2020

# Medical Billing Training: Certified Professional Biller (CPB™)

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Chapter 9

# Billing

## Introduction

Billing for the services physicians provide is critical to the viability of a practice. We will discuss the process of billing claims in this chapter. The objectives of this chapter include:

- Defining a physician fee schedule
- Reviewing processes to avoid delinquent claims
- Discussing accounts receivable deposit balancing
- Understanding electronic claims submissions
- Discussing facility billing

## Fee Schedules

A fee schedule is a list of fees physicians established as the fair price for the services they provide. The services listed on a fee schedule will vary depending on the type of medical practice. For example, a cardiologist's fee schedule will not be the same as a dermatologist's fee schedule because each provider performs different services based on their specialties. The service is reported with a HCPCS Level II or CPT® code and the fee is attached to the code.

Remember that a fee schedule and a payment schedule are two different types of schedules. The fee schedule is the fee the physician sets as a fair price for the services provided. A payment schedule is what Medicare or other insurance payers approve as the reimbursement amount for the service provided. For example, a physician may submit a charge of $95 (fee schedule amount) for E/M level 99214, but the payer may only reimburse 99214 at $85 based on its payment schedule.

There are many methods to calculate a fee schedule. The two most common methods include creating a cost-based fee schedule and creating a fee schedule based on the relative value units (RVUs) assigned by the Centers for Medicare & Medicaid Services (CMS). When determining a cost based-fee schedule, the total costs of each service or procedure the provider will perform must be calculated. These fees are determined by carefully accounting for every cost incurred by the medical practice to provide quality products and services to the patient. When calculating the costs, include lease or rental payments; utilities; office supplies and equipment; loan fees; maintenance fees; employee labor; malpractice and/or liability insurance (professional liability insurance purchased by providers to cover the cost of being sued for medical errors resulting in bad patient outcomes that are proven to have been caused by gross negligence or a deviation from the standard of care); health insurance; and other benefit costs. Once these costs have been determined, a fee is assigned to the corresponding procedure or service. This is the amount submitted to the payer when the service is rendered.

In 1992, the United States federal government implemented a standardized physician payment schedule utilizing a resource-based relative value scale (RBRVS) which bases payments on the cost of resources needed to provide services. The methodology is comprised of five components: physician work relative value units (work RVU), practice expense relative value units (PE RVU), professional liability insurance relative value units (PLI RVU), geographic practice cost index (GPCI), and the conversion factor (CF). A relative value unit is a unit of measure for each medical service that indicates the resources associated with providing a service. The components are defined as follows:

- Physician work component: This represents the relative time and intensity associated with furnishing a Medicare physician fee schedule (PFS) service and accounts for around 50 percent of the total payment associated with a service.
- Practice expense component: This represents the costs of maintaining a practice (renting office space, purchasing supplies and equipment, staff costs, etc.).
- Professional liability insurance component: This represents the costs of malpractice insurance.
- Geographic practice cost index component: This represents adjustments applied to each of the three relative values above (work, practice, liability) in calculating a physician payment. This is to account for the geographic variations in the costs of practicing medicine in different areas of the country.
- Conversion factor component: This is updated on an annual basis.

Below is the RBRVS formula:

[(Work RVU x Work GPCI) + (PE RVU x PE GPCI) + (PLI RVU x PLI GPCI)] x CF

In determining a fee schedule based on RVUs (CMS fee schedule), a medical practice may reference the current Physician Fee Schedule Relative Value Units (PFS RVU) file (http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html). Medical offices then create their own conversion factor and multiply it by the RVUs assigned to each procedure code to create the fee for their individual practice.

RVUs are categorized as either facility or non-facility. The physician's fee schedule is considered non-facility.

**EXAMPLE**

If the national conversion factor for the 2018 is $35.9996, and the PFS RVU file lists CPT® code 99214 with a non-facility RVU value of 3.04, the RVUs assigned are multiplied by the conversion factor to calculate the fee.

National fee for 99214: $35.9996 x 3.04 = $109.44 (rounded to the nearest cent)

If the office chooses to double the CMS fee for the fee schedule, the conversion factor would be $72.00 (rounded to the nearest cent).

Provider fee schedule based on double the CMS fee:

Provider's fee schedule for 99214: $72.00 x 3.04 = $218.88

This calculation is often rounded to the nearest whole dollar, which would make the fee for 99214 $219.00.

The calculation can also be done using the fee schedule. Take the national fee schedule for 99214 ($109.44) and multiply by 2:

$109.44 x 2 = $218.88

Rounded to the nearest dollar, the fee for 99214 would be $219.00.

## Data Entry

It is very important that information is keyed in properly and in a timely manner. Until the information is entered into the provider's practice management system, there is no progression towards receiving reimbursement from payers. Data entry may be the responsibility of several individuals in the organization. Regardless of who inputs or updates the data, the most important skills are accuracy and speed.

The data entry process is critical in the claims billing cycle. Data entry is used to capture demographic information, CPT®, HCPCS Level II, and ICD-10-CM codes necessary to report the services for patient encounters. Payments and adjustments from insurance carriers are also entered into the practice management system through data entry.

Even the smallest mistake can result in a denied claim. For example, when a number is transposed, which is a simple mistake, the result can be a denied claim for an invalid ID number, or invalid ICD-10-CM/CPT® code, depending on the number transposed. This small mistake can cause the practice time and money to work the claim to get paid for the service. Some offices have moved to electronic medical records (EMRs), which may also reduce the amount of data entry. In an EMR, typically information for entry is selected from a drop-down list. Information in a drop-down list comes from a database. A database is where related pieces of information is collected and stored. Many practice management systems and clearinghouse vendors have worked together to provide electronic posting of payments and adjustments from insurance companies.

**BILLING TIP**

Having a check and balance process in place will help reduce the number of errors in data entry.

## Reduce Payment Delay

Best practices for minimizing claim payment delays should be implemented, maintained, and monitored on a regular basis. The following processes will minimize the delay in payments and when functioning properly, will result in steady revenue flow which is important in maintaining a financially sound medical practice.

Following these steps throughout the lifecycle of a claim will reduce delays in payment.

- **Verify insurance**—One of the best ways to avoid payment delays is insurance verification. Front office or reception staff should ask to see the patient's insurance card at each visit—even if the patient was just seen the day before. Insurance verification not only detects payer changes, but also data entry errors. Compare the name and ID number on the insurance card to what is in the practice management system. Training front office staff to verify this information will reduce payment delays of this nature.
- **Submit Clean Claims**—A clean claim is a claim containing all the information required by the payer to process the claim. By submitting a clean claim the first time, the chance of denial and missing timely filing deadlines is reduced.

A clean claim will include the correct insurance, referring physician, submitting physician, and service information. Ensuring that specific payer billing guidelines have been followed will also assist in submitting a clean claim. Many practice management systems allow development of payer specific edits which can be designed to alert the medical biller to address specific criteria required by the payer.

- **Submit Claims Electronically**—Submitting claims electronically reduces clerical paperwork, cost of postage, envelopes and forms, and accelerates the process. Electronic submission supplies the practice with reports indicating claims were received and accepted or rejected. This allows the opportunity to respond immediately. When submitting on paper the practice must wait for correspondence from the insurance payer. Claims are rarely submitted on paper due to the significant delay inherent in this process.
- **Check Status Reports**—Status reports are generated by the payers identifying the status of the claims that were received. The report will identify each claim with the patient's name and date(s) of service and whether the claims were accepted, adjudicated, and/or received by the payer. If a claim does not appear on the claim status report from the insurance carrier, it will need to be reviewed for missing information and submitted again with the needed information. If the claim is suspended, the biller will need to find out why, correct the information, and resubmit the claim.
- **Submit Documentation**—When an insurance company requires additional documentation to process a claim, a written request will be sent to the provider. When a request is received by the provider, it is imperative that the provider submit that additional documentation in a timely manner. Without the additional documentation, the payer will process the claim with the information that they have which may result in denial of the claim. When a biller receives a request for medical records, the following actions should be taken:
  - Review the medical record to verify the services billed are accurate. This may require the assistance of a medical coder to determine accuracy of coding and supporting documentation.
  - Copy the medical record for the date of service requested. Only the information pertaining to the date of service for the claim should be sent to the insurance carrier due to the minimum necessary standards in HIPAA requirements.
  - Send the copy of the medical records to the insurance carrier along with the claim and remittance advice.
  - Make a note in the practice management system indicating the date that the requested medical records were sent to the insurance carrier. Including the date of service in the note will also assist that the correct information was sent. Example: John Doe's medical records for DOS 5/15/XX were submitted to XYZ Insurance Company on 6/15/XX as per payer request received 6/12/XX.
- **Post Contractual Adjustments**—A contractual adjustment is the amount that the provider agrees to accept as a participating provider with the insurance carrier. When contractual adjustments are not taken, it leaves a balance on the patient's account and may keep any deductibles and copays from being billed to a secondary insurance carrier. Properly applying contractual adjustments is important from both a customer service and accounts receivable standpoint to reflect a correct patient balance due amount. For example, patient is seen by a participating provider and the visit is coded as a 99214 *Established patient visit*. The patient's claim is billed to the insurance company for $115.00 (physician's fee schedule amount). Because the patient's physician is a participating provider with the patient's insurance company, the physician has contractually agreed to accept $100.00 for code 99214. The insurance payment is received and posted to the patient's account leaving a $15.00 balance remaining. The remaining amount of $15.00 will be removed and accounted for as a contractual adjustment, leaving the patient's balance due as zero. If the contractual adjustment is not posted, the patient will receive a bill for the remaining $15.00. The A/R now erroneously reflects payments that should not be collected. If the patient is billed and pays the $15.00, they should receive a refund based on the physician's contract with the payer.

## Section Review 9.1

1. Cost based fee schedules are developed using which of the following:

   A. RBRVS methodology
   B. Total costs of every procedure or service listed in the CPT®
   C. Total cost of all of the procedures the physician will perform
   D. Malpractice insurance and office operating costs

2. The physician payment schedule is determined by the:

   A. Physician
   B. Insurance payer
   C. Patient
   D. Billing office manager

3. Given the following information, determine the provider's fee schedule for 99203 New office patient visit using the following values:

   - National conversion factor $35.99
   - RVU value of 3.04

   A. $109.00
   B. $36.00
   C. $38.84
   D. $108.85

4. Failure to post a contractual adjustment to a patient's account will:

   A. have no effect on the patient's account balance
   B. have no effect on the A/R
   C. leave a balance on the patient's account that should not be there
   D. decrease the workload of the billing staff

5. Which of the following tasks is the most basic element of the billing process:

   A. Claims follow up
   B. Status report monitoring
   C. Data entry
   D. Patient follow up

## Prior Authorization

A prior authorization is a requirement imposed by insurance payers to determine the medical necessity and benefit coverage eligibility before the patient receives a service or undergoes a procedure. When the physician determines the patient needs medical or specialty care, the physician must obtain approval from a health plan to perform a specific service/procedure or prescribe a specific medication. Without this prior approval, the health plan may not provide coverage, or pay for, the procedure or medication.

Verify in the payer contract and policies whether prior authorization is required. When it has been determined that prior authorization is required, the best time to obtain prior authorization is when the surgical procedure or service is being scheduled. It is imperative that the prior authorization number is reported on the claim form when billing for pre-authorized procedures.

Typical information required for prior authorization is the following:

- Patient's name (as it appears on the insurance card)
- Patient's date of birth
- Insured's ID number
- CPT®/HCPCS Level II code(s)
- ICD-10-CM code(s)
- Location where service is performed
- Ordering physician
- Date of service for the procedure if scheduled

### EXAMPLE

Prior Authorization Policy

AAPC Health Plan Prior Authorization Policy

The following applies to AAPC Health Plan contracted providers rendering outpatient and inpatient services.

**Introduction**

To ensure the quality of member care, AAPC Health Plan is responsible for monitoring authorization, medical necessity, and appropriateness and efficiency of services rendered. Certain services require a referral or prior authorization to confirm that the member's primary care provider (PCP) or AAPC Health Plan has approved the member's specialty care services.

**Definitions**

Prior Authorization - A prior authorization is a process assisting the health plan to determine medical necessity and appropriateness of healthcare services under the applicable health benefit plan. Services that may require prior authorization may be surgical services, items of durable medical equipment (DME), drugs, etc.

**Prior Authorization**

AAPC Health Plan requires prior authorization for certain services, drugs, devices, and equipment as a condition of payment. Refer to the Clinical Resources section of the AAPC Health Plan website to determine which services require prior authorization and the department that is responsible for review.

Authorization for services, drugs, devices, and equipment is based on AAPC Health Plan criteria or on medical necessity guidelines. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Medical Necessity Guidelines are established and based on current literature review, including AAPC Health Plan consultation with practicing physicians in the AAPC Health Plan service area who are medical experts in the field, the policies of government agencies such as the U.S. Food and Drug Administration (FDA), and standards adopted by national accreditation organizations. The guidelines are revised and updated annually, or more frequently as new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines and AAPC Health Plan criteria are used in conjunction with the member's benefit plan document and in coordination with the provider recommending the service, drug, device, or supply.

**Prior Authorization through the Precertification Operations Department**

To obtain authorization for a service, device or equipment requiring prior authorization through our Precertification Department, the provider must submit the appropriate clinical documentation for review. As a condition of payment, the treating provider is required to submit documentation of medical necessity for services requiring authorization through the AAPC Health Plan Precertification Department. Documentation should detail:

- The member's diagnosis
- Planned treatment, including medical rationale for the service requested
- All pertinent medical information available for review

Note: Fax prior authorization requests to the Precertification Department at 801-555-1212. Providers can log on to the AAPC Health Plan secure website to see these authorizations in real-time 24 hours a day, 7 days a week.

Insurance contracts and policies should be reviewed to determine when a prior authorization is required. If one is required and was not obtained, the service will not be covered by the insurance company. Furthermore, the patient is not responsible for payment of this service if the prior authorization

was not obtained. Under these circumstances, the provider is required to write off the balance.

**BILLING TIP**

Many facilities will have an authorizations department. If authorization is not obtained prior to the procedure, some insurance carriers will allow for a retroactive authorization under special circumstances.

## Claim Scrubbers

A claim scrubber is a software program that reviews claims for key components and flags any detected errors before claims are sent to an insurance company. The medical biller is often tasked with the responsibility to monitor and respond appropriately to any identified errors. Correcting the identified errors at this point in claims processing is the key to reduce, if not eliminate, the number of rejected or denied claims a practice receives.

Common edits that are identified by claim scrubbers are data entry errors. The patient demographic data is an area where mistakes are commonly found. For example, keying in an incorrect procedure code that is gender specific would be an error that the scrubber would flag. Edits check for a valid patient name and subscriber ID number.

The claim scrubber verifies CPT®/HCPCS Level II codes and ICD-10-CM codes. The scrubber looks at the procedure code and diagnosis code to justify the medical necessity of the procedure. Additional edits may include the gender, age, date of service, place of service, required modifiers, and NCCI edits. The claim scrubber will also verify that the ICD-10-CM codes support medical necessity and identify bundled services, if this is built into the system.

Some practice management systems can build in medical necessity policies based on the insurance carrier. This can be cumbersome to maintain. A more manageable process is to have the NCDs and LCDs for your area loaded in the system and maintained as many insurance carriers will follow CMS guidelines.

Claim scrubber systems may be utilized at multiple points within the billing process. Claims may be scrubbed within the medical billing department prior to submitting to the clearinghouse, and then again by the clearinghouse before submitting to the payer.

The skilled medical biller will understand the nature of edits identified by the claims scrubber and know how to remedy errors appropriately. Applying their knowledge of coding concepts and payer policies will increase the professional medical biller's value to a medical practice. Their value will be realized as claims will be submitted accurately and timely, allowing for the practice to maintain a healthy revenue flow.

## A/R Deposit Balancing

Accounts receivable or A/R is money owed to the practice for services rendered and billed. Payments due from patients, payers, or other guarantors are considered accounts receivables.

### Daily Deposits

When patients are seen in the office, any copayments, deductibles, coinsurance, or patient balances may be collected by the office staff. Patient payments will also come into the office by mail, along with payments from insurance companies where direct deposit is not an option. Every day, charges and payments are posted to patient accounts. Daily deposits should be made for the mail receipts and personal payment receipts. Daily receipts of cash, checks, and credit card transactions should be balanced to the totals in the practice management accounting system. Keeping the checks and cash in the office for more than a day opens the practice up to liability for the cash and checks. Daily deposits of the mail receipts and personal payment receipts should also be balanced each day. The amount posted in the practice management system must match the deposit amount for that batch. If there is a discrepancy, it should be researched and corrected until the two amounts match.

### Direct Deposits

Many insurance payers pay claims using direct deposit. When the adjudication process has been finalized, the payer sends the remittance advice (RA) to the provider and an explanation of benefits (EOB) to the patient. The provider may receive a paper or electronic remittance advice. Payers often list multiple patient payments on one RA. Once the RA and the checks or direct deposits are received, the payments must be posted to the corresponding patient's account. This process must be performed with great accuracy to avoid posting errors. The medical biller may be tasked to post payments as part of his or her job responsibilities. The direct deposits received and posted need to be balanced at the end of the day.

## Section Review 9.2

1. The function of a claim scrubber is to:

   A. identify errors that will prevent a claim from being paid
   B. determine the reimbursement amount
   C. determine patient's deductible amount
   D. identify practice management errors

2. Payments due from patients, payers, or other guarantors are considered to be:

   A. active receivable
   B. accounts receivable
   C. allowed receivable
   D. accounts refundable

3. Prior authorization for a service or procedure is required by the:

   A. parent or legal guardian of a minor
   B. patient
   C. patient's insurance payer
   D. physician performing the procedure or service

4. The remittance advice is generated by the:

   A. front office reception staff
   B. medical assistant (MA) prior to patient being seen by the provider
   C. medical biller
   D. insurance payer

5. When a claim has been paid, an EOB is sent to the:

   A. Clearinghouse
   B. Patient
   C. Provider
   D. Insurance company

## Technology and Claims Submission

Healthcare claims can be submitted manually, by paper, or electronically by computer. Electronic claims submission has many benefits such as:

- Minimize claim rejections and re-submissions
- Deliver the claims to health insurers in real time
- Expedite payer responses and boost the cash flow
- Reduce cost of claim submission

The savings inherent in electronic claims submission is substantial. When considering the following cost estimates from the physician's standpoint, it's easy to see why electronic

claims submission is preferred over manual or paper claim submission:

- Cost to submit manual claims: $6.63 x 6,200 = $41,106
- Cost to submit electronic claims: $2.90 x 6,200 = $17,980
- Average annual savings per physician from automating claims submission: ≈$23,126*
- Based on an annual average of 6,200 claims submitted for a single physician.

Source: Milliman, Inc., "Electronic Transaction Savings Opportunities for Physician Practices." Technology and Operations Solutions. Revised: Jan. 2006

Additionally, many payers require the submission of electronic claims.

## Electronic Claims

Electronic claims can be submitted to a carrier from a provider's office using a computer with software that meets electronic filing requirements as established by the HIPAA claim standards. There are a variety of methods for transmitting claims data electronically:

- DSL—A DSL or digital subscriber line is a very high-speed connection that uses the same wires as a regular telephone line. Providers install software on their computer to use a DSL service.
- Extranet—An extranet is a private computer network allowing controlled access to the payer's system. The provider has limited access to payer and patient data elements on their patients only.
- Internet—The internet is a vast computer network linking smaller computer networks worldwide. Using the internet allows providers secure transmission of claims without the need for additional software.
- Magnetic tape, disk, or compact disc media—Magnetic tape, disk, or compact disc media can be used to manually move or transmit information. In this case, claims data information is downloaded onto a compact disc media and then this disc would be mailed to the payer.
- Electronic data interchange (EDI)—describes the process of transferring data between providers and insurance payers. To transfer data electronically, claims data must be changed or converted into an electronic flat file format. ANSI ASC X12 is the electronic file format used for EDI.

## Clearinghouse Report

Due to the vast amount of insurance payers, each with their own specific criteria for submitting claims, it would be an overwhelming task for individual practices and billing companies to maintain the required billing software needed to submit claims to each individual payer. This dilemma is resolved through the services of a clearinghouse. A clearinghouse is an entity that processes or facilitates the processing of claims for providers and healthcare plans. Clearinghouses have the capability to convert nonstandard data received from payers to standard transaction data to meet HIPAA requirements. Clearinghouses typically charge providers for the service with a start-up fee, a monthly service charge, and/or a per-claim transaction fee based on the volume. Clearinghouses can also offer other services such as claims status tracking, insurance eligibility determination, and secondary billing services.

How does a clearinghouse work? A claim or batch of claims is submitted electronically to the clearinghouse. Typically, within 24 hours the clearinghouse will send a report back to the provider identifying the status of all claims sent and all rejected claims. The rejected claims must then be reviewed and corrected before resubmitting to the insurance payer. Each clearinghouse report will have the same basic information.

Here's a sample report demonstrating the information that is reported back to the provider:

**View Clearinghouse Report**

**File name:** 1234567_8901.car.pgp

**Received:** 06/30/20XX 6:00:50 AM

**ABC EDI Daily Claim Processing Report**

**Provider Tax ID:**

| Type | Claim ID | Patient Name | DOS | Charge | Payer | AEDI Claim ID | Ref. Date | Status |
|---|---|---|---|---|---|---|---|---|
| OT01 | 78956 | Jenning, Susan | 06/25/20XX | 325.00 | 123 Ins | 0630201801 | 06/27/20XX | ACK |
| OT01 | 45678 | Field, Robert | 05/25/20XX | 115.50 | 123 Ins | 0630201802 | 06/27/20XX | REJ |

ERROR: Cannot identify the patient

Print Close Mark As Reviewed

REJ—claim rejected, make corrections and rebill

ACK = acknowledged, claim forwarded to the payer

The clearinghouse report provides feedback on whether the claim was rejected or forwarded to the payer. If the claim is rejected, there will be a statement identifying the error. In the example report above, the claim is rejected because the patient cannot be identified. In this case, the patient's demographic data and insurance card is reviewed against the information in the practice management system. Once the error is identified, the claim is corrected and resubmitted to the clearinghouse.

When selecting a clearinghouse for claims submission, a provider should select a clearinghouse that is accredited by the Electronic Healthcare Network Accreditation Commission (EHNAC). Accreditation by this entity will ensure that the clearinghouse adheres to standards that promote and support interoperability, stakeholder trust, regulatory compliance, and quality service.

**BILLING TIP**

Claims rejected from a clearinghouse are typically due to invalid data entry errors, such as an invalid ID number, invalid provider number, or missing information. When a claim is rejected from the clearinghouse, the information submitted should be verified before taking action. If the information is incorrect, the information should be corrected in the system and the claim resubmitted.

## Timely Filing

Timely filing is the deadline for submitting a clean claim to an insurance payer. Each payer has its own timely filing limits, which should be clearly stated in the contract. When a claim is denied for timely filing, the biller can use the electronic acceptance reports from the payer to prove the claim was filed within the timely filing limit originally.

In cases when the timely filing deadline was missed, obtaining payment for these types of claims can be challenging. There may be a valid reason that timely filing was not met. For example, a patient received services and wasn't aware that he or she had coverage at the time of the service. Later, it is determined that the patient did have coverage. In this case, an appeal should be made. Draft an appeal letter explaining the circumstances responsible for missing the deadline. Whenever there is a valid explanation, it's worth appealing.

Best practice is to avoid missing timely filing deadlines altogether. Be aware of each payer's timely filing criteria and develop a systematic approach to consistently meet or beat the deadlines.

## Section Review 9.3

1. A patient with ABC insurance is seen on May 1, and the claim is submitted on July 15 of the same year. Has the claim met the timely filing deadline?

   A. Yes. All payers have the same timely filing deadline of one year from date of service.
   B. No. All payers have a 30-day timely filing deadline.
   C. Maybe. ABC's timely filing policy should be reviewed to determine if the deadline was met.
   D. Maybe. Prepare an appeal letter just in case the claim is denied.

2. To submit claims data through EDI, claims data must be changed to:

   A. Filled files format
   B. Flat files format
   C. Individual file format
   D. Media file format

3. A batch of claims is submitted to the clearinghouse for processing. The status report shows that 20 claims were acknowledged and forwarded on to the payer for payment and 10 claims were rejected. What is the next step the medical biller should take in this situation?

   A. Contact the clearinghouse to determine why the 10 claims were rejected.
   B. Contact the payer to determine the reason the claims were denied.
   C. Notify the billing department manager of the rejected claims.
   D. Review the status report to identify the reasons for rejection, make needed corrections and resubmit for payment.

4. At the clearinghouse level, when a claim is returned to the provider, it is considered to be:

   A. Denied
   B. Pending
   C. Rejected
   D. Incomplete

5. The purpose of EHNAC is to:

   A. monitor coding practices of providers.
   B. develop standards for clearinghouses.
   C. promote interoperability, quality service, and regulatory compliance.
   D. accomplish both b and c.

## Audits

An audit is a review and evaluation of healthcare procedures and documentation for comparing the quality of services or products provided in a given situation. Audits may be initiated both internally and externally.

In medical billing, internal audits or monitoring should be in place for each aspect of the billing process. Monitoring compliance with payer contracts, understanding the cause of denials, detecting lost charges, follow up on resubmitted claims, and appeals are areas that require internal auditing. When areas of concern are detected, processes should be implemented to improve the overall effectiveness of the billing process. Audits may be performed at various stages within the medical billing process. A pre-payment audit occurs before a claim is submitted for payment. A post-payment audit would be performed after a claim has been submitted and either paid or denied. Reviewing paid claims, as well as denied claims, can offer valuable insight into the payer's behavior and determining whether claims are being paid appropriately, as defined in the payer contract.

External or payer audits are initiated by an entity outside of the provider's office or facility. For medical billing, the entity will be an insurance payer. When being audited, it is important to have all the documentation available to support the charges. The patient's medical record, the CMS-1500 claim form, along with the encounter form need to be reviewed. The encounter form will show the diagnosis code(s), procedure(s), supplies, and other services provided during the patient encounter. The CMS-1500 claim form will show if there is an issue between what is entered from the encounter form and what is displayed on the claim form. Discrepancies can arise due to a keying entry error or a practice management system that has billing rules by payer built into the system.

## Hospital Facility Billing

Provider's offices and facilities both report services performed in the facility. The provider bills for the professional services he or she provides within the facility. The facility reports the use of the facility and the resources in the facility used to provide those services. The UB-04 claim form is used for reporting the hospital facility's charges.

### Chargemaster

A hospital charge description master (CDM), also called a chargemaster, is a master price list of all services, supplies, devices, and medications charged for inpatient or outpatient services by a healthcare facility. It is like a charge ticket or encounter form in the medical office, but much more extensive. The design and functionality of the chargemaster allows for services and procedures to be captured at the time the service is delivered or the procedure is performed. Because of this functionality, the CDM must be continually monitored and updated as necessary to ensure accuracy and compliance. Virtually every area within the facility that provides services or performs procedures has interest in the chargemaster data.

When a service or procedure is rendered during a patient's hospital stay, healthcare workers enter the data into the facility's software system, which gathers the data and holds it in the patient's account until the patient is discharged. Upon discharge the patient's account is reviewed and verified by the billing department personnel. Once the review is complete, the data is transmitted electronically in UB-04 claim format either directly to the payer or to a clearinghouse. If error free, reimbursement is made to the facility.

Reimbursement for Medicare and other payers is based on either the medical severity—diagnosis related group (MS-DRG) payment amount for the inpatient stay or the ambulatory payment classification (APC) payment amount for outpatient encounters or services. In the case of Medicare reimbursement for outpatient services, CPT® or HCPCS Level II codes assigned to charges will be translated into APC groups. Each APC will generate a predetermined payment amount, which is multiplied by the number of units of the charge.

Although many separate APCs may be billed and reimbursed for covered outpatient services on one claim or date of service, most supplies and many of the drugs associated with the services are bundled and will not receive a separate APC payment. As a result, capture and coding of all service charges, medical visits, or diagnostic and surgical procedures are critical to facility reimbursement per encounter, because the APC payment theoretically includes payment for drugs and supplies.

Like Medicare, third-party payers each have their own respective reimbursement guidelines. They may or may not reimburse a charge without a CPT® or HCPCS Level II code, but they will all require at least a revenue code for reimbursement of charge items. A revenue code indicates the location or type of service provided for an inpatient and is reported with a four-digit code. Although most state Medicaid programs follow Medicare rules, many have created coding requirements specific to their states.

The example below illustrates the typical hospital's CDM layout.

| Dept/Inventory No | Description | HCPCS | Revenue Code | Revenue Charge |
|---|---|---|---|---|
| 100/1001 | Chest X-ray | 71045 | 0320 | $155 |
| 200/44653 | ED visit | 99283 | 0450 | $195 |
| 200/44654 | ED visit | 99284 | 0450 | $230 |
| 325/67245 | Colonoscopy | 45378 | 0750 | $800 |
| 325/67247 | Sigmoidoscopy | 45342 | 0750 | $420 |
| 400/56425 | EKG | 93005 | 0730 | $150 |
| 525/75902 | Major surgery, first 15 minutes | *** | 0360 | $275 |
| 525/75902 | Major surgery, each additional 15 minutes | *** | 0360 | $150 |
| 550/35412 | Pharmacy – busulfan per 6mg IV | J0594 | 0636 | $305 |

The symbol *** indicates that these services do not have a CPT®/HCPCS Level II code built into the CDM. Some services, such as surgeries, are dynamically coded (hand entered) on a case-by-case basis and reviewed quarterly, semiannually, or annually, depending on the facility.

Hospitals may have a CDM task force or a single individual who is responsible for maintaining accurate data within the CDM to ensure compliant and optimal billing, reimbursement, and data collection. The CDM task force is responsible for:

1. Review at least annually.
2. Maintain updates throughout the year as new procedures or supplies are incorporated into the hospital's service line.
3. Review and maintain payer information (bulletins, transmittals) and make CDM adjustments based on that information.

The coder and biller are not always involved in every aspect of the code assignment in the hospital. However, it is important to have an overall understanding of coding and billing and its impact on reimbursement for the facility.

Many other departments are involved in the CDM process. Depending on the size of the facility, information management services, the compliance department, and patient financial services (reimbursement department) may also be involved in updating the CDM.

The CDM is essential for obtaining appropriate reimbursement. Approximately 75 percent of outpatient services are driven by the CDM. There are typically between 3,000 and 30,000 (or more) line items, and literally hundreds of CPT® code changes each year.

## CDM Review Tasks

1. Ensure all codes are valid (CPT® and HCPCS Level II).
2. Deactivate outdated or unused codes.
3. Add new codes.
4. Evaluate all unlisted CPT® codes.
5. Verify code description is accurate and corresponds to CPT®/HCPCS Level II descriptor.
6. Once review is complete, compare to Medicare's Outpatient Code Editor (OCE) to determine if any services should not be billed.
7. Review CPT®/HCPCS Level II for correct revenue code assignment.
8. Evaluate third digit to ensure accuracy for revenue code assignment.
9. Review for more appropriate revenue code.

Ensure that all outpatient services have a corresponding CPT®/HCPCS Level II code.

- Charges submitted without a CPT®/HCPCS Level II code will not be paid under an APC
- Monitor for duplication of services

Review departments' charge tickets to ensure codes correlate to CDM. Review sample UB-04 claim forms prospectively and remittance advice notices retrospectively to verify information.

## Inpatient versus Outpatient Payment Errors

Generally, to be classified as an inpatient, the physician must order the patient to be admitted to a hospital, with an anticipated length of stay of more than 24 hours. The medical record documentation must support medical necessity to qualify for inpatient reimbursement. The difference between inpatient and outpatient classification will depend on how the patient's stay is coded and rules and regulations provided by Medicare, Medicaid, and private insurers.

Sometimes, a patient may have an outpatient surgery; then develop a complication that requires the patient to be admitted as an inpatient. The inpatient admission converts the outpatient procedure that would have been paid under the Outpatient Prospective Payment System (OPPS) to an inpatient admission, which is paid under the Inpatient Prospective

Payment System (IPPS). Under IPPS, claims are paid based on MS-DRGs, which are based upon the diagnosis code(s) assigned to the patient at admission. Under OPPS, outpatient services base their payment on Ambulatory Payment Classifications (APCs) which is based upon the procedure code(s) assigned to represent the services performed. If an outpatient surgical procedure is converted to inpatient, but improperly billed as outpatient, the payment amount will be incorrect or denied.

## Primary vs. Secondary Insurance

Patients may be covered under more than one health insurance policy. When this happens determine which insurance is primary and which is secondary. When a patient is the subscriber for their insurance coverage, this insurance payer is considered the patient's primary insurance. If the patient is also covered under another insurance, for instance from a spouse, the spouse's coverage would be the secondary insurance.

When a child is covered by insurance plans from both parents, the birthday rule is used to determine the primary and secondary insurance. According to the National Association of Insurance Commissioners, under the birthday rule, the health plan of the parent whose birthday comes first in the calendar year is designated as the primary plan. The year of birth is not a factor in this rule. The month and day are the only factors the health plan considers.

Billing secondary payers may be offered as a courtesy for patients or may be required depending on the office policy. Billing departments may designate billing staff that concentrate only on billing secondary claims. Secondary claims can be submitted once the primary payer has processed the initial claim. The remittance advice (RA) from the primary payer will accompany the claim to the secondary payer. Both primary and secondary payers will only reimburse for services or procedures that are qualified under the payer's policy and that are demonstrated as medically necessary.

Many group health insurance policies have a coordination of benefits provision in place to prevent multiple payers from paying benefits covered by other policies. Coordination of benefit provisions also define the order or sequencing of payment when more than one payer is involved. Some major payers have the capability to transfer primary claims data through electronic files to the secondary payer to facilitate the process. Medicare performs this process, which they call "crossover" claims.

### Section Review 9.4

1. The billing department manager reviews the claims paid by HIJ insurance company. This would be considered which type of audit?

   A. Pre-payment audit
   B. Post-payment audit
   C. Coding audit
   D. Payer audit

2. A physician writes an order for his patient to be admitted to the hospital for observation for suspected dehydration. The patient is observed for 8 hours and discharged to home following hydration therapy. This patient is considered to be:

   A. Outpatient
   B. Inpatient
   C. New patient
   D. Established patient

3. A family has health insurance coverage from both the father and mother. The father's birthday is May 29, 1989 and the mother's birthday is May 26, 1990. Which insurance would be primary for their three children?

   A. The father's insurance would be primary because he was born before the mother.
   B. The mother's insurance would be secondary because she was born after the father.
   C. The mother's insurance would be primary based on the month and day of her birthday.
   D. The father's insurance would be primary based on the month and day of his birthday.

4. Inpatient reimbursement is based on which of the following methodologies:

   A. IPPS and APC
   B. OPPS and MS-DRG
   C. OPPS and APC
   D. IPPS and MS-DRG

5. In the chargemaster, the four-digit code that reports the location or type of service is known as the:

   A. Key indicator
   B. Revenue code
   C. Diagnosis pointer
   D. Department/inventory number

## Glossary

**Account receivables**—Money owed to the practice for services rendered and billed.

**Adjudication –** The process of paying or denying claims submitted after comparing claims to benefit or coverage requirements.

**Audit**—A review and evaluation of healthcare procedures and documentation for the purpose of comparing the quality of services or products provided in a given situation.

**Birthday rule**—Under the birthday rule, the health plan of the parent whose birthday comes first in the calendar year is designated as the primary plan.

**Chargemaster**—A hospital-specific electronic list that includes all hospital procedures, services, supplies, and drugs that are billed to payers. Synonymous with charge description master (CDM).

**Claim scrubber**—A software program that reviews claims for key components before the claims are presented to an insurance company.

**Clean claim**— A claim with all the elements necessary to adjudicate the claim.

**CMS 1500 Form**—The standard claim form used by a non-institutional provider or supplier to bill claims.

**CPT®**—Current Procedural Terminology is a five-digit code used to describe medical, surgical, radiology, laboratory, anesthesiology, and evaluation/management services of physicians, hospitals, and other healthcare providers.

**Electronic data interchange (EDI)**—Describes the process of transferring data electronically between providers and insurance payers.

**Fee schedule**—A list of fees the physician establishes is the fair price for the services they provide.

**HCPCS Level II**—Alphanumeric codes that primarily include non-physician services, such as ambulance services and prosthetic devices, and represent items and supplies and non-physician services.

**HIPAA**—The Health Insurance Portability and Accountability Act, a federal law designed to provide privacy standards to protect patients' medical records and other health information.

**LCD**—Local coverage determination is when a contractor or fiscal intermediary makes a ruling as to whether a service or item can be reimbursed.

**NCD**—National coverage determination rulings specify the Medicare coverage of specific services on a national level.

**Prior authorization**—A requirement that a physician obtain approval from a health plan to perform a specific service, procedure, or prescribe a specific medication.

**Subrogation**—When an insurance company attempts to recoup expenses for a paid claim when another payer should have been responsible.

**UB-04 claim form**—The standard claim form used by an institutional provider to bill claims.