



Healthcare Foundations

Claims

Learning Services

Agenda

Claims Operations

- Indicate three key uses of claim data by payers
- Identify three standard code sets

Payment/Denial Explanations

Identify correct claim form based on provider type and service billed

- Professional Claims (1500)
- Facility Claims (UB 04)
- Describe the purpose of remittance advice and explanation of benefit statements

Claims Administration

What is a Claim ?

A **claim** is a request to an insurer or health plan for payment of benefits.

- Billed by provider on behalf of member
- The person or entity submitting a claim is called the **claimant**; this may be an insured, but in health coverage it is most often a provider.
- **Claims administration** or **claims processing** is the receiving, reviewing, adjudicating, and paying of claims.
- In a health plan, the claims function varies by plan type and provider compensation arrangement

- The claim links every facet of the healthcare community.



The claim provides important data to the payer.

Disease management

Reporting and Analysis

Provider Reimbursement

Premium Determination

Benefit Determination

HEALTH INSURANCE CLAIM FORM

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

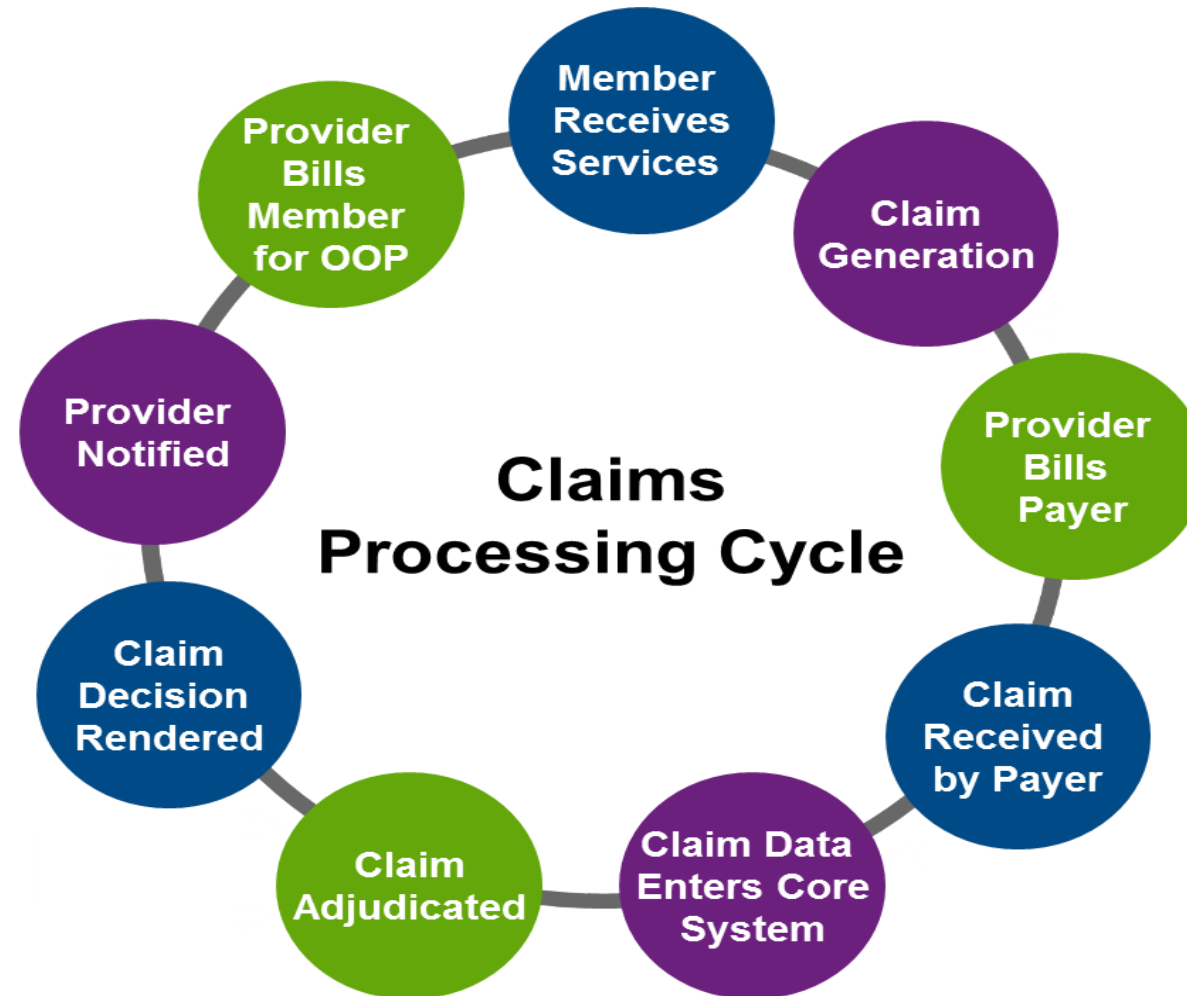
PATIENT AND INSURED INFORMATION										PHYSICIAN OR SUPPLIER INFORMATION									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA (LNU) <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare) (Medicaid) (TRICARE) (Champion) (Group Health Plan) (FECA) (Other)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										7. INSURED'S ADDRESS (No. Street)									
5. PATIENT'S ADDRESS (No. Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY STATE										CITY STATE									
ZIP CODE TELEPHONE (include Area Code)										ZIP CODE TELEPHONE (include Area Code)									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										11. INSURED'S POLICY GROUP OR FECA NUMBER									
4. OTHER INSURED'S POLICY OR GROUP NUMBER										4. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
5. RESERVED FOR NUCC USE										5. OTHER CLAIM ID (Designated by NUCC)									
6. RESERVED FOR NUCC USE										6. INSURANCE PLAN NAME OR PROGRAM NAME									
7. RESERVED FOR NUCC USE										8. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete Items 9, 10a, and 11c.</i>									
8. INSURANCE PLAN NAME OR PROGRAM NAME										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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.										14. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
SIGNED										SIGNED									
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (UMP) DATE QUAL. MM DD YY										15. OTHER DATE QUAL. MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NAME 17b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Circle A-L to service the below (2HE) (CD In) ICD 10										22. SUBMISSION CODE ORIGINAL REF. NO.									
A. L. E. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE (EAS) C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS (ICD-10) F. \$ CHARGES G. \$ CHARGES H. \$ CHARGES I. \$ CHARGES J. RENDERING PROVIDER ID #																			
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
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.)										32. SERVICE FACILITY LOCATION INFORMATION									
SIGNED DATE										33. BILLING PROVIDER INFO & PH # ()									

NUCC Instruction Manual available at: www.nucc.org

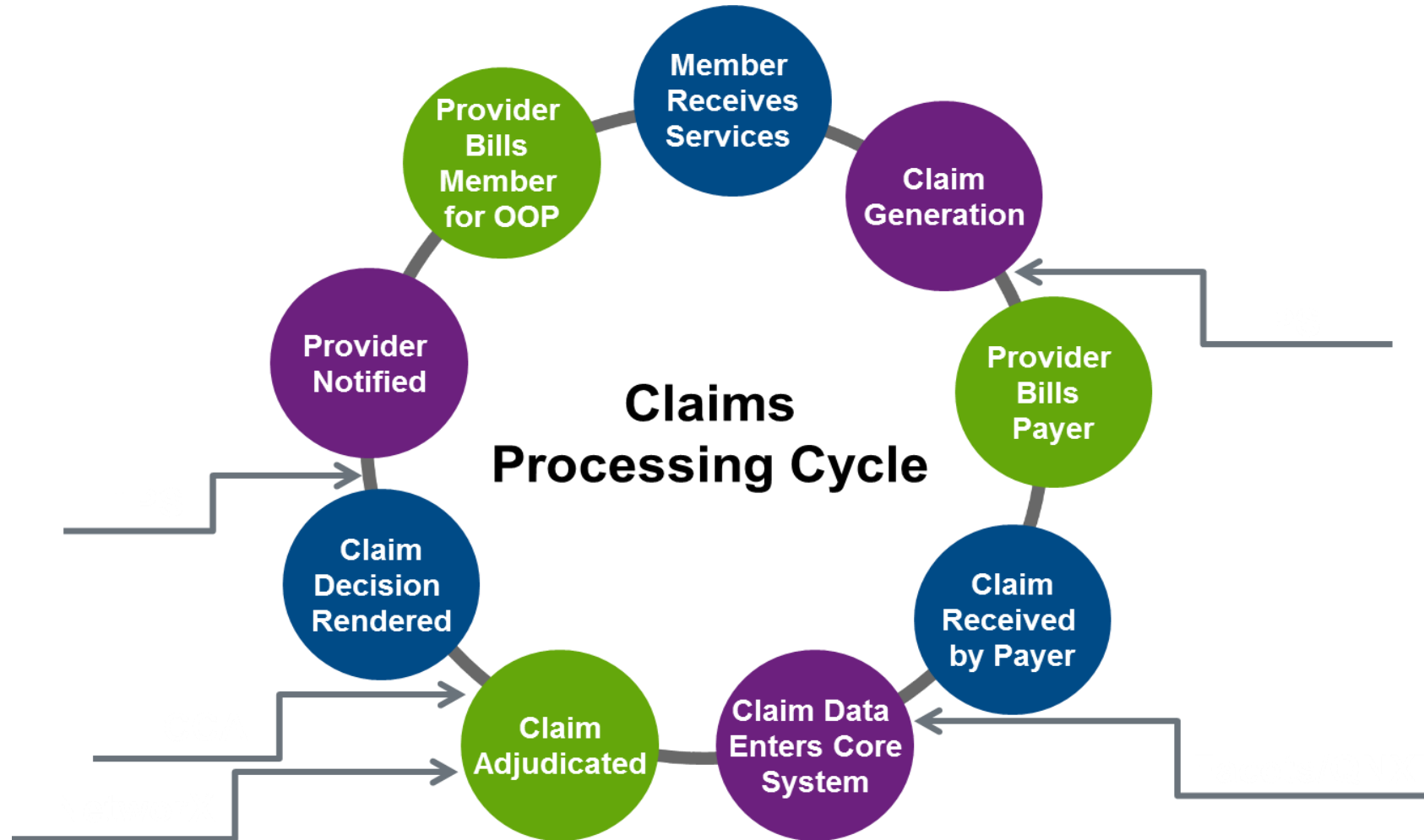
PLEASE PRINT OR TYPE

APPROVED OMS-0938-1197 FORM 1500 (02-12)

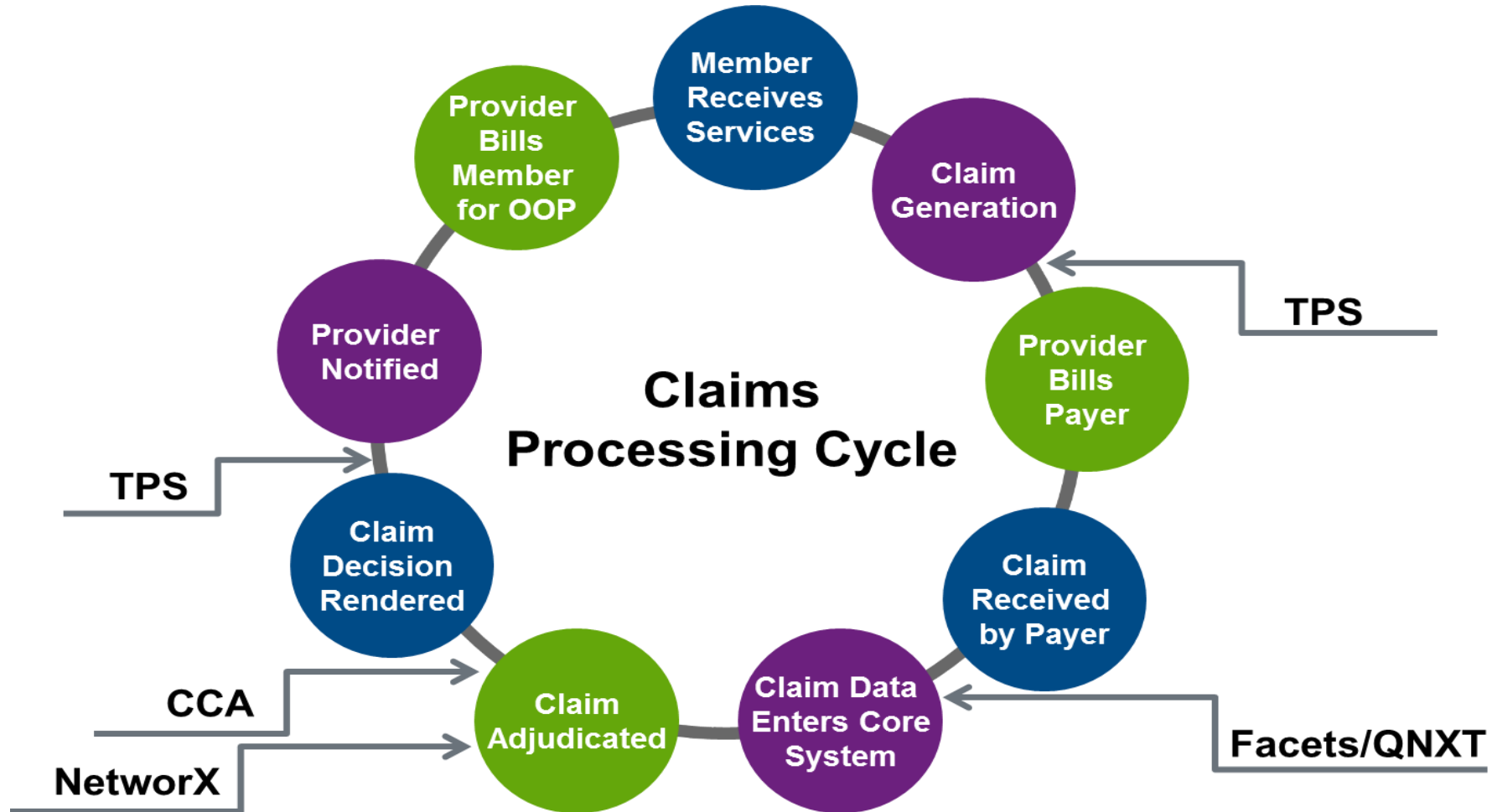
Claims Processing Cycle



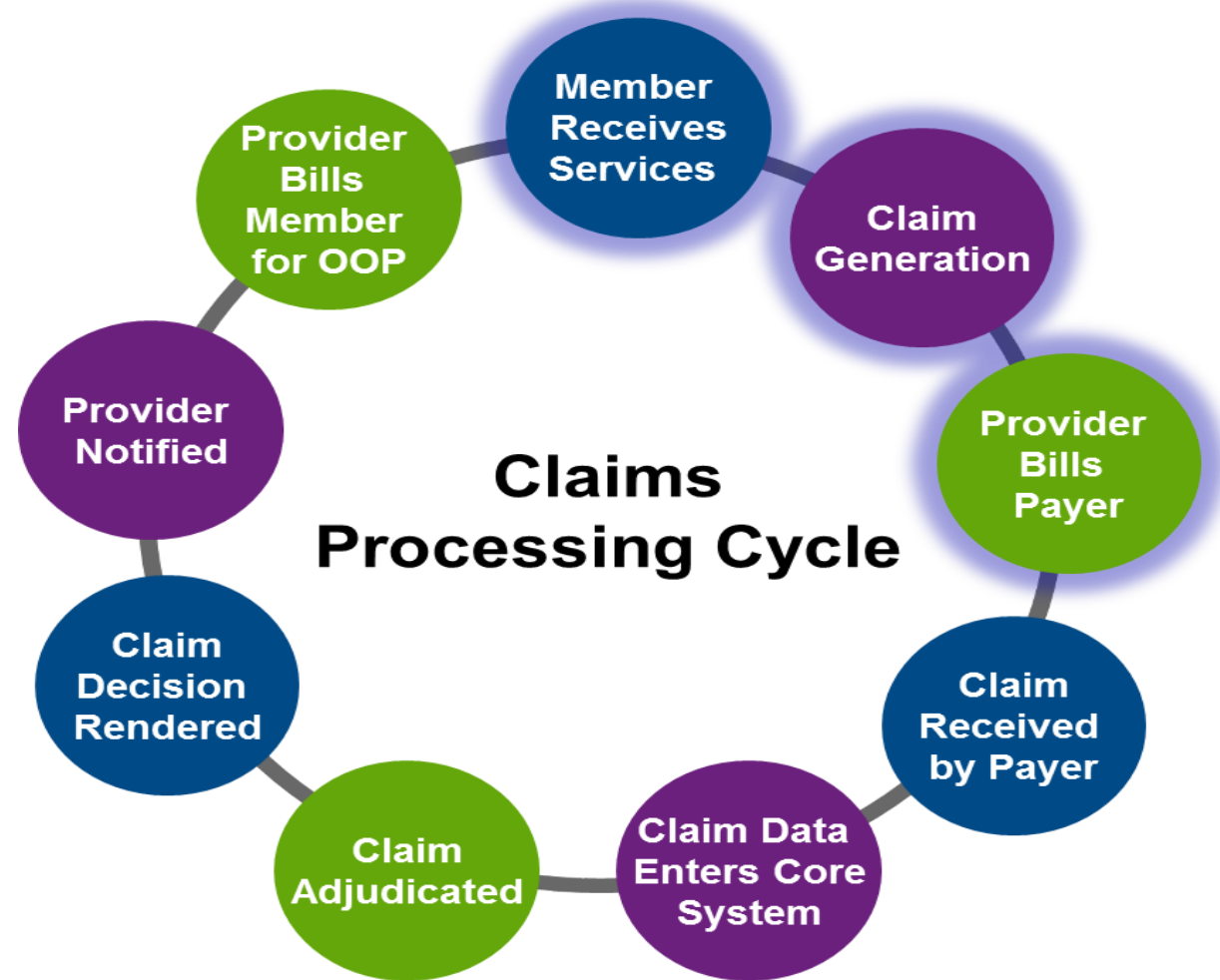
Claims Processing Cycle – Contd..



Claims Processing Cycle – Contd..



Claims Processing Cycle – Contd..



Member Visit Case Study

- Visit to PCP office for bronchitis symptoms
- Member has a PPO plan
- Deductible has not been met for the year
- Member's first visit in over 12 months to PCP



Claim Generation

Before Visit

- Eligibility Verification
- HIPAA Release

During Visit

After Visit

Claim Generation – Contd..



Before Visit

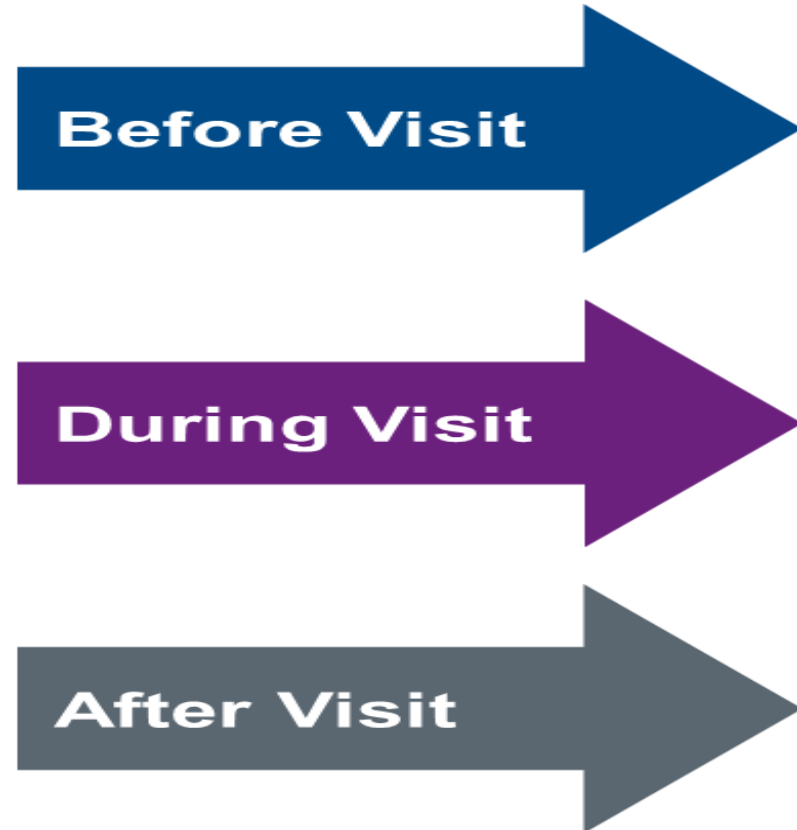
- Eligibility Verification
- HIPAA Release

During Visit

- Services Provided
- Documentation of Visit
- Medical Billing

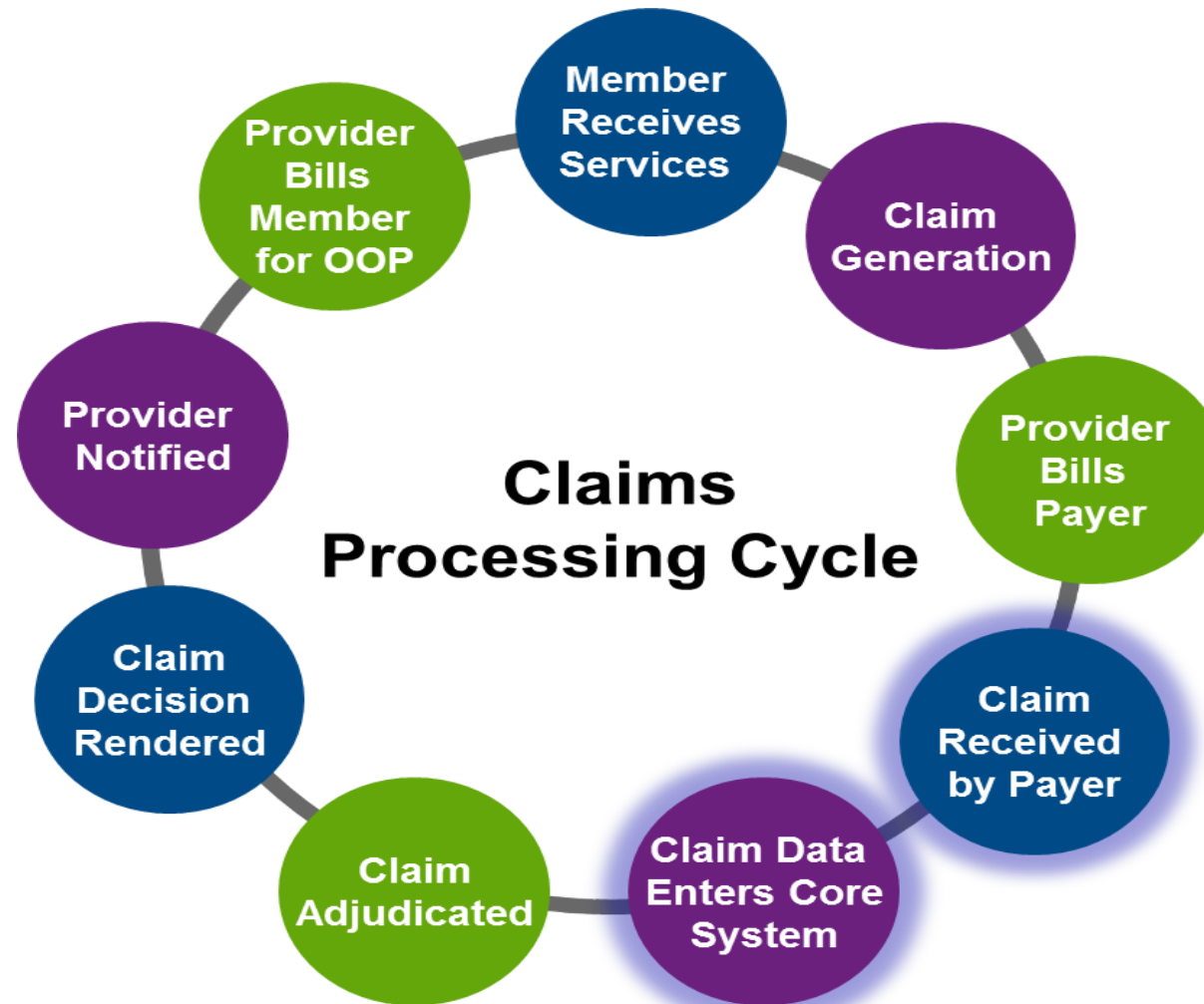
After Visit

Claim Generation – Contd..

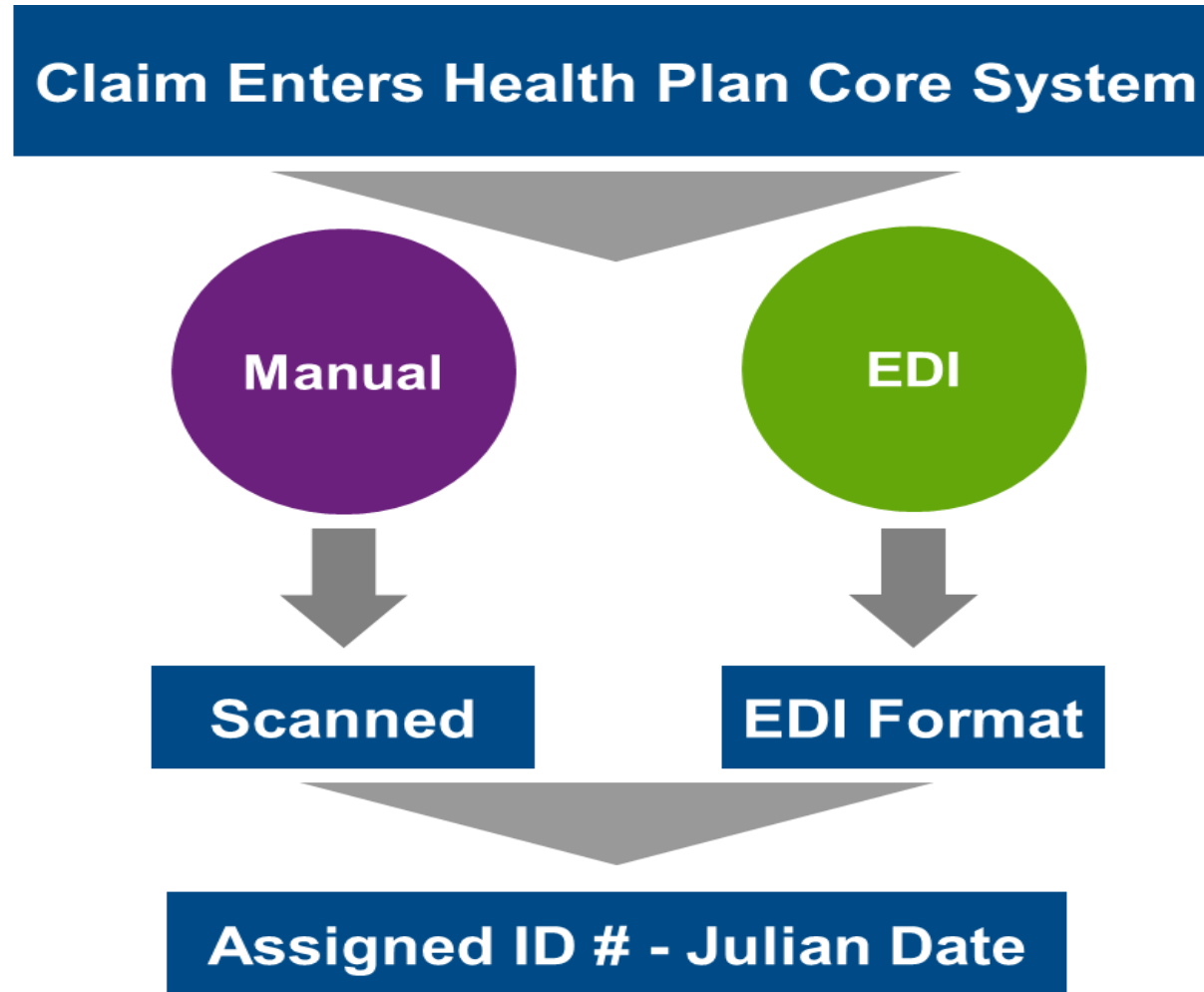


- Eligibility Verification
- HIPAA Release
- Services Provided
- Documentation of Visit
- Medical Billing
- Claim Created
- Claim Submission via EDI

Claims Processing Cycle – Contd..



Claims Processing Cycle – Contd..



Julian Date

What is a Julian Date?

- Method to represent the date in a 3-digit format
- Every day in the year is a sequential number

Examples:

- January 27 = 027
- March 5 = 064
- March 10 =

Julian Date – Contd..

What is a Julian Date?

- Method to represent the date in a 3-digit format
- Every day in the year is a sequential number

Examples:

- January 27 = 027
- March 5 = 064
- March 10 = 069

Payment Method

Payment Method	Provider is paid:
Lesser of	Contracted fee or the charge billed (the lesser of the two)

Payment Method – Contd..

Payment Method	Provider is paid:
Lesser of	Contracted fee or the charge billed (the lesser of the two)
Per Diem	A daily rate regardless of total charges incurred to provide services to the member

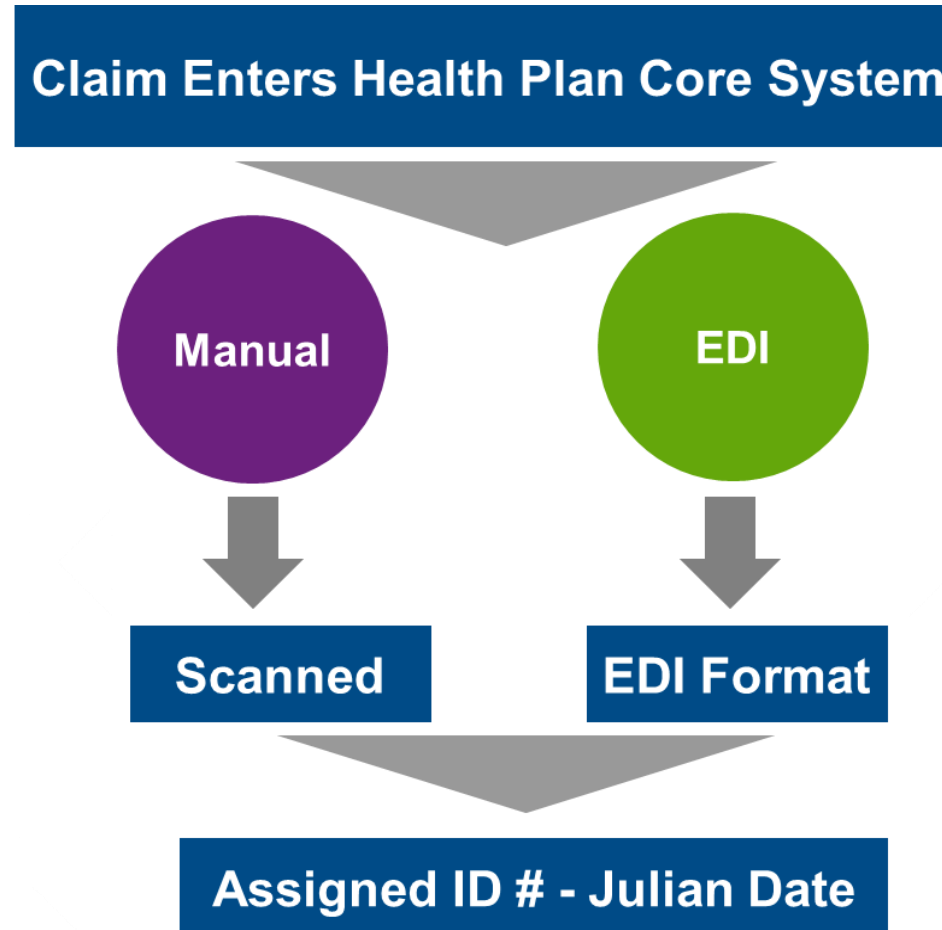
Payment Method – Contd..

Payment Method	Provider is paid:
Lesser of	Contracted fee or the charge billed (the lesser of the two)
Per Diem	A daily rate regardless of total charges incurred to provide services to the member
RBRVS	Resource-Based Relative Value Scale fees are paid based on amount of time and resources associated with services (RVU-Relative Value Unit)

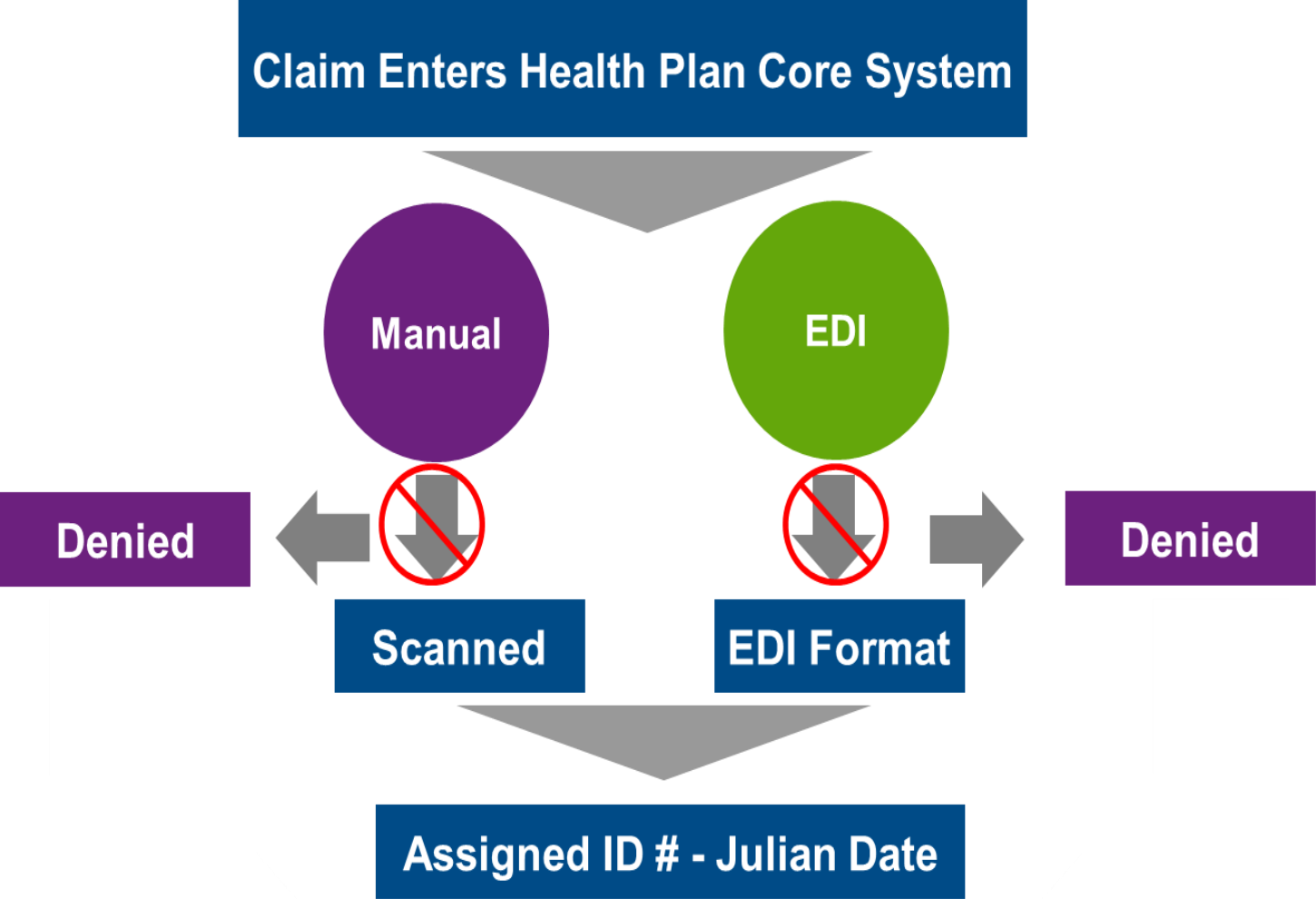
Payment Method – Contd..

Payment Method	Provider is paid:
Lesser of	Contracted fee or the charge billed (the lesser of the two).
Per Diem	A daily rate regardless of total charges incurred to provide services to the member.
RBRVS	Resource-Based Relative Value Scale fees are paid based on amount of time and resources associated with services (RVU-Relative Value Unit).
Global/Case Rate	A flat fee by bundling codes for payment for an episode for services for same diagnosis.

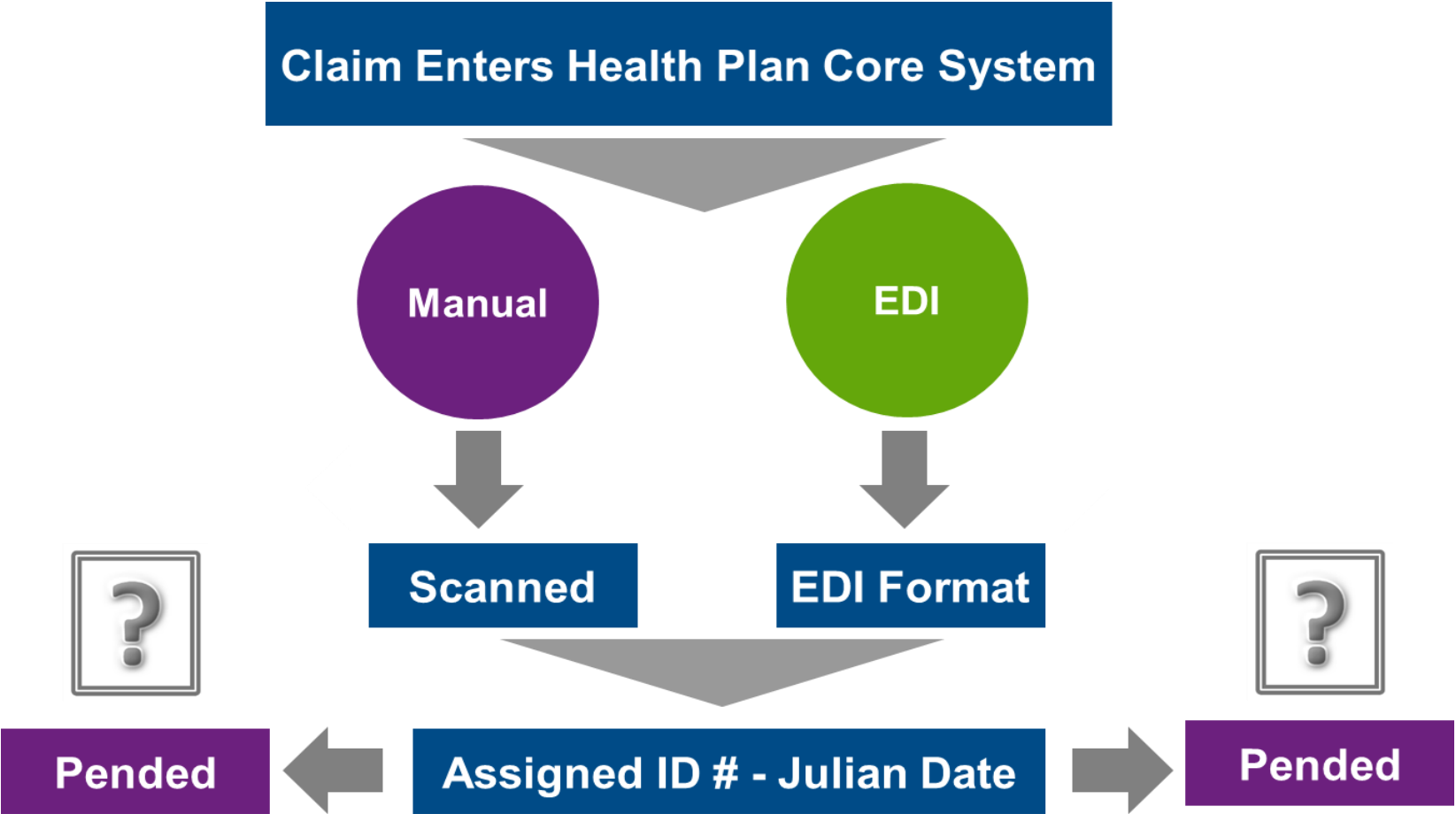
Claims Processing – Contd..



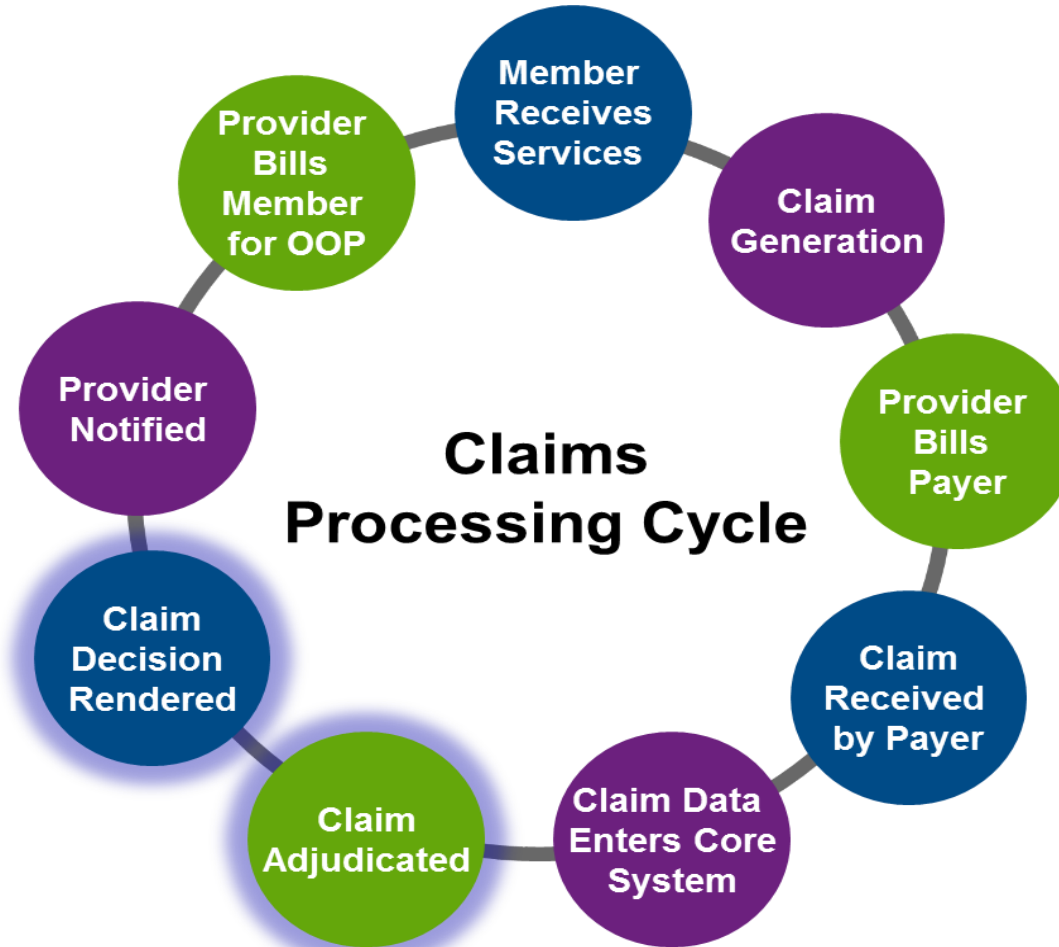
Claims Processing – Contd..



Claims Processing – Contd..



Claims Processing Cycle – Contd..



Claims Components

Key Claim Components

Member

Provider

Coding

Claims Components – Contd..

Key Claim Components

Member

Provider

Coding

Claim denials or rejects if key pieces are missing

Claims Components – Contd..

Key Claim Components

- Member Name
- Health Plan ID
- Date of Birth
- Gender
- Verification important
- Accuracy important

Member

Claims Components – Contd..

Key Claim Components

- Provider Name
- Tax ID Number
- National Provider Identifier (NPI)



Provider

Claims Components – Contd..

Key Claim Components

Language of Healthcare:

- Represents Service Provided
- Reimbursement Code Based
- Benefits and Out of Pocket Costs

Coding

Language of Healthcare

CPT

Current Procedural Terminology : Professional Billing

- 99214 – Office visit
- 36415 – Venipuncture

ICD

International Statistical Classification of Disease and Related Health Problems : Professional and Facility Billing

- ICD-9: 250.00 – Diabetes
- ICD-10: E08.00 – Diabetes

Rev

Revenue Code: Facility Billing

- 0110 – Room & Board (Private)
- 0191 – Subacute Care – Level I

DRG

Diagnostic Related Groups: Facility Billing

- 292 – Heart Failure & Shock w/cc
- 089 – Concussion w/cc

POS

Place of Service : Professional and Facility Billing

- 11 – Office visit
- 21 – Inpatient Hospital

Required Claim Formats

- What are the two types of standard claim forms?



Required Claim Formats – Contd..

- What are the two types of standard claim forms?



CMS 1500



Required Claim Formats – Contd..

- What are the two types of standard claim forms?



CMS 1500



UB 04

Required Claim Formats – Contd..

- What are the two types of standard claim forms?



CMS 1500



UB 04

- What types of providers bill on the two forms?



Required Claim Formats – Contd..

- What are the two types of standard claim forms?



CMS 1500



UB 04

- What types of providers bill on the two forms?



Professional



Required Claim Formats – Contd..

- What are the two types of standard claim forms?



CMS 1500



UB 04



Professional



Facility

- What types of providers bill on the two forms?

CMS 1500 – Professional Claims

Standard claim form for non-institutional providers

Medicare requires EDI billing of the 1500

What are the three key claim components?



CMS 1500 – Professional Claims – Contd..

Provider Type	Service Example
Primary Care Physician	Hospital visit for a patient in the hospital
Specialty Care Physician	Surgery charges for knee replacement
Physician Assistant	Office visit for strep screening
DME Supplier	Charges for a wheelchair
Psychologist	Behavioral health consult



CMS 1500: Language of Healthcare

HCPCS

Health Care Common Procedure Coding System

- A0429 – Ambulance service, basic life support, ER transport
- L0120 – Cervical, flexible, non-adjustable foam collar

CPT

Current Procedural Terminology

- 99214 – Office visit
- 36415 – Venipuncture

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International Statistical Classification of Disease and Related Health Problems

- ICD-9: 250.00 – Diabetes
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POS

Place of Service

- 11 – Office visit
- 21 – Inpatient Hospital

UB 04 – Facility Claims

Standard claim form for institutional providers

Medicare requires EDI billing of the UB 04

What are the three key claim components?



UB 04 – Facility Claims – Contd..

Provider Type	Service Example
Inpatient Procedures	Hospital stay including associated supplies
Surgical Procedures	Non-physician surgery charges
Outpatient Procedures	Non-inpatient services, e.g., same day surgery
Radiology Procedures	Services provided for MRI or an x-ray
Home Health Services	Services provided in a patient’s home



UB 04: Language of Healthcare

Rev

Revenue Code

- 0110 – Room & Board (Private)
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Health Care Common Procedure Coding System

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Diagnostic Related Groups

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- 089 – Concussion w/cc

POS

Place of Service

- 11 – Office visit
- 21 – Inpatient Hospital

CMS 1500 or UB 04?

- Patient Story: Injured Runner



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	UB04



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	UB04
Marathon City ER Physicians	ER Physician Consult	



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	UB04
Marathon City ER Physicians	ER Physician Consult	CMS 1500



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	UB 04
Marathon City ER Physicians	ER Physician Consult	CMS 1500
Ortho R Us Physicians	Orthopedic Physician Consult and Treatment in ER	



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	UB 04
Marathon City ER Physicians	ER Physician Consult	CMS 1500
Ortho R Us Physicians	Orthopedic Physician Consult and Treatment in ER	CMS 1500



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	UB 04
Marathon City ER Physicians	ER Physician Consult	CMS 1500
Ortho R Us Physicians	Orthopedic Physician Consult and Treatment in ER	CMS 1500
We See You Physicians	Radiologist Reading the X-ray	



CMS 1500 or UB 04? – Contd..

Provider	Services	Claim Form
Marathon City Hospital ER	ER, X-Ray, Casting Supplies	UB 04
Marathon City ER Physicians	ER Physician Consult	CMS 1500
Ortho R Us Physicians	Orthopedic Physician Consult and Treatment in ER	CMS 1500
We See You Physicians	Radiologist Reading the X-ray	CMS 1500



CMS 1500 or UB 04 ? – Contd..

- Patient Story: Motorcycle Accident

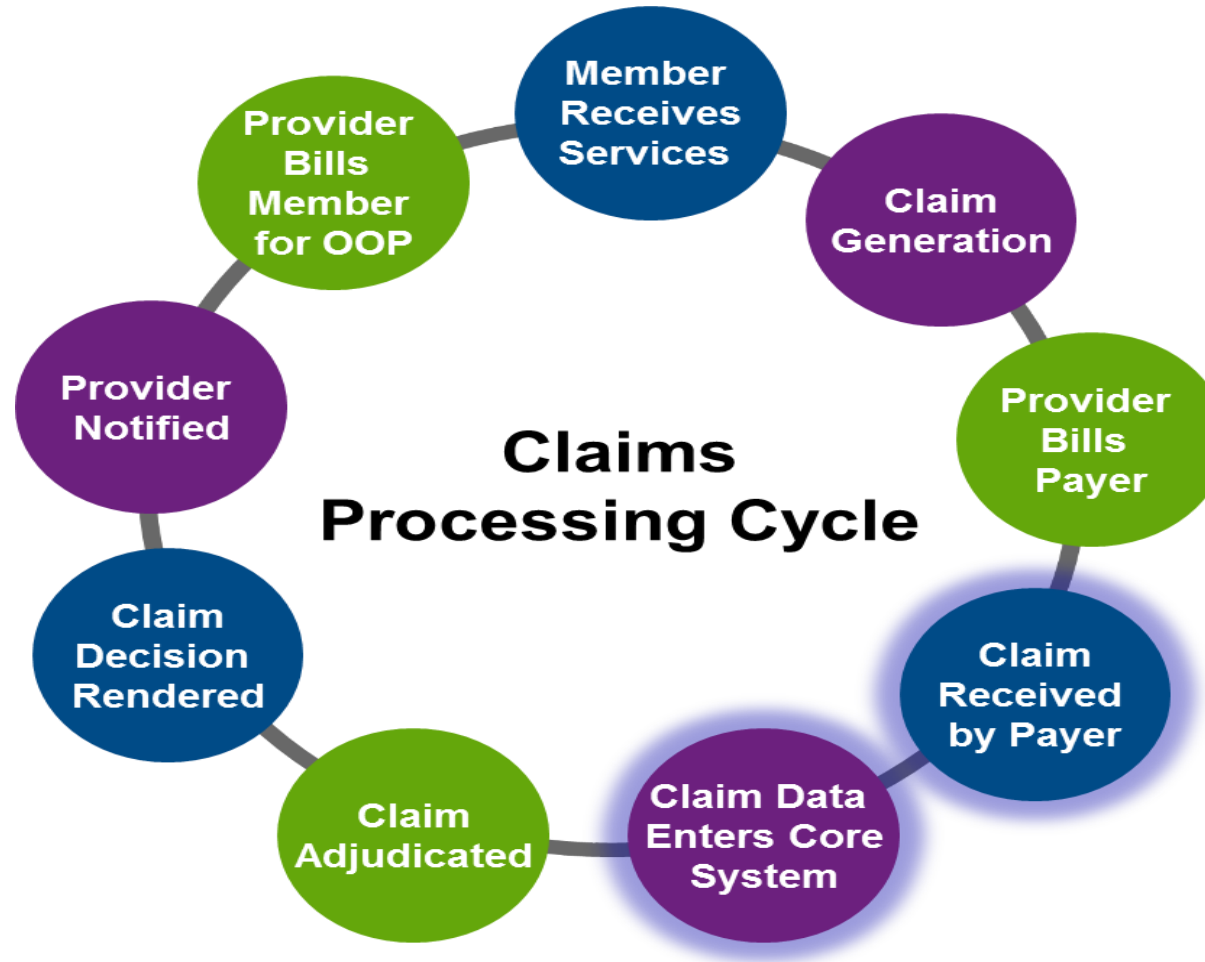


CMS 1500 or UB 04 ? – Contd..

- Patient Story: Cold and Cough Symptoms



Claims Processing Cycle – Contd..



Claims Administration

An **encounter** is a visit by a plan member to a provider of healthcare or related services.

An encounter report includes the services provided, the date of service, the diagnosis, and other information.

A health plan uses encounter reports to track utilization and provider practice patterns and as a basis for future capitation amounts.

Claims administration department includes Data entry clerks, **claims examiners, processors, reviewers, analysts, or adjudicators**. Their exact duties may vary by title or plan, but essentially they review and adjudicate claims that are not electronically processed for some reason.

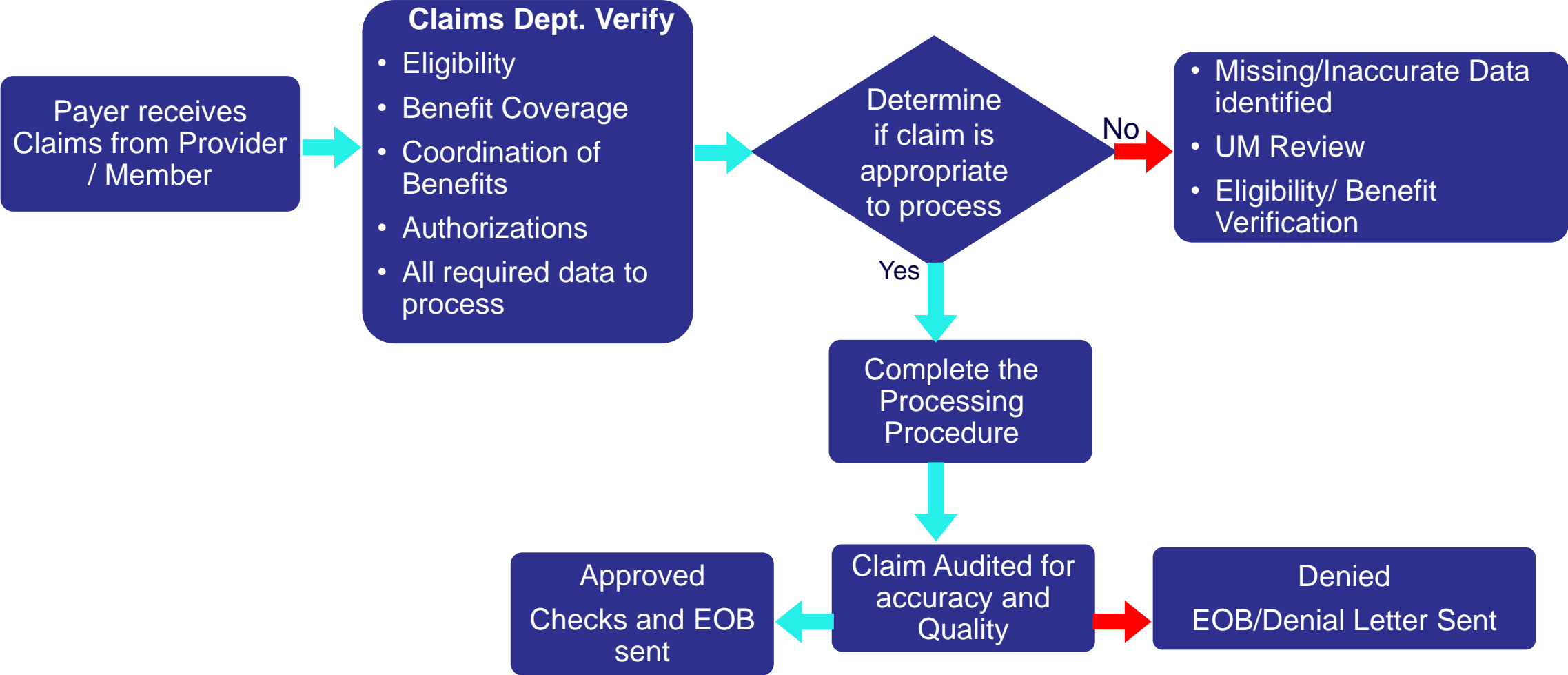
Claims adjustors deal with claims that have been paid incorrectly.

Claims Adjudication

- Adjudicating a claim (determining whether it should be paid and if so how much) can be thought of as satisfying a number of questions about the claim.
- Verifying Member Status - Was the member eligible to receive benefits under the plan at the time services were provided?
- Verifying Provider Status - Was the provider a participant in the plan's network?
- Determining Appropriateness of Treatment Provided - Was the treatment provided medically appropriate and/or medically necessary?
- Verifying Authorization –
 - Was a preauthorization or referral required for the service or treatment?
 - Was a preauthorization or referral given for the service or treatment?
- Verifying That the Service Is Covered by the Plan - Is the service covered under the plan?
- Verifying That the Service Was Actually Provided - Determining the Amount of Benefits to Pay
- What benefits are payable? - Does the member have other health insurance coverage?

- Claims Forms - UB-04(Institutional) and CMS-1500 (Professional)
- Edits- criteria that, if unmet, will prompt further investigation of a claim
- Claim investigation

Claims Adjudication – Contd..



Payment and Denial Explanations

Evidence of payment or denial

Provided to member, payer, or provider

Members receive an Explanation of Benefits

Providers receive a Remittance Advice

Medicare and most payers provide data through EDI

Explanation used to reconcile payment or denial

Explanation Of Benefit (EOB) - Sample

Medicare EOB Summary Info

Claim Info - E14019000100

Submitter Name [REDACTED] PHYSICIANS
SERVICE

Address 1

Address 2

Medicare Paid Date 01/17/2014

BillingProviderName

Billing Provider NPI [REDACTED]

Billing Provider TIN [REDACTED]

Submitted Charges \$744.02

Total Medicare Paid Amount \$48.15

Primary Payer Info

ICN Number 00501140170504

Other Carrier Subs. Name [REDACTED]

Patient Name [REDACTED]

OC Subscriber ID [REDACTED]

Medicare Assignment A

Claim Level Adjustment Info

Paid Date	DOS	Medicare Allowed	Total Charges	Medicare Paid	Medicare Ded	Medicare Coins	Medicare Copay	Medicare Non-Covered	Medicare WO/DC
01/17/2014	08/30/2013 - 08/30/2013	\$80.50	\$744.02	\$48.15	\$0.00	\$32.35	\$0.00	\$0.00	\$467.50

Line Level Adjustment Info

Item#	Rev. Code	Proc/ Mod	Paid Date	Medicare Allowed	Charge	Medicare Paid	Medicare Ded	Medicare Coins	Medicare CoPay	Medicare Non-Covered	Reason Code	Reason Amount	Medicare Write-off/ Discount	Reason Code	Reason Amount
1	0320	74230	01/17/2014	\$80.50	\$548.00	\$48.15	\$0.00	\$32.35	\$0.00	\$0.00			\$467.50	CO45 CO253	\$466.52 \$0.98
2	0440	G8996GN	01/17/2014	\$0.00	\$0.01	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00			\$0.00		
3	0440	G8998GN	01/17/2014	\$0.00	\$0.01	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00			\$0.00		
4	0444	92611GN	01/17/2014	\$0.00	\$196.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00			\$0.00		
Total				\$80.50	\$744.02	\$48.15	\$0.00	\$32.35	\$0.00	\$0.00			\$467.50		

Explanation of Benefits – Contd..

- The EOB is sent by the Health Plan to covered individuals.
- EOBs explain what medical treatments and/or services have been paid or denied.
- Similar information to a remittance advice.
- Typically a simple version of remittance advice.

Thank you