April 2008 Volume 4 Number 4

SPECIAL NEEDS RESOURCE PROJECT e-newsletter

Things to Think About!

By Brandan Atkin

If you need any further assistance on how to understand and manage your insurance claims, please feel free to visit these sites:

http://www.insure.com/articles/healthinsurance/claim-denial.html

http://www.insure.com/articles/healthinsurance/claim-denials.html

http://www.sdcers.org/images/pdf/carecounsel_manage_claim_records.pdf

http://articles.moneycentral.msn.com/Insurance/KnowYourRights/HowToFileAnInsuranceClaimAndWin.aspx

If there is anything that is not discussed in our newsletters and you would like to see it discussed, or you would like to be added to our newsletter mailing list, please contact us at snrproject@hotmail.com

Managing Medical Claims: Part II

What to Do When a Medical Claim Is Denied

By Linda Jorgensen

One of the most frustrating occurrences I deal with nearly every month is the denial of at least one insurance claim. Like many parents of a special needs child I am responsible for monitoring, and paying, a myriad of medical bills generated by our daughter's monthly medical treatments. This is not always an easy task but a necessary one. We simply cannot afford to be paying extra bills. I prefer to spend my hard earned dollar on other necessities. Like gas or groceries.

Many families believe a denial letter is the "end" of the road and the claim is now their responsibility. Just because a claim has been denied, no matter the reason, does not mean you have to take it lying down. Claims are denied for a wide variety of reasons. Failure to find out why a claim was denied frequently means the difference between getting the claim paid by the insurance company or you paying the bill out of your own pocket. Quite often it's a matter of the insurance company needing more information but you won't know this if you don't ask. In order to do this you must file an appeal.

There are seven basic steps in filing an appeal. Each step is important and should be followed in order.

Step One: The first step in launching a denial appeal is the same as filing the claim in the first place. **Review your Benefits and Policy Manual**. Was there something there that you missed? Did you read the fine print? Are you sure of the detail? Did you need a preauthorization and fail to get one? Having a firm understanding of your policy will help you know what questions need to be asked.

Step Two: Once you have reviewed your policy manual you'll need to **contact your insurance company** about your claim, the process to use and information you will need to appeal the denial. Be sure to document all pertinent information you discuss. I recommend using an SNRP Call Form. Be sure to document all of the following on your call form or in your notes if you are not using a call form:

- Company name
- Date and time of the conversation
- Name and title of the person you talked to. Be sure to note any other individuals you may talk to during your call.
- Account number and any questions you may have regarding the claim in question.

- Write a detailed summary of what was discussed and any instructions or information you were given.
- Write a short summary of any decisions or agreements reached.
- Be sure to add your signature to the bottom of the page, as this will allow reviewers to know whom the conversation was recorded by and provided the information. This could always be used as a legal document later, if needed. Information on this document may be used as part of the documentation packet submitted with your appeal letter. Remember. ***"If it isn't on paper, it didn't happen".***

Step Three: Write your letter of appeal. After you have contacted your insurance company and you understand what information you need it's time to sit down and write a letter requesting an appeal. Be sure to be clear and concise. State you are requesting an appeal, and why. Quote the manual when appropriate for reference. Use your copies of the medical bill, letter of denial, copies of all conversations (completed call forms) and correspondence relating to the denied claim. Be sure to outline the steps you have taken and list the documents you are attaching for review.

Step Four: Ask for help. Once you have your letter written you may need further assistance in proving your case. If so, get help. Contact your Primary Care Physician and tell him/her you are appealing a claim denial and need assistance. Ask for a letter of medical necessity, medical records or any other information requested by the insurance company which will aide you in stating your case.

Still need help? Contact your company Human Resources Office and ask for assistance in mediating an insurance claim denial. Many companies have an insurance mediator assigned to assist employees with difficult medical claims. They are also good at reading the fine print.

Step Five: Once you have gathered all your supporting documentation, asked for help and written your letter it is time to **submit your appeal packet**. Make copies of all documents in your appeal package. If sending by US Post, send the packet with a Delivery Confirmation slip and tracking number. Be sure to file this information with your copy of the packet.

Step Six: Track your appeal! This is the most important part of the process. You'll need to stay in touch with your insurance company. With many large companies an appeal could take a few weeks or even a few months. Most folks think, "No news is good news". No news makes ME nervous, unless I am told to wait for a specific amount of time. If a deadline passes and I still haven't heard anything, I call and ask for a status report on my appeal. The biggest majority of folks that lose out on benefits don't lose them because they are denied it's because they fail to follow through. If you want that bill paid for appropriately you're going to have to follow through until you have that determination letter in your hand.

Step Seven: Document the outcome. Every time you get a denial from someone, KEEP IT! A denial for a medical claim will give you extra leverage when filing for other assistance programs and using justifications for financial assistance. DENIALS ARE GOOD! I know, I can hear parents groaning about paperwork and bureaucracy but it is often imperative to go through the denial process in order to get other services available. If you want the services you need you have to fight for them. Unfortunately paperwork is a part of the system we have to deal with.

Military Families:** *Active Duty Military Members, or Reserve/National Guard Military members on Active Duty orders may find it helpful to start with the TriCare Benefits Appeal Information Line (see the US Military Resource Links list for contact information for the TriCare network provider in your Region.) Be sure to have the claim in question in your hand when you call. You may also find it helpful to contact your local TriCare Benefits and Services office located on the nearest Military Base. Most often the TriCare office is housed in the same building as the Base clinic. Don't know where to find it? Contact your local Base operator.* ***Military families still need to document all conversations and follow all other steps in filing an appeal.

Filing an appeal for a denied medical claim is not always an easy task but a necessary one. The time you spend may very well save you many dollars in the long run. Remember. ***"If it isn't on paper, it didn't happen".***