

Dealing with Insurance

Everything You Need to Know to Become a Smarter Healthcare Consumer



Handle a Denied Medical Claim

Explanations of benefits (EOBs) from the insurance company are complicated and difficult to understand. It's no wonder they are frequently tossed aside – unopened. However, that EOB is critically important! It explains how much of the claim your insurance company covered and paid to the provider, or (gasp!) it may reveal that your claim was denied. A denied medical claim is anything but welcomed, and often arrives without warning. This occurs when your insurance company does not approve payment for treatment or other medical services.

A denied medical claim can happen for a number of different reasons, even sometimes legitimately. Here are some examples: you have hit your maximum lifetime benefit, you have received a non-covered service or experimental treatment, the provider coded the services incorrectly, you might have a pre-existing condition that is still not covered. The list goes on. That's why it is important to open and read your EOB. Once you start opening your EOBs (if you already do – good for you!), knowing how to handle a denied claim and the insurance company's reason for denial, makes the process of appealing the claim a little bit easier and somewhat less stressful.

Preventative measures:

Before we dig into the details of how to appeal a denied claim, let's start with some preventative measures:

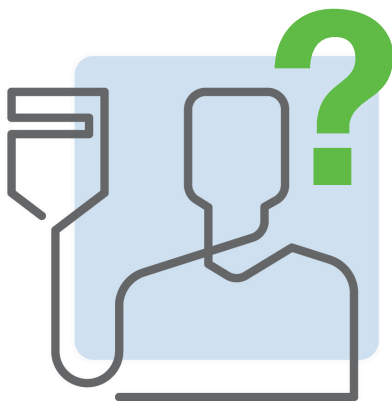
Understand your insurance policy and benefits

Knowing what your plan will and will not cover, prior to a procedure or doctors appointment, allows you to make more informed decisions about your healthcare. Depending on your carrier and benefit plan, this information will be outlined on the insurance company's web site or is available from your HR department.

Know when you need to obtain pre-authorization

It is your responsibility to know when you need to obtain pre-authorization for a procedure or doctors appointment, and to make sure you and/or your provider receives approval. You can also find this information in the benefit plan documentation or by calling the insurance company's customer service.

How do you know if a claim is denied



You already paid your co-payment and saw the doctor. It's over and done, right? Well not exactly. No one particularly enjoys sorting through the paperwork after a doctor's visit or surgery, but the EOB, sent by your insurance company, is one of the only ways to determine what the insurance paid to the provider and how much you may still owe. It will also disclose if your claim has been denied! How do you know? For starters, the insurance company payment will show \$0. This may or may not be a denial depending on your insurance policy, but this \$0 payment should be followed by a "Reason Code(s)," which will provide an explanation for the lack of payment. If you're lucky (ha!) the insurance company will send you a letter confirming the denied medical claim and detailing their reason(s) for denial.

How to appeal a denied claim?

If all or part of your claim is denied and you have reason to believe it should be covered, follow these steps:

Step One:

Collect and organize all information pertaining to the denied claim. Make sure you have the original bill (containing the date(s) of service and the provider's name), your EOB and your insurance card before placing a call. If the insurance company sent you a letter, have that available as well. **Most importantly, review a copy of your insurance policy and know what part of the policy leads you to believe this claim should not have been denied.**

Step Two:

Call the number provided on the letter from your insurance company, or if you did not receive a letter, the customer service number. There is a possibility the claim was denied because of missing information. Once the missing information is provided, the claim will be re-processed, and you're done.

If this is not the cause, ask the representative for suggestions or guidelines for appealing a denial. If you would like an appeal form, ask them to send one via the mail or email. Make sure you have the address for the appropriate department to return the completed appeal documents. Always keep a record of the date, time and the name of the customer service representative you talked with, along with a brief summary of the discussion. Keep this with copies of any documents you send to the insurance company.

Step Three:

In appealing the denied claim, you should have the opportunity to review the information the insurance company used to make their decision. If necessary, get your doctor involved. Their office has staff that can help explain, and even send a letter explaining why the procedure/care was needed, or "medically necessary."

Step Four:

Remember each insurance company has its own appeal process and time constraint, or deadline, for appeals (typically 90-120 days from the date of service). Before submitting your information, make sure you have completed and include all required paperwork per your specific insurance company's website or customer service representative. Once all documents are complete, make a copy of everything for your reference.

Step Five:

If your insurance company denies the claim again, in most cases, you can contact them to request an external appeal, which will be conducted by a medical professional not associated with the insurance company.

NOTE:

Remember to stay calm as you're talking on the phone with an insurance representative. A written appeal that is clear and factual carries more impact than a lengthy emotional telephone call.

TERMS TO KNOW

Appealing a denial: the process to contest a denied medical claim. Most insurance carriers have their own processes and timeline for contesting.

Carrier: the insurance company that issues your insurance policy.

Claim: an overview of delivered care and a request for reimbursement, typically submitted by the provider to the patient's insurance company. Claims are reviewed by the insurance company. This review process determines coverage of services and ultimate payment to the provider.

Co-payment: the fixed amount that an insured patient is expected to pay out-of-pocket at the time of service.

Denied medical claim: rejection of a request for reimbursement for healthcare services delivered to the insured patient. The insurance company often informs the patient of the rejection and explains why the services are believed to be outside of those agreed upon in the insurance policy.

Insurance carrier: see carrier

Medically necessary: medical services that are essential or required for the diagnosis and/or treatment of a medical condition.

Notes:

Explanation of Benefits (EOB): documentation created for the patient by their insurance company to communicate the results of a claim submitted on the patient's behalf. The EOB format may vary widely between insurance companies, but they all present the same basic information.

Insurance policy: a contract between the insured individual and the insurance company detailing which health and medical services are covered by the insurer and the price for coverage paid by the individual.

Reason Codes: an alpha-numeric system typically presented and defined at the bottom of an Explanation of Benefits (EOB), used to further clarify how the insurance claim was processed. They are very important in understanding why the insurance company denied all or part of your claim.

Pre-Authorization: confirmation of coverage by the insurance company to a patient for a service or product prior to receiving the service or product from the medical provider.

Provider payment: amount of money paid to the healthcare provider from the insurance company.

CHECKLIST

Make sure to have these important items when speaking with an insurance representative.

- Original Bill
- EOB
- Insurance Card (Group Number)
- Customer Service Phone Number