Get Your Health Insurer to Pay Up
Former Claims Examiner Tells All

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Every time you make a claim under your health insurance policy, there is a substantial possibility that your insurer will decide to reject it. When claims are rejected, policyholders must either pay out of pocket for medical bills—some of which can be massive—or spend an inordinate amount of time battling a corporate bureaucracy about complex insurance issues that they do not fully understand. The more you know about how the system works and what you can do to make it work better for you, the more success you likely will have.

Here’s how to reduce the odds that your health insurance claims will be rejected—and what to do when a claim is rejected.

BEFORE OBTAINING TREATMENT
When you require out-of-the-ordinary non-emergency medical care, especially from a provider that you haven’t used before...

Get the go-ahead for the procedure from your insurer. This may seem obvious, but people often forget. It is worth doing whenever you need medical care that is more complex than the standard doctor’s visit—even if the same procedure has been covered in the past. Ask to have this “preauthorization” sent to you in writing.

Obtaining preauthorization prevents the insurer from later denying your claim, on the grounds that the procedure or the test was not medically necessary. Insurers have begun to demand preauthorization more and more in recent years, and they are denying claims when it is not obtained. If your insurer will not preauthorize a procedure, do not assume this rejection is final. Ask your doctor to submit a letter to the insurer explaining why the procedure is required in your case.

Problem: The health-care provider entered a billing code incorrectly. Every medical procedure has a five-digit “Current Procedural Terminology” (CPT) code. Every medical diagnosis has a specific code, too. If your health-care provider enters a code or diagnostic code incorrectly—which happens with surprising frequency—your insurer isn’t likely to waste time trying to figure out what’s wrong. It will just reject the claim.

What to do: When an insurer rejects your claim, confirm that the policy number and group number on the paperwork corresponds with your current policy.

Problem: The insurer continues billing you after you’ve met deductible and/or out-of-pocket maximums. If your insurer fails to properly track the medical procedures that you have had and/or the payments you’ve made during a year, you might be asked to pay more than you should.

What to do: Keep a file each year of your medical bills...health insurance Explanation of Benefits (EOB) statements...and a tally of the amounts you pay out of pocket.

OUTSIDE HELP
If speaking with the insurer proves to be fruitless, your options include...

Tell the insurer that you plan to contact local legislators and the local media. If necessary, go to the legislators and the media and explain why you believe the insurer is being especially unfair and how this might affect other consumers, too. This often works well.

If you have group coverage, call your employer’s human resources representative, your union, or the organization through which you obtained insurance. Ask for help negotiating with the insurer.

If you’re age 65 or older, contact your state, county or local Department of Aging to request assistance. (Enter “Department Aging” and your state, county, or municipality into a search engine to find this agency—its name might be slightly different in your state.) The agencies offer helpful advice and, in some cases, even pay the insurance, the medical provider and/or state insurance regulators.

Ask your state’s Department of Insurance for guidance. (Enter “Department Insurance” and the name of your state into a search engine. In some states, insurance issues are handled by the Department of Financial Regulation.) Often the regulators are very aggressive and helpful in getting insurers that are licensed by the state to pay—sometimes with interest.

Hire a claims-assistance professional. Locate a claims-assistance professional through the website of the National Association of Healthcare Advocacy Consultants (NAHAC)...or the Alliance of Claims Assistance Professionals (Claims.org). You should expect to pay $75 to $175 an hour for these services or, with some pros, up to 35% of the amount you save in medical costs.

A case may take as little as an hour to resolve if one phone call does the trick...or many hours in complex cases. The professionals understand state insurance laws and policy details, and insurers are less likely to think that they can push the process around.

More from Adria Gross

Negotiate Out-of-Network Bills

If you obtain medical treatment in a non-emergency situation from a health-care provider that is not in your insurance policy’s network, you might be left with especially large out-of-pocket expenses.

Before receiving such services, go to CMS.gov, the website of the Center for Medicare and Medicaid Services, and use the Physician Fee Schedule Search tool to find the appropriate Medicare fee schedule for the procedure code in your area. (Ask your doctor for their procedure’s five-digit CPT code.) Insurance companies often base their definitions of “usual, customary and reasonable” charges on Medicare fees.

Next, call the out-of-network provider’s billing representative, and ask for its rate for the services.

If the rate is above the Medicare rate in your area, cite that rate and ask whether the provider can match it. Often, the medical provider will accept that going rate or whichever rate your insurer is willing to pay.

If not, contact the billing department of other health-care providers in the area that can provide the services.

Also, contact your insurer to see whether it will increase the payment you can get closer to what the provider is billing. Sometimes this works. But don’t expect to receive 100% reimbursement for out-of-network costs under most insurance plans.