

# CMS OFFICE MANAGER<sub>R</sub>

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

May/June 1999

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## Feedback • Ideas • Articles

If you have any of these please let us know by **phone** at (303) 779-5554 or 1-800-654-5653, ext. 2428, fax at (303) 771-8657 or e-mail at [marilyn\\_rissmiller@cms.org](mailto:marilyn_rissmiller@cms.org).



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## Colorado Medical Society Hassle Factor Project

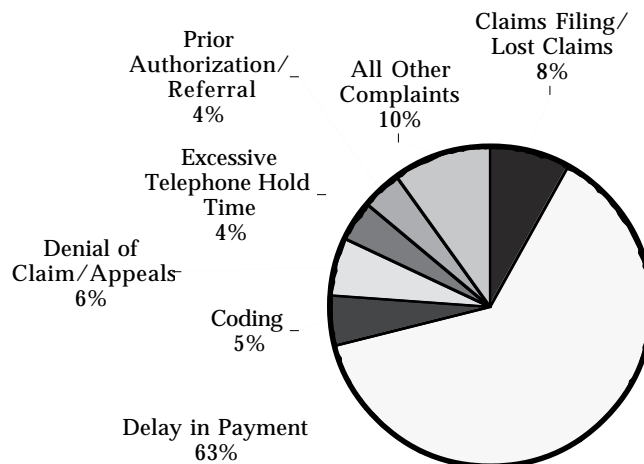
Hopefully most of you have heard of the CMS Hassle Factor Project by now. The project was announced last September in a statewide mailing to all members, and many of you have participated by submitting your complaints - over 900 to be precise. The goal of the project is to gather specific information regarding the wide variety of problems facing physicians' offices when dealing with third party payers. The information received is evaluated to determine what actions should be taken on behalf of CMS members.

What you may not be aware of is *what* CMS is doing with the information we receive. In response to these complaints:

- CMS staff has initiated meetings with representatives of several of the larger local insurance companies, as well as the Colorado Division of Insurance. In many cases ongoing meetings have been established not only to address problem claims, but to also be kept up to date on potential problems.
- The Colorado HMO Association has been briefed on the project, and they have expressed an interest in working cooperatively to resolve the issues. Some of the top complaints and suggestions for improvements will be presented at their meeting next month.
- CMS was part of the Timely Payment Work Group put together by the Colorado Division of Workers' Compensation to address similar problems in the area of workers' comp. We are working cooperatively with the Division to disseminate the information gathered during these meetings.
- Data from the Hassle Factor Project was helpful in gathering support for our timely payment bill (HB 99-1250) in the state legislature. (See page 2 for more details.)
- We are also networking nationally with the AMA and other state medical societies regarding common problems and solutions.

The second phase of the Hassle Factor Project is the development of a bimonthly newsletter for the office staff of CMS members. The purpose of this newsletter is to provide feedback directly to the people who will benefit from it the most. We will not only provide you with updates on the project, but also information and tips gained during our investigations which may alleviate some of the hassles (especially the "self-inflicted" ones).

We are excited to have this opportunity to communicate directly with the office staff. We hope you will find our newsletter helpful and informative. If you have ideas for articles, please provide us feedback!



### Hassle Factor Project Top 5 Complaints

- 63% Delay in Payment
- 08% Claims Filing/Lost claims
- 05% Coding
- 06% Denial of Claim/Appeals
- 04% Prior Authorization/Referral

# House Bill 99-1250

## What is ERISA?

House Bill 99-1250 concerning requirements for the prompt payment of health insurance claims was introduced into the Colorado Legislature this year as a **first step** toward resolving timely payment problems. The bill *requires health insurance entities to pay “clean” claims (i.e., those filed on the insurer’s standard form and containing all necessary information) within 30 days after electronic filing and 45 days after paper filing unless the claim is disputed. Requires investigation and payment or settlement of disputed claims within 90 days, absent fraud.*

Following are the important elements of the bill:

- A “clean claim” is defined as *a claim for payment of health care expenses that is submitted to a carrier on the carrier’s standard claim form with all required fields completed with correct and complete information in accordance with the carrier’s published filing requirements. “Clean claim” does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent...*
- Every carrier must provide a participating provider with a copy of its filing requirements when accepted into the carrier’s network, and within 30 days after any change in the standard form or filing requirements.
- A clean claim must be *paid, denied or settled within 30 days after receipt by the carrier if submitted electronically and 45 days if submitted by other means (hard-copy)...*
- If additional information is required to process the claim, the carrier must provide you (or the patient) with a complete explanation of the information required within 30 days after receipt of the claim. The carrier may deny the claim if you do not provide the additional information within 30 days of receipt of the request.
- The carrier must settle all claims, other than clean claims, within 90 days after receipt.
- A carrier that does not settle a clean claim within 30/45 days; contact you for additional information within 30 days; or settle any other claim within 90 days shall pay the physician (or patient if you are not participating with the plan) *interest at the rate of 10% annually on the total allowed amount, accruing from the date the payment was due...*
- A carrier that fails to pay, deny or settle a claim within 90 days after receipt shall pay a penalty of 3% of the total amount allowed.
- If a carrier delegates the claims processing function to another entity, such as a physician organization (e.g., PMG, POD), the carrier shall require that entity comply with these same timely processing standards.
- *This act shall take effect January 1, 2000 and shall apply to claims submitted on or after said date.*
- The bill applies to fully insured health insurance plans in the state of Colorado. It does not apply to self-insured health plans (such as unions and large employer groups). These plans are subject to federal ERISA (Employee Retirement Income Security Act) laws.
- The bill does not apply to Auto No-Fault and Worker’s Compensation, they are already subject to other processing requirements.

The insurers are not required to automatically access themselves interest and/or penalties if they do not meet these standards. It may be necessary for your office to monitor the processing and notify the carrier if it looks like the claim was not settled within the required timeframe. CMS is looking into the possibility of developing a form letter that can be used by physicians’ offices to expedite and track this process. If you would like a copy of the complete bill, you can contact Marilyn Rissmiller at (303) 779-5455 or 1-800-654-5653, ext. 2428.

It is the Employee Retirement Income Security Act of 1974. The primary purpose of this federal law was to protect private employee pension plans from abuse and mismanagement. However, the law also 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.







**The Colorado Division of Insurance estimates that 50% of the people getting health insurance through their employer are covered under an ERISA plan.**

In a 1990 policy paper, the American Society of Internal Medicine defined the “HASSLE FACTOR” as:

*The increasingly intrusive and often irrational administrative, regulatory review and paperwork burdens being placed on patients and physicians by the Medicare program and other insurers.*

## Cleaning up your claims submission:

There are a number of things to consider when your claims go unpaid. Inspection of your unpaid claims can reveal not only deficiencies in the insurance carrier's claim processing system, but also in your own submission. Claims go unpaid for any number of reasons and are often returned or held for additional information. Unfortunately, many times the returned claim or letter requesting additional information is not directed to the person in the office who originally filed the claim, so problems can continue to recycle themselves. Before automatically refiling a claim, look at it to be sure it has been completed correctly and includes all of the necessary information that patient's insurance carrier requires. Ginny Roath of Timely Insurance Payment Services, Inc. offers the following suggestions for improving your billing:

-  Maintain a verification system to confirm the carrier received your claims.
-  Keep records to track and monitor all returned, rejected and "unclean" claims.
-  Set up systems and strategies to reduce future unclean claims submission.
-  Audit for unpaid claim patterns that may indicate problems in your office.
-  Review unpaid claims with a provider rep. to further isolate submission problems.
-  Establish standards, goals and objectives for clean claim reporting in your office.

## When is a delay in payment not a delay?

Often the phrase *delay in payment* is used too loosely, what is really meant is *delay in processing*. Timely processing includes those instances when no payment is issued because the claim has been denied, applied toward the deductible, returned for additional/corrected information or "bundled" into another service. Even if no payment has been made, from the insurance company's point of view the claim has been *finalized*. From your point of view it is important to distinguish between these actions, as the follow up required can be very different. You are not going to be able to resolve most outstanding claims simply by refiling the original claim. That is generally only effective if the first claim was *really* lost. Consider the following:

- A denied claim that is rebilled without any new information will be denied again. At this point it is important to understand *why* the claim was denied. In some cases it is possible to submit a corrected billing, others may require a letter of explanation. Follow the insurance company's procedures for correcting your claim or requesting a review of their original determination.
- If your charges have been applied toward the patient's deductible, or if the claim has been denied because the patient was not a member at the time of the service, *the patient is responsible*.
- If a charge has been "bundled" it is important to understand what the other procedure or service is that it has been included into. These are usually issues that will require some type of medical review, and probably a letter from the physician indicating specifically why the procedures should be allowed separately.

## Medicare/Medicaid Crossover



### note

Did you know that the Medicare crossover message that states *this claim has been forwarded to Medicaid for processing* does not qualify as "proof" of timely submission of the claim. Timely filing for crossover claims is 120 days from the date Medicare processed the claim. Medicaid advises that you should allow 30 days from the date you receive the crossover message for their processing. If after 30 days the crossover claim does not appear on your Medicaid Remittance Statement, you should file the claim directly. There may be a problem with the Medicare-Medicaid numbers for the patient or the physician that keep the automated process from working correctly.

#### Other Medicare claims that don't crossover automatically:

- Railroad Retirees
- Denied claims
- Adjusted claims
- Claims allowed at 100%

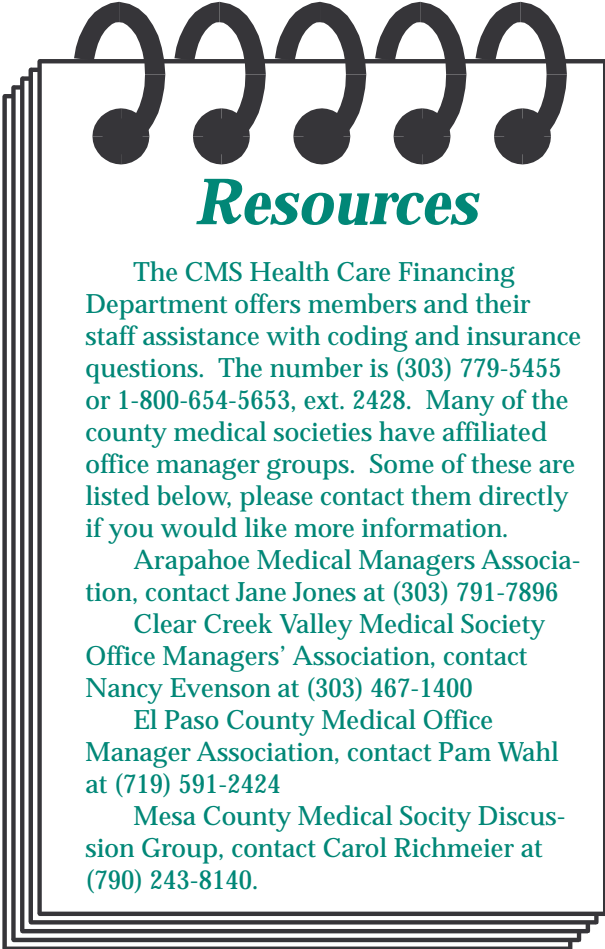
## Mark your calendar for the 1999 Medicare Workshop nearest you

The Medicare Carrier, Noridian Government Services, will be conducting Part B workshops throughout the state beginning in June. This year the workshops will be broken down into several different sessions. Those of interest to the physicians' office staff include: Medicare Basic Billing, Intermediate Billing and Surgery Billing. Attendees will receive updates for their "Medicare Basic Billing Manual" (if you don't have this manual, a copy will be provided at the workshop).

The Basic Billing workshop is a comprehensive all day session designed for the new billing staff. In addition to an introduction to Medicare, some of the topics to be covered include provider enrollment, claims submission, how to read the remittance advice and appeals rights. The Intermediate Billing workshop is a half day session for billing staff with more experience. It will cover medical policies and the Carrier Advisory Committee, modifiers and the Correct Coding Initiative, E&M visits and consultations, as well as the remittance advice and appeals rights. The Surgery workshop is a half day session for the more experienced staff. It will focus on issues such as bundled services, the global surgical period and surgical modifiers.

To register, you must return the pre-printed enrollment form approximately 14 days prior to the session you wish to attend. There is a charge of \$90 per person, for the all day session, and \$45 per person, for the half day sessions. If you did not receive the workshop form in the mail, call (303) 858-5989 or (701) 277-6565 to obtain one.

Colorado Medical Society  
P.O. Box 17550  
Denver, Colorado 80217-0550



## Resources

The CMS Health Care Financing Department offers members and their staff assistance with coding and insurance questions. The number is (303) 779-5455 or 1-800-654-5653, ext. 2428. Many of the county medical societies have affiliated office manager groups. Some of these are listed below, please contact them directly if you would like more information.

Arapahoe Medical Managers Association, contact Jane Jones at (303) 791-7896

Clear Creek Valley Medical Society Office Managers' Association, contact Nancy Evenson at (303) 467-1400

El Paso County Medical Office Manager Association, contact Pam Wahl at (719) 591-2424

Mesa County Medical Society Discussion Group, contact Carol Richmeier at (790) 243-8140.