Appealing Private Health Plan Denials: an Overview

Read your denial letter, to try and understand why your insurance plan denied the services.

- If the denial letter says these services are "not covered services" then your plan may be a type of health plan (called "self-funded") that does not have to provide benefits required under Massachusetts laws. You should call your employer's Human Resources Dept. to confirm this.
- If the denial letter say that the services were not "medically necessary" or that they are "not covered because they are not medically necessary" you have a strong basis to appeal the denial.

Take action as quickly as possible, be sure not to miss the appeal deadline. For private insurance, the deadline is 180 days after you receive any notice from the health insurer that says the plan will not pay for the requested service. This includes receiving the "Explanation of Benefits" or "EOB" document that usually says, "This is not a bill." (While documenting in your appeal in writing is ideal, if you are unable to do so, you can call your insurer to make your appeal over the phone.)

Ask your medical providers who recommended the denied service to help you by giving you:

- A copy of your medical records
- A letter explaining why the requested service was medically necessary for you.

Gather these supporting documents, and write your appeal. Be sure to:

- Include a copy of the denial you are appealing
- Include copies of your medical records
- Include a copy of any letters from your medical providers that support your need for the denied service
- Refer to letters and/or medical records from your medical providers, and describe how they support your need for the denied treatment or service
    - Send only copies, and save the original documents
- Send your appeal by certified or priority mail, so you can prove when it was sent and received, and save the tracking number.

What if I lose my first appeal to my insurance company or health plan?

For private insurance, you can request an "external review" appeal by an independent medical professional for any denial based upon medical necessity. The appeal decision should tell you the deadline is four months from the day you receive the appeal decision, and it should tell you whether to submit the external review request to the health plan, or to the Massachusetts Office of Patient Protection (OPP). You should get an answer to your external review within 45 days. This decision is binding upon the health plan.

To learn more: https://www.mass.gov/request-an-external-review-of-a-health-insurance-decision

I'm looking for more information, is there a resource?

Health Law Advocates offers a more detailed guide for private insurance appeals, available online at: https://www.healthlawadvocates.org/get-legal-help/resources/hla-guide-to-appeals

Appealing MassHealth Denials: an Overview

Read your denial letter, to try and understand why MassHealth or their managed care plan denied the services.

- If the denial letter say that the services were not “medically necessary” or that they are “not covered because they are not medically necessary” you may have a strong basis to appeal the denial, if your medical providers feel that the service is necessary.
- If the denial letter simply states that the denied treatment or service is “not covered” or “out of network,” then you can still appeal this denial, but it will likely be harder.

Take action as quickly as possible; be sure not to miss the appeal deadline. For MassHealth, the appeal deadline should be listed in the denial letter. If not, assume it is 30 days after you receive the denial notice, or 10 days if you want to continue treatment that has already begun.

Ask your medical providers who recommended the denied service to help you by giving you:

- A copy of your medical records; and
- A letter explaining why the requested service is medically necessary for you.

Write out your appeal and make copies of these supporting documents to submit together. Be sure to:

- Include a copy of the denial you are appealing, and refer to the plan’s reason for why the service is being denied in your appeal;
- Include copies of your medical records that support your need for the denied service;
- Include a copy of any letters from your medical providers, family, or friends that support your need for the denied service;
- Send your appeal by fax or certified mail so you can prove when it was sent and received, and then save the tracking number or fax confirmation sheet.

What if I lose my first appeal to my insurance company or health plan?

For MassHealth, you can request a hearing at the Board of Hearings using the fair hearing request form at https://www.mass.gov/how-to/how-to-appeal-a-masshealth-decision. The appeal decision, as well as the fair hearing request form, should tell you the deadline is 30 days from the day you receive the appeal decision, although you must submit the form within 10 days if you would like to continue receiving treatment while the hearing decision is pending. Indicate on the form if you would like to continue receiving treatment, as well as if you need any other accommodations, such as an interpreter or the option to participate in the hearing by phone rather than in person.

Approximately 4-10 weeks after the Board of Hearings receives your request for a fair hearing, you should receive a scheduling notice in the mail that will tell you when and where your hearing will be. You have the right to be represented at this hearing and to submit new evidence even if it was not included in your first appeal. You can also ask the Hearing Officer to ‘keep the record open’ for a short period after the hearing so that you can collect and submit additional documents or information to support your case or to show why MassHealth is wrong. If you are in a managed care plan, integrated care plan, or senior care options plan, you should receive a decision by mail approximately 45 days after the hearing. Otherwise, you can expect a decision within 90 days of the hearing.