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 your 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 Polices

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/bsca/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. The procedure should Be billed on one line with Modifier 50 and one unit with The full charge for both Procedures - COMM-Bilateral-Procedures-Policy	Overbilling would be charging 100% payment for both lines. Sampling this pattern for a large amount of claims might suggest whether it's a naive mistake or not.
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	Incorrect. According to CPT and ACOG coding guidelines, the following services are included in the delivery services codes and should not be reported separately: • Admission to the hospital Since no given diagnosis unrelated to The deilvery – deny seperate reimburement	If the E/M had a diagnosis that is Related to the pregnency – might Suggest that the provider simply Erred when not bundling the two Together.

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.	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	Incorrect. Imaging Guidance for Varicose Vein Surgery: This rule will deny as incidental to the primary procedure any imaging guidance and monitoring (Doppler, Duplex Ultrasound or Fluoroscopy) when performed on the same date of service as the Varicose Vein Surgery by the same provider. (Refer to the Imaging Guidance for Varicose Vein payment Policy). : This rule will deny CRNA claims when billing for anesthesia services without modifier QS, QX or QZ (and no modifier was provided in the bill..). PRV_Clinical-Editing-Overview.pdf.	Sampling similar patterns in similar claims.

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	Robotic_Assisted_Surgery = [S290] if <CPT> = <Data.’Robotic_Assisted_Surgery’>, then deny	l1: code = Robotic_Assisted_Surgery reject “l1.code not supported“
Pregnant service cant be perform on non female	if <CPT> is <**59400**> and patient is male then deny	l1: code = 54900,Gender not in [F] reject “l1.code cannot provided to not female“
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'	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	l1: code = <Data.Preventive_Medicine_E/M> l2: code = <Problem_Based_E/M> , Modifiers not ‘25’ l1.TIN=l2.TIN l1.patinet_id = l2.patinet_id l1.dos = l2.dos reject l2 “l2.code is included in l2.code“

Emergency Department Services (99281-99285) must be provided in hospital that have ER emergency room (place of service - 23)	if <CPT> >= 99281 AND <CPT> <= 99285 AND <Data.place_of_service> = 23 (//hospital) AND <Data.place_of_service.ER> = <false>, Then deny.	I1: code = 99281-99285 I1.pos = <hospital> I1.pos.ER = <false> Reject i1: “i1.code cannot be provided where place of service has no ER”
Patient can get get x-ray of Chest just from one provider on a single day [X-ray codes can be found here] CPT Radiology	Chest X-ray = 71100 OR 71101 OR 71110 OR 71111 If <CPT1> = <Chest X-ray> AND <CPT2> = <Chest X-ray> WITH NOT same <DOS> AND same <POS> Then deny	I1: code = <Chest X-ray> I2: code = <Chest X-ray> I1.patient_id = I2.patient_id I1.dos != I2.dos OR I1.pos != I2.pos Reject I2 “i2.dos and i2.pos must match I1.dos and i1.pos”
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	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	same_anatomical_area = (<CPT1.area> == <CPT2.Area>) ? true: false I1: code = <CPT1> I2: code = <CPT2> I1.patient_id = I2.patient_id I1.dos = I2.dos same_anatomical_area = true I1.CPT1.area.views > I2.CPT2.area.views Reject I2 “x-ray view of same anatomical area with higher views performed on the same date”
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	If claim contain <CPT> = <Data.Problem_Based_E/M> AND <patient.primary_operation.DOS> > (Now() - 45) WITH <modifier> Not equal to 78 OR <Data.first_latter> Not Equal to ‘I’, then deny	I1: code = <Data.Problem_Based_E/M>, modifiers not ‘78’ I1.patient_id.primary_operation.dos > (now() - 45) I1.Data.first_latter != ‘i’ Reject I2 “return visit is not injury or wasn’t marked with modifier 78”

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		

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).