Patient Billing & Insurance Information

Q&A

Patient Billing Requirements

At your first visit our office you are required to bring your insurance card and driver's license. Our office will copy this information to keep in your file. If you are a new patient and only have your insurance number written down, then we will need a copy of your driver's license or state identification number to verify your information. If you are an established patient and have new insurance you will need to have your card with you so that we can update your file and send the claims to the correct insurance company. **It is your responsibility to make sure that we have the correct insurance information**.

If you have not received an Explanation of Benefits (EOB) from your insurance company and your medical bill is 4 weeks old you should contact your insurance company. The following information will be helpful the next time you have to contact your insurance company.

- Write down the first and last name of the person you are speaking with.
- If your insurance company has received the claim you should ask when they will be issuing a check.
- If your insurance company has not received the claim you should ask for a fax number.
- Contact your physician's office and ask them to resubmit the claim. Give the office staff the name of the person you spoke with at your insurance company as well as the fax number.

Please contact our office to verify that **Our Physicians** are providers for your insurance company.

How Well Do You Know Your Plan?

We have created a list of questions that you should be able to answer about your insurance coverage. If you do not know the answer to any of the following questions, you should contact you insurance company and review your benefit package.

1. How much is your annual deductible?
2. When does your deductible start over?
3. Is your insurance company a PPO or HMO?

4. Are you required to use physicians listed in a preferred provider handbook?
   Will your benefit coverage change if you go to a provider out of the network? How much?

5. Do you have a list of your coverage exclusions? This can be found in your policy book.

6. Do you need to pre-certify scheduled surgical procedures?

7. Does you insurance require a second opinion on certain surgical procedures?

8. Do you have a prescription drug card?

Usual, Customary, and Reasonable (UCR)

Have you ever received an EOB from your insurance company informing you that your physician exceeds the usual and customary allowance? Did you notice that your insurance company would not pay the amount that they feel is above the usual and customary? If you had a minimal charge the amount is usually not much, but if they do this on a surgical bill it could be hundreds of dollars. You are responsible for the total amount that your provider billed even if your insurance company doesn't pay the total amount billed, unless there is a contract agreement between your insurance company and the provider. If there is a contract agreement, then the amount above the (UCR) is written off as a contractual write-off.

This situation is always very confusing because one insurance company might state that a physician is charging above UCR for a procedure while another insurance company is allowing full price for the exact same procedure.

New Patient vs Established Patient

A **new patient** is one who **has not** received medical services from his physician (or any other member of the physician's group in the same specialty) within the last **three years**.

An **established patient** is one who **has** received medical services from his physician (or another member of the group of the same specialty) within the last **three years**.

Insurance Exclusions

Almost every insurance plan has exclusions. Make sure that you are aware of what your policy does and does not cover. This information should be listed in your insurance handbook.

Tips:

1. If you are not sure if something is covered, contact your insurance company and ask. A customer service representative should be able to answer your questions.

2. Ask your physician to provide you with the codes that will be used to bill the insurance company. After obtaining this information, relay the information to a customer service representative with your insurance company. He or she should be able to tell you if the services are covered.

3. Always ask the name of the person that you speak with at your insurance company. This will prove helpful should your insurance company not pay for a service despite their claim that it would be covered.

Co-pay Confusion

If your insurance is a HMO or PPO you may have a co-pay amount listed on the front of your insurance card. When you visit a physician listed in your insurance company's preferred provider network, you are responsible for the co-pay amount at the time of the office visit. This is very cost effective. However, you must understand your insurance policy. This can also be very confusing!

We often receive calls from patients informing us that they received a statement from our office. The patient states that there must be an error in our billing because he paid his co-pay at the time of the visit. The following list includes just a few reasons that you may be responsible for more than your co-pay amount. We hope that you find this helpful.

1. What is your deductible amount? Have you met it? What costs or services are applied to the deductible?

2. Are x-rays or additional tests (lab work, etc.) covered with the co-pay amount if they are taken on the same day? You could be responsible for 10% of the additional charges in addition to your co-pay.

3. Is the service or device that you are receiving from your physician covered under your insurance plan? Check to see if your plan has exclusions. Your insurance will not pay for items that have been excluded from the plan. You would then be held responsible for payment. This could be alarming if you thought that you would only be responsible for the co-pay or 10% of the bill.

Once again, we urge you to review your insurance policy book. If you have any questions concerning coverage, contact your insurance company. By understanding your insurance coverage you could save yourself time and money.

When Medicare is the Secondary Payer

Under specific circumstances when beneficiaries are covered by other third party payers Medicare can be the secondary payer. Medicare is secondary to employer group insurance, certain health plans that cover aged and disabled beneficiaries, worker's compensation, automobile, and liability insurance. Please notify the physicians billing office if Medicare is considered your secondary insurance. There will be much confusion if Medicare is billed first.

What To Do If You Receive A Check From Your Insurance Company

If you have not paid your doctor you should:

- Contact your physician and inform them that you received a check from your insurance company.
- Find how much your account balance is.
- You can sign the back of the check and send it to your doctor. I have heard of situations when the patient received the check from the insurance company and then didn't pay the doctor.

If you receive a check in the mail from your insurance company I would encourage you to contact our office and make sure that your account is paid so that there are no problems with your account at a later time.

Deductibles

The deductible is the covered expense that the insured and each dependant must pay before the insurance will make a payment.

- Do you know what your annual deductible is?
- Do you know what your insurance company considers a calendar year? Example: Jan 1- Dec 31 or July 1-June 30
- Do you have a plan that waives the deductible if you are involved in an accident?

If you do not understand your yearly deductible, you should speak with a representative from your insurance company and have him explain this in greater detail.

Primary Coverage, VS. Secondary Coverage

There can be confusion concerning insurance coverage when the husband and wife are both employed and each have a primary insurance plan. You will need to determine which the primary is and which the secondary insurance is. In most

cases the subscriber or insured's insurance company is always primary for the subscriber. This means that the husband's insurance is primary for him and the wife's insurance is primary for her. Dependent coverage is determined by the "birthday rule." The insured whose birthday comes first in the year would be considered the primary insurer.

EXAMPLE: Husband's
birthday 11-13-71
Wife's Birthday 06-11-72

In the above example the wife would be the primary insurer. This is because the wife's birthday comes first in the year. The birth year does not matter.

If you have questions about your insurance coverage you should contact your employer and have them explain your insurance coverage to you.

The Level of Your Office Visit

New or Established Patient

Each time you visit your physician he/she must decide the level of your office visit. This is determined by many factors, which include medical history, examination, medical decision making, nature of presenting problem, counseling, coordination of care, and time. Your physician must meet certain criteria in each of the listed categories. This can be very time consuming and usually requires very accurate documentation.

Office Visit Codes

New Patient Office Visit	Established Patient Office Visit
99201-Level 1	99211-Level 1
99202-Level 2	99212-Level 2
99203-Level 3	99213-Level 3
99204-Level 4	99214-Level 4
99205-Level 5	99215-Level 5

These are only the office visit codes. There are many other codes that can be used for hospital visits, emergency room visits, consultations, critical care services, nursing home visits, and so on. Every code listed above should have a different cost. The 99201 or 99211 should cost least and the 99205 or 99215 should cost the most. If you have a minor problem that does not require much care you would probably be charged a level 1 or 2 office visit. If you have a medical problem that has high severity and requires immediate medical care you would probably be charged a level 4 or 5 office visit.

If you have questions about the level of your visit you should ask your physician's billing department. They should be able to answer any questions that you have.

Check Your Bill for Errors

When you receive a bill from a physician or hospital you should check it for errors. If you find something on your bill that you do not understand you should contact your physician's billing department. The billing staff should be able to explain the charges to you.

The following list will give you a few ideas of what you should look for on your bill.

- Make sure the dates on your bill match the dates that the physician saw you.
- Check to see what you were billed for at each visit.
- Check to see if your insurance company paid and if the correct amount was credited to your bill.
- Make sure that personal payments have been credited to your account.

Understanding Your Explanation of Benefits (EOB)

Your insurance company should send you an Explanation of Benefits after consideration of each medical claim. Understanding your EOB will help you make sure that your insurance company has paid correctly. The following items are typically what you would find on your EOB:

Date of Service - This is the date you were seen by your physician or tests were performed.

Amount Billed - This is the amount charged for the services in question.

Not Covered - This is the amount your insurance company will not pay. You are responsible for this amount.

Deductible - This is the dollar amount that was applied to your annual deductible.

Patient Co-Pay - This is the amount you would pay if your plan requires a co-pay for services. (Co-Pay information is usually listed on your insurance card.)

Your co-pay is only effective if you go to a provider listed in the insurance network.

PPO discount - This is used when you go to a provider in your insurance company's network. You should NOT be billed for this amount.

Covered Charge - This is the amount that your insurance company considers payable. Remember that your insurance will only pay a percentage of this amount!

Paid at amount - This will show the percentage that your insurance company has paid on your claim. (Example- 70% - 80% - 90%…)

Payable Amount - This is the amount that your insurance company paid for your service.

Other Common Questions

Why was I billed for another new patient office visit?
A physician can bill a new patient office visit if he has not treated his patient within a three year time period. This means that you were not seen by your physician or a member of the group anytime over the three year period.

Why is a new patient office visit more expensive than an established patient office visit?

When you are a new patient your physician must review your complete medical history. This is done to make your physician aware of your health conditions. If you are an established patient, your physician only needs to update your health history at each visit. Your physician must then determine the level of your visit. The level of the office visit will also determine the cost of the visit.

If you have questions about your bill you should contact our billing office for someone to explain the bill to you.