Health insurance claim is denied. What now?

Few things are scarier than racking up medical bills and then learning that your health insurance company won't pay.

It's a nightmare that could panic any policyholder. But before you worry about sinking into a black hole of medical debt, know that federal law offers a way to appeal.

"When a claim is denied, consumers should not view that as the end of the story," says Katherine Vukadin, an assistant professor at Texas Southern University's Thurgood Marshall School of Law in Houston.

The Affordable Care Act, or ACA — the law popularly known as Obamacare — gives a policyholder new rights to demand that an insurer reconsider any health claim denial.

And then, if your plan reviews the case and still won't budge, you can appeal to an independent third party, which will make a decision the insurer must accept.

Don't assume the process will be easy. "Appealing takes time and energy, on top of battling the underlying illness," Vukadin says.

Up to a quarter of claims are denied

A 2011 study by the U.S. Government Accountability Office found that claim denial rates vary significantly among states and health insurers. Of the small number of states tracking such information, denials ranged between 11 percent and 24 percent of claims.

Amy Bach, executive director at United Policyholders, an insurance consumer advocacy group, says claims may be denied for reasons such as:

Improper coding of the procedure, or other errors on the part of the health provider.

Care that was performed outside of the health plan's network.

Care that the insurer deems was not medically necessary, or was experimental.

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Your right to an appeal

Obamacare rules mandate that after you or your doctor has filed a claim, your insurer has a limited time to explain in writing any decision to deny payment:

Within 15 days if you are seeking authorization ahead of treatment.

Within 30 days for medical services you've already received.
Within 72 hours for urgent medical matters.
Before the ACA, not every state had a system for appealing a denial, says Cheryl Fish-Parcham, deputy director of health policy for the health care consumer group Families USA. States that had a process often had restrictions.
"In some states, you could appeal only if a certain dollar amount was in question," she says.
With passage of the ACA, appeal rights have become much broader across all states.
How to file for an internal appeal

If the health insurance company says it won't pay, formally ask it to take another look at your claim. You must request this "internal appeal" within 180 days of being notified that your claim was denied.
You may write a letter to your insurer, asking for a full and fair review of its decision. Or, you may file for your internal appeal by completing forms required by the insurer.
Bach recommends getting your physician to write a letter that supports your case that the claim should be paid.
"Make sure the doctor uses the magic words 'medically necessary' and avoids any suggestion that the treatment is in any way experimental," she says.
A prompt response is required
After your insurance company receives your request for an internal appeal, it must take another look at your claim and make a new decision in as short as 72 hours for urgent medical matters or up to 60 days for other types of care.
Note that the requirements on internal appeals apply to any health plan issued after March 23, 2010. Plans older than that date are said to be "grandfathered" and are not required to allow you to appeal. Insurers are supposed to notify consumers if they have a grandfathered plan.
"If the plans make certain changes, though, they are no longer grandfathered," notes Vukadin, who wrote a 2012 academic paper on the new rules.
Another 'no'? Then, seek an external review
If your claim is still rejected after your insurer's internal appeal, you can file for an "external review," in which an independent third party will go over your case.
Typically, the outside reviewers are health professionals who have experience managing the medical condition, procedure, treatment or other issue in question, Vukadin says.
An insurance company that holds firm to a denial must inform you how to initiate an external review, she says. You may, for example, be told to mail your request to a specified address.

You must file a written request for an external review within 60 days after your insurer sent its second decision. Some plans may allow you more time.)

Patients with urgent health situations can ask for an external review at the same time as their internal appeal.

An external review is binding

You can seek an external review over some of the typical reasons for a disputed denial, such as if your insurance company views a treatment as experimental. You also can request an outside review if your insurer cancels your insurance because it accuses you of providing false information on your application.

External reviews are often free, though there can be a charge of no more than $25 in some circumstances, such as if your health carrier has contracted with an independent review organization.

Rules laid out on the Obamacare website, HealthCare.gov, state that standard external reviews are decided quickly — in 60 days or less.

The external reviewer's ruling is final and is the last stop in the appeals process. The outside party will either uphold the insurance company's denial of your claim or reverse it in your favor. The insurer must accept the decision.

Getting help

Appeals are often worth all the trouble. A 2006 study by the industry group America's Health Insurance Plans found external reviewers decide in favor of the consumer about 40 percent of the time.

But, too many people fail to appeal because of the difficulty of wading through the process, Vukadin says. Estimates vary, but studies have found that up to 95 percent of denied claims are not appealed, she says.

"Any time consumers do not appeal a wrongly denied claim, they may well be leaving money on the table," Vukadin notes.

Fish-Parcham says expert help is available if you feel overwhelmed. "People really benefit from having someone who is knowledgeable about the appeal system and skilled at navigating it."

Your state's insurance department may offer guidance. Many states have consumer assistance programs providing free help with filing an appeal.