Health Care: Resolving Billing Problems

Health insurance billing is complex and oftentimes confusing, and you may find yourself receiving bills for services that should have been covered by insurance or you thought were already paid for.

Every health plan has different co-pays, deductibles, out of pocket maximums, and exclusions. With so many different plans, it’s hard to know which costs you are responsible for and which costs are covered by your plan.

Whatever steps you take to resolve any billing disputes, make sure you document them in writing. Keep a record of all phone calls you made with the date and time of the call, the number you called, the people you spoke with, and what you discussed. This will be important if you ever need to follow-up on the matter in the future and will strengthen your case if you file an appeal with your insurer or the state.

You received bills for services that should have been billed to your health plan:

1. Are the billed services covered by your insurance?

You will need to understand your particular plan’s policy. Many policies have particular exclusions, such as not covering maternity care or job-related physicals, so check your policy’s Summary Plan Description or Evidence of Coverage to make sure the billed services are covered by your plan. If the service is covered, verify that the correct billing code was used. Simple typos can result in you being charged for the wrong procedure or service.

2. Do you have an annual deductible and/or out-of-pocket maximum? If so, did you satisfy the amounts?

Depending on your particular policy, you may have to pay for medical care until you satisfy the deductible for the year. If you already met the deductible, your insurer may pay a percentage of the costs, leaving you to pay the remainder. You may have to pay some costs yourself until you meet the annual required out of pocket maximum, at which point your insurance will cover all the costs for the rest of the year. Every insurer and plan has different limits and terms, so it is important to understand your particular policy and how your insurer defines these terms.

If you have questions about your policy, check your Summary Plan Description or Explanation of Coverage, or call your plan’s customer service department.

3. Did the health care provider bill your insurance?

Do not automatically assume that the provider billed your insurance. If you have not received an explanation of benefits (EOB) or similar statement from your health plan within a couple of weeks of your appointment, check with the provider. Make sure they billed the correct health plan and that they have your correct information (your name, policy number, etc), and then follow-up with your health plan. Most states require insurers to pay claims within 30 or 45 days, so if it hasn’t been very long, the insurance company may just not have paid yet. It may take a couple weeks to get the claim approved and processed and for your provider to get paid.
4. If your provider billed your insurance, check with your plan to see whether they received the claim and ask if it was paid or not. If they denied the claim, ask why.

It may be that your plan paid for the services but your provider sent the bill before receiving or applying the payment to your account. If the plan denied the claim and refuses to pay, find out why. If you disagree with your plan’s decision, ask about the appeal or internal review process. For more about the review process, read the Formal Review sections below.

5. If your insurer paid the bill, check with the office that sent you the bill.

Some offices handle billing in-house, while others use a third-party biller. It may take some time for the payment to be credited to your account, especially if the payment went to the provider and the provider has to then forward it to the billing office.

Contact the party responsible for billing. If the payment still has not been credited to your account, ask how long it usually takes and then make sure to follow-up with them.

You continue to receive bills for services that were already paid for by you and/or your insurance:

1. Contact the billing department sending you the bills.

Find out what your current balance is. The bills may have been sent before any payments were applied. If the payment address is different than the billing office’s, there may have been a delay in processing your payment. You may be able to resolve the billing issue over the phone. If not, you will need to find the source of the discrepancy yourself.

2. Compare all relevant receipts, bills, and statements on your own.

Gather your receipts, credit card statements, cancelled checks, bills sent by your provider, and explanation of benefits (EOB) sent by your insurer. Simple typos on your account can lead to big bills, so make sure all charges and credits were applied correctly to your account.

Check also to see whether you were billed multiple times for the same services. Your doctor or other health care professional may have provided a number of services at one appointment but billed them on separate statements. If you find yourself being double-billed, notify your health provider. You may also want to send a written letter asking them to fix the discrepancy and include copies of documents that support your case. Creating a paper trail is important to show you notified them of the problem in a timely fashion, especially if the situation is not resolved quickly.

If you have tried unsuccessfully to resolve the dispute with your provider and the billing dispute does not involve your insurance, you may want to contact an attorney specializing in health law to find out what options you have.

For more information on the denied claims and the formal review process, visit the United Policyholders website, www.uphelp.org