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## Don't Give Up if Health Insurance Claim is Denied

Posted on July 19, 2011 by Robert Kraft

Columnist Pamela Yip of the Dallas Morning News is a wonderful source for information about all aspects of personal finance. I highly recommend you read her regular column, as she covers many topics of special interest to senior citizens.

One recent column applies to anyone who has health insurance, and really can be expanded to cover any other type of insurance. The bottom line is — don't take NO for an answer. There is always an avenue of appeal to any insurance company's initial denial of a claim. For that matter, this could also apply to any denial of benefits from a government agency.

Please read the column for details. Here are a few highlights:

“Just because a claim is denied doesn't mean by any stretch that it's final,” said Jared Wolfe, executive director of the Texas Association of Health Plans.

There are several reasons health insurance companies deny claims:

Your doctor or health care provider may have submitted incorrect or missing treatment codes or incomplete information on the claim form.

“By far, the biggest reason claims are denied is when they are submitted inappropriately or in duplicate by the provider,” Wolfe said.

Read the explanation of benefits or denial letter from your insurance company carefully to see why it denied your claim. Call your insurer if it isn't clear and ask what needs to be corrected to have the claim reprocessed.

Then have your health care provider make the corrections and resubmit the claim. Be sure you

follow up with the insurance company to ensure that it received the claim and that everything is in order.

**“You're dealing with bureaucracies that are making decisions,” said Martin B. Rosen, co-founder of Health Advocate Inc., a service offered by employers that enables employees to resolve clinical and administrative issues, including claims disputes with health insurance companies. “Things happen.”**

Texas law requires insurance companies to pay claims promptly and penalizes them if they don't.

However, the prompt-payment law does not apply to self-funded health insurance plans, even though they may use an insurance company or HMO to administer the health plan.

In a self-funded plan, employers pay the claims themselves instead of paying premiums to an insurance company to provide coverage.

However, both insurance companies and self-funded plans have internal appeals processes.

What's more, the federal Patient Protection and Affordable Care Act of 2009 governs how health care plans must handle an initial appeal.

If your plan upholds its decision after its internal review, the law permits you to appeal to an independent reviewer.

The law also requires self-funded plans to contract with accredited independent review organizations to handle external reviews. They weren't required to do so before the health care act was approved.