



Insurance 101

Infant and Toddler Coordinators Association

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Capital City Hyatt

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Agenda

- Basics of Health Insurance
- Frequently Asked Questions
- Early Intervention and working with Insurance Companies
- Questions

Definitions

Eligibility

- Verification for participation

Member Cost Sharing – Copayment or copay

- is a payment defined in the insurance policy and paid by the insured person each time a medical service is accessed. Copayments do not usually contribute towards any policy out-of-pocket maximums whereas coinsurance payments do.

Member Cost Sharing – Deductible

- is the amount of expenses that must be paid out of pocket before an insurer will pay any expenses. It is normally quoted as a fixed dollar amount.
- The deductible must be paid by the insured, before the benefits of the policy can apply. Typically, a general rule is: the higher the deductible, the lower the premium, and vice versa. Depending on the policy, the deductible may apply per covered incident, or per year.

Definitions

Referral

- is the transfer of care for a patient from one clinician to another service.

Authorization

- are typically required for specific items and services under most health plans. Specific benefits may vary by product and/or employer group. It is always recommended that you reference appropriate member materials (e.g., the Benefit Handbook, Certificate of Coverage and/or on line Provider Manual) for member-specific benefit information for each insurer.

Billing

- Electronic billing, also called *EBP* or *electronic bill and payment*, is the process in which the bill is sent to the customer and/or the insurance company over the internet.

Definitions

Procedure Codes

- Physicians bill their services using procedure codes developed by a seventeen member committee known as the CPT Editorial Panel. The AMA nominates eleven of the members while the remaining seats are nominated by the BCBS Association, Health Insurance Association of America, CMS and the American Hospital Association. The CPT Committee issues new codes two times per year.

Current Procedural Terminology (CPT)

- The CPT code set is maintained by the AMA CPT Editorial Panel. The CPT code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, patients, accreditation organizations, and payers for administrative and financial purposes.
- New editions are released annually, each October.
- CPT codes are typically referred to as Level 1 codes.

Healthcare Common Procedure Coding System (HCPCS)

- The HCPCS code set is based on CPT coding.
- HCPCS includes two levels of codes:
 - **Level I** consists of the CPT codes and is numeric.
 - **Level II** codes are alphanumeric and primarily include non-physician services for example, ambulance services and durable medical equipment devices, and represent items and supplies not covered by CPT.

Definitions

Relative Value Unit (RVU)

- is a measure of value used by Medicare as a reimbursement formula for physician services. Before RVUs were used, Medicare paid for physician services using “usual and customary” charges, which led to payment variability. The Consolidated Omnibus Budget Reconciliation Act of 1985 enacted a Medicare fee schedule. There currently about 7,000 distinct physician services listed.

Resource-based relative value scale (RBRVS)

- is a methodology used to determine how much money medical providers should be paid. It is used by Medicare and many health insurance companies in the US to determine fee schedules. For each service, a payment formula contains three RVUs,
 - one for *physician work*,
 - one for *practice expense*, and
 - one for *malpractice expense*.
- RBRVS assigns procedures performed by a physician or other medical provider a *relative value* which is adjusted by geographic region (so a procedure performed in NH may be worth more than a procedure performed in MA). This value is then multiplied by a fixed *conversion factor*, which changes annually, to determine the amount of payment.

Definitions

Diagnostic Codes

- are used to group and identify diseases, disorders, and/or symptoms, and are used to measure morbidity and mortality. There is typically not one code for all purposes. The National Centers for Health Statistics (NCHS) and CMS are responsible for overseeing all changes and modifications.
- The codes may be frequently revised as new knowledge is attained.
- Diagnosis codes are sometimes referred to as ICD-9 (*International Classification of Diseases*) codes or ICD-10 (implementation in October 2013).
- New editions are released annually, each October.



The Revenue Cycle

(enrollment, claims and customer service)

Self-service and best practices...

Throughout the revenue cycle

Scheduling & Patient Visit

- ✓ Verify eligibility
- ✓ Member cost sharing
- ✓ Referral/Authorizations
- ✓ Other Policies/Procedures

Clinical Programs

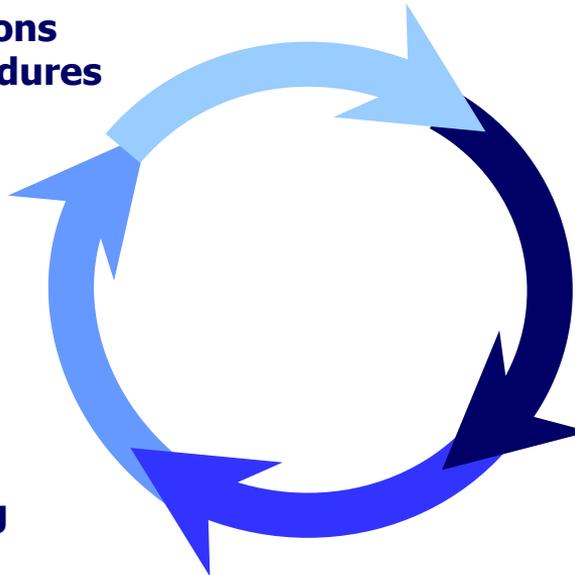
- ✓ Preventive Health
- ✓ Disease + Health Risk Management
- ✓ Clinical Guidelines

Claim Submission

- ✓ Re-verify Eligibility
- ✓ Referral/Authorization
- ✓ Submit Claim
- ✓ Policies

Reduce Outstanding Account Receivables

- ✓ Claim Status
- ✓ Timely appeals/corrections
- ✓ AR Reports/Trending
- ✓ Policies



Work In-Process or Rejected Claims

- ✓ Response Report/ File
- ✓ Claim Status
- ✓ Eligibility
- ✓ Policies

Electronic Claim Remittance Advice

- ✓ Auto post remittance



Frequently Asked Questions

What are the type of insurers?

There are two categories of insurers:

- Private or Commercial (privately held companies)
- Public or CMS; Centers for Medicare & Medicaid Services (maintained by federal and state government)

What is 3rd party payer reimbursement?

Health care finance experts make reference to third party payment or third party payers.

- The first party is the patient.
- The second party is the physician, clinic, hospital, nursing home or other health care entity also known as the provider.
- The third party is the insurance company or health agency that pays the provider or second party for the care or services rendered to the patient or first party.

What kinds of reimbursement limitations are there?

Reimbursement is limited in many ways...

- By medical policies and benefits -- the patient through their insurer, certain diagnosis and procedures are covered and others are not.
- By "networks" of providers. In order for patients to receive the maximum benefits (as well as the provider performing the service), patients should stay in network. Providers must "participate" in the insurance plan (Medicare, Medicaid or a commercial plan) in order to be paid according the established fee schedule.
- By the fee schedule established by the insurer for providers participating in their network. For maximum reimbursement the provider should be participating in the insurance plan.
- Some benefit packages limit the number of sessions a particular service can be provided, e.g., 40 therapy visits per calendar year or one annual well visit per year.
- Additionally, many services require prior authorization or referrals from the PCP prior to the service or procedure being performed. Payment could be denied if the proper steps are not taken in advance.

Why do insurance companies have their own rates vs. Medicare/Medicaid?

- Medicare is divided into jurisdictions and each jurisdiction is managed by a fiscal intermediary. In MA, the fiscal intermediary is National Heritage Insurance Company. This company is responsible for Medicare enrollment and providers rate setting following Medicare guidelines and claims processing and payment.
- Federal Medicaid law does not set precise requirements for reimbursement, hence each state has the ability to set its own Medicaid rates. In most states, Medicaid rates are lower than Medicare rates. Medicare pays less than commercial payers.
- Most insurance companies set their own rates using Medicare and/or Medicaid as their benchmark. Rates are set based on the regional need and demands of the provider community for reimbursement.

How is billing done?

- Billing is done via a claim form which varies by the place of service. For a hospital service billed under the hospital Tax Identification Number, a UB 04 form is used. For clinic or individual physicians or free standing ancillary provider, a HCFA 1500 form is used.
- Each payer including Medicare and Medicaid have their own billing guidelines. Most commercial payers mirror Medicare billing protocols with a few caveats. Most billing protocols are available on line or by calling the claims or provider service department of the payer.
- In all cases a TID and an NPI number (National Provider Identifier) are required on the form along with diagnosis codes and procedure codes. The provider of service must be entered into the payer claims system and in many cases a W-9 form is required prior to payment of claims.

Affordable Care Act

- The Affordable Care Act (commonly known as the health reform law) encourages the formation of “medical homes” and “accountable care organizations” (ACOs), in the belief that they will improve health care quality and slow the growth of health care spending in America.
- By organizing health care teams, technology and knowledge around patient needs, Accountable Care can help the system realize its full potential.
- The Affordable Care Act includes a provision that allows Medicare to reward health care organizations with a share of the savings that would result from improving care quality and reducing cost. To participate in this “shared savings programs,” health care organizations need to become Accountable Care Organizations (ACOs).
- Generally, an ACO can be defined as a set of healthcare providers --- including primary care physicians, specialists, and hospitals --- that work together collaboratively and accept collective accountability for the cost and quality of care delivered to a population of patients.
- The ACO concept that has been widely discussed among health researchers. According to the Commonwealth Fund, 54 percent of health care leaders believe that ACOs are an effective model of care. The Congressional Budget Office projects that the shared savings program will save \$5 billion over 5 years (2010–2015).

Affordable Care Act

- The Patient-Centered Medical Home model was proposed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association in 2007.
- Patient-Centered Medical Home is an enhanced primary care delivery model that strives to achieve better access, coordination of care, prevention, quality, and safety within the primary care practice, and strives to create a strong partnership between the patient and primary care physician.
- The Accountable Care Organization is also based around a strong primary care core. But ACOs are comprised of many “medical homes”, i.e., many primary care providers and/or practices that work together.
- The difference is that ACOs would be accountable for the cost and quality of care both within and outside of the primary care relationship. As such, ACOs must include specialists and hospitals in order to be able to control costs and improve health outcomes across the entire care continuum. ACOs by nature would be larger than a single medical home or physician’s office.



EI and working with Insurance Companies

EI and working with Insurance Companies

- EI coverage varies by State
- Know your insurance companies
- How best to work with your providers and insurance companies

Questions

