BEST PRACTICE GUIDELINES

OCTOBER 2004
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Executive Summary

Of the 15 billion provider claims submitted annually to health plans in the United States, 30 percent are rejected. Fully 15 percent of these rejected claims may never be resubmitted because of limited provider resources to resolve the discrepancies. Local health plan analysis suggests that half of all rejected claims are caused by missing or inaccurate member/patient identification information on the claim.

Patient ID cards are the most commonly accepted method of relaying critical patient and claims submission information to providers. However, these cards often contain extraneous information, or omit vital information, which leads directly to providers submitting claims to health plans destined inevitably to be rejected. The purpose of this Patient Identification Card Guideline is to decrease the percent of provider claims rejected by providing “best practices” for health plans to use in designing their ID cards.

It is important to note that this Guideline represents a consensus of provider and plan stakeholders, arrived at through an extensive two year review of the claims submission process and the “best” and “worst” practices currently being used by health plans and employers to design their patient ID cards.

The most consistent causes of rejection and delay found in our study were:

- The patient identification number displayed on the card is different in some manner from the identification number actually required by the health plan for claim submission.
- No product or plan type is listed (e.g., PPO, HMO, POS, EPO).
- The Employer “group number” is too long and cannot be accommodated by many practice management claims submission systems.
- No effective date or even issuance date is shown on the card.
- The background coloration of the card, embossing, or corporate/product logos obscure key data when the card is copied by the provider office.

This Guideline reflects actual provider office procedures as it sets out “best practices” in such additional areas as specific card content and the positioning of information on either the front or the back of the card. Also reflected in the Guideline is consensus on whether content information is “required” or “optional.” Recognizing that all stakeholders have a role in addressing unnecessary complexity in the health care system, the information on patient ID cards is complimented by a section on “best practices” for medical offices and for employers providing medical benefits, including the identification of effective work flow processes and patient/employee communication.

1 Med News “Insurance Claim Denials are Money Left Behind.” 3rd quarter 2002
2 Gateway EDI “Top Reasons Claims Rejected by Payors.” April 2002

Remove the guessing game from the patient ID card
Model Patient ID Card

The Patient ID Card:
- Can be photocopied clearly.
- Includes only information necessary to patient care and claims processing.
- Does not have logos or other non-member information obscuring text.
- Is produced on durable material (i.e., plastic).

Front

<table>
<thead>
<tr>
<th>Health Plan or Payor Logo</th>
<th>Network Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Product or Plan Type Designation (HMO, PPO, EPO, POS)</td>
</tr>
<tr>
<td></td>
<td>Website (if applicable)</td>
</tr>
</tbody>
</table>

All services are to be authorized by your primary care physician (if applicable)

Patient Name ID #: 0000000000
Group Name and / or ID Number
Pharmacy Benefits Manager Name (if applicable)
Effective or Issue Date: 0/00/00 (optional)
Payor Phone #: 800-000-000
Local: 000-000-0000

Co-Pays (if applicable)
Co-Ins and Deductible (optional)
Electronic Payor ID# (if applicable)
Provider Network Name (if applicable)
Vision or Dental Benefits (if applicable)
TPA Logo

Back

PCP Name (if applicable) PCP Phone # (if applicable)

To prior authorize all medical or surgical admissions or for Utilization Management review, call:
Toll Free: 800-000-0000
Local: 000-000-0000

If Emergency or urgent care is required, carrier must be contacted within 00 hours. (varies by carrier)
Lab Vendor Name (if exclusive)

For questions about your benefits:
000-000-0000 or www.yourmedplan.com

For Behavioral Health and Substance Abuse services, call:
Toll Free: 800-000-0000
Local: 000-000-0000
Submit claims to:
Company
000 Main Street
Anytown, USA 00000
000-000-0000
If out of area, call:
Toll Free: 800-000-0000
www.yourmedplan.com

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000 Main Street
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000-000-0000
If out of area, call:
Toll Free: 800-000-0000
www.yourmedplan.com

For questions about your benefits:
000-000-0000 or www.yourmedplan.com
Patient ID Card Content

When designing a patient ID card it is important to:
1. Decide what is the essential information.
2. Print the most fundamental information on the front of the card.
3. Remember that the ID card can’t possibly contain everything needed to complete a claim form.

The Patient ID Card should include:

<table>
<thead>
<tr>
<th>PPO</th>
<th>HMO, POS, and EPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FRONT SIDE OF CARD:</strong></td>
<td><strong>FRONT SIDE OF CARD:</strong></td>
</tr>
<tr>
<td>• Patient Name</td>
<td>• Patient Name</td>
</tr>
<tr>
<td>• Patient ID Number</td>
<td>• Patient ID Number</td>
</tr>
<tr>
<td>(precisely as needed for claims submission)</td>
<td>(precisely as needed for claims submission)</td>
</tr>
<tr>
<td>• Health Plan/Payor Name/Logo and Phone Number</td>
<td>• Health Plan or Payor Name/Logo and Phone Number</td>
</tr>
<tr>
<td>• Product or Plan Type (e.g. HMO, POS or EPO)</td>
<td>• Product or Plan Type (e.g. HMO, POS or EPO)</td>
</tr>
<tr>
<td>• Employer Group Name or Number</td>
<td>• PCP Name (or on Back)</td>
</tr>
<tr>
<td>• Health Plan/Payor Identification (Network)</td>
<td>• Employer Group Name or ID Number</td>
</tr>
<tr>
<td>• Co-pay Information (PCP, Specialists, ER, Hospital)</td>
<td>• Provider Network Name or Logo (if exclusive)</td>
</tr>
<tr>
<td>• Co-Ins and Deductible Information</td>
<td>• Electronic Payor ID Number</td>
</tr>
<tr>
<td>• PCP Name and Telephone Number (or on back, if applicable)</td>
<td>• Co-pay Information (PCP, Specialists, ER, Hospital)</td>
</tr>
<tr>
<td>• Effective Date or Issue Date (optional)</td>
<td>• Effective or Issue Date (optional)</td>
</tr>
<tr>
<td>• Third Party Administrator Name or Logo (optional)</td>
<td>• Third Party Administrator Name or Logo (optional)</td>
</tr>
<tr>
<td>• Payor Electronic Claim Submission ID Number (optional)</td>
<td>• Supplemental Benefits (optional)</td>
</tr>
<tr>
<td>• Supplemental Benefits (optional)</td>
<td><strong>BACK SIDE OF CARD:</strong></td>
</tr>
<tr>
<td><strong>BACK SIDE OF CARD:</strong></td>
<td>• Instructions to Patients with Benefit Questions</td>
</tr>
<tr>
<td>(e.g. Phone Number or Web Site Address)</td>
<td>(e.g. Phone Number or Web Site Address)</td>
</tr>
<tr>
<td>• Instructions for Hospital Admission, Prior Authorization and/or Utilization Review</td>
<td>• Instructions for Hospital Admission, Prior Authorization and/or Utilization Review</td>
</tr>
<tr>
<td>(e.g. Phone Number or Web Site Address)</td>
<td>(e.g. Phone Number or Web Site Address)</td>
</tr>
<tr>
<td>• Instructions for Out of Network Benefits</td>
<td>• Instructions for Out of Network Benefits</td>
</tr>
<tr>
<td>(e.g. Phone Number or Web Site Address)</td>
<td>(e.g. Phone Number or Web Site Address)</td>
</tr>
<tr>
<td>• Claims Submission Name, Address and Phone Number</td>
<td>• Claims Submission Name, Address and Phone Number</td>
</tr>
<tr>
<td>• Behavioral Health Network Contact Name and Phone Number (if applicable)</td>
<td>• Behavioral Health Network Contact Name and Phone Number (if applicable)</td>
</tr>
<tr>
<td>• Emergency and Urgent Care Information</td>
<td>• Emergency and Urgent Care Information</td>
</tr>
<tr>
<td>• Lab Vendor Name or Logo (if exclusive)</td>
<td>• Lab Vendor Name or Logo (if exclusive)</td>
</tr>
</tbody>
</table>
## Patient ID Card Content Guidelines - Front of Card

<table>
<thead>
<tr>
<th>Card Data Element</th>
<th>Definition</th>
<th>Required or Optional</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>Patient name will be displayed as:</td>
<td>Required</td>
<td>Patient name will be displayed as:</td>
</tr>
<tr>
<td></td>
<td>• Given name and initials</td>
<td></td>
<td>• Surname</td>
</tr>
<tr>
<td></td>
<td>• Surname</td>
<td></td>
<td>• Name Suffix (Sr., Jr., III)</td>
</tr>
<tr>
<td>Patient Identification Number</td>
<td>The unique identification (ID) number assigned by the health plan or payor.</td>
<td>Required</td>
<td>ID numbers on cards should represent the precise electronic format required for claims submission. Standardized placement on the middle left of the card is ideal.</td>
</tr>
<tr>
<td>Health Plan or Payor Name and Logo</td>
<td>Name and logo of the health card issuer sponsoring the health coverage.</td>
<td>Required</td>
<td>Space should be provided if trademark is to be used. Trademark generally on the front of the card, tag line could be on the back.</td>
</tr>
<tr>
<td>Health Plan or Payor Phone Number</td>
<td>The primary phone number to access health plan or payor customer services.</td>
<td>Required</td>
<td>The phone number may optionally be displayed on the back of the card.</td>
</tr>
<tr>
<td>Product or Plan Type</td>
<td>HMO, POS, EPO or PPO designation by the health plan or payor, indicating the type of benefit coverage.</td>
<td>Required</td>
<td>Ideally, the product or plan type should appear in the top right hand corner.</td>
</tr>
<tr>
<td>Primary Care Physician (PCP) Name</td>
<td>The first and last name of the patient’s PCP.</td>
<td>Required</td>
<td>This may only be relevant for HMO patient ID cards. The name may optionally be displayed on the back of the card.</td>
</tr>
<tr>
<td>Primary Care Physician (PCP) Phone Number</td>
<td>The phone number, including area code of PCP.</td>
<td>Optional</td>
<td>This may only be relevant for HMO patient ID cards. The phone number may optionally be displayed on the back of the card.</td>
</tr>
<tr>
<td>Employer Group Name or ID Number</td>
<td>The name, number or code assigned by the health plan or payor to identify the group for the patient.</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Provider Network Name or Logo</td>
<td>The name or logo of a network of physicians contracted with the health plan or payor.</td>
<td>Required</td>
<td>This information should be included if there is an exclusive network.</td>
</tr>
<tr>
<td>Card Data Element</td>
<td>Definition</td>
<td>Required or Optional</td>
<td>Comment</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Electronic Payor ID Number</td>
<td>The ID number required to submit an electronic claim by provider.</td>
<td>Required</td>
<td>This information is critical to the claims adjudication process. The ID number may optionally be displayed on the back of the card.</td>
</tr>
<tr>
<td>Co-pay (PCP and Specialist) Office Visit</td>
<td>Charge to a patient for a visit to a physician office.</td>
<td>Required</td>
<td>This may only be relevant for HMO patient ID cards. State actual dollar amount.</td>
</tr>
<tr>
<td>Co-pay Emergency / Urgent Care</td>
<td>Charge to a patient for a visit to the emergency department of a hospital.</td>
<td>Required</td>
<td>This could be relevant for HMO and PPO patient ID cards. State actual dollar amount.</td>
</tr>
<tr>
<td>Co-pay Pharmaceutical</td>
<td>Charge to a patient for drugs prescribed by a physician.</td>
<td>Optional</td>
<td>State actual dollar amount.</td>
</tr>
<tr>
<td>Co-pay Hospital</td>
<td>Charge to covered person for admission to a hospital.</td>
<td>Optional</td>
<td>State actual dollar amount.</td>
</tr>
<tr>
<td>Co-insurance and/or Deductible</td>
<td>The amount a patient must pay before the health plan or payor will make a payment for eligible benefits.</td>
<td>Optional</td>
<td>State actual dollar amount.</td>
</tr>
<tr>
<td>Effective or Issue Date</td>
<td>Ideally, the date a patient becomes eligible for benefits under an existing contract.</td>
<td>Optional</td>
<td>Effective Date - The date the patient’s benefits are effective. Issue Date- The date the identification card was printed. This will provide at least some indication of the cards accuracy.</td>
</tr>
<tr>
<td>Third Party Administrator Name or Logo</td>
<td>The payor identifying information for claims submission if a third party payor.</td>
<td>Required</td>
<td>The logo may also be displayed on the back of the card.</td>
</tr>
<tr>
<td>Supplemental Benefits</td>
<td>A code or description of optional benefits a health plan or payor provides in addition to basic health services.</td>
<td>Optional</td>
<td>If the health plan or payor adds other specialties such as vision and dental providers.</td>
</tr>
</tbody>
</table>
# Back of Card

<table>
<thead>
<tr>
<th>Card Data Element</th>
<th>Definition</th>
<th>Required or Optional</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructions to Patient with Benefit Questions</td>
<td>Instructions for obtaining covered benefits and access to specific services.</td>
<td>Optional</td>
<td>The phone number may be optionally displayed on the front of the card.</td>
</tr>
<tr>
<td>Instructions for Hospital Admission, Prior Authorization and/or Utilization Review.</td>
<td>Instructions to patients for hospital admission including the phone number to call and time period required for health plan or payor notification.</td>
<td>Required</td>
<td>This information maybe a web site address or phone number and is essential for the patient and health care providers.</td>
</tr>
<tr>
<td>Instructions for Out of Area Benefits</td>
<td>Instructions for obtaining approval for using services when patient is outside the contracted area.</td>
<td>Required</td>
<td>Best to include the payor phone number; however, some health plans or payors may prefer to include only a web site address.</td>
</tr>
<tr>
<td>Claims Submission Name, Address and Phone Number</td>
<td>Information for the submission of claims and/or customer service to assess patient eligibility for services.</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Network Contact Name and Phone Number</td>
<td>The name and phone number, including area code, for the entity coordinating behavioral health benefits.</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Emergency and Urgent Care Information</td>
<td>Instructions for obtaining approval and claims submission for emergency and urgent care services.</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Laboratory Vendor Name or Logo, If exclusive</td>
<td>The required lab vendor for laboratory services.</td>
<td>Required</td>
<td>The laboratory vendor name may optionally be displayed on the back of the card.</td>
</tr>
</tbody>
</table>

These guidelines are intended to reflect best practices for the development of patient ID health insurance cards. Adherence to these guidelines may increase patient access to timely and appropriate services as well as efficient claims filing and payment. However, specific contractual arrangements may preclude the implementation of a specific guideline recommendation.
Patient ID Card Stakeholder Best Practices

Medical Office
Provider office personnel should:
- Prior to patient arrival, check patient eligibility for services. This might be accomplished by:
  - Develop a method to access the next day’s schedule and matching each patient’s eligibility with the respective health plan/payor (e.g. through health plan web site).
  - Identifying practice management software capabilities to generate Patient Eligibility report that is submitted to clearinghouses for eligibility verification.
  - If patient is not eligible for services, alert the patient prior to their appointment, if possible.
- At the time of service, personnel will:
  - Ask each patient for their patient ID card upon arrival.
  - Copy the patient ID card and place the copy in the patient’s medical record.
  - Verify patient demographic information including subscriber name and date of birth as required for HIPAA for claims submission.
  - Enter patient ID number accurately into practice management software.
  - Collect appropriate patient financial responsibility amount.

Health Plans
In addition to following the Patient Identification Card Guidelines, it is recommended health plan/payors:
- Develop a process and train customer service personnel to verify patient eligibility without requiring a social security number (since HIPAA and many state laws prohibit the use of social security number on ID cards).
- Maintain member eligibility status for providers as close to “real time,” as possible and develop an effective means of communicating this information to providers.
- Develop a process to provide employer groups with timely notification of contract intervals.
- Issue new patient ID cards and new member materials in a timely manner (preferably prior to new effective date) and include a cover letter (see appendix A) explaining member responsibilities for patient ID card management.

Employer
It is recommended employers do the following:
- Provide timely notification to health plan/payor regarding employee new hire or termination as close to “real time” as possible.
- Develop a process to notify health plan/payor renewal decisions in a timely manner, preferably at least 14 days prior.
- Educate employees regarding:
  - Benefits and networks during open enrollment period and ongoing.
  - Characteristics of a good patient consumer such as:
    1) Arrives 15 minutes early to appointments.
    2) Calls to cancel appointments.
    3) Provides updated information to health care provider.
    4) Is aware of benefits, co-pays, co-insurance or deductible requirements.
{Date}

Dear Member:

As a valued member of {insert name of health plan/payor}, we are committed to serving and providing you the best health care coverage possible.

In order to continue to fulfill that promise, we are providing you the enclosed new patient ID card. **In order to ensure appropriate benefits coverage it is important to destroy your previous ID card.**

Please present your new ID card to your health care provider at your next appointment to ensure timely and accurate processing of future claims. Your health care provider might request additional information, not included on the ID card, to properly process your claims.

If you have any questions about your coverage, or your new ID card, please call the customer service phone number listed on the ID card.

We look forward to continuing to serve your health care needs.

Sincerely,

Member Services
{insert name of insurance carrier}
Project Participants

Health Plans

Blue Cross and Blue Shield of Kansas City
Cigna
Community Health Plan
Coventry Health Care of Kansas, Inc.
Family Health Partners
First Guard
Humana
United Healthcare of the Midwest, Inc.

Medical Offices

Discover Vision Centers
Heartland Hematology-Oncology Associates
Medical Plaza Consultants
North Kansas City Hospital
Women’s Health Network

Others

J2H2 Consultants
Kansas Office of Health Planning and Finance
Marsh USA, Inc.
Osco Drug
“The Coalition is on the cutting edge of building true public-private partnerships to address major, community-wide public health issues – What’s being done in Kansas City undoubtedly will serve as a model in the future for other communities nationwide.”  

Dr. David Satcher, Former U.S. Surgeon General

THE MISSION of the Coalition is to:

♦ Improve the health of employees and their families.
♦ Promote employee and community wellness and illness prevention.
♦ Develop strategies and initiatives for containing business health care costs.
♦ Generate and communicate health care information to the community.

OVER 25 YEARS OF COLLABORATION among the major employers, hospitals, physicians, health plans, universities and governments in the Kansas City region has proven that when the stakeholders in the health care delivery system come together, significant areas of agreement can lead to millions of dollars in savings.

KANSAS CITIANS ARE HEALTHIER because of the Coalition’s innovative projects, focusing on a spectrum of issues such as wellness, access to care, depression, high risk maternity and workers compensation.

SUPPORTED BY membership dues, gifts-in-kind and project grants from foundations, researchers and pharmaceutical companies. The Coalition is a 501(c)(3) charitable organization.

THE COALITION:

♦ Breaks down barriers to change in the health care delivery system by bringing together key organizations and individuals in a cooperative and creative problem-solving environment.
♦ Focuses employer energies on areas of common concern such as employee health/wellness and cost containment.
♦ Reduces health system complexities by facilitating stakeholder coordination of such procedures as billing, internet communications, credentialing and HEDIS® reporting.
♦ Develops model programs used by employers, health plans and hospitals throughout the region to contain costs and improve outcomes.
♦ Informs stakeholders about health care developments through workshops, conferences and publications.
♦ Serves as a national model for a more effective way to address the problems of the health care delivery system and to foster wellness both at the worksite and throughout the community.

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