Get Your Health Claims Covered

Appealing a claim denial isn't hard—and preventing the denial in the first place is even easier.

BY **DEBBIE KOENIG**

ILLUSTRATIONS **RICHARD LILLASH**

If you have health insurance, at some point you may receive a bill for something that you thought would be covered. A 2017 study from the Doctor-Patients Rights Project found that 24 percent of people with chronic illnesses (including diabetes) had a claim denied by their insurance company. But among those who appealed the decision, the denial was overturned nearly half the time. “Often people assume the insurance company made a mistake and will fix it—but without an appeal that doesn’t happen,” says Susan Null, a principal at the medical bill advocacy firm Systemedic, Inc. Anytime you get an unexpected bill, you need to be the one to start investigating, says Null. “Without you initiating conversations, nothing’s going to happen,” she says.

1 Prevention Is the Best Medicine

The best way to ensure claims are covered happens before you even see a provider: Call your insurance company. Your doctor doesn’t know the particulars of your plan, but your insurance company can tell you exactly what’s covered in your policy, as well as which providers and pharmacies are in-network. Call to check what’s covered before scheduling tests and procedures, or filling new prescriptions. For pre-approval of procedures, ask your doctor’s office for the Current Procedural Terminology (CPT) codes they plan to use, then read these exact codes to your insurance company. “If they say you don’t need something pre-authorized, get it in writing,” says Adria Gross of MedWise Insurance Advocacy.

Even what’s supposed to be a free annual physical can lead to unexpected out-of-pocket expenses, Null says, since the insurance company and your ctor may not have the same definition of routine testing. Arrive at your ysical with the specific CPT codes approved by the insurance company, ugh, and you should be fine.

2 If You Get a Denial

Even when you do everything right, sometimes an explanation of benefits (EOB) delivers bad news (or is confusing). EOBs differ in structure and substance across insurance companies—but they almost always give as little information as possible, says Null. This makes it hard to determine if your claim has been processed correctly. You'll need to call the insurance company and ask a representative to explain it to you.

Before you do, though, make sure you have an itemized bill from your provider, and compare it to what appears on the EOB. Did you see multiple doctors in one visit? Check that each is listed with separate procedure codes. "If the insurance company sees the same code listed twice for one doctor, they won't cover it," says Gross.

3 Making the Call

Anytime you call your insurance company, the more information you gather, the better. Here's step-by-step advice from medical billing advocates:

- Ask for a reference number and the name of the person you are speaking with. Write both of these down, along with the date and time. "I've gotten denials turned around because a representative gave incorrect information," Null says.
- In certain situations, Gross recommends requesting written confirmation of what you've been told: when the representative says a procedure is covered or pre-authorization isn't required, and when someone quotes you the cost of a procedure or medication. You may need to go up the ladder to get a verification letter.
- If something feels wrong or inconsistent, ask more questions. Don't hang up until you understand.
- Not getting answers? Ask to speak with a supervisor.
- If the representative says your provider made a mistake or didn't include enough information, call the provider immediately.
- If the provider points a finger back at the insurance company, go back and ask the representative to set up a three-way conversation, so you can all talk.
- At the end of each call, ask one last question: Are you certain about what you've just told me, or do you need additional information? Then ask whether the call has been recorded. "That seals the deal if you ever need to dispute something," Null says.

4 Filing an Appeal

If phone calls don't get you anywhere, it's time to appeal. Your EOB will include instructions on filing and timing, so consult it first. But before you start the process, check with your provider's office—they're entitled to appeal, too, and because they know the process better, they stand a better chance of winning. If the denial is for a medical reason (rather than because the treatment is simply not covered), your doctor can request a peer-to-peer review. She'll talk on the phone with a doctor at the insurance company and explain your treatment plan. If your provider's appeals don't succeed, find out what reason the insurance company gave, then refute it when building your own case.

Most claims that are denied for medical reasons will have three levels of appeal, two with the insurance company and then an external review, conducted by an independent party. You'll need to provide more information with each round, to counter the reason for each denial. Sometimes, you'll feel like you're playing detective. "You have to lead the insurance company from point to point and explain specifically, like in a legal case, why they shouldn't be denying the claim," says Null.

After your appeals have been exhausted, don't give up! Ask for an external review, and request someone who's trained in diabetes care to review the case. If that review goes in your favor, the insurance company is legally required to pay.

CASE STUDY

CHRISTEL APRIGLIANO

She's the CEO of the Diabetes Patient Advocacy Coalition, but sometimes Christel Aprigliano has to advocate for herself. After outpatient surgery for trigger finger (a complication of diabetes that causes a finger to get stuck in a bent position), she was billed $1,200—the anesthesiologist was out-of-network. Aprigliano pushed back immediately, arguing that since she'd gone through the proper pre-authorization procedures, she had no way of knowing.

Ultimately, she won.

CASE STUDY

MELISSA LEE

A community relations director in Milpitas, California, Melissa Lee has had type 1 diabetes for almost three decades. When she was denied coverage for a CGM system, she researched online to find the insurance company's medical policy, which isn't usually shared with patients. It spells out the criteria for coverage. She met all the criteria, so she was able to build a successful case using her logged glucose numbers and other documentation.

Insider Tips from Advocates

▪ As soon as you get a bill, pay attention. Don't assume someone else will catch mistakes.
▪ Many first appeals are denied outright—don't give up.
▪ If you're uncertain about how to file an appeal, your state's Consumer Assistance Program can help. If your state doesn't have a CAP, the Centers for Medicaid and Medicare Services' website (*cms.gov*) lists other agencies that can help you.
▪ If you see lots of doctors due to complications of diabetes, consider hiring a medical billing advocate as a sort of concierge who'll handle problems on your behalf. Rates can be as low as $50 a month per person, and it could save you hundreds, says Null. Consult the Alliance of Claims Assistance Professionals (*claims.org*) to find an advocate.