

# The Life of a Medical Claim

*By Patrick Shea*

Sometimes an insurance claim begins before a person arrives to the Doctor's office. When the appointment is made, a billing specialist could access policy information on-line to see how it is structured to know in advance what, if anything, to collect as a co-pay, co-insurance and/or deductible. They also may have to call the insurance carrier for authorization depending on the treatment and policy requirements. In insurance terms, this all comes under the broad heading of verification of benefits (V.O.B).

The insurance company is responsible for paying benefits that are covered under a specific policy. It means that not all services are covered under all policies. It is wise to do some research to avoid surprises at the physician's office or treatment facility. Do not hesitate to call your insurance company's customer service representative to clarify anything you don't understand. Reading an insurance policy may be a frustrating task, but it is advisable to read thoroughly to understand what is covered, and more importantly, what isn't. This is especially important when a relatively new treatment or drug is prescribed.

The office visit always starts with the filling out forms and insurance card copied by the receptionist. So what happens next? How does a claim go through once the card is in the hands of the doctor's office? Essentially, they file a claim, which can be filed in a number of formats. For instance, HCFA is the acronym for Health Care Financing Administration and has become the term of choice for the claim form submitted by a doctor's office. UB04 (a.k.a. UB) means Universal Billing and is the form that serves the same purpose for Hospital and other facility billing. These forms can be submitted by traditional mail or electronically.

Electronic billing is becoming more and more prevalent nowadays. In this method, following an office visit, your doctor's biller sends your claim to an insurance claims clearing house/processing center. The claim is electronically transmitted in data "packets" from the provider's computer to the clearinghouse through the internet. The clearinghouse batch and forwards claims to each insurance company. At this point, it is scanned to determine if the claims in a given batch have all the necessary information.

Missing or inaccurate information at this level can result in rejection of individual claims for correction or denial of individual claims. In each case, the submitter of the batch or of the individual claims is sent a response that indicates the error to be corrected or the reason for the denial. After successful transmission, an acknowledgment report is generated and is either transmitted back to the submitter of each claim, or placed in an electronic mailbox for downloading by that submitter.

One other bill type is less used but bears mentioning is known as a "super bill". This term covers all bills submitted in any other form than the above. This obviously covers a lot of ground. The important thing is, there is a lot of information to fill out, and, if not filled out accurately and completely, can result in denial or delay of your claim payment.

Sounds relatively straight forward, and most claims process smoothly with payment forthcoming in two to three weeks. However, you may encounter some of the aforementioned bumps in the road up to and including the dreaded denied claim.

Claims can be rejected for many reasons. Some of the most prevalent are:

1. The plan does not cover the procedure, medication or supply,
2. The insurance company deems it medically unnecessary or experimental.

3. The treatment was sought without prior approval,
4. Information, such as procedure codes or diagnosis is missing or incorrect
5. Timely filing, which means it, was not submitted within the required period of the policy.

Briefly (because it requires its own longer explanation), if a claim is denied for any reason, including administrative error on the part of the insurance company, a quick telephone call could solve the problem. If this doesn't work, you can request a formal review by the insurance provider. You may have to resubmit or appeal your claim. It can go a lot of ways and none of them especially pleasant which I'll get into next time.

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