MedBillsAssist

Health Insurance Newsletter

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Accidents and Those Pesky E-codes

According to the National Safety Council, 33.2 million people in 2004 received medical services due to an accident. Of those, about 28.1 million were treated in emergency rooms and 2.8 million were hospitalized. The accidents resulted in 58.4 million physician-office visits.

Insurance claims for accidents require a special e-code or two. Some codes describe the actual accident or injury, while others are more generic. The codes trigger a hold on the claim by the "insurance machine," followed by a letter to the injured.

These are mostly single-page, form letters asking for details of the accident. Their purpose is to determine financial liability. Employment-related claims will be paid by workers' compensation, public accidents could result in legal action and payment from a third party, medical bills due to car accidents may be covered by auto insurance, and so on. There could even be a dual liability between two insurance companies.

The best source of information is the patient who suffered the injury. It is therefore in the best interests of the injured person to respond to the letter promptly. Ignoring the letter will result in a denial of the claim.

In some cases, a doctor or hospital may be able to "dress up" the original claim with the additional codes that void the need for the letter. However, such advance interventions from providers are rare. It is more likely that the patient will be left to deal with the letter. Providing the necessary details to the insurer is the best way to ensure correct processing of the claim.

For more, see Q&A (p. 3).

Take a walk with me in the world of insurance.

This Issue:

Editor's note:

Welcome to the seventh issue of the Health Insurance Newsletter from MedBillsAssist.

Your comments and suggestions are welcome.

When HSA is a Better Choice

Most small-business owners complain that they pay high premiums for health insurance even though they seldom use medical services. In such situations, HSAs (Health Savings Account) are the ideal solution.

An HSA is a smart way to manage money because it reduces your premiums by about 30% and grows your savings in a special medical-expense bank account. This IRS-approved account enables you to save dollars tax-free and accumulate the savings year after year. The money can be used to pay for medical costs in the same or subsequent years. It can also be used for expenses not covered by traditional medical insurance plans, such as dental care, vision services, glasses, long-term care insurance, etc.

HSAs are front-loaded. They have high initial deductibles, but often cover preventive care on the first dollar. When shopping for insurance plans, put HSAs on the list.

Medicare Open Enrollment

From November 15 to December 31, a period known as Open Enrollment, Medicare beneficiaries can enroll in a prescription benefit plan or change a current one. They can also sign up for Medicare Advantage programs, which are administered by commercial insurance companies.

Which type of plan should you choose? That depends on your lifestyle and healthcare preferences. Traditional Medicare allows patients to receive medical care in any state. This benefits people who change their residence for the winter, or move to a different state during the year. However, it does not cover doctors who opt out of the program, a growing problem on the east coast.

Benefits for Medicare prescription plans change annually. Hence, coverage that was suitable this year may not be right the next. Some drugs may have been removed from the formulary, and changes to step therapies, authorizations and quantity limits could affect benefit levels.

Medicare Advantage may be a viable option for those who prefer yearly physicals and don't want a supplemental plan. Many Advantage products include prescription plans that eliminate the need to add Medicare part D coverage.

A strong Medicare Advantage plan, such as a PPO, provides access to a large network of doctors. The disadvantage of these policies is that they require extra administrative procedures such as pre-certifications and admission notifications.

Traditional Medicare has the benefit of covering medical care in any state.

Medicare Money Matters

The price of Medicare part B benefit rises every year. In 2008, it will be $96.40 per month for people whose income is below $82,000. Premiums for those with higher incomes are based on a sliding scale.

The cost of a supplemental plan is decided by its benefit level. For people with retirement or VA benefits, the cost depends on the retirement package. Some retirement benefit packages have a prescription plan attached. Employers typically issue a letter that aids in selecting a plan. The letter compares the retirement plan to the Medicare drug plan and points out the better choice.

Medicare prescription costs depend on the policy chosen. Premiums range from $14.07 to $99.50 per month. Knowing your needs will help you pick the right plan. The first step is to find a plan that covers all the medications you will take. Next, add step therapies, prior authorizations and quantity limits. Finally, if coverage in the "doughnut hole" is important to you, find the month when the doughnut hole is reached. This process will give you the plan that best fits your requirements.

Note: For an explanation of the "doughnut hole," call us.

Legal Issues

The U.S. Department of Health and Human Services/Office of Inspector General, the FBI and the Florida Attorney General's Medicaid Fraud Control Unit on October 24, 2007, executed a federal search warrant at the Tampa headquarters of WellCare Health Plans.

WellCare provides managed care services exclusively for government-sponsored healthcare programs, focusing on Medicare, Medicaid and Healthy Kids. Although the reason for the investigation has not been disclosed, experts speculate that the company inflated the amount it spent on mental health care in order to keep revenues it should have refunded to Florida's Medicaid program. The company's previous brushes with the law have included an investigation into enrollments of dead people in the WellCare Medicare program in Georgia.

In May and June 2007, WellCare representatives appeared, along with other insurance executives, at a Congressional hearing into aggressive Medicare marketing practices. WellCare agreed to temporarily halt marketing one type of Medicare plan. But two months later, it was cited again for violating several provisions of its Medicare contract.

Despite the Florida investigation, WellCare is still servicing its clients.

…….. investigation into enrollments of dead people in the WellCare Medicare program in Georgia.

Q & A

Q: Should I answer letters from my insurance company?

A: A letter from your insurance company can be about a number of things. It may give you information about changes in policy, or inform you of new service offers, or ask you information regarding a recent claim.

You should always read it carefully right away. The letter is often just a page long. Absorbing its contents will only take you a few minutes. What you do next will depend on what kind of letter you receive.

- If the letter asks for additional

information, you should reply within a few days. Such letters often dispute the coordination of benefits. They can be triggered by an accident (which requires proper e-codes), or a change in jobs, or by children turning 21 or 24. The information requested is probably fresh in your memory, so why wait? Give the date and other details, make a copy and send it back. Remember to date your reply.

- A denial of services should be dealt with quickly, as you will usually be given only 30 days to respond. Fully understanding the letter is critical. The reason for the denial is most important in deciding what the response should be. Was the claim denied because of an administrative problem? On a technicality such as authorization or pre-certification? Or on medical grounds? People often contest a denial without understanding the real reason. If the basis for denial is not obvious, call the insurance company. If it doesn't give you a clear answer, call us. There are only two levels of appeal. Making a mistake here can deprive you of benefits.

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MedBillsAssist

Our mission is to represent our clients' best interests and work on their behalf in an ethical manner, in compliance with state and federal regulations.

While offering a wide range of solutions, we tailor our services to each client's specific needs. Our services range from resolving claim problems from one specific illness to reviewing and tracking all health-related solutions.

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

Medicare trained specialists.

Licensed in Connecticut and New York.

In the next issue: