2020

Medical Billing Training: Certified Professional Biller (CPB™)

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Chapter 3

Patient Registration Process and Data Capture

Introduction

The information gathered during the registration process is crucial to the viability of a practice. In this chapter, we will discuss the patient registration process and information required for claims processing. The objectives for this chapter include:

- Identify patient types for registration purposes
- List demographic and insurance information required for the registration process
- Understand the process for verifying insurance coverage
- Read and apply information on the insurance card

Overview of an Office Visit

The processing of an insurance claim starts when the patient contacts the provider's office to schedule an appointment. Typically, the patient's demographic and insurance information are obtained by staff at this time, or a registration form is completed online prior to the visit or when the patient arrives at the office. Some offices send the new patient paperwork ahead of time and have the patient bring it to the office for their visit. After the information is entered into the practice management system (PMS), an encounter form is generated, or the patient is marked as ready in the electronic medical record (EMR). Once the provider evaluates the patient, procedure and diagnosis codes are selected to report what was performed and why it was performed during the visit. If using a paper encounter form, these codes are then entered into the practice's PMS. If using an EMR, the visit is marked as complete and the codes are submitted for billing. The claim information is sent through a claims scrubber to identify missing components. A claim is generated and sent to a clearinghouse or directly to the insurance carrier for processing. The insurance carrier processes the claim and sends a denial or payment to the provider. This is a general overview of the process that takes place when a patient is seen by a medical provider and a health insurance claim is generated. We will look at each step in more detail.

Schedule Appointment

Scheduling appointments in the physician's office is important as it keeps the office organized and prepared to see the patients for the day. It also helps the provider stay on task and on time. Appointments can be made by phone, in person, or online. Some offices have procedure rooms that are also scheduled. A provider's schedule can be set up to allow any type of appointment, only specific types of appointments at certain times or only a certain number of types of appointments each day (for example, only allowing two new patient visits per day).

Once appointments are scheduled there are steps that can be taken to mitigate the amount of people who cancel or do not show up for the appointment. No-show appointments cannot be eliminated altogether; however, it is beneficial to make reminder calls 1-2 days in advance. Double booking is not recommended and charging for the visit is not appropriate as a face-to-face encounter with the patient is required for this service. Some of the ways to remind the patient of the appointment is with the following:

- Reminder cards—If the patient schedules the appointment in the office, an appointment card can be given.
- Send reminders—Reminders can be sent by mail, email, or text confirmations to the patient.
- Phone calls—Phone calls can be made the day before the appointment to confirm the appointment. Many practices use an automated system to remind patients of appointments.

EXAMPLE

Appointment confirmation via text message:

Hello: this is the office of Dr. Smith. You have an appointment on Thursday, June 30 at 2 pm. If you are unable to keep this appointment, please call to reschedule.

The processing of an insurance claim starts when the patient contacts the provider's office to schedule an appointment. The provider, date and time of visit are selected, and the patient's name is recorded. Depending on office policies, the demographic data and insurance information may be collected from the patient over the phone. Some offices will send new patient forms to the patient or have them download the forms from the practice's website. Other offices will request the patient arrive 15–20 minutes early for their appointment to complete the paperwork at that time. All this information will be used to create the insurance claim. It is also important for the patient to provide their insurance coverage information and the staff can advise the patient if the physician participates with that insurance carrier. It is a best practice for the scheduling staff to have a list of insurance companies the provider participates with and common insurance carriers the provider does not

participate with. Some offices may utilize an online verification program to verify eligibility benefits, coverage, and participating physicians prior to patient's treatment. This is discussed later in the chapter.

BILLING TIP

All information that is gathered at the onset of the encounter is vital to the billing process but is also used in the treatment of the patient, such as referrals and authorizations.

Obtain Demographics

Demographics for each patient should be obtained for new patients and verified for established patients when the patient contacts the provider's office to schedule an appointment. This includes the patient's name, address and phone number, date of birth, Social Security number, occupation, place of employment, emergency contact information, health insurance information, and referring provider's name, among other demographic information needed to have a complete record for the patient. Many practices will also request a copy of a photo ID and the insurance card for their records.

The health insurance information can be taken from the health insurance ID card. It is necessary that the patient's name is entered into the PMS identical to how it is listed on the health insurance card. If the name sent on the claim is different than that on the insurance card, the claim will likely be returned to the provider stating the member cannot be identified. The insurance card will typically have the patient's identification number and group number. The group number identifies the employer group that covers the patient with health coverage. This information is used by the insurance company, along with the patient's name, to identify the patient and to know what benefits to apply to the claim. The card may also list the patient's copay for services. The back of the insurance card commonly has the address for where to send the insurance claims to, a website address, and phone number for providers to call for eligibility and claim status. This is discussed later in this chapter.

Patient Registration

The patient registration form or patient information sheet is used to collect the demographic information to register the patient in the PMS.

The demographic information can be collected in different ways. A patient registration form can be mailed to the patient and brought in for the appointment and verified by the patient once the patient arrives at the office for the scheduled appointment. Questions can be asked by the receptionist and entered into the PMS during the registration process or can be done online by the patient prior to the appointment. If the patient registration form is completed on paper, it should be added to the paper or electronic chart. This is a legal record that allows the practice to collect payment from the responsible party.

Information entered into the PMS must be correct, complete, and without error. The importance of accuracy should be stressed to the individual performing the data entry. This information is transmitted to the claim form at the end of the encounter and any error could result in a denied claim. Interview the patient when forms are not complete or lack vital information.

BILLING TIP

Data entry errors are a common source of claim denials. The payer cannot identify the patient if there is incorrect information or transposed numbers due to data entry errors.

Generate Encounter Forms

An encounter form may also be referred to as a superbill or fee ticket. The encounter form usually has a list of common services the provider performs and a place for a diagnosis. When EMRs and PMSs work together, the encounter form may be electronic. The encounter form is used for the provider to document what services or procedures were performed during that visit and why they were performed.

BILLING TIP

It is important that the encounter form provides an indication of what diagnosis should be associated with each service or procedure when there are multiple codes reported.

Medical Visit

A medical visit, which is also called a doctor's visit or physician office visit, is a meeting between a patient and a physician or other qualified healthcare provider to receive treatment or health advice for a symptom or condition. During the evaluation, a provider may determine to perform a minor surgery or other tests. A medical visit may also be preventive such as an annual exam.

Check-Out

The check-out process occurs after the patient has been seen by the provider. Typically, the receptionist verifies the encounter form is complete, collects payment or copayment if this was

not done during the check-in process, and makes follow-up appointments, if required.

BILLING TIP

The check-out staff should be trained to look at the encounter form and recognize missing information needed to complete the check-out process. (for example, diagnosis or need for follow up)

Enter Charges

Once the charge entry staff receives the encounter forms for the day, the charges should be entered into the PMS along with any payments made by the patient at the time of service, such as a copay. An important control in a medical office is to make sure all charges and payments are entered. This can be done by balancing the total of charges and payments from the encounter forms with the printed system report showing that day's charge entry. This is often referred to as a Day Sheet. It is also a good practice to compare the scheduled appointments with the encounter forms to make sure all encounters are billed. Most practice management systems assign a number to the encounter form and any missing tickets can be identified. Missing tickets can result in missing charges and lost revenue.

Some systems allow for batches and each date of service is posted in one batch. Each batch should balance. All payments, including checks, credit cards, and cash, should match the amount shown on the encounter form as being collected. The amount collected and the total from the encounter forms should equal the deposit that should be made daily by the practice. This will help reduce financial risk to the practice.

During the data entry process, the charges and diagnoses are linked to show medical necessity (discussed later in the curriculum). If the provider does not indicate which diagnosis should be linked with which procedure, the charge entry staff should ask the provider for clarification.

BILLING TIP

Any payment made by the patient should be documented on a receipt or an encounter form as these will be used to balance the deposit at the end of the day.

Generate Claims

After the charges and payments are entered, claims are generated. The PMS may send the charges through an editing system or a claim scrubber to verify all required components of the claim exist in the system. This creates a clean claim.

The Code of Federal Regulations published by the United States government states a clean claim is, *(1) A claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment; and (2) A claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare."*

A clean claim contains all required data elements needed to process and pay the claim. Each insurance carrier will define the elements required for a clean claim.

Prompt payment laws and state regulations define how quickly an insurance carrier must respond to a claim. The claim submitted is required to be a clean claim for the regulation to apply.

Submit Claims

The life cycle of a claim is the process a health insurance claim goes through from the time the claim is submitted by the provider until it is paid by the insurance carrier. The life cycle of a claim consists of four stages: claims submission and electronic data interchange (EDI), claims processing, claims adjudication, and payment/denial. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information.

Each practice can submit claims either directly to the insurance carrier or through a clearinghouse. Most practices utilize the services of a clearinghouse to submit claims instead of submitting the claims directly to the payer. The clearinghouse will send the batch of claims through an editing process and return claims to the provider for corrections prior to the claim being sent to the insurance carrier. A clearinghouse report shows when a claim has been received by the payer and may contain notes from the payer such as a patient not eligible for the date of service. If during the clearinghouse editing process an error is identified, the clearinghouse report will indicate the issue. The office must pay attention to this report, correct any errors, and resubmit the claim. The payer cannot pay a claim that was not received due to it being stopped by the edits at the clearinghouse level.

Once the claim makes it past the clearinghouse to the payer, the data file is processed and converted to a claim form for the claims analyzer or claims adjudicator to review. Most insurance payers have automated systems to automatically pay or deny services based on a set of rules or logic the payer builds into their processing system.

Patient Types

A patient type is a way to classify patients based on the type of insurance the patient has. Some examples of patient types include self-pay, Medicare, Medicaid, or commercial carrier.

BILLING TIP

The PMS can be set to meet the payer rules and contracts for each patient type. For example, some contracts may not allow for sending a bill to the patient before the payer adjudicates the claim.

Self-Pay

A patient who pays out of pocket for health-related services in the absence of insurance to cover the medical care or surgical procedure performed.

Medicare

Medicare is the United States government's national health insurance program for individuals aged 65 and older, or individuals under age 65 with certain disabilities, and individuals of all ages with End-Stage Renal Disease (ESRD). Medicare patients pay a deductible and a co-insurance for provider services.

Medicaid

The Medicaid program is primarily funded by the federal government and overseen by individual states. It provides medical and health-related services for individuals and families with low incomes and those with disabilities. Eligibility for Medicaid is typically determined on a month-by-month basis. The state's Medicaid program determines the patient cost share and what services are covered.

Commercial Carrier

Commercial health insurance or private health insurance is health insurance that is not offered and managed by a government program. Commercial insurance can be a group insurance plan which is often health insurance through an employer, an individual plan, or a personal plan available to those who are willing to pay premiums in exchange for coverage. The five most common plans are health maintenance organizations (HMO), preferred provider organizations (PPO), exclusive provider organizations (EPO), point-of-service plans (POS) and integrated delivery systems (IDS).

Section Review 3.1

1. The processing of an insurance claim begins with what process?

   A. Patient information
   B. Charge entry
   C. Scheduling an appointment
   D. Submitting a claim

2. Which of the following does NOT qualify a patient for coverage under Medicare?

   A. End stage renal disease (ESRD)
   B. Age 65 or older
   C. Under age 65 with disabilities
   D. Low-income individual

3. A claim that is sent for reimbursement that contains all the required data elements to process the claim is referred to as a:

   A. Submitted
   B. Adjudicated
   C. Clean claim
   D. Medically necessary

4. Listed below are examples of patient reminders for appointments. Which one is HIPAA compliant?

   A. This is the obstetrical office calling to remind you of your appointment Tuesday, April 12 at 9 am for your annual exam.

   B. This is Dr. Smith's office calling to remind you of your appointment Tuesday, April 12 at 9 am for your annual exam.

   C. This is to confirm your appointment for your first prenatal visit with Dr Jones. Please notify us if you are not able to keep this appointment.

   D. This is the doctor's office calling to remind you of your appointment Tuesday, April 12 at 9 am.

5. Which of the following statements is TRUE regarding patient demographics?

   A. Demographic information can only be provided by the patient.

   B. Patient demographic information can be released to a third party without the patient's consent.

   C. Patient demographic information entered incorrectly can result in claim denials.

   D. Claims processing is not affected by patient demographic information.

Collection of Demographic and Insurance Information

A patient registration form is given to patients to gather data such as demographics, insurance information, responsible party or guarantor information, and consent for treatment. Typically, these forms are given to new patients, but a practice may choose to issue them to established patients to update information.

Patient Information

The first part of the form includes the demographic information.

PATIENT INFORMATION

Date: _____

Patient name: First _____ Middle initial _____ Last _____

Address: _____ City: _____ State: ____ Zip Code: _____

Date of birth: _____ Age: ___Gender ____ Marital status _____ Social Security #: _____

Phone #: _____ Cell #: _____ Email address: _____ Work #: _____

Employer: _____ Employer's address _____

Emergency Contact: _____ Relationship to patient: _____

Phone #: _____ Cell #: _____ Work #: _____

Referring provider's name: _____ Phone #: _____

Patient Name—When registering the patient, use the patient's name exactly as it appears on the patient's insurance card. Many times, the patient will fill out the registration form with his or her nickname. If the claim is submitted to the patient's insurance with a different name than what the insurance company has on file, the claim will be denied as the payer will be unable to identify the patient.

Home Address and Telephone Number—The complete address, telephone numbers, and email address need to be completed. This information will be used to contact the patient when needed.

Date of Birth—The date of birth is commonly used to identify the correct patient in the PMS or EMR when the patient is in the office. The insurance carrier will also require the date of birth on the claim form to identify the patient. The date of birth for the individual carrying the insurance (guarantor or insured) will also be required, if this is different from the patient. Some scheduling systems require the patient's date of birth before an appointment can be scheduled or use the date of birth to identify the patient.

Social Security Number—The Social Security number is a nine-digit number issued to U.S. citizens, permanent residents, and temporary (working) residents under section 205(c)(2) of the Social Security Act. This can also be used to identify the patient in the office and for the insurance carrier to identify the patient. Most insurance companies now use ID numbers in lieu of Social Security numbers as patients are hesitant to give their Social Security number because of identity theft.

Employer and Employer's Address—The employer name and address are especially important if the insurance is through the employer (group coverage), and there is difficulty getting a claim paid. The employer might be helpful in working with the insurance payer. The employer information is also needed if the visit is due to a work-related injury. The employer information can also be used to contact the patient if the patient allows you to contact them at work. In cases where the patient is covered by more than one insurance, be sure to gather this information on all payers.

Emergency Contact—This medical information may be necessary in the event of serious illness or accident. The provider's office should obtain this information to be used in an emergency situation only and with the patient's consent.

Referring Provider's Name and Phone Number—The referring provider's name and phone number are important as the provider may have questions for the referring provider. Insurance companies may require this information to have claims paid. The provider may also send correspondence back to the referring provider concerning the patient.

BILLING TIP

A person does not live in a PO Box. Attempt to get a physical address or ask the patient for mile markers or cross streets. Most rural areas provide 911 addresses that allow for emergency services to locate the property.

Responsible Party Information

The next section on the patient registration form is the responsible party information. The responsible party may be referred to as the guarantor and is the person who is responsible for payment. A patient may be the guarantor. If the patient is a child, a parent or guardian is the responsible party. The information under this section contains the name, contact information, relationship to the patient, and employer.

RESPONSIBLE PARTY INFORMATION

Name: First _____ Middle initial _____ Last _____

Address: _____ City: _____ State: ____ Zip Code: _____

Date of birth: _____ Age: _____ Sex: ____ Marital status: _____ Social Security #: _____

Relationship to patient: _____ Home phone #: _____Work phone #:_____

Employer: _____ Employer's address: _____

Insurance Information

The insurance information is another section on the patient registration form. Some of the insurance information can be found on the patient's insurance card. Copy or scan the insurance card to keep in the patient's financial record. The policy holder's name, date of birth, and Social Security number may be required by the insurance company to process the claim.

INSURANCE INFORMATION

Are you covered by health insurance? _____ If no, please make payment arrangements with our business office.

Primary Insurance: _____ Policy # _____ Group #: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Social Security Number: _____ Copay: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Social Security Number: _____ Copay: _____

Consent for Payment

The last section of the patient registration form is the consent for payment. The consent for payment authorizes information to be sent to the insurance payer so payment of medical benefits can be processed. It also demonstrates responsibility of the patient or responsible party for copayments, coinsurance, deductibles, and fees that exceed the payment made by insurance if the physician does not participate with the patient's insurance. This agreement must be in writing to collect any amount from the patient.

CONSENT FOR PAYMENT

I hereby authorize payment of medical benefits billed to my insurance by ABC Physicians. I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if ABC Physicians do not participate with my insurance. I hereby authorize ABC Physicians to use and/or disclose my health information, which specifically identities me or which can reasonably be used to identify me, to carry out my treatment, payment, and healthcare operations.

I understand that while this consent is voluntary, if I refuse to sign this consent, the ABC Physicians can refuse to treat me. I understand this authorization can only be revoked in writing. If I revoke my consent, such revocation will not affect any actions that ABC Physicians took before receiving my revocation.

_____

Signature of Patient or Patient's Representative _____ Date _____

Printed Name of Patient: _____ Relationship of representative to patient: _____

Photocopy or scan the front and back of the patient's insurance card(s) and file the copy in the patient's financial record. The patient's completed registration form and front and back of the patient's photo ID card should also be kept on file. This information is used for identification purposes.

PATIENT INFORMATION

Date: _____

Patient name: First _____ Middle initial _____ Last _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of birth: _____ Age: _____ Sex _____ Marital status _____ Social Security #: _____

Phone #: _____ Cell #: _____ Email address: _____ Work #: _____

Employer: _____ Employer's address _____

Emergency Contact: _____ Relationship to patient: _____

Phone #: _____ Cell #: _____ Work #: _____

Referring provider's name: _____ Phone #: _____

RESPONSIBLE PARTY INFORMATION

Name: First _____ Middle initial _____ Last _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Date of birth: _____ Age: _____ Sex: _____ Marital status: _____ Social Security #: _____

Relationship to patient: _____ Home phone #: _____Work phone #:_____

Employer: _____ Employer's address: _____

INSURANCE INFORMATION

Are you covered by health insurance? _____ If no, please make payment arrangements with our business office.

Primary Insurance: _____ Policy # _____ Group #: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Social Security Number: _____ Copay: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Social Security Number: _____ Copay: _____

CONSENT FOR PAYMENT

I hereby authorize payment of medical benefits billed to my insurance by ABC Physicians. I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if ABC Physicians do not participate with my insurance. I hereby authorize ABC Physicians to use and/or disclose my health information which specifically identities me or which can reasonable be used to identify me to carry out my treatment, payment, and healthcare operations.

I understand that while this consent is voluntary, if I refuse to sign this consent, ABC Physicians can refuse to treat me. I understand this authorization can only be revoked in writing. If I revoke my consent, such revocation will not affect any actions that ABC Physicians took before receiving my revocation.

_____

Signature of Patient or Patient's Representative _____ Date _____

Printed Name of Patient: _____ Relationship of representative to patient: _____

Insurance Coverage Validation

An insurance card is a card sent by the insurance company to each person covered on the plan. This card identifies the information needed for a claim to be processed. The insurance card should be presented at each visit.

BILLING TIP

It is important that the insurance be verified at each visit. Possession of a card does not guarantee the patient is covered or that the coverage is in effect on the date of service.

How to Read an Insurance Card

Insurance cards are issued to each person covered by the insurance carrier. Although insurance cards come in different sizes, materials, and colors, they all contain the same type of information:

Policy holder name—The policy holder name may be the patient's name or subscriber's name. Some insurance cards show both the patient's name and the subscriber's name. The name must be entered into the PMS identical to how it is listed on the insurance card. Variances in how the name is listed will result in a denial of the claim. Some ID cards may provide the names of all family members covered under the policy on one card, others may state whether the employee (EMP), child (CH), or Spouse (SP) is covered without listing the names of those covered.

Identification Number—The identification number is also known as the policy number. Each insurance carrier has a different format for the insurance ID number. For example, Medicare uses an 11-character Medicare Beneficiary Identifier (MBI) that is randomly generated with no intelligence built into the numbers. BCBS typically has three letters followed by a 9-digit number. This number gives the carrier information on the coverage.

Group Number—The group number identifies what employer group the patient is insured under.

Benefits—This section lists the type of coverage the patient has. For example, medical, dental and vision.

Pharmacy Rx—This area lists the copayment amount for prescriptions. Some cards will have various amounts of copayments for tiers of prescription plans such as $15 Generic/$20 Name Brand or $10/$20/$40.

Deductible—A deductible is the amount of expenses that must be paid by the patient before health insurance begins to pay. The amount of the annual deductible will be listed here. You will need to check with the carrier to see how much of the deductible has been met. For example, your plan's deductible is $1,500. That means for most services, you'll pay 100 percent of your medical and pharmacy bills until the amount you pay reaches $1,500. After that, you share the cost with your plan by paying coinsurance and copays.

Copayment—A copayment is a fixed payment for a covered health service. Multiple copayment amounts may be listed on the insurance card as there may be a different amount for primary care physicians, specialists, and the emergency room. In the example below, there are separate lines for office, urgent care, and hospital visits. If the patient is admitted to the hospital from the ER then the ER copayment is not collected, and the inpatient copayment is collected.

Coinsurance—Instead of a copayment, some insurance carriers have a coinsurance for the patient's cost share. This is a percentage of the allowed amount due by the patient. For example, Medicare Part B has a 20 percent coinsurance. This means the Medicare patient is responsible for 20 percent of the Medicare allowed amount after the deductible has been met. For example, Peggy has allergies, so she sees a doctor regularly. She just paid her $1,500 deductible. Now her plan will cover 70 percent of the cost of her allergy shots. Lisa pays the other 30 percent; that's her coinsurance. If her treatment costs $150, her plan will pay $105 and she'll pay $45.

Front

Your Health Insurance Company	
Policy Holder Name	**ID:**
Deductible:	$2,500
CoPays:	
Office:	$35.00
InstaCare:	$50.00
Hospital:	$7.00

Back

Your Health Insurance Company
Questions? Call 800-123-4567
Hours: Mon-Fri 7:00 am to 8:00 pm
Submit Claims to: Address City, State, ZIP

The back of the insurance card shows the contact information for the insurance company. In this example, the phone number, hours of operation, and the address of where the claims should be submitted is shown on the insurance card.

BILLING TIP

Copies of the patient's insurance card and a photo ID should be retained in the patient's financial record.

Insurance Coverage Verification

Verifying patient coverage is a step that can save a practice time and money. Insurance coverage can be verified by phone or by an electronic eligibility verification tool with the insurance company. Most major payers have online access for providers they contract with. The patient's demographics and insurance information need to be available when verifying the insurance. If the patient is not eligible with the insurance company given, the patient needs to be contacted for updated insurance information. If the patient believes the information is correct and should be covered, the patient should contact the insurance company to have the eligibility files updated. When this occurs, allow the patient to decide if they want to reschedule their appointment or be considered a self-pay patient and pay for the service out-of-pocket.

BILLING TIP

It is good practice to maintain a record of the verification process, whether done online or by telephone. Document all information such as the number called, the person you spoke to, the date, and any relevant information provided by the insurance company.

Verification of Benefits

Verification of benefits provides information concerning the patient's coverage. This step verifies eligibility effective dates; patient coinsurance, copay, and deductible amounts, including how much of the deductible has been met to date; and plan benefits as they pertain to specialty and place of service. Benefit information allows staff to be informed and ready to collect the appropriate copay, deductible, coinsurance, or full balance due at the patient's visit.

Office Visits			
In-Network	**Co-Pay**	**Deductible**	**Pays Limits**
In-Network Office Visit	$35.00	$0.00	100%
In Network Office Surgery - PCP	$0.00	$5000.00	100%
In Network Office Surgery - Specialist	$0.00	$5000.00	100%
In-Network Chiropractic Manipulation	$0.00	$5000.00	100%
In-Network Office Specialist	$50.00	$0.00	100%

My Balances	Create Alerts
Remaining Coverage Amounts	Medical Deductible
Individual In-Network	$4256.19
Individual Out-of-Network	$10000.00

Primary vs. Secondary Insurance

Patients may be covered under more than one health insurance policy. When this happens, it is necessary to determine which insurance is primary and which is secondary. If the patient is the subscriber on their insurance plan, that is the patient's primary insurance. If the patient is also covered under another insurance, it would be a secondary insurance. For example, if Kate Smith is covered by insurance through her employment, and through her spouse's employment, Kate's insurance is primary, and her spouse's insurance is secondary.

Birthday rule—When a child is covered by two or more insurance plans (for example, insurance plans from both parents), the birthday rule is used to determine the primary and secondary insurance. According to the National Association of Insurance Commissioners, under the birthday rule, the health plan of the member covering the dependent whose birthday comes first in the calendar year is designated as the primary plan. The year of birth is not a factor in this rule. The month and day are the only factors the health plan considers.

EXAMPLE

A child visits the pediatrician. The child has insurance coverage through both his mom's insurance (DOB 02/08/1982) and his dad's insurance (DOB 09/04/1981). Because the mom's birthday falls earlier in the year, the mom's insurance is primary.

There are additional guidelines to the birthday rule:

A. If both parents have the same birthday the primary coverage reverts to the oldest policy

B. When regular coverage and COBRA coverage are in play, the regular coverage takes priority.

C. In divorce cases where the custodial parent has not remarried—the custodial parent's plan is primary, and the non-custodial parent's is secondary. If one parent has a group policy and the other has an individual plan, the group plan becomes the primary insurance.

D. In divorce cases where the custodial parent has remarried—The custodial parent coverage is primary, with the stepparent being secondary. The non-custodial parent is the payer of last resort.

This is not a law and may not be followed by all payers. State laws regarding coverage policies involving minors and custodial parents may supersede the payer's rules including the birthday rule.

BILLING TIP

Patient information forms should include the necessary information when dealing with patients that are children. This would include birthdays, employers, and insurance coverage of parents, including stepparent, if applicable. Also have a place for the parent to indicate which parent is the custodial parent.

Medicare provides a Medicare Secondary Payer (MSP) form for providers to determine if Medicare is a secondary insurance for a patient who has Medicare and another insurance. This will be discussed later in the curriculum.

Authorization Form

HIPAA—Section 164.508 of the final privacy rule states that covered entities may not use or disclose protected health information without a valid authorization, except as otherwise permitted or required in the privacy rule. This form should be updated no less than once a year. Below is an example of an authorization form.

Authorization to Use or Disclose Health Information

Patient Name _____ Date of Birth _____

Health record number _____

I authorize the use of disclosure of the above-named individual's health information as described below.

AAPC Physician Practice is authorized to make the disclosure.

The type of information to be used or disclosed is as follows:

_____ Problem list

_____ List of allergies

_____ Most recent history

_____ Lab results (dates or types) _____

_____ X-ray and imagining reports (dates or types) _____

_____ Consultation reports from _____

_____ Entire record

_____ Other _____

_____ Medication list

_____ Immunization records

_____ Most recent discharge summary

I understand that the information in my health record may include information relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

The information identified above may be used by or disclosed to the following individuals or organization(s):

Name: _____ Phone #: _____

Address: _____

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization will expire on _____.

Signature of patient or legal representative _____ Date _____

If signed by legal representative, relationship to patient _____

Signature of witness _____ Date _____

Encounter Form

An encounter form is also called a superbill or charge slip. This is a financial form generated for each patient encounter and records information about the diagnoses and services provided by the treating provider. Diagnosis and procedure codes on the encounter form should be reviewed annually to ensure outdated codes are removed or replaced. Many errors found during audits are due to invalid information or incorrect information found on an encounter form.

The provider signs the bottom of the form (which makes it a legal billing document) and attests that the services were performed and may be billed. For providers who have an EMR, the encounter form may be electronic instead of paper. EMR generated forms typically are numbered and can be used to identify missing tickets or lost charges. The information from the electronic encounter form auto populates from the EMR to the PMS.

Discharge Process

The discharge process is also called check-out. This is done after the patient has been seen by the provider. The receptionist should review the encounter form to make sure it has been completed. If the copayment was not collected at check-in, it should be collected at check-out. Any deductibles and payment for services not covered by insurance should also be collected. If the patient needs a follow-up appointment, it can be done during the check-out process.

Section Review 3.2

1. The parent with which the child resides is considered to be a:

   A. Stepparent
   B. Non-custodial parent
   C. Custodial parent
   D. Natural parent

2. A patient's insurance card will contain vital information that will allow a claim to be processed. Which of the following is NOT provided on the insurance card?

   A. Policy holder, group number
   B. Claim number, CPT® code, diagnosis
   C. Policy holder, copay, deductible
   D. Claims address, Group number

3. A child is brought into the doctor's office by the mother to be seen. The mother (DOB 02/08/83) is the custodial parent and is remarried. She has an individual policy. The father (DOB 10/10/82) is covered by a policy from work. The stepfather is also covered at work. Which of the following is correct?

   A. The mother's insurance is primary
   B. The stepparent is primary
   C. The father is always primary
   D. Either the mother or the father can be primary

4. HIPAA Section 164.508 states that covered entities may not use or disclose protected information without a valid authorization. In what circumstances can a practice NOT release protected information?

   A. Records sent to a physician asked to consult with the patient
   B. Payment of claims
   C. Records requested by the health department for communicable diseases
   D. Records requested for life insurance

5. Child presents for care with the father. Both parents have coverage, date of birth for mother is 3/21 and date of birth for father is 6/20. The mother is covered by a COBRA. What is the primary coverage for the child?

   A. The mother's coverage is primary based on the birthday rule
   B. The father's insurance is primary because the mother has COBRA
   C. The father is primary because he is older
   D. The father's is primary because he consented for care

Glossary

COBRA—COBRA was created under the Consolidated Omnibus Budget Reconciliation Act. It allows an employee who leaves a company to continue to be covered under the company's health plan, for a certain time period and under certain conditions.

Copayment—A copayment is a fixed amount that a patient is responsible to pay for a covered health service.

Coinsurance—A percentage of the allowed amount due by the patient.

Custodial Parent—The parent with physical custody of the child or the parent with whom the child resides.

Day Sheet—Also called manual daily accounts receivable journal; chronological summary of all transactions posted to individual patient ledger(s)/account(s) on a specific day.

Deductible—The amount of expenses that must be paid by the patient before health insurance begins to pay.

Electronic Medical Record (EMR)—An EMR or electronic medical record is defined as a digital collection of patient health information.

Guarantor—Person responsible for paying healthcare fees.

Health Insurance Portability and Accountability Act (HIPAA) of 1996—Includes the privacy rule. This regulates the use and disclosure of Protected Health Information (PHI).

Medicare Secondary Payer (MSP) form—Medicare Secondary Payer form is used to determine if Medicare is a secondary insurance for a patient who has Medicare and another insurance.

Patient Ledger—a computerized permanent record of all financial transactions between the patient and the practice, also called patient account record.

Practice Management System (PMS)—Software used by physicians for scheduling, registration, billing and account receivables management.

Primary care provider (PCP)—Responsible for supervising and coordinating healthcare services for patients.