

Processing an Insurance Claim

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MHA631
Health Insurance

Lecture 3



Objectives

- Understand the Processing of an Insurance Claim.
- Explore Managing New and Established Patients.
- Discuss Insurance Claim Life Cycle.
- Examine Claims Denials.

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Processing an Insurance Claim

- The processing of an insurance claim is initiated when the patient contacts a healthcare provider's office and schedules an appointment.
- The insurance claim used to report professional and technical services is known as the CMS-1500 claim.
- Claim information includes patient and insurance policy identification, codes and charges for procedures and/or services, and codes for diagnoses treated and/or managed during the encounter.

CMS-1500 claim

The image shows a blank CMS-1500 Health Insurance Claim Form. The form is divided into several sections for patient information, insurance details, provider information, and a table for listing services. The top section includes fields for patient name, address, date of birth, and sex. The middle section contains fields for insurance policy number, group number, and employer information. The bottom section features a table with columns for date of service, procedure code, diagnosis code, and charges. The form is labeled '1500 HEALTH INSURANCE CLAIM FORM' at the top left.

FIGURE 4-1 Blank CMS-1500 claim (For instructional use only) (Courtesy of the Centers for Medicare and Medicaid Services, www.cms.hhs.gov)

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Accounts Receivable Management

- **Accounts receivable** are the amounts owed to a business for services or goods provided.
- Accounts receivable management assists providers in the collection of appropriate reimbursement for services rendered.
- Health insurance plans may include a **pre-existing conditions** clause, which is used to determine patient eligibility for coverage. If the patient was treated for a medical condition prior to the effective date of health insurance coverage, the health insurance plan will not pay benefits for that particular illness. Usually, the clause expires one year after the health insurance plan's effective date. This means that the health care provided to the patient for a pre-existing condition is then covered by the health insurance plan.

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Managing New Patients

- The interview and check-in procedure for a patient who is new to the provider's practice is more extensive than for a returning patient.
- The purpose of the new patient interview and check-in procedure is to obtain information, schedule the patient for an appointment, and generate a patient record. Basic office policies and procedures (e.g., copayments must be paid at the time of visit) should also be explained to each new patient.
- **A participating provider (PAR)** contracts with a health insurance plan and accepts whatever the plan pays for procedures or services performed. PARs are not allowed to bill patients for the difference between the contracted rate and their normal fee.

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Managing New Patients

- A **nonparticipating provider (nonPAR)** (or out-of-network provider) does not contract with the insurance plan, and patients who elect to receive care from non-PARs will incur higher out-of-pocket expenses. The patient is usually expected to pay the difference between the insurance payment and the provider's fee.
- The patient registration form is used to create the patient's financial and medical records. Be sure to carefully review the completed form for identification, financial and medical history information.

Managing New Patients

EXAMPLE 1:

Dr. Smith is a *participating provider (PAR)* for the ABC Health Insurance Plan. Kathe Bartron is treated by Dr. Smith in the office, for which a \$50 fee is charged.

PAR provider fee	\$50
PAR provider contracted rate (or allowable charge)	\$40
Patient copayment	– \$10
Insurance payment	\$30
PAR provider write-off amount	\$10

Managing New Patients

EXAMPLE 2:

Dr. Jones is a *nonparticipating provider (nonPAR)*. Lee Noffske is treated by Dr. Jones in the office, for which a \$50 fee is charged.

nonPAR provider fee	\$50
Usual and customary rate (UCR)	\$45
Patient copayment	– \$8
Insurance payment	\$37
nonPAR provider may bill patient	\$5

Managing New Patients

MANAGED CARE ALERT!

- Prior to scheduling an appointment with a specialist, a managed care patient must obtain a referral from the primary care provider or case manager (i.e., preauthorization number is required).
- In addition, depending on the managed care plan, certain procedures and services must be preauthorized before the patient undergoes treatment.

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Managing New Patients

- When the patient has more than one policy, perform a **coordination of benefits (COB)** to be sure the patient has correctly determined which policy is primary, secondary, and so on. The determination of primary or secondary status for patients with two or more commercial policies is different for adults than for children.
- **Primary insurance** is the insurance plan responsible for paying healthcare insurance claims first. Once the primary insurance is billed and pays the contracted amount, the secondary plan is billed for the remainder, and so on. Group health insurance reimbursement cannot exceed the total cost of services rendered.

Managing New Patients

EXAMPLE: Cindy Thomas has two health insurance policies, a group insurance plan through her full-time employer and another group insurance plan through her husband's employer. Cindy's plan through her own employer is primary, and the plan through her husband's employer is secondary. When Cindy receives healthcare services at her doctor's office, the office first submits the insurance claim to Cindy's employer's health plan; once that health plan has paid, the insurance claim can be submitted to Cindy's secondary insurance (her husband's group insurance plan).

NOTE: Total reimbursement cannot exceed the total charges for healthcare services rendered by Cindy's doctor.

Managing New Patients

- **Child living with both parents:** If each parent subscribes to a different health insurance plan, the primary and secondary policies are determined by applying the birthday rule.
- Whose birth month and day occurs earlier in the calendar year holds the primary policy for dependent children.
- If the policyholders have identical birthdays, the policy in effect the longest is considered primary.

Managing New Patients

EXAMPLE 1: A child is listed as a dependent on both his father's and his mother's group policy. Which policy is primary?

Mother—birthdate 03/06/59—works for IBM

Father—birthdate 03/20/57—works for General Motors

Answer: Mother's policy is primary; her birthday is earlier in the calendar year.

Managing New Patients

EXAMPLE 2: A child is listed as a dependent on his father's group health insurance policy and his mother's group health insurance policy. The father was born on 01/01/1956, and the mother was born on 03/04/1945. Which policy is considered primary?

Answer: Father's policy is primary because his birthday is earlier in the calendar year.

Managing New Patients

EXAMPLE 3: A dependent child is covered by both parent group policies. The parents were born on the same day. Which policy is primary?

Father's policy took effect 03/06/86

Mother's policy took effect 09/06/92

Answer: Father's policy is primary because it has been in effect six years longer.

Managing New Patients

- The **encounter form** is the financial record source document used by healthcare providers and other personnel to record treated diagnoses and services rendered to the patient during the current encounter.
- In the physician's office, it is also called a **superbill**; in the hospital it is called a **chargemaster**.
- Clinical assessment and/or treatment of the patient is performed, after which the provider documents all current and pertinent diagnoses, services rendered, and special follow-up instructions on the encounter form.

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Managing Established Patients

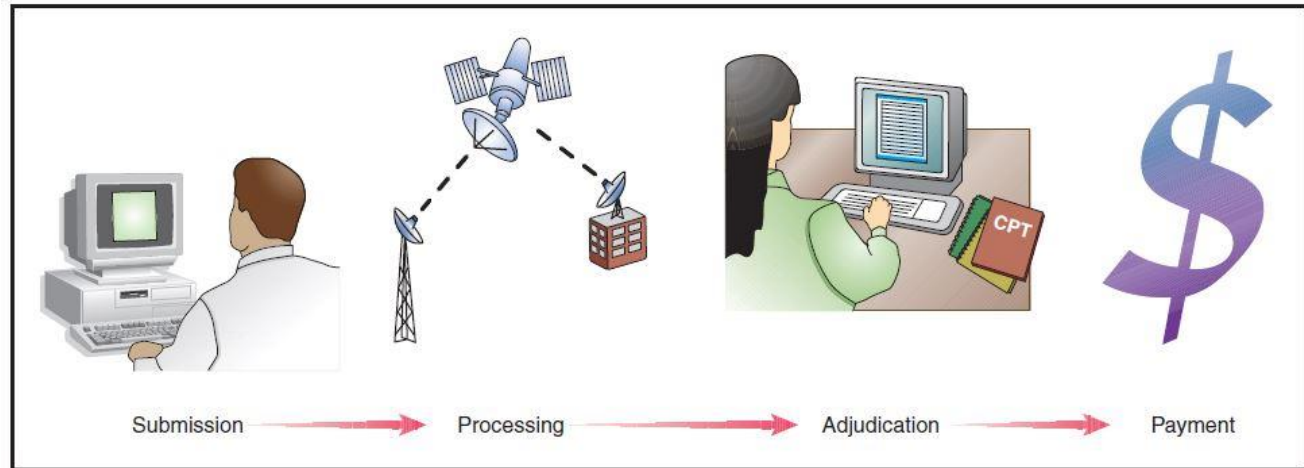
- It is important to ask all returning patients if there have been *any changes* in their name, address, phone number, employer, or insurance plan. If the answer is yes, a new registration form should be completed and the computerized patient database should be updated.
- Once the clinical assessment and/or treatment has been completed, the patient enters the post-clinical phase of the visit. The services and diagnosis(es) are added to the encounter form.

Insurance Claim Life Cycle

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Insurance Claim Life Cycle

- **The life cycle of a claim includes four stages:**
 - Claims Submission
 - Claims Processing
 - Claims Adjudication
 - Payment



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Claims Submission

- **Claims submission** is the electronic or manual transmission of claims data to payers or clearinghouses for processing.
- A **clearinghouse** is a public or private entity that processes or facilitates the processing of nonstandard data elements (e.g., paper claim) into standard data elements (e.g., electronic claim).
- Providers that generate paper-based claims submit them to healthcare clearinghouses, which convert them to a standardized electronic format for submission to payers.
- The audit/edit process results in a **clean claim**, which contains all required data elements needed to process and pay the claim (e.g., valid diagnosis and procedure/service codes and so on).

Claims Attachments

- **A claims attachment** is a set of supporting documentation or information associated with a healthcare claim or patient encounter.
- **Delayed claims** contain incomplete and inaccurate information.
- **Coordination of benefits (COB)** is a provision in group health insurance policies intended to keep multiple insurers from paying benefits covered by other policies; it also specifies that coverage will be provided in a specific sequence when more than one policy covers the claim.

Claims Processing

- **Claims processing** involves sorting claims upon submission to collect and verify information about the patient and provider.
- Clearinghouses and payers use software to automate the scanning and imaging functions associated with claims processing. Scanning technology “reads” the information reported on the claim and converts it to an image so that claims examiners can analyze, edit, and validate the data.

Claims Adjudication

- After the claim has been validated by the payer's claims examiner, it undergoes the **claims adjudication process**, in which the claim is compared to payer edits and the patient's health plan benefits to verify that the:
 - Required information is available to process the claim.
 - Claim is not a duplicate.
 - Payer rules and procedures have been followed.
 - Procedures performed or services provided are covered benefits.

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Claims Adjudication

- Any procedure or service reported on the claim that is not included on the master benefit list is a **noncovered benefit**, and will result in denial (rejection) of the claim. This means that the patient's insurance plan will not reimburse the provider for having performed those procedures or services.
- Procedures and services provided to a patient without proper authorization from the payer, or that were not covered by a current authorization, are **unauthorized services**. This means that the payer requires the provider to obtain preauthorization before performing certain procedures and services, and because it was not obtained, the claim is denied (rejected).

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Claims Adjudication

- Patients can be billed for noncovered procedures but not for unauthorized services.
- Providers process denials of unauthorized services as a business loss.
- The payer matches procedure and service codes (e.g., CPT) with diagnosis codes reported on the CMS-1500 claim to ensure the medical necessity of all procedures and services provided. Any procedure or service that is not medically necessary is denied.

Claims Adjudication

- A determination is made as to **allowed charges**, which is the maximum amount the payer will allow for each procedure or service, according to the patient's policy.
- Allowed charges vary from policy to policy, and they are less than or equal to the fee charged by the provider. This means that payment is never greater than the fee submitted by the provider.
- A determination of the patient's annual deductible, copayment, and/or coinsurance amounts, is also made.

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Claims Adjudication

- The **deductible** is the total amount of covered medical expenses a policyholder must pay each year out-of-pocket before the insurance company is obligated to pay any benefits.
- A **policyholder** (or subscriber or beneficiary) is the person in whose name the insurance policy is issued.
- **Coinsurance** is the percentage the patient pays for covered services after the deductible has been met and the copayment has been paid.
- For example, with an 80/20 plan, the insurance company pays 80 percent and the patient pays 20 percent.
- A **copayment (or copay)** is the amount the patient pays each time he or she receives healthcare services.

Claims Adjudication

- Once the claims adjudication process has been completed, the payer generates a **remittance advice** that contains information about payment, denials, and pending status of claims.
- If a claim is denied, the provider can appeal the decision by resubmitting the claim and attaching supporting documentation.
- Claims that are assigned pending status contain errors and omissions, and providers can correct those problems and resubmit the claim for processing.

Payment of Claims

- Once the adjudication process has been finalized, the claim is either denied or approved for payment.
- A remittance advice is sent to the provider, and an explanation of benefits (EOB) is mailed to the policyholder and/or patient.
- The remittance advice should be reviewed to make sure there are no processing errors (e.g., code changes, denial of benefits, and so on).

Payment of Claims

- The payer may need additional information to make a determination about a claim, and prompt compliance with such requests will expedite payment.
- It is common for payers to include multiple patients on one remittance advice and to send the provider one check for multiple claims.
- Providers also have the option of arranging for electronic funds transfer (EFT), which means that payers deposit funds to the provider's account electronically.

Maintaining Insurance Claim Files

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Maintaining Insurance Claim Files

- CMS requires providers to retain copies of any government insurance claims and copies of all attachments filed by the provider for a period of six years (unless state law stipulates a longer period).
- The provider could be audited during that period.
- In addition, the provider should keep the e-mailed report of the summary of electronic claims received from the insurance company.
- Appeals Process: An appeal is documented as a letter signed by the provider explaining why a claim should be reconsidered for payment. If appropriate, include copies of medical record documentation.

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Appealing Denied Claims

- A remittance advice may indicate that payment was denied for a reason other than a processing error.
- The reasons for denials may include:
 - (1) procedure or service not medically necessary,
 - (2) pre-existing condition not covered,
- A **pre-existing condition** is any medical condition that was diagnosed and/or treated within a specified period of time immediately preceding the enrollee's effective date of coverage.

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Appealing Denied Claims

- (3) non-covered benefit,
- Excluded items may include procedures such as cosmetic surgery.
- (4) termination of coverage,
- The patient is no longer covered by the insurance policy.
- (5) failure to obtain preauthorization,
- Many health plans require patients to call a toll-free number located on the insurance card to obtain prior authorization for particular treatments. If failure to obtain preauthorization was due to a medical emergency, it is possible to have penalties waived.

Appealing Denied Claims

- (6) out-of- network provider used,
- (7) lower level of care could have been provided. It occurs when:
 - (a) care rendered on an inpatient basis is normally provided on an outpatient basis,
 - (b) outpatient surgery could have been performed in a provider's office, or
 - (c) skilled nursing care could have been performed by a home health agency.

Key Takeaways

1. The insurance claim used to report professional and technical services is called the CMS-1500 claim.
2. The processing of an insurance claim begins when the new or established patient contacts the medical practice to schedule an appointment for health care.
3. New patients should be pre-registered so that identification and health insurance information can be obtained prior to the scheduled office visit.

Key Takeaways

4. Established patients are usually rescheduled at checkout of a current appointment.
5. The life cycle of a claim includes four stages: claims submission, claims processing, claims adjudication, and payment.
6. Reasons for denied claims.



Thank You