

Upfront Payment Guidelines

2010



Upfront Payment Guidelines 2010

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If you would like any further information about the Bermuda Health Council, or if you would like to bring a healthcare matter to our attention, we look forward to hearing from you.

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Introduction

The *Upfront Payment Guidelines 2010* provide best practice recommendations regarding payment for healthcare services. It also includes protocols for making the claims process more efficient. The Guidelines were developed to help reduce out of pocket expenses for insured individuals, and to help improve the processing of claims by providers and insurers.

The term “upfront payment” refers to an instance where an insured person has to pay 100% of the total billed charges (full payment) for a healthcare service at the time the service is given. Payments before the service is received (such as advance payments for eye glasses) and payments billed after the service is rendered (such as for a tooth crown) are excluded.

The purpose of publishing the *Guidelines* is to educate the public and providers about their role in reducing upfront payments.

Background Information

The Sector Guidelines were developed in response to complaints from the public to the Ministry of Health. Requiring patients to pay “upfront” can contribute to family cash flow problems and can prevent people from seeking health services in a timely manner. In addition, local healthcare providers reported delays in payment for services, and insurers reported that when incomplete or incorrect claims are submitted, this delays reimbursement. A 2009 telephone survey by the Bermuda Health Council (BHeC) found that 47% of providers sometimes or always require upfront payment.

The Upfront Payment Guidelines 2010 was facilitated by the Upfront Payments Committee (UPC). This committee was established by the BHeC at the request of the Ministry of Health. It included representatives from many regulated healthcare professions and insurance. Its objective was to develop an immediate response to upfront payments. The *Guidelines* were finalised following consultation and feedback from health professional bodies and insurers.

The Guidelines

The *Guidelines* are intended for all stakeholders in the healthcare system: patients, providers, employers, insurers, the BHeC and the Ministry of Health. They were developed based on suggestions from across the healthcare sector. Generally, the *Guidelines* are intended to help patients, insurers and providers have a shared

sense of what is possible and what is fair with respect to payment for healthcare¹. The nine guidelines are as follows:

1. 30-day guarantee for claims reimbursement

Objective

To improve how quickly a healthcare provider is paid for seeing an insured patient

Description

The 30 day Guarantee assures providers of reimbursement within 30 days or less for all “clean claims” submitted. A “clean claim” is a valid claim that includes patient information, diagnosis, and descriptions of services performed. The 30 day timeframe begins within 24 hours after the insurer acknowledges receiving the claim.

2. Standardize claim forms

Objective

To speed up claims processing time by encouraging providers to use a standard form to submit medical claims

Definition

A standardized claim form provides insurers with all the information they need to pay for a claim. The form includes demographic and patient information and descriptions for healthcare services using Current Procedural Terminology coding (CPT coding). All health professionals can complete medical claim forms including physicians, allied health professionals, nurses, optometrists, pharmacists and psychologists. For medical claims, providers can use the BHeC Health Insurance Claim Form (HICF), the HCFA-1500 or the HIAB claim form. For dental claims, providers use the CDA claim form.

3. Stakeholder responsibilities

Objective

To improve public and provider awareness about their role in the claims process

Description

Stakeholder responsibilities refer to the functions that are assigned to someone based upon their role, ordinary expertise and knowledge. The BHeC encourages the following defined stakeholder responsibilities:

¹ The Guidelines are intended to curtail the practice of charging upfront, but cannot eradicate it altogether. There are some services, such as receiving eye glasses or a crown for a tooth, which include overseas lab fees that providers have to pay for prior to or immediately upon delivery of the service; so they need to secure the payment at the time of ordering the service so they are not left out-of-pocket should the patient not return.

Providers are responsible for:

- Asking for patient insurance information (or verbal confirmation) at each visit
- Communicating costs and information about the healthcare service (including advising the patient that the costs of uninsured services are their responsibility)
- Timely submission of claims

Patients are responsible for:

- Providing proof of insurance status
- Informing providers of any changes to insurance coverage
- Awareness of their level of insurance coverage
- Awareness of health services and licensed professionals
- Ensuring ability to cover costs of their healthcare

Employers are responsible for:

- Providing information to the patient about their health insurance
- Providing insurers with updated employee information

Insurers are responsible for:

- Advising patients about their benefits and eligibility for coverage
- Confirming submission of claims
- Offering timely reimbursement within 30 days

The BHeC is responsible for:

- Advancing recommendations about upfront payments to the Ministry
- Educating the public about healthcare costs
- Facilitating professional education on CPT codes

The Ministry of Health is responsible for:

- Protecting patient safety
- Setting fee levels for regulated services
- Making regulations

4. Electronic access to patients' insurance status

Objective

To confirm insurance coverage of individuals and minimize claims submitted for uninsured people

Description

This refers to the way providers access information about a patient's insurance status. Through the internet, insurers can offer real time confirmation of insurance coverage. This includes information such as patient name, date of birth, level of insurance coverage and breakdown of benefits. The maximum insurance benefit available to each individual is not available.

5. Display of fee guides

Objective

To encourage disclosure of information about the cost of healthcare services before services are received

Definition

A fee guide is a listing of the provider's most commonly used services and their costs. It is recommended that it be accessible to patients, as follows:

- Patients may be informed about health service costs at the time an appointment is made and when it is confirmed.
- Providers display in a visible location a listing of their most commonly used services and their costs. .
- Patients may request written confirmation about the cost of services received.

6. Disclosure about specialists' referral costs

Objective

To inform patients about healthcare costs before they receive a service

Definition

The BHeC recognizes the public may not be aware of some costs that are significantly higher than regular office visit fees. Sometimes these costs are required upfront and are usually charged by specialists.

It is advised that patients:

- inquire about fees and payment options before attending an appointment
- know their level of insurance coverage for the specific service prior to the appointment

It is advised that, when referring a patient to a local physician specialist or an overseas consultant temporarily offering services in Bermuda, primary care providers should:

- inform patients that specialist costs/fees may be required at the point at which service is delivered
- encourage patients to confirm costs with the specialists' office before attending the appointment

7. Electronic claims submission procedures

Objective

To improve timing for submission of claims

Description

Electronic claim submission is when a provider gives their claim to the insurer via electronic upload. Currently there are provisions which allow providers to forward individual claim forms directly to some insurers using electronic data interchange (EDI). Providers with EDI capabilities may contact insurers directly to arrange claims submission. It is advised that:

- Providers submit claim forms electronically, individually or in bulk (many claims at the same time).
- The insurer should acknowledge receipt of electronically submitted claims in the format of submission (i.e. via computer software).
- Claims processing should begin 24 hours after the insurer acknowledges receiving the claim.
- Providers should track their own claim status. The template below may be of assistance:

Patient Name	Insurer	Date filed	Claim amount	Payment Date	Payment amount	Claim status	Action
Doe, Jane	Insurer A	02/23/09	255.00	03/10/09	180.00		
Smith, Joe	Insurer B	02/27/09	450.00			Pending	Claim submission confirmed by insurer/03/02/09
Wall, Ella	Insurer C	03/02/09	65.00			Lost claim	Resubmit 03/19/09

8. Electronic claims reimbursement procedures

Objective

To improve timeline of reimbursement of claims

Description

Electronic claim reimbursement refers to the way healthcare providers can be reimbursed for their services. It is advised that insurers should establish secure and appropriate mechanisms to reimburse providers electronically for claims submitted electronically.

9. Health Service Level Agreements (HSLAs)

Objective

To enhance communication about billing and payment between insurers and providers

Description

An HSLA is a contract between insurer and provider that details how providers will be paid for services given to insured persons. The contract can include provisions for definitions, work flow, stakeholder responsibilities, claims accuracy, standardized claim forms, reimbursement time, courier services, proof of claims receipt, and penalties/incentives. Implementation of this guideline will be determined in due course by an appropriate authority.

Conclusion

The Upfront Payment Guidelines 2010 represent an effort to encourage self-regulation within the healthcare sector, with respect to paying for healthcare. They highlight that all involved have responsibilities in this respect, including providers, insurers and patients. The Guidelines are intended to promote a level playing field and an environment of fairness and trust among the parties involved, by establishing a shared framework for what is possible and what is fair in paying for healthcare.