with you. In some states, the simple act of filing a complaint with the health plan's customer service department can trigger an inquiry by the State Department of Insurance. Other states may require you to submit a report in writing, or you may be required to fill out forms regarding the complaint. You should check with your state's department to determine what the process is.
The following link can help you determine your state insurance department[6]:
http://www.naic.org/state_web_map.htm

In extreme cases you may want to contact the media to get your story publicized. This is recommended only if you have tried and exhausted all other remedies, such as your legislators and Department of Insurance, with no success. There are a number of ombudsmen and consumer advocates you may contact through your local TV stations and/or newspapers that may be willing to help.

References: **1.** Obesity Law and Advocacy Center Web site. Available at: http://www.obesitylaw.com. Accessed December 11, 2007. **2.** Patient Advocate Foundation Web site. Your guide to the appeals process. Available at: http://www.patientadvocate.org/index.php?p=13. Accessed December 11, 2007. **3.** Consumers Union Web site. A consumer guide to handling disputes with your employer or private health plan, 2005 update. Available at: http://www.consumersunion.org/health/hmo-review/index.html. Accessed December 11, 2007. **4.** The Obesity Society Web site. Available at: http://www.obesity.org. Accessed December 11, 2007. **5.** Obesity Action Coalition Web site. Available at: http://www.obesityaction.org/home/index.php. Accessed December 11, 2007. **6.** National Association of Insurance Commissioners Web site. Available at: http://www.naic.org/index.htm. Accessed December 11, 2007.

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Know Your Rights:
A Patient Guide to Insurance Appeals

Every insurance company has an appeals process to allow you the opportunity to present your case. In some cases, the Prior Authorization Review is not handled properly the first time, therefore, for your protection, the appeals process was designed.[1] The checklist below will help to ensure that you have the best chance for a fair hearing.

The very first rule in any appeals process is to **KEEP GOOD RECORDS**. Following this rule will play an important part in meeting deadlines and will help to ensure a timely review. Protect yourself by keeping good records. In the event you choose to utilize the help of outside advocates, attorneys, and other assistance, keeping good records will serve to strengthen your position.[2]

If you do not already have a file and a notebook to document all correspondence, start one now. You should keep a record of all letters you receive and a log of all telephone calls you make or receive related to the insurance denial.[2] Be sure to ask anytime you are on the telephone whether or not the conversation is being recorded and be especially careful about noting what was said and the date and time in case you want to have those records retrieved. Over time, you may forget people's names and dates. This documentation will help you to stay organized and focused on your goal.

Thoroughly read your denial letter

What is the reason for the denial?[2]

- No covered benefits for any type of weight loss surgery?
- Is the surgery considered "experimental"?
- Is the doctor or hospital not participating?
- Is the surgery deemed medically unnecessary?

Clarify the denial reason

Call your insurer's customer service line (the number is usually located on the back of your insurance card) or review your health benefits certificate, which can be obtained through your human resources office.[2]

Consider outside assistance

If you are not comfortable handling the appeal by yourself, you may wish to engage the services of an experienced patient advocate.[2] If this is not an option, and depending upon the reason for your denial, your surgeon may be able to refer you to the LAP-BAND® System Appeal Advocacy Center. Ask your surgeon's office about this service.

First Level Appeal

Obtain your medical records

For your appeal you should show the documented efforts you have taken to lose weight. Obtain as many of your records as you can[2-4]:

- Primary care doctors who may have assisted you
- Specialists who helped evaluate and treat you
- Medication you currently take
- Health complications due to your current weight, such as arthritis, diabetes, hypertension, or skin rashes

Write a letter of appeal with a bariatric surgeon

The letter of appeal should be from you explaining the necessity for LAP-BAND® System surgery and what steps you have taken in the past to lose weight. Be sure to request that the reviewer is a surgeon familiar with bariatric surgery. (This is referred to as a "like specialist.") In addition, make sure the letter deals with the specific reason for the denial. For example, if your denial was because your health plan says the LAP-BAND® System is "experimental or investigational," your letter should include clinical information that shows it is not. This information can consist of copies of clinical articles as well as third-party recognition of the LAP-BAND® System, such as the Medicare National Coverage Determination. Your surgeon's office can assist you with requesting this type of information.[2,4]

Send the letter of appeal to your insurance carrier

When you send your letter and information by mail, be sure to send it certified mail with a return receipt. This will ensure that the information was received by the health plan. If the information is faxed, be sure to call the recipient to confirm that all pages were received. Make sure to document who received the faxed information along with the date and time. Be sure to retain your fax "confirmation sheet" which shows the number the fax was sent to and the number of pages received.[2]

Follow-up

Your insurance handbook, the denial letter, or the person you are working with at the health plan should be able to tell you how long a review of your appeal should take. Be sure to schedule a follow-up call at the end of the given time to inquire about the status. Failure to respond within the time frame outlined in your benefit plan can be considered breach of contract, and you can file a complaint with your state insurance commission.[2]

Approval/denial

Hopefully your letter of appeal has been approved at this point. If this is the case, you can now move forward with scheduling your LAP-BAND® System procedure! If the insurance company has denied your claim for a second time, don't give up. You still have options.[2,5]

Second level appeal

If your first appeal did not result in an approval, you may be able to appeal again. Your denial letter will tell you what your options are.[2]

Have your medical information available

For the second appeal, you will need copies of the same medical information you provided in the first appeal, plus any new medical records of events that have occurred since you filed the first time.[2]

Write the second letter of appeal

Typically, on a second-level appeal, your information will be reviewed by another group of people. Similar to the first letter, this one should address the specific reason for the denial and you should provide information that shows why you think the denial is wrong. Provide the same information as before, including any new information that might have become available. New clinical articles are published on a regular basis, so be sure to check with your surgeon.[2]

Send the letter

Again, if mailing the appeal, send it with a Certified Return Receipt request to document when the appeal was received and who signed for it. If you are faxing the information be sure to confirm receipt of all the pages you faxed and when and by whom the information was received.[2]

Follow-up

Keep a schedule of when to make follow-up calls and be sure to make the calls. Keep records of who you spoke with and what the results of the call were.[2]

Third level appeal

Some insurance policies may have a third level of appeal. Your denial letter will tell you if this is so or not. If this is the case, follow the same steps as before, addressing the reason for the denial, or consult your health plan book or Human Resources Department for more information.[2]

External Reviews

If your health plan does not have a third level of appeal, your state may require a process called an "External Review." In an External Review, the insurance company will send your appeal to an outside company that has been designated by the state you live in. This outside company will review the denial, your appeal, and any supporting or new information and use it to make a recommendation or determination to the insurance company. The External Review Board is typically made up of a variety of specialists, and can include nurses, case managers, legal experts, and/or doctors who specialize in the type of surgery you are asking the insurance company to cover. In some states the process is automatic, while in other states the law allows you to request that your case be sent for an external review.[2]

To determine if your state has an external review process go to http://www.consumersunion.org/health/hmo-review/states.html[3]

If you have exhausted all your appeals, if there is no External Review process or the decision did not go in your favor, you may still have the option of pursuing the issue in the courts.

Should you contact an attorney or any other type of outside advocate? When?

This is an important question and one that is asked frequently. Many people feel more secure discussing their case with an attorney when they receive the first denial. Most advocates or attorneys prefer looking at the case sooner rather than later because there may be more they can offer you at the beginning of the case than at the end. Because such consultations are usually done without charge, it is always best to seek out advice earlier in the process. You can always choose to appeal the decision on your own to see if it can be overturned without legal help and expense.[2]

If you decide to use an attorney or other advocate you should consider the following:

- Choose one that is experienced in healthcare law and, more specifically, one who is familiar with the issues around bariatric surgery.
- Make sure to find out what the fees are up front and get it in writing.
- Decide when in your appeal process the attorney will take over.

Some patients will try to handle the insurance denial on their own, completely exhausting the appeal process, before they ask an attorney to take over the case. If you are going to retain an attorney it is usually best to get them involved as early as possible in your appeal process as they will be familiar with how to file the appeals, the timing of submissions, and so forth. It is also best to have an attorney involved early in the process, especially if you end up deciding to take your case to court.[2]

If you are unsure about where to find a qualified attorney you can try contacting the American Obesity Association or the Obesity Action Coalition for a referral.[2]

Who else should you notify?

Is it helpful to notify your state and local representatives of insurance issues like this? In some cases it can be helpful, and in other cases it may get you nothing more than a form letter stating there is nothing your legislator can do. At the very least, you should ask yourself, "is there anything to lose?" You've already prepared and sent in the appeal letter. It's just as easy to send a copy of your denial letter and your appeal letter to your legislators and ask them for assistance.[2]

You may also be able to help your case by notifying your State Department of Insurance. The scope of their authority and who has responsibility for responding to complaints can vary from state to state. Primarily, the Department of Insurance's responsibility is to ensure the health plan is in accordance with the contract they have