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# Consumer Guide on Explanation of Benefits "EOB" or Summary of Health Plan Benefits "SHPP" and Medical Claims

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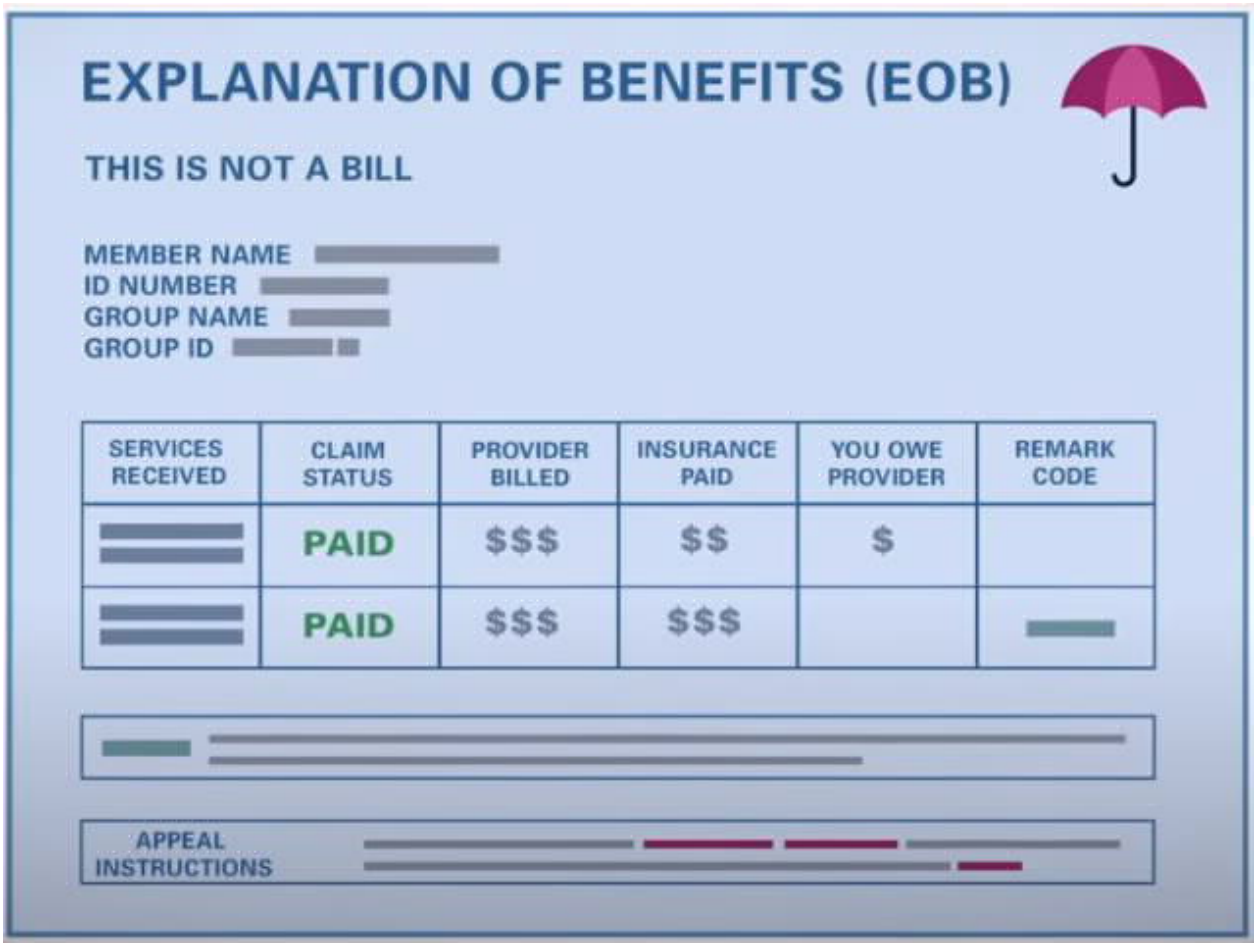
## Explanation of Benefits or Summary of Health Plan Benefits

After you receive medical care, your health insurer will send you information about your claim in an Explanation of Benefits (EOB) or Summary of Health Plan Benefits (SHPP). The EOB or SHPP is not a bill. It's the insurer's explanation of how the costs of services are shared between you and the insurer.

### What does an EOB or SHPP tell me?

An EOB or SHPP tells how much each provider charged, how much the health insurer paid, and how much you owe each provider. Be sure to compare the "owed" amounts on the EOB or SHPP with amounts on bills from your providers and what you've already paid.

### What does an EOB or SHPP look like?




Not all EOBs or SHPPS look alike, but here are a few things to look for on your EOB or SHPP.

- Information about the person who received the services. This includes the health insurance ID number and the member's name, sometimes identified as "patient." If it's your insurance, the EOB or SHPP often refers to the patient as "self." If the insurance is through your spouse or your parent, then their name will be on the EOB or SHPP.
- A list of services received, including the dates you received them. There also may be billing codes. If those aren't on the EOB or SHPP, there should be notes about how to get the codes if you need or want them.
- Information about the provider or facility. This will name the person (doctor, nurse practitioner, psychologist, physical therapist) or facility (laboratory, hospital) that provided the service.
- The amount the provider or facility billed the insurer.
- The "allowed" amount. This is the amount the insurer considers reasonable for the health care you receive. The allowed amount is negotiated between the provider and the insurer.
- The amount the insurer paid for each service.
- The amount you owe the provider. This may include money you paid during your visit.
- Information about denials and other details or notes. The insurer may use codes to explain denial reasons and notes. You should see an explanation of the codes on the EOB or SHPP.

### How else is an EOB or SHPP helpful?

An EOB or SHPP is an important tool to help you track how much you've spent out-of-pocket for covered health care costs. That helps you know how far along you are in meeting your deductible and out-of-pocket limit for the year. If you've reached your out-of-pocket limit and you're asked to pay for services, you should contact your insurer right away.

An EOB or SHPP can also ensure that your provider is charging your insurer (or you) for services that were performed. It can be used to discover billing errors.
You'll also find instructions on your EOB or SHPP to file a grievance or appeal if the insurer denies coverage for services or only pays part of the claim.

### Who receives an EOB or SHPP?

Usually, the insurer sends the EOB or SHPP to the primary person on the health plan. If the EOB or SHPP contains Personal Health Information for a dependent the primary insured may not be entitled to receive the EOB or SHPP. The EOB or SHPP would be sent to the patient.

If an employer provides the insurance, the employee usually receives the EOB or SHPP, including EOBs or SHPPs for a spouse and dependents on the plan.

You may ask the insurer to send your EOBs or SHPPS to a different address for confidential services or if the information on an EOB or SHPP would put you in danger.

## Filing Health Insurance Claims

When you receive medical care, you usually pay the provider (doctor, hospital, therapist, etc.) your share of the bill. You expect your health insurer to pay the rest of the bill. To get that payment, the provider files a claim with your insurer.

But sometimes you may have to file a claim with the insurer yourself. This could happen if you see an out-of-network provider or if the provider doesn't accept your insurance.

If you need to file your own health insurance claim, here's what you need to know:

### How do I file a claim with my insurer?

Most insurers, network providers will file a claim for you. If your provider does not file a claim for you, you'll find a claim form on most health insurers' websites, along with information on how to submit the claim. Look at your health insurance card for your insurer's website or a phone number to call for information about filing a claim.

### What will I need?

You will need the following to file a claim:

- An itemized bill from your health care provider. Ask the provider for this. The bill should include the date you received care and a list of services you received with the provider's charge and a description and/or billing code for each service.
- Your personal information, including your social security number, your health insurance ID number, and, if you received medical care due to an accident or illness at work, your employment status.
- Whether to send payment directly to the provider or to you. If the insurer sends the payment to you, you're responsible for paying the provider.

### When do I file the claim?

File the claim as soon as possible after you receive the medical care. Many insurers have a deadline to file a claim, such as no more than 90 days after you receive care.

### Where do I submit the claim?

Look for an address on the claim form. If it's not there, check the insurer's website and the back of your health insurance card or call your insurer.

### What happens after I file the claim?

After you file the claim, the insurer has a limited time to tell you if it will pay the claim. How long the insurer has varied by state.

After the insurer reviews the claim, it will send you an Explanation of Benefits or EOB or Summary of Health Plan Benefits or SHPP. If the insurer is paying the claim, it will send the payment as you directed, either to the provider or to you. If the payment is sent to you, it is money that is owed to the provider. You will want to contact the provider to obtain a mailing address and invoice number to forward a payment to.

Your health care provider may send you a bill before the insurer has reviewed the claim. If so, call the provider's billing office. Ask to delay payment until after the claim is processed. Check the EOB or SHPP to know the correct amount you owe the provider.

## Codes and Claims

To get paid for medical care you receive, providers usually bill your health insurer directly using what's known as a "claim" form. However, sometimes you may have to submit a claim yourself. To process a claim correctly, your insurer needs to know the billing codes for the medical care you received. You'll need a detailed bill with billing codes from your provider to send with your claim.

Usually, insurers pay claims. But, if your insurer denies a claim, it could be because you or your provider used the wrong billing code on the claim form. Knowing how codes are used can help you get your bill paid.

### How are billing codes used on a claim?

Providers use billing codes to describe the service(s) you received. The codes let providers send insurers very detailed information in a condensed way.
There are different types of billing codes. Two types are:

- Diagnosis codes, which also may be called the ICD-10 codes. These codes describe the condition for which you received treatment. For example, E10.9 is the diagnostic code for Type 1 diabetes mellitus without complications.
- Procedure codes, which include but aren't limited to Current Procedural Terminology ® (CPT) codes. These codes describe the treatment you receive. For example, CPT code 95251 is the procedure code for "ambulatory continuous glucose monitoring of

interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation, and report." You might refer to this simply as glucose monitoring.

Hospitals and other facilities also use billing codes to bundle a group of codes and charge one fee for the various items and services provided. An example is Diagnosis-Related Group (DRG) 638 for Diabetes without complications or comorbidities.

### Why would an insurer deny a claim based on a billing code?

An insurer may deny a claim for many reasons. A billing code could be one reason. An insurer could deny a claim if the billing code doesn't exist, your policy doesn't cover it, or if the code doesn't match the other information in the claim.

If your insurer denies your claim, you should call your insurer to ask questions. If the billing codes were the reason for the denial, ask your provider's billing office to check the code(s) submitted and re-submit the claim.

You also can file an appeal of a denied claim.

## Understanding Medical Necessity

### What is medical necessity?

Typically, health insurance plans only provide benefits for treatments or services that are "medically necessary." So, what does that mean?

"Medically necessary" means health care services, that are appropriate in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. Medically necessary care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professionals in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition; must be informed by the unique needs of each individual patient and each presenting situation; and help restore or maintain the member's health; or prevent deterioration of or palliate the member's condition; or prevent the reasonably likely onset of a health problem, or detect an incipient problem.

### How does medical necessity affect coverage of my health care services?

Medical necessity limits health insurance payments for cosmetic procedures, treatments that haven't been proven to be effective, or treatments that are more expensive than others that also are effective.

### How is "medical necessity" determined?

A doctor's prescription or order for a service is the first evidence of medical necessity. If the insurer ask/s for more proof that the claim meets the standard for medical necessity, it may ask your doctor or other provider for a "Letter of Medical Necessity." The request for a letter typically is part of a "certification" or "utilization review" process. This process lets the insurer review medical services to decide if they cover the service. This can be done before, during, or after the treatment.

In a "precertification review," the insurer decides if the requested treatment satisfies the plan's requirements for medical necessity before the treatment is provided. The insurer typically reviews the Letter of Medical Necessity, medical records, and the plan's medical policy.
In a "concurrent review," the insurer decides if the treatment is medically necessary while it's ongoing.

In a "retrospective review," the insurer decides if services already provided were medically necessary or, in the case of emergency services, whether they truly required emergency care. The decision is made after you receive the treatment.

### What are medical guidelines?

All insurers follow guidelines that determine if a treatment is within accepted standards in the medical community. An insurer must make its medical guidelines available to you if it used them to decide to deny you coverage.

### Are experimental, investigational, or cosmetic services medically necessary?

Some definitions of medical necessity specifically exclude services for "experimental, investigational, or cosmetic purposes." An insurer's medical guidelines determine if a treatment is considered experimental for your condition. An insurer also follows its medical guidelines to decide if treatments that could be considered cosmetic also have a medical purpose. Insurers may use medical records to decide if services are medically necessary, but they also may base decisions on the available scientific literature.

Does medical necessity affect coverage for emergency services?

After you receive emergency services, insurers may review your care to decide if emergency care was appropriate for your diagnosis and medically necessary. To decide, insurers use a "prudent layperson", standard. Getting approval before you receive medical services (precertification) isn't necessary if a prudent layperson who possesses an average knowledge of health and medicine standard, would believe there was an emergency condition and delaying treatment would make that condition worse.

## How to Appeal a Denied Claim

When you receive medical care, either you or your provider (doctor, hospital, therapist, etc.) must file a claim with your health insurer. Often, the provider files the claim.
Most of the time, the insurer pays the claim. But sometimes the insurer refuses to pay part or all the claim for services you believe should have been covered. You have a right to appeal that decision.

There are two types of appeals—an internal appeal and an external review.
Here are the steps you can take if your insurer denies a claim:

### File an Internal Appeal

You file an internal appeal to ask your insurer to review a decision to deny a claim. You have up to six months (180 days) after you learn a claim was denied to file an internal appeal.

- To learn how to file an internal appeal, look at the claim denial or call the customer service number on your insurance card/materials.
- An internal appeal usually requires you to write a letter. Be sure to include in the letter your name, claim number, and health insurance ID number, and any other information you have to support your claim. (See sample letter, below.)

If the insurer denied a claim for a medical reason, you'll need your health care provider's help to file an appeal. Ask your provider to write a letter explaining why the care was medically necessary. Send that letter with your appeal. If the appeal is non-urgent the managed care organization shall notify the member and the member's treating provider within a reasonable period but no later than sixty (60) calendar days after receipt of the appeal.

If a delay in receiving medical care could harm your life, health, or ability to function, you can ask that the appeal be reviewed quickly ("on an expedited basis").

### File an External Review

If your insurer still denies the claim after the internal appeal, you can ask for an external review. An independent review organization will do the external review. You may have a limited time to ask for an external review after you receive the decision from your internal appeal.

- You should find the information about how to ask for an external review on your internal appeal notice.
- Your state's insurance regulatory agency is usually in charge of the external review process.
- You can submit information you didn't include in your internal appeal to support your position.
- The external reviewer has a limited time to reach a decision.
- The external reviewer will give you and your insurer a written notice of its decision.

- The insurer must cover the services or pay the claim if the external reviewer decides the insurer should.

## Things to Keep in Mind

### *Medicare and Medicaid*

If you're enrolled in Medicare or Medicaid, there are different rules for appeals.

- For Medicare, call 1-800-MEDICARE to ask for information about free help to appeal a decision.
- For Medicaid assistance, call 1-800-250-8427 for Vermont's Medicaid agency.

### *Keep Records*

Keep detailed records, including bills from your provider, notices from your insurer, copies of denial letters, appeal requests, and medical information related to your case.

### *Take Detailed Notes and Set Response Deadlines*

Keep notes about the dates/times of all calls and other communication, names of people with whom you had conversations, and details of all conversations. Ask about and make notes of any set deadlines for expected responses or information from your insurer.

## Sample letter to request an internal appeal

Add your own information when you see italics below.

Your Name Your Address

Date

Address of the Health Plan's Appeal Department Re: Name of Insured
Plan ID#:
Claim #:

To Whom It May Concern:

I am writing to request a review of your denial of the claim for treatment or services provided by name of provider on date provided.

The reason for the denial was listed as (reason listed for denial), but I have reviewed my policy and believe the service should be covered. Here is where you may provide more detailed information about the situation. Write short, factual statements. Do not include emotional wording. If you're including documents, include a list of what you're sending here.

If you need additional information, I can be reached at telephone number and/or e-mail address. I look forward to receiving your response as soon as possible.

Sincerely, Signature

Typed Name Telephone Number Email address