Basics of the Healthcare Professional's Revenue Cycle

Payer View of the Claim and Payment Workflow

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Objective

Explain the claim workflow from the initial interaction through payment reconciliation:

- Eligibility and benefit verification
- Claim Submission
- Claim Status
- Claim Payment
- Patient Collection
- Reconciliation

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About Cigna

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Diversified Product Portfolio

HealthCare

Int'l Health, Life & Accident

Expatriate Benefits

Pharmacy

Disease Management

Behavioral

Dental and Vision

Voluntary

Life and Accident

Disability

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About Cigna

- **CIGNA Corporation:** Leading Global Health Services company with more than 70 million customer relationships worldwide. Cigna's global work force is approximately 30 thousand.
  - ➢ 2011 Revenue from ongoing operations: $22 billion
  - ➢ 2011 Earnings from ongoing operations: $1.43 billion

- **US Healthcare:** National provider of health and wellness services to a variety of business segments.
  - ➢ Strong national franchise of commercial business, strong penetration of large and middle market accounts, serving a diversified mix of employer sub segments
  - ➢ Established specialty capabilities, including dental behavioral, pharmacy, health advocacy and onsite healthcare
  - ➢ Strong expansion into the Individual segment

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- **International:** Global Life, Health and Accident Services
  - Rapidly growing business segment
  - Leading expatriate carrier with the largest proprietary network
  - Over 8 million customer relationships in 200+ countries. 30 countries and jurisdictions with local licenses and business partnerships

- **Group Disability and Life:** Leading disability claims management programs
  - Leader in productivity optimization programs
  - Best-in-class return to work results

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$3.8 billion acquisition of HealthSpring (Aquired January 31, 2012)

- Positioned with leading industry capabilities across life and health stages
- Scaled presence in the attractive Seniors Segment
- Creates added diversification and leverage opportunities with commercial membership

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First Contact

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Eligibility and Benefit Verification

Whether the patient first contact is a scheduled appointment or an urgent walk-in, there are important things that need to be verified:

- What kind of coverage does the patient have?
- What type of plan does the patient have?
- Are there multiple coverages?
- Who is the policy holder?
- Are all services covered?
- What amount is the patient responsible to pay?
  - Upfront patient estimates help educate patients on their portion of the payment before services are rendered.

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Eligibility and Benefit Verification Tools

The tools used to verify Eligibility and Benefits vary widely, such as:

- ID cards
- Payer websites
- Third party websites
- Practice Management Systems
- Clearinghouses
- Interactive Voice Response (IVR)
- Customer Service

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Precertification

- Many plan designs require notification of specific services or supplies, such as inpatient stays, high tech radiology services and some drugs.

- As part of the notification review, a coverage determination and review of clinical information is completed to determine whether clinical guidelines for coverage are met.

- The services that require prior authorization vary by
  - Payer
  - Plan design or product
  - Rendering provider or facility network participation

- If services requiring prior authorization are delivered without obtaining precertification, claims for those services may be denied or reimbursed at a lower rate.

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Claim Submission

Claim Forms

Edit Claim Form

ADA 2002
Denti-Cal
ADA 2000
HCFA-1500
HCFA-1500 preprinted
ADA 2000
DC-217-2007
ADA 2006 (default)
1500
DC-217-2007

Set Default

Reassign

Reassign all insurance plans that use the selected claim form at the left to the claim form below

Advanced Users Only

Add | Export
Delete | Import
Make a Copy

Close

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Claim Submission

- The type of service directs which claim form should be used:

Type of Service	Paper Claim	Electronic Claim
Facility charges	UB-04	837I (Institutional)
Physician charges	CMS 1500 (HCFA)	837P (Professional)
Dental charges	ADA Claim Form	837D (Dental)
Patient claim submission – format varies		

- Some services require additional documentation, for example:
  - Lab results
  - X-rays
  - Pre-op notes
  - Treatment plans

- Most payers have a timely filing requirement from between 90 to 180 days.

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Clean Claim Requirements

Most payers require specific data elements be submitted on the claim for processing, for example:

Patient's ID number	Date of service, or admit and discharge dates
Patient's date of birth	Diagnosis codes (ICD-9, DRG)
Patient's first and last name	Standard code sets (CPT-4, Revenue Code, HCPCS, NDC) and description of procedure
Patient's address	Charge amount for each procedure
If the patient is not the subscriber: Subscriber's name, ID number, and date of birth	Place of service
Name, Tax ID, and National Provider Identifier (NPI) of the billing provider	Prior authorization number, if service required precertification
Name and NPI of the: - Rendering provider - Attending physician - Referring physician	For coordination of benefit claims, claim and payment information from the previous payer
The address of the billing provider	

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Claim Acknowledgments and Status

- Payers validate claims before accepting into their system for processing:
  - Does the claim meet minimal format compliance requirements?
  - Are the codes submitted on the claim current and valid?
  - Are the codes consistent with the age or gender of the patient?
  - Does the patient have coverage that was effective on the date of service or admission?
  - Does the claim meet all of the clean claim requirements?

- A claim acknowledgment can be sent confirming the claims acceptance for processing.
  - If the claim does not pass the initial validations a rejection can be sent.
  - Additional acknowledgments can be sent after verifying claim acceptance:
    - Pend notification
    - Request for additional information

- Most health care professionals have a process to request the status of a claim if it remains unpaid after 15 to 45 days.

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Real-time Claim Submission

Using software, claims can be completed in the office or hospital and sent in real-time to the payer.

- Some payers return an estimate of how the claim will be processed and any patient responsibility amounts.

- Some payers for limited services are able to process the claim in real-time and provide an immediate response on how much will be paid and include patient responsibility amounts.

- These services help
  - Improve patient collections
  - Reduce costs in collection follow-ups

- Payments are not sent in real-time.
  - Health care professionals still wait days to a week for the payment.
  - Additional reconciliation is required once the payment is received.

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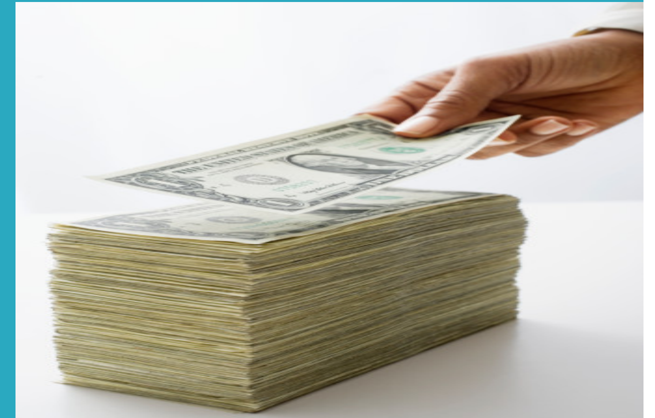
Claim Payment and Reconciliation



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Payment Reconciliation Options*

Paper Check

Returned by mail

Explanation of Payment (EOP)
- *Payments*
- *Denials*
- *Pends*

OR

Returned by mail

Pend Notification Letter

plus

Returned within 24-72 hours of check run

ERA
- *Payments*
- *Denials*

for the payment cycle

Electronic Funds Transfer (EFT)

Returned by mail

Explanation of Payment (EOP)

for the EFT

plus

Returned by mail

Explanation of Payment (EOP)
- *Denials*
- *Pends*

OR

Returned by mail

Pend Notification Letter

plus

Returned within 24-72 hours of EFT

ERA
- *Payments*
- *Denials*

for the payment cycle

*Options may vary by payer

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Payment to Remittance Association

- When receiving EFT and ERA, the payment may not travel with the remittance.
- To reassociate with the remittance with the payment, the health care professional must match the information from the CCD+ Record to the payment information on the Electronic Remittance Advice.

Minimum ACH CCD+ Reassociation Data Elements			**Corresponding ERA (835 V5010) Data Elements**	
CCD+ Record #	**Field #**	**Field Name**	**Data Element Segment**	**Data Element Name**
5	9	Effective Entry Date - date the payer intends to provide funds to the payee via EFT	BPR16	EFT Effective Date
6	6	Amount	BPR02	Payment Amount
7	3	Payment Related Information - payment-related ASC X12 data segments	TRN02 and TRN03	EFT Trace Number and Payer Identifier

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Claim Reconciliation

Once the payment had been associated to the remittance, each claim must be reconciled.

- Does the payment match the expected reimbursement amount? If not,
  - Contact the payer for an adjustment
  - Submit an appeal to have denied charges reviewed

- Was the full billed charge paid?
  - Are there write off amounts?
  - Are there any remaining patient responsibility amounts?
    - Have the patient amounts already been collected?
  - Is there additional coverage that needs to be billed?

- Before the claim can be closed, confirm
  - All responsible payer payments have been received.
  - All open appeals or adjustment requests with the payer have been closed
  - All patient payments have been received or will be written off

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Reconciliation Examples

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Example 1

- Patient has a high deductible PPO plan with $10.00 remaining of their $3000 individual deductible.
- Patient has coverage through a single payer.
- The health care professional billed $125.00
- The PPO plan paid $6.00
- The patient paid $10.00

Procedure Code	Billed Amount	Allowed Amount	Payer Paid	Payer Explanation	Patient Paid
85025	$45.00	$6.00	$0.00	Patient Deductible	$6.00
80053	$50.00	$10.00	$6.00	Patient Deductible	$4.00
80076	$30.00	$0.00	$0.00	Included in another procedure	$0.00
Total	$125.00	$16.00	$6.00		$10.00

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Example 2

- Patient has coverage through two payers
  - Primary payer – $1000 deductible has been met ; coinsurance of 20%
  - Secondary payer –no deductible; coinsurance of 20%
- Health care professional billed the primary payer $1800.00
  - The primary payer paid $650.00
- Health care professional bills the secondary payer and includes the primary payer payment information.
  - The secondary payer paid $568.00
- The patient bill amount is $12.00

Revenue and Procedure Code	Billed Amount	Primary Payer Allowed Amount	Primary Payer Paid Amount	Primary Payer Explanation	Secondary Payer Allowed Amount	Secondary Payer Paid Amount	Secondary Payer Explanation	Patient Paid Amount
750 45378	$1640.00	$650.00	$520.00	Patient Coinsurance	$650.00	$520.00		$0.00
324 71010	$75.00	$0.00	$0.00	Non-covered service, not a medical necessity	$30.00	$24.00	Patient Coinsurance	$6.00
636 J2250	$85.00	$0.00	$0.00	Included in another procedure	$30.00	$24.00	Patient Coinsurance	$6.00
Total	$1800.00	$650.00	$520.00		$710	$568.00		$12.00

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