



Navigating Long-Term Care Insurance Appeals

AN EXPERT GUIDE

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Summary

This white paper provides a comprehensive guide for policy holders who face a denial in their long-term care insurance (LTC) claim and to equip policyholders with the necessary knowledge and strategies to successfully appeal and overturn a denial. The document outlines the common reasons for LTC insurance denials, the appeal process, practical tips for managing an appeal, and resources for additional support.

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Expert Support

With over seven years of experience, our in-house long-term care insurance expert can handle all the filing necessary for our clients to receive their maximum benefit. We will take over the administrative aspects of each claim, allowing families to focus on their loved ones.

Introduction

Long-term care insurance is critical for many individuals as it covers services and supports not typically covered by regular health insurance, Medicare, or Medicaid. However, policyholders can face challenges when their claims are denied. Understanding the reasons for denial and the appeal process is crucial to obtaining the funds needed to get care.

Common Reasons for LTC Claim Denials

1. NON-QUALIFYING CONDITIONS

- Claims can be denied if the care needed does not meet the policy's criteria for long-term care. This includes not meeting the required number of ADLs (Activities of Daily Living; dressing, bathing, toileting, continence care, transferring, or feeding) or showing medical need due to a cognitive impairment.

2. LACK OF MEDICAL NECESSITY

- If the third-party nurse that assessed the insured determines that the care is not medically necessary, they may deny the claim.

3. INCOMPLETE DOCUMENTATION

- Insufficient or incomplete documentation of the care needed can result in claim denial. This can include not submitting all the necessary forms in the initiation packet, medical records requested, or provider information.

The Appeal Process

1. INITIAL REVIEW

- **Understand the reason for denial:** Typically, the insurance company will send the insured a letter via mail explaining why their claim was denied. The language in this letter will be used to appeal the claim.

2. FORMAL APPEAL

- **File a formal appeal letter:** Outline why the claim should be reconsidered and include any new or overlooked information. This includes an outline of need with at least 2 out of the 6 assistances of daily living (feeding, dressing, toileting, continence care, transferring, or bathing) or a cognitive impairment. When we mention assistances of daily living, it is imperative to use words like “hands on” or “total assistance” in your appeal when discussing need. The need for assistance in daily living and/or cognitive impairment will be used to counter each of the reasons for why the insurance company chose to deny the claim.
- **Provide supporting documents:** Submit all relevant medical records (hospitalizations, conditions, surgeries), a doctor’s statement, and any other evidence supporting the need for long-term care. The medical documents don’t have to be recent. You can use documents, conditions, etc. that have been written years ago for appeals. LifeWorx can also provide care notes that are written by the caregiver who is in the home with the insured party outlining the assistance of daily living they support them with, as well as a plan of care that can be conducted by our Registered Nurse.
- **Providing proof of continuous care:** It is important to continue showing that the policy holder is receiving care, even if their claim was initially denied. This is done by submitting invoices from an agency or facility. It can be stressful to continue care after being denied by your insurance provider as many policy

holders worry that they won't get reimbursed. What many don't know is that even if they write an appeal but cut off services, the insurance company can use that as further proof that they don't really "need the services" if they are able to stop care abruptly. Once the policy holder is approved, their start of care is retroactive, meaning we can submit invoices from the start of service, not just from when they got approved.

3. EXTERNAL REVIEW

- If the internal appeal is unsuccessful, the policyholder can seek an external review by an independent third party. This can typically take between 60-90 days.

4. LEGAL ACTION

- As a last resort, legal action may be considered. Consulting with an attorney who specializes in insurance law can provide guidance as well as filing a complaint with the state towards the insurance company.

Best Practices for Managing an Appeal

1. DOCUMENTATION

- Keep detailed records of all communications, submitted forms, and received documents related to the claim. Examples of key documentation for an appeal include the denial letter from the insurance company, detailed care notes, medical records, communication records with healthcare providers, appeals forms, and any correspondences with the insurance company.

2. TIMELINESS

- Be aware of and adhere to all deadlines for filing appeals to avoid automatic denial due to procedural delays.

2. PERSISTENCE

- Staying persistent and following through with all appeal stages is essential for overturning a denial. Policyholders should follow up with the insurance company's claims department or the designated appeals manager.

Conclusion

Navigating the appeals process for a declined long-term care insurance claim can be challenging, but with proper preparation and understanding, many denials can be overturned, and care can be better afforded. LifeWorx aims to empower policyholders with the knowledge to effectively manage and appeal denials, ensuring they receive the benefits they rightly deserve.

Additional Resources

LifeWorx has put together an additional long-term care guide and other resources that anyone can access to learn everything from the essentials to expert policy management tips.

- [Long-Term Care Guide](#)
- [FAQs](#)
- [Resources](#)