Introduction to Insurance Business

Insurance - A way to share risk with others

Insurance is a way of protecting against the risk of financial loss. An individual or business enters into a contract with an insurance company by purchasing an insurance policy. The person or business pays a relatively small, fixed amount (a premium) to the insurer at regular intervals (such as monthly or yearly). In exchange, if the person or business incurs a financial loss covered by the insurance policy, the insurer makes a payment (a benefit) or payments to cover or help cover this loss.

Now that you have a better understanding of what insurance is in general, let's look at medical insurance (or Health Insurance, as it is frequently called). Medical insurance narrows down the "undesirable events" mentioned earlier to illness and injuries. The insurance company promises to pay part (or sometimes all, depending upon the policy) of the financial expenses incurred as a result of medical procedures, services, and certain supplies performed or provided by healthcare professionals if and when an individual becomes sick or injured.
Some insurance policies also pay medical expenses even if the individual is not sick or injured. Healthcare providers and companies that sell health insurance have determined that it is often less costly to keep an individual well or to catch an emerging illness in its early stages, when it is more treatable, than to pay more exorbitant expenses later on should that individual become seriously ill. This practice is referred to as preventive medicine.

Individual and Group Insurance

Insurance can take the form of individual or group coverage. In individual insurance a private person buys a policy from an insurer. He/she is the policyholder (the party to the insurance contract), he/she pays the premium, and he/she (and in some cases his/her dependents) are insured. In group insurance a business buys a policy that covers its employees, or an association or union buys a policy for its members.
The policyholder is the business association, or union; the employees or members and often their dependents are insured; and while employees or members may pay all or part of the premiums, they do so through the policyholder.

History

Insurance is not a recent phenomenon. The word insurance is derived from the Latin word Securitas, which translates into English word Security.

From the beginning of time, people have looked for ways to ease some of the hardships of human existence. It has been common knowledge down through the ages that it has been difficult for any one individual to survive for long on his or her own. Prehistoric humans quickly learned that to survive, the resources of others must be pooled. The beginnings of modern

health insurance occurred in England in 1850, when a company offered coverage for medical expenses for bodily injuries that did not result in death.

By the end of that same year in the United States, the Franklin Health Insurance Company of Massachusetts began offering medical expenses coverage on a basis resembling health insurance as we know it now. By 1866, many other insurance companies began writing health insurance policies. These early policies were mostly for loss of income and provided health benefits for a few of the serious diseases that were common at that time-typhus, typhoid, scarlet fever, smallpox, diphtheria, and diabetes. People did not refer to these arrangements as insurance, but the concept was the same.
In the United States, the birth of health insurance came in 1929 when Justin Ford Kimball, an official at Baylor University in Dallas, Texas, introduced a plan to guarantee school teachers 21 days of hospital care for $6 a year. Other employee groups in Dallas soon joined the plan, and the idea caught on nationwide. This plan eventually evolved into what we know as Blue Cross. The Blue Shield concept grew out of the lumber and mining camps of the Pacific North West at the turn of the 20th Century. Employers, wanting to provide medical care for their workers, paid monthly fees to “medical service bureaus”, which were
composed of groups of physicians. The Blue Cross and Blue Shield plans traditionally established premiums by community rating-that is, everybody in the community paid the same premium.

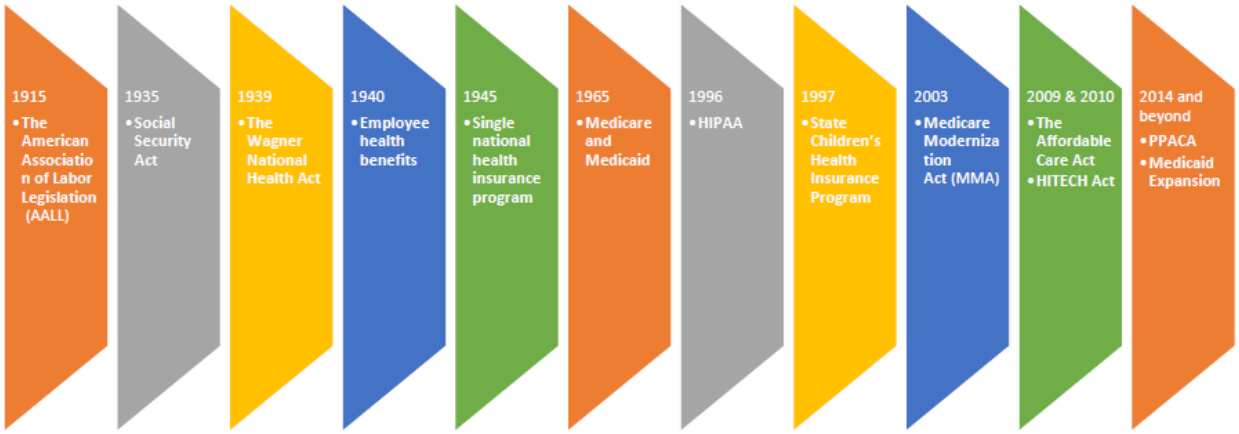
Health Insurance Timeline

1900s	American Medical Association (AMA) becomes a powerful national force. Membership increases from about 8000 physicians in 1900 to 70,000 in 1910—half of them in the U.S. This is the beginning of “organized medicine.” Surgery is becoming more common. Physicians are no longer expected to provide free services to all hospital patients. United States lags behind European countries in finding value in insuring against costs of sickness. Railroads are the leading industry to develop extensive employee medical programs.
1910s	U.S. hospitals are now modern scientific institutions, valuing antiseptics and cleanliness, and using medications for the relief of pain. American Association for Labor Legislation (AALL) organizes first national conference on “social insurance.” Progressive reformers gaining support for health insurance. Opposition from physicians and other interest groups and the entry of the United States into World War I in 1917 undermine reform front.
1920s	Reformers emphasize the cost of medical care instead of wages lost to sickness—the relatively higher cost of medical care is a new and dramatic development, especially for the middle class. Growing cultural influence of the medical profession—physicians’ incomes are higher, and prestige is established. Rural health facilities are seen by many as inadequate. Penicillin is discovered, but it will be 20 years before it is widely used to combat infection and disease.
1930s	The Depression changes priorities, with greater emphasis on unemployment insurance and “old age” benefits. Social Security Act is passed, omitting health insurance. Against the advice of insurance professionals, Blue Cross begins offering private coverage for hospital care in dozens of states.
1940s	Penicillin comes into use. Prepaid group healthcare begins, seen as radical. To compete for workers, companies begin to offer health benefits, giving rise to the employer-based system in place today. Congress is asked to pass an “economic bill of rights,” including the right to adequate medical care. President offers a single-system, national health program plan that would include all Americans.
1950s	Attention turns to Korea and away from health reform; United States has a system of private insurance for people who can afford it and welfare services for the poor. Federal responsibility for the sick is firmly established. Many more medications are available now to treat a range of diseases, including infections, glaucoma, and arthritis, and new vaccines become available that prevent dreaded childhood diseases, such as polio. The first successful organ transplantation is performed.

1960s	In the 1950s, the price of hospital care doubled. Now in the early 1960s, people outside the workplace, especially the elderly, have difficulty affording insurance. More than 700 insurance companies sell health insurance. Major insurance endorses high-cost medicine.
	President signs Medicare and Medicaid into law. Number of physicians reporting themselves as full-time specialists grows from 55% in 1960 to 69%.
1970s	Prepaid group healthcare plans are renamed health maintenance organizations (HMOs), with legislation that provides federal endorsement, certification, and assistance. Healthcare costs escalate rapidly; U.S. medicine is now seen as in crisis. Growing complaints by insurance companies that the traditional fee-for-service method of payment to physicians is being exploited. Healthcare costs rise at double the rate of inflation. Expansion of managed care helps to moderate increases in healthcare costs.
1980s	Overall, there is a shift toward privatization and corporatization of healthcare. Under President Reagan, Medicare shifts to payment by diagnosis (DRG) instead of by treatment. Private plans quickly follow suit. Growing complaints by insurance companies that the traditional fee-for-service method of payment to physicians is being exploited. A specific fee or payment amount per patient (capitation) to physicians becomes more common.
1990s	Healthcare costs rise at double the rate of inflation. Expansion of managed care helps moderate increases in healthcare costs. By the end of the decade, 44 million Americans—16% of the nation—have no health insurance at all. Human Genome Project to identify all of the >100,000 genes in human DNA gets under way. By June 1990, 139,765 people in the United States have HIV/AIDS, with a 60% mortality rate.
2000s	Healthcare costs continue to rise. Medicare is viewed by some as unsustainable under the present structure and must be "rescued." Changing demographics of the workplace lead many to believe the employer-based system of insurance cannot last. The Human Genome Project's identification of all of the >100,000 genes in human DNA was completed in 2003, and all individual chromosome papers were completed in 2006; papers analyzing the genome continue to be published. Direct-to-consumer advertising for pharmaceuticals and medical devices is on the rise.

You should now be familiar with how health Insurance got started, how it developed into what we know as modern health insurance today, how it has changed throughout history, and what caused these
changes. Politics has played a big role in the development of health insurance in the United States and is responsible for the advent of major government-sponsored plans - Medicare and Medicaid- and HMOs.

Great Moments in the History of Insurance



1. 1915: The American Association of Labor Legislation (AALL) drafts a model health insurance bill that would cover the working class and all others who make less than $1,200 a year.

Opponents denounce the bill as socialist insurance. With the U.S. entry into World War I and subsequent Red Scare, the national health insurance debate would come to an end for the time being.

2. 1935: President Roosevelt signs the Social Security Act into law. The Act establishes a system of social welfare and social insurance programs, including provisions for the elderly, disabled persons, widows and widowers, children, and the unemployed. In the midst of the Great Depression, the Act omits compulsory health insurance in favor of unemployment insurance and benefits for seniors.

3. 1939: The Wagner National Health Act proposes a national health program funded by federal grants to states and administered by states and localities. Southern Democrats and Republicans unite to oppose the bill, viewing it as a form of government expansion.

4. 1940s: Employers begin to provide employee health benefits in order to overcome wage and price controls set during World War II and to compete for workers. With a cushion against health care costs, workers show minimal interest in a national health insurance plan.

5. 1945: President Truman calls for a single national health insurance program that would provide benefits for all Americans. Strong opposition to the proposal, which was labeled socialized medicine, among other things, would lead to its death in congressional committee. From this defeat, however, an interest in hospital insurance for the elderly would arise.

6. 1965: While the 1950s see an increase in health care costs and expanded medical treatments, multiple legislative proposals for health insurance fail. But in the 1960s, the growing need for health insurance for the elderly and those outside the workplace gains national attention. In 1965, President Johnson signs the Medicare and Medicaid programs into law, providing comprehensive, low-cost health insurance coverage to millions of Americans in need

7. 1990s: The 1970s bring HMO's and battling national health care proposals, while the 1980s establish COBRA and the Americans with Disabilities Act. Then in 1993, aiming for a broad reworking of the health care system, President Clinton proposes a universal health care plan. Officially known as the Health Security Act, the bill fuels opposition from Republicans, the health care industry and employers. It also draws competing plans from Democrats in Congress and eventually suffers defeat in 1994.

8. 1997: Congress approves the State Children's Health Insurance Program (SCHIP), which expands health care coverage for children in low-income families that do not qualify for Medicaid.

9. 2003: President Bush signs the Medicare Modernization Act (MMA), which includes a prescription drug benefit. The bill passes by a narrow margin and comes under fire for its complex funding and subsidies to private insurers.

10. 2010: After an intense, yearlong debate, President Obama signs the Affordable Care Act into law. This sets in motion a series of comprehensive health insurance reforms, including the creation of health insurance marketplaces, free preventive care and coverage for adults under 26 years old. The Affordable Care Act struggles through its share of controversy, from the individual mandate to a fumbled website rollout, and it undergoes multiple votes for repeal in the House of Representatives. Nevertheless, it remains the law of the land, with the Supreme Court upholding it as Constitutional in 2012.

2014 and Beyond: Some of the most significant (and contentious) parts of the Affordable Care Act came into effect on January 1st of this year. These include banning pre-existing conditions, eliminating lifetime limits on coverage, the expansion of Medicaid, and the individual mandate, which requires Americans who can afford health insurance to purchase minimum coverage.

In the United States, health insurance is any program that helps pay for medical expenses, whether through privately purchased insurance, social insurance, or a social welfare program funded by the government. Synonyms for this usage include "health coverage," "health care coverage," and "health benefits."
In a more technical sense, the term is used to describe any form of insurance that provides protection against the costs of medical services. This usage includes private insurance and social insurance programs such as Medicare, which pools resources and spreads the financial risk associated with major medical expenses across the entire population to protect everyone, as well as social welfare programs such as Medicaid and the State Children's Health Insurance Program, which provide assistance to people who cannot afford health coverage.

In addition to medical expense insurance, "health insurance" may also refer to insurance covering disability, long-term nursing, or custodial care needs.
According to the United States Census Bureau, roughly 55% obtain insurance through an employer, while about 10% purchase it directly. About 31% of Americans were enrolled in a public health insurance program: 14.5% (45 million – although that number has since risen to 48 million) had Medicare, 15.9% (49 million) had Medicaid, and 4.2% (13 million) had military health insurance (there is some overlap, causing percentages to add up to more than 100%). Employers may also provide reimbursement for health insurance purchased individually by their employees through a Defined Contribution Health Benefits Plan. Employers are allowed to pay employees cash in lieu of health insurance, but this is uncommon as it is subject to strict IRS regulations.

Health Plans

We noted previously that the term health plan has many meanings. You will recall that we defined a health plan as the integration of the financing and the delivery of healthcare within a system that seeks to manage the cost, access, and quality of care. For this reason health plans may also be called managed care plans or managed care organizations.

The term “health plan” may be used to refer to a single organization or to a company that offers several types of health insurance or health plan products. In this course, we will use the term “health plan” to refer to any entity that utilizes certain concepts or techniques to manage the cost, access, and quality of healthcare.

Just as it is difficult to define a health plan, it is an equally complex task to describe and distinguish among the different types of health plans and health plan products. In some cases, the same term may be used to describe both a type of health plan and a type of health plan product. Examples of health plan types are Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Physician-Hospital Organizations (PHOs).

Indemnity Plan

Also called “Freedom of Choice” Members can access care through any licensed provider; there are no networks in this plan.

- Freedom of choice
- No referrals
- No PCP

Basic Features of Indemnity Health Insurance:

Provider Choice

In traditional indemnity health insurance, when an insured needs healthcare, he/she can go to any physician, specialist, hospital, or other healthcare provider she chooses. He/She does not have to use a provider affiliated with a network, nor will he/she pay more if she uses a non-network provider, as is the case in some health plans.

Benefit Payment

Under an indemnity policy, an insured receives care from a provider, the provider charges her for the services rendered, she submits to her insurer a claim (a request for payment based on the terms of the policy), and the insurer reimburses her. Or more commonly, the insured assigns benefits to the provider—under assignment of benefits, the provider bills the insurer directly, and the insurer reimburses the provider.

Typically in indemnity insurance, the provider bills the insurer her usual fee for the service she performed, and the insurer pays this amount. This system is known as fee-for-service (FFS). There are limits, however—typically, an insurer will not pay a fee considerably higher than the usual and customary charge for the service in the locality.

Managed Health Care

We think of managed care and health plans as modern developments, but in fact early versions have existed since the beginning of the 20th century. A few historical milestones:

- 1910. The earliest examples of health plans appeared in the form of prepaid group practices. These were healthcare systems in which plan members paid a monthly premium and in return received a wide range of medical services through an exclusive group of providers.
- 1929. Blue Cross plans providing prepaid hospital care were established.
- 1930. Blue Shield plans providing reimbursement for physician services were established.
- 1954. Individual Practice Associations (IPAs), which contracted with physicians in independent fee-for-service practices, emerged as a competitive response to Health Maintenance Organizations (HMOs), which were based on group practices.

For many years health plans accounted for only a small fraction of all health coverage. In recent decades they have grown dramatically, and they now cover a large portion of the U.S. population. There have been many reasons for this growth, but we will focus on three key factors: the HMO Act of 1973, consumer and employer demand, and government involvement.

The HMO Act of 1973

One of the most important causes of the expansion of health plans was the federal Health Maintenance Organization Act of 1973. This legislation was designed to reduce the cost of healthcare by increasing competition in the health coverage market and to increase access to health coverage for individuals without insurance or with only limited benefits. The main features of the HMO Act are:

- Federal qualification: HMOs were given the option of becoming federally qualified. To do so, they had to meet a number of standards related to minimum benefit packages, provider network adequacy, enrollee grievance systems, financial stability, and quality assurance.
- Dual choice: Employers that offered indemnity health insurance to more than 25 employees had to also offer a federally qualified HMO (if an HMO requested it).
- Federal funding: To encourage their development, grants and loans were made available to federally qualified HMOs. Funding could be used to expand the service area of an existing HMO or establish a new HMO.
- State law exemption: Federally qualified HMOs were exempted from state laws that restricted their development.

Although federal qualification was optional, many HMOs sought it because of the advantages mentioned above and because it could be cited as a “stamp of approval” in marketing. But on the other hand, in some ways it weakened the competitive position of qualified HMOs, since they had to meet the federal standards and traditional indemnity insurance or other health plans did not.

From 1976 to 1996, the HMO Act was modified by a series of amendments. These gave health plans more flexibility in designing and marketing products and increased the emphasis on quality. Many of the standards for federally qualified HMOs were reduced or eliminated, and the dual choice mandate was repealed in 1995.

The HMO Act played a major role in the early establishment and growth of HMOs, and although federally qualified status no longer carries the weight it had previously, some HMOs still maintain it.

Consumer and Employer Demand

HMOs had significant success in containing healthcare costs and holding down premium increases, and by the early 1990s consumers and employers sponsoring health coverage had come to embrace them. A traditional HMO required members to receive healthcare only from providers affiliated with the plan (that is, in the plan's network), and consumers became dissatisfied with this restriction. They wanted the lower cost of an HMO but more leeway in choosing providers. New health plan types were developed to address this demand. Two of the most important were PPOs and POS products.

Preferred Provider Organizations (PPOs) like HMOs, have a network of providers. Unlike traditional HMOs, they cover services delivered by non-network providers, although the member pays a greater share of costs than for network care (typically higher copayments or coinsurance). While traditional HMOs require members to obtain a referral from their primary care physician to see a specialist, PPOs generally do not.

Point-of-Service (POS) products combine elements of traditional indemnity insurance with elements of health plans. Members do not have to choose how they receive services until they use them and may
obtain care from network providers and/or non-network providers. However, as with a PPO, members pay more for out-of-network care. Visits to specialists may require a referral from a primary care physician.

Consumers also wanted coverage of specialty healthcare, such as dental care, vision care, behavioral health, and prescription drugs. Employers wanted more cost-effective ways of providing such benefits. In response, health plans developed specialty "carve-out" plans and products with specialized provider networks. Specialty coverage may be integrated into a comprehensive health plan or offered as a stand-alone product.

Around the beginning of the new century, health premiums began to go up again, and consumers and employers looked for new solutions. One approach is Consumer-Directed Health Plans (CDHPs). CDHPs are based on employer funding of a core set of benefits, employee financial responsibility, and increased accountability of the health plan and providers. Under a CDHP, the individual has both a health insurance plan with a high annual deductible and a tax-advantaged health savings account. He or she uses money from the account to pay for healthcare expenses before the high deductible of the health plan is satisfied, as well as

other out-of-pocket healthcare costs, generally on a tax-free basis. This approach both makes possible a low premium and gives consumers an incentive to make prudent healthcare choices, as they pay much of the cost themselves.

These and other health plan types and products will be discussed in the modules that follow.

Health Insurance plans are usually described as either

- Traditional Indemnity Plan
- Managed Care Plan

Health Plan Products

In an effort to meet changing customer demand for customization and flexibility of product options, health plans are offering more and different health plan product types and models. In general, there are some basic characteristics that distinguish the different types of products from one another. Product types are becoming less clearly distinguishable from one another, and there few rigid and absolute distinctions among different types. It is likely that these distinctions will blur even further as the health plan industry continues to evolve.
Examples of types of health plan products:

- Health Maintenance Organizations (HMOs) — plans that typically utilize physicians as gatekeepers.
- Preferred Provider Organizations (PPOs)—plans that usually contract at discount prices with physicians.
- Exclusive Provider Organization (EPOs) – Requires a referral, will cover only in network unless it is an emergency.
- Point-of-Service (POS) products—plans in which members do not have to select how to receive services until they use them.
- Consumer-Directed Health Plans (CDHPs)—plans that combine a health savings account with a high-deductible health insurance plan.

There are also specialty health plan products for specific types of services and populations. Examples include:

- Dental HMOs and PPOs,
- Vision care HMOs and PPOs,
- Medicare HMOs, and
- Medicaid plans.

Health Insurance Options

Type of Plan	What it Offers	Method Of Control	Features
HMO (Health Maintenance Organization)	Services from network providers only	“Gatekeeper” managing utilization and referrals Negotiated provider discounts	Comprehensive care low co-payments Low out-of-pocket expenses
Indemnity	Services from any providers	None	Freedom to choose any provider

PPO (Preferred Provider Organization)	Services from any provider, but at a lower cost inside the provider network	Discounts negotiated with providers Prior approval for hospitalization	Freedom to choose any provider Savings when participating network providers are used
POS (Point of Service)	Services from any provider, but at a lower cost inside the provider network	Within network, “gatekeeper” manages utilization. Negotiated provider discounts.	Freedom to choose any provider Savings when participating network providers are used Preventive care is covered
EPO (Exclusive Provider Organization)	Services are covered only within the EPO network. The only exception is for emergency care.	Within network	Members may not need a referral to see a specialist.

The Consumer Choice Philosophy

The movement toward consumer choice may represent one of the greatest paradigm shifts in the healthcare market since the rise of managed care. At its core consumer choice involves empowering healthcare consumers to play a greater role in the purchase of their healthcare services, while simultaneously giving them greater responsibility for the cost of that care.
It represents a fundamental shift away from the traditional third-party payment approach, which for years has left the consumer with little awareness of or concern about the cost of the services he or she uses. The expectation is that if consumers have increased decision-making power and financial responsibility they will become more judicious in the way they purchase healthcare services as well as in the type and amount of services they use.
By having more "skin in the game," consumers have a greater incentive to get the best product, service, and value for their money.

Consumer-Directed Health Plans

Under the consumer choice paradigm, employers choose an insurance carrier or third-party administrator to manage benefits, the network, and to pay claims. Benefits are provided through a Consumer-Directed Health Plan (CDHP), a health plan design that combines financial incentives with information about cost and quality to help consumers make better-informed decisions about their healthcare.
CDHPs typically have two components:

A High-Deductible (or “Catastrophic”) Health Plan (HDHP). Such a plan does not pay for the first few thousand dollars of healthcare expenses (the deductible) but usually covers most if not all costs above this amount.

A tax-advantaged personal healthcare account. Account funds can be used to pay for healthcare expenses before the deductible is satisfied, and such funds are generally exempt from taxation. Because HDHPs do not pay for the first few thousand dollars of expenses, they generally have lower premiums than traditional plans, and the money saved can be used to help fund the personal healthcare account.

The Evolution of Consumer Choice Models

CDHPs are not new. They were introduced in the late 1970s, and they have been retooled several times since. All CDHP products provide federal tax advantages while allowing consumers to save money for their healthcare, but each has a unique design and is subject to a unique set of federal rules. Early CDHP models had limited popularity because of restrictions that consumers disliked, but more recent plan types have attempted to improve on earlier models in an effort to widen consumer appeal.

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs), a type of benefit arrangement offered under an employer's cafeteria plan, were introduced in the late 1970s and are the oldest type of personal healthcare account. FSAs are established by employers, and employees may elect to participate in them for reimbursement of certain expenses while saving money on taxes. There are dependent care FSAs (used mostly for child care expenses) and healthcare FSAs for uninsured (out-of-pocket) medical expenses. Employers, employees, or both may contribute to an FSA, although most often only the employee contributes. Before the start of the plan year, employees designate the amount they want deducted from their wages that year and contributed to their FSA, and equal amounts are withheld from each paycheck throughout the year. However, employers must make the full annual amount elected by the employee available at the start of the plan year.
Example: Chloe chooses to contribute $1,200 annually to her FSA, so $50 is deducted from each semi-monthly paycheck. From the start of the year, she can receive $1,200 in reimbursement. So when she incurs $500 in expenses in January, they are reimbursed, even though she contributed only $50.
The limited popularity of FSAs is partly the result of design-related restrictions on funding and use, including these rules:

- The "use-it-or-lose-it" rule. FSA balances must be used during the plan year and may not be "rolled over" to the following year. (Some employers have a two-and-a-half-month —grace period)
- The lack of portability. Employees who change jobs or retire cannot take FSAs with them.

Archer Medical Savings Accounts (MSAs)

Archer Medical Savings Accounts (MSAs) are tax-exempt trust or custodial accounts authorized as a demonstration project by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). MSAs were limited to helping self-employed individuals and employees of small businesses obtain reimbursement of medical care costs. Participants had to enroll in an MSA-qualified high-deductible health plan. In regard to rollover and portability, MSAs provided considerably greater flexibility than FSAs, but nonetheless they failed to achieve popularity during their demonstration period. MSAs were seen as an improvement over FSAs because they are portable, allowing employees to take the funds with them when they change jobs. The demonstration program was phased out at the end of 2007, and MSAs were essentially replaced by Health Savings Accounts (HSAs) (see below).

Health Reimbursement Arrangements (HRAs)

Health Reimbursement Arrangements (HRAs) were introduced by employers in 2000 (although they were not officially recognized as HRAs until 2002). The establishment and funding of HRAs is limited exclusively to employers; self-employed individuals are not eligible, and employees cannot make contributions. HRA funds may (at the option of the employer) be rolled over from year to year tax-free, increasing their appeal. There is some limited portability.

Health Savings Accounts (HSAs)

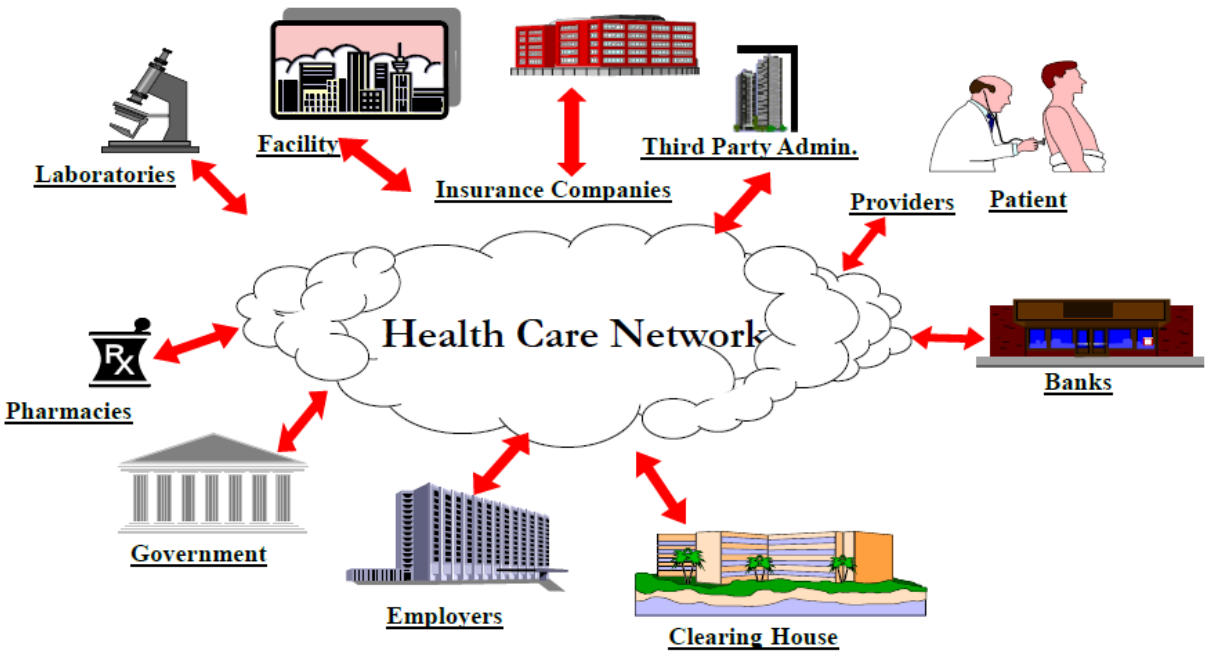
The Medicare Modernization Act (MMA) of 2003 amended the Internal Revenue Code to provide an income tax deduction to individuals for amounts contributed to a Health Savings Account (HSA), and this accelerated the consumer-directed healthcare movement. The HSA is designed to address several of the limitations of earlier personal healthcare accounts. It provides for funding by both employees and employers, direct employee ownership of the account, true account portability, year-to-year rollover, and investment opportunities.

Comparing FSAs, HRAs, and HSAs

	FSA	HRA	HSA
Funded By	Employee (and sometimes employer)	Employer Only	Employee, employer, or individual
Portable?	No	Limited, at employer option	Yes
Annual roll-over?	No	Employer option	Yes
Earns interest?	No	No	Yes

To set up and contribute to an HSA, an individual must be covered by an High-Deductible Health Plan that meets specific federal requirements (a qualified High-Deductible Health Plan). He/She must also not have other health insurance that is not a high-deductible plan, not be enrolled in Medicare, and not be claimed as a dependent on someone else's tax return.

Entities Involved in Healthcare System



Providers

A provider can be anyone who provides services to a patient. It can be a physician,hospital, pharmacist, nurse, or laboratory etc. There can be two types of healthcare,provider either Contracted or Non-Contracted. The basic difference between these two is their participation and non-participation with the insurance companies and getting paid for the services rendered according to their contract with the insurance company.

PCP – Primary Care Provider

A primary care provider (PCP) is a health care practitioner who sees people that have common medical
problems. This person is usually a doctor, but may be a physician assistant or a nurse practitioner. Your
PCP is often involved in your care for a long time, so it is important to select someone with whom you will
work well.

A PCP is a main health care provider in non-emergency situations. A PCP's role is to:

- Provide preventive care and teach healthy lifestyle choices

- Identify and treat common medical conditions
- Assess the urgency of your medical problems and direct you to the best place for that care
- Make referrals to medical specialists when necessary .

Primary care is usually provided in an outpatient setting. However, if you are admitted to the hospital, your PCP may assist in or direct your care, depending on the circumstances.

Patient

A patient can be any individual who makes a visit to a physician for illness treatment. He/she can be a subscriber or dependent on the policy.

Insurance Companies

Payers are insurance companies providing different health plans to their subscribers.
Claims are accepted by most insurance companies' electronically through EDI format but many of them also accept the claims on paper through a CMS 1500 or UB04.
Health insurance is a type of insurance where by the insurer pays the medical costs of the insured if the insured becomes sick due to covered causes, or due to accidents.

i. Private health insurance
ii. Publicly funded medicine

Who pays for the services of healthcare providers?

- Government Programs
- Private Payers
- Self-Funded Groups

Facility

- Hospitals
- Ambulatory Surgery Centers
- Skilled Nursing Facilities
- Home Health Agencies
- Freestanding Substance Abuse Facilities
- Hospice
- End-Stage Renal Disease Centers

Laboratory

Laboratory is defined as any facility which performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, treatment of disease or impairment, or assessment of health.

Laboratory Reimbursement

Factors that can influence billing and payment of laboratory services include:

- Point of Service
- Code Selection
- Modifier
- Units of Service
- CLIA (Clinical Laboratory Improvement Amendments) – regulatory authority

Point of Service: Reimbursement methods may be specific to a laboratory type or point of service.

Code Selection: Valid procedure and diagnosis codes are to be used.

Modifier: For repeat procedures, appropriate modifiers are to be used.

Units of Service: Number of times a particular test was conducted is to be specified.

CLIA: All clinical laboratories must enroll in CLIA and be certified to test in order to receive payments.

Pharmacy

A pharmacy is an entity providing pharmaceuticals. Pharmacies also play an important role in healthcare system. Medicines are the most commonly used form of healthcare treatment. Pharmacies bill insurance companies for prescription drugs.

Employer/Plan Sponsor

Employers and/or Plan Sponsors are the organizations for which an individual's work provides medical insurance to their employees including their spouses and dependents.

Third Party Administrators

A TPA is essentially an outsourcer that works with an organization on many aspects of their medical benefit plans.

• An entity that processes claims or subcontracts the processing of claims under a written service contract with an employer, client, insurance company, etc. Medical claims include surgical, dental, vision, pharmaceutical, disability, long-term care, cafeteria plans with a health component, non-self-funded worker's compensation medical plans, and credit disability.

• An insurance producer/agent who processes claims for health care benefits under a service contract with a carrier, as defined above.

• Subsidiaries of a TPA that are processing health claims need to be dually certified as TPAs. Divisions of the TPA that are processing claims do not need to be separately certified as TPAs.

Clearing House

Clearing houses act as an intermediary between the provider and payer.
The "electronic clearing house" system replaces a paper-based claims process for physician practices with an automated, electronic solution that adjudicates claims, adjusts the coding to the insurance companies standards, and provides physicians with real-time access to their claims processing.
Initially, claims come to the clearing house either electronically or on paper (CMS1500 or UB04) from the providers end and are forwarded to the various payers.
Administrative Functionality:

- Distributing claims to Payers (EDI & Mail).
- Converting paper claims to Electronic Format.

Banks

- Patient credit and collection
- Financial management
- Accounts reconciliation

Providers receive payment either as:

- Check
- EFT (Electronic Funds Transfer) – Direct deposit

Cost-Sharing

While indemnity insurers generally pay providers' fees, this does not mean that insurers cover all healthcare costs and insureds pay nothing.
Indemnity health insurance policies generally have cost-sharing—insureds must pay a portion of the expenses they incur.
In indemnity insurance, cost-sharing usually takes the form of a deductible and coinsurance.

Deductible

The insured must pay a specified dollar amount of expenses covered by the policy before the insurer begins paying benefits.
For instance, if a policy has a $500 annual deductible, each year the insured must pay for the first $500 of covered medical expenses.
Once this is done (that is, the deductible is satisfied), the insurer pays benefits for any additional covered expenses for the remainder of the year.

Copayments

A copayment is a flat dollar amount a plan member pays for a certain service.

Example: Jake is a member of a health plan. Whenever he sees his primary care physician, he makes a $10 copayment. The amount is always $10 regardless of the actual cost of the services the physician provides.
The purpose of cost-sharing is to hold down the cost of health coverage by reducing the amount the insurer pays in benefits, and also to give insureds an incentive not to use healthcare services unnecessarily.

Out-Of-Pocket (OOP)

Health insurance plans defines an upper limit for the member expenses. This limit is called out-of-pocket (OOP).
OOP is a combination of deductible, copay, and coinsurance. Generally after the OOP limit for a plan year is met, the member has to pay only copay.
The insurer will pay the remaining medical expenses. [Subjected to benefit plan]

Coinsurance

After the deductible is satisfied, the insurer pays a percentage of covered medical expenses, and the insured pays a percentage. For instance, the insured might pay 20 percent coinsurance and the insurer the remaining 80 percent.

Example: Mark is covered by a health insurance policy. It has a $500 annual deductible and 20 percent coinsurance. At the beginning of the year, Mark is hospitalized and incurs $5,000 in

medical expenses covered by his policy. What amount of these expenses will Mark pay? What amount will the insurer pay?

Mark pays the first $500 (the deductible). Of the remaining $4,500, he pays 20 percent coinsurance, or $900, for a total of $1,400 dollars. The insurer pays the other $3,600.

Plan Funding

Plan funding is the method that an employer or other payer or purchaser uses to pay medical benefit costs and administrative expenses.
A health plan may be financed or funded in a variety of ways, subject to federal and state requirements.
In this section we describe two common types of plans: fully funded plans and self-funded plans.

Fully Funded Plans or Fully Insured

In a fully funded plan an insurer or health plan bears the responsibility of guaranteeing claim payments, paying for all incurred covered benefits, and administering the health plan.
If the dollar amount of claims or administrative expenses exceeds the dollar amount of premiums collected, the health plan or insurer is responsible for the difference. On the other hand, if the group has fewer claim expenses than anticipated, the health plan or insurer has an opportunity to make a profit that is greater than anticipated. A fully funded plan is the traditional funding arrangement for a group health plan.
The group's policyholder, typically an employer, makes monthly premium payments to the health plan.

Self-Funded Plans or Administrative Services Only (ASO)

In a self-funded plan (also called a self-insured plan), an employer or other group sponsor, rather than a health plan or insurance company, is financially responsible for paying plan expenses, including claims made by group plan members.
The group sponsor, typically a large employer or group of employers, assumes complete financial responsibility for the incurred covered benefits and related expenses. A group may be partially or fully self-funded. Under the Employee Retirement Income Security Act (ERISA), a self-funded plan is exempt from specified state insurance regulations.

In a self-funded plan, the money that an employer and employees would have paid in premiums to an insurer or health plan is deposited into an account, called the funding vehicle, until the money is paid out. Employers pay only for incurred healthcare costs in a self-funded plan, so they save money when employees' utilization of medical care is lower than expected. However, employers are responsible for all incurred claims and other expenses, even if the funded amount is exhausted.

Administration - In a fully funded plan the insurer or health plan usually handles both the administrative and claims paying functions. In a self-funded plan, an employer or group sponsor must decide whether to perform the administrative duties on its own. An employer has several options in plan administration. The employer may self-pay, which means that the employer administers the plan itself by hiring a staff and purchasing the appropriate information

management systems. Alternatively, the employer may hire an independent third party to administer the plan. A third-party administrator (TPA) is an organization that administers group benefit plans for self-funded groups, but does not have the financial responsibility for paying benefits. The employer retains the financial responsibility for paying claims for the self-funded group.

Coordination of Benefits

A Coordination of Benefits (COB) provision of a health insurance policy is designed to prevent duplication of benefits when a person is covered by two policies (such as a child whose parents both have employer-sponsored coverage that includes dependents). Under a COB provision, one policy is considered primary and the other is secondary. The primary policy pays all the benefits it normally would, and if there are any expenses not covered by the primary policy but covered by the secondary policy, the secondary policy pays additional benefits. In this way, no benefits in excess of the actual expenses incurred are paid.

Example: Amelia is covered by both her father's and her mother's employer-sponsored group health insurance policy. Amelia receives healthcare services costing $1,000, all of which are covered by both policies. Her father's policy has 30 percent coinsurance, so it pays $700. Her mother's policy has 20 percent coinsurance, so it pays $800. But both policies have COB provisions, and the father's policy is the primary policy. So the father's policy pays $700 (the normal benefit), and the mother's policy pays $100 (the difference between the normal benefit and what has already been paid by the other policy).

Primary Carrier: the carrier that has been determined to be responsible for primary payment by applying the criteria to determine the order of benefits.

Secondary Carrier: the carrier that has been determined to be responsible for secondary payment (also referred to as paying as secondary).

Tertiary Carrier: the carrier that has been determined to be responsible for payment after the primary and secondary payment (if any)

Explanation of Benefits: (EOB) is a detailed explanation of payment or denial of a claim made by an insurance carrier. An EOB may also be referred to as a remittance advice.

NAIC

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories.
Through NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight.

Rules for Determining Primary & Secondary Carrier

The most common rules for determining the order of payment are the Non-dependent/Dependent Rule, Active/Inactive Rule and Birthday Rule.

Non-dependent/Dependent Rule: The first rule governing the order of benefit determination is that the plan covers the individual as an employee, member, or subscriber before plan benefits in which the individual is considered a dependent.

Active/Inactive Rule: A policy which covers an individual as an active employee is the primary payer over the policy covering the individual as a retired or laid off employee. This rule also applies to dependents covered under two policies.

Birthday Rule: This is a method used to determine when a plan is primary or secondary for a dependent child when covered by both parents' benefit plan. The parent whose birthday (month and day only) falls first in a calendar year is the parent with the primary coverage for the dependent. If both parents have the same birthday, then the plan that has been in effect the longest pays as primary.

Gender Rule: When both parents have programs covering the dependent children and one or both programs use the “gender” rule, the father’s plan will be primary and the mother’s plan will be secondary.

For dependents of divorced or separated parents, benefits are determined in the following order:

- First, the program of the parent with custody of the child shall be primary to any other dependent coverage.
- Second, the program of the child’s stepparent who is married to the child’s custodial parent.
- Third, the program of the non-custodial parent.
- Finally, the stepparent who is married to the non-custodial parent.

When Medicaid is a payer, it is always the payer of last resort. Similar rules apply to Medicare subscribers.

Traditional

Traditional coordination of benefits allows the beneficiary to receive up to 100 percent of expenses from a combination of the primary and secondary plans.

Maintenance of Benefits (MOB) or Non – Duplication COB

Maintenance of Benefits (MOB) allows patients to receive benefits from all health insurance plans they are covered under, while maintaining responsibility for coinsurance and/or copay amount on these coverages. The total combined payment from all sources cannot be more than the total charges for all services.

Maintenance of Benefits (MOB) reduces covered charges by the amount the primary plan has paid, and then applies the plan deductible and coinsurance criteria.

- Secondary payers only allow benefits up to their own maximum allowable for the specific service(s).
- If the primary carrier's payment is equal to or more than what the secondary carrier's payment would have been as primary, no additional benefits will be remitted.
- Can result in members having out-of-pocket expenses.

Medicare

Medicare is the federal government program established under Title XVIII of the Social Security Act of 1965 to provide hospital, medical, and other covered benefits to elderly and disabled persons. Medicare is available for:

- Persons age 65 or older
- Persons with qualifying disabilities (regardless of age)
- Persons with End-Stage Renal Disease (ESRD)

Overall responsibility for administering Medicare rests with the Centers for Medicare & Medicaid Services, (CMS) the federal agency that runs the Medicare program, and that works with the state governments to run the Medicaid program. CMS contracts for traditional Medicare claims processing functions and other billing and payment related tasks. These third party contractors are called Intermediaries under Medicare Part A and Carriers under Medicare Part B.

- Basics: Medicare is a federal program that covers individuals aged 65 and over, as well as some disabled individuals.
- Administration: Medicare is a single-payer program administered by the government; single-payer refers to the idea that there is only one entity (the government) performing the insurance function of reimbursement.
- Financing: Medicare is financed by federal income taxes, a payroll tax shared by employers and employees, and individual enrollee premiums (for parts B and D).
- Benefits: Medicare Part A covers hospital services, Medicare Part B covers physician services, and Medicare Part D offers a prescription drug benefit. [Medicare Part C refers to Medicare Advantage – HMO's that administer Medicare benefits].

Program Components

Initially, Medicare consisted of two components: Medicare Part A and Medicare Part B. These components defined the covered benefits available to eligible program beneficiaries.

Medicare Part A (Institutional)

Medicare Part A provides basic hospital benefits that cover the costs of inpatient hospital services, confinement in skilled nursing facilities or other extended care facilities after hospitalization, home care services following hospitalization, and hospice care. Individuals who satisfy Medicare eligibility requirements are automatically enrolled in Medicare Part A. Funding for Medicare Part A comes primarily from a payroll tax imposed on employers and workers. Additional funding comes from Social Security taxes. Individuals who meet Medicare eligibility requirements pay no premiums for Part A coverage. However, beneficiaries are required to pay an annual deductible for inpatient hospital care and specified coinsurance amounts for inpatient and skilled nursing care. Changes to deductibles and coinsurance amounts are formula-driven and approved by Congress each year.

Medicare Part B (Professional)

Medicare Part B provides benefits to cover the costs of physicians' professional services, whether the services are provided in a hospital, a physician's office, an extended-care facility, a

nursing home, or an insured's home. Benefits under Medicare Part B also include ambulance services, medical supplies and equipment, hospital outpatient surgery and services, diagnostic tests, laboratory and other services necessary for the diagnosis or treatment of illness or injury. Unlike Medicare Part A, Medicare Part B is a voluntary program. Part B benefits are available to persons age 65 or older and persons under age 65 who are entitled to Part A benefits, but beneficiaries must enroll for Part B coverage. Nearly all eligible beneficiaries do enroll in Part B coverage. Funding for Part B comes primarily from beneficiary monthly premiums and copayments. An eligible person who elects to participate in Medicare Part B pays a monthly premium deducted from his or her Social Security benefits. Medicare Part B also includes an annual deductible and coinsurance. Under the standard "80/20" Medicare coverage rule, enrollees are required to pay 20% of all covered healthcare expenses in excess of the deductible, and Medicare is responsible for the remaining 80%.

Medicare Advantage Plans / Medicare Part C

The Balanced Budget Act (BBA) of 1997 added a new Medicare Part C benefit to Title XVIII of the Social Security Act of 1965 that offered alternatives to fee-for-service Medicare through the Medicare+Choice (M+C) program. The M+C program is significant in that it formed the basis for the renamed Medicare Advantage program established under the Medicare Modernization Act of 2003 (MMA). Under Medicare Part C as amended by the MMA, licensed private health plans can provide a Medicare HMO, Preferred Provider Organization (PPO), Point of Service (POS), Private Fee-for-Service (PFFS) or Medical Savings Account (MSA) option as alternatives for beneficiaries on a regional or local basis.

Medicare Part D

The Medicare Modernization Act of 2003 brought sweeping changes to the Medicare Program. Foremost was the addition of a new Medicare Part D prescription drug benefit delivered through new Medicare Advantage (MA) (formerly Medicare + Choice) plans and stand-alone Prescription Drug Plans (PDPs). More than 27 million Americans are currently enrolled in the Part D program.

The below chart demonstrates the benefits and delivery methods of Medicare Parts A-D.

Medicare Part A (Hospital Insurance)	Medicare Part B (Medical Insurance)
• Helps cover inpatient care in hospitals (includes critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals). • Helps cover skilled nursing facility (not custodial or long-term care), hospice, and home health care services.	• Helps cover doctor services and outpatient care. • Helps cover some preventive services to help maintain a person's health and to keep certain illnesses from getting worse. • Generally pays 80% of the Medicare-approved amount for covered services
Medicare Part C (Medicare Advantage Plans)	**Medicare Part D (Prescription Drug Coverage)**
• A way to get Medicare benefits through private companies approved by and under contract with Medicare. • Includes Part A, Part B, and usually other benefits Medicare doesn't cover. Most plans also provide prescription drug coverage.	• Run by private companies approved by Medicare, which can either be Medicare Advantage Plans or separate Medicare Prescription Drug Plans. • Helps cover the cost of prescription drugs. • Each plan can vary in cost and drugs covered.

There are many gaps in Medicare coverage, including incomplete coverage for skilled nursing facilities, incomplete preventive care coverage, and no coverage for dental, hearing, or vision care. Because of this, the vast majority of enrollees obtain supplemental insurance. Overall, seniors pay about 22% of their income for health care costs despite their Medicare coverage.

Medicare Supplement Insurance / Medigap

Although traditional FFS Medicare covers some of the cost of hospitalization and basic medical services, it does not pay the full costs of these services because of deductible and coinsurance requirements. In addition, FFS Medicare does not pay benefits for prescription drugs, eyeglasses, hearing aids, and basic dental services. In order to cover some of the "gap" between FFS Medicare coverage and the actual cost of services, beneficiaries often rely on Medicare supplements. Because Medicare Advantage plans offer comprehensive benefit packages, Medicare supplements are not necessary for Medicare Advantage enrollees.

A Medicare supplement (also known as Medigap) is a state approved private medical expense insurance policy that provides reimbursement for services not covered by Medicare such as out-of-pocket expenses, (e.g., deductibles and coinsurance payments), or benefits for some medical expenses specifically excluded from Medicare coverage. Medicare supplements are available in two major forms: Medigap and Medicare SELECT policies.

Medicaid

- **Basics:** Medicaid is a program designed for the low-income and disabled. By federal law, states must cover very poor pregnant women, children, elderly, disabled, and parents. Childless adults are not covered, and many poor individuals make too much to qualify for Medicaid.
    - States have the option of expanding eligibility if they so choose. For example, states can choose to increase income eligibility levels.
    - As mentioned, under PPACA eligibility for Medicaid will be substantially expanded. As of January 2014, states will be required to cover all persons with income at or below 133 percent of the FPL.
- **Administration:** The states and the District of Columbia are responsible for administering the Medicaid program; as such, there are effectively fifty- one different Medicaid programs in the country.
- **Financing:** Medicaid is financed jointly by the states and federal government through taxes. Every dollar that a state spends on Medicaid is matched by the federal government at least 100%. In poorer states, the federal government matches each dollar more than 100%. Overall, the federal government pays for 57% of Medicaid costs.
- **Benefits:** Medicaid offers a fairly comprehensive set of benefits, including prescription drugs. Despite this, many enrollees have difficulty finding providers that accept Medicaid due to its low reimbursement rate.

Other public programs

- **CHIP -** The Children's Health Insurance Program (CHIP) is a federal-state program that pays for healthcare for children from families not poor enough to qualify for Medicaid but too poor to afford private-sector health coverage. As with Medicaid, the federal government sets broad guidelines, and within those guidelines each state administers its own program, establishes eligibility rules, and provides coverage. Also like Medicaid,

CHIP is jointly funded by the federal government and the states, but the federal government pays a higher percentage of costs than for Medicaid.

- **VA -** The Veteran's Administration is a federally administered program for veterans of the military. Health care is delivered in government-owned VA hospitals and clinics. The VA is funded by taxpayer dollars and generally offers extremely affordable (if not free) care to veterans.
- **CHAMPVA -** (Civilian Health and Medical Program of the Department of Veterans Affairs) is a federal health benefits program administered by the Department of Veterans Affairs.
- **CHAMPUS/Tricare -** Civilian Health and Medical Program of the Uniformed Services. A program of medical benefits available to inactive military personnel and military spouses, dependents, and beneficiaries through the Military Health Services System of the Department of Defense.
- **Federal Employees Health Benefits (FEHB) Program -** provides health coverage for full-time employees of the United States government, qualified retirees, and their spouses, dependents, and survivors. Under FEHB a large number of insurance companies and employee associations (including labor unions) offer health plans, and employees choose one. FEHB is operated by the federal Office of Personnel Management (OPM), and it is the largest employer-based group health insurance program in the world, providing coverage to more than 8 million people.
- **Workers' Compensation is a state-**mandated insurance program that provides benefits to cover healthcare costs and lost earnings for employees who suffer a work-related injury or illness. Every state has a workers' compensation law, and all states except Texas require employers to provide workers' compensation benefits. Most employers meet this requirement by purchasing workers' compensation insurance from an insurer. Some larger employers obtain permission from the state to self-insure or purchase high-deductible policies under which the employer retains much of the risk. Self-insured employers often hire a third-party administrator to manage their program.

Claim

A health-related bill submitted for payment to a health insurance company by the policy holder or health care provider.

Reimbursement

Repaying money to a person or institution who has spent it. The process by which health care providers receive payment for their services.
For both electronic and manual submissions, the claims process generally follows similar steps. Claims processes vary by payer, but the following general outline describes how the system is supposed to work.

- Claim submission
- Claims adjudication
- Notification of adjudication (EOB)
- Tracking and payment

Common Pitfalls

Major reasons that payers reject or delay payment on a claim include:

- The health plan didn't receive the claim.
- The submitted codes are invalid.
- Provider and/or patient identifiers are not included.
- The health plan information is incorrect.
- The plan does not cover the service.
- Administrative errors or delays by the payer can also result in processing errors and delays.
-

OCR Claim: OPTICAL CHARACTER RECOGNITION

The Recognition engine captures all machine print characters, interprets check boxes, detects signatures, performs field parsing, and validates data.

The steps in a claim lifecycle are:

- Generating a claim: This is the first step in the claim lifecycle. A member who is not feeling well visits the provider. The provider provides the adequate treatment and captures the healthcare information in the standard format.
- Filing a Claim: A generated claim, which is captured in the standard
- format, is sent to the insurer.
- Claim administration: A filed claim is received, reviewed, and adjudicated by the insurer.
- Claim reporting: After the claim administration process, the claim is archived for referral, financing reporting, and regulatory purposes.

Claims Administration

Claims administration is the process of receiving, reviewing, adjudicating, and processing claims for either payment or denial. By examining claims, the health plan can determine the number and type of healthcare services delivered to plan members. This information allows the health plan to understand each provider's practice patterns and level of compliance with the health plan's procedures for the delivery of care, as well as to monitor the number and types of services provided by the entire network.

Providers compensated through a capitation reimbursement arrangement do not submit claims. Instead, capitated providers send encounter forms to supply the health plan with information about members' healthcare visits, diagnoses, treatment, and plans for follow-up care. The provider relations staff can facilitate the processing of claims and encounter form information by helping providers stay up-to-date on the codes that they use to indicate diagnoses and procedures performed.

Claims Adjudication and Auto-Pay

Once the paper claim is converted to an electronic format, it should act just like a claim submitted via electronic data interchange (EDI). Once claims are submitted they are given an Internal Control Number (ICN) OR CLAIM IDs.

Claims Adjudication Process

Once a claim reaches a payer, it undergoes a process called adjudication. In adjudication, a payer evaluates a medical claim and decides whether the claim is valid/compliant and, if so, how much of the claim the payer will reimburse the provider for. It’s at this stage that a claim may be accepted, denied, or rejected.

A quick word about these terms. An accepted claim is, obviously, one that has been found valid by the payer. Accepted does not necessarily mean that the payer will pay the entirety of the bill. Rather, they will process the claim within the rules of the arrangement they have with their subscriber (the patient).
A rejected claim is one that the payer has found some error with. If a claim is missing important patient information, or if there is a miscoded procedure or diagnosis, the claim will be rejected, and will be returned to the provider/biller. In the case of rejected claims, the biller may correct the claim and resubmit it.

A denied claim is one that the payer refuses to process payment for the medical services rendered. This may occur when a provider bills for a procedure that is not included in a patient’s insurance coverage. This might include a procedure for a pre-existing condition (if the insurance plan does not cover such a procedure).

Once the payer adjudication is complete, the payer will send a report to the provider/biller, detailing what and how much of the claim they are willing to pay and why. This report will list the procedures the payer will cover and the amount payer has assigned for each procedure. This often differs from the fees listed in the initial claim. The payer usually has a contract with the

provider that stipulates the fees and reimbursement rates for a number of procedures. The report will also provide explanations as to why certain procedures will not be covered by the payer.
(If the patient has secondary insurance, the biller takes the amount left over after the primary insurance returns the approved claim and sends it to the patient's secondary insurance).

The biller reviews this report in order to make sure all procedures listed on the initial claim are accounted for in the report. They will also check to make sure the codes listed on the payer's report match those of the initial claim. Finally, the biller will check to make sure the fees in the report are accurate with regard to the contract between the payer and the provider.

If there are any discrepancies, the biller/provider will enter into an appeal process with the payer. This process is complicated and depends on rules that are specific to payers and to the states in which a provider is located. Effectively, a claims appeal is the process by which a provider attempts to secure the proper reimbursement for their services. This can be a long and arduous process, which is why it's imperative that billers create accurate, "clean" claims on the first go.

Stages of Claim Adjudication

1. Field Edits - Is the information on the submitted claim sufficient to determine what was done, who did it, when it was done, and who it was done to?
Claim Status' that applies to this stage:

- batch claim has not been adjudicated
- field edits

2. Membership Eligibility - Is the recipient of claim services identifiable by the administrative plan or does the claim qualify for assumed eligibility processing?
Claim Status' that applies to this stage:

- membership eligibility

3. Provider Eligibility - Are the provider of services on the claim identifiable by the administrative plan and are those providers licensed to provide those services?
Examples of claim status' that applies to this stage:

- provider eligibility
- provider on review

4. Duplicate Claim Checking - Has a claim for similar or other services for the same member been previously submitted for review?
Examples of claim status' that applies to this stage:

- Dupe check

5. Benefit and Referral Eligibility - Does the member on the claim have coverage with another insurer who might have primary responsibility for covering the loss? Is the identified member on the claim actually covered for the services rendered?

Examples of claim status' that applies to this stage:

- COB injury/accident determination
- COB determination
- Benefit/referral eligibility
- Member conditions for pre-existing, waiting periods, and disability

6. Pricing Resolution - What benefits are payable to the provider, what dollar amounts are the member's responsibility, etc.

Examples of claim status' that applies to this stage:

- Coding audit, integration coding audit, and right coding user exit
- Pre-pricing and pricing
- Pricing calculation fund - is not associated with a status

7. Benefit Resolution - Has the member exceeded his allowable benefits based on the past history of claims?

Examples of claim status' that applies to this stage:

- Benefit resolution
- Note – some of the steps within this stage are performed after the COB Resolution stage:
- Premium Delayed paid to date edits
- Special Claim Pend Criteria (user configured)
- Manual Pend EX Codes
- Private Room Patient Responsibility Room Rate edits
- Subscriber Liability

8. COB Resolution - If the member has other benefits (COB/Accident or injury benefits), what dollar amounts need to be calculated at this time?

Examples of claim status' that applies to this stage:

- Injury/accident resolution
- COB Resolution

9. End of Line Resolution - Are there other dollars that need to be applied, investigation that needs to occur or a 3rd party that must be contacted before the claim resolves (for example, re-pricing, reinsurance, or queries to third party systems)?

Examples of claim status' that applies to this stage:

- Re-pricing
- Reinsurance and audit check limit resolution
- General Pend
- Special Claim Pend Criteria
- Tooth History User Exit
- N/A - Patient Responsibility Amount calculation

10. File Updates

Examples of claim status' that applies to this stage:

- Void claim
- Automatic Denied claim
- Ignored line on a claim
- Returned Claim
- FEP
- System approved -paid
- Manually paid
- Manually denied
- Cash Adjusted
- Statistical adjusted
- Cash Void adjusted
- Statistical Void adjusted

McKesson Claim Check

McKesson Claim Check is a clinically based, expert software system that evaluates claim information.
Claim Check uses rule-based logic to:

- Assess provider claims information including CPT/HCPCS procedure codes against a series of edit programs.
- Recommend CPT/HCPCS procedure codes. Payer payment is based on the recommended code. The integrity of the claim is not altered.

Automated tools are used by payers to automate their existing medical policies and guidelines to:

- Pay claims appropriately and accurately.
- Apply consistent payment policies across providers
- Enhance operational efficiencies and therefore reduce costs
- Decrease claims suspensions and increase processor productivity.

The clinical knowledge base supports correct coding and utilization initiatives, while minimizing manual handling and rework.
Sources of clinical knowledge base:

- Current Procedural Terminology (CPT)
- CPT Assistant
- CPT Coding Symposium
- Specialty society coding guidelines
- Medicare Guidelines

CPT codes, descriptions and two digit modifiers are developed, owned and copyrighted by the American Medical Association (AMA)

Example of Claim Check edits:
Duplicate:
A Duplicate edit occurs when a procedure code description contains terminology that does not warrant multiple submissions of that procedure for a single date of service.
This includes the following terms:
Bilateral/Unilateral/Single/Multiple
A Duplicate edit also occurs when a procedure is submitted multiple times, exceeding the maximum allowance that would be clinically appropriate.

Gender conflict:
The Gender Conflict edit occurs when a gender-specific procedure code is incorrectly assigned based on the gender of the patient referenced on the claim.

Modifiers:
Service or procedure can be further described by using 2-digit modifiers. When more than one modifier is submitted, the modifiers must be ranked. The following categories serve as a reference point when ranking modifiers.

A. Pricing Modifiers are considered part of the seven-digit procedure code by the CMS and are used to determine the reasonable charge or fee for a service. *TC *26

B. * Denotes modifiers which are valid for the first modifier field only.

C. Statistical Modifiers that Affect Pricing are appended to a procedure code and always cause the reasonable charge or fee for the code billed to be modified in the same way every time.

Examples: 23- Unusual Anesthesia, 26- Professional Component, 50- Bilateral Procedure, 80- Assistant Surgeon, 47- Anesthesia by Surgeon

Re-bundling:

Procedure unbundling, which occurs when two or more procedure codes are used to report a service when a single, more comprehensive procedure code exists that represents the service submitted.
To correct this type of coding error, the unbundled procedure code(s) is re-bundled to the comprehensive procedure code.

Up-coding:

Medical providers who bill Medicare, Medicaid, and other Government programs use a standardized system of numerical codes for patient services. The misuse of these standardized codes to obtain more money than is allowed by law is termed up-coding/up-charging.

Undercoding:

As a precaution some clinics may feel it is necessary to under code to avoid fraudulent claims, however, undercoding can result in fines.
Bundling and Unbundling:
Fragmentation or unbundling is the separate reporting of component parts of a procedure instead of reporting a single code that includes all services integral to accomplishing the entire comprehensive procedure.

Following services are not eligible for separate reimbursement

- Incidental
- Mutually exclusive
- Integral to the primary service rendered
- Part of a global allowance

Encounter

An Encounter Claim is a claim submitted by the provider that records services rendered by the provider. Encounter claims have previously been paid by a contracted pre-determined means. The purpose of the encounter claim is to provide validation that the payment previously made has been earned, or to assist in justification that a review for a higher reimbursement may be needed.

- Encounter claims contain detailed information about individual health care related services provided by a managed care organization (MCO) or other state-designated managed care providers.
- Encounter claim data is equivalent to a standard Medicaid claim except that the provider submits the data to provide service delivery information to the state and is not eligible for reimbursement.
- Payment for individual encounter claims filed to Medicaid are not remitted because the MCO receives a monthly capitation payment for the consumer, regardless of how many encounters the provider has with the consumer for that month.
- Encounters are paid either via capitated or ASO (Admin Services Only) agreement. Encounters are used by government entities for quality assessments and calculation of the capitated rates.

Why Are Encounters Important?

Visibility

- Encounters provide payers visibility into services provided to members.
- They also offer the State details regarding those services (i.e. dates, diagnosis, procedures, provider information, member information, etc.)

Rate Setting

- Payers uses encounters to determine the Per Member Per Month (PMPM) rates for a given period of time.
- Payers sets rates based on the completeness and accuracy in which the encounters are submitted and accepted.
- This means that rates are adjusted each year (either increase or decrease) based on the previous year's encounters submissions and acceptance.

Risk Adjustment

- Encounters offer visibility into the high risk members served by the plan and the services provided to them.
- In addition to completeness and accuracy, payers may adjust rates based on risk level.

Kick Claims

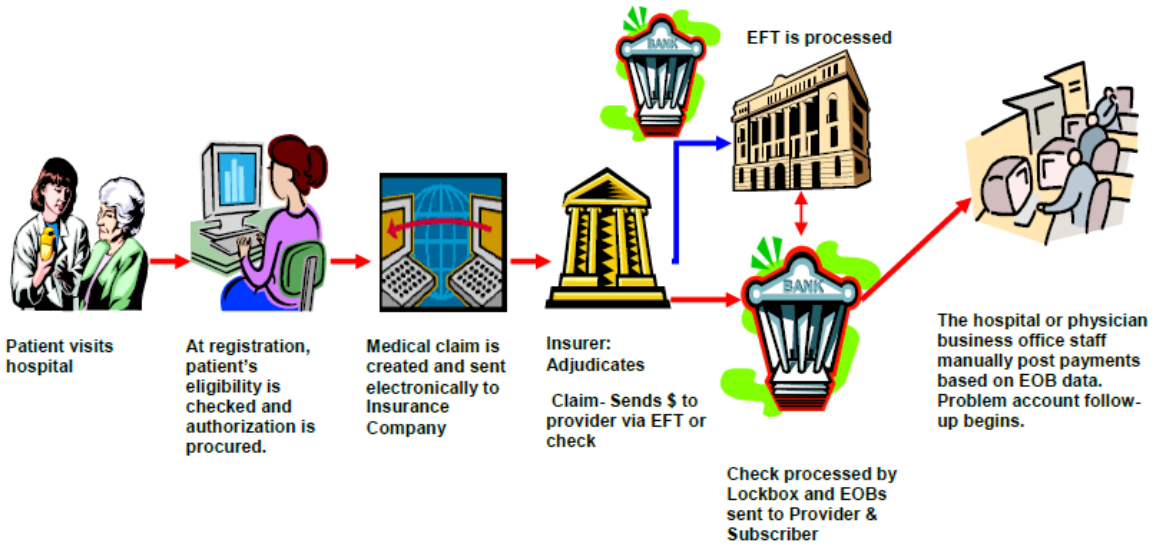
- Some encounters result in specific kick payments from AHCA. Examples of kick payments include transplants, maternity, newborn, etc.

Risk of Fines and Penalties

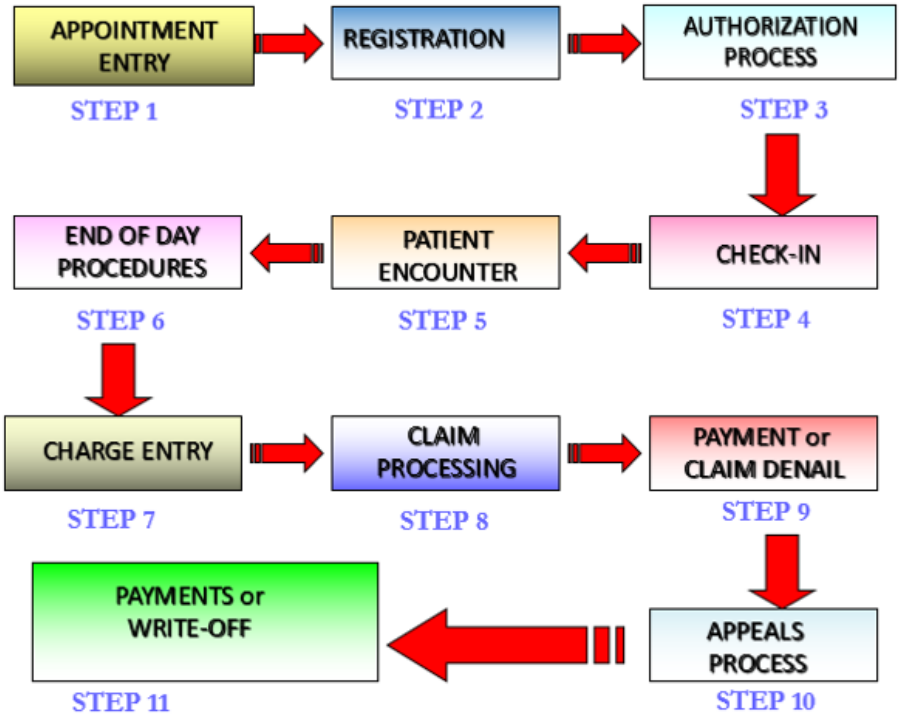
- Under the MMA contract, AHCA has outlined very stringent penalties and fines for any plans not meeting the required Service Level Agreements (SLAs).

Medical Billing

Medical billing is the process of submitting claims to insurance companies in order to receive payment for services rendered by a healthcare provider. The same process is used for most insurance companies, whether they are private companies or government-owned.



Medical Billing Process Work Flows



STEP 1: Appointment Entry

- Medical record assignment through obtaining patient demographics.
- Confirmation with patient of existing insurance coverage.
- Appointment types and provider templates.

STEP 2: Registration

- Creation or update patient's account with billing address and phone.
- Verification of insurance coverage with payer. (Direct phone contact, passport's online search and batch files, envoy real-time verification)
- Coordination of Benefits (COB) when multiple payers are billed sequentially.

STEP 3: Authorization Process

- Patient referral for specialized consult and/or treatment.
- Payer requirements for referrals using authorization numbers for tracking.
- Storing and tracking of number of visits or services approved by payer.
- Required referral report identifies missing referrals for visits with coverage requiring referrals, either not obtained or promptly linked in system.

STEP 4: Check In

- Verification of actual insurance card presented and patient's address and phone.
- Collection of co-payment based on system-prompt or amount indicated on card.
- Alert physician when patient presents and referral/authorization process not completed to determine necessity for visit.
- Selection of appropriate account type for services to be provided.

STEP 5: Patient Encounter

- Physician codes procedures and diagnoses.
- Physician / clinical staff determine medical necessity for procedure for Medicare patients; alerts for advanced beneficiary notice (ABN) to be completed for patient signature acknowledging patient liability for non-covered service.
- Determination whether additional procedures during this visit will require authorization with a process to contact payer for approval or reschedule patient.

STEP 6: End of Day Procedure

- Reconciliation of combined department report to actual encounter forms.
- Reconciliation of user batch report to cash drawer and prepare deposit.
- Batching of professional and technical encounter forms;
- Quality control review to ensure data elements complete with appropriate coding specific to specialty.
- Final review to determine next-day appointments missing referral/authorization.

STEP 7: Charge Entry

- Reconciliation of transaction count to user batch report to verify charges entered.
- Minimize charge lag between date of service to post Date
- Ensure co-payment is patient liability to reduce undistributed payments.
- Review charge entry warning messages before posting charges.
- Missing encounter form report (encounters without charges 2–12 weeks after visit)

STEP 8: Claim Processing

- Submission through electronic format or paper claims based on payer.
- Claim edits for missing registration information, payer-assigned provider numbers, and missing inpatient/day surgery authorization numbers.
- Release hold between 5 to 15 days beyond date of service based on payer.
- Electronic clearinghouse and payer's electronic rejections understate denials.

STEP 9: Payment or Claim Denial

- Remittance advice or explanation of benefits (EOB) indicating allowable, contractual, payment, patient responsibility, or denial reason.
- Correspondence with denial reason.

STEP 10: Appeals Process

- Contact the payer; correct the system; and/or provide additional documentation.
- Outpatient denials for not authorized and medical necessity distributed to practices for resolution.
- Denial management through review of denials by reason, payer, provider, and procedure with feedback for process improvement or system updates.

STEP 11: Payments or Write-Off's

- Successful appeal yields payment.
- Review of subsequent denial following appeal; write-off occurs if no additional support for appeal can be identified; supervisory approval for write-offs.
-

Billing Procedure

Uniform Claim Forms

- UB04
- CMS-1500
- NCPDP
- American Dental Association

Uniform Claim Codes

- ASA codes
- CDT codes

- CPT codes
- HCPCS codes
- ICD9, ICD10 -CM codes
- NDC codes
- Revenue codes

Filing a Claim

Prepare Claim / Check Compliance

Once the patient checks out, the medical report from that patient's visit is sent to the medical coder, who abstracts and translates the information in the report into accurate, useable medical code. This report, which also includes demographic information on the patient and information about the patient's medical history, is called the "superbill."

The superbill contains all of the necessary information about medical service provided. This includes the name of the provider, the name of the physician, the name of the patient, the procedures performed, the codes for the diagnosis and procedure, and other pertinent medical information. This information is vital in the creation of the claim.

Once complete, the superbill is then transferred, typically through a software program, to the medical biller. The medical biller takes the superbill from the medical coder and puts it either into a paper claim form, or into the proper practice management or billing software. Biller's will also include the cost of the procedures in the claim. They won't send the full cost to the payer, but rather the amount they expect the payer to pay, as laid out in the payer's contract with the patient and the provider.

Once the biller has created the medical claim, he or she is responsible for ensuring that the claim meets the standards of compliance, both for coding and format.The accuracy of the coding process is generally left up to the coder, but the biller does review the codes to ensure that the procedures coded are billable. Whether a procedure is billable depends on the patient's insurance plan and the regulations laid out by the payer.

While claims may vary in format, they typically have the same basic information. Each claim contains the patient information (their demographic info and medical history) and the procedures performed (in CPT or HCPCS codes). Each of these procedures is paired with a diagnosis code (an ICD code) that demonstrates the medical necessity. The price for these procedures is listed as well. Claims also have information about the provider, listed via a National Provider Index (NPI) number. Some claims will also include a Place of Service code, which details what type of facility the medical services were performed in.

Transmit Claims

Since the Health Insurance Portability and Accountability Act of 1996 (HIPAA), all health entities covered by HIPAA have been required to submit their claims electronically, except in certain circumstances. Most providers, clearinghouses, and payers are covered by HIPAA.

Note that HIPAA does not require physicians to conduct all transactions electronically. Only those standard transactions listed under HIPAA guidelines must be completed electronically. Claims are one such standard transaction.

Billers may still use manual claims, but this practice has significant drawbacks. Manual claims have a high rate of errors, low levels of efficiency, and take a long time to get from providers to payers. Billing electronically saves time, effort, and money, and significantly reduces human or administrative error in the billing process.

In the case of high-volume third-party payers, like Medicare or Medicaid, billers can submit the claim directly to the payer. If, however, a biller is not submitting a claim directly to these large payers, they will most likely go through a clearinghouse.
A clearinghouse is a third-party organization or company that receives and reformats claims from billers and then transmits them to payers. Some payers require claims to be submitted in very specific forms. Clearinghouses ease the burden of medical billers by taking the information necessary to create a claim and then placing it in the appropriate form. Think of it this way: A practice may send out ten claims to ten different insurance payers, each with their own set of guidelines for claim submission. Instead of having to format each claim specifically, a biller can simply send the relevant information to a clearinghouse, which will then handle the burden of reformatting those ten different claims.

Common ways of transmitting claims:

- Through Web Portal
- Through Clearing House
- Through Post-n-Track Solution

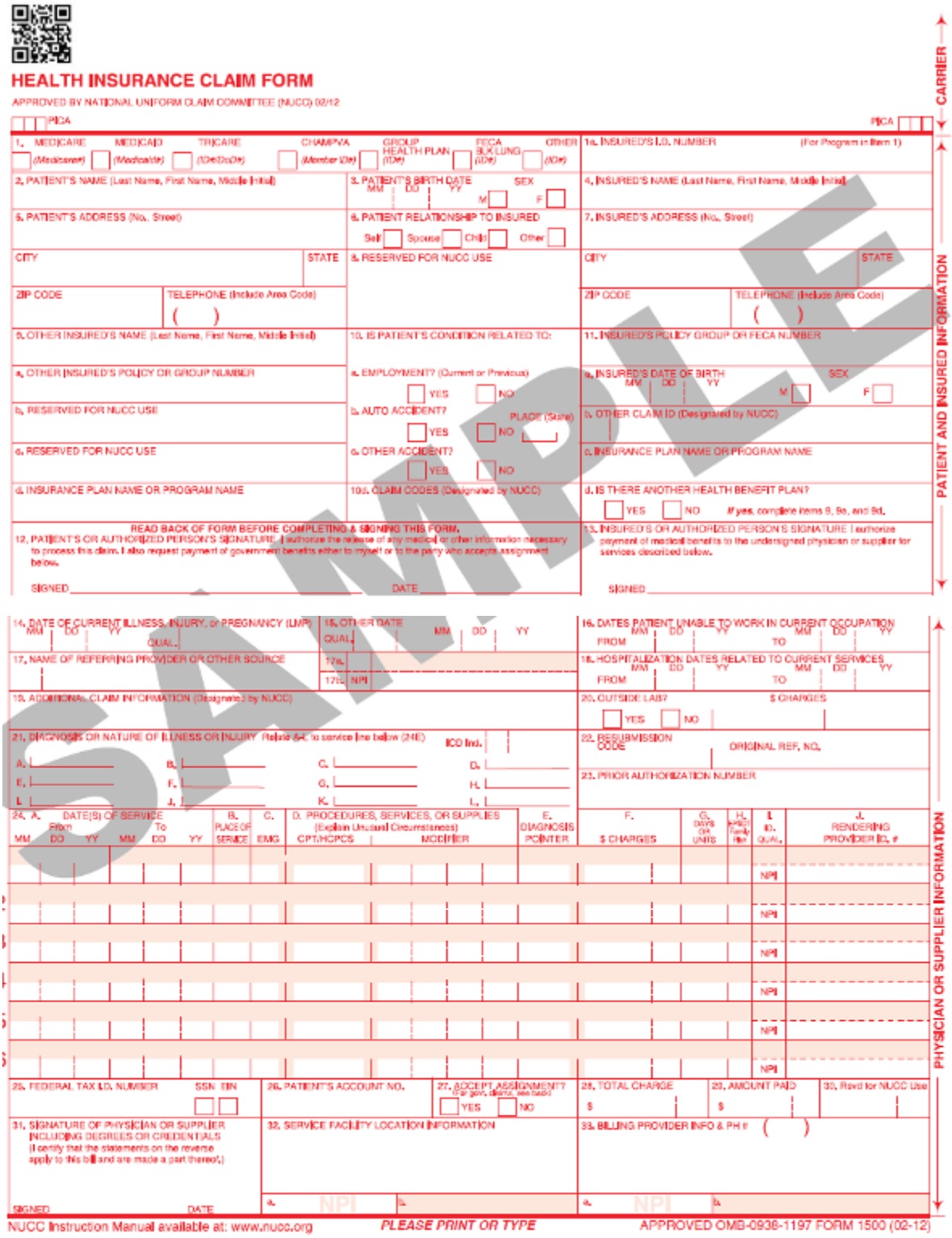
Claim Forms

HIPAA regulations mandate that most claim transmissions be completed electronically. That doesn't mean that all claims are submitted electronically, though that would probably be ideal. Under HIPAA regulations, standard transactions like claims are required to be submitted electronically. There are some exceptions to this rule, however. For one, a practice under 10 employees may use manual claims. Also, a practice that has experienced a power outage may submit claims manually if those claims are time-sensitive.

The two most common claim forms are the CMS-1500 and the UB-04. CMS-1500 forms are used for non-institutional healthcare facilities (e.g., private practices), while UB-04 (CMS-1450) forms are generally used in institutional healthcare facilities, such as hospitals. Apart from these, for submitting a dental claim ADA form is being used and for Pharmacy claims NCPDP Claim Form is used.

Understand CMS-1500 Form

The CMS-1500 is commonly used for filing a paper claim to the insurance companies by most of the providers. Professional services are billed on CMS-1500.
This is what a CMS-1500 looks like:



Understand UB 04– CMS 1450 Uniform Bill

UB04 is commonly used for filing a paper claim to the insurance companies by the Hospitals. Technical or Institutional components are billed on UB04.

This is what a UB04 looks like:

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES	29 ACDT STATE	30

31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37

38		39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
	a			
	b			
	c			
	d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
							1
							2
							3
							4
							5
							6
							7
							8
							9
							10
							11
							12
							13
							14
							15
							16
							17
							18
							19
							20

21									22
	PAGE ____ OF ____	CREATION DATE		TOTALS ➡					
23									23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. IND.	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							A
B						57 OTHER PRV ID	B
C							C

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A				A
B				B
C				C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		A
B		B
C		C

66 DX	67	A	B	C	D	E	F	G	H	68
		I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

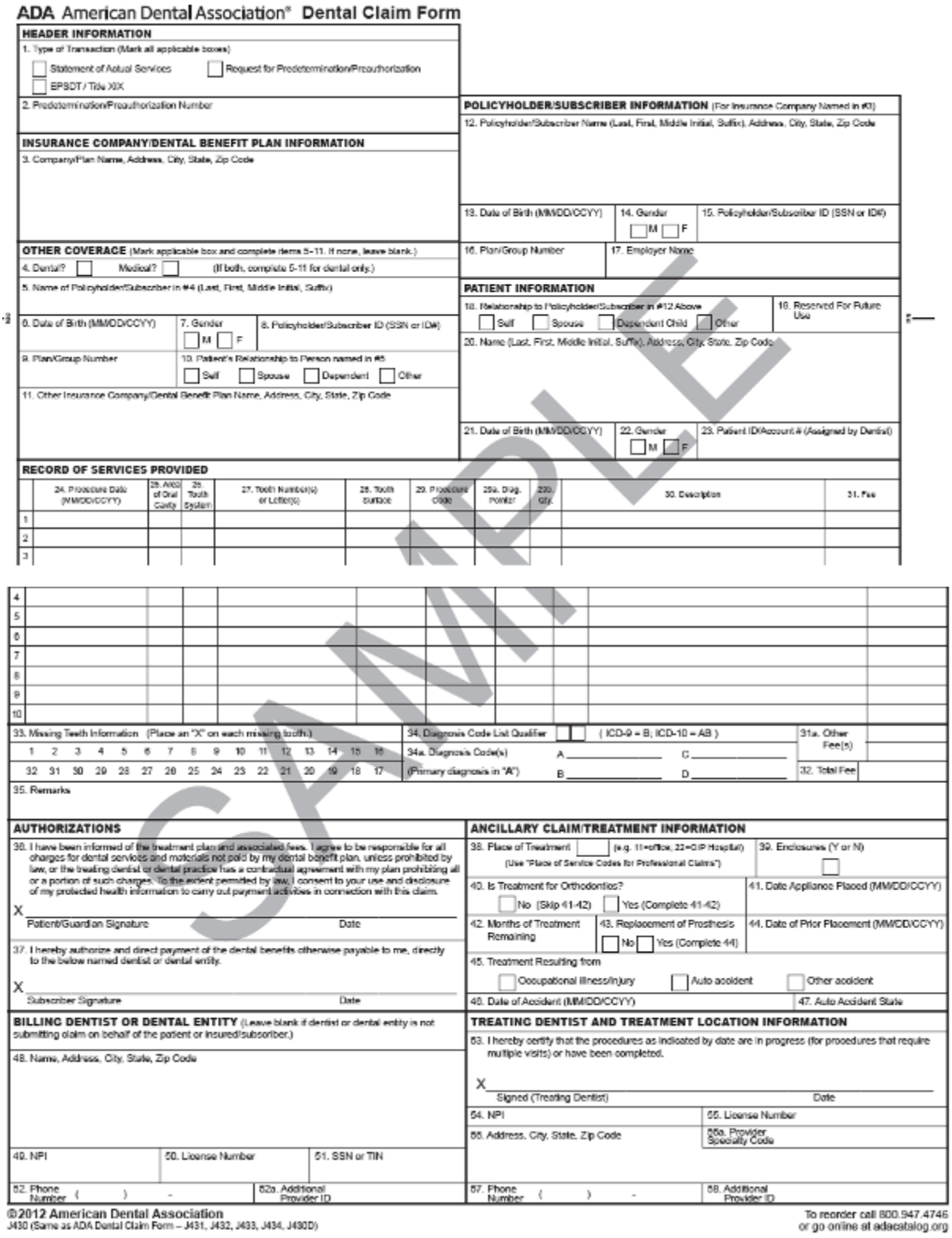
76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC a		
	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO. THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee
LIC9013257

Understand ADA Form (Dental)



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5–11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐ ☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office, 22=OP Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

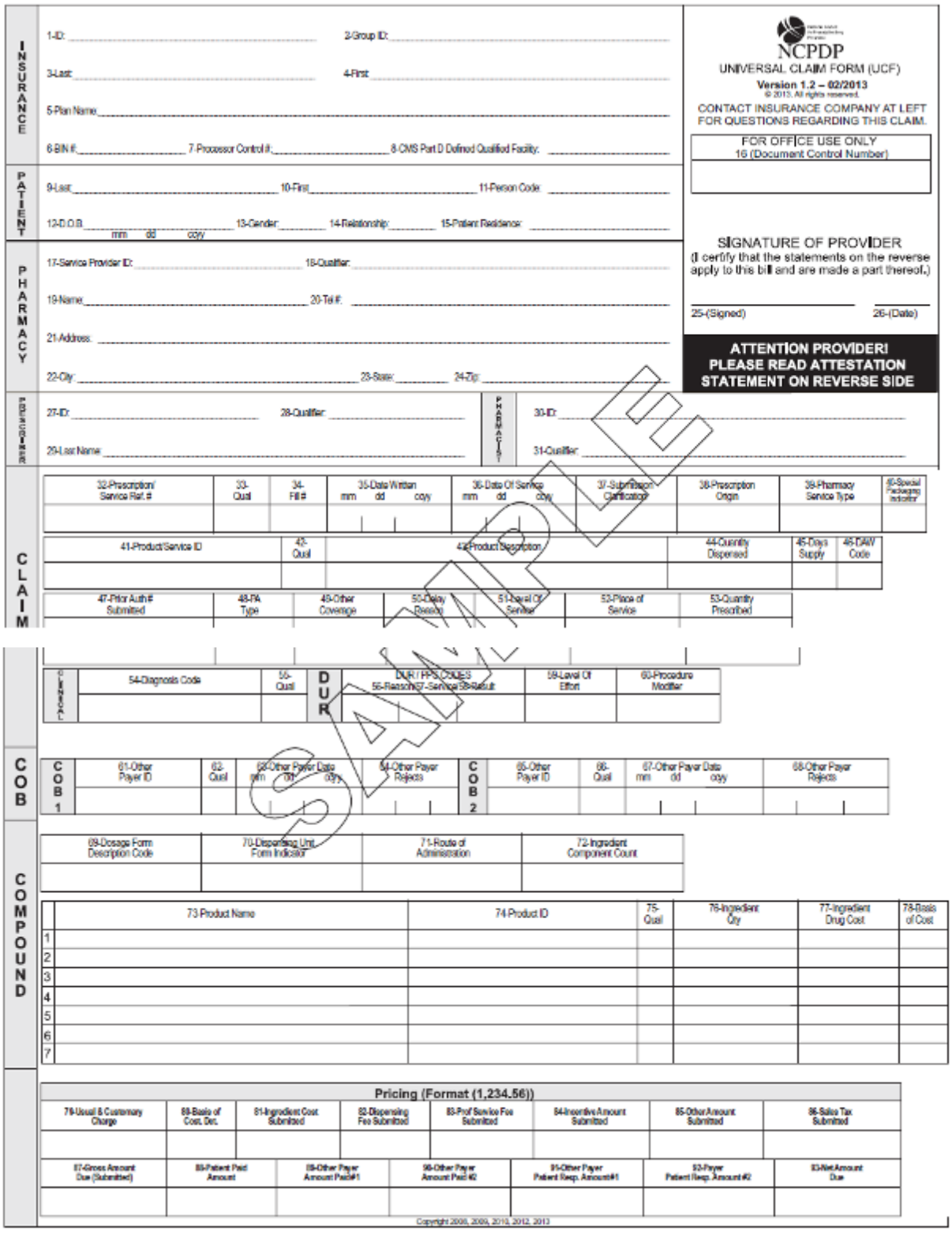
56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J490D)

To reorder call 800.947.4746
or go online at adacatalog.org

Understand NCPDP Claim Form



NCPDP
UNIVERSAL CLAIM FORM (UCF)
Version 1.2 – 02/2013

CONTACT INSURANCE COMPANY AT LEFT FOR QUESTIONS REGARDING THIS CLAIM.

INSURANCE
1-ID: 2-Group ID:
3-Last: 4-First:
5-Plan Name:
6-BIN #: 7-Processor Control #: 8-CMS Part D Defined Qualified Facility:

PATIENT
9-Last: 10-First: 11-Person Code:
12-D.O.B. mm dd ccyy 13-Gender: 14-Relationship: 15-Patient Residence:

PHARMACY
17-Service Provider ID: 18-Qualifier:
19-Name: 20-Tel #:
21-Address:
22-City: 23-State: 24-Zip:

FOR OFFICE USE ONLY
16 (Document Control Number)

SIGNATURE OF PROVIDER
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)
25-(Signed) 26-(Date)

ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE

PRESCRIBER
27-ID: 28-Qualifier:
29-Last Name:

PHARMACY
30-ID:
31-Qualifier:

CLAIM

32-Prescription/ Service Ref. #	33-Qual	34-Fill #	35-Date Written mm dd ccyy	36-Date Of Service mm dd ccyy	37-Submission Clarification	38-Prescription Origin	39-Pharmacy Service Type	40-Special Packaging Indicator

41-Product/Service ID	42-Qual	43-Product Description	44-Quantity Dispensed	45-Days Supply	46-DAW Code

47-Prior Auth # Submitted	48-PA Type	49-Other Coverage	50-Delay Reason	51-Level Of Service	52-Place of Service	53-Quantity Prescribed

CLINICAL	54-Diagnosis Code	55-Qual	DUR	DUR / PPS CODES 56-Reason 57-Service 58-Result	59-Level Of Effort	60-Procedure Modifier

COB

	61-Other Payer ID	62-Qual	63-Other Payer Date mm dd ccyy	64-Other Payer Rejects		65-Other Payer ID	66-Qual	67-Other Payer Date mm dd ccyy	68-Other Payer Rejects
COB 1					COB 2				

COMPOUND

69-Dosage Form Description Code	70-Dispensing Unit Form Indicator	71-Route of Administration	72-Ingredient Component Count

	73-Product Name	74-Product ID	75-Qual	76-Ingredient Qty	77-Ingredient Drug Cost	78-Basis of Cost
1						
2						
3						
4						
5						
6						
7						

Pricing (Format (1,234.56))

79-Usual & Customary Charge	80-Basis of Cost Det.	81-Ingredient Cost Submitted	82-Dispensing Fee Submitted	83-Prof Service Fee Submitted	84-Incentive Amount Submitted	85-Other Amount Submitted	86-Sales Tax Submitted

87-Gross Amount Due (Submitted)	88-Patient Paid Amount	89-Other Payer Amount Paid #1	90-Other Payer Amount Paid #2	91-Other Payer Patient Resp. Amount #1	92-Payer Patient Resp. Amount #2	93-Net Amount Due

EDI – Electronic Data Interchange

EDI is a critical part of Electronic Commerce because it enables computers to exchange data electronically, which is much faster, cheaper, and more accurate that paper-based systems.
EDI is the electronic transfer of information between two trading partner's systems using a set of transactions that have been adopted as a national or international standard for a particular business function.
EDI is computer-to-computer exchange of standardized business documents, such as purchase orders, product information and invoices or EFT.

EDI Standards:

There are four major sets of EDI standards:

- **The UN recommended UN/EDIFACT is the only international standard and is predominant outside of North America.**
- **The US standard ANSI ASC X12 (X12) is predominant in North America.**
- **The TRADACOMS standard developed by the ANA (Article Numbering Association) is predominant in the UK retail industry.**
- **The ODETTE standard used within the European automotive industry.**

What is ASC X12?

In 1979, the American National Standards Institute (ANSI) chartered the Accredited Standards committee (ASC) X12 to develop uniform standards for interindustry electronic interchange of business transactions – Electronic Data Interchange (EDI). Accredited Standards Committee (ASC X12) - An ANSI accredited standards organization responsible for the development and maintenance of electronic data interchange (EDI) standards for many industries. The "X12" or insurance section of ASC X12 handles the EDI for the health insurance industry's administrative transactions. Under HIPAA, X12 standards have been adopted for most of the transactions between health plans and providers.

ASC X12 SUBCOMMITTEES

- **X12A Education and Administration**
- **X12C Communication and Controls**
- **X12F Finance**
- **X12G Government**
- **X12H Materials Management**
- **X12I Transportation**
- **X12J Technical Assessment**
- **X12M Supply Chain**
- **X12N Insurance**

Administrative Simplification

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers.
As the industry has implemented these standards, and increased the use of electronic data interchange, the nation's health care system will become increasingly effective and efficient.

Key ASC X12N transaction types are in the HIPAA mandate

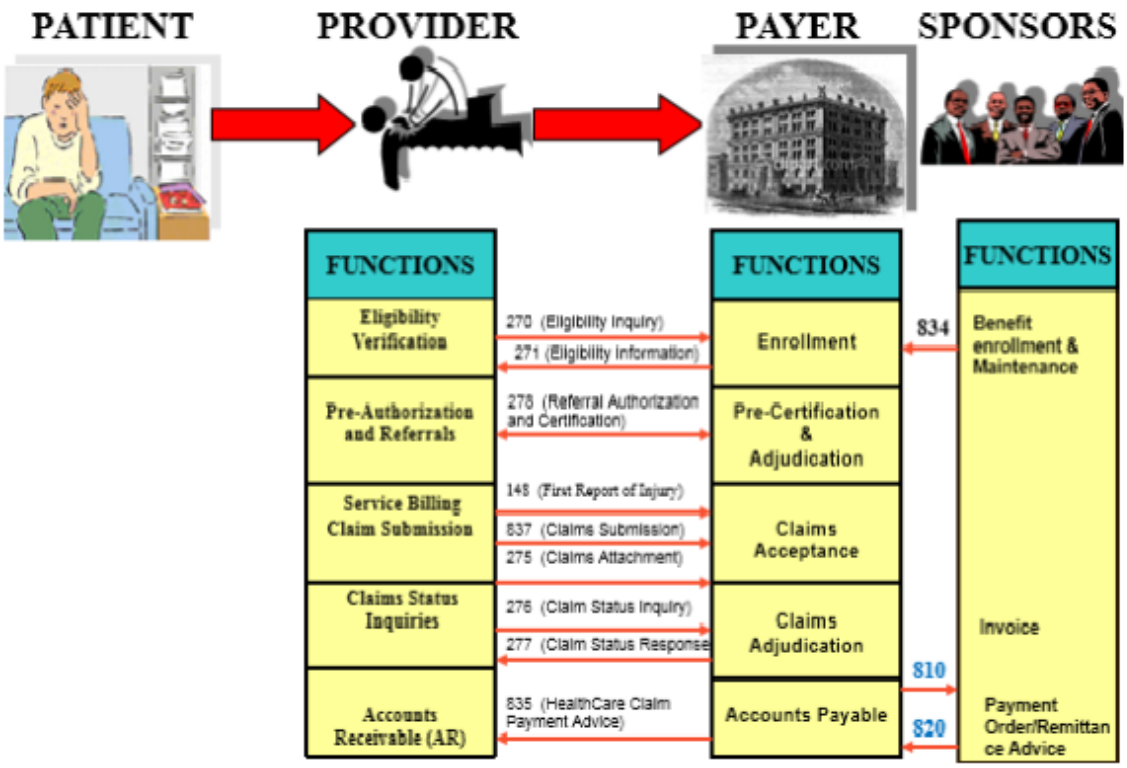
- **270 - Eligibility, Coverage, or Benefit Inquiry**
- **271 - Eligibility, Coverage, or Benefit Information**
- **276 - Health Care Claim Status Request**
- **277 - Health Care Information Status Notification**
- **278 - Health Care Services Review Information**
- **820 - Payment Order / Remittance Advice**
- **834 - Benefit Enrollment & Maintenance**
- **835 - Health Care Claim Payment/Advice**
- **837 - Health Care Claim (Dental, Institutional, or Professional)**

Transaction set codes and Descriptions

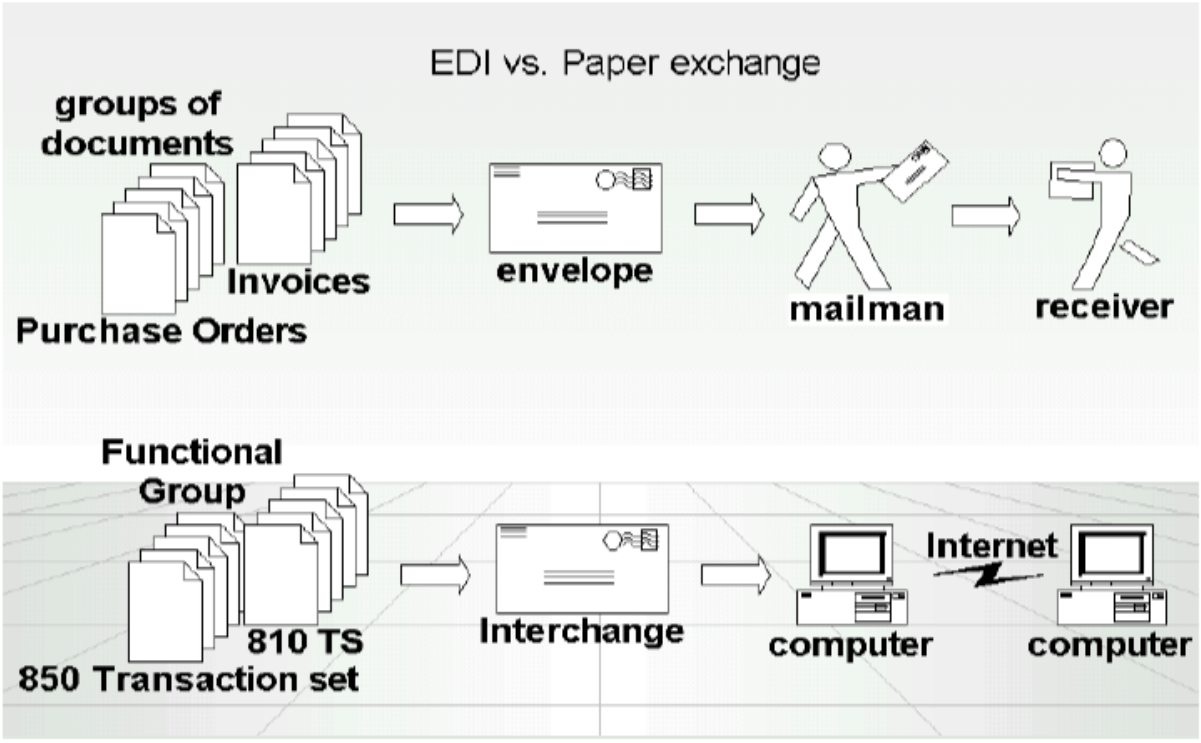
Transaction Code	Significance	Description
270	Benefit and Eligibility inquiry	270 is used to inquire about the health care benefits and eligibility associated with a subscriber or dependent.
271	Benefit and Eligibility response	271 is used to respond about the health care benefits and eligibility associated with a subscriber or dependent.
276	Claim Status Request	276 is the transaction code which is used to get the status of the submitted claims. Can be used by the healthcare provider / Members / TPA - claim billing department.
277	Claim Status Response	This transaction set can be used to respond status of the submitted claims.
278	Service review information	This transaction set can be used to transmit health care service information, such as subscriber, patient, demographic, diagnosis or treatment data for the purpose of request for review, certification, notification or reporting the outcome of a health care services review.

Transaction Code	Significance	Description
835	Claim Payment/ Remittance Advice	835 transaction code signifies the claim payment made to the provider or EOB (Explanation of Benefits) or remittance advice either directly from Health Insurance or any financial institutions.
837	Claim Submission	837 transaction code signifies the claim submission electronically from the providers / clearing house / TPA to the insurance company.
837 - I	Institutional claims	Signifies only Institutional Electronic claims (Hospital claims); Equivalent Paper claim submitted via UB04 form.
837 - P	Professional claims	Signifies only Professional claims (Medical claims); Equivalent claim Paper claim submitted via CMS 1500R form.
837 - D	Dental claims	Signifies only Dental claims. Equivalent claim Paper claim submitted via ADA 2006 form.
834	Benefit Enrollment and Maintenance	834 transaction code can be used by the Employers / Plan sponsors / Government agencies to enroll members to the payers.
820	Premium payment	820 is a transaction set which can be used to make a premium payment for insurance Plans.

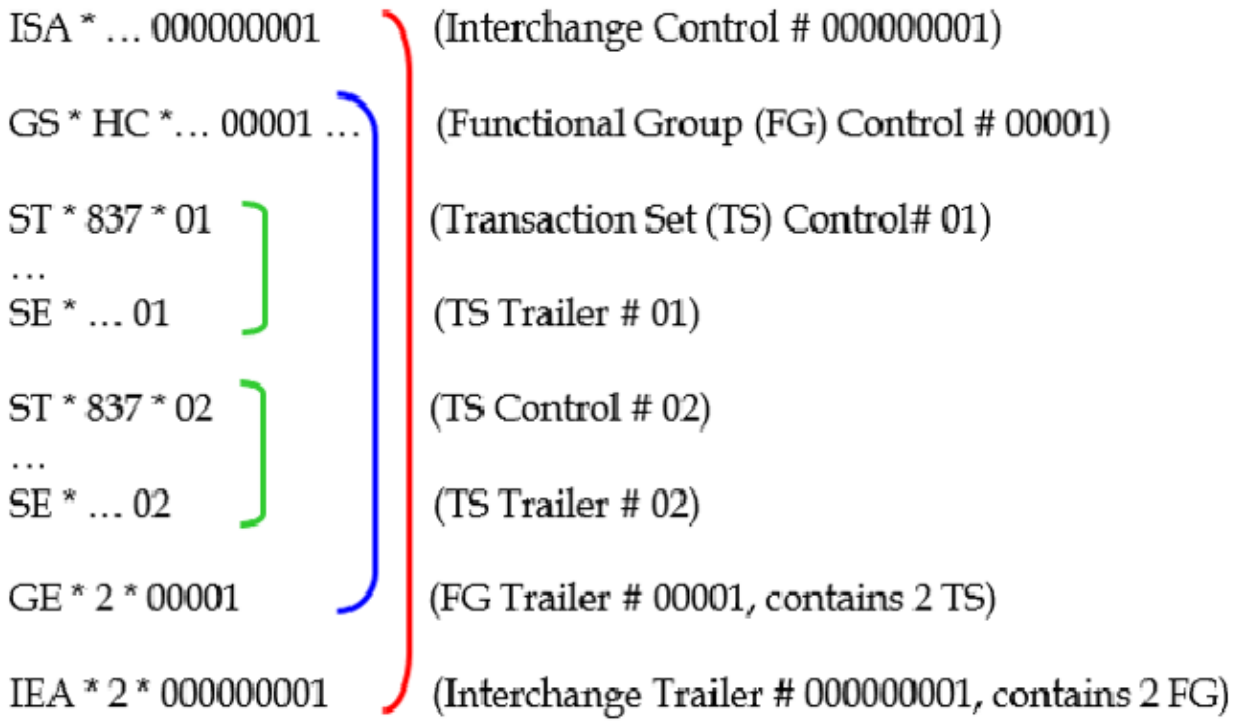
Data Flow within Healthcare System



Paper vs EDI Claim



Interchange Control Structure



Sample 276 EDI Format

```
ISA*00*          *00*          *ZZ*TDRT99999*ZZ*HESXTDRT99999*140605*0630*^*00501*000001406*0*T*{~
GS*HR*XYZTD2769OOA*HPBESXTD2769999*20140605*0630*1406*X*005010X212~
ST*276*135406*005010X212~
BHT*0010*13*PIC 130111 384796*20140606*1759509~
HL*1**20*1~
NM1*PR*2*XYZ*****PI*050~
HL*2*1*21*1~
NM1*41*2*SCLH5*****46*050~
HL*3*2*19*1~
NM1*1P*2*ABC HEALTH SYSTEM*****SV*P0199010~
HL*4*3*22*0~
DMG*D8*19580726*M~
NM1*IL*1*WMVLM*RFHFRST****MI*960117911~
TRN*1*BGTUOPNDKG8U73A3MTHMAOL755~
REF*LU*PB~
REF*6P*810232124~
AMT*T3*65.5~
DTP*472*RD8*20130730-20130730~
SVC*HC{99203*6*****1~
REF*FJ*2637245-1P~
DTP*472*RD8*20130730-20130730~
SVC*HC{83615*59.5*****1~
REF*FJ*2637245-2P~
DTP*472*RD8*20130730-20130730~
SE*23*135406~
GE*1*135460~
IEA*1*000135460~
```

EDI Transaction Sets

1. EDI Health Care Claim Transaction set (837) Used to submit health care claim billing information, encounter information, or both, except for retail pharmacy claims (see EDI Retail Pharmacy Claim Transaction). It can be sent from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment.

For example, a state mental health agency may mandate all healthcare claims, Providers and health plans who trade professional (medical) health care claims electronically must use the 837 Health Care Claim: Professional standard to send in claims. As there are many different business applications for the Health Care claim, there can be slight derivations to cover off claims involving unique claims such as for Institutions, Professionals, Chiropractors, and Dentists etc.

2. EDI Retail Pharmacy Claim Transaction (NCPDP Telecommunications Standard version 5.1) Used to submit retail pharmacy claims to payers by health care professionals who dispense medications, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit claims for retail pharmacy services and billing payment information between payers with different payment responsibilities where coordination of benefits is required or
between payers and regulatory agencies to monitor the rendering, billing, and/or payment of retail pharmacy services within the pharmacy health care/insurance industry segment.

3. EDI Health Care Claim Payment/Advice Transaction Set (835) Can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.

4. EDI Benefit Enrollment and Maintenance Set (834) Can be used by employers, unions, government agencies, associations or insurance agencies to enroll members to a payer. The payer is a healthcare organization that pays claims, administers insurance or benefit or product. Examples of payers include an insurance company, health care professional (HMO), preferred provider organization (PPO), government agency (Medicaid, Medicare etc.) or any organization that may be contracted by one of these former groups.

5. EDI Payroll Deducted and other group Premium Payment for Insurance Products (820) A transaction set which can be used to make a premium payment for insurance products. It can be used to order a financial institution to make a payment to a payee.

6. EDI Health Care Eligibility/Benefit Inquiry (270) Used to inquire about the health care benefits and eligibility associated with a subscriber or dependent.

7. EDI Health Care Eligibility/Benefit Response (271) Used to respond to a request inquire about the health care benefits and eligibility associated with a subscriber or dependent.

8. EDI Health Care Claim Status Request (276) This transaction set can be used by a provider, recipient of health care products or services or their authorized agent to request the status of a health care claim.

9. EDI Health Care Claim Status Notification (277) This transaction set can be used by a health care payer or authorized agent to notify a provider, recipient or authorized agent regarding the status of a health care claim or encounter, or to request additional information from the provider regarding a health care claim or encounter. This transaction set is not intended to replace the Health Care Claim Payment/Advice Transaction Set (835) and therefore, is not used for account payment posting. The notification is at a summary or service line detail level. The notification may be solicited or unsolicited.

10. EDI Health Care Service Review Information (278) This transaction set can be used to transmit health care service information, such as subscriber, patient, demographic, diagnosis or treatment data for the purpose of request for review, certification, notification or reporting the outcome of a health care services review.

11. EDI Functional Acknowledgement (997) This transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. Although it is not specifically named in the HIPAA Legislation or Final Rule, it is necessary for X12 transaction set processing. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets. Transaction Set (997) will be replaced by Transaction Set (999) "acknowledgement report".

HL7 – Health Level Seven

- Established in 1987, Health Level Seven (HL7) is an ANSI accredited, not-for-profit standards-development organization, whose mission is to provide standards for the exchange, integration, sharing, and retrieval of electronic health information; support clinical practice; and support the management, delivery and evaluation of health services.
- The name comes from 'Healthcare' and the top level (Level 7) of the Open Systems Interconnection (OSI) model, which carries the meaning of information exchanged between computer applications.
- More than 28 of the developed nations have affiliates of HL7

Trigger Event:

- Trigger event is an event in the real world of healthcare creates the need for data to flow among systems
- Trigger events are identified by a unique 3 character code. This code is known as an event type.
- 'Z' trigger codes are reserved for locally-defined trigger event
- A trigger event generates a message

Two types of data flow:

1. unsolicited update/acknowledgement
2. query/result

Example: Trigger Events

Message	Description
A01	ADT/ACK – Admit / Visit Notification
A02	ADT/ACK – transfer a patient
O01	ORM – Order Message
O02	ORR –Order Response
R01	ORU/ACK-Order Result

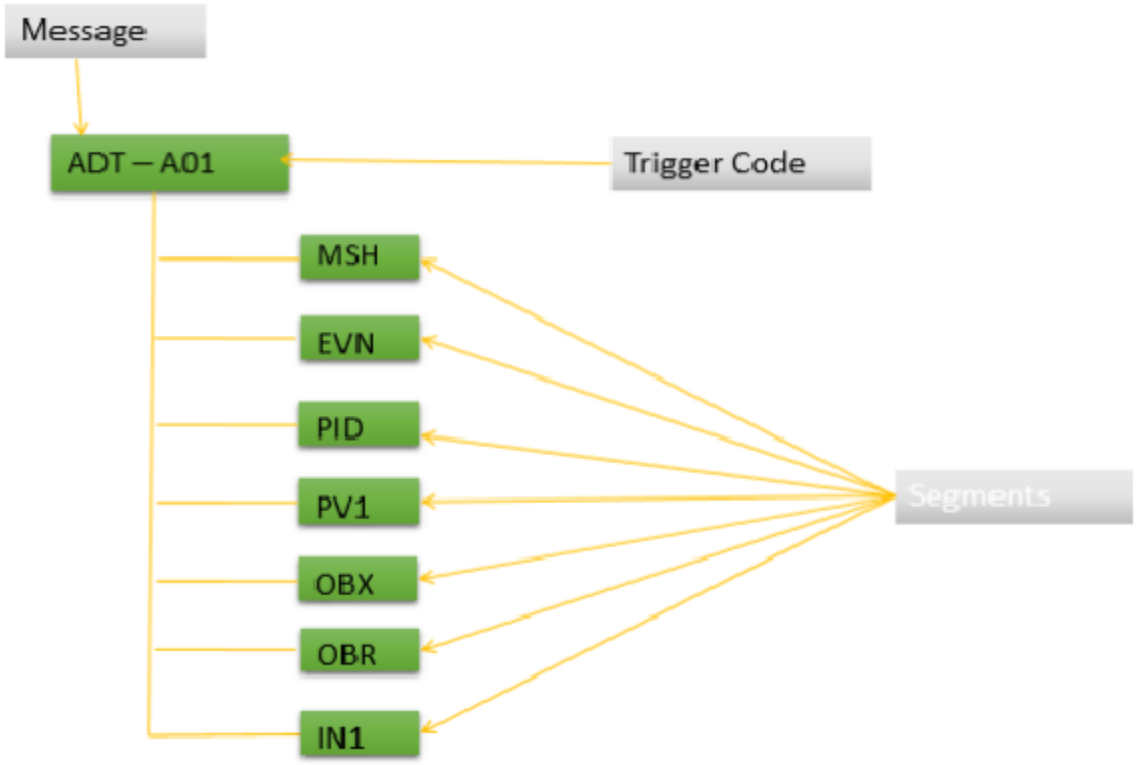
Message Type:

- A message is the atomic unit of data transferred between systems.
- Each message has a message type that defines its purpose.
- HL7 provides an HL7 message structure for each message.
- For example, the ADT Message type is used to transmit portions of a patient's Patient Administration (ADT) data from one system to another.

- There is a one-to-many relationship between message types and trigger event codes
- A message type may be associated with more than one trigger event
- A message is comprised of a group of segments in a defined sequence

Example: Message Type

Message	Description
ACK	General Acknowledgement Message
ADT	Admit Discharge and Transfer
ORM	Order Result Message
ORU	Order Result
DFT	Detailed financial Transaction



Sample HL7 Format:

MSH|^~\&|LABGL1||DMCRES||199812300100||ORU^R01|LABGL1199510221838581|P|
2.3 |||NE|NE

PID|||6910828^Y^C8||ABC^DEF^E||19720812|M||W|25 Whitefield ^^
Bangalore^KA^85201^^P||(555)777-6666|(444)677-7777||M||773789090

OBR||110801^LABGL|387209373^DMCRES|18768-2^CELL COUNTS+DIFFERENTIAL TESTS (COMPOSITE)^LN|||199812292128||35^ML|||||||IN2973^ABC^DEF^^^^MD^UPIN ||||||||||^Once||||||KA20837^ABC^DEF^^^^MD^UPIN

OBX||NM|4544-3^HEMATOCRIT (AUTOMATED)^LN||45||39-49 ||||F|||199812292128||CA20837

OBX||NM|789-8^ERYTHROCYTES COUNT (AUTOMATED)^LN||4.94|10*12/mm3 |4.30-5.90||||F|||199812292128||CA20837

DICOM – Digital Imaging and Communications in Medicine

DICOM develops standards for transmitting images, such as X-rays, digital images, MRI, CT, slides, and pictures. DICOM Specifies:

- For network communications, a set of protocols to be followed by devices claiming conformance to the standard.
- The syntax and semantics of commands and associated information which can be exchanged using these protocols.
- For media communication, a set of media storage services to be followed by devices claiming conformance to the standard, as well as a file format and a medical directory structure to facilitate access to the images and related information stored on interchange media.
- Information that must be supplied with an implementation for which conformance to the standard is claimed.

Providers

A provider is any healthcare professional (an individual), facility, or organization that renders medical care to a health plan's membership. The term practitioner is sometimes used to refer to an individual provider who is trained and licensed or certified to deliver a specific set of healthcare services. A provider network, also called a provider panel, is the group of healthcare providers that a specific health plan has contracted with to deliver medical services to its members in exchange for negotiated compensation.

Participating Versus Nonparticipating Providers: A participating provider (PAR) is one who contracts with the payer and agrees to abide by certain rules and regulations of that carrier. In doing so, the provider usually must accept the insurance carriers allowable fee as payment in full (after patient deductibles and coinsurance are met) and may not bill the patient for the balance. Some insurance companies offer certain incentives to providers if they agree to become PARs such as processing claims more quickly and furnishing claims with pre identifying information. Another advantage of becoming PAR is that payment from the insurer is paid directly to the provider rather than to the patient.

A nonparticipating provider (nonPAR) has no contractual agreement with the insurance carrier, the provider does not have to accept an insurance company’s reimbursement as payment in full. Patients can be billed for the difference between the insurance carriers’ allowed fee and the providers’ actual fee. (Medicare limits how much a nonPAR can charge, however). One disadvantage of being nonPAR is that, typically, insurance payments are sent to the patient, rather than to the provider.

A financial adjustment for PAR providers of the difference between submitted and allowable charges is known as a write-off.

Terms Related to Provider domain

- **NPI:** A National Provider Identifier (NPI) is a unique ten-digit identification number required by HIPAA for all health care providers in the United States. Providers must use their NPI to identify themselves in all HIPAA transactions.
- **UPIN:** The Unique Physician Identification Number was established by the HCFA as a unique identifier in lieu of the SSN.
- **GROUP ID:** For the physician who are working under certain group/area/region.
- **Federal Tax ID:** A federal tax identification number (also known as an employer identification number or EIN), is a number assigned solely to any business by the IRS.
- **NPDB:** The National Practitioner Data Bank (NPDB)-contains information on various actions taken against physicians and dentists.
- **HIPDB**: The HIPDB (Healthcare Integrity and Protection Data Bank) - Contains information on various actions taken against health care practitioners, providers and suppliers.
- **Credentialing:** A review process conducted by or for a health plan to determine the current clinical competence of a provider and to ensure that the provider meets the health plan's standards. During the credentialing process, the provider's credentials (the documentation related to licenses, certifications, training, and other qualifications) are obtained and verified. Then, a health plan committee made up of the provider's professional colleagues reviews the credentials to determine whether the provider meets the health plan's pre-established criteria for participation in the network.
- **Recredentialing:** A health plan's periodic reexamination and verification of a provider's qualifications to ensure that the provider still meets the health plan's standards for network participation.
- **Profiling**, also known as provider profiling, is the collection and analysis of information about the practice patterns of individual providers. Profiling produces information on such parameters as quality of care, outcomes, patient satisfaction, utilization of resources, cost-effectiveness, and compliance with the plan's protocols.
- **Network:** A network is the group of physicians, hospitals, and other medical care professionals that a health plan has contracted with to deliver medical services to its members.

- **Primary Care.** General medical care that is provided directly to a patient without referral from another physician. It is focused on preventive care and the treatment of routine injuries and illness.
- **Primary Care Provider (PCP).** A physician or other medical professional who serves as a group member's first contact with a plan's healthcare system. Also known as a primary care physician, personal care physician, or personal care provider. Note: Many health plans pay for a specialists only if the patient is referred by his or her PCP.

Provider Contract Rates

- **DRGs:** Diagnosis-Related Groups are a classification of hospital case types into groups expected to have similar hospital resource use. Medicare uses this classification to pay for inpatient hospital care. The groupings are based on diagnoses, procedures, age, sex, and the presence of complications or comorbidities.
- **DFFS:** Discounted Fee for Service Under this system the physician and other workers are reimbursed according to the number and type of different services provided to the patient. A specific price is set for each service, which may be fixed or variable.
- **Fee Schedule:** The fee determined by a health plan to be acceptable for a procedure or service, which the physician agrees to accept as payment in full. Also known as a fee allowance, fee maximum, or capped fee.
- **APC:** Ambulatory Payment Classification These are the Medicare payment categories for services provided in hospital outpatient departments under the Hospital Outpatient Prospective Payment System (HOPPS).
- **Relative Value Scale (RVS):** A method used by health plans of determining provider reimbursement that assigns a weighted value to each medical procedure or service. To determine the amount the health plan will pay to the physician, the weighted value is multiplied by a money multiplier. Also known as relative value of services.
- **Resource Based Relative Value System (RBVS):** is used to calculate the Medicare physician fee schedule, which determines reimbursement for medical services to Medicare patients.
- **Usual, Customary, and Reasonable (UCR):** The amount commonly charged for a particular medical service by physicians within a particular geographic region. UCR fees

are used by traditional health insurance companies as the basis for physician reimbursement. When an insurance carrier has a UCR charge, the patient may be responsible for paying this difference. This is called Balance Billing.

- **Per Diem:** Hospitals and other facilities are paid “by day” for specific services. Based on the service provided there are is medical per diem, surgical per diem, obstetrics per diem etc.
- **Capitation:** Capitation rate is also referred to as Per Member Per Month (PMPM) payment. Provider is paid the same amount every month for each member regardless of how often the member receives care during that month and regardless of the cost of that care.
- **Global Budget:** Global budget is a variant of Capitation. Global Budget is a payment fixed in advance to cover aggregate expenditures in a given period.
- **Withhold:** A percentage of a provider's payment that is "held back" during the plan year to offset or pay for any cost overruns for referral or hospital services. Any part of withhold not used for these purposes is distributed to providers.

Basics of Medical Management

In order to operate effectively, a health plan must be able to manage both the cost and the quality of healthcare services. Without adequate cost management, a health plan may not be able to maintain its financial viability. Without adequate quality management, it may not be able to meet the healthcare and service quality needs of members, providers, purchasers, and regulatory and accrediting bodies.

The system that health plans and their providers use to achieve and maintain both high quality and cost effectiveness is referred to as medical management.

Medical management activities can be divided into three broad categories: Utilization Management, Clinical Practice Management, and Quality Management. Utilization Management (UM) refers to health plan programs that manage the use of medical services so that plan members receive necessary, appropriate medical care in a cost effective manner, in an

appropriate setting. Clinical Practice Management involves the development and implementation of parameters for the delivery of healthcare services to plan members. Quality Management (QM) is an organization-wide process of measuring and improving the quality of the healthcare and services a health plan's members receive.

The Utilization Management Function

Utilization review, case management, and disease management are strategies health plans use primarily to address the needs of members with existing medical conditions.

Utilization Review (UR) An evaluation of the medical necessity, appropriateness, and cost effectiveness of healthcare services and treatment plans for a given patient. Utilization review activities can be classified into three broad types: prospective review, concurrent review, and retrospective review.

- **Prospective review.** The review and possible authorization of proposed treatment plans for a patient before the treatment is implemented.
- **Concurrent review** occurs while treatment is in progress and typically applies to services that continue over a period of time. Concurrent review can be used to evaluate outpatient courses of care, such as chemotherapy or radiation therapy, physical therapy, home healthcare, and counseling, or for inpatient care.
- **Retrospective review.** A type of utilization review that occurs after treatment is completed in order to authorize payment and medical necessity and appropriateness of care.

Case Management (CM)

A process of identifying plan members with special healthcare needs, developing a healthcare strategy that meets those needs, and coordinating and monitoring care.

Disease Management (DM)

sometimes called disease state management, is a coordinated system of preventive, diagnostic, and therapeutic measures intended to provide cost-effective, quality healthcare for a patient population who have or are at risk for a specific chronic illness or medical condition. Disease

management focuses on the comprehensive care of the patient over time rather than on individual episodes of medical care.

Referral Management

Seamless referral management process requires:

- PCP support for utilization of referral guidelines.
- Specialist/vendor support for utilization of referral guidelines.
- PCP/office staff knowledge of preferred specialists/ vendors.
- PCP/office staff accessibility to preferred specialists/ vendors and to different benefit guidelines for different insurers.
- PCP training in patient management and effective communication skills.
- PCP authority to issue global referrals (i.e., all services associated with a surgical procedure, total OB care, etc.).
- Automatic payment of certain types of referrals (i.e., all referrals to "preferred" specialists, certain emergency room diagnoses, etc.).
- Referral and claims systems which communicate correctly to each other, ensuring that all appropriate claims are paid.
- Referral-based information, by PCP, specialist, and patient diagnosis, of the types and number of referrals issued.

Pre-certification/Pre-Admission Review

Approval by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or in-patient facility, granted prior to the admittance. The process is also used to review selected outpatient procedures. E.g. MRIs.

Preadmission testing

A requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to non-emergency hospital admission. The testing is designed to reduce the length of a hospital stay.

Preauthorization

A voluntary process that allows physicians and other professional providers to determine, before treating a patient, if an insurance company will cover the cost of a proposed service.

Appeal of Preauthorization denials

The Medical Support department handles all appeals of preauthorization denials except for home health care, hospice care, outpatient cardiac or pulmonary rehabilitation, physical rehabilitation programs, skilled nursing care, and skilled nursing facility care.

Medical Support handles three types of appeals/inquiries:

- Appeal of Preauthorization denials.
- Appeals of medical necessity denials after a claim is filed and benefits for services are denied. E.g. Mental Illness, Alcoholism and Drug Abuse benefits.
- Inquiries related to denials for type of service or other reasons after the claim is filed and benefits for services are denied.

Second surgical opinion

A cost-management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended that a non-emergency or elective surgery be performed.

Fraud

Insurance fraud or false insurance claims are insurance claims filed with the intent to defraud an insurance provider. Fraud can be committed by either member or provider.

What is Insurance Fraud?

The intentional misrepresentation of material facts, knowingly made, and with intent to defraud an insurance company.

- This applies to:
    1. The application for insurance
    2. The presentation of a claim
- The result of the misrepresentation
    - An insurance carrier bound coverage or paid a claim that it would not normally have.

Insurance fraud is both:

1.Internal

- Misrepresentation of facts by insurance company employees, agents or brokers for their personal enrichment or to prevent regulators from taking certain actions.

2. External

- Fraudulent activity committed by applicants for insurance, policyholders, third-party claimants, or professionals who provide insurance services to claimants.

What are False Insurance Claims?

False claim schemes are the most common type of health insurance fraud. The goal in these schemes is to obtain undeserved payment for a claim or series of claims. Such schemes include any of the following when done deliberately for financial gain:

- Billing for services, procedures, and/or supplies that were not provided.

- Misrepresentation of what was provided; when it was provided; the condition or diagnosis; the charges involved; and/or the identity of the provider recipient.
- Providing unnecessary services or ordering unnecessary tests.
- Charging for a service that was not performed.
- Unbundling of claims: Billing separately for procedures that normally are covered by a single fee. An example would be a podiatrist who operates on three toes and submits claims for three separate operations.
- Double billing: Charging more than once for the same service.
- Up-coding: Charging for a more complex service than was performed. This usually involves billing for longer or more complex office visits (for example, charging for a comprehensive visit when the patient was seen only briefly), but it also can involve charging for a more complex procedure than was performed or for more expensive equipment than was delivered. Medicare documentation guidelines describe what the various levels of service should involve.

How to Detect Healthcare Fraud:

- CMS programs.
- Decision applications – profiling technology.
- Fair Isaac's Payment Optimizer – predictive models.
- Blend of predictive models and expert decision logic.
- Prepayment advanced Decision systems.

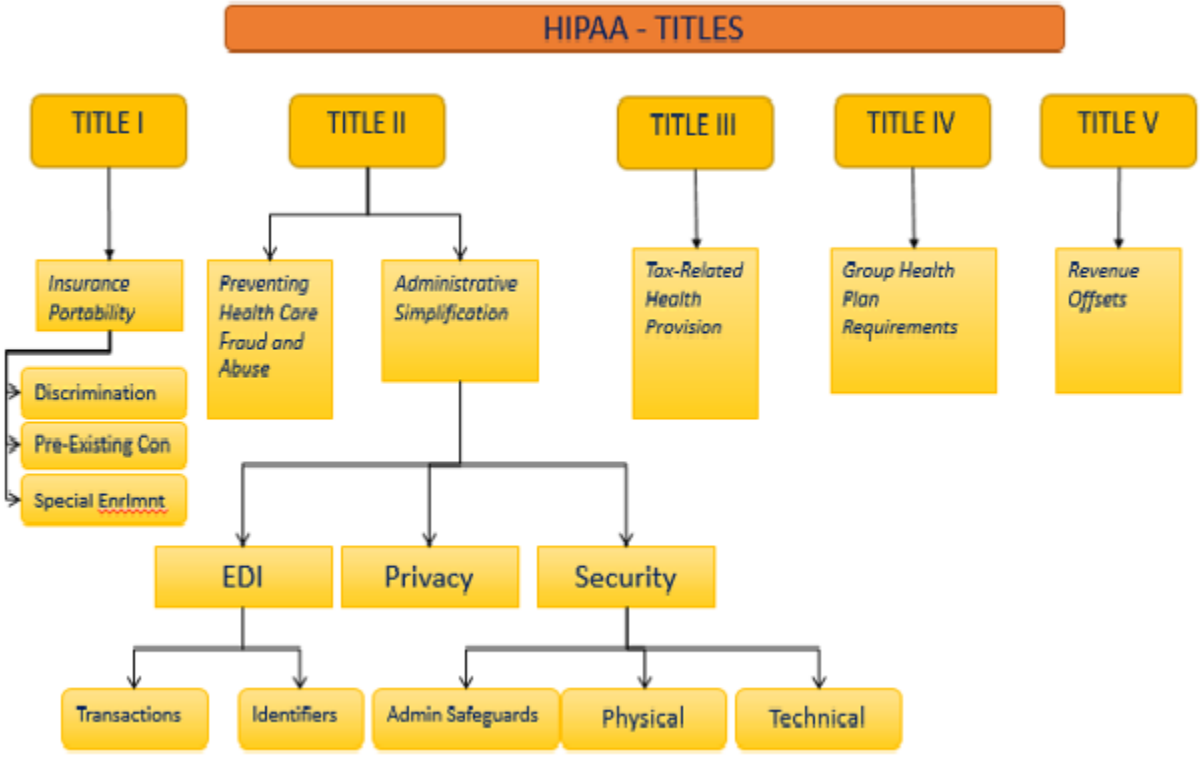
Abuse

Incidents and practices which, although not usually considered fraudulent, are inconsistent with accepted sound medical, business or fiscal practices.

- Unnecessary or excessive services.
- Increasing charges to Medicare beneficiaries but not to other patients.
- Improper billing practices:
    - Billing Medicare instead of primary payer
    - Exceeding limiting charge allowance

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- Federal law passed by Congress
- Part of the Social Security Administration Act
- HIPAA is a federally enacted law containing five provisions designed to:
- Assure portability of health insurance;
- Decrease health care fraud and abuse;
- Improve efficiency and effectiveness of health care;
- Guarantee security and privacy of patient health information



The HIPAA rules focus on:

- Protected health information (PHI) generally includes medical records and any other individually identifiable health information in any form (written, verbal or electronic).
- “Individually identifiable” - explicitly linked to an individual or reasonably expected to permit individual identification.

In the HIPAA regulations, the Secretary of Health and Human Services (HHS) adopted certain standard transactions for Electronic Data Interchange (EDI) of health care data. These transactions are: claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, coordination of benefits and premium payment. Under HIPAA, if a covered entity conducts one of the adopted transactions electronically, they must use the adopted standard– either from ASC X12N or NCPDP (for certain pharmacy transactions). Covered entities must adhere to the content and format requirements of each transaction. Under HIPAA, HHS also adopted specific code sets for diagnoses and procedures to be used in all transactions. The HCPCS (Ancillary Services/Procedures), CPT-4 (Physicians Procedures), CDT (Dental Terminology), ICD-9 (Diagnosis and hospital inpatient Procedures), ICD-10 (As of October 1, 2015) and NDC (National Drug Codes) codes with which providers and health plan are familiar, are the adopted code sets for procedures, diagnoses, and drugs.

The Health Information Technology for Economic and Clinical Health (HITECH) Act

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

What did HITECH accomplish?

- Formalized the definition of security and/or privacy “breach”
- Created rules for notifying individuals whose protected health information (PHI) has been acquired, accessed, used or disclosed by unauthorized individuals or entities.
- Set more stringent standards on Business Associate Agreement.
- The HIPAA enforcement rule also allows for individuals to be held responsible as well.

Patient Protection and Affordable Care Act (PPACA)

The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) or, colloquially, Obamacare, is a United States federal statute signed into law by President Barack Obama on March 23, 2010.

The ACA was enacted to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government. It introduced mechanisms like mandates, subsidies, and insurance exchanges. The law requires insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of pre-existing conditions or sex.

Accountable Care Organization (ACO)

Though the key focus area of the Patient Protection and Affordable Care Act (PPACA) are about expanding coverage to the uninsured and regulating the health insurance market, it also includes provisions to reform the healthcare delivery system as it exists today. This transformation will be driven by accountable care organizations (ACOs) – provider-led organizations that will be accountable for the cost and quality of care delivery to the Medicare members assigned to them. These ACOs will share the treatment cost savings achieved with Centers for Medicare and Medicaid Services (CMS).

The ACO is considered as one of the key solutions to reform today's unsustainable health system. By aligning it with improvements in outcome and reduced treatment costs, it goes beyond payment reform to transform healthcare delivery. The transformative nature of ACO model enables both payers and providers to share financial risk of health insurance.

Goals of an ACO are to determine how to successfully

- Keep patients within the ACO, and encourage them to stay healthy and take responsibility for their own healthcare.
- Encourage patients to use healthcare providers that are part of ACO network to keep all overall costs down within the organization.

Health Insurance Exchange (HIX)

Health Insurance Exchanges (HIX) are web-based marketplaces where consumers can shop for healthcare plans by comparing benefits and prices and choosing plans that suit them best. Though HIX have been in existence for some time, they have recently gained prominence in North America because of provisions in the American Patient Protection and Affordable Care Act (PPACA).

Under the PPACA, individual states had the option of setting up their own HIX or using the US Federal Government's HIX. Eighteen (18) states in the US have decided to operate their own HIX while the rest have opted to use the US Federal Government's HIX. Marketplaces provide a set of government-regulated and standardized health care plans from which individuals may purchase health insurance policies eligible for federal subsidies.

Health Information Exchange (HIE)

Health information exchange (HIE) is the mobilization of healthcare information electronically across organizations within a region, community or hospital system. In practice the term HIE may also refer to the organization that facilitates the exchange.

HIE provides the capability to electronically move clinical information among different health care information systems. The goal of HIE is to facilitate access to and retrieval of clinical data to provide safer and more timely, efficient, effective, and equitable patient-centered care. HIE is also useful to public health authorities to assist in analyses of the health of the population.

HIE systems facilitate the efforts of physicians and clinicians to meet high standards of patient care through electronic participation in a patient's continuity of care with multiple providers. Secondary health care provider benefits include reduced expenses associated with:

- The manual printing, scanning and faxing of documents, including paper and ink costs, as well as the maintenance of associated office machinery.
- The physical mailing of patient charts and records, and phone communication to verify delivery of traditional communications, referrals, and test results.
- The time and effort involved in recovering missing patient information, including any duplicate tests required to recover such information.

MITA Overview

The Medicaid Information Technology Architecture (MITA) is an initiative of the Center for Medicaid & State Operations (CMSO), and it is aligned with the National Health Infrastructure Initiative (NHII). MITA is intended to foster integrated business and IT transformation across the Medicaid enterprise. It will establish national guidelines for technologies and processes that can enable improved program administration for the Medicaid enterprise. Medicaid communities want to ensure that the mission and goals of the Medicaid program are met. The MITA initiative includes an architecture framework, processes, and planning guidelines for enabling state Medicaid enterprises to meet common objectives within the framework while supporting unique local needs.

Its common business and technology vision for state Medicaid organizations will emphasize:

- A patient-centric view not constrained by organizational barriers
- Common standards with, but not limited to, Medicare
- Interoperability between state Medicaid organizations within and across states, as well as with other agencies involved in healthcare
- Web-based access and integration
- Software reusability
- Use of commercial off-the-shelf (COTS) software
- Integration of public health data

MITA Goals	MITA Objectives

- Develop seamless and integrated systems that effectively communicate, achieving common Medicaid goals through interoperability and standards
- Promote an environment that supports flexibility, adaptability, and rapid response to changes in programs and technology
- Promote an enterprise view that supports enabling technologies aligned with Medicaid business processes and technologies
- Provide data that is timely, accurate, usable, and easily accessible to support analysis and decision making for health care management and program administration
- Provide performance measurement for accountability and planning
- Coordinate with Public Health and other partners and integrate health outcomes within the Medicaid community
- Adopt data and industry standards
- Promote secure data exchange
- Promote reusable components through modularity Promote efficient and effective data sharing to meet stakeholders' needs
- Provide a beneficiary-centric focus
- Support interoperability and integration using open architecture standards
- Promote good programmatic practices, such as the use of the Software Engineering Institute's Capability Maturity Model (SEI CMM), as well technical practices such as the use of a data warehouse to separate on line analytical processing (OLAP) from on line transaction processing (OLTP)
- Support the integration of clinical and administrative data to enable better decision making
- Break down artificial boundaries between systems,

geography, and funding (with the Title XIX program)

-

Glossary of Acronyms and Terms

Acronym	Definition / Explanation / Full Form
AHCAA	Association of Health Care Administrative Assistants
Balance Billing	The amount you could be responsible for (in addition to any co-payments, deductibles or coinsurance) if you use an out-of-network provider and the fee for a particular service exceeds the allowable charge for that service.
Benefit	A general term referring to any service (such as an office visit, laboratory test, surgical procedure, etc.) or supply (such as prescription drugs, durable medical equipment, etc.) covered by a health insurance plan in the normal course of a patient's healthcare.
Benefit Package	A description of the healthcare services and supplies that a health insurance company covers for members of a specific health insurance plan.

Capitation	A method of compensation sometimes employed by health insurance companies, in which payment is made to a healthcare provider on a per-patient rather than a per-service basis. For example, under capitation an HMO doctor may be paid a fixed amount each month to serve as the primary care physician for a specific number of HMO members assigned to his or her care, regardless of how little or how much care each member needs.
Carrier	Any insurer, managed care organization, or group hospital plan, as defined by applicable state law.
Carry-over Provision	A provision of some health insurance plans allowing medical expenses paid for by the member in the last three months of the year to be carried over and applied toward the next year's deductible.
Case Management	When a member requires a great deal of medical care, the health insurance company may assign the member to case management. A case manager will work with the patient's healthcare providers to assist in the management of the patient's long-term needs, with appropriate recommendations for care, monitoring and follow-up. A case manager will also help ensure that the

	member's health insurance benefits are being properly and fully utilized and that non-covered services are avoided when possible.
Centers for Medicare and Medicaid Services	Formerly known as the Health Care Financing Administration, the Centers for Medicare and Medicaid Services (CMS) is part of the federal government's Department of Health and Human Services, and is responsible for the administration of the Medicare and Medicaid programs. The CMS establishes standards for healthcare providers that must be complied with in order for providers to meet certain certification requirements.
Certificate of Coverage	A document given to an insured that describes the benefits, limitations and exclusions of coverage provided by an insurance company.
Claim	A bill for medical services rendered, typically submitted to the insurance company by a healthcare provider.
COB (Coordination of Benefits)	This is the process by which a health insurance company determines if it should be the primary or secondary payer of medical claims for a patient who has coverage from more than one health insurance policy. See also, Non-duplication of Benefits.

Coinsurance	The amount that you are obliged to pay for covered medical services after you've satisfied any co-payment or deductible required by your health insurance plan. Coinsurance is typically expressed as a percentage of the charge or allowable charge for a service rendered by a healthcare provider. For example, if your insurance company covers 80% of the allowable charge for a specific service, you may be required to cover the remaining 20% as coinsurance.
Co-payment	A specific charge that your health insurance plan may require that you pay for a specific medical service or supply, also referred to as a "co-pay." For example, your health insurance plan may require a $15 co-payment for an office visit or brand-name prescription drug, after which the insurance company often pays the remainder of the charges.
Cost-sharing	Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include deductibles, coinsurance, and co-payments. Balance-billed charges from out-of-pocket physicians are not considered cost-sharing. Beginning in 2014, PPACA limits total cost-sharing to $5,950 for an individual and $11,900 for a family. These amounts will be adjusted annually to reflect the growth of premiums.
Deductible	A specific dollar amount that your health insurance company may require that you pay out-of-pocket each year before your health insurance plan begins to make payments for claims. Not all health insurance plans require a deductible. As a general rule (though there are many exceptions), HMO plans typically do not require a deductible, while most Indemnity and PPO plans do.

Department of Health and Human Services	A department of the federal government responsible for certain social service functions, such as the administration and supervision of the Medicare program.
DRG	Diagnosis Related Group is a statistical system of classifying any inpatient stay into groups for the purposes of payment. DRGs are assigned by a "grouper" program based on ICD (International Classification of Diseases) diagnoses, procedures, age, sex, discharge status, and the presence of complications or comorbidities.
Drug Formulary	A list of prescription medications selected for coverage under a health insurance plan. Drugs may be included on a drug formulary based upon their efficacy, safety and cost-effectiveness. Some health insurance plans may require that patients obtain preauthorization before non-formulary drugs are covered. Other health insurance plans may require that a patient pay a greater share or all of the cost involved in obtaining a non-formulary prescription.
Drug Utilization Review (DUR)	The process by which health insurance companies evaluate or review the use of prescription drugs for appropriateness in the treatment of a patient.
Durable Medical Equipment (DME)	Medical equipment used in the course of treatment or home care, including such items as crutches, knee braces, wheelchairs, hospital beds, prostheses, etc. Coverage levels for DME often differ from coverage levels for office visits and other medical services.
Enrollee	An eligible person or eligible employee who is enrolled in a health insurance plan. Dependents are not referred to as enrollees.

Enrollment	The process through which an approved applicant is signed up with the health insurance company and coverage is made effective. This term may also be used to describe the total number of enrollees in a health insurance plan.
EPO (Exclusive Provider Organization):	An EPO is a Exclusive Provider Organization. As a member of an EPO, you can use the doctors and hospitals within the EPO network, but cannot go outside of the network for care. There are no out-of-network benefits.
Explanation of Benefits (EOB)	A statement sent from the health insurance company to a member listing services that were billed by a healthcare provider, how those charges were processed, and the total amount of patient responsibility for the claim.
Gatekeeper	A term used to describe the role of the primary care physician in an HMO plan. In an HMO plan, primary care physicians serves as the patient's main point of contact for healthcare services and refer patients to specialists for specific needs.
Grace Period	A time period after the payment due date, during which insurance coverage remains in force and the policyholder may make a payment without penalty.
Grandfathered plan	Health insurance coverage that existed as of March 23, 2010 that is subject only to certain provisions of the PPACA. Any policy sold in the individual health insurance market after March 23, 2010 will not be grandfathered even if the product sold was offered before that date. New employees may be added to group plans that are grandfathered, and new family members may be added to all grandfathered plans. If you're not sure whether you have a Grandfathered plan, please contact the plan directly.

Group Health Insurance	A health insurance plan that provides benefits for employees of a business or members of an organization, as opposed to individual and family health insurance.
HCFA	Health Care Financing Administration
HIPAA (Health Insurance Portability and Accountability Act of 1996)	Legislation mandating specific privacy rules and practices for medical care providers and health insurance companies, designed to streamline the healthcare and insurance industries and to protect the privacy and identity of healthcare consumers. HIPAA also provides additional protections for consumers, designed to help them obtain or retain health insurance coverage in certain circumstances.
HMO	HMO means "Health Maintenance Organization." HMO plans offer a wide range of health care services through a network of providers that contract exclusively with the HMO, or who agree to provide services to members at a pre-negotiated rate. As a member of an HMO, you will need to choose a primary care physician ("PCP") who will provide most of your health care and refer you to HMO specialists as needed. Some HMO plans require that you fulfill a deductible before services are covered. Others only require you to make a copayment when services are rendered. Health care services obtained outside of the HMO are typically not covered, though there may be exceptions in the case of an emergency.
Home Health Care	Part-time care that is provided by medical professionals in the home setting rather than in a hospital or skilled nursing facility.

Hospice Care	Care rendered either on an inpatient basis or in the home setting for a terminally ill patient. Often referred to as "palliative" or "supportive" care, hospice care emphasizes the management of pain and discomfort and the emotional support of the patient and family.
Length of Stay (LOS):	The total number of days that a patient stays in a facility such as a hospital.
Major Medical Insurance	A type of medical insurance plan that provides benefits for a broad range of healthcare services, both inpatient and outpatient. Major medical insurance plans often carry a high deductible.
Managed Care	A general term used to describe a variety of healthcare and health insurance systems that attempt to guide a member's use of benefits, typically by requiring that a member coordinate his or her healthcare through a primary care physician, or by encouraging the use of a specific network of healthcare providers. The management of healthcare is intended to keep costs -and monthly premiums- as low as possible. There are several different types of managed care health insurance plans, including HMO, PPO, and POS plans.
Maximum Out-Of-Pocket Costs	An annual limitation on all cost-sharing for which patients are responsible under a health insurance plan. This limit does not apply to premiums, balance-billed charges from out of network health care providers or services that are not covered by the plan.
Medicaid	A state-funded healthcare program for low income and disabled persons.

Medical Necessity	A basic criterion used by health insurance companies to determine if healthcare services should be covered. A medical service is generally considered to meet the criteria of medical necessity when it is considered appropriate, consistent with general standards of medical care, consistent with a patient's diagnosis, and is the least expensive option available to provide a desired health outcome. Of course, preventive care services that may be covered under a health insurance plan are not always subject to the criteria of medical necessity.
Medicare	A national, federally-administered health insurance program authorized in 1965 to cover the cost of hospitalization, medical care, and some related health services for most people over age 65 and certain other eligible individuals.
National Association of Insurance Commissioners (NAIC)	The NAIC is a national association of state officials charged with regulating insurance. The NAIC was formed to help provide some measure of national uniformity in insurance regulation.
National Drug Code (NDC)	A system employed by healthcare providers and insurance companies for classifying and identifying drugs. Each prescription drug in common use is assigned an NDC number.
Network	A "Network" plan is a variation on a PPO plan. With a Network plan you'll need to get your medical care from doctors or hospitals in the insurance company's network if you want your claims paid at the highest level. You will probably not be required to coordinate your care through a single primary care physician, as you would with an HMO, but it's up to you to make sure that the health care providers you visit participate in the network. Services rendered by out of network providers may not be covered or may be paid at a lower level.

Open Enrollment Period	A time period during which eligible persons or eligible employees may opt to sign up for coverage under a group health insurance plan. During an open enrollment period, applicants typically will not be required to provide evidence of insurability.
Over-the-counter (OTC) Drugs	Drugs that may be obtained without a prescription.
Participating Provider	Generally, this term is used in a sense synonymous with Network Provider. However, not all healthcare providers contract with health insurance companies at the same level. Some providers contracting with insurers at lower levels may sometimes be referred to as "participating providers" as opposed to "preferred providers."
POS	POS stands for "Point of Service." POS plans combine elements of both HMO and PPO plans. As a member of a POS plan, you may be required to choose a primary care physician who will then make referrals to specialists in the health insurance company's network of preferred providers. Care rendered by non-network providers will typically cost you more out of pocket, and may not be covered at all.
PPO	PPO means "Preferred Provider Organization." Like the name implies, with a PPO plan you'll need to get your medical care from doctors or hospitals on the insurance company's list of preferred providers if you want your claims paid at the highest level. You will probably not be required to coordinate your care through a single primary care physician, as you would with an HMO, but it's up to you to make sure that the health care providers you visit participate in the PPO. Services rendered by out of network providers may not be covered

	or may be paid at a lower level. A broad variety of PPO plans are available, many with low monthly premiums.
Premium	The total amount paid to the insurance company for health insurance coverage. This is typically a monthly charge. Within the context of group health insurance coverage, the premium is paid in whole or in part by the employer on behalf of the employee or the employee's dependents.
Respite Care	Normally associated with hospice care, respite care is a benefit often made available for family members of a patient, providing the patient's primary caretaker with a break or respite from caring for the patient. Respite care may be provided for the patient in either the home or a nursing home setting.
Rider	An amendment or modification to an insurance contract.
Second Surgical Opinion	Some health insurance companies may require a second opinion from a qualified physician or specialist before extending coverage for certain surgical procedures.
Self-funded Health Insurance Plan	A health insurance plan that is funded by an employer rather than through a health insurance company. A health insurance company will typically handle the administration of such a plan, but the cost of claims will be paid for by the employer through a fund set up for this purpose. See also, Administrative Services Only (ASO) Agreement.

Subrogation	The process by which a health insurance company determines whether medical bills should be paid for by the health insurance company itself or by another insurer or third party. For example, claims are frequently subject to subrogation when medical care is rendered as the result of an automobile accident. In most cases the automobile insurer is considered the primary payer. When a health insurance company has determined through the subrogation process that the automobile insurer will no longer pay on medical claims, then the health insurance company will typically become the primary payer.
Subscriber	This term may be used in two senses: First, it may refer to the person or organization that pays for health insurance premiums; Secondly, it may refer to the person whose employment makes him or her eligible for group health insurance benefits.
Triage	A method of classifying sick or injured patients according to the severity of their conditions in order to ensure that medical facilities and staff are most effectively utilized.
Underwriting	The process by which an insurer determines whether it will accept an application for insurance based upon risks and projections, and through which a determination on monthly premium is made.
Utilization Management/Review	This term is often used to describe a group (or the work performed by a group) of nurses and doctors who work with health insurance plans to determine if a patient's use of healthcare services was medically necessary, appropriate, and within the guidelines of standard medical practice. Utilization Management/Review may also be referred to as Medical Review.

References:

http://www.cms.gov/
http://www.healthcare-informatics.com
http://innovations.cms.gov
http://www.healthcare.gov/law/timeline/full.html-
http://www.qualityforum.org
http://www.ncqa.org/
http://www.ahrq.gov/