Key Strategies for Successful Out of Network Billing

ASC BILLING SPECIALIST, LLC
Suzanne Webb - COO

What does it mean to be Out of Network?

- In simple terms it means you as the provider do not have a contract with this Insurance Company or Specific Payer.
- The patient also has to have benefits that allow him to utilize your facility or practice if you are out of network.

How do you find the Employers that offer PPO Benefits

- Do your homework.
- Contact the employers in your area and ask for their benefit package, most are listed on-line.

Benefits are decided by Employers *NOT* Insurance Carriers.

This is very important as each business gets to elect their insurance plans. There are great PPO plans with Aetna, Cigna, United Healthcare and others.

Don't get confused by Insurance Companies we are looking for employer plan.

Who are the Employers?

1) From your EMR, PM or whatever system you use run a report that will give you the Aetna Employers. If the information is not on the insurance cards go to the EOB's (Explanation of Benefits) they will list the employers group.
2) Start your own data base of the Employers in your area.
3) Then market directly to them.
4) For example in Los Angeles there was a great plan...(employer) up until 2012 offered a plan that provided for employee advocates they would reopen the claim with Aetna Global Claims Services (GCS) which would offer 55-90% of billed charges. Not a percentage of Medicare but a percentage of billed charges.
5) This is what you are looking for, employers that offer a PPO plan based on billed charges. The next slide will explain the verification process required.

Next Step

Pricing of Claims

- ✓ Based on Global Fee for time & supplies
- ✓ Be consistent
- ✓ If $5,000 OR time, add in Setup fee of $1,750 & Recovery of $1,250 per hour.
- ✓ If something is brought into the OR for the patient then it is added to supplies & worked up

Sample A
Paid Cases both Insurance & Patient
Monthly 2012 DOS only

Payer	Charges Amount	# cases	Payments	Payer Mix %	Avg Pymnt	% of Rev	IN$ AR	PT AR
Aetna	$ 44,140.00	9	$ 28,342.75	6.92%	$ 3,149.19	22.22%		$ 500.00
APIPA	$ 26,950.00	5	$ 3,155.00	3.85%	$ 631.00	2.47%		
BC Federal	$ 4,270.00	1	$ 150.00	0.77%	$ 150.00	0.12%	$ 4,270.00	$ 500.00
BC Local	$ 3,000.00	1	$ 227.00	0.77%	$ 227.00	0.18%		
BC Out of Area	$ 13,370.00	3	$ 1,022.05	2.31%	$ 340.68	0.80%		$ 1,457.75
BC Medicare replace	$ 7,350.00	1	$ 481.43	0.77%	$ 481.43	0.38%		$ 250.00
Banner	$ 24,750.00	4	$ 7,785.70	3.08%	$ 1,946.43	6.10%		
Cigna	$ 15,850.00	2	$ 10,388.65	1.54%	$ 5,194.33	8.14%		
Corp Benefit	$ 4,900.00	2	$ 3,332.00	1.54%	$ 1,666.00	2.61%		
Gallagher Bassett	$ 14,700.00	2	$ 13,437.50	1.54%	$ 6,718.75	10.53%		
Golden Rule	$ 4,900.00	2	$ 548.00	1.54%	$ 274.00	0.43%		
Health NZ	$ 9,800.00	2	$ 4,500.00	1.54%	$ 2,250.00	3.53%		
Humana	$ 13,400.00	1	$ 1,628.59	0.77%	$ 1,628.59	1.28%		
Liberty	$ 4,963.75	1	$ 4,963.75	0.77%	$ 4,963.75	3.89%		
Medicare	$ 21,987.82	39	$ 19,906.79	30.00%	$ 510.43	15.60%	$ 537.72	$ 100.00
Pacificare	$ 9,800.00	2	$ 613.84	1.54%	$ 306.92	0.48%		$ 153.46
Tricare	$ 19,600.00	4	$ 1,827.00	3.08%	$ 456.75	1.43%		$ 261.00
United Healthcare	$ 225,600.00	47	$ 21,065.59	36.15%	$ 448.20	16.51%		$ 2,311.98
Zenith	$ 9,800.00	2	$ 4,200.00	1.54%	$ 2,100.00	3.29%		
TOTALS	$ 479,011.57	130	$ 127,575.64	100.00%	$ 987.35	100.00%	$ 4,807.72	$ 5,484.19

Payer Mix 76.93% Medicare or Lower than Medicare contract rates.

Collection rate 98.46% Processed cases 128 primary insurance claims.

Payer Mix Analysis

Where's the revenue coming from?

- Aetna has 22%
- United Healthcare 16 %
- Medicare 15%

Let's look at the amount of time spent on Aetna patients. There were 9 cases that brought in $28,341.75. Average case rate of $3,149.19.

Now UHC was second in revenue but had 47 cases for revenue of $21,065.59, average case rate $448.20

Let's discuss this …….

Facility Negotiations

Out of Network Facility Claims Paid at Usual and Customary are negotiated by a 3rd party per the industry

- Viant
- Multi-Plan
- HealthNow
- National Care Network
- Global Claims Services

Facility
Negotiations
Updated 09/30/2012

Negotiations

Employer	Patient Name	3rd Prty Nego'tr	DOS	Payer	Billed Charges	Allowable Amount	Date of Signed Agreement	Agreed Payment	Check Date
Employer #1	Patient #15	GCS	05/22/2012	Aetna	$ 25,000.00	$ 17,000.00	06/25/2012	$ 17,000.00	07/18/2012
Employer #20	Patient #34	NCN	01/06/2012	BlueCross	$ 15,000.00	$ 9,600.00	02/15/2012	$ 9,385.16	07/13/2012
Employer #21	Patient #36	GCS	02/10/2012	Aetna	$ 14,100.00	$ 11,985.00	02/28/2012	$ 9,312.61	07/27/2012
Employer #22	Patient #38	NCN	05/10/2012	BlueCross	$ 10,000.00	$ 6,000.00	06/14/2012	$ 5,542.16	06/27/2012

Negotiations – 4 Biggest Companies

If plan allows a reopen of a claim:

Aetna uses Global Claims Services -

- Offer will be faxed
- Sign and Return it

Anthem uses National Care Network -

- Offer will be emailed
- Counter back by email
- Max Offer usually after 1 counter
- Keep your own date to set expectation

Re-Opened Claims

A lower than Usual and Customary claim is paid:

- It's okay to cash the check
- Contact the Insurance company's claim department and re-open the claim
- You do not have to accept the underpriced allowable amount
- The Insurance Co. prices the allowable in their favor

Facility
Re-opens Low Payments

Employer	Patient Name	3rd Prty Reqstr	DOS	Payer	Billed charges	Allowable Amount	Date of Signed Agreement	Initial Payment	Second Payment	Check Date
Employer #1	Patient #1	OCS	05/23/2012	Aetna	$ 16,500.00	$ 10,500.00	07/12/2012	$ 23,954.34	$ 24,944.13	07/27/2012
Employer #2	Patient #2	Vert	04/06/2012	Cigna	$ 14,100.00	$ 7,000.00	06/12/2012	$ 922.39	$ 840.21	07/23/2012
Employer #3	Patient #3	OCS	04/06/2012	Aetna	$ 20,000.00	$ 16,000.00	07/02/2012	$ 9,969.90	$ 6,331.98	07/10/2012
Employer #4	Patient #4	Vert	06/12/2012	Cigna	$ 14,100.00	$ 4,940.00	06/14/2012	$ 3,888.13	$ 1,250.87	07/01/2012

INSURANCE VERIFICATION

Provider Name
123 Main Street
City, ST 12345
Tax ID: 123456789 NPI: 1234567890

Patient name: _____ Date of Birth: _____ Self / Spouse / Child / Other
Subscriber Name: _____ Date of Birth: _____
Ins Carrier: _____ Eligibility Tel#: _____ Primary / Secondary / Other
Claim submission address: _____ Timely Filing: _____
Subscriber ID: _____ Group#: _____ Effective Date: _____ Active
Surgeon: _____ Tax ID#: _____ NPI#: _____ Inpatient / Outpatient
Scheduled Date: _____ Benefit Type: Outpatient Surgery: Non-Par/Out of Network ASC

CPT Code: _____ _____ _____
Description of procedure (s) *(include (yes/no) equipment/implic(if invoiceable)*

ICD-9 Code: _____ _____ _____ _____ _____ _____
Description of diagnosis(s)

Plan Type (Circle): PPO - POS - Indemnity - Medicare Replacement - HMO – Workers Comp
Plan/Product Name: _____

In Network	Deductible Amount	Amount Met	Coinsurance Year	Other		
Individual			Out of Network Individual	Deductible Amount	Amount Met	
Family			Family			
In Network	Out of Pocket	Amount Met	Out of Network	Out of Pocket	Amount Met	
Individual			Individual			
Family			Family			
Benefits Cross Accumulate/Combine INSCON			Applies to Out of Pocket	Limit	Costs	

Allowable based on (Circle): MNRP - UCR/R&C - Benefit Limit - Medicare – Fee Schedule

Benefit Levels		Benefit Limitations	
In-Network Hospital:	%	Lifetime:	
In-Network Facility:	%	Annual:	
Out of Network Professional:	%	Lifetime:	Unlimited / Other
Out of Network Facility:	%	Accident/Occurrence:	

Separate copay or deductible for outpatient surgery/ambulatory surgical facility: _____
Pre-Existing/Waiting Period: N/A: ____ Effective Date: _____ Expiration Date: _____
Pre-Certification/Authorization#: _____ Require Separate Facility Auth: Y N
Reference#/Representative Name: _____
Name of Person Completing Form: _____ Date/Time: _____

Workers Compensation Information:

Adjuster:		Tel#:		DOI:	
Claim#:		Auth#:		ICD9:	
Employer:		Carrier:		Referring Dr:	

STEP BY STEP

Instructions for Insurance Verification Form

Complete the following sections prior to the call so that all information is readily available:

- Patient Name
- DOB
- Subscriber Name (if applicable)
- Subscriber DOB (if applicable)
- Insurance Carrier Name
- Eligibility Telephone#
- Subscriber ID#
- Surgeon
- Surgeon Identifying Information (Tax ID#/NPI)
- Scheduled Date
- Benefit Type/Category
- CPT Code
- ICD-9 Code
- Name of Person Completing Form
- Date/Time

If available, complete as much of the form utilizing carrier websites/automated systems then VERIFY the information that you obtained through a live representative at the insurance carrier. Specifically address all discrepancies with the representative. Most carriers will have a designated prompt available for benefits & eligibility. Procedure is not considered completed until all details have been confirmed by a live representative in the appropriate department & recorded by reference#/representative name/date/time.

It is your responsibility to fully understand the benefits quoted to you and to clarify any aspects that you could not fully explain to an inquiring provider or patient. Representatives tend to speed through their quotes if they go to fast ask them to slow down or repeat the details. If necessary request to be transferred to another representative or supervisor.

Complete the form based on the benefit quote received:

- Is the plan subscriber the patient (self) or another person (spouse, child, other)? Include subscriber information if available
- Effective Date: Record the original & effective (if applicable). Verify date Coordination of benefits(COB) was last updated
- Is the plan currently active? If plan is a month to month the representative will only be able to confirm if premiums are paid through a certain date, benefits should be verified again immediately preceding the procedure to confirm status.
- Benefit Type/Category: Outpatient Surgery at a non-participating/OON Ambulatory Surgical Center, Non-Hospital Facility (UB form)
- Record the plan type & product name, if available
- Is the plan a calendar year plan (benefits calculated from January to December, note: some plans may allow carryover from the previous year to be applied)
- Record the quote of Deductible & Out of pocket/Stop Loss amounts & accumulations
  - Clarify what applies to the plan out of pocket-deductible, coinsurance, non-covered amounts, etc.

INSTRUCTIONS

  - Do the benefits cross accumulate/Combine INSCON?
- Record the benefit levels
  - Confirm how the allowed amount is determined:
    - MNRP=Maximum Non-Network Reimbursement Price: Rate based on a percentage (typically between 110-150%) of the published rates allowed by Medicare.
      - Amgen changed to this type of benefit effective: 1/11/12 (Aetna)
    - UCR/R&C=Usual, Customary, Reasonable or Reasonable & Customary: Rate based on statistically credible information derived from a comparison of fees charged by providers of equal specialty or credentials within the same geographic area during the same time period.
    - Medicare Fee Schedule
    - Shared Savings/Negotiations: Rates negotiated through a 3rd party vendor. If the representative states a specific vendor is used by the plan notate the name & contact information, if available.
    - Fee Schedule: Even if the provider is out of network some plans will limit reimbursement to the same fee schedule that contracted providers agree to. Representative should be able to tell you the exact amount since the fee schedules are published, or be able to connect you to a department that can. If the carrier requires a separate form to release the fee schedule request a copy be forwarded.
    - Benefit Limit: Maximum allowable/payable amount limited by benefit per day (per diem), annually, lifetime or per occurrence.

      Be sure to clarify if the limitation applies to an "allowed amount" or "payable amount". If the plan limits the allowed amount then the coinsurance levels may still apply, but if it limits the payable amount then the facility should receive the entire per diem reimbursement. Any amount over the per diem owed to the facility fees/charges that must be verified through the carrier.

      - Common Max plans include:
        - Blue Cross CA plans: $350 or $540
          Typical ID Format: 3 letters, 3 numbers, "A", five numbers (XXX123445678)
        - Blue Shield CA plans $350 or $600
        - Aetna: $400
        - UHC: "Alternate Facility" Allowable limited to $2500
        - Screen Actors Guild (SAG): $1,000
        - United Food Commercial Workers (UFCW): $1,000
        - Operating Engineers
    - Other: If the method used to determine is not one listed here clarify with the representative & inquire the description of those benefits are available in writing.
- Is there a separate copay/deductible for either outpatient surgery or non-participating facilities? Note the amount & any accumulation; typically these types of patient responsibilities are due per occurrence not just once a year like most deductibles.

- Is the patient currently subject to any pre-existing condition policies or waiting periods? Double check with the representative if the plan effective date is within the last 18 months. If a waiting period has been imposed record the Effective & Expiration date and inquire if it is for all services or limited to a specific diagnosis.
- Is Pre-certification/Authorization/Notification required? (pay attn/ these terms as they vary by plan) Many plans do not require pre-certification for outpatient surgery even when performed at a non-participating ASC, but that MUST be confirmed. Even after the representative says "outpatient surgery doesn't require auth (pre-cert)" you are REQUIRED to verify by inquiring if "Can you please confirm if separate review is required because the facility is non-participating/out of network" After they verify that then explain that occasionally the plan wont require it for the facility but does due to the coding and ask them to verify the specific cpt codes. If the codes do not require review of any kind the representative should still be able to confirm that they are valid & billable. If review is required & you have all required information (see below) request to be transferred at the completion of the benefit quote to the appropriate department to begin the authorization.
  - Confirm Non-Participating/Out of Network Status & Outpatient
  - Patient Identification information
  - Facility Identification information, including address & contact info
  - Surgeon Identification information, including address & contact info
  - Date of procedure, # of days requested+1
  - Specific diagnosis & procedure codes

Record the representative name & reference# for both the benefit quote & the authorization request.

ASC BILLING SPECIALIST, LLC

Suzanne Webb - COO
Main: 602-298-2653
www.ascbill.com
Suzanne@ascbill.com

Billing Specialist, LLC