

CMS OFFICE MANAGER

A newsletter to provide medical office staff with information on health insurance.

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Feedback • Ideas • Articles

If you have any of these please let us know by **phone** at (303) 779-5455 or 1-800-654-5653, ext. 2428, fax at (303) 771-8657 or e-mail at marilyn_rissmiller@cms.org.



This newsletter is provided to you free of cost by the Colorado Medical Society.

Please share this information with others, but we ask that you acknowledge the source.

Why the Hassle Factor Project?

“Have you lost your mind!”

The Hassle Factor Project encompasses many of the activities we in the CMS Health Care Financing Department have been doing for years – but on a much larger scale. We have always been available to assist members and their staff with questions and problem claims. In the past we have used the CMS magazine *Colorado Medicine* as our primary means of communicating with physicians.

Why? As you know all too well, there are lots of reasons why this project was needed (there are 1000 of them in our office alone). Over the past two years we have noticed a continual increase in the frequency and pervasiveness of problems dealing with third party payers. As managed care has “trimmed the fat from the healthcare dollar,” it has also created cut backs in their communication and training (both internally and externally).

Why CMS? We have both the expertise and the opportunity. The staff of the Health Care Financing Department has experience in claims processing, billing and coding, so we can “speak the language”. We have the opportunity as representatives of 5000 member physicians to act as facilitators of change.

Our philosophy has been to first try working cooperatively with the health plans to resolve a problem. Only if those efforts fail do we seek legislative or regulatory solutions. That is why CMS staff gave a presentation to representatives of the HMO Association early last month on the Hassle Factor Project. We let them know what *you* have identified as the top issues. In addition, we also laid several suggestions aimed at alleviating the problems on the table for discussion. We are still waiting for feedback.

Some of the ideas we shared with the HMO Association included:

- Development of a system to verify receipt of paper claims, as well as a report to assist in reconciling electronic claims receipt
- Standardization of billing requirements for the 1500 form
- Capability to check claim status via fax
- Availability of an automated response unit for claim status (*with* the capability of speaking directly to a representative)
- Increased availability of Provider Reps. and educational programs

We feel that improved communication and education would go a long way toward easing *most* hassles. Which leads us to this newsletter, as these are the two primary reasons for its existence. We *seriously* want your input and ideas. What do you want to see covered? Do you want to contribute an article or idea for an article? If you don't agree with something, please let us know. The phone number, fax number and e-mail address is right here on the cover.

House Bill 97-1122

Consumer Protection Standards Act for the Operation of Managed Care Plans

Although this bill became a law on July 1, 1997, very few offices are aware of it or really understand the types of problems it was intended to address. In this article we will provide information on some of the sections of this lengthy statute. If you are interested in obtaining a copy of the statute or regulations please let us know.

The purpose of this bill was *to incorporate consumer protections in the creation and maintenance of provider networks by carriers; to establish standards to assure the adequacy, accessibility and quality of health care services offered under a managed care plan; and to establish requirements for written agreements between carriers offering managed care plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide services to covered persons.*

Primarily a consumer bill, it can also assist "providers" as well. Section 10-16-704(4) requires that *when a treatment or procedure has been preauthorized by the plan, benefits cannot be retrospectively denied except for fraud and abuse. If a health carrier provides preauthorization for treatment or procedures that are not covered benefits under the plan, the carrier shall provide the benefits as authorized with no penalty to the covered person.* In addition, plans cannot require prior authorization for emergency services if the patient has good reason for believing that a life or limb-threatening situation exists.

The law also requires that a plan must establish grievance procedures, which conform to the Colorado Division of Insurance rules concerning prompt investigation of health claims involving utilization review (UR). The UR regulations (CCR 4-2-17) define the required procedures for handling review decisions, requests for reconsideration and two levels of appeal for adverse determinations. Plans are required to meet strict time limits for responding to requests for prior authorizations and appeals. The plan must provide a reasonable explanation of the basis for the denial. And, all plans are required to have an expedited appeals process in place to handle situations where the normal review time frame would seriously jeopardize the patient's health or ability to recover.

The UR regulations are meant to deal with an adverse determination concerning availability of care, continued stay or other health care service that does not meet the health carrier's requirement for medical necessity, and coverage is denied, reduced or terminated. The regulations were not meant to assist in disputes concerning the level of payment, coding or contractual issues. The Division of Insurance has summarized these regulations in a brochure for consumers titled *What happens when your health insurance company says no.**

Section 10-16-705(13) requires that *a carrier shall establish procedures for resolution of administrative, payment, or other disputes between providers and the carrier.* The "internal dispute resolution mechanism" is intended to provide you with a reasonable and expedient means to resolve these issues. It does not guarantee that the outcome will always be favorable, only that the carrier will respond to your dispute and provide you with the basis for their determination.

Provisions of this law may be of assistance in your dealings with third party payers. In another article we will give you tips on how to effectively incorporate these references in your communications. Remember, however, this is a Colorado state law and state laws do *not* affect ERISA plans.

*Division of Insurance Brochure

If you are interested in obtaining copies of the brochure titled *What happens when your health insurance company says no* for your patients, you can do so by contacting the State Forms Center at (303) 321-4164. The cost is \$4.25 per package of 50, plus tax and shipping. If you would like just one copy for yourself, you can contact the Division of Insurance at (303) 894-7499 or 1-800-930-3745, press 0 and tell the operator that you would like to speak to a Consumer Affairs Analyst.

What is ERISA?

ERISA = Employee Retirement Income Security Act of 1974, this federal law includes language which preempts self-funded health plans from state regulation as long as they meet certain federal reporting and solvency requirements. Large employer groups with multi-state operations and unions with specific collective-bargaining agreements generally use self-funded plans (examples: Teamsters, King Soopers, Lockheed-Martin). If in doubt, the quickest way to find out is to call the carrier noted on the patient's insurance card.

In the language of health insurance, an appeal is not when you get down on your knees and beg forgiveness, rather it is a request for review of the insurance company's original determination. To be effective your request must be stated clearly and include the basis for your disagreement.

When can I bill the patient?

This is a question we get asked a lot. *In general*, if you are participating with the patient's insurance plan there are limited circumstances when you can bill them directly. The obvious ones include:

- ☺ Patient's responsibility – deductible and coinsurance
- ☺ Services that have been denied by the patient's insurance because they are not a benefit of the plan; e.g., cosmetic surgery, routine care.






Following are examples of charges that *probably* cannot be billed to the patient by a participating physician:

- ☺ Services that have been denied for no referral or no prior authorization - Under HB97-1122 the responsibility for obtaining the necessary preauthorization rests with the participating physician who recommends or orders the services.
- ☺ Charges that exceed the plan's maximum allowable, including multiple surgery reductions
- ☺ Charges that have been denied as included in another service or procedure (bundled)
- ☺ Charges which the plan has been *terminally* slow in paying

If you want to be certain, check your participation agreement or contract with the patient's insurance.

How “appealing” is your request for review?

Estimates are that up to two-thirds of those appeals submitted are misdirected or mishandled within a payer's regular customer service or claims processing system, without any actual review ever being done. The following simple suggestions are offered by Ginny Roath of Timely Insurance Payment Services, Inc., to reduce some of your frustrations and ensure your request is handled correctly:

-  Design appeal form letters for your office on attention capturing colored paper, clearly labeled at the top in large letters – A P P E A L.
-  State your case clearly, attach all documentation to support your position, and attach a copy of the claim and/or remittance statement showing how the claim was originally processed.
-  Obtain specific payer appeal mailing addresses. When possible, direct appeals to the attention of personnel you know will ensure their proper handling.
-  Utilize certified mail, and enclose those mail certification numbers in the context of your appeal letter.
-  Retain copies of all appeal submissions, monitor and track the handling of appeals by payers.

BCBS of Colorado Takes Steps to Improve Customer Service

Customer service complaints such as excessive telephone hold times, and a constant busy signal have been among the top 10 complaints submitted to the CMS Hassle Factor Project. We have been advised by Blue Cross, Blue Shield of Colorado that they are taking steps to improve their customer service levels. They have hired and trained additional customer service representatives, and beginning sometime in July they will implement a voice response system for Colorado providers. They tell us that the first application to be available will be a 24 hour eligibility verification system, with enhancements, such as claims status planned for later in the year. Blue Cross, Blue Shield has provided us with the following brief explanation of how their voice response system will work.

The eligibility option will be available through all phone numbers servicing providers. After entering the subscriber or membership number, the system will speak back the effective date of plan with a clarification on type of coverage: HMO, PPO, or Indemnity. Our plastic identification cards have been replaced in most lines of business with paper and provide basic benefit information along with deductible and co-payment amounts. This information with verification of eligibility will provide a fast response on common inquiries.

We have recently converted our Group PPO & Indemnity business to the Amisys system, so the majority of our business is now on the same system. Amisys membership numbers are 11 digits, specific to each family member. If only 9 digits are known, the patient's date of birth is necessary for clarification of member. The system will verify status of most recent coverage or a service date of choice. If the member has an HMO plan we will provide information on the contracted hospital and medical management.

Eligibility for out-of-state members is not available but held at the respective Blue Cross Blue Shield plans. During business hours the caller will have an option to connect with a representative at any time. There will be unlimited access allowing multiple inquiries when the system becomes available sometime in July. We will provide additional updates in our provider newsletters. Feedback can be directed to John Hess at JGHESS@BLUEMAIL.COM or 303-831-2161.

note

If you have tried to utilize the plan's appeal process and they have been unresponsive, the dispute resolution procedures required by HB97-1122 may be of assistance. Write a letter to the plan's Compliance Officer, President or Legal Counsel identifying what the problem is and the steps you have taken to try and resolve the issue. Include the pertinent time lines and copies of supporting documentation. State that you want to “invoke the dispute resolution procedures required under section 10-16-705 (13) of the Colorado Revised Statute.” Send a copy of your letter to the Colorado Division of Insurance, Consumer Affairs, 1560 Broadway, Suite 850, Denver, CO 80202.

What caused the Dark Ages?

Y1K.



We have made a serious attempt *not* to jump on the Y2K bandwagon – it seems way too crowded. But, with less than six months left in the year, we feel compelled to share some information/thoughts specific to your billings.

- The Medicare Carrier for Colorado has been certified by HCFA as Y2K compliant. Ask the other plans you deal with if they are ready.
- If you haven't done so, talk to your electronic claims vendor or software company. Are they Y2K ready?
- The Colorado Medicare Carrier is ready to begin electronic claims testing. You or your vendor should contact them directly for the specifics at 1-701-277-6901.
- HCFA *swears* that if you can get a valid claim to them, they will be ready to process it. Dropping your claims to paper is *not* a good contingency plan – imagine the backlog if every office decided to do that!
- Have you done an inventory of your business for potential Y2K problems – anything that depends on a microchip or date entry could be affected.
- Take advantage of all of the information that is available on the internet. For starters, you can visit the HCFA web site at www.hcfa.gov/y2k or AMA's web site at www.ama-assn.org/not-mo/y2k/index.htm.

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Resources

- ✓ E&M documentation training will be one of the educational sessions for physicians at this year's CMS Annual Meeting on September 18, 1999 in Beaver Creek. (If your doctor is interested check the June or July issues of *Colorado Medicine* for details.)
- ✓ Know any good web sites; consultants, trainers or EDI vendors you would recommend to a friend? Let us know so we can share the information with our readers.
- ✓ Correction to the phone number of Pam Wahl with the El Paso County Medical Office Manager Assoc., the correct number is (719) 591-8723.