

# Why Denied — And What If Denied Again?

Why requests get denied, and the escalation paths most people never find — including external review, state regulators, and ombudsman programs.

HEALTHCARE NAVIGATION | DENIALS & ESCALATION | FREE - NO EMAIL REQUIRED

## PART ONE

### Why Requests Get Denied

#### A DENIAL IS NOT A JUDGMENT

Receiving a denial can be frustrating and confusing, especially when your provider believes the treatment is appropriate. In most cases, a denial does not mean the care is unnecessary. It usually means the submitted information did not meet the insurer's criteria at the time of review.

#### COMMON DENIAL REASONS

##### INCOMPLETE DOCUMENTATION

Insurance reviewers make decisions based only on what is submitted. Common missing elements: prior treatments not documented, physical therapy history, outside testing, medication history from other providers, and functional limitations. Documentation must be submitted — not just available.

##### STEP THERAPY REQUIREMENTS NOT MET

Many plans require lower-cost treatments to be attempted first. If prior treatments were completed years ago or at another clinic, documentation may not be available unless specifically requested.

##### DIAGNOSIS DOES NOT MATCH COVERAGE CRITERIA

If the diagnosis code submitted does not align with coverage criteria, the request may be denied — even if the treatment is medically appropriate. Relevant comorbidities may not have been included.

##### INSUFFICIENT SEVERITY OR FUNCTIONAL IMPACT

Some approvals depend on demonstrating how significantly the condition affects daily life. Vague symptom descriptions without functional impact documentation often fail to meet criteria.

##### ADMINISTRATIVE OR TECHNICAL ERRORS

Incorrect patient information, missing forms or signatures, submission to the wrong payer, or coding errors can all trigger denials unrelated to clinical necessity.

#### AUTOMATED SCREENING DECISIONS

Many insurers use automated systems that may deny a request before a human reviewer evaluates the case — even when the treatment is clearly appropriate.

#### WHY PROVIDERS MAY NOT PURSUE EVERY APPEAL

Appeals and peer-to-peer reviews require significant time. Providers must balance these tasks with direct patient care. In some cases it may be faster to recommend an alternative — an efficiency decision, not a clinical one.

#### PART TWO

## What If I'm Denied Again?

#### THE APPEAL WAS DENIED. NOW WHAT?

Most people stop when their appeal is denied. That is often the biggest mistake — because the most effective escalation paths are the ones that come after internal appeals fail.

An internal appeal decision is not final. External review decisions are legally binding on your insurer. Regulatory complaints can trigger formal investigations.

#### EXTERNAL INDEPENDENT REVIEW

If your internal appeal has been denied, you typically have the right to an independent external review conducted by an organization with no affiliation to your health plan.

- External review is free under the ACA for most plans
- The reviewer's decision is binding on the insurer
- You do not need a lawyer to request external review
- File through the process described in your appeal denial letter, or contact your state Department of Insurance

#### STATE, FEDERAL, AND OTHER ESCALATION PATHS

PLAN TYPE	REGULATOR / PATH	WHEN TO USE
Commercial (fully	State Department of Insurance	Plan not following state law, no response, improper

insured)		denial
Self-insured / ERISA	DOL EBSA ( <a href="http://dol.gov/agencies/ebsa">dol.gov/agencies/ebsa</a> )	Federal ERISA violations, plan misconduct
Medicare Advantage	CMS / 1-800-MEDICARE	Unsafe denials, appeal process not followed
Medicaid	State Medicaid agency	Coverage violations, managed care issues
Any plan	External Independent Review	After internal appeals are exhausted

Self-insured employer plans (ERISA plans) are governed by federal law. Your state DOI typically has limited authority over them. For these plans, escalate to the Department of Labor's EBSA division.

#### PATIENT ADVOCACY AND OMBUDSMAN PROGRAMS

- State Insurance Commissioner offices often have consumer assistance programs
- Many hospitals have patient advocates who can intervene directly with payers
- The Patient Advocate Foundation offers case management services
- Some states have independent insurance ombudsman programs

#### WHEN TO CONSIDER LEGAL COUNSEL

- The denied treatment involves a life-threatening condition
- You have been denied coverage for care you already received
- You believe the plan has acted in bad faith
- The monetary value of the denial is significant

Patient rights attorneys often work on contingency for insurance cases. Your state bar association's referral service can connect you with one.

#### A DENIAL IS NOT THE END

- Providing additional documentation
- Correcting errors or missing information
- Demonstrating prior treatment history
- Submitting a formal appeal
- Requesting peer-to-peer review

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- Filing for external review when available

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- Escalating to state or federal regulators

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