



Illinois Insurance Facts

Illinois Department of Insurance

Usual and Customary Fees and other Fee Methodologies used by Health Insurers for Health Insurance Claims

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Note: This information was developed to provide consumers with general information and guidance about insurance coverages and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

If you have ever had a claim payment reduced due to Usual and Customary provisions or other fee methodologies used by insurers, you know this can be an unwelcome surprise. Most, if not all, traditional insurance policies pay claims based upon the Usual and Customary fee allowance (also called Reasonable and Customary fee or Usual and Customary and Reasonable fee). Preferred Provider Option policies (PPOs) sometimes pay non-participating providers based upon usual and customary provisions, but are increasingly paying those providers based on the negotiated fee schedule used for participating providers. This Fact Sheet explains these fees and how you can appeal unsatisfactory claim settlements.

What are Usual and Customary Fees?

The Usual and Customary fee is defined as **the charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area**. To determine the Usual and Customary fee for a specific medical procedure or service in a given geographic area, insurers often analyze statistics from a national study of fees charged by medical providers, such as the data base profile set up by the Health Insurance Association of America (HIAA). Some insurers compile their own data using their own claim information. The insurers use these statistics to chart a range of fees for each geographical area in which services are provided. Then, when you submit your claim for a specific treatment or procedure, the insurer pays all or part of the claim, depending on whether the amount of the claim is within the Usual and Customary allowance.

For example, an insurer may determine that it will pay Usual and Customary fees falling below the 80th percentile of the fee range. If you have a tonsillectomy in Bloomington, Illinois and your medical provider charges a fee for a tonsillectomy that is higher than what 80% of the providers charge in that region (according to the insurer's usual and customary fee schedule), the plan will exclude coverage for the amount over the 80th percentile and that amount will be your responsibility. If your provider charges a fee that is below what 80% of the providers in the region charge for a tonsillectomy (according to the company's usual and customary fee schedule), your claim will not be reduced. Remember, your coinsurance amount is calculated **after** the Usual and Customary fee is determined. Therefore, if your policy pays 80% for the tonsillectomy, the benefit will be 80% of the usual and customary fee, which is calculated at the 80th percentile in our example.

When an insurer disallows a portion of a charge as being in excess of the Usual and Customary allowance, it means only that the charge is in excess of the standard the company used to determine Usual and Customary. Providers are free to charge whatever fee for service they choose. Your insurance coverage is designed to provide benefits up to the plan's Usual and Customary percentile and is priced accordingly.

Your policy should contain a definition of Usual and Customary and explain how claims will be paid. However, policies seldom tell you the percentile of Usual and Customary upon which your claims will be calculated.

What Other Methodologies Are Being Used by Insurers?

If you are covered by a preferred provider option policy (PPO), then you must use participating providers to obtain the best benefit available under the policy. The PPO policy allows you flexibility to use non-preferred or non-participating providers (as opposed to Health Maintenance Organizations (HMOs), which limit you to the closed network of providers). However, this flexibility may come at a great out of pocket cost which you may not realize when reviewing your benefits. **Many PPOs now pay non-participating providers based upon the negotiated rate that would have been paid to a participating provider had you used one.** For example, let's say that your PPO policy pays 70% for non-participating surgeon charges and you incur a bill for \$5,000 from a non-participating surgeon. Now let's say that a participating provider would have been paid \$2,000 for the same surgery. Using the contracted or negotiated rate as a basis for payment, the insurer will pay 70% of \$2,000 for the surgery. You will be out-of-pocket \$600.00 for the 30% copayment and another \$3,000 for the amount over the negotiated fee. Note that the \$3,000 does not accrue to your out-of-pocket maximum on the policy.

Another fee methodology being used by some insurers is payment for non-participating provider claims based on a percentage (for example 200%) of the Medicare published rate for the same or similar service. This methodology can result in very low reimbursement of the non-participating provider claim because Medicare rates are relatively low rates established by the federal government for payment of Medicare claims.

To find out how your PPO Policy pays non-participating provider claims, look at the definition section of the policy for "eligible expense" or "maximum allowable fee" or a similar term that defines the basis of payment for participating and non-participating providers.

How Are These Fees Regulated?

For non-participating provider claims 215 ILCS 356z.3 and 215 ILCS 5/370i(c) requires PPO policies to include the following disclosure in the policy:

"WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed

to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts.

There are no Illinois insurance laws or rules regulating the compilation and use of Usual and Customary fee schedules or other fee methodologies. Insurers are allowed to define “eligible expense” or “maximum allowable expense” within the policy and to determine the method used to calculate payment for non-participating provider claims, including the percentile of usual and customary that will be paid.

How To Appeal a Claim Reduction

If you receive a reduction on a claim due to Usual and Customary provisions or other fee methodologies within the policy, you may appeal the determination. Insurers are aware that fees charged by providers are affected by factors such as medical complications and underlying medical factors that may not be apparent by looking at the claim. To appeal an adverse determination, you should ask the treating provider to write a letter to the insurer explaining any extenuating circumstances or medical complications, as well as provide all pertinent medical records and operative reports. Sometimes an insurer will adjust the benefit after receiving additional information that justifies the higher charge.

If the claim was paid based upon usual and customary provisions, you may also wish to contact other providers in your geographic area and ask what they charge for the procedure in question. If the fee charged by your provider is equal to or less than what other area providers charge, the company may review that information and make a favorable adjustment, depending upon the percentile they use for Usual and Customary fee determinations.

You may also contact the Department of Insurance for assistance. Although the Department cannot require a company to pay additional benefits, we can request that the company review the claim and give it further consideration.

For More Information

Call our Consumer Services Section at (312) 814-2427 or
our Office of Consumer Health Insurance toll free at (877) 527-9431
or visit us on our website at <http://www.insurance.illinois.gov/>

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