INSURANCE PRIMER

I. To help estimate your coverage in advance:

Please contact your carrier, prior to your first visit to ask them if your plan provides out-of-network coverage.

If the answer is, "no"— or if you are enrolled in only Medicare or Medicare supplemental insurance – then you will be responsible for your visit in FULL -- your insurance company will not offer reimbursement.

If the answer is, "yes" – you do have out-of-network coverage OR if you are a Medicare participant with a secondary policy from an employer or private insurer you should find out:

1) What is your out-of-network deductible?
2) How much of it have you met (note: some policies have a joint in and out of network deductible; with others they're exclusive of one another)?
3) Is your reimbursement is based on "usual and customary" (UCR) fees OR on a Medicare schedule? Note: *Historically, reimbursements were always based on what is considered "usual and customary" fees for services rendered. Only recently, when the attorney general found these fee schedules were unfairly distorted by the insurance companies that created them (and ordered them to be set by an impartial panel) many policies retaliated by switching their reimbursement basis to a much lower Medicare schedule. Visit fairhealth.org for a transparent look at what the non-profit organization deems a reasonable reimbursement for services rendered (often useful to compare that to what your company is reimbursing when shopping new policies).*
4) After your deductible has been meet, what percentage of either the allowable fees are reimbursed? *Dr. Asher attempts to set his fees at or near to what has traditionally been considered fair and reasonable, so your company is offering a percentage of UCR that percentage should be a fairly accurate indication of your reimbursement (assuming deductible conditions have been met)*. If your insurance provider uses a Medicare schedule you will likely receive at most half – sometimes significantly less – of your fees.

Our office is happy to provide you with the list of potential New Patient and frequently used diagnostic CPT codes.

Benjamin F. Asher, MD, PC

INSURANCE PRIMER

Medicare subscribers will receive Dr. Asher's "Opt-out" letter, which will allow you to collect from any **secondary** insurers. Dr. Asher is not a Medicare or Medicaid provider; Neither Medicare and Medicaid nor their supplemental policies cover any services provided by Benjamin F. Asher M.D, P.C.

Benjamin F. Asher MD, PC cannot, at any time, be held responsible for the amount of reimbursement received.

II. To help insure you've obtained optimal reimbursement.

It has come to our attention that many of our patients are ***not receiving the full reimbursement they are entitled to per their insurance policy!***

Your plan administrator or policy underwriter should be able to assist you in straightening out any of the common problems listed below, but here's a summary of what to look for.

PLEASE CAREFULLY REVIEW THE EOB (explanation of benefits) that accompanies your insurance reimbursement check – or reimbursement denial.

The areas you want to consider on the EOB most closely are:

- **amount charged**
- **amount allowed**
- ***discount amount***
- **not covered**
- **remarks**

IF THERE IS A DISCREPANCY, IT IS BETTER TO CONTACT YOUR INSURANCE COMPANY BEFORE YOU DEPOSIT THE CHECK (although you are always entitled to recoup the disputed amount).

Amount Charged vs. **Allowed Amount vs. Discount Amount**

Your reimbursement check should be based on a percentage of what your insurance company "allows" **(allowed amount)** rather than the actual amount charged OR the discount amount. Although Dr. Asher provides exemplary care, we do attempt to set our fees at what the non-profit fairhealth.org has determined is reasonable and customary – historically amount charged and allowed amount were the same. However, in recent years many policies have switched to a Medicare schedule to determine "allowed amount" so it can be lower than what the actual charges were.

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Discount amount **is the most common cause of insufficient reimbursement. IT SHOULD NEVER READ ANYTHING GREATER THAN $0.00.** "Discounted amounts" usually apply to in-network physicians who are forced to agree to a lesser reimbursement to be part of the network. Some out-of-network practitioners may also at times agree to contractually accept a reduced fee in order to receive out-of-network reimbursements directly from insurance providers (this is typically done in the situation of high-ticket items, like major surgery, and the carrot is usually an expedited reimbursement schedule).

Our practice never negotiates discount amounts! (This would be allowing the insurance company to reimburse you less than they have contractually agreed to).

If the discounted amount does not match the allowed amount, it is a mistake – you should have your reimbursement re-calculated based on the allowed amount.

Frequently, insurance companies computers erroneously assign a discounted amount that was never actually negotiated. ***It is up to you to catch this error****! If you work do with a provider (in or out of network) who has agreed to a negotiated discounted rate, the provider is obligated to bill at that lesser amount, so actual charges and legitimate discounted amount should always be the same.*

For EOBS that pertain to our practice visits: the ONLY DEDUCTIONS you should have from the allowed amount are your deductible (if it has not been met) and your co-pay / coinsurance (percentage not covered).

Remarks

PLEASE CHECK THE "REMARKS" SECTION (they usually provide a code in the box and the explanation of that code is at the bottom or back of the EOB).
Common ones are:

- claim has been previously submitted (make sure that's accurate and that you've been appropriately reimbursed or had your deductible appropriately credited
- deductible has not been met (again, check to be certain)
- pre-existing condition (shouldn't matter under the Affordable Care Act – check with your plan administrator)
- plan does not provide "out-of-network" coverage (nothing you can do about this)

If there's a remark that is unclear, call and make sure you're confident it's accurate before accepting the EOB at face value.

Here are some other common insurance company errors we have noted:

MAKE SURE THE "CHARGED AMOUNT" MATCHES WHAT YOU WERE BILLED. Even if the form is filled out perfectly, we've often seen numbers transposed or decimals omitted – so a $330.00 visit is reimbursed based on a $3.30 payment.

Benjamin F. Asher, MD, PC

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ONE CHARGE DENIED BECAUSE TWO CHARGES WERE LISTED IN ONE VISIT (i.e. you were billed for the visit **and** a procedure). You may see a code remark such as: "cannot be billed for 2 procedures in the same 24 hour period." **THIS IS NOT TRUE!** Sometimes all we need to do is resubmit the claim as is, and sometimes we need to clarify in "insurance speak" via a different modifier. PLEASE call us if you receive this denial; in the majority of these cases we can help you get it straightened out.

IMPROPER PLACE OF SERVICE – This is usually their typo and can be easily corrected.

THEY REQUEST ADDITIONAL INFORMATION – They may want copies of our notes or lab results, but more often it's something as small as an apartment number, social security number, or seemingly insignificant detail. Please don't overlook this request; it's usually a "stalling" technique – but ignoring it could mean you don't get your money.

MEDICARE PATIENTS

The majority of our Medicare patients who have a secondary policy (not a supplemental policy) do receive SOME reimbursement. If you have been denied reimbursement from your secondary because Medicare was not billed, please call the office and we will help you explore your options.

When dealing with insurance companies it is clear that reimbursement goes to the tenacious!

Our office will always do our best to support you in your efforts. However, they are contracted with and obligated to you, not us – therefore, they will always be more responsive to you (and in many cases will flatly refuse to discuss your reimbursement situation with us).

Good luck!

The Staff of Benjamin F. Asher, MD, PC