Secure Successful Healthcare Reimbursement
Know the Insider's Tips Across Settings
Become a Reimbursement Expert

The healthcare payer system in the U.S. is among the most diverse and complex in the world. This special report is intended to provide patient advocates with information that will explain terms and define the major reimbursement systems you may encounter in your practice when working with patients across the care continuum.

As part of the assessment process, patient advocates have the opportunity to understand the type of healthcare coverage the client has and review the provisions and options the policy contains. Understanding the benefit plan is a critical step in helping the client access needed resources. If there are no benefits for specific services, the patient advocate will need to explore other options, such as community resources, pharmaceutical company’s advocacy programs or other services.

Many providers offer a service for discounted rates, so taking the time to explore options is part of the process. Dorland Health offers a digital version of the Case Management Resource Guide – www.cmrg.com – that has a wealth of information that advocates can use when developing the plan of care after the assessment.

Reimbursements systems vary widely, so patient advocates must take the time to read the client’s member handbook and visit the health plan’s website before making recommendations to the plan of care and assisting the client with decisions. If a client is covered by one of the safety-net programs, reading the website and connecting with those who can answer questions and understand the rules and regulations is important.

It is my hope that you use this report as a resource throughout your practice.

Cordially,

Anne Llewellyn, RN-BC, MS, BHSA, CCM, CRRN
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Professional Patient Advocate Institute
Dorland Health
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Thank you for your participation. If you have any questions regarding the special report or the continuing education credit process, please feel free to email allewellyn@accessintel.com or call at 954-476-7143.
Understanding terminology related to healthcare insurance is important to ensure processes are followed to ensure appropriate reimbursement for the treatment, products and services you need to meet individual healthcare needs. Here are some common terms that may be helpful in practice.

**Allowed Charge:** Discounted fees that insurers will recognize and pay for as covered services. Insurers negotiate these discounts with providers in their health plan network, and network providers agree to accept the allowed charge as payment in full. Each insurer has its own schedule of allowed charges.

**Accountable Care Organization:** A group of healthcare providers who provide coordinated care and chronic disease management with the goal of improving quality of care and containing healthcare costs. The organization's payment is tied to achieving healthcare quality goals and outcomes that result in cost savings.

**Affordable Care Act:** The comprehensive national healthcare reform law that was enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Healthcare and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

**Annual Limit:** A cap on the benefits an insurance company will pay in a year while a member enrolled in a particular health insurance plan. These caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, the member must pay all associated healthcare costs for the rest of the year. According to the Affordable Care Act, starting with plan years or policy years that began on or after September 23, 2010, health plans can no longer impose a lifetime dollar limit on spending for these services. All plans, except grandfathered individual health insurance policies, must phase out annual dollar spending limits for these services by 2014.

**Attorneys:** Attorneys are legal professionals licensed by a state to practice law. In a medical malpractice case, the plaintiff attorney generally represents the patient/family or the injured worker in a workers’ compensation or disability case. The defense attorney traditionally represents the practitioner, the organizations, or the employer/carrier.

**Benefits:** The healthcare items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan’s coverage documents.

**Birthday Rule:** The Birthday rule governs how to process a claim for a child who is covered under both parents’ policies. The parent with the earlier birthday in the calendar year – not the older parent – is the primary benefit provider. In other words, if the father’s birthday is in February and the mother’s in July, the father’s plan will be primary for claims processing.

**Capitation:** A method of paying healthcare service providers a set amount for each enrolled person assigned to a managed care organization that physician or group of physicians agree to care for, whether or not that member seeks care.

**Care Coordination:** The organization of care across several healthcare providers. Medical homes and accountable care organizations are two common ways to coordinate care. Patient advocates are one of the many professionals responsible for care coordination.

**Catastrophic Plan:** A type of insurance plan that is designed to cover certain types of expensive care, procedures or hospitalizations. These plans usually have high deductibles, meaning the plan begins to pay claims only after a certain amount is reached.

**Chronic Disease Management:** An integrated care approach to managing chronic illnesses that can include such things as health screenings, check-ups, monitoring, coordination of treatment, and patient education. Chronic disease management can improve a person’s quality of life while reducing your healthcare costs by preventing or minimizing duplication of services and providing education to reduce exacerbations related to the disease(s).
Claim: A request for payment that a healthcare provider submits to the health insurer when a member receives a healthcare product or service.

COBRA: A federal law that may allow a person to temporarily keep their health coverage after employment ends. If a person elects COBRA coverage, the person must pay 100 percent of the premiums, including the share the employer used to pay, plus a small administrative fee.

Co-insurance: The percentage of allowed charges for covered services that a person is required to pay for health insurance. For example, the health insurance may cover 80 percent of charges for a covered hospitalization, leaving the member responsible for the other 20 percent. This 20 percent is known as the coinsurance.

Community Rating: A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors.

Coordination of Benefits: Rules exist to govern insurance plans when there are two or more types of coverage on a claim, such as when a husband and wife each have coverage for themselves and their family through employer plans, or when an employee with Medicare is still working and covered under employee health benefits.

Copayment: A flat dollar amount a person must pay for a covered benefit. For example, a managed care company may require the member to pay a copayment for each visit to their primary care physician.

Cost Sharing: The share of costs covered by insurance that the member is required to pay out of pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges.

Deductible: The amount a person must pay for covered care before health insurance begins to pay.

Dependent Coverage: Insurance coverage for family members of the policyholder, such as spouses or children.

Disability: A limit in a range of major life activities. This includes activities like seeing, hearing, walking and tasks like thinking and working. Different programs may have different disability standards, so it is important to check the program the client maybe eligible.

Early Periodic Screening, Diagnostic & Treatment Services: A term used to refer to the comprehensive set of benefits covered for children in Medicaid.

Essential Health Benefits: The Affordable Care Act defines essential health benefits to include the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

According to the Affordable Care Act, insurance policies will be required to cover these benefits in order to be certified and offered in Exchanges, and all Medicaid State plans must cover these services by 2014.

Exchanges: A new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Exchanges will offer consumers a choice of health plans that meet certain benefits and cost standards.

Exclusions: Items or services that aren’t covered under a contract for insurance and for which an insurance company won’t pay. For example, a person’s policy may not cover pregnancy care or any services related to a pre-existing condition.

Family and Medical Leave Act (FMLA): A federal law that guarantees up to 12 weeks of job protected leave for certain employees when they need to take time off due to serious illness or disability, to have or adopt a child, or to care for another family member. When on leave under FMLA, the person can continue coverage under your job-based plan.

Federal Poverty Level: A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits.

Federally Qualified Health Center: Federally funded non-profit health centers or clinics serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of a person’s ability to pay. Services are provided on a sliding scale fee based on a person’s ability to pay.

Fee for Service: A method in which doctors and other healthcare providers are paid for each service performed. Examples of services include tests and office visits.
Flexible Benefits Plan: A benefit program that offers employees a choice between various benefits including cash, life insurance, health insurance, vacations, retirement plans, and child care. Although a common core of benefits may be required, consumers can choose how remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes a person can contribute more for additional coverage.

Flexible Spending Account: An arrangement set up through an employer to pay for an employee's out-of-pocket medical expenses with tax-free dollars. These expenses can include insurance copayments, deductibles, certain prescription drugs, insulin and medical devices. If offered, the employee decides how much of their pre-tax dollars they want to be taken out of their paycheck and put into a FSA. Employers may set a limit on the amount of money an employee can put into an FSA each year. There is no carry-over of FSA funds. This means that if all of the FSA funds are not spent by the end of the plan year they cannot be used for expenses in the next year. An exception is if the employer's FSA plan permits employees to use unused FSA funds for expenses incurred during a grace period of up to two-and-a-half months after the end of the FSA plan year. (Note: These accounts are sometimes called Flexible Spending Arrangements.)

Formulary: A list of drugs an insurance plan covers. A formulary may include how much a member pays for each drug. (If the plan uses "tiers," the formulary may list which drugs are in which tiers.) Formularies may include both generic drugs and brand-name drugs.

Grandfathered Health Plan: According to the Affordable Care Act, grandfathered health plans are health plans that were created – or an individual health insurance policy that was purchased – on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers.

Guaranteed Renewal: A requirement that health insurers must offer to renew a person's policy as long as the person continues to the pay premium. Except in some states, guaranteed renewal doesn't limit how much a person can be charged if they renew the coverage.

Healthcare Providers: A healthcare provider means a physician or any recognized practitioner who provides skilled services pursuant to a prescription or under the supervision or direction of a physician, and who is recognized by the state's workers' compensation system as a healthcare provider. The term healthcare provider also includes a healthcare facility providing healthcare services. Examples of healthcare professionals who are considered providers include, but are not be limited to, physicians, podiatrists, chiropractors, psychologists, physician assistants, nurse practitioners, rehabilitation nurses, case managers, life-care planners, occupational therapists, physical therapists, speech therapists, rehabilitation counselors, and vocational evaluators.

Health Savings Account: A medical savings account available to taxpayers who are enrolled in a high deductible health plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a flexible spending account (FSA), funds roll over year to year if they are not spent.

Health Status: Refers to a person's medical conditions (both physical and mental health), claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, and disability.

High Deductible Health Plan: A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with a health savings account or a health reimbursement arrangement to allow the insured to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

High Risk Pool Plan: Similar to the new Pre-Existing Condition Insurance Plan under the Affordable Care Act, for years many states have offered plans that provide coverage if the consumer has been locked out of the individual insurance market because of a pre-existing condition. High-risk pool plans may also offer coverage if the person is HIPAA-eligible or meets other requirements. High-risk pool plans offer health insurance coverage that is subsidized by a state government. Typically, the premium can be up to twice as much as a person would pay for individual coverage if you were healthy.

HIPAA Eligible Individual: The status a person must have once they have had 18 months of continuous creditable health coverage. To be HIPAA eligible, at least the last day of creditable coverage must have been under a group health plan; the person also must have used up any COBRA or state continuation coverage; the person must not be eligi-
ble for Medicare or Medicaid; must not have other health insurance; and must apply for individual health insurance within 63 days of losing prior creditable coverage. When buying individual health insurance, HIPAA eligibility gives the consumer greater protections than they would otherwise have under state law.

**Hospital Readmissions:** A situation where a person was discharged from the hospital and goes back in for the same or related care within 30, 60 or 90 days. The number of hospital readmissions is often used in part to measure the quality of hospital care, since it can mean that a person's follow-up care wasn't properly organized, or that the person was not fully treated before discharge.

**Individual Health Insurance Policy:** Policies for people that aren’t connected to job-based coverage. Individual health insurance policies are regulated under state law.

**Individual Responsibility:** Under the Affordable Care Act, starting in 2014, a person must be enrolled in a health insurance plan that meets basic minimum standards. If not, the person may be required to pay an assessment. Consumers won't have to pay an assessment if they have very low income and coverage is unaffordable, or for other reasons including religious beliefs. Consumers can also apply for a waiver asking not to pay an assessment if they don't qualify automatically.

**Insurance:** A system of reducing a person's exposure to risk of loss by having another part (insurance company or insurer) assume the risk.

**Job-based Health Plan:** Coverage that is offered to an employee (and often his or her family) by an employer.

**Medical Loss Ratio:** A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80 percent. A medical loss ratio of 80 percent indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, etc. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.

**Medically Necessary:** Services or supplies that are needed for the diagnosis or treatment of your health condition and meet accepted standards of medical practice.

**Medical Underwriting:** A process used by insurance companies to try to figure out a person's health status when they are applying for health insurance coverage to determine whether to offer coverage, at what price, and with what exclusions or limits.

**Nondiscrimination:** A requirement that job-based coverage not discriminate based on health status. Coverage under job-based plans cannot be denied or restricted. Consumers also cannot be charged more because of their health status. Job-based plans can restrict coverage based on other factors such as part-time employment that aren't related to health status.

**Out-of-Pocket Limit:** The maximum amount a person will have to pay for covered services in a year. Generally, this includes the deductible, coinsurance, and copayments. This definition may vary from plan to plan. For example, in some plans the out-of-pocket limit doesn't include cost sharing for all services, such as prescription drugs. Plans may have different out-of-pocket limits for different services. In Medicaid and CHIP, the limit includes premiums.

**Open Enrollment Period:** The period of time set up to allow consumers to choose from available plans, usually once a year.

**Out-of-Pocket Costs:** Expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

**Patient-Centered Outcomes Research:** Research that compares different medical treatments and interventions and that provide evidence on which strategies are most effective in different populations and situations. The goal is to empower patients and the treating doctor with additional information to make sound healthcare decisions.

**Payment Bundling:** A payment structure in which different healthcare providers who are treating a person for the same or related conditions are paid an overall sum for taking care of their condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments.

**Plan Year:** A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, employees check your plan documents or ask your employer.
Pre-existing Condition Insurance Plan: A new program that will provide a health coverage option for consumers if they have been uninsured for at least six months, have a pre-existing condition, and you have been denied coverage (or offered insurance without coverage of the pre-existing condition) by a private insurance company. This program will provide coverage until 2014 when consumers will have access to affordable health insurance choices through an Exchange.

Pre-Existing Condition (Job-based Coverage): Any condition (either physical or mental) including a disability for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date in a health insurance plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. Pregnancy cannot be considered a pre-existing condition and newborns, newly adopted children and children placed for adoption who are enrolled within 30 days cannot be subject to pre-existing condition exclusions.

Pre-Existing Condition (Individual Policy): A condition, disability or illness (either physical or mental) that a person has before enrolling in a health plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. This term is defined under state law and varies significantly by state.

Pre-existing Condition Exclusion Period (Job-based Coverage): The time period during which a health plan won’t pay for care relating to a pre-existing condition. Under a job-based plan, this cannot exceed 12 months for a regular enrollee or 18 months for a late enrollee.

Pre-existing Condition Exclusion Period (Individual Policy): The time period during which an individual policy won’t pay for care relating to a pre-existing condition. Under an individual policy, conditions may be excluded permanently (known as an “exclusionary rider”). Rules on pre-existing condition exclusion periods in individual policies vary widely by state.

Premium: A monthly payment made to the insurer to get and keep insurance coverage. Premiums can be paid by employers, unions, employees or individuals or shared among different payers.

Prevention: Activities to prevent illness such as routine check-ups, immunizations, patient counseling, and screenings.

Preventive Services: Routine healthcare that includes screenings, check-ups and patient counseling to prevent illnesses, disease or other health problems.

Primary Care: Health services that cover a range of prevention, wellness and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners and physician assistants. They often maintain long-term relationships with patients and advise and treat a range of health-related issues. They may also coordinate care with specialists.

Public Health: A field that seeks to improve lives and the health of communities through the prevention and treatment of disease and the promotion of healthy behaviors such as healthy eating and exercise.

Qualified Health Plan: Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.

Rate Review: A process that allows state insurance departments to review rate increases before insurance companies can apply them to you.

Reinsurance: A reimbursement system that protects insurers from very high claims. It usually involves a third party paying part of an insurance company’s claims once they pass a certain amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable.

Resource-based Relative Value Scale: A model used to determine how much money medical providers should be paid. It is currently used by Medicare and by nearly all health maintenance organizations.

Rescission: The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel the entire policy if a person made a mistake on the initial application. Under the Affordable Care Act, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.
**Rider:** A rider is an amendment to an insurance policy. Some riders will add coverage (for example, if a person buys a maternity rider to add coverage for pregnancy to the policy). In most states today, an exclusionary rider is an amendment, permitted in individual health insurance policies that permanently excludes coverage for a health condition, body part, or body system. Starting in September 2010, under the Affordable Care Act, exclusionary riders cannot be applied to coverage for children. Starting in 2014, no exclusionary riders will be permitted in any health insurance.

**Risk Adjustment:** A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their healthcare outcomes or healthcare costs.

**Self-Insured Plan:** Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator, or they can be self-administered.

**Skilled Nursing Facility Care:** Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

**Special Enrollment Period:** A time outside of the open enrollment period during which the consumer and the family have a right to sign up for job-based health coverage. Job-based plans must provide a special enrollment period of 30 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other job-based health coverage.

**Special Healthcare Need:** The healthcare and related needs for children who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that required by children generally.

**State Continuation Coverage:** A state-based requirement similar to COBRA that applies to group health insurance policies of employers with fewer than 20 employees. In some states, state continuation coverage rules also apply to larger group insurance policies and add to COBRA protections. For example, in some states, if an employee is leaving a job-based plan, they must be allowed to continue your coverage until you reach the age of Medicare eligibility.

**Subrogation:** Subrogation refers to the right of an insurance company or self-insured employer to be repaid for the cost of medical care or wage loss benefits. Repayment can be sought from any money a policy holder receives in a law suit or any settlement from a third party. There are many instances and many reimbursement systems in which subrogation can occur.

**Uncompensated Care:** Healthcare or services provided by hospitals or healthcare providers that don't get reimbursed. Often uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care.

**Value-Based Purchasing:** Linking provider payments to improved performance and outcomes for managing a patients care. This form of payment holds healthcare providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

**Waiting Period:** The time that must pass before coverage can become effective for an employee or dependent, who is otherwise eligible for coverage under a job-based health plan.

**Well-baby and Well-child Visits:** Routine doctor visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21. Services include physical exam and measurements, vision and hearing screening, and oral health risk assessments.

**Wellness Programs:** A program intended to improve and promote health and fitness that's usually offered through the workplace, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventive health screenings.

Source: www.healthcare.gov
Section 2: Charting the Wide Range of Reimbursement Systems
Auto Liability Insurance

It only takes the blink of an eye for a car accident to happen. Vehicle insurance (also known as auto insurance, gap insurance, car insurance, or motor insurance) is insurance purchased for cars, trucks and other road vehicles. Its primary use is to provide financial protection against physical damage and/or bodily injury resulting from traffic accidents and against liability that would arise from an accident. Auto liability policies have limits. The limit is the total amount of money the policy will pay out to cover you.

Traditionally there are two kinds of policies:

1. Combined Single Limit Policies. These policies cover damage to property and bodily injury in one policy.

2. Split Limit Policies. These policies have separate amounts of coverage for property damage and bodily injury. The coverage for bodily injury can also be split. A policy may cover the insured on a maximum payment per person or maximum payment per accident.

In the United States, automotive insurance covering liability for injuries and property damage is compulsory in most states, but different states enforce the insurance requirement differently, so the amount of coverage varies from state to state.

In states where medical coverage is offered under auto liability policies, benefits are called personal injury protection (PIP). Personal injury protection is also known as Medical Payment Insurance or Medpay. Auto insurance compensates the policy holder for bodily injury damages occurring in an accident by providing payment for medical and hospital expenses, child care expenses for bodily injury caused by a covered accident, loss of services and funeral expenses.

PIP will pay for your medical expenses, as will your health insurance, if the driver has coverage. But PIP also may pay for other things that health insurance is not designed to, such as lost wages, home care, or other compensations for pain and suffering. Also, PIP will cover injuries to your passengers, or other licensed drivers who may be using your vehicle. Your personal health insurance policy will not. You cannot “lose” your PIP insurance, as long as you keep your auto insurance policy in effect.

Uninsured/underinsured motorist coverage

Uninsured motorists (UM) coverage pays for medical bills if an uninsured driver strikes another car or if a person is a victim of a hit-and-run. Uninsured/Underinsured Motorist coverage is required by law in 20 states and the District of Columbia. The states are: Connecticut, Illinois, Kansas, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Virginia, West Virginia and Wisconsin.

Similarly, underinsured motorists (UIM) coverage kicks in when someone causes an accident but doesn't have enough insurance.

States That Require PIP Coverage

➤ Arkansas
➤ Delaware
➤ Florida
➤ Hawaii
➤ Kansas
➤ Kentucky
➤ Maryland
➤ Massachusetts
➤ Michigan
➤ Minnesota
➤ New Jersey
➤ New York
➤ North Dakota
➤ Oregon
➤ Pennsylvania
➤ Utah

Source: Insurance Information Institute
Section 2: Charting the Wide Range of Reimbursement Systems

to cover all medical bills. In that case, the at-fault person’s insurance pays out to its maximum and then the Uninsured/Under-insured Motorist coverage pays for the remaining bills, up to the driver’s own limit. UM and UIM coverage also covers pain and suffering claims and, in some states, property damage.

Patient advocates need to review the client’s auto liability insurance policy when they are called in to assist a client with medical management of injuries, assist them in understanding who is responsible to pay claims or to cover home care or other needs that result from an auto accident.

Children’s Health Insurance Program (CHIP)

The State Children’s Health Insurance Program (SCHIP) – later known more simply as the Children’s Health Insurance Program (CHIP) – is a program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid.

At its creation in 1997, SCHIP was the largest expansion of taxpayer-funded health insurance coverage for children in the U.S. since Medicaid began in the 1960s. The statutory authority for SCHIP is under title XXI of the Social Security Act and allocated about $20 billion over 10 years to help states insure low-income children who are ineligible for Medicaid but cannot afford private insurance. States receive an enhanced federal match (greater than the state’s Medicaid match). The Act was sponsored by Senator Ted Kennedy in a partnership with Senator Orrin Hatch with support coming from First Lady Hillary Rodham Clinton during the Clinton administration.

In 2007, after President Bush and Congress could not agree on CHIP reauthorization details, the program was extended through March 2009. In February 2009, the Children’s Health Insurance Program Reauthorization Act of 2009 was approved by Congress and signed by President Obama. In concert with the signing, President Obama sent a memorandum to CMS requesting that they immediately withdraw the August 17, 2007, Directive sent to state health officials which imposed conditions on states and limited their options to provide coverage to uninsured children. He requested that they implement CHIP from this time forward without these requirements.

Patient advocates can call 1-877-KIDS-NOW (1-877-543-7669) to find out how to get an application to apply to the state CHIP program. In some states, the application can be completed over the phone or online. In other states, the application may need to be sent in through the mail.

Community Living Assistance Services and Supports (CLASS) Program

CLASS (Community Living Assistance Services and Supports) is a new voluntary, federally administered insurance program created under the Affordable Care Act (ACA). Most working adults age 18 or older will be able to voluntarily enroll in this new program either directly or through their employers, without answering questions about their health.

According to the CLASS website, the purpose of this Act was to establish a national voluntary insurance program for purchasing community living assistance services and supports in order to:

➤ Provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the commu-
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nity through a new financing strategy for community living assistance services and supports.

➤ Establish an infrastructure that will help address the nation's community living assistance services and supports needs.

➤ Alleviate burdens on family caregivers.

➤ Address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.

It is estimated that approximately 10 million Americans need long-term services and supports, ranging from having an aide visit for a few hours a week to living in a nursing home with around-the-clock care. As America ages, that number is rising steadily. By 2020, that number is expected to rise to 15 million Americans who will need some kind of long-term care.

It is known that one out of six people who reach the age of 65 will spend more than $100,000 on long-term care – and far more will need less extensive but still substantial care as well. Twenty-two percent of those who enter a nursing home will spend their own resources and qualify for Medicaid after virtually exhausting their savings. Unfortunately, only about 8-10 percent of Americans have private long-term care insurance coverage, and new enrollment is declining while major long-term care competitors have exited the market. Taken together, this means that many Americans are not well prepared to finance the long-term services and supports they will need.

There are a number of reasons behind the reluctance of consumers to prepare for long-term care needs. The first reason is a misunderstanding of the available resources. Today, four out of five Americans mistakenly believe that Medicare provides them with extensive coverage for long-term care. It does not.

In addition, while Medicaid is the nation's primary payer for long-term care, paying approximately 50 percent of the nation's nursing home expenditures, qualifying for long-term services and supports under Medicaid requires that an individual impoverish themselves, with only modest protections for the needs of one's spouse.

Second, Americans frequently misjudge the risk that they will need long-term services and supports. There is a natural impulse not to think about becoming dependent on others as a result of physical or cognitive decline.

Third, many people are unaware of the costs of these kinds of services and supports. Even if they understand that a year of nursing home care now costs about $75,000, they are unlikely to have considered the costs of home health aides that can help people remain more independent and living in their homes. A year of home healthcare costs about $18,000.

In addition to individuals, costs of long-term care is a source of financial stress on public budgets. Recent data from the CMS Office of the Actuary show that in 2009 Medicaid spent $111.2 billion on long-term care services and that spending growth on these services is projected to accelerate as the population ages, stressing both federal and state budgets.

CLASS is not available yet. The Affordable Care Act (ACA) states that the Secretary of Health and Human Services has until October 1, 2012, to designate the CLASS benefit plan. Enrollment will not take place before the plan is announced, and no one will pay premiums until after they enroll.

Once the Secretary of Health and Human Services announces the plan, enrollment in CLASS will be voluntary and will be available to most working adults. Pre-existing medical conditions will not disqualify someone from enrolling. Individuals who enroll will be eligible to receive benefits if they meet specific requirements regarding functional limitation, earnings and premium payment. Enrollees pay the premiums. Benefits will be paid from premiums and earnings on those premiums. Taxpayer funds will not be used to pay benefits.

CLASS will be administered through the federal government. Enrollment will be available to most working adults. Unlike most long-term care insurance offered by private insurers, pre-existing medical conditions will not disqualify someone from enrolling. In addition, CLASS enrollees will have to meet specific requirements regarding functional limitation, earnings and premium payment in order to receive benefits.

Patient advocates should watch for this new program as it will be an important benefit consumers can take advantage of to prepare for long-term care needs. (www.healthcare.gov/foryou/disabilities/lontermcare/class/)
CorpsCare

CorpsCare is an affordable, private, comprehensive health insurance policy for those who volunteer for the Peace Corps. The program is designed to complement the benefits provided for service-related medical problems under the PC-127C authorization and FECA. Peace Corps will explain the benefits of the policy and pay the first month's premium to all volunteers.

Peace Corps will also pay the first month’s premium for each of the volunteer’s children, less than 18 years old and residing with the volunteer when service ends. Spouses are also eligible for CorpsCare, however, the volunteer must pay all monthly premiums for a spouse, including the first month. Before the end of their service, volunteers will be given the opportunity to extend their CorpsCare enrollment for up to 18 months and to enroll qualified dependents.

According to the Website, CorpsCare provides coverage for non-service-related healthcare needs. Specifically, it covers:

- Most pre-existing conditions, including health conditions that existed prior to volunteer service, were disclosed to the Peace Corps prior to service, and were not exacerbated by service.
- Post-service healthcare for health problems that developed while a volunteer was in the U.S. but not directly engaged in Peace Corps business.
- Health problems that develop during vacations, home leave, emergency leave, or while on medevac may be covered if they are not covered by FECA.
- Healthcare for any non-service-related health condition that arises while CorpsCare coverage is in effect.
- This coverage is subject to certain exclusions described in the CorpsCare contract

To learn about this coverage visit the website www.peacecorps.gov.

Disability Insurance

Disability insurance generally provides periodic payments to replace income lost when an insured person is unable to work as a result of an injury or illness. Typically, disability insurance is packaged under short-term disability (STD) and long-term disability (LTD) policies that may or may not provide medical services along with wage-replacement. STD pays benefits during the time a disability exists to a covered person who remains disabled for a specified period, often not to exceed two years. LTD insurance can be issued to a group or individual to provide a reasonable replacement of a portion of income lost due to a serious or prolonged illness. STD plans can dovetail into LTD plans, or stand alone. Likewise, LTD plans can be available without STD benefits.

An important aspect of disability insurance is the “own occ/any occ” rule. Salary replacement can be based upon the plan holder's own occupation (own occ) or any comparable occupation (any occ), depending upon the plan’s benefit. Under the “own occ” provision, a person may receive wage loss replacement even if limited from performing only one aspect of an entire job.

It is important to remember that disability insurance coverage is plan specific. Although the “own occ/any occ” rule exists, benefit coverage and limitations will vary depending upon the policy.

Regardless of the type of coverage, the role of the disability insurance carrier is to promote early intervention, quality
medical care, and customized transitional return-to-work programs, as well as to integrate disability insurance and workers’ compensation benefits when available.

Many disability management companies utilize case managers to manage care. The disability case manager generally cannot direct medical care, but can help control costs and outcomes by facilitating return-to-work. The disability case manager often requests that the treating physician evaluate the functional level of the patient to explore the ability of the patient to return to gainful employment, whether at the existing job, a modified version of the job, or a different job.


The Federal Employees Health Benefits Program

The Federal Employees Health program was created in 1960. Employer sponsorship of health insurance in the United States became prevalent during World War II, as one of the few ways by which employers could escape wage and price control limitations on employee wages. The government originally proposed a system that would revolve around a dominant government-directed plan, but unions and employee associations, which had sponsored their own plans, protested and, reflecting the political pressure they brought the Congress, modified the Executive Branch proposal; all existing plans were “grandfathered” into the program.

The Federal Employees Health Benefits (FEHB) provides health insurance for those who work for the federal government and their families. Federal employees, retirees and their survivors enjoy the widest selection of health plans in the country.

Plans include consumer-driven and high deductible plans that offer catastrophic risk protection with higher deductibles, health savings/reimbursable accounts and lower premiums, or fee-for-service (FFS) plans, and their preferred provider organizations (PPO), or health maintenance organizations (HMO) for those who live/work within the area serviced by the plan.

The program is administered by the United States Office of Personnel Management (OPM).

The underlying legislation for the FEHB program is minimal and remarkably stable, particularly in comparison to the Medicare program. The FEHB statute is only a few dozen pages long, and only a few paragraphs are devoted to the structure and functioning of the program. Regulations are minimal. In contrast, the Medicare statute found in title 18 of the Social Security Act is about 400 pages long and the accompanying regulations consume thousands of pages in the U.S. Code of Federal Regulations.
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According to the Office of Personnel Management website, the FEHB program has often been proposed as a model for national health insurance and sometimes as a program that could directly enroll the uninsured. In enacting the Medicare Modernization Act in 2003, Congress explicitly modeled the reformed Medicare Advantage program and the new Medicare Part D Prescription Drug program after the FEHB program. One of the prominent proposals for health reform in the United States, the proposed bipartisan Wyden-Bennett Act, is largely modeled after the FEHB program, as have recent “Republican Alternative” proposals by Representative Paul Ryan.

Patient advocates who work with clients who are covered by the FEHB program can collaborate with the internal case manager to coordinate the plan of care.

Indian Health Service

The Indian Health Service (IHS) is an agency within the Department of Health and Human Services. They are responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship, which was established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions and Executive Orders.

The IHS is the principal federal healthcare provider and health advocate for Indian people and its goal is to raise their health status to the highest possible level. The IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 564 federally recognized tribes in 35 states.

According to the Indian Health Service website, the mission of the IHS is to raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level.

Their goal is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indians and Alaska Natives.

Their foundation is to uphold the federal government’s obligation to promote healthy American Indian and Alaska Native people, communities and cultures and to honor and protect the inherent sovereign rights of Tribes.

To learn more about the Indian Health Service program visit the website www.ihs.gov.

Long-Term Care Insurance

Long-term care insurance is a type of insurance developed specifically to cover the costs of long-term care services, most of which are not covered by traditional health insurance or Medicare. These include services in your home, such as assistance with activities of daily living as well as care in a variety of facility and community settings.

There is a great deal of choice and flexibility in long-term care insurance policies. Consumers can select from a range of care options and benefits that allow them to get the services they need in the settings that suit them best. The cost of long-term care insurance policy is based on the type and amount of services a person chooses to have covered, how old they are when they buy the policy, and any optional benefits they choose, such as inflation protection.

If a person is in poor health or already receiving long-term care services, they may not qualify for long-term care insurance, or they may only be able to buy a more limited amount of coverage, or buy coverage at a higher “non-standard” rate.
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Long-term care insurance policies have a benefit period or lifetime benefit maximum, which is the total amount of time or total amount of dollars up to which benefits will be paid. Common benefit periods for long-term care policies are two, three, four and five years, and lifetime or unlimited coverage. Other options between five years and lifetime/unlimited coverage are also available from many companies. Most policies translate these time periods into dollar amounts and do not actually limit the number of days for which they will pay for care – just the overall dollar amount that the policy will pay. There are fewer companies today willing to offer an unlimited/lifetime policy, although some have a "high coverage option" like a $1 million lifetime limit.

With long-term care insurance, the person pays for the policy in amounts they know in advance and can budget for, and the policy pays – up to its coverage limits – for the long-term care you need when you need it. Typically, premiums are waived during the time you are receiving benefits.

In the past, LTC insurance provided only nursing home care, but today’s expanded healthcare arena allows many services potentially covered by a LTC insurance policy. These may include:

➤ Hospice.
➤ Adult day care centers.
➤ Sub-acute or skilled nursing facilities.
➤ Transitional living centers.
➤ Home healthcare.
➤ Custodial care.

What is long-term care?
Long-term care refers to care that individuals may need for a long time because they are unable to take care of themselves due to an illness, disease, the aging process, or cognitive impairment (for example, Alzheimer’s disease).

Most long-term care is non-skilled personal care, such as help with everyday tasks, called activities of daily living (ADLs):

➤ Bathing.
➤ Dressing.
➤ Using the toilet.
➤ Transferring (moving to or from a bed or chair).
➤ Caring for incontinence.
➤ Eating.

The goal of long-term care is to provide help with routine functions when being fully independent is not possible. Long-term care can be provided at home, in a community setting or in an institution. Most people prefer to receive long-term care at home.

An LTC policy will state how many ADLs (usually at least two) must be deficient and to what degree before the policy benefits take effect. Cognitive impairments are defined as a deficiency in either short-term or long-term memory as to person, place or time, or deductive or abstract reasoning.

Some contracts also allow for medical necessity, which permits an insured to access benefits if s/he does not meet the ADL or cognitive impairment standard. Under medical necessity, a physician or other healthcare professional can certify that the requested care is correct and appropriate to the insured’s care.

Often, LTC plans use case managers to make evaluations in order for the plan to make a determination. The case manager will visit the policy holder in his/her home, assessing the patient’s health status, and functional and cognitive needs. Needs for ADL assistance are noted. The determination for benefits will be based largely upon this comprehensive assessment.

Patient advocates working with patients possessing LTC insurance policies must be aware of the level of service provided in the policy – skilled care, intermediate or custodial. If the plan does cover custodial care, the patient may be covered only if cognitive deficits are present, or two or more ADLs are impaired. These are called “benefit triggers,” which define the clinical conditions that must be present in order for the insured to receive benefits.
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Managed Care

Managed care as a term has come to define a broad array of systems and processes meant to control escalating healthcare costs while coordinating quality healthcare services and products through a network of approved providers. These providers agree to assume the risk of caring for all individuals in an aggregate population for capitated, predetermined dollar amounts.

Capitation is a term that explains the method of payment under managed care in which the healthcare provider is paid a fixed amount for each person over a specific period of time, regardless of the actual number or nature of services/products provided to each person. This is known as per member, per month.

A fixed monthly payment is provided for each member covered in the plan, regardless of whether the plan members utilize, underutilize, or overutilize the provider's services. The provider assumes the risk associated with a fixed fee.

Despite the implementation of managed care over the past several years, debate continues as to whether managed care has provided coordination and efficiency of quality service, or has simply managed costs. The management of costs has been packaged in a variety of offerings in the name of managed care to employer groups, private pay insurance, Medicaid plans, Medicare plans, and to special group associations. Some of the most common terms under managed care are:

Health Maintenance Organization

A health maintenance organization (HMO) is set up to provide healthcare for a specific population in a specific geographic area. The HMO accepts responsibility for delivering an agreed-to set of services and products to an enrolled group. The HMO collects a pre-determined periodic payment paid in advance (usually on the first of each month) on behalf of each individual enrollee. Each enrollee is then responsible to assume a co-payment (usually $5–$25) that can vary in cost when seeking the services of a primary care physician, specialty physician, diagnostic center, or treatment facility.

Enrollees are required to seek services from specific providers listed as the HMO's network providers. Enrollees are also required to first seek the medical attention of a pre-appointed primary care physician or what many have called a gatekeeper. Specialty physicians (with the usual exception of pediatricians, internists and gynecologists) will be covered through the HMO only if the patient sees them based upon a written referral from the patient's primary care physician. They must be an authorized provider in the insurance company's network, or preauthorization for their services must have been provided by the insurance company as an out-of-network service.

The primary goal of an HMO is to enhance quality of care through a coordinated network. It is not to enhance cost savings through limitation of benefits. Yet many accuse HMOs of rationing healthcare through limitation of benefits and incentivizing gatekeepers to not refer patients for treatment or specialty care. The debates will no doubt continue as HMOs continue to occupy a large share of the managed-care market.

Integrated Delivery Systems

Integrated delivery systems (IDS) emerged in the 1990s as a method of “risk sharing” under contract with managed care organizations. In an IDS system, services range from the acute to the post-acute continuum of care, and all are integrated. This system was established primarily to:

➤ Share the risk of capitation, spreading the risk across several entities to hedge against a loss in any one delivery system.

➤ Maximize available funding and benefits coverage from the pay source.

➤ Move the patient through the continuum of care in a seamless system.

➤ Enhance coordinated care delivery by ensuring that the patient's care is communicated and coordinated between various delivery systems.

Patients in an IDS system were formerly moved through the integrated system by discharge planners, without regard for offering the patient choices in other available post-acute services outside the IDS. The federal government circumvented this practice in the latter part of the 1990s when it prevented entities accepting Medicare from self-referring patients to integrated post-acute services within the IDS, without offering the patient choices of other service providers.

IDS systems continue to evolve to meet the needs of patients who are being discharged quicker and sicker from acute care settings. Examples of successful IDS are Kaiser Permanente, Intermountain Healthcare and Geisinger Health System. Integrated Delivery Systems are one of the models that
could form an accountable care organization.

Patient advocates who work with clients who are part of an integrated delivery system need to work within the established network unless they do not provide the services required to meet the needs of the patient.

**Types of Managed Care Plans**

**IPA**

An Independent Practice Association (IPA) is an HMO that contracts in a risk-sharing or full-risk arrangement with physicians. The physicians still see patients in their own private offices, and are reimbursed on a capitated basis.

**PPO**

A preferred provider organization (PPO) is a managed care system of healthcare delivery in which a third-party payer contracts with a group of medical care providers who furnish services at a lower-than-usual fee in return for prompt payment and a certain volume of patients.

In a PPO plan, the enrollee usually has a greater list of providers to choose from in the network than in an HMO managed care plan, since providers are paid at better negotiated, capitated, or formula rates for services provided. Further, the enrollee does not need to obtain written referrals for specialty physicians from the primary care physician (gatekeeper).

PPO plans cover a broad range of delivery systems. Many PPO systems are voluntary members of the American Association of Preferred Provider Organizations (AAPPO), a national nonprofit membership organization dedicated to promoting quality in PPO systems.

**POS**

A point-of-service plan usually offers both HMO and PPO levels of coverage, so that the enrollee has greater flexibility in choosing providers either in the managed care network, at an optimally cost-efficient fee, or outside the managed care network, in which services will still be paid, but at a reduced rate. There are many variations to POS plans offered by various insurers. Many are open-access HMOs, whereby the guidelines of an HMO apply, but without a confined network of providers from which to choose. Some have the guidelines of a PPO, but limit access to specialty physicians by requiring a referral from the primary (gatekeeper) physician. Another version may allow open access into and out of a network, but will impose financial penalties for stepping outside the network for care.

**Medicare**

Medicare is a federally funded government program that was enacted by federal legislation in 1965, and is administered by the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS).

Most people age 65 and older are entitled to free Medicare Part A, which is considered hospital insurance. Part A covers inpatient hospital services, skilled nursing facilities, approved home health services, and hospice care.

Persons eligible for Medicare include those eligible for Social Security Income (SSI) retirement benefits, those eligible for Railroad Retirement benefits, and those under 65 who have been eligible for Social Security Disability Income (SSDI) benefits for at least 24 months. Persons may claim Medicare 24 months after the date of injury or after the illness is diagnosed and documented by a physician. There is a five-month waiting period for persons seeking eligibility. A “fast track” application process exists for persons seeking eligibility. A “fast track” application process exists for persons diagnosed with a terminal illness who are considered to have six months or less to live.

In addition, those under age 65 who have kidney disease that “appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life” are also eligible for free Part A Medicare. Medicare Part A recipients are automatically eligible for Medicare Part B.
(medical insurance), providing they can pay the designated monthly premiums established through insurance companies providing Part B insurance. Part B covers physician services, outpatient hospital services, medical equipment and supplies. Premiums for Part B insurance vary widely, particularly because some Part B policies are fee-for-service, or indemnity plans, and some are managed care plans. Senior citizens may have excellent Part B coverage, more limited managed care coverage, or no Part B coverage at all.

Through a managed care plan they may have some coverage for prescriptions, under a “prescription card coverage,” in which they may be responsible for a co-pay on prescription drugs. Under the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, seniors and people living with disabilities were provided with a voluntary prescription drug benefit through Medicare, effective in 2006. The intent of the MMA is to offer more choices and better benefits. In fact, approval of the MMA represented the most significant improvement to senior healthcare in nearly 40 years. Passage of the MMA was also intended to offer more health plan choices, including regional preferred provider organizations (PPOs), to provide better benefits, higher quality care and substantial cost savings for Medicare beneficiaries.

In addition to the standard drug benefit, which is available to all beneficiaries with a 75 percent premium subsidy, passage of the MMA provided low-income seniors and people with a disability who have limited means – about a third of all people with Medicare – with greater access to coverage offering limited premiums and deductibles and no gaps in coverage. Medicare beneficiaries with retiree coverage benefited from a set of options to obtain more affordable enhanced coverage, including a new retiree drug subsidy as well as options for employers and unions to wrap around Medicare coverage or offer Medicare-subsidized drug coverage themselves. In addition, states, other individuals and charitable organizations can contribute toward a beneficiary’s out-of-pocket costs and still have those contributions count toward catastrophic coverage.

Plans under managed care are called Medicare Advantage Plans. These types of plans are offered by a private company that contracts with Medicare to provide beneficiaries with Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If someone is enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren’t paid for under original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

These plans are referred as Medicare Part D. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare. Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a “donut hole”). This means that after the member has spent a certain amount of money for covered drugs, the member will have to pay all costs out-of-pocket for prescriptions up to a yearly limit. Once the limit has been reached, the coverage gap ends and your drug plan helps pay for covered drugs again.

To learn more about Medicare visit www.medicare.gov.

Medicaid

Medicaid is the second safety-net system for those under a certain income level. Medicaid is served through joint federal and state programs and varies in covered benefits state-to-state. Medicaid was enacted in 1965 under Title XIX of the Social Security Act.

Eligibility for Medicaid is based on income and other financial resources of the applicant. In addition to financial need, an individual may qualify for Medicaid based on medical need, as well as categorical need, meaning that the person is already receiving some form of government benefits, such as Social Security Income (SSI). If a child is under the age of 21 and has an impairment severe enough to meet the
disability standards under SSI, the parental income is disregarded in determining Medicaid benefits.

The provision of Medicaid benefits can vary somewhat from state to state, although in all states Medicaid will pay for skilled home healthcare nursing services, as well as for long-term care in a nursing home, provided financial minimal requirements are met. Within broad guidelines established by the federal government, each state sets criteria for its Medicaid program, including:

- Eligibility standards.
- Type, amount, duration and scope of eligible services.
- Rate of payment for services offered.
- Administration of the program.

Mutual and Indemnity

Mutual and indemnity plans refer to traditional profit-making, premium-based insurance companies where reimbursement or compensation for loss or personal injury is provided via a contract that is preset and includes premiums. Companies selectively purchase these policies in much the same way as individuals would purchase homeowners’ or automobile insurance. Indemnity group and individual health insurance plans were quite common in the 1960s, 1970s and even the 1980s, until their annual increases in premiums became more than employers and consumers could manage. As a result many turned to managed care plans offering lower premiums.

Indemnity plans largely reimburse for services based on a “usual and customary charge,” and then use these pre-set charges to calculate payment of a majority percentage of the total bill, usually about 80 percent. Payments are made retrospectively, so that if a provider is not willing to “accept assignment” – that is, to accept direct payment from the indemnity plan without collecting funds from the insured at the time services are rendered – the insured will then be responsible to pay the bill in full, and seek a portion of reimbursement from the insurance company.

Providers can also require the insured to pay the stated percentage he/she is personally responsible to cover under the plan (20 or 30 percent are customary percentages) up front, or in installments. The provider then bills the insurance company, obtaining payment for services under a “reasonable and customary” formula, which may or may not be equal to the amount billed.

Military Health System

The U.S. Military Health Service System (MHSS), formerly known as Champus, uses a managed care delivery system known as TRICARE. TRICARE was initiated to manage the rising costs of healthcare in the military system.

TRICARE is operated under the Department of Defense and is the nation’s largest healthcare system with more than 8.3 million individuals eligible to receive care. All active duty military personnel, their families, retirees and their families, and survivors of active duty military personnel who are not eligible for Medicare based upon age can participate in one of three levels of TRICARE. Additionally, individuals under the age of 65 who are eligible for Medicare because of disability and end-stage renal disease may also choose to participate.

The three levels of TRICARE are: TRICARE Prime, TRICARE Standard, and TRICARE Extra. All active duty men and women are automatically enrolled in TRICARE Prime.
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The focus of TRICARE Prime is to keep the enrollees “fit for duty.” In this regard, TRICARE Prime leads the nation in providing a coordinated, systemwide wellness program. TRICARE Prime uses a strong case management and disease management approach to support its wellness and illness/injury prevention model.

Other military eligible individuals can choose among the Prime, Standard and Extra levels of TRICARE. Once retired military personnel, their families and survivors reach 65, they are eligible under Medicare and are not usually eligible for TRICARE.

To learn more about military healthcare visit www.tricare.mil.

Veterans Benefits

Service men and women who can no longer continue in active duty and retired military personnel are eligible for a wide array of benefits from the Veterans Administration (VA). The VA provides a wide range of benefits, including Disability, Education and Training, Vocational Rehabilitation and Employment, Home Loan Guarantee, Dependent and Survivor Benefits, Medical Treatment, Life Insurance and Burial Benefits.

Those who are eligible for VA benefits include:

➤ Veteran.
➤ Veteran’s dependent.
➤ Surviving spouse, child or parent of a deceased Veteran.
➤ Uniformed service member.
➤ Present or former reservist or National Guard member.

The Wounded Warrior Case Managers work with service men and women who cannot return to active duty to assist them with the transition to the Veterans Administration.

To learn more about Veterans Healthcare visit www.va.gov.

Self-Insurance

Self-Insurance (also referred to as self-funding) is an alternative type of insurance that is used by tens of thousands of employers across the country to finance their group healthcare and workers’ compensation liabilities.

Self-Insurance has become an increasingly attractive option for many employers due to the rising costs associated with healthcare and workers’ compensation commercial insurance.

To learn more about Self-Insurance visit www.siia.org/i4a/pages/index.cfm?pageid=4451.
Third Party Administrator

A third-party administrator (TPA) is an organization that engages in claims administration service contracts with self-insured companies and employer groups.

TPAs assume administrative responsibility at a fixed rate to handle all claims; to process claims; to handle all customer correspondence, complaints, appeals, etc; and to act as a liaison between the payer and the provider groups.

TPAs are able to undertake the care coordination and documentation systems that self-funded groups are often not equipped or financially able to handle. Many self-insured employ TPAs to act as their claims administration arm.

Patient advocates often report to the Third Party Administrator because the Administrator is responsible to manage those aspects of care coordination that the patient advocate influences – cost, quality and access to care.

Student Health Insurance

The Student Health Plan provides college students health insurance with strong benefits, guaranteed coverage for members, multiple coverage options, and flexible payment plans.

The program is ideal for part-time, full-time or non-traditional students seeking an affordable alternative to limited coverage school-sponsored plans or the lengthy underwriting requirements of traditional permanent policies. A number of insurance companies provide Student Health Insurance as part of their plan offerings.

The plan is designed for members of College Parents of America. Those who are not currently a member may enroll at the time of purchase and receive all of the benefits available to student members.

To learn more visit the website www.estudentinsurance.com/college-student-health-insurance.

Vocational Rehabilitation

Vocational Rehabilitation (VR) is viewed as a reimbursement system that is overseen by each state. Eligibility criteria is set by the individual states in accordance with federal law.

In general, to be eligible for services provided through state VR programs, persons must have a physical or mental impairment that impedes employment; and must be reasonably expected to become employable as a result of services provided.

In this regard, a disabled child who is not nearing the employment age of 16 would not be eligible for VR services. Likewise, a disabled individual over the retirement age of 70 would not be eligible.
The intent is to address the individual's physical, mental, behavioral and environmental needs so that successful, gainful employment can be achieved, moving the disabled person to self-reliance and independence.

VR is often termed “the payer of last resort,” meaning that all other pay systems must be exhausted before a person is eligible.

In addition to funding medical services, vocational rehabilitation provides training and education for individuals who otherwise have little or no medical and/or vocational coverage. Services provided include:

➤ Vocational training.
➤ Secondary education necessary to achieve appropriate degree from a school of nursing or a bachelor's degree in computer technology.
➤ Financial support during rehabilitation.
➤ Communication services (i.e., readers and note-takers to assist a blind candidate while in a school or training institution funded by VR).
➤ Physical and mental rehabilitation services (i.e., acute and post-acute medical care; prosthetic and assistive devices; transportation; home and jobsite modifications for independence; therapies, such as OT, PT, speech).

Patient advocates should look to their state vocational rehabilitation system as a resource for their clients when other funding is running out.

Workers’ Compensation

Workers’ compensation is a no-fault, individually state-governed insurance system that addresses work-related injuries and illnesses. The system was implemented in 1911, when the Workers’ Compensation Act was passed. The Act mandates states to govern wage replacement and medical benefits for both temporary and permanent disabilities, regardless of whether the employer or the worker is at fault for the injury or illness. The goal of workers’ compensation is to provide prompt medical care coordination to return the worker to gainful re-employment.

Employees are immediately covered under an employer’s workers’ compensation insurance policy at the time of hiring. There is no waiting period, nor are there eligibility requirements. The employer is required by law to carry workers’ compensation insurance for all part-time and full-time employees. Workers’ compensation pays for the following if an injury or developed occupational disease occurs because of conditions related to the job:

➤ All reasonable and medically necessary care.
➤ A percentage of lost wages.
➤ Death benefits and burial expenses to a deceased worker’s dependents.

There are several differences in how medical benefits are covered under state workers’ compensation programs, as each state sets its own rules. Some states have managed care workers’ compensation arrangements whereby the managed care company directs care similar to group health managed care policies. In this model, a primary care physician evaluates the patient to determine the extent of the injury, coordinates appropriate services, refers the injured worker to physician specialists and evaluates the ability of the injured worker on each visit.

The managed care systems were enacted to control costs and lower variations in care. Still, many variables exist in workers’ compensation systems, including how much providers can charge for certain services, and who will be an approved service provider under the reimbursement system. The nature and extent of vocational services offered to injured workers often varies considerably based on state governance. The nature and extent of ancillary services, such as home modifications and transportation, are also very different state to
state. Other variables include wage-loss compensation, such as when compensation begins, what methodology is used to determine the amount of weekly compensation, how employees report injuries to the employer, and how employers report the initial injury or event to the state system, as well as to the insurance carrier.

As the system is based on providing care for work-related injuries, it is essential that injuries are reported when they occur so the insurance company can review the claim, investigate questionable claims, and assign a claims adjuster or claims manager to oversee the claims payment process and ensure the state rules are followed by all parties.

Many times a nurse case manager is assigned to work closely with the claims adjuster or claims manager and is responsible to report all activity to this individual.

Besides providing medical services to the injured worker, the claims adjustor is also responsible for ensuring the injured worker receives his/her compensation. Traditionally there is a waiting period for workers’ compensation wage-loss benefits to begin. This period is in place to circumvent compensation for minor injuries and reduce frivolous claims. A waiting period can range from three days to three weeks. If the lost time from work exceeds the waiting period, benefits are then usually paid from the date of injury.

The wage-loss benefits are dependent upon the pre-injury earnings of the injured worker. Each state establishes a formula so that standard benefits are determined, including a minimum and a maximum allowable benefit. All workers’ compensation wage-loss benefits are nontaxable income to the injured worker. Because workers’ compensation is a return-to-work system, some states end the wage benefit at retirement age or allow a phase-out period. Wage-loss benefits under workers’ compensation can be coordinated with available LTD benefits, social security disability income (SSDI), and Medicare benefits when the employee is eligible to receive these benefits. It is the responsibility of the carrier to inform the injured worker about potential benefits if the carrier suspects or confirms that the injured worker may be eligible. However, the carrier cannot reduce or withhold wage-loss benefits from the employee prior to the employee’s receipt of additional benefits.

The main stakeholders in any state workers’ compensation system include the employee, the employer, the insurance company, the healthcare providers and the attorneys. Each has a distinctive role in this very complex system. Patient advocates who may become involved in this system must make sure they understand the system and follow the rules outlined by the state. Working with the claims adjustor in a collaborative manner is crucial.

The goal for all involved in a workers’ compensation claim is for professionals involved to coordinate prompt, appropriate medical care with an end-focus of returning the individual to gainful employment.

Patient advocates who work with employers can also assist the employer and their employees to prevent further injury by promoting safety in the workplace.
Section 3: Utilization Review...In Review
Today, a major theme in the healthcare reform talks is how to ensure consumers have access to safe, quality, evidence-based care in the least restrictive setting for the most cost-effective price. Most payers have a team of professionals whose main job is to ensure that services, products, admissions and continued stays in hospitals and rehabilitation centers meet clinical guidelines in order to continue services. This chapter will discuss the history of utilization management and explain the processes so patient advocates can be aware when working with clients.

Background

The debate on rising healthcare costs has been going on for years. The discussion first gained the full attention of the healthcare industry in 1972, when an amendment to the Social Security Act created the Professional Standards Review Organization (PSRO). The purpose of this organization was to involve local practicing physicians in ongoing professional peer review and evaluation of healthcare services delivered under Medicare.

To avoid sanctions by Medicare, hospitals supported PSRO committees as a means to address the appropriateness of services delivered and whether acute care days were justified. Registered nurses were put into positions to review the same information that the PSRO committee would review if a site inspection were to occur.

The goal was to anticipate cases that might be denied or investigated, and work with the physicians to provide necessary documentation to justify services. The nurses performing the PSRO functions, and the departments created to oversee this process in each hospital became known as the utilization review (UR) department. Ironically, despite the fact that UR became an active department throughout hospital systems, Congress was dissatisfied with the results. The PSRO was later replaced by Peer Review Organization (PRO). In 1982 the PRO was replaced by the Quality Improvement Organizations (QIO). This organization is still in place today and is funded by Congress.

The QIOs have a specific scope of work they are mandated to report on an annual basis. QIOs can be found in each State and can be a resource for patient advocates. (www.cms.gov/QualityImprovementOrgs)

In an attempt to further decrease Medicare costs, Congress enacted the Prospective Pay System in 1983. This measure significantly changed Medicare reimbursement from a fee-for-service system to services reimbursed on a pre-determined fixed price formulated through diagnostic related groups (DRGs). A Medicare pricing formula was established for 492 specific diagnostic categories. DRGs became a source of huge discussions in UR departments, as well as in the offices of chief financial officers. The financial implications of the DRG payment system caused hospitals to critically look at how care was provided to address long-term financial viability. For the first time, hospitals became accountable to treat patients who fell into a given DRG at a pre-determined cost, despite the length of time the patient remained in the hospital. Hospitals soon identified four primary ways in which costs of a DRG could be reduced:

- Reduce the price paid for resources.
- Reduce the length of stay.
- Reduce the intensity of service provided.
- Improve the efficiency of the service delivered.

Hospital administrators began to analyze each department as cost centers that could impact the total delivery cost of a specific DRG. The UR department played a large role in this determination. Utilization review nurses were pressured to reduce lengths of stay by taking an active role in the management of resources. They were expected to ensure that any diagnostic test performed on a Medicare patient had a medical reason for being performed. If there was no clear rationale provided in the medical record, the physician who ordered the diagnostic test was questioned regarding its appropriateness. To improve efficiency, if diagnostic tests were not performed in a timely manner, supervisors of the department were held accountable. Further, as soon as diagnostic reports were available and placed in the patients’ charts, the
Section 3: Utilization Review...In Review

utilization review nurse would call the physician to discuss the results and ask for the next step in the treatment plan.

This change in patient management caused an adversarial relationship throughout the entire healthcare system, but was justified by administration as a means to remain financially viable. Meanwhile, many hospitals took active steps to diversify their case mix so they would not rely solely on the Medicare population.

Commercial insurance carriers were following the direction that Medicare had started, and were beginning to look at the cost of care. Initially, they did this by retrospectively reviewing records, using their own utilization review nurses to match cost with care. If charges did not match the documentation in the medical record, payment was denied by the payer. In addition to retrospective review, they began sending nurses into hospitals to follow patients while they were hospitalized; this is called concurrent review. Many payers also sent in nurses or had their in-house nurses call the hospital utilization review department for an update on the progress/lack of progress the patient was making. If the patient did not meet criteria to remain in the hospital, the physician was pressured to produce documentation to justify the hospital stay. If adequate documentation was not received, payment for a portion of the hospital stay was deducted from the payment. Eventually, this practice also spread to other provider settings, such as home care, skilled care facilities, and post-acute programs.

In time, the industry realized that focusing solely on the cost of care was not the most efficient way to manage resources, and jeopardized quality and continuity of care. Thus, the focus of utilization review was broadened to focus more attention on utilization management (UM) of resources that would include quality of care and resource allocation in an attempt to improve services, and to reimburse for services.

Today, both payers and providers of healthcare services have various models, levels, and processes of utilization management in place to ensure attention is given to resource management, cost-effectiveness and quality. Some blend utilization functions into case management, while others keep utilization management and case management as separate and distinct departments. Those professionals, who have been involved in the healthcare industry for some time have witnessed what started as a subtle change and now understand the monumental paradigm shift that has occurred over the years.

While utilization management continued to retrospectively address escalating healthcare costs through the 1980s and early 1990s, the practice of case management was gaining attention as a proactive approach to cost, quality and access to appropriate services. Many payers were experiencing success when case managers worked with catastrophic patients, and believed that case management could be equally effective for patients with lesser acuity. By assigning patients to case management services early on and addressing their course of care in a proactive fashion, admissions were being avoided, resources were being used less frequently, and patients were reporting greater satisfaction.

Payers and providers alike began to define and redesign a blended model of utilization management and case management. By integrating principals of utilization management and case management, providers and payers found that they could independently and collaboratively manage both the benefits and the patients without compromise of one or the other. This occurred using retrospective monitoring of resources used by the majority of plan members through the utilization management approach, and proactive monitoring of high cost, high acuity plan members through case management.

Utilization management has broadened to include a process still used today – providing a stepping stone into case management. Through the use of ongoing monitoring, patients who have repeat admissions, those who experience major setbacks to their conditions, or have social problems that impede adherence to the plan of care are most often triaged by the utilization nurse to the case manager or a disease manager. The case manager’s first role is to do a comprehensive assessment so that an individualized plan of care could be developed to address issues and make recommendations to the plan of care. The ability to do this has evolved further with the sophistication of IT systems that provide risk stratification and patient identification.

As the population ages and scientific advances allow people to live longer, controlling chronic illness and complications inherent to the aging process will become more critical. The emergence of disease management has enabled medical professionals to understand disease processes and to provide specific interventions geared to effectively control disease processes. Blending principles of disease management, utilization management and case management provides payers and providers with a three-pronged approach to medical management across the continuum of life. The blending of these distinct principles will continue to evolve over time. In addition, healthcare professionals must have a clear understanding of how healthcare services are reimbursed so they can meet the requirements of each pay system.
Provider Networks

Managed care organizations and other types of reimbursement systems have rules that members need to comply with in order to ensure services are covered under their specific insurance policy. Patient advocates need to read the member handbook when they become involved so they also are familiar with the process as they work with clients.

“Patient advocates need to read the member handbook when they become involved so they also are familiar with the process as they work with clients.”

In order for the managed care organization to ensure they can provide quality services and control costs, provider’s networks are set up. Members are informed as to who they can use when medical care is needed. Several factors are taken into consideration when a network considers its list of providers. Providers seeking to join a managed care organization’s network must meet certain criteria and standards. Standards may be set by the managed care network, by a state legislative agency if the state mandates that managed care networks exist, or by an accreditation organization. All requirements are outlined in a provider contract that providers must sign.

All hospitals, insurance companies and other entities that contract with providers have processes in place to review each provider before they become part of their network or organization. This is called the credentialing process. During this process, the managed care organization will want to ensure that a provider has a valid license to practice, has adequate liability coverage in case of a lawsuit, has a DEA number so they can prescribe medications and narcotics, have an office where patients can go for care and possess Board Certification in their specialty. In addition, there are checks through national databases to know if the provider has had lawsuits or sanctions by Medicare. If there are any issues that are found during the review process the provider must provide documentation of the case and explain his/her part. A committee of peers reviews the information to determine if the issues are severe enough to question the provider’s ability to provide quality care. If the committee finds that the issues are severe, the provider may be barred from participating in that network. This is a consumer protection process. On the other hand, if the committee finds the issues not to be severe to question the provider’s ability to practice safe medicine, they will be allowed in the network.

These requirements are necessary to ensure that the providers in the network follow the standards set by the managed care organization and by imposed legislation. Policies and procedures are usually reviewed on an annual basis when provider contracts are renewed. Once a contract is signed, the provider can begin to serve members in the managed care organization. Patient advocates have a responsibility to monitor the care provided. If care is not up to the expectations they can file a grievance against the provider through the Network Development department of the managed care organization or the organization they work for. Likewise, patients can also file grievances against network providers.

DENIALS AND APPEAL PROCESS

Managed care has been difficult for many providers and consumers to understand and adapt to over the years. This is mainly because many of the rules and regulations implemented by managed care organizations are viewed as roadblocks to prevent access to needed medical care. The essence of the managed care concept is to provide care to members of an organization in a timely manner using providers who appropriately manage access to care while ensuring quality and cost-effectiveness.

For the providers to ensure proper utilization there are national guidelines set up that payers and providers must follow. Documentation to ensure the patient meets the guidelines is important as it is the evidence the payers use to determine if a service is needed. If the documentation does not meet the guidelines, the treatment can be denied.

Provider case managers need to be alert to this, and remember that they hold many of the answers to questions that the managed care organizations require. If the utilization management department of a managed care organization denies an admission, a day, a treatment, or a procedure, the provider and the patient have a right to “due process,” and can appeal the decision.

Many states, as well as the accrediting organizations, require managed care organizations to inform members and providers that they have the right to an appeal, and to provide information regarding the appeal process as well as the criteria that was used to evaluate the claim/denial. When an issue arises that the provider or member does not agree with, an appeal can be made to the managed care organization, asking for reconsideration of the decision.
There is also a process that patient advocates can encourage providers to take advantage of if a denial does occur; it is called a peer-to-peer call. This is when the treating physician talks directly to the managed care medical director about the case and why they are ordering a test, keeping the patient at the current level of setting or requesting additional testing/therapy. Many times after the peer-to-peer discussion the payer will reverse the denial as they have the additional information they need to approve the service. Unfortunately many providers do not take the time for the peer-to-peer discussion because they are busy.

Managed care organizations, as part of their structure, are required to establish policies and procedures to handle both appeals and grievances. Each managed care organization has a department specified to process appeals and grievances. Providers also have departments that respond to denials and compile the documentation to support the request.

An appeal is a formal method of lodging a disagreement over a claim payment or benefit denial. Once an appeal is filed, the managed care organization is obligated to answer the appeal within a certain period of time. In the case of precertification denials or appeals, the time period to make a decision is shorter.

If a provider feels there is an urgent need for treatment and the request is denied, the provider must notify the payer that an appeal is urgent, so that the process can be expedited.

When appealing a claim, it is important that the medical documentation supporting the need for the service or procedure be provided. In addition to the appeal process within each managed care organization, most states also require an external review process (ERP) to allow consumers and providers an opportunity to challenge the payer’s denial of medical coverage. The external review process provides an opportunity to have a third party, independent of the managed care organization, examine the file of a denied claim to render an opinion. To initiate an independent review claim, the provider or patient must have a written notice from the payer that a claim is denied. The information is then turned over to the state insurance commissioner’s office and a medical specialist, certified in the healthcare field pertinent to the denial, will review the claim. The specialist has the authority to determine whether the medical claim should be covered. If the decision is in favor of the claim, the payer must cover the claim.

**Grievance**

In addition to the appeals process, managed care organizations are required to set up a process whereby providers and members are able to voice complaints or grievances. A grievance is a formal method of lodging a complaint with the managed care organization. Of note is that grievances can be filed by the managed care organization against a network provider, or by the network provider against the managed care organization, or by a patient regarding the managed care organization and/or the network provider.

“Patient advocates should be aware of each individual payer’s utilization processes, so they can follow the rules as well as ensure the payer is following their own policies.”

Grievances can be filed when there is a problem or an issue that causes a delay in care, or other care-related issues that the managed care member or provider may have. Some of the reasons that a grievance may be reported include timeliness of claims handling, an unprofessional experience with a network provider, a problem with a provider’s office staff, a delay in treatment or service caused by the managed care organization due to the untimely approval of a service, or a product/service that is medically necessary and is not a covered benefit.

Filing a written grievance gives the managed care organization a formal opportunity to address the problem and rectify the situation. If a provider or a member takes the time to file a grievance, the managed care organization is obligated to respond in writing regarding what action was taken to correct the situation.

This process also is similar for provider organizations, specifically hospitals, rehabilitation centers, skilled care facilities and other organizations that provide care for patients. Patient advocates can assist their clients in filing complaints and grievances as needed.

**AUTHORIZATION AND CERTIFICATION**

Utilization management is achieved through prospective, concurrent, and retrospective review techniques. Patient advocates should be aware of each individual payer’s utilization processes, so they can follow the rules as well as ensure the payer is following their own policies. Generally
these are the type of processes that take place in most management care models.

**Preauthorization Review**

Preauthorization or pre-admission review is performed before a product is provided or a service is started. Pre-admission review is used to ensure that the procedure or service is medically necessary to meet the needs of the patient as outlined by national guidelines and compared to the documentation submitted by the provider. Once this review is done, a decision is rendered; in most cases, this ensures payment for the requested service. As noted above, if a denial is rendered the provider has an opportunity to appeal the decision.

**Concurrent Review**

Concurrent review is a process used to review the continuation of a service that a patient may be receiving, such as a continued hospital stay. It occurs concurrently with the services/products being delivered to ensure that eligibility criteria for the service/product continue to be met. Concurrent review is most common when a patient is hospitalized, is in a rehabilitation facility, or receiving care on an outpatient basis such as physical therapy. To certify a continued stay, the provider needs to present documentation that supports the level of care or the services being provided and the patient's response. Depending on the outcome of the review, a decision is made and, if approved, the next review date will be provided for the next review.

If the continued stay is denied and the multidisciplinary team feels strongly that it is in the patient's best interest to remain, objective documentation to support the need must be provided. If the request is denied again, an appeal can be made, or the alternative plan can be put into place. Detailed documentation regarding all discussions and documentation should be incorporated into the patient's chart.

**Retrospective Review**

A retrospective review is performed after care or service is provided. Retrospective reviews can be viewed as part of the continuous quality improvement process that both the provider and the payer use to improve services. Many managed care organizations have reduced or eliminated the precertification process, but are looking retrospectively to see how providers have managed the care of its members. Providers use retrospective reviews to see how they could improve the care provided, especially if it was a complex case or there were issues that prolonged or complicated the case. If the payer or the provider is seen as an outlier or identifies issues that could have been handled differently, processes can be reviewed and process improvement plans can be put into place to improve the system. Retrospective review paints a picture of what occurred, and allows both payers and providers to determine potential changes that can be made to promote continuous quality improvement.
Section 4: Coding Is Everything: CPT, ICD-9-CM, and EOB
Section 4: Coding Is Everything: CPT, ICD-9-CM, and EOB

Coded Is Everything: CPT, ICD-9-CM, and EOB Analysis

By Andrew Dean, CPC, CPAR, PAHM, PHIAS

Most practices don’t realize how much they can learn from studying their EOB’s (Explanation of Benefits, formerly called Provider Remittance Advice) more closely. Study of your current and historical EOB’s to look for coding, billing and reimbursement patterns can be used to help improve your operational efficiency, productivity and revenue.

If you could cover how to read a bill, what the codes mean (you don't have to list them all – just the most common for the area of medicine or specialty involved) just review what CPT (Current Procedural Terminology) and ICD-9-CM (International Statistical Classifications of Diseases Clinical Modification) codes are and why there used, one would understand the impact they have on bills. It is also beneficial to explain what is coming with ICD-10 and how that will change the system for all. It is also important to review bills, as mistakes happen, and if you have questions , to know who to ask: the provider, the insurance company, and/or a certified coder; these are your best resources. Also, this is where you can bring in the patient advocate and the role the professional coder/billing specialist would be useful to help interpret/correct bills.

It really starts with asking the right questions. For example:

➤ What coding errors cause the highest number of rejections with commercial payers?
➤ Do you have charges billed to Medicare carriers where the carrier disallows everything?
➤ Are you getting a higher than normal number of claims denied as duplicates?

The answers to these and dozens of other questions can help to greatly improve your practice revenue.

As anyone who has tried to decipher a health plan's EOB knows, coding is everything. That's where many errors occur; if the CPT code that describes the medical service or test you received doesn't correspond to the ICD-9-CM code that describes your diagnosis, your claim may well be denied, a decision that will probably be communicated via a “rejection code” on the EOB.

Medical services aren't the only thing that must be in sync with the diagnosis: The CPT code needs to correlate with age and sex as well. In other words, if the CPT code is for a routine physical for an adult, but the patient is a 10-year-old child, the claim will be denied.

Sometimes, claims that appear to be denied because the treatment isn't appropriate – a particular service isn't considered “medically necessary,” for example, or is deemed “experimental or investigational” – are actually coding errors, say experts, because the diagnosis code is wrong, for example.

One cannot prevent providers from miscoding care or insurers from misinterpreting your plan or eligibility 100 percent of the time, but the provider or insurer cross-references the treatment with the diagnosis and make sure the two are in sync.

Why focus on these coding issues?

AMA: Eliminating claims errors would save $17 billion annually

Claims-processing errors among commercial insurers add an estimated $17 billion in unnecessary administrative costs to the healthcare system annually, according to the AMA, which released its fourth annual National Health Insurer Report Card in conjunction with the group's annual delegates meeting in Chicago.

The 2011 report card is based on a random sampling of about 2.4 million electronic claims for approximately 4 million medical services submitted in February and March 2011 to Aetna, Anthem Blue Cross Blue Shield, Cigna, Health Care Service Corp., Humana, the Regence Group, UnitedHealthcare and, for comparison, Medicare, according to the AMA. The claims were gathered from
more than 400 physician practice groups in 80 medical specialties in 42 states. The average claims-processing error rate for the six commercial insurers that were analyzed both in 2010 and in 2011 was 19.3 percent this year – an increase of 2 percent over last year. That increase is expected to add $1.5 billion in administrative costs over the course of this year, according to the AMA. The AMA estimates that eliminating this 20% error rate among health insurers would save $17 billion.

“Claims-processing errors by health insurance companies waste billions of dollars and frustrate patients and physicians.”

Claims-processing errors by health insurance companies waste billions of dollars and frustrate patients and physicians. To encourage a more efficient claims payment system, the AMA’s National Health Insurer Report Card provides an annual check-up for the nation’s largest health insurers and benchmarks the systems they use to manage, process, and pay claims. Key findings from this year’s report card include:

**Insurer Non-payment.** Physicians received no payment at all from commercial health insurers on nearly 23 percent of claims they submitted. There are many reasons a legitimate claim may go unpaid by an insurer. Claims may be denied, edited or deferred to patients. During February and March of this year (2011), the most common reason insurers didn’t issue a payment was due to deductible requirements that shift payment responsibility to patients until a dollar limit is exceeded. Real-time claims processing would save time and money.

**Denials.** Dramatic reductions in denial rates have occurred since last year at many insurers; however, lack of patient eligibility for medical services continues to be the most frequent reason for denials.

**Administrative Requirements.** For the first time, the report card measured how frequently claims included information on insurers requiring physicians to ask permission before performing a treatment or service. In a November 2010 survey, the AMA found that policies that require physicians to ask permission from a patient’s insurance company before performing a treatment negatively impact patient care. This was the first national physician survey by the AMA to quantify the burden of insurers’ preauthorization requirements for a growing list of routine tests, procedures and drugs.

According to the November 2010 AMA survey, 78 percent of physicians believe insurers use preauthorization requirements for an unreasonable list of tests, procedures and drugs. The AMA’s survey of approximately 2,400 physicians indicates that health insurer requirements to preauthorize care has delayed or interrupted patient care, consumed significant amounts of time, and complicated medical decisions. Highlights from the AMA survey include:

- More than one-third (37%) of physicians experience a 20 percent rejection rate from insurers on first-time preauthorization requests for tests and procedures.
- More than half (57%) of physicians experience a 20 percent rejection rate from insurers on first-time preauthorization requests for drugs.
- Nearly half (46%) of physicians experience difficulty obtaining approval from insurers on 25 percent or more of preauthorization requests for tests and procedures.
- More than half (58%) of physicians experience difficulty obtaining approval from insurers on 25 percent or more of preauthorization requests for drugs.
- Nearly two-thirds (63%) of physicians typically wait several days to receive preauthorization from an insurer for tests and procedures, while one in eight (13%) wait more than a week. More than two-thirds (69%) of physicians typically wait several days to receive preauthorization from an insurer for drugs, while one in 10 (10%) wait more than a week.
- Nearly two-thirds (64%) of physicians report it is difficult to determine which tests and procedures require preauthorization by insurers. More than two-thirds (67%) of physicians report it is difficult to determine which drugs require preauthorization by insurers.

Preauthorization policies deliver costly bureaucratic hassles that take time from patient care. Physicians spend up to 20 hours per week on average just dealing with pre-authorizations. Studies show that navigating the managed care maze costs physicians $23.2 to $31 billion a year.

The National Health Insurer Report Card is the cornerstone of the AMA’s Heal the Claims Process campaign. Launched in June 2008, the campaign’s goal is to spur improvements in the industry’s billing process so physicians and patients are no longer at the mercy of a chaotic payment system.
Section 4: Coding Is Everything: CPT, ICD-9-CM, and EOB

15 Most Common Reasons for Rejected Claims Found on EOBs

(Exact rejection codes vary for each payer/insurer; consult the carrier for a legend of the rejection codes they use.)

Some of the more common causes of claim rejections are:

➤ Errors to patient demographic data / Incorrect patient identifier information.
  ➤ Name spelled incorrectly.
  ➤ Date of birth doesn’t match; age, sex, or address is incorrect.
➤ Errors to provider data: No referring provider ID or NPI number.
➤ Incorrect patient insurance ID: Subscriber number missing or invalid.
➤ Patient no longer covered – policy is not up to date / coverage terminated.
➤ Incorrect, omitted, or invalid ICD or CPT codes.
➤ Treatment code doesn’t match the diagnosis code.
➤ Incorrect modifiers.
➤ Lack of pre-authorization or lack of referral verify insurance benefits prior to services being rendered.
  (You can attempt to file an appeal but most insurance carriers will not reverse their decision for failure to pre-certify.)
➤ Incorrect place of service code.
➤ Lack of medical necessity.
➤ No response to request for medical records.
➤ Services non-covered.
  ➤ This is another reason why it is important to contact the patient’s insurance prior to services being rendered. It is poor customer service to bill a patient for non-covered charges without making them aware that they may be responsible for the charges prior to their procedure.
➤ Coordination of Benefits.
  ➤ Other insurance is primary.
  ➤ Missing EOB.
  ➤ Member has not updated insurer with other insurance information.
➤ Bill Liability Carrier.
  ➤ If the claim has been coded as an auto or worker-related accident, some carriers will refuse to pay until the auto or worker’s compensation carrier has been billed.
  ➤ Timely filing.
  ➤ Be aware of timely filing deadlines for each insurance carrier.

Other Causes of Medical Billing Errors

Superbills that are difficult or impossible to read for the employee(s) responsible for entering the information into the practice management system. (If the provider is not readily available to answer questions and clarify, sometime it is up to the employee to determine.)

Getting up-to-date patient information. When a patient checks in, that's the time to ask if there are any insurance changes, address changes, etc. The front desk employees play an extremely important role in the reimbursement process.

“The easiest way to increase claim payments is through prevention.”

Untrained or inexperienced employees. Many providers don’t see the need to pay well for certified, experienced coders. For this, they get untrained and inexperienced employees who are not proficient on using the practice management software or the insurance claim process. Hiring more mature and experienced staff may cost a little more, but it's money well spent, and that's true also for a healthcare billing service.

Charges are not posted. Many providers don’t realize the importance of posting insurance and patient payments for successful healthcare claim processing. If insurance payments are not posted, you can’t bill patients for the remaining uncovered yet eligible charges, copays or coinsurance, nor can secondary claims be created.

All of this adds up to a lot of money. A provider also frequently doesn’t know how the practice is performing financially. Without posted payment information, you can’t run the reports necessary to show accounts receivable, outstanding claims, which insurance companies are paying, what they are denying – all critical information for a practice.

Medical Billing Practices to Prevent Billing Errors

Probably the easiest way to increase claim payments is through prevention.
➤ Submitting a clean claim the first time without any errors: If information is difficult to read or doesn’t look right, go back to the originating documents such as the superbill or patient insurance card.

➤ Have the front office employees ask each patient as they sign in for any changes in insurance or patient info. Getting this information after the claim has been rejected is a lot more time-consuming and difficult.

➤ Most clearinghouses or practice management software will catch any obvious errors such as missing or invalid information, but they don’t have the capability to catch coding errors. Double check claims when entering.

➤ Make sure the EOB’s are being interpreted correctly. This takes experience and training. Many uncertified medical coders do not know how to interpret the sometimes cryptic codes and messages the insurance payers provide on the EOB for denied or unpaid claims.

➤ Use your practice management software to routinely run reports. Most all health insurance claims and practice management software have reporting features that allow you to analyze your accounts receivables and unpaid claims. Look for the percentage of claims that are being denied, what the most common reasons are for denial, and the insurance companies that are the most troublesome.

➤ The sooner you follow up on a claim, the more likely it is to be paid. In healthcare claim processing time is an enemy to getting denied claims paid. Most insurance payers have timely filing limits to getting paid, which differ from payer to payer, so identifying problems and resolving them promptly is important.

Resolving many denied or unpaid claims requires actually calling the insurance company. This can be a very time-consuming effort. Especially when you have to work through phone menus that require you to enter insurance ID’s, provider ID’s, dates of service, etc.

Many reoccurring health claim processing errors fall into the “80/20” rule, which means that 80 percent of your problems are caused by 20 percent of the coding. When processes or employee issues are identified as the root cause of the medical billing errors, it’s important to communicate this to the billers and coders. Likewise, asking for their input from the beginning can be a valuable way to identify and improve healthcare claim processing. Many times, the billing functions are handled by the newer and inexperienced employees who lack the experience and training for such an important function. Some time spent one-on-one in training or enrolling them in training is money and time very well spent. It’s important the coding and billing processes are well defined and understood by everyone involved in the process – if it’s a few people in a small practice or several in a large, multiprovider one.

**Appeals**

Some denied claims require an appeal letter to be submitted. This letter should clearly communicate why the denied charges should be reconsidered. Be sure to include all the specific claim data and documentation with the appeal. Supporting notes, lab results, and other documentation can be very helpful in backing up your case. Send this by certified or registered mail to ensure it is received by the payer.

Many insurance payers have a representative that can be very helpful for resolving denied claims. Using your local insurer-assigned representative contacts can help navigate the process. If the insurance payer is troublesome, report them to the state insurance commissioner.

It’s a good idea to become familiar with the appeals process described in contracts with the insurance payer. Some payers have specific criteria and time periods for appealing claims. If you need to submit a corrected claim because of typographical errors, incorrect provider or patient information, identification numbers, or ICD-9-CM & CPT codes, note on the claim that this is a corrected claim when sending via paper or attach a letter stating what the corrections were. Many insurers require adjustment codes to previously submitted claims and will reject new, corrected claims as duplicates.

**Healthcare Claim Processing Errors by Insurance Carriers**

Even when “clean” claims reach the insurance company, that doesn’t guarantee they will get paid. The American Medical Association has determined that insurers’ electronic healthcare claim processing accuracy ranges from 73
percent to 88 percent, depending on the payer. This is due to a lack of healthcare claim processing standard require-
ments - they vary with insurer. Some insurers use unfair practices and cumbersome appeals processes, which con-
tribute to reduced provider payments. The AMA estimates that physicians spend up to 14 percent of their income deal-
ing with health insurer requirements.

In summary, healthcare claim processing and medi-
cal billing errors are inherent given the complexity of the process and the players involved. Identifying prob-
lems early and addressing them promptly and ag-
gressively can save a practice significant lost income.

In recent years, Andrew Dean served as Program Coordi-
nator for a neuroimaging lab at the University of Alabama (UAB) School of Medicine in Birmingham, where he created information resources for patients while improving revenue through creation of a prior-determination insurance review process for technologies that were considered investigational/experimental. Additionally, Mr. Dean implemented claim de-
nial review processes to reduce denials through EOB (Expla-
nation of Benefits) Analysis, reviewing all debt in his depart-
ment prior to collection.

Before his tenure at UAB, Mr. Dean graduated from the Un-
iversity of Alabama with a B.S. in 1994, after which he entered the corporate insurance industry, where he was quickly pro-

toted to Sr. Data Analyst before entering healthcare admin-
istration in 2005.

Mr. Dean has also been recently been elected as Treasurer for the Birmingham, Alabama Chapter for the 2011 calendar year, where he has spoken on Revenue Cycle Management and is co-
organizing of the Chapter’s Annual Conference in August 2011.

Andrew has completed these certifications: AAPC CPC and the HFMA CPAR. Andrew has also completed designations from America’s Health Insurance Plans: Professional, Academy of Healthcare Management (PAHM) and Professional, Health Insurance Advanced Studies (PHIAS). He now serves as a healthcare consultant.
Section 5: The ICD Coding System: From the Beginning to Now
The ICD Coding System: From the Beginning to Now

By Bonnie Schreck, CCS, CPC, CPC-H, CCS-P

While three centuries have contributed something to the scientific accuracy of disease classification, there are many who doubt the usefulness of attempts to compile statistics of disease, or even causes of death, because of the difficulties of classification.

History of the International Classification of Diseases

The International Classification of Diseases (ICD) had its beginning in the late 1800's. Starting from the International Statistical Institute and its meeting in Vienna in 1891, this meeting was led by Jacques Bertillon, the Chief of Statistical Services for Paris, who charged a committee to prepare a classification of causes of death. This committee created a report, which was based on the classification of causes of death used by the city of Paris (with other European influences) and was adopted in Chicago in 1893.

This was first called the Bertillon Classification of Causes of Death and received approval and was adopted by several countries and cities. In 1898, when meeting in Ottawa, Canada, the American Public Health Association recommended the adoption of the Bertillon Classification and that the classification be updated every 10 years.

At the First and Second International Conference to revise the Bertillon Classification, a corresponding list (classification of diseases) to the classification of cause of death was adopted and revised. Based on these revisions, the English translation of the International Classification of Causes of Sickness and Death was published by the United States Department of Labor in 1910. Although more information was included in the listing during the Fourth International Conference, because of the limited expansion of the cause of death list, these revisions only receive minimal acceptance.

The Third, Fourth, and Fifth Conferences were held respectively in 1920, 1929 and 1938. During this time, only few changes were made to the list, although the lists were brought up to date based on the advancement of science.

In 1940, the Surgeon General of the U.S. Public Health Service and the Director or the United States Bureau of the Census published a list of diseases and injuries for tabulation of morbidity statistics. In 1944, based on this list, The Manual for Coding Causes of Illness According to Diagnosis Code for Tabulating Morbidity Statistics was published. This contained diagnoses codes, a list of inclusions, and an alphabetic index.

“Although the transition will be monumental for some healthcare organizations... it is one that will benefit healthcare and advance it into the future.”

At the Fifth International Conference in 1945, a subcommittee was appointed to prepare a draft of a Proposed Statistical Classification of Diseases, Injuries and Causes of Death. After reviewing what other countries had developed, a final draft was adopted, titled International Classification of Diseases, Injuries, and Causes of Death. This draft was circulated throughout the governments involved and changes were incorporated that improved the utility and acceptance of the classification. The committee then assembled a list of diagnostic terms under each classification title and a comprehensive alphabetic index of diagnostic statements was developed.

At the Sixth International Conference in 1948, this classification was adopted. In the same year, the First World Health Assembly (which included the World Health Organization – WHO) endorsed the report of the Sixth International Conference and adopted the WHO Regulations No. 1, which included the use of the Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death (6th Revision). This manual consisted of two volumes, the first one the list of diseases and inclusions, and the second, the alphabetic index.

The International Conference held their Seventh Revision conference under the direction of WHO in 1955. This revision was limited to needed changes and the correction of errors and inconsistencies. In 1965, the Eighth Revision
Conference was held, and more essential changes occurred than in the previous revision, although the basic structure was unchanged. It was during this time that countries provided modifications to the ICD code set for details needed.

In 1975, at the International Conference for the Ninth revision, guided by the WHO, based on the need to adapt a coding system to the needs of countries, the final proposals that were accepted at the Conference stated that ICD-9 should retain the basic structure, but with much additional detail at subcategories and the addition of optional subdivisions and the identification of disease manifestations.

For the Tenth Revision, the involved parties realized the need for a more stable and flexible classification system. It was necessary to experiment with different structures to accommodate these issues to devise a classification that would not require revision for many years. It was here that the World Health Assembly determined that updating the classification every 10 years was too soon because of the necessary evaluation of the most recent Revision and the information gathering necessary to make a thorough assessment of the classification system. Based on the information gathered and comments made, ICD-10 was endorsed in 1990 and in 1994 it came into use by the WHO member states.

Note: All of the International Conferences were part of the decision to update the list of causes of death every 10 years. The revisions of the International Classification of Diseases (ICD) are based on the Conferences (e.g., ICD-10 is the 10th revision).

The United States and ICD-10
The United States is only industrialized country that has not yet transitioned to ICD-10. Although the U.S. has been working on the Clinical Modification (ICD-10-CM – diagnoses) and Procedural Coding System (ICD-10-PCS – inpatient hospital procedures) and now has published a final rule establishing ICD-10-CM and ICD-10-PCS as the new national coding standard. On January 15, 2009, the Department of Health and Human Services (HHS) set an implementation date for October 1, 2013 – a date in which is very unlikely to change.

The National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS) oversee the modifications to the ICD codes, in cooperation with the WHO.

Benefits of ICD-10
There are many benefits to the transition from ICD-9-CM to ICD-10-CM and ICD-10-PCS. Although the transition will be monumental for some healthcare organizations, it is a necessary one, one that will benefit healthcare and advance it into the future, something in which the current coding system cannot do.

More Detail
ICD-10-CM and -PCS offer the capability to update and incorporate new diseases, technologies and procedures. This detail will allow for better quality data and data measurement, which provides more information on tracking disease management care outcomes, and the development of disease management programs that are more effective for patients.

The more granular detail can also improve research. Relationships between diagnoses and other information can be discovered, as well as other data that was otherwise unknown that can improve upon the quality of life and the preservation of resources.

Another area in which will improve is the details related to the classification of diseases. The ICD-10-CM coding system will more effectively describe injuries and how severe they are, as well as assessing the mortality risk and residual impairment.

There is the potential expectation that there will be a reduced need for supporting documentation for claims processing because of the details in the codes themselves.

Health Information Sharing
The United States in the only industrialized nation not using an ICD-10 classification system, so it is difficult to share health data with other countries that are using it. By adopting the ICD-10 system, the ability to share information, especially in crucial times, becomes more timely and effective.

Better Data
The improvement of data based on ICD-10 coding will offer providers and payers clearer and more concise data to develop organizational efficiencies in resource management, performance improvement, healthcare policy decisions, and the monitoring of outcomes. It may also improve the ability for healthcare organizations to forecast health trends and needs.

Reimbursement
The original intent of the ICD coding system was to gather information on morbidity and mortality and not for reim-
burscement. The ICD-10-CM and -PCS systems were built with reimbursement in mind, hence the greater specificity. This will assist in the development and implementation of reimbursement programs, such as the pay-for-performance systems.

The current thought is the ICD-10-CM and -PCS systems will lower the coding error rate, based on a more logically and organized coding system, resulting in fewer rejected claims. Also, the ability to determine medical necessity by comparing reported codes with clinical documentation will prevent claims adjudication.

Preparing for ICD-10-CM and -PCS

There are many different opinions about who, what, when and how to prepare for the ICD-10 transition in October of 2013. An implementation plan that is well managed and well thought out will have a higher success rate and increase the chances of a smooth transition from ICD-9-CM to ICD-10-CM and PCS.

Some of the areas of change will be assessing staff training and education needs, and the allocation of financial investment in systems changes and other resources requirements dedicated to the ICD-10 implementation process, which will be required over the next three years.

The first assessment is to determine a team and/or person in charge of the implementation process. The team leader or charge person can establish which staff members will be affected (directly or indirectly), information systems/technology (IT) requirements, both hardware, software and budgetwise, and what training will be necessary for both coding and IT. To get an idea of the impact this transition will have, the following is a list of individuals and departments that may be affected by the change:

- Coding professionals.
- Senior management.
- Clinical professionals.
- IT department.

Coding Professionals

Coding professionals may be the most affected. Within ICD-10-CM alone, making the leap from a 13,700 diagnostic code set to one that has over 68,000 codes is a daunting task. For hospital coders, not only do they need to make the diagnostic change, but they also need to make the move from 3,800 procedural codes to 72,000 codes in the PCS (procedural coding system). While the ICD-9-CM code systems were much less flexible in accommodating new codes, the ICD-10-CM/PCS code systems have the ability to expand easily with new codes (for new technology and emerging diagnoses and includes more detail), which is why the more extensive number of codes.

Attending educational sessions will be beneficial in becoming more proficient, which may include:

- Webinars.
- Online training.
- Conference presentations.

Coding professionals will need to understand the:

- Structure, and organization of the ICD-10-CM and PCS code sets, which consists of the following training needed to accommodate more detail in ICD-10:
  - Laterality (right and left sides).
  - Pregnancy trimesters.
  - Injuries (e.g., initial and subsequent visits).
  - Combination diseases (physiology).
  - Disease and disorder location (anatomy).
- Medical record documentation requirements.
- Rules and guidelines for CMS and other payer for ICD-10-CM and PCS.

Additionally, other departments can be directly and indirectly affected, such as:

- Other health information professionals.
- Accounting.
- Billing.
- Auditors.
- Patient registrations.
- Data analysts.
- Ancillary departments.
- Compliance offices.
- Quality management.

Senior Management

Senior management will need to be aware of the budgetary considerations and how the implementation process will affect the organizational operations, such as:

- IT systems.
  - 5010 claim form requirements for covered entities (see below).
Section 5: The ICD Coding System: From the Beginning to Now

➤ Accommodating for the new code sets.
➤ Coding productivity and accuracy.
➤ Practice management software updates or replacement.
➤ Training for new codes sets and technologies.
➤ Vendor review to make sure they can accommodate new code sets.
  ➤ ICD-10 solutions.
  ➤ 5010 compliance.
➤ Superbill updates.
➤ Clinical documentation quality.

Clinical professionals
Because some clinical professionals do their own coding, they need to be aware of the impact of the changes between ICD-9-CM and ICD-10. They will also need to attend educational sessions (as listed above under Coding Professional). For those who do not, it is still important that they understand the impact that the change will have on their practices, which include:
  ➤ Documentation practices and the need for documentation improvement for the new coding systems.
  ➤ Implementation processes.
  ➤ Financial impact.

For those medical professionals who work in a hospital setting, the most important factor above is documentation.

Information Technology (IT) Systems
For the IT department, there are many system changes from the ICD-9-CM to the ICD-10 code sets:
  ➤ Larger field needed for larger seven-digit codes.
  ➤ Change from 3- to 5-digit codes to a 3- to 7-digit codes.
  ➤ Change from all numeric to alphanumeric codes.
  ➤ Larger storage space needed for larger code set.
    ➤ From 13,700 to 69,000+ diagnosis codes.
    ➤ From 3,800 to 72,000+ procedure codes.
  ➤ Transition period – need for larger storage space.
    ➤ Systems will need to run both ICD-9-CM and ICD-10-CM and PCS simultaneously.
    ➤ Systems will need to run both 4010/4010A and 5010 simultaneously.

An audit should be performed prior to IT changes to determine the areas needing attention:
  ➤ Internally vs. external application service provider accommodation.
  ➤ Manual vs. electronic import of code sets.
  ➤ Data quality check.
  ➤ Interface of systems.
  ➤ Any reports containing code sets.

Overall, every provider will be affected by the change of code sets that will be coming in October of 2013.

Bonnie G. Schreck, CCS, CPC, CPC-H, CCS-P, has been in healthcare for 25 years. She started in the field in medical records at an HMO, and then worked at a major University teaching facility, billing, coding, ED, outpatient and inpatient visits. She has worked at the AAPC as a coding manager and with two major healthcare data companies, having had responsibility for healthcare coding content. She has also performed many seminars and audits for hospitals and physicians, mainly on ICD-9-CM and ICD-10, CPT and HCPCS coding. Bonnie currently is a Product Manager for VitalWare, where she manages healthcare data content. She is a member of AHIMA and the AAPC.
Section 6: Who’s Who in the Healthcare Team
Who’s Who in the Healthcare Team

Today, there are many people and roles throughout the healthcare system in place to assist consumers and their families in navigating the diverse channels and conduits. Here is a list of “who’s who” on the healthcare team and how these professionals can assist advocates in achieving their work, educating their clients and facilitating their care.

**Behavioral Health Professionals:** Professionals who offer services for the purpose of improving an individual’s mental health or who treat mental illness. Professionals include psychiatrists, clinical psychiatrists, clinical psychologists, social workers, psychiatric nurses, mental health counselors and intensive case managers.

**Case/Care Managers:** Advanced professionals who specialize in care coordination to ensure patients receive safe, quality, cost-effective care. Case managers work in every sector of the healthcare system. The majority of case managers come from the discipline of nursing, but the practice also is made up of social workers, rehabilitation professionals and other disciplines according to the work settings. Case managers work on the payer side as well as the provider side to meet the needs of the patient and family. Patients should feel free to ask for a case manager to assist with meeting their individual needs and to help streamline the care process in complicated cases. Usually there are no charges to the patient for a case manager as the costs are covered by the organization that employs the case manager. Most case/care managers work with patients during episodes of care, like during a hospital stay, for example. There are times when one case manager will work with the patient over multiple settings, but overall a case/care manager will work with the patient in one setting and then hand over to another case manager.

**Certified Disability Management Specialists:** These are professionals who work with clients who are injured or disabled. They can be nurses or other healthcare professionals trained to understand issues surrounding disability. Their goal is to work with clients to assist them in reaching their maximum potential and improving their quality of life. They can be part of the workers’ compensation team or work for a disability management company.

**Certified Registered Rehabilitation Nurse:** Rehabilitation nursing is a specialty practice area within the scope of professional nursing. It involves the diagnosis and treatment of human responses of individuals and groups to actual or potential health problems resulting from altered functional ability and altered lifestyle. The goal of rehabilitation nursing is to assist individuals with disabilities and chronic illnesses in the restoration, maintenance, and promotion of optimal health. This includes prevention of common complications following chronic illness or disability.

**Claims Adjustor:** Professionals who investigate insurance claims by interviewing the claimant, providers, medical records and inspecting property/physical damage to determine the extent of the company’s liability. In workers’ compensation, a claims adjuster is responsible to ensure that the state workers’ compensation laws are followed.

**Clinical Nurses:** Nurses who work in the hospital or other healthcare setting. Nurses can be Registered Nurses (RN) or Licensed Practical Nurses (LPN). Each have specific rules they must follow according to the individual State Board of Nursing. An RN will overseeing an LPN as the LPN cannot work independently but needs someone to oversee their work.

**Geriatric Care Managers:** Advanced practice professionals who specialize in the geriatric population to coordinate healthcare needs but also will assist the patient with their social and financial needs. Geriatric care managers usually are paid for directly by the patient or their family.

**Guardian Ad Litem:** A person who has the legal authority (and the corresponding duty) to care for the personal and property interests of another person. The person can be a child, an adult or the elderly.

**Hospital Patient Advocates:** Professionals who work in the hospital setting who provide a voice for the patient in...
understanding the healthcare system. They also respond to patient complaints and work to address issues to prevent an injury/accident from occurring or to resolve an issue if one does occur.

Hospitalists: Hospitalists are physicians who work in the hospital and manage patients’ care on behalf of the primary care physician. They can also provide teaching, research, and leadership related to hospital care.

Independent Advocates: Professionals who work with clients directly and have no ties to the payer or provider. They provide direction and assist in navigating the healthcare system.

Laboratory Technicians: Professionals who draw blood and perform laboratory testing.

Nurse Practitioners: Also known as NPs, they are advanced practice nurses who provide high-quality healthcare services similar to those of a physician. NPs diagnose and treat a wide range of health problems. They have a unique approach and stress both care and cure. Besides clinical care, NPs focus on health promotion, disease prevention, health education and counseling.

Occupational Therapists: Occupational therapists help patients improve their ability to perform tasks in living and working environments. They work with individuals who suffer from a mentally, physically, developmentally, or emotionally disabling condition. Occupational therapists use treatments to develop, recover, or maintain the daily living and work skills of their patients.

Ombudsman: A person who acts as a trusted intermediary between a person and an organization while representing the broad scope of the interests. An ombudsman can be found in nursing homes, continuing care retirement centers and other settings.

Physicians: Medical doctors who diagnosis and treat patients in all settings, from pre-birth to death. Most physicians see patients according to their training. For example, there could be internists, who are physicians specializing in internal medicine or general medicine. Also there are family practice physicians who work with families.

Physician Assistants: Also known as PAs, they practice medicine under the supervision of physicians and surgeons. PAs are formally trained to provide diagnostic, therapeutic, and preventive healthcare services, as delegated by a physician. Working as members of a healthcare team, they take medical histories, examine and treat patients, order and interpret laboratory tests and X-rays, and make diagnoses. They also treat minor injuries by suturing, splinting and casting. PAs record progress notes, instruct and counsel patients, and order or carry out therapy. Physician assistants also may prescribe certain medications. In some establishments, a PA is responsible for managerial duties, such as ordering medical supplies or equipment and supervising medical technicians and assistants.

Physician Specialists: These are physicians who specialize in various areas such as neurology, cardiology, pediatrics, orthopedics, obstetrics/gynecology, hematology/oncology, etc. Most of these physicians receive referrals from the primary physician.

Physical Therapists: Physical therapists are healthcare professionals who diagnose and treat individuals of all ages, from newborns to the very oldest, who have medical problems or other health-related conditions, illnesses or injuries that limit their abilities to move and perform functional activities as well as they would like in their daily lives.

Radiology Technicians: Professionals who perform diagnostic imaging examinations like X-rays, computed tomography, magnetic resonance imaging and mammography.

Respiratory Therapists: Respiratory therapists are professionals who specialize in working with patients who have airway or respiratory problems. They are commonly found in hospital intensive care units, emergency departments, on critical care transport teams and in the operating room. They also can work in long-term acute care centers (LTACs) and assist with management of complex patients who have chronic medical conditions. Other areas where therapists can be found are sleep diagnostic facilities, cardiac cath labs, cardiac stress testing labs and pulmonary function testing labs. Respiratory therapists are also critical members of the code team and who often perform cardio-pulmonary-resuscitation and work to ensure the patient has an open and functioning airway.

Social Workers: Professionals who assist people by helping them cope with and solve issues in their everyday lives, such as family and personal problems and dealing with relationships. Some social workers help clients who face a disability, life-threatening disease, social problem, such as inadequate housing, unemployment or substance abuse. Social workers also assist families that have serious domestic conflicts, sometimes involving child or spousal abuse. Additionally, they may conduct research, advocate for improved services, or become involved in planning or policy development. Many social workers specialize in serving a particular population or working in a specific setting. In all settings, these workers may also be called licensed clinical social workers, if they hold the appropriate state-mandated license.
Section 6: Who’s Who in the Healthcare Team

**VA Patient Advocate:** A patient advocate is an employee who is specifically designated at each VHA facility to manage the feedback received from veterans, family members and friends. The patient advocate works directly with management and employees to facilitate resolutions.

**Vocational Specialists:** Professionals who provide evaluation services for persons with disabilities or other occupation injuries as well as counseling and case management.

**Wounded Warrior Case Manager:** Professionals who integrate and coordinate care and services for military service men and women injured in the line of duty in order to assist them achieve optimum health or improved functional capability in the right setting.
Billing & Reimbursement Resources

1. **How to read a medical bill?** Trisha Torrey, patient advocate educator, provides a good explanation and examples that patient advocates can use to become better acquainted with reviewing their client’s paperwork. [http://patients.about.com/od/costsconsumerism/ig/Read-a-Medical-Bill](http://patients.about.com/od/costsconsumerism/ig/Read-a-Medical-Bill) and [http://patients.about.com/od/costsconsumerism/ss/readdocreceipt.htm](http://patients.about.com/od/costsconsumerism/ss/readdocreceipt.htm)


3. **Reading and Negotiating Medical Bills.** Many times advocates can negotiate their client’s hospital bill if they do not have insurance or find themselves unable to pay co-payments. This article provides some tips that might be helpful. [http://patients.about.com/od/costsconsumerism/ss/readdocreceipt.htm](http://patients.about.com/od/costsconsumerism/ss/readdocreceipt.htm)

4. **Protecting Credits Scores from the Medical Bill Maze.** Many times due to an illness or an injury, keeping up to date on bills can be a challenge. Not paying medical bills can impact credit scores. Read this article to get some important tips to share with clients. [www.nytimes.com/2010/12/18/health/18patient.html?ref=your-money](http://www.nytimes.com/2010/12/18/health/18patient.html?ref=your-money)

5. **Save Thousands on Your Medical Bills:** Don’t let a big IOU ruin you financially. You have more ways to cut the price than you think. An interesting article from Kiplinger Magazine that advocates can share with their clients. [www.kiplinger.com/magazine/archives/2008/08/save-thousands-on-medical-bills.html](http://www.kiplinger.com/magazine/archives/2008/08/save-thousands-on-medical-bills.html)


7. **80% of Medical Bills Contain Errors:** [www.alzheimersreadingroom.com/2010/03/80-percent-of-medical-bills-contain.html](http://www.alzheimersreadingroom.com/2010/03/80-percent-of-medical-bills-contain.html)


10. **A Patient’s Guide to Medical Records and Codes:** [http://patients.about.com/od/medical-codes/Medical_Codes_101_Helping_Patients_Understand_Medical_Coding.htm](http://patients.about.com/od/medical-codes/Medical_Codes_101_Helping_Patients_Understand_Medical_Coding.htm)