VA Regional Benefit Office, 1-800-827-1000
- **Medicare:** Area Agencies on Aging, 1-877-353-3771, or Legal Services for the Elderly, 1-800-750-5353

If you have any questions about this Guide or the appeal steps, call our Consumer Assistance HelpLine. We can help you understand your rights, answer your questions, and guide you through your appeal. Sometimes we also represent people in their appeal. This means that we act for that person and work with their doctors and insurance company. In these cases, we can actually file the appeal for them. If you feel that you need help, call us to learn more. **Our Consumer Assistance HelpLine number is 1-800-965-7476. All calls to our HelpLine are free and confidential.**

About the Appeal Guide Author

Consumers for Affordable Health Care is a non-profit advocacy organization committed to helping all Maine people obtain quality, affordable health care.



Our activities include:

- Helping people find affordable, quality health care in Maine.
- Helping people advocate for more affordable health care.
- Helping people know and exercise their rights.
- Providing training and education to consumers, professionals and policy makers.
- Producing research and policy analysis.

We have been helping Mainers since 1988.

Visit us at www.mainecahc.org to learn more.

Call our Consumer Assistance HelpLine
with your coverage-related questions.

1-800-965-7476



How to Use This Appeal Guide

This guide is broken into sections that help you decide if you should appeal and the first steps once you do.

- There are sections to help you find out what kind of health insurance plan you have and what kind of denial you received.
- This is important because the steps are different based on the type of health plan you have and the denial you are appealing.
- Use the Table of Contents to find the sections that fit you.
- The appendix at the end of the Guide has a [glossary](#). It explains terms we use in this guide. It also includes sample letters and other templates you can use in your appeal.

Do you live in another state? This guide is for people in Maine, but a lot of the information might be helpful even if you live in another state. If you live in another state, you should contact your state insurance department, or your state's consumer assistance program.

- Find your state insurance department:
http://www.naic.org/state_web_map.htm
- Find your state's consumer assistance program:
<https://www.cms.gov/cciiio/resources/consumer-assistance-grants/>

Have you been denied a service that you need right away?

If so, you may be able to get an expedited or rushed appeal to get a faster decision. Read about quick, expedited appeals in [Section 4](#) or call the Consumer Assistance HelpLine at 1-800-965-7476 right away.

Section 1: Getting Started

The first thing to do is to get organized.

- **Make an appeal folder for your papers.** Include any letters or documents you have about the denial, your medical services, and your health insurance plan.
- **Document everything.** Use the Appeal Case Organizer in [Appendix A](#) to help you create a timeline of events and a call record to keep track of when things happen, including who you speak to and the time you called.

Don't let your bills go to collections.

If you want to appeal a service or treatment you've already had, you may start getting bills for that service from your doctor. **Don't ignore your medical bills.**

Call your doctor's office right away.

- Tell them that you want to appeal the denial. Ask if they will wait until after the appeal to bill you.
- Or, pay the whole bill or set up a monthly payment plan for an amount you can afford. If you win your appeal, you'll get back money you paid that should have been covered by your plan.

Have debt collectors called or sent you letters?

- If it has been **less than 30 days** from the first phone call or letter they sent, you can use the template letter from Pine Tree Legal in [Appendix B](#) to request validation of the debt. This will stop them from trying to collect payment while you appeal. You can change the letter to fit your situation. You can also find the sample letter here:

http://ptla.org/sites/default/files/debt_collection_validation_request_letter.pdf

- If it has been **more than 30 days** from the first phone call or letter they sent, you can use the template letter from Pine Tree Legal in [Appendix C](#) to stop them from calling and sending you letters. You can change the letter to fit your situation. You can also find this sample letter here:

http://ptla.org/sites/default/files/debt_collection_stop_calling_letter.pdf

If you have questions about your rights in the debt collection process, call Pine Tree Legal at 207-774-8211 or visit <http://ptla.org/debt-collectors-are-calling-me-what-can-i-do>.

This handy toolkit focused on avoiding and dealing with medical debt from the Maine Youth Transitions Collaborative is also a good resource.

<https://www.maine-ytc.org/navigating-medical-bills-debt/>



Section 2: Understanding Your Written Decision

Before you appeal, it's important to understand why your insurance company isn't covering the health care you thought it should. The written decision from your insurance company to deny coverage for your service will either be a denial letter, or an Explanation of Benefits or EOB. The kind of written decision you get usually depends on whether you've already had the service or not.

Both letter and EOB written decisions will include information about your appeal rights and how to request an appeal. Look for the deadline that you have to appeal by and put the date in your calendar. **You will have at least 60 days to request an appeal. Often you will have 180 days to request an appeal. If you miss this deadline, you will likely lose your chance to appeal.** Call 1-800-965-7476 for help.

What kinds of written decisions or denials are there?

1. Decision letters for services that haven't happened yet

Sometimes you have to get approval from your insurance company before you get certain services covered by your plan. This is called prior-approval, prior-authorization or PA. After you or your doctor have asked for prior-approval, your insurance company will send you a letter with its decision. The letter tells you if they have approved or denied coverage for the service. It should say how the decision was made. You can see a sample denial letter in [Appendix D](#).

2. Explanation of Benefits or EOB for services that already happened

Whenever you use your health insurance for an office visit, lab test or any procedure, you will get an EOB in the mail. Or you can ask to have it emailed. It may take a few weeks after you get services to get an EOB. See the sample EOB on the next page.

The EOB shows:

- Basic information, like the date of service and name of your doctor.
- If the service was covered by your plan and the reason why it was, or was not. The reason is usually shown by a code of numbers or letters. You can find the meaning of these codes at the bottom of the page or the end of the EOB.
- How much your insurance company paid, how much was counted towards your deductible, and how much you may have to pay out of pocket.

For help you can call your doctor's office or our HelpLine at 1-800-965-7476.



This is Not a Bill

Patient: Tom Responsible
Member ID: A0123456
Provider: Dr. Getwell
Provider participation status: In- network
Claim #: XY678910
EOB Date: 4/1/16

Explanation of Benefits

"Allowed Amount", or "Negotiated Rate" might also be called "Eligible Charges": The amount your insurance company agreed your provider will be paid for a service. You may be responsible for paying some or all of this amount. You can find out what you owe by looking at your out of pocket cost amounts of your EOB.

The allowed amount is a discounted rate you get for being a member of your plan. If an in-network provider charges more for a service than the allowed amount, you can't be billed for the difference. If you go out of network or if your service is denied, then your provider can bill you for the difference. This is called **"balance billing."**

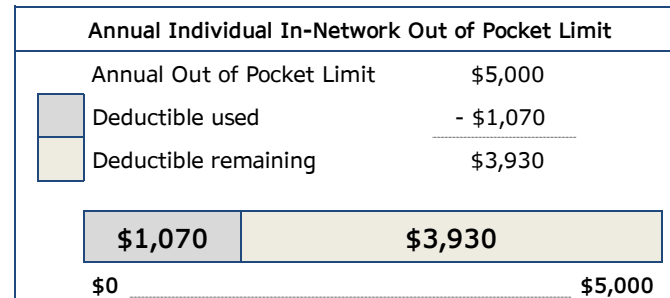
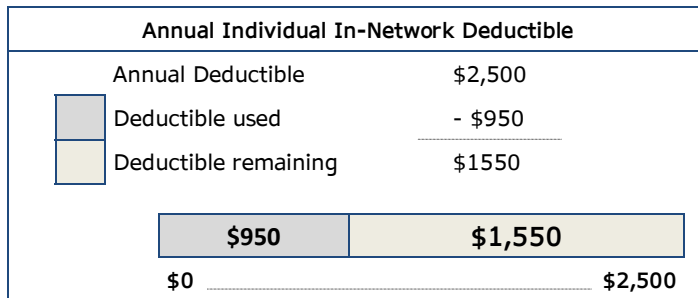
If the allowed amount for a service is \$0.00, this means the service was denied by the insurance company and you're responsible for the full amount of the provider charges.

Provider Charges: The full amount your provider charged for a service.

Service Information: A description and date of the service you received.

Provider Adjustment, Plan Discount, or Provider Responsibility: The difference between the provider charge and the allowed amount.

Date of Service	Service	Service Code (CPT code)	Provider Charges	Allowed Amount	Provider Adjustment	Co-Pay	Deductible	Coinsurance	Member Responsibility	Plan Payment	Reason Code(s)
3/7/16	Office Visit	99200	\$120.00	\$80.00	\$40.00	\$20.00	\$0.00	\$0.00	\$20.00	\$60.00	1
3/7/16	Laboratory	0300	\$170.00	\$110.00	\$60.00	\$0.00	\$110.00	\$0.00	\$110.00	\$0.00	2
3/7/16	X-ray	73600	\$220.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$220.00	\$0.00	3
Total:			\$510.00	\$190.00	\$100.00	\$20.00	\$110.00	\$0.00	\$350.00	\$60.00	



Reason Codes:

- 1: This is the member's co-pay amount
- 2: This amount has been applied to the member's deductible
- 3: Service is not covered because it did not receive prior-authorization

See other side for more





Fine Print Insurance Company
135 Rainy Day Way
Somewhere, Maine 04123

<Sample>

Member Services: 1-234-567-8900

This is Not a Bill

Explanation of Benefits

Patient: Tom Responsible
Member ID: A0123456
Provider: Dr. Getwell
Provider participation status: In- network
Claim #: XY678910
EOB Date: 4/1/16

Member Responsibility: The total amount of all out of pocket costs you're responsible for. If a service was denied, you'll also owe the full amount the provider charged or the service. This may or may not be included in the Member Responsibility amount on your EOB.

***Some EOBs incorrectly list the member responsibility amount as \$0.00 for denied services.** If your EOB shows this amount as \$0.00, check the reason code and the amount listed under "Allowed Charges" to find out if the service was denied.

Out of Pocket Costs: The separate kinds of out of pocket costs you are responsible for.

Plan Payment: The amount your insurance company is responsible for.

Date of Service	Service	Service Code (CPT code)	Provider Charges	Allowed Amount	Provider Adjustment	Co-Pay	Deductible	Coinsurance	Member Responsibility	Plan Payment	Reason Code(s)
3/7/16	Office Visit	99200	\$120.00	\$80.00	\$40.00	\$20.00	\$0.00	\$0.00	\$20.00	\$60.00	1
3/7/16	Laboratory	0300	\$170.00	\$110.00	\$60.00	\$0.00	\$110.00	\$0.00	\$110.00	\$0.00	2
3/7/16	X-ray	73600	\$220.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$220.00	\$0.00	3
Total:			\$510.00	\$190.00	\$100.00	\$20.00	\$110.00	\$0.00	\$350.00	\$60.00	

Annual Individual In-Network Deductible	
Annual Deductible	\$2,500
Deductible used	- \$950
Deductible remaining	\$1,550

\$950	\$1,550
\$0	\$2,500

Annual Individual In-Network Out of Pocket Limit	
Annual Out of Pocket Limit	\$5,000
Deductible used	- \$1,070
Deductible remaining	\$3,930

\$1,070	\$3,930
\$0	\$5,000

Reason Codes:

- 1: This is the member's co-pay amount
- 2: This amount has been applied to the member's deductible
- 3: Service is not covered because it did not receive prior-authorization

Reason Code(s): Tell why a service was covered the way it was or why it was denied. The code is made up of numbers or letters. The code meanings are usually at the bottom of the EOB.

Why was my service denied?

Here are 7 common reasons insurance companies deny services:

1. Not medically necessary
2. The doctor is out of network
3. Experimental or investigational
4. Billing and coding mistakes
5. Not enough information
6. The service is excluded or not covered
7. You did not get a referral or pre-authorization

1. Not medically necessary

Your plan defines what services are medically necessary in your health plan agreement. They use medical guidelines to decide when a service or treatment meets the definition for medically necessary. If this is the reason your service was denied, then your insurance company doesn't think you meet their medical guidelines. Read about medical guidelines in the next section, "Understanding what your plan covers."

Example: Debbie went to her therapist to get help for depression, but even after having regular visits, her depression kept getting worse. Her therapist suggested she go to a treatment center where she could stay for a couple of weeks and get more intensive help.

However, the insurance company denied prior-approval for services at the treatment center. The written decision stated that this level of care was not medically necessary for Debbie since she didn't meet the plan's medical guidelines for services at this type of treatment center, and could get the care she needed from seeing her therapist regularly at his office.

Debbie appealed the denial and her therapist wrote a letter explaining why regular visits at his office would not be enough for Debbie, and why she needed to go this type of treatment center in order to get the level of care she needed.

2. The doctor is out-of-network

All plans have a network of doctors, hospitals, and other health care providers that it covers. If you see a doctor in your plan's network, your plan will pay more of the costs for those services. If you go to a doctor that isn't in your plan's network, your plan may cover the services at a lower level of coverage. It may not cover the services at all. No matter what kind of plan you have, it should cover certain kinds of out-of-network services as if they were in-network, including:

- Emergency services
- Services you can't get from an in-network doctor, like a specialist with expertise in a certain kind of treatment

If your service was denied for being out of network, it means your insurance company doesn't think it was an emergency and thinks you could get the same care from an in-network doctor.

Example: Jim has a rare form of cancer. He was referred by his doctor to see a specialist in Boston who was not in his health insurance plan's network.

The services were denied because his insurance company said he could have gotten the same care from an in-network cancer specialist in Maine. Jim appealed, arguing that the in-network doctors didn't have enough experience treating his specific kind of cancer.

3. Experimental or investigational

The insurance company believes the treatment or procedure is not scientifically proven to work, or not proven to work for your specific conditions. Your insurance company defines what kinds of services are experimental or investigational in your health plan agreement. They use medical guidelines to decide when a service or treatment is considered to be experimental or investigational. Read more about medical guidelines in the next section, "Understanding what your plan covers."

Example: Rosa has a rare condition that causes her to have very bad headaches and puts her at risk for other serious health issues, like stroke. She has tried different kinds of drugs and treatments, but none of them seem to work for her so her doctor suggested she have a surgery.

Approval for the surgery was denied. The insurance company said it was experimental because it hadn't been proven to help people with Rosa's condition through enough medical studies.

Rosa appealed the denial and explained that she had already tried every other kind of treatment and none of them have helped her. Her doctor also explained that there weren't a lot of studies about this surgery, because the condition Rosa had was so rare that there hadn't been many studies done about it. But, he also explained that he and other doctors who specialize in treating Rosa's condition all agree that this surgery can help people like Rosa and that going without the surgery would put her health at great risk.

4. Billing and coding mistakes

Every health service has a billing code. Sometimes doctor's offices use the wrong code. Billing errors are common and can be fixed quickly. If you think a service was denied because of a billing mistake, call your doctor's office and see if they can help.

Example: Jan is 51 years old. She was billed \$1,865.68 for a preventive screening colonoscopy. The EOB showed that the \$1,865.68 charge had been applied to her plan's \$2,000 deductible. But, under her plan, this preventive service should have been 100% paid for by her insurance, even if she hadn't met her deductible.

Jan called her doctor's office and found out they made a mistake. Instead of billing her health plan for a preventive screening, they had coded the colonoscopy as a diagnostic service.

Once Jan's doctor billed the insurance company with the right code, her health plan paid the full amount, and no appeal was needed.

5. Not enough information

Services can be denied if the insurance company doesn't have enough information about why you need or needed a service. Sometimes the EOB will make this very clear by saying that they did not get information or medical records they asked for from you or your doctor. But, other times, they may just deny a service as not medically necessary if they don't have all the information or medical records to show why you need it.

Example: Reza hurt his leg in a ski accident and was in a lot of pain. His doctor requested to have an MRI on his leg so she could see how badly Reza had hurt himself.

However, the insurance company didn't know about Reza's injury, so they denied his doctor's request for a MRI since they didn't have any information that showed why he needed it.

Reza called his doctor and she sent the insurance company Reza's medical records and her notes explaining his injury. Once the insurance company had information about his injury, they approved the MRI without Reza having to appeal the denial.

6. The service is excluded or not covered

Some services are excluded and aren't covered by your plan. If your plan excludes a service, then it doesn't matter whether or not you meet the medical guidelines for that service. Check your health plan agreement to find out what services are and aren't covered by your plan and if there are any exceptions to your plan's exclusions.

Example: Jennifer fell off of her bike and broke several of her teeth and part of her jaw. Her insurance company denied to pay for any of the medical services related to fixing her teeth and jaw because her health plan excluded dental coverage for adults.

Jennifer requested a copy of her health plan agreement and learned that there was an exception to her plan's exclusion for dental services that were related to an accident or injury. Jennifer appealed the denial arguing that she met this exception.

7. You didn't get a referral or pre-authorization

Some plans require you to get a referral before you see a specialist. Many plans also require that you get approval before you get certain kinds of services, like an x-ray or test. Asking for approval first is called prior-approval, prior-authorization or PA. Other times you may simply need a referral from your primary care provider to see a specialist. Check your health plan agreement to find out what services need a referral or prior-approval, and how to get it.



Section 3: Should Your Plan Cover That Service?

Once you know what your EOB or denial letter says, the next step is to find out what your plan covers. To do this, you may need to look at a few different documents.

1. The Summary of Benefits and Coverage or SBC
2. Health plan agreement
3. Medical guidelines

1. The Summary of Benefits and Coverage or SBC

The SBC is a chart that shows a basic overview of your plan deductible, copays, and coinsurance for different services. It's usually about 8 pages long. It can help you understand what services are subject to the deductible, or what your share for the cost of a service should be, but it doesn't have detailed information about how your plan works. For that, you should look in the health plan agreement.

Here is what your SBC looks like:

Find your full Health Plan Agreement at the web link here.

Insurance Company 1: Plan Option 1		Coverage Period: 01/01/2015 – 12/31/2015
Summary of Benefits and Coverage: What this Plan Covers & What it Costs		Coverage for: Individual + Spouse Plan Type: PPO
<p>This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].</p>		
Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$500 person / \$1,000 family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes. \$300 for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers \$2,500 person / \$5,000 family For non-participating providers \$4,000 person / \$8,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.[insert].com or call 1-800-[insert] for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .
<p>Questions: Call 1-800-[insert] or visit us at www.[insert]. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.</p>		<p>OMB Control Number 1545-2229, 1210-0147, and 1930-1186 1 of 8 Created on May 11, 2012</p>

2. The Health Plan Agreement

The full health plan agreement may be called a certificate of coverage or COC, summary plan description or SPD, member benefit agreement, member handbook, or something like that. It is usually at least 50 pages long.

The health plan agreement has detailed information about what services are covered and how your plan works. It tells which services you need to get prior-approval for. It says when you need a referral from your doctor. It will say what is medically necessary, experimental or investigational. Your full health plan agreement is usually more helpful than the SBC for appeals.

You can find your full health plan agreement online at the web link listed on your SBC or you can find out how to request a copy of your health plan agreement on the next page.

What to look for in your health plan agreement

When you get a copy of your health plan agreement, see what it says about the services that were denied in your situation. For example, if a service was denied because the doctor wasn't in-network, see what your health plan agreement says about when it will cover out-of-network doctors. Look for exceptions to the rule. You can also see how your insurance company defines terms like "medically necessary," "experimental or investigational," or "emergency". Details are very important. For example, some services such as vision and dental care are not usually covered for adults under medical plans. But, there are often exceptions to this rule. Your plan may cover dental care if you had an injury that caused you to lose a tooth. So, you can sometimes find exceptions in your health plan agreement.

When in doubt, check it.

Even if you don't find an exception that fits your situation, don't give up yet. There could be many things specific to your situation and your claim that aren't covered in the plan agreement. There is another place to check – the medical guidelines.

3. The Medical Guidelines

The medical guidelines, also called clinical criteria, clinical policy bulletins or medical policies, are the guidelines your insurance company uses to determine when a service is or isn't medically necessary. If you have a denial letter, it should tell you what, if any, guidelines were used to make the decision. Many companies also post their medical guidelines for services online. You can also request a paper copy to be mailed to you. We cover [how to get the documents you need](#) on the next page.

What to look for in the medical guidelines

Once you find the medical guidelines used to make the decision for your service, you should see if you fit the guidelines for the service to be medically necessary. These guidelines can be very complicated. Ask your doctor to help you see where you fit.



As with the health plan agreement, don't give up just because you don't meet your plan guidelines for a service. Sometimes a service can be medically necessary for one person even though it usually isn't for most people, like if someone tried all of the regular "medically necessary" treatments, but still had health issues. Another example is if they had other health issues that could get worse if they tried the regular treatments.

How to get the documents you need

You have the right to see all information about your claim and any guidelines or other standards your insurance company used to make its decision.

If you don't have these documents, request copies from your insurance company:

- Your full health plan agreement
- Any medical guidelines that were used to make the decision
- The specific treatment and diagnostic codes related to your situation and their meanings, so you can be sure you find all of the claims or services involved
- A complete copy of your administrative file, including phone records, all EOBs or other written decisions, and any written reasons for the denial

You can request these documents by calling member services at your insurance company, or sending a written request by mail. You can use the Written Request sample letter in [Appendix E](#) to request your claim file and documents. If you have trouble getting these documents, call the Consumer Assistance HelpLine at 1-800-965-7476 for help.

You may need copies of your medical records, including the service or treatment that was denied, and why the doctor said you needed it. You can get copies of this information by calling or visiting your doctor's office.



Section 4: How Do I Start My Appeal?

First, find out what kind of plan you have.

Your rights and the appeal steps depend on the kind of health plan you have, the reason for the denials, and how quickly you need to get a service approved. When you know what kind of plan you have, you can be sure you're reading about the steps that apply to you.

Below, you will figure out:

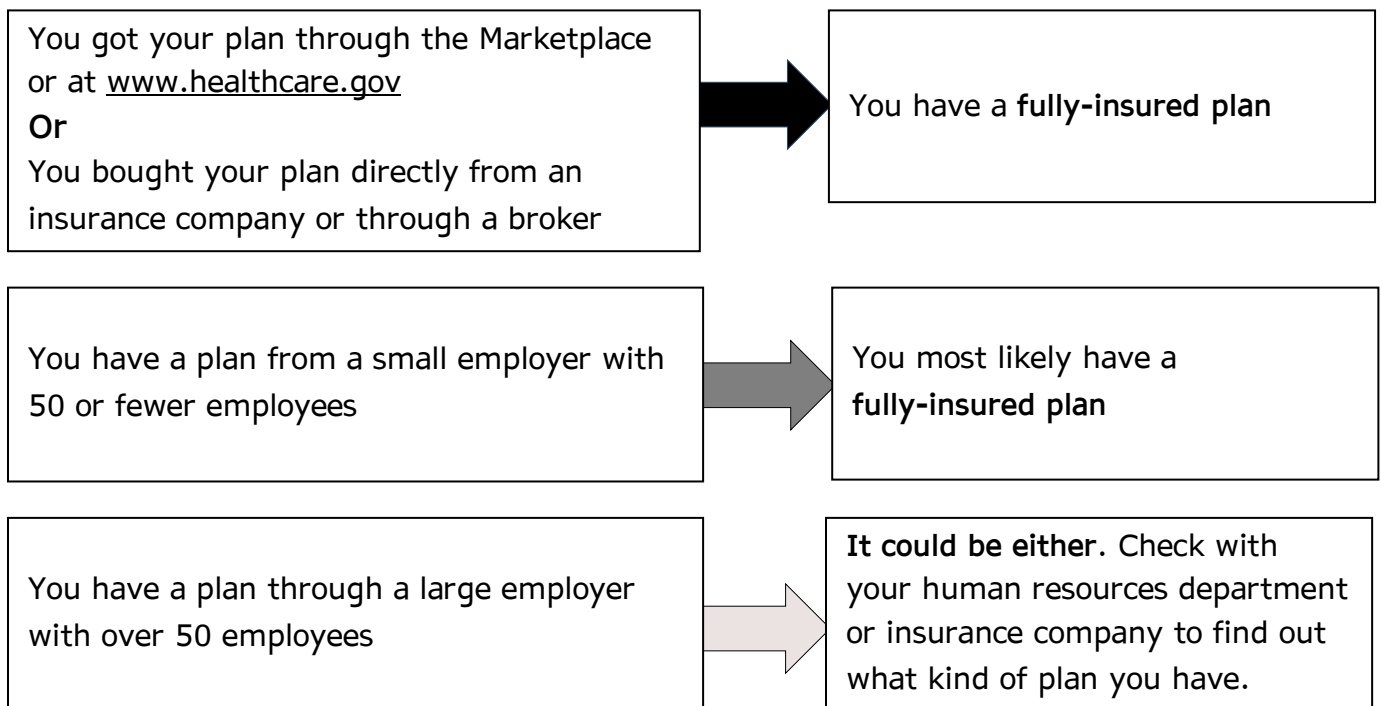
- If you have a fully-insured or self-insured plan
- If you are appealing a medical or non-medical decision
- If you are appealing an urgent service

There are two kinds of health plans:

1. Fully-insured, also called fully-funded
2. Self-insured, also called self-funded

Although the rules and appeal steps are similar, there are some differences, so it is important.

How do I know what kind of plan I have?



	Self-Insured or Self-Funded Plans	Fully-Insured or Fully-Insured Plans
Where would someone get this kind of plan?	Large employers like Hannaford, LL Bean, and many hospitals.	Purchased individually, or offered by small or large employers.
Who takes care of claims when I use my insurance?	<p>The employer offering the plan pays your health plan benefits from its own funds when you receive services.</p> <p>Many employers that offer self-insured plans use insurance companies, like Anthem, to oversee the plan benefits. This means you may deal with the insurance company when using your plan, like to request prior authorization or appeal a denial.</p> <p>However, a self-insured plan is not considered to be an insurance policy, so your employer is still the one responsible for covering the costs for your health plan benefits when you use your insurance.</p>	Your insurance company or HMO pays for your health plan benefits and oversees your claims.
Who will I get mail from?	Insurance card, EOBs, and decision letters all come from the insurance company that administers your plan, or the employer.	Insurance card, EOBs, and decision letters all come from insurance company.
What are the rules these plans have to follow?	<p>Self-insured plans follow rules of the U.S. Department of Labor.</p> <p>Most self-insured plans do not follow state insurance laws. A federal law called ERISA (Employee Retirement Income Security Act), makes most self-insured plans exempt from state insurance laws.</p>	Fully-insured plans and certain governmental benefits trusts, like the Maine Education Association Benefits Trust, follow Maine laws and the rules set by the Maine Bureau of Insurance.



Second, find out what kind of denial you are appealing

The denial from your insurance company is either based on a medical or non-medical decision. It's important to know what kind of decision you've been given because it could affect your appeal rights.

Medical Decision

If your decision is a medical decision, the reason for denial may be one of these:

- The service is not medically necessary
- The service is experimental or investigational
- You want to see an out-of-network specialist but the insurance company says there are in-network doctors who could give the same care

Non-Medical Decisions

If your decision is a non-medical decision, the reason for denial may be one of these:

- The cost was applied to your deductible
- The doctor or provider is out-of-network – see above for an exception
- The service is not covered under the plan
- Billing or coding errors
- They did not get the information or medical records they requested
- A referral or prior-approval was not requested for the service

Can I get an expedited appeal for an urgent service?

Expedited appeals are available for urgent services. Usually, each level of the appeal process takes about a month to get through. Some things can't wait that long. If your doctor thinks that **your health, life, or ability to fully recover is at serious risk**, then ask for an expedited appeal.

How do I get an expedited appeal?

Ask for an expedited appeal when you request the appeal. Explain why waiting for a regular appeal would put your health, life, or ability to fully recover at serious risk. See Section 5 for tips on what to include in your request. You should also ask your doctor to write you a letter of support to include with your appeal.



Section 5: Make Your Best Case

Organize and Prepare

Make sure that you have everything you need for your appeal. Keep all these documents together in your appeal folder.

- The explanation of benefits (EOB) or denial letter that gives the reasons your insurance company denied the claim.
- A copy of the medical guidelines used by your insurance company to deny your claim.
- Any relevant medical records from your doctors or health care providers.
- If needed and you have it, include research showing that the treatment is effective for someone in your situation. Your doctor might help you with this.
- Remember, you can get any missing documents, including your complete claim file, free from your insurance company or employer. If you have trouble getting this file, call Consumers for Affordable Health Care at 1-800-965-7476 or the Maine State Bureau of Insurance at 1-800-300-500 for help.

Get Letters of Support

You need a letter of support from your doctor. Your doctor's letters of support are possibly your most important pieces of evidence. Ask your doctor to write letters explaining:

- Who they are, their qualifications and how long they have been treating you.
- A description of the circumstances and the clinical evaluation that led to the decision to get the health service you need.
- Why the health service you seek is evidence-based practice, effective, necessary and appropriate. The letters should tell why the service is better than other services the health plan may have suggested.
- Why the decision should be overturned, based on the health plan's medical guidelines or definition of medical necessity and their reason for denial.
- What positive outcomes are expected, especially compared to other treatment options.

It is helpful to have a letter from each doctor or health care provider involved in your care or who understands why this service is important. It shows your health insurance company that your health care team agrees.

Example. Susan needs mental health treatment. Her therapist requested it. Susan also gets medication from a psychiatrist. A letter of support from both the psychiatrist and therapist would be very helpful.

If you are not able to get a letter of support from your doctor, don't give up. You can still write a good letter yourself.



Write Your Appeal Letter

Write a letter to the appeal or grievance department at the address or fax number listed in the notice you got from the insurance company. Call the company if you are not sure where to send it. If you are still unable to find the information, call the Maine Bureau of Insurance at 1-800-300-5000 or our HelpLine at 1-800-965-7476 for help.

You can use the [first level appeal template letter](#) to write your appeal letter. Make your letter like ours by putting in all of the facts and details you have. The letter should be organized to show that your medical situation meets the criteria for insurance company coverage for the treatment and that their denial of the coverage was wrong.

Here are some tips on how to organize the paragraphs in your appeal letter:

Paragraph 1: Describe what you are appealing. Write a simple introductory paragraph: "I am appealing the decision denying coverage for [Name or explain the medical service and list the dates of service]. I needed this treatment in order to treat [briefly state your medical condition.] I think this decision is a mistake and the treatment should be covered."

Paragraph 2: Lay out the facts of your case, to show what you have done, who you have seen and how not having the treatment has affected you. Include the dates of main events. For instance, list any other treatment options you've already tried. Give dates you saw your doctor or had another health care service. If you are in pain, say that you are in pain and for how long you have been in pain. If you can't sleep, say that you can't sleep. List all the ways that this treatment would improve your health, work and home life.

Paragraph 3: Make your argument. If you think you meet your plan's medical guidelines, then include a copy of those guidelines and explain how you meet them. If you don't think you meet the medical guidelines, find out how your plan defines medically necessary services in the health plan agreement. Include the medical guideline definition in your letter to explain why your service meets this definition.

Refer to medical records, research, or anything else that shows that your treatment was medically necessary. "As shown in my doctor's letter of support, I meet these guidelines because..." Add anything else you think is important showing you meet the medical guidelines or definition of medically necessary.

Paragraph 4: State why the health insurance company's reason was wrong. Start this paragraph by saying what the reason was. Often health insurance companies will say that there is a less expensive way to get the same results. Sometimes they will say that the treatment is investigational or experimental. So you might write: "The health plan's reason for denial was that I would have been fine with [a certain other treatment]." Or say, "The health plan says this treatment has not been proven to be effective." Now, say why the company was wrong to deny the service. If you can, refer to your doctor's letter. Your doctor is your expert. Also make any points of your own that you would like. You might say, "As my



doctor's letter states, the treatment I received was the only one that would work for me. This is because....[state why]." Or "As my doctor's letter states, this treatment is now widely used by doctors and research shows it is effective."

Paragraph 5: Conclusion. End with a simple paragraph. "For these reasons, I am requesting that you cover these services. If you need any further information, please contact me."

In addition to an [Appeal Letter Template](#) for you to fill in, you can also find a [Sample Appeal Letter](#) is in the Appendix.

Your Appeal Package Check List

Now you are ready to send your appeal out to your insurance company. It includes:

- Your appeal letter
- A copy of the Explanation of Benefits or denial letter you are appealing
- Your doctor's letter of support
- Anything else important: for example, other letters of support, copies of key medical records, articles of research, or other relevant documents

Important!

- Make a copy of your appeal packet before you send it.
- Send your appeal packet by certified or registered mail so you'll have proof.
- If you send a fax, keep the fax confirmation.

It's a good idea to call to make sure they got your appeal request, especially if you sent it by fax. Be sure to write down who you spoke to and the date and time of the call.



Prepare for the hearing

There are multiple steps to the appeals process. These steps are different for different kinds of plans. In the next sections, we will explain the different steps you may go through. As part of this process, you may request a hearing. Your hearing might happen during different steps in your appeal, such as during your second level appeal or during external review. The hearing might take place over the phone or in person. But the hearing process and how you should prepare for it are very similar.

Who attends the hearing?

- An appeals coordinator from your insurance company or the independent review organization (IRO)
- The person or people who will review and decide the appeal, such as the medical reviewer, someone with relevant medical knowledge, called the medical reviewer, or someone else from your insurance company who knows about your plan
- You or someone you pick to be your authorized representative or to speak in support of your case, or both. This could be your doctor, family members or friends, someone from a consumer assistance program, or even a lawyer. **We strongly recommend that you ask your doctor to speak at your hearing.**

What to expect during the hearing

Most in-person appeal hearings are held at the insurance company or plan administrator's office in Maine. However, some members of the appeal panel may still join by phone, even if you go in person. Hearings held over the phone are done through teleconference and you will be given a phone number and access code to dial in order to join the hearing call.

The hearings are pretty informal and usually last between 20 minutes to an hour. All hearings generally follow the same basic process once you arrive or join the hearing call:

- 1) The hearing will start with introductions and a short statement explaining what issue is being reviewed.
- 2) After introductions, you will get a chance to make your case and can have someone speak for you, or in support of your case. Then, members of the review panel or the medical reviewer may ask you or your doctor questions.
- 3) If the hearing is for an external review, the insurance company will then explain why it thinks the service should be denied and answer any questions from the reviewer. If the hearing is for a second level appeal, it will skip this step and go right to the 4th step.
- 4) After all the questions have been answered, you will have a final chance at the end to say anything you forgot earlier, or want to stress as very important.

You will not find out the decision during the hearing. A final decision will be sent to you in writing usually a week after the hearing, or as soon as possible for expedited appeals.



Tips & tricks to prepare for your hearing

- Ask your doctor to speak in support of your case. A lot of doctors are busy and may not have time to stay on the line for the entire hearing call. Let them know that if they are short on time they can speak first and then hang up after they finish answering the reviewer's questions. This can take as little as 10 to 20 minutes.
- Make an outline of your argument. Use the same tips we gave earlier for organizing your appeal letter when you're organizing your outline of what to say during the hearing. If your doctor will be speaking, you should share the plan or medical guidelines that were used to make the denial with them so they know what points to focus on.
- Be specific and give examples from your medical records. Don't just broadly state that you meet the medical guidelines. Give specific dates and examples from your medical records that illustrate why you meet each guideline.
- Keep your argument focused on why the service should be approved. During the hearing, try to avoid bringing up problems related to other claims you've had or other issues with your insurance company that aren't directly related to your appeal.
- If you're asked a question about something you don't know the answer to, don't panic. Ask the reviewer if you could share the answer or follow up with more information after the hearing. If they say yes, make sure to write down exactly what they are asking for and the address or fax number where you should send it.



Section 6: Appeals for Fully-Insured Plans

Below is an overview of the appeal process for fully-insured plans and some federal, state and local government plans, such as benefit trusts. More details about each step can be found after the overview. Remember, fully-insured plans are regulated by the Maine Bureau of Insurance. For information about self-insured plans, go to [Section 7](#).

You may also file a complaint about the insurance company or their decision with the Maine Bureau of Insurance at 1-800-300-500. Call our HelpLine for help at 1-800-965-7476.

<p>Step 1 Provider Reconsideration</p> <p>Only for medical decision denials</p>	<p>Your doctor can request reconsideration from the insurance company at any time during the appeals process. Your doctor would call the reviewer to try to resolve the issue outside of an appeal. It is possible that your doctor has already done this.</p> <p>Your insurance company makes a decision within 1 working day.</p> <p>This step is optional. You can skip to first level appeal.</p>
<p>Step 2 First Level Appeal</p>	<p>You must request a first level appeal from your insurance company within 180 days of last decision.</p> <p>Generally, a decision is made by your insurance company within: 72 hours for expedited appeals 30 days without a hearing 50 days with a hearing (45 days to hold hearing plus 5 days to decide)</p> <p>The decision may take longer if you or the insurer requests more information.</p>
<p>Step 3 Second Level Appeal</p>	<p>You must request this from your insurance company within 180 days of the last decision. You have the option to attend a hearing in person or by phone.</p> <p>Generally, a decision is made by your insurance company within: 72 hours for expedited appeals without a hearing 30 days without a hearing 50 days with a hearing (45 days to hold hearing + 5 days to decide)</p> <p>This step is optional. You can skip to external review, if available.</p>
<p>End of appeals process for non-medical decisions.</p>	
<p>Step 4 External Review</p> <p>Only for medical decisions and rescissions.</p>	<p>You must request this from the Maine Bureau of Insurance or BOI, within 12 months of the last decision. The BOI will then send your case to an independent review organization or IRO, to be reviewed. You have the option to attend this review hearing over the phone.</p> <p>The IRO makes a decision within: 72 hours for expedited appeals 30 days for non-expedited appeals</p>

Step 1: The Provider Reconsideration

If the denial you want to appeal is based on a medical decision, we recommend that you ask your doctor to request reconsideration, also called a “peer-to-peer review.” The peer-to-peer review is a phone call between your doctor and the person who made the decision to deny your service, or the “reviewer.”

This gives your doctor a chance to talk informally with the reviewer to explain exactly why you need to have this service. The reviewer will then reconsider the service and make a new decision within 1 working day of the call.

Your doctor can request a reconsideration at any point before or during the appeals process. **This is not a required step, so you don’t need to do this in order to appeal.** But, it could help you get a service approved more quickly than through an appeal.

If the decision you want to appeal is not a medical decision, then you should go right to Step 2: The First Level Appeal.

Key things to know about reconsiderations

- Your doctor can request reconsideration any time before or during the appeals process.
- This is not a required step, so you don’t need to do this in order to file an appeal. It does not use up one of your appeal levels.
- A request for reconsideration must be made by the doctor who will perform the service.
- Usually, the insurance company doctor or nurse who originally denied your request must do your review. But sometimes another doctor or nurse with a similar medical background may do the review.
- There’s no downside! The process is very fast, easy, and takes just 1 day. It can help get a service approved more quickly than an appeal.



Step 2: The First Level Appeal

This is your first formal appeal with your insurance company. It's your first chance to make your case to the insurance company about why they should cover your service. Unlike the provider reconsideration, the first level appeal can't be decided by the person who made the original denial or anyone else that was involved in making that decision, unless there is new information. However, it will still be decided by someone at your insurance company.

Your insurance company must:

- Give you at least 180 days to appeal from the date of your last decision.
- Give you documents and information about your denied service that you request.
- Give you a chance to explain your side and include any documents that support your argument.
- Tell you if they find any new information or think of a new reason that's different from the one they used in their first decision to not cover your care. They must give you a chance to respond to the new information before they make their decision.
- Have someone review and decide your appeal who was not involved in the first denial decision you are appealing, unless there is new information.

How do I request a first level appeal?

You usually have 180 days to request an appeal from the date you received the denial. Some plans might give you even more time. You can ask for a first level appeal by calling your insurance company or by sending them a letter. If you can, we recommend asking for your appeal in writing. That way you can make sure all the information you have is included. For tips on what to include in your appeal, go to Section 5: [Make Your Best Case](#). Whatever the case, be sure to follow the instructions sent to you in the denial letter or EOB.

Don't forget to ask your doctor for help!

See Section 5 to see how your doctor can support your case.



What can I expect after I request a first level appeal?

After you request an appeal, your insurance company should send you a letter to let you know they got your appeal. The letter should be signed by someone like an “appeals coordinator.” This is the person you should contact if you have questions about your appeal. The coordinator may ask you or your doctor for more information. If so, you or your doctor should send the information as soon as possible.

After they review the information, they will send you a written decision that will tell you:

- 1) What the decision is
- 2) How the decision was made
- 3) What rights you still have to appeal again

How long does the first level appeal take?

Once your insurance company receives your appeal, generally it must make a decision within:

- 72 hours for expedited appeals
- 30 days without a hearing
- 50 days with a hearing (45 days to hold hearing plus 5 days to decide)

If coverage is approved: Congratulations, your appeal was successful! If the approval is for a service you already paid for, you will get back any money you paid that should have been paid by your health plan. Usually, your insurance company will pay your doctor, and then your doctor will pay you back any money owed to you. Even if a service is covered, you may still have to pay some amount out-of-pocket, like a copay or coinsurance, depending on your plan.

If coverage is not approved: Don't give up! The written decision will include the reasons why your plan still won't cover the service, and you can use this information to make your case even stronger for your next appeal.

Next Steps: If the first level appeal is denied, you still have another shot to appeal directly to your insurance company in the [Second Level Appeal](#).

Some plans also have the option to skip the second level appeal and go directly to the external review, if the appeal qualifies for one. If you do this, you can reach the [external review](#) sooner. This review will not be decided by your insurance company. In taking this step you also give up your second level appeal right.

You can see your options in the written response to your first appeal, or in your health plan agreement.



Step 3: The Second Level Appeal

The second level appeal process is a lot like the first level appeal. This appeal level is also decided within the insurance company, just like the first level was. You have all of the same rights, plus, the right to attend your hearing, in person or over the phone.

How do I file a second level appeal?

You can find information about your appeal rights in the written decision for your first appeal. It will tell you how to appeal and when the deadline is for your next appeal.

How long does the second level appeal take?

You will have at least 180 days after you receive the first level decision to file a second level appeal. Once the insurance company gets your appeal, it must make a decision within:

- 72 hours for expedited appeals without a hearing
- 30 days without a hearing
- 50 days with a hearing (45 days to hold hearing + 5 days to decide)

The Second Appeal Hearing

You can ask for a hearing in your second level appeal letter. A hearing gives you a chance to explain your case in person or over the phone to the people at your insurance company that will decide your appeal. This group is called a "review panel." The review panel may include:

- Someone with relevant medical knowledge, if it's for a medical decision
- Someone who knows about your plan, how it works, and what it covers

Make sure to write in your letter if you want to attend the hearing in person or by phone. You will find out the date and time of the hearing at least 15 days ahead. The final decision will be mailed to you within 5 days after the hearing.

Read about what to expect during the hearing and tips for how to prepare in Section 5: [Make Your Best Case](#).

Ask your doctor to help! If you have a hearing, ask your doctor to be on the hearing call. Tell your doctor they can speak first during the hearing, in case they can't stay for the entire call. Usually hearings are 20-60 minutes long.

If your doctor can't join the hearing, ask if they'll write a letter of support that you can include with your appeal request.



Step 4: The External Review

After you've completed at least one appeal level, or in some cases two, you may be able to get an independent external review.

This is different from the other appeal levels because this time your appeal won't be reviewed by people who work for your insurance company. Instead, **the external review is decided by an independent review organization or IRO that is completely separate from your insurance company.** The insurance company must follow the IRO's final decision.

What kinds of appeals qualify for an external review?

You can request an external review for appeals that are about:

- Medical decisions, including:
 - Medical necessity
 - Experimental or investigational treatments
 - Disagreements about diagnosis, level of care, setting of care, or treatment
- Cancellation of coverage based on your insurer's claim that you gave false or misleading information when you applied for coverage. Also called rescissions of coverage.

External reviews are not available for legal and contractual decisions that are not related to a medical decision, such as if a service was denied because you didn't get prior authorization.

How do I request an external review?

You can request an external review by calling or writing a letter to the Maine Bureau of Insurance or BOI, which coordinates the external review process.

Consumer Health Care Division, Maine Bureau of Insurance
34 State House Station, Augusta, Maine 04333
1-800-300-5000 or 207-624-8475
<http://www.maine.gov/pfr/insurance/complaint.html>

You must request an external review within 12 months from the date of last decision. After you contact the BOI, it will select an IRO to review your case. You'll be able to send any supporting documents you have to the IRO. Make copies of anything you send. Keep a to-do list as you prepare for the hearing.

What can I expect during the external review hearing?

You have the right to have a hearing over the phone to explain your case to the medical reviewer from the IRO who will make the final decision for your appeal. Hearings for external reviews are always held over the phone. If you want a hearing, then you should ask for one when you request the external review.



Read about what to expect during the hearing and tips for how to prepare in Section 5: [Make Your Best Case](#).

How long does the external review take?

You have up to 12 months from the date of last appeal decision to request an external review. Once the IRO receives your request from the BOI, it must make a decision within:

- 72 hours for expedited appeals
- 30 days for non-expedited appeal

What if you lose your final level of appeal?

If you still feel that the insurance company was wrong to deny your services, you may want to talk to an attorney. An attorney can help you decide whether to take your case to court to force the insurance company to cover your service. Some legal service may be offered at low or no cost to you.

Section 7: Appeals for Self-Insured Plans

In this section, the insurance company is called a plan administrator.

Below is an overview of the appeal process for most self-insured group health plans. Most self-insured plans are regulated by the U.S. Department of Labor.

Complaints about the plan administrator or their decision can be made to the U.S. Department of Labor at 1-617-565-9600. Call our HelpLine for help at 1-800-965-7476.

<p>Step 1 Provider Reconsideration Not offered by all plans and only available for issues of medical decisions.</p>	<p>If offered, your doctor can request this from the plan administrator at any time during the appeals process to try to resolve the issue outside of an appeal.</p> <p>Your plan administrator makes a decision within 1 working day.</p> <p>If available, this step is optional. You can skip to first level appeal.</p>
<p>Step 2 First Level Appeal</p>	<p>Request from your plan administrator within 180 days of the last decision.</p> <p>From the time you file your appeal request, a decision is made by your plan administrator within:</p> <ul style="list-style-type: none"> 72 hours for expedited appeals 15 days for pre-service appeals (service hasn't happened yet) Post-service appeals (service already happened) <ul style="list-style-type: none"> • for plans that offer a second level appeal: 15 days • for plans that don't offer a second level appeal: 30-60 days
<p>Step 3 Second Level Appeal Not offered by all plans.</p>	<p>If offered, request from your plan administrator within the timeframe given in the first level written decision. You may have the option to attend a hearing in person or by phone.</p> <p>The plan administrator makes a decision within:</p> <ul style="list-style-type: none"> 72 hours for expedited appeals 15 days for pre-service appeals 30 days for post-service appeals
<p>End of appeals process for decisions for non-medical decisions.</p>	
<p>Step 4 External Review Only available for issues of medical decisions and rescissions in coverage.</p>	<p>Follow the instructions given in the last denial decision to request an external review. You will have at least four months from the date you received the last decision to ask for an external review.</p> <p>The IRO makes a decision within:</p> <ul style="list-style-type: none"> 72 hours for expedited appeals 45 days for non-expedited appeals



You may have the right to another review by your employer. Information about this is in your health plan agreement or in the appeal rights section of your denial letter.

Step 1: The Provider Reconsideration

If the denial you want to appeal is based on a medical decision, we recommend that you ask your doctor to request reconsideration, also called a “peer-to-peer review.” This may not be available in self-insured plans, but it is worth a try if it is.

The peer-to-peer review is a phone call between your doctor and the person who made the decision to deny your service, called the “reviewer.”

This gives your doctor a chance to talk informally with the reviewer and explain exactly why you need to have this service. The reviewer will reconsider the service and make a new decision within 1 working day of the call.

Your doctor can request a reconsideration at any point before or during the appeals process. **This is not a required step, so you don’t need to do it in order to appeal.** But, it could help you get your service approved more quickly than through an appeal. Not all plans offer provider reconsiderations, but many do. It’s worth having your doctor call and ask for one.

If the decision you want to appeal is not a medical decision, you should skip to [Step 2: The First Level Appeal](#).

Key things to know about reconsiderations, if they are available

- Your doctor can request reconsideration any time before or during the appeals process.
- This is not a required step. You don’t need a reconsideration to file an appeal. It does not use up one of your appeal levels.
- A request for reconsideration must be made by the doctor who will perform the service.
- Usually, the doctor or nurse who originally denied your request must do your review. But sometimes another doctor or nurse with a similar medical background may do the review.
- There’s no downside! The process is very fast, easy, and takes just 1 day. It can help get a service approved more quickly than an appeal.



Step 2: The First Level Appeal

This is your first formal appeal with your plan administrator. It's your first chance to make your case to the insurance company about why they should cover your service. Unlike the provider reconsideration, the first level appeal can't be decided by the same person who made the original denial or anyone else who was involved in making that decision, unless there is new information. However, because it is an internal appeal, it will still be decided by someone who works for your plan administrator.

All self-insured plans must:

- Give you at least 180 days to appeal from the date of your last decision.
- Give you documents and information about your denied service you request.
- Give you a chance to explain your side and include any documents that support your argument.
- Tell you if they find any new information or think of a new reason that's different from what was used in the first decision to not cover your care. They must give you a chance to respond to the new information before making a decision.
- Have someone review and decide your appeal who was not involved in the first denial decision you are appealing, unless there is new information.

You can find information about the appeals process for your plan administrator in the letter that was sent with your EOB or denial letter, or in your health plan agreement or summary benefit description.

How do I request a first level appeal?

You usually have 180 days to request an appeal from the date you received the denial. Some plans may give you more time. You can usually ask for a first level appeal by calling your plan administrator or by sending them a letter. If you can, we recommend asking for your appeal in writing. That way, you can make sure all the information you have is included. For tips on what to include in your appeal, go to Section 5: [Make Your Best Case](#). Whatever the case, be sure to follow the instructions sent to you in the denial letter or EOB.

Don't forget to ask your doctor for help!

See Section 5 to see how your doctor can support your case.



What can I expect after I request a first level appeal?

After you request an appeal, your plan administrator should send you a letter to let you know they got your appeal. The letter should be signed by someone like an “appeals coordinator.” This is the person you should contact if you have questions about your appeal. The coordinator may ask you or your doctor for more information. If so, you or your doctor should send the information as soon as you can.

After they review the information, they will send you a written decision that will tell you:

- 1) What the decision is
- 2) How the decision was made
- 3) What rights you still have to appeal again

How long does the first level appeal take?

Once the plan administrator receives your appeal, it must make a decision for:

- Expedited appeals within **72 hours**
- Pre-service appeals (service hasn’t happened yet) within **15 days**
- Post-service appeals (service already happened)
 - for plans that offer a second level appeal within **15 days**
 - for plans that **don’t** offer a second level appeal within **30-60 days**

If coverage is approved: Congratulations, your appeal was successful! If the approval is for a service that you already paid for, then you will get back money you paid that should have been covered by your plan administrator. **Usually your plan administrator will pay your doctor and then your doctor will pay you back any money owed to you. Even if a service is covered, you may still have to pay some amount out-of-pocket, like a copay or coinsurance, depending on your plan.**

If coverage is denied: Don’t give up! The written decision will include your remaining appeal rights as well as the reasons why your plan still denied the service. You can use this information to make your case even stronger for your next appeal.

Are there other levels?	Is this available for all plans?	What appeals qualify?
<p>Second Level Appeal: You may be able to request a second appeal directly to your plan administrator.</p>	<p>No. Check the first level written decision or your health plan agreement to find out if your plan offers second level appeals.</p>	<p>Each kind of appeal, as long as a second level appeal is offered at all.</p>
<p>External Review: An appeal to an independent review organization or IRO, decided by someone outside of your plan administrator</p>	<p>Yes.</p>	<p>Only appeals for: Medical decisions Rescissions of coverage</p>



Step 3: The Second Level Appeal (not available for all plans)

If offered, the second level appeal is a lot like the first level appeal. This appeal is also decided within the plan administrator, just like the first level was. You have all the same rights, **plus you may be able to also attend a hearing either in person or over the phone.**

How do I file a second level appeal?

You can find information about your appeal process in the written decision for your first appeal. It will tell you how to appeal and when the deadline is for your next appeal. For tips on writing your appeal letter, go to Section 5: [Make Your Best Case](#).

How long does the second level appeal take?

Once the plan administrator receives your appeal, it must make a decision for:

- Expedited appeals within **72 hours**
- Pre-service appeals (service hasn't happened yet) within **15 days**
- Post-service appeals (for service already happened) within **30 days**

The Second Appeal Hearing

If offered, you can ask for a hearing in your second level appeal letter. This gives you the chance to explain your case in person or over the phone to the people at your insurance company that will review and decide your appeal. This group is called a "review panel." Your review panel may include:

- Someone with relevant medical knowledge, if it's for a medical decision
- Someone who knows about your plan, how it works, and what it covers

Make sure to write in your letter if you want to attend the hearing in person or by phone.

Read about what to expect during the hearing and tips for how to prepare in Section 5: [Make Your Best Case](#).

Ask your doctor to help! If you have a hearing, ask your doctor to be on the hearing call. Tell your doctor they can speak first during the hearing, in case they can't stay for the entire call. Usually hearings are 20-60 minutes long.

If your doctor can't join the hearing, ask if they'll write a letter of support that you can include with your appeal request.

Step 4: The External Review

After you've completed at least one appeal level, or two levels for some plans, you may be able to get an independent external review.

This is different from the other appeal levels because this time your appeal won't be reviewed by people that work for your plan administrator. Instead, **the external review is decided by an independent review organization or IRO that is completely separate from your plan administrator.** The insurance company must follow the IRO's final decision.

What kinds of appeals qualify for an external review?

You can request an external review for appeals that are about:

- Medical decisions, including:
 - Medical necessity
 - Experimental or investigational treatments
 - Disagreements about diagnosis, level of care, setting of care, or treatment
- Cancellation of coverage based on your insurer's claim that you gave false or misleading information when you applied for coverage. Also called rescissions of coverage.

External reviews are not available for legal and contractual decisions that have nothing to do with medical judgment. For example, you can't get an external appeal if a service was denied because you didn't get prior authorization.

How do I request an external review?

Follow the instructions given in your health plan agreement or in the appeal rights section of your denial letter to request an external review. You will have at least four months from the date you received the last decision to ask for an external review. Remember, if you send your request by mail it is a good idea to send it registered or certified if you can.

Once the IRO receives your request, it will tell you within 6 business days if you qualify for an external review. If your request was considered incomplete, you will have until the deadline to appeal or 48 hours to send in the necessary information, whichever is later.

If your request is approved for an external review, you will have 10 days to submit additional information. Again, never send original documents and make copies of everything you send.

How long does the external review take?

The amount of time the IRO has to make a decision begins when it gets your request. It will make a decision for expedited appeals within **72 hours**. For all other appeals, it will make a decision within **45 days**. If you request a hearing for an expedited external review, it could take a few days longer than the 72-hour timeframe to get the final decision, depending on how quickly the hearing is scheduled.

What can I expect during the external review hearing?

You have the right to have a hearing and explain your case to the medical reviewer from the IRO who will make the final decision for your appeal. Hearings for external reviews are always held over the phone. If you want a hearing, then you should ask for one when you request the external review.

Read about what to expect during the hearing and tips for how to prepare in Section 5: [Make Your Best Case](#).

What if you lose your final level of appeal?

You may have the right to an additional review by your employer. You can find information about this in your health plan agreement or in the appeal rights section of your denial letter.

You should also file a complaint with the Employee Benefits Security Administration of the U.S. Department of Labor. You can file a complaint online, by calling, or by mailing a letter.

Employee Benefits Security Administration
Boston Regional Office,
JFK Federal Building
15 New Sudbury Street, Room 575
Boston, MA 02203

617-565-9600

<https://www.askebsa.dol.gov/WebIntake/Home.aspx/Tel>

If you have finished all of the appeal levels and you still feel that the plan administrator was wrong to deny your services, you may want to talk to an attorney. An attorney can help you decide whether to take your case to court to force the plan to cover your service. Some legal service may be offered at low or no cost to you.



Appendix A: Appeal Case Organizer

Case Reference Information

Appeal Case ID #:	
Service/ prescription:	
Claim #(s):	
Denial reason:	

Case Timeline

Event/Document	Date	Other Event/Documents	Date
Initial denial/EOB			
Documents requested from insurer			
Documents received from insurer			
BOI complaint sent			
Received response from BOI			
1 st level appeal sent			
1 st level appeal decision			
2 nd level appeal sent			
2 nd level appeal decision			
External review requested			
External review decision			

Where to Get Help

Consumers for Affordable Health Care	Maine Bureau of Insurance	Employee Benefits Security Administration
PO Box 2490 Augusta, ME 04330	34 State House Station Augusta, ME 04333	Boston Regional Office, JFK Federal Building 15 New Sudbury Street, Room 575 Boston, MA 02203
Phone: 1-800-965-7476	Phone: (207) 624-8475 or 1-800-300-5000	617-565-9600
Fax: 1-888-214-5233	Fax: (207) 624-8599	
www.maine cahc.org	http://www.maine.gov/pfr/insurance	https://www.askebsa.dol.gov/WebIntake/Home.aspx/Tel



	Other:	Other:
Contact Name		
Mailing Address:		
Phone:		
Fax:		

Contact Information

	Insurance Company:	Provider:
Contact Name		
Mailing Address:		
Phone:		
Fax:		

General Notes



Call Record

Name:	Notes:
Organization:	
Phone #:	
Date: Time:	
Call Reference #:	
Name:	Notes:
Organization:	
Phone #:	
Date: Time:	
Call Reference #:	
Name:	Notes:
Organization:	
Phone #:	
Date: Time:	
Call Reference #:	
Name:	Notes:
Organization:	
Phone #:	
Date: Time:	
Call Reference #:	
Name:	Notes:
Organization:	
Phone #:	
Date: Time:	
Call Reference #:	

Call Record, Cont.

Name:	Notes:
Organization:	
Phone #:	
Date: Time:	
Call Reference #:	
Name:	Notes:
Organization:	
Phone #:	
Date: Time:	
Call Reference #:	
Name:	Notes:
Organization:	
Phone #:	
Date: Time:	
Call Reference #:	
Name:	Notes:
Organization:	
Phone #:	
Date: Time:	
Call Reference #:	
Name:	Notes:
Organization:	
Phone #:	
Date: Time:	
Call Reference #:	

Appendix B: Template “Debt Validation” Letter

Today's Date: _____

Collector's Name: _____

Collector's Address: _____

RE: _____ (your name), account number _____

Dear Collector,

I am writing in response to your letter or phone call dated _____. I do not believe that I owe this debt or what you say I owe.

Pursuant to the Fair Debt Collection Practices Act, Section 809(b), Validating Debts:

“If the consumer notifies the debt collector in writing within the thirty-day period described in subsection (a) that the debt, or any portion thereof, is disputed, or that the consumer requests the name and address of the original creditor, **the debt collector shall cease collection of the debt**, or any disputed portion thereof, until the debt collector obtains verification of the debt or any copy of a judgment, or the name and address of the original creditor, and a copy of such verification or judgment, or name and address of the original creditor, is mailed to the consumer by the debt collector.” (emphasis added)

I respectfully request that you provide me with the following:

1. The amount of the debt;
2. The name of the creditor to whom the debt is owed;
3. Verification or copy of any judgment (if applicable);
4. Proof that you are licensed to collect debts in Maine;
5. Proof of the last payment made on the account.

I am asserting my rights under the federal and state Fair Debt Collection Practices Acts and the Fair Credit Reporting Act, including these rights:

Because I have disputed this debt in writing within 30 days of receipt of your initial notice, you must obtain verification of the debt or a copy of the judgment against me and mail these items to me at your expense.

You cannot add interest or fees except those allowed by the original contract or state law.

Any attempt to collect this debt without validating it violates the FDCPA.

Also be advised that I am keeping accurate records of all correspondence from you and your company, including recording all phone calls, and I will not hesitate to report violations of the law to my State Attorney General, the Federal Trade Commission and the Better Business Bureau.

I have disputed this debt. Therefore, until it is validated, your information concerning this debt is assumed to be inaccurate. Accordingly, if you have already reported this debt to any credit-reporting agency (CRA) or Credit Bureau (CB), then you must immediately inform them of my dispute with this debt. Reporting information that you know to be inaccurate or failing to report information correctly violates the Fair Credit Reporting Act § 1681s-2. Should you pursue a judgment without validating this debt, I will inform the judge and request that the case be dismissed based on your failure to comply with the FDCPA.

Finally, if you do not own this debt, I demand that you immediately send a copy of this dispute letter to the original creditor so they are also aware that I dispute the debt.

Sincerely, _____

Address: _____

Appendix C: Template "Stop Call" Collections Letter

Today's Date: _____

Collector's Name: _____

Collector's Address: _____

RE: Account of _____ (your name)

Dear Collector:

I am writing to request that you stop calling me.

The federal law requires you to cease all communication with me after being notified in writing that I no longer wish to communicate with you (Fair Debt Collection Practices Act [FDCPA] Section 805(c): CEASING COMMUNICATION).

I demand that you stop calling me at home, at work, on my cell phone and at any other location.

Now that you have received this "stop calling" letter, this law allows you to contact me only to inform me that you:

- are terminating further collection efforts;
- are invoking specified remedies which are ordinarily invoked by you or your company;
- or intend to invoke a specified remedy.

Any other future contact by you or your company violates the FDCPA.

Since you already have my location information, calls made by you or your company to any 3rd party concerning me violates section 805(b)2 of the FDCPA.

Be advised that I am keeping accurate records of all correspondence from you and your company, including tape recording all phone calls. If you continue calling me, I will pursue all available legal actions to stop you from harassing me and my family.

Sincerely, _____

Address: _____



Appendix D: Sample Denial Letter



Fine Print Insurance Company
135 Rainy Day Way
Somewhere, Maine 04123



Mrs. Responsible Customer
 246 Pete's Dragon Way
 Passamaquoddy, Maine 04000

Member: Mrs. Joan Responsible
Member DOB: 02/31/1983

Reference Number: 123X4567Z

Dear Mrs. Responsible,

Thank you for your medical service authorization request. We have reviewed the medical information your provider sent to us, the health plan guidelines, and the review by our physician reviewer, and have determined that the service requested cannot be approved because it is not medically necessary.

Service Dates	Service Description	Service Code	Number/QTY
1/31/16-2/01/16	Spinal Surgery	CPT-63047	1

Coverage for this service has been denied for the following reasons(s):

Based on the Covered Services section and definition of "Medically Necessary" in your health benefit plan, the information your provider gave to us does not show that this service is medically necessary. We used the health plan guidelines and Clinical Policy Criteria CPC: Spinal Surgery- CPC 0011223 to make this decision.

If you and your provider decide that you should receive this service, you will be responsible for the charges for this service.

If you disagree with this decision, see the attached information to find out about your appeal rights. Please contact us with any questions at 1-800-123-4567.

Sincerely,

James Smith

James Smith, Fine Print Insurance Company Utilization Management

Appendix E: Template Document Request Letter

_____ [Date]

Appeals Coordinator,
[Insert appeals address for the insurance company here]

Re: Request for Information and Documentation for a Full and Fair Review

Member: _____ [Patient name]
Date of Birth: _____ [Patient date of birth]
Member ID: _____ [ID number from your card]
Reference Number: _____ [Reference number on the denial letter, if any]
Referred to Provider: _____ [Provider who will do the procedure]
Date of Service: _____ [Date the service will be provided]
Diagnosis: _____ [Specify the diagnosis here]

Dear Appeals Analyst:

I am writing to you with respect to the decision by [Insurance company name here] to deny coverage of [name of procedure or treatment denied] to be performed by [Doctor to perform the procedure or treatment]. In order to receive a full and fair review, I request that you provide me with:

- (1) The Certificate of Coverage for my health plan;
- (2) Any documentation used or created in making the denial decision, including, but not limited to the medical necessity criteria or policy for this procedure;
- (3) Any documentation related to the doctor request for reconsideration conducted between [Doctor] and [insurance company's name] reviewer; and
- (4) A complete copy of your administrative file on [Patient name], including but not limited to: all call records,
 - medical records,
 - related claims,
 - denials,
 - EOB's
 - and any other communications.

If you have any questions about this matter, please do not hesitate to contact me at [phone number].

Sincerely,

[sign your name]

[print your name]

Appendix F: First Level Appeal Template Letter

_____ [Date]

Appeals Coordinator

[Insert appeals address for the insurance company here]

Re: Request for First Level Appeal and Telephonic Hearing

Member: _____ [Member name]
Date of Birth: _____ [Member date of birth]
Member ID: _____ [ID number from your card]
Reference Number: _____ [Reference number on the denial letter, if any]
Referred to Provider: _____ [Provider who will do the procedure]
Date of Service: _____ [Date the service will be provided]
Diagnosis: _____ [Specify the diagnosis here]

Dear Appeals Analyst:

Please accept this letter as my appeal of _____ [Insurance Company's] decision to deny coverage for _____ [denied service]. Based on your _____ [Date of letter] denial letter, it's my understanding that this procedure has been denied because _____ [Quote the specific reason or reasons for the denial stated in the denial letter]. _____ [Patient] has had _____ [Diagnosis] since _____ [Date].

_____ [Discuss the detailed medical history. Use a timeline leading up to the need for this procedure].

_____ [Add details about how the symptoms affect daily activities and why this procedure is needed].

_____ [Doctor] believes that _____ [Patient] will benefit significantly from _____ [Procedure Name]. Please see the enclosed letter from _____ [Doctor] that discusses why this procedure is medically necessary.

_____ [Patient] believes that you did not have all the necessary information at the time of your initial review. _____ [Patient] has also included a letter from _____ [Doctor's Name] from _____ [Place of care], a specialist in _____ [Specialty]. _____ [Doctor's] letter discusses the procedure in more detail and explains why it is medically necessary. Also included are medical records and other supporting documentation, including journal articles, explaining the procedure and the results.

Based on this information, _____ [Patient] asks you to reconsider your previous decision and allow coverage for the procedure outlined in _____ [Doctor's] letter.

The treatment is scheduled to begin _____ [Date]. If you need more information, please contact _____ [Patient] at _____ [Phone Number]. _____ [Patient] will look forward to hearing from you in the near future.

Sincerely,

_____ [sign your name]

[print your name]

Appendix G: Sample Appeal Letter

April 1, 2016

Appeals Coordinator
Grievances and Appeals Major Health Insurance
P.O. Box 8600
Somewhere, KT 0555-8600 Phone: 555-555-5555 Fax: 555-555-5555

Re: Request for Expedited First Level Appeal with Hearing by Phone

Member Name: Jane R. Doe
Member Date of Birth: July 4, 1975
Member ID: XHZ 1234M56789
Reference Number: 1234567891
Referred to Provider: Dr. Margaret C. Smith, MD
Date of Procedure or Service: TBD
Diagnosis: Idiopathic Intracranial Hypertension, Pseudotumor Cerebri

Dear Appeals Coordinator:

Please accept this letter as my appeal of Major Health Insurance (“Major’s”) decision to deny coverage for venous angioplasty with stent placement (SURG.00122 or CPT 37238). It is my understanding based on Major’s denial letter dated March 1st, 2016, that this procedure has been denied because the procedure is not medically necessary. I am requesting **an expedited first level review of this decision with a hearing by phone**. I also request that the review be performed by a board certified endovascular neurosurgeon. My surgeon, Dr. Margaret C. Smith, believes that this procedure is medically necessary and has also provided a letter (attached) explaining why. In addition, my primary care physician and my ophthalmologist, who agree with Dr. Smith, have provided supporting letters (also attached).

A. Background

On February, 2016, I was diagnosed with Idiopathic Intracranial Hypertension (“IIH”) also called Pseudotumor Cerebri. On July 4, 2016, I went to see my primary care physician, Dr. Arthur C. Doyle, because I continued having these terrible headaches, blurred vision and also weakness in my left arm. He sent me to an Ophthalmologist (Dr. Shel Silverstein) who diagnosed me with papilledema and immediately sent me to see a Neurologist (Dr. Jane Austin). Dr. Austin examined me, diagnosed me with IIH, and recommended that I see Dr. Smith for possible surgery. Dr. Smith examined me on May 18, 2016. She recommended that I have an intracranial stent placed to relieve the pressure.

Since February 2016, I have experienced continuous and debilitating headaches that have severely disrupted my life, including my ability to exercise, to maintain healthy relationships with my friends and family, and my ability to perform as well at work. I am on the maximum dose of Diamox, which is damaging my liver and is causing more neurological symptoms, such as limb tingling. Additionally, I have had multiple (eight) lumbar punctures to relieve the intracranial pressure. Of these eight lumbar punctures, only five have been even somewhat helpful -

meaning I was temporarily relieved of my head pain for approximately twelve to forty-eight hours after which time the debilitating headaches returned as ferocious as before.

The baseline pain level of my headaches is between 4 and 5 on a pain scale of 1 to 10. This means that every hour of every day I have at least a level of pain equal to 4-5 on that scale. On particularly bad days, however, that pain level skyrockets to 8 or 9 at which point I also lose my vision or have double vision. Because of the continuous pain, I do not sleep well unless I am able to sleep at a precise angle, but I cannot afford the adjustable bed to allow me to sleep at that angle, so I am out of luck and have to endure the pain throughout the night, every night.

I cannot do many activities outside of the house because any loud noises or bright lights make my headaches worse. I love to swim for exercise, but for days at a time I cannot swim because of the lumbar punctures. Even the simple act of bending over makes my headaches worse, so my husband and children must assist me with everything that involves bending.

Because of this unrelenting pain, I have developed anxiety and depression, which further affects my quality of life and exacerbates my symptoms. The more anxious I become, the greater the pressure in my blood vessels and the worse the headaches become. I now have to seek counseling to deal with the anxiety and depression that resulted from the IIH, which could have been avoided had I been treated with this surgical procedure.

B. Medically Necessary Health Care

In the August 20, 2016 denial letter, Major defined medically necessary health care as follows:

Medically Necessary Health Care Health care services or products provided to a member for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of “best practices” in the medical profession; and
- Not primarily for the convenience of the member or physician or other health care practitioner.

In my case, the surgery is medically necessary. It is consistent with generally accepted standards of medical practice; is clinically appropriate; is demonstrated through scientific evidence to be effective in improving outcomes in patients with IIH; having the procedure is representative of “best practices” in the medical profession because it has been proven effective in multiple case series and meta-analyses for people with IIH; and because I have tried every other treatment possible to relieve the pain and pressure and my medication regimen is already at its maximum, there are no other viable options for me than more invasive brain surgery or this venous stenting procedure. Obviously, the less invasive procedure is the optimal route to take for me to take. Please see the supporting letter from Dr. Smith explaining further why this procedure is medically necessary for me.



The following is a list of the literature that supports the use of this procedure in my case:

- R.M. Ahmed, et al., Transverse Sinus Stenting for Idiopathic Intracranial Hypertension: A Review of 52 Patients and of Model Predictions, 32 AM. J. OF NEURORADIOL. 1408-14 (2011).
- David A. Kumpe, et al., Dural Sinus Stent Placement for Idiopathic Intracranial Hypertension, 116 J. NEUROSURG. 538–548 (2012).
- Jeremy D Fields, et al., Dural Venous Sinus Angioplasty and Stenting for the Treatment of Idiopathic Intracranial Hypertension, 5 J. NEUROINTERVENT. SURG. 62-68 (2013).
- R.M. Ahmed, et al., Transverse Sinus Stenting for Pseudotumor Cerebri: A Cost Comparison with CSF Shunting, 35 AM. J. OF NEURORADIOL. 952-58 (2014).
- Michael R Levitt, et al., Venous Sinus Stenting for Idiopathic Intracranial Hypertension is not Associated with Cortical Venous Occlusion, 0 J. NEUROINTERVENT. SURG. 1-3 (2015).
- S.R. Satti, L. Leishangthem, and M.I. Chaudry, Meta-Analysis of CSF Diversion Procedures and Dural Venous Sinus Stenting in the Setting of Medically Refractory Idiopathic Intracranial Hypertension, 10.3174 AM. J. OF NEURORADIOL., 1-6 (2015).

C. Conclusion

In conclusion, for the abovementioned reasons, Major should find, in an expedited manner, that this procedure is medically necessary and cover it.

Sincerely,

Jane R. Doe

Jane R. Doe

CC: Consumer Health Care Division, Maine Bureau of Insurance

Appendix H: Glossary

Many definitions were adapted from the <https://www.healthcare.gov/glossary/>

Allowed amount: The amount your insurance company agreed to pay your doctor.

Appeal: When you ask your insurance company to review and change a decision.

Appeal, External Review: A meeting by phone or conference call between:

1. A person who has been denied a service or payment by an insurance company (you, your authorized representative, and your doctor, if available),
2. Staff from the insurance company, and
3. An independent medical expert who is not from your insurance company, who will be familiar with the (your) specific problem or condition. The medical expert at the external review may overturn all or part of the insurance company's decision or may uphold that decision.

Authorized Representative: A person you choose to act on your behalf, like a family member, other trusted person, or someone from your state's consumer assistance program. This person may speak for you in an appeal. Some authorized representatives may have legal authority to act on your behalf.

<https://www.healthcare.gov/glossary/authorized-representative/>

Billing Code: A code with letters, numbers or both, used to describe a treatment or procedure.

Certificate of Coverage: This booklet is the contract between you and the insurance company. It has detailed information about the benefits covered by the plan. It is important to fully understand this information when evaluating whether the policy covers the health care services you need. This may also be called the Summary Plan Document.

Claim: When you or your doctor request payment of benefits from your insurance company after you've had treatment or services, called reimbursement, or before you get treatment, called prior authorization.

Clinical Criteria: Rules or standards a health insurance company decides on and publishes. The company uses these guidelines or rules when making decisions about what to cover. These are sometimes called Clinical Policy Bulletins or Medical Policies.

Collections: When someone you owe money to sends your debt to a debt collector. Usually this happens if you are behind on payments. The debt collection company may buy your debt or just be hired to try to get the money back for the place you owe it to (like your doctor or hospital). People have rights that can protect them in some ways from debt collectors.

Coinsurance: Your share of the allowed amount of the cost of a service. It is usually a percent. You pay a part of the cost, such as 30%, and the insurance company pays the other part, such as 70%.

Copay: A flat fee or fixed amount you pay for a kind of service, like \$25 for an office visit. Usually you pay this at the time when you get the service.

Deductible: The amount you owe each year for covered health care services before your health insurance plan begins to pay. Some services, such as some preventive services, are covered even if the deductible isn't met yet.

Denial: The insurance company has decided not to pay for the service or medication your doctor wanted you to have.

Department of Labor: The US Department that regulates employee benefits, including employer sponsored insurance plans, such as self-insured or self-funded plans.

EOB or Explanation of Benefits: A paper or document you get from your insurance company usually *after* you receive health care and a claim is submitted to them for payment. It tells what claims they paid or did not pay, and why.

Expedited appeal: A faster appeal you can request when the need for a service is very urgent. You can ask for an expedited appeal if waiting for a standard appeal would put your health, life, or ability to fully recover at serious risk.

Experimental or investigational: A medical service that your insurance company thinks has not been proven through scientific research to be safe or useful.

External Review: Review that is typically held after you have finished your internal appeals, which serves as an additional step in the appeals process. The external review is conducted by an independent review organization that is separate from your insurance company.

File an appeal: When a request is sent to appeal a decision made by your insurance company.

Fully-insured or fully-funded: A kind of health insurance plan that pays for claims using money the insurance company gets from its customers' monthly premiums.

Health Plan Agreement: This booklet is the contract between you and the insurance company. It has detailed information about the benefits covered by the plan. It is important to fully understand this information when evaluating whether the policy covers the health care services you need. This may also be called the health plan agreement, Summary Plan Document or Certificate of Coverage.

Hearing: A meeting, in person or by phone, where people or groups that disagree on something work toward an agreement (like you and your insurance company).

Independent Review Organization or IRO: An organization contracted with by the Maine Bureau of Insurance that is separate from the insurance company and makes decisions for external reviews involving fully-insured or fully-funded plans. Some fully-insured or fully-funded plans must also contract with IROs to provide independent reviews.

Investigational or experimental: Words used by the insurance company to describe a medical service that it thinks is not proven through scientific research to be safe or useful.

Maine Bureau of Insurance: State of Maine insurance department, that regulates almost all insurance policies sold in Maine. You can call them at 1-800-300-5000.

Marketplace: The place where people without health insurance can find information about health insurance options and buy health insurance, either through a website, on the phone, or by mail. Some people can get financial help paying for it. Also called the Exchange.

Medical decision: A decision by an insurance company, using its medical guidelines, to cover or deny a service or procedure.

Medical Guidelines: Rules or standards a health insurance company decides on and publishes. The company uses these guidelines or rules when making decisions about what to cover. These are sometimes called Clinical Policy Bulletins or Medical Policies.

Medically necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

In Maine they must be:

- A. Consistent with generally accepted standards of medical practice;
- B. Clinically appropriate in terms of type, frequency, extent, site and duration;
- C. Demonstrated through scientific evidence to be effective in improving health outcomes;
- D. Representative of "best practices" in the medical profession; and
- E. Not primarily for the convenience of the enrollee or physician or other health care practitioner.

Member Benefit Agreement: This booklet is the contract between you and the insurance company. It has detailed information about the benefits covered by the plan. It is important to fully understand this information when evaluating whether

the policy covers the health care services you need. This may also be called the health plan agreement, Summary Plan Description or Certificate of Coverage.

Network: A group of doctors or health care providers that is covered by your plan.

Non-medical decision: A decision by an insurance company that is based on business or legal rules and agreements, like whether a doctor is in or out-of-network.

Out of Pocket Limit: Also called out of pocket max or maximum. It is the most you'll have to pay for covered services in a policy period, usually one year. After you reach this amount, your health plan pays 100% for covered benefits. It includes the yearly deductible and may also include any cost sharing (copayments and coinsurance) you have after the deductible. It doesn't have to count premiums, balance billing amounts for non-network doctors and other out-of-network cost-sharing, or spending for non-essential health benefits. Pharmacy benefits may have a separate out of pocket maximum.

Peer-to-peer review: Also called a request for reconsideration. When your doctor asks to have a conversation with someone from your insurance company to explain why a service that was denied should be covered.

Plan administrator: The insurance company or business entity that administers a self-insured group health plan that you receive through your employer. It may be a third party administrator like Anthem, Aetna, Cigna, UnitedHealth, or Harvard Pilgrim.

Post-service denial: When an insurance company refuses to pay for a service after the medical service is given.

Pre-service appeal: An appeal that happens, or is asked for, before the medical service is given.

Prior approval: Also called prior authorization. It is the permission given by the health insurance company before a medical service that says the company will pay for that service.

Prior authorization: Also called prior approval. Permission given by the health insurance company before a medical service that says the company will pay for that service.

Private plan: An insurance plan sold by a private company, such as Anthem, Aetna, Cigna, Harvard Pilgrim or United. These are unlike public, government plans like Medicaid, Medicare and Tricare.

Provider: Any person, group or place recognized by an insurance company or a health care consumer as giving or providing health care services like a doctor, nurse practitioner or therapist.

Public plan: A health insurance plan set up and run by a government like Medicaid, Medicare and Tricare.

Request for reconsideration: Also called a peer to peer review. When your doctor asks to have a conversation with someone from your insurance company to explain why a service that was denied should be covered.

Referral: A health care provider, like a doctor, gives an OK for a patient to see a different doctor. Sometimes a referral is required for insurance coverage.

Rescission: The ending or cancelling of a health insurance policy after the policy has already been provided to a person.

Self-insured or Self-funded: A plan in which the employer itself is responsible for paying covered health care costs for participating employees and family members. Claims may be administered by an insurance company, but there is no insurance policy involved. Under federal law called ERISA (Employee Retirement Income Security Act), self-insured plans are exempt from most state insurance laws.

Summary of Benefits & Coverage or SBC: An easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans.

Summary Plan Description or SPD: Similar to a Certificate of Coverage. The SPD includes important information about your plan such as information on how the plan works, eligibility requirements, what benefits the plan provides, and how those benefits may be obtained.

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**Consumers for
Affordable
Health Care**

*Advocating the right to quality, affordable health care for
every person in Maine since 1988.*
