Watch Your Deadlines

You have time to make your case, but you must do so within the deadlines:

- When your plan notifies you that it won't cover a service, you have 180 days to appeal to the insurer.
- You have 4 months after you get your plan's decision about the appeal to request an external review.

Other Reasons for Appeal

- **Wellness Incentives**
  Some plans offer rewards (lower premiums or cost-sharing, cash, gifts, etc.) to people who achieve certain health goals, such as weight loss or a good blood pressure level. If you can't meet the plan's goal due to your medical condition and your plan didn't offer you a reasonable alternative goal, you may want to appeal following the procedure outlined in this brochure.

- **Appropriate Setting for Care**
  A plan that covers long-term care might make decisions about where it will pay for your care. For instance, will it cover care in the hospital, in a nursing home, or at your home? Appeal if you disagree about whether this is the best setting for you, following the procedure outlined in this brochure.
- **Pre-Existing Condition Exclusion**
  Some plans do not cover treatment that is related to a medical condition an adult had prior to joining the plan. (Plans cannot exclude coverage of children's pre-existing conditions. Starting in 2014, plans won't be able to exclude coverage of adults' pre-existing conditions.) If you disagree about whether you actually had the condition prior to joining the plan, you can appeal following the procedure outlined in this brochure.
- **Coverage Rescissions**
  Be sure to answer all questions on a health insurance application honestly. Plans can revoke coverage back to when your policy began if they think you intentionally deceived them on your application. If you believe you completed the application to the best of your ability, you can appeal to your health plan. In these cases, if you still cannot resolve the matter, you can appeal to the DC Department of Insurance, Securities and Banking (DISB).

Sound daunting?

Don't worry.

The Office of Health Care Ombudsman and Bill of Rights will help!

Office of Health Care Ombudsman
and Bill of Rights
One Judiciary Square
441 4th Street, NW
Suite 250 North
Washington, DC 20001
Office: 202-724-7491
Confidential Fax: 202-442-6724
Toll Free Number: 1-877-685-6391
Email: healthcareombudsman@dc.gov
www.healthcareombudsman.dc.gov

Member: International Ombudsman Association

Health Coverage In DC:

Appealing Health Insurance Decisions

Office of Health Care Ombudsman
and Bill of Rights

If you've received a denial of service and you disagree with your health plan's decision, you can appeal. You can appeal other types of health plan decisions too, like the ones on on the back of this brochure. The Office of Health Care Ombudsman and Bill of Rights is available to help you throughout this process.

Where to Appeal

Call your health plan for more information about their decision before you start the appeals process. In most cases, you will appeal to the health plan first. In emergency situations, where waiting for the plan's appeal decision could seriously jeopardize your physical or mental health, you can go straight to an external reviewer.

- **Appeal with Your Insurance Company (Internal Appeal)**
  The health plan will select health care professionals to review your claim who were not involved in the original decision.
- **Appeal with an Independent Review Organization (External Review)**
  If you are not satisfied with the outcome of an internal appeal, if it is urgent or an emergency, or if your plan is not following the proper process and deadlines for an internal appeal, you can appeal to an independent reviewer who is not part of your health plan. Contact the Office of Health Care Ombudsman and Bill of Rights, and they will assign your case to a qualified independent review organization that will use expert health care professionals to review your case.

Building Your Case

To build your case, you will need to gather information and materials from your plan and your medical provider or doctor. The Office of Health Care Ombudsman and Bill of Rights can help you through this process. You will need to do the following:

- **Provide Authorization**
  You will need to authorize the reviewers to get relevant information from your health plan and authorize your medical professionals to share important evidence, such as medical records. If you want assistance from the Health Care Ombudsman and/or other advocates, authorize them to get information on your behalf and to assist you. You can get authorization forms from the Health Care Ombudsman's office.

- **Understand Your Plan's Reason**
  You probably received a notice from your insurer telling you what it paid for or did not pay for and a very general reason. If you ask for more details about the denial, the plan must send you all the information it has about the diagnosis, requested service, reason for a denial, and the documents received about your case. We recommend that you get the answers to the following questions:
  - What does your plan list as your diagnosis?
  - Does your plan have correct information about all of your diagnoses?
  - What service was denied?
  - If the plan has guidelines that say it will only pay for a service in certain circumstances—do they have correct information about whether you fit those circumstances?
  - What documents has your reviewer received about your case?
- **Learn More about Your Plan's Guidelines**
  When you request it, the plan must give you its internal rules or guidelines about when it does and does not cover a particular treatment. The Health Care Ombudsman and your health professionals can help you review these guidelines.
- **Gather Evidence from Your Medical Providers**
  Letters from your medical providers should specifically address why your treatment fits the plan's guidelines and should be reimbursed or why the plan's guidelines for treatment of your condition are wrong or outdated. Medical records, such as progress notes, labs, x-rays, and other tests should back up your case.
- **Look into the Latest Medical Research**
  The Health Care Ombudsman, disease societies, and your medical providers can help you find the latest research about treatment of your condition.

For an online library of medical journal articles, go to www.pubmed.gov.