Medicaid Introduction to Verification of Benefits

Facilitator Guide

Acknowledgements

Document Summary

This module begins discussion on what a Verification of Benefits (VOB) inquiry is from a common standpoint and why it is important that members and providers call to receive a verification of their benefits prior to service.

This module was created to educate Humana Associates on the definition of benefits to determine the caller's benefits and level of coverage for specific services. This module is specific to Medicaid.

Learning Objectives

After completing this program, participants will be able with 85% accuracy to:

- Define a benefit
- Describe a Verification of Benefits inquiry
- Diagram the main steps of verifying a benefit

Program Timing

- 1 hour of instruction

Pre-work

- None

Required Supplemental Materials

- N/A

Set-up

- None

Security Access Requirements

- Learners need access the CRM Service Training Sandbox

Prerequisites

- None

Introduction

Objectives

After completing this section of the module, the learner will...

- Define a benefit
- Describe a Verification of Benefits inquiry
- Diagram the main steps of verifying a benefit

Objectives

Overview

Providing accurate benefit information is one of the many responsibilities of the Customer Care Specialist (CCS). It should be the goal of every CCS to strive to go beyond the callers' initial question by asking probing question and anticipating the surrounding needs of the caller.

To accurately quote benefits, it is important to dissect the caller's questions to precisely quote benefit information. Benefits are quoted to members based on information obtained from the caller and utilizing tools such as CRM Service.

Asking the initial questions ensures you are familiar with the caller. In order to accurately quote the benefit, it is also important to follow a progression of steps to get to the root of the question and to be proactive.

Say This

Ask Learners

- Do you remember the first time you purchased health insurance?
- How many of you did so very easily?
- Did you simply accept what plan your company had to offer?
- Where there different options to choose?
- Did you know what type of coverage you needed?
- Allow time for discussion

Q&A

Ask Learners (cont.)

Q&A

While we have just started to explore the topic, think a moment about your past or present health coverage and the types of benefits you received. Now let me ask...

- **Question**: What types of Verification of Benefits calls do you think our member's may call about?
- **Answer**: *(Allow for discussion, then provide the following. Learners can note these in their workbooks)*
  - The most common VOB calls include:
    - Determining If the patient is insured under one of our health plans.
    - Determining the specific benefits available for the condition treated and the services performed.
    - Identifying How much of a benefit has been issued to date.
    - Advising the inquirer of any applicable co-payment, co-insurance, deductible, and out of pocket amounts.
    - Determining whether or not a service is covered under a policy.
    - Providing the benefit products offered under a group.

Why we get Benefit Questions

Say This

For many, it isn't until they have to use their insurance that they begin to understand the choices they made. One may begin to understand what was in the plan they chose when asked for a co-payment by a doctor.

- Before going to your Primary Care Physician (PCP) and being asked for a co-payment, did you know where to locate this information? ***(See Important Note)***
  - Our members call us with the same questions that you may have had when you selected a new health insurance plan. You may know the answers to some of our members benefit questions because you understand the plans Humana offers.
- Since you are familiar with Humana's plans, do you know where to go to look up answers to your own questions?
  - Our members may ***not*** know where to begin. What may be some of the reasons for their confusion?

Explain

Say This

Who is familiar with the term Explanation of Benefits (EOB)?

(If no one replies sufficiently, advise that an EOB is a summary of the payments made by an insurer or health plan on behalf of an insured to a health care provider and any appeal rights the insured may have.)

Odds are you may have received one of these from a prior insurance company when you had services rendered. If so, when looking at your own Explanation of Benefits (EOB), did it always have the same information about the service that you had anticipated? Probably not. Often, they contain listings of services that we may have no idea even occurred or perhaps some terms we have no familiarity with.

- Understanding our benefits is usually easier if we ask "someone else". Who have *you* turned to for benefit questions? Did you get the answers you needed? Was it correct? If so, how did you know?

In this role at Humana, you are now that "someone else". You are here to provide members with perfect service and to that end, how can being accurate assist a member calling about benefits? How is being reliable going to assist a member who doesn't understand their EOB?

Important Note

Explanation of Benefits are often suppressed for Medicaid members since there is frequently a zero dollar co-pay. The EOB is presented here for a holistic view of using insurance benefits.

Glossary Anywhere

Group Activity

- Instruct learners to use Glossary Anywhere to locate the definition of benefit and benefit package.
  - Glossary Anywhere is something that you may need to use on calls. It is a great resource with easy-to-understand definitions. Sometimes reading these definitions to callers may help them more clearly understand their benefits.
- Have learners write the definitions for **Benefit** and **Benefit Package** in the respective place in their Workbook

Ask Learners to share/explain

Q&A

- **Question**: What is the difference between a Benefit and a Benefit Package?
- **Answers**:
  - A ***benefit*** is the amount payable by an insurer to a claimant, assignee, or beneficiary under the terms of a health care plan.
    - In other words, the amount of money the insurance company agrees to pay to a healthcare provider for specific healthcare services a member receives when they visit the doctor or hospital.
  - A ***benefit package*** is the services that an insurer or health plan offers to a Group or individual under the terms of the Certificate of Coverage.

When explaining a benefit to a member, these benefit definitions may seem a little awkward since they are written from the insurance industry perspective.

Cost-Sharing

Humana plans offer a variety of coverage levels and many contain a form of cost-sharing between the member and the Insurance Company. When you hear the term "cost-sharing" how do you think it is defined?

Cost sharing can be defined as the share of costs covered by your insurance and the amount that you pay out of your own pocket. (Source: Healthcare.gov)

Important Note

Cost-sharing is very limited and sometimes non-existent on Medicaid plans. Again, it is presented here for a holistic understanding of Medical benefits.

Ask Learners

Q&A

- **Question**: What are the different forms of Cost-Sharing?
- **Answer**: Some Cost-Sharing options may include the following:
  - Deductibles
  - Co-payments
  - Maximum Out of Pocket expenses
  - Accumulated benefit limits *(i.e. Visits or "Dollar caps")*

Ensure learners can define these cost-sharing terms. If not, they may use Glossary Anywhere or Google to define.

Examples of Benefits

Say This

A benefit is a contractual agreement in which Humana promises to compensate the insured, member or service provider, for specific services received. The member may be responsible for a premium, percentage, and/or dollar amount according to the predetermined guidelines. Humana considers many healthcare services including medical, hospital, dental, vision, and surgical expenses.

Use a Flip Chart to illustrate some Examples of Benefits:

- Physician office visit with $0 co-payment:
  - Total Cost of visit = $150
  - Total Allowable Amount = $100
  - Member co-payment = $0
  - Humana considers = 100% remaining balance, up to total allowable amount ($100)

Verification of Benefits

Giving Information to the Member

When verifying the member's benefit(s), the **Effective date** of the plan should always be given to the caller. When appropriate for the benefit in question, the following should also be provided: Note that if there is no cost-share for the benefit that fact should be provided.

- Co-payment
- Benefit Limit

Say This

Co-payments

While we have begun to discuss this previously, let's make sure before we take a deeper dive that we are all using the same vocabulary.

Question: What is a co-pay?

Answer: A fixed amount of health care costs for which the member is responsible under the member's health benefit policy

- *For example, a member might pay $15 for each visit to a physician, with the health coverage policy considering the remaining cost*

Say This

Question: Based on your current knowledge, do you think Medicaid members have co-pays for the majority of their services?

Answer: Most Medicaid covered benefits come with a zero dollar co-pay.

Question: If most Medicaid benefits are zero dollar co-pays, why is it still important that we understand the term?

Answer: Answers may vary

Co-payments (cont.)

Question: When a member does have a co-pay responsibility for a benefit, generally speaking, when are they responsible for paying it?

Answer: Co-payments are usually due on the same day the service is rendered.

Say This

*Please Note: A Co-payment is a financial obligation of the member, to the provider – Humana is **not** directly involved with the collection of a co-payment*

Benefit Limits

Question: What is a benefit limit?

Answer: Any provision, other than an exclusion, which restricts coverage regardless of Medical Necessity, e.g. number of visits of therapy.

Say This

Question: Based on your current knowledge, do you think Medicaid members have maximum out of pockets on their plan?

Answer: This one is tricky unless you have prior knowledge. So far, we have said on most of these terms that Medicaid plans usually don't have the aspects associated with the plan. They do, however, have benefit limits on certain benefits.

Important Note

As has been stated and as we will see as we move deeper into Medicaid benefits, often times there are no member responsibilities associated with the covered service. We do not want to always assume that for several reasons. Humana is always actively seeking to expand its Medicaid business and regulations may vary State to State. Therefore, it is possible that you do encounter a benefit with cost-sharing. Also, State regulations change, so what may have historically been a zero dollar benefit, may change based on State guidance.

More Definitions

Say This

Without a doubt, we have covered some of the most important terms related to health benefits, but we still have a few more to go. Granted, some of these start to move into the claims territory, but knowing them helps complete the big picture.

Total (Billed) Charge is the total dollar amount submitted by a provider of service as their fee for the services or supplies rendered to the patient

Allowed Amount - Charges for services rendered or supplies furnished by a health care provider, which qualify as covered expenses. You may here the term Medicaid

allowable. This simply means the maximum amount Medicaid will allow a provider to be reimbursed for a given service.

Provider Write-off is the difference between the ***Total/Billed*** charge and the ***Allowable Amount***, that a network provider ***cannot*** charge to a patient who belongs to a health insurance plan that utilizes the provider network

While that probably isn't a full list of the terms we will discuss over the course of this training, it certainly helps us along the way to better understanding the overall benefit process.

Mentor Reference:

Mentor

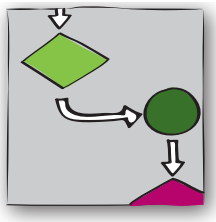
Please have learners access...

Verification of Benefits Medicare and Medicaid Overview

Once accessed, have learners click the link for...

Verification of Benefits Calls for Medicaid

Explain the steps for a VOB Inquiry:



Process

Please note that the steps below are considered high level and not meant to replace the steps outlined in the Verification of Benefits Calls for Medicaid Mentor document.

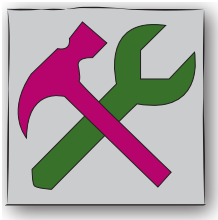
Review the Stages outlined in the VOB Call Details document for a high level overview of the process.

- Locate the member's policy in CRM Service
- Verify member is eligible *(i.e., is member's plan active for the date of service in question? Is the member paid through, on their premium?)*
  - If ***not***, advise the caller the member in question is not eligible
- Determine if the member called previously about the same benefit
  - If yes, warm transfer the member to the Advanced Resolution Team
- Ask probing questions to determine benefit/service type

  - Check to see if the member has any exclusionary riders

- Obtain and communicate benefits (sources may vary e.g. Benefit Grid, Benefit Summary, Evidence of Coverage, CRM Service Benefits link)
- Validate participating status of service provider
- Provide applicable accumulations to the caller.
- Provide additional benefits to the member, when applicable.
- After the benefit is quoted, verify any authorization requirements for the service using the on-line PreAuth/Referral form appropriate for the service in question and the appropriate Mentor document for the Authorization process (this will be covered in the Authorizations section of training).
- Conclude call

Tools and Resources Available:



Tools

Along with asking probing questions, beginning a verification of benefits inquiry and determining the benefit level, providing benefits can be done by using a multitude of tools and resources.

Provide benefit information from:

- CRM Service
- CGX
- Member Handbook
- Limitations and Exclusions
- Evidence / Certificate of Coverage
- Benefit Plan Documents
- Benefits Grids in databases
- Other benefit-specific documents in Mentor

Important Note

Note that not all plan types will not utilize all of these tools as some are specific to plan types.

In Summary:

It is nearly impossible to get a complete list of all services that Humana covers in their benefits. There are many resources available to help you locate the service the caller is inquiring about in order to locate the most accurate benefit. As you can see, there are many different services for Humana to pay. In addition, there can be wide variations of benefits offered among different Humana healthcare plan types.

There are lots of dynamics to benefits. Knowing how to properly verify a benefit will enable you to determine the correct information to give to the member.

Say This

Review Objectives:

Objectives

At the start of this content we stated that you would be able to...

- Define a benefit
- Describe a Verification of Benefits inquiry
- Diagram the main steps of verifying a benefit

What questions do you have?

(Ensure the learners are comfortable with having met the objectives before moving on to additional content.)