Learning Outcomes

After studying this chapter, you should be able to:

3.1 Explain the method used to classify patients as new or established.
3.2 Discuss the five categories of information required of new patients.
3.3 Explain how information for established patients is updated.
3.4 Verify patients’ eligibility for insurance benefits.
3.5 Discuss the importance of requesting referral or preauthorization approval.
3.6 Determine primary insurance for patients who have more than one health plan.
3.7 Summarize the use of encounter forms.
3.8 Identify the eight types of charges that may be collected from patients at the time of service.
3.9 Explain the use of real-time claims adjudication tools in calculating time-of-service payments.

KEY TERMS

accept assignment
Acknowledgment of Receipt of Notice of Privacy Practices
assignment of benefits
birthday rule
cash flow
certification number
charge capture
chart number
coordination of benefits (COB)
direct provider
event referral certification and authorization
indirect provider
established patient (EP)
financial policy
gender rule
guarantor
HIPAA Coordination of Benefits
HIPAA Eligibility for a Health Plan
HIPAA Referral Certification and Authorization
insured
new patient (NP)
nonparticipating provider (nonPAR)
partial payment
participating provider (PAR)
patient information form
primary insurance
prior authorization number
real-time claims adjudication (RTCA)
referral number
referral waiver
referring physician
secondary insurance
self-pay patient
subscriber
supplemental insurance
tertiary insurance
trace number
From a business standpoint, the key to the financial health of a physician practice is billing and collecting fees for services. To maintain a regular cash flow—the movement of monies into or out of a business—specific medical billing tasks must be completed on a regular schedule. Processing encounters for billing purposes makes up the pre-claim section of the medical billing cycle. This chapter discusses the important aspects of these steps:

- Information about patients and their insurance coverage is gathered and verified.
- The encounter is documented by the provider, and the resulting diagnoses and procedures are posted.
- Time-of-service payments are collected.

Patients leave the encounter with a clear understanding of their financial responsibilities and the next steps in the billing cycle: filing claims, insurance payments, and paying bills they receive for balances they owe.

### 3.1 New Versus Established Patients

To gather accurate information for billing and medical care, practices ask patients to supply information and then double-check key data. Patients who are new to the medical practice complete many forms before their first encounters with their providers. A **new patient (NP)** is someone who has not received any services from the provider (or another provider of the same specialty/subspecialty) who is a member of the same practice within the past three years. A returning patient is called an **established patient (EP)**. This patient has seen the provider (or another provider in the practice who has the same specialty) within the past three years. Established patients review and update the information that is on file about them. Figure 3.1 illustrates how to decide which category fits the patient.

### THINKING IT THROUGH 3.1

1. Why is it important to determine whether patients are new or established in the practice?

### 3.2 Information for New Patients

When the patient is new to the practice, five types of information are important:

1. Preregistration and scheduling information
2. Medical history
3. Patient/guarantor and insurance data
4. Assignment of benefits
5. Acknowledgment of Receipt of Notice of Privacy Practices

**Preregistration and Scheduling Information**

The collection of information begins before the patient presents at the front desk for an appointment. Most medical practices have a preregistration process to check that patients’ healthcare requirements are appropriate for the medical practice and to schedule appointments of the correct length.

**Preregistration Basics**

When new patients call for appointments, basic information is usually gathered:

- Full legal name
- Telephone number
FIGURE 3.1 Decision Tree for New Versus Established Patients

- Address
- Date of birth
- Gender
- Reason for call or nature of complaint, including information about previous treatment
- If insured, the name of the health plan and whether a copay or coinsurance payment at the time of service, is required
- If referred, the name of the referring physician

**BILLING TIP**

**Referring Physician**

A referring physician sends a patient to another physician for treatment.

**Scheduling Appointments**

Front office employees handle appointments and scheduling in most practices and may also handle prescription refill requests. Patient-appointment scheduling systems are often used; some permit online scheduling. Scheduling systems can be used to
automatically send reminders to patients, to trace follow-up appointments, and to schedule recall appointments according to the provider’s orders. Some offices use open-access scheduling that allows patients to see providers without having made advance appointments; follow-up visits are scheduled.

**BILLING TIP**

**MCOs and Appointments**

Many managed care organizations require participating physicians to see enrolled patients within a short time of their calling for appointments. Some also require PCPs to handle emergencies in the office, rather than sending patients to the emergency department.

**Provider Participation**

New patients, too, may need information before deciding to make appointments. Most patients in PPOs and HMOs must use network physicians to avoid paying higher charges. For this reason, patients check whether the provider is a participating provider, or PAR, in their plan. When patients see nonparticipating, or nonPAR, providers, they must pay more—a higher copayment, higher coinsurance, or both—so a patient may choose not to make an appointment because of the additional expense.

**Medical History**

New patients complete medical history forms. Some practices give printed forms to patients when they come in. Others make the form available for completion ahead of time by posting it online or mailing it to the patient. Practices may also enable the patient to complete the medical history electronically in the reception area using portable check-in devices such as a tablet or wireless clipboard.

An example of a patient medical history form is shown in Figure 3.2 on pages 81 and 82. The form asks for information about the patient’s personal medical history, the family’s medical history, and the social history. Social history covers lifestyle factors such as smoking, exercise, and alcohol use. Many specialists use less-detailed forms that cover the histories needed for treatment.

The physician reviews this information with the patient during the visit. The patient’s answers and the physician’s notes are documented in the medical record.

**BILLING TIP**

**Know Plan Participation**

Administrative staff members must know what plans the providers participate in. A summary of these plans should be available during patient registration.

**Patient/Guarantor and Insurance Data**

A new patient arriving at the front desk for an appointment completes a patient information form (see Figure 3.3 on page 83). This form is also called a patient registration form. It is used to collect the following demographic information about the patient:

- First name, middle initial, and last name
- Gender (F for female or M for male)
- Race and ethnicity
- Primary language
- Marital status (S for single, M for married, D for divorced, W for widowed)
- Birth date, using four digits for the year
- Home address and telephone numbers (area code with seven-digit number)
FIGURE 3.2 Medical History Form

- Social Security number
- Employer’s name, address, and telephone number
- For a married patient, the name and employer of the spouse
- A contact person for the patient in case of a medical emergency
- If the patient is a minor (under the age of majority according to state law) or has a medical power of attorney in place (such as a person who is handling the medical
decisions of another person), the responsible person’s name, gender, marital status, birth date, address, Social Security number, telephone number, and employer information. If a minor, the child’s status if a full-time or part-time student is recorded. In most cases, the responsible person is a parent, guardian, adult child, or other person acting with legal authority to make healthcare decisions on behalf of the patient.

- The name of the patient’s health plan
### PATIENT INFORMATION FORM

**THIS SECTION REFERS TO PATIENT ONLY**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Sex:</th>
<th>Marital Status:</th>
<th>Birth Date:</th>
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<tr>
<th>Address:</th>
<th>SS#:</th>
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<table>
<thead>
<tr>
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<th>Zip:</th>
<th>Employer:</th>
<th>Phone:</th>
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<th>Work Phone:</th>
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<table>
<thead>
<tr>
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<th>Spouse’s Employer:</th>
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### FILL IN IF PATIENT IS A MINOR

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<table>
<thead>
<tr>
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<th>State:</th>
<th>Zip:</th>
<th>Employer’s Address:</th>
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<th>City:</th>
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<th>Zip:</th>
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### INSURANCE INFORMATION

<table>
<thead>
<tr>
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<th>Secondary Insurance Company:</th>
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<table>
<thead>
<tr>
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<th>Subscriber’s Name:</th>
<th>Birth Date:</th>
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<th>SS#:</th>
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<table>
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<th>Group #:</th>
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<th>Group #:</th>
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<table>
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<tr>
<th>Copayment/Deductible:</th>
<th>Price Code:</th>
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### OTHER INFORMATION

<table>
<thead>
<tr>
<th>Reason for visit:</th>
<th>Allergy to medication (list):</th>
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<table>
<thead>
<tr>
<th>Name of referring physician:</th>
<th>If auto accident, list date and state in which it occurred:</th>
</tr>
</thead>
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<tr>
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</table>

I authorize treatment and agree to pay all fees and charges for the person named above. I agree to pay all charges shown by statements, promptly upon their presentation, unless credit arrangements are agreed upon in writing.

I authorize payment directly to VALLEY ASSOCIATES, PC of insurance benefits otherwise payable to me. I hereby authorize the release of any medical information necessary in order to process a claim for payment in my behalf.

(Patient’s Signature/Parent or Guardian’s Signature) (Date)

I plan to make payment of my medical expenses as follows (check one or more):

- Insurance (as above)
- Cash/Check/Credit/Debit Card
- Medicare
- Medicaid
- Workers’ Comp.

**FIGURE 3.3** Patient Information (Registration) Form
The health plan’s policyholder’s name (the policyholder may be a spouse, guardian, or other relation), birth date, plan type, policy number or group number, telephone number, and employer.

If the patient is covered by another health plan, the name and policyholder information for that plan.

**BILLING TIP**

**Subscriber, Insured, Recipient, or Guarantor?**

Other terms for policyholder are insured or subscriber. This person is the holder of the insurance policy that covers the patient and is not necessarily also a patient of the practice. The guarantor is the person who is financially responsible for the bill.

---

**Inspection Cards**

For an insured new patient, the front and the back of the insurance card are scanned or photocopied. All data from the card that the patient has written on the patient information form are double-checked for accuracy.

Most insurance cards have the following information (see Figure 3.4):

- Group identification number
- Date on which the member’s coverage became effective
- Member name
- Member identification number
- The health plan’s name, type of coverage, copayment/coinsurance requirements, and frequency limits or annual maximums for services; sometimes the annual deductible
- Optional items, such as prescription drugs that are covered, with the payment requirements

**Photo Identification**

Many practices also require the patient to present a photo ID card, such as a driver’s license, which the practice scans or copies for the chart.

**Assignment of Benefits**

Physicians usually submit claims for patients and receive payments directly from the payers. This saves patients paperwork; it also benefits providers because payments are faster. The policyholder must authorize this procedure by signing and dating an assignment of benefits statement. This may be a separate form, as in Figure 3.5, or an entry on the patient information form, as in Figure 3.3 on page 83. The assignment of benefits statement is filed in both the patient medical and billing records.

**Acknowledgment of Receipt of Notice of Privacy Practices**

Under the HIPAA Privacy Rule (see the chapter about EHRs, HIPAA, and HITECH), providers do not need specific authorization in order to release patients’ PHI for treatment, payment, and healthcare operations (TPO) purposes. These uses are defined as:

1. **Treatment:** This purpose primarily consists of discussion of the patient’s case with other providers. For example, the physician may document the role of each member of the healthcare team in providing care. Each team member then records actions and observations so that the ordering physician knows how the patient is responding to treatment.
2. **Payment:** Practices usually submit claims on behalf of patients; this involves sending demographic and diagnostic information.
3. **Healthcare operations:** This purpose includes activities such as staff training and quality improvement.
State Law on Assignment of Benefits

The following states have laws mandating that the payer must pay the provider of services (rather than the patient) if a valid assignment of benefits is on file and the payer has been notified of the assignment of benefits: Alabama, Alaska, Colorado, Connecticut, Georgia, Idaho, Louisiana, Maine, Missouri, Nevada, New Jersey, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, Texas, and Virginia.

1. **Group identification number**
   The 9-digit number used to identify the member’s employer.

2. **Plan codes**
   The numbers used to identify the codes assigned to each plan; used for claims submissions when medical services are rendered out-of-state.

3. **Effective date**
   The date on which the member’s coverage became effective.

4. **Member name**
   The full name of the cardholder.

5. **Identification number**
   The 10-digit number used to identify each plan member.

6. **Health plan**
   The name of the health plan and the type of coverage; usually lists any copayment amounts, frequency limits, or annual maximums for home and office visits; may also list the member’s annual deductible amount.

7. **Riders**
   The type(s) of riders that are included in the member’s benefits (DME, Visions).

8. **Pharmacy**
   The type of prescription drug coverage; lists copayment amounts.

**FIGURE 3.4** An Example of an Insurance Card

Providers must have patients’ authorization to use or disclose information that is not for TPO purposes. For example, a patient who wishes a provider to disclose PHI to a life insurance company must complete an authorization form (see Figure 2.6 in the chapter about EHRs, HIPAA, and HITECH) to do so.

**BILLING TIP**

**Release Document**

State law may be more stringent than HIPAA and demand an authorization to release TPO information. Many practices routinely have patients sign release of information statements.

Under HIPAA, providers must inform each patient about their privacy practices one time. The most common method is to give the patient a copy of the medical office’s privacy practices to read, and then to have the patient sign a separate form called an
Assignment of Benefits

I hereby assign to Valley Associates, PC, any insurance or other third-party benefits available for healthcare services provided to me. I understand that Valley Associates has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Valley Associates, I agree to forward to Valley Associates all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian: ____________________________
Date: __________________

FIGURE 3.5 Assignment of Benefits Form

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that the providers of Valley Associates, PC, may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand that Valley Associates has the right to change this notice at any time. I may obtain a current copy by contacting the practice's office or by visiting the website at www.xxx.com.

My signature below constitutes my acknowledgment that I have been provided with a copy of the notice of privacy practices.

Signature of Patient or Legal Representative: ____________________________
Date: __________________
If signed by legal representative, relationship to patient: ____________________________

FIGURE 3.6 Acknowledgment of Receipt of Notice of Privacy Practices

Acknowledgment of Receipt of Notice of Privacy Practices (see Figure 3.6). This form states that the patient has read the privacy practices and understands how the provider intends to protect the patient's rights to privacy under HIPAA.

The provider must make a good-faith effort to have patients sign this document. The provider must also document—in the medical record—whether the patient signed the form. The format for the acknowledgment is up to the practice. Only a direct provider, one who directly treats the patient, is required to have patients sign an acknowledgment. An indirect provider, such as a pathologist, must have a privacy notice but does not have to secure additional acknowledgments.

If a patient who has not received a privacy notice or signed an acknowledgment calls for a prescription refill, the recommended procedure is to mail the patient a copy of the privacy notice, along with an acknowledgment of receipt form, and to document the mailing to show a good-faith effort that meets the office’s HIPAA obligation in the event that the patient does not return the signed form.
3.3 Information for Established Patients

When established patients present for appointments, the front desk staff member asks whether any pertinent personal or insurance information has changed. This update process is important because different employment, marital status, dependent status, or plans may affect patients’ coverage. Patients may also phone in changes, such as new addresses or employers.

To double-check that information is current, most practices periodically ask established patients to review and sign off on their patient information forms when they come in. This review should be done at least once a year. A good time is an established patient’s first appointment in a new year. The file is also checked to be sure that the patient has been given a current Notice of Privacy Practices.

If the insurance of an established patient has changed, both sides of the new card are copied, and all data are checked. Many practices routinely scan or copy the card at each visit as a safeguard.

Entering Patient Information in the Practice Management Program

A practice management program (PMP) is set up with databases about the practice’s income and expense accounting. The provider database has information about physicians and other health professionals who work in the practice, such as their medical license numbers, tax identification numbers, and office hours. A database of common diagnosis and procedure codes is also built in the PMP. After these databases are set up, the medical insurance specialist can enter patients’ demographic and visit information to begin the process of billing.

The database of patients in the practice management program must be continually kept up-to-date. For each new patient, a new file and a new chart number are set up. The chart number is a unique number that identifies the patient. It links all the information that is stored in the other databases—providers, insurance plans, diagnoses, procedures, and claims—to the case of the particular patient. Figure 3.7 shows a sample of a PMP screen used to enter a new patient into the patient database.

Usually, a new case or record for an established patient is set up in the program when the patient’s chief complaint for an encounter is different than the previous chief complaint. For example, a patient might have had an initial appointment for a comprehensive physical examination. Subsequently, this patient sees the provider because of stomach pain. Each visit is set up as a separate case in the PMP.

Communications with Patients

Service to patients—the customers of medical practices—is as important as, if not more important than, billing information. Satisfied customers are essential to the financial health of every business, including medical practices. Medical practice staff members must be dedicated to retaining patients by providing excellent service.

The following are examples of good communication:

▶ Established and new patients who call or arrive for appointments are always given friendly greetings and are referred to by name.
▶ Patients’ questions about forms they are completing and about insurance matters are answered with courtesy.
When possible, patients in the reception area are told the approximate waiting time until they will see the provider.

Fees for providers’ procedures and services are explained to patients.

The medical practice’s guidelines about patients’ responsibilities, such as when payments are due from patients and the need to have referrals from primary care physicians, are prominently posted in the office (see Figure 3.12 on page 103, where financial policies are explained).

Patients are called a day or two before their appointments to remind them of appointment times.

Like all businesses, even the best-managed medical practices have to deal with problems and complaints. Patients sometimes become upset over scheduling or bills or have problems understanding lab reports or instructions. Medical insurance specialists often handle patients’ questions about benefits and charges. They must become good problem solvers, willing to listen to and empathize with the patient while sorting out emotions from facts to get accurate information. Phrases such as these reduce patients’ anger and frustration:

“I’m glad you brought this to our attention. I will look into it further.”
“I can appreciate how you would feel this way.”
“It sounds like we have caused some inconvenience, and I apologize.”
“I understand that you are angry. Let me try to understand your concerns so we can address the situation.”
“Thank you for taking the time to tell us about this. Because you have, we can resolve issues like the one you raised.”

Medical insurance specialists need to use the available resources and to investigate solutions to problems. Following through on promised information is also critical. A medical insurance specialist who says to a patient “I will call you by the end of next week with that information” must do exactly that. Even if the problem is not solved, the patient needs an update on the situation within the stated time frame.

THINKING IT THROUGH 3.3

1. Review these multiple versions of the same name:
   Ralph Smith
   Ralph P. Smith
   Ralph Plane Smith
   R. Plane Smith
   R. P. Smith

   If “Ralph Plane Smith” appears on the insurance card and his mother writes “Ralph Smith” on the patient information form, which version should be used for the medical practice’s records? Why?

2. Refer to the patient information form below. According to the information supplied by the patient, who is the policyholder? What is the patient’s relationship to the policyholder?

   PATIENT INFORMATION FORM

   THIS SECTION REFERS TO PATIENT ONLY

   Name: Mary Anne C. Kopelman
   Sex: F
   Marital status: □ S □ M □ D □ W
   Birth date: 9/7/73

   Address: 45 Mason Street
   City: Hopewell
   State: OH
   Zip: 43800

   SS#: 465-99-0022

   Employer: TriCare
   Employer’s address:
   Home phone: 999-555-6877
   Work phone:

   Spouse’s name: Arnold B. Kopelman
   Spouse’s employer: U.S. Army, Fort Tyrone

   Emergency contact: Arnold B. Kopelman
   Relationship: husband
   Phone #: 999-555-0018

   INSURANCE INFORMATION

   Primary insurance company: TriCare
   Policyholder’s name: Arnold B. Kopelman
   Birth date: 4/10/73
   Plan: TriCare
   SS#: 230-56-9874
   Policy #: 230-56-9874
   Group #: USA9947

   Secondary insurance company:
   Policyholder’s name: Arnold B. Kopelman
   Birth date:
   Plan:
   SS#: 230-56-9874
   Policy #: 230-56-9874
   Group #: USA9947
3.4 Verifying Patient Eligibility for Insurance Benefits

To be paid for services, medical practices need to establish financial responsibility. Medical insurance specialists are vital employees in this process. For insured patients, they follow three steps to establish financial responsibility:

1. Verify the patient’s eligibility for insurance benefits
2. Determine preauthorization and referral requirements
3. Determine the primary payer if more than one insurance plan is in effect

**BILLING TIP**

**Plan Information**

Be aware of the copayments, preauthorization and referral requirements, and noncovered services for plans in which the practice participates.

The first step is to verify patients’ eligibility for benefits. Medical insurance specialists abstract information about the patient’s payer/plan from the patient’s information form (PIF) and the insurance card. They then contact the payer to verify three points:

1. Patients’ general eligibility for benefits
2. The amount of the copayment or coinsurance required at the time of service
3. Whether the planned encounter is for a covered service that is medically necessary under the payer’s rules

These items are checked before an encounter except in a medical emergency when care is provided immediately and insurance is checked after the encounter.

**BILLING TIP**

**Payers’ Rules for Medical Necessity**

Medicare requires patients to be notified if their insurance is not going to cover a visit, as detailed in the Medicare chapter. Other payers have similar rules.

**Factors Affecting General Eligibility**

General eligibility for benefits depends on a number of factors. If premiums are required, patients must have paid them on time. For government-sponsored plans for which income is the criterion, like Medicaid, eligibility can change monthly. For patients with employer-sponsored health plans, employment status can be the deciding factor:

- Coverage may end on the last day of the month in which the employee’s active full-time service ends, such as for disability, layoff, or termination.
- The employee may no longer qualify as a member of the group. For example, some companies do not provide benefits for part-time employees. If a full-time employee changes to part-time employment, the coverage ends.
- An eligible dependent’s coverage may end on the last day of the month in which the dependent status ends, such as reaching the age limit stated in the policy.

**BILLING TIP**

**Getting Online Information About Patients**

A portal is a website that is an entry point to other websites. Many insurers have portals to be used to check patient eligibility for coverage, get information on copayments and deductibles, process claims, and submit preauthorization requests.
If the plan is an HMO that requires a primary care provider (PCP), a general or family practice must verify that (1) the provider is a plan participant, (2) the patient is listed on the plan’s enrollment master list, and (3) the patient is assigned to the PCP as of the date of service.

The medical insurance specialist checks with the payer to confirm whether the patient is currently covered. If online access is used, Web information and e-mail messages are exchanged with provider representatives. If the payer requires the use of the telephone, the provider representative is called. Based on the patient’s plan, eligibility for these specific benefits may also need checking:

- Office visits
- Lab coverage
- Diagnostic X-rays
- Maternity coverage
- Pap smear coverage
- Coverage of psychiatric visits
- Physical or occupational therapy
- Durable medical equipment (DME)
- Foot care

**BILLING TIP**

**Check the Lab Requirements**

Because many MCOs specify which laboratory must be used, patients should be notified that they are responsible for telling the practice about their plans’ lab requirements, so that if specimens are sent to the wrong lab, the practice is not responsible for the costs.

**Checking Out-of-Network Benefits**

If patients have insurance coverage but the practice does not participate in their plans, the medical insurance specialist checks the out-of-network benefit. When the patient has out-of-network benefits, the payer’s rules concerning copayments/coinsurance and coverage are followed. If a patient does not have out-of-network benefits, as is common when the health plan is an HMO, the patient is responsible for the entire bill.

**Verifying the Amount of the Copayment or Coinsurance**

The amount of the copayment, or coinsurance, if required at the time of service, must be checked. It is sometimes the case that the insurance card is out of date, and a different amount needs to be collected.

**Determining Whether the Planned Encounter Is for a Covered Service**

The medical insurance specialist also must attempt to determine whether the planned encounter is for a covered service. If the service will not be covered, that patient can be informed and made aware of financial responsibility in advance.

The resources for covered services include knowledge of the major plans held by the practice’s patients, information from the provider representative and payer websites, and the electronic benefit inquiries described below. Medical insurance specialists are familiar with what the plans cover in general. For example, most plans cover regular office visits, but they may not cover preventive services or some therapeutic services. Unusual or unfamiliar services must be researched, and the payer must be queried.
Electronic Benefit Inquiries and Responses

An electronic transaction, a telephone call, or a fax or e-mail message may be used to communicate with the payer. Electronic transactions are the most efficient. When an eligibility benefits transaction is sent, the computer program assigns a unique **trace number** to the inquiry. Often, eligibility transactions are sent the day before patients arrive for appointments. If the PMP has this feature, the eligibility transaction can be sent automatically.

The health plan responds to an eligibility inquiry with this information:

- **Trace number**, as a double-check on the inquiry
- **Benefit information**, such as whether the insurance coverage is active
- **Covered period**—the period of dates that the coverage is active
- **Benefit units**, such as how many physical therapy visits
- **Coverage level**—that is, who is covered, such as spouse and family or individual

The following information may also be transmitted:

- The copay amount
- The yearly deductible amount
- The out-of-pocket expenses
- The health plan’s information on the insured’s/patient’s first and last names, dates of birth, and identification numbers
- Primary care provider

**Procedures When the Patient Is Not Covered**

If an insured patient’s policy does not cover a planned service, this situation is discussed with the patient. Patients should be informed that the payer does not pay for the service and that they are responsible for the charges.

Some payers require the physician to use specific forms to tell the patient about uncovered services. These financial agreement forms, which patients must sign, prove that patients have been told about their obligation to pay the bill before the services are given. For example, the Medicare program provides a form, called an **advance beneficiary notice (ABN)**, that must be used to show patients the charges. The signed form, as explained in the Medicare chapter, allows the practice to collect payment for a provided service or supply directly from the patient if Medicare refuses reimbursement. Figure 3.8 is an example of a form used to tell patients in advance of the probable cost of procedures that are not going to be covered by their plan and to secure their agreement to pay.
3.5 Determining Preauthorization and Referral Requirements

Preauthorization

A managed care payer often requires preauthorization before the patient sees a specialist, is admitted to the hospital, or has a particular procedure. The medical insurance specialist may request preauthorization over the phone, by e-mail or fax, or by an electronic transaction. If the payer approves the service, it issues a **prior authorization number** that must be entered in the practice management program so it will be stored and appear later on the healthcare claim for the encounter. (This number may also be called a **certification number**.)

To help secure preauthorization, best practice is to:

- Be as specific as possible about the planned procedure when exchanging information with a payer.
- Collect and have available all the diagnosis information related to the procedure, including any pertinent history.
- Query the provider and then request preauthorization for all procedures that may potentially be used to treat the patient.

Referrals

Often, a physician needs to send a patient to another physician for evaluation and/or treatment. For example, an internist might send a patient to a cardiologist to evaluate heart function. If a patient's plan requires it, the patient is given a **referral number** and a referral document, which is a written request for the medical service. The patient is usually responsible for bringing these items to the encounter with the specialist.

A paper referral document (see Figure 3.9) describes the services the patient is certified to receive. (This approval may instead be communicated electronically using the HIPAA referral transaction.) The specialist’s office handling a referred patient must:

- Check that the patient has a referral number
- Verify patient enrollment in the plan
- Understand restrictions to services, such as regulations that require the patient to visit a specialist in a specific period of time after receiving the referral or that limit the number of times the patient can receive services from the specialist

Two other situations arise with referrals (but always verify the payer’s rules):

1. A managed care patient may “self-refer”—come for specialty care without a referral number when one is required. The medical insurance specialist then asks the patient to sign a form acknowledging responsibility for the services. A sample form is shown in Figure 3.10a.
2. A patient who is required to have a referral document does not bring one. The medical insurance specialist then asks the patient to sign a document such as that shown in Figure 3.10b. This **referral waiver** ensures that the patient will pay for services received if in fact a referral is not documented in the time specified.
### Referral Form

<table>
<thead>
<tr>
<th>Label with Patient’s Personal &amp; Insurance Information</th>
</tr>
</thead>
</table>

Physician referred to_____________________________________

**Referred for:**
- [ ] Consult only
- [ ] Follow-up
- [ ] Lab
- [ ] X-ray
- [ ] Procedure
- [ ] Other

Reason for visit__________________________________________

Number of visits__________

Appointment requested: Please contact patient; phone: ______________

**Primary care physician**

Name_____________________________________________________

Signature________________________________________________

Phone___________________________________________________

---

**FIGURE 3.9** Referral

---

**Member Self-Referral Acknowledgment**

I, _________________________, understand that I am seeking the care
of this specialty physician or healthcare provider, ___________________,
without a referral from my primary care physician. I understand that
the terms of my Plan coverage require that I obtain that referral, and
that if I fail to do so, my Plan will not cover any part of the charges,
costs, or expenses related to this specialist’s services to me.

Signed,

_________________________ ______________________

(member’s name) (date)

***********************************************************

Specialty physician or other healthcare provider:

Please keep a copy of this form in your patient’s file

---

**FIGURE 3.10** (a) Self-referral Document, (b) Referral Waiver
Billing Supplemental Plans

Supplemental insurance held with the same payer can be billed on a single claim. Claims for supplemental insurance held with other than the primary payer are sent after the primary payer’s payment is posted, just as secondary claims are.

**THINKING IT THROUGH 3.5**

1. What is the difference between a referral and a preauthorization requirement?

---

### 3.6 Determining the Primary Insurance

The medical insurance specialist also examines the patient information form and insurance card to see whether other coverage is in effect. A patient may have more than one health plan. The specialist then decides which is the primary insurance—the plan that pays first when more than one plan is in effect—and which is the secondary insurance—an additional policy that provides benefits. Tertiary insurance, a third payer, is possible. Some patients have supplemental insurance, a “fill-the-gap” insurance plan that covers parts of expenses, such as coinsurance, that they must otherwise pay under the primary plan.

As a practical matter for billing, determining the primary insurance is important because this payer is sent the first claim for the encounter. A second claim is sent to the secondary payer after the payment is received for the primary claim.

Deciding which payer is primary is also important because insurance policies contain a provision called coordination of benefits (COB). The coordination of benefits guidelines ensure that when a patient has more than one policy, maximum appropriate benefits are paid, but without duplication. Under the law, to protect the insurance companies, if the patient has signed an assignment of benefits statement, the provider is responsible for reporting any additional insurance coverage to the primary payer.

Coordination of benefits in government-sponsored programs follows specific guidelines. Primary and secondary coverage under Medicare, Medicaid, and other programs is discussed in the chapters on these topics. Note that COB information can also be exchanged between provider and health plan or between a health plan and another payer, such as auto insurance.
Guidelines for Determining the Primary Insurance

How do patients come to have more than one plan in effect? Possible answers are that a patient may have coverage under more than one group plan, such as a person who has both employer-sponsored insurance and a policy from union membership. A person may have primary insurance coverage from an employer but also be covered as a dependent under a spouse’s insurance, making the spouse’s plan the person’s additional insurance.

General guidelines for determining the primary insurance are shown in Table 3.1.

Guidelines for Children with More than One Insurance Plan

A child’s parents may each have primary insurance. If both parents cover dependents on their plans, the child’s primary insurance is usually determined by the birthday rule. This rule states that the parent whose day of birth is earlier in the calendar year is primary. For example, Rachel Foster’s mother and father both work and have employer-sponsored insurance policies. Her father, George Foster, was born on October 7, 1971, and her mother, Myrna, was born on May 15, 1972. Since the mother’s date of birth is earlier in the calendar year (although the father is older), her plan is Rachel’s primary insurance. The father’s plan is secondary for Rachel.

Note that if a dependent child’s primary insurance does not provide for the complete reimbursement of a bill, the balance may usually be submitted to the other parent’s plan for consideration.

Another, much less common, way to determine a child’s primary coverage is called the gender rule. When this rule applies, if the child is covered by two health plans, the father’s plan is primary. In some states, insurance regulations

Table 3.1 Determining Primary Coverage

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the patient has only one policy, it is primary.</td>
<td></td>
</tr>
<tr>
<td>If the patient has coverage under two group plans, the plan that has been in effect for the patient for the longest period of time is primary. However, if an active employee has a plan with the present employer and is still covered by a former employer’s plan as a retiree or a laid-off employee, the current employer’s plan is primary.</td>
<td></td>
</tr>
<tr>
<td>If the patient has coverage under both a group and an individual plan, the group plan is primary.</td>
<td></td>
</tr>
<tr>
<td>If the patient is also covered as a dependent under another insurance policy, the patient’s plan is primary.</td>
<td></td>
</tr>
<tr>
<td>If an employed patient has coverage under the employer’s plan and additional coverage under a government-sponsored plan, the employer’s plan is primary. For example, if a patient is enrolled in a PPO through employment and is also on Medicare, the PPO is primary.</td>
<td></td>
</tr>
<tr>
<td>If a retired patient is covered by a spouse’s employer’s plan and the spouse is still employed, the spouse’s plan is primary, even if the retired person has Medicare.</td>
<td></td>
</tr>
<tr>
<td>If the patient is a dependent child covered by both parents’ plans and the parents are not separated or divorced (or if the parents have joint custody of the child), the primary plan is determined by the birthday rule.</td>
<td></td>
</tr>
<tr>
<td>If two or more plans cover dependent children of separated or divorced parents who do not have joint custody of their children, the children’s primary plan is determined in this order:</td>
<td></td>
</tr>
<tr>
<td>– The plan of the custodial parent</td>
<td></td>
</tr>
<tr>
<td>– The plan of the spouse of the custodial parent if remarried</td>
<td></td>
</tr>
<tr>
<td>– The plan of the parent without custody</td>
<td></td>
</tr>
<tr>
<td>Dependent coverage can be determined by a court decision, which overrules these guidelines.</td>
<td></td>
</tr>
</tbody>
</table>
require a plan that uses the gender rule to be primary to a plan that follows the birthday rule.

The insurance policy also covers which parent’s plan is primary for dependent children of separated or divorced parents. If the parents have joint custody, the birthday rule usually applies. If the parents do not have joint custody of the child, unless otherwise directed by a court order, usually the primary benefits are determined in this order:

- The plan of the custodial parent
- The plan of the spouse of the custodial parent, if the parent has remarried
- The plan of the parent without custody

### Entering Insurance Information in the Practice Management Program

The practice management program contains a database of the payers from whom the medical practice usually receives payments. The database contains each payer’s name and the contact’s name; the plan type, such as HMO, PPO, Medicare, Medicaid, or other; and telephone and fax numbers. Like the patient database, the payer database must be updated to reflect changes, such as new participation agreements or a new payer representative’s contact information.

The medical insurance specialist selects the payer that is the patient’s primary insurance coverage from the insurance database. If the particular payer has not already been entered, the PMP is updated with the payer’s information. Secondary coverage is also selected for the patient as applicable. Other related facts, such as policy numbers, effective dates, and referral numbers, are entered for each patient.

### Communications with Payers

Communications with payers’ representatives—whether to check on eligibility, receive referral certification, or resolve billing disputes—are frequent and are vitally important to the medical practice. Getting answers quickly means quicker payment for services. Medical insurance specialists follow these guidelines for effective communication:

- Learn the name, telephone number/extension, and e-mail address of the appropriate representative at each payer. If possible, invite the representative to visit the office and meet the staff.
- Use a professional, courteous telephone manner or writing style to help build good relationships.
- Keep current with changing reimbursement policies and utilization guidelines by regularly reviewing information from payers. Usually, the medical practice receives Internet or printed bulletins or newsletters that contain up-to-date information from health plans and government-sponsored programs.

All communications with payer representatives should be documented in the patient’s financial record. The representative’s name, the date of the communication, and the outcome should be described. This information is sometimes needed later to explain or defend a charge on a patient’s insurance claim.

### THINKING IT THROUGH 3.6

1. When a patient has secondary insurance, the claim for that payer is sent after the claim to the primary payer is paid. Why is that the case? What information do you think the secondary payer requires?
After the registration process is complete, patients are shown to rooms for their appointments with providers. Typically, a clinical medical assistant documents the patient’s vital signs. Then the provider conducts and documents the examination. After the visit, the medical insurance specialist uses the documented diagnoses and procedures to update the practice management program and to total charges for the visit.

**Encounter Forms**

During or just after a visit, an encounter form—either electronic or paper—is completed by a provider to summarize billing information for a patient’s visit. This may be done using a device such as a laptop computer, tablet PC, or PDA (personal digital assistant), or by checking off items on a paper form. Physicians should sign and date the completed encounter forms for their patients.

Encounter forms record the services provided to a patient, as shown in the completed office encounter form in Figure 3.11 on page 99. These forms (also called superbills, charge slips, or routing slips) list the medical practice’s most frequently performed procedures with their procedure codes. It also often has blanks where the diagnosis and its code(s) are filled in. (Some forms include a list of the diagnoses that are most frequently made by the practice’s physicians.)

Other information is often included on the form:

- A checklist of managed care plans under contract and their utilization guidelines
- The patient’s prior balance due, if any
- Check boxes to indicate the timing and need for a follow-up appointment to be scheduled for the patient during checkout

**Paper Preprinted or Computer-Generated Encounter Forms**

The paper form may be designed by the practice manager and/or physicians based on analysis of the practice’s medical services. It is then printed, usually with carbonless copies available for distribution according to the practice’s policy. For example, the top copy may be filed in the medical record; the second copy may be filed in the financial record; and the third copy may be given to the patient.

Alternatively, the form may be printed for each patient’s appointment using the practice management program. A customized encounter form lists the date of the appointment, the patient’s name, and the identification number assigned by the medical practice. It can also be designed to show the patient’s previous balance, the day’s fees, payments made, and the amount due.

**BILLING TIP**

**Numbering Paper Encounter Forms**

Encounter forms should be prenumbered to make sure that all the days’ appointments jibe with the day’s encounter forms. This provides a check that all visits have been entered in the practice management program for accurate charge capture.

**Communications with Providers**

At times, medical insurance specialists find incorrect or conflicting data on encounter forms. It may be necessary to check the documentation and, if still problematic, to communicate with the physician to clear up the discrepancies. In such cases, it is important to remember that medical practices are extremely busy places. Providers often have crowded schedules, especially if they see many patients, and have little time to go over billing and coding issues. Questions must be kept to those that are essential.
Also, encounter forms (and practice management programs) list procedure codes and, often, diagnosis codes that change periodically. Medical insurance specialists must be sure that these databases are updated when new codes are issued and old codes are modified or dropped (see the chapters about diagnostic and procedural coding). They also bring key changes in codes or payers’ coverage to the providers’ attention. Usually the practice manager arranges a time to discuss such matters with the physicians.
Review the completed encounter form shown in Figure 3.11 on page 99.

1. What is the age range of the patient?
2. Is this a new or an established patient?
3. What procedures were performed during the encounter?
4. What laboratory tests were ordered?

### 3.8 Understanding Time-of-Service (TOS) Payments

**Routine Collections at the Time of Service**

Up-front collection—money collected before the patient leaves the office—is an important part of cash flow. Practices routinely collect the following charges at the time of service:

1. Previous balances
2. Copayments
3. Coinsurance
4. Noncovered or overlimit fees
5. Charges of nonparticipating providers
6. Charges for self-pay patients
7. Deductibles for patients with consumer-driven health plans (CDHPs)
8. Charges for supplies and copies of medical records

**BILLING TIP**

**Collecting TOS payments**

- Many offices tell patients who are scheduling visits what copays they will owe at the time of service.
- Keep change to make it easier for cash patients to make time-of-service payments.
- Ask for payment. “We verified your insurance coverage, and there is a copay that is your responsibility. Would you like to pay by cash, check, or credit or debit card?”

**COMPLIANCE TIP**

Never refuse to provide medical record copies because a patient has a balance due; this is unethical and, in many states, illegal.

**Previous Balances**

Practices routinely check their patient financial records and, if a balance is due, collect it at the time of service.

**Copayments**

Copayments are always collected at the time of service. In some practices, they are collected before the encounter; in others, right after the encounter.

The copayment amount depends on the type of service and on whether the provider is in the patient's network. Copays for out-of-network providers are usually higher than for in-network providers. Specific copay amounts may be required for office visits to PCPs versus specialists and for lab work, radiology services such as X-rays, and surgery.

When a patient receives more than one covered service in a single day, the health plan may permit multiple copayments. For example, copays both for an annual physical examination and for lab tests may be due from the patient. Review the terms of
the policy to determine whether multiple copays should be collected on the same day of service.

**Coinsurance**

As healthcare costs have risen, employers have to pay more for their employees’ medical benefit plans. As a result, employers are becoming less generous to employees, demanding that employees pay a larger share of those costs. Annual health insurance premiums are higher, deductibles are higher, and in a major trend—a shift from copayments to coinsurance—many employers have dropped the small, fixed-amount copayment requirements and replaced them with a coinsurance payment that is often due at the time of service.

**BILLING TIP**

**Copayment Reminder**

Many practice management programs have a copayment reminder feature that shows the copayment that is due.

**Charges for Noncovered/Overlimit Services**

Insurance policies require patients to pay for noncovered (excluded) services, and payers do not control what the providers charge for noncovered services. Likewise, if the plan has a limit on the usage of certain covered services, patients are responsible for paying for visits beyond the allowed number. For example, if five physical therapy encounters are permitted annually, the patient must pay for any additional visits. Practices usually collect these charges from patients at the time of service.

**Charges of Nonparticipating Providers**

As noted earlier in this chapter, when patients have encounters with a provider who participates in the plan under which they have coverage—such as a Medicare-participating provider—that provider has agreed to accept assignment for the patients—that is, to accept the allowed charge as full payment. Nonparticipating physicians usually do not accept assignment and require full payment from patients at the time of service. They also do not file claims on patients’ behalf. An exception is Medicare, which requires all providers to file claims for patients as a courtesy.

**Charges for Services to Self-pay Patients**

Patients who do not have insurance coverage are called self-pay patients. Because many Americans do not have insurance, self-pay patients present for office visits daily. Medical insurance specialists follow the practice’s procedures for informing patients of their responsibility for paying their bills. Practices may require self-pay patients to pay their bills in full at the time of service.

**Deductibles for Patients with Consumer-Driven Health Plans (CDHPs)**

Patients who have consumer-driven health plans (CDHPs) must meet large deductibles before the health plan makes a payment. Practices are responsible for determining and collecting those deductibles at the time of service.
Billing for Supplies and Other Services

Many practices bill for supplies and for other services, such as making copies of medical records, at the time of service.

Other TOS Collection Considerations

In the typical medical billing process, after the routine up-front collections are handled, a claim for insured patients is created and sent. The practice then waits to receive insurance payments, post the amount of payment to the patient’s account in the PMP, and bill the patient for the balance. This process is followed because until the claim is adjudicated by the payer, the patient’s actual amount due is not known. The adjudication process often results in a change to the amount due initially calculated. Of course, how much of an annual deductible the patient has paid affects that amount. Differences in participation contracts with various payers also may reduce the physician’s fee for a particular service (this topic is covered in the chapter about visit charges and compliant billing).

However, following this process creates a problem for the practice in that it delays receipt of funds, reducing cash flow. For this reason, many practices are changing their billing process to increase time-of-service collections.

For example, a practice may decide to collect patients’ unmet deductibles or to adopt the policy of estimating the amount the patient will owe and collecting a partial payment during the checkout process. For example, if the patient is expected to owe $600 and practice policy is to collect 50 percent, the patient is asked to pay $300 today and to expect to be billed $300 after the claim is processed.

THINKING IT THROUGH 3.8

1. Why is collecting balances from patients at the time of service an important part of revenue cycle management?

3.9 Calculating TOS Payments

What patients owe at the time of service for the medical procedures and services they received depends on the practice’s financial policy and on the provisions of their health plans.

Financial Policy and Health Plan Provisions

Patients should always be informed of their financial obligations according to the credit and collections policy of the practice. This financial policy on payment for services is usually either displayed on the wall of the reception area or included in a new patient information packet. A sample of a financial policy is shown in Figure 3.12 on page 103.

The policy should explain what is required of the patient and when payment is due. For example, the policy may state the following:

For unassigned claims: Payment for the physician’s services is expected at the end of your appointment unless you have made other arrangements with our practice manager.

For assigned claims: After your insurance claim is processed by your insurance company, you will be billed for any amount you owe. You are responsible for any part of the charges that are denied or not paid by the carrier. All patient accounts are due within thirty days of the date of the invoice.

Copayments: Copayments must be paid before patients leave the office.
We sincerely wish to provide the best possible medical care. This involves mutual understanding between the patients, doctors, and staff. We encourage you, our patient, to discuss any questions you may have regarding this payment policy.

Payment is expected at the time of your visit for services not covered by your insurance plan. We accept cash, check, MasterCard, and Visa.

Credit will be extended as necessary.

**Credit Policy**
Requirements for maintaining your account in good standing are as follows:

1. All charges are due and payable within 30 days of the first billing.
2. For services not covered by your health plan, payment at the time of service is necessary.
3. If other circumstances warrant an extended payment plan, our credit counselor will assist you in these special circumstances at your request.

We welcome early discussion of financial problems. A credit counselor will assist you.

An itemized statement of all medical services will be mailed to you every 30 days. We will prepare and file your claim forms to the health plan. If further information is needed, we will provide an additional report.

**Insurance**
Unless we have a contract directly with your health plan, we cannot accept the responsibility of negotiating claims. You, the patient, are responsible for payment of medical care regardless of the status of the medical claim. In situations where a claim is pending or when treatment will be over an extended period of time, we will recommend that a payment plan be initiated. Your health plan is a contract between you and your insurance company. We cannot guarantee the payment of your claim. If your insurance company pays only a portion of the bill or denies the claim, any contact or explanation should be made to you, the policyholder. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

**Insufficient Funds Payment Policy**
We may charge an insufficient funds processing fee for all returned checks and bankcard charge backs. If your payment is dishonored, we may electronically debit your account for the payment, plus an insufficient funds processing fee up to the amount allowed by law. If your bank account is not debited, the returned check amount (plus fee) must be replaced by cash, cashier’s check, or money order.

**FIGURE 3.12** Example of a Financial Policy

However, a health plan may have a contract with the practice that prohibits physicians from obtaining anything except a copayment until after adjudication. Medicare has such a rule; the provider is not permitted to collect the deductible or any other payment until receiving data on how the claim is going to be paid. In this case, the health plan protects patients from having to overpay the deductible amount, which could occur if multiple providers collected the deductible within a short period of visits.
Estimating What the Patient Will Owe

Many times, patients want to know what their bills will be. For practices that collect patient accounts at the time of service and for high-deductible insurance plans, the physician practice also wants to know what a patient owes.

To estimate these charges, the medical insurance specialist verifies:

▶ The patient’s deductible amount and whether it has been paid in full, the covered benefits, and coinsurance or other patient financial obligations
▶ The payer’s allowed charges for the planned or provided services

Based on these facts, the specialist calculates the probable bill for the patient.

Other tools can be used to estimate charges. Some payers have a swipe-card reader (like a credit card processing device) that can be installed in the reception area and used by patients to learn what the insurer will pay and what the patient owes. Most practice management programs have a feature that permits estimating the patient’s bill, as shown below:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Description</th>
<th>Est.</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aetna Choice (EPO)</td>
<td>$16.00</td>
<td>$115.00</td>
</tr>
<tr>
<td>2</td>
<td>Medicare Nationwide</td>
<td>$28.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>3</td>
<td>21st Century Blue</td>
<td>$15.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Adjust</td>
<td></td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>

Policy Copay: 15.00  O/A: 0.00  YTD: $0.00
Annual Deductible: 0.00  Balance: $101.00

Real-Time Claims Adjudication

The ideal tool for calculating charges due at the time of service is the transaction called **real-time claims adjudication (RTCA)**. Offered to practices by many health plans, RTCA allows the practice to view, at the time of service, what the health plan will pay for the visit and what the patient will owe. The process is to (1) create the claim while the patient is being checked out, (2) transmit the claim electronically to the payer, and (3) receive an immediate (“real-time”) response from the payer. This response:

▶ Informs the practice if there are any errors in the claim, so these can be fixed and the claim immediately resent for adjudication
▶ States whether the patient has met the plan’s deductible
▶ Provides the patient’s financial responsibility
▶ Supplies an explanation of benefits for this patient, so that any questions the patient has about denial of coverage or payment history can be immediately answered.

Note that the RTCA does not generate a “real-time” payment—that follows usually within twenty-four hours. This brief waiting period is also a great improvement over the time it normally takes payers to send payments.

**BILLING TIP**

**Use of Credit and Debit Cards**

Accepting credit or debit cards requires paying a fee to the credit card carrier. It is generally considered worth the cost because payments are made immediately and are more convenient for the patient.

**Financial Arrangements for Large Bills**

If patients have large bills that they must pay over time, a financial arrangement for a series of payments may be made (see Figure 3.13 on page 105). The payments may begin with a prepayment followed by monthly amounts. Such arrangements usually require the approval of the practice manager. They may also be governed by state laws. Payment plans are covered in greater depth in the chapter about patient billing and collections.
1. Read the financial policy shown in Figure 3.12. If a patient presents for noncovered services, when is payment expected? Does the provider accept assignment for plans in which it is nonPAR?

**FIGURE 3.13** Financial Arrangement for Services Form

**THINKING IT THROUGH 3.9**

**Patient Name and Account Number**

**Total of All Payments Due**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEE</td>
<td>$______</td>
</tr>
<tr>
<td>PARTIAL PAYMENT</td>
<td>$______</td>
</tr>
<tr>
<td>UNPAID BALANCE</td>
<td>$______</td>
</tr>
<tr>
<td>AMOUNT FINANCED</td>
<td>$______</td>
</tr>
<tr>
<td>FINANCE CHARGE</td>
<td>$______</td>
</tr>
<tr>
<td>ANNUAL PERCENTAGE RATE</td>
<td>$______</td>
</tr>
<tr>
<td>TOTAL OF PAYMENTS DUE</td>
<td>$______</td>
</tr>
</tbody>
</table>

**Rights and Duties**

I (we) have reviewed the above fees. I agree to make ______ payments in monthly installments of $______, due on the ____ day of each month payable to ________, until the total amount is paid in full. The first payment is due on ________. I may request an itemization of the amount financed.

**Delinquent Accounts**

I (we) understand that I am financially responsible for all fees as stated. My account will be overdue if my scheduled payment is more than 7 days late. There will be a late payment charge of $______ or _____% of the payment, whichever is less. I understand that I will be legally responsible for all costs involved with the collection of this account including all court costs, reasonable attorney fees, and all other expenses incurred with collection if I default on this agreement.

**Prepayment Penalty**

There is no penalty if the total amount due is paid before the last scheduled payment.

I (we) agree to the terms of the above financial contract.

Signature of Patient, Parent or Legal Representative  
Date

Witness  
Date

Authorizing Signature  
Date
### Chapter Summary

<table>
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<tr>
<th>Learning Objective</th>
<th>Key Concepts/Examples</th>
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</table>
| **3.1** Explain the method used to classify patients as new or established. Page 78 | • Practices gather accurate information from patients to perform billing and medical care.  
• New patients are those who have not received any services from the provider within the past three years.  
• Established patients have seen the provider within the past three years.  
• Established patients review and update the information that is on file about them. |
| **3.2** Discuss the five categories of information required of new patients. Pages 78–87 | Five types of information collected:  
• Basic personal preregistration and scheduling information  
• The patient’s detailed medical history  
• Insurance data for the patient or guarantor  
• A signed and dated assignment of benefits statement by the policyholder  
• A signed Acknowledgement of Receipt of Notice of Privacy Practices authorizing the practice to release the patient’s PHI for TPO purposes |
| **3.3** Explain how information for established patients is updated. Pages 87–89 | • Patient information forms are reviewed at least once per year by established patients.  
• Patients are often asked to double-check their information at their encounters.  
• The PMP is updated to reflect any changes as needed, and the provider strives for good communication with the patient to provide the best possible service. |
| **3.4** Verify patients’ eligibility for insurance benefits. Pages 90–93 | To verify patients’ eligibility, the provider:  
• Checks the patient’s information form and medical insurance card (except in medical emergency situations)  
• Contacts the payer to verify the patient’s general eligibility for benefits and the amount of copayment or coinsurance that is due at the encounter, and to determine whether the planned encounter is for a covered service that is considered medically necessary by the payer |
| **3.5** Discuss the importance of requesting referral or preauthorization approval. Pages 93–95 | • Preauthorization is requested before a patient is given certain types of medical care.  
• In cases of referrals, the provider often needs to issue a referral number and a referral document in order for the patient to see a specialist under the terms of the medical insurance.  
• Providers must handle these situations correctly to ensure that the services are covered if possible. |
| **3.6** Determine primary insurance for patients who have more than one health plan. Pages 95–97 | • Patient information forms and insurance cards are examined to determine whether more than one health insurance policy is in effect.  
• If so, the provider determines which policy is the primary insurance based on coordination of benefits rules.  
• This information is then entered into the PMP and all necessary communications with the payers are performed. |
| **3.7** Summarize the use of encounter forms. Pages 98–100 | • Encounter forms are lists of a medical practice’s most commonly performed services and procedures and often its frequent diagnoses.  
• The provider checks off the services and procedures a patient received, and the encounter form is then used for billing. |
Learning Objective | Key Concepts/Examples
--- | ---
3.8 Identify the eight types of charges that may be collected from patients at the time of service. Pages 100–102
- Practices routinely collect up-front money from patients at the time of their office visit as an important source of cash flow.
- Eight different types of charges may be collected from patients at the time of service:
  1. Previous balances
  2. Copayments
  3. Coinsurance
  4. Noncovered or overlimit fees
  5. Charges of nonparticipating providers
  6. Charges for self-pay patients
  7. Deductibles for patients with CDHPs
  8. Charges for supplies and copies of medical records

3.9 Explain the use of real-time claims adjudication tools in calculating time-of-service payments. Pages 102–105
- Real-time claims adjudication tools:
  - Allow the practice to view, at the time of service, what the health plan will pay for the visit and what the patient will owe
  - Provide valuable information and checks so that the practice and patients are aware of the expected costs and coverage
  - Inform or remind patients of the financial policy and give estimates of the bills they will owe

Review Questions
Match the key terms with their definitions.

1. **LO 3.2** direct provider
2. **LO 3.2** assignment of benefits
3. **LO 3.1** new patient
4. **LO 3.6** secondary insurance
5. **LO 3.7** encounter form
6. **LO 3.1** established patient
7. **LO 3.2** insured
8. **LO 3.6** coordination of benefits
9. **LO 3.3** primary insurance
10. **LO 3.2** patient information form

A. Form used to summarize the treatments and services patients receive during visits
B. Policyholder, guarantor, or subscriber
C. Authorization by a policyholder that allows a payer to pay benefits directly to a provider
D. The insurance plan that pays benefits after payment by the primary payer when a patient is covered by more than one medical insurance plan
E. The provider who treats the patient
F. A clause in an insurance policy that explains how the policy will pay if more than one insurance policy applies to the claim
G. A patient who has received professional services from a provider or another provider in the same practice with the same specialty in the past three years
H. Form completed by patients that summarizes their demographic and insurance information
I. A patient who has not received professional services from a provider, or another provider in the same practice with the same specialty, in the past three years
J. The insurance plan that pays benefits first when a patient is covered by two medical insurance plans
Select the letter that best completes the statement or answers the question.

1. **LO 3.2** A patient’s group insurance number written on the patient information or update form must match
   A. the patient’s Social Security number
   B. the number on the patient’s insurance card
   C. the practice’s identification number for the patient
   D. the diagnosis codes

2. **LO 3.4** If a health plan member receives medical services from a provider who does not participate in the plan, the cost to the member is
   A. lower
   B. higher
   C. the same
   D. negotiable

3. **LO 3.2** What information does a patient information form gather?
   A. the patient’s personal information, employment data, and insurance information
   B. the patient’s history of present illness, past medical history, and examination results
   C. the patient’s chief complaint
   D. the patient’s insurance plan deductible and/or copayment requirements

4. **LO 3.6** If a husband has an insurance policy but is also eligible for benefits as a dependent under his wife’s insurance policy, the wife’s policy is considered _____ for him.
   A. primary
   B. participating
   C. secondary
   D. coordinated

5. **LO 3.5** A certification number for a procedure is the result of which transaction and process?
   A. claim status
   B. healthcare payment
   C. coordination of benefits
   D. referral and authorization
   and remittance advice

6. **LO 3.9** A practice’s rules for payment for medical services are found in their
   A. coordination of benefits
   B. documentation
   C. financial policy
   D. compliance plan

7. **LO 3.7** The encounter form is a source of _____ information for the medical insurance specialist.
   A. billing
   B. treatment plan
   C. third-party payment
   D. credit card

8. **LO 3.9** Under Medicare, what must a provider receive before it is permitted to collect a deductible or any other payment?
   A. the patient’s coinsurance
   B. the patient’s copayment
   C. authority to accept assignment
   D. data on how the claim is going to be paid

9. **LO 3.8** Which charges are usually collected at the time of service?
   A. copayments, lab fees, and therapy charges
   B. copayments, noncovered or overlimit fees, charges of nonparticipating providers, and charges for self-pay patients
   C. deductibles and lab fees
   D. coinsurance

10. **LO 3.6** The tertiary insurance pays
    A. after the first and
    B. after the first payer
    C. after receipt of the claim
    D. before all other payers

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Answer the following questions.

1. Define the following abbreviations:

   A. **LO 3.2** nonPAR

   B. **LO 3.6** COB

   C. **LO 3.2** PAR

   D. **LO 3.1** NP

   E. **LO 3.1** EP

---

**Applying Your Knowledge**

**Case 3.1 Abstracting Insurance Information**

**LO 3.1** Carol Viragras saw Dr. Alex Roderer, a gynecologist with the Alper Group, a multispecialty practice of 235 physicians, on October 24, 2014. On December 3, 2016, she made an appointment to see Dr. Judy Fisk, a gastroenterologist also with the Alper Group. Did the medical insurance specialist handling Dr. Fisk’s patients classify Carol as a new or an established patient?

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**Case 3.2 Documenting Communications**

**LO 3.3, 3.7** Harry Cornprost, a patient of Dr. Connelley, calls on October 25, 2016, to cancel his appointment for October 31 because he will be out of town. The appointment is rescheduled for December 4. How would you document this call?

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**Case 3.3 Coordinating Benefits**

Based on the information provided, determine the primary insurance in each case.

A. **LO 3.6** George Rangley enrolled in the ACR plan in 2008 and in the New York Health plan in 2006.

   George’s primary plan: __________________________

B. **LO 3.6** Mary is the child of Gloria and Craig Bivilaque, who are divorced. Mary is a dependent under both Craig’s and Gloria’s plans. Gloria has custody of Mary.

   Mary’s primary plan: __________________________

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C. **LO 3.6** Karen Kaplan’s date of birth is 10/11/1970; her husband Carl was born on 12/8/1971. Their child Ralph was born on 4/15/2000. Ralph is a dependent under both Karen’s and Carl’s plans.

Ralph’s primary plan: _____________________________________________________________________________________

D. **LO 3.6** Belle Estafahan has medical insurance from Internet Services, from which she retired last year. She is on Medicare but is also covered under her husband Bernard’s plan from Orion International, where he works.

Belle’s primary plan: _____________________________________________________________________________________

E. **LO 3.6** Jim Larenges is covered under his spouse’s plan and has medical insurance through his employer.

Jim’s primary plan: _____________________________________________________________________________________

Case 3.4 Calculating Insurance Math

A. **LO 3.8, 3.9** A patient’s insurance policy states:
   - Annual deductible: $300.00
   - Coinsurance: 70-30

   This year the patient has made payments totaling $533 to all providers. Today the patient has an office visit (fee: $80). The patient presents a credit card for payment of today’s bill. What is the amount that the patient should pay?

B. **LO 3.8, 3.9** A patient is a member of a health plan with a 15 percent discount from the provider’s usual fees and a $10 copay. The day’s charges are $480. What are the amounts that the HMO and the patient each pay?

C. **LO 3.8, 3.9** A patient is a member of a health plan that has a 20 percent discount from the provider and a 15 percent copay. If the day’s charges are $210, what are the amounts that the HMO and the patient each pay?