

Managed Care, Third Party Reimbursement, and Audits

Mark Wright and Roger Kamen

THE EVOLUTION OF MANAGED CARE

During the past 50 years, the financing of health care in the United States has changed drastically. Before the mid-20th century, patients paid their health care providers directly “out of pocket.” There was little, if any, involvement of employers or government in fee payments. Providers set fees, and patients paid them.

In the mid-20th century, primarily because of the impetus of unions, employers began to offer health insurance to employees as a low-cost alternative to salary increases. Insurance companies, which had managed traditional life and property insurance, began offering health coverage. Health insurance programs were modeled after the casualty insurance programs these companies were accustomed to providing. Casualty insurance is an indemnity plan (payment for specific services up to specific amounts), used to protect against catastrophic loss. Health insurance assumed this same indemnity format, at a very low cost to employers offering a group program. In 1965, the federal government became a major player in financing health care with the introduction of Medicare and Medicaid.

Health insurance became more comprehensive as employers and the federal government added additional benefits for their employees. Over time, this low-cost health benefit turned into a high-cost item, which today, continues to strap businesses competing in a global market and a federal government struggling with sizable deficits.

HEALTH CARE REFORM

The federal government has been considering health care reform for many years and it appears inevitable. The US government is facing multiple economic hardships, including a weak economy and tougher competition in the global marketplace. Unemployment adds to the problem because as more people lose their jobs, those same people lose their health benefits and must rely on government aid. With tax revenues declining and budget deficits rising, the federal government is under pressure to reduce the amount of money it spends on health care. In many other countries, health care is provided

by the government at no direct cost to employers. This is called a *single payor system*. Health care reform, however, does not mean that our government is looking to adopt the single payor system. Our leaders seem committed to preserving a system that offers both public and private health care options. The cost to the US government for health care reform is significant, but there may be greater potential cost downstream if something is not done now.

With health care reform inevitable, optometry is expected to serve a greater role in providing primary medical care. National health care leaders are beginning to recognize that an eye examination is one of the most medically beneficial health assessments available. For example, a June 2007 study by Mercer Consulting and the Washington, DC-based Partnership for Prevention, showed that adult eye examinations were deemed to have a higher return on investment than screening for cholesterol, obesity, depression, and hearing abnormalities (available at http://www.prevent.org/images/stories/PDF/whyinvest_web_small.pdf).

Eye examinations are noninvasive and provide valuable insight into diabetic and vascular health, which is an important concept to policy makers considering reform. Other factors to consider include savings and convenience. There is a great cost savings when a patient sees an optometrist for medical eye care services. The patient is able to bypass the traditional managed care model of first seeing the primary care physician and then being referred to a specialist. As for convenience, optometrists tend to be located in all urban, suburban, and rural areas, providing patients excellent access to care.

Optometrists today are well qualified to treat and help patients manage chronic diseases, such as glaucoma, hypertension, and diabetes, up to the scope of licensure allowed by law in the state(s) in which they practice. Optometrists are also relied on to work in cooperation with other medical disciplines to ensure patients receive the comprehensive level of care that is needed. Finally, health care reformers must consider that there is an acute shortage of primary care physicians in the US. In many communities, particularly in rural America, optometrists may be the only primary care provider for miles around.

Health care reform has the potential to direct more managed care patients to optometry, which means that optometrists will be relied on to provide more medical services than ever before. Forward-thinking optometrists today, especially those in independent practice settings, are expanding their scope of practice from the traditional refraction and prescription eyewear business to one that is weighted more toward medical eye care services. Health care reform presents optometry with an opportunity to improve America's health care delivery system, thus ensuring a bright future for the profession.

UNDERSTANDING MEDICAL PLANS

Third-party reimbursement occurs when someone other than the patient directly pays the cost for the health care provided. (Patients pay indirectly in the form of premiums, taxes, and benefits.) Managed care is a health care system that controls the use, cost, and quality of care. It includes both the delivery and financing of health care.

Medicare and Medicaid are the two major federal thirdparty plans. Optometrists are intimately involved in both programs. An understanding of these programs is essential to a practitioner's financial and professional well-being. Because managed care has become more pervasive in these programs, optometrists need to remain vigilant about changes in eligibility and reimbursement.

There are various types of health care plans, including traditional indemnity insurance, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and service plans. Today, there are hybrid programs that cannot be categorized into health plans. In the past, particularly during the period that saw huge increases in health care costs (1970s through the early 1990s), traditional indemnity insurance was the primary health care plan. Most indemnity plans were fee-for-service plans, so that for every service provided, a fee was paid. Under that type of system, providers are actually rewarded financially for performing more and more procedures for patients. There are no controls on cost or use. As long as the patient has a medical problem, the services are covered. One can see how this kind of system promotes utilization and increased health care costs. From that type of environment, managed care has blossomed. HMOs and PPOs became the major types of managed care systems.

MEDICARE AND MEDICAID

The government executes and finances numerous third-party insurance plans that involve optometric participation. These plans include programs such as Medicare; Medicaid; Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); the Veterans Administration; the Department of Defense; the Public Health Service; health departments; Vocational Rehabilitation; the Developmental Disabilities Program; and Maternal, Child Health, and Crippled Children's Services. This chapter focuses on the two most commonly used programs—Medicare and Medicaid.

Although this chapter describes government as a thirdparty financier, it is important to understand that much overlap exists between government (or public sector) and private sector (nongovernment) programs. For example, HMOs are private sector programs with significant government involvement, especially with regard to grants. Medicare and Medicaid are government programs managed in many states by private insurance companies.

Medicare

The Medicare program was authorized by the US Congress in 1965 as Title XVIII of the Social Security Act. Medicare originally provided hospital and medical insurance benefits to persons age 65 and older. Throughout the years, the Medicare program has expanded to include care for people younger than 65 who are blind or disabled or who suffer from chronic renal disease.

Medicare benefits include basic hospital insurance (Part A) and medical insurance for physicians' services (Part B). Part A is financed by universal compulsory contributions. Part B is obtainable on an elective basis. It is partially financed by the government and partially financed by premium payments from enrollees.

Eligibility

The Social Security Administration determines who is eligible for Medicare. To be eligible for Part B, a person must be one of the following:

- 65 years old or older
- Younger than age 65 with permanent kidney inadequacy
- Younger than age 65 and permanently disabled

The Social Security Administration issues a card to all patients entitled to Medicare benefits. To determine whether a patient is eligible for medical benefits (Part B), it is necessary to review the patient's Medicare card. The card identifies the Medicare recipient and contains the following details:

- Name
- Medicare health insurance claim number
- Enrollee's signature
- Date of entitlement
- Kind of benefits for which the beneficiary is entitled under the Medicare policy (Part A, Part B, or both)

It is critical to check a patient's Medicare card at least once a year. Medicare numbers and suffixes can change according to the beneficiary's record of entitlement. Changes are particularly significant in the case of marriage or remarriage.

On claim forms, the name and health insurance claim numbers (HICNs) should be entered exactly as shown on the Medicare card. All claim forms are transmitted to one of nine host sites, where records regarding Medicare eligibility and deductible status are kept. Any mistake in entering the name and HICN on the Medicare Request for Payment form (HCFA CMS-1500) will cause the claim to be rejected because it will not agree with the Social Security register.

Claim Submission

Beginning October 16, 2003, with limited exceptions, Medicare requires electronic submission of claims. The exceptions are:

Exceptions	Unusual Circumstances
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- | | |
|---|---|
| <ul style="list-style-type: none"> • Claims submitted by a 'small provider' (fewer than 10 full time employees for Part B) • Roster billing of vaccinations • Claims submitted to Medicare Demonstration Project • MSP claims with more than one primary payer • Claims submitted by Medicare Beneficiaries • Dental claims • Services furnished outside the United States | <ul style="list-style-type: none"> • Disruption in electricity or phone/communication service for more than two business days • Provider submits fewer than 120 claims to Medicare per year • Non-Medicare Managed Care Organization claims billed for copayments • Employees have documented disabilities that prevent using computers • Other unusual situation documenting that enforcement would be "against equity and good conscience" |
|---|---|

Medicare requires the use of the HCFA CMS-1500 claim form (Figure 34-1) for the submission of paper claims. The claim form is available in a single sheet, a two-part snap-out, and a two-part computer pin-feed continuous form. Optometrists are responsible for purchasing their own claim forms, which can be obtained through the US Government Printing Office or through commercial outlets. Commercial forms must contain the information required by the Centers for Medicare and Medicaid (formerly known as the Health Care Financing Administration [HCFA]) on both the front and back of the form. The current version (12/90) has been in use since 1992. Claim forms must be printed in "drop-out red." (See Chapter 35 for information on completing the form.) The best method for claim submission is electronic, which can be done by using software in the office or by sending claims to an electronic clearinghouse. By statute, electronic claims cannot be paid sooner than 14 days after submission; however, paper claims are paid after the 29th day.

Diagnostic Codes. All Medicare providers must use the Healthcare Common Procedure Coding System (HCPCS) Levels I, II, and III procedures codes for claim submission.

Level I codes are the procedures contained in the *Current Procedural Terminology*, 4th edition (CPT-4), which is revised periodically (Chicago, 2001, American Medical Association). (See Chapter 35 for a description of these codes.)

Level II codes are national alphanumeric codes that supplement the CPT-4 codes. These five-digit codes include services, such as audiology, physical therapy, and vision care, and supplies, such as drugs and durable medical equipment (including frames, lenses, contact lenses, and prosthetic devices). The codes start with a letter (A through V) and are followed by four numbers.

Level III codes are local codes assigned by the local carrier for Medicare. These codes cover procedures not included in the first two levels. The codes begin with a letter (W through Z) followed by four numbers.

Time Limits for Filing Medicare Claims. Claims must be filed by the end of the calendar year after the year in which services are provided. Services provided during the last 3 months of the calendar year are considered, for billing purposes, to be provided in the next calendar year.

Covered Services

Eye examinations by an optometrist (or physician) for the purpose of determining or changing the prescription for eyeglasses or contact lenses are not covered under Medicare. In these situations, the eye examination should be billed to the patient and paid on the day of the examination. Eye examinations are covered in the following situations:

- When performed in conjunction with the fitting and prescribing of postsurgical lenses when the lens of the eye has been removed (aphakia or pseudophakia). (Refractive services are excluded from coverage, even with the diagnosis of aphakia or pseudophakia. Bill the refractive services and collect payment the day of the examination.)
- When performed for a medical condition, diagnosis, sign or symptom, or ongoing care for an existing medical condition.

Therefore eyeglasses or contact lenses that are required to replace a lens removed as a result of intraocular surgery or to replace congenitally missing lenses are covered benefits. Corneal bandage contact lenses are a covered benefit when used as a moist bandage to aid corneal healing, relieve pain, reduce erosion, and improve vision.

Independent procedures are covered benefits when billed with an appropriate diagnosis but require a medical sign or symptom or ongoing care for an existing medical condition as the initial reason for the examination. A sampling of independent procedures includes gonioscopy, extended ophthalmoscopy, external photography, retinal photography, color vision testing, contrast sensitivity testing, ultrasonography, and electrodiagnostic testing.

Claim Payment

Every Medicare carrier is charged with processing claims in accordance with Medicare regulations. No payment may be made for any items or services that is not reasonable or medically necessary for the diagnosis or treatment of an illness or injury.

During each calendar year a deductible (\$135 for 2009) must be satisfied before payment can be made. Bills for services are applied toward the deductible on the basis of incurred medical expenses. The deductible is applied to the approved charge. Noncovered services do not count toward the deductible.

Expenses are allocated to the deductible in the order in which the bills are received by Medicare. Enrollees must satisfy the deductible—regardless of when during the calendar year they became eligible—before they can receive any medical benefits.

After the Part B deductible has been satisfied, Medicare reimburses 80% of the approved charge incurred during the

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or IC) FECA (SSN) OTHER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Vision Joseph A

3. PATIENT'S BIRTH DATE
MM : DD : YY 01 : 02 : 31 M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
2020 Refraction Lane

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY Anytown STATE MI

8. PATIENT STATUS
Single Married Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO
b. AUTO ACCIDENT? YES NO
c. OTHER ACCIDENT? YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER
None

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE 9/1/08

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature on File

14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (MP)
MM : DD : YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE
MM : DD : YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM : DD : YY TO MM : DD : YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM : DD : YY TO MM : DD : YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 250 .50

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24	A	B	C	D	E	F	G	H	I	J	K						
	DATE(S) OF SERVICE			Place of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE					
1	9	1	08	9	1	08	11	3	99245	1	175	00	001				013
2																	
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER 123-45-6789 SSN EIN

26. PATIENT'S ACCOUNT NO. 531

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE \$ 175 .00

29. AMOUNT PAID \$

30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED John O'Dee MD DATE 9/1/08

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)
O'Dee John MD
2020 Vision Street
Insight MI 49000

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 616-555-2020
OE 123-45-6789

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

FIGURE 34-1 Sample HCFA CMS-1500 form used for billing a Medicare claim.

calendar year. The remaining 20% is the responsibility of the patient, as co-insurance. For services rendered on or after January 1, 1992, Medicare payments are based on physician payment reform. The payment methodology reform contains the following three major elements.

National Fee Schedule: For dates of service on or after January 1, 1992, reimbursement for physician services is based on a fee schedule. The fee schedule is based on a resourcebased, relative value scale adjusted by geographic cost differences.

Medicare Volume Performance Standard (MVPS): MVPS is a mechanism for limiting growth in Medicare Part B expenditures.

Beneficiary Protection: Under physician payment reform, the new limiting charge caps the amount that nonparticipating physicians may bill Medicare patients above the fee schedule.

The fee schedule is a relative value scale that is resource based. A relative value unit is assigned to each procedure and is based on the relative amount of provider work (time and intensity), overhead expense, and malpractice expense for the procedure. This unit value (adjusted for geographic location) is then multiplied by a conversion factor (multiplier) to obtain the reimbursement amount.

Medicare Assignment Agreement

Under Medicare law, a physician who accepts assignment is one who accepts the carrier's allowable (approved) charge as the full charge. Medicare will reimburse 80% of this allowable amount if the deductible has been met. The beneficiary is responsible to the physician for the remaining 20%. The beneficiary also is responsible for any portion of the unmet deductible and the full charge for services not covered by Medicare.

For services covered under the assignment agreement, a physician cannot bill the patient the difference between the allowable amount and the actual charge. Medicare law also requires that for an assigned claim, a physician must make a reasonable effort to collect from the beneficiary any deductible amount, as well as the co-insurance. Repeated, willful violations of the assignment agreement can result in fines of \$2,000, up to 6 months of imprisonment, or both.

Medicare rules require that the patient be informed in writing of any noncovered fees before the service or material is provided. If this is not documented in the record with the patient's signature, then the provider cannot bill the patient. The form to use for this documentation is the Advance Beneficiary Notice (ABN) form. It is available on the Medicare Website: www.cms.gov.

Participating or Nonparticipating Provider

Providers are either participating ("par") or nonparticipating ("nonpar"). The par provider must accept assignment for all covered services on all claims. The nonpar provider can accept assignment on a claim-by-claim basis but must stay within the limiting charge. There are incentives given to providers to become par providers. Examples of these incentives include the following:

- Reimbursement that is 5% more than for nonpar providers
- A listing in the directory of providers
- Exemption from limiting charges
- Direct payments (reimbursement) from Medicare
- "One stop" billing for Medigap coverage

Even if the nonpar provider accepts assignment, reimbursement will be based on a 5% lower fee schedule. If a nonpar provider does not accept assignment, the charge for the procedure is subject to a limiting charge. This charge is the maximum amount the nonpar provider is allowed to bill

the patient. Currently, this amount is 115% of the nonpar fee schedule amount.

The Medicare carrier issues an Explanation of Medicare Benefits (EOMB) as the final step in the processing of a Medicare claim. The EOMB is sent to the beneficiary. A copy is not provided to the physician if assignment was not accepted. When assignment is accepted, the original EOMB is sent to the physician, and the beneficiary also receives a copy. If benefits cannot be paid for a claim or if all the benefits are applied to the deductible, the EOMB still will be issued, advising the beneficiary and the physician of the disposition of the claim.

The EOMB gives detailed information on the action taken on the claim. It shows the name of the physician, dates of service, amount billed, amount approved, and total payable amount. It also provides the beneficiary with the current deductible status.

For assigned claims, Medicare uses the Remittance Notice for settlement of assigned Medicare claims. The check sent to the provider often includes payment for several patients. This helps reduce paperwork. Claims are processed on a weekly basis. If there is no reimbursable amount due on the summary statement, the statement is still issued, and it provides detailed information on every claim listed. Each claim line shows the date of service, type and place of service, procedure code, amount billed, and amount approved for payment.

Medigap and Crossover Claims

Medigap is a private, supplemental insurance that is used to fill the "gaps" in Medicare benefits—in particular the 20% coinsurance. Only par providers can take advantage of the single claim submission to Medicare and the Medigap company. With single-claim submission, neither the provider nor the beneficiary needs to file a secondary claim. After the Medicare carrier finishes processing the Medicare benefit, a payment record is sent to the Medigap carrier for the payment of supplemental insurance benefits.

Crossover claims involve an automated process in which Medicare sends an electronic EOMB to the supplemental insurance carrier. This service applies to both par and nonpar providers. The crossover carriers have a contract (fee per claim) to receive this information for their insurees. Medicare and Medicaid crossover claims are an example of this process.

A Medicare and Medicaid crossover claim is a claim for services covered under two separate programs. Crossover claims must contain covered Medicare services provided to a Medicare patient who is also eligible under the individual state Medicaid program. Benefits are paid by both programs on the basis of a single claim. The claim is first submitted to the Medicare carrier and then transferred, or crossed over, to the Medicaid program.

Medicare determines the approved charge for the service, which is established if an annual deductible has been met, and Medicare pays 80% of the approved charge. Medicaid considers payment of any unmet deductible and the remaining 20% of the approved charge.

Medicare and Medicaid crossover claims must clearly identify that the patient is covered by Medicaid for the claim to be crossed over. Many claims do not crossover because the provider does not indicate that the patient is covered under the Medicaid program. The patient should be identified on the HCFA CMS-1500 form as covered by

Medicaid, and a copy of the Medicaid identification card, proof of eligibility label, or eligibility number should be included (Figure 34-2).

For claims to crossover, the provider must accept assignment and the assignment must be checked on the claim form. The claim must include positive identification of the patient's

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APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 12345678A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Vision Joseph A

3. PATIENT'S BIRTH DATE MM DD YY 01 02 31 SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 2020 Refraction Lane

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

8. PATIENT STATUS Single Married Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER None

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (MP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

LINE	A		B		C	D	E	F	G	H	I	J	K
	DATE(S) OF SERVICE FROM MM DD YY	TO MM DD YY	Place of Service	Type of Service									
1	9 1 08	9 1 08	11			99213	1	28 00	001				013
2	9 1 08	9 1 08	11			92015	1	10 00	001				013
3													
4													
5													
6													

24. FEDERAL TAX I.D. NUMBER 123-45-6789 SSN EIN

25. PATIENT'S ACCOUNT NO. 531

26. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

27. TOTAL CHARGE \$ 38.00

28. AMOUNT PAID \$

29. BALANCE DUE \$

30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) John O'Dee MD DATE 9/1/08

31. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 2020 Vision Street, Insight MI 49000

32. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 616-555-2020

33. SIGNATURE OF AUTHORIZED PERSON Signature on File

34. SIGNATURE OF AUTHORIZED PERSON Signature of File

35. DATE 9/1/08

36. DATE 9/1/08

37. PRN GRP 0E 123-45-6789

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-99) FORM CWCIP-1500 FORM F18B-1500 #19423 - ©2003 - Medical Arts Press Use with Electronic #14145 approved or #14146 (self-mail)

FIGURE 34-2 Sample HCFA CMS-1500 form used for billing a crossover claim.

Medicaid eligibility. The claim must have paid at least one covered item or must have applied at least one covered item on the claim to the patient's deductible.

Medicare and Medicaid crossover claims should be submitted to the Medicare carrier on the customary HCFA CMS-1500 claim form. Separate billing to the Medicare carrier and to the Medicaid carrier is required when services included on the crossover claim do not automatically transfer for payment. For example, dual billing requirements for eyewear might be required.

Services that are denied or not covered under Medicare but that are Medicaid benefits will not automatically crossover. These services can be billed to the Medicaid program. For example, eyeglasses for a patient who has not had cataract surgery is a noncovered service under Medicare. If the patient is eligible for Medicaid, the eyeglasses should be billed to the Medicaid program. If the provider did not know that the patient was eligible for Medicaid at the time of Medicare billing, the billing will not cross over. Another important example is the fee for refraction. Medicare does not cover a refraction; however, Medicaid does. If the refraction is submitted on the Medicare claim, when it is denied it will crossover and Medicaid will reimburse the fee. This also is true for any spectacle dispensing fees. The Medicare EOMB should be attached to a Medicaid form to bill for deductible and co-insurance amounts that did not cross over.

Services and supplies not covered by Medicare, but payable by Medicaid, should be billed separately to the Medicaid program, indicating they are not Medicare-covered services. These services can be billed directly to the Medicaid program.

Medicare and Managed Care

Managed care has expanded into the Medicare program because the federal government hopes to control the high cost of health care for Medicare patients. The Tax Equity and Fiscal Responsibility Act of 1982, implemented in 1985, provided the means for managed care to become involved with Medicare. Since then, other laws have strengthened the ties between managed care organizations and Medicare.

In the past there were three basic types of managed care contracts with the government for Medicare: risk contracts, cost contracts, and Medicare demonstration programs.

Risk Contracts

Federally qualified HMOs and competition medical plans contract with Medicare on a prepaid basis to provide covered services to eligible patients under risk contracts.

Cost Contracts

Federally qualified HMOs and health care prepayment plans contract with Medicare to provide covered services on a cost recovery basis. This contract is less advantageous to Medicare than risk contracts.

Medicare Demonstration Programs

In the past there were two Medicare demonstration programs.

Medicare Insured Group (MIG): An entity (corporation or union) contracts with Medicare to provide both the Medicare benefits and supplemental coverage for the beneficiary.

Medicare Select: Medicare supplemental insurance carriers are allowed to offer a preferred provider organization for basic Medicare coverage and supplemental benefits.

All of these programs were optional for the Medicare beneficiary. However, there were some advantages for patients to forgo the fee-for-service Medicare plan in favor of these managed care plans. Possible incentives include the waiving of the 20% co-insurance and the use of additional benefits not normally covered by Medicare (e.g., prescription drugs, screening procedures). Currently, managed care has been fully integrated in Medicare.

Medicare+Choice

The Medicare managed care carve-out plans are called Medicare+Choice. (Sometimes these plans are called Medicare C.) Medicare+Choice plans present as:

- PPOs
- HMOs with a Point of Service (POS)
- Provider-Sponsored Organizations (PSOs)
- Private fee-for-service plans (PFFSPs)
- Medical Savings Accounts (MSAs)

Individuals could enroll or withdraw in these plans on a monthly basis until the year 2002. During that year, they could make a special election to change plans. After 2003, Medicare+Choice plans can be changed only during the first 3 months of the year.

Fraud and Abuse

Abuse refers to practices by Medicare providers that are not consistent with accepted sound medical, business, or fiscal practices. Examples include the following:

- Excessive charges for services or supplies
- Claims for services that are not medically necessary
- Breach of assignment agreements
- Exceeding the limiting charges
- Submission of bills to Medicare instead of to the primary insurer
- Routine waiver of copayments and deductibles

Fraud is an intentional deception by the provider that results in some unauthorized benefit to the provider. Examples include the following:

- Billing for services not provided
- Altering claim forms to obtain a higher payment amount
- Soliciting, offering, or receiving a kickback
- Claims for noncovered services billed as covered services

The Medicare carrier is responsible for identifying and investigating incidents of suspected fraud or abuse. These cases can then be referred to the Office of the Inspector General for further investigation and possible criminal, civil, or administrative sanctions.

Medicaid

Medicaid is a joint federal-state program that provides funding of health care for the poor. Title XIX, an amendment of the Social Security Act known as Medicaid, became effective January 1, 1966. Although Medicaid operates under federal guidelines, it is administered by individual states. Funding is provided by both federal and state governments.

Each state develops a single comprehensive medical care program. Twenty-one services are permissible under the federal act. States are given broad authority in the determination of eligibility requirements and covered services, but federal guidelines require the inclusion of the following seven services in any plan:

- Inpatient hospital services
- Outpatient hospital services
- Laboratory and x-ray services
- Skilled nursing home services
- Physician's services
- Home health services
- Early and periodic screening, diagnosis, and treatment (EPSDT)

The other services are optional and can be included if the state desires. Vision care is an optional service. Nevertheless, a 1992 survey conducted by the American Optometric Association (AOA) found that optometrists were used to provide periodic vision examinations to Medicaid-eligible individuals in all states, but significant variations existed among the states in covered services. The survey reported the following:

- In 11 states, the approval of gatekeepers or prior approval from the Medicaid carrier is needed before contact lenses, low vision therapy, and vision therapy can be provided.
- In 13 states, contact lenses, low vision devices, and vision therapy cannot be provided.
- In 12 states, spectacles cannot be provided to adults.
- Significant limits exist in all states with respect to spectacle lenses and frames. Restrictions include the cost of ophthalmic materials, the dioptric changes in prescriptions needed before eyewear can be changed, and the limited availability of frame styles.
- EPSDT screenings typically are performed by optometrists or nurses. There are only three states in which physicians are used for vision screenings.
- Reimbursement in the vast majority of states is based on a fixed fee schedule. CPT-4 codes are used in all but nine of the states.

The screenings, required by EPSDT for eligible individuals younger than 21 years, must include vision testing. If vision deficits are discovered during the screening, the patient must be referred for diagnosis and treatment at Medicaid's expense. In this manner, eye examinations, eye appliances, vision therapy, and other visual treatments can be covered in a state that does not offer vision care services.

Billing Information

Because of the great variance that exists from state to state, it is not possible to address the issue of billing in any detail.

The 1992 AOA survey found that fees for vision examinations under Medicaid ranged from \$16 to \$55. Individual state vision care provider manuals must be consulted for information on billing.

Medicaid and Managed Care

Medicaid program costs have significantly increased for the state and federal governments during the past few decades. The states and Centers for Medicare and Medicaid Services are encouraging managed care organizations to become involved with Medicaid in the hope that costs can be controlled. The following three plans are available:

Risk contract: Federally qualified or state-qualified HMOs contract with the state on a prepaid basis for providing covered services to eligible patients.

Prepaid health plan: This is an organization that contracts with the state to provide care for covered services on a risk and noncomprehensive basis.

Primary care case management plan: A primary care case management plan contracts with the state to provide services on a fee-for-service basis, with an additional fee for case management. There is a wide variety of managed care plans available, and individual states will have to be surveyed to obtain information on the services provided.

HEALTH MAINTENANCE ORGANIZATIONS

HMOs incorporate the delivery and financing of health care. Traditionally, HMOs offer a prepaid system to deliver care to an enrolled group at a predetermined rate; this is known as the per member per month rate. It covers all services provided to the member (patient). Currently, there are five types of HMOs.

Staff Model

The HMO owns the facility, and the providers are employees. Kaiser is one of the best examples of a staff model HMO.

Group Model

The HMO contracts with one or multiple medical groups to provide services.

Network Model

The HMO contracts with separate networks to provide services at various locations. In some cases, these networks may be owned and/or operated by competitors.

Independent Practice Association (IPA) Model

The HMO contracts with a provider association, comprised of a network of providers who work in their own respective personal offices.

Point of Service Model

The point of service (POS) model is a hybrid HMO that gives members the option of going outside the HMO for a particular needed service but at higher personal cost. The POS HMO seems to have overcome the main complaint of many HMO members—the inability to go outside the HMO for care when the member believes it is in his or her best interest.

PREFERRED PROVIDER ORGANIZATIONS

The second type of managed care organization is the PPO, which is a network of select providers (panel) operating under utilization management and negotiated fee schedules. Patients might use nonpanel providers but at a higher personal cost. Another difference with a PPO is the money trail. The provider bills the PPO, the PPO bills the employer, the employer pays the PPO, and then the PPO pays the provider, according to the contractual fee schedule. PPO programs generally are more costly to employers than HMO plans; although provider choice coverage, from the member's point of view, is typically better under a PPO than an HMO.

One type of PPO is the specialty PPO, which consists of one specialty or type of provider. Many vision plans are examples of specialty PPOs.

Service plans can be part of a managed care organization. Service plans pay providers set fees for covered services but may or may not involve utilization management and quality control. An important provision of the plan is that the provider must accept the fee schedule as payment in full (i.e., no balance billing).

As managed care has evolved, the distinction between the various systems has become blurred. Traditional indemnity insurance has added utilization management and is more appropriately labeled *managed indemnity*. PPOs and HMOs have taken on common features, some of which include permitting patients access to outside providers (at higher personal cost), utilization management, and the passing of financial risk to the provider. The provider therefore needs to look closely at the plan organization, not just at the label or classification of the health plan, to determine its actual status. Obtaining information from colleagues can be invaluable to ascertain the merit and abilities of doing business with the best health plans. Additionally, it is critical for the provider to be aware of the details of the contracts signed with health plans, insurance companies, and other payors. All are far from alike.

Currently, health plans are turning toward an integrated system of health care delivery. This system involves the integration of many types of providers or a hospital/provider network. Integration allows for greater cost reduction, better efficiency, and more convenience for patients. Examples of integration include the following:

- Independent practice association
- Group practice without walls
- Group practice
- Physician-hospital organization

Optometrists can be included in each of these network types, joining with ophthalmologists and other physicians to offer the convenience of “one-stop” health care.

UNDERSTANDING VISION PLANS

Many employees in today's workforce receive a comprehensive set of health care benefits, including a medical plan, a dental plan, and a vision plan. Vision plans emerged in the 1950s but did not become commonplace until the 1980s and 1990s when companies were prompted to enhance employee benefits to become or remain competitive in their respective industries.

PARTICIPATION IN VISION PLANS

Vision insurance has evolved into a highly regarded employee benefit that continues to grow in popularity. Vision plans not only provide benefits to employees, but in many cases, coverage is extended to dependents and retirees as well. In fact, 49% of all Americans are covered by a vision insurance plan (Consumer Perceptions of Managed Care, 2008, Jobson). Millions more receive discount plans in which doctors agree to accept a preset reduction on fees and services, much like a coupon. (For a fully insured member, the doctor files a claim and is reimbursed by the insurance company. With a discount plan, the patient pays the balance out of pocket and no claim is filed.)

The prevalence of vision insurance in today's marketplace lowers the number of people who pay entirely out of pocket for their vision care. The vast majority of optometrists accept multiple vision insurance plans; however, as referenced earlier, there is wide variation in service, promptness of payment, and administrative capability. All of these are very important to help build a successful optometric practice.

MAJOR VISION PLANS

Some vision insurance companies are small regional plans that will be seen only in limited areas of the country. Others are large national plans that provide benefits to millions of people. The four national vision insurance companies that cover the most lives are the following:

- VSP
- EyeMed
- Spectera
- Davis Vision

There are many differences in the business models of these four companies. VSP is a privately held US-based not-for-profit corporation that provides eye care services through private practice optometrists and a small percentage of ophthalmologists who own and operate their own businesses. EyeMed, Spectera, and Davis Vision provide services through corporately owned retail practices and private practices. EyeMed is owned by Luxottica, and Spectera is owned by United Health Group. Davis Vision is owned by Highmark, a large Blue Cross health care benefits company.

The Competitive Landscape

Competition among managed vision care plans is growing. Most are competing for the same clients and patients, and it is important to understand how that competition affects an optometrist's business. Managed care plan participation should be carefully evaluated before any contracts are signed. The relationship(s) established could impact the rate of growth and success of one's business, and how much control the optometrist retains over his or her practice over the term of a contract. It is also important to focus on the penalty provision(s) in the contract, in the event that early disengagement is desired. To illustrate this, two giants within the managed vision care arena are reviewed.

The VSP family of companies includes VSP Vision Care, which supports private practice optometry. The family also includes two frame companies: Marchon and Altair. In addition, VSP owns EyeFinity/Officemate, a practice management and business solutions company. VSP also owns and operates a nationwide network of optical laboratories.

Luxottica, an Italian company, is the parent company of EyeMed, which supports retail and private-practice optometry. Luxottica owns LensCrafters, Pearle Vision, Sears Optical, Target Optical, and Sunglass Hut. Luxottica also owns optical laboratories and manufacturing plants, as well as multiple frame companies and brand licenses.

What does all of this mean to an optometrist in practice? When establishing a relationship with a vision care plan an optometrist should know that he or she may be required or influenced to use specific laboratories, frames, or other optical goods and services that support the plan's parent company. It is up to each optometrist to determine whether the business relationship being established will support his or her practice's success and growth or cause hardships to the business.

Competition among plans can also affect the practice when employer contracts come up for renewal. Vision insurance companies enter into a competitive bid process for most contracts, and from time to time employers do switch carriers. This can cause one's practice to gain or lose a significant number of patients depending on the plan(s) carried.

Selecting Vision Insurance Plans

An optometrist must have patients to operate a successful business. The primary function of a vision insurance plan (from the optometrist's point of view) is to deliver patients to the practice.

Perhaps there is a major manufacturing plant in the city in which one intends to practice. The plant may employ 10% of the city's population. The employer may provide a vision plan to its employees and provide dependent benefits to another 10%. The optometrist's participation on that panel provides an inside track on securing patients from 20% of the city's population. The employees and dependents should seek optometric services because only optometric panel doctors will be able to honor their vision benefit to the full extent of coverage. One should not have to unnecessarily spend marketing dollars to attract those patients.

There is, however, a trade-off. Optometrists must agree to accept discounts on usual and customary fees to participate on a vision insurance panel. Discounts vary widely between vision insurance companies and their variety of plans.

The independent optometrist must do his or her homework to determine which vision plan(s) are potentially profitable and which ones are not. Calculate the total cost of having a patient with a particular insurance plan in the office, and measure that cost against the plan reimbursement and the amount of money the patient is likely to pay "out-of-pocket" for goods and services ("out-of-pocket" is cash the patient spends beyond the coverage level of his or her insurance plan). One obviously wants to select a plan, or plans, that provide acceptable returns for provided services, and reject those that do not.

Also, keep in mind that each insurance company has a unique system for administrative tasks, like checking eligibility and filing claims. There is an administrative expense to consider in the level of complexity that each plan brings to the office. It may not be cost effective to train one's staff on an insurance plan that will provide only a few patients per year.

Contract Responsibilities

A vision insurance company must fulfill contractual obligations under its employer contracts. The core responsibility is to ensure that employees receive consistent, high-quality care. Therefore a vision insurance company will set standards of care that the optometrist must meet to participate on its panel. One's idea of what constitutes a comprehensive eye examination may differ from that of the insurance carrier. One may be required to perform tests that would normally not be provided. Or, there may be tests that are part of the normal examination that are not covered by the insurance company. An optometrist can perform extra tests and not get paid by the insurance company, but he or she does not have the option of disregarding elements of the examination required by the carrier. If one fails to meet contractual obligations for standards of care, the optometrist can be disciplined or removed from the panel. In addition, legal action is a possibility if the optometrist engages in conduct that is considered fraudulent.

A contract agreement between an optometrist and a vision insurance company will contain provisions for audits. Insurance providers must perform periodic audits to meet their regulatory or other requirements. Audits are also necessary, so the insurance carrier can establish that it has delivered on its contractual obligations to the employer group. The audit process will require that the optometrist open his or her patient records and financial records to the insurance company, so the carrier can ensure that contract obligations are being met.

Optometrists and business owners have interests that are also to be considered in contractual agreements with vision insurance companies. First and foremost, one should have the right to accurate and timely payment for services and goods provided. One should also determine whether the insurance company provides an acceptable level of customer support to the optometrist and staff, so questions or issues can be resolved quickly and professionally.

MEDICAL OR VISION INSURANCE

An often confusing issue for many patients and for some optometrists is the case of a patient with separate coverage for vision and medical needs.

Vision Insurance

Coverage usually provides for basic periodic vision examinations (covered services), ophthalmic lenses, eyeglass frames, and contact lenses (covered materials). Often the cycle of covered services is different than the cycle for covered materials (e.g., vision examination once per year, spectacles every 2 years). Vision claim forms can request information about the vision examination procedures performed, refractive diagnosis, visual acuities, lens prescription details, and frame data.

Medical Insurance

Coverage is limited to medical services and supplies. Regardless of the final diagnosis, a medical sign or symptom is needed as the initial reason for the examination before reimbursement is allowed. Medical necessity is needed to bill major medical plans for services and supplies rendered. A medical diagnosis has to be included on the claim form to substantiate medical necessity. Examples of medical diagnoses include headaches, hypertensive retinopathy, blepharitis, glaucoma, and conjunctivitis.

In instances where the patient has both vision insurance and medical insurance, the optometrist must first decide which plan (vision or medical) to bill for services rendered. This decision is based on the reason for the office visit. If the reason for the office visit is refractive, the vision plan not the medical plan is normally billed. However, if there is a medical reason for the office visit, the medical plan should be billed.

There are exceptions. Some third-party insurance companies allow optometrists to bill the vision plan for the refractive services portion and the medical plan for the medical services portion. However, a provider may not bill both the vision plan and the medical plan for the same service rendered. It is important for providers to review the patient's coverage and the vision plan contract before billing either plan. Fraudulent billing can result in fines and other disciplinary action.

COMPENSATION METHODS

Health care plans reimburse for patient care through different methods. It is essential for the provider to understand how the plan reimburses for services. Examples of compensation methods include fee-for-service, discounted fee-for-service, fee allowance schedule, relative value scale, and capitation.

Fee-for-Service Programs

Under the fee-for-service method, providers are compensated for services rendered. Compensation is determined by a "usual and customary" fee. Usual and customary compensation is based on the provider's fee record as it equates to that

of different providers in the region. The "usual fee" is the standard fee that is charged by the provider for a given procedure to private paying patients. Usual fees are determined by the provider and are on record with the health care plan as the provider's fee profile.

"Customary fees" for each particular procedure are set by the health care plan. The health care plan determines the customary fee as a percentile of the usual fees charged by providers in the same general area (e.g., 90th percentile).

Under a fee-for-service program, providers are paid the actual amount of their usual fees, if those fees fall within the range of customary fees. If the provider charges more than the customary fee, the provider will be paid only the customary fee (in essence, writing off the difference). On the other hand, if the provider charges less than the customary fee, the provider will be paid the usual fee. Under discounted fee for service programs, providers receive their usual and customary fee, minus a certain discount (e.g., 25%). Another common variation is for the third party to pay a percentage of the Medicare allowable fee (e.g., 70% of Medicare allowable). It is important to recognize that the Medicare allowable fee is a discounted program, so a plan offering a percentage of Medicare as a fee schedule is a discounted discount plan.

Fee Allowance Schedule (Fee Schedule)

Under a fee allowance schedule, providers are compensated based on a schedule of fees for each procedure. The fee schedule is not correlated to the provider's usual and customary fees.

Relative Value Scale

Under a relative value scale, the health care plan assigns a numeric score to each procedure (described by a CPT code), indicative with the "value" associated with that procedure. For example, the intermediate eye examination, new patient (CPT code 92002) can be assigned a relative value of 1.1, whereas a comprehensive eye examination, new patient (CPT code 92004) can be assigned a relative value of 1.7. Reimbursed amounts are determined by multiplying the relative value of the procedure by a predetermined negotiated number (the multiplier). For example, if the multiplier was \$30, then the reimbursement for the respective relative values above would be \$33 for 92002 and \$51 for 92004. Medicare uses a form of this method, called a resource-based relative value scale (see Chapter 35).

Capitation

Capitation, although not as popular as it once was, is a prepayment program that pays the provider a fixed amount for each member (patient) per month. The amount paid covers all provided health care services for the member regardless of the number of visits or the associated cost of those services provided. If the patient is healthy and requires little service, then the provider is in a positive revenue status position. On the

other hand, if the patient is ill and requires many services, the provider might be in a negative revenue status position. It is assumed that the overall mix of members will result in a positive revenue status for the provider. With the capitation method, the provider assumes this financial risk.

Optometrists may participate in health care plans that might use any of the aforementioned compensation methods. In fact, and as previously stated, optometrists deal with patients who can have two kinds of applicable insurance—vision and medical.

COST SHARING

One aspect of third-party reimbursement is cost control through cost sharing. To achieve this goal, third-party health plans use two important concepts: deductibles and co-payments.

Deductibles

A deductible is a specified sum that the beneficiary must pay toward the cost of care before the health plan benefit goes into effect. Deductible amounts can range from \$0 to \$2,000, with \$100 to \$300 being most common. Deductibles might be required for each individual covered by the plan, or for the entire family. If a patient has not paid the deductible, the provider should collect the deductible from the patient at the end of the examination. This is a complicated process, because many patients do not know the amount of their deductible or whether they have already paid their deductible. The provider's office often will have to call the plan to obtain this information.

Co-Payments

A co-payment is the patient's share of cost for covered materials and services. It usually is set as a fixed dollar amount per visit. Another term, co-insurance, is used to describe a sharing of cost when the amount is a percentage of the covered materials and services. Common major medical insurance plans are often termed as *80/20 plans*. After the patient has met the deductible, the plan pays 80% of covered services and the patient is responsible for the remaining 20%. An example of an 80/20 payment can be found in Box 34-1.

Other cost-sharing measures include maximums and exclusions.

BOX 34-1

Example of Co-payment (80/20 Plan)

Procedure: Gonioscopy (90020)
 Total charge: \$35.00
 Insurance coverage (80%): \$28.00
 Patient portion (20%): \$7.00

Maximums

Health care plans can stipulate a maximum amount to be paid over a given year or during a lifetime. For example, Medicare pays a set maximum for an eyeglass frame once in a lifetime (one for each eye) for a patient with a diagnosis of pseudophakia.

Exclusions

Health plans can exclude payment for certain services and materials. Examples of exclusions include the following:

- Preexisting conditions
- Cosmetic contact lenses
- Orthoptics

Individual plan provisions should be carefully analyzed to determine the requirements and limitations for a particular patient.

CLAIM FORM

The most widely used claim form is the HCFA CMS-1500 (Figure 34-3), which is used in billing for medical conditions. Like most claim forms, it has two primary information sections. Patient and subscriber information is found on the top half of the form in sections 1 through 13. Physician information is recorded on the bottom half of the form in sections 14 through 33.

Sections 1 through 13 can be completed by office personnel after the information has been reported by the patient on the registration form. It is important to have the patient sign line 12, regarding release of information. Information about the patient's diagnosis and treatment is confidential and can be released only with the patient's permission. The patient's signature on line 12 gives the practitioner authorization to disclose details regarding medical or vision care to the insurance company.

Item 13 provides an assignment of benefits and should be signed by the patient, if the practitioner prefers to collect benefits from the insurance company directly. The patient's signature authorizes the insurance company to pay allowable benefits directly to the practitioner. If the patient does not sign box 13, the insurance payment will go directly to the patient.

If benefits are assigned to the practitioner, financial settlements of the patient's share (deductibles, co-payments) of the costs are usually made at the end of the office visit. If benefits are not assigned to the practitioner, financial arrangements are made for the total fee to be paid directly by the patient. When benefits are not assigned, it is as if the patient had no insurance. In that case, the patient pays the practitioner directly for the materials and services provided.

Signature on File

It is important to have patients review and sign statements authorizing release of information and payment of benefits on a patient registration form. The registration form should have wording similar to the wording in boxes 12 and 13 of the HCFA CMS-1500 form. If the patient is not available to sign an insurance claim form, it is permissible to type "signature on file," since that authorization is provided on the registration form.

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB 0938-0008

HEALTH INSURANCE CLAIM FORM

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 12345678A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Vision Joseph A

3. PATIENT'S BIRTH DATE 01 02 31 M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 2020 Refraction Lane

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

8. PATIENT STATUS Single Married Other

9. EMPLOYED Full-Time Student Part-Time Student

10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO b. AUTO ACCIDENT? YES NO c. OTHER ACCIDENT? YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER None

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: Signature of File DATE: 9/1/08

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: Signature on File

14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. 373 02

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

LINE	A (DATES) OF SERVICE		B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F \$ CHARGES		G DAYS OR UNITS	H EPSON Family Plan	I EMS	J CDB	K RESERVED FOR LOCAL USE
	From MM DD YY	To MM DD YY											
1	9 1 08	9 1 08	11		99213	1	28 00	001					013
2	9 1 08	9 1 08	11		92015	1	10 00	001					013
3													
4													
5													
6													

25. FEDERAL TAX I.D. NUMBER 123-45-6789 SSN EIN

26. PATIENT'S ACCOUNT NO. 531

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE \$ 38 00

29. AMOUNT PAID \$

30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED: John O'Dea MD DATE: 9/1/08

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) O'Dea, John MD 2020 Vision Street Insight MI 49000

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 616-555-2020 PNR GRPY 0E 123-45-6789

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM CWP-1500 FORM IIRB-1500 #1923 - 429423 - Medical Arts Press Use with Enrollment #16145 (approved) or #16146 (self-act)

FIGURE 34-3 Sample HCFA CMS-1500 form.

Physician Information

Items 14 through 33 are to be completed by office personnel. Most of the boxes are self-explanatory, and additional instructions can be found in the provider manuals for each health plan. Line 21 requires a diagnosis listed by ICD code—carried out to two decimal points, if possible. The first diagnosis listed

should be primarily attributable to the patient's visit that day. This should be followed by additional codes describing any current coexisting conditions.

Box 24D requires a CPT procedure or HCPCS material code. Box 24E should list the diagnosis (referenced by line number) that corresponds to the billing procedure or materials.

Item 24B requires a code for the place of service. “Place of service” refers to the practitioner’s office, hospital, nursing home, and so forth, where services were actually rendered. Type of service (item 24C) refers to medical care, surgery, consultation, or other service actually provided.

For a variety of reasons, third parties are moving toward electronic claims submission. It is helpful if the office practice management software can arrange the patient data and communicate directly with a third party for claims submission.

PROCESSING PROCEDURES FOR CLAIMS

Because of the current environment affecting managed care, practitioners first need to determine whether care can be provided to a particular patient. Many health care delivery systems use a closed network or panel of providers (e.g., HMOs and PPOs). If the practitioner is not a member of the panel, the practitioner may not provide the care being sought. Even if the provider is a member of the panel, there still can be utilization requirements and controls, including the necessity of a primary care physician as a gatekeeper to authorize any care. A provider needs to understand the structure and organization of the particular health plan.

If a practitioner determines that care can be provided, several issues still must be addressed, including eligibility, patient information, processing steps, and computerization of claims.

Eligibility The provider needs to determine whether a patient is entitled to benefits, and to what extent under the health plan or the vision plan. For example, a patient can be eligible for a vision examination only once every year. If it has been 11 months since the last vision examination, the plan might not pay for the visit. Other plans may pay for the visit, but only if a preauthorization request is filed before the examination occurs.

It is important to verify whether spouses and children are covered under the plan. If questions arise regarding eligibility, it is best to call the plan directly to determine who is eligible for and any limitations to services and materials. Most plans have authorization cards that provide a telephone number to verify coverage. It is prudent to verify coverage before substantial fees are charged because payment can be lost if there is a misunderstanding.

Patient Information

Information is needed to provide details about plan beneficiaries and the plan that supplies reimbursement. It is best to obtain patient information on a registration form (Figure 34-4). This information must be correct and complete because a claim will be rejected without proper facts. If information is incorrect, the claim will be returned for correction. In such an event, payment will be delayed and extra work will be created.

Processing Steps

As patients schedule appointments, the receptionist should request that all insurance forms, identification cards, and benefits information be brought to the appointment. With so many different carriers and policy provisions, it is helpful to have trained staff review and explain applicable coverage to patients.

When the patient arrives, the registration form should be completed and the patient’s identification card should be reviewed to confirm coverage. It is wise to photocopy the identification card for the patient’s record and for future reference.

The patient should be informed of his or her benefits, deductibles, and co-insurance. At the end of the visit, the patient’s share of the services and material fees should be collected.

Claims should be mailed or electronically submitted to the plan at a suitable time, and within the plan’s claim submission timeframe. Unprocessed claims represent money owed to the practice. All claims should be complete and legible, often called a *clean claim*. A copy of the claim should be kept in a “claims pending” file for review until payment is received.

If claims have not been paid within 4 weeks, it is advisable to call the carrier to determine whether a problem exists. Most states now have laws that set time limits on third parties to either deny or pay a clean claim submitted. Practitioners should know what the law is for the state in which they practice. If a claim is returned because of errors, corrections should be made and the claim resubmitted in a timely manner. Many carriers can deny claims if they are not submitted within a specified period, and that time may be as short as 30 days for some carriers.

Computerization of Claims

Many of the computer software packages available for office management include the ability to complete claim forms such as the CMS-1500. The computer templates match the claim form, and the information can be automatically transferred to the form. It is important to enter the correct diagnosis, procedures, fees, patient insurance information, and any additional information required.

“Electronic claims submission” refers to the ability to send claims to the insurance company through telephone lines. The office’s computer links with the carrier’s computer and information is transferred electronically. The process is virtually instant, eliminating time that would be lost and the expense of regular mail. It also reduces errors since the data does not have to be re-entered by the carrier into its computer. Payment is often faster, because of the time saved in processing of the claim. It is anticipated that, in the future, electronic submission of claims may become a requirement by some third-party payors such as Medicare.

Health care financing is in a state of flux, particularly with the possibility of health care reform in the near future. The pace of change is exponential, with no sign of slowing down. All practitioners need to understand the basics of managed care and third-party reimbursement. Managed care has spread

PATIENT REGISTRATION FORM			
<i>PLEASE COMPLETE THE FOLLOWING INFORMATION SO THAT YOUR VISION RECORD WILL BE COMPLETE. ALL INFORMATION IS NECESSARY.</i>			
NAME _____			
FIRST	MIDDLE	LAST	
ADDRESS _____			
NUMBER AND STREET		CITY	ZIP
HOME PHONE () _____		WORK PHONE () _____	
SOCIAL SECURITY NUMBER _____			
BIRTHDATE _____		SEX () MALE () FEMALE	
DRIVER'S LICENSE NUMBER _____			
REFERRED BY _____			
OCCUPATION _____			
NAME OF EMPLOYER _____			
WORK ADDRESS _____			
ARE YOU COVERED BY MEDICARE? () YES () NO			
ARE YOU COVERED BY MEDICAID? () YES () NO			
ARE YOU ENROLLED IN AN HMO SUCH AS KAISER, FHP, CIGNA, OR OTHERS?			
() YES () NO			
VISION INSURANCE COMPANY _____			
MEDICAL INSURANCE COMPANY _____			
NOTIFY IN CASE OF EMERGENCY _____			
RELATIONSHIP _____		TELEPHONE NUMBER _____	
I consent to optometric evaluation and treatment by Dr. _____			

(signature)			
I authorize the release of any medical information necessary to process my insurance claims. I also request payment of my insurance benefits to Dr. _____			

(signature)			

FIGURE 34-4 Sample patient registration form.

throughout the country, and no region or area is necessarily unaffected. The knowledgeable practitioner will likely flourish in this environment, whereas the uninformed practitioner will likely struggle and perhaps not survive.

AUDITS

Every doctor will eventually be audited by a third party. It can be as simple as a routine audit or as complicated as an outlier audit. (A doctor whose coding falls outside normal patterns is classified as an outlier.) This section will help you understand the audit process and help you implement systems within the office to ensure third-party compliance.

It is important to understand that the doctor is personally responsible for coding. Staff may assist in the process but it is ultimately the doctor who bears the burden for proper coding

and billing. According to the Office of Inspector General, doctors "... have a duty to ensure that the claims submitted to the federal health care programs are true and accurate." For this reason, every doctor needs to understand what happens in an audit.

Audit Triggers

There are four common triggers for an audit: complaints, computer analysis, scheduled audits, and random audits.

Third parties actively encourage both patients and staff members to report suspicious coding and billing activities. There are financial rewards for such reporting. The financial rewards can include a percentage of monies recovered. Websites maintained by third parties educate people about suspicious billing and coding activities and explain the process for reporting.

Third-party software programs constantly monitor doctor coding patterns. Any doctor whose coding or billing falls outside normal patterns is classified as an outlier. Examples of outlier patterns would be doctors who only use CPT 92002/92012 codes for all examinations, doctors who never code above a level 3 99000 evaluation and management (E/M) code, or doctors who only use a limited number of diagnoses. Doctors who use a high percentage of diagnosis codes ending in .8 or .9 are also at risk of being audited. Doctors who use uncomplicated diagnosis codes with complicated procedure codes are at risk of being audited. Undercoding is just as much a trigger for audit as overcoding.

Some third parties schedule audits. They can be scheduled simply as a matter of passage of time or as a follow-up to a previous audit where a problem was discovered. Third parties that schedule audits of every doctor every 3 years are doing it as a matter of quality control. It permits the marketing department of that third party to make claims about the quality of the examinations given by all participating doctors. When a third party identifies a problem, it is not unusual for the next audit to be scheduled to ensure resolution has occurred.

Some audits are randomly triggered. In an effort to ensure the third-party auditing system is working appropriately, random audits can occur. The random third-party audit is another way to ensure compliance and give the third party additional insight into doctor coding and billing patterns.

The Audit

Auditors will commonly ask for 10 to 30 specific records. The doctor is given a list of patient names and office visit dates. These records have been identified by the third party as having potential problems or are records where the doctor used a code the third party is interested in auditing. If no problems are discovered, the auditor moves on to the next doctor. If problems are discovered, the auditor asks for additional records for confirmation.

Auditor's Logic

The auditor has a list showing patient name and date of service. The first thing an auditor looks for is a match between patient name and date of service. If there is a mismatch, for example, a missing or incorrect date of service, the auditor will deny the claim and move to the next record.

For medical third parties, the auditor looks next at the reason for the visit. If the reason for the visit is anything but a medical sign, medical symptom, or ongoing care for a medical condition, the auditor will deny the claim and move to the next record.

The auditor then looks for documentation supporting the procedure and diagnosis codes billed. If additional tests were ordered and billed, the auditor looks on the primary medical record for two things: a statement of medical necessity for the additional test and a medical order for the test. The additional tests should be documented separately from

the primary medical record (i.e., a separate piece of paper). If the additional test requires a report, the auditor looks for a clearly identifiable report.

Errors, Fraud, and Abuse

Three types of problems are uncovered in audits: errors, fraud, and abuse. Most problems uncovered are errors that are simple mistakes. Common mistakes are misspelling the patient's name, having an incorrect date, transposing numbers, or not matching the diagnosis code with the procedure code. Errors are not actionable unless they cross the line of fraud or abuse.

Fraudulent claims are submitted with actual knowledge of the falsity of the claim. Doctors who use diagnosis and procedure codes for the purpose of receiving reimbursement for diagnoses or procedures that are not covered are submitting intentionally fraudulent claims. Doctors who solicit, offer, or accept kickbacks, as well as doctors who routinely waive copayments are guilty of fraudulent claims.

Abuse has four possibilities: volume, improper billing, payment for services not meeting recognized standards of care, or payment for medically unnecessary services.

Abuse as a result of volume is an easy situation to occur for the average doctor. This is especially true of the doctor who uses a routing slip that is not updated at least yearly. When an excessive number of improper billing submissions exists, intent is not relevant. It does not matter that the doctor did not intend to abuse the system, the volume of improper billing submissions abused the system. Doctors must know and follow third-party rules when accepting third-party reimbursement.

Abuse can be a matter of improper billing practices. Examples of improper billing practices would be misrepresenting the procedure or the diagnosis to receive higher reimbursement, up coding, submitting duplicate claims, routine waiver of coinsurance and deductibles, billing third-party patients a higher amount than self-pay patients, billing for excessive services, or failure to maintain adequate records. Failure to maintain adequate records is a common problem. Medical documentation guidelines must be followed by participating providers.

Abuse can be payment for services not meeting recognized standards of care. "The most common legal definition of standard of care is how similarly qualified practitioners would have managed the patient care under the same or similar circumstances." Abuse can be payment for medically unnecessary services. Just because a third party covers a procedure does not mean the procedure is considered medically necessary for every patient visit. An example would be an eye doctor managing a central corneal ulcer for the first time. The doctor may choose to see the patient more frequently than an experienced eye doctor. The third party should not be charged for the education of the eye doctor managing a central corneal ulcer for the first time. The third party should be charged for the visits that would be considered medically necessary for the experienced eye doctor.

Audit Results

There are four situations that occur as a result of an audit: nothing, warnings, return of money, and penalties. It is not unusual for auditors to tell doctors after an audit, "If you do not hear from us, it is good news." From the doctor's perspective, not knowing can be a source of stress. Doctors prefer to have a written report. Warnings occur when problems were discovered but are not serious enough to warrant return of money or penalties. It is not unusual after an audit for third parties to ask for return of money paid inappropriately to doctors. Penalties can include monetary fines. Penalties can range from probation to legal action for fraud and abuse. Penalties can result in permanent dismissal from the third-party program, loss of license, and incarceration.

Appeals

Every third party has an appeals process. The Medicare appeals process is an excellent example of the levels of the appeals process. There are five levels in the Medicare Part A and Part B appeals process. The levels in order are as follows:

1. Redetermination by the Medicare carrier, fiscal intermediary (FI), or Medicare Administrative Contractor (MAC).
2. Reconsideration by a qualified independent contractor (QIC)
3. Hearing by an Administrative Law Judge (ALJ) in the Office of Medicare Hearings and Appeals
4. Review by the Medicare Appeals Council
5. Judicial Review in Federal District Court It is wise to have legal counsel for levels 3 through 5.

Office of Inspector General Compliance Program Guidance for Physician Practices

The best course of action is to have systems in the office preventing negative outcomes from audits. The Office of Inspector General (OIG) published the Compliance Program Guidance for Individual and Small Group Physician Practices with this goal in mind. The OIG Compliance Program document states that it "... will serve as a positive step towards assisting providers in preventing the submission of erroneous claims or engaging in unlawful conduct involving the Federal health care programs."*

The OIG Compliance Program contains the following components which should be created in the eye doctor's office:

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards
- Designating a compliance officer or contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and developing corrective action
- Developing open lines of communication
- Enforcing disciplinary standards through well-publicized guidelines

* From Federal Register/Vol 65, No 194/10-5-00/p 59434-59452.

The purpose of the OIG Compliance Program is to implement systems in the eye care office ensuring third-party compliance. To start the program, at least once a year, five or more records per doctor per third party should be audited to make sure documentation supports the coding and billing, that services or materials provided are reasonable and medically necessary and that there are no incentives for unnecessary services. For these records, examine the entire process from patient intake through payment. If a problem is identified, create an education and training program to resolve the problem. 3 months after the education and training program is implemented, perform a focused audit on five more records making sure the problem is resolved.

In following the OIG Compliance Program in the office as records are audited, target the following four areas to ensure compliance:

1. Coding and billing
2. Reasonable and necessary services
3. Documentation
4. Improper inducements, kickbacks and self-referrals

Over time, as one follows the OIG Compliance Program, noncompliance will be discovered. A noncompliance conduct report should be made any time a problem is identified. The contents of this report should include the following:

- Incident date
- Name of the reporting party
- Description of the incident
- Action plan
- Education
- Discipline
- Changes to policies and procedures
- Name of the person responsible for taking action
- The follow-up action taken

After education and training, staff noncompliance may still occur. The OIG Compliance Program lists an eight-step process for disciplinary actions. This process should be followed and documented.

1. Oral warnings
2. Written reprimands
3. Probation
4. Demotion
5. Temporary suspension
6. Termination
7. Restitution of damages
8. Referral for criminal prosecution

CONCLUSION

Since all doctors will be audited eventually, it is prudent to review the material presented in this chapter periodically. Particular attention should be placed on identified audit triggers, the audit process, reexamining the auditors logic, the types of problems found, explanations of what can result from an audit, the Medicare Appeals process as an example of what to do if the audit is unfavorable and the overview of the OIG Compliance Program. Understanding audits and implementing systems to ensure compliance will help doctors through an audit.

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Website

www.cms.hhs.gov. US government website for the Medicare and Medicaid programs.

<http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Jurisdiction>