Medical Billing Frequently Asked Questions and Common Terms: How Medical Billing Relates to Health Insurance Denials and Appeals

Have you ever wondered how medical billing works? Or what to do if your insurance company denies a claim? This tip sheet will answer some common questions and define key terms regarding medical billing. Understanding medical billing is essential for empowering yourself and advocating for your healthcare rights.

UNDERSTANDING MEDICAL BILLING

WHAT IS MEDICAL BILLING?

Medical billing is the process of sending claims to health insurance companies to get paid for medical services. Healthcare providers, like doctors and hospitals, send claims to your insurance company. Your insurance company reviews the claim to see if it is covered and then pays the provider accordingly.

WHY IS ACCURATE DOCUMENTATION IMPORTANT?

Accurate documentation helps ensure your medical claims are processed correctly. This means that you are less likely to have your claims denied or delayed. Accurate documentation also helps to protect you from being billed for services you did not receive.

WHAT IS A HEALTH INSURANCE DENIAL?

A health insurance denial can occur when your insurance company refuses to pay for a medical service or procedure. There are many reasons why a claim might be denied, such as:

- The service is not covered by your plan
- The service is not medically necessary
- The provider is not in your network
- There is an error on the claim

WHAT IS A HEALTH INSURANCE APPEAL?

An appeal is a process where you can ask your insurance company to reconsider a denied claim. You can appeal a claim if you believe the denial was incorrect. It gives you a chance to provide additional information or evidence to support the medical necessity of a procedure. For additional information on the appeals process, check out Patient Advocate Foundation's publication, ***Engaging with Insurers: Appealing a Denial.***

WHAT STEPS CAN I TAKE TO PREVENT A HEALTH INSURANCE DENIAL?

- **Understand your insurance policy:** Make sure you know what is covered by your plan and what is not. Familiarize yourself with the coverage details, including deductibles, copayments, and coverage limitations. This information is found in your policy language, which can be found on your health policy's member portal or website.
- **Provide accurate information:** Ensure that all information provided to your providers and insurance company is complete, accurate, and up-to-date. Double-check details such as names, dates, and policy numbers to avoid errors that could lead to denials.
- **Obtain pre-authorization:** Some procedures, testing, and medications require pre-authorization from your insurance company before you get them, if you don't, it may result in claim denials.
- **Keep good records:** Maintain copies of all your medical records, bills, and correspondence with healthcare providers and insurance companies. These documents serve as valuable evidence and can support your case if you have to appeal.
- **Review Explanations of Benefits (EOBs):** Carefully review the EOBs received from your insurance company, comparing them to the services you received. If you notice any issues, contact your insurance company for clarification. Taking notes during conversations with your providers and insurance companies helps to keep track of important names, dates, and other details.

COMMON TERMS IN MEDICAL BILLING

COINSURANCE

Coinsurance refers to the percentage of costs you share with your insurance company after meeting your deductible. After you've met your deductible, you are still responsible for paying a percentage of the covered expenses, known as coinsurance. The insurance company will cover the remaining percentage. For example, if you have a coinsurance rate of 20%, you will pay 20% of the covered costs, and your insurance company will pay the remaining 80%. Even after meeting your deductible, you will continue to share a portion of the medical expenses with your insurance company through coinsurance until you reach your out-of-pocket maximum.

COPAYMENT

A copayment is a fixed amount you pay out of pocket for specific medical services, usually at the time of the visit.

DEDUCTIBLE

A deductible is an amount you must pay before your insurance starts to pay. It is typically an annual requirement. You first need to meet your deductible before your insurance plan starts to pay its share of covered expenses. Once you've paid the full amount of your deductible for the year, your insurance begins to cover more of the costs.

EXPLANATION OF BENEFITS (EOB)

An EOB is a document you receive from your insurance company explaining how your medical claim was processed. It provides details about the amount billed, the amount covered, and any patient responsibility (deductibles, copayments, etc.).

MEDICAL NECESSITY

Medical necessity refers to the requirement that a medical service or procedure is essential for the diagnosis, treatment, or prevention of a medical condition. Insurance companies often evaluate claims based on medical necessity criteria to determine coverage.

OUT-OF-NETWORK

Out-of-network refers to healthcare providers or facilities that do not have a contract with your insurance company. Services obtained from out-of-network providers may result in higher out-of-pocket costs or reduced coverage.

PRE-AUTHORIZATION

Pre-authorization is the process of obtaining approval from your insurance company before receiving certain medical services or procedures. Failure to obtain pre-authorization may result in claim denials.

Remember, understanding medical billing empowers you to navigate the complex world of health insurance. If you have any questions or concerns about your medical bills, don't hesitate to reach out to your healthcare provider or insurance company for assistance.

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