

## Don't give up... if health insurance claim is denied

By PAMELA YIP | *The Dallas Morning News*

When your health insurance company denies a claim for payment, your first impulse may be to give up. Don't.

You have the right to appeal if your claim is denied, and you may be able to get the decision reversed.

"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."**

Another possible reason: The treatment isn't covered by your insurance policy.

Understand your insurance policy thoroughly and review it regularly, particularly the exclusions and limitations on coverage.

"If your policy only pays for in-network care but you chose to go to a non-contracted provider without prior approval, it will be denied," said Erin Moaratty, chief of external communications at the nonprofit Patient Advocate Foundation.

It's critical that you follow your policy to the letter, she said.

"If it dictates that prior authorization is required, then don't receive care without obtaining that authorization," Moaratty said.

"Doctors work with many insurers, and you really should verify benefits," she said. "Don't assume it is a covered or most cost-effective option."

The insurance company doesn't consider the treatment medically necessary and views it as experimental or investigational.

Health care services, procedures, therapies, devices or supplies that an insurance company considers medically unproven are considered experimental or investigational. Such treatments are typically excluded from coverage.

Make sure your doctor understands what treatments and medications are covered by your policy.

**"Where your doctor is going to be important is documenting the need for a procedure," Rosen said.**

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.

**Review the details of your insurance appeals process. "Insurance companies are**

**required to give you all the tools you need to properly make an appeal," Rosen said. "There are certain time frames to appeal, so make sure you act fast."**

Ask to see the policy language backing up the denial of your claim.

Make sure you have all your paperwork in order. Keep records of everything - the bills from your provider, your explanations of benefits, copies of denial letters, your medical records and letters from your health care provider.

Take detailed notes when you speak to the insurance company. Write down the time and date, length of the call, the name and title of the person you speak with and all the details of the conversation. Make note of any follow-up activities and next steps by all parties.

Contact your employer's human resources department. It can give you some direction and translate the fine print of your policy.

Write down your argument. Make notes of exactly what happened, when and why. If you are seeking approval for treatment, note any supporting science, clinical evidence and expected benefits. Be clear, firm and concise. Make it clear that you plan to pursue the appeal until it's resolved and the claim is paid or care is approved.

While you certainly have an emotional investment in your health and that of your loved ones, keep emotions out of your appeal. This is a business decision.

**"You need to frame the issue objectively around what was the reason for the denial," Rosen said. "Because 'My poor child is suffering' is not the reason why it should be covered. It should be whether there should be coverage for the issue in the first place."**