Ivy Pediatrics
Infant, Child, & Adolescent Medicine

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What are co-pays and co-insurance?
Co-pays and co-insurance are out-of-pocket expenses that are part of your contract with your insurance. Co-pays are usually a specific dollar amount (ie.$20.00). Co-insurance is usually a percentage of the allowed charges (ie. 20%). Your insurance card will usually specify what your co-pay/co-insurance portion is. You are obligated to pay your portion prior to insurance paying the rest of the claim.

When are co-pays and co-insurance due?
Co-pays and co-insurance are due at the time of service, prior to seeing the doctor. In the event that your co-pay or co-insurance amount is unknown, we will ask you to pay a specific amount today, then bill you for the difference, or credit your account if you overpaid.

What are deductibles?
A deductible is a clause in your insurance contract that exempts your insurance from paying an initial, specified amount. Once you have met your deductible amount as specified in your contract, your insurance will pay claims within your plan provisions.

Why am I getting a bill when I have insurance and/or Medicaid?
Our financial contract is with you, not with your insurance. If there are any unpaid amounts you will be sent a statement to inform you of your account status. There are several reasons why you may be receiving a statement, even with insurance. Some of the most common are:

- Insurance has denied the claim.
- Insurance has applied the claim to a deductible.
- Insurance has not received a copy of your claim, usually due to incomplete/invalid information.
- Insurance has not responded to the claim within the time frame allowed.
- Accurate insurance information has not been provided; an old insurance is being billed.
- We have received a response from your primary insurance and are in the process of billing your secondary insurance.

- Insurance has processed the claim and left a higher co-pay or co-insurance amount than what was paid at the time of service.

Why do you need my Medicaid card at every visit; can't you just look at last month's card?
Medicaid eligibility goes from month-to-month so we require a copy of your child's card to make sure we can accept your benefits as listed. The Medicaid card itself also states "This card must be presented before receiving Medicaid services". We cannot bill using previous month's Medicaid card because, although the Medicaid number is usually the same, the HMO, PCP and other critical information may have changed, and those changes may affect your benefits or our ability to accept the card. Presenting a copy of the current month's Medicaid card is also for your protection. If Medicaid denies your claim for eligibility reasons, we need to have a copy of the card for the month in question in order for Medicaid to honor the claim. If we don't receive a copy of your child's current Medicaid card at the time of service we will set your account up as self-pay until we receive a copy.

Can you bill my ex-spouse for this?
The person bringing the patient into the office, and who signs our financial agreement, is who we will hold financially responsible for any balances. You may have a divorce decree that states your ex-spouse is responsible for part or all of your dependant's medical bills, but Ivy Pediatrics doesn't have the authority to enforce a divorce decree. It is up to you, your ex-spouse and the court to work out details and enforcement of a divorce decree. We will send correspondence to the person we have a financial contract with. You may forward the statement to your ex-spouse if they require a bill in order to pay their portion, but we do not bill them directly.

How do I add my newborn to my policy?
Most insurance payers give you 30 days to add a baby to your policy. If you miss this deadline you will have to wait until the next open enrollment period to add the child. As soon as your baby is born you will need to get an Insurance Change Form from your Human Resource department. Fill it out completely and return it to HR as soon as possible. Your HR department will then submit the information to the insurance company. Make sure that the information on the form (ie. spelling of the child's name, birth date, etc.) is correct. If the information we are submitting on claims does not match the information you submitted on the change form, your claims may be denied.

What if my newborn's claims are denied?
It can take up to 2-3 weeks for your insurance to update their records after receiving your Insurance Change Form. In the meantime, we are submitting claims for services rendered so claims are being denied because the insurance can't locate the patient on your policy. Once the baby has been added, most insurance companies will do a search for claims that were denied. Some claims, however, are denied on EDI (front-end) edits and are never accepted into the payer's system. In either case, once you have confirmed with your insurance that the newborn has been added to the policy, you can contact us and we will resubmit the claims.

What if my insurance is denying claims for pre-existing conditions?
Most insurance companies will place a new member in a "pre-existing condition" status. Each claim will be denied or suspended until the insurance can determine whether the patient was seen for a previously diagnosed, or pre-existing, condition. This is very time consuming since the normal practice is to request a patient's medical record for review. If the insurance can determine that the diagnosis is a chronic or continuous care diagnosis, they may deny the claim under the pre-existing provision of your policy. If there was no break in coverage when you went from one insurance to another, you can provide your new insurance with a Certificate of Credible Coverage (you get this from your old insurance company(ies)). With this Certificate, your insurance can waive or reduce your "pre-existing period" which will result in quicker turn-around times on your claims, and reduced denials for pre-existing conditions.

How do I know which of my insurance policies is primary, and which is secondary?
There are different rules that insurance companies follow to determine who should be paying as primary and who should be paying as secondary. Some of these rules are situational, or dependant on other variables. Keep in mind that primary/secondary status may be different for your children than it is for you.

- Medicaid is **always** the payer of last resort. This means that Medicaid will always be billed last, regardless of any other coverage or circumstance.
- Payers go by the "Birthday Rule" to determine primary and secondary coverage in most cases. The policyholder whose birthday falls first in the year will have the primary insurance.
- If the same person holds two policies, the policy that has been in effect the longest will be the primary insurance.
- Military insurance coverage (Tri-Care, Tri-West) will be the payer of last resort with any other insurance but Medicaid.
- In divorce situations, the divorce decree will determine the order of insurance coverage. Both insurance companies may need a copy of the decree in order to coordinate benefits correctly.

What do I do if both of my insurance policies are paying as primary or denying clams for other coverage?
If both insurance companies are paying claims as if they were the primary payer there is most likely confusion about who should be primary, or they are unaware that there is another policy. Payers have up to 36 months (3 years) to request or retract overpayments due to coordination of benefit errors. You will want to work with both insurance policies to make sure they have the coordination of benefit information they need to process the claims correctly. Otherwise, you could be stuck with a bill when both payers retract their payments later on. If you are receiving denials on claims, your insurance has most likely requested other coverage information from the policyholder, which they have not received. Most payers will request this information on an annual basis to keep their records as up-to-date as possible. Once the information and supporting documentation (as in the case of a divorce) has been received, they will be able to correctly coordinate benefits.

How do I know when my insurance has responded to a claim?
Your insurance should send you an Explanation of Benefits (EOB) as soon as a claim has been processed. The EOB will

show what (if any) was paid on the claim, what (if any) was denied and why, and what (if any) your portion is. Your EOB is usually sent prior to the response being issued to us, so you may see it 1-2 weeks before the payment is posted to your account. Your insurance may also send a request for information (ie. other insurance coverage) in the form of a letter, and your claims will be pended until they get the requested information. Always carefully read anything you receive from your insurance company and respond immediately in order to expedite claim response time.

Why am I getting service charges?
Our system is set up to charge statement fees on accounts with private (patient) balances that are over 30 days old. This is to encourage prompt payment and it also helps us recoup the cost of sending statements each month. Unfortunately the system does not have situation awareness, so it cannot tell if delay in payment is due to slow insurance response or other valid reasons. If you have questions regarding service charges, please contact us.

How much do you charge for office visits and/or other services?
Although we have specific prices assigned to each code we bill for, we can't determine what the cost for your visit is until the physician has actually seen your child. There are different levels of office visits, which are determined by the complexity of the condition and/or time the patient is being seen for. There are also additional charges for immunizations, medications, labs, etc. that are not known until the services are provided. You may contact us prior to receiving services for an **estimate** of charges, but a final determination cannot be made until the physician has seen your child.

Why am I getting a statement when my insurance doesn't even show that you've sent a claim?
If your insurance does not show a claim on file it could be for one of three reasons: we do not have correct insurance information on file and claims are going to the wrong payer; the information in our system does not match the information in the payer's system so claims are being rejected on front-end edits; or claims are being lost. We send electronic claims to most of our payers, so if they don't show the claim on file it is usually due to incorrect or incomplete information. Contact us to verify the information and have us resubmit the claim.

What if my insurance denies a service as non-covered?
Non-covered services are your responsibility. Before seeing the doctor, it is always a good idea to check with your insurance and verify which services are covered under your policy. Although they won't guarantee payment on a claim prior to the claim being submitted, they can give you a good idea of whether or not a type of service is covered (ie. preventive care, immunizations, mental health, etc.).

What if my insurance denies a service as inclusive?
An inclusive denial means that the insurance believes that one or more service that was billed should have been included in other services on the claim. An inclusive denial is something we will work out with your insurance through the appeals process. Until we have a response on the appeal you will not be held responsible for the charges that were denied as inclusive. If your insurance upholds their original denial we will adjust the denied charges off according to our contract with them. If they reverse their original denial, you may end up being responsible for part or all of the charge if it is applied to a co-pay, co-insurance or deductible, or if it is denied for another reason.

Can you change how you billed my child's visit so my insurance will pay the claim?
We are required by Federal law to report the exact services provided and the exact reason for providing them. It is fraudulent to report a different procedure or diagnosis code in order to make a visit "fit" your insurance plan. The only time a service or diagnosis can be changed is if we originally reported them incorrectly to your insurance. You may want to check with your insurance, prior to being seen, to determine whether a service is covered under your plan so you know what to expect.

Can I still be seen if I don't have insurance?
We do accept self-pay patients. Payment in full is expected at time of visit.

What if my insurance doesn't cover preventive care or I have a preventive care maximum benefit?
Preventive care checks are crucial for the health and proper development of your child. However, many insurance plans do not cover preventive care services, or they have a benefit cap which will only pay so much toward preventive care per year. In either of these situations, the State of New Jersey has programs to help ensure your child's health while helping you manage the cost of preventive care services. The Vaccine for Children (VFC) program provides immunizations for many patients including those whose insurance does not cover vaccinations, or one whose benefits have a preventive care maximum. The vaccine is provided at no cost, and all you pay is an injection administration fee per shot.

How do I know if my doctor is on my insurance plan?
Our web site lists most of the payers we are contracted with. However, some of these payers are national payers, or have some plans that contract through other entities, which we may not be paneled with. In order to determine whether your doctor is covered under your specific plan, please contact your insurance company and give them your doctor's name. They have access to your plan, and to the most up-to-date contract information. You will want to verify this information prior to receiving services.

How do I know what services are covered under my insurance plan?
Your member benefit manual will give you a good idea of which services are covered under your plan. When in doubt, call your insurance. They can give you specific information regarding your plan benefits, although they will not guarantee payment until the claim is processed. If you know of specific services you would like to receive, we can provide the codes for those services so your insurance can give you more accurate information.

What can I do if I don't agree with how insurance processed my claim?
First, refer to your member benefits manual and make sure you understand your benefits. If, after verification, you determine that insurance processed the claim incorrectly, the next step is to call Member Services at your insurance company. They may be able to resolve the issue over the phone and send the claim back for reprocessing. You can also appeal, in writing, with your insurance company and provide documentation supporting your argument that the claim was processed incorrectly according to your benefits.