

## Insurance Plan Set-up

Go to **Tables, Insurance Plan**.

From the Insurance Plan Table window, create a code for the new insurance in the **Code** field. If the code is not already on file, you will be asked to add it.

The screenshot shows the 'Insurance Plan Table' window. The 'Code' field is circled in red and contains 'BCBS'. The 'Carrier' field also contains 'BCBS'. The 'Plan' field contains 'Blue Cross And Blue Shield'. The 'General Info' tab is selected, and the 'Address' field is highlighted with a red box, containing 'PO Box 22999'. Other fields include 'Carrier: Blue Cross And Blue Shield', 'Payer ID: 00804', 'Clearinghouse ID: 4408', 'City: Rochester', 'State: NY', 'Zip Code: 14692', 'Plan Type: BC/BS', 'Category: BC/BS', and 'Formulary: None'. There are buttons for 'Save', 'Delete', 'Label', and 'Cancel' at the bottom.

On the **General Info** tab, enter the full mailing address.

**Note: Please make sure you are entering the address on the FIRST address line and not in the Con't address field.** The claim will be rejected if no address is entered on the first line. Entering the phone# and fax# of the insurance is recommended as it will carry over to reports which will make follow-up with insurance easier.

**Enter the Payer and Clearinghouse ID #'s.**

**Payer ID:** Payer ID codes are the primary identifier used to route your EDI transactions to the appropriate entity. It is issued directly to the insurance carrier.

**Clearinghouse ID:** Four digit number issued by the clearinghouse. In our case, this would be RelayHealth. You can obtain this number directly from RelayHealth's website (Collaboration Compass) or contact HST for the number.

**Plan Type:** Has to be set up correctly as it ties specific settings to each insurance carrier (e.g. MVP, Blue Choice, Medicare, No Fault).

*These settings carry over to the claim.*

**Category Type:** Not directly tied to claim submission but can be used as a screening type for reporting.

**Billing Info tab** options allow you to control what information for the new insurance plan carries over into the claim. We recommend that you check the first four options under Plan Settings. The remaining options should be reviewed per your practice guidelines. Some options are outlined below but most are self-explanatory.

The screenshot shows the 'Insurance Plan Table' window with the following details:

- Code: BCBS
- Carrier: BCBS
- Plan: Blue Cross And Blue Shield
- Plan is no longer in use:
- Active tabs: General Info, **Billing Info**, Copay, Other
- Plan Settings (Left Column):**
  - Assigned
  - Participate in Plan
  - Post Payment by Procedure
  - Write-Off Disallowed Amount
  - Write-Off Unpaid Balance
  - Does not require complete ICD-10
  - Medigap Plan
  - Use Physicians Asst Modifier
  - Referring Physician Required
  - Uses Summary Billing Codes
  - Nurse Visits Are Counted
  - Use Initial Treatment Date
  - Exclude Legacy ID Prefix
  - Primary Deductible Not Covered
  - Bill using individual provider info
  - Service Facility Required
  - Bill E&M code with a CPE
  - Leave Box 32 Blank
  - Bill claim balance in box 30
  - Always print a "thru" date in box 24
  - Exclude NDC Codes
  - Use unique NPI for DME
  - Always report Rendering Prv
  - Require eligibility confirmation
  - Use Alternate Billing Address
- Plan Settings (Right Column):**
  - Do not print provider ID's in box 24
  - Do not print carrier address
  - Do not use practice NPI
  - Do not print taxonomy in box 33b
  - Do not report patient payments
  - Do not report loop 2320 info
  - Show patient address in box 32 for home visits
- Billing Set-Up:**
  - Fee Schedule: None
  - Billing Format: RelayHealth
  - Paper Format: CMS-1500
  - Enrollment Set: Blue Cross/Blue Shield
  - Code Set: Practice Default
  - Place of Serv Method: Standard
  - Misc Claim Info: NY Medicaid
- Review Outstanding Claims After: 30 Days

**Medigap Plan:** Medigap is secondary to Medicare. Checking this option will prompt the user to answer if you want the claim to automatically cross over or if you want to choose send it over.

**Referring Physician:** Some insurance plans require this information for certain services. Checking this box will prompt a system edit making sure you have entered a referring physician on the claim level.

**Authorization Number:** If this number is required by the insurance plan, checking this box will prompt a system edit making sure you have entered an authorization number on the claim level.

\*\*If this information is required and you don't have it, they will be caught at System Edits and tell you its missing.

**Initial Treatment Date:** checking this box will place a date range on the claim.

**Bill Using Individual Provider Info:** System will prefer what's in the provider table.

**Service Facility Required:** Check if patient was seen someplace other than the provider's office.

**Box 32 Blank-**Some carriers request this be left blank. If a provider does not have a group NPI number (in addition to your individual NPI) the national standard for EDI claims is that Box 32 is not necessary as it is already displayed in Box 33.

**Always print a "thru" date in box 24:** checking this will give you a date range in Box 24 on the individual claim level.

**Using Alternate Billing Address:** checking this will prefer the address that is in service facility table labeled "Bill".

**Do not print Provider ID's in Box 24:** checking this will suppress the individual NPI # from the claim.

**Do not use practice NPI:** checking this will suppress group NPI and use individual NPI from the Provider Table.

**Do Not Report Patient Payments:** Checking this means the entire claim balance is billed regardless of patient payment.

### **Billing Set-up**

**Fee Schedules:** Attach to correct one. Default is Regular.

**Billing Format:** options allow you to choose how claim will be queued to be sent to the insurance. You may preset a format for each carrier. Generally, the format is Relay or CMS 1500. If necessary, an alternate setting may be created by HST for your practice. Paper claims are usually generated on CMS 1500 forms but may be switched to other forms such as NYS Workers' Comp form.

**Enrollment Set-**Standard unless exception

**Code Set-**No longer applicable. Leave as Practice Default.

**Place of Serv Method**-Generally set as standard.

**Copay tab** allows you to choose the copay arrangement for your practice and this insurance plan.

The screenshot shows the 'Insurance Plan Table' window. At the top, there are fields for 'Code: BCBS' and 'Carrier: BCBS'. Below that, the 'Plan:' field contains 'Blue Cross And Blue Shield' and a checkbox for 'Plan is no longer in use'. The interface has four tabs: 'General Info', 'Billing Info', 'Copay' (which is highlighted with a red box), and 'Other'. The 'Copay' tab is active and contains two main sections: 'Calculation Method' and 'HMO Co-Payments'. The 'Calculation Method' section has six radio button options: 'Medicare Co-Payment', 'HMO Co-Payment', 'Flat Percentage Co-Payment', 'Non-covered Portion Co-Payment' (which is selected), 'HMO/Percentage Combination', and 'No Co-Payments'. The 'HMO Co-Payments' section includes input fields for 'Office', 'Radiology', 'Surgery', and 'Lab', a checked checkbox for 'Collect Only One Co-Pay', and a 'Maximum Visits' field. To the right of these sections is a 'Coverage Percentages' table with nine rows labeled 'Proc Cat 1' through 'Proc Cat 9', each with an empty input field.

**Calculation Method:**

Medicare: calculates 20%

HMO Co-Payment: pulls what was entered for individual patient when attaching their insurance plan.

Flat Percentage: auto-calculates copay based on % entered in the next tab (Other).

**HMO Co-payments section** for individual services are rarely used. This applies when a plan has known a copay amount for certain services such as radiology or labs.

The **Other** tab allows you to set up payment posting information.

The screenshot shows the 'Insurance Plan Table' application window. At the top, there are fields for 'Code: BCBS' and 'Carrier: BCBS'. Below that, a 'Plan:' field contains 'Blue Cross And Blue Shield' and a checkbox for 'Plan is no longer in use'. The 'Other' tab is selected, highlighted with a red box. The 'Other' tab contains several sections: 'Payment Option' with radio buttons for Regular, Medicare, HMO, Capitation, and Corporate Invoice; 'Transaction Codes' with input fields for Payment, Deductible, Write-Off, and Risk; 'Other Info' with input fields for Payer Office, OCNA ID, Medicaid Code, and Typology Code, and checkboxes for 'Radiology Authorization Required' and 'Covers Chronic Care Management'; 'Related Organizations' with dropdown menus for 'Affiliated Lab' (ACM Labs) and 'Employer' (None); 'Prescription Coverage' with a dropdown for 'Tier Program' (None) and an input field for 'Days Covered'; and 'Eligibility Info' with input fields for 'Payer ID', 'User Name', and 'Password', and a checkbox for 'Do not use Eligibility Checking'. There is also a 'Secure Portal' section with an 'Enroll' button and a checkbox for 'Enrolled in Portal'.

**Payment Option** fields: Choose what you want to show on patient account.

Regular- coinsurance field

Medicare-coinsurance field and risk

HMO-risk and copay

Capitation-Deductible

**Transaction Codes:** Choose individual payment, deductible and write-offs for each plan.

Linking it here will link it to auto-posting, creating for example, AETNA DEDUCTIBLE.

**Related Organizations:** Utilize this section if a patient is required by their plan to go to a specific lab. Otherwise, they may be responsible for a higher rate if they go to an out of network lab. This information is required by law to be listed this on the requisition. Contact HST Support if you need a lab added to the system.

**Eligibility Info:** Enter the **ELIGIBILITY PAYOR ID** not the insurance ID. This information is available from RelayHealth.

User Name and Password are only needed in a portal situation. RelayHealth will let you know if that information needs to be passed through to the insurance payer.