Health Insurance - Appealing a Denial

Learn about the different types of appeals available to challenge a denial of coverage for transgender-related health care.

This section covers how to appeal medical necessity denials only, not denials due to blanket exclusions, so make sure you've reviewed the Understanding a Denial section first to know the difference. This section also covers things outside of the formal appeals process that might help overturn a denial.

- Peer-to-peer appeals
- Internal appeals
- External appeals
- Fair hearings
- Civil rights complaints
- Talking to the employer
- Insurance division complaints

Learn more about each type by expanding the buttons below.

Peer-to-Peer Appeals

A peer-to-peer appeal is when your doctor has a phone conversation with a medical director for the insurance company. Your doctor has the opportunity to explain why the care is appropriate for you and why the denial is incorrect. This can be a quick way to resolve certain types of problems.

It will be most effective when there is a clear reason for the insurance company to make an exception to its clinical policy. For example, if the insurance company requires the person to be on hormones before surgery, the doctor could explain why that should not apply to this patient, such as being unable to take hormones because an unrelated medical condition makes it impossible or the person is nonbinary and doesn't need hormones to treat their gender dysphoria. Another example could be if the insurance company requires 12 months of living full-time, but the person has not been out at work, the peer-to-peer appeal could be used explain more about the person's individual situation and why surgery is still appropriate for them at this time.

A peer-to-peer review is less likely to be successful where the insurance company's clinical policy has a written exclusion for the care that you need. In those cases, a written appeal is likely necessary.

Internal Appeals

If you have not reviewed the Understanding a Denial section, it's very important to do so to make sure that an internal appeal is the most effective or even an applicable way for you to challenge a denial.

First-level internal appeals

Depending on your plan, you will have one or two levels of internal appeal. In an internal appeal, the insurance company's own appeals department re-reviews your case to see if they made an error. You

can find out how many appeals and what the deadlines are in your plan booklet. You should also receive a copy of the appeals procedure with your denial letter.

Getting a first-level appeal denial will start the clock running on the deadline to file your next appeal. In many cases, the decision from the first-level internal appeal is the "final adverse determination" even if you have an optional second-level internal appeal. Getting a "final adverse determination" is often the trigger the deadline for when you must file an external appeal, so it's important to be aware of that deadline even if you will pursue the second-level internal appeal.

Second-level internal appeals

The second-level internal appeal is often voluntary, meaning you don't have to complete it before filing an external appeal. It is generally reviewed by a different set of people than who made the first denial. If it's an employer-based plan, this is the time during which the employer may be able to get involved to override a denial, which is possible when the plan is self-funded. Sometimes the second-level appeal affords you the opportunity to speak directly with the appeals team so that you can share your personal story.

Note that the deadline to file an external appeal may be before the second-level appeal is decided. You don't want to miss your external appeal deadline by waiting for the result of a second-level appeal. You can file the second-level appeal at the same time as an external appeal, so you don't need to wait for the decision if time is running short on your external appeal deadline.

Appeal deadlines

It is important to be aware of the deadline to appeal a denial. Check the deadlines for your plan because if you miss them, you may lose the opportunity to challenge a denial. The first-level appeal is due 180 days from when you receive the denial letter. The insurance company has 30 days to issue a decision for a service you haven't had yet and 60 days if you've already had the service.

Second-level appeals are typically due 60 days after the denial and they may have 45 days to issue a decision.

And if you have already paid out of pocket, there are also deadlines to file a claim, so look in your plan booklet to find out how quickly you must submit your claim.

External appeal deadlines are sometimes set by the state. Four months is a common deadline, but be sure to check your plan for your specific deadline, which may be shorter.

Appeals must be thorough

It's important that your appeal is thorough and filed on time. Particularly if you've already paid out of pocket for surgery, you don't want to waste your appeals because you only have a certain number of them. By not doing the appeals process properly, you might be forfeiting your rights later on. For example, if you don't submit all of proper documentation during the appeals process, you might not be able to submit new information if you have to bring a lawsuit. Speaking with an advocate experienced in transgender appeals is the best way to make sure your appeal contains all the information necessary to be effective and preserve your rights if it does not succeed.

How to file an appeal

For most insurance companies, you can initiate an appeal simply by calling on the phone. You generally do not want to do this. When you're calling the insurance company to ask about a denial, be careful that you don't inadvertently initiate an appeal. If you initiate an appeal by phone, they may make a decision without you having provided any additional information. That's like throwing away an appeal.

To file an internal appeal, you need to:

- Complete all forms required by your health insurer. Or you can write to your insurer with your name, claim number, and health insurance ID number.
- Submit any additional information that you want the insurer to consider, such as letters from your providers.
- If your state has a Consumer Assistance Program, they can help you file an appeal.

Provider-initiated appeals

If your health care provider offers to file the appeal for you, make sure that you have signed a form from the insurance company authorizing them to do so. If you do not designate your provider as an authorized representative, the appeal can be rejected and the decision will be delayed.

If your provider is willing to help with the appeal, that is helpful, but make sure you have done your research to understand the reason for the denial. If there is an exclusion in your plan, it won't matter if your provider can show that the procedure is medically necessary for you because it will still be denied under the exclusion in your plan. If you are unsure, you can always ask us for help in understanding your plan.

External Appeals

An external review or external appeal is where the insurance company's decision is reviewed by an independent third party. Information on how to request the external appeal should be included with a denial letter.

In an external appeal, the case is first assigned to an independent medical review organization—a company that specializes in this service. Common names of such companies include IPRO, MAXIMUS, or MCMC. The review organization then assigns the case to an individual reviewer—a medical or mental health professional who reviews the facts to determine if the care is medically necessary for that individual.

New information can be submitted for the external appeal that was not included in the internal appeals. It's best to gather all of that information before requesting the appeal because once it has been submitted to the review organization, they have only a set amount of time to review the claim and they request that all additional information be submitted on a very short deadline.

You will submit your evidence of medical necessity to an external, independent body that will assess whether or not the insurance company made the correct decision. The external appeal does not always succeed, but it is more likely to than an internal appeal. The external appeal can overturn an insurance denial, and it is binding on the insurance company.

The people who review the appeals may or may not have expertise in gender dysphoria. In your appeal, you can request that the appeal be assigned to someone with experience with gender dysphoria. This does not always happen, and even when the case is assigned to someone experienced with gender dysphoria, sometimes the decisions to not always follow the WPATH *Standards of Care*.

If an external appeal decision is inconsistent with the WPATH *Standards of Care* or has other obvious errors, you can request that the independent review organization re-review it. In egregious cases, there may also be options to challenge it in court, but in general, the external review is binding on both parties and it is often the end of the road for the formal administrative appeals process.

Fair Hearings

Medicaid and Medicare plans have a final appeal stage that is a fair hearing before an administrative law judge. The fair hearing must be requested and then a date will be assigned. Information on how to request the hearing should be provided with the denial letter. The hearing is like a mini trial where both sides can present evidence. It may be conducted over the phone or in-person. A decision is generally mailed several weeks after the hearing.

If you have Medicaid, it's worth reaching out to your local legal aid organization for help with the fair hearing process as they are typically familiar with the process. TLDEF can provide assistance to legal aid attorneys who need help with the transgender-specific aspects of the case.

For Medicare appeals and fair hearings, contact us for more information.

Civil Rights Compliants

This is not part of the appeals process and does not substitute for filing an appeal with the appropriate appeals department. This can be pursued simultaneously to filing the appeal.

Pursuant to 2016 regulations under the Affordable Care Act, insurance companies have generally created an internal Civil Rights Coordinator. The information for the Coordinator is generally provided to you when the insurance company sends you any important correspondence. You should have received a sheet with your denial letter that lists their contact information. You can also Google "civil rights coordinator" and your insurance company's name to find the information.

If you have experienced any kind of discrimination with your insurance company, you can file a civil rights complaint with them. The deadline is 30 days from the incident. If you have been misgendered when speaking to a customer service representative or experienced other harassing or discriminatory treatment, you can file a civil rights complaint.

If you believe you are being unfairly denied care for a reason that is related to being transgender or another protected class (race, color, age, or disability) you can file a complaint with them.

Additionally, if you have been denied care because of a blanket exclusion in your insurance company's clinical policy, you should go through the appeals process, but it is also helpful to file a civil rights complaint. You can explain that you have been denied care under a discriminatory policy that categorically excludes certain treatments solely because they are transgender-related.

Talking to the Employer

For health plans that are provided by an employer or union, talking with human resources or your union representative is another avenue to pursue when challenging a denial. This does not substitute for filing an internal or external appeal, but it can be pursued simultaneously.

If medically necessary care is being denied under an employee health plan simply because it is for the purpose of treating gender dysphoria, the employer is likely facing legal liability. For that reason, it is in the employer's interest to make sure such denials are not happening.

If the plan is self-funded, there is typically leeway for an employer to override a denial where the denial is based on a lack of "medical necessity" (as opposed to a denial based on a plan exclusion, which requires a different approach). If the plan is not self-funded, there may not be much the employer can do, but there are other things they could do such as choosing a different insurance company that doesn't routinely deny care, talking to their insurance representative and urging them to change their

clinical policy to not exclude such care. Some companies have other insurance plans or funds that cover care that is not covered under the health plan.

In general, it is helpful to let human resources know that you are having problems accessing care under the health plan. If they don't know about the problem, they definitely can't do anything to try to fix it. Some people have concerns about retaliation due to reporting unfair treatment. Retaliation is illegal. However, some employers do not always follow the law. Retaliation by an employer, such as making working conditions less favorable or firing someone based on another reason as a pretext, is a possibility. If you have had a good performance record and they have no excuse to fire you or eliminate your position, the risk of being fired is low.

Insurance division complaints

If you have an insurance plan (as opposed to a self-funded plan), filing a complaint with a state insurance division is another avenue to pursue where care is being denied. This does not substitute for filing an internal or external appeal, but it can be pursued simultaneously.

The denial letter or plan booklet should indicate which state's insurance division applies. An employer-based plan may be issued in a different state from where the member lives, but it's the state where the plan was issued that matters for purposes of filing a complaint against the insurance company.

In many states, the insurance division has explicitly issued guidance or there are laws or regulations that prohibit insurance denials based on transgender status. So complaints in those states are more likely to be successful, but even if the state has no explicit protections, it doesn't hurt to file a complaint.

Complaints to state insurance divisions can also be helpful where the issue is a denial based on something other than medical necessity, such as the following:

- Refusal to pay a claim related to alleged deficiencies with the bills from an out-of-network provider
- Refusal to grant a network gap exception where there is no qualified in-network provider near you
- Discriminatory treatment such as misgendering
- Problems with correcting one's name or gender on insurance records
- Misinformation given by a representative about care being covered
- Repeatedly processing a claim incorrectly
- Denials for sex-specific care based on a gender-marker mismatch

Short of filing a complaint, state insurance divisions also often have consumer assistance hotlines that can help you understand denials.

Content last updated on Mar 30, 2021 - PDF generated from: https://transhealthproject.org/trans-health-insurance-tutorial/appealing-a-denial/ on Jan. 20, 2025.

If you find this helpful, please consider making a donation at https://transgenderlegaldefense.networkforgood.com to support our work.
