How to manage an appeals process

Continue treatment during the appeals process.

Appeals can take weeks or months to complete, and health professionals and facilities that treat eating disorders advise that it's very important for the patient's well-being to stay in treatment if at all possible to maintain progress in recovery.

Clarify with the insurer the reasons for the denial of coverage.

Most insurers send the denial in writing. Claims advocates at treatment centers advise patients and families to make sure they understand the reasons for the denial and ask the insurance company for the reason in writing if a written response has not been received.

Send copies of the letter of denial to all concerned parties with documentation of the patient's need.

Claims advocates at treatment centers state that sending documentation of an appeals request to the medical director, the human resources director of the company where the patient works (or has insurance under), if applicable can help bring attention to the situation. Presenting a professional-looking and organized appeal with appropriate documentation, including an evidence-based care plan makes the strongest case possible. Initial denials are often overturned at higher appeal levels, because higher-level appeals are often reviewed by a doctor who may have a better understanding than the initial claims reviewer of the clinical information provided, especially well-organized, evidence-based documentation.

Ask the insurer what evidence-based outcome measures it uses to assess patient health and eligibility for benefits.

Some insurance companies may use body mass index (BMI) as a criterion for inpatient admission or discharge from treatment for bulimia nervosa, for example, which may not be a valid outcome measure. This is because patients with bulimia nervosa can have close-to-ideal BMIs, when in fact, they may be very sick. Thus, BMI does not correlate well with good health in a patient with bulimia nervosa. For example, if a patient with bulimia nervosa was previously overweight or obese and lost significant weight in a short timeframe, the patient's weight might approach the norm for BMI. Yet, a sudden and large weight loss in such a person could adversely affect his or her blood chemistry and indicate a need for intensive treatment or even hospitalization.

Ask that medical benefits, rather than mental health benefits, be used to cover hospitalization costs for bulimia nervosa-related medical problems.

Claims advocates advise that sometimes claims for physical problems such as those arising from excessive fasting or purging, for example, are filed under the wrong arm of the insurance benefit plan—they are filed under mental health instead of medical benefits. They say it's worth checking with the insurance company to ensure this hasn't happened. That way, mental health benefits can be reserved for the patient's nonmedical treatment needs like psychotherapy. Various diagnostic laboratory tests can identify the medical conditions that need to be treated in a patient with eating disorders. Also, if a patient has a diagnosis of two mental disorders (also called a dual diagnosis), and if that diagnosis is considered by the insurance company to be more "severe" than an eating disorder, the patient may be eligible for more days of treatment.