Don’t Take No for an Answer When Insurer Denies Your Medical Claim

Pamela Yip  
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When you’re sick, dealing with the illness can be hard enough. But when your insurance company denies your claim for treatment or payment, that’s another — often bigger — headache. Rest assured, however. You don’t have to take no for an answer. "If a patient’s got insurance and their claim has been denied, they shouldn’t take that as the final decision, especially now under the Affordable Care Act," said Mark Rukavina, principal at Community Health Advisors LLC in Chestnut Hill, Mass.

The ACA ensures your right to appeal health insurance plan decisions. The law also requires that your plan must notify you of:
• The reason your claim or coverage was denied.
• Your right to file an internal appeal, with instructions on how to submit an appeal.
• The deadline for submitting your appeal.

The first step is an internal appeal in which you ask your insurance plan to reconsider its decision to deny payment for a service or treatment. If your plan still denies payment after this step, the law permits you to have an independent party review the plan’s decision. This external review means that the insurance company no longer has the final say over whether to pay a claim. Under the ACA, your insurance company can’t drop your coverage or raise your premium because you asked it to reconsider a denial. Here’s what you need to know about appealing.

Head off trouble
“Try, if at all possible, to avoid the denial,” said Martin Rosen, co-founder of Health Advocate. “There are plenty of things that consumers can do to avoid a denial, starting out with understanding and following the directions and the descriptions of the health plan.”

Before undergoing a procedure, ask how much it will cost and how much your insurance company will cover. Much of that will depend on whether you’ve met your deductible and annual out-of-pocket maximum.

Know the rules. Your insurance company may require pre-authorization for a procedure. Get your doctor on your side because he or she will be able to show the insurance company that the procedure is medically necessary.

“Your doctor would call up and do a peer-to-peer conversation with the medical team at the insurance company,” Rosen said. “You really want to enlist the support of your doctor to make sure that you’re making the best possible case.” Stay in network. Rosen said many denials result from someone unknowingly doing something that their plan doesn’t allow. “For example, going out of network,” he said. “It’s as clear as day in some plans that if you go out of network, you’re not going to be covered. Or you’ll be covered at a much lower rate and pay more money.”

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Understand your plan
A health insurance plan can be self-funded or fully insured. In a self-funded plan, an employer pays for its own medical claims directly and hires an administrator, such as an insurance company, to process claims.

In a fully insured plan, a company pays a premium to an insurer, which pays health claims based on the policy the employer has purchased. If your company’s plan is self-funded, “the employer may maintain influence in the ultimate decisions” related to the payment of medical claims, according to the Patient Advocate Foundation. “Although your company has likely contracted with a third-party organization to manage the plan, in essence, the company sponsoring the plan can make decisions as your medical insurer.”

For that reason, keep your company’s human resources and employee benefits departments aware of your appeal intentions. Tell them about the insurance barriers you’re running up against and how they’re affecting your health care.

Check your info
No matter which type of plan you’re in, “patients should always pay close attention to the documentation associated with an insurer’s decision,” said Kelly Alvord, spokeswoman for the Patient Advocate Foundation.

That includes “the specific reason for denial, the timelines associated with appealing, as well as medical documentation related to the treatment/procedure in question.”

Make sure there’s no missing or incorrect information. “A lot of denials happen because the information provided by the provider is inaccurate or incomplete,” Rosen said. Check the Explanation of Benefits sent by the insurance company to make sure the information on it is accurate and complete.

Also, make sure your doctor used the proper treatment or procedure code. An improper code may result in a claim being rejected or incorrectly paid.

Be sure to keep good records.
“Keep good notes and write things down, including conversations that you might have had either with a provider or with an insurance company,” Rosen said. “Documentation is really important when you get to the appeals stage.”

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Find more information on your appeal rights under the federal Affordable Care Act:


Texas Department of Insurance: tdi.texas.gov/pubs/consumer/cb057.html.