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Get Your Health Insurer to Pay Up

Former Claims Examiner Tells All

Adria Gross
MedWise Billing, Inc.

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.

If preauthorization is again denied, ask your doctor to try again, this time describing your health situation and the necessity of the procedure in greater detail. Insurers often back down when patients and doctors persist.

IF A CLAIM IS REJECTED

Investigate why the claim was rejected before paying a medical bill out of pocket. There might be a way to get your insurer to pay it after all. Possible problems and solutions…

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 number, too.

If your health-care provider enters a procedure 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. >>

Bottom Line/Personal interviewed Adria Gross, CEO of MedWise Billing, Inc., Monroe, New York, a medical-billing advocacy company that assists health insurance customers in disputes with their insurers. She previously worked as a claims examiner with Blue Cross/Blue Shield and American International Group. MedWise Billing.com

>> *What to do:* If you believe that a code-entry error might be responsible for the claim rejection, present your concerns to the health-care provider's billing department and ask it to resubmit the bill to your insurer with the correct codes.

Problem: The health-care provider billed under the wrong insurance policy. This is particularly likely if your insurance recently has changed…or if this is the first time that you have received treatment from the health-care provider.

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 your deductible and/or out-of-pocket maximum. 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.

When you believe that you have reached your annual deductible and/or out-of-pocket maximum, make sure that the insurer doesn't keep requiring you to pay more. If it does, ask the insurer to review its records and to explain why its tally doesn't match yours. Keep in mind that the insurer may not count the full amounts charged by out-of-network providers.

Problem: It isn't clear why the insurer won't pay a claim. Insurance company claim rejections can be very difficult to understand.

What to do: Call up the insurer's customer service department, and ask for a plain-English explanation of why the claim was rejected. If you don't understand or agree with what you're told, ask to speak with a supervisor. If the first person you speak with doesn't provide clarity, call back repeatedly and speak with a different representative and supervisor. Take notes documenting the time and date of each call, the person you spoke with and what you were told.

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 often provide helpful advice and, in some cases, even may call the insurer, 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.com)…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 pros 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 the 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 departments 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 to 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.