If a physician prescribes a service, treatment or medication for dementia, but the insurance provider denies the claim, you may appeal. Learn why claims are denied and what you can do about it.



## When a claim is denied by your insurance provider

There are many reasons an insurance provider might deny a service or treatment. They might include:

- There are lower cost services or treatments available.
- The insurance provider hasn't decided if they will pay for a new treatment.
- Certain medications, dosages or method of delivery may not be on the approved list.
- The treatment or service was prescribed "off-label," meaning it wasn't indicated for use in the way your doctor is prescribing.
- Supplies or equipment deemed not medically necessary.
- Clerical errors or missing data (incorrect insurance number, diagnostic code, date of service, etc.).

For whatever reason, if a service or treatment your doctor ordered is denied, contact the insurance provider and ask for a written detailed explanation. Carefully review the explanation, checking for any errors. In some situations, correcting the error may be enough to change the decision.

## Things to consider before filing an appeal

Review the criteria below to decide if filing an appeal makes sense in your situation:

- Is the treatment medically necessary?
- Is the treatment indicated?
    - When the FDA approved a medication, they also issue guidance or "indications" for when it is appropriate to be prescribed. Insurance providers will use these indications to make decisions on coverage.
- Is it clearly listed on the coverage plan that this service or treatment is not covered?
    - If it is listed as not covered, it will be very difficult to appeal.

## Formal appeal process

All insurance companies and Medicare have a formal appeal process.

1. Call the number on the back of your insurance card and ask for instructions for how to make a formal appeal. Provide all the information requested on the appeal form.

2. There is often a time limit on appeals, so it is best to act as soon as possible.
3. Keep records/copies of all correspondence with the insurance provider.
4. Your doctor may be able to help you with the appeal.

## Medicare appeals

Under Original Fee-For-Service Part A or Part B, the beneficiary should receive a denial notice. The medical provider is responsible for submitting a claim to Medicare for the medical service or procedure. If Medicare denies payment of the claim, the denial must be in writing and state the reason for the denial. This notice is called the Medicare Summary Notice (MSN) and is usually issued quarterly. Look for the reason for denial.

Sometimes payment is denied because of a problem with the claim form (e.g., missing information, errors or incorrect codes). Other times, the notice states that the service or procedure was "not medically necessary" or that the case "does not support the need for this many visits or treatments."

If the claim was denied due to “local coverage determination” (a local coverage rule), it must be stated on the notice. In addition, the notice must identify the applicable local coverage determination and how to obtain a copy.

## What the beneficiary/caregiver can do

If the claim is denied because there is a problem with the claim form, contact the provider or the provider’s billing office and ask

them to correct the mistake and resubmit the claim. The beneficiary/caregiver can also file an appeal as provided in the notice. If the claim is denied because the medical service/procedure was "not medically necessary," there were "too many or too frequent" services or treatments, or due to a local coverage determination, the beneficiary/caregiver may want to file an appeal of the denial decision. In these cases, it is important to alert your provider who may be able to assist you in this process.

## Appeal the denial of payment

The standard appeal procedures for Part A and Part B of Original fee-for-service Medicare have five similar levels. There is also an expedited appeals process for individuals who are being discharged or whose services are being terminated in a hospital, skilled nursing facility, home health, hospice or comprehensive outpatient rehabilitation facility (CORF).

The appeal procedure must be included on the denial notice. Read the instructions carefully. Be sure to file the appeal within the stated time requirements. If the claim was denied because it was “not medically necessary” or the services were “too many or too frequent,” it is helpful to submit supporting information from the treating doctor and other medical providers.