Billing 101

Pearland Pediatrics would like to provide a guide to help our families better understand the insurance business and how different benefits translate into a visit to the doctor. We hope this helps answer any questions you may have regarding how we bill and why you may have a balance after the visit.

We currently accept many insurance plans and are considered in network, however, we recommend checking with your insurance carrier for details specific to your plan. For insurance carriers we are currently unable to participate with, we have many patients who choose to see us as "out of network" doctors. Typically, once you meet a predefined deductible, our reasonable and customary charges will be covered at 70-80%, depending on your specific plan. You may also use your insurance to pay for some radiology services, medications, lab tests, physical therapy, and specialist services we may refer you to if you are eligible for those benefits through your plan. We participate in Texas Vaccines for Children Plan which provides the majority of your child's vaccines for free when eligible.

Many HMO, POS, & EPO plans require a primary care physician (PCP) to be selected. We may require a PCP be selected within our office prior to your appointment. This is necessary to prevent any delay in referred services or payment from the insurance.

Understanding Your Rights and Responsibilities

Pearland Pediatrics recognizes that health care costs are significant, and insurance premiums (though not reimbursements) have risen rapidly in the last several years. We have 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, medical record requests, and other administrative fees. Our after-hours/weekend fees are modest, our phone charges are rare, and there are no hidden fees for any of our services. We have carefully analyzed every charge to minimize your cost while maintaining our level of practice. Please refrain from asking billing questions at the front desk-our receptionists are focusing on scheduling visits and getting your sick children seen promptly. If you have concerns about your bill please contact our billing staff and we will be happy to help.

Please understand that at Pearland Pediatrics we are committed 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 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 when 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 copay information. If your card does not have this information, make sure you bring it with you to the doctor's office, as is vital for ensuring your eligibility and network plan. 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 the 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.

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 deducible 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 checkup, 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 any 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 "modifier -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 copay 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 copayment 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.

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. For that reason, we very carefully set our charges at a reasonable and customary amount, and allow a 30% cash discount for self-pay patients. Second, you will see "provider responsibility"-this is the discount part of the fee that Pearland Pediatrics has agreed to when contracting your insurance. 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.

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 test may not be covered. **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, https://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 (numbers refer to the codes submitted for payment):

Hearing Screen: 92551	Vision Screen: 99173	Fingerstick blood sample: 36416	Hemoglobin: 85018
Venous Puncture: 36415	Urinalysis: 81002	Wart Removal: 17000	Destruction of warts: 17111 or 17110

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 determine covered and uncovered 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 copay, 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 types 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 of your family, as well as financial problems that might arise if you

choose the plan that is wrong for you. Also, always verify that your provider is in-network with your plan before making your decision.

Primary vs. 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 would be primary and Dad's secondary. Pearland Pediatrics will file to your primary carrier and once the claim has been finalized we will file to the secondary. This is a general rule of thumb, however, some instances will be different, such as in divorce situations or if specified by the insurance administer. Medicaid and Tricare are always secondary to a primary commercial policy. Contact your insurance benefits and to clarify which one of your insurances is considered primary.

Do Not Ignore Bills

If you receive a statement that shows an amount due from patient and feel this is incorrect please contact your insurance carrier or our office immediately. There are some instances in which your insurance will deny claims incorrectly. They can deny due to Coordination of Benefits, meaning your medical claims will not be paid until your insurance receives word from the policy holder informing of any other insurance. At times the patient's date of birth or PCP is incorrect with the insurance, these are corrections that need to made to the policy in order to facilitate claim payment.

New babies may have incorrectly denied charges as well, this is common when claims make it to the insurance before the baby is added to the policy. A simple phone call to your carrier will usually result in claim payment.