# What to Do When Denied Health or Disability Benefits

## by Scott M. Riemer, Esq.

To control ever–rising costs, insurance companies are increasingly denying health and disability benefit claims. Many of these denials are unjustified. What can you do when it happens to you and how can you best protect your rights? The most obvious answer is to call a lawyer. But there are certain things that you can do to help recover your benefits without incurring legal expenses.

All health and disability insurers have internal appeal procedures and usually require appeals to be made within 60 days of the denial. These appeals are very important because the law requires that they be exhausted before a claim can be taken to court. They also provide a valuable opportunity to resolve the dispute without much expense. If an appeal is done effectively, many insurers reverse their decisions and award benefits.

The following steps can be taken to increase the likelihood of making a successful internal appeal. These steps should be taken as soon as possible in order to meet the insurer's 60-day deadline. Your right to challenge the denial in court may be lost if this deadline is not met. For your protection, all letters described below should be sent Certified Mail–Return Receipt Requested.

1 Send a letter to the insurer demanding that it provide a more specific statement of the reasons for denial. More often than not, particularly with health claims, the initial denial will consist of a totally incomprehensible computer-generated letter with a code number as the reason for denial. If your health or disability coverage is through your own or your spouse's employer (except for government and church employers), such a denial letter fails to comply with the law.

Under federal regulations, the denial letter should include the following information in understandable language:

- the specific reason for the denial;
- a reference to the plan provision(s) on which the denial is based;
- a description of the additional material and information that is needed before the insurer will pay the claim and an explanation of why this is needed; and
- a description of the steps that must be taken in order to appeal the denial.

Your letter should request this information and state that the information is required under Department of Labor Regulation 2560.503(f).

2 Write a letter demanding copies of the summary plan description and the plan document itself (assuming you already do not have copies of both). This letter should be addressed to the Plan Administrator of your plan, care of the employer, and should state that these documents are being requested under the Employee Retirement Income Security Act (ERISA). Copies of these documents must be furnished within 30 days of your request. If they are not, you may be able to obtain statutory penalties against the Plan Administrator of up to $100 for each day the documents are not provided.

These documents will be helpful in making an appeal and are absolutely essential in assisting your lawyer if and when you hire one. Laws governing the insured's rights vary from state–to–state. For instance, in New York and Connecticut, the more advantageous terms of the summary plan description supercede those of the plan document, *even if* the summary contains a proviso disclaiming this fact.

3 Obtain a letter from your doctor which addresses the insurer's reason(s) for denial. For instance, if coverage of the medical treatment was denied because it was not "medically necessary," the doctor should specifically explain why the treatment was medically necessary. Similarly, if the insurer denies disability benefits, the doctor should specifically explain why you are unable to work, sit, walk, type, lift heavy objects, etc. and what objective evidence exists to support this explanation.

4 Once the requested documents are received, send a letter to the insurer requesting review by the insurer's appeal board. This letter should include the insurer's appeal form(s) (if any) and a written statement explaining why the denial was contrary to the terms of the plan and/or contrary to the medical evidence. The statement should cite and quote from the letter from your doctor (which should also be attached to the statement) and specific provisions of the plan and/or summary which support your claim.

In the event the insurer's deadline is coming to a close and you have not received the requested documents, a letter should be sent to the insurer prior to the expiration of the deadline. The letter should notify the insurer that an appeal will be made once the requested documents are received. In most cases, this is sufficient to "take the teeth" out of the deadline.

If you follow these steps you may find that the insurer will reverse its earlier denial. If it does not, nothing is lost because you are required to exhaust all internal appeals before the insurer can be sued in court. You also did a lot of your lawyer's legwork and will therefore save money if and when a lawyer is hired. ■

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