Reimbursement, Session Two

Reimbursement is an issue that is complex and involved. Obtaining reimbursement at most levels will take a concerted effort from individual members, NATA and interested groups.

- The "paying" field is large and contains many payers. Neither one person nor a committee can cover it all.
- We must educate ourselves on reimbursement and third party issues. We need to understand the reimburser's mindset while educating the public and healthcare personnel to the benefits and roles athletic trainers can play in the healthcare system.
- We need to develop data, maintain records and factual information on positive outcomes, so we may more easily demonstrate our value as health care providers.

The reimbursement issue is like a spider web. Acknowledgement that ATCs are like any other affiliated health care provider when it comes to reimbursement is the open center of the web, the strands and the sections of the web are the paths and sometime sticky situations we must traverse to reach our final destination.

The first NATA training session provided you with a starting point; this session will provide you with a road map manual of "how to" information.
You may use it to chart your course and avoid or overcome any bumps in the road that may await your efforts.

Cordially,

Paul Carter
National Manager of Markets and
Revenue, NATA

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Section 1
The Payers

According to an American Medical Association survey conducted in 1999, 30% of all employees' health care was covered by an HMO, 11% was covered by indemnity or traditional insurance, 16% by a POS program and 43% by a PPO.

Insurance is the term widely used to identify all types of third party payers. It is an incorrect usage. There are a number of payers, each with their own peculiarities. In this section we will identify and discuss each one.

- Insurance-The definition of insurance in its simplest form is "the relief from the burden of financial loss." Health insurance provides reimbursement or indemnifies an insured from financial losses resulting from covered perils, after the loss. Deductibles and co-insurance payments normally apply to covered conditions in a health insurance policy. These are the patient's responsibility. Traditional insurance is sometimes called FFS or Fee For Service insurance.

- Managed Care-Managed Care is a term loosely used to describe everything from HMOs to traditional insurance. Almost all programs that use any type of utilization controls over reimbursement or benefits can be classified as Managed Care.

- HMO-Health Maintenance Organizations have been around in various forms for more than a 100 years. The prepayment of health care providers for services they may or may not render is not new; the year 1929 saw the first "modern" version of an HMO. The Ross Loos plan in Los Angeles has been credited with being the first modern HMO. Other HMO organizations followed and adaptations and changes have been significant. The basic idea of an HMO was to limit the providers that a member could access, pay those providers a reduced fee, normally in the form of capitation, and have other systems in place to control "unnecessary" procedures and expenses. The basic forms that HMOs take are, staff model, IPA model, group model and network model. Normally there are no deductibles for the members but there are co-payments to be paid at time of service.

- PPO-The Preferred Provider Organization is a less restrictive access method for providing health coverage. In place of not paying for a claim that is "out of network" the PPO penalizes you, monetarily, for not using the company's Preferred Providers. There are normally co-payments/co-insurance costs for using preferred providers, and larger deductibles, and higher co-insurance/co-payments for using non-preferred providers. Hospital deductibles and co-insurance payments are usually required when using a PPO; the same theory applies, higher out of pocket costs to the member for choosing to use non-preferred providers.

- EPO-Exclusive Provider Organizations are a variation on the HMO/PPO theme. These organizations would like to be viewed as being similar to PPOs, however the majority of them are very restrictive in the number and types of providers they have paneled, and consequently are more closely aligned with a closed panel HMO. Most will not pay anything if you use "out of network" providers. Deductibles/co-insurance/co-payments may apply. These organizations are rare.

- POS-Point of Service, this plan is a hybrid. The simplest explanation is a POS plan combines an HMO with a PPO and the member can chose which plan they will use at the point or time of service. The normal restrictions apply per the plan chosen for use.

- PHO-Physician Hospital Organization is a combination of a major hospital or hospital chain and its admitting physicians. This allows the PHO organization to contract directly with employers to provide services and/or contract with a Managed Care organization sometimes under more favorable terms than contracting with a Managed Care organization individually. PSO (Physician Service Organization) is a Federal designation given when a PHO accepts capitation for services rendered to enrolled Medicare beneficiaries.

- TPAs-Third Party Administrators, come in many forms and are employed for a number of reasons. Most frequently they are used to administer services and to pay claims for self-insured group plans. In this capacity they become pseudo insurance companies. They can perform the gambit of services such as member services, enrollment and billing and assist with controlling utilization without the financial risk.

- The Blues Organization-Blue Cross/Blue Shield and other named entities are part of the 43 member Blues Organization. Blue Cross is the Hospital organization and Blue Shield is the Physicians program. The Blues were traditionally non-profit but in the last few years a number of the plans have moved to a for profit status. Today the lines differentiating the Blues companies and traditional insurers/managed care companies are blurred. For purposes of reimbursement the Blues should be considered in the same manner as a more traditional insurance/managed care organization. The Blues are listed separately as they have been viewed as service organizations and not seen or even regulated in the same way that insurance companies are. The Blues can be separate organizations, Blue Cross vs. Blue Shield, but more commonly they have merged and are now one. The various Blue plans have separate HMOs that work with or in conjunction with their more traditional programs. The traditional BC/BS program has participating providers and non-participating providers. The participating providers are usually paid directly, and are in agreement to accept the BC/BS fee schedule as payment in full.

- Medicare-Is the Federal health insurance program for the aged, disabled and those requiring kidney dialysis. Most people at retirement age qualify for Medicare benefits. There are two parts or sections to Medicare, part A the hospital portion is normally premium free at retirement to the beneficiaries. Part B is the physician section and there is a monthly premium charge to the beneficiary. The monthly premium for part B changes annually. There are also deductibles and co-insurance percentages/amounts that are paid by the beneficiary under both part A and part B. Athletic Trainers are not allowed to bill Medicare for services rendered to a Medicare beneficiary.

- Medicaid-The health insurance program for people with low incomes and limited resources. Both the federal government and the states fund Medicaid with the state responsible for handling the administration of the program. Benefits vary by state. The claim payers can be a contracted entity or the state. Any willing provider is the standard network model for Medicaid.

- SCHIP/CHIP-State Children's Health Insurance Program. SCHIP is a State and Federal program for uninsured and low-income children. SCHIP is similar to Medicaid but sometimes with a broader range of benefits and easier participation or admittance requirements. The claim payers can be a contracted entity or the state.

- Tricare/Champus-Tricare is the Defense Department's regional managed health care program. Tricare has three plans, Tricare Prime is similar to an HMO, Tricare Extra which has an expanded network and can be used at the point of service (think POS) and Tricare Standard which works in a similar fashion to Champus (think traditional insurance). Champus or Tricare standard allows more freedom to participants but with higher out of pocket costs.

- Intermediaries/Carriers-Intermediaries or Fiscal Intermediaries are the Medicare Part A (hospital and some part B) claim payers and adjudicators. Carriers are contracted with Centers for Medicare and Medicaid Services, CMS, to pay and adjudicate Part B (physician services, PT, OT and other services) claims. Durable Medical Equipment claims are handled by Regional Carriers, known as DMERCs (Durable Medical Equipment Regional Carriers). RHHIs are Regional Home Health Intermediaries; they are the contracted fiscal intermediaries that specialize in processing home health and hospice claims. All intermediaries/carriers can be insurance or managed care organizations; various Blue Cross/Blue Shield organizations hold a number of these contracts.

- Workers Compensation-The laws and benefits for injured workers are mandated by the states through workers compensation commissions. Though the benefits are mandated by the states, employers pay the premiums and the claims are adjudicated by Workers Compensation Insurance Carriers. The insurance companies that specialize in this program have a financial interest in returning injured workers back to the work force as soon as practical.

- Private Automobile Insurance-A patient could seek treatment from an injury caused by an auto accident, this claim may be covered by automobile insurance.

- Cash-There is nothing wrong with accepting cash for services rendered. Good old American greenbacks are still legal tender. Accepting cash and allowing the patient to bill their carrier for reimbursement removes the burden from the ATC and places it with the person who has the most influence with their carrier, the member or patient. Before you start to accept cash/charge cards/checks, you must set up a system for handling the cash and issuing receipts. A check verification program may be one service that you wish to investigate. You also must become associated with the various charge companies whose cards you will be accepting; there is a fee for accepting credit cards. All of this can take time, energy and resources. Be prepared.

ATCs, can bill directly to third party payers, citing your own contract or provider number. ATCs can also have their services billed "incident to". That term is used to designate a procedure performed incident to working with a physician, also in some cases a PA or NP. Under incident to billing the claim is submitted as though the physician had performed the procedure(s). Most third party payers reimburse for incident to procedures. Prior to a recent change in Medicare's policies, ATCs could perform a procedure and have the physician bill for those services under incident to for Medicare patients. Right now only non-therapy services performed by an ATC can still be billed under "incident to" criteria for Medicare patients. For other third party payers all services provided, incident to a physician, can be billed incident to. This can be confusing, if you have any questions about incident to billings and procedures please contact Paul Carter at NATA. paulc@nata.org or by phone @ 1-800-879-6282 ext. 133

Section 2
Contracting

In this section we will discuss, in brief detail, contracting with payers, how to and what to look for. These few paragraphs cannot hope to make you a contracting guru, but they may provide you with enough information to ask the right questions.

- Capitation-Capitation has gotten a bad rap; it is not a bad method, and is still used by some Managed Care HMO entities. Simply, in capitation the provider is paid a set fee per member assigned, per month (PMPM). The amount paid varies with specialty, need and practice size. For example, a typical therapy practice that is handling 10,000 members may receive .50 cents PMPM. That equates to $5000 per month! Each and every month you are contracted under this arrangement the practice would receive the $5000. Whether any patients are seen or whether all 10,000 are seen, the practice receives the same $5000. The idea behind this arrangement is it gives the providers an incentive to manage their patients and to maintain their health.

- Case Rate-A fee negotiated for a particular case or course of treatment.

- Reduced Fee For Service-Undoubtedly the most variable of the contracting methods, you produce a fee schedule for the services you may render, the carrier then negotiates from that schedule. The fee schedule could be 100% of normally charged fees or any variation from that.

- RBRVS-Resource Based Relative Value Scale, this is the system and fee schedule under which almost all provider bills are adjudicated for Medicare. This scale or payment rate is reviewed by CMS at least every 5 years. Numerous organizations use RBRVS as the starting point for payment, they may adjust up or down from this scale. You will commonly hear, “We pay 100% of RBRVS” or “We pay 90% of Medicare” (same as RBRVS). The AMA conducted a national survey that showed 63% of respondents were using RBRVS for at least one product line, a Deloitte-Touche survey found that 72% of respondents were using or intended to use RBRVS and with the BC/BS organizations that percentage jumped to 87%. RBRVS is not the only value scale used, there are others so be cognizant of what scale a carrier is using and what year it was implemented.

- Full Risk Contract-A contract where the provider group assumes the entire financial risk of caring for the members, this is done in exchange for a set fee PMPM similar to capitation. This arrangement includes any and all covered service(s). The contracting provider group would need to sub-contract for any specialties or services that their practice cannot handle.

These are the basic contracting models; there are variations from these.

How do you start the contracting process? First make certain that you wish to be contracted. Traditional insurance programs and non-managed care entities normally do not require contracts. They usually pay Usual, Customary and Reasonable, UCR, charges from any recognized health care provider operating within their license and Scope of Practice. If you do wish to go further and actually contract with carriers there are some first steps:

- Contact the carrier, normally the first contact is with a Provider Representative, this person may have limited contracting discretion if any. They can and will carry your message back to the Manager or Director of the unit. Occasionally the lead person of this unit is the Medical Director but normally it is a non-medical person. This unit does defer to the Medical Director for any medical services that are unknown to them, you may have to present your case to both the medical Director and the Contracting Director.

- If you have decided to move forward with trying to contract with a carrier, you need to ascertain if they recognize ATCs as allied health care professionals. If not then you have to fight the battle to have ATCs recognized first.

- Assuming they do acknowledge that ATCs are a reimbursable health care profession, you must begin to think like the payer. You must ask yourself, why? Why should they add an ATC or a clinic to their panel of providers? What value do you bring to that carrier? Remember that for the most part, the insurance/managed care organizations primary concerns are costs/profits. How do they minimize the costs and maximize the profits? That is primary, providing care for the members is sometimes a secondary consideration.

- You will need to meet with the Provider Representative and propose your availability to contract. Let the carrier raise or bring their objections to you. Ask for clear and precise reasons why they will not consider contracting with ATCs. In one state the BC/BS organization has stated that they have no desire to contract with any ATCs. They feel that their current providers are already handling any covered service that an ATC can provide. (MDs, PTs, OTs, Chiros etc.) They are correct!

- In most managed care programs the fewer the number of providers, the more cost effective the plan is. Why should they wish to add additional providers if the members are currently receiving the care they require? That is the question that you need to develop an answer(s) for, answers that will impact the carrier and their cash position positively. What does an ATC offer that would convince a payer to offer them a contract, better outcomes? If so, how does this translate into a benefit for the carrier? How do we "prove" we have better outcomes?

Some common paragraphs used in managed care/insurance contracts that you need to be aware of:

- Hold Harmless Clause-This clause stipulates that if the contracted party does not reimburse you for covered services you have no right to bill or expect payment from the patient. This even includes the carrier going out of business. You are specifically prohibited from billing the members for any amount other than co-payments/co-insurance or non-covered services.

- Gag Clause-A clause that may prohibit contracted providers from discussing alternative treatments, experimental treatments and costs. May also bar you or limit you from sharing other information with a member or patient. A number of states have laws prohibiting companies from including the Gag Clause in their contracts.

- Favored Nation Clause-This clause stipulates that you cannot contract with any other carrier (s) on a more favorable basis. If you do then the clause allows the first carrier the same options and rates.

- Exclusivity Clause-If this clause is included in the contract you are prohibited from contracting with any other like entity.

- Mandatory Time Limit On Claims-A clause that stipulates a time frame for the filing of claims.

- Termination Provision-The clause that outlines the methods and time frames under which the provider can terminate the contract.

- Quality or Outcome Participation Requirement-A provision that the provider must participate with the carrier in collection of information and documentation efforts and/or with their quality programs.

- Supersession Provision-A provision that a State regulation would supersede any contract clause.

- Contract Update or Renegotiation Clause-Stipulates how and when the contract will be renegotiated and/or for what amount of increase.

- Evergreen Clause-States that the contract is valid and in force in perpetuity or until a stated date or occurrence.

These clauses could be beneficial to the ATC and their practice but you should be aware of the pluses and minuses with each one.

Section 3
Staking your claim

There are several claim forms available for use. We will concentrate on the most common, the Center for Medicare and Medicaid Services (CMS) forms. Most health care payers accept the CMS forms; form1500/ HCFA 1500 is a standard claim form for non-institutional providers and suppliers. CMS form 1450/HCFA 1450 or UB92 is the form used to bill for hospitalization and institutional services. Both of these forms are required when filing Medicare/Medicaid claims. They are available in paper or electronic format.

Another type of claim form is the “Superbill” it contains everything that some insurance companies require and it also is available in hard copy or electronic form. Your billing person* needs to determine by payer what form they require. There are a number of firms that sell the CMS forms and the Superbills. In this section we have included information on a couple of them.

The filing and re-filing of claims can be costly, frustrating and very time consuming, so completing the claim filing correctly the first time is essential. You should be aware that the majority of claim payers have prompt filing rules, rules that if violated may allow your claim to be rejected and denied. Know the payers time requirements, as well as any other requirements they may have, especially if they are not universal requirements. In some states there are also prompt payment laws that protect providers by mandating the turn around time for a “clean” claim. The Medicare time requirement for filing claims is “within one full calendar year following the year in which services were provided”. The Medicare time limit is liberal compared to many payers who prescribe a 30, 60 or 90 day time limits for filing a claim.

One of the most important things to do prior to treating a patient is to copy their “insurance” card and their driver’s license and/or the driver’s license and insurance card information of the responsible party. These two documents should provide you with most of the information you need to bill a carrier for services rendered. The insurance card also should have the phone number you will need to call for any pre-authorizations and instructions from the carrier. You should also have the patient or responsible party complete an information or data sheet for your records; one is included in this section as an example. Make sure that the policy number and members ID number are correct, include all letter designations and/or numeral sub sets, these have meaning to the payer. Most payers utilize a member’s social security number as their member ID number. There are normally modifications to this number for each family member. Some plans do not use the Social Security number. Copy both the front and back of the insurance ID card, there is usually information on both sides. Claim adjusters are usually non-clinical personnel. Remember that in discussions or in any dealings you may have with them, you may have to explain your procedures in simplified or laypersons terms.

*Billing services are discussed on the next page.

Provider ID numbers are issued by a carrier or payer. To bill under Medicare the physician or allied health professional eligible to work and bill Medicare must use a Unique Physician Identification Number-UPIN. Commonly carriers will use the provider’s social security number or tax ID number as their provider number.

Claim forms should be filled out neatly and correctly, include all required information. Make certain that your diagnosis codes, ICD9, match your treatment codes, CPT4s. Submitting a diagnosis code for a sprained wrist and then submitting a treatment code for a sprained ankle will earn you a promptly rejected claim!

How do you submit a claim?

There are steps to follow when submitting a claim correctly. If you have a billing department or a billing clerk, work with them. They are probably used to the idiosyncrasies of the various insurance programs. They also should have the latest CPT4, ICD9, DME and HCPCS code manuals. If not, you may have to supply them with the codes they will need. Additionally the clerk should be familiar with your State’s practice law or Act. You do not want to commit fraud or overstep your legally allowable duties.

If you do not have a billing clerk on staff there are alternative methods for billing. Depending on anticipated volume, you can choose the method that is right for you. There are billing services, companies that will bill and fight with the carriers for you, naturally for a fee. Some billing services only receive re-numeration, a percentage of the claims collected or a commission amount, on claims submitted or paid. There are also billing systems and billing software available. You will need to evaluate all methods of billing and collection to determine which is the best for you and that best coincides with your style, practice and volume. You also need to think about and possibly develop a policy for bad debts.

Make certain you have the proper address where to send the claims. The address for services or the local address and the claim center’s address may be different.
Most insurance/managed care organizations use centralized/regionalized claim centers. However the claim center for regular indemnity insurance coverage and for HMOs may be different. If your claim or bill is sent to the incorrect address, do not expect that some kind, caring person will re-route it for you. In all likelihood it will be trashed.

Section 4
I received ten cents out of the dollar I billed, what happened?

There are a number of reasons, some are even legitimate, why you may not receive the reimbursement that you billed for. We will review several of the common mistakes.

- You have a contracted rate with the carrier; you contracted for one price then your billing clerk billed “fee for service” rates. The carrier will catch that in their system and only reimburse you for the negotiated rate.

- You’ve billed the incorrect code(s) or you have made an error in your coding. Again the carrier will most likely catch the error and may adjudicate the claim based on what they believe is the correct information.

- The carrier only paid you for partial services, they may have deemed some services inappropriate for the condition or code listed. Some of the service you provided may not be a covered benefit under the patient’s plan, some of the service you provided was not pre-approved or authorized. The carrier removed those charges.

- The carrier may be waiting to pay additional reimbursement after a primary carrier adjudicates the claim.

- You did not collect the co-payment/co-insurance charge from the patient, you billed for the whole amount and the carrier deducted the patient’s responsibility.

Section 5

They have paid $0, I've been rejected! Why?

If you are not paid or if the claim for payment is rejected, the carrier should send you a statement stating the reason. Some of the more common reasons are:

- ❖ You are not a contracted entity; in the case of most HMOs for non-contracted providers there is no payment. You would have to seek reimbursement directly from the patient.
- ❖ The carrier does not recognize that athletic trainer's services are reimbursable and/or they may not be reimbursable under the carrier's program or the patient's plan.
- ❖ Services were not pre-approved or pre-authorized and they were required to be.
- ❖ You used the incorrect codes or you did not supply a code or the codes you used were outdated. Make sure the billing staff is kept up to date with the latest coding manuals.
- ❖ You used the wrong forms; HCFA 1500 was used for an inpatient stay when a HCFA 1450 should have been used.
- ❖ You did not submit your bill within the required time frame. You were delayed and did not meet the timely filing provision.
- ❖ Pattern billing, billing of a single code creating a pattern effect. The computers are programmed to catch this and it may reject your claim or forward it for investigation.
- ❖ Duplicate billing. You already billed for this service and the claim was adjudicated.
- ❖ Billing for services/procedures not performed, more common than you may think.
- ❖ Medical Record documentation not complete or lack of documentation; missing information.
- ❖ You treated an HMO or other managed care member and you did not or they did not obtain a referral for treatment.
- ❖ The most common error is missing or un-readable information on a claim.

There are numerous errors that can be made, luckily most of the errors only delay the claim or cause a re-submittal of the claim, costly and time consuming but fixable.

Section 6
Challenge the system!

If you believe the carrier/claim payer is in error, they rejected your claim and/or they paid incorrectly and/or they have not paid or rejected the claim and it has been months since it was submitted. What can you do?

First, make sure your facts are correct and that you have all of your documentation in order. You can send a letter to the carrier but the most common result from your letter would be a form letter response in return.

- Call the claims area and speak to a Supervisor or above. The claim technician, the one that answers the call, may be unable to assist you beyond providing you with information you may already have. The Supervisors, Managers, Directors are normally the only people with the power to override an already adjudicated decision. So speak to them! If you do not understand the reasoning for his or her decision, the technician may be able to aid you, but once you need to have a decision reversed or corrected you will probably need to speak to someone in Management.

- If the claim you submitted was “clean”, the term **clean** indicating it was filled out properly with no errors, you may be able to rely on the state insurance board to assist you. In a number of states laws have been enacted that require insurance programs/managed care companies to pay clean claims promptly.

- If you are **right,** do not take NO for an answer, move up the chain of management, asking to speak to the next person’s supervisor and then the next etc. Before using this technique, make double sure you are correct! Remain polite, do not burn any bridges, but be insistent.

Section 7
Help!

Where do you go for help when all else fails? There are a number of places:

- Your local State reimbursement council or state representative.
- The Regional/District Representative on the Committee on Reimbursement.
- Paul Carter, the NATA National Markets and Revenue Manager.
- Your state insurance board or managed care office may assist. Normally these are the same offices but possibly different divisions.
- The Internet, the web has numerous claim information sites.
- Your billing department, your contracting department, your patient.

Section 8

Glossary;

Know the native tongue; make sure you and the carrier are speaking the same language.

Section 9

***Success stories*.**

When you are having trouble getting even a minor claim accepted or paid, it is difficult to believe that ATCs will ever be treated fairly. We have had and continue to have a number of successful ventures. We would like to share just a few with you.

Section 10

Misc.

A closing thought; You may be entering a new environment with new ideas, obstacles, interactions, and rejections. You will need someone to post payments, handle transactions, send bills and collect bad debts. You or a staff person will need to confront reticent third party payers and challenge them. You will need to maintain records and documentation unlike you have done previously. You will have to learn coding CPT, ICD, HCPCS, V and E codes a whole new language for some. These and numerous other challenges will present themselves, is it all worth it? Of course it is! To truly move athletic training into the new century and continue building our program into a recognized allied health profession the pain has to be endured before the gains can be secured! Thank you.