MedBillsAssist

Medical Claims Solutions

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The Specific Question

During medical emergency or urgent situations all we really want is proper medical and timely care. We assume that the hospital and doctors will do the right thing. That is to take our insurance and don't overcharge us. Fortunately, it does happen that way most of the times. Then there are some times when we assume taking our insurance means they are participating in our insurance network. Unfortunately, that is often not the case. Taking our insurance simply means that the hospital or doctor will bill our insurance. If they get any payment it will be deducted from their total bill and send us the balance due.
If you are unsure the specific question to ask is exactly this: **Are you a participating provider in my insurance network?** To your surprise the answer to this question may be this " I don't participate in any insurance network." So the next reasonable question will be: how much do you charge for this service? I am willing to bet that most doctors, and even hospitals will not give you an answer. They simply don't know.
You want to ask: how can that be?

The answer is rather simple. In the case of a hospital the clinicians simply use an internal billing code, that is often not a code for the actual procedure; it is simply a computer system code that transfers into insurance procedure code a few days later in the computer software.
In the case of doctors, the billing company or office does the billing. The doctor may even know the actual codes and charges, but in most cases they will not disclose that information to the patient.
At this point the best one can do is getting a promise from the doctor that his or her changes are reasonable to our services.
Of course planned visits, such as office consultation, radiology services, or surgery can be financially pre arranged. It does take some work, and often putting a pressure on each party. A person need to get a CPT (procedure code), and diagnosis code from the doctor's office. Then provide that to the insurance company and request the allowed payment amount from the insurance. Some will give it just for asking, while others have to be pressured to do so.

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?"

ACA - More Exemptions and Delays

The Affordable Care Act has two types of enrollments; state run and federally run. In CT and NY states the Exchanges were set up on the state level, on time and more importantly fully functional. Residents in many federally run Exchanges have been struggling to complete the enrollment process. I would guess that these problems are mostly due to computer errors. Programmers simply didn't do a good job within the website in connecting back to the federal government, insurance companies, Medicaid offices, etc. Acknowledging this problem the White house announced yet another extension for those who had tried and could not sign up for health insurance prior to the March 31st deadline. It is called a special enrollment, which is a common term in medical insurance.

In addition for people with enrollment difficulties special enrollment exemption is granted for legal immigrants who were improperly denied coverage, victims of domestic abuse, for those who were enrolled to a "wrong " plan, families with twins whom weren't allowed to sign up together, and Medicaid applicant whose paperwork were not properly transferred to their local Medicaid agencies.

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Quiet Changes in Medicare

One significant change in Medicare coverage has been in the works for years. Physical, occupational and speech therapies had a medical requirement where the patient had to improve their condition and the therapist had to document this improvement. If improvement in not achieved Medicare stopped paying for therapy. It is nearly impossible to show significant improvement for people with chronic conditions. The reason they are receiving therapy to slow the physical progress of the disease.
Finally starting this year this requirement has been corrected. The Medicare manual, did not intend this restriction; this was simply misinterpreted by the Medicare Intermediaries. The organizations that process Medicare claims. Sadly, it took a law suit by the Medicare Rights Center, and a few other organizations, to correct the actual Policy Manual.

The other significant Medicare issue was kicked around and received another patch without much of a fanfare. The House passed the bill with voice vote, no debate, and no records of how votes were cast. The Senate approved it and the president signed it on April 1st. H.R. 4302, Protecting Access to Medicare Act of 2014 delayed the doctor's scheduled pay cut for the 17th time. The temporary "fix" ensured that your doctors did not get a 24% pay cut.

Definitions:

CMS: Center for Medicare and Medicaid Services

ACA: The Patient Protection and Affordable Care Act

OIG: Office of Inspector General

CPT: Current Procedural Terminology

Medicare Intermediaries: Insurance companies that process Medicare claims for the Federal Government

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 ended on March 31, 2014
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; it 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 estimated to be 1% of taxable income in 2014, per family member

MedBillsAssist

Our Mission is to represent our clients' best interests. We work on your behalf in an ethical manner in compliance with state and federal regulations.

We tailor our service to your specific needs.

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

When you need a patient advocate to negotiate with medical providers and insurance companies, give us a call.

Medicare trained specialist.

Licensed in Connecticut, New York and Virginia.

Legal Issues or Who is in Trouble this Time?

This story has no legal proceeding; simply a sad fact that many nursing facilities provide substandard care.

A recent analysis published by the Office of Inspector General (OIG) reports that nearly one third of Medicare patients were harmed by Skilled Nursing Facilities. Most harmful events included medication errors, physical injuries, such as falls and pressure ulcers, and infections. Most of these preventable incidents are due to staffing deficiencies. These problems have been reported to its regulatory agency Medicare (CMS) for years.

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