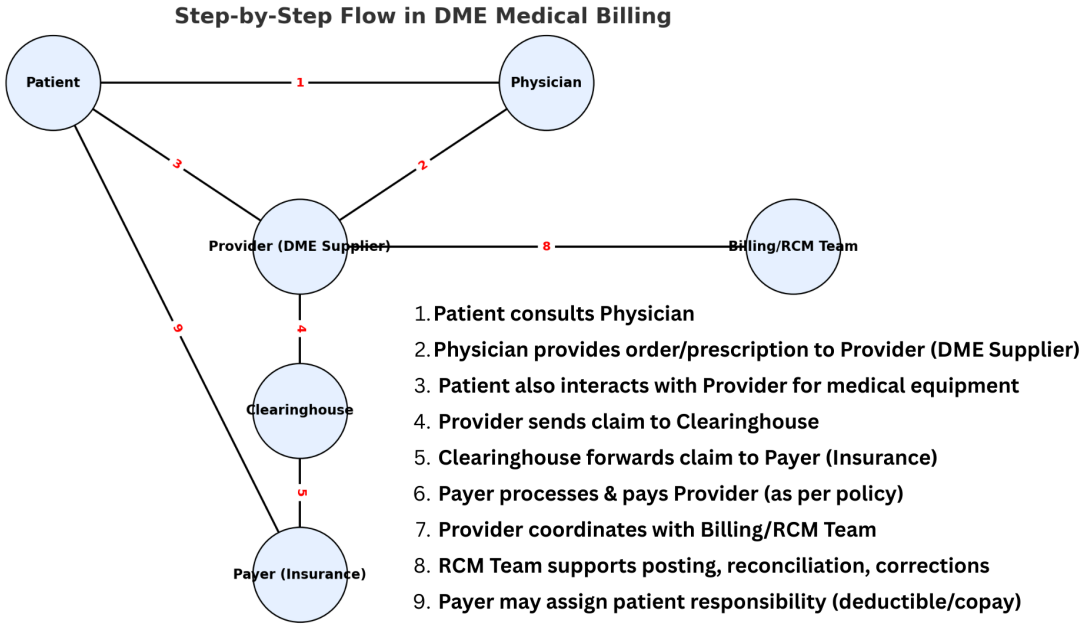
Comprehensive Notes on US Medical Billing

Interaction of Main Players in Medical Billing (FLOW)

1. **Patient** gets prescription from **Physician**.
2. **Provider (DME Supplier)** delivers equipment & creates claim.
3. Claim goes via **Clearinghouse** → **Insurance Company (or Payer)**.
4. **Insurance** reviews → Pays provider (or denies).
5. **Billing/RCM Team** posts payment, reconciles accounts.
6. If denied, **Provider/RCM** appeals with more documents.
7. **Patient** may pay deductible/coinsurance.
8. **CMS/Govt** oversees compliance & rules.



FOUNDATION OF MEDICAL BILLING

I. Introduction to Medical Billing

- **Core Parties Involved:**
    - **Patient:** The individual receiving medical services.
    - **Provider:** The entity providing the service (e.g., hospital, physician).
    - **Payer:** The insurance company responsible for payment.
- **Three Main Types of Billing:**
    - Hospital Billing.
    - Physician Billing.
    - DME (Durable Medical Equipment) Billing.
- **Key Regulations and Concepts:**
    - **HIPAA (Health Insurance Portability and Accountability Act of 1996):** Federal law creating national standards to protect sensitive patient health information.
    - **PHI (Protected Health Information):** Any health information that can be tied to an individual.
    - **RCM (Revenue Cycle Management):** The financial process for managing claims, payment, and revenue. It begins with a patient's appointment and concludes with payment collection.

II. Government Insurance Programs

A. Medicare

A federal government health insurance program.

- **Eligibility:**
    - Individuals aged 65 or older.
    - Must have paid federal taxes for 40 quarters (10 years).
    - Physically disabled individuals.
    - Individuals with End-Stage Renal Disease (ESRD).
- **The Four Parts of Medicare:**
    - **Part A (Hospital Insurance):** Covers inpatient services where a patient is admitted for more than 24 hours.

    - **Part B (Medical Insurance):** Covers outpatient services. Patients pay a monthly premium and a yearly deductible. It covers ambulance, MRI, CT scans, and DME.
    - **Part C (Medicare Advantage Plan):** An alternative plan combining Parts A and B. Often covers services not included in traditional Medicare, like dental, vision, and gym memberships.
    - **Part D (Prescription Drug Plan):** Covers prescription drugs.
- **MAPD (Medicare Advantage Prescription Drug Plan):** A plan that combines Medicare Parts C and D.

B. Medicaid

A health insurance program run by state governments.

- **Key Features:**
    - Often pays 100% of the cost with no patient responsibility.
    - Considered the "payer of last resort".
    - The single largest source of health coverage in the U.S..
- **Eligibility:**
    - Individuals with income below the Federal Poverty Line (FPL).
    - Permanently physically disabled individuals.
    - Pregnant women.

C. SCHIP (State Children's Health Insurance Program)

Provides coverage for orphans, homeless children, and dependents of families with income below the FPL.

D. TRICARE (formerly CHAMPUS)

A healthcare program for uniformed services, military personnel, and their families.

- **Beneficiaries:** Active duty, retired personnel, and their dependents.
- **Administration:** It's not an insurance program; private companies called fiscal intermediaries process claims.

E. CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs)

A healthcare program where the Department of Veteran Affairs covers health service costs for eligible veterans and their families.

III. Commercial (Private) Insurance Programs

These are non-governmental plans, also known as commercial carriers.

- **Payment Structure:** Often pay a percentage (e.g., 80%) of the allowed amount, with the patient responsible for the rest.
- **Examples of Commercial Plans:** BCBS (Blue Cross Blue Shield), UHC (United HealthCare), Aetna, Cigna, Humana.
- **Special Types of Insurance:**
    - **No-fault and Liability Insurance:** Pays for healthcare services resulting from an injury where fault is not a factor, such as an auto accident.
    - **Worker's Compensation:** Provides coverage for employees injured on the job.

IV. Types of Managed Care Organizations (MCOs)

- **HMO (Health Maintenance Organization):** The cheapest option; only covers **in-network providers**. Authorization and referrals are mandatory.
- **EPO (Exclusive Provider Organization):** A costlier plan that also only covers **in-network providers**. Authorization and referrals are not required.
- **POS (Point of Service):** Covers both **in-network and out-of-network providers**. Authorization and referrals are required only for out-of-network services.
- **PPO (Preferred Provider Organization):** The most expensive option. It covers both **in-network and out-of-network providers** and does not require authorization or referrals.
- **In-Network vs. Out-of-Network:**
    - **In-network** providers have a contract with the insurance company.
    - **Out-of-network** providers do not have a contract with the insurance company.

V. The Revenue Cycle Management (RCM) Process

1. **Pre-Process & Registration:** The patient schedules an appointment and provides personal, clinical, and financial data. Eligibility is verified with the payer (e.g., Medicare, Commercial) to confirm coverage.
2. **Authorization:** The provider obtains prior authorization from the insurer if required.
3. **Service Delivery & Coding:** The patient receives the medical service. Services are translated into medical codes (CPT/HCPCS, ICD-10).
4. **Charge Entry & Claim Submission:** Charges are assigned, and the claim is sent to the insurance company, often via a **Clearing House** which checks for errors.
5. **Payment Posting:** Payments from insurance and patients are recorded. This can be a complex area involving portal-based entries, handling negative balances, and using specific MCR (Medicare) transaction numbers.

6. **A.R. & Denial Management:** The Accounts Receivable (A.R.) team follows up on unpaid claims. If a claim is denied, the team investigates and works to resolve the issue.

VI. Medical Coding, Forms, and Modifiers

A. Billing Forms

- **CMS-1500:** Used by individual, non-institutional providers (e.g., physicians).
- **CMS-1450 (UB-04):** Used by facility providers (e.g., hospitals).

B. Coding Systems

- **CPT (Current Procedural Terminology):** Numeric codes for medical, surgical, and diagnostic procedures.
- **HCPCS (Healthcare Common Procedure Coding System):** Codes for medical products, supplies, and services. This includes specific codes for items like **oxygen concentrators** and **wheelchairs**.
- **ICD-10 (International Classification of Diseases, 10th Revision):** Alphanumeric codes describing a patient's diagnosis.

C. Place of Service (POS) Codes

These codes indicate where the service was rendered.

- **11:** Office
- **12:** Home
- **21:** Inpatient Hospital
- **22:** Outpatient Hospital
- **31:** Skilled Nursing Facility (SNF)
- **34:** Hospice

D. Modifiers

Modifiers provide additional information about a service or procedure.

- **RT/LT:** Right / Left
- **NU:** New Equipment Purchase
- **RR:** Rental Equipment
- **KX:** Medical Necessity documentation is on file
- **GY:** Item or service is statutorily excluded or does not meet the definition of a Medicare benefit.
- **KH, KI, KJ:** Modifiers for the 1st, 2nd-3rd, and 4th-13th months of DME rental, respectively.

VII. Key Terminology and Concepts

- **Authorization:** Approval from an insurer before a service is rendered.
- **Referral:** A physician's recommendation for a patient to see a specialist.
- **Deductible:** The amount a patient must pay before their insurance starts to pay.
- **Co-payment (Co-pay):** A fixed amount a patient pays for a service.
- **Co-insurance:** The percentage of costs a patient pays after meeting their deductible.
- **AOB (Assignment of Benefits):** A form allowing the provider to be paid directly by the insurer.
- **ABN (Advanced Beneficiary Notice):** A form where a Medicare patient accepts financial responsibility if a service is denied.
- **COB (Coordination of Benefits):** The process of determining the order of payment when a patient has multiple insurance policies.
- **EOB/ERA (Explanation of Benefits / Electronic Remittance Advice):** A statement from the insurer detailing how a claim was processed.
- **Charge Amount:** The full price a provider bills for a service.
- **Allowed Amount:** The maximum amount an insurer will pay for a covered service.
- **DHHS (Department of Health and Human Services):** The U.S. government's principal agency for protecting the health of all Americans.
- **PRS (Patient Responsibility):** The total amount the patient owes, including deductible, co-pay, and co-insurance.

VIII. A.R. and Denial Management

This involves investigating and resolving rejected or denied claims.

- **Common Reason for Denial:** The most common denial is for missing or invalid authorization.
- **Common Denial Codes:** Claims can be denied for numerous reasons, often indicated by specific codes on the EOB/ERA. Some common codes include:
    - **CO 16:** Claim/service lacks information which is needed for adjudication.
    - **CO 18:** Duplicate claim/service.
    - **CO 27:** Expenses were incurred after coverage terminated.
    - **CO 29:** The time limit for filing has expired.
    - **CO 97 (Auth):** The benefit for this service is included in the payment/allowance for another service that has been performed. Often relates to authorization issues.

    - **CO 118:** Escheatment.
    - **CO 197/198:** Precertification/authorization/notification absent or penalties applied.
    - **PR 1, 2, 3:** Codes indicating patient responsibility for Deductible, Co-insurance, and Co-payment.

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PAYMENT POSTING

What is Payment Posting?

Payment Posting is the process of recording payments from insurance companies and patients into the medical billing system. It involves reading the **Explanation of Benefits (EOB)** or **Electronic Remittance Advice (ERA)** to update a patient's account with payments, adjustments, and denials.

Why It's Important

- **Keeps Finances Accurate:** Ensures the provider's financial records are correct.
- **Catches Problems:** It's the first step to identifying claim denials or incorrect payments from insurance.
- **Enables Patient Billing:** You can't accurately bill a patient until you know what their insurance has paid.

The 5-Step Payment Posting Flow

The process is a straightforward flow from receiving the payment information to finalizing the account.

1. **Receive Remittance** 📬 Get the payment details from the insurance company, either as a paper **EOB** or an electronic **ERA** file.
2. **Post Payment** 💵 Apply the insurance payment amount to the correct patient's claim in the billing software.
3. **Post Adjustments** ✍️ Write off the **contractual adjustment**, which is the difference between the high amount you billed and the lower amount the insurance agreed to pay (the "allowed amount").
4. **Transfer Balance** ➡️ Move the remaining balance (like a deductible or co-pay) to the patient's responsibility or to a secondary insurance company for billing.
5. **Handle Denials** 🚫 If a claim is denied (paid $0), identify the denial reason code and send the claim to the Accounts Receivable (A/R) team to be investigated and fixed.

(9) HCPCS & CPT, Oxygen concentrator codes, Wheelchairs

(1) Excel — VLOOKUP, COUNTIF, Sumif, Conditional formating If, Pivot, Data Validation, Sorting (Multilevel).

(2) Preprocess — Medicare, Medicaid, Elegibility Criteria Commercial Ins, Champ VA Champ US, (Veterans) Tricare.

MCR — MCOs (EPO, PPO, HMO, POS).
HIPAA - 1996, Abv.

(3) Abv. — (ABN, EOB, COB, EDI, DHHS, CMS, Charge Amount, Billed Amount, PRs.

(4) Common Denials — 29, 197, 198, Par, Auth, 4, 16, 18, 27, 29, 118,

(5) Modifiers — GY, NU, LT, RT, NURR, KH, KI Capped Rental KJ, Home, Office, (11, 12).

(6) Sums —

(7) Sentense Formatting (English).

(8) Payment Posting Core questions (60%) Negative FB, ES, 2 titles (-) Portal related, RMs, MCR transactions numbers.

📘 Detailed Notes for Team Lead – Payment Posting (DME Medical Billing)

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1. Excel (For Payment Posting & DME Reporting)

👉 **Why important for TL in DME**: Posting payments for multiple rentals, capped equipment, and insurance policies involves **huge data sets**. Excel helps track rentals, denials, and patient balances.

Key Functions:

- **VLOOKUP** → Match HCPCS code with payment/allowed amount.
    - Example: `=VLOOKUP("E1390", A2:D200, 3, FALSE)` → Find allowed for Oxygen concentrator (E1390).
- **COUNTIF** → Count denial codes.
    - Example: How many denials with code “198” (missing auth).
- **SUMIF** → Sum payments per insurance (Medicare vs Commercial).
- **Conditional Formatting** → Highlight unpaid rentals after 13th month (capped rental).
- **Pivot Tables** →
    - Denials by insurance.
    - Rental vs Purchase claims.
    - Monthly posting per team member.
- **Data Validation** → Prevent wrong HCPCS entry (only valid codes allowed).

✅ **TL Use Case in DME**:

- Track rental life cycle (KH → KI → KJ → capped).
- Report productivity per rep.
- Highlight accounts with recurring denials.

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2. Pre-Process Knowledge (Insurance Types in DME)

👉 In DME billing, insurance rules are very strict. **Eligibility checks** avoid denials.

- **Medicare**:
    - Covers medically necessary DME.
    - Example: Oxygen concentrator (E1390) if O2 < 88%.
    - Rental-based: Capped after 13 months.
- **Medicaid**:
    - State-specific. Covers wheelchairs, hospital beds, CPAPs.
- **Commercial Insurance**:
    - BCBS, UHC, Aetna → Different fee schedules.
    - Prior authorization usually required for expensive items (wheelchairs, power scooters).
- **CHAMPVA / Tricare / VA**:
    - Military patients (common in DME).

✅ **TL Role**: Ensure eligibility verified → correct insurance type → avoid "Not Covered / Terminated Coverage" denials.

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3. Abbreviations (Used in DME Payment Posting)

- **ABN** → Advance Beneficiary Notice → If Medicare won't cover equipment.
- **EOB** → Explanation of Benefits (insurance response).
- **ERA** → Electronic Remittance Advice.
- **LOB** → Line of Business (Medicare, Medicaid, Commercial, VA).
- **EDI** → Electronic transmission of claims/payments.
- **DHHS** → Department of Health and Human Services.
- **CMS** → Centers for Medicare & Medicaid Services.
- **Charge Amount** → Provider submitted for DME (e.g., $150 for wheelchair).
- **Allowed Amount** → Insurance approved (e.g., $100).
- **Patient Responsibility** → Copay, Deductible, Coinsurance.

✅ **TL Role**: Ensure staff interpret **EOB/ERA correctly** → Apply write-offs, patient balance, and rental continuation correctly.

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4. Common Denials (DME-Specific)

Denials are frequent in DME because equipment requires strict documentation.

- **29** → Timely filing expired.
- **197** → Authorization required (wheelchair, hospital bed).
- **198** → Pre-authorization missing.
- **4** → Coverage terminated.
- **16** → Claim lacks information (e.g., missing doctor's order).
- **18** → Duplicate claim.
- **27** → Expenses after coverage ended.
- **118** → Charges exceed fee schedule (common in rentals).

✅ **TL Role**:

- Create Denial Summary → Highlight top 3 denials for team.
- Ensure proper documentation (Doctor's order, Certificate of Medical Necessity (CMN), Prior Authorization).

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5. Modifiers (Most Important for DME)

👉 DME depends heavily on **HCPCS codes with correct modifiers**.

- **GY** → Item/service not covered.
- **NU** → New equipment.
- **RR** → Rental.
- **LT / RT** → Left or Right side (e.g., prosthetics).
- **KH** → First rental month (Capped Rental).
- **KI** → 2nd–3rd month rental.

- **KJ** → 4th–13th month rental.
- **POS (Place of Service)**:
    - **12** → **Home** (most common for DME).
    - **11** → **Office** (when dispensed in clinic).

✅ **TL Role**: Ensure billing team applies correct modifier.
Example: Wheelchair rental billed as RR + KH (month 1). If wrong → insurance denies.

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6. Sums (DME Posting Calculations)

In DME, most claims are **rental-based**, so amounts need careful calculation.

- **Billed Amount** → Charge entered by DME provider.
- **Allowed Amount** → As per Medicare/Insurance fee schedule.
- **Paid Amount** → Actual insurer payment.
- **Adjustment (Write-off)** → Difference between billed & allowed.
- **Patient Responsibility** → Deductible, Copay, Coinsurance.

Formula:
```
Billed − Allowed − Paid = Patient Responsibility
```

✅ **Example**:
Oxygen concentrator billed: $150
Allowed: $100
Paid: $80
Adjustment: $50
Patient Responsibility: $20

✅ **TL Role**: Double-check adjustments → Prevent under/over-posting.

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7. Sentence Formatting (Professional English – DME Context)

👉 For **client communication, payer escalations, team handling**.

Examples:

- “The claim for HCPCS E1390 was denied with code 197 due to missing authorization. Resubmission initiated with updated authorization.”
- “Patient responsibility applied correctly as per EOB, deductible amount shifted to patient ledger.”
- “Rental claim for wheelchair billed under KH modifier was incorrectly posted by the associate, correction applied.”

✅ **TL Role**: Mentor team to use **clear professional English** in emails and ticket updates.

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8. Payment Posting – Core Questions (DME Focus)

This is **60% of weightage** → TL must master this area.

- **Negative Balance** → Reasons:
  - Overpayment from insurance.
  - Duplicate posting.
  - Claim reversal not posted.
    ✅ Example: Medicare recoups money after rental ends → results in negative balance.
- **FB (Full Balance) vs Partial Posting**:
  - **FB**: Payer pays entire allowed amount.
  - **Partial**: Patient portion (deductible, coinsurance) remains → must be transferred.
- **Portal Related Posting**:
  - Sometimes ERA missing → TL/team checks Medicare, Medicaid, or Commercial portals to confirm payment.
- **RMS (Revenue Management System)**:
  - DME billing software used for posting and reconciliation.
- **MCR Transaction Numbers**:
  - Medicare assigns transaction control numbers → Required for reconciliation.

✅ **TL Role**:

- Ensure ERA/EOB, portal data, and RMS match.

- Investigate negative balances.
- Audit rental postings (KH → KI → KJ).

🧠 Mind Map (DME Version)

```
DME Payment Posting
|
├── Excel
|   ├── VLOOKUP for HCPCS
|   ├── Pivot (Rental vs Purchase)
|   ├── Denial/Payment Reports
|
├── Pre-Process
|   ├── Medicare (13-month rentals)
|   ├── Medicaid
|   ├── Commercial
|   └── Tricare / VA
|
├── Abbreviations
|   ├── ABN / EOB / ERA
|   ├── CMS / DHHS
|   └── Allowed vs Billed
|
├── Denials
|   ├── 29, 197, 198
|   ├── 16, 18, 27, 118
|
├── Modifiers
```

```
|    ├── RR, NU, LT/RT
|    ├── KH / KI / KJ
|    └── POS 12 (Home), 11 (Office)
|
├── Sums
|    ├── Billed vs Allowed
|    ├── Adjustments
|    └── Patient Resp
|
├── Sentence Formatting
|    └── Client & Payer Emails
|
└── Core Questions
     ├── Negative Balances
     ├── FB vs Partial
     ├── Portal Posting
     ├── RMS
     └── MCR Txn Numbers
```

⚡ Now you have **DME-focused detailed notes** that are tailored to your IJP.

Do you also want me to make a **one-page PowerPoint-style cheat sheet with diagrams & icons** for **last-day revision**?