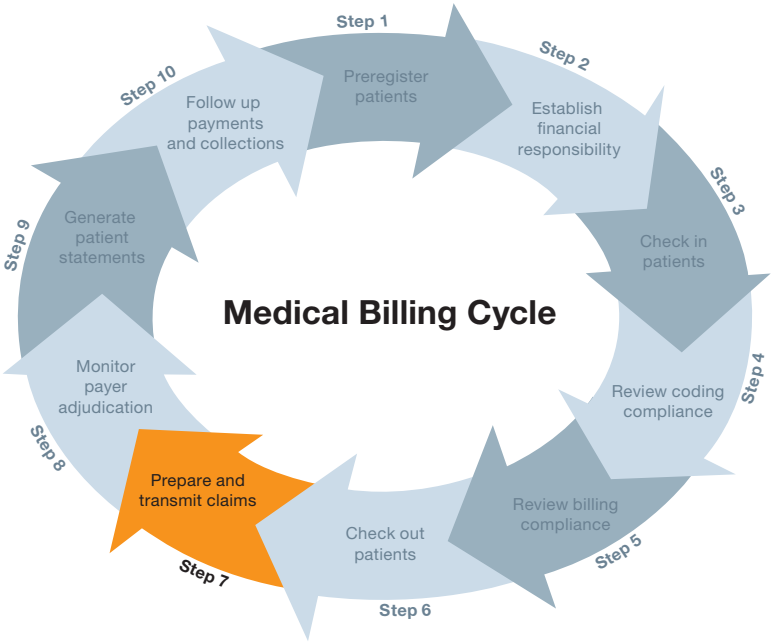
PRIVATE PAYERS/BLUECROSS BLUESHIELD

8



Learning Outcomes

After studying this chapter, you should be able to:

- **8.1** Compare employer-sponsored and self-funded health plans.
- **8.2** Describe the major features of group health plans regarding eligibility, portability, and required coverage.
- **8.3** Discuss provider payment under the various private payer plans.
- **8.4** Contrast health reimbursement accounts, health savings accounts, and flexible savings (spending) accounts.
- **8.5** Discuss the major private payers.
- **8.6** Analyze the purpose of the five main parts of participation contracts.
- **8.7** Describe the information needed to collect copayments and bill for surgical procedures under contracted plans.
- **8.8** Discuss the use of plan summary grids.
- **8.9** Prepare accurate private payer claims.
- **8.10** Explain how to manage billing for capitated services.

KEY TERMS

administrative services only (ASO)
BlueCard
BlueCross BlueShield Association (BCBS)
carve out
Consolidated Omnibus Budget Reconciliation Act (COBRA)
credentialing
creditable coverage
discounted fee-for-service
elective surgery
Employee Retirement Income Security Act (ERISA) of 1974
episode-of-care (EOC) option
FAIR (Fair and Independent Research) Health
family deductible
Federal Employees Health Benefits (FEHB) program
Flexible Blue
flexible savings (spending) account (FSA)
formulary
group health plan (GHP)
health reimbursement account (HRA)
health savings account (HSA)
high-deductible health plan (HDHP)
home plan
host plan
independent (or individual) practice association (IPA)
individual deductible
individual health plan (IHP)
late enrollee
maximum benefit limit
medical home model
monthly enrollment list
open enrollment period
parity
pay-for-performance (P4P)
plan summary grid
precertification
repricer
rider
Section 125 cafeteria plan
silent PPOs

Continued

KEY TERMS *(continued)*

stop-loss provision
subcapitation
Summary Plan Description (SPD)
third-party claims administrators (TPAs)
tiered network
utilization review
utilization review organization (URO)
waiting period

Group Health Plan Regulation

Employer-sponsored group health plans must follow federal and state laws that mandate coverage of specific benefits or treatments and access to care. When a state law is more restrictive than the related federal law, the state law is followed.

Medical insurance specialists must become knowledgeable about the billing rules of the private plans that insure their patients, especially how they affect coverage of services and financial responsibility. This chapter covers procedures for billing under the leading types of managed care plans. Also covered are plans with funding options controlled by patients, which have become a popular insurance model. Because these consumer-driven health plans (CDHP) have high deductibles due before benefits start, patients need to understand what their bills will be, and medical insurance specialists need to know how to collect these amounts. In every case, a clear financial policy that describes patients' financial obligations is increasingly important for medical practices.

8.1 Private Insurance

People who are not covered by entitlement programs such as government-sponsored health insurance are often covered by private insurance. Many employers offer their employees the opportunity to become covered under employee healthcare benefit plans. Sponsorship of medical insurance is an important benefit to employees, and it also gives employers federal income tax advantages.

Employer-Sponsored Medical Insurance

group health plan (GHP) plan of an employer or employee organization to provide healthcare to employees, former employees, or their families

Many employees have medical insurance coverage under **group health plans (GHPs)** that their employers buy from insurance companies. (Note that when an individual is covered under a GHP, the group is the "policyholder" and the individual is a "certificate holder.") Human resource departments manage these healthcare benefits, negotiating with health plans and then selecting a number of products to offer employees.

rider document modifying an insurance contract

Both basic plans and riders are offered. **Riders,** also called options, may be purchased by employees to add voluntary benefits such as vision and dental services. Another popular rider is for complementary healthcare, covering treatments such as chiropractic/manual manipulation, acupuncture, massage therapy, dietetic counseling, and vitamin and minerals.

carve out part of a standard health plan changed under an employer-sponsored plan

Employers may **carve out** certain benefits—that is, change standard coverage or providers—during negotiations to reduce the price. An employer may:

- Omit a specific benefit, such as coverage of prescription drugs.
- Use a different network of providers for a certain type of care, such as negotiating with a local practice network for mental health coverage.
- Hire a pharmacy benefit manager (PBM) to operate the prescription drug benefit more inexpensively. (Because PBMs do this work for many employers, they represent a large group of buyers and can negotiate favorable prices with pharmaceutical companies for each employer.)

open enrollment period time when a policyholder selects from offered benefits

During specified periods (usually once a year) called **open enrollment periods,** the employee chooses a particular set of benefits for the coming benefit period (see Figure 8.1). The employer provides tools (often web-based) and information to help employees match their personal and family needs with the best-priced plans. Employees can customize the policies by choosing to accept various levels of premiums, deductibles, and other costs.

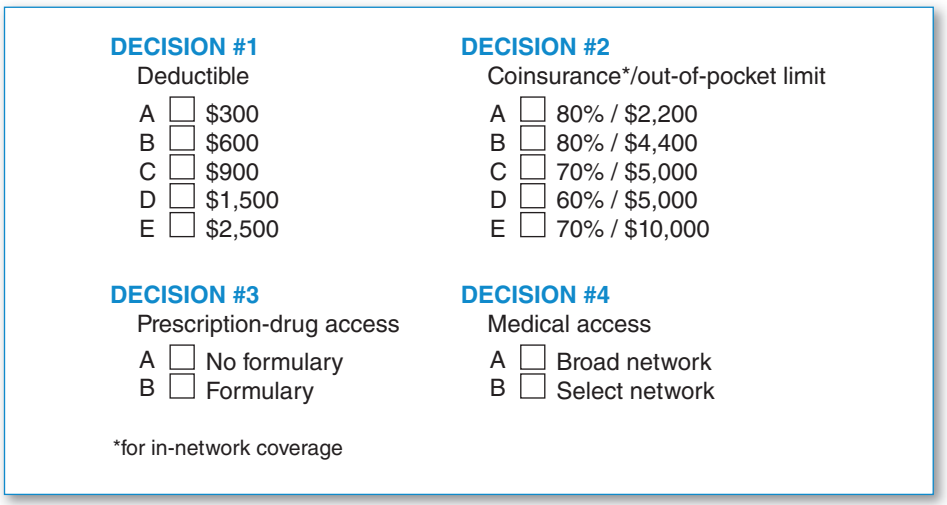


FIGURE 8.1 Example of Selecting Benefits During Open Enrollment

Federal Employees Health Benefits Program

The largest employer-sponsored health program in the United States is the **Federal Employees Health Benefits (FEHB) program,** which covers more than 8 million federal employees, retirees, and their families through more than 250 health plans from a number of carriers. FEHB is administered by the federal government's Office of Personnel Management (OPM), which receives and deposits premiums and remits payments to the carriers. Each carrier is responsible for furnishing identification cards and benefits brochures to enrollees, adjudicating claims, and maintaining records.

Self-Funded Health Plans

To save money, many large employers cover the costs of employee medical benefits themselves rather than buying insurance from other companies. They create self-funded (or self-insured) health plans that do not pay premiums to an insurance carrier or a managed care organization. Instead, self-funded health plans "insure themselves" and assume the risk of paying directly for medical services, setting aside funds with which to pay benefits. The employer establishes the benefit levels and the plan types offered to employees. Self-funded health plans may set up their own provider networks or, more often, lease a managed care organization's networks. They may also buy other types of insurance—such as a vision package—instead of insuring the benefit themselves.

In contrast to employer-sponsored "fully insured plans," which are regulated by state laws, self-funded health plans are regulated by the federal **Employee Retirement Income Security Act (ERISA) of 1974.** ERISA is run by the federal Department of Labor's (DOL) Pension and Welfare Benefits Administration. Self-funded plan members receive a **Summary Plan Description (SPD)** from the plan that describes their benefits and legal rights.

Self-funded health plans often hire **third-party claims administrators (TPAs)** to handle tasks such as collecting premiums, keeping lists of members up to date, and processing and paying claims. Often an insurance carrier or managed care organization works as the TPA under an **administrative services only (ASO)** contract.

Individual Health Plans

Individuals can purchase **individual health plans (IHPs).** Almost 10 percent of people with private health insurance have individual plans. People often elect to enroll in individual plans, although coverage is expensive, in order to continue their health insurance

FEHB

www.opm.gov/insure/health

TPAs Are Business Associates

Third-party claims administrators are business associates of health plans and must satisfy the normal privacy and security requirements during healthcare transactions.

Group Health Plans and PHI

Both employer-sponsored health plans and self-funded health plans are group health plans (GHPs) under HIPAA and must follow HIPAA rules.

Federal Employees Health Benefits (FEHB) program covers employees of the federal government.

Employee Retirement Income Security Act (ERISA) of 1974 law providing incentives and protection for companies with employee health and pension plans

Summary Plan Description (SPD) required document for self-funded plans stating beneficiaries' benefits and legal rights

third-party claims administrators (TPAs) business associates of health plans

administrative services only (ASO) contract under which a third-party administrator or insurer provides administrative services to an employer for a fixed fee per employee

individual health plan (IHP) medical insurance plan purchased by an individual

between jobs. Purchasers also include self-employed entrepreneurs, students, recent college graduates, and early retirees. Individual insurance plans usually have basic benefits without the riders or additional features associated with group health plans.

BILLING TIP

Timely Payments

Group health plans must follow states' Clean Claims Act and/or Prompt Payment Act and pay claims they accept for processing on a timely basis. ERISA (self-funded) plans, under the DOL, do not have similar rates, so the terms of payer contracts apply.

THINKING IT THROUGH 8.1

1. Some employers offer limited-benefit health plans, which usually involve both low cost and low benefits. For example, one plan has these costs and benefits:

   Basic annual benefit: $1,000 (per insured person)

   Weekly premium for an individual: $6.92

   Weekly premium for a family: $21.55

   Basic deductible: $50

   Doctor visits: $15 copay

   Discuss the possible effect on the practice's cash flow if many patients have this type of coverage.

8.2 Features of Group Health Plans

Section 125 cafeteria plan employers' health plans structured to permit funding of premiums with pretax payroll deductions

A common way that employers organize employees' choices of plans is by creating a tax structure called a **Section 125 cafeteria plan** (the word *cafeteria* implies that employees may choose from a wide array of options). Under income tax law, the employer can collect an employee's insurance cost through a pretax payroll deduction, and that money is excluded from the income the employee has to pay taxes on. (When a policyholder pays premiums any other way, the policyholder generally pays income tax on that money and can deduct the cost only if the entire year's medical expenses are more than 7.5 percent of his or her income.)

Eligibility for Benefits

The group health plan specifies the rules for eligibility and the process of enrolling and disenrolling members. Rules cover employment status, such as full-time, part-time, disabled, and laid-off or terminated employees, as well as the conditions for enrolling dependents.

Waiting Period

waiting period amount of time that must pass before an employee/dependent may enroll in a health plan

Many plans have a **waiting period,** an amount of time that must pass before a newly hired employee or a dependent is eligible to enroll. The waiting period is the time between the date of hire and the date the insurance becomes effective.

Late Enrollees

late enrollee category of enrollment that may have different eligibility requirements

The plan may impose different eligibility rules on a **late enrollee,** an individual who enrolls in a plan at a time other than the earliest possible enrollment date or a special enrollment date. For example, special enrollment may occur when a person becomes a new dependent through marriage.

Premiums and Deductibles

As explained in the introductory chapter, most plans require annual premiums. Although employers once paid the total premiums as a benefit for employees, currently they pay an average of 80 percent of the cost.

Many health plans also have a deductible that is due per time period. Non-covered services under the plan that the patient must pay out-of-pocket do not count toward satisfying a deductible. Some plans require an **individual deductible** that must be met for each person—whether the policyholder or a covered dependent—who has an encounter. Others have a **family deductible** that can be met by the combined payments of any covered members of the insured's family.

individual deductible fixed amount that must be met periodically by each individual of an insured/dependent group

family deductible fixed, periodic amount that must be met by the combined payments of an insured/dependent group before benefits begin

Benefit Limits

Plans often have a **maximum benefit limit** (also called a lifetime limit), a monetary amount after which benefits end, and may impose a condition-specific lifetime limit. For example, the plan may have a $500,000 lifetime limit on all benefits covered under the plan for any policyholder and a $2,000 limit on benefits provided for a specific health condition of an individual policy-holder. Some plans may also have an annual benefit limit that restricts the amount payable in a given year.

maximum benefit limit amount an insurer agrees to pay for lifetime covered expenses

Tiered Networks

Tiered networks reimburse more for providers who are considered of highest quality and cost effectiveness by the plan. The aim of tiered networks is to steer patients toward the best providers (under the plan's performance measurements). Tiered networks are common for prescription drug coverage; medications in the plan's drug **formulary,** a list of approved drugs, have smaller copayments than do nonformulary drugs.

tiered network network system that reimburses more for quality, cost-effective providers

formulary list of a plan's selected drugs and their proper dosages

State Law and Preexisting Condition Exclusions

The six-month look-back period and the length of the preexisting condition limitation extension period are shortened under the laws of some states.

Portability and Required Coverage

A number of regulations govern group health coverage in situations such as changing jobs, pregnancy, and certain illnesses.

COBRA

The **Consolidated Omnibus Budget Reconciliation Act (COBRA)** (1985; amended 1986) gives an employee who is leaving a job the right to continue health coverage under the employer's plan for a limited time at his or her own expense. COBRA participants usually pay more than do active employees, because the employer usually pays part of the premium for an active employee, but a COBRA participant generally pays the entire premium. However, COBRA is ordinarily less expensive than individual health coverage.

Consolidated Omnibus Budget Reconciliation Act (COBRA) law requiring employers with more than twenty employees to allow terminated employees to pay for coverage for eighteen months

HIPAA

HIPAA (1996) adds more rules to COBRA to help people with preexisting conditions when they are newly employed. For cost control, many private plans limit or exclude coverage of patients' previous illnesses or conditions. HIPAA regulates these exclusions. Plans can "look back" into the patient's medical history for a period of six months to find conditions that they will exclude, but they cannot look back for a longer period. Also, the preexisting condition limitation cannot last more than twelve months after the effective date of coverage (eighteen months for late enrollees).

COBRA Information

www.dol.gov/ebsa

The patient's previous **creditable coverage** also must be taken into account when an employee joins a new plan. Creditable coverage is health insurance under a group health plan, health insurance, or the Medicaid program known as CHIP (see the chapter on Medicaid). Note that medical discount cards are not insurance and do not qualify as creditable coverage.

creditable coverage history of coverage for calculation of COBRA benefits

Pregnancy and Childbirth Rules

A preexisting condition exclusion cannot be applied to pregnancy or to a newborn, adopted child, or child placed for adoption if the child is covered under a group health plan within thirty days after birth, adoption, or placement for adoption.

If the patient was previously covered by medical insurance, that plan had to supply a certificate of coverage when the patient's coverage ended. The patient gives this document to the new plan because having previous coverage can reduce the length of limitation the plan can put in the person's new insurance policy. Under the standard calculation method, the patient receives credit for previous coverage that occurred without a break of sixty-three days or more. (Any coverage occurring before a break in coverage of sixty-three days or more is not credited against a preexisting condition exclusion period.)

Other Federally Guaranteed Insurance Provisions

Four other federal laws govern private insurance coverage:

- The Newborns' and Mothers' Health Protection Act provides protections for mothers and their newborn children relating to the length of hospital stays after childbirth. Unless state law says otherwise, plans cannot restrict benefits for a hospital stay for childbirth to less than forty-eight hours following a vaginal delivery or ninety-six hours following delivery by cesarean section. Plans are permitted to require preauthorization for the hospitalization.
- The Women's Health and Cancer Rights Act provides protections for individuals who elect breast reconstruction after a mastectomy. Plans must cover all stages of breast reconstruction, procedures on the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphodema. State laws may be more restrictive than this act and may require a minimum length of hospitalization after the procedure.
- The Mental Health Parity Act provides for **parity** (equality) with medical/surgical benefits when plans set lifetime or annual dollar limits on mental health benefits (except for substance abuse or chemical dependency).
- The Genetic Information Nondiscrimination Act prohibits both group health plans and employers from using genetic information to discriminate against a person. Participants cannot be required to take a genetic test for a disease that has not yet appeared in the person, and premium costs cannot be affected by genetic information.

parity equality with medical/surgical benefits

BILLING TIP

PPOs

About half of all consumers with health insurance are enrolled in a PPO.

THINKING IT THROUGH 8.2

1. If a GHP has a ninety-day waiting period, on what day does health coverage become effective?
2. In terms of enrollment in a health plan, what is the status of an infant born to a subscriber in the plan?
3. A patient pays for a cosmetic procedure that is not medically necessary under the terms of the plan. Does this payment count toward the deductible?
4. Why is it important to verify a patient's eligibility for benefits? Can you think of events, such as job-status change, that might affect coverage?

8.3 Types of Private Payers

Preferred provider organizations (PPOs) are the most popular type of private plan, followed by health maintenance organizations (HMOs), especially the point-of-service (POS) variety. Few employees choose indemnity plans because they would have to pay more. Consumer-driven health plans (CDHPs) that combine a high-deductible health plan with a funding option of some type are rapidly growing in popularity among both employers and employees. See Table 8.1 for a review of private payer plan types that were introduced earlier in this text. Figure 8.2 on page 284 presents typical features of a popular PPO plan.

BILLING TIP

Private Payers

Private payers do not necessarily operate under the same regulations as government-sponsored programs. Each payer's rules and interpretations may vary. The definitions of basic terms (for example, the age range for neonate) differ, as do preauthorization requirements. Research each payer's rules for correct billing and reimbursement.

Preferred Provider Organizations

Physicians, hospitals and clinics, and pharmacies contract with the PPO plan to provide care to its insured people. These medical providers accept the PPO plan's fee schedule and guidelines for its managed medical care. PPOs generally pay participating providers based on a discount from their physician fee schedules, called **discounted fee-for-service.**

discounted fee-for-service payment schedule for services based on a reduced percentage of usual charges

Under a PPO, the patient pays an annual premium and often a deductible. A PPO plan may offer either a low deductible with a higher premium or a high deductible with a lower premium. Insured members pay a copayment at the time of each medical service. Coinsurance is often charged for in-network providers.

A patient may see an out-of-network doctor without a referral or preauthorization, but the deductible for out-of-network services may be higher and the percentage the plan will pay may be lower. In other words, the patient will be responsible for a greater part of the fee, as illustrated by the "in-network" versus "out-of-network"

Table 8.1 Types of Private Payer Plans

Plan Type	Participating Provider Payment Method
Preferred Provider Organization (PPO)	Discounted Fee-for-Service
Staff Health Maintenance Organization (HMO)	Salary
Group HMO	Salary or Contracted Cap Rate
Independent Practice Association (IPA)	PCP: Contracted Cap Rate Specialist: Fee-for-Service
Point-of-Service (POS) Plan	PCPs: Contracted Cap Rate Referred Providers: Contracted Cap Rate or Discounted Fee-for-Service
Indemnity	Fee-for-Service
Consumer-Driven Health Plan (Combined High-Deductible Health Plan and Funding Option)	Up to Deductible: Payment by Patient After Deductible: Discounted Fee-for-Service

Standard Benefits

This is a preferred provider organization (PPO) plan. That means members can receive the highest level of benefits when they use any of the more than 5,000 physicians and other healthcare professionals in this network. When members receive covered in-network services, they simply pay a copayment. Members can also receive care from providers that are not part of the network; however, benefits are often lower and covered claims are subject to deductible, coinsurance and charges above the maximum allowable amount. Referrals are not needed from a Primary Care Physician to receive care from a specialist.

PREVENTIVE CARE	In-Network	Out-of-Network
Well child care		
Birth through 12 years	OV Copayment	Deductible & Coinsurance
All others	OV Copayment	Deductible & Coinsurance
Periodic, routine health examinations	OV Copayment	Deductible & Coinsurance
Routine eye exams	OV Copayment	Deductible & Coinsurance
Routine OB/GYN visits	OV Copayment	Deductible & Coinsurance
Mammography	No Charge	Deductible & Coinsurance
Hearing Screening	OV Copayment	Deductible & Coinsurance
MEDICAL CARE	**In-Network**	**Out-of-Network**
PCP office visits	OV Copayment	Deductible & Coinsurance
Specialist office visits	OV Copayment	Deductible & Coinsurance
Outpatient mental health & substance abuse – *prior authorization required*	OV Copayment	Deductible & Coinsurance
Maternity care – *initial visit subject to copayment, no charge thereafter*	OV Copayment	Deductible & Coinsurance
Diagnostic lab, x-ray and testing	No Charge	Deductible & Coinsurance
High-cost outpatient diagnostics – *prior authorization required. The following are subject to copayment: MRI, MRA, CAT, CTA, PET, SPECT scans*	No Charge OR $200 Copayment	Deductible & Coinsurance Deductible & Coinsurance
Allergy Services		
Office visits/testing	OV Copayment	Deductible & Coinsurance
Injections – *80 visits in 3 years*	$25 Copayment	Deductible & Coinsurance
HOSPITAL CARE – Prior authorization required	**In-Network**	**Out-of-Network**
Semi-private room *(General/Medical/Surgical/Maternity)*	HSP Copayment	Deductible & Coinsurance
Skilled nursing facility – *up to 120 days per calendar year*	HSP Copayment	Deductible & Coinsurance
Rehabilitative services – *up to 60 days per calendar year*	No Charge	Deductible & Coinsurance
Outpatient surgery – *in a hospital or surgi-center*	OS Copayment	Deductible & Coinsurance
EMERGENCY CARE	**In-Network**	**Out-of-Network**
Walk-in centers	OV Copayment	Deductible & Coinsurance
Urgent care centers – *at participating centers only*	UR Copayment	Not Covered
Emergency care – *copayment waived if admitted*	ER Copayment	ER Copayment
Ambulance	No Charge	No Charge
OTHER HEALTHCARE	**In-Network**	**Out-of-Network**
Outpatient rehabilitative services – *30 visit maximum for PT, OT, and SLP per year. 20 visit maximum for Chiro. per year*	OV Copayment	Deductible & Coinsurance
Durable medical equipment / Prosthetic devices – *Unlimited maximum per calendar year*	No Charge OR 20%	Deductible & Coinsurance
Infertility Services (diagnosis and treatment)	Not Covered	Not Covered
Home HealthCare	No Charge	$50 Deductible & 20% Coinsurance

KEY: Office Visit (OV) Copayment; Emergency Room (ER) Copayment; Urgent Care (UR) Copayment; Hospital (HSP) Copayment; Outpatient Surgery (OS) Copayment

PREVENTIVE CARE SCHEDULES

Well Child Care (including immunizations)
- 6 exams, birth to age 1
- 6 exams, ages 1 – 5
- 1 exam every 2 years, ages 6 – 10
- 1 exam every year, ages 11 – 21

Adult Exams
- 1 exam every 5 years, ages 22 – 29
- 1 exam every 3 years, ages 30 – 39
- 1 exam every 2 years, ages 40 – 49
- 1 exam every year, ages 50+

Mammography
- 1 baseline screening, ages 35 – 39
- 1 screening per year, ages 40+

Vision Exams
- 1 exam every 2 calendar years

Hearing Exams
- 1 exam per calendar year

OB/GYN Exams
- 1 exam per calendar year

FIGURE 8.2 Example of Range of PPO Benefits for a Popular Plan

columns in Figure 8.2. This encourages people insured by PPOs to use in-network physicians, other medical providers, and hospitals.

Health Maintenance Organizations

A health maintenance organization (HMO) is licensed by the state. For its lower costs, the HMO has the most stringent guidelines and the narrowest choice of providers. Its members are assigned to primary care physicians and must use network

providers to be covered, except in emergencies. In an *open-panel HMO*, any physician who meets the HMO's standards of care may join the HMO as a provider. These physicians usually operate from their own offices and see non-HMO patients. In a *closed-panel HMO*, the physicians are either HMO employees or belong to a group that has a contract with the HMO.

Health maintenance organizations were originally designed to cover all basic services for an annual premium and visit copayments. This arrangement is called "first-dollar coverage" because no deductible is required and patients do not make out-of-pocket payments. Because of expenses, however, HMOs may now apply deductibles to family coverage, and employer-sponsored HMOs are beginning to replace copayments with coinsurance for some benefits. HMOs have traditionally emphasized preventive and wellness services as well as disease management.

An HMO is organized around a business model. The model is based on how the terms of the agreement connect the provider and the plan. In all, however, enrollees must see HMO providers in order to be covered.

Staff Model

In a staff HMO, the organization employs physicians. All the premiums and other revenues come to the HMO, which in turn pays the physicians' salaries. For medical care, patients visit clinics and health centers owned by the HMO.

Group (Network) Model

A group (network) HMO contracts with more than one physician group. In some plans, HMO members receive medical services in HMO-owned facilities from providers who work only for that HMO. In others, members visit the providers' facilities, and the providers can also treat nonmember patients.

The practices under contract are paid a per member per month (PMPM) capitated rate for each subscriber assigned to them for primary care services. Practices may hire other providers to handle certain services, such as laboratory tests. The other providers work under a **subcapitation** agreement (a PMPM that covers their services) or an **episode-of-care (EOC) option,** which is a flat fee for all services for a particular treatment. For example, an EOC fee is established for coronary bypass surgery or hip replacement surgery; the fixed rate per patient includes preoperative and postoperative treatment as well as the surgery itself. If complications arise, additional fees are usually paid.

subcapitation arrangement by which a capitated provider prepays an ancillary provider

episode-of-care (EOC) option flat payment by a health plan to a provider for a defined set of services

Independent Practice Association Model

An **independent (or individual) practice association (IPA)** type of HMO is an association formed by physicians with separately owned practices who contract together to provide care for HMO members. An HMO pays negotiated fees for medical services to the IPA. The IPA in turn pays its physician members, either by a capitated rate or a fee. Providers may join more than one IPA and usually see nonmember patients.

independent (or individual) practice association (IPA) HMO in which physicians are self-employed and provide services to members and nonmembers

Point-of-Service (POS) Plans

A point-of-service (POS) plan is a hybrid of HMO and PPO networks. Members may choose from a primary or secondary network. The primary network is HMO-like, and the secondary network is often a PPO network. Like HMOs, POS plans charge an annual premium and a copayment for office visits. Monthly premiums are slightly higher than for HMOs but offer the benefit of some coverage for visits to nonnetwork physicians for specialty care. A POS may be structured as a tiered plan, for example, with different rates for specially designated providers, regular participating providers, and out-of-network providers.

COMPLIANCE GUIDELINE

Termination of Patients

HMOs and POSs regulate a primary care physician's decision to terminate a relationship with a patient. The PCP must first ask the payer for permission to do so, and must then send a certified letter to the patient, who must sign and return it. The PCP must provide emergency care until the patient has a new PCP.

Indemnity Plans

Indemnity plans require premium, deductible, and coinsurance payments. They typically cover 70 to 80 percent of costs for covered benefits after deductibles are met. Some plans are structured with high deductibles, such as $5,000 to $10,000, in order to offer policyholders a relatively less expensive premium. Many have some managed care features because payers compete for employers' contracts and try to control costs.

BILLING TIP

POS: Two Meanings

POS for claims means place of service; POS relating to health plans means point of service.

Medical Home Model

medical home model care plans that emphasize primary care with coordinated care involving communications among the patient's physicians

A growing number of payers have developed plans that seek to improve patient care by rewarding primary care physicians for coordinating patients' treatments. Called **medical home model** (or *patient-centered medical home model*) plans, these are intended to replace illness-based primary care with coordinated care that emphasizes communications among the patient's physicians. The primary care physician is responsible for arranging a patient's visits to specialists and for proactively planning and managing care.

Payment models vary. As one example, a state program to manage care for children is based on a fee-for-service contract with a physician that is supplemented by a per member per month payment. Generally, medical home model plans are *risk adjusted*—that is, the primary care physician is paid more for sicker or older patients than for healthy ones.

THINKING IT THROUGH 8.3

1. Why is it important for medical insurance specialists to be able to determine the type of plan a patient has?

8.4 Consumer-Driven Health Plans

Consumer-driven (or consumer-directed) health plans (CDHPs) combine two components: (1) a high-deductible health plan and (2) one or more tax-preferred savings accounts that the patient (the "consumer") directs. The two plans work together: The high-deductible health plan covers catastrophic losses, and the savings account pays out-of-pocket or noncovered expenses. (Note that some payers refer to these plans simply as "high-deductible plans.")

CDHPs empower consumers to manage their use of healthcare services and products. Experts in the healthcare industry believe that people who pay medical expenses themselves will be more careful about how their dollars are spent. CDHPs eliminate most copayment coverage and shift responsibility for managing the dollars in the savings accounts to individuals. Therefore, people will research medical issues and make informed choices. For the CDHP approach to work, then, consumers must be able to find accurate healthcare information. Companies (and health plans) meet this need by providing explanations of common medical conditions and treatments. Companies also have web-based tools to compare cost estimates for in-network or out-of-network visits and for drug prices. CDHPs encourage people to seek routine well-care benefits.

Table 8.2 Comparisons of CDHP Funding Options

Health Reimbursement Account	Health Savings Account
Contributions from employer	Contributions from individual (regardless of employment status), employer, or both
Rollovers allowed within employer-set limits	Unused funds roll over indefinitely
Portability allowed under employer's rules	Funds are portable (job change; retirement)
Tax-deductible deposits	Tax-deductible deposits
Tax-free withdrawals for qualified expenses	Tax-free withdrawals for qualified expenses
	Tax-free interest can be earned
Flexible Savings (Spending) Account	
Contributions from employer and/or employee	
Unused funds revert to employer	
No portability	
Tax-advantaged deposits	
Tax-free withdrawals for qualified expenses	

The High-Deductible Health Plan

The first part of a CDHP is a **high-deductible health plan (HDHP),** usually a PPO. The annual deductible is more than $1,000. Many of the plan's covered preventive care services, as well as coverage for accidents, disability, dental care, vision care, and long-term care, are not subject to this deductible.

high-deductible health plan (HDHP) health plan that combines high-deductible insurance and a funding option to pay for patients' out-of-pocket expenses up to the deductible

The Funding Options

Three types of CDHP funding options (Table 8.2) may be combined with high-deductible health plans to form consumer-driven health plans.

Health Reimbursement Accounts

A **health reimbursement account (HRA)** is a medical reimbursement plan set up and funded by an employer. HRAs are usually offered to employees with health plans that have high deductibles. Employees may submit claims to the HRA to be paid back for out-of-pocket medical expenses. For example, an employee may pay a health plan deductible, copayments, coinsurance, and any medical expenses not covered by the group health plan and may then request reimbursement from the HRA. If the employer authorizes this approach, funds in the account that are left at the end of the benefit period can roll over to the next year's HRA.

health reimbursement account (HRA) consumer-driven health plan funding option that requires an employer to set aside an annual amount for healthcare costs

Health Savings Accounts

The most popular type of account is the **health savings account (HSA)** that also is designed to pay for qualified medical expenses of individuals who have high-deductible health plans (HDHPs) and are under age sixty-five.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added a section to the Internal Revenue Service (IRS) tax code to permit HSAs. An HSA is a savings account created by an individual. Employers that wish to encourage employees to set up HSAs offer a qualified high-deductible health plan to go with it. Both employee and employer can contribute to the HSA. The IRS sets the maximum amount that can be saved each year. The IRS also sets the maximum out-of-pocket spending under HSA-compatible high-deductible health plans.

health savings account (HSA) consumer-driven health plan funding option under which funds are set aside to pay for certain healthcare costs

The HSA money can be held in an account by an employer, a bank, or a health plan. This holder is referred to as a "custodian" for the account. The federal government decides the limit on the amount of the contribution that is tax sheltered, just as it does for IRAs.

HSAs do not have to be used up at the end of a year. Instead, the account can roll over from year to year and be taken along by an employee who changes jobs or retires. HSAs can earn tax-free interest and can be used for nonmedical purposes after age sixty-five.

Flexible Savings (Spending) Accounts

flexible savings (spending) account (FSA) consumer-driven health plan funding option that has employer and employee contributions

Some companies offer **flexible savings (spending) accounts (FSAs)** that augment employees' other health insurance coverage. Employees have the option of putting pretax dollars from their salaries in the FSA; they can then use the fund to pay for certain medical and dependent care expenses. The permitted expenses include cost-sharing (deductibles, copayments, coinsurance), medical expenses that are not covered under the regular insurance plan (such as routine physical examinations, eyeglasses, and many over-the-counter medical supplies), and child care. Employers may contribute to each employee's account.

The FSA may be used in one of two ways. In some companies, the employee has to file a claim with the plan after paying a bill. For example, the employee may submit a receipt from a drugstore for a prescription or an Explanation of Benefits (EOB) from the health plan that shows that the patient, not the plan, paid the bill. In the other way, the company gives the employee a credit or debit card to use to pay the bills as they occur, and the employee is responsible for keeping records that prove that the expenses were in the "permitted" category.

The disadvantage of an FSA as compared with an HSA is that unused dollars go back to the employer under the "use it or lose it" rule at the end of the year. Employees must try to predict their year's expenses to avoid either overfunding or underfunding the account. For this reason, HSAs are growing in popularity.

Billing Under Consumer-Driven Health Plans

Consumer-driven health plans reduce providers' cash flow because visit copayments are being replaced by high deductibles that may not be collected until after claims are paid. As more employer-sponsored plan members are covered under CDHPs, physician reimbursement up to the amount of the deductible will come from the patient's funding option and, if there is not enough money there, out of pocket. CDHP payment works as follows:

- The group health plan establishes a funding option (HRA, HSA, FSA, or some combination) designed to help pay out-of-pocket medical expenses.
- The patient uses the money in the account to pay for qualified medical services.
- The total deductible must be met before the HDHP pays any benefits.
- Once the deductible is met, the HDHP covers a portion of the benefits according to the policy. The funding option can also be used to pay the uncovered portion.

Following is an example of payments under a CDHP with an HSA fund of $1,000 and a deductible of $1,000. The HDHP has an 80-20 coinsurance. The plan pays the visit charges as billed.

Office visits for the patient:

First visit charge	$150	$150 paid from HSA (leaving a balance in the fund of $850)
Second visit charge	$450	$450 paid from HSA (leaving a balance in the fund of $400)

Third visit charge	$600	$400 paid from HSA (emptying the HSA fund) $160 paid by the HDHP (the balance of $200 on the charge × 80%) $40 coinsurance to be paid by the patient (the balance of $200 × 20%)

For medical practices, the best situation is an integrated CDHP in which the same plan runs both the HDHP and the funding options. This approach helps reduce paperwork and speed payment. For example, if an HSA is run by the same payer as the HDHP, a claim for charges is sent to the payer. The payer's remittance advice states what the plan and the patient are each responsible for paying. If payment is due from the patient's HSA, that amount is withdrawn and paid to the provider. If the patient's deductible has been met, the plan pays its obligation.

BILLING TIP

CDHP Enrollment

Most enrollees in consumer-driven healthcare are in plans that build on insurance carriers' existing provider network and negotiated rates.

Another popular payment method is a credit or a debit card provided by the plan. The patient can use it to pay for health-related expenses up to the amount in the fund. The cards may be preloaded with the member's coverage and copayment data.

Educating patients about their financial responsibility before they leave encounters, extending credit wisely, and improving collections are all key to avoiding uncollectible accounts under CDHPs.

THINKING IT THROUGH 8.4

1. Why do payers consider consumer-driven health plans desirable? Do you agree with the rationale that payers use to support such plans?

8.5 Major Private Payers and the BlueCross BlueShield Association

A small number of large insurance companies dominate the national market for commercial insurance and offer employers all types of health plans, including self-funded plans. Local or regional payers are often affiliated with a national plan or with the BlueCross BlueShield Association. Private payers supply complete insurance services, such as:

- Contracting with employers and with individuals to provide insurance benefits
- Setting up physician, hospital, and pharmacy networks
- Establishing fees
- Processing claims
- Managing the insurance risk

Many large insurers own specialty companies that have insurance products in related areas. They may handle behavioral health, dental, vision, and life insurance. Many also work as federal government contractors for Medicare and Medicaid programs and handle prescription management divisions.

Major Payers and Accrediting Groups

The major national payers are listed below. Note that the BlueCross BlueShield Association (BCBS), which has both for-profit and nonprofit members, is not a payer; it is an association of more than forty payers. Its national scope, however, means that knowing about its programs is important for all medical insurance specialists.

- *WellPoint, Inc.:* WellPoint is one of the nation's largest health insurers. It is also the largest owner of BlueCross BlueShield plans (see the discussion of the BlueCross BlueShield Association below).
- *UnitedHealth Group:* UnitedHealth Group is another large health insurer that runs plans under its UnitedHealthcare subsidiary and owns other major regional insurers.
- *Aetna:* With more than 44 million members, Aetna has a full range of products, including healthcare, dental, pharmacy, group life, behavioral health, disability, and long-term care benefits.
- *CIGNA Health Care:* CIGNA is a large health insurer with strong enrollment in the Northeast and the West.
- *Kaiser Permanente:* The largest nonprofit HMO, Kaiser Permanente is a prepaid group practice that offers both healthcare services and insurance in one package. It runs physician groups, hospitals, and health plans in western, midwestern, and southeastern states plus Washington, D.C.
- *Health Net:* Health Net operates health plans in the West and has group, individual, Medicare, Medicaid, and TRICARE programs.
- *Humana Inc.:* Humana is particularly strong in the South and Southeast. It offers both traditional and consumer-driven products. Humana handles TRICARE operations in the Southeast.
- *Coventry:* Coventry Health Care is a national managed healthcare company based in Bethesda, Maryland, operating health plans, insurance companies, network rental/managed care services companies, and workers' compensation services companies. It provides a full range of risk and fee-based managed care products and services.

Outside agencies accredit and rate private payers. The major accrediting organizations are summarized in Table 8.3. Industry groups such as the National Association of Insurance Commissioners also monitor payers.

BILLING TIP

Pay for Performance

BCBS is often a leader in efforts to improve healthcare. One example is **pay-for-performance (P4P)** programs that have financial incentives like bonuses for excellence in such performance measures as the NCQA HEDIS rating. See Table 8.3.

pay-for-performance (P4P) health plan financial incentives program based on provider performance

BlueCross BlueShield Association

BlueCross BlueShield Association (BCBS) national healthcare licensing association

Founded in the 1930s to provide low-cost medical insurance, the **BlueCross BlueShield Association (BCBS)** is a national organization of independent companies and a federal employee program that insures nearly 100 million people and a number of nonprofit companies. All offer a full range of health plans, including consumer-driven health plans, to individuals, small and large employer groups, senior citizens, federal government employees, and others. In addition to major medical and hospital insurance, the "Blues" also have freestanding dental, vision, mental health, prescription, and hearing plans.

Table 8.3 Plan Accrediting Organizations

- *National Committee for Quality Assurance (NCQA):* An independent nonprofit organization, NCQA is the leader in accrediting HMOs and PPOs. Working with the healthcare industry, NCQA developed a group of performance measures called HEDIS (Health Plan Employer Data and Information Set). HEDIS provides employers and consumers with information about each plan's effectiveness in preventing and treating disease, about policyholders' access to care, about documentation, and about members' satisfaction with care. NCQA's guidelines on the process by which plans select physicians and hospitals to join their networks, called **credentialing,** include performance measures. NCQA requires plans to review the credentials of all providers in their plans every two years to ensure that the providers continue to meet appropriate standards of professional competence.
- *Utilization Review Accreditation Commission (URAC):* URAC, also known as the American Accreditation Healthcare Commission, is another leading accrediting group. Like NCQA, it is a nonprofit organization that establishes standards for managed healthcare plans. URAC has accreditation programs addressing both the security and privacy of health information as required by HIPAA.
- *The Joint Commission (TJC, formerly the Joint Commission on Accreditation of Healthcare Organizations or JCAHO):* TJC sets and monitors standards for many types of patient care. TJC is made up of members from the American College of Surgeons, the American College of Physicians, the American Medical Association, the American Hospital Association, and the American Dental Association. TJC verifies compliance with accreditation standards for hospitals, long-term care facilities, psychiatric facilities, home health agencies, ambulatory care facilities, and pathology and clinical laboratory services. TJC works with NCQA and the American Medical Accreditation Program to coordinate the measurement of the quality of healthcare across the entire healthcare system.
- *American Medical Accreditation Program (AMAP):* AMAP helps alleviate the pressures facing physicians, health plans, and hospitals by reducing cost and administrative effort and simultaneously documenting quality. As a comprehensive program, AMAP measures and evaluates individual physicians against national standards, criteria, and peer performance in five areas: credentials, personal qualifications, environment of care, clinical performance, and patient care.
- *Accreditation Association for Ambulatory Health Care, Inc. (AAAHC):* AAAHC has accredited managed care organizations for more than twenty years. Its program emphasizes an assessment of clinical records, enrollee and provider satisfaction, provider qualifications, utilization of resources, and quality of care.

credentialing periodic verification that a provider or facility meets professional standards

Subscriber Identification Card

Because BCBS offers local and national programs through many individual plans, subscriber identification cards are used to determine the type of plan under which a person is covered. Most BCBS cards list the following information:

Plan name

Type of plan (A PPO in a suitcase is the logo for BCBS PPO members; the empty suitcase is the logo for Traditional, POS, or HMO members).

Subscriber name

Subscriber identification number (the subscriber's Social Security number has been replaced with a unique ID) that can be a total of seventeen characters, a three-position alphabetic prefix that identifies the plan, and fourteen alphanumeric characters

Effective date of coverage

BCBS plan codes and coverage codes

Participation in reciprocity plan with other BCBS plans

Copayments, coinsurance, and deductible amounts

Information about additional coverage, such as prescription medication and mental healthcare

Blues Companies

www.bcbs.com/listing/index.html

Information about preauthorization requirements

Claim submission address

Contact phone numbers

Types of Plans

An indemnity BCBS plan has an individual and family deductible and a coinsurance payment. Individual annual deductibles may range from as little as $100 to as much as $2,500 or more. The family deductible is usually twice the amount of the individual deductible. Once the deductible has been met, the plan pays a percentage of the charges, usually 70, 80, or 90 percent, until an annual maximum out-of-pocket amount has been reached. After that, the plan pays 100 percent of approved charges until the end of the benefit year. At the beginning of the new benefit year, the out-of-pocket amount resets, and 100 percent reimbursement does not occur until the out-of-pocket maximum for the new year has been met. Once the cap has been met, charges by nonparticipating providers are paid at 100 percent of the allowed amount. If the charges exceed the allowed amount, the patient must pay the balance to the provider, even though the annual cap has been met.

BILLING TIP

BCBS Participation

Participating providers in BCBS plans are often called member physicians.

BCBS plans also offer many types of managed care programs, including the following:

- *HMO:* A patient must choose a primary care physician who is in the BCBS network. HMO has an Away From Home Care Program that provides emergency room coverage if the subscriber needs care when traveling. Many BCBS plans also have a Guest Membership through the Away From Home Care Program. A Guest Membership is a courtesy enrollment for members who are temporarily residing outside of their home HMO service area for at least ninety days.
- *POS:* Members of a POS plan may receive treatment from a provider in the network, or they may choose to see a provider outside the network and pay a higher fee. Depending on the particular plan, a patient may or may not have a primary care provider.
- *PPO:* Physicians and other healthcare providers sign participation contracts with BCBS agreeing to accept reduced fees in exchange for membership in the network. As network members, providers are listed in a provider directory and receive referrals from other network members. PPO subscribers have the PPO on their Blue ID cards. A patient may choose to see a network provider or, for higher fees, a nonnetwork provider.

BlueCard Program

BlueCard program that provides benefits for subscribers who are away from their local areas

The **BlueCard** program is a nationwide program that makes it easy for patients to receive treatment when outside their local service area and also for a provider to receive payment when treating patients enrolled in plans outside the provider's service area. The program links participating providers and independent BCBS plans throughout the nation with a single electronic claim processing and reimbursement system. It works as follows:

1. A subscriber who requires medical care while traveling outside the service area presents the subscriber ID card to a BCBS participating provider.
2. The provider verifies the subscriber's membership and benefit coverage by calling the BlueCard eligibility number. Only the required copayment can be collected; the provider cannot ask the patient to pay any other fees.

3. After providing treatment, the provider submits the claim to the local BCBS plan in his or her service area, which is referred to as the **host plan.**
4. The host plan sends the claim via modem to the patient's **home plan** (the plan in effect when the patient is at home), which processes the claim and sends it back to the host plan.
5. The host plan pays the provider according to local payment methods, and the home plan sends the remittance advice. For example, if a subscriber from New Jersey requires treatment while traveling in Delaware, the provider in Delaware can treat the patient, file the claim, and collect payment from the Delaware plan.

host plan participating provider's local BlueCross BlueShield plan

home plan BlueCross BlueShield plan in the subscriber's community

Flexible Blue Plan

BlueCross BlueShield companies also offer a consumer-driven health plan called **Flexible Blue.** This plan combines a comprehensive PPO plan with either an HSA, an HRA, or a FSA. Also parts of the CDHP are online decision-support resources.

Flexible Blue BlueCross BlueShield consumer-driven health plan

THINKING IT THROUGH 8.5

1. Given the many different insurance plans with which medical insurance specialists work, what do you think are the most important items of information that should be available about a plan?
2. Review the PPO plan benefits shown in Figure 8.2 on page 284. How would you summarize the rules for in-network versus out-of-network preventive care? Medical care? Is preauthorization needed for in-network hospital care?

8.6 Participation Contracts

Providers, like employers and employees, must evaluate health plans. They judge which plans to participate in based primarily on the financial arrangements that are offered. Because managed care organizations are the predominant healthcare delivery systems, most medical practices have a number of contracts with plans in their area. See Figure 8.3 for the notice of participation posted in an orthopedic specialty.

BILLING TIP

Participation

Most physicians participate in more than twenty health plans.

Contract Provisions

When a practice's contract evaluation team is considering a participation contract, an experienced medical insurance specialist may be asked to assist. A practice manager or a committee of physicians usually leads the team; an outside attorney typically reviews the contract as well. The managed care organization's business history, accreditation standing, and licensure status are reviewed.

The major question to be answered is whether participation in the plan is a good financial opportunity. All plans pay less than the physicians' fees schedules, so there is less revenue for each procedure. Some plans pay very low fees, and even gaining many more patients who have this plan may not make participation profitable. The evaluation team checks the fees the plan pays for the CPT codes that the practice's providers most often bill. If the plan reduces payment for these services too much, the evaluation team may decide not to join even though doing so would bring in more patients.

Other aspects of the plan, such as its medical necessity guidelines, are also considered. Some physicians do not accept certain plans because, in their view, complying with the plans' healthcare protocols will limit their professional medical judgment in treating patients.

Welcome to Newton Major Orthopedic Associates, PC

In order to make your visit as pleasant as possible, we have compiled a list of the most commonly asked questions regarding insurance and billing in this office.

With which insurance plans does NMOA participate?

Aetna/US Healthcare Plans
CIGNA
Blue Choice PPO: POS, PPO, Prestige, Select
Focus Workers Compensation PPO
Health Care Value Management, Inc.
Health Choice
Health Direct
Kaiser Permanente
Medicare
Medicaid
MedSpan
MD Health Plan
Oxford Health Plan
Physician Health Services
Prudential Healthcare
POS Plan
Wellcare

What can I expect if NMOA participates with my insurance?

We will file a claim with your insurance company for any charges. Your insurance may require you to pay a copay at the time of services. You are responsible for any deductibles and non-covered services. You may need to obtain a referral from your primary care physician. Failure to obtain a referral may result in rescheduling of your appointment until you can obtain one.

What can I expect if NMOA does not participate with my insurance?

Payment is expected at the time of service. You will receive a statement within two weeks. Use it to file a claim. As a courtesy, NMOA will submit any surgery claims to your insurance carrier, but you are responsible for payment.

FIGURE 8.3 Example of Practice Participation List

The main parts of participation contracts are the following:

- Introductory section (often called "recitals" and "definitions")
- Contract purpose and covered medical services
- Physician's responsibilities
- Managed care plan obligations
- Compensation and billing guidelines

Introductory Section

The introductory section is important because it lists the names of the contracting parties and defines the terms used in the contract. Often the contract mentions that the provider's manual is part of the agreement and is to be referred to for specific points. The section also states the ways the plan may use participating physicians' names. Some plans wish to provide lists of participating physicians to plan members. Other plans, however, want to use the providers' names in newspaper, radio, or television advertisements.

This section also specifically indicates who the payer is, such as "First Health Plan, a federally qualified health maintenance organization," or "Golden Gate Insurance Company, a stock company." Payer information must be noted so that claims will be sent to the correct organization. For example, although a self-funded health plan may create the plan, a third-party administrator (TPA) may be responsible for processing and paying claims.

Contract Purpose and Covered Medical Services

Because MCOs offer multiple products—HMO, PPO, POS, CDHP, and fee-for-service options—a contract may be for one or several of these products. The contract should state the type of plan and the medical services to be provided to its members. In addition to office visits and preventive medical services, which are usual, obstetrician-gynecologist, behavioral health, physical and occupational therapy, emergency and urgent care, and diagnostic laboratory services may be covered.

BILLING TIP

No Copay for Preventive Care

Waiving copays for preventive services is a leading trend in both CDHP and traditional plans.

Under a capitation plan, the exact covered services (with a list of CPTs) included in the cap rate should appear. For example, when a provider gives a patient an MMR (measles, mumps, and rubella virus) vaccine, two fees are involved: one for giving the injection (called the administration of the immunization) and a second for the dosage of the vaccine itself. Under a capitated primary care contract, the covered medical services provisions state whether both the fee for injecting vaccines and the cost of injectable materials are included in the cap rate, or just the immunization administration.

BILLING TIP

Withdrawing from a Contract

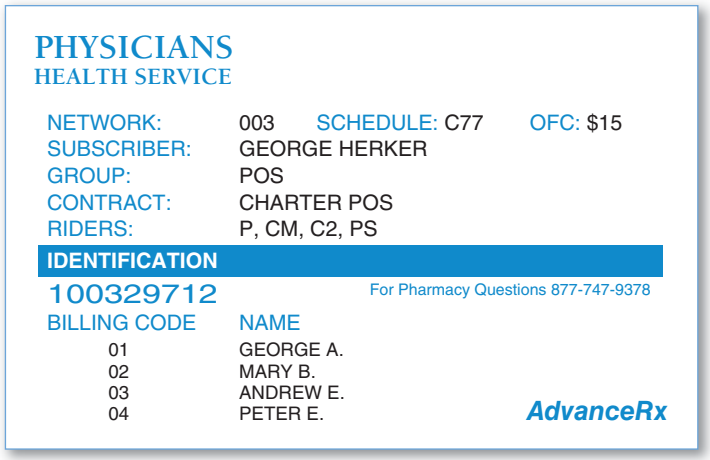
Most participation contracts require physicians to notify patients if the physicians withdraw from the patients' managed care organization.

Physician's Responsibilities

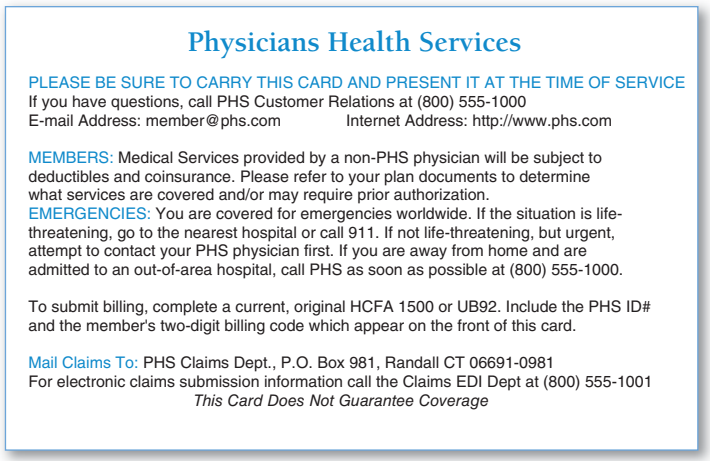
The physician's responsibilities under the plan include the following:

- *Covered services:* The contract should stipulate the services that the provider must offer to plan members.
- *Acceptance of plan members:* The contract states whether providers must see all plan members who wish to use their services or some percentage or specific number of members. For example, capitated plans often require primary care physicians to accept at least a certain number of patients who are enrolled in the plan. If treating this number of patients means that the plan's enrollees will make up a large part of the practice, providers must decide whether the plan's payment structure is high enough before agreeing to participate.
- *Referrals:* This part of the contract states whether providers must refer patients only to other participating providers. It also covers the conditions under which the referral rules do not apply, such as in an emergency.
- *Preauthorization:* If the provider is responsible for securing preauthorization for the patient, as is the case in most HMOs, this is stated.
- *Quality assurance/utilization review:* Providers typically must agree to allow access to certain records for the payer's quality assurance and utilization review (QA/UR) activities. **Utilization review** refers to the payer's process for determining medical necessity—whether the review is conducted before or after the services are provided.
- *Other provisions:* Providers' credentials, health plan protocols, HIPAA Privacy policies, record retention, and other guidelines from the payer's medical review program are covered.

utilization review payer's process for determining medical necessity



Front



Back

FIGURE 8.4 Example of an Insurance Card for a POS Plan

Managed Care Plan Obligations

Managed care plan obligations include the following:

- *Identification of enrolled patients:* The plan's method of identifying enrolled patients should be specified. Usually, this is with an identification card like the one shown in Figure 8.4. In this example, the provider network, the schedule of benefits, the office visit copayment, the name of the policyholder, the group, the type of contract, the patient's identification number, and the patient's dependents are listed.
- *Payments:* A claim turnaround time is specified in the contract. This tells how long it will take for a physician to be paid for services.
- *Other compensation:* This indicates whether any incentives, bonuses, and withholds apply.
- *Protection against loss:* If the provider is assuming financial risk for the cost of care, as happens under capitation, the contract should have a **stop-loss provision.** This clause limits the provider's costs if there is an unexpectedly high use of services. Stop-loss provisions state a dollar amount over which the provider will be repaid.

stop-loss provision
protection against large losses or severely adverse claims experience

Under plans in which providers must refer patients only to other participating providers, the providers' compliance is evaluated by the plan, and incentives or bonuses may be tied to how well a provider observes the referral rules. For this

reason, a stated obligation of the plan should be to provide and regularly update the list of participating providers so that providers are sure they are referring their patients correctly.

BILLING TIP

List All NPIs

The contract should list the NPIs (National Provider Identifiers) of all practitioners who will bill under it, not only the NPI for the practice itself.

Compensation and Billing Guidelines

The compensation and billing guidelines cover fees, billing requirements, claim filing deadlines, patients' financial responsibilities, and balance-billing rules. The rules for collecting patients' payments are described, as are how to coordinate benefits when another plan is primary. The contract should also state how far back in time a plan is permitted to go for refunds of overpayments or incorrect payments.

THINKING IT THROUGH 8.6

1. In what section of a participation contract is each of the following phrases located?

   A. Physician has accurately completed the Participating Physician Credentialing Application that accompanies this agreement and has been accepted by the Plan. Physician shall promptly notify Plan of any change in this information, including any change in its principal place of business, within seven days of such change.

   _____

   B. "Members" means enrollees or enrolled dependents covered by a Plan benefit agreement.

   _____

   C. Physician agrees to accept the Plan fee schedule or physician's billed charges, whichever is less, as payment in full for all medical services provided to members.

   _____

   D. Physician agrees to allow review and duplication of any data free of charge and other records maintained on members that relate to this agreement.

   _____

   E. Plan agrees to provide current identification cards for members.

   _____

   F. Plan shall deduct any copayments and deductible amounts required by the Plan benefit agreement from the allowed payment due Physician under this agreement.

   _____

   G. Plan intends, by entering into this agreement, to make available quality healthcare to Plan members by contracting with Physician. Physician intends to provide such care in a cost-effective manner.

   _____

8.7 Interpreting Compensation and Billing Guidelines

Participation contracts other than for capitated plans often state the basis for the payer's allowed amounts. A payer may base allowed amounts on a percentage of the Medicare Physician Fee Schedule (MPFS) or a discounted fee-for-service arrangement.

BILLING TIP

When the MPFS Is the Base

If a payer's fee schedule is based on the Medicare Physician Fee Schedule, the contract should state which year's MPFS is going to be used.

Compiling Billing Data

Practices generally bill from their normal fee schedules rather than billing the contracted fees, even if they are known. Writing off the differences between normal fees and payments under the participation contract is done when the RA is processed. Billing this way permits the practice to track how much revenue it loses by participating in a particular contract, which is valuable information for future contract negotiations.

Physician's Fee Schedule for CPT 99211	$25
Contract Fee for Participating Providers (PARs) for CPT 99211	18
Loss of Revenue per Visit for CPT 99211	7
Service Performed × 500 Visits Annually	
Annual Lost Revenue for This CPT Code	3,500

A record of lost revenue per each commonly billed CPT code can be kept. To negotiate higher fees, a practice may compare the difference in payer accounts over a year for its commonly billed procedures and use this comparison when negotiating contract renewal and reviewing fee schedules.

BILLING TIP

Increasing Covered Services

Keep a record of services that were not paid over a year's billing period. This record provides a basis for negotiating a revised contract in order to cover more services.

BILLING TIP

Payment for New Procedures

Payment policy for a new procedure may be announced by a payer. If the practice performs this procedure, it should notify its other PAR plans that this procedure will be reported for payment in the future and should request their allowed charge and any other regulations for payment.

Billing for No-Shows

The contract determines whether a participating provider can charge a patient for a product used to set up a procedure when the patient cancels. Often, a physician may bill only for a rendered service, not for a service that is not delivered, including cancellations and no-shows. In nonparticipating situations, have patients agree in writing to pay before scheduling procedures. Follow the practice's financial policy for billing for no-shows or cancellations.

BILLING TIP

Prompt-Payment Discounts

Payers may offer prompt payment in return for larger-than-contracted fees. Acceptance of these offers for expedited review and payment is a matter of practice policy.

COMPLIANCE GUIDELINE

Avoid Price Fixing

Office of Inspector General (OIG) rules prohibit practices from discussing pricing and rates with other practices.

Collecting Copayments

Required copayment(s) vary according to payer. Some plans require a copayment only when an evaluation and management (E/M) service is provided, and others require it when the patient visits an office for any procedure or service. Copayment amounts may also vary according to the service performed. Some plans have different copayment amounts for office visits, emergency room visits, ambulance services, and preventive services. When two services, such as an E/M service and a billable procedure, are performed on the same date of service, either one or two copayments may be required, again depending on the payer.

Another variable in collecting copayments involves primary and secondary plans. Medical insurance specialists should verify whether a copayment is to be collected under the secondary plan. Usually it is not, unless the primary plan does not cover the service or if the member is satisfying a deductible for the primary plan.

The payer's rules about copayment calculations also need to be understood. Most plans require the patient's copayment to be subtracted from the amount due to the provider from the payer. This treats the copayment like a deductible or coinsurance payment. The contract (or provider's manual) states the policy in terms such as "All member copayments, deductibles, and coinsurance apply." (The word *apply* means that they should be taken into account when the payer calculates the balance due to the provider.)

The plan is a PPO that pays 75 percent of the provider's usual charge. A $5 copayment is due, and the copayment is applied toward the provider payment.

Provider's usual charge	$100.00
Payer allowed fee ($100 × 75%)	$ 75.00
Patient copay subtracted	$ 5.00
Payer pays	$ 70.00
Provider collects a total of	$ 75.00

Note that a few plans, though, do not deduct the patient's copayment from the usual charge. Instead, the plan has a lower allowed fee for the service, so often the provider collects the same amount in the end. For example:

The plan is a PPO that pays 70 percent of the provider's usual charge. A $5 copayment is due to the provider as well.

Provider's usual charge	$100.00
Payer allowed fee ($100 × 70%)	$ 70.00
Patient copay collected	$ 5.00
Payer pays	$ 70.00
Provider collects a total of	$ 75.00

Both approaches are acceptable. The rules must be clear to the medical insurance specialist for correct calculations of the expected payment from the payer.

COMPLIANCE GUIDELINE

Collect Copays

The practice is obligated to follow payer copayment guidelines. Routinely waiving copays and deductibles may be fraudulent under participation contracts. This should be stated in the financial policy that patients are given.

BILLING TIP

State Prohibition of Silent PPOs

A number of states (California, Illinois, Louisiana, Minnesota, North Carolina, Oklahoma, and Wisconsin) prohibit silent PPOs, and state insurance commissions in other states may be considering such laws.

Avoiding Silent PPOs

Silent PPOs—also called *network-sharing agreements*—occur when a managed care organization leases its PPO provider network list to another entity, such as a smaller PPO, so the other entity can take advantage of the discounts negotiated by the original PPO. This can cause a practice to accept a PAR payment for a service to a patient who is not enrolled in a plan in which it participates. In most cases, the physician is led to believe that the discount is legitimate. Most experts recommend trying to negotiate a phrase in participation contracts stating that the MCO cannot lease any terms of the agreement—including the physician's discounted services—or assign benefits to another payer.

silent PPOs MCO that purchases a list of participating providers and pays their enrollees' claims according to the contract's fee schedule despite the lack of a contract

precertification preauthorization for hospital admission or outpatient procedures

BILLING TIP

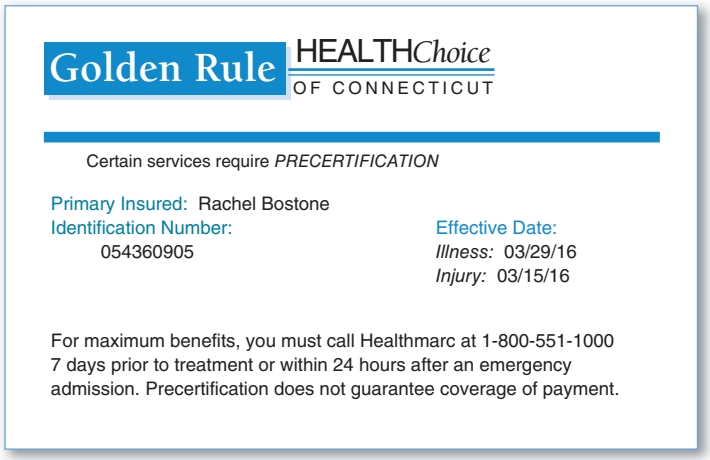
The Term Precertification

Precertification ("precert") is another term for preauthorization. It is usually applied to hospital admissions and outpatient surgery. Both terms have the same meaning.

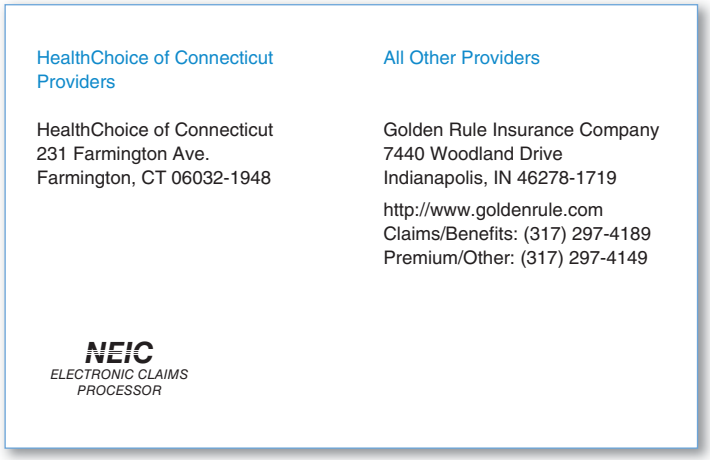
Billing Surgical Procedures

elective surgery nonemergency surgical procedure

Most managed care plans have rules for authorizing emergency surgical procedures and elective surgery. Emergency surgery usually must be approved within a specified period, such as forty-eight hours, after admission was required. **Elective surgery** is a procedure that can be scheduled ahead of time, but which may or may not be medically necessary. It usually requires preauthorization during a specified period before the service is performed. The preauthorization requirement is usually shown on the patient's insurance card (see Figure 8.5). The practice must send a completed preauthorization form or online application for review in advance of the admission. See Figure 8.6 on page 301 for an example of a precertification form.



Front



Back

FIGURE 8.5 Example of an Insurance Card Showing Precertification Requirement

PRECERTIFICATION FORM

Insurance carrier _____

Certification for [ ] admission and/or [ ] surgery and/or [ ] _____

Patient name _____

Street address _____

City/state/zip _____

Telephone _____ Date of birth _____

Subscriber name _____

Employer _____

Member no. _____ Group no. _____

Admitting physician _____

Provider no. _____

Hospital/facility _____

Planned admission/procedure date _____

Diagnosis/symptoms _____

Treatment/procedure _____

Estimated length of stay _____

Complicating factors _____

Second opinion required [ ] Yes [ ] No If yes, [ ] Obtained

Corroborating physician _____

Insurance carrier representative _____

Approval [ ] Yes [ ] No If yes, certification no. _____

If no, reason(s) for denial _____

FIGURE 8.6 Precertification Form for Hospital Admission or Surgery

Some elective surgical procedures are done on an inpatient basis, so the patient is admitted to the hospital; others are done on an outpatient basis. The following are common outpatient surgeries:

- Abdominal hernia
- Bunionectomy
- Carpal tunnel
- Destruction of cutaneous vascular proliferative lesions
- Knee arthroscopy
- Otoplasty
- Sclerotherapy

For a major course of treatment, such as surgery, chemotherapy, and radiation for a patient with cancer, many private payers use the services of a **utilization review organization (URO).** The payer hires the URO to evaluate the medical

utilization review organization (URO) organization hired by a payer to evaluate medical necessity

Case number: G631000
Procedure: Axillary node dissection

Dear Patient:

As you may know, ABC is a utilization review company that contracts with insurance companies, managed care organizations, and self-insured groups to review the healthcare services provided to people covered under their medical plans and to make recommendations regarding the medical necessity and efficiency of these healthcare services. ABC is not an insurer, and does not make eligibility, benefit, or coverage decisions.

We have received information about the procedure scheduled for 08/12/2016 at Downtown Hospital. Based on review of this information, we find this outpatient procedure to be medically necessary and efficient.

If the treatment plan is changed, or if admission to the hospital is necessary, please contact your insurance company immediately.

ABC's recommendation is not a decision regarding payment of a particular claim. Your medical plan payer is responsible for making final payment and eligibility decisions. Any questions about a claim, deductible, or copayment should be directed to your medical plan.

Sincerely,

ABC Reviewer
Medical Care Coordinator

cc: George Ballister, MD
Downtown Hospital

FIGURE 8.7 Example of Letter from Utilization Review Organization

necessity of planned procedures. When a provider (or a patient) requests preauthorization for a treatment plan, the URO issues a report of its findings. As shown in Figure 8.7, the patient and provider are both notified of the results. If the planned services are not covered, the patient should agree to pay for them before the treatment begins.

BILLING TIP

Out-of-Network Services

Many plans require preauthorization for out-of-network services even though they are covered under the plan.

THINKING IT THROUGH 8.7

1. Read the following referral policy for a payer's HMO plan and answer the questions that follow.

Referral Policy

The following points are important to remember regarding referrals:

- The referral is how the member's PCP arranges for a member to be covered for necessary, appropriate specialty care and follow-up treatment.
- The member should discuss the referral with his or her PCP to understand what specialist services are being recommended and why.
- If the specialist recommends any additional treatments or tests that are covered benefits, the member needs to get another referral from his or her PCP prior to receiving the services. If the member does not get another referral for these services, the member may be responsible for payment.
- Except in emergencies, all hospital admissions and outpatient surgery require a prior referral from the member's PCP and prior authorization by the plan.
- If it is not an emergency and the member goes to a doctor or facility without a referral, the member must pay the bill.
- In plans without out-of-network benefits, coverage for services from non-participating providers requires prior authorization by the plan in addition to a special nonparticipating referral from the PCP. When properly authorized, these services are fully covered, less the applicable cost-sharing.
- The referral provides that, except for applicable cost-sharing, the member will not have to pay the charges for covered benefits, as long as the individual is a member at the time the services are provided.

A. In plans with out-of-network benefits, under what three circumstances does this HMO plan require referrals from the plan member's primary care provider (PCP)?

B. What two approvals are needed for nonemergency hospital admissions and outpatient surgery?

C. If the plan does not have out-of-network benefits:

(1) Is it possible for a plan member to be covered for services from non-participating providers?

(2) What must the plan member do to secure coverage?

(3) What charges apply?

8.8 Private Payer Billing Management: Plan Summary Grids

Organizing job aids, such as the plan summary grid described below, and following the steps of the billing cycle will provide answers to these essential questions:

- What services are covered under the plan? What conditions establish medical necessity for these services? Are these correctly coded and linked?
- Which services are not covered?
- What are the plan's billing rules—the bundling and global periods?
- What is the patient responsible for paying at the time of the encounter and after adjudication?

plan summary grid quick-reference table for health plans

Medical insurance specialists organize each plan's benefit and payment information for easy access. For each participation contract and employer, a **plan summary grid** should be prepared or updated. The grid summarizes key items from the contract, such as the payers' names and plans, patient financial responsibility (copayments; which services are subject to deductibles), referral and preauthorization requirements, covered and noncovered services, billing information, and participating labs. Some offices use a form like the one in Figure 8.8.

Other key information includes:

- The major code edits for bundled procedures and services
- The global follow-up times for major and minor surgical procedures
- The policies for multiple procedure reimbursement (whether the payer fully reimburses multiple procedures performed on the same date of service or pays fully for the first service only and pays the rest at a reduced percentage)

PAYER NAME_____
PLAN NAME _____
PLAN TYPE (PPO, HMO, FFS, OTHER)_____
PAYER WEBSITE_____

PARTICIPATION CONTRACT ACTIVE DATE?_____
Provider Customer Service Phone Contact to check benefits, eligibility, claim status, request verification_____
Correspondence, Claim Appeals, and Reconsiderations to:_____

REQUIRED FACILITIES AND PREAUTHORIZATION FOR: YES NO
Referrals: In Network _____
Out-of-Network_____
Imaging:
CT Scans _____
MRA Scans _____
MRI Scans _____
Nuclear Cardiology Studies_____
PET Scans _____
Other _____

Participating Labs _____
Hospital Admission _____
Known Excluded Services _____

PATIENT FINANCIAL RESPONSIBILITY
Copayments: Office Visit _____
Well Care, age birth to ____ Amount:_____
Well Care, age _____ to _____ Amount:_____
Labs Covered in Office _____
Outside Labs_____
Deductible
No _____Yes____Amount_____Collect Before or After Service?_____
CDHP Plan?
No _____Yes____Amount_____Collect Before or After Service?_____
Coinsurance
No _____Yes____Amount_____Collect Before or After Service?_____
Excluded Services Collect Before or After Service?_____

CLAIMS
Electronic Payer ID: _____
Paper Claims to:

Timely Filing: _____

FIGURE 8.8 Plan Summary Grid

- Verification procedures
- Documentation requirements, such as special reports for unlisted procedure codes or the name of the serum, the dosage, and the route of administration for immunizations
- Appeal procedures

The practice management program (PMP) is also updated with each payer's name and contact information, the plan type, and payment information.

278 Referral and Authorization

The HIPAA 278 Referral and Authorization is the electronic format used to obtain approval for preauthorizations and referrals.

BILLING TIP

Consult Versus Referral

Plans often have forms that misuse the terms *refer* and *consult.* A consultation occurs when a physician, at the request of another physician, examines the patient and reports an opinion to the requestor. Under a referral, care (a portion or all) is transferred to another physician. However, a plan's referral form may in fact be the correct one to use when consultation is required. This usage should be clarified with the plan.

THINKING IT THROUGH 8.8

1. Read the following preauthorization policy from a typical PPO plan and answer the questions that follow:

   Preauthorization is the process of collecting information prior to inpatient admissions and selected ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage, and communication with the physician and/or member. It also allows the PPO to coordinate the member's transition from the inpatient setting to the next level of care (discharge planning), or to register members for specialized programs like disease management, case management, or maternity management programs. In some instances, preauthorization is used to inform physicians, members, and other healthcare providers about cost-effective programs and alternative therapies and treatments.

   Certain healthcare services require preauthorization under this plan. When a service requires preauthorization, the provider is responsible to preauthorize those services prior to treatment. However, if the patient's plan covers self-referred services to network providers or self-referrals to out-of-network providers, and the patient is able to self-refer for covered benefits, it is the member's responsibility to contact the plan to preauthorize those services.

   A. What does the plan state are the purposes of preauthorization?

   B. In your own words, define *self-refer.*

   C. Under what circumstances is it the patient's responsibility to obtain preauthorization approval?

8.9 Preparing Correct Claims

The first seven steps of the standard medical billing cycle are followed to complete correct claims and transmit them to private payers. Study the steps below. (Chapters 13 and 14 cover the last three steps of the cycle for private payers, covering adjudication and RA, appeals, and patient billing and collections.)

Step 1. Preregister Patients

The general guidelines apply to the preregistration process for private health plan patients: Collect and enter basic demographic and insurance information.

Step 2. Establish Financial Responsibility for Visits

The initial information for a new patient's plan is taken from the patient's information form (PIF). Changes in insurance coverage for established patients are noted on an update to the PIF.

Verify Insurance Eligibility

Based on the copies of insurance cards, contact the payer to double-check that the patient is eligible for services. Be sure to accurately enter the patient's name and ID number as it appears on the card.

BILLING TIP

Lab Requirements

Practices should post a notice to patients stating that if patients do not tell them about their plans' lab requirements and the specimen is sent to the wrong lab, the practice is not responsible for the costs.

The payer ID and logo on the insurance card identify the payer. If the card lists multiple PPOs and is not clear, contact the payer to select the correct payer for that patient. If the provider is a primary care physician and the plan requires registration of a PCP, the insurance card often lists the correct provider's name.

Check Coverage

Depending on the type of practice, coverage for some of the following services may need to be specifically verified:

- Office visits
- Lab coverage (note that many managed care organizations specify which laboratory must be used for tests)
- Diagnostic X-rays
- Pap smear coverage
- Coverage of psychiatric visits, including the number of visits covered and the coinsurance for each
- Physical or occupational therapy
- Durable medical equipment (DME)
- Foot care

270/271 Eligibility for Benefits Transaction

The HIPAA 270/271 Eligibility for a Health Plan transaction (the inquiry from the provider and the response from the payer) is the electronic format used to verify benefits.

A patient with a self-funded health plan may have an ID card with a familiar plan to which claims should be sent. But that plan is handling the claims processing only; it is not providing the insurance. Do not assume that the patient's coverage is the same as it is for members of that health plan. Locate the actual name of the self-insured plan to verify eligibility and check benefits (for example, Lehigh Portland Cement or Tufts).

Coordinate Benefits

Next, determine the primary plan for the patient by following the guidelines on page 96. Under coordination of benefits provisions, if the patient has signed an assignment of benefits statement, the provider is responsible for reporting any additional insurance coverage to the primary payer. Review the PIF to determine whether the patient has secondary or supplemental coverage that should be reported on the primary payer's claim.

Meet Preauthorization/Referral Requirements

Additionally, check for and meet the payer's preauthorization and/or referral requirements. Referrals and preauthorizations are examples of the provider's contractual

requirement to give the plan notice of services performed. In most cases, payers require data that support clinical necessity if a required preauthorization was not obtained according to plan guidelines.

BILLING TIP

Unbundling

Unbundling for private payers can be complex. Each payer establishes its own billing guidelines, and therefore the definition of *unbundling* can change from payer to payer. Best practice is to require that payers spell out all billing guidelines in participation contracts.

Out-of-Network Billing

Providers that do not participate in patients' plans tell patients this before their encounters and inform them of their responsibility to pay for services they will receive.

If the patient does not have out-of-network benefits, many practices collect either a deposit or full payment at the time of service. In this case, the provider's regular fee schedule is used to calculate the amount due.

However, what fee schedule applies if the patient has out-of-network medical and surgical benefits under a plan? Three of four people covered by group health plans have this option. In this situation, the plan has a role in determining the charge. Often plans have hired a **repricer,** a service company that sets up fee schedules and discounts.

repricer vendor that processes a payer's out-of-network claims

In 2008, however, consumer advocates charged that the plans' prices are routinely set too high—causing patients to pay more than they should under their cost-sharing policy. The health plans and repricers had based the fees on "reasonable and customary" calculations using amounts supplied by Ingenix, Inc. These fees are set too low, it was argued, so that the amount the provider balance-billed to patients was very high. For example, assume a plan pays 80 percent of the out-of-network charge. If the provider charges $100 for an office visit, but the Ingenix schedule says the visit is worth only $50, the plan pays its 80 percent of that fee, or $40, and the patient is balance-billed for $60.

A 2009 court settlement between UnitedHealth Group, the insurer that is the parent company of Ingenix, and the attorney general of the state of New York has altered this situation. UnitedHealth Group has agreed to use a new database for determining out-of-network payments. Likewise, more than a dozen insurance companies have agreed to use this new database. The new database has been set up by a nonprofit company named FAIR **(Fair and Independent Research)** Health Inc. and is available online. Plan beneficiaries as well can use the database to check prices before receiving services.

FAIR (Fair and Independent Research) Health nonprofit company that sets up a database that beneficiaries can use to check prices of healthcare services

Another issue that affects billing is some plans' practice of paying their members directly for out-of-network claims they receive from providers. Medical insurance specialists must be aware of the applicable state laws and contract language. When this is payers' practice or state law, upfront collections are even more important.

Step 3. Check In Patients

Be sure that the correct copayment has been collected from the patient for the planned service. For example, if the plan summary grid for the patient's plan lists an office visit copay and that is the nature of the encounter, collect the copay and post it to the patient's account.

FAIR Health
www.fairhealthus.org/

Step 4. Review Coding Compliance

Verify that the diagnosis and procedure codes are current as of the date of service. Check that the codes are properly linked and documented, showing the medical necessity for the services.

Step 5. Check Billing Compliance

Using the plan summary grid, verify that all charges planned for the claim are billable.

Step 6. Check Out Patients

Based on the encounter information, update the practice management program to reflect the appropriate diagnoses, services, and charges. Analyze the patient's financial responsibility, according to the practice's financial policy, for:

- Deductibles, especially in consumer-driven health plans
- Payment for noncovered services
- Balance due from previous encounters

Apply collected payments to the patient's account and provide a receipt for payment.

BILLING TIP

Payer Instructions May Vary

The NUCC instructions do not address any particular payer. Best practice for paper claims is to check with each payer for specific information required on the form.

Step 7. Prepare and Transmit Claims

Participating providers submit claims to payers on behalf of patients; nonparticipating providers may elect to do this as well. Private payer claims are completed using either the HIPAA 837P claim or the CMS-1500 paper claim. CMS-1500 general completion guidelines are described in Table 7.3 on pages 255–256. and shown in Figure 8.9 on page 309. Claims must be submitted according to the plan's guidelines for timely filing. The filing deadline is based on the date of service on the claim, not the sent or received date.

BILLING TIP

Audits

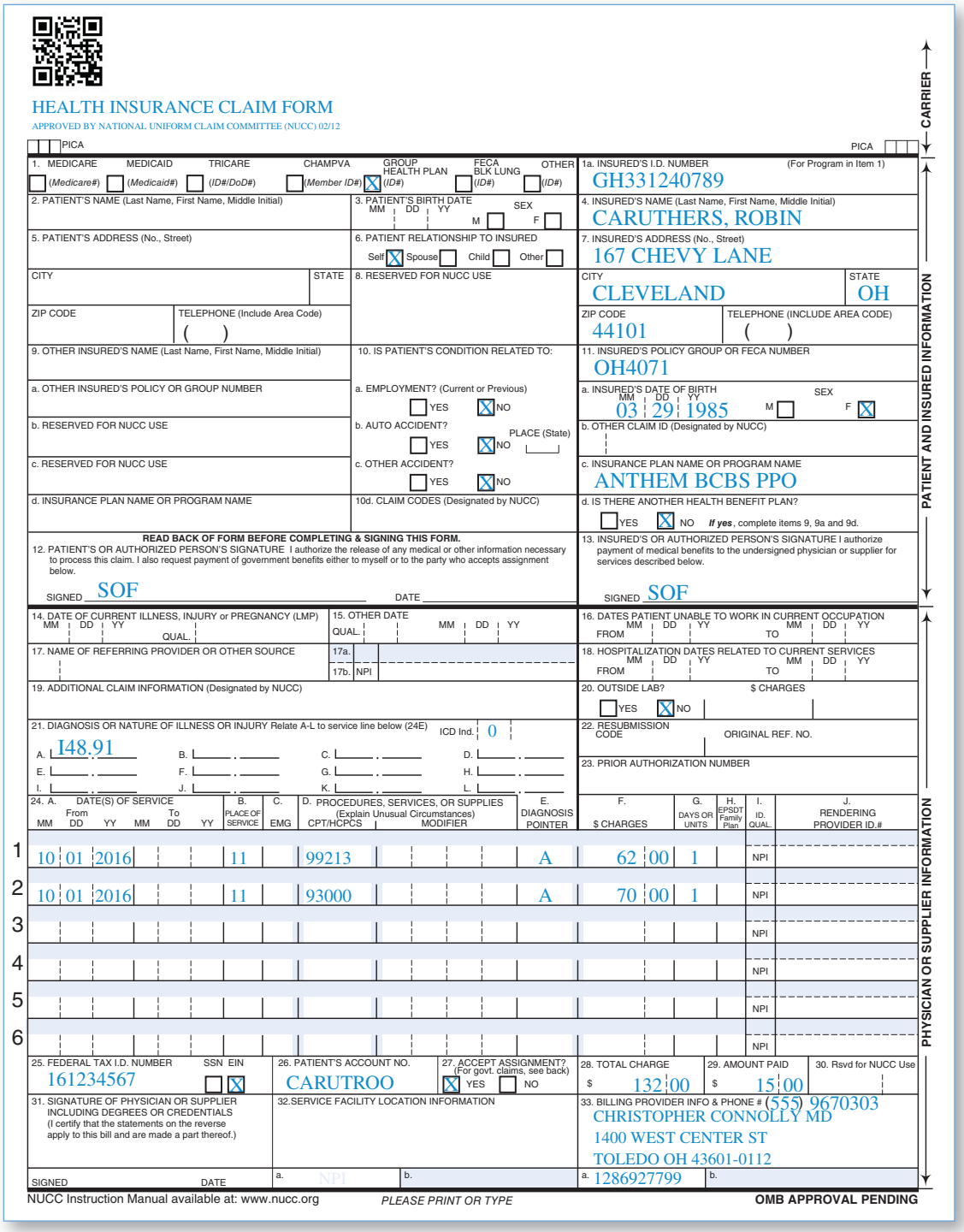
Internal claim audits before transmission are the best way to check claims. During this review, a staff member other than the claim preparer checks the claim's coding and billing compliance for the payer.

Following are some claim preparation tips:

- *Taxonomy codes:* The participation contract may state that certain specialties receive higher rates for various procedures. For example, if a pediatrician is board certified in pediatric cardiology, the correct taxonomy code—either for pediatrician or for pediatric cardiology—would be reported with the associated service.
- *Identifying numbers:* Supply the appropriate NPIs and check with the payer for any other required numbers.
- *Contract information:* The participation contract may require a contract-type code, contract amount, contract percent, contract code, discount percent, or contract version identifier.
- *Description of services for modifiers 22 and 23:* Many plans require a complete description of the services including supporting documentation when these modifiers are used.

The plan's claim submission guidelines are also followed. Contact the payer representative to clarify the procedure for claim attachments or other points.

(Note: Steps 8, 9, and 10 are covered in Chapters 13 and 14.)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) [X] FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): GH331240789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY; SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): CARUTHERS, ROBIN

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 167 CHEVY LANE

CITY | STATE

8. RESERVED FOR NUCC USE

CITY: CLEVELAND | STATE: OH

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE: 44101 | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: OH4071

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 03 29 1985; SEX M F [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: ANTHEM BCBS PPO

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO [X] *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SOF DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SOF

14. DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. I48.91 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID.#
1 10 01 2016		11		99213		A	62 00	1		NPI	
2 10 01 2016		11		93000		A	70 00	1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 161234567 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: CARUTROO

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO

28. TOTAL CHARGE: $ 132 00

29. AMOUNT PAID: $ 15 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PHONE # (555) 9670303

CHRISTOPHER CONNOLLY MD

1400 WEST CENTER ST

TOLEDO OH 43601-0112

a. 1286927799 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

OMB APPROVAL PENDING

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

FIGURE 8.9 CMS-1500 (02/12) Completion for Private Payers

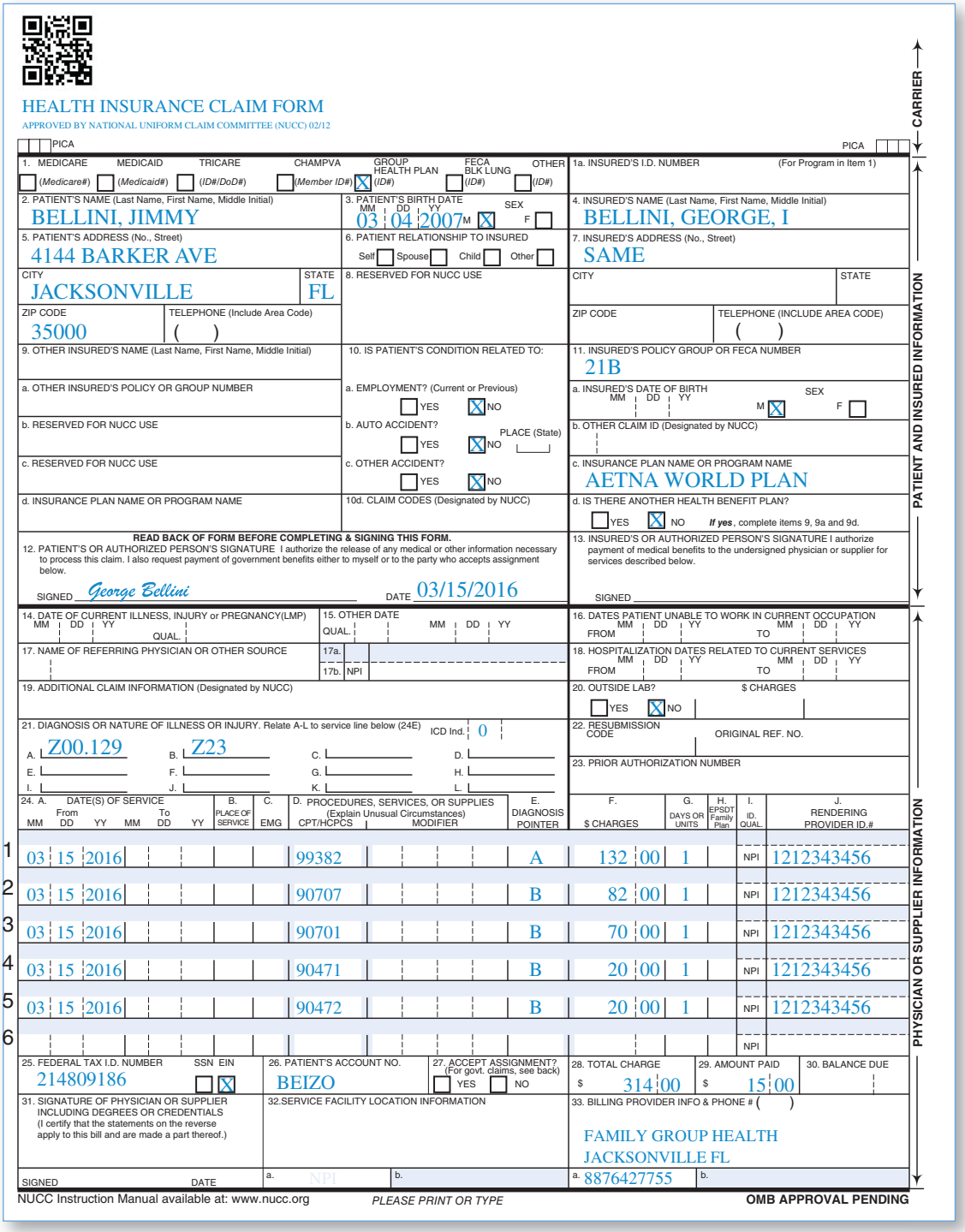
BILLING TIP

Secondary Claims and Coordination of Benefits

In covering steps 8, 9, and 10 of the medical billing cycle, Chapters 13 and 14 discuss processing RAs/EOBs, secondary claims, coordination of benefits, and appeals for private payers.

Communications with Payers

Good communication between payers and the medical insurance staff is essential for effective contract and claim management. As claims are processed, questions and requests for information go back and forth between the practice staff and the payer's claim processing group. When claims are long overdue or there are repeated difficulties, however, these problems are the responsibility of the payer's provider representatives.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) [X] FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BELLINI, JIMMY

3. PATIENT'S BIRTH DATE: 03 04 2007 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): BELLINI, GEORGE, I

5. PATIENT'S ADDRESS (No., Street): 4144 BARKER AVE

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY: JACKSONVILLE STATE: FL

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 35000 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 21B

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA WORLD PLAN

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED George Bellini DATE 03/15/2016

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY or PREGNANCY(LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. Z00.129 B. Z23 C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID.#
1 03 15 2016				99382		A	132 00	1		NPI	1212343456
2 03 15 2016				90707		B	82 00	1		NPI	1212343456
3 03 15 2016				90701		B	70 00	1		NPI	1212343456
4 03 15 2016				90471		B	20 00	1		NPI	1212343456
5 03 15 2016				90472		B	20 00	1		NPI	1212343456
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 214809186 [X]

26. PATIENT'S ACCOUNT NO.: BEIZO

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 314 00

29. AMOUNT PAID $ 15 00

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PHONE # ( )

FAMILY GROUP HEALTH

JACKSONVILLE FL

a. 8876427755 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

OMB APPROVAL PENDING

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

FIGURE 8.10 Claim for Thinking It Through 8.9

To avoid major problems, many practices routinely meet with payers to address the practice's specific problems and questions. A meeting should also be held when a new participation contract is signed to discuss the payer's major guidelines, fee schedule, and medical record documentation requirements.

THINKING IT THROUGH 8.9

1. Audit the private-payer primary claim shown in Figure 8.10 on page 310. What problems do you find in the preparation of the claim? List the item number and the problem or question you would raise.

Item No.	Problem/Question
A.	_____
B.	_____
C.	_____
D.	_____
E.	_____
F.	_____

8.10 Capitation Management

When the practice has a capitated contract, careful attention must be paid to patient eligibility, referral requirements, encounter reports, claim write-offs, and billing procedures.

Patient Eligibility

Under most capitated agreements with primary care physicians, providers receive monthly payments that cover the patients who chose them as their PCPs for that month. The **monthly enrollment list** that the plan sends with the payment should list the current members. This list, also called a "provider patient listing" or "roster," contains patients' names, identification numbers, dates of birth, type of plan or program, and effective date of registration to the PCP.

monthly enrollment list document of eligible members of a capitated plan for a monthly period

At times, however, the list is not up-to-date. To be sure that the patient is eligible for services, the insurance coverage is always verified.

Referral Requirements

An HMO may require a PCP to refer a patient to an in-network provider or to get authorization from the plan to refer a patient to an out-of-network provider. Patients who self-refer to nonparticipating providers may be balance-billed for those services. Both PCPs and specialists may be required to keep logs of referral activities.

Encounter Reports and Claim Write-offs

Most HMOs require capitated providers to submit encounter reports for patient encounters. Some do not require regular procedural coding and charges on the reports; the payer's form may just list "office visit" to be checked off. However, some plans do require the use of a regular claim with CPT codes.

The practice management program (PMP) is set up so that charges for service under capitated plans are written off as an adjustment to the patient's account. The billing staff knows not to expect additional payment based on a claim for a capitated-plan patient. If the service charges were not written off, the PMP would double-count

the revenue for these patient encounters—once at the beginning of the month when the capitated payment was entered for a patient, and then again when a claim was created for a patient who has had an encounter during the month. Thus, the regular charges for the services that are included in the cap rate are written off by the biller. Only the monthly capitated payment remains on the patient's account—unless the patient has incurred charges beyond those items.

Billing for Excluded Services

Under a capitated contract, providers bill patients for services not covered by the cap rate. Medical insurance specialists need to organize this information for billing. For example, a special encounter form for the capitated plan might list the CPTs covered under the cap rate and then list the CPTs that can be billed. The plan's summary grid should indicate the plan's payment method for the additional services to be balance-billed, such as discounted fee-for-service.

THINKING IT THROUGH 8.10

1. Refer to the description of services covered under a PCP's cap rate on page 221. Under this agreement, would the provider be permitted to bill the patient for a flu shot? A Pap test? A PSA test?

Chapter Summary

Learning Objective	Key Concepts/Examples
8.1 Compare employer-sponsored and self-funded health plans. Pages 278–280	Employer-sponsored health plans: • Employers organize plans to provide healthcare benefits to employees. • Insurance coverage is purchased from an insurance carrier or managed care organization. • Group health plans are subject to state laws for coverage and payment. Self-funded health plans: • Employers also organize plans, but the employers insure the plan's members themselves rather than buying insurance coverage. • Employers often hire third-party administrators and have administrative-services–only contracts for tasks such as subscriber enrollment and claim processing. • Federal ERISA law rather than by state law controls plans.
8.2 Describe the major features of group health plans regarding eligibility, portability, and required coverage. Pages 280–282	Group health plans: • Establish and regulate health plans for employees. • Decide on basic plan coverage and optional riders; eligibility requirements; and premiums and deductibles. • Must observe federal COBRA and HIPAA laws to ensure portability and coverage as required.
8.3 Discuss provider payment under the various private payer plans. Pages 283–286	• Preferred provider organizations (PPOs) pay providers under a discounted fee-for-service structure. • In health maintenance organizations (HMOs) and point-of-service (POS) plans, the payment may be a salary or capitated rate, depending on the business model. • Indemnity plans basically pay from the physician's fee schedule.

Learning Objective	Key Concepts/Examples
8.4 Contrast health reimbursement accounts, health savings accounts, and flexible savings (spending) accounts. Pages 286–289	Consumer-driven health plans use three types of funding options for out-of-pocket expenses: • A health reimbursement account (HRA) is set up by an employer to give tax-advantaged funds for employees' expenses. • Health savings accounts (HSAs) and flexible savings (spending) accounts (FSAs) both can be funded by employees and employers on a tax-advantaged basis. • HSA funds can be rolled over and taken by the individual to another job or into retirement, like an IRA; FSAs do not roll over.
8.5 Discuss the major private payers. Pages 289–293	A small number of large insurance companies dominate the national market: • WellPoint, Inc. • UnitedHealth Group • Aetna • CIGNA Health Care • Kaiser Permanente • Health Net • Humana Inc. • Coventry BlueCross BlueShield Association (BCBS): • BCBS is the national organization of independent companies called member plans that insure nearly 100 million people. • BCBS offers the BlueCard program and the Flexible Blue plan.
8.6 Analyze the purpose of the five main parts of participation contracts. Pages 293–297	Participation contracts have five main parts: 1. The introductory section provides the names of the parties to the agreement, contract definitions, and the payer. 2. The contract purpose and covered medical services section lists the type and purpose of the plan and the medical services it covers for its enrollees. 3. The third section covers the physician's responsibilities as a participating provider. 4. The fourth section covers the plan's responsibilities toward the participating provider. 5. The fifth section lists the compensation and billing guidelines, such as fees, billing rules, filing deadlines, patients' financial responsibilities, and coordination of benefits.
8.7 Describe the information needed to collect copayments and bill for surgical procedures under contracted plans. Pages 298–303	• Under participation contracts, most plans require copayments to be subtracted from the usual fees that are billed to the plans. • To bill for elective surgery requires precertification (also commonly called preauthorization) from the plan. • Providers must notify plans about emergency surgery within the specified timeline after the procedure.
8.8 Discuss the use of plan summary grids. Pages 303–305	• Plan summary grids list key information about each contracted plan and provide a shortcut reference for the billing and reimbursement process. • Grids include information about collecting payments at the time of service and completing claims.
8.9 Prepare accurate private payer claims. Pages 305–311	These seven steps of the medical billing cycle are followed to prepare correct claims: 1. The general guidelines apply to the preregistration process for private health plan patients when basic demographic and insurance information is collected. 2. The financial responsibility for the visit is established by verifying insurance eligibility and coverage with the payer for the plan, coordinating benefits, and meeting preauthorization requirements.

Learning Objective	Key Concepts/Examples
	3. Copayments are collected before the encounter. 4. Coding compliance is checked, verifying the use of correct codes as of the date of service that show medical necessity. 5. Billing compliance with the plan's rules is checked. 6. Any other payments due at the end of the encounter, such as deductible, charges for noncovered services, and balances due, are collected according to the practice's financial policy. 7. Claims are completed, checked, and transmitted in accordance with the payer's billing and claims guidelines.
8.10 Explain how to manage billing for capitated services. Pages 311–312	• Under capitated contracts, medical insurance specialists verify patient eligibility with the plan because enrollment data are not always up-to-date. • Encounter information, whether it contains complete coding or just diagnostic coding, must accurately reflect the necessity for the provider's services.

Review Questions

Match the key terms with their definitions.

_____ 1. **LO 8.10** monthly enrollment list

_____ 2. **LO 8.7** precertification

_____ 3. **LO 8.1** rider

_____ 4. **LO 8.4** high-deductible health plan

_____ 5. **LO 8.1** carve out

_____ 6. **LO 8.7** utilization review organization

_____ 7. **LO 8.8** plan summary grid

_____ 8. **LO 8.5** home plan

_____ 9. **LO 8.6** stop-loss provision

_____ 10. **LO 8.7** elective surgery

A. Payer preauthorization for elective hospital-based services and outpatient surgeries

B. Insurance plan, usually a PPO, that requires a large amount to be paid before benefits begin; part of a consumer-driven health plan

C. Quick-reference table for health plans

D. Part of a standard health plan that is changed under a negotiated employer-sponsored plan

E. Document of eligible members of a capitated plan registered with a particular PCP for a monthly period

F. Document that modifies an insurance contract

G. Surgical procedure that can be scheduled in advance

H. In a BlueCard program, the provider's local BCBS plan

I. A company hired by a payer to evaluate the appropriateness and medical necessity of hospital-based healthcare services

J. Contractual guarantee against a participating provider's financial loss due to an unusually large demand for high-cost services

Select the letter that best completes the statement or answers the question.

_____ **1.** **LO 8.1** The largest employer-sponsored health program in the United States is
- **A.** Medicare
- **B.** Medicaid
- **C.** Federal Employees Health Benefits program
- **D.** workers' compensation

_____ **2.** **LO 8.1** In employer-sponsored health plans, employees may choose their plan during the
- **A.** carve out
- **B.** open enrollment period
- **C.** contract period
- **D.** birthday rule period

_____ **3.** **LO 8.2** Which laws govern the portability of health insurance?
- **A.** ERISA and HIPAA
- **B.** COBRA and HIPAA
- **C.** PPO and HMO
- **D.** FEHB and ERISA

_____ **4.** **LO 8.1** Self-funded health plans are regulated by
- **A.** PHI
- **B.** PPO
- **C.** FEHB
- **D.** ERISA

_____ **5.** **LO 8.5** BlueCross BlueShield Association member plans offer
- **A.** all major types of health plans
- **B.** indemnity plans only
- **C.** PPOs only
- **D.** HMOs only

_____ **6.** **LO 8.7** Emergency surgery usually requires
- **A.** a deductible paid to the hospital or clinic
- **B.** precertification (preauthorization) within a specified time after the procedure
- **C.** a referral before the procedure
- **D.** a maximum benefit limit

_____ **7.** **LO 8.3** Providers who participate in a PPO are paid
- **A.** a capitated rate
- **B.** a discounted fee-for-service
- **C.** an episode-of-care payment
- **D.** according to their usual physician fee schedule

_____ **8.** **LO 8.3** Under a capitated HMO plan, the physician practice receives
- **A.** an encounter report
- **B.** precertification for services
- **C.** a monthly enrollment list
- **D.** a secondary insurance identification number

_____ **9.** **LO 8.6** What document is researched to uncover rules for private payers' definitions of insurance-related terms?
- **A.** ERISA
- **B.** participation contract
- **C.** HIPAA Security Rule
- **D.** rider

_____ **10.** **LO 8.4** Consumer-driven health plans have what effect on a practice's cash flow?
- **A.** A high-deductible payment from the patient takes longer to collect than does a copayment.
- **B.** The health plan's payment arrives faster than under other types of plans.
- **C.** There is no effect on cash flow.
- **D.** The effect is the same as the effect of a capitated plan.

Answer the following questions.

1. List the five main parts of participation contracts.

   A. **LO 8.6**

   _____

   _____

   _____

   _____

   _____

2. List the seven steps of the medical billing cycle that lead to completion of correct private payer claims.

   Step 1 **LO 8.9** _____

   Step 2 **LO 8.9** _____

   Step 3 **LO 8.9** _____

   Step 4 **LO 8.9** _____

   Step 5 **LO 8.9** _____

   Step 6 **LO 8.9** _____

   Step 7 **LO 8.9** _____

Applying Your Knowledge

Case 8.1 Abstracting Insurance Information

LO 8.7, 8.8 Based on the following notes, fill out the precertification form on page 317 for Betty Sinowitcz.

Encounter Data: 5/4/2016
Patient: Elizabeth R. Sinowitcz
Date of Birth: 8/2/1943
Address: 45 Maple Hill Road, Apt. 12-B, Rangeley, MN 55555
Home Telephone: 555-123-9887
Employer: Argon Electric Company, 238 Industry Way, Rangeley, MN 55554

Betty is on Medicare. She also has insurance coverage through Argon Electric in the Horizon PPO. Her insurance card shows her member number as 65-PO; no group number is shown.

Betty was referred to Dr. Hank R. Ferrara, a Horizon-participating ophthalmologist (PIN 349-00-G), for evaluation of her blurred and dimmed vision. After conducting an examination and taking the necessary history, Dr. Ferrara diagnoses the patient's condition as a cortical age-related cataract of the left eye that is close to mature (ICD -10-CM H25.012). Dr. Ferrara decides to schedule Betty for lens extraction; the procedure is ambulatory care surgery with same-day admission and discharge. The procedure will be done at Mischogie Hospital's Outpatient Clinic on 5/10/2016. Horizon PPO requires precertification for this procedure (CPT 66984).

Case 8.2 Applying Insurance Rules

Jan Wommelsdorf, of Fargo, North Dakota, was on vacation in Portland, Oregon, when she became ill. She has BCBS BlueCard insurance, so she telephoned the BlueCard toll-free number to find a provider near her in Portland. She was examined by Dr. Vijay Sundaram and provided a special diet to follow until she returns home and visits her regular physician.

A. **LO 8.5** Who submits the claim, Jan Wommelsdorf or Dr. Sundaram?

B. **LO 8.5** Is the claim submitted to Jan's local BCBS plan in North Dakota or to Dr. Sundaram's local plan in Oregon?

Case 8.3 Calculating Insurance Math

A. A physician's usual fee for a routine eye examination is $80. Under the discounted fee-for-service arrangement the doctor has with Plan A, the fee is discounted 15 percent for Plan A members. This month, the doctor has seen five Plan A members for routine eye exams.

1. **LO 8.6, 8.7** What is the physician's usual fee for the five patients?
2. **LO 8.6, 8.7** What will the physician be paid for one Plan A member's exam?
3. **LO 8.6, 8.7** What will the physician be paid for the five Plan A eye exams?

B. Using this fee schedule for three different payers for orthopedic procedures, complete the questions that follow.

Code	Description	BCBS	United	Medicare
29871	Knee arthroscopy, surgical; for infection, lavage, and drain	$ 908.95	$1,179.12	$485.06
29876	Knee arthroscopy, surgical; major synovectomy	$1,097.78	$1,356.58	$584.21
29877	Knee arthroscopy, surgical; debridement	$1,031.60	$1,240.64	$549.58
29880	Knee arthroscopy, surgical; with meniscectomy, medial AND lateral	$1,167.23	$1,385.82	$621.21
29881	Knee arthroscopy, surgical; with meniscectomy, medial OR lateral	$1,080.44	$1,292.96	$575.04

PRECERTIFICATION FORM

Insurance carrier ____________________

Certification for [ ] admission and/or [ ] surgery and/or [ ] ____________

Patient name ____________________

Street address ____________________

City/State/Zip ____________________

Telephone ____________ Date of birth ____________

Subscriber name ____________________

Employer ____________________

Member no. ____________ Group no. ____________

Admitting physician ____________________

Provider no. ____________________

Hospital/facility ____________________

Planned admission/procedure date ____________________

Diagnosis/symptoms ____________________

Treatment/procedure ____________________

Estimated length of stay ____________________

Complicating factors ____________________

Second opinion required [ ] Yes [ ] No If yes, [ ] Obtained

Corroborating physician ____________________

Insurance carrier representative ____________________

Approval [ ] Yes [ ] No If yes, certification no. ____________

If no, reason(s) for denial ____________________

1. **LO 8.5–8.7** A patient with BCBS PPO coverage had surgical knee arthroscopy with medial and lateral meniscectomy. The plan has an 80-20 coinsurance, with no copayment for surgical procedures. The annual deductible is met. What will the plan pay, and what amount does the patient owe?
2. **LO 8.5–8.7** A United patient has a high-deductible plan with a $1,200 deductible for this year that has not been met and 75-25 coinsurance. He has surgical knee arthroscopy with debridement. What will the plan pay, and what amount does the patient owe?
3. **LO 8.5–8.7** Another payer offers the practice a contract based on 115 percent of the Medicare Fee Schedule. What amounts are offered for the codes above?

Case 8.4 Completing Correct Claims

LO 8.3, 8.6–8.8 The objective of these exercises is to correctly complete private payer claims, applying what you have learned in the chapter. Following the information about the provider for the cases are two sections. The first section contains information about the patient, the insurance coverage, and the current medical condition. The second section is an encounter form for Valley Associates, PC.

Data from the first section, the patient information form, have already been entered in the program for you. You must enter information from the second section, the encounter form, to complete the claim. If you are instructed to use the Medisoft simulation in Connect, follow the steps at the book's Online Learning Center (OLC), **www.mhhe.com/valerius6e,** to complete the cases at **connect.mcgraw-hill.com** on your own once you have watched the demonstration and tried the steps with prompts in practice mode.

If you are gaining experience by completing a paper CMS-1500 claim form, use the blank claim form supplied to you (from the back of the book or printed from the book's Online Learning Center) and follow the instructions on pages 255–256 to fill in the form by hand. Alternatively, the Online Learning Center provides an electronic CMS-1500 form that can be used to fill in and print claims. See *The Interactive Simulated CMS-1500 Form* in Appendix B at the back of this text for further instructions.

The following provider information, which is also preloaded in the Medisoft database, should be used for Cases 8.4A and 8.4B on pages 319 and 320, respectively.

Provider Information

Name	David Rosenberg, MD.
Address	1400 West Center Street Toledo, OH 43601-0213
Telephone	555-967-0303
Employer ID Number	16-2345678
NPI	1288560027
Assignment	Accepts
Signature	On File (1-1-2016)

Also note the following fee schedule information, which applies to all claim-completion exercises in this and subsequent chapters.

Price Code A: Standard fees, used for all payers except Medicare and Medicaid

Price Code B: Reduced fees, used for Medicare (Medicare Nationwide and Medicare HMO) and Medicaid payers

The amounts shown on the encounter forms in the claim-completion cases are based on Price Codes A and B. Assume that all patient copayments are made at the time of the office visit.

A. Based on the following patient and encounter information, complete a claim for the patient.

From the Patient Information Form:

Name	David Belline
Sex	M
Birth Date	01/22/1957
Marital Status	Married
SSN	439-01-3349
Address	250 Milltown Rd. Alliance, OH 44601-3456
Employer	Kinko's
Health Plan	Anthem BCBS PPO
Insurance ID Number	35Z29005
Assignment of Benefits	Y
Signature on File	Y (06/01/2016)
Condition unrelated to Employment, Auto Accident, or Other Accident	
Copayment	$20

VALLEY ASSOCIATES, PC

David Rosenberg, MD - Dermatology
555-967-0303
NPI 1288560027

PATIENT NAME	APPT. DATE/TIME
Belline, David S.	10/13/2016 10:00 am
PATIENT NO.	**DX**
BELLIDA0	**1.** E11.9 Type 2 Diabetes mellitus without complications **2.** **3.** **4.**

DESCRIPTION	✓	CPT	FEE	DESCRIPTION	✓	CPT	FEE
OFFICE VISITS				**PROCEDURES**			
New Patient				Acne Surgery		10040	
LI Problem Focused		99201		I&D, Abscess, Smpl		10060	
LII Expanded		99202		I&D, Abscess, Mult		10061	
LIII Detailed		99203		I&D, Pilonidal Cyst, Smpl		10080	
LIV Comp./Mod.		99204		I&D, Pilonidal Cyst, Compl		10081	
LV Comp./High		99205		I&R, Foreign Body, Smpl		10120	
Established Patient				I&R, Foreign Body, Compl		10121	
LI Minimum		99211		I&D Hematoma		10140	
LII Problem Focused		99212		Puncture Aspiration		10160	
LIII Expanded		99213		Debride Skin, To 10%		11000	
LIV Detailed		99214		Each Addl 10%		11001	
LV Comp./High		99215		Pare Benign Skin Lesion		11055	
				Pare Benign Skin Lesion, 2-4		11056	
CONSULTATION: OFFICE/OP				Pare Benign Skin Lesion, 4+		11057	
Requested By:				Skin Biopsy, Single Les.		11100	
LI Problem Focused		99241		Skin Biopsy, Mult Les.		+11101	
LII Expanded		99242		Remove Skin Tags, 1-15		11200	
LIII Detailed		99243		Remove Skin Tags, Addl 10		+11201	
LIV Comp./Mod.		99244		Trim Nails		11719	
LV Comp./High		99245		Debride Nails, 1-5		11720	
				Debride Nails, 6+		11721	
CARE PLAN OVERSIGHT				Avulsion of Nail Plate,1	✓	11730	107
Supervision, 15-29 min.		99339		Avulsion of Nail Plate,Addl 1		+11732	
Supervision, 30+ min.		99340		Nail Biopsy		11755	
				Repair Nail Bed		11760	
				Excision, Ingrown Toenail		11765	

B. Based on the following patient and encounter information, complete a claim for the patient.

From the Patient Information Form:

Name	Gwen Remarky
Sex	F
Birth Date	11/05/1968
Marital Status	Married
SSN	221-84-3902
Address	9 Sealcrest Drive. Brooklyn, OH 44144-6789
Employer	Brooklyn Day Care
Health Plan	Aetna Choice
Insurance ID Number	BP3333-X89
Assignment of Benefits	Y
Signature on File	Y (01/01/2016)
Condition unrelated to Employment, Auto Accident, or Other Accident	
Copayment	$15

VALLEY ASSOCIATES, PC
David Rosenberg, MD - Dermatology
555-967-0303
NPI 1288560027

PATIENT NAME	APPT. DATE/TIME
Remarky, Gwen	10/13/2016 11:30 am
PATIENT NO.	**DX**
REMARGWE0	**1.** L03.031 chronic paronychia, right big toe **2.** **3.** **4.**

DESCRIPTION	✓	CPT	FEE	DESCRIPTION	✓	CPT	FEE
OFFICE VISITS				**PROCEDURES**			
New Patient				Acne Surgery		10040	
LI Problem Focused		99201		I&D, Abscess, Smpl		10060	
LII Expanded		99202		I&D, Abscess, Mult		10061	
LIII Detailed		99203		I&D, Pilonidal Cyst, Smpl		10080	
LIV Comp./Mod.		99204		I&D, Pilonidal Cyst, Compl		10081	
LV Comp./High		99205		I&R, Foreign Body, Smpl		10120	
Established Patient				I&R, Foreign Body, Compl		10121	
LI Minimum		99211		I&D Hematoma		10140	
LII Problem Focused	✓	99212	46	Puncture Aspiration		10160	
LIII Expanded		99213		Debride Skin, To 10%		11000	
Requested				Remove Skin			