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CB&C NEWS

SIMPLIFING CHIROPRACTIC INSURANCE ISSUES

Volume 5, Issue 1

"Not Appealing" translates to *"Lost Revenue"*

Appeals! Does the thought of it makes you cringe! Well then, how does '*lost revenue'* grab ya? That's even worse! Yet – providers ARE throwing away **thousands** of dollars writing off services not authorized or denied for medical necessity. Why are providers in this position?

Well, let's evaluate. How often are you required to send in treatment plans or notes or other documentation to support a patient's care? Are you doing so? And even when you send the requested information, entire dates of services are still denied as 'not medically necessary—or you are left with specific CPT codes paid but others still denied. What are YOU doing upon receipt of those denials? If you are doing nothing—**you are losing revenue**.

Truth is you and/or your staff may be struggling with knowing exactly *what* to do at that point? Are you one of the many providers that simply write them off? What a tremendous amount of lost revenue! You have other options. You could file an appeal!

If you are writing them off – you are not helping yourself or your profession. This epidemic of 'medical necessity' reviews has become rampant and WILL CONTINUE TO SPREAD unless providers dig their heels in and start to fight back. Every year, more and more insurance carriers are working with ODS (Outside Delivery Service) companies:

Landmark reviews for Healthnet	ASHN reviews for Cigna and Empire BC/BS
TRIAD reviews for Aetna	Optum Health reviews for UHC and Oxford

You gain zero if you are writing your services off! That's your money! Fight for it! I understand providers are tired - but what is the alternative? Charge the patient's directly for their care? Do they have those funds handy? Ok but if you are a participating provider it may be in your contract that you can't bill the patient for denied services. (TURN TO PAGE 3 to continue)

Your chiropractic office experts!

Points of interest:

- *Appeals in your practice*
- *BC/BS vs. Out of State BC/BS?*
- *Silent PPOs*
- *ASHN/Cigna*
- *Q&A's*

Frustrated with Cigna / ASHN? You're not alone!

If you are having problems weaving through the Cigna / ASHN maze, you are not alone. Most providers are finding it hard to understand this relationship simply because it seems Cigna and ASHN are having the same problem. I am sure you have all experienced calling Cigna and getting one answer and then calling ASHN with the same question and getting a totally different answer! Let's clarify a few things causing confusion:

Where do claims go? If you are a nonparticipating provider with ASHN – ALL your claims go to Cigna for ALL products. PERIOD! If anybody tells you different they are incorrect. It is that simple! If you are participating with ASHN, claims for Cigna OAP, POS, HMO products all go to ASHN directly but PPO claims still go to Cigna. It is important that you ask during verification which type of policy it is.

Do all Cigna policies require pre-cert with ASHN? The rule sort of follows the claim submission guidelines noted above. If you are non participating, you don't necessarily need pre-cert for anything. OAP/POS products may require a medical necessity review through ASHN. If so, you can choose to fill out their paperwork for authorization or you can send in notes for a retrospective review. If you are a participating provider, you are required to follow the pre-cert requirements for HMO, POS, OAP policies as outlined in your participating provider contract. Currently, Cigna PPO products do not require pre-cert whether you are participating or non participating.

I am a participating provider—can you explain those ASHN EOBs? I agree, they are horrible. If you're like us, you take evaluating your EOBs for proper payment seriously. But the only time these EOBs are easy to understand is if the patient's benefit is a copay. If the policy requires a deductible or coinsurance and you have tried to reconcile your EOBs, you've probably realized they don't seem correct. (cont. on page 4)

'Silent PPOs' - Quietly reducing your claims payments!

I would bet that half the readers of this newsletter are suffering with Silent PPO reductions from claims payments….. but have no idea it's happening. Even though we have tried and tried to make providers aware of this situation, it continues to be a problem. In a nutshell, the involvement of a silent PPO in your claims payment causes a reduction of your fees BEFORE the patient's out of network benefits are applied. Confused?

Basically, your claim goes to the insurance carrier – lets use UHC as an example. UHC will first search your name or tax ID# or NPI # for a participating provider contract. If they find you are participating with UHC directly, they will obviously assign the UHC fee schedule, and process the claim at the patient's in-network benefit. OK simple enough. No silent PPO involvement here.

Now let's say the provider submitting the claim is out of network with UHC. UHC receives the claim and finds the provider has no contract with UHC so they can't assign the UHC fee schedule. They then search your name, tax ID#, NPI, etc. again for other PPO contracts you may hold (like Multiplan, Beech Street, Viant, PHCS, etc., etc.). If they find that you are affiliated with one of these PPOs, they will actually reduce your billed charges to the fee schedule of that PPO, BUT since you are not participating with UHC directly, you are still an out of network provider and the out of network benefits will be applied. So, what does this mean for you? It means that instead of your billed charges going to the deductible— the reduced charges will. Instead of the payment being based on your billed charges, it will be based on this fee schedule. Yes – this means you are suffering from fee schedule reductions on your out of network claims.

Our research shows most providers don't even realize the reduction is happening!

Don't think it's happening to you? Take a few minutes to check your out of network EOBs over the course of the next month. Notice if there are reductions of your billed charges to an 'allowed amount'. If there is a PPO reduction to your fees, it will say so right on the EOB. It just seems offices do not pay close enough attention AND don't realize this reduction is '*optional*'. It can be stopped.

I am not here to say you should or should not participate in the insurance carriers or in the managed care companies such as those listed above (by the way there are many, many more Silent PPOs). This is a very personal decision and should not be taken lightly. What I am suggesting is that you evaluate what contracts you have and ***why***. If you have a direct contract with a carrier because you want to be a direct participating provider with Aetna (for example), then you have a specific reason to remain in-network. It's the word 'direct' that I want to stress here. Evaluate your reason for remaining in the Silent PPOs and remember you are not a participating provider for all the carriers that are using them. Even more so, my concern is that the participation status is not even something the provider is aware of. It usually stems from a contract the provider signed years ago, for an entirely different reason (like to be in-network with an insurance carrier), but it is now being used in this fashion.

If you do decide to remove yourself from these networks, send a letter to the PPO requesting your contract be terminated. Specify that you want your name, tax ID# or SS#, your NPI, your facility name and NPI (if applicable) ALL be terminated. You may also want to request to be terminated from that PPO *and all it's affiliates.* Trust me when I say be very specific in your request. Also, include in the letter that you require they provide you a termination letter that gives the specific date of your termination. You will need that when the carriers continue to take reductions anyway! Follow-up with the PPO until you have that letter. For a more complete list of Silent PPOs, you can contact CB&C via fax or email.

Horizon BC/BS vs. Out of State BC/BS Plans..... Simplified!

What does 'Blue Card' mean anyway? What is the difference between Horizon BC/BS and those out of state BC/BS plans?

Good questions. So let's first compare 'The Blues' to other carriers you are familiar with. Let's use UHC. They are a nationwide insurance carrier. Therefore, where ever you are in the US, there is a really good chance you will be able to find a participating provider if you need healthcare.

Ok—so how does that compare to BC/BS? Well, I am sure you have noticed that Horizon BC/BS is only 1 of many BC/BS carriers in the country. If a carrier wants the rights to use the BC/BS name and emblem, they have to apply to do so through the Blue Card Association. They are then assigned an area that they can function as a carrier under the BC/BS umbrella.

Each BC/BS carrier is a separate and distinct company—and there are quite a few of them. It is obviously NOT feasible for providers to directly contract with every BC/BS carrier is the country. So in comparing to the UHC example—how does a Horizon BC/BS insured member find an in-network provider if they need healthcare services in another state? Hence—the Blue Card Program. This program basically allows insured members of—for example BC/BS of Florida - to seek out participating providers of the local BC/BS carrier to utilize their in-network benefits. The out of state BC/BS is usually referred to as the 'home plan' and our BC/BS carrier (Horizon BC/BS) is usually referred to as the 'local plan'. This concept makes sense right?

If you think about that scenario, it makes sense that as a provider in NJ, you have to submit the claims to the Blue Card address in Neptune for Out of State BC/BS patients. How else is that BC/BS (again let's use Florida BC/BS) carrier going to know if you are a participating provider with your local BC/BS carrier or not if the claim does not pass through them first? Since they are separate and distinct carriers, BC/BS of Florida has no information available regarding provider contracts with Horizon BC/BS. Therefore, the only way for the program to work is that the provider submit the claims to the local carrier (continued on page 4)

Frequently Asked Insurance Q&A

Q*—*What is COB?

A—COB means 'coordination of benefits'. This is the process of an insurance carrier updating their records regarding status of a spouse or dependents on an insured's policy. The purpose is to look for another carrier potentially available to the spouse or dependents and then determine which should be primary and which should be secondary. For example, in the case of both adults having insurance, generally, each will be primary on their own and secondary on the other. It is necessary for the insured members to notify both carriers involved so there is COB on file with both to avoid claim denials. Many carriers update COB yearly or bi-yearly.

Q*—*Why is it important to distinguish if a policy is a self funded policy or a fully funded policy while doing your insurance verification?

A—If a policy is fully funded it is governed by NJ DOBI. If a policy is self funded, it is NOT governed by NJ DOBI, it is generally governed by the ERISA laws. Therefore, when NJ DOBI passes a law (like the assignment law in Jan 2011 and the most recent copay law) it is applicable to

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Not Appealing translates to *Lost Revenue* *– continued…..*

If you are an out of network provider you need to weigh if the patient can afford to pay for an adjustment as well any other services you perform in a day. Some patients may be able to pay $50 a visit, but what if the visit costs $100 or more? If you are pretty sure your patients will pay you upfront – I strongly suggest you go ahead and do that. If you are concerned your patients cannot afford the immediate out of pocket expense, you really want to jump on board with this fight. And by the way, the fight does NOT have to be that overwhelming.

Let's assume you have properly diagnosed and properly treated your patient. And you have properly documented your services, and then correctly billed them to the carrier. Why would you settle for any less than full payment for those services?

When providers don't appeal and write off what is denied, the insurance carriers gain. They ultimately see huge savings in their own pockets! Why wouldn't they attribute it to the medical necessity reviews being conducted or – even worse – that the ODS must be doing a 'good' job. Therefore, why would the carriers not continue to expand the relationships with ODS companies. Maybe Aetna will soon have TRIAD review the 'W' policies (right now they are just reviewing the managed care policies such as BBQE4KLA or MEB7GHIE). Maybe UHC expands their relationship with Optum Health to include out of network providers too. Providers need to get involved with this fight no matter how tired they are.

Ok – so enough ranting. Let's hope I got you fired up enough that you are going to commit to fighting for your rightful reimbursement instead of losing revenue. If so, consider the following. Every office can learn how to file appeals. It is a process, but just like any other process it can be – and should be – learned. The reality is, staff has learned how to do insurance verifications, how to submit billing, how to use billing software, how to run a front desk, etc – they can certainly learn to file appeals.

One way to go about it is to read. You can research on your own by reading articles, going online, etc. You can go to the NJDOBI website and read about filing fully funded appeals and you can do the same with the ERISA laws and procedures for self funded appeals. Another way to begin the learning process is to use resources that are experts in appeals. If you are a member of the ANJC, they have consultants that are available to you. Of course, you can also have CB&C come in and do consulting with your staff and train you on the appeals process

I would like to leave you with this — however you choose to go forward is up to you - but DO go forward. Whether you are a practice that accepts insurance or whether your patients pay upfront and expects to be reimbursed by their carrier – having an appeal process will continue to become more important and more necessary in this profession. Stop this epidemic before it spreads even further. Just remember, although there is always some trial and error in learning a new process, it is worth it.

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Open and learn the best kept secrets to assisting your Chiropractic office achieve its financial potential.

SIMPLIFING CHIROPRACTIC INSURANCE ISSUES

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Aside from working with our clients, we are also Chiropractic patients and therefore appreciate and value Chiropractic care. We understand that the less time the Chiropractor and the office staff spend on dealing with the insurance companies, etc. the more time that is available to focus on what's important— YOUR PATIENTS!

Cigna/ASHN cont…..

That is because the way in which the payment is calculated is deceiving. Your payment is figured at the ASHN fee schedule, but the patient's responsibility is figured on the Cigna fee schedule!

Follow this….: 'Patient X' has a $1000 deductible and is covered 80%. Let's say the deductible is met for the year. Patient X receives services. The CPT codes are billed to ASHN at the provider's fees. So let's say the provider bills a spinal adjustment, a therapeutic exercise, and e-stim and has $175 in submitted charges. When processing the payment, ASHN will apply the ASHN fee schedule because the provider is participating. So let's say that $175 is reduced to the ASHN fee schedule of $46. You would therefore expect the $46 to be paid at 80%. This would breakdown to $36.80 from ASHN and $9.20 from the patient. However, then the EOB comes in and shows ASHN's payment at less than 80%.

What is actually happening is that ASHN calculates their payment based on the fee schedule and then the policy percent, BUT the patient's responsibility is actually based on the CIGNA fee schedule—not the ASHN fee schedule. So, in the example above, where the ASHN fee schedule may be only $46, the Cigna fee schedule for the same codes may be $89. ASHN then figures that the pt's 20% would be $17.80. They then deduct the $17.80 from the $46 and pay the provider the difference ($26.20 from ASHN - and $19.80 from the pt). Yes, that is how they do it.

We have questioned this method of processing over and over with both Cigna and ASHN. They state it is defined in the contract and therefore is an appropriate way to process claims! Their position is that as a participating provider you have agreed to a total payment of $46 (in the example above). You are getting what you are entitled to it's just that more of it comes from the patient! …… I can't believe it either!!!!!!!

Blue Card Program cont…..

Horizon BC/BS, and they identify you as a participating or non participating provider before forwarding the claim to the home plan for processing.

Furthermore if you are a participating provider with Horizon BC/BS, they will re-price the claim at the Horizon BC/BS fee schedule and apply their payment guidelines before forwarding it to the home plan. If you are a non participating provider, the claim is supposed to be forwarded from Horizon BC/BS to the home plan identifying you as a non-par provider. In that case the claim is generally paid at the processing guidelines of that home plan.

Please note that doing follow-up on these patients is tricky. The home plan holds the benefits not Horizon BC/BS, yet when you call the home plan directly, they will instruct you to call the local.

When you call Horizon BC/BS Blue Card with a problem, they will send 'an inquiry' to the home plan to try to get the claim fixed. This often does not work. If you feel you are getting the run-around, you need to be assertive and get a supervisor. You should also learn how to decide what can be handled through Horizon BC/BS Blue card and what you really do need to be persistent and call the home plan directly for a resolution.