

Supervising Your Own Health Insurance Claims

By Jacques Chambers, CLU

Dealing with health insurance and how it covers your medical bills can be a complicated and stressful issue. You may have an Indemnity or Preferred Provider Organization (PPO) Plan that pays medical bills after they are incurred. Or you may be covered under one of the many varieties of Health Maintenance Organization (HMO) Plans that “pre-authorize” certain treatments and disallow others. Either way, problems can arise in how the claims are handled, and unless caught early, they can grow into major financial and legal dilemmas.

It’s tempting to ignore the whole medical payment process and assume that the insurance company and the doctors are handling everything satisfactorily. However, a rude awakening will usually occur when you receive a large bill for charges the insurance “denied or disallowed” or your HMO doctor finally admits that some of the treatments she recommended were not approved by the “HMO Committee.”

Whether it is claims payments or treatment authorizations, most billing and precertification communication between a doctor and the insurance company is in codes, and one misplaced digit can make a substantial difference in the medical care paid for or allowed. It is important to catch those small errors early, and you, as the claimant, are the best person to do it.

You do not have to become an insurance expert to be able to oversee just how your insurance company is processing the medical bills you are incurring. At the least, you can get minor errors corrected quickly; at worst, you have built a solid file that will save the attorney or benefits counselor you hire a lot of billable time. It will take some time and effort on your to understand how the process works and how you can affect it, but it will be well worth it.

The first step is, of course, “Know Your Coverage.” Easy advice to give, but this is often the biggest problem in overseeing your coverage. Insurance contracts are scary; they’re hard to read; they don’t make a lot of sense if you’re not a lawyer. You don’t need to memorize your plan or know every single provision to understand how it works.

Get a copy of your coverage. It may be an insurance policy, a booklet of coverage, a Summary Plan Description, or a chapter in an employee benefits manual. The health plan description will cover twenty to thirty pages or more.

Don't try to sit down and read it all the way through. That would put anyone to sleep. But, look through it. Note the different parts. There will be parts that describe the benefits. There will be sections that tell when you become covered and when your coverage ends and what may be available after it ends. Don't try to memorize every provision of your plan so much as just get familiar with where things are so you can refer to them as you deal with the insurance company.

Things you should try to find are:

The Schedule of Benefits – This is often at the front of the plan. It's the part that tells what the insurance company pays and what you pay. It lists the deductibles, the insurance percentages they pay, the co-pays you are expected to pay at each doctor's visit, etc.

Covered Benefits – Often separate from the schedule of benefits, this will be a listing of what is covered. In some plans this will be a fairly long list; others will give a short list of a broad range of benefits covered.

Exclusions and Limitations – This lists the things that the plan will not cover like experimental treatment, or cosmetic surgery. It also lists the things that it will cover but puts special limits on, such as mental health, or convalescent home care, or treatment for conditions that existed when your coverage started. You may want to paperclip this section, as you may need to refer to it more frequently.

Claims Procedures – This will be a couple of pages that talks about filing claims. The important section here is the part that tells you how to appeal denials. You may want to read that through, as there are usually some important time limits and other information there.

Mark it up. This is the rulebook that the insurance company must play by so don't hesitate to use paperclips, tabs, highlighting and underlining to make it easier for you to use.

The policy alone may not be that helpful, but you will find it valuable as you work with the insurance company and your medical provider when there are claims questions since it must contain the basis of

their denials or cutbacks.

How you watch the medical claims depends on what type of plan you are under. If you have coverage through an Indemnity Plan or a Preferred Provider Organization (PPO) Plan, the insurance company will process the claims and pay their portion after you have received the treatment.

With these plans you will receive an Explanation of Benefits (EOB) every time they process a charge. Review each EOB carefully. Was everything “allowed” in full even if only a percentage was paid. If not, call and ask for an explanation. There will usually be a toll-free number on the EOB. Take notes as to whom you talk to and what they say. Don’t be bashful about asking for more clarification. Follow the appeal procedures to challenge their decision, if you disagree. Ask for your doctor’s help with supporting your appeal.

For Health Maintenance Organization (HMO) Plans, most of the claims work is done between your doctor and the HMO and consists of authorizing treatment before it is given, not paying the bill after. Learn about your medical condition. Know what alternatives to treatment are available.

Then you need to spend some time with your doctor (or your doctor’s insurance clerk) to understand when and what has to be pre-authorized by the HMO. How successful are they in obtaining approvals? How often are they denied? Can you be notified of denials and participate in appeals?

Health insurance is not maintenance free. It can’t be just “turned on and forgotten.” Just as you must take an active role in your health care and treatment as a patient, you must also stay alert and active as an insured with how your medical care is authorized and paid for.

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