

Supervising Your PPO Health Insurance Claims **By Jacques Chambers, CLU**

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Dealing with health insurance and how it covers your medical bills can be a complicated and stressful issue. This is especially true if you have a Preferred Provider Organization (PPO) Plan. Additionally there are other types of indemnity plans that pay medical bills after they are incurred. This article focuses on the claim processing of those plans.

PPO Plans are those plans that have deductibles and pay a higher percentage of the bills if you use their contracting providers. These plans typically pay only part of a medical bill, while you are expected to pay the remainder directly to the provider.

If you are covered under one of the many varieties of Health Maintenance Organization (HMO) Plans, they directly provide medical care through their staff or contracting providers. There are still co-pays to be paid, and the level of those co-pays, especially for hospitalization, are increasing; however, they don't usually create the confusion that the other plans can, because they don't flood you with paperwork showing how they processed your claim.

Unfortunately, because these notices, called Explanations of Benefits (EOBs), can be confusing to read, too many people prefer to ignore the whole medical payment process and assume that the insurance company and the doctors are handling everything satisfactorily, letting the envelopes from insurance companies stack up unopened.

However, this can cause a rude awakening when you receive a large bill from a doctor stating the insurance payment doesn't pay any or only a small part of the bill. By the way, don't ignore this bill, but let the billing department know you are questioning it with the insurance company.

Most billing 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 part to understand how the process works and how you can affect it, but it will be well worth it.

The first step to understanding how your health claims are processed is to have a good idea of how your coverage works. 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. But you don't need to memorize your plan or know every single provision to have a good idea how it works.

The Plan Document

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 normally 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. 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.

Among the things you should try to find are:

- **The Schedule of Benefits** – This is often at the front of the plan. It's the specific amounts 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.
- **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.
- **Definitions** – This will define terms used in the document. Often words that have special definitions will be capitalized or printed in bold to let you know there is a definition of the term in the Definitions section.

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 seem 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. It is important that you review each EOB carefully.

The Explanation of Benefits (EOB)

Too often, EOBs look confusing at first glance, but this is the best tool you have for making sure the insurance plan is paying as it is supposed to. You need to learn how to read them; it is not that difficult.

An EOB does contain a lot of information, and it often takes a little study to understand exactly what is on your company's EOB. However, you do not need to understand every code and column to know that your claim was properly processed. You should be aware that many times the insurance company will list more than one charge on the same EOB.

Typically, an EOB will include:

- The claim number and the date the claim was processed
- The name of the doctor or other provider submitting the charge.
- The date the charge was incurred. This is important because insurance companies frequently file claims by Date of Service and Amount Charged.
- The full amount charged by the provider.
- There will be additional columns showing either amount disallowed or denied or the "Covered Amount" which is often less than the full amount charged.
- There may be a column that shows your savings for having used a network provider. Neither you nor the insurance company has to pay that amount.
- Frequently there will be columns showing what, if anything, was applied to the deductible, how much the insurance company is actually paying, and how much you are expected to pay.
- Footnotes – There will always be footnotes explaining the various amounts and how they were arrived at. Typical codes will tell you: why an amount was denied or disallowed; how the insurance company arrived at the "Covered Amount" ; why you don't owe what the insurance company did not pay; etc.

By tracking the doctor's bill from Amount Charged to the Patient's Responsibility columns, you should be able to see why they paid what they paid

Most important on the EOB is the toll-free telephone number for questions. If you do not understand the EOB or a part of it, you should call the toll-free number and ask for a more complete explanation. 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 the appeal. He or she may be able to explain why a denied procedure was "medically necessary" or what made your treatment differ from the "normal medical protocols."

If you are just starting the process of checking EOBs, take two or three EOBs, call the customer service number and ask for help going through them so that you will understand them better.

Also, be sure to note the representative's name. When calling the carrier, always have pen and paper. Note the date, time, and name of the person you speak with as well as a summary of what was discussed for later reference, if needed.

It is not uncommon to find billing or calculation errors in both EOBs and doctor bills. The longer you wait to question the charges, the more difficult it will be to get any errors corrected, so you should review every bill and EOB when they arrive.

A simple filing system is to have three folders, one for newly arrived EOBs, one for newly arrived medical bills from the providers, and one for EOBs attached to the medical bill which have been reviewed and you are satisfied that the calculation was accurate.

If there is an underpayment by the insurance company or an overcharge by the provider, you will be the person who is expected to pay for the error, unless you have been reviewing the bills and EOBs and can document the errors.