BILLING RULE SHEET

Billing Rules on this sheet are separated into three models. All insurance companies that AH currently works with follow one of the three models.

Some things that are common between billing groups:

1. There are 2 types of treatments when it comes to billing
   1. Visit Based Treatments – means that regardless of how much time you spend performing this treatment the max you can bill for it is 1 unit.
   2. Time Based Treatments – All groups use this type of billing but in different ways.
   3. The systematic determining factor of whether

**Group 1:**

**Medicare, Medicaid,** and **Priority Health** all follow the 8 minute rule for one on one procedure codes.

0-7 Minutes =0 Units

8-22 Minutes =1 Unit

23-37 Minutes =2 Units

38-52 Minutes =3 Units

53-67 Minutes =4 Units

68-82 Minutes =5 Units

**Group 1 Time Based Treatment/Procedure Billing Rules:**

* Time is translated into Units based on the Insurance Rules table above.
* The system must differentiate by service code if a service is a Time Billed Treatment or a Visit Based Treatment
* Time for Group 1 is collectively rolled up across all Time Based Treatments within one appointment.
  + Minimum overall treatment service time to get paid for group 1 is 8 minutes
  + Next level of collective treatment time where you can get paid additional units is at 15 minute increments beyond the 8 minutes.

Example:

* + - 8 Minutes Pays 1 unit
    - 8+15 = 23 minutes minimum of total services within one appt is the next trigger point where AH can bill for the 2nd unit
    - 23+15= 38 minutes minimum of total services within one appt is the next trigger point where AH can bill for the 3rd unit
    - And so on 38+15 = 53, 53+15 = 68
* How does the system support the billing rules and provide guidance to AH Clinicians?
  + System recognizes the following things about each client to determine what billing rules should be utilized for each case and appointment:
    - Insurance used by the patient – this dictates what billing rules group should be used for the patient
    - Separates the service types based on the cpt codes (time vs. visit based)
    - Orders most expensive treatments at top to least at the bottom.
  + The System will auto fill the cpt codes and descriptions from the Plan of Care or most recently changed Daily Note for a specific case
  + System will have custom intuitive time drop down for each billing insurance group
    - The first service for which the user selects treatment time will default to and **bold** the first time threshold for billing. Example for group one is that it would default to 8 minutes.
      * The time drop down would remain fully functional allowing the user to select any time below or above the 8 minutes.
      * User should select the actual time spent on the treatment.
    - Option 1 next services time entry: The second service for which the user wants to enter time of treatment the system will auto calculate how many minutes should have been spent to collectively get to the next billing point threshold and set the drop down to select time to that next billing point and **bold** it.
      * Example would be: Clinician spent 10 minutes on first treatment.
    - Option 2 next services time entry: The second service for which the user wants to enter time of treatment the system will auto calculate how many minutes should have been spent to collectively get to the next billing point threshold.
  + System should calculate totals of minutes and allowable units to be billed

If 3 treatments add up to less than 3 units then the system should select the 2 treatments that with the highest reimbursement and send those through to billing since you cannot bill for all three treatments.

System wide treatments should be listed in order of highest reimbursement to lowest. This is especially important in Daily Notes within the specific categories.

**Group 2:**

**BCBS** and **BCN** use the following rule:

Must have 15 minutes of a procedure to charge, then use 8 minute rule per procedure.

15-22 minutes = 1 unit

23-37 minutes = 2 units

38-52 minutes = 3 units

53-67 minutes = 4 units

However- this is per procedure and not rolled up like Medicare.

Example:

23 minutes of 97110 = 2 units

23 minutes of 97140 = 2 units

Total visit 46 minutes =4 units

**Group 3:**

**All other insurances** follow this rule.

1-15 Minutes 1 Unit

16-30 Minutes 2 Units

31-45 Minutes 3 Units

46-60 Minutes 4 Units

**Timed Based Procedure codes:**

97110

97140

97112

97116

97761

97530 through 97542

97760

97032 through 97140

**Visit Based Procedure codes- only one per visit:**

97001

97002

97010 through 97028

G0283

97150

Assets needed:

Service codes showing what services are Time Based and Visit Based Services

Showing what services are highest paid

* + - CPT (service) Codes pre-assigned to the case in the Plan of Care of in the previous Daily Notes – this is important because the system should separate the service types into the Time Based and Visit Based categories based on the service code.

Can CPT Codes / Descriptions be edited?