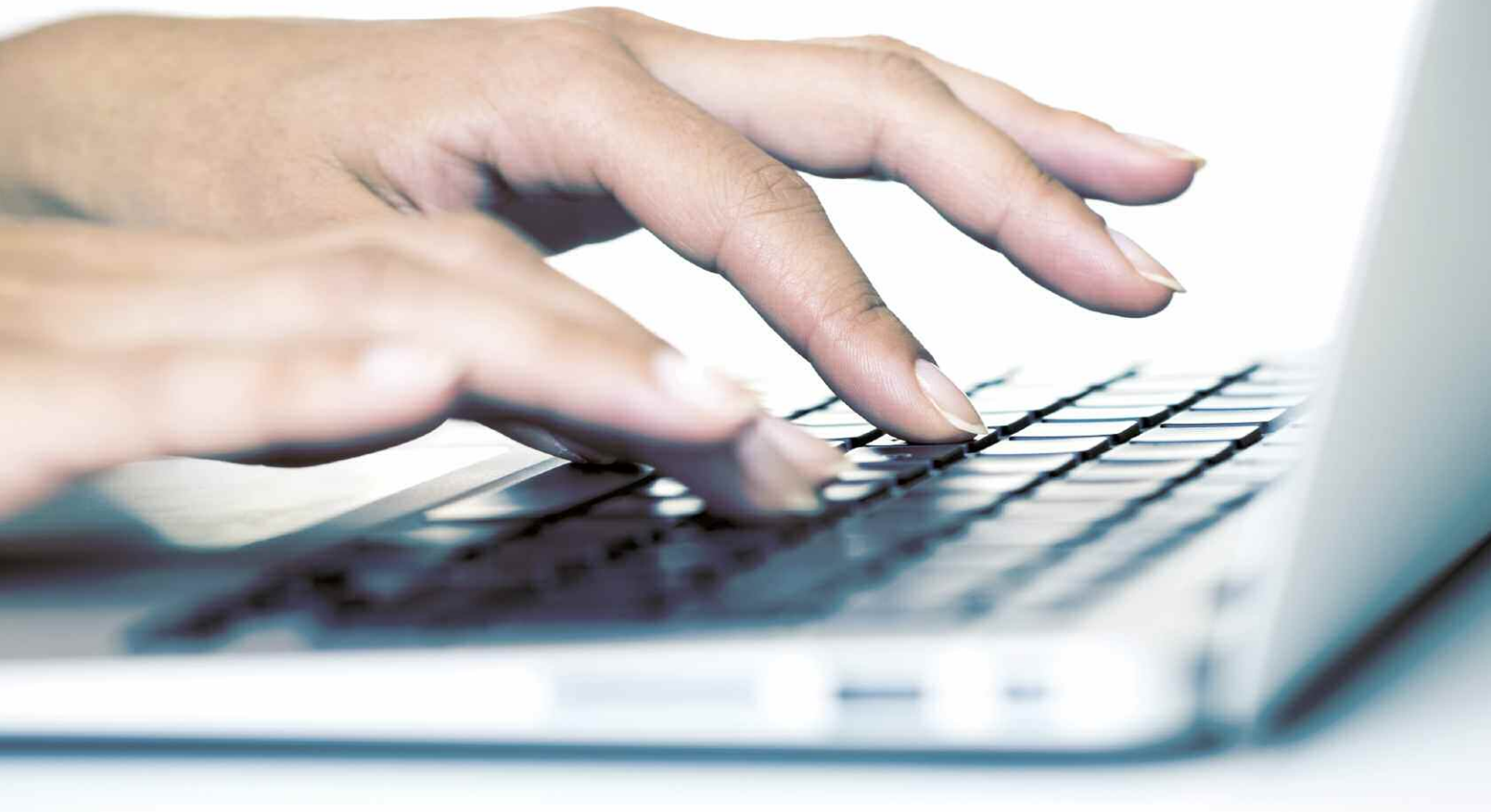
Courtesy of *IG Living* magazine

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.



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 an 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! According to the late Jennifer Jaff, attorney and former executive director of Advocacy for Patients with Chronic Illness Inc., 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.

Immune Globulin Coding

Below is the list of codes for immune globulin products to make an insurance claim for treatment. HCPCS codes are used to bill for the drugs. CPT codes are used to bill for medical services to administer the drugs.

HCPCS Codes

Bivigam: J1556
Carimune NF: J1566
Flebogamma 5% and 10% DIF: J1572
Gammagard Liquid: J1569
Gammagard S/D (Low IgA): J1566
Gammaked: J1561
Gammaplex: J1557
Gamunex-C: J1561
Octagam: J1568
Privigen: J1459

CPT Codes

96365: intravenous infusion up to 1 hour
96366: intravenous infusion each additional hour
96367: intravenous infusion, additional sequential infusion up to 1 hour
96368: intravenous infusion, concurrent infusion
96369: subcutaneous infusion up to 1 hour (including pump set-up and establishment of subcutaneous sites; excludes infusions of 15 minutes of less [96372])
96370: subcutaneous infusion each additional hour (infusions of more than 30 minutes beyond 1 hour)
96371: additional pump set-up with establishment of new subcutaneous infusion sites

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. IG therapy requires several components such as supplies, nursing and the IG 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 Immune Globulin Coding.)

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.

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 new healthcare reform law, the Affordable Care Act (ACA), which went into effect in 2010, there are two stages of appeals to choose from to pursue if a claim is denied: an internal appeal and an external (or independent) review. Individuals 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. An external review is an independent medical review of an insurer's decision that a healthcare service is experimental, investigational or not medically necessary. The decision to rescind a policy is also

Reimbursement Q&A

Several of the immune globulin manufacturers have websites and/or hotlines for general reimbursement questions.

Websites

Biotest Pharmaceuticals: www.bivigam.com/clientuploads/pdfs/BivigamReimbursementGuide.pdf

CSL Behring: www.cslbehring-us.com/reimbursement-resource-center.htm

Grifols: www.grifols.com/en/web/eeuu/our_patients

Hotlines

Baxter: (800) 548-4448
Bio Products Laboratory: (866) 398-0825
Biotest Pharmaceuticals: (855) 248-4426
CSL Behring: (800) 676-4266
Grifols: (888) 325-8579
Kedrion: (855) 353-7466
Octapharma: (800) 554-4440

subject to external review. Medical professionals from an independent review organization (IRO) with no connection to the health plan must conduct the review. And, the IRO must be a physician who specializes in the disease for which a claim was denied. For instance, for chronically ill patients who have a primary immunodeficiency, that would mean an immunologist must be part of the IRO. However, external reviews do 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.). External reviews apply 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 IG as a treatment for the disease (See Websites for Peer-Reviewed Immune Globulin Treatment Articles)

The timeline. Nothing will lose an appeal faster than not sticking to the allotted timeline. Fortunately, the process of appealing an insurer's decision about reimbursement has been made more transparent, accountable and fair under the ACA.

In most cases, an internal appeal must be made before an external review can be requested. In an internal appeal, also known as a grievance procedure, the ACA requires insurers to adhere to a strict timeline and provide detailed and complete information for free about the reason for denying the claim. An insurer must provide notice of a decision to deny a claim within 72 hours for an urgent care claim, as determined by a doctor; 30 days for a non-urgent care claim submitted before the service is provided; 60 days for a non-urgent care claim submitted after the service is provided; and 24 hours for ongoing treatment that the insurer has approved, but is seeking to reduce or stop. Once a claim is denied, patients have 180 days to file an internal appeal. Most importantly for the chronically ill, while an internal appeal is pending, the insurer cannot reduce or stop coverage for ongoing treatment. If at any time the insurer doesn't fulfill its obligations, an external review can be filed.

Typically, an external review is filed after an internal appeal has been exhausted. Patients have four months to file an external review after notice that the internal appeal has been denied. Should the insurer determine that the claim is eligible for external review, it must provide information from the request to one of three contracted IROs assigned randomly.

> The appeal letter should be formally written, devoid of any personal ranting and raving.

Patients whose situations are urgent can file an internal appeal and external review concurrently. A concurrent filing is eligible if any of the following conditions apply:

• The patient's health or life may be in serious jeopardy, or the patient may not be able to regain maximum function if treatment is delayed while waiting for a decision

• The health plan insurer's decision concerns an admission, continued hospital stay, availability of care or healthcare service for which the patient received emergency services but have not yet been discharged from a facility

• The patient's treating physician believes that the experimental or investigational treatment requested would be less effective if not started right away

The patient's treating physician must certify in writing that any of the conditions apply to the patient's case.

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.

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 common variable immune deficiency (CVID), patient must have an IgG level of 400 or less.

— My IG levels clearly fall within the parameters for a diagnosis of CVID.

— 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.

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,' immune globulin 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. ■

Websites for Peer-Reviewed Immune Globulin Treatment Articles

Autoimmune diseases:
emedicine.medscape.com/article/210367-overview#aw2aab6b3

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