Health Care: Resolving Billing Problems and Claim Denials

There are 5 sections to this tip sheet:

- Billing disputes
- Denied claims
- Formal review – internal review/appeal
- Formal review – external/independent review
- Chart: state agencies that regulate HMOs and PPOs

BILLING DISPUTES

Health insurance billing is complex and oftentimes confusing, and you may find yourself receiving bills for services that should have been covered by insurance or you thought were already paid for.

Every health plan has different co-pays, deductibles, out of pocket maximums, and exclusions. With so many different plans, it's hard to know which costs you are responsible for and which costs are covered by your plan.

Whatever steps you take to resolve any billing disputes, make sure you document them in writing. Keep a record of all phone calls you made with the date and time of the call, the number you called, the people you spoke with, and what you discussed. This will be important if you ever need to follow-up on the matter in the future and will strengthen your case if you file an appeal with your insurer or the state.

You received bills for services that should have been billed to

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your health plan:

1. Are the billed services covered by your insurance?

You will need to understand your particular plan's policy. Many policies have particular exclusions, such as not covering maternity care or job-related physicals, so check your policy's Summary Plan Description or Evidence of Coverage to make sure the billed services are covered by your plan.

If the service is covered, verify that the correct billing code was used. Simple typos can result in you being charged for the wrong procedure or service.

2. Do you have an annual deductible and/or out-of-pocket maximum? If so, did you satisfy the amounts?

Depending on your particular policy, you may have to pay for medical care until you satisfy the deductible for the year. If you already met the deductible, your insurer may pay a percentage of the costs, leaving you to pay the remainder. You may have to pay some costs yourself until you meet the annual required out of pocket maximum, at which point your insurance will cover all the costs for the rest of the year. Every insurer and plan has different limits and terms, so it is important to understand your particular policy and how your insurer defines these terms.

If you have questions about your policy, check your Summary Plan Description or Explanation of Coverage, or call your plan's customer service department.

3. Did the health care provider bill your insurance?

Do not automatically assume that the provider billed your insurance. If you have not received an explanation of benefits (EOB) or similar statement from your health plan within a couple of weeks of your appointment, check with the provider. Make sure they billed the correct health plan and that they have your correct information (your name, policy number, etc), and then follow-up with your health plan.

Most states require insurers to pay claims within 30 or 45 days, so if it hasn't been very long, the insurance company may just not have paid yet. It may take a couple weeks to get the claim approved

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and processed and for your provider to get paid.

4. If your provider billed your insurance, check with your plan to see whether they received the claim and ask if it was paid or not. If they denied the claim, ask why.

It may be that your plan paid for the services but your provider sent the bill before receiving or applying the payment to your account.

If the plan denied the claim and refuses to pay, find out why. If you disagree with your plan's decision, ask about the appeal or internal review process. For more about the review process, read the **Formal Review** sections below.

5. If your insurer paid the bill, check with the office that sent you the bill.

Some offices handle billing in-house, while others use a third-party biller. It may take some time for the payment to be credited to your account, especially if the payment went to the provider and the provider has to then forward it to the billing office.

Contact the party responsible for billing. If the payment still has not been credited to your account, ask how long it usually takes and then make sure to follow-up with them.

You continue to receive bills for services that were already paid for by you and/or your insurance:

1. Contact the billing department sending you the bills.

Find out what your current balance is. The bills may have been sent before any payments were applied. If the payment address is different than the billing office's, there may have been a delay in processing your payment.

You may be able to resolve the billing issue over the phone. If not, you will need to find the source of the discrepancy yourself.

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2. Compare all relevant receipts, bills, and statements on your own.

Gather your receipts, credit card statements, cancelled checks, bills sent by your provider, and explanation of benefits (EOB) sent by your insurer. Simple typos on your account can lead to big bills, so make sure all charges and credits were applied correctly to your account.

Check also to see whether you were billed multiple times for the same services. Your doctor or other health care professional may have provided a number of services at one appointment but billed them on separate statements. If you find yourself being double-billed, notify your health provider. You may also want to send a written letter asking them to fix the discrepancy and include copies of documents that support your case. Creating a paper trail is important to show you notified them of the problem in a timely fashion, especially if the situation is not resolved quickly.

If you have tried unsuccessfully to resolve the dispute with your provider and the billing dispute does not involve your insurance, you may want to contact an attorney specializing in health law to find out what options you have.

DENIED CLAIMS

If you went to the doctor and the claim was denied, look into the situation as soon as possible. There is usually a time limit on filing for an internal review or appeal, so don't lose the possibility of a formal appeal because of delays. Always keep a written record of all phone calls and documents as a reference for yourself and if you file a formal appeal in the future. Record the phone number you called, the time you called, the names of people you spoke with, and what you discussed. If your plan is going to look into the matter for you, make sure to follow-up within the specified time frame.

Determine whether the claim was for a service covered by your insurance plan. Every health plan is different, so you'll need to know what your plan covers and what it does not cover. Check your Summary Plan Description or Explanation of Coverage booklet for a detailed list of covered services and exclusions, which many plans also make available online.

If your plan has an annual deductible or out-of-pocket maximum, as most preferred provider organization (PPO) plans and even some health maintenance organization (HMO) plans do, your health plan may not

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have paid because you did not met your annual share of costs. Find out if the year is based on the calendar year (starting on January 1) or if it's based on when your policy began (for example, starting on August 15). Generally, you have to meet the deductible before your plan will cover a portion of the costs, and you have to meet the out-of-pocket maximum before the plan covers all costs. However, plans may define the terms differently, so it is important that you find out what your annual share of costs is. You can find that information in your Summary Plan Description, Explanation of Coverage booklet, on your health plan's website, or by calling your plan's customer service department.

If the denied claim is for a covered service and you think you have met your share of costs, call your plan's customer service department and ask to discuss the denied claim. A few phone calls may resolve the situation, but if not, you'll need to file for a formal appeal or internal review with your insurance plan.

FORMAL REVIEW – INTERNAL REVIEW / APPEAL

If you have tried unsuccessfully to resolve the billing dispute or denied claim informally through phone calls or written letters, you will have to file a formal appeal with your health insurer. Every plan handles appeals differently, so it is important to learn how it works for your particular plan.

Check your Summary Plan Description or Explanation of Coverage or call your plan's customer service department to find out the appeals process as well as any deadlines. Appeals can fail due to late filings or mistakes made in the appeals process, so make sure you file your appeal completely, on time, and in the proper manner.

Fill it all paperwork completely and include copies of supporting documents – explanation of benefits forms, receipts, bills, and notes that support your case. Never send original documents, since you are unlikely to get them back. Highlight or write your name and your identification numbers (policy number, group number, etc) on every page, and organize the paperwork in a clear manner. Make copies of the complete packet for your records and as insurance in case your original filing is misplaced. You may also want to send the packet by certified mail or through a shipping company such as FedEx so that you have proof that your packet was delivered to and accepted by your health plan. Also follow-up with your plan to make sure they received your appeals packet and the process is started.

During the appeals process, make sure to respond in a timely manner to any requests made by your

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plan. How long it takes will vary between plans and may depend on the matter being reviewed, so find out when you will likely hear by. If your appeal is for an urgent medical service, make sure your plan's review board knows that. Some plans have an expedited appeal process and can come to a decision within a few days.

If you have gone through your plan's internal appeals process and do not agree with the outcome, you have the option of filing an external or independent review with your state.

FORMAL REVIEW – EXTERNAL/INDEPENDENT REVIEW

If you disagree with the outcome of your plan's internal review, you can contact your state's regulatory agency. Most states require that you contact the insurance company first and may require you to complete the internal review process before they will take your complaint, so find out what your state's process is.

Even if you are just getting started with your plan's internal review, it is good to know ahead of time what your state's external review process is. That way, should the need arise, you will know how and when to proceed.

At the end of this document is a chart listing the agencies that regulate HMOs and PPOs within all 50 states and the District of Columbia. While the research is deemed to be accurate, departments can change and duties may be allocated to other departments, so make sure the department handles complaints for your particular plan before you file a complaint or request for independent review.

It is important to note that Medicare and self-funded employer plans are regulated by different agencies from those regulating private health insurance, so do not rely on the chart below for those plans.

As with the internal review, fill out the paperwork completely and accurately and make sure to file it at the right time. Many reviews fail due to incomplete filings, because the complaint was filed with the wrong department, or because the health plan's internal review was not yet complete.

Many states have online complaint forms, but if you have supporting documents, you may be required to file the complaint by fax or mail. If you send any documents to your state's agency, make sure to send

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copies, not originals. Originals may not be returned and should only be sent if specifically requested.

Include your contact information on every page in case they are misplaced, and keep a copy of the complete packet for your records. Send it by whatever manner is appropriate, but if you send it by mail, get proof of delivery.

If you are unsatisfied with the outcome of the external review, you may be able to take your case to the courts. Contact an attorney who specializes in health law to determine what your options are.

United Policyholders thanks and acknowledges volunteer **Joyce Lee, Esq**. who prepared this tip sheet *pro bono*.

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