HEALTH CARE CLAIM FACT SHEET

Fred's son, Jimmy, exhibited behavioral challenges from a young age. As a teenager, Jimmy exhibited less control. Jimmy's treating psychiatrist concluded that intensive out-patient therapy wasn't working and Jimmy needed in-patient treatment. Jimmy's psychiatrist determined the best treatment facility was located in the Western US, far from Jimmy's home in an Eastern state. Fred's health care insurer, part of the Blue Cross Blue Shield, was non-committal about pre-approval. The psychiatric facility agreed to accept Jimmy as a patient, because most Blue Cross system members covered the costs of care which ran $18,000 per month. After 6 months of in-patient treatment, Jimmy was discharged as his condition had markedly improved. The health insurer refused to pay the claim. Fred now faced paying a health care bill in excess of $100,000.

Disputing a Health Care Claim Denial

Receiving denial of a health care claim from insurance company can cause a great deal of financial worry especially if you have accrued large medical bills. We understand the panic and stress our clients feel about escalating medical bills, but there is light at the end of the medical debt tunnel.

The bad news is that health care claim denials are not uncommon for certain treatments. The good news is that when a claim is denied you have the right to demand that an insurer reconsider your health claim denial.

Remember a denial is the beginning not the end. If your plan reviews the case and still won't reconsider its decision you have the right to appeal.

Don't assume the process will be easy. Unfortunately, appealing a health care claim denial takes time and energy which is even more challenging when you or a family member is sick.

3 Common Reasons for Health Care Claim Denials

1. Improper coding of the procedure, or other errors on the part of the health provider.
2. Care that was performed outside of the health plan's network.
3. Care that the insurer deems was not medically necessary, or was experimental.

Insurance Companies Have to Explain Why

After you or your medical provider have submitted a claim, by law health insurers have a limited time to explain in writing their decision to deny payment. Typically, the health insurer must provide

- Timeline for Written Explanation of Denial of Payment
- Within 15 days if you are seeking authorization ahead of treatment
- Within 30 days for medical services you've already received

If the health insurance company says it won't pay, you need to formally ask it to take another look at your claim. You must request this "internal appeal" within time limits of your plan. The time limits vary. Some are generous and can be as-long-as 1 year. Often the time limit is 60-days. Check your plan.

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Quick Response to Appeals is Required

After your insurance company receives your request for an internal appeal, it must take another look at your claim and make a new decision. For urgent medical matters, this can be 72 hours or up to 60 days for other types of care.

Still "No" - Request an External Review *

If your claim is still rejected after your internal appeal, you can file for an "external review," in which an independent third party will go over your case. Many states have external review procedures but not all. If your state doesn't have an external review process that meets the minimum consumer protection standards, the federal government's Department of Health and Human Services (HHS) will oversee an external review process for health insurance companies in your state.

Meets Parallel

Arkansas
California
Colorado
Connecticut
Hawaii
Idaho
Illinois
Iowa
Indiana
Kansas
Kentucky
Louisiana
Maine
Maryland
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Rhode Island
South Carolina
South Dakota
Tennessee
Utah
Vermont
Virginia
Washington
West Virginia

Territory

Puerto Rico

Meets Similar

Arizona
Delaware
District of Columbia
Massachusetts
Michigan
New Mexico
Texas
Wyoming

HHS Administered Process/Independent Review Organization Process

Alabama
Alaska
Florida
Georgia
Pennsylvania
Wisconsin

Territories

American Samoa
Guam
Northern Mariana Islands
Virgin Islands

* As of March 2016

Usually the outside reviewers are health professionals who have experience managing medical issues in the nature of coverage sought. The quality varies by state. External reviewers consider

- Any denial that involves medical judgment where you or your provider may disagree with the health insurance plan
- Any denial that involves a determination that a treatment is experimental or investigational
- Cancellation of coverage based on your insurer's claim that you gave false or incomplete information when you applied for coverage

Good Chance of Winning Your Appeal

Many people give up too easily. Although a tedious process, we have found that if done correctly there is a good chance that you could win you appeal.

6 Tips for Winning Your Health Care Claim Denial Appeal

A health care claim can be denied for numerous reasons. Here are a few easy steps that can help your chances of wining your appeal

1. **Learn why your claim was denied**
   You need to understand why your claim was denied before you can fight. Start with reviewing your explanation of benefits (EOB) and the codes used to explain the decision. The EOB is a standard form sent by the insurance company whenever you have a claim, regardless if it is approved or denied. Research the codes on your EOB and learn what they mean and if they are correct.
2. **Investigate Errors**
   Sometimes a payment was denied due to a simple error. Check:

   - Misspelling
   - Insurance ID Number
   - Date of Service
   - Other coding

   If a mistake was made ask the insurance company or health care provider to correct it and resubmit your claim.
3. **Compile Medical Evidence**
   Gather all the evidence to show that the services you need covered are medically necessary. Referrals, prescriptions from your doctor and any relevant information about your medical history may help your claim get approved the second time around.
4. **Proper Paperwork is Important**
   If you need to write a letter to your insurance company make sure to include the correct claim number and the number on your health insurance card. Check to see if you can use standard insurance company appeals form, it will speed up the process. Your insurance company should give you information about this. Don't limit your documents to forms. Provide as much relevant documentary evidence as you can.

5. **Keep a Paper Trail**
   Keep track of all your paperwork and take careful notes during every phone call with the insurance company. Record the name and the job title of the person you're speaking to and write down the date of the conversation and any next steps. Ask for a "call reference number," and if an appeal was submitted, get the "document image number." This information will help you build your case and enable you to brief the next customer service agent and help you move the appeal process forward.

6. **How to Accelerate the Process if Needed**
   It's the law, you can file an expedited appeal if the timeline for the standard appeal process would seriously jeopardize your life or your ability to regain maximum function. In such cases, file internal and external appeals simultaneously. If you're too sick to take care of this on your own, your doctor can file an external appeal on your behalf.

   Our clients benefit from having someone on their side who understands the complicated appeal process and is skilled at navigating it. Last resort, file suit.

   To talk with a lawyer you can trust about fighting your health care claim visit us at www.erisaattorneys.com, or call us at **617-357-9700** or toll-free at **866-396-9722**. Your initial consultation is free.