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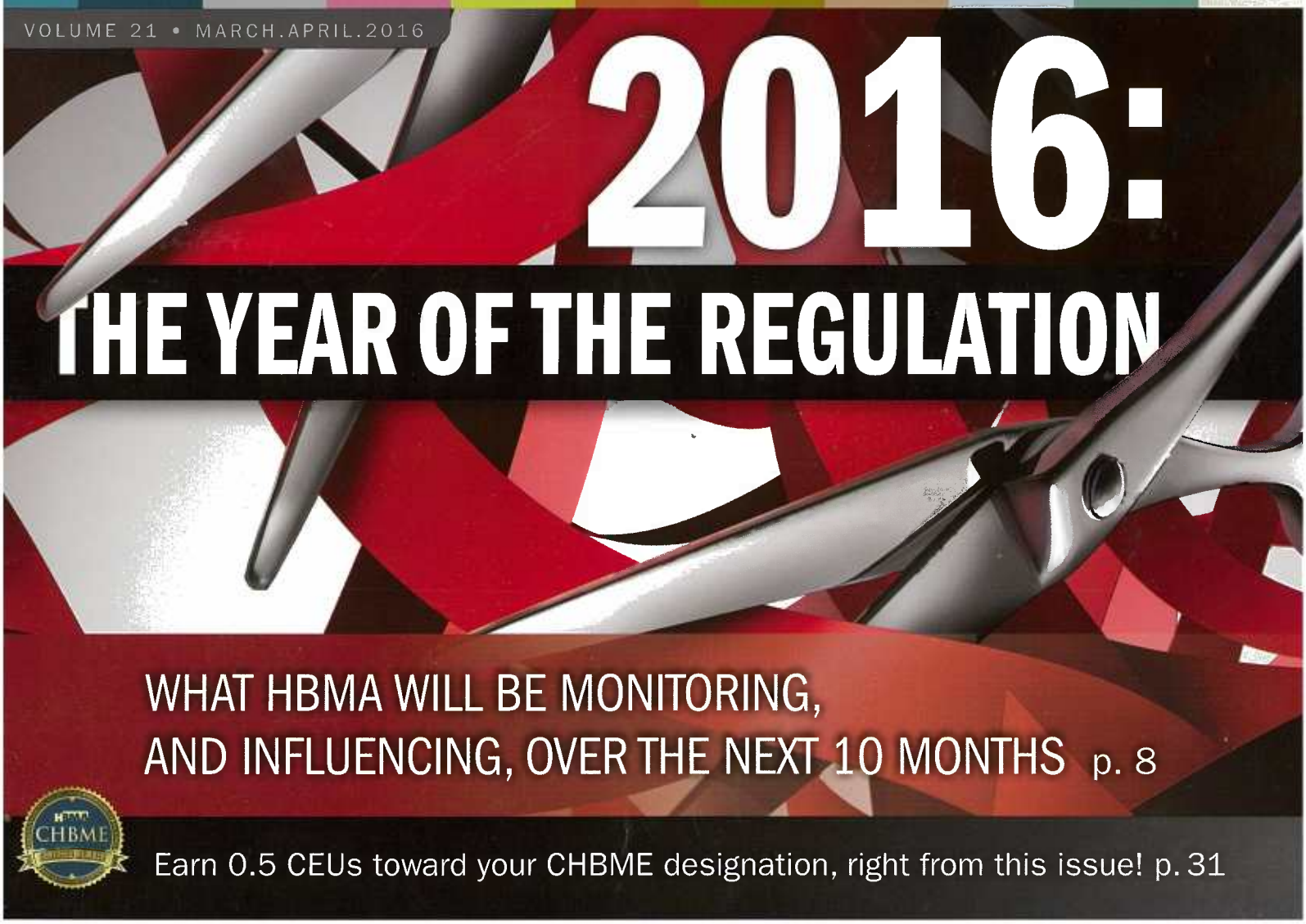

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Navigating the Insurance Claim Process

APPROVAL IS IN THE DETAILS

By Jeffrey L. Greyber, Esq.

I had a great discussion with a few billing company owners at HBMA's Fall Annual Conference regarding how important it is to approach the insurance claim process in detailed, organized fashion. These folks realized that the oft bumpy insurance claim process can be smoothed out if approached thoughtfully and thoroughly.

Of course, approved insurance claims make life easier on everybody – the medical provider, the patient, and the billing company. There are several things that the medical provider or patient can do to facilitate insurance claim approval, but providers and patients are not the focus of this article. This article is directed toward someone else who can, in an effort to foster claim approval, do more than just go through the billing motions – the billing company.

The Initial Claim Process

This much is clear: it is much more difficult for an insurance company to deny a well-documented claim. So, here are some simple suggestions for billing companies to keep in mind during the initial stage of the insurance claim process. (This first batch of suggestions applies to the billing company's involvement from start to finish, including the appeal process.)

- **Most (if not all) communications with the insurance company should be in writing.** Oral communications all too often get lost in the shuffle, and the old insurance company adage that you should be familiar with is "If it is not in the claim file, it never happened." So, you need to make sure (via written communication) that your efforts make their way into the insurance company's claim file.
- **Keep a journal or diary of all phone calls with the insurance company.** Write down what happened during the phone call while on the call or shortly thereafter, not days or weeks after the fact. And, if you are up for it, it is great to follow a phone call with a letter to the insurance company listing the date of the call and what was discussed. The primary purpose of this kind of letter is simply to memorialize the phone call, not to convey additional commentary or opinion to the carrier.
- **Any documents you send to the insurance company should be sent via certified mail or some other trackable method.** Insurance companies may say they never received something, so certifying or tracking all mailings can go a long way toward preventing that.
- **Make sure you keep a thorough file of your own.** The success of your claim may hinge on you proving that certain documents were sent to the insurance company. Having a thorough file of your own, of course, can go a long way toward that end.

The Appeal Process

If your detailed, organized claim presentation does not succeed initially, it will increase the chance of a successful appeal. Typically, insurance policies will prescribe both internal and external appeal procedures for reconsideration of a denied claim.

I do not recommend, for myriad legal and practical reasons, that a billing company (or medical provider) exhaust a patient's appeal rights without first consulting an insurance attorney. In fact, I think it is best for an attorney to handle the appeal process from day one.

If you, the billing company representative, undertake an appeal of a denied claim, you should heed the following message: before officially initiating an appeal, you should request a copy of the carrier's entire claim file and let the carrier know that its claim file is vital to you or your client. This kind of a request may have to come from the patient or the medical provider under an assignment. In other words, you may not have contractual standing to make this kind of a request, but it certainly would not hurt to try. In the group insurance context, the carrier is typically contractually and legally required to oblige this request. In the individual insurance context, the carrier will often still oblige this request. To give you a feel for this, my letters to insurance companies requesting the claim file usually read, in pertinent part, along these lines:

> Please provide me with the complete file(s) regarding the above-captioned claims. The file(s) should contain, but not necessarily be limited to, the following: (1) a complete, certified copy of all plan documents (e.g., master policy and summary plan description) in effect at the time of the subject treatments; (2) identification of the exact master policy and summary plan description language the carrier's claim denial relies upon; (3) copies of any manuals or guidelines interpreting the master policy and summary plan description language the carrier's claim denial relies upon; (4) copies of all documentation (e.g., reports, scholarly articles, medical treatises, records) the carrier relied on in deeming the subject medical conditions to be preexisting, (5) copies of all documentation the carrier otherwise relied on in denying the subject claims; (6) contact information for any medical professionals whose services were enlisted by the carrier in assessing the purported preexisting nature of the subject medical conditions; (7) copies of all correspondence exchanged between the carrier and subject medical providers or facilities regarding the subject claims; (8) copies of all billing paperwork submitted to the carrier by the aforementioned subject medical providers in relation to the subject claims; (9) copies of all correspondence exchanged between the carrier and Ms. Doe regarding the subject claims; (10) copies of all correspondence exchanged between the carrier and [Group Plan Policyholder] regarding the subject claims; (11) copies of all correspondence exchanged between the carrier and anybody else regarding the subject claims; (12) recordings and/or transcripts of all phone calls between the carrier and Ms. Doe; and (13) recordings and/or transcripts of all phone calls between the carrier and Ms. Doe's medical providers, in particular recordings and/or transcripts of phone calls wherein the carrier and Ms. Doe's medical providers discussed preauthorization or coverage.

It is much more difficult for an insurance company to deny a **well-documented claim**.

All too often I see claimants or claimant representatives simply regurgitate their underlying claim file in the appeal process, without first reviewing the carrier's claim file or obtaining additional claim decision explanation from the carrier. This approach is unlikely to succeed because your appeal package, if possible, should provide the carrier with additional information targeted at the areas of your initial claim submission(s) that the carrier perceives to be weak.

So, once you obtain the claim file, carefully review it along with past carrier correspondence to better learn what the carrier perceives to be the weak points of the claim. If after doing so the reasons for claim denial are still not clear, send a letter to the carrier requesting a thorough explanation (grounded in the facts, the law, and insurance contract language) for its claim denial. In Florida, for example, the carrier is statutorily required to fully explain its reasons for claim denial.

Once you know what the carrier perceives to be weak points

of the claim, here are some ways in which you might be able to add the detail to the overall claim submission needed for approval:

- **In order to achieve reversal of a claim denial via appeal, you may have to delve into the insurance policy.** So, as noted above, obtain a full, certified copy of the insurance policy in effect at the time of sickness, injury, or disability onset. Sometimes, such as in the group insurance setting, the policy is referred to as a summary plan description or benefits booklet. Once you receive the policy, check to see that the insurance company's initial claim denial letters or explanations of benefits have actually cited the policy correctly and in context. Then familiarize yourself with the policy in an effort to show the insurance company that the facts of the claim fall squarely within the coverage grants of the policy.
- **Perhaps your medical provider client was a little light on their records and that is what is holding up claim approval.** In that case, you may need to communicate with your medical provider client to complete needed forms (e.g., attending physician statement) or to perhaps write a simple letter or report detailing diagnosis, needed treatment/services, and prognosis. If your medical provider clients want the bills paid, they should be willing to somewhat cooperate with you.
- **In order to get a claim paid, perhaps you will need to communicate with the patient for some additional information or documentation.** For example, did the patient keep a record (e.g., a daily journal) of disability or health symptoms, pain levels, and the manner in which the disability or health conditions compromised daily functional abilities? Did the patient keep a record of treatment, rehabilitation, or medication efforts? Can the patient have friends, family, work colleagues, or others familiar with the disability or health conditions, symptoms, and limitations attest to them by, for example, letters to the insurance company? If the symptoms and limitations associated with the patient's disability or health conditions are visible, perhaps they could be videotaped? Did the patient complete and return claimant statements that the insurance company requested?
- **In order to get the claim paid, you may need to help coordinate a recorded statement from the medical provider or patient, or coordinate an independent medical examination of the patient.** If you get involved with this, it would behoove you to suggest to the medical provider or the patient that they have a third party with them to witness the statement or examination, request that the statement or examination dialogue be transcribed, or request that the statement or examination be videotaped. If the insurance company is familiar with industry standard or policy requirements and wishes to adhere to them, it should pay for the transcription or videotaping. If, however, the carrier refuses to pay for transcription or videotaping, get that refusal in writing and urge the medical provider or patient to consider arranging for transcription or videotaping on their own.
- **With respect to disability insurance claims, gather documents (e.g., pay stubs, bank statements, tax records) evidencing income from a few years prior to the date of disability onset through the present.** These records will sometimes show a dip in income following the onset of disability. These records do not necessarily need to evidence as much in order for the disability claim to be approved, but the chances of a prompt claim approval will increase if this is what these records show.

Next Steps

If, after approaching the claim and appeal processes in this detailed, organized fashion, you still encounter difficulties in achieving swift claim resolution (or encounter a claim underpayment or denial),[1] there are still things you can do to inspire the carrier to expeditiously and fully pay the claim. Oftentimes, statutory tools are available to policyholders or policyholder representatives confronted with carrier delay, underpayment, or denial tactics. For example, in Florida, Section 626.9541 of the Florida Statutes sets forth various unfair trade practices that insurance companies are not supposed to engage in, and a couple of these unfair trade practices pertain to the timeliness of claim adjustment and decision-making. And Section 624.155 of the Florida Statutes affords a private cause of action to policyholders damaged by an insurer's violation of 626.9541. One condition precedent to the statutory bad faith cause of action is the Civil Remedy Notice (CRN), which affords the insurance company 60 days to cure (usually by way of paying the claim) the wrongs complained of in the CRN. If cure does not occur within the 60-day safe harbor period, the insurance company is exposed to extra-contractual damages (e.g., consequential and punitive damages) in addition to the underlying contractual damages. Given that the CRN is a public record, you should remain cognizant of HIPAA requirements concerning protected health information.

If your state does not have statutory tools similar to the Florida tools mentioned above, I have found that bringing the carrier's claim delay, underpayment, or denial to the attention of your state's Department of Insurance or insurance commissioner via letter sometimes encourages the carrier to do the right thing – promptly pay the claim. If you do so, be sure to carbon copy the carrier. Also, if your letter is going to contain PHI, be careful of HIPAA – perhaps obtain the patient's written consent before sending the letter, designate your letter as confidential, or include something like this in the letter: "Given privacy concerns, this letter is not to be publically disseminated."

Although you can carry out just about all of the aforementioned suggestions without a lawyer, it would be wise to consult with a lawyer before submitting a claim and during the claim process. I have found that the chances of a successful appeal are increased simply by virtue of the appeal package being submitted under legal letterhead explaining, from an attorney's perspective, why the carrier's claim decision was wrong.

In carrying out all of the above, remain cordial and professional at all times. No matter how frustrated you might get during the claim process, there is simply no place for oral or written invective, as it will only hinder a favorable outcome. Here's to smooth sailing, my friends! ■

QUICK TIP!

DO I REALLY NEED TO USE THIS PROCESS FOR SMALL CLAIMS?

Perhaps surprisingly, the practices described here do not apply only to high-dollar claims. Several small-dollar claims can be worth a lot – even upwards of a million dollars – if later bunched together. So, good claim-handling practices should be followed on both small- and high-dollar claims to the extent possible by the practice.

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Resources

[1] A couple of the many nice reads on the subject, in case you are interested, include *From Good Hands to Boxing Gloves: The Dark Side of Insurance* and *Delay, Deny, Defend: Why Insurance Companies Don't Pay Claims and What You Can Do About It.*