MedBillsAssist

Medical Claims Solutions

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Out of Network - The Hidden Cost

A young family purchased insurance from a broker. Their understanding of the policy was that it pays 90% when the doctor is out of network. Mary had a baby boy and her baby was delivered by an out of network obstetrician. Baby and mommy are healthy and all is well. A happy family, until the bills have started to arrive. Out of frustration the new daddy contacted me and asked to look into the large bills and minimal insurance payments.

Upon review of the entire policy I had to inform him that the policy covers 90% of the Medicare rates. What does that actually means? Lets start by stating that the obstetrician and all other providers involved can charge any amount they desire. Medicare has a set rate for each region and procedure, but in general pays 30% on charges billed by a physician, who is not in network.

The policy the young couple purchased paid 90% of the Medicare rates for out of network providers. Samples of what this means in actual numbers…

Delivering a healthy newborn: $11,500.
Insurance payment: $2,123.
Office visit: $300.
Insurance payment: $43.
Ultrasound: $2,400.
Insurance payment: $440.

With all expenses related to the birth of the baby considered, the couple's cost share is $45,000. A very expensive lesson learned here by the young parents.

Their case underscores the importance of reading and understanding your policy. The broker's explanation of the policy may, or may not had been adequate for out of network benefits. Regardless of any verbal agreement, it is the written policy that governs the insurance coverage. The policy somewhat "clearly" states the benefits for an out of network provider.

Somewhat "clearly" since the policy may or not actually state the source of the *"eligible expenses"* and/or *"allowed expenses".* For most people, these definitions mean covered expenses, but that's not the case as the young couple had learned. Even if the policy does state the definition of *"eligible expenses",* there is no actual cost for procedures listed anywhere in the policy. It will state percentage instead, like in this couple's case, it does list 90% of the eligible expenses for out of network providers.

You would never purchase anything under these condition, but you have no choice when it comes to health insurance. You can thank to your State Insurance Commission, that has approved the policy language and the stated percentages.

Quote of the Quarter

Quote from Linda Tiano, an attorney at the law firm of Epstein Becker and Green

"Before the ACA, the states all had policies regarding what was illusory coverage. And you couldn't offer a policy that had 50% [actuarial value]…and in New York nothing below 70%. So right now it's down to 60% for bronze and if you go down to 50% or 40% actuarial value, is that really insurance coverage?"

Colonoscopy - Preventive or Diagnostic

Part of the routine preventive care is the first colonoscopy usually at age 50. Most medical insurance policies cover this service as preventive care, guided by the Affordable Care Act.

Over the past few years I keep coming across colonoscopies that are considered by the insurance companies as part of the normal medical part of the policy. The difference between the two scenarios are the cost and who will pay?

The preventive colonoscopy should be coded as such. A medical diagnosis on the claims sent to the insurance should be a preventive care code. If it is coded correctly, the insurance will pay the physician, anesthesiologist, pathologist and the hospital in full. If there is medical illness code listed on the bill the insurance will process it under the medical provision of the policy.

Given that policies have high deductible and co-insurance cost share, this coding difference can add up to thousands of dollars. Most of us usually get angry with our insurance companies, but in this situation it is often the medical provider at fault.

If you found yourself getting bills after a routine colonoscopy, it is time to call the physician and have them take a second look at coding.

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Medicare Supplements

People enrolling in Medicare coverage soon learn it that Medicare doesn't cover medical care in full. Doctor and outpatient hospital services leave a 20 percent liability for patients.

Hospitalizations have deductibles and so do physician services. Knowing this most people will sign up for a Medicare supplemental, also known as Medigap policy, that will pay the 20 percent patient liability.

There is a confusing menu of supplement policies with Medicare assigned letters. This makes it confusing to differentiate between the type of Medicare coverages, such as A,B,C and D, and supplement policies of A, B, C, D, F, G, K, L, M, and N. The coverage and cost of each policy with a designated letter varies by state to state. Furthermore the actual options (as stated by letters) may not be available in your home state. Which policy to chose is a decision that is much the same for medical policies; it should be a supplement policy that is meeting a personal need.

The differences in a nutshell:

Medigap plan A is the basic coverage, then as letters progressing the coverage and price is increasing F. Plans K,L, M and N offers reduced coverage with a reduced price.

Medigap policies don't cover prescriptions, hence there is a definite need for a separate drug plan, known as Medicare Part D.

Definitions:

Medicare: A program for people aged 65 and for the disabled.

Out of Network: Medical care provided by a doctor, hospital or entity that is not participating with an insurance network.

COBRA: Federal abbreviation for continuing employer based medical insurance.

Co-Insurance: Patient cost share, much like co-pay. However, unlike co-pays co-insurance is a percentage of an allowed amount, with an annual maximum amount.

12 ACA Facts

1. All legal US residents are eligible to sign up
2. Policy choices depends on the state of residence
3. Subsidies are available for those who qualify
4. Open enrollment for next year will start on November 1.
5. Special enrollment is available for those who qualify
6. People with Medicare coverage are not eligible to participate
7. Employer sponsored health insurance more likely offers more coverage and protection
8. Signing up through the Exchanges are optional
9. People can purchase private insurance from brokers or directly from insurance companies
10. People presently on COBRA can wait until their policy ends , then sign up for an ACA insurance plan; this is called special enrolment
11. A promise from President Obama , if you like your insurance plan you can keep it, was just a misguided promise. Policies created after March 2010, that did not comply with the ACA were terminated , never to be reinstated again
12. The actual penalty for not having medical insurance is based on the income. It is not a predetermined amount for everyone.

Legal Issues or Who is in Trouble this Time?

Walgreens contracted with a blood testing company named Theranos. It is a recent start up company with their own Edison device. Walgreens was too eager to make a deal without properly evaluating the capabilities and accuracy Theranos' testing device. It turns out that the device is not working properly and testing results are inaccurate and unreliable. The company recently voided two years worth of test results. Theranos issued corrected blood test reports to doctors and patients using traditional testing machines due to regulatory concerns. As a result two patients have filed lawsuits and federal sanctions and criminal charges are looming against Theranos. Walgreens has tried getting out from its contract with Theranos, but it could not.

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We work with claims in collection or track and resolve claim problems for the entire family.

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