



FACT SHEET

Understanding Health Plan Medical Claims

October 2009

What is a medical claim?

A claim is a request by an individual's provider to that individual's insurance company to pay for services obtained from a health care professional. Claims payment requests, which are submitted after care has been provided, should not be confused with requests for pre-authorization. Pre-authorization is sometimes required to be obtained before a provider provides care to ensure an individual is covered for that service and it is medically necessary.

When is a medical claim filed?

Claims are submitted to the health plan for payment of the costs incurred after care is provided.

What services can a health plan be billed for?

California is unique because the preferred system for delivering care and payment for that care is the "delegated model." Under this system, organized groups of physicians (physician groups) accept responsibility for managing the care of the health plan enrollee.

Health Plans generally pay physician groups a monthly (or yearly) fixed amount per health plan member regardless of how little or often that member sees the doctor. This method of payment is frequently referred to as capitation. Providers are not reimbursed for services that exceed the allotted amount. In some instances, claims may be filed by physicians or physicians' groups when the services provided fall outside the contract with the provider group. Capitation also allows physicians to make the decisions about the appropriate course of treatment for their patient, rather than the health plan.

What are the reasons claims are denied?

Claims are often denied for reasons that most often do not involve patients but are related to administrative errors. Some examples of these administrative denials include:

- Claims that are wrongly sent to the health plan instead of the physician group,
- Claims that are submitted to the wrong health plan,
- Claims that lack complete information, and
- Duplicate claims submissions.

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-American Medical Association
National Health Insurer Report Card (2008)

None of these reasons impact care or cost for the individual. In some cases, claims are denied because the services provided to an individual are not included their health plan benefits or some other reason.

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Can individuals appeal a denied claim?

The vast majority of claims are paid. "Denied" claims may ultimately be paid when administrative errors, like incomplete information, are corrected. Further, individuals may dispute denied claims related to their benefits or some other specific reasons to regulators, who may decide that a claim should be paid. Publicly available data does not indicate the reasons why claims are denied or whether those denials are later resolved.

To appeal a denied claim for care that has already been provided, individuals can contact their health plan to file a grievance, or, in some circumstances, contact the Department of Managed Health Care to request an independent medical review of a patient's specific case. The DMHC provides more information at www.hmoHELP.ca.gov. For more information on [Independent Medical Review in California](#), please see CAHP's July 2009 Fact Sheet.

Please contact Maral Farsi at mfarsi@calhealthplans.org or 916.558.1545 with any questions about this fact sheet.

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