

Tasks for Technical Program Manager (Content Platform)

Overview

The goal is for you to familiarize yourself with the domain and gain insight into its daily challenges. During the interview, you will be asked questions on some of these topics.

Once you read please perform Tasks 1 - 3

General Background

The below are some topics relate to Payment flow in the US health industry , read and understand the concepts

 [The weird CPT code process you need to understand | Out-Of-Pocket](#)

 [How Healthcare Payments Work with Candid Health | Out-Of-Pocket](#)

Reimbursement Policies

The following policies outline restrictions, and bypassing them could result in overbilling. Please read and understand the concepts thoroughly.

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Bilateral-Procedures-Policy.pdf>

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Global-Days-Policy.pdf>

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Obstetrical-Policy.pdf>

This document contains a summary of many rules in high level

https://www.blueshieldca.com/content/dam/basca/en/provider/docs/2024/March/PRV_Clinical-Editing-Overview.pdf

Task 1

Respond with "Correct" or "Incorrect" based on the information provided above.

If the answer is "Correct," explain how to determine whether this mistake could lead to overbilling.

Use Case	Provider submitted	Correct or Incorrect (explain and give reference)	How to detect if this is overbilling or naive mistake
Provider perform operation 29806 for shoulder arthroscopy	Provider submit claim with two lines to be charged for each one of the shoulder	Incorrect. This code is on the Bilateral Eligible List, so it should fit the rule under Bilateral Modifier (50) - The procedure should be billed on one line with modifier 50 and one unit with the full charge for both procedures.	Go over the provider submission to understand if they meant to write a bilateral procedure. They are probably unaware of the rules for this submission, but to make sure we can check their past submission to see if it's a pattern.
A pregnant woman arrived to hospital with bad feeling on Sunday and on Monday she gave birth	Provider submit 59409 for the delivery on Monday and 99223 for the general EM on Sunday	Correct. The Global Period for a procedure having a Global Days Value of 010 or 042 includes E/M services provided on the day of the procedure and E/M services provided during the 10 or 42 days following the procedure, beginning the first day after the procedure.	If the general EM on Sunday was part of the routine of the labor then it would be a mistake to submit it separately.

<p>Sarah's vein isn't working, causing pain. Her doctor uses a tiny tube to inject glue, sealing the vein. To guide the procedure, he uses imaging called venography to monitor the vein in real-time. Blood reroutes through healthy veins, and she feels better quickly.</p>	<p>The provider submit code 76998 for the monitoring (e.g, ultrasound\imaging) procedure and 36482 for the surgery procedure also codes from 00100-01999 range were used to reflects Anesthesia that provider to the patient</p>	<p>Incorrect. The 36482 code has the 000 global days assignment, so the service of code 76998 is part of the procedure because it was performed by the same doctor and therefore should not be submitted separately. Under Services Included in the Global Surgical Package: "...when provided within the Global Period by the Same Specialty Physician or Other QHP, are included in the Global Surgical Package and are not separately reimbursable except as specified."</p> <p>Also, if the anesthesia was provided by the same doctor it is incorrect for the same reason.</p>	<p>Look in the submission for the doctor details who provided each service. If the same doctor details repeats and this is one of the services included in the Global Surgical Package, then it should not have been submitted separately.</p>
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Task 2

Complete the table below (the first three entries are provided as examples).

Review the claims fields in the appendix before you start

Use case\Rule	Condition Abstraction	Implementation (pseudo- code)
At this example we've a rule that that implement a policy that simply says that some service (Robotic_Assisted_Surgery) is not covered	<pre>Robotic_Assisted_Surgery = [S290] if <CPT> = <Data.'Robotic_Assisted_Surgery'>, then deny</pre>	<pre>I1: code = Robotic_Assisted_Surgery reject "I1.code not supported"</pre>
Pregnant service cant be perform on non female	if <CPT> is <59400> and patient is male then deny	<pre>I1: code = 54900,Gender not in [F] reject "I1.code cannot provided to not female"</pre>
Preventive care included EM service , so in the same session provider can charge for both EM and Preventive service, in rare case the provider can mark that the EM is not related to the preventive service by adding modifier '25'	<pre>IF claim contain <CPT1> = <Data.Preventive_Medicine_E/M > AND <CPT2>= <Data. Problem_Based_E/M > WITH <modifier> not equal to 25 on same <DOS> and same <Tax ID>, then deny <CPT2> For same Provider</pre>	<pre>I1: code = <Data.Preventive_Medicine_E/M> I2: code = <Problem_Based_E/M> , Modifiers not '25' I1.TIN=I2.TIN I1.patinet_id = I2.patinet_id I1.dos = I2.dos reject I2 "I2.code is included in I1.code"</pre>

<p>Emergency Department Services (99281-99285) must be provided in hospital that have ER emergency room (place of service - 23)</p>	<p>If <CPT> in [99281-99285] AND<POS> not equal to 23 then deny</p>	<p>I1: code in [99281, 99282, 99283, 99284, 99285] I1.POS not 23 reject I1 "Code cannot be provided to no ER hospital"</p>
<p>Patient can get x-ray of Chest just from one provider on a single day [X-ray codes can be found here] CPT Radiology</p>	<p>IF claim contain <CPT1> = <Data.Chest_Xray> AND <CPT2>= <Data.Chest_Xray> with overlapping <DOS> and same <patient_id> and same <TIN>, then deny <CPT2></p>	<p>I1: code in [74022, 71045, 71046, 74047, 71048] I2: code in [74022, 71045, 71046, 74047, 71048] I1.patient_id = I2.patient_id I1.TIN = I2.TIN I1.dos_start <= I2.dos_end AND I1.dos_end >= I2.dos_start reject I2 "I2.code cannot get chest X-rays from same provider on I2.dos"</p>
<p>When more than one x-ray view of the same anatomical area is performed on a single date of service, only the code with the higher number of views performed will be reimbursed. (e.g., submitting a CPT code for a chest x-ray, single view and a CPT code for a chest x-ray, two views; only the code for two views will be reimbursed). [X-ray codes can be found here] CPT Radiology</p>	<p>IF CMS 1500 claim form contain <CPT_1 - Xray> and <CPT_2-Xray> on same day and <CPT-1> views is higher then <CPT-2> reject CPT-2</p>	<p>[Here you might need to write several rules and not one implementation] Group by same area and date: I1: code = <Data.XRAY_CODES> I2: code = <Data.XRAY_CODES> I1.anatomical_area = I2.anatomical_area I1.DOS.is_single_day = True I2.DOS.is_single_day = True I1.DOS.start = I2.DOS.start I1.anatomical_area = I2.anatomical_area Keep only higher-view code: I1.views > I2.views: reject I2 "I2.code has lower number of X-ray views"</p>
<p>Provider should cover patient any EM (Evaluation and Management) 45 days after primary operation (e.g., 54910,...] unless the return is injury or there was unrelated operation</p>	<p>IF claim contains <CPT1> = <Data.Primary_Operation> AND <CPT2> = <Data.EM> within 45 days after, for same <patient_id> and same <TIN>, AND <diagnosis_code> not start with 'I', AND <modifier> not equal to 78, then deny <CPT2></p>	<p>I1: code = <Data.Primary_Operation> I2: code = <Data.EM>, diagnosis_code not starts with 'I', modifier not 78 I1.patient_id = I2.patient_id I1.TIN = I2.TIN I1.dos_end < I2.dos_start I2.dos_start <= I1.dos_end + 45 days reject I2 "EM service within 45 days post-operation is included in global period unless injury-related or unrelated procedure"</p>

Injury case can be detected by Diagnostic code that start with 'I' also provider can notify that the service is unrelated to the by adding modifier 78		
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Appendix - Claims fields

Field	Description
Patient Information	
Patient ID/Member Number	Unique identifier for the patient within the insurance system.
Date of Birth (dob)	Patient's birth date for identity verification.
Gender	
Provider Information	
National Provider Identifier (NPI)	A unique identifier assigned to healthcare providers in the U.S.
Tax Identification Number (TIN)	The provider's business or tax identification number.
Claim Details	
Claim Number	Unique number assigned to the claim by the payer or provider.
Lines Details	NOTE, each claims has many lines
Date(s) of Service (DOS)	The date or range of dates when the services were provided.
Place of Service (POS)	Code identifying the location where the services were rendered.
Diagnosis Code(s) (ICD-10)	Codes that describe the patient's condition or reason for treatment.
Procedure Code(s) (CPT/HCPCS)	Codes that describe the specific services or procedures performed.
CPT/HCPCS Code	Code identifying the medical procedure or service provided.

Units of Service	Number of times the procedure/service was provided.
Amount Billed	Total charge for each service or procedure provided.
Modifiers	Additional code that modifies or adds information about the procedure (e.g., bilateral).