MedBillsAssist

Medical Claims Solutions

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Health Insurance - Fake Insurance

I kept getting phone calls for limited extension enrollment for medical insurance. Until recently I have ignored those calls. Then I got a request from someone to help appeal a denial for a Cigna insurance policy application. It was explained that this is not a Marketplace policy.
When the next call came in from the limited extension enrollment for health insurance it definitely peeked my interest. Is there a cheaper medical insurance that I don't know about? I took the call and went over the painfully slow process to apply for insurance.
All was going ok until I had to listen to the disclosure. I was instructed just to listen, not to interrupt. I listened with a careful ear. In the disclosure I am told that the policy have $50,000 hospital coverage. I had to stop and ask to verify. When I probed into it I was told that the insurance pays $50,000 dollars. Seeing hospital bills well over that amount on a regular basis I know that amount will not cover a major illness. That is when I halted the application process and declined to move forward.
The good news is that I have health insurance. It is very expensive and have a high deductible. Past that deductible the ACA based insurance cover major illness without a limit.
That is a difference between health insurance and fake insurance.

In the past few years there are major changes in health insurance. Congress never ending attempt to eliminate the Affordable Care Act, removing provisions, and weekending the law, allows these fake insurance offers.

Real health insurance will cover unlimited dollar amounts. Limited policies are just that. It seems like medical insurance, but when needed the most it will quickly stop covering expensive care.
It is like to common saying: if it is too good to be true, it probably is. A $230 per month premium will not buy real health insurance.

Prescription Troubles

Prescription coverage is just as complicated as medical insurance. Our prescription coverage is outsourced to a specific company that manages only prescriptions. The line becomes blurry; where the prescription management company, such as Express Scripts or Optum makes the rules and where the rules are originating form the medical insurance.

Coverage for drugs is driven by the Formulary (list of covered drugs). You can avoid surprises at the drug store by checking your formulary first. Drugs are moved from the list, fluctuating pricing and authorization rules are common.

If there is a surprise in the drug store start asking questions: What is the reason for the increase? Do you have my correct insurance information? Do I need prior authorization? Is there a cheaper equivalent drug available?

If don't understand the responses have the pharmacist put your drug on hold and call your insurance. Ask about the drug and your policy. You will be surprised all the additional information you will discover just by asking a lot of questions.

If the drug you needed is urgent you can ask to have a few days supply given to you, until you have sorted the problem out with your insurance. It will hold you over until you have the answers to make an intelligent decision.

If you are taking maintenance medication shop around, look for manufacturer coupons, or even shop in Canada. Don't be fooled. Canadian's often take the same drugs, from the same manufacturers. Our drug supply in the US isn't any safer than other nations.

Quote of the Quarter

In last December, Professor Philip Alston from UN Human Rights Commission prepared a Special Report on extreme poverty and human rights in the US.

"The United States is alone among developed countries in insisting that while human rights are of fundamental importance, they do not include rights that guard against dying of hunger, dying from a lack of access to affordable healthcare, or growing up in a context of total deprivation".

Link to full report

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Medicare ABN - Take Notice

Medicare will pay seamlessly for most medical procedures. Unlike other health insurance, Medicare works based on "post-service review". What this really means that Medicare have rules for many services. Once a claim is submitted the computer system checks the claim based on those rules. It the coding fits the rules the claim gets paid.
ABN is an abbreviation for Advanced Beneficiary Notice. It is issued prior to services when the medical provider knows that the claim will get denied. The most common use of this letter is in a laboratory settings. Based on the code for a specific test and the diagnosis, the laboratory already knows which test Medicare will not pay for. To ensure payment is received the lab have the patient sign a letter allowing the patient to decide if he want to pay for the test. Once the letter signed the bill is submitted with an additional code that tells Medicare that the patient will pay for the test.
While the solution is advantageous for the laboratory, it is not the best interest of the patient. Often enough the better solution is a call to the ordering doctor. The questions should be asked: why did he/she ordered the test? Is there a medical diagnosis that makes it necessary to order such a test?
In most cases there is a supporting diagnosis; it is just left off from the order sheet.

Before you sign the ABN letter you should ask those questions. Either there is a good reason to get the test, or it was something ordered that you did not need.
Being smart with your medical expenses is just as important with any other financial expenditures.

Definitions:

NCD: National Coverage Determinations

ACA: The Patient Protection and Affordable Care Act

LCD: Local Coverage Determinations

Formulary: A list of covered drugs and their designations

Medicare ABN : Advanced Beneficiary Notice

14 Tips for Successful Appeals

1. Understand what is denied and why
2. Clarify the denial; medical necessity versus coverage denial
3. Look up your health insurance policy provision relevant to the denial
4. Gather supporting information, documents, studies, records
5. The appeal needs to state facts; leave your emotions at home
6. Be sure to follow the appeal instructions
7. Time is important. Most first level appeals have a limit of 180 days
8. Mark your calendar for 30 days, and follow up on your filed appeal
9. Don't give up on the level one denial. Most appeals are routinely denied at the first level
10. Prepare for the second level appeal
11. Make sure you understand what needs to be done in the second level
12. Policy types and state regulations define appeal rights. Be sure to understand your own policy. Self-funded versus fully-funded
13. Fully-founded policies are true health insurance and regulated on the state level
14. Self-funded policies are insurance administration only. Your employer is the payee of the claims. It is regulated by the Department of Labor

Legal Issues or Who is in Trouble this Time?

Texas Supreme Court recently ruled on the case involving Cypress Hospital to disclose insurance negotiated rates for uninsured patients. Justice Debra H. Lehmann wrote:

"The reimbursement rates sought, taken together, reflect the amounts the hospital is willing to accept from the vast majority of its patients as payment in full for such services. While not dispositive, such amounts are at least relevant to what constitutes a reasonable charge."

This ruling have far reaching consequences on hospital charge master practices on the long term. Read more about it at:

Texas Hospital Loses Fight To Protect Reimbursement Info

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.

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