



Complex Child E-Magazine

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Getting the Most from Your Insurance

by Jill Flinton

Having a child with medical complexity is difficult enough. Having a difficult insurance company does not help. But having insurance--of any type--is a must. So how do you get what you need without driving yourself crazy?

I have successfully argued \$10 co-payments to \$1,750 lab tests using the procedures discussed below. The key is knowing what services were provided, what was billed, and what you are responsible for.

The Basics

The first thing is to make sure you know the effective dates of your child's coverage. Some plans have different tiers with different waiting periods. In addition, children can be covered on a parent's insurance until age 26, and in some cases longer if children are incapable of self-care.

The second thing is to know what your insurance covers. If you have private insurance, make sure you have a copy of your plan documents. Some companies are now providing these electronically to save costs, so make sure you know how to get one and save it to your computer or print it. If you have Medicaid make sure you have a case manager you can contact at any time with any sort of coverage question. If possible, get a listing of items that Medicaid covers.

The third thing is to know how to review claims. Does your insurance company mail an Explanation of Benefits statement to you for every service? Can you review claims online?

Finally, keep your records. I have a three-ring binder with all the Explanation of Benefit (EOB) statements, prior approval letters, letters I have written, and receipts from providers.

Copays, Prior Approvals, and Referrals

Most insurance companies provide for full coverage of well-care visits and visits with immunizations, since this is mandated by the Affordable Care Act. This means that there

should be no co-payment required from the family. When making doctor appointments make sure you ask for a well-care visit, if appropriate, or whether the visit will include immunizations. If you are asked for a co-payment for a visit that you don't believe requires one, ask the doctor to bill you. Most will not have a problem with doing so.

If your insurance requires referrals for specialists or specific tests, make sure you get the required referral. Most pediatricians, especially if they have been working with you on your child's complex needs, will be willing to provide the referral to the requested specialist or testing center. In some cases, they will even make the appointment for you.

Some tests or equipment require prior approval. A doctor needs to contact the insurance company and request the specific test (like an MRI) or equipment (like feeding pumps) and provide a justification. Contact the doctor to make sure the office staff has submitted the documentation. You can also call your insurance company and ask for the prior approval department to see if the request has been received. This department may become a frequent contact, so see if you can find one person to contact and make sure all prior approval requests are submitted to that one person. When the insurance company makes its decision, they should provide you with some type of documentation stating what is being covered, when it is being covered and what the approval number is for billing purposes. Make a copy of this letter and bring the copy with you so the provider has the approval number.

Encountering Problems

So what do you do if you did everything the insurance company required but it still denied the claim or is requiring a co-payment?

The first thing to do is call the provider. In some cases, it's a simple billing error. I had one provider who typed a service date incorrectly and the claim was denied. Once I called them and explained the situation, they rebilled the insurance company. In other cases, the provider has an incorrect member or subscriber number.

If contacting the provider doesn't provide a resolution, contact the insurance company. Every insurance company has a process to appeal a decision. In some cases you can call them and they can explain and review the claim fairly quickly. I had routine pediatrician appointments processed as specialist claims (with a higher co-payment) due to an insurance company system coding error. A phone call resolved the problem.

If you can't resolve the issue with a phone call, write a letter. This is where your insurance coverage book is important. In your letter explain what you are appealing. For example:

I am appealing the co-payment requirement on (date of service) because my child, (child's name), received an immunization.

Then copy that section of your plan document into your letter, even indicating the page number. For example:

According to the plan document of (your employer), page 30 states: Co-payments are not required for services when immunizations are administered.

Make sure you include a copy of the bill or explanation of benefits statement, even though the insurance company should have the information. Also include contact information if the insurance company has any questions. Copy the letter and any supporting documentation before you send it. If you think your insurance company will claim they never received it, send it with the requirement of a signature when it is delivered, or fax it and keep the fax receipt showing the date and time of transmission. Contact the insurance company a few days later to determine if the letter was received. Contact them again near the end of the period of time they have to review the appeal.

Most issues can be resolved with a letter. If the letter does not suffice, the insurance company should provide you with a detailed letter as to why the claim was denied. This letter should also include additional details on an appeal procedure. If you need to, follow those details to continue your appeal process.

How to Get Your Money Back

Some providers require payment up front no matter what the service or your insurance coverage. If you have to provide funds up front and you know that your insurance will provide coverage, make sure you get a receipt and keep it in a safe place. If you receive notification from the insurance company that you did not have any payment requirement find your receipt. Call the billing office of the provider and ask them for a refund of the fees that you paid. If the provider does not appear willing to refund your funds, write a letter. Include a copy of your receipt and the insurance notification and request a refund of the funds you paid by a certain date. I would give the provider 20 days or so to return the funds. Again, include contact information for the provider to contact you if they have questions. Copy the letter and supporting documents before mailing or faxing them and contact the provider to see if they were received.

If the provider is uncooperative, you can contact the insurance company and provide a copy of your receipt and your letter to the provider. The insurance company may reimburse you for your costs and then recover the funds from the provider.

In other cases, you may not realize that the insurance company will provide coverage for some services until a later date. Before my child was born, I attended a birthing class. My insurance company reimbursement me 50% once I submitted a copy of the attendance certificate and proof of payment. I purchased a breast pump before I left the hospital. I was able to obtain a copy of the detailed receipt from the hospital showing the cost of the pump. My insurance company reimbursed me for 80% of the cost because they considered it durable medical equipment. All I needed was a letter, the billing

statement, and proof of payment.

Medicaid Coverage

Medicaid coverage is state specific, within the overall general structure set up by the Center of Medicare and Medicaid Services within the US Department of Health and Human Services. Medicaid coverage is income based, but there are waivers which provide the ability to obtain Medicaid coverage for children alone if they have complex medical needs, even if the household income is in excess of the income limitations. Your doctor will need to provide substantial medical documentation supporting the diagnosis and needs in order for your child to enter a Medicaid waiver program.

Medicaid coverage can be retroactive to the date the application was filed or some other date, depending on the state. Make sure you keep receipts for all costs that potentially could be covered. This includes all co-payments and over-the-counter medical supplies. Document mileage costs to and from physicians and other providers, as well as tolls, parking and meal expenses. If you are entitled to retroactive coverage, you will need to provide all those receipts to Medicaid in order to be reimbursed. Write a letter explaining that you are requesting payment for the out-of-pocket expenses that you incurred during the retroactive period. Include a summary of the costs you are requesting and copies of those receipts. You may need to include copies of cancelled checks or credit card statements to provide that you actually paid the expenses.

If you have private insurance and Medicaid coverage, Medicaid should be billed as a secondary insurance. What this means is that if a doctor charges \$100 for an office visit, they need to bill the private insurance first. The private insurance will pay the doctor whatever they usually do. The doctor will then bill Medicaid for any co-payment that you would have been responsible for and any uncovered services.

Conclusion

I hope these tips have been useful and will help you get the most out of your insurance policy. Although there is time involved in contacting providers and insurance companies, you may save yourself some money, which can always be put to better use.

Jill Flinton spent over 10 years reviewing insurance claims and the past five years using that knowledge to get the most coverage for the least cost for her son with medical complexity.