**MEDICAL BILLING**

**What is Medical Billing**

It is the process of sending the Claim forms (CMS 1500 foam) to the Insurance company on behalf of the provider office.

**EOB (Explanation Of Benifits)**

The statement of response which we received from the insurance company after submit a claim .

**ERA (Electronic Remitance Advice)**

It is a electonic format of EOB.

**DENIAL**

It is a statement received from insurance company stating that they are not going to pay the claim and the statement is called denial.

OR

It is the information mentioned in denied claim EOB.

**CPTCODE (OR) CURRENT PROCEDURAL TERMINOLOGY**

The treatment done by the provider to the patient is converted in to alpha numeric code is called “**CPTCODE**” .

Range is 5 digits.

( OR )

IT REPRESENTS PROVIDER SERVICE

**CPT CODE MENETIONED IN CMS 1500 --- BLOCK NO 24 D**

**REFERENCE BOOK**

Healthcare Common Procedure Coding System (HCPCS).

**It is the codes which specifies range for a speciality of provider**

CPT Code Ranges and Values:

Office Visit : 99202 - 99215

EM (Evaluation and management service): 99201 - 99215

New Patient Cpt Codes : 99201 – 99205

Established Patient CPT Codes : 99211 - 99215

Anesthesia : 00100 - 01999

Surgery : 10000 – 69990

Radiology : 70010 - 79999 (X-ray , scanning)

Laboratory : 80000 - 89999

**DIAGNOSIS CODE OR DX CODE**

The disease or illness of the patient is converted in to alpha numeric code is called “DIAGNOSIS CODE ” it’s range is Upto 7 digits.

( OR )

IT REPRESENTS PATIENT DISEASE

**REFERENCE BOOK**

**ICD 10CM** (International classification of disease of 10th revision clinical modification). It is effective from october 2015 before that ICD9CM.

**DOS (Date of Sevice )**

It is the date when the treatment was taken by patient .

**DOS MENTIONED IN CMS 15000 - Block 24A**

**REVENUE CYCLE MANAGEMENT**

**The total process from Retriving of files to AR follow up is called "RCM".**

**CAN U EXPLAIN RCM FOR ME OR CAN U PLEASE TELL ME THE STEPS INVOLVED IN RCM?**

**ANS :** It include process like

* Patient
* Registration
* Encounter (Facing)
* Demo Entry (Demo Sheets)
* Medical Transcription (Voice Files)
* Medical Coding
* Charge Posting Or CDM (Charge Discription Master)
* Payment Posting/Correspondence
* Account Receivables
* Collections

**MODIFIER**

It is alpha numeric code that gives extra meaning to the cpt code.

**BLOCK NO IN CMS 1500 FORM - BLOCK NO 24 D**

**What are the modifiers you used in your previous office or tell me some modifiers what you know ?**

ANS . We have used modifiers

24 – **It** is defined as an unrelated evaluation and management

service by the same physician

26 - It represents physician services and it is most commonly submitted with

diagnostic tests, including radiological procedures

TC – It represents technical component service

LT – It represents service done for left side organ of body

RT - It represent service done for Right side organ of body

50 – Bilateral services (Both sides organ of the body)

**51**  - It indicates that a second procedure was performed, and it is not a component code of the first procedure

57 - It is used to indicate an Evaluation and Management (E/**M**) service resulted in the initial decision to perform surgery either the day before a major surgery (90 day global) or the day of a major surgery.

59 - It it is distinct service ( used for 0 to 8 starting cpt codes)

25 - It it is distinct service (used for 9 series cpt codes)

76 - It represents represents same service done twice by same provider

77 - It represents same represents service done twice by differenet provider

**Social Security Number (SSN)**

It is a nine digit unique number issued to US citizens (permanent residents and temporary working residents.)

**Format is 854- 46- 7896**

**Primary Care Physician (PCP)**

PCP is the provider who provides initial care and refer the patient to the other provider for special services.

**BLOCK NO WHERE IT IS MENTIONED IN CMS 1500**  - **BLOCK NO 17**

**National Provider Identifier (NPI)**

It is a 10 digit number given for every US provider by US government.

**RENDERING PROVIDER NPI NUMBER IN CMS 1500 - BLOCK NO 24J**

**REFERRING PROVIDER OR PCP NPI NUMBER IN CMS 1500** - **BLOCK NO 17B**

**TAX ID**

Tax payer identification number (TIN) It is a 9 digit unique number given for every provider by US government.

**TAX ID NUMBER IN CMS 1500 FORM** - **BLOCK NO 25**

**BILLLED AMOUNT (OR) CHARGED AMOUNT (OR) TOTAL AMOUNT**

It is the total amount charged for a claim service.

**BILLED AMOUNT IN CMS 1500 FORM** -- **BLOCK NO 28**

**FEE SCHEDULE**

It is the document that gives the cost for each cpt code.

**ALLOWED AMOUNT**

The maximum amount fixed by the insurance company for a CPT code is based on the insurance fee schedule.

**Paid Amount**

It is the amount paid to the provider by insurance.

**Patient Responsibility**

It is the amount patient has to pay.

It is Co- Insurance, Co-Pay, and Deductible.

**Deductible**

Patient has to satisfy certain amount which was fixed by insurance company after satisfying that amount only insurance will pay for his medical benefits.

**Copay**

It is the initial amount paid to the provider before taking the service by patient

**Co Insurance**

It is patient responsibility that patient has to pay if there is no secondary insurance**.**

**INSURANCE**

**Primary Insurance**

It is the insurance that is first responsible for making payments to the providers.

**Secondary Insurance**

It is the insurance that is second responsible for making payments to the provider after the primary insurance.

**,Teritiary Insurance**

It is the insurance responsible for making the payments after secondary insurance.

**Co ordinate Benefit**

Patient has to decide who is primary and who is secondary before taking policy .

Allowed amount = paid amount + patient responsibility

Paid amount = allowed amount - patient responsibility

**Medicare**

It provides health care benefits for the people who are above age 65, who is physically handicapped people and who is suffering from (ESRD) End Stage Renal Disease.

**What are the plans involved in MEDICARE**

They are four types of plan in Medicare they are

Medicare Part A : Hospital coverage or It will cover inpatient

Medicare Part B : Physician services or Outpatient

Medicare Part C : Medicare advantage plan (instead of Medicare other commercial insurances will pay)

Medicare Part D : Medicines or Drugs

**Medicare cross over claim**

The automatic transfer of a claim from primary medicare to the patient’s secondary payer is known as medicare crossover (or) piggyback claims.

**Medigap Policy**

Medigap policy is also known as “**Medicare Supplemental Plan**”.

* It is always pay as secondary.
* It will not pay for copay,co-insurance,deductible.
* It will cover only one person.

**Railroad Medicare**

It is Medicare program offered to retired railway employees (who are above 65).

**What is TFL for Medicare?**

TFL for Medicare 1 year

**MEDICARE PART B ANNUAL DEDUCTIBLE AMOUNT**

* **$198.00 for** **2020**
* **$ 203.00 for 2021**

**MEDICARE PREMIUM**

* **$148.50 For 2021**
* **$144.60 For 2020**

**Medicare insurance id looks like**

Previously It Is a SSN# followed by suffix and now it is changed to Alpha numeric code.

SSN# - 452 -30 -8619

Previous Medicare Id- 452308619A

Present Medicare Id - MRXT5H99

**IN WHAT CASES MEDICARE WILL PAY AS SECONDARY INSURANCE**

1 Worker Compensation

2. Auto Insurance

3. Veterans Administration insurance

**Medicaid**

It will provides the health care benefits for the people who are below poverty line , pregnant women , people with disability.

**Medicaid spend down program (Or) Medicaid spend down cost (SDC)**

**(Or) Share On Cost (SOC)**

If a person earnings totally spent on health care expenses he is eligible for medicaid spend down program.

**Tricare**

It will provides the health care benefits for Uniformed people and their families and retired employees.

OR

It is a regionally managed healthcare program for active duty & retired members of the uniformed services and there families.

**CHAMPVA**

It will provides health care benefits for the spouse or child of a veteran who has been rated permanently and totally disabled for a service connected disability.

**Work Compensation**

It will provide the health care benefits for the employee who subjected to illness or accidents which happens during the work time.

(OR)

It will provide the health care benefits for the employee( who become ill or injured in worked time)

**Advance Beneficiary Notice**

It is a **notice** sent to patient by provider when they believe this service will not cover by **Medicare.**

**PTAN**

**Provider Transaction Access Number** (**PTAN**) is a number issued to providers by **Medicare,** after enrolling with **Medicare**

**Commercial Insurance**

* UHC +1-877-842-3210 TFL 90 Days
* AETNA 1 800-624-0756 TFL 120 Days
* CIGNA 1 800-102-4464 TFL 90 Days
* HUMANA 1 800-457-4708 TFL 180 Days For (Physicians)

90 Days For (Ancillary Providers)

* BLUE CROSS BLUE SHIELD (BCBS) TFL 90 Days

**Place of service**

It is the place were service is rendered.

Tele Health - 02

Office visit – 11

Home - 12

In patient - 21

Out patient -22

Emergency - 23

Ambulatory services -24

Skilled Nursing Facility- 31

Nursing Facility - 32

Hospice – 34

Ambulance (Land) – 41

Ambulance (Air & Water) - 42

**POS MENTIONED IN CMS 1500 -- Block 24B**

Physical Address or Facility –

it is place where provider office or facility is located.

**FACILITY MENTIONED IN CMS 1500 -- BLOCK NO 32**

**Billing address**

it is place where EOB and cheques are sent by insurance company .

POS MENTIONED IN CMS 1500 -Block 33

**Clearing House**

It is an Middle office between provider and insurance company.

**What is the clearing house you are using in previous office?**

**GATEWAY**

**Rejection**

claims will be returned from Clearing office or insurance company is called rejection.

**PAYMENT WILL BE MADE IN THREE WAYS:**

**1 CHEQUE**

**2. EFT**( Electronic fund transfer)

It is way of transferring fund electrically.

**3. CREDIT CARD OR DEBIT CARD**

**Charge Sheet or SuperBill**

Simply it is called medical records.

It contain details of provider name, Date of service,disease and service details.

**HIPAA** **(Health insurance portability and accountability act)**

It is Law implemented in 1996 by CMS. It is used to protects health records from third party.

**Appeal**

A formal request sent to insurance company asking to reprocess the claim.

**Reprocess**

If insurance denied claim incorrectly we are asking to reverify the claim to get the payment it is called Reprocess

**CMS**

Centre For Medicare and Medicaid service.

**HCFA**

Health care financing administration. formerly known as CMS

**Assignment of Benefits** **(AOB)** - It is an legal agreement between patient and insurance company to release funds to the provider.

AOB MENTIONED IN CMS 1500 --- BLOCK NO 13

**Release of Information** **(ROI)** - It is agreement between patient and provider to release patient health information to insurance company.

ROI MENTIONED IN CMS 1500 --- BLOCK NO 12

**Claim will be sent in 3 ways**

1.Electronic payor id

2.mailing address

3.fax#

**MEDICARE INSURANCE YOU WIL TRANSFER THE CLAIMS ELECTRONICALLY OR THRU MAILING ADDRESS?**

ANS : ELECTRONICALLY

**MANAGED CARE PLANS:**

* Managed care plans are mainly introduced to give better health benefits plan at affordable price and also to avoid patient’s misuse of the policy.
* Co-pay was introduced in managed care plan .
* Network and PCP concept applicable.
* Preventative service are covered.
* Authorization concept has been introduced.
* Premium is less compared to indemnity/traditional plan.

**TYPES OF MANAGED CARE PLANS:**

They are four types of managed care plans they are

1 HMO (Health Maintainence Organization)

2 PPO (Preferred Provider Organization)

3 EPO (Exclusive Provider Organization)

4 POS (Point Of Service)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | HMO | PPO | EPO | POS |
| PCP | YES | NO | YES | YES |
| REFERRAL | YES | NO | YES | YES |
| INNETWORK | YES | YES | YES | YES |
| OUTNETWORK | NO | YES | NO | YES |
| AUTHORIZATION | YES | YES | YES | YES |

**HMO PLAN**

IT IS MANAGED CARE PLAN

* IF WE TAKE HMO PLAN PCP IS COMPULSARY AND REFERAL IS COMPULSARY
* NEED TO VISIT INNETWORK PROVIDER AND OUTNETWORK NOT ELIGIBLE
* AUTH IS NEEDED FOR ALL HIGH DOLLAR AMOUNT CLAIM

**PPO PLAN**

IT IS MANAGED CARE PLAN

* IF WE TAKE PPO PLAN PCP AND REFERAL IS NOT NEEDED .
* INNETWORK AND OUTNETWORK PROVIDERS ELIGIBLE
* AUTH IS NEEDED FOR ALL HIGH DOLLAR AMOUNT CLAIM

**EPO PLAN**

IT IS MANAGED CARE PLAN

* IF WE TAKE EPO PLAN PCP IS COMPULSARY AND REFERAL IS COMPULSARY
* NEED TO VISIT INNETWORK PROVIDER AND OUTNETWORK NOT ELIGIBLE
* AUTH IS NEEDED FOR ALL HIGH DOLLAR AMOUNT CLAIM

**POS PLAN**

IT IS MANAGED CARE PLAN

* IF WE TAKE HMO PLAN PCP IS COMPULSARY AND REFERAL IS COMPULSARY
* INNETWORK AND OUTNETWORK PROVIDERS ELIGIBLE
* AUTH IS NEEDED FOR ALL HIGH DOLLAR AMOUNT CLAIM

**PTAN**

IT IS THE NUMBER GIVEN FOR EVERY US PROVIDER AFTER REGISTERING WITH MEDICARE INSURANE

**CORRECTED CLAIM**

After making Necessary changes in claim form it is considered as CORRECTED CLAIM.

**HOW YOU WILL SUBMIT CORRCTED CLAIM?**

After making necessary changes I will type CORRECTED CLAIM in 19 TH BLOCK and I will submit to insurance company.

**W9 Form**

**W9** form is used for updating the provider billing office address and provider related information with insurance.

**Date Of Birth**

According to date of birth rule for a child primary and secondary insurance is selected (when mother and father is having insurance)

Mother 02/09/1992

Father 06/27/1990

In this case according to month decision is taken not year

Hence, Mother insurance is primary and father is secondary

**Beneficiary OR Insured Person**

A person eligible for receiving benefits under insurance policy. He is also called as subscriber.

**HOSPICE**

It provides Medical care and Treatment for persons who will be dying soon.

**AGING**

Aging report is useful for catching charges that are going unpaid. It has breakdown of aging bucket and it is calculated from dos.

30 FRESH CLAIM

30-60 1 ST FOLLOWUP

60-90 2ND FOLLOWUP

90-120 3RD FOLLOWUP

120+ FOLLOWUP