Insurance Resource Center for Autism & Behavioral Health

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Cropped shot of a group of unrecognizable people holding hands

Insurance Denials and Appeals

What is an insurance denial?

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

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

A partial authorization is the same as a partial denial. In some cases, the insurer may "negotiate" with the provider to approve reduced hours from what the provider requests. This is appealable, but it may require the provider or the family to request that the insurer issue a denial in order to appeal the reduced hours. If you are appealing a partial denial, in many cases the provider can continue to service your child for the number of hours authorized from the previous treatment plan. For example, if your child has been receiving 10 hours of applied behavior analysis (ABA) therapy/week, but the insurer only approved 6 hours/week in the reauthorization request, the provider can usually continue with 10 hours/week during the appeal process. The provider needs to tell the insurer that they are appealing the denial and expect services to be covered under Continuity of Care while the appeal is proceeding.



Asian disabled boys and autistic girl learning to color/paint in school

What is medical necessity and how does it relate to a service denial?

Medical necessity is a standard used by an insurance company to determine whether treatment or services are appropriate and effective given a patient's health needs and based on scientific evidence. Every insurer or health plan will include a list of requirements that must be met in making this determination. If an insurer issues a partial or full denial, it is usually due to "lack of medical necessity." However, there are sometimes other reasons for a denial; these should be explained in the denial letter.

What are my options if I receive a denial?

You have several options to pursue when you receive a denial. It is important to first review the denial letter carefully so that you understand what is being denied and why. The denial letter should not only explain the reason for the denial but include the process to appeal and the deadlines. You will also want to review your coverage documents to determine the type of plan that you have, as that will clarify which laws and regulations apply. A good first step may be to outreach to your Human Resources (HR) department, if you are comfortable doing that. HR departments often have higher-level contact at the insurance companies who can be helpful in resolving issues without needing to formally appeal. You may, instead, decide that you want to appeal. While the appeal process may seem daunting, it is effective, and our experience is that a majority of denials are ultimately overturned on appeal. In addition, you also have the option of filing a regulatory complaint. (This process is outside the scope of this Fact Sheet, but you can obtain more information from the Insurance Resource Center).

What should I do first if I decide to file an appeal?

First, you should ask your insurance company for a copy of your "claim file" and any records relating to the denial. You can also request a transcript/log of phone calls. You should make this request in writing, rather than by phone. Your claim file includes a copy of the criteria or standards that the insurer used to evaluate the claim and all documents related to the claim. Your insurer is required to provide this free of charge.

You should also may note of any plan time limits (deadlines) to file an appeal so that your appeal will be submitted timely. Appeals typically have to be submitted within 180 days, but confirm with your plan.

When will I receive a copy of my claim file and phone call log?

Your insurer has 30 days to comply with your request.

What do I do after I receive my claim file?

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

Providers are often in the best position to respond to appeals based on medical necessity. If your provider is willing to submit the appeal on your behalf, be sure to include any necessary plan authorizations.

Should my appeal be in writing or can I appeal over the phone?

It is important that your appeal be in writing to ensure that your position is not misunderstood or misrepresented.

What information do I need to include in my appeal letter?

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

If you believe that the carrier's medical necessity guidelines do not align with generally accepted standards of care, you will need to explain why.

How long will it take before my insurer makes a decision on my appeal?

If the service has not yet been received, the insurer must issue a decision within 30 days. For denial of a treatment you have already received, the decision must be made within 60 days.

How many times can I appeal a denial?

Many insurers allow two internal appeals before you can request an external review of your denial. You may be required to exhaust the insurer's internal review process before requesting an external review.

What if my insurer offers an expedited appeal?

It is not generally recommended you accept the offer. An expedited appeal may not give you enough time to obtain copies of medical records and other pertinent information, and it often does not give your provider enough time to address the reason(s) for the denial. However, an expedited review may be appropriate when a decision is needed urgently and quickly.

What is an external review?

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

Can I appeal Speech/OT/PT annual plan limits?

Yes. Follow the instructions listed above. Your appeal will be based on Federal Mental Health Parity law, which says that your health plan cannot impose a stricter standard for mental health benefits than it does for medical/surgical benefits. Even if your plan has limits on Speech/OT/PT for other medical conditions, under Mental Health Parity laws they may not be applicable when the therapy is treating autism. Contact our Center for information on the Mental Health Parity Law.

Can I appeal a denial that isn't based on a numerical limit (e.g. exceeded visit maximum) but still limits services?

Yes. Health Plans may have a number of processes, standards, and other factors that are not expressed numerically, but still limit the duration or scope of benefits. These types of treatment limitations may also be Mental Health Parity violations if they are applied more stringently to Behavioral Health benefits than medical/surgical benefits. These types of Non-Quantitative Treatment Limitations (NQTLs) include things such as a plans Medical Necessity and Prior Authorization requirements. For example, families can challenge a denial when there has been excessive scrutiny on a diagnosis (e.g., plan is denying services because they require a certain type of testing). Other examples include denials where coverage is limited based on the level of parental participation in treatment, or a denial based on service location (e.g. services provided in the community or elsewhere). NQTL challenges are complex and you may want to reach out to our Center.

Is there a different external appeal process if I have a fully insured vs. a self-funded plan?

Yes. Depending on your plan, here is the process:

- Fully insured health plan: A request for an external review must be submitted to the Massachusetts Office of Patient Protection (OPP) website (https://www.mass.gov/orgs/office-of-patient-protection) or call 800-436-7757 for more information.
- Self-funded health plan: A request for an external review must be submitted to the U.S. Department of Labor. You can access their online complaint intake portal (https://www.askebsa.dol.gov/WebIntake/Home.aspx) or you can call 866-444-3272 to talk with a benefits advisor. You can also file the request with the local Massachusetts office: Department of Labor, Employee Benefit Security Administration JFK Federal Bldg., 25 New Sudbury Street, Room 525-A, Boston, MA 02203.
- Under either form of insurance (fully insured or self-funded0:
  - You must file your request for an external review within four months of the internal review denial.
  - Federal law requires that your health insurer provide for an external review by an independent review organization (IRO) at no cost to you.

Where can I obtain examples of a claim file request letter and an appeal letter?

Health Law Advocates (HLA) has a Guide to Appeals that is available for free. This guide includes sample letters for you and your provider to use to help with your appeal. Download the Guide to Appeals (https://www.healthlawadvocates.org/get-legal-help/resources/hla-guide-to-appeals) or call 617-338-5241.

Autism Law Summit Playbook (https://autismlawsummit.com/about/the-playbook/). This includes more information about Mental Health Parity, sample appeal letters, and other information.



Diverse group of children laying down looking up at the camera

For further information and assistance, please contact the IRC at 774-455-4056 or email airc@umassmed.edu. This fact sheet and other important information is available at our website, www.massairc.org.

Scan the QR Code to view this fact sheet online

https://bit.ly/42KhGGL

The Insurance Resource Center for Autism and Behavioral Health is a program of the UMass Chan Medical School's Eunice Kennedy Shriver Center. Partial funding for the Center is provided through grants and contracts from the Massachusetts Executive Office of Health and Human Services (EOHHS), Massachusetts Department of Developmental Services (DDS), Massachusetts Department of Mental Health (DMH), Massachusetts Department of Elementary and Special Education (DESE), Massachusetts Department of Public Health (DPH), The Nancy Lurie Marks Family Foundation, the Doug Flutie Jr. Foundation for Autism, Bailey's Team for Autism, the Blue Cross Blue Shield Foundation of Massachusetts, Boston Children's Hospital, and UMass Chan Medical School.
This fact sheet was updated 01/2025
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