HealthShop

Your Health Plan

Issue Highlights

Understanding Your Explanation of Benefits 01

Disputing a Benefit Claim 01

How is Your Doctor Paid? 02

Disputing a Benefit Claim

At some point, you will most likely have to dispute a benefit claim that has been denied by your insurance company. Some issues will be minor and easily resolved simply by calling the health plan's member services department.

Some issues may not be as simple to resolve. In these cases, if you have insurance through your employer, first speak with your HR department, or seek help from your state insurance department, attorney general's office or consumer affairs department.

You have a right to appeal the way a health insurance claim was paid (or not paid). Most states have laws that require appeals to be processed within a certain time. Your state's appeal policy should be clearly written in your benefit summary. Once you have filed an appeal, your insurance company is required to respond within a specified period.

Follow these guidelines when handling more complex claim disputes:

CONTINUED ON PAGE 2

Understanding Your Explanation of Benefits

An explanation of benefits (EOB) is a form that insurance companies send to their members to explain what part of a claim was paid by insurance, what was not paid, and why. Many people find EOBs difficult to understand because they differ from one insurance company to another.

Most EOBs include the following information:

- Name and address of the policyholder
- Name of the patient
- The group number
- The member ID number
- Claim number
- Date the claim was processed
- Date of service
- Name of the health care facility and the provider name
- Name of the procedure or service and the billing code
- Amount that was billed to the insurer by the provider
- The portion of the bill that is eligible for insurance coverage
- The portion of the bill that is not covered by insurance
- The amount paid by insurance
- The reason why the noncovered portion was not paid
- The amount of the charges that are subject to the patient's deductible

The main purpose of your EOB is to help you determine if your claim has been paid, how much has been paid by your insurance company and how much is your responsibility. Then, you will know which invoices to pay and how much.

To figure out who has been paid, match the treatment dates and the providers from the invoices to the dates of service and providers listed on your EOB. Make sure your provider gives you an itemized invoice so you can effectively match your EOB to your invoices.

(continued on page 2)

Understanding Your Explanation of Benefits

continued

Keep in mind that insurance companies rarely pay 100 percent of a claim. You will likely need to pay your part in applicable deductibles, coinsurance, and/or copayments.

Some common reasons for partial payment of a claim by your insurance company may be:

- Part, or all, of the claim was charged to you to satisfy your deductible or coinsurance requirement.
- Part of the claim was charged to you in the form of a copayment.
- The charges for the services exceeded the maximum benefit available for the service.
- Your insurance policy was not in force on the date of service.
- The claim was a duplicate and had previously been paid.
- The charges exceed the insurance company's reasonable and customary limitation (this happens more frequently when you use out-of-network providers).
- The charges are for a noncovered service, such as cosmetic surgery.

If you receive an EOB showing that your insurance company did not pay for your entire claim, first determine the reason why, and then determine if the reason is valid. If you believe there has been an error, contact your health plan's member services department and ask them to review the claim. ◊

CONTINUED FROM PAGE 1

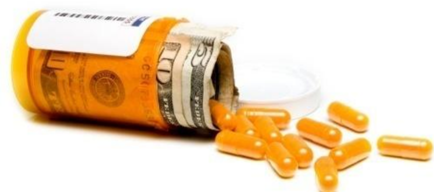
Disputing a Benefit Claim

- Any dispute should clearly indicate that the service is a benefit under your medical plan, and that it was medically necessary. Provide any supporting documentation, including copies of your benefit summary or a letter from your provider saying that it was a medically necessary service.
- If you have been denied service due to medical necessity, you must supply proof that the procedure was medically necessary in order to have a denial overturned. You will need to provide information about your condition, symptoms, previous treatments and your provider's recommendation for the treatment in dispute.
- Clearly state the reason for your appeal. Remember that another person is going to read it, so ask yourself if the evidence supports reversing the denial. A well-written appeal always increases your chances for a reversal. ◊

How is Your Doctor Paid?

Health plans reimburse providers for the services they provide in a variety of ways. For example:

- ✓ **Fee-for-service** – The health plan pays the provider for a certain set amount for each service or procedure delivered.
- ✓ **Discount fee** – When a provider submits a bill to your health plan, it has already negotiated a reduced rate for the service or procedure. The plan will pay a predetermined percentage of the total bill.
- ✓ **Salary** – Some managed care organizations employ their own physicians and pay them a salary with additional incentives for meeting quality of care and patient satisfaction goals.
- ✓ **Capitation** – A medical group or individual provider receives a set fee each month for each health plan member enrolled in the clinic or practice, no matter how many services the member actually receives.
- ✓ **Case rates** – For a selected set of services or procedures, the provider receives a set fee—a case rate—up to an agreed-upon maximum amount of procedures and services for a designated period.
- ✓ **Withhold arrangements** – A portion of the provider's payment is set aside until the end of the year, depending on criteria, which may include patient satisfaction levels and quality of care goals. ◊



© 2004-2008, 2012, 2014 Zywave, Inc. All rights reserved.