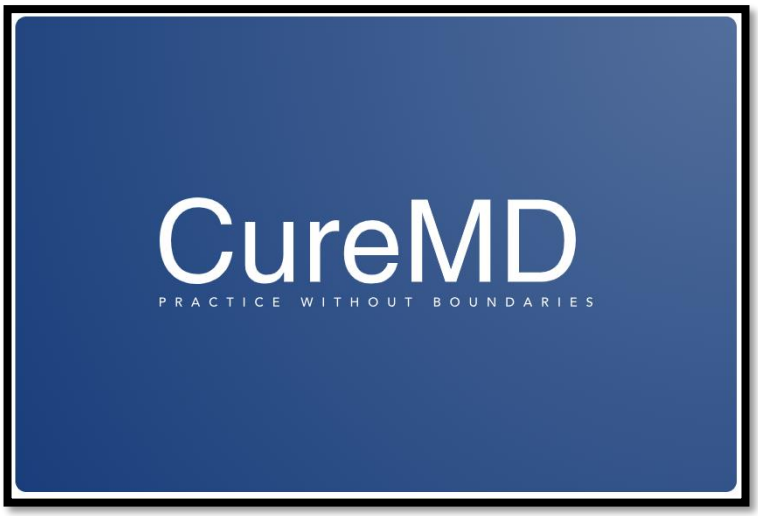


MEDICAL BILLING DOMAIN TRAINING

Mastering Medical Billing Processes for Accurate Reimbursements and Optimal Practice Management.

ABSTRACT

Medical Billing domain training equips participants with the essential knowledge and skills to efficiently manage billing processes, ensuring accurate reimbursements and effective healthcare practice management.

CureMD

TABLE OF CONTENTS

MEDICAL BILLING TERMINOLOGIES

TIN: (Tax Identification Number) is a unique identification number assigned by tax authorities to individuals or businesses for tax purposes.

PIN: (Provider Identification Number) is a unique identifier assigned to healthcare providers, often used for electronic health records and insurance claims processing.

NPI: (National Provider Identification) is a unique 10-digit identification number for healthcare providers, used for standardizing identification in electronic transactions.

ROI: (Release of Information) is the process of providing access to or disclosing protected health information to authorized individuals or entities in accordance with applicable laws and regulations.

AOB: (Assignment of Benefits) is a legal agreement in which a patient assigns their insurance benefits to a healthcare provider, allowing the provider to receive payment directly from the insurer.

CPT: (Current Procedural Terminology) is a standardized medical code set used to describe and report medical, surgical, and diagnostic procedures for billing and documentation purposes.

ICD: (International Classification of Diseases) is a globally recognized system that assigns codes to various medical conditions and diseases for standardized reporting and statistical purposes.

HIPAA: HIPAA (Health Insurance Portability and Accountability Act) is a U.S. federal law that establishes standards to protect the privacy and security of individuals' health information and ensures their ability to maintain health insurance coverage during job changes or life events.

CMS: (Center for Medicare and Medicaid Services) is a federal agency within the U.S. Department of Health and Human Services responsible for administering Medicare and Medicaid programs and promoting healthcare quality and accessibility.

EOB: (Explanation of Benefits) is a document provided by health insurance companies to policyholders, detailing the costs and payments for healthcare services covered under their insurance plan.

ERA: (Electronic Remittance Advice) is an electronic version of an Explanation of Benefits (EOB) that provides healthcare providers with detailed information about claims payments and adjustments made by insurance companies.

EFT: (Electronic Funds Transfer) is a digital method of transferring funds from one bank account to another, enabling secure and efficient electronic payments.

EMR: (Electronic Medical Records) is a digital system that stores and manages patients' medical and health information in a healthcare provider's electronic database.
It is also known as billing software.

EHR: (Electronic Health Records) is a comprehensive digital record of a patient's medical history, including medical and clinical information, maintained by healthcare providers and accessible across various healthcare settings.

ABN: (Advance Beneficiary Notice) is a notice given to Medicare beneficiaries (Patients who has Medicare Insurance) by healthcare providers, informing them that Medicare may not cover certain services, and they may be responsible for the costs.

COB: (Coordination of Benefits) is the process used by insurance companies to determine the order in which multiple health insurance policies will pay for a patient's healthcare expenses to avoid overpayment or duplication of benefits.

DOS: (Date of Service) is the specific date on which a healthcare service or procedure was provided to a patient and for which the billing and documentation are based.

EDI: (Electronic Data Interchange) is the computer-to-computer exchange of structured data in a standardized electronic format between business partners to facilitate seamless and automated transactions.

FFS: (Fee-for-service) is a payment model in healthcare where providers are reimbursed based on the individual services they deliver, rather than receiving a fixed amount for overall patient care.

HCPCS: (Healthcare Common Procedure Coding System) is a standardized coding system used to identify and bill for specific medical services and procedures provided to patients by healthcare providers.

HMO: (Health Maintenance Organization) is a type of managed healthcare plan that provides comprehensive medical services to members through a network of healthcare providers and requires a primary care physician for referrals to specialists.

INN: (In-Network) refers to healthcare providers, hospitals, or pharmacies that have contracted with a specific health insurance plan to offer services to its members at negotiated, discounted rates.

OON: (Out of Network) refers to healthcare providers, hospitals, or pharmacies that do not have a contract with a particular health insurance plan and may result in higher costs for the patient when seeking services.

NDC: (National Drug Code) is a unique numeric identifier assigned to medications, enabling accurate and standardized identification of drugs for billing, reporting, and regulatory purposes.

PA: (Prior Authorization) is a process in which healthcare providers must obtain approval from an insurance company before certain medical services or medications can be covered under the insurance plan.

PCP: (Primary Care Physician) is a medical doctor who provides general health care, manages common medical conditions, and coordinates overall patient care.

RVU: (Relative Value Unit) is a measure used in healthcare to determine the relative complexity and resource utilization of medical services, which is used in calculating reimbursements for physicians and other healthcare providers.

WC: (Workers' Compensation) is a system that provides medical benefits and wage replacement to employees who are injured or become ill while performing their job duties.

MCO: (Managed Care Organization) is a healthcare organization that manages and coordinates healthcare services for its members, often using a network of providers to control costs and ensure quality care.

CAQH: (Council for Affordable Quality Healthcare) is a non-profit organization focused on streamlining healthcare provider data and improving the accuracy of credentialing processes.

MEDICAL BILLING

The process of collecting fee for medical services is called medical billing, a medical bill is called a claim.

AS per AAPC (American Academy of Professional Coders)

Medical billing is the process of generating healthcare claims to submit to insurance companies for the purpose of obtaining payment for medical services rendered by providers and provider organizations. After translating a healthcare service into a billing claim, the medical biller follows the claim to ensure the organization receives reimbursement for the work the provider performed. A knowledgeable medical biller can optimize revenue performance for the physician practice or healthcare organization.

PATIENT

Patient: a person receiving or registered to receive medical treatment.

Types of Patients: There are two types of patients.

New Patient: A new patient is a person who "has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years."

Established Patient: Similarly, an established patient would be a person who has received those services from a healthcare practitioner within that three-year period.

A Patient can be Self-Pay or Insured.

Self-Pay: Patients who pay for their medical services personally are Self-Pay patients. Claims are not submitted to insurance.

Insured Patient: Patients who are covered by insurance are called insured patients. Claims are submitted to insurance.

Name Format: In United States there are two naming conventions in written form.

When a name is written with a Comma sign like, Michael, Jordan. The Name "Michael" before Comma sign would be Last name and the name "Jordan" after comma sign would be first name.

When a name is written without Comma sign like, Michael Jordan then “Michael” would be first name and “Jordan” would be last name.

Date Format: In United States date format is MM/DD/YYYY, in Pakistan 02/08/2023 mean August 2nd, 2023 but in the US, it is February 8th, 2023.

Address Format: The address format is as following

Address

Street Address
City, State, Zip Code. For example;

795 E DRAGRAM (Street Address)

TUCSON AZ 85705 (City, State, Zip Code)

States are represented by two letters. For example, NJ = New Jersey, NY = New York and AZ = Arizona.

Patient Chart / Demographics: Information related to patient that is required to submit a claim is called patient chart or demographics.

Mandatory VS Optional Information

To submit a claim to insurance, claim information is required and patient’s information is among the required information. Patient information is divided into two parts.

Mandatory Information: Patient Information that is necessary to report on a claim is called mandatory information. It includes;

- Title (Mr., Mrs., Ms., NP, Prof, Dr, Facility, Miss)
- First and Last Name
- DOB (Date of Birth)
- Gender
- Address (Street Address)
- Address (City, State, Zip Code)
- Location (Facility Location)
- Preferred Language
- Insurance Name
- Insurance ID
- Insurance Address / Payer ID
- Sign on File
- Insured Party First and Last Name
- Insured Party Street Address
- Insured Party (City, State, Zip Code)

Optional Information: Information that is collected from patient but not mandatory to report on claim is optional information and its mostly used for reporting purpose. It includes;

- Middle Name
- Gender Identity
- Sexual Orientation
- Status (Single, Married, Divorced, etc.)
- Contact
- Sexual Orientation
- Patient Previous First and Last Name
- Email
- Religion

PROVIDER

Provider is a term used for health professionals who provide health care services. Sometimes, the term refers only to physicians. Often, however, the term also refers to other health care professionals or facilities such as hospitals, nurse practitioners, chiropractors, physical therapists, and others offering specialized health care services.

In simple words a provider could be a doctor, a hospital, a nurse practitioner or any other provider who provide medical services.

Types of Providers:

Following are the different types of providers.

Rendering Provider:

Provider who is providing/rendering the services is called a rendering provider.

Billing Provider:

And individual, agent, business or corporation receiving payments on behalf of rendering provider is known as billing provider.

Referring provider/Ordering:

An ordering/referring provider is the individual who orders or refers an item or service for patient (e.g., laboratory diagnostic tests, imaging services, specialty services, durable medical equipment) that will be furnished and billed by another provider or supplier (e.g., laboratory, imaging center, specialist, DME supplier).

Participating VS Non-Participating Providers:

The physicians or other health care providers that have an agreement of payments and covered services with a specific insurance payer are known as Participating providers. The terms and conditions of participation for both the payer and the provider are outlined by these agreements.

The physicians or other health care providers that haven't agreed to enter into a contract with a specific insurance payer, unlike participating providers are known as Non-participating providers. They might also be termed as out-of-network providers.

Individual VS Group Provider:

One of the most complex parts of starting a new practice is insurance credentialing. There are couple of ways for credentialing with insurance, first is to get all the practitioners credentialed with insurance as individual and second is to credential your practice as a group. Both options follow the similar application process. So, what's the difference?

The Process: The process for both group and individual is similar, send an application for practitioner(s) including their resumes, specialties, work history, academic certificates and much more. A separate application will be sent to every insurance you want to credential with. Application must be complete and there should be an opening on insurance panel.

Credentialing process takes between 60-180 days, if application is not complete it can add weeks to the process. These days most the of the insurances will ask for a **CAQH** for group and individual applicants.

Each application follows three steps: first, application is reviewed for completion and supporting documents. Second, credentials of practitioner are verified. And third, application goes through a review. The review system might be different for every insurance but it usually has clinical staff and peers.

The individual: the practitioners who enroll as individuals can move between practices with relative ease. When a practitioner is credentialed as individual the insurance will accept them regardless what practice they are working with. That's because an individual provider has been given their own Tax ID separate from practice.

Individual practitioners will only be credentialed for the specialties they are licensed in. But being individually credentialed means more freedom and flexibility than group credentialed practice.

The Group:

While some practitioners prefer to be individually credentialed it is also worth looking into credentialing as a group. When a group is credentialed each practitioner must submit their information in one big application. Each practitioner must meet the requirements of the credentialing panel before the group will be accepted.

Both individual and group credentialing provide great options to fit your practice's needs. But there is also a third option that sits in the middle of these two. Some insurance agencies give the option for practitioners to credential individually but connect with a practice's tax ID number.

INSURANCE

Insurance: An arrangement by which a company or the state undertakes to provide a guarantee of compensation for specified loss, damage, illness, or death in return for payment of a specified premium.

Why Get Insurance: There is always a risk of damage or loss of health, life, business or personal asset, to cover that risk factor people acquire insurance. For example;

A person can get sick or can get into an accident which may lead to high healthcare expenditures, and may also lead to bankruptcy. To ease the financial burden in time of dismay, insurance is acquired.

Types of Insurance: There are different types of insurances in the USA.

Govt. Insurances: Medicare, Medicaid, Tricare, Champ VA, FECA (Federal Employees Compensation Act).

Commercial Insurances: Blue Cross Blue Shield (BCBS), United Health Care (UHC), AETNA etc.

Medicare: Medicare is the national health insurance system that Americans qualify for if they're 65 year or older or have certain disabilities. The program was signed into law in 1965. Medicare is run by the U.S. Centers for Medicare and Medicaid Services agency **(CMS)**. It's not the same as Medicaid. Medicare Provide Coverage in four parts known as

- Medicare Part A – Hospital coverage
- Medicare Part B – Medical coverage (Professional service or Doctor's Fee)
- Medicare Part C – Medicare Advantage (Acquiring Medicare benefits through commercial insurance)
- Medicare Part D – Prescription drug coverage / Pharmacy Benefits

Medicaid: In all states, Medicaid provides health coverage for some low-income people, families and children, pregnant women, the elderly, and people with disabilities. In some states the program covers all low-income adults below a certain income level.

TRICARE: Is the uniformed services health care program for active duty service members (ADSMs), active duty family members (ADFMs), National Guard and Reserve members and their family members, retirees and retiree family members, survivors, and certain former spouses worldwide.

CHAMPVA: The Civilian Health and Medical Program of the Department of Veterans Affairs is a comprehensive health care insurance in which the VA shares the cost of covered health care services and supplies with eligible beneficiaries. In general, the CHAMPVA program covers most health care services and supplies that are medically and psychologically necessary. Upon confirmation of eligibility, you will receive program material that specifically addresses covered and non-covered services and supplies in the form of a CHAMPVA handbook.

To be eligible for CHAMPVA, you cannot be eligible for TRICARE/CHAMPUS, and you must be in one of these categories:

The spouse or child of a veteran who has been rated permanently and totally disabled for a service-connected disability by a VA regional office OR

The surviving spouse or child of a veteran who died from a VA-rated service connected disability OR

The surviving spouse or child of a veteran who was at the time of death rated permanently and totally disabled from a service connected disability OR

The surviving spouse or child of a military member who died in the line of duty, not due to misconduct (in most of these cases, these family members are eligible for TRICARE, not CHAMPVA).

TRICARE VS CHAMPVA: The United States Armed Forces prides itself on having the world's most elite Military Health System (MHS), both on and off the battlefield. As such, they know that this means more than just combat medicine, but ensuring that active duty members, veterans, and their dependents can receive high-quality medical care, at affordable rates, anywhere in the world.

In addressing the needs of a wide range of servicemembers and veterans, there are several plans available, both through the MHS and the Department of Veterans Affairs (VA). The two main programs – TRICARE and CHAMPVA – are often confused but are completely separate programs. The key takeaway is that if you are eligible for TRICARE, you are not eligible for CHAMPVA.

This civilian health care program became known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in 1966

Active duty service members and active duty family members continue to have no enrollment fees. Retirees, their family members, and most others must pay an annual enrollment fee for their coverage

The Federal Employees' Compensation Act (FECA): The FECA program covers all civilians employed by the federal government, including employees in the executive, legislative, and judicial branches of the government. Both full-time and part-time workers are covered, as are most volunteers and all persons serving on federal juries.

Claims Administration adjudicates new claims for benefits and manages ongoing cases; pays medical expenses and compensation benefits to injured workers and survivors; and helps injured employees return to work when they are medically able to do so.

In FY 2021, over 96,400 new cases were created. The program provided $2.938 billion in benefits to more than 183,000 workers and survivors for work-related injuries or illnesses. Of these benefits payments, over $2.023 billion was for wage-loss compensation, $771 million for medical and rehabilitation services, and $143 million for death benefits payments to surviving dependents.

Commercial Insurances: Other than Govt. Insurances there are commercials insurances that provide coverage in exchange of premium paid by insured Person. These insurances are acquired by individual personally or provided by employers to their employees. Most famous commercial insurance in United States are BSBC, UHC, AETNA CIGNA etc.

Managed Care Organizations (MCOs): are entities within the healthcare system that oversee and coordinate the delivery of medical services to their members. Their primary goal is to manage healthcare costs while ensuring the provision of quality care. MCOs achieve this through various strategies, such as negotiating contracts with healthcare providers, implementing utilization management techniques, and focusing on preventive care and wellness initiatives. To make insurance more affordable MCOs offer different kinds of insurance plans, four of these plans are explained below.

EPO: A larger network makes life easier

An Exclusive Provider Organization (EPO) is a lesser-known plan type. It covers only in-network care, but networks are generally larger than for HMOs. They may or may not require referrals from a primary care physician. Premiums are higher than HMOs, but lower than PPOs.

Karen, 35, manages a chain of restaurants with locations across the country. She has asthma, and usually sees her specialist a couple of times a year. Because she travels a lot on business, Karen chose an EPO with a large national network: If she ever needs care away from home, she knows she'll be able to find an in-network specialist. Her EPO also doesn't require referrals, a convenience she's willing to pay a bit more for.

PPO: The plan with the most freedom

A Preferred Provider Organization (PPO) has pricier premiums than an HMO or POS. But this plan allows you to see specialists and out-of-network doctors without a referral.

Copays and coinsurance for in-network doctors are low. If you know you'll need more health care in the coming year and you can afford higher premiums, a PPO is a good choice.

Jenelle, 38, of Jacksonville, FL, has been married for five years. The couple is having difficulty conceiving and has seen a number of fertility specialists. When her employer offered three choices for health plans, Jenelle picked the PPO. She pays more for one fertility doctor who's out of network, but she doesn't mind: Her goal is to get pregnant.

HMO: A Health Maintenance Organization (HMO) plan is one of the cheapest types of health insurance. It has low premiums and deductibles, and fixed copays for doctor visits. HMOs require you to choose doctors within their network. When you sign up for the plan, you'll select a primary care physician (PCP), whom you'll see for regular checkups and visits are funneled through your PCP, it's important to find one you trust. HMOs are a good choice if you're on a tight budget and don't have many medical issues.

Example: Gayle, 30, is single and living at home with her parents in Raleigh, North Carolina, while she pays off her college loans. When it's time to enroll in one of her employer's health plans, she chooses the HMO because it costs the least. This will help her keep expenses down and pay off her debt faster.

Gayle doesn't have any serious health problems — just seasonal allergies and occasional migraines. Her regular doctor and allergist are included in the HMO's network. Her main doctor will be her PCP, who'll give her referrals to in-network specialists like her allergist. She doesn't mind the extra step, and she'll get the care she needs at a price she is comfortable with. Your PCP will need to give you a referral before you can see a specialist, like a dermatologist (skin doctor).

POS: As with an HMO, a Point of Service (POS) plan requires that you get a referral from your primary care physician (PCP) before seeing a specialist. But for slightly higher premiums than an HMO, this plan covers out-of-network doctors, though you'll pay more than for in-network doctors. This is an important difference if you are managing a condition and one or more of your doctors are not in network.

Donald, 43, is a divorced father living in Houston. His son attends college in Atlanta, and Donald's sister lives in New Orleans. Donald has Type 1 diabetes and regularly sees several specialists. In the event he gets sick while visiting his sister or his son out of state, he knows he'll be covered. His son is also able to see out-of-network physicians in Atlanta during the school year. For Donald, paying for more flexibility is worth it.

ELIGIBILITY

Patient eligibility and benefits verification is the process by which medical practices confirm insurance coverage for planned care. This insurance coverage report will include information such as coverage, co-payments, deductibles, and coinsurance with a patient's insurance company. Patient eligibility and benefits verification is an important process of Revenue Cycle Management (RCM), which comprises the steps practices must take to keep track of revenue and ensure they get paid. By verifying eligibility, practices determine patient insurance coverage prior to appointment and can cross-check any updates in demographic information. Proper eligibility and benefits verification will ensure a complete insurance coverage report prior to appointment, resulting in lesser denials and increased patient collections.

Checking Patient Eligibility and Benefits:

Practices mostly use two different methods to verify eligibility i.e., electronic real-time eligibility checks and manual checking. You can use electronic real-time eligibility to run checks at least 48 hours before the patient's appointment. Electronic real time eligibility may not be suitable option for small practices with lesser visits. Small practices manually check patient eligibility and benefits. Practices call the insurance rep and ensure insurance coverage details like patient's insurance status and benefits; patient's benefit plan; unpaid deductibles; co-payment; and dollar amount against tentative procedure codes. Practices also ensure patient demographics is updated along with information like primary care physician (PCP) and coordination of benefits (COB).

In case of a manual eligibility check, simply call the insurance company's contact number listed on the back of the patient's insurance card or log into the payer's web portal. When you call insurance, information required will be subscriber name; patient name; patient's relationship to the subscriber; patient date of birth (DOB); patient gender; patient member number; group name and number; and plan type coverage date. The insurance rep will ask and cross-check any of the patient's demographic details and practice details to ensure that you are an authorized, person. Practices should proactively check eligibility. The most effective time is before the patient is seen by the physician, ideally 48 hours before the visit.

Best Practices for Eligibility and Benefits:

To decrease denials and potential delays in revenue, follow these best practices prior to the visit:

- Check for inactive plans and flag the accounts.

- When patients have multiple insurance plans, remind them to update their COB (Which Insurance will pay first) with each payer. Check for primary, secondary, and tertiary insurance, note that Medicaid is always considered the payer of last resort.
- For patients 65 or older, it is always best to verify whether their insurance coverage is 'traditional' Medicare coverage.
- Confirm the services covered under the patient's insurance policy and whether a referral or prior authorization is needed. Ensure referrals and authorizations are approved, entered in the system, and linked to the correct visits.
- See if a benefit limit is listed, specifying how much of the benefit remains.
- Some plans may have limitations for the dollar amount of each visit or the frequency and time frame in which the services must be delivered (e.g., a benefit limit of 12 visits, with a visit limit of two visits per month). Insurance plans may indicate that the provider should call customer service for psychiatric and substance abuse benefits information.
- Determine the amount of a co-payment, coinsurance, and deductible amount.
- Obtain as much demographic information as possible. Some demographic details (i.e., preferred language, sex, race, ethnicity, and date of birth) will affect Meaningful Use (MU) reporting.
- Always ask if the patient has had a change in insurance, whether a new policy or change in coverage.

What is a co-pay in health insurance?

A copay, short for "copayment," is a fixed amount that a patient pays out of pocket for a specific healthcare service or prescription medication.

At time of acquiring insurance if insurance has decided that your copay will be $20.00 then very time you visit your doctor you will pay $20.00 at front desk first in addition to any other costs like that will be determined after claim has been processed, like Co-Ins or Deductibles.

What Is Coinsurance and How Does It Work?

Coinsurance is what you—the patient—pay as your share toward a claim. Coinsurance is a form of cost-sharing, or splitting the cost of a service or medication between the insurance company and consumer. You typically pay coinsurance after meeting your annual deductible.

Let's use 20% coinsurance as an example.

What Does 20% Coinsurance Mean?
A 20% coinsurance means your insurance company will pay for 80% of the total cost of the service, and you are responsible for paying the remaining 20%. Coinsurance can apply to office visits, special procedures, and medications.

Let's say you visit a doctor because you have an eye infection.

Scenario #1: If the examination by your doctor cost $100, you would pay $20 out of pocket while your insurance company would pick up the tab for the remaining $80.

Scenario #2: Let's say your primary care physician couldn't provide the full treatment for your eye infection and had to refer you to an eye specialist. Your visit to the specialist cost $120 so you paid $24 (20% of $120), and your insurance company paid the remaining $96 of the bill.

The specialist prescribed you some medication for your eye, so you head to the pharmacy to pick it up. The prescription costs $60, so you are asked to pay $12 out of pocket (20% of $60), and your insurance takes care of the remaining $48.

While the equation may seem simple enough, it's important to understand the terminology around coinsurance and what you're obligated to pay under your insurance plan. Many plans are different and cover a different percentage of cost. A licensed insurance agent can help you review your coinsurance options when you're ready to shop for a new plan.

Coinsurance vs. Copay: What's the Difference?

You also may have heard of copays. Copays (or copayments) and coinsurance are very similar except for one key difference: While coinsurance is a *percentage* of the of total bill on the other hand copay is a fixed amount that does not change by percentage of total bill.

Let's stick with the example from above. If you had a treatment that called for copays instead of coinsurance under your policy, you might be asked to pay a flat fee of $20 for the doctor visit, whether the doctor billed insurance for $100 or $300.

You'll pay a $20 Co-pay for the specialist visit, no matter what services you receive. And when you pick up your prescribed medication from the pharmacy.

The benefit of a copay is that it provides consumers with greater predictability and is typically more affordable. When you have a copay, you know you'll pay a fixed amount for any doctor's visit. On the other hand, with coinsurance, you pay a percentage of the total bill, meaning the higher the bill, the more you'll need to pay.

Coinsurance and copays fall under the category of "out-of-pocket" expenses, which implies additional payments you need to make for healthcare services, in addition to your monthly

premium. Depending on your plan, you might have a copay for one type of service and coinsurance for another.

To gain a complete understanding of how out-of-pocket expenses function, you should familiarize yourself with three more terms: deductibles, out-of-pocket maximums and Annual Limit.

Deductibles:

A deductible is a fixed amount you need to pay before your insurance company starts covering its share of the expenses. For instance, if your policy has a $1,000 deductible, you'll be responsible for paying the initial $1,000 of your healthcare costs within the policy year. After reaching this amount, your insurance company will start contributing its part to the bills.

Deductibles do not apply to all services. Many health insurance plans will cover routine services and even prescription drugs. In fact, the Affordable Care Act (ACA) mandates that preventive care, like yearly exams, mammograms, and immunizations, not require payment toward a copay, coinsurance, or deductible.

High-deductible plans usually come with lower monthly premiums, meaning you'll pay less each month for your plan but will have to pay more out of pocket before your plan starts contributing.

A low-deductible plan usually means higher costs for the monthly premium, but because you'll reach your deductible more quickly, your insurance will begin covering expenses sooner.

Though less common, there are also health insurance plans without deductibles.

Deductibles are a key difference between copayments and coinsurance. Copays are usually required both before and after reaching a deductible. Some health plans count copayments toward the deductible and others do not.

Out-of-Pocket Maximum:

An out-of-pocket maximum is just as the name suggests: it's the most you are allowed to pay out of pocket during a policy year. Once you reach that limit, the insurance company bears the remainder of any costs for the rest of the year.

Deductibles, coinsurance, and copays all count toward your out-of-pocket maximum.

Fortunately, the Affordable Care Act now prohibits insurance providers from placing annual dollar limits on most health benefits for employer-based and individual health plans, though there are exceptions.

Annual Limit: Annual limits are the total benefits an insurance company will pay in a year while an individual is enrolled in a particular health insurance plan. If your insurance has decided your annual limit as $250,000 then that's the most amount insurance will pay and if expenses occur beyond that amount then patient will pay the rest out of pocket.

What is Coinsurance After Deductible?

Coinsurance does not begin until *after* you meet your deductible, meaning you'll pay all of your medical costs (except for certain covered services) until reaching your deductible. Then, you will pay only a percentage of the costs while the insurance company covers the rest.

CHARGE ENTRY

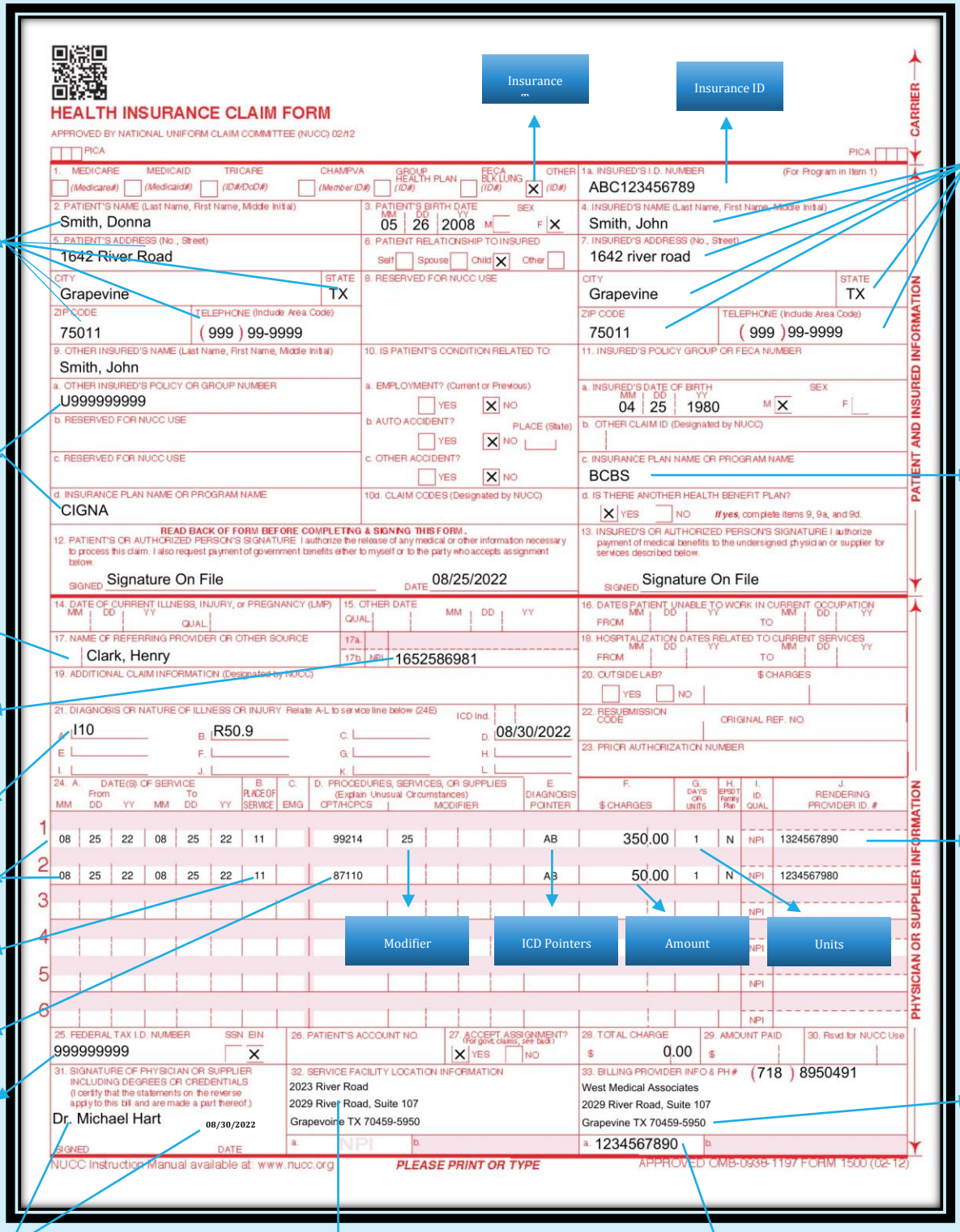
Charge Entry:

process where you enter valid medical claim information like, ICD or diagnosis codes, CPT or procedures codes, and modifiers before you file a medical insurance claim. Even one mistake could lead to a rejected or denied claim, resulting in thousands of dollars in lost revenue

ICD: International Classification of Disease ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.

CPT: Current Procedural Terminology (CPT codes) are codes assigned to every task and service a medical practitioner may provide to a patient including medical, surgical, and diagnostic services. They are used by insurers to determine the amount of reimbursement that a practitioner will receive by an insurer for that service.

Modifier: A CPT Modifier is a **two-position alpha, alpha-numeric or numeric code** used to identify certain situations that require the basic value of a procedure to be either enhanced or diminished. A modifier provides the means by which a service or procedure that has been performed can be altered without changing the procedures code.


HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12
PICA
1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) X
1a. INSURED'S I.D. NUMBER ABC123456789 (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Donna
3. PATIENT'S BIRTH DATE 05 26 2008 SEX M F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Smith, John
5. PATIENT'S ADDRESS (No., Street) 1642 River Road
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child X Other
7. INSURED'S ADDRESS (No., Street) 1642 river road
CITY Grapevine STATE TX
8. RESERVED FOR NUCC USE
CITY Grapevine STATE TX
ZIP CODE 75011 TELEPHONE (Include Area Code) (999) 99-9999
ZIP CODE 75011 TELEPHONE (Include Area Code) (999)99-9999
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Smith, John
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER U999999999
a. EMPLOYMENT? (Current or Previous) YES NO X
a. INSURED'S DATE OF BIRTH 04 25 1980 SEX M X F
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES NO X PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO X
c. INSURANCE PLAN NAME OR PROGRAM NAME BCBS
d. INSURANCE PLAN NAME OR PROGRAM NAME CIGNA
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature On File DATE 08/25/2022
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature On File
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL
15. OTHER DATE QUAL MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Clark, Henry
17a.
17b. NPI 1652586981
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. I10 B. R50.9 C. D. 08/30/2022
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL | J. RENDERING PROVIDER ID. #
1 | 08 25 22 | 08 25 22 | 11 | | 99214 | 25 | AB | 350.00 | 1 | N | NPI | 1324567890
2 | 08 25 22 | 08 25 22 | 11 | | 87110 | | AB | 50.00 | 1 | N | NPI | 1234567980
3 NPI
4 NPI
5 NPI
6 NPI
25. FEDERAL TAX I.D. NUMBER 999999999 SSN EIN X
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO
28. TOTAL CHARGE $ 0.00
29. AMOUNT PAID $
30. Rsvd. for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Dr. Michael Hart
SIGNED 08/30/2022 DATE
32. SERVICE FACILITY LOCATION INFORMATION
2023 River Road
2029 River Road, Suite 107
Grapevoine TX 70459-5950
a. NPI b.
33. BILLING PROVIDER INFO & PH # (718) 8950491
West Medical Associates
2029 River Road, Suite 107
Grapevine TX 70459-5950
a. 1234567890 b.
NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-1197 FORM 1500 (02-12)
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
CARRIER
Insurance
Insurance ID
Insured's Name, Address, Contact
Patient's Name, Address, Contact
Secondary Ins. Info.
Primary Ins. Name
Referring Provider Name
Referring Provider NPI
ICD
Date of Service
Place of Service
CPT Codes
Tax Identification Number
Modifier
ICD Pointers
Amount
Units
Rendering Provider NPI
Billing Provider
Provider's Sign and Date
Facility Address
Billing NPI

PRIOR AUTHORIZATION

Pre-Certification/Pre-Authorization:

Prior authorization in health care is a requirement that a provider (physician, hospital, etc.) obtains approval from your health insurance plan *before* prescribing a specific medication for you or performing a particular medical procedure. Without this prior approval, your health insurance plan may not pay for your treatment, leaving you responsible for the full bill.

Prior authorization is also known as precertification, predetermination, and pre-approval.

There are several reasons that a health insurance provider requires prior authorization. Your health insurance company uses a prior authorization requirement as a way of keeping healthcare costs in check.

By using prior authorization, your insurer wants to make sure that:

- **You really need it:** The service or drug you're requesting must be truly medically necessary.
- **It's recommended for your situation:** The service or drug must follow up-to-date recommendations for the medical problem you're dealing with.
- **It makes financial sense:** The procedure or drug should be the most economical treatment option available for your condition. For example, Drug C (cheap) and Drug E (expensive) both treat your condition. If your healthcare provider prescribes Drug E, your health plan may want to know why Drug C won't work just as well. If you can show that Drug E is a better option, it may be pre-authorized. If there's no medical reason why Drug E was chosen over the cheaper Drug C, your health plan may refuse to authorize its use. Some insurance companies require step therapy in situations like this, meaning that they'll only agree to pay for Drug E after you've tried Drug C with no success. The same concept applies to other medical procedures. For example, your health plan may require prior authorization for an MRI, so that they can make sure that a lower-cost x-ray wouldn't be sufficient.
- **The service isn't being duplicated:** This is a concern when multiple specialists are involved in your care. For example, your lung doctor may order a chest CT scan, not realizing that, just two weeks ago, you had a chest CT ordered by your cancer doctor. In this case, your insurer won't pre-authorize the second scan until it makes sure that your lung doctor has seen the scan you had two weeks ago and believes an additional scan is necessary.
- **An ongoing or recurrent service is actually helping you:** For example, if you've been having physical therapy for three months and your doctor is requesting

authorization for another three months, is the physical therapy actually helping? If you're making slow, measurable progress, the additional three months may well be pre-authorized. If you're not making any progress at all, or if the PT is actually making you feel worse, your health plan might not authorize any further PT sessions until it speaks with your healthcare provider to better understand why he or she thinks another three months of PT will help you.

Retro-Authorization

Sometimes Insurance allow retro authorization as well, it simply mean the authorization is requested after performing the services but insurance rarely approve a retro authorization request.

The No Surprises Act

was enacted in 2020 and went into effect on January 1, 2022. It provides federal consumer protections against unanticipated out-of-network bills called "surprise bills."

Surprise bills arise in emergencies when patients typically have little or no say in where they receive care. They also arise in non-emergencies when patients at in-network hospitals or facilities receive care from providers (such as anesthesiologists) who are not in-network and whom the patient did not choose.

The law requires surprise bills must be covered without prior authorization and in-network cost sharing must apply.

DENIAL MANAGEMENT

When EOBs/ERAs are received, some claims are paid and some are denied, paid amounts are posted into system and denied claims are reviewed and resubmitted.

Denial Codes: Like CPTs and ICDs represent services and diagnosis performed by provider, similarly claim status is also represented by codes called Adjustment codes and Remark codes.

Claim Adjustment Reason Codes: Explain why a claim was paid differently than it was billed.

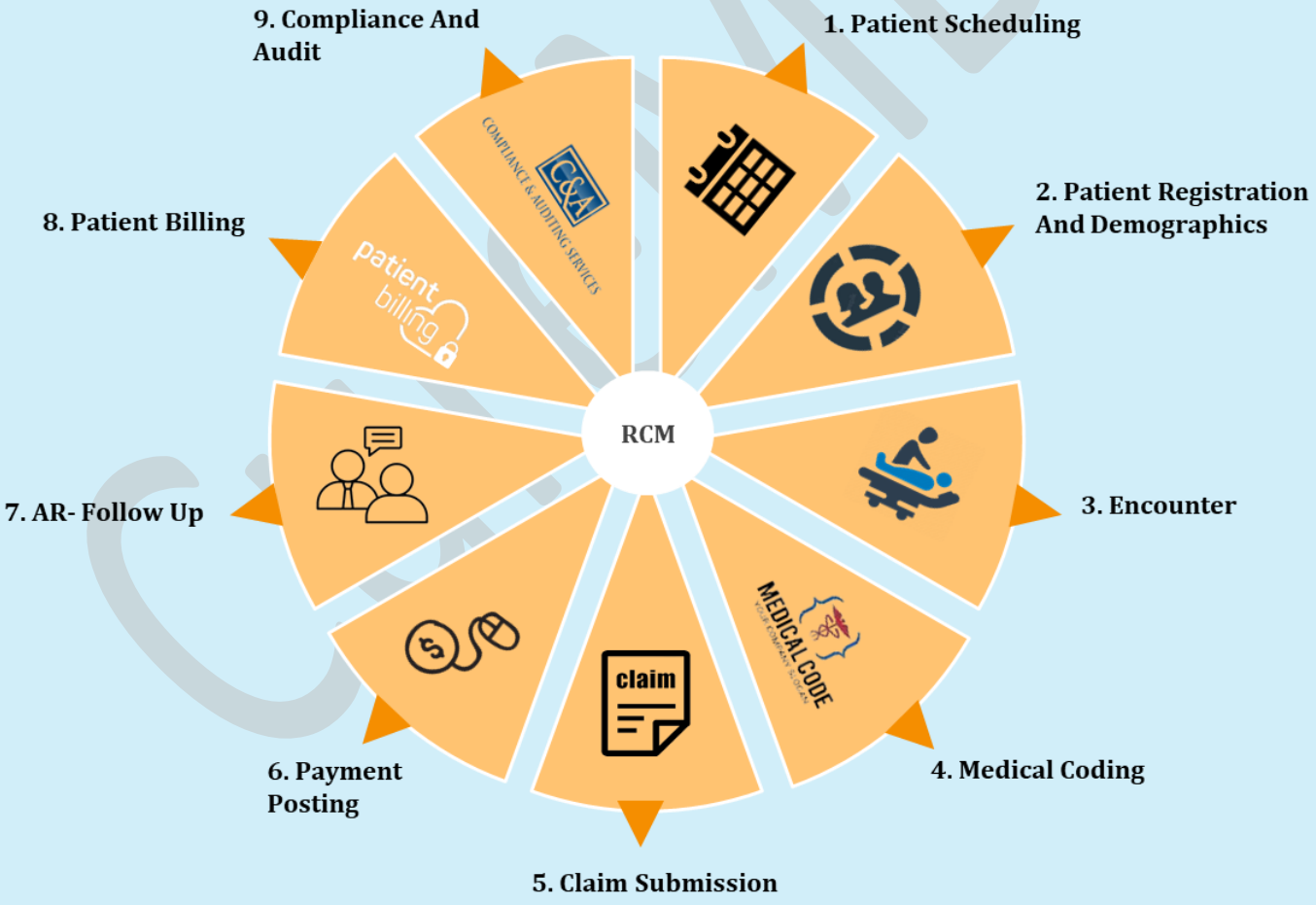
Remittance Advice Remark Codes: provide additional information about an adjustment already described by a CARC and communicate information about remittance processing.

Denial code prefix meaning:

CO – Contractual Obligations (provider is financially liable)
OA – Other Adjustments (no financial liability).
PI – Payer Initiated reductions
PR – Patient Responsibility (patient is financially liable).

CR – Correction and Reversal (no financial liability).

REVENUE CYCLE MANAGEMENT



PATIENT SCHEDULING

The process of getting an appointment with doctor is called scheduling. With scheduling in advance doctors can manage their time efficiently. there are different scenarios that can occur in scheduling and can disrupt or waste a doctor's time, so managing scheduling efficiently is most important job of front desk staff. You should be aware of the following scenarios in scheduling.

Appointment: When a patient wants to see a doctor, they can call doctor' office and book a meeting with doctor for a specific day and time. It's called appointment or Scheduling. Appointment can also be scheduled online from provider's website.

Reschedule: Sometimes patients cannot visit the doctor of various reasons, like they forgot the appointment or have another urgent piece of work, in that scenario they can call doctor's office and Rescheduling their appointment at another time. Usually patients have to call 24 hours in advance to reschedule their appointment.

Cancel Appointment: If a patient wants to cancel an appointment they can inform provider's office 24 hours in advance.

No show: If a patient does not cancel an appointment 24 hours in advance and fails to show up for the appointment, they are called No-Show. Doctor has the right to bill the patient in case of No-Show.

Check-In: When Patient arrive in provider's office, their appointment is marked as check-In, that means patient has arrived.

All the necessary paper work is done at this point, like signing consent forms, ROI (release of information), AOB (Assignment of Benefits) or ABN (Advance Beneficiary Notice).

Check-Out: When patient has seen the doctor and heading out of the doctor's office, it's called Check-Out.

ENCOUNTER

In medical billing, a patient encounter refers to any interaction between a patient and a healthcare provider or facility where healthcare services are provided or rendered. This interaction can take various forms, such as an office visit, hospital admission, consultation, diagnostic test, therapy session, or any other service delivered to the patient.

During the patient encounter, the healthcare provider assesses the patient's condition, makes a diagnosis, and delivers appropriate medical treatment or services. Following the encounter, the healthcare provider documents all relevant details, including the date of service, the services provided, any procedures performed, and the patient's medical history. This information is crucial for generating accurate and complete medical claims for reimbursement from the patient's insurance company or payer. Proper documentation of the patient encounter is essential to ensure that the services provided are appropriately coded and billed, leading to timely and accurate payments.

MEDICAL CODING

Medical coding is the process of assigning standardized codes to medical diagnoses, procedures, and services provided to patients during their healthcare encounters. These codes are used to accurately and uniformly describe the patient's medical condition and the services rendered for billing, reimbursement, and statistical purposes.

There are several coding systems used in medical billing, including:

ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification): This system is used to code and classify diagnoses and symptoms related to patient conditions. It helps in identifying the medical reason for the encounter.

CPT (Current Procedural Terminology): This system is developed and maintained by the American Medical Association (AMA) and is used to code the medical procedures, treatments, and services performed during the patient encounter.

HCPCS (Healthcare Common Procedure Coding System): This system complements the CPT codes and includes additional codes for services and supplies not covered by CPT, such as ambulance services and durable medical equipment.

By assigning appropriate codes, medical coders ensure that the healthcare services are accurately documented, and the claims submitted to insurance companies or other payers are correctly billed. The codes determine the amount of reimbursement the healthcare provider will receive for their services. Accurate and specific coding is essential to prevent claim denials, reduce billing errors, and streamline the revenue cycle for healthcare facilities and providers. It also contributes to proper statistical reporting and analysis for public health and research purposes.

CLAIM

A medical claim is a bill that healthcare providers submit to a patient's insurance provider. This bill contains unique medical codes detailing the care administered during a patient visit. The medical codes describe any service that a provider has rendered.

Types of Claims: There are different types of claim but we will talk about Professional and Institutional claims.

What is Professional Medical Billing?

Professional billing refers to the process of invoicing and collecting payments for healthcare services provided by medical professionals, such as physicians, surgeons, nurses, and other licensed healthcare practitioners. It involves generating accurate and detailed billing statements, including the services rendered, fees, and any applicable insurance information, to be submitted to patients or their insurance companies for reimbursement or payment. Professional billing ensures that healthcare providers receive appropriate compensation for the medical services they deliver to patients.

What is Institutional Medical Billing?

Institutional billing is the process of charging claims for in-patient and out-patient services performed by hospitals or healthcare organizations. For the same reason, hospital billing is often known as institutional billing.

In addition, hospital billing accounts for the services provided by professional nurses. It also bills claims for medical services such as laboratory tests, medical supplies, equipment, imaging, etc. Institutional billers are occasionally assigned responsibilities that are not the same as professional billers. Most institutional billers are simply in charge of billing or do both billing and collections. The achievement of collecting, charging, and billing are critical tasks of institutional billers.

The fundamental difference between professional billing and institutional billing is that professional billing is limited to the services provided by a physician or multiple physicians, whereas institutional covers all the charges related to interventions & administrative charges during the patient's stay in a hospital or outpatient emergency department.

Capabilities of Professional Billing and Institutional Billing

Medical billers play a vital role in the healthcare industry, whether in professional or institutional billing. All billers must understand critical areas:

- Medical billers have access to large amounts of data for each insurance company to file medical claims effectively.
- Medical billing staff have access to sensitive, confidential client health information and must be aware of HIPAA privacy and security standards.
- Experience with the billing system saves time, reduces mistakes, and eliminates problems.
- Understanding the importance of benefits verification involves knowing what is covered in the patient's plan and how to bill claims correctly to avoid payment delays.

Types of Medical Billing Claim forms:

1. CMS-1500 For Professional Billing

CMS-1500 form is used for professional billing. The **837-P,** which is the electronic counterpart of the CMS 1500 form, is used in professional billing. The letter "P" refers to professional configuration.

2. UB-04 For Institutional Billing

The **UB-04 form** is used for institutional billing. The **837-I** is used for electronic claims in institutional billing. The letter "I" represents the institutional configuration.

Claim Submission: Claim are usually submitted electronically, but paper claims are also submitted.

Paper Claim: It means to fill out a paper claim form manually and mailing it to insurance's physical address.

Electronic Claims: It means claim will be created and submitted electronically using an EHR (CureMD) and a Clearing House (CureConnnect).

- **EHR:** An electronic health record (EHR) is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider's office and can be inclusive of a broader view of a patient's care. EHRs are a vital part of health IT and can:
- Contain a patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory and test results
- Allow access to evidence-based tools that providers can use to make decisions about a patient's care
- Automate and streamline provider workflow.

Health Care Clearing House

A healthcare clearinghouse is essentially the middleman between the healthcare providers and the insurance payers. A clearinghouse checks the medical claims for errors, ensuring the claims can get correctly processed by the payer. Once clean claims are established, the claims and any associated medical records are sent electronically to all appropriate medical organizations. Clearinghouses also provide the ability to take in non-standard data and process it into standard data formats that can be ingested into the payers' adjudication system.

Claim Status: It means to check if a claim has been paid or denied by insurance, there are five possible types of claim status that a medical biller might encounter.

Paid, Partially Paid, In Process, Denied and Not on file.

Claim Not on File: In this scenario, confirm the payer ID or Claim submission address of insurance.

Following chart shows what information you should collection from insurance when you are inquiring for a claim's status.

Claim Status	Denial Reason	Denial/Paid Date	Paid Amount	Check#	Check Amount	Check Issue Date	Claim#	Call Ref#	Rep Name	Remarks
Paid		✓	✓	✓	✓	✓	✓	✓	✓	✓
Partially Paid	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Denied	✓	✓					✓	✓	✓	✓
In-Process							✓	✓	✓	✓
Not on File								✓	✓	✓

PAYMENT POSTING

Payment posting is simply posting payments from the insurance company into the system. The insurance company either pay by a check or Electronic Fund Transfer (EFT). On the EOB/ERA the insurance company will tell you the allowed amount and the amount they paid. You would then bill the patient any copays, coinsurance or deductibles.

Payment by Check: Insurance pays by a paper check.

Payment By EFT: Payment is transferred directly into provider's bank account.

Credit Card: Sometimes Insurance pay by a onetime use temporary credit card, they send an image of credit card like EOB and providers can deposit that amount into their account.

EOB: Explanation of Benefits a paper document that contains information regarding insurance payment and patient responsibility, like, copay, Co-Insurance and Deductible after the claim has been processed.

ERA: Electronic Remittance Advice is the electronic equivalent of EOB. EOB is paper format and ERA is the electronic format.

Allowed Amount: Amount that insurance company allows as payment to the provider.

Paid Amount: Amount actually paid by insurance to provider.

Patient Responsibility: Amount that insurance make patient liable to pay for like, copay, co-insurance and deductibles.

Write Off Amount: Amount that provider will not be paid by insurance or patient. It is a pre-decided contractual discount by provider.

Let's understand by example; claim billed amount is $100.00, insurance allowed amount is $80.00 (Allowed Amount). Insurance pays $70.00 (paid Amount), $10.00 is copay (Patient Responsibility) and $20.00 is not paid (write off) by insurance or provider.

AR-FOLLOW UP

AR-Follow Up (Accounts Receivable Follow Up) in medical billing refers to the process of tracking and managing outstanding claims and unpaid invoices from insurance companies or patients. After submitting medical claims for reimbursement, the healthcare provider or medical billing team monitors the accounts receivable (AR) to ensure timely and full payment for the services rendered.

The AR-Follow Up process typically involves the following steps:

1. Claim Submission: After providing healthcare services to patients, the medical provider submits claims to the relevant insurance companies for reimbursement. These claims contain detailed information about the patient encounter, including diagnoses, procedures performed, and the charges for the services.
2. Claim Adjudication: Once the insurance company receives the claim, they review it for accuracy and medical necessity. They compare the provided information with the patient's insurance coverage and the terms of the policy.
3. Payment Posting: If the claim is approved, the insurance company processes the claim and sends payment to the healthcare provider. The payment amount depends on the insurance contract, the services covered, and any copayments, deductibles, or coinsurance amounts.
4. AR Tracking: The medical billing team monitors the claims to ensure they are processed promptly and accurately. They keep track of the payment statuses for each claim, identifying any claims that remain unpaid or have been denied.

5. Denial Management: In case a claim is denied, the billing team investigates the reason for the denial and takes the necessary steps to correct and resubmit the claim.

6. Follow-Up: For unpaid claims, the billing team initiates follow-up with the insurance company to inquire about the status and reasons for non-payment. They may need to provide additional information or appeal denials.

7. Patient Billing: If the patient has a financial responsibility for the services, such as copayments, deductibles, or services not covered by insurance, the billing team sends out patient statements to collect the outstanding balances.

8. Resolving Discrepancies: During the AR-Follow Up process, the billing team also addresses any discrepancies in payments, such as underpayments or overpayments, and ensures that correct reimbursements are received.

Efficient AR-Follow Up is crucial for the financial health of healthcare providers, as it helps them optimize revenue and reduce outstanding balances. It requires attention to detail, strong communication with insurance companies and patients, and the ability to navigate the complexities of medical billing and insurance claims processing.

PATIENT BILLING

Patient billing in the context of healthcare refers to the process of invoicing patients for the medical services they have received and the associated costs. It is a crucial aspect of medical practice management and revenue cycle management. Patient billing involves generating statements or invoices for patients, detailing the services provided, the corresponding charges, and any outstanding balances they owe.

The patient billing process typically involves the following steps:

1. Charge Capture: Healthcare providers record the details of the services rendered to patients, including medical procedures, consultations, diagnostic tests, medications, and any other billable items.

2. Insurance Verification: Before billing the patient, the healthcare provider verifies the patient's insurance coverage to determine the applicable copayments, deductibles, and other patient responsibilities.

3. Claim Submission: The provider submits claims to the patient's insurance company for reimbursement. The insurance company processes the claims and pays the provider according to the terms of the insurance policy.

4. Explanation of Benefits (EOB): After processing the claim, the insurance company sends an Explanation of Benefits (EOB) to the patient, explaining the coverage and the patient's financial responsibility.

5. Patient Statement: If there are patient responsibilities such as copayments, deductibles, or services not covered by insurance, the provider generates a patient statement. This statement includes a breakdown of the charges, the insurance payments, and the patient's outstanding balance.

6. Payment Collection: Patients receive the statement and are expected to make payments for their portion of the medical expenses. They may pay through various methods, such as credit cards, checks, or online payment portals.

7. Follow-Up and Collections: In case of unpaid balances or delayed payments, the medical billing team conducts follow-up with patients, sending reminders and making phone calls to collect the outstanding amounts.

8. Payment Posting: Once the payments are received, they are posted to the patient's account, and the remaining balance, if any, is adjusted accordingly.

9. Financial Counseling: In some cases, patients may have difficulty paying their bills. Healthcare providers may offer financial counseling and explore payment plans or financial assistance options.

Accurate and efficient patient billing is essential for the financial stability of healthcare providers and ensures that patients understand their financial responsibilities for the healthcare services they have received. Transparency and clear communication are crucial to maintaining a positive patient-provider relationship during the billing process.

COMPLIANCE AND AUDIT

Compliance and audit in medical billing are essential components of the healthcare industry to ensure accuracy, adherence to regulations, and prevent fraudulent practices. Let's break down each concept:

1. Compliance in Medical Billing: Medical billing compliance refers to the adherence to various rules, regulations, and guidelines set forth by government entities, private payers, and healthcare organizations. It involves following the established billing and coding practices to accurately document and submit claims for medical services rendered to patients. The key aspects of compliance in medical billing include:

a. Coding Standards: The use of accurate and updated medical codes, such as Current Procedural Terminology (CPT) codes, International Classification of Diseases (ICD) codes, and Healthcare Common Procedure Coding System (HCPCS) codes.

b. Documentation Requirements: Ensuring proper documentation of medical services provided, including medical records, physician's notes, and patient demographics.

c. Billing Guidelines: Adhering to payer-specific billing guidelines and policies to prevent claim denials and rejections.

d. Anti-Fraud Measures: Implementing measures to detect and prevent fraudulent billing practices, including upcoding, unbundling, and double billing.

e. Privacy and Security: Protecting patient information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable data privacy laws.

2. Audit in Medical Billing: A medical billing audit involves a systematic review and examination of healthcare providers' billing and coding practices to assess their compliance with regulations and internal policies. Audits can be internal (conducted by the healthcare organization itself) or external (performed by governmental or third-party auditors). The main objectives of medical billing audits are:

a. Ensuring Accuracy: Verifying that billed services match the provided medical services and that the appropriate codes and modifiers are used.

b. Identifying Errors and Discrepancies: Detecting billing errors, under-coding, over-coding, or other irregularities that may lead to financial losses or compliance issues.

c. Validating Compliance: Assessing whether the billing practices align with legal requirements, contractual agreements with payers, and internal policies.

d. Fraud Detection: Uncovering any fraudulent activities or intentional misrepresentation of medical services for financial gain.

e. Education and Improvement: Offering feedback and training to healthcare providers and billing staff to enhance their understanding of compliance standards and improve future billing accuracy.

In summary, compliance and audit in medical billing are critical in maintaining the integrity of the healthcare billing process, ensuring proper reimbursement, and safeguarding patient data and overall financial well-being. By adhering to these principles, healthcare organizations can foster trust with patients, payers, and regulatory authorities while providing quality care to their patients.

WHAT IS HIPPA

The HIPAA (Health Insurance Portability Accountability Act) Privacy Rule is the specific rule within HIPAA Law that focuses on protecting Personal Health Information (PHI). It established national standards on how covered entities, health care clearinghouses, and business associates share and store PHI. It established rules to protect patient's information used during health care services.

5 Main HIPAA Rules:

- **Privacy Rule.**

The Privacy Rule protects the PHI and medical records of individuals, with limits and conditions on the various uses and disclosures that can and cannot be made without patient authorization. This rule also gives every patient the right to inspect and obtain a copy of their records and request corrections to their file.

- **Security Rule.**

The security rule defines and regulates the standards, methods and procedures related to the protection of electronic PHI on storage, accessibility and transmission. There are three safeguard levels of security. The Administrative safeguards deal with the assignment of a HIPAA security compliance team; the Technical safeguards deal with the encryption and authentication methods used to have control over data access, and the Physical safeguards deal with the protection of any electronic system, data or equipment within your facility

and organization. The risk analysis and risk management protocols for hardware, software and transmission fall under this rule.

- **Transactions Rule**

This rule deals with the transactions and code sets used in HIPAA transactions, which includes ICD-9, ICD-10, HCPCS, CPT-3, CPT-4 and NDC codes. These codes must be used correctly to ensure the safety, accuracy and security of medical records and PHI.

- **Identifiers Rule**

HIPAA uses three unique identifiers for covered entities who use HIPAA regulated administrative and financial transactions. These identifiers are: National Provider Identifier (NPI), which is a 10-digit number used for covered healthcare providers in every HIPAA administrative and financial transaction; National Health Plan Identifier (NHI), which is an identifier used to identify health plans and payers under the Center for Medicare & Medicaid Services (CMS); and the Standard Unique Employer Identifier, which identifies and employer entity in HIPAA transactions and is considered the same as the federal Employer Identification Number (EIN).

- **Enforcement Rule**

This rule is derived from the ARRA HITECH ACT provisions for violations that occurred before, on or after the February 18, 2015 compliance date. This expands the rules under HIPAA Privacy and Security, increasing the penalties for any violations. This addresses five main areas in regards to covered entities and business associates: Application of HIPAA security and privacy requirements; establishment of mandatory federal privacy and security breach reporting requirements; creation of new privacy requirements and accounting disclosure requirements and restrictions on sales and marketing; establishment of new criminal and civil penalties, and enforcement methods for HIPAA non-compliance; and a stipulation that all new security requirements must be included in all Business Associate contracts.