Cleveland Clinic

Understanding Insurance and Our Billing Process

Thank you for choosing Cleveland Clinic for your healthcare needs. We appreciate the confidence you have placed in us.

This brochure has been prepared to answer many common questions that patients have about insurance, billing and financial assistance for our services. Please let us know if we can answer any additional questions to help make the financial side of your experience with us as easy as possible, so you can focus on your health and wellness.

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Understanding Insurance and Our Billing Process

Not sure about what your insurance covers? Having a hard time figuring out your physician and hospital bill? Cleveland Clinic's Patient Financial Services (PFS) team has prepared this pamphlet to answer questions you may have about insurance, billing, financial assistance and related topics.

If you need more information, we are here to help. Please call PFS at 216.445.6249 or toll-free at 866.621.6385.

Our website also provides information on insurance and billing. See us at http://my.clevelandclinic.org/patients-visitors/billing-insurance/default.aspx

Insurance

1. **When do I make a co-payment or deductible payment?**

   Most insurance companies require patients to pay a portion of their doctor's visit or hospitalization costs. This is called a co-payment or a deductible, and these payments are generally made before your appointment, procedure or admission. If these payments are not made, we may have to reschedule your appointment. If you have questions when you come in for care, the financial counselor in that area can help.

2. **I have surgery scheduled soon. How do I know it will be covered?**

   Many insurance plans require prior authorization (sometimes called pre-

certification) for services such as inpatient surgery. When Cleveland Clinic schedules these services, we check with the patient's insurance company. If they do not approve the service, we notify the patient before the service takes place. Patients who decide to proceed with the service are responsible for payment.

If you are scheduled for surgery at any Cleveland Clinic inpatient or outpatient surgery location, you can also view a free online video that can help you figure out what your insurance covers, including referrals, pre-certifications and out-of-pocket costs.

To access this video, please visit: http://my.clevelandclinic.org/patients-visitors/billing-insurance/default.aspx.

3. My primary care physician wants me to see a specialist. How do I know I'll be covered?

You should check with your insurance company. Most managed care plans, health maintenance organizations (HMOs) and point of service (POS) plans require a referral from a primary care physician before they will cover a visit to a specialist. Please discuss this with your primary care physician before scheduling an appointment with a Cleveland Clinic specialist – and if a referral is required, make sure you get one. If a referral is necessary and you do not get one, your appointment with the specialist may have to be rescheduled, or you may be responsible for paying for the visit.

4. How would I be covered if I'm placed under *observation status*?

When your physician places you under observation status, this means our clinical staff will closely monitor you for the next several hours. Your observation period will be used to determine if you can be sent home or need to be admitted as a hospital inpatient. Observation status includes medically reasonable and necessary services such as ongoing short term treatments, assessments and close monitoring, tests and certain procedures. Observation status for 24-48 hours is generally covered by healthcare plans. If it extends beyond that, you may be financially liable for the additional care. Insurance companies require that we bill all observation status care as outpatient services. If you have questions about how your healthcare plan treats observation services and whether these are covered as outpatient care, please contact your insurance company.

If you are a Medicare subscriber, observation status is not considered a hospitalization and does not affect your Medicare Part A benefits. No hospital days are used, and the Part A deductible is not required. This also means that observation status does not count toward the three day qualifying stay requirement for admission to a skilled nursing facility. Observation status is covered by Medicare Part B. There is an annual deductible and co-pay for these services. In addition, you should know that while you are in the hospital during an outpatient observation period, Medicare does not

pay for "self administered drugs" such as oral medications, eye drops, creams, ear drops, ointments, inhalers, suppositories, and insulin – even if a nurse administers them to you. If you have questions about observations status services covered by Medicare, please call 1.800.MEDICARE (1.800.633.4227).

5. **I don't have health insurance. What are my options?**

   Please call PFS at 216.445.6249 or toll-free at 866.621.6385 and we will be glad to tell you about financial assistance programs available through the government and Cleveland Clinic and how to apply for them.

   Financial assistance applications can be downloaded from http://my.clevelandclinic.org/patients-visitors/billing-insurance/financial-assistance.aspx

6. **Do I have any options if I recently lost my job?**

   If you are unemployed and no longer covered by insurance, you may be eligible for COBRA, an insurance program established by the federal government to provide out of work individuals with temporary healthcare benefits. If you cannot make the monthly payments, you may be eligible for a program where Cleveland Clinic pays COBRA on your behalf for a specific course of treatment and period of time. If you do not qualify, you will be evaluated for other assistance programs.

Billing

1. **Will I receive one bill – or separate bills – for the care I receive at Cleveland Clinic?**

   When you receive care at any of our Cleveland Clinic inpatient or outpatient facilities, you will receive one billing statement for all Cleveland Clinic physician and hospital services. This same bill will include charges for medical or technical services, supplies and equipment as well as physician and clinical professionals, treatment and procedures. The statement will show any co-payments or deductible payments you made.

   One exception: If you receive care from an independent physician who is affiliated with Cleveland Clinic but not part of our group practice, you will receive a separate bill for these services.

2. **How do I make a payment?**

   You have several options:

   - Cash, check or money order
   - All major credit cards
   - Electronic checks
   - myaccount.clevelandclinic.org
   - 3-month payment plan
   - USBank loan

3. **Can I pay my bill online?**

   Yes. You can sign up for MyAccount to receive your billing statement electronically and pay online. Here's how to enroll:

   Log in to: **myaccount.clevelandclinic.org**
   Choose: Sign Up Online
   Complete: Demographic screens

4. What can I do to ensure a smooth billing process?

We encourage you to take these steps:

- Bring your most recent insurance cards and picture ID to your health visit.
- When making an appointment and arriving for your health visit, make sure we have your correct address.
- Check your insurance plan to find out what is and isn't covered. If you have questions, please contact your insurance company *before* your health visit.
- Confirm with your insurance company that Cleveland Clinic health system is a contracted provider of services for your plan.
- If your insurance company requires a co-pay or deductible payment for your health visit, be prepared to pay. Services may be postponed if a payment isn't made.

5. On my bill, why did I get charged a facility charge when I was seen in a doctor's office?

Cleveland Clinic's physician offices and outpatient clinics are considered hospital outpatient departments (also called provider based) by Medicare. This means you will see a facility and/or treatment room charge under the Hospital Services section of your billing statement.

Facility charge covers the use of the room and any medical or technical supplies or equipment. Your billing statement will also include charges for doctor's services, treatment or procedures, which will be classified as "Physician and Clinical Professionals".

6. What does "provider based" mean?

Provider based is a Medicare classification. It means that hospitals have met specific Medicare regulations to have their outpatient doctors' offices and clinics classified as provider based. Most large hospital systems are classified as provider based by Medicare, which results in uniform billing.

7. Does provider based billing apply to me if I am not covered by Medicare?

Yes. Provider-based billing applies to all patients, not just to those covered by Medicare.

8. How does provider-based billing affect me if I have Medicare?

The charges listed under Hospital Services will be billed to Medicare Part A. The physician and clinical professionals charge will be billed to Medicare Part B. You will receive two Medicare Summary Notices (MSNs), one for Part A and one for Part B.

If you have **secondary or supplemental insurance**, we will submit any balance to that insurance plan. If your secondary insurance does not cover the balance, or if you do not have secondary or supplemental insurance, the balance will be billed to you.

9. I am covered by Medicare but don't have supplemental insurance. How can I find out what my Part A and Part B charges will be?

Medicare requires that we give you an **estimate** of your Part A and Part B charges if you do not have secondary insurance. These amounts may be different, depending on the services you receive. Listed below is an example of what a Medicare patient may be responsible to pay in 2012 if there is no secondary insurance.

Part A (Hospital Services)

Office visit level 1	$11
Office visit level 5	$35
Emerg Dept visit level 1	$10
Emerg Dept visit level 5	$65
Joint injection	$36
Chest x-ray	$9
Cystosocopy	$95
Skin biopsy	$21

Part B (Physician/Professional)

Office visit level 1	$5
Office visit level 5	$32
Emerg Dept visit level 1	$4
Emerg Dept visit level 5	$35
Joint injection	$10
Chest x-ray	$2
Cystosocopy	$26
Skin biopsy	$10

You can get additional estimates by calling PFS Customer Services toll free at 1.866.621.6385 or by seeing one of our financial counselors.

10. How does provider-based billing affect me if I am not covered by Medicare?

The way your insurance company handles provider-based charges may be different from Medicare. Some insurance companies may apply these charges to your annual deductible. To find out what will be covered, contact your insurance company.

11. If I am unable to make full payment immediately, can I set up a payment plan?

Yes, please contact our Credit and Collections Department at 216.444.4775 or 1.866.737.4358 to establish a payment plan or to learn about our loan program.

Please be aware that patients are responsible for account balances, and payment is due upon receipt of the bill. Cleveland Clinic employs third-party collection agencies to help us resolve unpaid balances. If you are unable to pay your bill, you may be eligible for financial assistance.

12. I was given an estimated cost of services and I made the required deposit for half that amount. How will that be handled once the actual bill is determined?

You will receive a statement for the remaining balance. Payment is due upon receipt. If the deposit turns out to be more than your final bill, you will be refunded once the insurance balance has been settled. If there was no insurance involved, we will refund your money once all charges have been totaled.

13. Whom should I contact with questions about my billing statement?

If you have questions, need to update your insurance information, or would like an itemized statement, please call PFS at 216.445.6249 or 1.866.621.6385.

Financial Assistance

1. Is financial assistance available?

Yes. The Cleveland Clinic Health System has a generous financial assistance program. Please see the eligibility requirements below:

- At Ohio facilities, must be a resident of Ohio.
- At Florida facilities, must be a resident of Broward or Palm Beach counties; distance to other providers will be considered for eligibility.
- At Nevada facilities, must be a resident of Nevada and reside within a 150-mile radius of Cleveland Clinic facilities.
- Must follow the Medicaid eligibility process with a Cleveland Clinic representative or one of our vendor companies.

2. How does financial assistance work?

Cleveland Clinic participates in the Ohio Hospital Care Assurance Program (HCAP). Ohio residents who apply for financial assistance are considered for HCAP coverage. Applicants are screened for Medicaid assistance in Ohio, Florida or Nevada, depending on where they receive care.

A financial counselor will ask you a few questions to see if you meet the initial requirements. If you do, you will be referred to one of our Medicaid vendors, Human Arc of Ohio or Firstsource Solutions. They will work with you and the state to secure Medicaid coverage.

Please comply with our vendor company and the process so you can remain eligible for Cleveland Clinic financial assistance. In Florida, we do not contract with a Medicaid vendor company, but we do have a representative on site to assist you.

Patients who do not qualify for HCAP or Medicaid will next be considered under the Cleveland Clinic financial assistance policy.

Important point: Until patients are approved for Medicaid, they will continue to receive billing statements from Cleveland Clinic.

Please be aware that Cleveland Clinic does not contract with most out-of-state Medicaid plans. Patients covered by Medicaid in other states will need to seek medical services within their home states.

3. How do I apply for financial assistance?

To get a financial assistance application, Cleveland and Nevada patients can call 216.444.4775 or 1.866.737.4358 or visit http://my.clevelandclinic.org/patients-visitors/billing-insurance/financial-assistance.aspx.

Florida patients can call 954.689.5166. If you apply, you will receive a letter within 14 business days explaining if you qualify for financial assistance and the level of coverage that will be provided.

4. If I qualify for financial assistance, will I need to re-apply at some point?

Yes. You will be asked to reapply for every inpatient service and every 90 days for outpatient services. You will also be required to reapply if your family income changes. If you qualify for less than 100% financial assistance coverage,

you will be asked to pay 50% of the estimated balance for either elective inpatient or outpatient services prior to scheduling and to make arrangements for payment of remaining balances after services are provided.

5. Can I receive financial assistance if my income is too high?

A patient may qualify for financial assistance in exceptional situations, even if their annual family income is greater than 400% of the federal poverty guidelines. The patient must provide information to support the exceptional medical circumstances and will be considered for assistance if your total annual medical expenses are greater than 25% of their annual family income. All requests for exceptional circumstances will be reviewed by the Financial Assistance team.

6. Could I qualify for Ohio Medicaid's Spenddown program?

If your income is too high for Medicaid but you are elderly, blind or have a disability, you may still qualify for Medicaid through the Spenddown program, which allows certain individuals to deduct medical expenses from their income so that it falls within Medicaid guidelines.

7. How does the Spenddown program work?

Eligibility for the Spenddown program is a monthly process determined by the Ohio Department of Jobs and Family Services (ODJFS). The Medicaid Spenddown Program requires an individual to share with their ODJFS caseworker proof of out-of-pocket medical expenses that are his or her responsibility to pay. These expenses are totaled and compared against a monthly Spenddown dollar amount set by ODJFS. (Expenses covered by other insurance plans are not eligible toward this amount.) Once the monthly Spenddown amount has been reached, the individual is eligible for Medicaid – and the use of a Medicaid card issued by the county where they live – to cover medical expenses for the rest of the month.

Here are a few important points to remember about the Spenddown program:

- Your date of Medicaid coverage begins on the date the total amount of your out-of-pocket medical or pharmacy bills equals your monthly Spenddown amount.
- Once your Medicaid card has been issued by the county, you are responsible for paying the expenses used to satisfy the monthly Spenddown amount.
- Cleveland Clinic patients who have been approved for the Ohio Medicaid Spenddown program may use their current or past unpaid medical or pharmacy expenses to satisfy their monthly Spenddown amount.
- You can use past unpaid medical bills to satisfy your monthly Spenddown amount for more than one month. **Example:** Your monthly Spenddown limit is $100. You already have $800 in past qualifying medical expenses, which is the equivalent of eight months of Spenddown expenses.

- In some Ohio counties, you can "pay in" your monthly Spenddown amount – just like an insurance premium – to have your Medicaid card issued. You simply go to the county office and pay your monthly Spenddown amount.

8. How can Cleveland Clinic assist me with the Spenddown process – and what can I do?

All Cleveland Clinic hospitals have an on site financial counselor who can guide you through the process by:

- Printing itemized statements outlining your charges.
- Faxing information to your caseworker so your Medicaid card can be issued.
- Providing you with other information to assist you in resolving balances on your account.

Here's how you can help:

- Provide the financial counselor with your caseworker's name, telephone and fax numbers and your monthly Spenddown amount.
- Follow up with your caseworker to be sure charges have been received and the Medicaid card has been issued.
- Once the Medicaid card has been issued, provide billing information to PFS Customer Services toll free at 1.866.621.6385.

9. I have a child with special healthcare needs. Are there financial assistance programs that can help?

The Bureau for Children with Medical Handicaps (BCMH) is a healthcare program offered by the Ohio Department of Health (ODH). BCMH links families of children with special healthcare needs to a network of quality providers and helps families obtain payment for the services their children need. These needs can include care for medical conditions that require ongoing treatments, such as diabetes, heart defects, chronic lung disease, cancer and hearing loss. BCMH may pay for some services that are not covered by insurance and/or Medicaid.

If your child needs special support and services through BCMH, our financial counselors and social workers will refer you to our vendor, Firstsource Solutions, who will work with you to establish eligibility for BCMH coverage. If your child is not eligible for BCMH, your family may be eligible for other financial assistance.

Special Topics

1. I am an international visitor to the United States. Are there special services for patients like me?

Yes. Global Patient Services (GPS) offers a wide range of support services for international patients and their families. GPS has a full-time, multi-lingual staff who can help facilitate all financial aspects of an international patient's visit, including insurance verification and pre-payment arrangements for patients who will be paying their charges themselves.

GPS can also help with scheduling medical appointments, airline and hotel arrangements and ground transportation, as well as activities for family members

assisting the patient. For more information, please contact Global Patient Services in Cleveland at 216.444.6404 or send an email to interna@ccf.org. In Florida, call 954.659.5080.

2. **I don't speak English. Can I get an interpreter?**

   Yes. Our Global Patient Services (GPS) area provides interpreters to assist with communication in many languages. To arrange for these services, please contact GPS in Cleveland at 216.444.6404 or send an email to interna@ccf.org. In Florida, call 954.659.5080. The registration staff also can assist in obtaining interpreter support.

3. **Does Cleveland Clinic offer any educational courses to help patients or family members understand insurance and billing?**

   Yes – we offer several free educational forums, and they are open to everyone. Here are some of the topics:

   - **Puzzled by health insurance and billing?**
     Learn how to read your evidence of coverage, explanation of benefits, and Cleveland Clinic billing statement; find out what specific insurance terms mean and have your questions answered by insurance experts.
   - **About to retire?**
     If you are 63 or older and are still employed or do not have Medicare, prepare for the transition from commercial insurance to Medicare.

   Learn the difference between Medicare and a Medicare HMO, find out if you need a supplemental plan, discover what is not covered by Medicare, and have your questions answered by Medicare experts.

   - **Need help understanding your hospital bill?**
     Hospital bills are sometimes confusing. You are invited to attend our Patient Education seminars where our customer service and billing experts can help you understand your Cleveland Clinic billing statements. They also will explain co-insurance and deductibles and how those items are displayed on your bill.

     Reservations are suggested. Please call 216.636.1121 to reserve your place. For a full calendar of upcoming sessions, please go to http://my.clevelandclinic.org/Documents/Patients/patient-education-sessions.pdf

Additional Questions

If you have questions about any of the information in this brochure, your bill or financial assistance, please contact Customer Service. We will be happy to assist you.

Customer Service

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