INSURANCE COVERAGE TOOLKIT

Tips and Tools for Navigating Insurance Coverage for Inherited Metabolic Disorders

MNT4P

Inherited Metabolic Disorders

This toolkit was developed as a resource to guide patients and their families on how to navigate and understand insurance terminology for medical foods. The information in this toolkit was compiled by Raenette Franco, CEO, CBCS, Founder of CompassionWorks Medical, LLC.

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TIPS FOR INSURANCE COVERAGE

BASICS

- ✓ **In-network:** Providers that participate with your plan.
- ✓ **Out-of-network:** Providers that do not participate with your plan.
- ✓ **Deductible:** Amount that you **must** pay before the insurance kicks in.
- ✓ **Out-of-Pocket:** A predetermined amount of money for a chance to increase your insurance to 100%. It can be a bit confusing with the deductible. The good news is that you don't have to meet any amount before your coverage kicks in. Sometimes confused with deductible.

WHAT IS A PRE-CERTIFICATION, ALSO KNOWN AS A PRIOR AUTHORIZATION?

- ✓ **Pre-certification** serves as a utilization management tool, allowing payment for services and procedures that are medically necessary, appropriate and cost-effective, without compromising the quality of care to you.
- ✓ Pre-certification for medical foods must be approved before your insurance will cover.

WHAT IS A GAP EXCEPTION?

- ✓ **What is a Gap Exception?** It is asking permission from your insurance carrier to use a particular provider that is out-of-network and getting the same benefits as the in-network level.
- ✓ **How can I request for a Gap Exception?** Usually your out-of-network provider will make the request. It is based on no other comparable providers that can provide the requested service within 30 miles of your residence proximity.

WHAT IS AN ALLOWED AMOUNT?

- ✓ **Allowed Amount:** Maximum amount on which payment is based for covered health care services. This may be called *"eligible expense," "payment allowance"* or *"negotiated rate."* If your provider charges more than the allowed amount, you may have to pay the difference.

- ✓ All of us with health insurance think that 100% is covered in full, or even with coverage at 80%, 70%, 60%, or 50% we think that the insurance will pay the full percentages, right?
  - ➢ The answer is "NOT typically." This is how it works.
    Example: The **Allowable Charge** is typically a discounted rate rather than the actual charge and considered payment in full from your insurance company and the supplier.

- ✓ **Out of Network Providers**: If, however, the supplier you purchased your medical foods from is not an in-network provider with your insurance company, then you may be held responsible for everything that your health insurance company will **not pay**, up to the full charge of the bill. This is your responsibility!

- ✓ You can check the charges, allowed amount, and your patient responsibility from your **EOB (Explanation of Benefits)**. An EOB is a statement, not a bill, provided by your insurance company. You can also ask for a copy of the EOB from your provider.

- ✓ **It may be helpful to consider an example**: You have just purchased your medical food. The total charge for the medical food comes to $100. If the provider is a member of your health insurance company's network of providers **(in-network)**, they may be required to accept $80 as payment in full for the medical food. If the supplier is out-of-network, then you are responsible for the $80. **This is the Allowable Charge**.

A STEP-BY-STEP GUIDE FOR CALLING YOUR INSURANCE COMPANY TO DETERMINE COVERAGE (TERMINOLOGY FOR INSURANCE VERIFICATION)

1. Verifying ***Medical Benefits*** through health plan automated prompts (follow prompts).
2. Ask to verify medical benefits:
    - "I would like to verify my benefits for both in- and out-of-network services"
    - "I have certain service codes that I would like to verify"
3. Give 4 Service Codes (HCPCS)
    a. B4157
    b. B4162
    c. S9435
    d. S9434
4. Full service description: Enteral Formula, Medical Foods for Inborn Error of Metabolism
5. Diagnosis code for PKU is E70.0. If you do not know your diagnosis code, please contact your dietitian.
6. Ask benefit questions:
    - What is the effective date?
    - Are there any termination dates?
    - Is the policy fully insured or self-funded?
    - What is the co-insurance?
    - What is the deductible?
    - Has the deductible been met?
    - What is the out-of-pocket?
    - Does the out-of-pocket include the deductible?
    - Has anything been met?
    - Is there a Lifetime Max?
    - Is there an Annual Year Max?
    - Do the service codes require prior authorization (i.e. Pre-Certification)?
        - **If not**, ask if you can request a pre-determination and get a fax number.
    - Is there any exclusion to the service codes or service?
    - Are there any Pharmacy Benefits? If so, get the name and phone number.
    - May I have a reference number for this call?

Please be sure to ask the name of the benefits customer service representative that you are speaking with. You will also want to get the reference number for the call. Be sure to ask any additional questions that you may have!