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Recommended Procedure in Case of Denial of Coverage for Surgery by Accident Insurance in Switzerland

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1. **Request a Formal Written Decision**
    - **Action:** Contact the accident insurance provider and request a detailed written explanation for the denial.
    - **Legal Basis:** Under Article 49 of the Federal Act on the General Part of Social Insurance Law (ATSG, SR 830.1), accident insurance providers are required to provide a written and reasoned notification of their decisions, known as a "decision on insurance benefits."
    - **Importance:** This formal decision is essential to initiate the appeal process and understand the specific reasons for the denial.

2. **Analyze the Decision Based on Legal Criteria and Listed Diagnoses**
    - **Definition of an Accident:** Verify that the event meets the legal definition of an accident, which includes a sudden event, an external factor, and an involuntary injury to health (Article 4 ATSG). The decision to classify an event as an accident is a **legal decision**, and the burden of proof lies with the patient. It must be demonstrated that it is **more than 75% likely** that the event caused the injury for causality to be recognized.
    - **Case of Listed Diagnoses:** If the causality of the accident in the classical sense is rejected, the accident insurer is obligated to check whether the injury can be classified as a **listed diagnosis** (Article 9, Paragraph 2 LAI). In the case of a **tendon rupture**, for example, it is sufficient for a medically relevant event to be present, even if it does not constitute an accident in the legal sense. If this condition is met, the accident insurer is liable to pay benefits.
        - If the accident insurer also rejects the listed diagnosis, **the burden of proof is reversed**. The insurer must then prove that it is **more than 50% likely** that the injury is of degenerative origin.
    - **Current Practice:** According to experts such as Diane Günthart, author of the book *Causality Issues of Rotator Cuff Lesions as a List Diagnosis (« Listendiagnose ») from a Medico-Legal Perspective*, accident insurers, including SUVA, often fail to perform this essential check. However, affected patients can demand that the insurer carry out this review.

3. **File an Objection**
    - **Action:** If you dispute the decision, file a written objection with the insurer within 30 days of receiving the formal decision. You can contest the classification of the event as a non-accident or request a review to determine whether it qualifies as a covered injury or a listed diagnosis.
        - If the insurer rejects the request, it must provide a detailed explanation of why the event is not classified as an accident or a covered injury. If the rejection is based on wear and tear or illness, request a precise and detailed justification for this argument.
    - **Legal Basis:** Article 52 ATSG allows insured individuals to file an objection within 30 days of receiving the decision.
    - **Justification for the Objection:** Include any additional evidence to support your claim. If a listed diagnosis is in question, insist that the insurer fulfill its legal obligation to check for this possibility and provide proof if it denies the claim.
    - **Legal Protection Insurance:** If you have legal protection insurance, it may cover the costs associated with filing the objection.

4. **Appeal to the Cantonal Insurance Court**
    - **Action:** If the objection is denied, you can appeal to the competent cantonal insurance court in your canton of residence within 30 days of receiving the objection decision.
    - **Legal Basis:** Article 56 ATSG allows appeals against objection decisions to the insurance court.
    - **Contact Legal Protection Insurance:** If you have legal protection insurance, contact them before filing the appeal. They can provide legal assistance and cover the costs of the procedure.
    - **Importance of the Appeal:** This appeal is an additional means of asserting your rights. The procedure is often free, and although legal assistance is not mandatory, it is recommended for complex cases.

5. **Inform Your Health Insurance Provider**
    - **Action:** Notify your health insurance provider (LAMal) as soon as you receive the denial of coverage from the accident insurance.
    - **Importance:** If the accident insurance denies coverage, the health insurance provider may be required to cover the costs of the procedure under the LAMal framework. This ensures that your treatment is not delayed due to disputes between insurers.
    - **Advice:** Attach a copy of the written decision from the accident insurer to support your request.

6. **Consult a Specialist and Contact the Ombudsman**
    - **Consultation with an Expert:** It is recommended to consult a legal expert specializing in insurance law who can help prepare your appeal by gathering the necessary medical and legal evidence to support your claim.
    - **Assistance from the Ombudsman:** Contact the health insurance ombudsman for free advice and support throughout the appeal process. This body can help facilitate dispute resolution.

Procedure Summary

1. Request a formal written decision (Article 49 ATSG).
2. Analyze the decision based on the definitions of an accident and listed diagnoses (Articles 4 ATSG and 9, Paragraph 2 LAI).
3. File an objection within 30 days (Article 52 ATSG).
4. If the objection is denied, appeal to the cantonal insurance court and contact legal protection insurance if available (Article 56 ATSG).
5. Inform your health insurance provider of the accident insurance's denial.
6. Consult a specialist and contact the ombudsman to maximize your chances of success.

By following this structured procedure and considering **listed diagnoses**, you can effectively challenge the insurer's decisions and assert your rights under the ATSG and LAI.

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