Insurance 101: Understanding your Rights and Responsibilities

Village Pediatrics recognizes that health care costs are significant, and insurance premiums (though not reimbursements) have risen rapidly in the last several years. Dr. Nikki and Dr. Jenn created Village Pediatrics with the goal of providing physician driven, timely and personalized care. Most pediatric offices can financially survive only by seeing large volumes of patients and instituting charges for school forms, after-hours phone calls to nurse triage services, weekend/holiday visits and other administrative fees. We are able to limit our number of patients, increase our visit times, and have providers return all after hours phone calls by limiting our insurance carriers to those who pay at acceptable rates, and by subsidizing many uncovered administrative costs by our Added Benefits Plan. Our after-hours/weekend fees are modest (the lowest in the area), our phone charges are rare (typically for extended phone care that replaces the need for a visit) and there are no hidden fees for any of our services. We have carefully anazlyed every charge to minimize your cost while maintaining our level of practice. Please refrain from asking billing questions at front desk – our receptionists are focusing on scheduling visits and getting your sick children seen promptly. If you have concerns about your bill, and have not been able to get a timely or acceptable answer from our billing service, please email us at vpbilling@yahoo.com and the appropriate staff will respond promptly.

Please understand that at Village Pediatrics we are commited to practicing evidence based medicine and not letting insurance companies dictate what we can and cannot do. We strive to keep your children healthy through many screening methods, including developmental screening, hearing and vision monitoring, lipid panel checks, and vaccinations. It is impossible for us to keep track of what each individual policy covers, and what we recommend for your child is not based on insurance company policy. If you are concerned there may be extra charges at the time of a visit, you should delve deep into understanding the plan that your family has selected for your children. In our experience insurance companies are much more concerned about their bottom line than your child's health.

Insurance Basics

Understanding your insurance policy is vital to coordinating your child's health care. Here are a few tips to ensure the correct handling of your insurance claims:

Carry your insurance card with you at all times. It should have your name or the names of your covered dependents, the policy and group numbers, the claims mailing address and phone number, and the co-pay information. If your card does not have this information, make sure you bring it with you to the doctor's office, as it is vital for ensuring your eligibility. Your doctor may not be able to see you without verification of insurance benefits, or you may have to pay out-of-pocket for the visit.

Understand your insurance benefits. Your insurance plan decides which benefits are covered, and whether or not they will allow the benefit and pay for the service. Your doctor's office does not make this decision. If your policy does not cover the service, you will be responsible for the full amount. If your insurance allows the service but applies it to your deductible, you will be responsible for the allowable amount, as negotiated between your insurance company and your doctor's office.

Understand which specialists and laboratories are in-network with your plan. The best way to verify that the specialist, doctor, or lab is in-network is by calling your insurance company directly. Not verifying this information may cause you a costly mistake if it turns out that your doctor is not in-network and the full amount of the visit is applied to your balance.

Know when your coverage dates begin, and when your policy comes up for renewal. If there is a problem with your coverage, call your doctor's office as soon as possible to let them know, and to see if they can help you resolve the issue. Your doctor's office may also be able to help you resolve any further claims issues, including filing appeals and making sure claims were processed correctly.

Knowing your insurance benefits and how your claims are processed will help you save time, energy, and money.

Know Your Financial Responsibilities

There are three different categories of patient responsibility: Co-pay, deductible, and coinsurance. The **co-pay** is the amount of money that you must pay up-front before seeing the doctor. The **deductible** is the amount of money that you must pay out-of-pocket before the insurance will begin paying on claims. The deductible is not the full amount of charges, however. It is the amount allowed by your insurance company as negotiated between your doctor and your plan, and the limit may be set very low ($250) or very high ($5,000), depending on your plan. Once you have met your deductible, insurance will begin paying your doctor the allowed amount of charges. If you have a plan that requires you to pay after you have met your deductible, you will be paying a coinsurance amount. **Coinsurance** is generally a percentage of the allowed amount, as negotiated between your doctor's office and your plan. For example, if you have a 20% coinsurance, then you will be responsible for 20% of the allowed charges, and your insurance will pay the remaining 80%.

QUESTIONS YOU NEED TO ASK YOUR INSURANCE COMPANY BEFORE YOUR CHILD'S NEXT WELL VISIT

Many insurance carriers limit the amount they will pay for physical examinations and immunizations, i.e. well visits, for dependent children. The practice is becoming more common and the limits are getting lower.

Typically the limits are expressed in terms of dollars per child per calendar year. In some cases the limits vary with the age of a child. In other words, if you have children of different ages, each may have different well visit reimbursement limits under your insurance policy. **In all cases, you are expected to pay for amounts your insurance company deems fair but which exceed a child's well visit limit.**

To avoid unpleasant financial surprises, here is what you should do before your child's next well visit:

- ✓ Read your insurance policy carefully to see if there are limits on payments for well visits. If you have trouble understanding what the policy says, call your carrier's customer service department and ask. You might also enlist the help of your employer's benefits person. Do whatever you have to do to find out if you have a well visit limit. Don't just make sure you have well *benefits*; find out if there is a well visit *reimbursement limit*. Because of the number of patients we have, it is impossible for us to obtain this information. Since your insurance policy represents an agreement between you and your insurance company, furthermore, it is appropriate that *you* should obtain the information.

- ✓ If you do have a limit, you also need to find out how much the insurance company has already paid against it. As an example, if your calendar year limit is $500 for a child, and if your insurance company has already paid us and/or other physicians $480 for well visits, they are going to pay us only $20 for that child's next well visit, regardless of what our charges are. You will be expected to pay us the remaining portion of the amount allowed by your insurance company.

Charges at a Well Visit? "I thought well visits were covered…"

Not uncommonly, when a child comes in for a check-up, and has another presenting problem that is dealt with on the same day, the doctor codes an additional charge. **One charge is considered the preventative medicine service (the well check), and the other is a problem-oriented service (problem visit).** For example, you present for your baby's 12 month check up, but he also has an earache and is diagnosed with an ear infection. The doctor will perform all necessary well child exam protocols, including growth, development, and administering vaccines, as well as a problem-oriented exam of the ear infection, including any necessary prescriptions. Another less clear-cut example would be that you present to the office with your five-year old for his well child exam. As well as performing all necessary preventive evaluation and management services for the well check, the doctor also discusses his medical history of asthma with the parent, asks any problem-oriented questions regarding his asthma, as well as any necessary physical exams, and refills his

prescriptions for asthma medications. The same guidelines would apply for any other abnormality or preexisting problem encountered at the well child exam.
According to the American Medical Association's coding guidelines, "if an abnormality(ies) is encountered or a preexisting problem is addressed in the process of performing a preventive medicine evaluation and management service, and if the problem/abnormality(ies) is significant enough to require additional work to perform the key components of a problem-oriented service, then the appropriate office/outpatient code should also be reported…The appropriate preventive medicine service is additionally reported" (page 30, *CPT 2004* {professional edition}). Thus when we complete a well visit, as well as addressing an acute or chronic illness at the same time, we bill for two services (two "E&M" codes) attached to a "modifer -25" to indicate that two separate and distinct services were provided at the same visit.

A new twist in the use of the Modifier -25 is that insurance companies are putting this cost to the consumer, which is what leads to many billing questions. The extra cost often includes a co pay on the same day of service, since multiple issues were covered on that date. Please understand that it is your insurance contract that requires you to pay this portion, not our office specifically. We cannot write-off this co-payment as it would be considered insurance fraud on our part. It is also illegal to code a well-visit as a sick visit to alter a patient's payment responsibilities.

Unfortunately, because of your insurer's payment policy, in some cases we may have to complete your wellness care and your illness care in **two separate visits** to allow appropriate billing. If you have a health problem you want to discuss with your doctor during your well visit, the doctor may decide to treat that problem and ask you to schedule another appointment for your well visit. If the additional concerns are not urgent, you will be asked to schedule a separate visit to have that problem addressed.

An "Explanation" of the "Explanation of Benefits"

You will see several basic areas- first is the **provider charge**. Typically office charges in medical offices are set high, to "capture" the highest allowable insurance payment. We realize that many of these charges are now passed on to you, either as a self-pay patient or due to unallowed charges by low cost insurance plans. For that reason, we very carefully set our charges at a reasonable and customary amount, and allow a 20% "cash discount" **if the charges are paid at the time of visit**. Our cash prices are on average similar in cost to insurance negotiated payments, and in several cases lower than some insurance payments.

Second, you will see **"provider responsibility"-** this is the discounted part of the fee that Village Pediatrics has agreed to when contracting with your insurance plan.

Third, you will see **"amount allowed by benefit"** These charges may be paid by your insurance, or may be passed on to you due to a deductible. If a charge is "disallowed" the charge will be passed on to the patient. We cannot discount the costs passed on to the patient by your insurance company, as it is illegal and would violate the terms of our contract with your insurance company.

Many insurance plans seem to save you money, but do not cover all of the typical costs of an office sick or well visit. Tests such as hearing, vision, and certain blood tests may not be covered. Often physical exams are limited to every few years. WE DO NOT PRACTICE MEDICINE BASED ON INSURANCE ALLOWED CHARGES. We practice medicine based on our extensive training, experience, and by the "Bright Futures Guidelines" as set out by the Academy of Pediatrics , http://brightfutures.aap.org/index.html. These guidelines detail the recommended screening tests and immunizations pediatricians are expected to carry out at each well visit through the age of 18.

If your insurance company has decided that they will not pay for a particular procedure the payment will be your responsibility. We have had patients ask us "not to do anything not covered by insurance." We cannot practically do that as there are thousands of plans within the four insurances we accept. We ethically cannot do that as it would violate our standards of care. If you are concerned about your coverage, please contact your insurance company prior to your child's visit to see if the following common physical exam charges are covered:

Hearing: 92587 OR 92553

Vision: 99173 OR 92015

Fingerstick blood sample: 36416

Hemoglobin: 85018

Lead: 83655

Lipid panel: 80061

Urinalysis: 81002

If you wish to waive any of the above tests we will require you to sign a waiver acknowledging that you are opting out of a recommended screening test for your child. If your child has had one of the tests elsewhere (i.e. sees an eye doctor yearly, or had bloodwork elsewhere) the tests DO NOT need to be repeated in our office. You must notify the front desk of your wish to waive any tests **prior to being triaged by our Medical Assistant**.

In recognition of the expense of medical care, and the increasingly limited coverage of many insurance plans, we are happy to offer a 20% discount to cash payments at the time of visit for "uncovered services" i.e. services that are not covered at all by your plan and not applied to your deductable or copay." If you know in advance that a particular procedure will not be covered we can extend the cash price if PAID AT THE TIME OF THE VISIT. Again, we must ask that you contact your insurance company prior to your visit to determined covered and covered charges. "Amounts allowed by benefit" that are passed on to the patient as part of a deductible or copay have ALREADY BEEN DISCOUNTED, thus cannot be adjusted

Time to Renew Your Policy?

Some things to consider

Many policies have re-enrollment periods in the fall or near the end of the year. During this time, make sure you review all new information to ensure that your policy will remain the same. Many plans will change the co-pay, deductible and coinsurance amounts, which could affect your wallet later on in the year.

During the re-enrollment period, you may also be able to change plans entirely, so it's important to know what to look for in family coverage. In order to choose the right insurance, review the policy information carefully, including what benefits are covered. Vaccinations are very expensive, and some plans exclude them, so make sure they will be covered for your children. Also, verify the coverage amounts for both well child exams and sick visits, as they may be processed differently.

Understand which type of visits will be subject to deductibles or coinsurance amounts, and weigh the pros and cons of high-deductible plans with low premiums and low- or no-deductible plans with higher premiums. There are many varieties of plans available, so take into account your general healthcare needs and the needs of your family, as well as financial problems that might arise if you choose the plan that is wrong for you.

Furthermore, do some research on the different classes of insurance plans: Fee-for-service, HMO, and PPO. Always verify that your provider is in-network with your plan before making your decision. You may also want to consider an HRA or HSA account to help you cover your healthcare costs.

Primary v. Secondary

How to coordinate your insurance benefits

If your child is insured by more than one parent, he will have both a primary and secondary insurance. Most commercial medical insurance plans go by the **birthday rule**. That is, the parent with the first birthday in the year will hold the primary insurance, and the parent with the second birthday in the year will hold the secondary insurance. For instance, if Mom's birthday is in January, and Dad's birthday is in November, and they both hold family insurance policies, Mom's insurance will be the primary insurance and Dad's will be secondary. That means that your doctor will file with your primary insurance carrier first, and will file the secondary insurance after the first insurance claim has been finalized, if there is a remaining balance. Some offices do not file secondary insurance, in which case you will have to contact your

secondary insurance carrier to file the secondary claim. Medicare and Tricare will always be secondary to a primary commercial policy. Please note that these are general rules of thumb, and your insurance may administer your plan differently. Contact your insurance benefits and to clarify which one of your insurances is considered primary.
Every once in a while, if you have two insurances, or if you have recently changed insurances, your claim will be denied pending **Coordination of Benefits**. This means that your medical claims will not be paid until your insurances receive word from the policy holder in order to determine which one is primary. In this instance, all you need to do is call your insurance company and let them know which insurance is primary. If you only have one insurance, simply let them know and they should release all claims for payment. Many insurance companies update the coordination of benefits information annually, so don't be surprised if you have to update your insurance every year.
If one insurance policy is cancelled, make sure you update your carriers as soon as possible in order to avoid any mistakes in the payment of your claims.

Health Insurance Glossary

Co-Insurance: Co-insurance refers to money that an individual is required to pay for services, after a deductible has been paid. In some health care plans, co-insurance is called "co-payment." Co-insurance is often specified by a percentage. For example, the employee pays 20 percent toward the charges for a service and the employer or insurance company pays 80 percent.

Co-Payment: Co-payment is a predetermined (flat) fee that an individual pays for health care services, in addition to what the insurance covers. For example, some HMOs require a $10 "co-payment" for each office visit, regardless of the type or level of services provided during the visit. Co-payments are not usually specified by percentages.

COBRA: Federal legislation that lets you, if you work for an insured employer group of 20 or more employees, continue to purchase health insurance for up to 18 months if you lose your job or your employer-sponsored coverage is otherwise terminated. For more information, visit the Department of Labor.

Denial Of Claim: Refusal by an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for health care services obtained from a health care professional.

Explanation of Benefits: The insurance company's written explanation to a claim, showing what they paid and what the client must pay. Sometimes accompanied by a benefits check.

Health Maintenance Organizations (HMOs): Health Maintenance Organizations represent "pre-paid" or "capitated" insurance plans in which individuals or their employers pay a fixed monthly fee for services, instead of a separate charge for each visit or service. The monthly fees remain the same, regardless of types or levels of services provided, Services are provided by physicians who are employed by, or under contract with, the HMO. HMOs vary in design. Depending on the type of the HMO, services may be provided in a central facility, or in a physician's own office (as with IPAs.)

HIPAA: A Federal law passed in 1996 that allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also creates the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care. Full name is "The Health Insurance Portability and Accountability Act of 1996."

Indemnity Health Plan: Indemnity health insurance plans are also called "fee-for-service." These are the types of plans that primarily existed before the rise of HMOs, IPAs, and PPOs. With indemnity plans, the individual pays a pre-determined percentage of the cost of health care services, and the insurance company (or self-insured employer) pays the other percentage. For example, an individual might pay 20 percent for services and the insurance company pays 80 percent. The fees for services are defined by the providers and vary from physician to physician. Indemnity health plans offer individuals the freedom to choose their health care professionals.

Preferred Provider Organizations (PPOs): You or your employer receive discounted rates if you use doctors from a pre-selected group. If you use a physician outside the PPO plan, you must pay more for the medical care.

Primary Care Provider (PCP): A health care professional (usually a physician) who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a "quarterback" for an individual's medical care, referring the individual to more specialized physicians for specialist care.

An **Explanation of Benefits** (commonly referred to as an **EOB form**) is a statement sent by a health insurance company to covered individuals explaining what medical treatment and/or services were paid for on their behalf.

An EOB typically describes:

- the service performed—the date of the service, the description and/or insurer's code for the service, the name of the person or place that provided the service, and the name of the patient
- the doctor's fee, and what the insurer allows—the amount initially claimed by the doctor or hospital, minus any reductions applied by the insurer
- the amount the patient is responsible for.

There normally also will be at least a brief explanation of any claims that were denied, along with a point to start an appeal