THE SELF-HELP GUIDE TO MEDICAL BILLS

PATIENT GUARDS

You Will Need:

- ✓ The Bill You Received
- ✓ Your Plan Summary and ID Card
- ✓ The Medical Record
- ✓ The Claim Form
- ✓ The EOB

Determining if a Medical Bill is accurate is like a puzzle and there will just not be a complete puzzle without all the pieces.

The medical bill process is complex. So much so that professionals in the field study extensively to manage all of the codes, the instructions, and the laws.

Unfortunately, even that is not enough to keep errors from occurring.

Some errors can be identified and resolved by the patient. Others, it must be said, are unlikely to be manageable without the extensive process knowledge.

Tips on Preventing Medical Billing Errors Before They Happen

Receiving an unexpected or inaccurate medical bill can add unnecessary stress to an already challenging circumstance.

However, you do have rights and the ability to be proactive and prevent some medical billing errors before they happen.

Here are some key tips:

1. Know Your Rights:

- **The No Surprises Act (NSA)** protects you from receiving a bill for more than the amount you would have paid "in-network" for certain out-of-network services (like emergency care or lab tests from an out-of-network provider at an in-network facility). Familiarize yourself with the NSA provisions to understand your billing rights. Resources like the Kaiser Family Foundation (https://www.kff.org/affordable-care-act/video/in-focus-with-kff-what-to-know-about-the-new-ban-on-surprise-bills/) offer clear explanations.
- **Individuals' Right under HIPAA to Access Your Health Information (45 CFR § 164.524)** This federal law allows you to request a copy of your medical records from any healthcare provider you've received services from. Having access to your medical records empowers you to review charges and ensure everything listed is accurate and reflects the services you received. A key provision under this Federal Law is access to the **"Designated Record Set".**

Individuals have a right to access PHI in a "designated record set." A **"designated record set" is defined at 45 CFR 164.501** as a group of records maintained by or for a covered entity that comprises the:

- **Medical records and billing records about individuals maintained by or for a covered health care provider;**
- Enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
- Other records that are used, in whole or in part, by or for the covered entity to make decisions about individuals. This last category includes records that are used to make decisions about any individuals, whether or not the records have been used to make a decision about the particular individual requesting access.

The term "record" means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for a covered entity.

Thus, individuals have a right to a broad array of health information about themselves maintained by or for covered entities, including: medical records; billing and payment records; insurance information; clinical laboratory test results; medical images, such as X-rays; wellness and disease management program files; and clinical case notes; among other information used to make decisions about individuals. In responding to a request for access, a covered entity is not, however, required to create new information, such as explanatory materials or analyses, that does not already exist in the designated record set.

2. Ask Questions:

- **Before any procedure:** Before scheduling a medical service, inquire about potential costs, especially for out-of-network providers or non-covered procedures. Ask for an estimate or "good faith estimate" of the expected charges.
- **During your visit:** Discuss any billing questions or concerns with your healthcare provider's billing department before you leave. This opens a door for clarification and can help prevent future disputes.

3. Verify and Review:

- **Pre-Authorization:** Certain procedures require pre-approval from your insurance company. Ensure your provider has secured pre-authorization before proceeding, especially for non-emergent services.
- **Explanation of Benefits (EOB):** Carefully review your EOB from your insurance company. This document details what your insurance covered, any remaining out-of-pocket costs, and any denied services. Contact your insurance company directly if you have any questions or discrepancies with the EOB.

4. Keep Records:

- **Maintain copies of all medical records:** Having a paper trail of your medical records and related billing documentation is crucial. This allows you to easily reference details when reviewing bills or addressing any discrepancies.
- **Save estimates and pre-authorization documents:** Retain copies of any pre-authorization forms, estimates provided by your provider, and any communication you have with your insurance company regarding costs.

By knowing your rights, actively engaging in communication, and diligently reviewing information, you can significantly reduce the risk of encountering medical billing errors. Remember, you are an active participant in your healthcare, and financial transparency is an essential part of that.

Empower yourself with knowledge and avoid the unwelcome surprise of a medical bill that is not true and accurate!

The Complexities of Medical Billing

Receiving a medical bill, especially a large one, can be alarming.

The medical billing process is an intricate system that often leaves patients feeling overwhelmed and frustrated. However, it's essential to understand the complexities involved before diving into criticisms.

Physicians dedicate years of their lives to rigorous education and training, incurring significant financial burdens to assume the immense responsibility of patient care. It's only fair that they receive appropriate compensation to sustain their practices. The medical billing process is a mechanism to ensure this, as well as cover operational expenses.

While the system may appear overly complex, it's crucial to recognize the challenges inherent in standardizing the billing process for a vast array of unique medical cases. Each patient's medical history, treatments, and insurance coverage differ, requiring a flexible yet universal system to accommodate these variations.

It's important to acknowledge that errors can occur at any stage of the medical billing process, from provider documentation to insurance claim processing. Despite efforts to streamline the system, human error and system glitches are inevitable.

While patient frustration is understandable, it's essential to approach the issue with empathy for both patients and healthcare providers. By understanding the intricacies of the medical billing process, patients can become more informed advocates for themselves and work collaboratively with healthcare providers to resolve billing issues.

It's important to remember that not all bills contain errors. However, the unfortunate truth is that a significant number do. The challenge lies in identifying these errors, which can be daunting for those unfamiliar with the complexities of the healthcare billing system. This is where expert assistance can be invaluable.

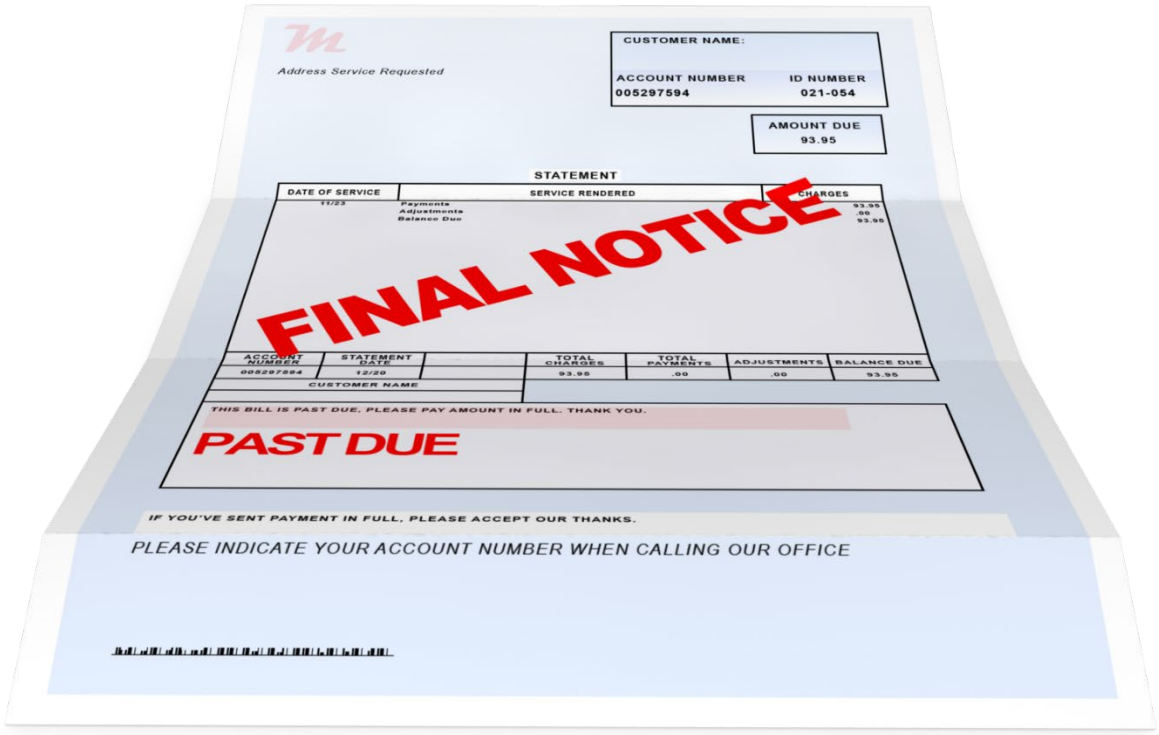
The role of a Medical Coder and Medical Biller is far more complex than the cashier at a store that scans an item and tabulates a total. Medical notes are translated into codes that each have detailed definitions, guidelines, and even laws that govern their assignment. This role is a profession. Thus, the average patient will find it quite difficult to navigate unless they wish to go through all of the necessary training to in fact become a professional medical coder or biller. To draw a comparison, one may be able to find and read laws, but to adequately navigate many legal questions takes someone that is familiar with law such as a paralegal or an attorney.

Many ask “Why?”. Why does it have to be so complex? This is truly a case of “be careful what you wish for”. If there was no structure, no standard definitions, no commonly agreed upon system to categorize and communicate medical services, then imagine each medical provider doing whatever they want when it comes to charging fees. If you think it is chaos in the present, let your imagination run with that idea.

Many also are quick to rush to judgment of medical providers when there is an error. This is because the receipt of a bill from that medical provider is normally the trigger or alert to a problem, so it becomes a “shoot the messenger” scenario. However, many issues are a result of errors on the insurance plans side of the process. In these cases, the medical provider is just as vulnerable as the patient.

Medical coders and billers are trained to read the medical language of providers and turn that language into these standardized codes to replace information that could be written in many different ways. The problem is, few are perfect at it and many could use improvement. In addition, inadequate staffing where too much of this work is thrust upon too few resources. Other issues such as providers assigning codes on their own without an appropriate understanding of the process, untrained staff tasked with this role, and more are all very real root causes. As mentioned earlier, the cause is not always with the provider and can be as much an insurance plan issue.

The Bill That You Have Received



To accurately identify any errors, the bill that you are receiving will provide the foundation for any dispute. This will be used to compare any other relevant documents to show that the bill received is inaccurate.

Medical Record Note For The Services In Question

Medical Office Note

Patient Information:

Name: John Doe

DOB: 01/01/1970

Date of Visit: 07/26/2024

Reason for Visit:

Follow-up for Type 2 Diabetes Mellitus

The patient reports generally feeling well but mentions occasional dizziness and fatigue over the past month.

Reports adhering to prescribed medication and dietary recommendations but admits to occasional lapses in diet control, particularly during social events.

No episodes of hypoglycemia or hyperglycemia requiring emergency intervention.

Vital Signs: BP: 130/85 mmHg HR: 72 bpm Temperature: 98.6°F Weight: 180 lbs (stable)

Height: 5'10" BMI: 25.8

Physical Examination:

General: Alert and oriented, no acute distress.

Cardiovascular: Normal S1 and S2, no murmurs, rubs, or gallops.

Neurological: No focal deficits, sensation intact.

Laboratory Results:

HbA1c: 7.2% (slightly elevated, previous was 7.0%)

Fasting Glucose: 140 mg/dL

Lipid Panel: Total cholesterol: 180 mg/dL, HDL: 50 mg/dL, LDL: 110 mg/dL, Triglycerides: 150 mg/dL

Assessment:

Type 2 Diabetes Mellitus, uncontrolled

Plan:

Medications:

Continue Metformin 1000 mg twice daily.

Continue Glipizide 5 mg daily before breakfast.

Discussed starting a GLP-1 receptor agonist; patient to consider and follow up in 2 weeks.

Lifestyle Modifications:

Reinforce adherence to diabetic diet.

Encourage regular physical activity: at least 30 minutes of moderate exercise 5 times a week.

Patient education on managing dietary choices during social events.

Monitoring:

Check blood glucose levels daily, particularly fasting levels.

Schedule follow-up visit in 3 months to re-evaluate HbA1c and overall management.

Referrals:

Next Appointment:

Scheduled for 10/26/2024 for follow-up and repeat HbA1c test.

Any charge starts with the documentation. No documentation, no charges.

This is where it all begins.

Since no two patient encounters are the same, the documentation is as unique as a fingerprint.

Imagine asking 100 people to write a paragraph about a boy and his dog. You would get 100 unique essays. The same is true for medical records.

It is for this reason that medical codes exist. This allows for a standard system of reporting information such as diagnoses, treatment, procedures, supplies, and medications.

There are 4 primary code sets.

ICD 10 CM which reports diagnosis information

CPT® which is the main procedure code set

HCPCS which reports medicines, supplies, equipment, and services

ICD 10 PCS reports procedures performed during inpatient admissions

ICD 10 CM has over 75,000 codes

CPT® has over 11,000 codes

HCPCS has over 8.000 codes

ICD 10 PCS has over 80,000 codes

There are many ways to tell that story about a boy and his dog and many more ways to tell the story of the Doctor and their patient.

For each single code in all of the sets mentioned, there are detailed instructions, guidelines, and even laws that govern their use.

Fees are primarily associated with procedure codes with the diagnosis codes providing support for the medical appropriateness of the procedure.

Professionals study extensively to be proficient in the use of these codes.

It therefore simply not reasonable to expect a patient to effectively make sense of them on an isolated basis. Adding to the challenge is that CPT® codes are copyrighted and therefore not readily available in enough detail without the purchase of a full version. Even then, navigating all of the descriptions, instructions, rules, and laws adds many more layers of complexity.

Root causes of errors at this stage can include:

- Insufficient provider documentation
- Errors in the assignment of codes
- Fees not adhering to allowed amounts when applicable

This stage of the process is perhaps the most unlikely for a patient to identify or overcome any deficiencies.

Understanding the 1500 and UB-04 Claim Forms in Medical Billing

The two primary claim forms used in this process are the CMS-1500 and the UB-04. These forms serve different purposes and are used in various healthcare settings.

The CMS-1500 Claim Form

Overview

The CMS-1500 claim form, also known as the Health Insurance Claim Form, is predominantly used by professional service healthcare providers and practices. It was developed by the Centers for Medicare & Medicaid Services (CMS) and is the standard form for billing services to insurance, Medicare, and Medicaid for these providers.

Structure and Content

The CMS-1500 form contains numerous fields that capture detailed information about the patient, provider, and services rendered. Key sections include:

1. **Patient Information:** Fields for the patient's name, address, date of birth, and insurance information.
2. **Provider Information:** Details about the healthcare provider, including their name, address, and National Provider Identifier (NPI).
3. **Service Details:** Specifics about the services provided, such as dates of service, procedure codes (CPT/HCPCS), diagnosis codes (ICD-10), and charges.

The form is divided into 33 fields, each designated for specific data points. Accurate completion of these fields is crucial for the timely and correct processing of claims.

Usage

The CMS-1500 form is primarily used by:

- Physicians
- Private practices
- Therapists
- Non-institutional providers

It is utilized to bill services such as office visits, outpatient visits, and other professional services such as labs, supply and equipment suppliers, and more.

The UB-04 Claim Form

Overview

The UB-04 claim form, also known as the CMS-1450, is used by institutional providers to bill for services such as Inpatient Admissions. This form was developed by the National Uniform Billing Committee (NUBC) and is widely used across various healthcare settings.

Structure and Content

The UB-04 form is more complex than the CMS-1500 due to the nature of services it covers. It includes 81 fields (referred to as form locators) that gather comprehensive information about the patient's stay and the services provided. Key sections include:

1. **Patient Information:** Similar to the CMS-1500, this section captures basic patient details.
2. **Hospital/Facility Information:** Information about the institution, including name, address, and NPI.
3. **Service and Stay Details:** Detailed information about the patient's admission, discharge, type of stay, and services provided. This includes room and board, nursing services, and ancillary services.
4. **Revenue Codes:** Used to categorize hospital services by the department where the services were provided.
5. **Diagnosis and Procedure Codes:** Diagnosis codes (ICD-10) and procedure codes (ICD-10-PCS) related to the patient's treatment.

Usage

The UB-04 form is used by:

- Hospitals
- Skilled nursing facilities
- Home health agencies
- Rehabilitation centers

- Hospice care providers

It is designed to bill for inpatient, outpatient, emergency room, and other institutional services.

Key Differences Between CMS-1500 and UB-04

While both forms are used for medical billing, their purposes and users differ significantly:

1. **Provider Type:**
    - **CMS-1500:** Used by professional services providers and practices.
    - **UB-04:** Used by institutional providers, such as hospitals and nursing facilities.
2. **Complexity:**
    - **CMS-1500:** Simpler, with 33 fields focusing on outpatient and professional services.
    - **UB-04:** More complex, with 81 fields covering comprehensive details of institutional services.
3. **Services Billed:**
    - **CMS-1500:** Bills for professional services, such as office visits and outpatient care.
    - **UB-04:** Bills for institutional services, including inpatient stays, emergency room visits, and other facility-based services.

Claims are most often filed electronically to the various health benefit coverage providers. This is done in a standardized file format that contains the same details as the paper forms, just in an electronic format.

For self-education on the full fields and completion of these forms, the following sites provide this information. This is a part of the information that professional medical billers and coders have studied extensively and a patient advocate is an expert in.

1500 Form - https://www.nucc.org/index.php/1500-claim-form-mainmenu-35/1500-instructions-mainmenu-42

UB 04: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/ub04_instructions.pdf

https://www.verywellhealth.com/preparing-the-ub-04-form-2317061

Under the Health Insurance Portability and Accountability Act (HIPAA) patients have a right to the "Designated Record Set" and these forms are defined and included in this set by law.

See - https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html

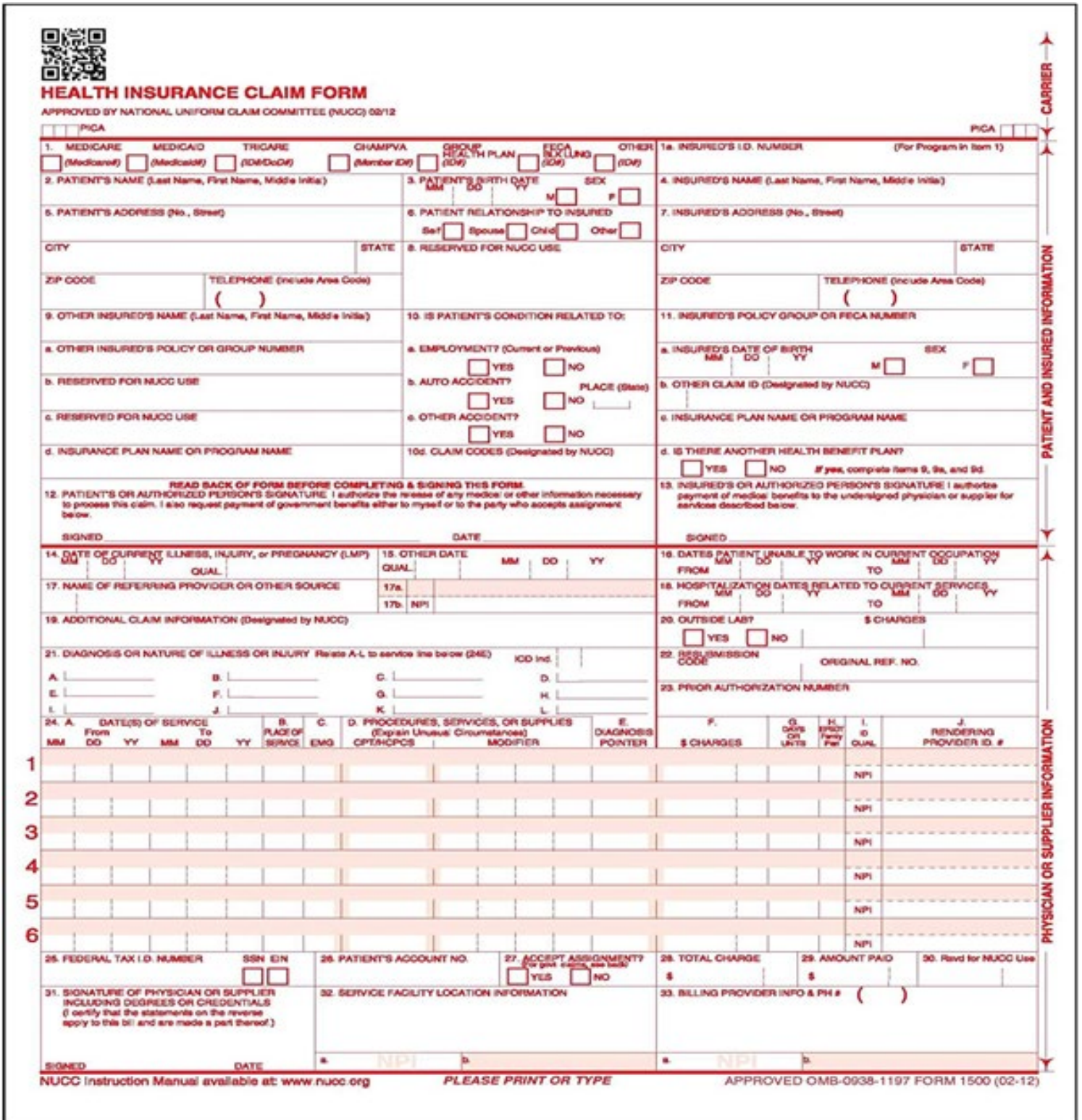
If your medical provider has a patient portal, you may be able to access these forms for any services rendered through that access.

If not, you have the right by law to request them and have them provided to you.

Claim Forms

On the following 2 pages are the standard claim forms used to submit fees to insurance plans. These are rarely if ever the “bill” that a patient receives. There are a few reasonable reasons for this. However, no matter how justifiable the reason, it makes the prospect of patients validating accuracy incredibly difficult.

1500 Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

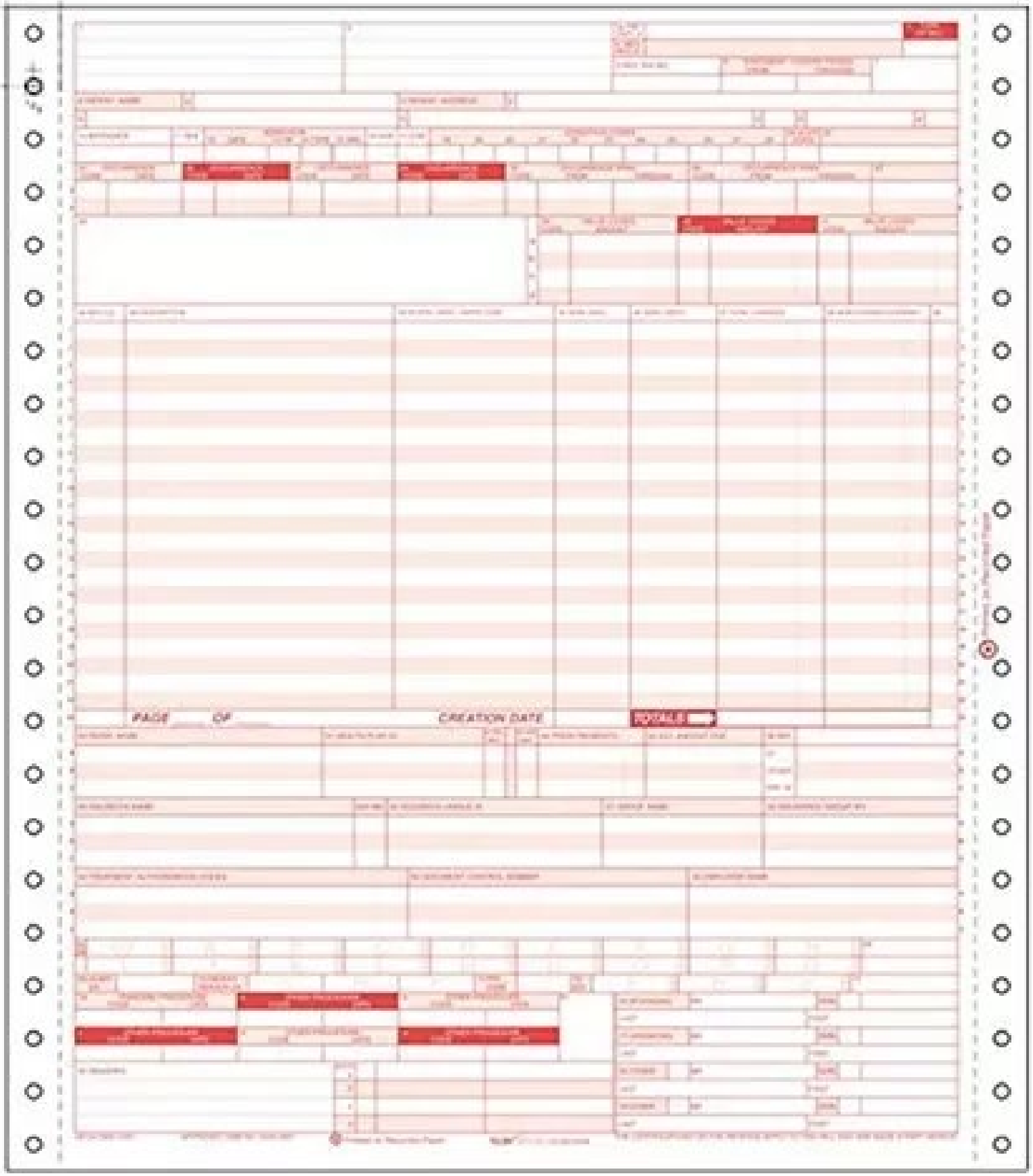
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

UB 04 Claim Form



Your Insurance Details

⚠ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/office visit and 20% coinsurance for other outpatient services; deductible does not apply	40% coinsurance	None
	Specialist visit	$50 copay/visit	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay/test	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$50 copay/test	40% coinsurance	
If you need drugs to	Generic drugs (Tier 1)	$10 copay/prescription	40% coinsurance	

You will need your insurance coverage information to determine such details as if services are covered, at what coverage level, under what circumstances, and more.

It is not possible to dispute a benefit issue without understanding what the basis of the dispute is or without having the agreement available. Some details are fairly **straight**

forward such as In Network, Out of Network, benefit percentages, etc. Other factors may be more complicated and “subjective”. For example, whether a benefit is considered medically necessary or appropriate, the duration of the treatment or number of units, and many more determinations may be open for varying opinions, primarily in the judgment of treating practitioners. These types of disputes typically require a certain level of clinical knowledge to present a compelling argument if the insurance plan’s determination is adverse to the patient.

Patients should take the time to understand their benefits before services are rendered to avoid complications in payment for treatment.

Related to this is understanding when authorizations, referrals, and other pre-approvals are required.

Explanation of Benefits (EOB)

A common cause of confusion for many patients is reading and understanding their EOB detailing payment or denial of insurance benefits.

Decoding the EOB: Common Challenges Patients Face

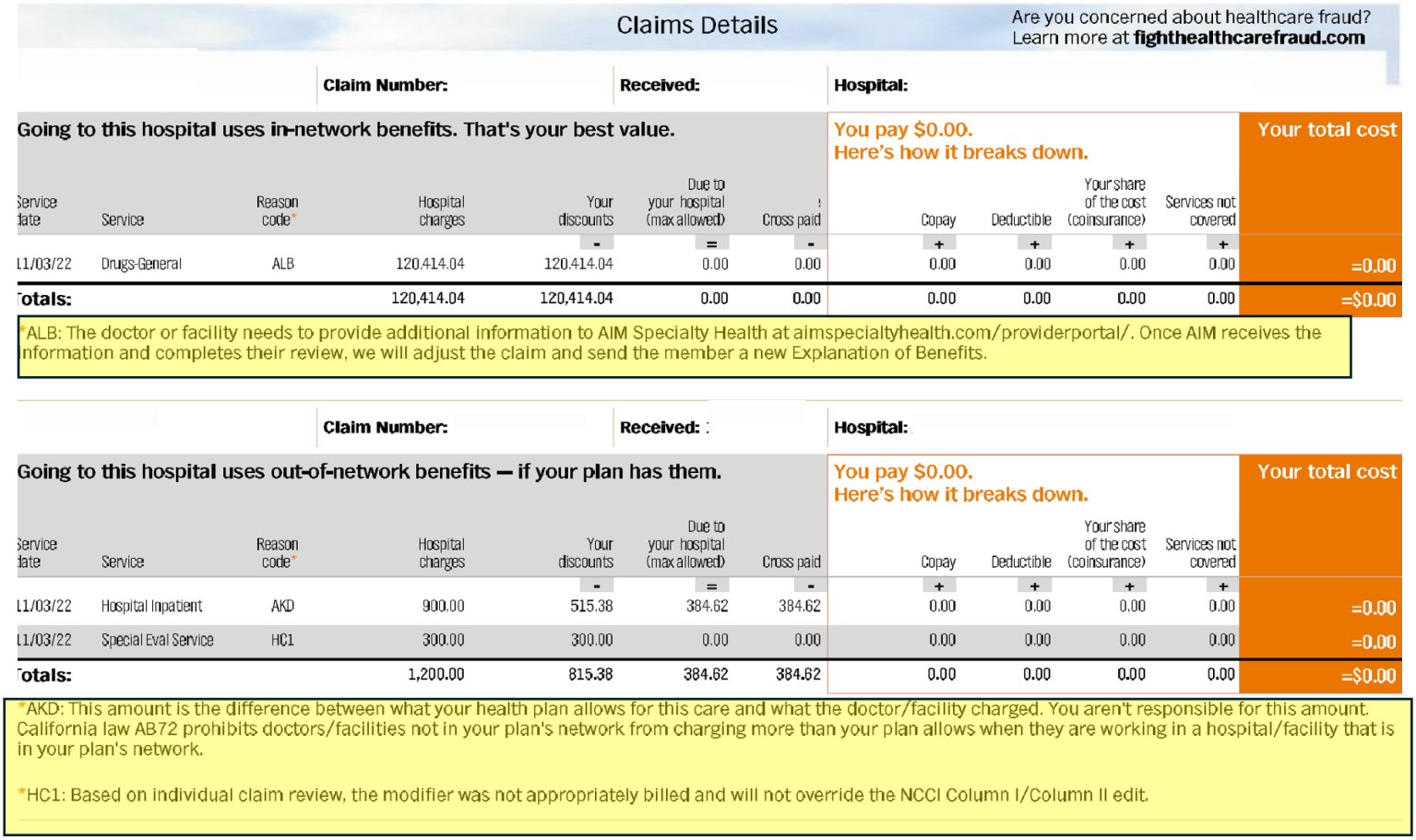
An Explanation of Benefits (EOB) is a document sent by your health insurance provider detailing the services you received, the costs incurred, and the amount your insurance covered. While it's a crucial tool for understanding your healthcare expenses, many patients find EOBs to be confusing and overwhelming.

Here are some common challenges patients face when trying to decipher their EOBs:

- Jargon and Medical Terminology: EOBs are filled with medical terms and insurance jargon that can be difficult for non-medical professionals to understand. Words like "copay," "deductible," "coinsurance," and "allowed amount" can be confusing.
- Allowed Amount: While this term may seem clear, it is in fact quite vague or arbitrary. The definition of “Allowed Amount” varies by the type of coverage, contractual relationships, and plan benefit definitions. This is not a universal term that can be interpreted as meaning that anything exceeding it is not permissible.
- Complex Calculations: Determining the exact amount you owe can be challenging due to complex calculations involving deductibles, copays, coinsurance, adjustments, and out-of-pocket maximums.
- Errors and Discrepancies: Mistakes in billing or processing claims can lead to incorrect information on the EOB, making it difficult to understand your financial responsibility. In particular, coding errors on the part of the provider submitting a claim. Just because insurance makes payment, this does not mean that the coding is correct. There are many errors that can only be truly detected by a review and comparison of the medical record and the codes assigned.
- Multiple Providers and Claims: If you received care from multiple providers, your EOB might include information from different claims, making it even harder to understand.
- Lack of Clarity: EOBs can often be poorly formatted or lack clear explanations, making it difficult to find the information you need.

Understanding your EOB is essential for managing your healthcare costs and identifying potential errors. If you're struggling to understand your EOB, don't hesitate to contact your insurance provider for clarification or an independent expert such as an advocate.

On the EOB below, the areas highlighted in yellow indicate potential areas that need clarification.



Claims Details

Are you concerned about healthcare fraud?
Learn more at **fighthealthcarefraud.com**

Claim Number: **Received:** **Hospital:**

Going to this hospital uses in-network benefits. That's your best value.

Service date	Service	Reason code*	Hospital charges	Your discounts	Due to your hospital (max allowed)	Cross paid	You pay $0.00. Here's how it breaks down. Copay	Deductible	Your share of the cost (coinsurance)	Services not covered	Your total cost
				-	=	-	+	+	+	+	
11/03/22	Drugs-General	ALB	120,414.04	120,414.04	0.00	0.00	0.00	0.00	0.00	0.00	=0.00
Totals:			120,414.04	120,414.04	0.00	0.00	0.00	0.00	0.00	0.00	=$0.00

*ALB: The doctor or facility needs to provide additional information to AIM Specialty Health at aimspecialtyhealth.com/providerportal/. Once AIM receives the information and completes their review, we will adjust the claim and send the member a new Explanation of Benefits.

Claim Number: **Received:** **Hospital:**

Going to this hospital uses out-of-network benefits — if your plan has them.

Service date	Service	Reason code*	Hospital charges	Your discounts	Due to your hospital (max allowed)	Cross paid	You pay $0.00. Here's how it breaks down. Copay	Deductible	Your share of the cost (coinsurance)	Services not covered	Your total cost
				-	=	-	+	+	+	+	
11/03/22	Hospital Inpatient	AKD	900.00	515.38	384.62	384.62	0.00	0.00	0.00	0.00	=0.00
11/03/22	Special Eval Service	HC1	300.00	300.00	0.00	0.00	0.00	0.00	0.00	0.00	=0.00
Totals:			1,200.00	815.38	384.62	384.62	0.00	0.00	0.00	0.00	=$0.00

*AKD: This amount is the difference between what your health plan allows for this care and what the doctor/facility charged. You aren't responsible for this amount. California law AB72 prohibits doctors/facilities not in your plan's network from charging more than your plan allows when they are working in a hospital/facility that is in your plan's network.

*HC1: Based on individual claim review, the modifier was not appropriately billed and will not override the NCCI Column I/Column II edit.

*ALB: The doctor or facility needs to provide additional information to REDACTED]. Once [REDACTED] receives the information and completes their review, we will adjust the claim and send the member a new Explanation of Benefits.

HCl: Based on individual claim review, the modifier was not appropriately billed and will not override the NCCI Column I/Column II edit.

This message refers to a very complex guideline on codes that can / cannot be billed together. The typical patient without training in this guideline would be highly challenged in resolving this.

Appealing Insurance Decisions

To have the best chance of a successful appeal, it is important to state facts, cite coverage terms, and indicate why a determination was incorrect and should be reversed. If the appeal is regarding an issue of coverage for a particular service based on “medical review”, providing valid medical literature supporting why the service should be covered would be the appropriate approach.

YES

“A specialist copay was applied to my claim however I saw my PCP as listed on my card and in my plan profile. Please review and make the necessary correction as per my coverage.”

NO

“The health system is broken and this insurance is so expensive that I can’t afford my basics. This is so unfair.”

An appeal analyst looks for facts and gaps in the details of plan responsibilities. They are not permitted to allow emotional pleas to influence their review of the facts.

Resources That Professionals Utilize

CAUTION: The resources below may be complicated and technical. They are provided to demonstrate the vast amount of information that Professionals rely on. It is not a complete list. Those not trained or proficient in their use are cautioned in attempting to use them without appropriate training.

ICD 10 CM

Official Guidelines

https://stacks.cdc.gov/view/cdc/133289

Code Set

https://icd10cmtool.cdc.gov/?fy=FY2024

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HCPCS

https://hcpcs.codes/search/

CMS Physician Fee Schedule

https://www.cms.gov/medicare/physician-fee-schedule/search

NCCI Medicare National Correct Coding Initiative Edits

https://www.cms.gov/medicare/coding-billing/ncci-medicare

1500 Claim Form Instructions

https://www.nucc.org/index.php/1500-claim-form-mainmenu-35/1500-instructions-mainmenu-42

UB 04 Claim Form Instructions

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c25.pdf

Medicare Coverage Determinations (National and Regional) Many insurance plans closely follow Medicare Clinical Coverage Guidelines. However, they are not required to and there may be variations by health plans.

https://med.noridianmedicare.com/web/jea/policies/ncd

HIPAA Health Insurance Portability And Accountability Act

https://www.hhs.gov/hipaa/index.html

ACA Affordable Care Act

https://www.healthcare.gov/glossary/affordable-care-act/

Fair Debt Collection Practices Act

https://www.ftc.gov/legal-library/browse/rules/fair-debt-collection-practices-act-text

OIG- Office of Inspector General

https://oig.hhs.gov/

U.S. Department of Health & Human Services

https://www.hhs.gov/

CMS Centers for Medicare & Medicaid Services

https://www.cms.gov/