For Your BENEFIT
STATE OF LOUISIANA • OFFICE OF GROUP BENEFITS
PPO • EPO • MCO • HMO

# Understanding Your Health Care Claims

## *A Message from Malcolm Veazie*

***OGB Deputy Assistant Secretary***

Health care is complicated. In fact, when you read some of the initials used in health care, it looks a whole lot like a bowl of alphabet soup. There are HRAs, PBMs, HMOs and EOBs. The list just goes on and on. It's no wonder most of us are so confused when we receive medical bills, letters and explanations of benefits in our mailboxes. And it seems as though these confusing letters arrive at the worst possible times—when we're sick or feeling stressed.


At each of the seven Office of Group Benefits offices around the state, the OGB staff spends a great deal of time helping our members understand their health care statements. While we are always thrilled to help you on an individual basis, we believe that now is a good time to review the basics of your health plan. Therefore, we have dedicated this entire issue of our For Your Benefit newsletter to helping our plan members get the most from their health care benefits.

This issue covers several basic but important topics. You will learn about health care terminology, claims payment, reading health care bills and benefit explanations and avoiding costly mistakes.

We hope this issue helps to untangle some of the confusion about your health care benefits.

If you still have questions, we invite you to call your nearest OGB office. You can find the telephone number and address for each office on the back cover of this newsletter.

All of your colleagues at OGB wish you and your family a happy and healthy new year.

## INSIDE

# Avoiding Costly Mistakes When Obtaining Health Care Services

As health care costs continue to rise across America, OGB plan members pay more each year for access to quality health care. OGB remains committed to helping you spend your health care dollars wisely. Here are ways you can easily avoid costly mistakes that plan members frequently make:

• Use network providers for health care services unless only non-network providers are available.

• Buy generic drugs when available instead of brand name prescriptions.

• Compare the bill from your provider to the corresponding EOB from OGB to make sure you owe the listed amount before paying it.

• Attend an OGB annual enrollment meeting each year. The meetings are designed to make sure plan members receive needed information about changes in plans and benefits.

• Understand that OGB cannot pay for services that are not covered by the plan or that are specifically excluded or are not medically necessary, such as:

- Shoe wedges or shoe inserts;
- Glucometers;
- Obesity services, supplies or surgery (including resections for excessive skin or fat following weight loss or pregnancy);

- Maternity expenses incurred by dependents other than plan member or legal spouse;
- Injuries sustained as an aggressor and expenses incident to or caused by an actual or attempted felony or misdemeanor;
- Artificial organ or penile implants, treatment of infertility or complications after initial diagnosis (including services, drugs, procedures or devices) and reversal of sterilization procedures; and
- Administrative fees, interest or penalties.

***Remember, a recommendation from your doctor does not guarantee that a procedure, service, item, provider or facility is covered by your health care plan! Any time you're in doubt or have questions about what OGB's PPO plan covers, contact an OGB Customer Service office.*** A complete list of offices and phone numbers is found on the back of this newsletter.

# How OGB Claims Are Filed, Processed & Paid

*Plan member visits doctor or hospital and shows ID card. Health care provider accesses OGB's secure website to get information on plan member's eligibility, copayments and deductibles.*

*After treatment, provider completes claim form using procedure and diagnosis codes and submits form by mail or electronically.*

*OGB receives claim form by mail and uses scanner to image and store claim form electronically.*

*OGB claims staff, aided by automated software, processes over 2 million claims each year, usually within 14 days — with an accuracy rate of over 98%.*

*OGB staff enters claim data into OGB computer system.*

*OGB sends payment and explanation of benefits (EOB) to provider.*

*OGB sends explanation of benefits (EOB) to plan member.*

# Understanding Your OGB

## Commonly Used Terms

**Customer Service Information** – list of telephone numbers for OGB offices throughout Louisiana that OGB plan members can call for assistance

**Initial Date of Service** – date on which plan member first received services from provider

**Service Code** – CPT, Revenue or HCPCS code

**CPT (Current Procedure Terminology) codes** are used to classify services or procedures by physicians, ambulatory surgical centers and hospital outpatient services, laboratories, etc. CPT codes are categorized by ranges for various types of services:

- 00100-01999 anesthesiology
- 10000-69999 surgery or procedure
- 70000-79999 radiology
- 80000-89999 pathology/labs
- 90000-99999 office visits/medical

**Rev. (Revenue) Codes** are used to classify inpatient services.

**HCPCS (Healthcare Common Procedure Coding System)** alpha-numeric codes are used to categorize services, procedures and supplies

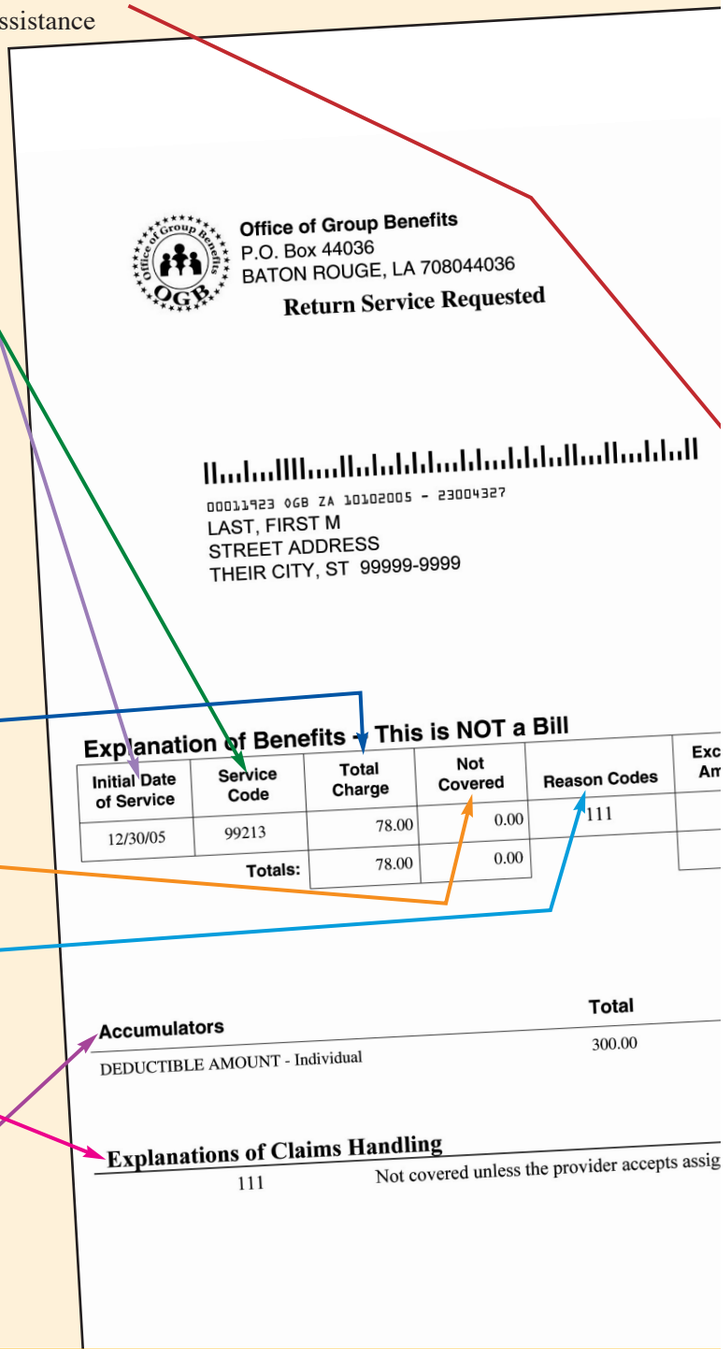
**Total Charge** – total charge submitted by provider for services rendered prior to any adjustments or discounts; may include both eligible and ineligible charges

**Not Covered** – charges not eligible for coverage under OGB Plan Document and for which plan member is responsible

**Reason Codes** – explanations of why charge was denied or how charge should be handled by either provider or plan member

**Explanation of Claims Handling** – brief description of reason codes listed (if applicable)

**Accumulators** – indicates amount of plan year deductible (Total), amount of deductible satisfied (Met) and any balance remaining on the plan year deductible (Remaining)



Office of Group Benefits
P.O. Box 44036
BATON ROUGE, LA 708044036
Return Service Requested

00011923 OGB ZA 10102005 - 23004327
LAST, FIRST M
STREET ADDRESS
THEIR CITY, ST 99999-9999

Explanation of Benefits - This is NOT a Bill

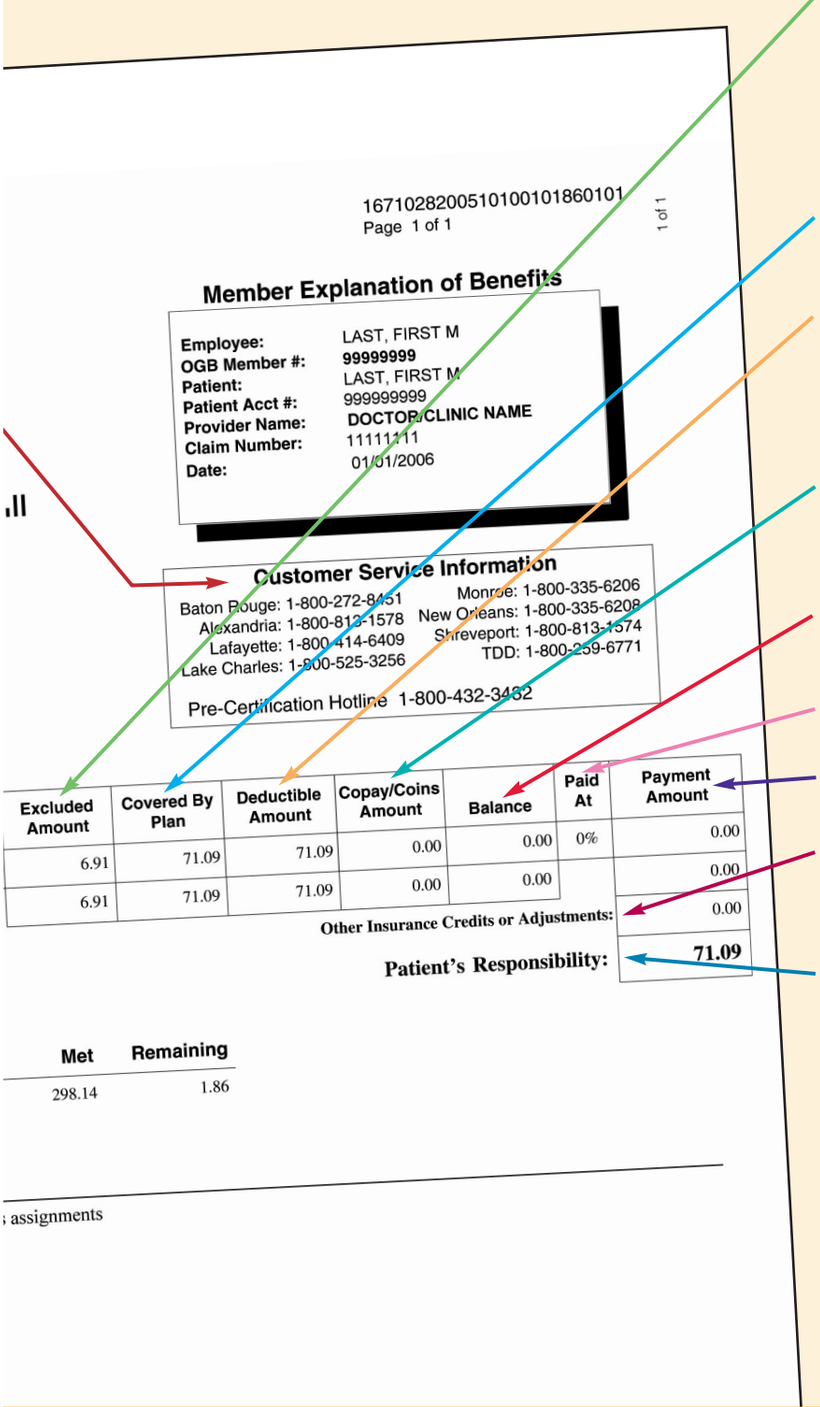
| Initial Date of Service | Service Code | Total Charge | Not Covered | Reason Codes | Exc Am |
|---|---|---|---|---|---|
| 12/30/05 | 99213 | 78.00 | 0.00 | 111 | |
| | Totals: | 78.00 | 0.00 | | |

| Accumulators | Total |
|---|---|
| DEDUCTIBLE AMOUNT - Individual | 300.00 |

Explanations of Claims Handling

111 Not covered unless the provider accepts assig

# B Explanation of Benefits



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Page 1 of 1

1 of 1

**Member Explanation of Benefits**

| | |
|---|---|
| Employee: | LAST, FIRST M |
| OGB Member #: | 99999999 |
| Patient: | LAST, FIRST M |
| Patient Acct #: | 999999999 |
| Provider Name: | DOCTOR/CLINIC NAME |
| Claim Number: | 11111111 |
| Date: | 01/01/2006 |

**Customer Service Information**

Baton Rouge: 1-800-272-8451
Alexandria: 1-800-812-1578
Lafayette: 1-800-414-6409
Lake Charles: 1-800-525-3256
Monroe: 1-800-335-6206
New Orleans: 1-800-335-6208
Shreveport: 1-800-813-1574
TDD: 1-800-259-6771

Pre-Certification Hotline 1-800-432-3432

| Excluded Amount | Covered By Plan | Deductible Amount | Copay/Coins Amount | Balance | Paid At | Payment Amount |
|---|---|---|---|---|---|---|
| 6.91 | 71.09 | 71.09 | 0.00 | 0.00 | 0% | 0.00 |
| 6.91 | 71.09 | 71.09 | 0.00 | 0.00 | | 0.00 |
| | | | | | | 0.00 |
| | | | | | | 71.09 |

Other Insurance Credits or Adjustments:

Patient's Responsibility:

| Met | Remaining |
|---|---|
| 298.14 | 1.86 |

assignments

**Excluded Amount** – amount exceeding maximum allowable charge in OGB fee schedule that cannot be billed to plan member by OGB-contracted providers (Non-contracted providers who have accepted assignment of benefits, as indicated by having plan member's signature on file, should not bill plan member for this amount.)

**Covered By Plan** – maximum allowable charge in OGB fee schedule

**Deductible Amount** – amount of covered charges for which no benefits will be paid and plan member is responsible; before benefits can be paid in each plan year, a covered person must meet deductible

**Copay (Copayment)/Coins (Coinsurance) Amount** – amount due by plan member after satisfaction of applicable deductibles and OGB payment

**Balance** – amount remaining after discounts and deductibles have been applied to provider charge

**Paid At** – percentage at which charges were paid by OGB

**Payment Amount** – total amount paid to provider

**Other Insurance Credits or Adjustments** – primary carrier's payments or adjustments credited prior to determining amount for which patient is responsible

**Patient's Responsibility** – actual amount patient owes; may include deductible, copayment/coinsurance and non-covered charges

# Frequently Asked Questions

**Q How are OGB claims submitted?**

**A** Claims can be submitted by plan members or health care service providers. They can be mailed or hand-delivered to OGB, or submitted electronically by providers. OGB's mailing address is P.O. Box 44036, Baton Rouge, LA 70804. All claims must be received by OGB within one year from the date of service.

**Q How do I submit an OGB claim if I am covered by Medicare or another insurance company?**

**A** Usually the provider will submit the claim for you if they are a Medicare provider. Benefits cannot be paid until the explanation of benefits (EOB) from the primary carrier is submitted for the claim. However, OGB encourages plan members and providers to submit claims with or without the EOB to meet the timely filing deadline.

**Q How long does it take OGB to process a claim?**

**A** On average, OGB processes 99 percent of claims within 14 days of receipt if the claim contains all information needed for processing. OGB strives to process claims as quickly as possible.

**Q What is my plan year deductible?**

**A** The OGB plan year begins July 1 and ends June 30. The plan year deductible is $500 for actively employed OGB plan members and dependents or $300 for retired plan members and dependents. The family unit maximum is reached when three individual family members meet their appropriate deductibles. This means deductibles for all remaining family members are then waived for the plan year.

**Q What is my emergency room deductible?**

**A** PPO plan members pay a $150 emergency room deductible for every ER visit. The deductible is waived if the member is admitted directly from the ER to the hospital.

**Q What are ancillary charges?**

**A** Ancillary charges are fees for health care services requested by your physician (such as laboratory work, radiology procedures or anesthesia) that are performed by another health care provider or facility. For example, if you're in the hospital for surgery, ancillary charges are incurred when other medical professionals administer anesthesia, perform and interpret the results of laboratory tests and X-rays to pinpoint a diagnosis or provide additional treatment or services.

**Q What are usual and customary (U&C) charges? And what does it mean when a charge exceeds the fee schedule?**

**A** U&C charges are the amounts allowed by OGB health plans for each service and are also referred to as the OGB fee schedule. When a charge exceeds the U&C allowable amount, the excess amount must be written off by OGB contracted/network providers. However, these amounts can be billed to the plan member if services are rendered by a provider that is not contracted with OGB and the plan member did not assign benefits to the provider.

**Q What are assigned benefits?**

**A** Louisiana law states that when a health care provider contracts with OGB, he or she agrees to accept fees listed in the OGB fee schedule as sole reimbursement for medical services, treatment or health care and may not bill the plan member or covered patient for the balance of the fees charged. A copy of the law is available on the Plan Member page of the OGB website.

**Q How are benefits assigned?**

**A** There are several ways in which benefits can be assigned. The plan member or patient's signature on a standard claim form (HCFA 1500) or on a separate form issued by the provider authorizes OGB to pay medical benefits directly to the provider. If a non-contracted provider refuses to write off the excess fee schedule amount, OGB will not dispute this with the provider or remain involved in any way. OGB does NOT render legal advice or offer opinions to plan members about their financial obligations to a non-contracted provider.

**Q How can I determine which providers have contracted with OGB?**

**A** Visit OGB's website (www.groupbenefits.org) for the latest information or contact any of theOGB Customer Service offices listed on the back of this newsletter.

Remember, taking a few minutes beforehand to contact OGB to find a network provider can save you from being billed for thousands of dollars in medical charges that exceed the OGB fee schedule!

**Q What is a network?**

**A** OGB contracts with health care providers to build a network. These providers are referred to as network providers or contracted providers. Providers who sign contracts with OGB agree to write off any charges that exceed the OGB fee schedule, which saves money for both OGB and our plan members.

**Q What are the benefits of using a network provider when OGB is my primary health insurance carrier?**

**A** Utilizing a network provider increases the percentage of benefits payable by OGB and decreases the plan member's out-of-pocket expense. The OGB Plan Member Handbook and OGB Plan Document list all percentages payable.

**Q What should I do if my contracted physician or hospital bills me for an amount that exceeds the OGB fee schedule?**

**A** OGB contracted providers should not bill you for an amount that exceeds the fee schedule. If you are billed by a contracted provider for the excess, please call one of our OGB Customer Service offices located throughout the state for assistance.

**Q I paid for services in full at a network provider, but my EOB indicates there was an excluded amount. Am I due a refund?**

**A** Yes. To receive a refund, you can either mail a copy of the EOB to the provider or deliver it in person. The provider should apply the discount to your account and refund any overpayment to you.

**Q The bill I received from my doctor or hospital includes charges I did not incur. What should I do?**

**A** Contact the provider to determine if there is a billing error. If so, ask them to submit a corrected claim with the original OGB claim number on the corrected billing.

**Q What should I do if OGB has overpaid my claim?**

**A** Call any OGB Customer Service office for instructions.

**Q How do I appeal a claim determination for benefits or eligibility?**

**A** Appeals must be submitted to OGB in writing and must include the plan member's name and member number, the patient's name, the provider's name and the date(s) of service and should clearly state the reasons for the appeal. Appeals must be received within 90 days from the date of the EOB (explanation of benefits), denial of eligibility or denial after review by the Utilization Review Organization or Prescription Benefits Manager.

**Q Why was my claim denied?**

**A** OGB pays claims in accordance with the terms outlined in the OGB Plan Member Handbook and the OGB Plan Document. Claims may be denied for a number of reasons, including:

- Insufficient information
- Date of service not provided
- Physician information not supplied
- Missing or invalid procedure or diagnosis codes
- Missing explanation of benefits (EOB) from plan member's primary health carrier
- Duplicate billings
- Claim not submitted within filing deadline (one year from date of service)
- Pre-authorization (pre-certification) or utilization review not obtained or obtained after deadline (at least 72 hours prior to planned admission or within two working days after emergency admission)
- All days not approved for case management
- Additional information needed
- Medical records
- Accident details
- Other information required to process claim

**Q The OGB explanation of benefits (EOB) is a bit complicated. Why doesn't OGB make it easier to read?**

**A** OGB's EOB was designed to follow the standard health insurance industry layout. The sample EOB on pages 4 and 5 includes an explanation of each item and the terms commonly used on the EOB.

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## Vision

***OGB envisions itself as a leader in improving and preserving quality of life.***

## Mission

***OGB will offer an employee benefits system that meets or exceeds industry standards and/or benchmarks.***

## OGB Area Customer Service Offices

### Alexandria
900 Murray St.
Room F-100
Alexandria, LA 71301
318.487.5731
800.813.1578

### Baton Rouge
5825 Florida Blvd.
Baton Rouge, LA 70806
225.925.6625
800.272.8451

### Lafayette
825 Kaliste Saloom Rd.
Building II, Suite 101
Lafayette, LA 70508
337.262.1357
800.414.6409

### Lake Charles
710 W. Prien Lake Rd.
Suite 109
Lake Charles, LA 70601
337.475.8052
800.525.3256

### New Orleans
3421 N. Causeway Blvd.
Suite 400
Metairie, LA 70002
504.838.5136
800.335.6208

### Monroe
1400 N. 19th St.
Monroe, LA 71201
318.362.3435
800.335.6206

### Shreveport
1525 Fairfield Ave.
Room 669
Shreveport, LA 71101
318.676.7026
800.813.1574

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225.925.6770
800.259.6771