2020

Medical Billing Training: Certified Professional Biller (CPB™)

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Chapter 2

Health Insurance Models and Consumer Driven Health Plans

According to 45 CFR 160.103, the term health plan is "an individual or group plan that provides, or pays the cost of, medical care." We will examine the major health insurance models and consumer driven health plans (CDHP) in this chapter, along with different subtypes and how each is driven. We will also look at the role primary care providers' play in the system. A CPB™ should have a working knowledge of the major health insurance models and plans, and their respective requirements. The objectives for this chapter include:

- Understand health maintenance organizations (HMO) and models
- List and describe types of managed care organizations (MCO)
- Provide an overview of government payers
- Explain and identify consumer driven health plans (CDHP)
- Discuss an overview of Workers' Compensation and Liability Insurance
- Understand the role of utilization review organizations (URO)

Group versus Individual Health Plans

Before health insurance was popular in the United States, sickness insurance was utilized. It provided supplementary income to lessen the effects of financial loss due to missing work. Back in the early 1900's, the cost of missing wages was higher than the cost of healthcare, as most treatment was still performed in the patient's home. During World War II, wages were frozen by the National War Labor Board and there was a shortage of workers. Employers began seeking ways to entice employees to fill positions and retain them. The Revenue Act of 1939 established an employee tax exclusion for compensation for injuries, sickness, or both received under workers' compensation, accident, or health insurance. So, workers' health benefits were not subject to income tax or Social Security payroll tax. These things assisted in making health insurance more desirable. We will look at the differences between group and individual health plans.

Individual Health Plans

Individual health plans are those purchased by individuals for themselves or their families, not as part of a group plan. This type of insurance is usually purchased by the self-employed or by those who are employed but are not offered group insurance by their employers. The insurance companies will gather a lot of information on the individual and/or family's health status, desired deductible, and copayments to assemble a quote. Once a plan has been chosen, an application is completed to obtain approval from the insurance company.

The Patient Protection and Affordable Care Act (ACA) has made a federal mandate for all persons to have minimum essential coverage for themselves and their dependents. If a person does not comply with the law, they will pay a penalty as part of their income tax returns.

The ACA allows people to shop and purchase individual plans through the health insurance marketplaces, or exchanges. The exchanges include websites, call centers, and physical locations. People may purchase their insurance from anywhere, but if they purchase through the marketplace, they may be eligible for government subsidies. Key provisions of coverage for patients under the ACA include:

- Health plans may no longer limit or deny benefits to children under the age of 19 due to a pre-existing condition.
- Children under the age of 26 may be eligible to be covered under their parent's health plan: Prior to the ACA, health plans could remove a child at the age of nineteen, sometimes older if they were in college. Under the ACA, most health plans allow coverage to the age of 26, even if they are married, not living with their parents, attending school, not financially dependent on their parent, or eligible to enroll in their employer's plan.
- Lifetime limits on most benefits are banned: Under the ACA, lifetime limits are banned on any health plans issued or renewed on or after September 23, 2010. The law also bans annual dollar limits on most covered benefits as of January 1, 2014. A health plan may place annual and lifetime limits on healthcare services that are not considered essential.
- Appeal rights for patients on denied coverage: The ACA allows for patients to have the right to appeal a health plan's decision to deny payment for a claim or termination of health coverage. There are both internal and external appeals processes.
- Expanded preventive health services: There are 15 covered preventive services for adults, including cholesterol screenings, colorectal cancer screening, type 2 diabetes screening, and recommended immunizations. There are 22 covered preventive services for women (including

pregnant women) including BRCA (breast cancer genetic testing) counseling about genetic testing, breast cancer mammography, cervical cancer screening, osteoporosis screening, and well-woman visits. There are 26 covered services for children including autism screening, depression screening, obesity screening, vision screening, hematocrit/hemoglobin screening, and recommended immunizations.

Individual plans may not deny coverage due to a pre-existing condition. As of January 2014, ACA eliminated pre-existing condition clauses. A person cannot be denied coverage, charged higher premiums, or denied treatment based on their health status or gender.

The ACA also requires individual and small-group insured health plans to have certain essential health benefits including hospitalization, prescription drugs, maternity care, newborn care, mental health services, and preventive care among others.

Group Health Plans

The employer decides on the type of coverage and the costs. If an employer offers health insurance, it must be made available to all employees who are determined to be eligible by the employer's standards. Employers decide how much of the premium they will pay and how much the employee, if any, must contribute. The HIPAA law of 1996 limited exclusions for pre-existing medical conditions which was followed by the pre-existing condition exclusion under the ACA. A group health insurer cannot deny coverage to an eligible employee or family member because of a pre-existing condition.

Common types of group insurance available include:

Fully Insured Employer Group—The employer contracts directly with the insurance company to provide certificates to covered employees. The employer contracts with the health plan to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs. The employer pays a premium that is at a fixed rate for a year based on the number of employees enrolled in the plan.

Small Employer Group—Insurance companies may group certain industries together and then gather small employers to form a larger group, which enables the insurance company to better predict the cost of insurance.

Self-Funded ERISA—The group contracts with the insurance company or third-party administrator to handle the paperwork. This is available to large groups, which pays for the operation of the insurance plan itself and the costs for administration. With this type of plan, the employer pays for each out of pocket claim as it is incurred instead of paying a fixed premium (fully-insured).

Association Group—This is offered by a different type of group other than an employer, like a credit card company offering insurance benefits to its cardholders.

Provider Participation

When it comes to health plans, commercial or government, providers choose whether to participate. A participating (PAR) provider signs a contract with a health plan to agree to accept assignment for all covered services furnished to its members and to submit claims for the services they provide. In some cases, the member is responsible for deductibles and coinsurance amounts. A participating provider must write-off any amounts billed on covered services that are above the negotiated rate. Non-participating providers (non-PAR) choose to not accept assignment. A non-participating provider may bill the patient for the difference between the amount billed and the amount paid by the health plan (except for Medicare).

The advantage of participating is that the health plan agrees to direct covered members to the provider. The health plan also agrees to pay the provider directly for the services provided, sometimes in an expedited manner in relation to non-participating providers. In the case of Medicare participating providers, the fee schedule amount is five percent higher than that of non-participating providers.

If a provider decides not to participate, the patient usually receives the payment and the office must collect all money due from them. In the case of Medicare, a limiting charge applies to non-participating providers, which is 115 percent of the physician fee schedule amount. Some states have more stringent guidelines on limiting charges. For example, in New York the limiting charge is set at 105 percent instead of 115. The provider is still required to submit a claim to Medicare for services rendered.

MEDICARE EXAMPLE

Non-Participating	Participating
Fee Schedule Amount = $95.00	Fee Schedule Amount = $100
Limiting Charge Calculation	
115 percent x $95 = $109.25	None
Most Each Can Collect	
$109.25	$100

For Medicare, there is a third option regarding participation. Providers may opt-out of the Medicare program. These providers are not limited to any specific charge limit on their patients. They do not submit claims to Medicare for their services and have their patients sign private contracts regarding payment for services rendered. The patient is respon-

sible for payment in full for services as Medicare will not pay any amount to either the patient or provider in this situation.

Providers have an open enrollment period just like patients. Toward the end of each calendar year, usually from mid-November through December 31, all MAC/carriers hold open enrollment. This is the only time providers can change their participation status with Medicare. New providers can sign the participation agreement at the time of their enrollment into the Medicare program and will become effective on the date of filing.

The State Health Insurance Assistance Program (SHIP) is a program that offers free health benefits counseling to Medicare beneficiaries, their families, or caregivers. Each state has a SHIP and it can be located at the following website: https://www.seniorsresourceguide.com/directories/National/SHIP. They can educate patients on participating/non-participating/opt-out providers and what it means for them. They also hold free workshops and will have calendar listings on their websites for Medicare Monday events. This is a good resource to direct patients to for additional assistance.

Below is the Medicare Participating Physician or Supplier Agreement.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0373

MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant*	National Provider Identifier (NPI)*
_____ _____ _____	_____

*List all names and the NPI under which the participant files claims with the Medicare Administrative Contractor (MAC)/carrier with whom this agreement is being filed.

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. Meaning of Assignment: For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the MAC/carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.
2. Effective Date: If the participant files the agreement with any MAC/carrier during the enrollment period, the agreement becomes effective _____.
3. Term and Termination of Agreement: This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:
    a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every MAC/carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.
    b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

Signature of participant (or authorized representative of participating organization)		Date
Title (if signer is authorized representative of organization)		Office Phone Number (including area code)
Received by (name of carrier)	Initials of Carrier Official	Effective Date

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Form CMS-460 (04/10) 1

Health Maintenance Organizations (HMO)

The Health Maintenance Organization Act of 1973 was signed by President Nixon on December 29, 1973. The Act authorized $375 million dollars over a five-year period to encourage development of HMOs with grants and contracts, loans, and loan guarantees. It also required employers to offer an HMO option in their health benefits plans offered to employees. HMOs are entities which provide basic health services to their enrollees for a fixed monthly payment. An HMO must also provide the option of supplemental health services to its enrollees.

Basic health services, according to the Act, means:

- Physician services (including consultation and referral services by a physician)
- Inpatient and outpatient hospital services
- Medically necessary emergency health services
- Short-term outpatient evaluative and crisis intervention mental health services (not to exceed 20 visits)
- Medical treatment and referral services for the abuse of or addiction to alcohol and drugs
- Diagnostic laboratory and diagnostic and therapeutic radiologic services
- Home health services
- Preventive health services to include voluntary family planning services, infertility services, preventive dental care for children, and children's eye exams conducted to determine the need for vision correction

Supplemental health services, according to the Act, means:

- Services of facilities for intermediate and long-term care
- Vision care not included as a basic health service
- Dental services not included as a basic health service
- Mental health services not included as a basic health service
- Long-term physical medicine and rehabilitative services to include physical therapy
- The provision of prescription drugs prescribed during the provision by the health maintenance organization of a basic health service

HMO Models

There are several HMO models:

Group Model HMO: HMO that contracts with a multi-specialty group that provides care to the members. The HMO pays an established rate, which is distributed to the individual physicians as part of their salaries. The group may work solely with the HMO or may offer services to other patients. Care may be provided in facilities owned by the group or the HMO. The HMO pays the group in bulk and the group is responsible for reimbursing physician members and contracted facilities.

Staff Model HMO: HMO that employs the physicians on salary to provide care to the members in the clinics and other facilities owned by the HMO. It is also called a closed-panel HMO, as the physicians are contracted to provide medical services to only HMO patients.

Network Model HMO: HMO that contracts with more than one multi-specialty group, individual practice groups, and individual physicians so a variety of services may be offered to its members. This allows formation of a "provider network" and allows care to be provided in a larger geographic service area and offers the patient a choice of physicians and managed costs.

Individual/Independent Practice Association (IPA): HMO that contracts with independent physicians who maintain their offices and provide services to HMO and non-HMO patients, for which they receive a fixed amount per patient. This is also called an open-panel HMO. With an IPA, primary care providers may refer patients to medical services outside the network, but the HMO may not provide as much coverage as if the patient would have stayed within the network.

Mixed Model HMO: HMO that combines features of the individual practice association model and group models together. The HMO will contract with multi-specialty group practices, independent practice associations, and fully independent physicians all together. Mixed model HMOs offer the biggest variety of choices and largest geographic coverage area to its members, giving patients more choices of clinics, laboratories, pharmacies, and hospitals.

Primary Care Provider (PCP)

Upon joining an HMO, a member chooses a primary care provider, or PCP. This provider, sometimes called a gatekeeper, is responsible for providing a broad range of routine services. Their duty is to manage the member's treatment, as they are responsible for the member's healthcare decisions and referrals to other facilities (for example, inpatient admissions), in-network specialists, or out-of-network specialists when necessary. They are the group member's primary contact with the health plan. Most plans require a referral, or the member is responsible for the cost of treatment. Each covered member of a family may choose a different PCP. A PCP is usually a family or general medicine provider, an internal medicine provider, or a pediatrician. PCP's are the entry point for almost all the group member's healthcare needs. They provide disease prevention, health promotion, health maintenance, counseling, patient education, and diagnosis and treatment of acute and chronic illnesses.

Managed Care Organizations (MCO)

Managed care organizations (MCOs) combine the functions of health insurance, delivery of care, and administration. MCO is an umbrella term for organizations that are affiliated with or own hospitals, physician groups, and other providers which provide a wide range of coordinated health services. MCOs manage benefits and develop participating provider networks. These include Exclusive Provider Organizations (EPOs); Health Maintenance Organizations (HMOs), which have already been discussed; Integrated Delivery Systems (IDSs), Preferred Provider Organizations (PPOs), and Triple Option Plans. Managed care organizations offer managed care provisions that provide insurers with ways to manage the cost, use, and quality of healthcare services received by group members, including:

- **Utilization review:** The process of reviewing the appropriateness and quality of care provided to patients. It may take place before, during, or after the services are rendered.
- **Preadmission certification:** Authorization for hospital admissions given by a healthcare provider to a group member prior to hospitalization. Failure to obtain preadmission certification in non-emergency situations reduces, and in some cases eliminates, the healthcare provider's obligation to pay for services rendered.
- **Preadmission testing:** A requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to non-emergency hospital admission. This is performed to reduce the length of the hospital stay.
- **Non-emergency weekend admission restriction:** A requirement that imposes limits on reimbursement to patients for non-emergency weekend hospital admissions.
- **Second surgical opinion:** This is a cost-management strategy that either encourages or requires patients to obtain the opinion of another physician after a physician has recommended that a non-emergency or elective surgery be performed. If the second opinion is required, reimbursement may be reduced or denied if the patient does not obtain the second opinion. These opinions are usually required to be received from board-certified specialists with no personal or financial interest in the decision.

Exclusive Provider Organizations (EPO)

An EPO is an organization that has entered into contracts with medical care providers or groups of medical care providers to provide healthcare services to members. An EPO differs from an HMO in that if the member does not receive services from an in-network provider or facility, the member pays for all costs incurred, unless there is an emergency. Providers usually sign an exclusive contract with the EPO that restricts them from contracting with other managed care plans. As with an HMO, EPO members choose a PCP upon enrollment. Members then pay a percentage of every medical bill up to a yearly maximum out-of-pocket. Some EPOs allow members to go to a specialist without a referral. EPOs earn more money by charging an access fee to the insurer for use of the network. EPOs negotiate with the medical care providers of the organization in order to set fee schedules, help resolve differences between the insurer and medical care providers, and contract with other EPOs to strengthen their networks in certain areas.

Integrated Delivery Systems (IDS)

An IDS is a network of affiliated facilities and providers that work together to offer joint healthcare services to members. There are several IDS models:

Physician-Hospital Organization (PHO): A PHO is owned by hospitals and physician groups that work cooperatively to develop improved methods of healthcare delivery, oversee integration of physicians and hospitals into health delivery networks, assist in voluntary group formation, and collect, analyze, and disseminate information. They contract with managed care organizations or directly to employers with joint risk sharing and developing standards of care. PHOs provide an organized way for physicians and hospitals to work together on utilization management and quality improvement. They can provide administrative duties like credentialing; collaborate with managed care companies; and align incentives among physicians with establishing reimbursement and risk-sharing amounts.

Management Service Organization (MSO): An MSO is a business that provides nonclinical services to providers, like practice management services to individual physician practices. An MSO may also acquire a practice's asset and enter into agreements to provide the practice with space and/or equipment. MSOs may be owned by non-healthcare provider investors, by a hospital, by a group of physicians, a joint venture between a hospital and physicians, or a health plan. An MSO can provide a menu of services for providers to select from to meet their needs. These can include those stated already, and screening and hiring employees; providing office staff, billing, and coding personnel, IT personnel, in-service training, monitoring and implementing policies and procedures for coding and billing; compliance, claims submission, appeals, and auditing services; and assist with managed care contracting and negotiations.

Group Practice Without Walls (GPWW): A GPWW is a medical practice formed to share economic risk, expenses, and marketing efforts. Physicians retain separate offices and finances. It is formed when several small practices, usually in the same specialty, trade under a common tax identification

number. This allows them to jointly negotiate fees and avoid federal antitrust issues. The GPWW will have a common fee schedule, standardized benefits, and equally shared ancillary service revenue. Some may incorporate other components, like centralized billing or shared management.

Integrated Provider Organization (IPO): An IPO is a corporate umbrella for the management of diversified healthcare delivery system. The system may include one or more hospitals, a large group practice, and other healthcare operations. Physicians practice as employees of the organization or in a closely affiliated physician group. IPOs can perform many services, such as evaluate new payer arrangements; evaluate and negotiate risk contracts; administer credentialing agreements; establish and monitor group purchasing programs; prepare annual budgets and monthly income statement and balance sheets; and review contracts.

Preferred Provider Organizations (PPO)

A PPO is a type of insurance plan that allows members to choose the doctors and hospitals they want to visit from providers within the network (preferred providers). Unlike HMOs, patients are not required to obtain prior approval or go through a gatekeeper if they wish to see a specialist. They also are not required to choose a primary care provider. If they choose not to see a preferred provider, the services are still covered, but the patient will pay more out-of-pocket costs as the services provided by non-participating providers are reimbursed at a lower rate. These types of plans usually have a deductible and coinsurance responsibility. In some cases, they may need to obtain prior approval for non-emergency hospital visits and outpatient surgery.

EXAMPLE: COST IN NETWORK VS. OUT OF NETWORK FOR A PPO

Benefit Plan Feature	In-Network Cost	Out-Of-Network Cost
Annual Deductible		
Individual/Family	$2500/$5000	$6000/$12000
Annual Out-Of-Pocket Maximum		
Individual/Family	$7500/$15000	$16000/$32000

Triple Option Plans

A triple option plan is usually operated by a single insurance plan or a joint venture among two or more insurance payers. A triple option plan allows an insurer to administer three different healthcare plans so that members may select the benefit options they want: straight indemnity insurance, an HMO, or a PPO. An indemnity plan allows the patient to choose any physician and facility of their choosing. The health plan then pays a set portion, such as 80 percent, of the total charges. Many plans utilize usual, customary, and reasonable rates, or UCR rates, to base the reimbursement percentage for payment. A UCR rate is stated to be the amount that providers in the area where the services were rendered typically charge for the same service. These plans are also referred to as fee-for-service plans. A triple option plan allows the member to choose the option that is best for them. The indemnity plan is costlier but gives the patient the most choices of providers and facilities. The PPO is in the middle, as it is more restrictive, but less costly than an indemnity policy, and less restrictive, but costlier, than an HMO. The HMO is the most restrictive, and least costly of all the plans.

Accountable Care Organizations (ACO)

Section 3022 of the ACA, which was signed into law by President Obama in March 2010, includes provisions for creation of a shared savings program. It states that, "under such program:

A. Groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization; and

B. ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings."

The Shared Savings Program is designed to improve beneficiary outcomes and increase the value of care by promoting accountability for the care of Medicare fee-for-service beneficiaries, requiring coordinated care for all services provided under Medicare fee-for-service, and encouraging investment in infrastructure and redesigned care processes.

An ACO is made up of physicians and other providers, networks of individual practices of ACO professionals, partnerships, or joint venture arrangements between hospitals and ACO professionals, hospitals employing ACO professionals, and other providers and suppliers as determined by the Secretary of HHS. Any Medicare enrolled provider or supplier in good standing can participate in an ACO. An ACO must sign an agreement to participate for a period of at least three years and agree to accept responsibility for at least 5,000 Medicare fee-for-service beneficiaries.

The basic idea for an ACO is that in the traditional fee-for-service arena providers are paid for each test and procedure performed. This may drive up costs as it rewards providers for doing more, even if it is not medically necessary. Medicare

still pays ACO providers and suppliers as it does under the fee-for-service payment system but creates an incentive to be more efficient and keep costs down. There are specific quality benchmarks that are set that focus on disease prevention and management of patients with chronic diseases. CMS also sets benchmarks for each ACO if the ACO elects to share responsibility for losses. If the ACO does not save money or meet performance benchmarks, it may have to pay a penalty. If the ACO saves money and meets benchmarks, though, it is then eligible to share in savings under the program.

ACO programs offered by Medicare include:

- Medicare Shared Savings Program—ACO for fee-for-service beneficiaries.
- Advance Payment ACO Model—ACO for providers already in or interested in the Medicare Shared Savings Program. Selected participants will receive upfront and monthly payments. It is designed for smaller ACOs with less access to capital to give them the ability to participate in the Shared Savings Program. There are three types of payments available: 1) an upfront, fixed payment, 2) an upfront, variable payment based on the number of its historically assigned beneficiaries, and 3) a monthly payment of varying amount depending on the size of the ACO based on its historically assigned beneficiaries.
- Pioneer ACO Model—ACO for healthcare organizations and providers already experienced in coordinating care for patients across care settings. This model allows for higher levels of shared savings and risk for ACOs. These ACOs will be in the shared savings payment model the first two years of the program and, in year three, if they have shown a specified level of savings, they will be eligible to move a large portion of their payments to a population-based model.

ACOs are like HMOs in that they have accountability and shared risk. They are unlike HMOs in that they do not function as insurance companies and they may be formed with only 5,000 beneficiaries. HMOs usually have enrollees in the hundreds of thousands.

HOW DO ACOS DIFFER FROM HMOS?

Health maintenance organizations (HMOs) are insurance programs that provide healthcare to a defined population for a fixed price.

ACOs and HMOs both rely on the creation of physician networks, promotion of member health and resource management to control costs. And, like HMOs, Pioneer ACOs will move to capitation payments in their third year of implementation.

However, important differences do exist between ACOs and HMOs. ACOs are not insurance companies and their providers will be financially rewarded for coordinating all aspects of patient care. Primary care providers will need to increase their reliance on nurse practitioners, pharmacists, and other members of the healthcare team to track appointment compliance, manage medication schedules, and oversee lifestyle changes.

ACO patients can be seen by any physician of their choice. Patient participation in ACOs is strictly voluntary, there are no enrollment or lock in provisions. Patients who are unhappy with their care are free to seek treatment elsewhere. Consistent with traditional Medicare rules, there are no gate keeping or pre-authorization provisions in the ACO model and patients aren't required to obtain a referral before consulting with another provider

Source: https://www.rmf.harvard.edu/Clinician-Resources/Article/2012/ACOs-vs-What-We-Know

Government Payers

Beside the commercial insurers, the federal and state governments in the United States also provide insurance. In this section, we will review Medicare, Medicaid, and TRICARE.

Medicare

Medicare provides health insurance to Americans age 65 and older, and to some younger people with certain disabilities and other health conditions (permanent kidney failure, Lou Gehrig's disease). Prior to this, people age 65 and older had to either purchase private insurance or pay for healthcare themselves if they weren't covered under an employer's plan. Medicare is a social insurance program and covers over 59.1 million people. It is the largest health program in the United States.

When it was first enacted, Medicare had two parts: Part A for hospital coverage paid for by payroll deductions and Part B for optional medical insurance coverage. No premiums are charged for Part A if a person has contributed through the workforce. Part B, since it is optional, charges a monthly premium to those who wish to participate. The first beneficiaries paid a $40 annual deductible for Part A and paid a monthly premium of $3 for Part B. The biggest change to Medicare came in 2003, when President George W. Bush signed the Medicare Modernization Act (MMA) into law on December 8. It added outpatient prescription drug benefits and allowed for coverage of preventive benefits. In 2006, the voluntary Part D outpatient prescription drug benefit became available.

Medicare now has four parts:

- Part A: Hospital insurance
- Part B: Medical insurance for things not covered by hospital insurance (physician's services, medical supplies, etc.)

- Part C: Medicare Advantage plans, which are private plans (like HMOs and PPOs) run through Medicare that must at least be equivalent to regular Part A and Part B
- Part D: Prescription drug coverage

As with the other plans discussed earlier, providers agree to participate with Medicare, accept assignment on covered services and be reimbursed under a fee schedule. Medicare uses the Medicare Physician Fee Schedule (MPFS) for reimbursement for physician services and other types of services. The MPFS came into use on January 1, 1992. This replaced the old "customary, prevailing, and reasonable" (CPR) payment system. The MPFS is funded by Part B and is comprised of resource costs associated with physician work, practice expense, and professional liability insurance, with each of these three elements assigned a Relative Value Unit (RVU). Each CPT® code has RVUs assigned for each component: physician work (work RVU), practice expense (PE RVU), and professional liability insurance, malpractice (MP RVU). These RVUs are adjusted based on the Geographical Practice Cost Index (GPCI) associated with various geographic areas for different medical costs and wage differentials. These factors are multiplied by a conversion factor, which is the national dollar amount that is multiplied by the total geographically adjusted RVU to determine the Medicare allowable amount for physician services.

For example, the Non-Facility Formula is: [(Work RVU x Work GPCI) + (Transitional Non-Facility PE RVU x PE GPCI) + (MP RVU x MP GPCI)] x Conversion Factor. Examples of non-facility settings include the physician office or patient home. This is discussed in more detail in chapter 11. Medicare pays at 80 percent of the fee schedule once the patient has met the deductible.

EXAMPLE

A patient is seen in the office and CPT® code 99214 is billed to Medicare Part B for $150.00. A Medicare Remittance Advice (RA) is received at the office, listing the allowed amount as $107.83. Medicare paid 80 percent of the allowed ($107.83) or $86.26 as the patient had met his deductible. The patient's coinsurance amount is $21.57. $42.17 (charged amount $150.00 minus the allowed of $107.83) is a contractual write-off taken by the provider.

Medicare Eligibility

Individuals are eligible for Part A Medicare at age 65 if:

- They receive or are eligible to receive Social Security benefits.
- They receive or are eligible to receive railroad retirement benefits.
- Their spouse receives or is eligible to receive Social Security or railroad retirement benefits.
- They or their spouse worked long enough in a government job where Medicare taxes were paid.
- They are the dependent parent of a fully insured deceased child.

If a person does not meet the eligibility requirements, they may be able to get Part A by paying a monthly premium.

Individuals are eligible for Part A Medicare before age 65 if:

- They have been entitled to Social Security Disability Insurance (SSDI) for 24 months.
- They receive a disability pension from the railroad retirement board and meet certain conditions.
- They receive SSDI because of Lou Gehrig's disease.
- They worked long enough in a government job where Medicare taxes were paid and they have been entitled to Social Security disability benefits for 24 months; or they are the child or widow(er), age 50 or older including a divorced widow(er), of someone who has worked long enough in a government job where Medicare taxes were paid and they meet the requirements of the Social Security disability program; or they have permanent kidney failure and require maintenance dialysis or a kidney transplant and:
  - They are eligible for or receive monthly benefits under Social Security or the railroad retirement system.
  - They have worked long enough in a Medicare-covered government job.
  - They are the child or spouse of a worker who has worked long enough under Social Security or in a Medicare-covered government job.

Medicare Coverage, Deductibles, and Coinsurances

Part A Medicare covers hospital care, skilled nursing facility care, nursing home care, hospice, and home health services.

Part B Medicare covers medically necessary services, such as physician visits, ambulance services, durable medical equipment, and mental health services.

Part B has also greatly expanded coverage for preventive services. The following are covered under Medicare Part B:

- abdominal aortic aneurysm screening
- alcohol misuse screening and counseling
- bone mass measurements (bone density)
- cardiovascular disease screening
- cardiovascular disease (behavioral therapy)
- cervical and vaginal cancer screening
- colorectal cancer screening
- depression screening
- diabetes screening
- diabetes self-management training

- glaucoma tests
- hepatitis C virus screening
- HIV screening
- lung cancer screening
- mammograms (screening)
- nutrition therapy services
- obesity screening and counseling
- Welcome to Medicare visit
- prostate cancer screening
- sexually transmitted infections screening and counseling
- flu shots, hepatitis B shots, pneumococcal shots
- tobacco use cessation counseling
- Annual Wellness Visit

BILLING TIP

Medicare screening services will often have specific diagnosis requirements. When billing preventive services, understand the full policy set by Medicare for screening services.

If a person does not meet the eligibility requirements to receive Part A at no charge, the Part A premium is $437 for 2019. The Part B premium for 2019 for most Americans is $135.50 per month. Americans with higher Adjusted Gross Incomes (AGIs) may pay a slightly higher premium.

EXAMPLE

In 2019, a patient with Medicare Part A is hospitalized for 70 days. The patient's deductible of $1,364 is applicable for the first 60 days. From the 61st day through the 70th day the patient owes a co-insurance amount of $341 per day.

Below are the deductibles and coinsurances for 2019 (2020 is not released at the time of print).

Part A	Part A	Part B	Part B
Inpatient deductible	$1,364 per benefit period	Annual deductible	$185 per calendar year
Co-insurance days	$0 per benefit period (days 1-60) $341 per day (days 61–90)	Co-insurance amount	20 percent of Medicare approved amount
Lifetime Reserve days	$682 per each lifetime reserve day (days 91–150) Beyond life-time reserve days: all costs	Limiting Charge	15 percent above the Medicare approved amount
Skilled Nursing Coinsurance	$170.50 per day (days 21–100) per benefit period	Premiums	$135.50 per month regardless of effective date (potentially higher depending on income)

The days in the table are referring to the hospitalization days.

Section Review 2.1

1. This type of insurance is paid for by employers for employees and takes advantage of purchasing power of having large member numbers.

   A. Individual health plan
   B. Group health plan
   C. Medicare
   D. Medicaid

2. An internist sees a 20-year-old patient for an office visit. The patient needs to see an endocrinologist for a consultation regarding her diabetes. The internist is a participating provider in her plan. She can choose any provider she wishes for her consultation, but she will save money if she sees a specialist that is in her network. She does not require a referral for her consultation. What type of insurance does the patient have?

   A. HMO
   B. Indemnity insurance
   C. Medicare Advantage
   D. PPO

3. What are the options for a provider with regards to participation with Medicare?

   A. It is mandatory for every provider to participate in Medicare
   B. Providers may participate, may choose not to participate, or may opt-out of Medicare
   C. Providers are automatically opted-out
   D. Only participating providers must file claims

4. A family practitioner sees a Medicare patient and bills a 99213. This provider has opted-out of Medicare. His fee for the service is $125.00. Medicare's approved amount is $73.08, and the patient has met $0 of his deductible. What can the provider bill the patient?

   A. $125.00
   B. $73.08
   C. $14.62
   D. $58.46

5. Under the Patient Protection and Affordable Care Act (ACA), what is banned?

   A. Expanded preventive health services
   B. Lifetime limits
   C. Patient appeal rights
   D. Coverage for children under the age of 26

Medicaid

Medicaid is a health insurance program for low-income individuals and families who cannot afford healthcare costs. There are different types of Medicaid coverage available for individuals with different needs. Primary oversight is performed federally, but each state establishes its own eligibility standards, determines the type and scope of services, sets the rate of payment for services, and administers its own Medicaid program.

Medicaid Eligibility

A person may be eligible for Medicaid if he or she:

- Is a U.S. citizen or provides proof of eligible immigration status, unless applying for emergency services.
- Has a Social Security number or has applied for one.
- Meets the requirements for the Temporary Assistance for Needy Families (TANF) program.
- Is a child under the age of 6 whose family incomes are at or below 133 percent of the federal poverty level (FPL).
- Is a pregnant woman with family income below 133 percent of the FPL.
- Receives Supplemental Security Income (SSI).
- Is a recipient of adoption or foster care assistance under Title IV of the Social Security Act.
- Falls under a special protected group such as those who lose cash assistance due to earnings from work or from increased Social Security benefits.

- Is born after September 30, 1983, under 19, and in a family with incomes at or below the FPL.

States may choose to provide Medicaid coverage to other groups that share some characteristics with those above, but are more broadly defined, like the aged, blind, or disabled adults with incomes below the FPL, or low-income institutionalized individuals.

Medicaid Coverage, Deductibles, and Coinsurances

Although the individual states decide what their Medicaid plans will cover, there are some mandatory federal requirements that the state must meet to receive federal matching funds. These services include:

- Inpatient hospital services
- Outpatient hospital services
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility services for persons aged 21 or older
- Family planning services and supplies
- Rural health clinic services
- Home healthcare for persons eligible for skilled-nursing services
- Laboratory and X-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services
- Federally qualified health-center (FQHC) services and ambulatory services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21

There are also 34 optional approved Medicaid services that a state may provide and receive matching federal funds for, including optometry services, clinic services, prosthetics, and physical therapy.

Medicaid provides some enrollees with benefits under a fee-for-service delivery system. CMS reviews all state plan reimbursement methodologies to make sure reimbursement is consistent with federal statutes and regulations. States usually develop their payment rates based on the costs of providing the service, a review of commercial payer reimbursement, and a percentage of what Medicare pays for equivalent services.

Many states now offer a managed care program for Medicaid benefits as an option. In some states, the plans are a requirement for enrollees. These managed care programs include:

- Managed Care Organizations (MCOs): Like HMOs, these companies agree to provide most Medicaid benefits to enrollees in exchange for a monthly payment from the state.
- Limited benefit plans: These companies are like HMOs, but only provide one or two Medicaid benefits.
- Primary Care Case Managers: These are individual providers or groups of providers that agree to act as an individual's primary care provider. They receive a small monthly payment for helping coordinate referrals and other medical services.

Some states use Managed Long-Term Services and Supports (MLTSS) to offer services. This type of program delivers long term services and supports through capitated Medicaid managed care programs. The number of states with these types of programs is increasing.

States have the option to charge premiums and out-of-pocket spending requirements for enrollees, which may include copayments, coinsurances, deductibles, and other similar charges. Certain groups, like pregnant women and children, are exempt from most out-of-pocket costs and cannot be charged coinsurances and copayments for certain services.

The Children's Health Insurance Program, or CHIP, is designed to offer free or low-cost health insurance coverage to those whose incomes are too high to qualify for Medicaid but can't afford private coverage. It is administered by the states like Medicaid but is jointly funded by the federal government and the states. Every state administers its own CHIP program with broad guidance from CMS. States can design their CHIP program through Medicaid expansion, through a separate child health insurance program, or a combination of the two. The ACA maintains the CHIP eligibility standards through 2019.

BILLING TIP

Medicaid policies differ from state to state. It is important for a biller to understand the Medicaid program within the states they are billing for.

Some people may qualify for the spenddown program under Medicaid. This program is available for people who earn too high an income or have too many assets to qualify for Medicaid. Spenddown is similar to a deductible. The person pays for the cost of their medical care up to a set amount each month which can be made up of medical care bills, drugs, and medical supplies. Once the monthly spenddown amount has been met, a medical card will be issued to pay any other medical services the patient needs for the month. The amount of the spenddown will be different for each person and is based on an individual's income and assets. The types of medical

expenses that can be counted toward a patient's spenddown include:

- Physician services
- Hospital services
- Nursing home services
- Clinic services
- Dentist services
- Podiatrist services
- Chiropractor services
- Medicines, medical supplies, and equipment prescribed by a provider
- Eyeglasses
- Medical or personal care in the home
- Health insurance premiums, including Medicare premiums
- Speech, occupational, and physical therapy
- Transportation to and from medical care
- Co-payments or deductibles paid for medical care

Unpaid medical bills, up to six months prior to the month they are counted for, may be used to meet the spenddown, as can bills paid for by someone other than the patient. Any medical bills for the patient or any person that the patient is legally responsible for (spouse, children under the age 18) may be used to meet the spenddown. Bills can be used for the month they were accrued and for up to six months afterwards. For example, if a patient pays for medication in April, the receipt may be used to meet the spenddown in April, or any month through September of that same year. A bill can only be used once to meet spenddown. A bill that is larger than the spenddown may be used to meet multiple months' spenddown. For example, if a patient has a spenddown of $20 and has receipts for $60, it can be used to meet the spenddown for three months. A patient also chooses what month they want their spenddown used for. If a patient meets their spenddown on July 25, they can use the spenddown for August.

BILLING TIP

Make sure that you give patients receipts for all services that are on a spenddown, so they may turn them in to their caseworker.

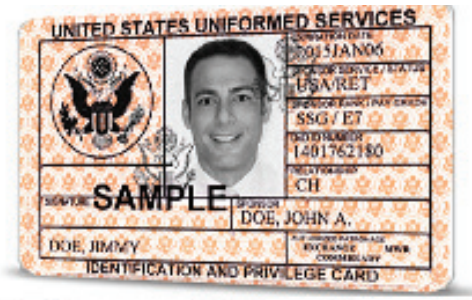
TRICARE

TRICARE is a healthcare benefit program for military personnel in all seven uniformed branches—the Army, the U.S. Navy, the Air Force, the Marine Corps, the Coast Guard, the Commissioned Corps of the U. S. Public Health Service, and the Commissioned Corps of the National Oceanic and Atmospheric Administration. It was formerly known as the Civilian Health and Medical Program of the Uniformed Services, or CHAMPUS. TRICARE is managed in three separate stateside regions, North, South, and West, by separate carriers.

Eligibility for TRICARE requires enrollment in the Defense Enrollment Eligibility Reporting System (DEERS). TRICARE is one of the most confusing plans. Some plans require care to be provided in a military treatment facility and care outside the facility must be approved by the Primary Care Manager. Deductibles and copayments depend on the plan selected and the military status of the patient. Coverage is typically extended to the spouse and unmarried children, but there are restrictions of age and military status at the time of care.

Below is a sample of a TRICARE Common Access Card (CAC) and other military ID cards.

Common Access Card (CAC)



Uniformed Services ID Card

Source: http://www.cac.mil/

TRICARE utilizes network providers in the same manner as other types of health plans. TRICARE offers coverage choices for health plans: TRICARE Prime®, TRICARE SelectSM, TRICARE for Life, TRICARE Reserve Select®, TRICARE Retired Reserve®, and TRICARE Young Adult.

BILLING TIP

It is critical for the biller to verify coverage, military status, and marital status before filing a claim.

Consumer Driven Health Plans (CDHP)

Consumer driven health plans (CDHP) are third tier insurance plans that give the members more control over their healthcare budgets. They allow patients to shop around and compare prices and providers. Health Savings Accounts were established in the Medicare Modernization Act of 2003 that was signed into law by President George W. Bush. CDHPs can be employer sponsored or purchased through the individual health insurance market. In this section, the different types of CDHPs will be reviewed.

Customized Sub-Capitation (CSC)

With a CSC, an individual is given a choice of providers of each type and given sub-capitation premiums that each provider charges. The individual chooses the providers he or she wants, and a customized premium is made of the sum of the sub-capitation rates for the providers selected. Each provider is paid a fixed amount per month to provide only the care that the individual requires from that provider (sub-capitation). The individual can make choices based on provider quality and price.

Flexible Spending Account (FSA)

An FSA is an account that an individual contributes money into that is used to pay for certain out-of-pocket healthcare costs. It is a tax-advantaged healthcare account available for most employees as no taxes are paid on the money in the account. FSAs are only available with employer-based health plans and can be used to pay for deductibles, copayments, and other medical and dental expenses. The main advantage of an FSA is that it is "pre-tax" dollars, so no federal income tax or social security tax are paid on the amount that is contributed. In some states, state tax is not paid either. By participating, the employee lowers their overall taxable income, so the overall amount of taxes paid is decreased.

Up to $2,700 (2019) may be contributed into an FSA each year, but it requires planning on the part of the employee. For the most part, if the money is not used during the plan year it is forfeited. An employer may offer two options to carry some money over. An employer can provide a grace period of up to 2½ extra months to use the money in the FSA. It can also allow an employee to carry over up to $500 per year to use in the following year. The employer may not offer any options, or one of the two, but not both.

The amount an employee wishes to contribute is deducted from their paycheck in equal amounts each pay period. As the employee incurs healthcare expenses throughout the year, the employee may need to turn in receipts with a form for reimbursement. Some employers have a special debit card that the employee would use, and the money would be taken directly from their account. An FSA is in effect for one plan year. The employee needs to re-enroll each year if they wish to continue to participate. If there are qualifying life events during a plan year (marriage, divorce, birth of a child, etc.), an employee may change their enrollment.

Health Savings Account (HSA)

HSAs were created in 2003. An HSA combines high deductible health insurance with a tax-advantaged savings account. The money deposited in the account can pay for the deductible, and once met, the money left in the account earns interest. HSAs can be funded by employers or employees and they are portable, which means that the account stays with the employee if they change employers or leave the work force. They are tax-free income to employees, they accumulate tax-free and are not taxed when withdrawn for eligible medical expenses, including for dental or vision expenses. To access the advantages of an HSA, Congress has imposed strict requirements, including (amounts for 2019 - updated annually):

- An individual must be covered under a high deductible health plan (deductible of at least $1,350 for individual or $2,700 for family) and caps on the out-of-pocket amounts that the individual will have to pay of $6,750 for individual coverage and $13,500 for family coverage
- The employee cannot be enrolled in Medicare
- An individual and/or employer can make contributions to the HSA up to the plan's deductible, but no more than $3,500 for an individual or $7,000 for family for 2019.
- Contributions may be made by the employee, the employer, family member, or any other person on behalf of the eligible individual.
- The HSA annual contribution limit is greater than the otherwise applicable limit by $1,000 for policyholders and covered spouses age 55 and older.
- Employers contributing to an HSA must make available comparable contributions on behalf of all employees with comparable coverage.
- Distributions from an HSA that are for qualified medical expenses are excluded from gross income; those that are not qualified are included in gross income and have a 10 percent penalty if the distribution is taken prior to the age of 65

Annual amounts can be found on the US Department of Treasury website: https://www.irs.gov/publications/p969 or at http://www.hsacenter.com/how-does-an-hsa-work/2019-hsa-contribution-limits/.

BILLING TIP

The increase in use of high deductible health plans alongside an HSA has increased patient balances for healthcare services. Facilities and providers should have strict patient balance collection policies in place.

Healthcare Reimbursement Account (HRA)

With an HRA, an employer can offer tax free reimbursement of an employee's health insurance premiums paid for by an employer. It is an IRS-approved, tax-advantaged health benefit plan. They can be used to pay for covered expenses and non-covered qualified medical expenses, including insurance premiums, with after-tax dollars. The employer has full power over structuring the employee's use of HRA funds. Unlike an HSA or FSA, there is no limit to the amount an employer can contribute to an employee's healthcare reimbursement account. The account balances may also roll over from year to year. They can be used by former employees and retirees to continue to have access to unused reimbursement amounts. Eligible medical care expenses as defined by the IRS are those items and services that are meant to diagnose, cure, mitigate, treat, or prevent illness or disease, including transportation that is primarily for medical care. Examples include:

- Health plan deductibles
- Co-insurance and co-payments
- Eligible dental expenses, including exams, X-rays, and cleanings
- Eligible vision care, including exams, eyeglasses, contact lenses, and laser eye surgery
- Certain over-the-counter medications, if allowed by your plan
- Certain healthcare items, like band-aids, aspirin, antacids, laxatives, etc., if allowed by the plan and requirements are met

Ineligible expenses include:

- Cosmetic surgery and procedures
- Herbs, vitamins, and supplements for general health
- OTC medicines for which the member does not have a prescription
- Family or marriage counseling
- Personal use items (lip balm, shaving cream, moisturizer, etc.)
- Prescription drugs imported from another country
- Expenses reimbursed by another plan or program (FSA or HSA account, etc.)
- Any other item or service that is not used for medical care as defined above by the IRS

Capitation

Capitation payments are used by managed care organizations (MCOs) to control healthcare costs by putting the physicians at financial risk for services provided to patients. Payments are based on a per-person rate, rather than a fee-for-service rate. The MCO measures rates of resource utilization in physician practices to ensure its members are receiving appropriate care. These reports are made available to the public for quality measures. They may also be linked to bonuses which are financial incentives to encourage efficiency for physicians to reduce or limit services.

EXAMPLE

Dr. Taylor is a family practice provider in a capitated plan. The provider receives a flat rate per member, per month from the capitated plan. For the year, the provider is paid $100,000 under the capitated plan. At the end of the year he evaluates his cost for care of the patients and determines a cost of $105,000. Based on the capitated contract, the provider loses $5,000 on this contract.

If the provider determined a cost of $80,000 for the care of the patients, the provider has a profit of $20,000 for this capitated contract.

The MCO sets the rate after determining the services that will be provided and the length of time they will be provided, using local costs and average service utilization to set the rate. The amounts may vary from region to region. There are also risk pools that are sometimes created as a percentage of the capitation withheld from the physician until the end of the fiscal year. The physician will receive the money if the health plan does well and is forfeited if the plan does poorly. This table is an example of what a capitation rate schedule may cover. Rates for each member are based on age ranges as the costs for providing care for patients are, overall, different for different age ranges. It also indicates a withhold amount. Some plans may offer different schedules by patient sex, different categories of ages, and different withhold amounts.

Member's Age	Capitation per Member, per Month	10 percent Withhold	Payment per Member, per Month
0–1	$25.00	$2.50	$22.50
2–4	$10.00	$1.00	$9.00
5–20	$5.00	$0.50	$4.50
20–50	$15.00	$1.50	$13.50
50–65	$25.00	$2.50	$22.50

Most capitated plans for primary care services include preventive, diagnostic, and treatment services; injections, immunizations, and medications that are administered in an office;

outpatient laboratory testing performed in the office or designated lab; and routine vision and hearing screenings. Along with capitation, though, some additional services are paid on a fee-for-service basis, called "carve-out" services.

Advantages of Capitation

The advantage of capitation is that a stronger relationship is built between patient and physician since the patients will receive most of their care from the same physician. It lowers the risk of patients having unnecessary services or being over-treated as the physician is vested in keeping costs down and not ordering medically unnecessary treatments. The cost of treatment is spread out among all members, so the cost of treatment is lower per patient overall. Since the physician will prosper if the patients are better, capitation promotes preventive measures, counseling, and patient education. When a patient does require treatment, the physician will choose the best treatment for the patient as there is no interest in choosing costly treatments for higher reimbursement.

The benefits of capitation to a physician, if care is managed correctly, include:

- Guaranteed income with a check of a specified amount at the same time each month
- Decreased cost of bookkeeping as no statements need to be sent, no write-offs taken on accounts, no untimely payments, no bad debt, etc.
- Decreased time for billing staff as no claims (except carve-out services) are sent and no appeals are necessary so billers may concentrate on other payers
- The physician does not have to wait for reimbursement
- Possible increase in market share as capitated patients may talk to others about the provider

Disadvantages of Capitation

The disadvantage to capitation is that it involves total assumption of risk on the part of the physician. It is difficult to predict the costs of all healthcare to all patients in advance. It may cause physicians to take on too large a roster of members into its practice to increase its payment.

Other disadvantages include:

- Patients must receive primary care from only one physician or physician group
- Physicians may have to limit capitated patients seen to control costs
- If one group has a large sick capitated population, they may make little or no profit, or suffer financial loss
- Specialists may be hesitant to enter into capitation as they are at risk for over-utilization by primary care physicians
- Sophisticated software may be necessary for large groups to track utilization, costs, and perform risk calculations

Workers' Compensation and Liability

Workers' compensation and employers' liability insurance is required by law for all business owners who have any employees in most states. Any employer is liable if an employee suffers an injury at work or develops an occupational disease covered by workers' compensation laws. If an employee is injured, he or she is guaranteed fixed monetary amounts from the employer's workers' compensation insurance for medical costs and a percentage of lost wages. This policy also covers the employer for the liabilities the business will suffer due to work-related injuries.

There are two types of basic workers' compensation coverage:

- Workers' compensation insurance provides payments to employees who incur work-related injuries or occupational illnesses. Referred to as Part One.
- Employers' liability insurance protects the employer against lawsuits due to employment-related injuries and illnesses. Referred to as Part Two.

Types of workers' compensation benefits include:

- Medical care
- Temporary disability benefits
- Permanent disability benefits
- Vocational rehabilitation services
- Death benefits

This insurance may be purchased through a licensed insurance company or from a state compensation insurance fund. Standard benefits are established by each state.

Homeowners' Insurance

There are different types of policies with homeowners' insurance, No-fault insurance pays for healthcare services a patient needs because of an injury they suffer on their property, regardless of who is at fault. Liability insurance protects against claims for negligence that causes someone to get injured. Liability insurance includes medical payments to other's coverage, which provides payment for necessary medical expenses for accidentally injured guests. No-fault insurance or liability insurance would be the primary insurance in these cases instead of a patient's own medical insurance.

If the provider/office/practice/facility knows the patient has a no-fault or liability insurance claim, the claim should be filed to the no-fault or liability insurer first. In the case of a Medicare patient, if the insurance company does not pay the claim within 120 days, Medicare may be billed to make a conditional payment. A conditional payment means that Medicare will pay the bill, but Medicare must be repaid when a settlement, judg-

ment award, or other payment is made. Medicare has a guide entitled, "Medicare and Other Health Benefits: Your Guide to Who Pays First." This guide gives instruction on how Medicare coordinates with other types of coverage and which coverage should pay first. Below is a portion of a table from that guide that indicates primary coverage for liability and no-fault insurance.

If you	Situation	Pays first	Pays second
Are 65 or over OR disabled and covered by Medicare and COBRA coverage	Entitled to Medicare	Medicare	COBRA
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or liability insurance for services related to accident claim	Medicare
Are covered under workers' compensation because of a job-related illness or injury	Entitled to Medicare	Workers' compensation for services related to workers' compensation claim	Usually doesn't apply. However, Medicare may make a conditional payment (a payment that must be repaid to Medicare when a settlement, judgment, award, or other payment is made.)
Are a Veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	Medicare pays for Medicare- covered services. Veterans' Affairs pays for VA-authorized services. **Note:** Generally, Medicare and VA can't pay for the same service.	Usually doesn't apply
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare- covered services. TRICARE pays for services from a military hospital or any other federal provider.	TRICARE may pay second.
Have black lung disease and are covered under the Federal Black Lung Benefits Program	Entitled to Medicare and the Federal Black Lung Benefits Program	The Federal Black Lung Benefits Program for services related to black lung.	Medicare

EXAMPLE

A patient presents with lacerations and puncture wounds to her arm. She states she was at her neighbor's house for dinner and was bitten by their dog. She gives the office a copy of her neighbor's homeowners' insurance information and her commercial insurance card. The homeowners' insurance is billed.

When a payer is billed and pays a claim incorrectly, the claim goes into subrogation. This is when an insurance company attempts to recoup expenses for a paid claim when another payer should have been responsible. This is seen commonly in auto accidents and liability cases when the auto insurance or liability insurance is not provided by the patient during the visit.

Role of Primary Care Providers/Gatekeepers

Primary care physicians (PCP) and other providers play a vital role in patient care. They provide consistency of care for their patients, reduce unnecessary hospitalizations, reduce complications due to chronic illnesses, and provide health education to their patients, among other services. A gatekeeper is a physician—typically a primary care physician, like a family practitioner, internist, or pediatrician—who is responsible for determining a patient's primary services and coordinating care so that the patient receives the appropriate needed services. The gatekeeper is in charge of all of the covered members' healthcare lives, managing their total care.

Without access to primary care providers, people will overutilize emergency departments and urgent care centers, which overburdens those systems. It also does not provide consistency and follow-through of care. Patients without primary care providers may not receive preventive care and screenings that may uncover a condition or disease needing treatment. Access to good primary care helps patients live better, longer, and healthier lives.

Physician Credentialing/NPI Requirements

Physician credentialing is a process used to evaluate the qualifications and practice history of a physician, which includes a review of a physician's completed education, training, residency, and licenses. It also includes any certifications issued by a board in the physician's area of specialty. The process may also involve investigating any liability claims, association memberships, and status with HHS.

Medical credentialing is used by various organizations and insurance companies to ensure that their healthcare providers meet all of the necessary requirements and are appropriately qualified. Physicians must have the necessary credentials and go through the process to participate with an insurance company. For Medicare, credentialing is required to receive reimbursement. Credentialing allows a physician to become affiliated with insurance companies to be able to accept third-party reimbursement.

At a hospital, after a physician has met the credentialing requirements, the physician undergoes further privileging. This assesses the physician's expertise in a specific practice, like cardiology or surgery, based on documented competence in the specialty in which privileges are requested.

Each organization may require different information for the credentialing process. For example, Aetna's credentialing process includes:

1. Gathering information about a doctor's background and qualifications through a formal application process:
   a. Checking the background information
   b. Checking the information against reliable sources, including the National Practitioner Data Bank and the American Board of Medical Specialties
2. Contacting:
   a. Any state where the doctor reports an active medical license and sees our members
   b. Schools and hospital programs, to be sure the doctor's training is complete and accepted by the specialty board
   c. The National Technical Information Service, Drug Enforcement Agency or Controlled Substance Registration, as confirmation that the doctor is authorized to write prescriptions
   d. Medicare/Medicaid, to be sure the doctor is not banned from caring for Medicare/Medicaid patients
3. Reviewing the doctor's:
   a. Personal history, to determine if any disciplinary actions have been taken
   b. Malpractice insurance, to confirm active coverage
   c. Malpractice claims history
   d. Hospital privileges, to determine if privileges have been lost or limited
   e. Work history and employment background
   f. Information with Aetna's Credentialing and Performance Committee, to determine whether or not the doctor should be included as participating in the network

Aetna also gathers specific information, including:

- Provider name and office location
- Provider gender
- Specialty(ies)

- Patient age focus
- Languages spoken
- Hospital affiliation
- Medical group affiliation
- Board certification
- Office status (indicating if office is accepting new patients)

Credentialing of a new provider can be very time consuming, but it's an essential process for providers to provide services at facilities and participate with health plans. Billers must ensure that they have complete information on the providers and fill the applications out with detailed attention. The credentialing process can take months to complete on a new provider, but if not done properly, the provider will not be paid and will not be having admitting privileges.

NPI Requirements

A National Provider Identifier (NPI) is a unique 10-digit identification number required by HIPAA. In the past, providers had different identification numbers for each payer, but the introduction of the NPI is a single identifier for all payers to improve efficiency of the healthcare system. It will also help reduce fraud and abuse. It is an "intelligence-free" number, meaning that there is no personal identifying information (birthdate or social security number) other than a name and business address.

All healthcare providers that are covered entities must obtain an NPI. This is applicable for individuals or organizations. An NPI doesn't: 1) ensure a provider is licensed or credentialed; 2) guarantee payment by a health plan; 3) enroll a provider in a health plan; 4) make a provider a covered provider; 5) require a provider to conduct HIPAA transactions; or 6) change or replace the Medicare enrollment or certification process.

NPI numbers are issued by the National Plan and Provider Enumeration System (NPPES), which was developed by CMS. NPPES processes applications, assigns NPIs, stores information about enumerated providers, and applies updates to provider information. The application process for NPIs can be done online, on paper, or through a third-party organization.

NPIs are used on electronic HIPAA compliant transactions including claims submission, eligibility, claim status inquiry, and referral/authorizations.

There are two types of NPI entities: Entity Type 1 and Entity Type 2.

- Entity type 1: sole proprietor/sole proprietorship, which is an individual. The individual must apply using his/her own Social Security number. Only one NPI is needed, regardless of how many locations he or she will provide services since it is not allowable to have subparts as a type 1 entity.
- Entity type 2: group healthcare providers. These are entities with EIN numbers, whether they have one employee (the physician) or thousands. These may include hospitals, home health agencies, clinics, and nursing homes.

Utilization Review Organizations (URO)

A URO is an entity that has established one or more utilization review programs which evaluate proposed or provided healthcare services for medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures, and facilities according to the provisions of the applicable health plans. These organizations perform reviews to safeguard against unnecessary and inappropriate medical care. UROs work with insurance companies, healthcare providers, workers' compensation bureaus, the military, correctional facilities, and government agencies. They advise the healthcare entities on hospital admissions, length of stay issues, imaging studies, surgeries, medications, and referrals among other things. They follow strict policies to determine if patients meet the standards for insurance reimbursement, pre-certification for medical procedures, and hospitalizations as part of the services provided. They play an important role in containing healthcare costs.

Services provided include:

- Coordinating referrals
- Coordinating hospital admissions and medical appointments
- Pre-authorizations/pre-certifications
- On-going monitoring of patients' treatment plans
- Collaborating with treating physicians to ensure the most appropriate treatment for patients

Section Review 2.2

1. A Medicaid patient presents for services on the first day of the month. He has a $50 spenddown and has had no services this month. The visit for today was $100.00. If the patient wants to be covered as long as possible from today's visit, what can he do?

   A. Turn the receipt in to his caseworker and be eligible for two months of coverage
   B. Turn the receipt in to his caseworker and be eligible for the month with $50 to be assessed by Medicaid for the visit that is above his spenddown
   C. Coverage is automatic and the patient will be reimbursed the $100 from Medicaid
   D. Turn in the receipt to his caseworker and be eligible for coverage for the current month, plus two additional months

2. An active duty military soldier is seen as a patient. He has a primary care manager who sees him for his healthcare needs. At this visit he is given a referral for some services that are not available at the military treatment facility. What type of plan does this man have?

   A. TRICARE Standard
   B. TRICARE Extra
   C. TRICARE Prime
   D. Medicare

3. A patient has receipts for her dental cleaning, vision exam, and contact lenses. Her employer has set up special accounts for each employee and there is no limit to the amount the employer can contribute, and the balances roll over from year-to-year. What type of account is this?

   A. Flexible Spending Account (FSA)
   B. Health Savings Account (HSA)
   C. Health Insurance Account (HIA)
   D. Healthcare Reimbursement Account (HRA)

4. A patient presents to be seen in the office. He does not pay at the time the services are rendered as the provider is his primary care provider, or gatekeeper. The large group practice has 800 covered members under this plan as is paid on a monthly basis with a set amount that is based on the number of members covered and their ages. What type of plan is this?

   A. PPO
   B. Capitation
   C. Fee-for-service
   D. Indemnity

5. Why must a provider obtain an NPI number?

    I. To submit claims

    II. To prove that he is licensed

    III. To be HIPAA compliant

    IV. To guarantee payment by a health plan

A. I, II, III

B. II, III, IV

C. I, II, III, IV

D. I, III

Glossary

Accountable Care Organizations (ACO)—A healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

Capitation—Fixed payment remitted at regular intervals to a medical provider by a managed care organization for an enrolled patient.

Carve-out—A service not covered in a health insurance contract, usually reimbursed according to a different arrangement or rate formula than those services specified under the contract umbrella.

Consumer Driven Health Plans (CDHP)—Third tier insurance plans that give the members more control over their health budgets.

Copay —A specified dollar amount the policyholder must pay to a healthcare provider for each visit or medical service received. This is typically found on the insurance card.

Credentialing—A process that is used to evaluate the qualifications and practice history of a physician which includes a review of a physician's completed education, training, residency, and licenses.

Customized Sub-Capitation (CSC)—Managed care plan in which healthcare expenses are funded by insurance coverage; the individual selects one of each type of provider to create a customized insurance premium.

DEERS (Defense Enrollment Eligibility Reporting System)—A worldwide computerized database of all uniformed service members, their spouses and family members, and others who are eligible for TRICARE.

Deductible—An annual specified dollar amount the policyholder must pay before the insurance carrier begins paying for services.

Employers' Liability Insurance—Insurance that protects an employer from damages from a lawsuit resulting from an injury due to the employer's negligence.

Exclusive Provider Organization (EPO)—An organization that has entered into contracts with medical care providers or groups of medical care providers to provide healthcare services to members.

Flexible Spending Account (FSA)—A tax-advantaged healthcare account an individual contributes money into that is used to pay for certain out-of-pocket healthcare costs.

Gatekeeper—A physician, typically a primary care physician, like a family practitioner, internist, or pediatrician, who is responsible for determining a patient's primary services and coordinating care so that the patient receives the appropriate needed services.

Group Health Plans—Health plans that are purchased by employers for its employees. A portion of the group health plan premium may be paid by the employer.

Group Practice Without Walls (GPWW)—A medical practice formed to share economic risk, expenses, and marketing efforts.

Health Maintenance Organization (HMO)—An organization that provides comprehensive healthcare to voluntarily enrolled

individuals and families in a geographic area by member physicians with limited referral to outside specialists, and that is financed by fixed periodic payments determined in advance.

Health Savings Account (HSA)—A savings account used in conjunction with a high-deductible health insurance policy that allows users to save money tax-free against medical expenses.

Healthcare Reimbursement Account (HRA)—An employer-funded plan that reimburses employees for incurred medical expenses that are not covered by the company's standard insurance plan.

Individual Health Plans—Health plans that are purchased by individuals for themselves or their families, not as part of a group plan.

Integrated Delivery Systems (IDS)—A network of affiliated facilities and providers working together to offer joint health-care services to members.

Integrated Provider Organization (IPO)—A corporate umbrella for the management of diversified healthcare delivery system.

Managed Care Organization (MCO)—An organization that combines the functions of health insurance, delivery of care, and administration.

Management Service Organization (MSO)—A business providing nonclinical services to providers, like practice management service, to individual physician practices.

Medicaid—U.S. government program, financed by federal, state, and local funds, of hospitalization and medical insurance for persons of all ages within certain income limits.

Medicare—U.S. government program of hospitalization insurance and voluntary medical insurance for persons aged 65 and older and for certain disabled persons under 65.

National Provider Identifier (NPI)—A unique 10-digit identification number required by HIPAA.

Physician-Hospital Organization (PHO)—An organization that is owned by hospitals and physician groups working cooperatively to develop improved methods of healthcare delivery, oversee integration of physicians and hospitals into health delivery networks, assist in voluntary group formation, and collect, analyze, and disseminate information.

Primary Care Provider (PCP)—A healthcare practitioner, such as a family practitioner, internist, or pediatrician who is chosen by an individual to provide continuous medical care, trained to treat a wide variety of health-related problems.

Privileging—Assesses the physician's expertise in a specific practice, like cardiology or surgery, based on documented competence in the specialty in which privileges are requested.

TRICARE—A coverage plan available for military personnel and their families. It is extended to active and retired personnel.

Triple Option Plans—Allows an insurer to administer three different healthcare plans so that members may select the benefit options they want: straight indemnity insurance, an HMO, or a PPO.

Workers' Compensation Insurance—U.S. social insurance system for industrial and work injuries regulated at a state level.