

How to Write an Effective Appeal Letter

Appealing denials of insurance coverage for expensive therapies, such as immune globulin, can be time-consuming and frustrating, but patients can succeed by following the proper steps.



By Kris McFalls

Not much can make a person's heart skip a beat more than the arrival of a letter or explanation of benefits (EOB) statement from the insurance company that denies a claim, leaving the patient on the hook for tens of thousands of dollars. Because immune globulin (IG) therapy

is such an expensive treatment, the best way to avoid receiving such a shock is for the patient to request authorization before treatment begins. In fact, most private insurers require prior authorization before they will agree to pay for treatment. Even with prior authorization, however,

insurance companies reserve the right to review medical records after the fact and can still deny claims. In either case, an appeal will need to be filed, and the process and the tools to appeal either a denial of authorization or denial of a claim are identical.

Don't Give Up: Appeal

Filing an appeal can be stressful and frustrating for even the healthiest people. For those with a chronic illness, having to fight for lifesaving treatment on top of battling disease can be a daunting task. Many people would rather give up than continue fighting a system with so much red tape and so little transparency. According to Advocacy for Patients with Chronic Illness Inc., "although 94 percent of insurance denials are never appealed, approximately 70 percent of those that are appealed are granted. Clearly, then, the odds are good for a successful outcome for the patient who appeals."

A Proper Approach for Appeal

To help ensure a successful appeal, proper steps need to be followed. Be forewarned: A person should never take the seemingly easy route when filing an appeal. For example, when an insured calls to inquire about a denial, insurance companies often offer to start the appeal right away over the phone. As tempting as that can be, don't! Jennifer Jaff, attorney and former executive director of Advocacy for Patients with Chronic Illness Inc., gives this piece of advice: "Even though a denial letter will invite the insured to initiate an appeal by calling the insurance company to inform it of the intent to appeal, individuals should *never* appeal by phone, nor should they simply send a note without medical records and other documentation to back up the appeal. Instead, the appeal should be packaged so that the insurer will be left with no questions and little chance but to grant the appeal and cover the treatment needed."

Before the Appeal Is Filed

Before writing an appeal letter, it's important to gather some information.

Coding errors. An American Medical Association study revealed that one out of five medical claims contains errors. Several of those errors pertain to coding. Immune globulin therapy requires several components, such as supplies, nursing and the immune globulin itself, and each of these components requires a separate code. For instance, in the case of nursing, the first hour of care is one code and each additional hour is a separate code.

Additionally, the diagnosis and site of treatment have specialized codes. If any of the codes are wrong or do not mesh with the other codes, the entire claim or authorization request will be denied automatically. Individuals should double-check that the proper codes were used when the claim was filed. (See the listing of manufacturer sites of reference for code numbers and reimbursement questions on page 16.)

Treatment policies. It used to be that a doctor could write a script for a diagnosis, and treatment would be given, no questions asked. That is no longer the case. Insurers have specific policies for specific disease states. And, they have medical policies listing the medical criteria each patient must meet to justify treatment. If a patient is denied treatment, the medical policy detailing the medical criteria must be provided free of charge. So, prior to filing an appeal, the insurer's policy should be checked. Many insurers now have these policies available for viewing via the Internet.

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Plan types. There is a difference between a fully insured and self-funded insurance plan. This difference will help to determine how an appeal is processed, what an individual's rights are, and if a plan is governed by state laws or by the Employee Retirement Income Security Act (ERISA).

- Fully insured plans are governed by state regulations. Monthly premiums are paid by an employer to an insurance company, and the insurance company determines the benefits and pays the claims. So, an appeal will be made to the insurance company itself.

- Self-funded plans are common for large companies and are governed by ERISA. The employer hires an insurance company to administer the plan, but the employer actually pays the claims. And, the employer has the right to make exceptions and pay a claim an insurer has denied. So, in some cases, an appeal can be made directly to the employer's human resources department, which can choose to overrule the denial.

In addition, under the healthcare reform law, which went

into effect in September 2011, those covered under self-funded plans now have the right to ask an independent review organization to review the denial of coverage and consider whether to overturn the insurer's or plan's decision. However, this change does not apply to "grandfathered" plans, those that existed on the day when healthcare reform was signed into law that do not substantially modify their character (benefits package, copays, deductibles, etc.). The change applies only to plans that do make modifications, and requires them to comply with all of the provisions of the new law, including the expanded right to appeal.

Submitting the package. When making an appeal, it is important for a complete package to be submitted. A complete package includes:

- Name, date of birth, subscriber number and contact information
- Letter of medical necessity from the prescribing doctor detailing the diagnosis and need for treatment
- Lab reports and test results detailing how the patient fits the medical criteria (It is not enough to state that a patient is weak or that the patient called complaining of an infection. Weakness must be explained, and infections need to be validated. For instance, instead of stating that a patient is weak, it should be explained that the patient can no longer stand without assistance. In the case of

infections, cultures and radiology reports are hard evidence that cannot be ignored.)

- Doctor's notes detailing treatments that have been tried and failed
- Peer-reviewed articles supporting immune globulin as a treatment for the disease (See website listings on page 17.)

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The timeline. Nothing will lose an appeal faster than not sticking to the allotted timeline. On average, most insurance companies require appeals to be made within 30 days. But, in some cases, the timeline for an appeal can be as long as 360 days or as short as 14 days. Each company's timeline is different, and it can be found on the back of the EOB statement.

Keeping a journal can assist individuals to file an appeal within the allotted timeline. It can be used to track when letters are received, as well as to list the names, dates and times of people spoken to. This can be especially helpful because dates can be tricky. Many insurers date the letters of denial on the date they write the letter, which is usually at least a week before the letter is received. Therefore, the envelope with the postmark should be kept as proof of the date of receipt.

Return receipt. Last, the entire appeal package should be submitted Certified Mail Return Receipt, requiring the recipient at the insurance company to sign for the document and the post office to provide notification of receipt to the sender.

IVIG Coding and Reimbursement Websites

Several of the immune globulin manufacturers have websites that list codes to make an insurance claim for IVIG treatments, as well as answer general reimbursement questions.

Coding sites:

CSL Behring: www.cslbehring-us.com/Products/Universal-Billing-Codes

Gammagard: www.gammagard.com/healthcare-professionals/ordering-and-reimbursement/suggested-coding.html

Privigen: www.privigen.com/professional/ordering-privigen/privigen-coding.aspx

Reimbursement sites:

CSL Behring: www.cslbehring-us.com/physicians-and-healthcare-professionals/reimbursement-resource-center.htm

Grifols: http://www.grifolsusa.com/en/web/international/results?p_p_auth=Kt32SDgj&p_p_id=101&p_p_lifecycle=0&p_p_state=maximized&p_p_mode=view&p_p_col_id=column-2&p_p_col_count=1&_101_struts_action=%2Fasset_publisher%2Fview_content%2FassetEntryId=178368&_101_type=content&_101_groupId=10192&_101_urlTitle=reimbursement-poli-1&redirect=%2Fen%2Fweb%2Finternational%2Fresults%3Fq%3Dreimbursement

Octapharma: www.octapharma.com/en/about-octapharma/corporate-profile/subsidiaries/octapharma-usa-inc/octapharma-usa-inc.html

Writing the Appeal Letter

The appeal letter should be formally written, devoid of any personal ranting and raving. Personal information should be in the heading of the letter, and should include the individual's name, contact information, subscriber identification number, date of birth and the reference or claim number of the denial.

The first paragraph of the letter should clearly and succinctly state the reason for writing the letter. For instance: "I am appealing the decision of denial for treatment of (insert disease) with immune globulin. ABC insurance wrongfully denied my claim stating (denial reason). I disagree with ABC's decision of (the reason).

The next paragraph should clearly state what the facts are, and each fact should be referenced. Bullet points work well to outline main points and how they correlate with the insurance criteria. For instance, a patient with a primary immune disease may want to list immune levels and chronic recurring bacterial infections with poor response to antibiotics as bullet points. Then, under each bullet point, further detail can be provided.

Example:

- ABC policy: For a diagnosis of CVID, patient must have an IgG level of 400 or less.
- My IG levels clearly fall within the parameters for a diagnosis of common variable immune deficiency (CVID).

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— My IgG level of 395, as shown on 123 lab report, is clearly within the range in ABC's stated policy. See attached 123 lab report dated xx-xx-xxxx.

- ABC Policy: Patient must show evidence of serious recurrent bacterial infections despite adequate treatment.

— I have had pneumonia three times in the past 12 months, requiring six courses of oral antibiotics and one hospitalization for intravenous antibiotics.

— Attached is Good Sam hospital's chest X-ray report confirming pneumonia dated xx-xx-xxxx.

— Attached is Dr. Smith's office note dated xx-xx-xxxx showing poor response to antibiotics, as well as the doctor's note ordering intravenous antibiotics.

— Attached is Good Sam hospital's note regarding my hospital stay for treatment.

Websites for Peer-Reviewed IVIG Treatment Articles

Autoimmune diseases:

www.advocacyforpatients.org/resources.html

IVIG Tool Kit: www.aaaai.org/practice-resources/management-tools-and-technology/ivig-toolkit.aspx

Neurology: www.neurology.org

PIDD Journal of Allergy and Clinical Immunology (JACI):

www.aaaai.org/members/jaci.stm

The facts section of the letter should conclude by referencing current medical literature. For example: "Treating CVID with IG is clearly the standard of treatment as supported in peer-reviewed articles. As stated in Dr. Smith's article, titled 'Treatment of CVID with IG,' immunoglobulin replacement therapy is the only ..."

Once the facts have been presented, the consequences from lack of treatment should be stated. For instance, a person with chronic demyelinating polyneuropathy (CIDP) might write: "Lack of treatment with IVIG will result in decreased mobility, increased dependency and an overall increase in healthcare needs. Treatment with IVIG is the most prudent way to regain lost motor skills and improve my overall health, thus decreasing my chances of severe or permanent disability."

The closing paragraph should reiterate the need for treatment and request a positive solution without delay. A person with CIDP might write: "Treating my CIDP with IVIG is reasonable and medically necessary. ABC insurance should immediately reverse its decision of non-coverage based on medical necessity to prevent further regression."

Good Reason to Appeal

Despite the legwork required and the frustration of filing an appeal for a denial of authorization or claim, it's in the best interest of a patient to do so. By following the guidance in this article to file the appeal properly, there's a 70 percent chance of success. ■

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Editor's note: This article was updated on August 16, 2013.