**Health Insurance Portability and Accountability Act (HIPAA)**

HIPAA is United States legislation that provides security privacy and security provisions for safeguarding medical information.

**Primary Objectives of HIPAA**

* Assure health insurance portability by eliminating job-lock due to pre-existing medical conditions.
* Reduce healthcare fraud and abuse.
* Enforce standards for health information.
* Guarantee security and privacy of health information.

**Common HIPAA Privacy Violations:**

1. Losing Devices

The biggest problem with HIPAA compliance today is devices with stored patient health information, i.e. desktop computers, laptops, tablets and smartphones, being stolen or lost.

1. Getting Hacked

Data from several healthcare network servers have been hacked into over the last few years, and the numbers continue to rise. In 2021, [**50 million individuals**](https://www.hipaaguide.net/healthcare-data-breach-statistics/#:~:text=In%202021%2C%20this%20figure%20grew,in%20a%20healthcare%20data%20breach.) were affected by a healthcare data breach – 15% of the US population at the time.

1. Employee Dishonestly Accessing File

Unfortunately, you can’t trust everyone. Sometimes, staff misconduct can lead to a severe breach in HIPAA compliance, commonly in the form of snooping through medical information without proper access. They do this out of curiosity, spite or because a friend or relative asked them to. No matter their excuse, it’s unethical, but it’s still something that continues to happen.

**What is the Role of HIPAA in Healthcare?**

Following are the roles of HIPAA given below

* HIPAA plays a crucial role in ensuring that the PHI of patients is handled in a confidential manner by covered entities which include health plans, healthcare clearinghouses, and healthcare providers that conduct certain transactions electronically.
* HIPAA also introduced several new standards that were intended to improve efficiency in the healthcare industry, requiring healthcare organizations to adopt the standards to reduce the paperwork burden.
* It also requires covered entities to train their employees on the importance of PHI privacy and security and to report any data breaches or unauthorized disclosures of PHI to the Department of Health and Human Services (HHS).
* Additionally, HIPAA gives individuals the right to access and control their own PHI, and to receive a notice of privacy practices from covered entities that explain how their PHI may be used and disclosed.
* Overall, HIPAA plays a crucial role in ensuring that the privacy and security of an individual's health information is protected in the US healthcare system. By establishing standards for the use, disclosure, and protection of PHI, HIPAA helps to promote trust in the healthcare system and to ensure that individuals' health information is kept confidential.

**What is Considered PHI under HIPAA?**

The 18 HIPAA identifiers are the identifiers that must be removed from a record set before any remaining health information is considered to be de-identified.

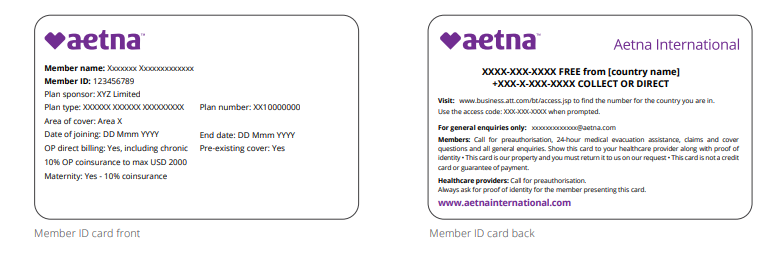
* Names
* Dates, except year
* Telephone numbers
* Geographic data
* FAX numbers
* Social Security numbers
* Email addresses
* Medical record numbers
* Account numbers
* Health plan beneficiary numbers
* Certificate/license numbers
* Vehicle identifiers and serial numbers including license plates
* Web URLs
* Device identifiers and serial numbers
* Internet protocol addresses
* Full face photos and comparable images
* Biometric identifiers (i.e., retinal scan, fingerprints)
* Any unique identifying number or code

**Why PHI is important?**

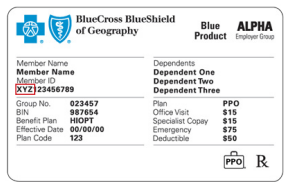
The importance of PHI is due to the fact that it is private information that, if disclosed, could have serious consequences for individuals. For example, the release of PHI could result in identity theft, discrimination in employment or insurance, or embarrassment. The improper use or disclosure of PHI can also lead to violations of trust between patients and their healthcare providers.

Moreover, PHI is also an important resource for healthcare providers, as it helps them make informed decisions about a patient's care, track the effectiveness of treatments, and ensure the continuity of care. The protection and confidentiality of PHI is crucial for maintaining the privacy and security of patients, promoting trust in the healthcare system, and advancing medical research.

**Aetna International Standard Card Format**



**BlueCross BlueShield Card Format**



**What is the difference between PII and PHI?**

**PII (Personally Identifiable Information)** and **PHI (Protected Health Information)** are both terms used to refer to sensitive information, but they are used in different contexts and have different implications in terms of privacy and security.

**PII** refers to any information that can be used to identify an individual, such as a full name, Social Security number, driver's license number, or home address. PII is protected under various laws and regulations.

**PHI**, on the other hand, specifically refers to health information that can be used to identify an individual and is protected under the Health Insurance Portability and Accountability Act (HIPAA) in the United States. This includes information such as medical records, treatment plans, diagnoses, and laboratory results. HIPAA requires that healthcare organizations implement administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and availability of PHI.

**Conclusion:**

In summary, PII is a broader term that refers to any information that can identify an individual, while PHI is a specific type of PII that pertains to health information and is protected under HIPAA in the US healthcare system.

**What are Covered Entities?**

Covered entities under HIPAA are individuals or entities that transmit protected health information for transactions for which the Department of Health and Human Services.

Transactions include transmission of healthcare claims, payment and remittance advice, healthcare status, coordination of benefits, enrollment and disenrollment, eligibility checks, healthcare electronic fund transfers, and referral certification and authorization.

**Types of Covered Entities:**

**Health Plans**

* Providers, or entities that pay for the cost of medical care such as health, dental, vision, and prescription drug insurers.
* HMOs, Medicare, Medicaid, Medicare Choice and Medicare supplement insurers.
* Long-term care insurers.
* Employer-sponsored group health plans, government and church-sponsored health plans, and multi-employer health plans.

**Healthcare Providers**

Every healthcare provider, regardless of size, who electronically transmits health record information in connection with certain transactions, including institutional providers such as hospitals and non-institutional providers such as physicians, dentists and other practitioners.

**Healthcare Clearinghouses**

These entities process nonstandard information received from another entity into a standard format or data content. They include billing services, repricing companies, community health management information systems, and value-added networks.

**What are Business Associates?**

Business associates are entities in the US healthcare system that perform functions or activities on behalf of a covered entity that involve the use or disclosure of protected health information (PHI). A business associate is any person or entity that creates, receives, maintains, or transmits PHI on behalf of a covered entity, such as a healthcare provider, health plan, or healthcare clearinghouse.

**Examples of business associates include:**

* **Third-party administrators:** companies that provide administrative services to health plans, such as claims processing and customer service.
* **Billing companies:** entities that provide billing and collections services for healthcare providers.
* **Data storage companies:** companies that provide data storage and management services for healthcare providers, health plans, and clearinghouses.
* **Medical transcription companies:** entities that provide medical transcription services to healthcare providers.
* **Medical equipment companies:** companies that provide medical equipment and supplies to healthcare providers.

**Conclusion:**

Overall, business associates play a critical role in the US healthcare system by performing functions and activities on behalf of covered entities and ensuring the confidentiality and security of PHI. By entering into business associate agreements with covered entities, business associates help to promote the delivery of quality healthcare services and maintain trust in the healthcare system.

**Health Care Plan Types**

Following are the different types of healthcare plans

1. **Health Maintenance Organization (HMO)**

An HMO delivers all health services through a network of healthcare providers and facilities. With an HMO, you may have:

* The least freedom to choose your health care providers
* The least amount of paperwork compared to other plans
* A primary care doctor to manage your care and refer you to specialists when you need one so the care is covered by the health plan; most HMOs will require a referral before you can see a specialist.

**What doctors you can see.**Any in your HMO's network. If you see a doctor who is not in the network, you'll may have to pay the full bill yourself. Emergency services at an out-of-network hospital must be covered at in-network rates, but non-participating doctors who treat you in the hospital can bill you.

**Paperwork involved.** There are no claim forms to fill out.

1. **Preferred Provider Organization (PPO)**

With a PPO, you may have:

* A moderate amount of freedom to choose your health care providers -- more than an HMO; you do not have to get a referral from a primary care doctor to see a specialist.
* Higher out-of-pocket costs if you see out-of-network doctors vs. in-network providers
* More paperwork than with other plans if you see out-of-network providers

**What doctors you can see.**Any in the PPO's network; you can see out-of-network doctors, but you'll pay more.

**Paperwork involved.**There's little to no paperwork with a PPO if you see an in-network doctor. If you use an out-of-network provider, you'll have to pay the provider. Then you have to file a claim to get the PPO plan to pay you back.

1. **Exclusive Provider Organization (EPO)**

With an EPO, you may have:

* A moderate amount of freedom to choose your health care providers -- more than an HMO; you do not have to get a referral from a primary care doctor to see a specialist.
* No coverage for out-of-network providers; if you see a provider that is not in your plan’s network – other than in an emergency – you will have to pay the full cost yourself.
* Lower premium than a PPO offered by the same insurer

**What doctors you can see.**Any in the EPO's network; there is no coverage for out-of-network providers.

**Paperwork involved.**There's little to no paperwork with an EPO.

**Difference between HMOs, PPOs, EPOs**

|  |  |  |  |
| --- | --- | --- | --- |
| **Categories** | **HMO** | **PPO** | **EPO** |
| [Network](http://www.insurance.ca.gov/01-consumers/110-health/10-basics/terms.cfm#network) | You get care from the doctors, labs, and other providers in your plan's network. | You pay less to see providers in your plan's network. These are called preferred providers. | You get covered care from the doctors, hospitals, and other providers in your plan's network. |
| Out-of-Network | You cannot see providers out-of-network except in an emergency or if your plan gives you pre-approval. | You can go out-of-network, but you pay more. | You can go out-of-network, but you will pay the full our-of-pocket costs for the service. The only exception is if you have an emergency or need urgent care. |
| [Primary Care Doctor](http://www.insurance.ca.gov/01-consumers/110-health/10-basics/terms.cfm#primecarephy) | You must have a primary care doctor. This is the doctor you must usually see first when you need care. | You may not be required to have a primary care doctor. | You may not have to use a primary care doctor. |
| Referrals | You need referrals to see specialists or to get lab tests. | You may be able to get many health services without a referral. | You do not need to get referrals to see specialists if they are in the EPO's network. |
| [Costs](http://www.insurance.ca.gov/01-consumers/110-health/10-basics/health-ins-costs.cfm) | You are less likely to have a yearly deductible.  You usually pay a co-pay or flat fee for most services. | You may have a yearly [deductible](http://www.insurance.ca.gov/01-consumers/110-health/10-basics/terms.cfm#deduct).  You may also have deductibles for hospital care and prescription drugs.  Care in the network costs a lot less than care outside the network. | You are likely to have higher [out-of-pocket](http://www.insurance.ca.gov/01-consumers/110-health/10-basics/terms.cfm#ooplimit) expenses.  You are less likely to have a yearly deductible.  You usually pay a [co-pay](http://www.insurance.ca.gov/01-consumers/110-health/10-basics/terms.cfm#copay) or flat fee for most services. |

**Plan Categories**

Following are the plan categories

* Platinum: covers 90% on average of your medical costs; you pay 10%
* Gold: covers 80% on average of your medical costs; you pay 20%
* Silver: covers 70% on average of your medical costs; you pay 30%
* Bronze: covers 60% on average of your medical costs; you pay 40%

**Copay**

A copay is a fixed out-of-pocket amount paid by an insured for covered services. It is a standard part of many [health insurance plans](https://www.investopedia.com/terms/h/healthinsurance.asp). Insurance providers often charge co-pays for services such as doctor visits or prescription drugs.

**How Co-Pay works**

Copay fees vary among insurers but typically are $25 or less. For example, an insurance plan with copays may require the insured to pay $25 per doctor visit or $10 per prescription. Review the terms of your insurance plan to determine your copayment option.

**How do Copays and Deductibles Affect each other?**

A deductible is an amount an insured party [pays out-of-pocket](https://www.investopedia.com/terms/o/outofpocket.asp) before an insurance company pays a claim. For example, if you have a $5,000 deductible, you will spend the entirety of your medical expenses until you reach that $5,000 limit. At that point, your insurance company covers the costs, less your copay.

**For Example:**

Imagine your co-pay is $20 per medical visit. You see a physician, and the cost is $200. If you have not reached your deductible, you pay for the entire appointment. If you have reached your deductible, you [will pay only the copay](https://www.investopedia.com/ask/answers/051415/what-difference-between-copay-and-deductible.asp) of $20.

**Differences between the Rendering Provider and Billing Provider**

In the context of medical billing, the "billing provider" and "rendering provider" refer to two different roles in the process of seeking reimbursement for medical services.  
  
The "billing provider" is the individual or organization responsible for submitting a claim to a payer (e.g. Medicare, Medicaid, private insurance) for payment for services rendered to a patient. The billing provider is typically the entity that has a direct financial relationship with the payer.  
  
The "rendering provider" is the individual or organization that actually provides the medical service to the patient. This could be a doctor, nurse, or other medical professional. The rendering provider may be different from the billing provider, as the medical service may be provided by one entity, but the billing and financial responsibilities may be handled by another entity.  
  
**For example**, a physician may work for a hospital, but bill for their services under their own name. In this case, the physician would be the rendering provider and the billing provider. The hospital would only be involved as the place where the service was rendered, but would not be responsible for billing the insurance company.

**Note:**

The billing provider and rendering provider can be the same person. In healthcare, the billing provider is the individual or organization responsible for submitting a claim to insurance for reimbursement, while the rendering provider is the person who actually provides the service. If a single individual provides the service and submits the claim, they can be both the billing and rendering provider.

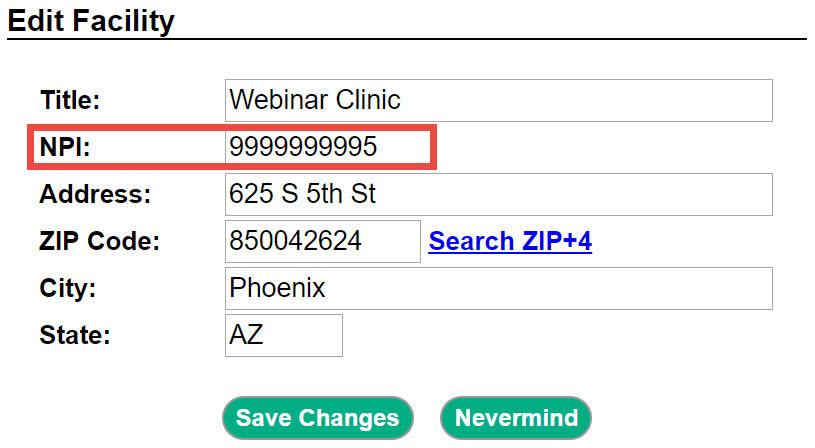
**Providers Types**

Following are the different types of providers

* **Primary Care Physicians (PCPs):** These are doctors who serve as the first point of contact for patients seeking medical care. They are responsible for diagnosing and treating common medical conditions, and they often manage a patient's overall healthcare needs. PCPs include family medicine doctors, internal medicine doctors, and pediatricians.
* **Specialists:** These are doctors who have advanced training in a specific area of medicine, such as cardiology, dermatology, or neurology. They provide specialized care for patients with specific medical conditions or illnesses.
* **Hospitals:** Hospitals are healthcare facilities that provide inpatient and outpatient care, as well as emergency services. They are staffed by a wide range of healthcare providers, including doctors, nurses, and other clinical professionals.
* **Clinics:** Clinics are healthcare facilities that provide a wide range of medical services, including diagnosis and treatment of illnesses, preventative care, and routine check-ups. Some clinics specialize in certain areas of care, such as women's health, mental health, or pediatrics.
* **Pharmacies:** Pharmacies are healthcare facilities that dispense medications and provide medication-related advice and services to patients. They are staffed by pharmacists, who are experts in the safe and effective use of medications.
* **Nursing Homes:** Nursing homes are long-term care facilities that provide medical and personal care services to individuals who are unable to live independently. They are staffed by nurses, certified nursing assistants, and other clinical professionals.

**NPI**

The NPI (National Provider Identifier) number is a 10-digit numerical identifier that identifies an individual provider or a healthcare entity. An NPI number is shared with other providers, employers, health plans, and payers for billing purposes.



**Why Are NPI Numbers Necessary?**

Prior to the implementation of NPI numbers, health plans and federal payers assigned identification numbers to healthcare providers and suppliers. The identification numbers were not standardized, resulting in a single provider using multiple identification numbers issued by the various health plans with which a provider was enrolled. This complicated the provider’s claim submission processes, often resulting in the same identification number being assigned to different healthcare providers by the different health plans.

**Types of NPI Providers?**

There are two types of NPI number assignments

* Type 1 NPI includes individuals, such as dentists, physicians, and surgeons. A provider is eligible for a single NPI.
* Type 2 NPI are organizations and may include acute care facilities, health systems, hospitals, physician groups, assisted living facilities, and healthcare providers who are incorporated.

**Understanding NPI Lookup Results**

* **NPI:** As explained above, the NPI is a unique, 10-digit National Provider Identifier assigned to the provider.
* **Enumeration Date:** The enumeration date refers to the date the NPI was assigned.
* **NPI Type:** There are two types of NPI numbers. Type 1 NPIs are assigned to individual providers. Type 2 NPIs are assigned to organizational providers.
* **Status:** This shows whether the NPI is active or deactivated.
* **Address:** This refers to the address associated with the NPI. It may include a mailing address, a primary address, and/or a secondary address.

**International Classification of Diseases (ICD)**

ICD stands for the International Classification of Disease. The ICD provides a method of classifying diseases, injuries, and causes of death. The World Health Organization (WHO) publishes the ICDs to standardize the methods of recording and tracking instances of diagnosed disease all over the world, making it possible to conduct research on diseases, their causes, and their treatments.

**ICD Medical code Sets:**

ICD consist of medical code set.

* ICD-10-CM

**ICD-10-CM**

ICD-10-CM stands for the International Classification of Diseases, Tenth Revision, Clinical Modification. Used for medical claim reporting in all healthcare settings, ICD-10-CM is a standardized classification system of diagnosis codes that represent conditions and diseases, related health problems, abnormal findings, signs and symptoms, injuries, external causes of injuries and diseases, and social circumstances. Use ICD-10-CM diagnosis codes on all inpatient and outpatient health care claims.

**Structure of ICD-10 Codes**

ICD-10-CM codes consist of three to seven characters. Every code begins with an alpha character, which is indicative of the chapter to which the code is classified. The second and third characters are numbers. The fourth, fifth, sixth, and seventh characters can be numbers or letters.

**Tabular List**



**ICD Versions**

|  |  |
| --- | --- |
| **ICD-9-CM** | **ICD-10-CM** |
| 13,000 codes | 68,000 codes |
| 3-5 characters in length | 3-7 characters in length |
| First digit may be alpha (E or V) or numeric; digits 2-5 are numeric | Digit 1 is alpha (to indicate the category); Digit 2 is numeric (in the future, alpha characters may be used if code expansion is needed); Digits 3-7 can be alpha or numeric |
| Limited space for adding new codes | Flexible for adding new codes |
| Lacks detail | Very specific |
| Lacks laterality | Includes laterality (i.e., codes identifying right vs. left) |

**What are the reasons of using ICD-10-CM instead of ICD-9-CM?**

Here are few reasons for changing from ICD-9-CM to ICD-10-CM

* The current ICD-9-CM coding system lacks specificity and detail. If the reader has attempted data extraction utilizing the ICD-9-CM system, you have probably encountered difficulty obtaining the exact diagnosis for which you were searching.
* ICD-9-CM is running out of code capacity to expand and keep up with advances in technology. Most of the categories contained in ICD-9-CM are completely full with no room for expansion.
* Clinical trials require specific information on comorbid conditions, adverse events, and past medical, surgical, and social histories. Another reason to convert is the inability of ICD-9-CM to support the U.S. initiative to transition to a health data exchange.
* By converting to the new ICD-10-CM system, we will expect to obtain better data for measuring the quality, safety, and efficacy, (2) researching, and (3) gaining more efficiency in our healthcare system.
* The new ICD-10-CM system will allow for future expansion to accommodate the rapid introduction of new technologies into the healthcare system. In addition, we will finally be able to align the United States data with other ICD-10 coding systems worldwide.
* There is an anticipated reduction in coding errors due to the specificity of the codes, and an overall lowering of costs and improving efficiencies in the healthcare system.

**What are Headers Codes?**

Header codes is identified by the CDC, which are not valid for HIPAA transactions or considered proper coding. There are about 70,000 HIPAA-valid ICD-10 codes. And there are approximately 22,000 additional header codes. Header codes require more digits to indicate the appropriate level of specificity. The increased level of specificity is expected to provide significantly better data analysis opportunities for the health-care industry.

**What are Billing Codes?**

Billing codes are used on health care claims to identify (a) the patient’s treating diagnosis and relevant medical conditions (e.g., speech, language, or hearing disorder; autism spectrum disorder); (b) services provided (e.g., audiometric testing, swallowing intervention); and (c) durable medical equipment and devices supplied (e.g., hearing aids, speech-generating devices).

**ICDs codes which are Billable**

There are more than 73,643 ICD-10-CM codes are billable/specific and can be used to indicate a diagnosis for reimbursement purposes as there are no codes with a greater level of specificity under each code.

For Example:

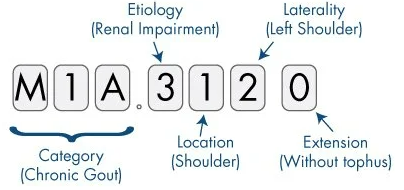
* A01.00  Typhoid fever, unspecified
* A01.01  Typhoid meningitis
* A01.02 Typhoid fever with heart involvement

**ICDs codes which are not Billable**

There are 23,106 ICD-10-CM codes are non-billable/non-specific and should generally not be used to indicate a diagnosis for reimbursement purposes.

* A00 Cholera
* A01 Typhoid and paratyphoid fevers
* A02 Other salmonella infections

**ICD-10-CM Code Structure**



**What is meant by Bit in ICD-10-CM in US Healthcare?**

In ICD-10-CM, a bit refers to a digit in a code that provides additional information about a specific aspect of a diagnosis or procedure. For example, the seventh character in certain codes provides information about the episode of care, such as initial encounter, subsequent encounter, or sequela. Another example is the use of a "X" as a placeholder in certain codes to indicate that a more specific code is not available. The use of bits in ICD-10-CM helps to provide greater detail and specificity in coding and can be important for accurate reimbursement and statistical analysis.

**CPT Codes**

Current Procedural Terminology, more commonly known as CPT®, refers to a set of medical codes used by physicians, allied health professionals, nonphysician practitioners, hospitals, outpatient facilities, and laboratories to describe the procedures and services they perform.

Specifically, CPT® codes are used to report procedures and services to federal and private payers for reimbursement of rendered healthcare.

**Types of CPT Codes:**

Given the vast number of services and procedures, the AMA has organized CPT® codes logically, beginning with classifying them into three types:

* **CPT® Category I:** The largest body of codes, consisting of those commonly used by providers to report their services and procedures
* **CPT® Category II:** Supplemental tracking codes used for performance management
* **CPT® Category III:** Temporary codes used to report emerging and experimental services and procedures

**CPT Category I codes are**

1. Evaluation & Management (99202–99499)
2. Anesthesia (00100–01999)
3. Surgery (10021–69990) — further broken into smaller groups by body area or system within this code range
4. Radiology Procedures (70010–79999)
5. Pathology and Laboratory Procedures (80047–89398)
6. Medicine Services and Procedures (90281–99607)

**CPT Category II codes are**

1. Composite Measures (0001F–0015F)
2. Patient Management (0500F–0584F)
3. Patient History (1000F–1505F)
4. Physical Examination (2000F–2060F)
5. Diagnostic/Screening Processes or Results (3006F–3776F)
6. Therapeutic, Preventive, or Other Interventions (4000F–4563F)
7. Follow-up or Other Outcomes (5005F–5250F)
8. Patient Safety (6005F–6150F)
9. Structural Measures (7010F–7025F)
10. Non-measure Code Listing (9001F–9007F)

**CPT Category III Codes**

Category III codes, depicted with four numbers and the letter T, typically follow Category II codes in the code book. Category III codes are temporary codes that represent new technologies, services, and procedures.

**Healthcare Common Procedure Coding System (HCPCS)**

The Healthcare Common Procedure Coding System (HCPCS) is a code set developed by CMS for reporting medical procedures and services. HCPCS is based on the American Medical Association's Current Procedural Terminology (CPT) coding system and its use was optional up until 1996 with the passing of the Health Information Portability and Accountability Act (HIPAA).

**Types of HCPCS Codes**

Adopted by CMS in 1983 and formed on the American Medical Association’s (AMA) CPT coding system, the HCPCS code is divided into three categories—Level I, Level II and Level III.

* **LEVEL I:** The Level I HCPCS codes consist of CPT (Current Procedural Terminology) codes and are numeric. Centers for Medicare & Medicaid Services (CMS) didn’t improve these codes and included them in HCPCS. However, when these codes are used for Medicaid and Medicare, they are technically considered as HCPCS codes and not CPT codes. For example, if you have an elderly Medicare patient who needs the placement of the tracheal stent then the code **CPT code 31631** will be used as HCPCS code. Level I codes can be quite confusing to use due to the technicality; therefore, hospitals must hire a well-trained medical coder. Also, CPT codes are only used for diagnostic, medical and surgical services.
* **LEVEL II:** The difference between CPT and HCPCS is visible in the Level II HCPCS codes and HCPCS modifiers. The HCPCS codes in this category are alphanumeric and are used to cover products, supplies, and services that do not fit in Level I. Some examples of HCPCS level II items are ambulance rides, wheelchairs, walkers, etc.
* **LEVEL III:** The Level III codes are referred to as HCPCS local codes—suggesting that these codes were created by local/state Medicare and Medicaid agencies/contractors and private health care insurers. Unlike Level I and Level II, these codes aren’t recognized at the national level and are used within certain jurisdictions.

**Diagnosis Pointers**

Diagnosis Pointers are used to describe sometimes complex many to many relationships between submitted diagnosis and service line treatment information on health claims and encounters.

**Who uses Diagnosis Pointer?**

Claims departments use them to determine if they will pay the claim.  After loading the pricing for that provider and determining eligibility and coverage, claims decides if the treatment is covered.  Among other decisions being made is whether the treatment is covered for the diagnosis.  For something simple like an office visit, almost any reason will do, but for something more specific they must match.  If the diagnosis is broken toe and the treatment is removed kidney, the claim will not be paid.  This is a way to prevent fraud and also a way to avoid paying expensive claims that are really a result of a keying error.

**How many Diagnosis Pointer can be there?**

On any given service line there are up to 4.  In current EDI (version 5010 of the 837P) the value must be between 1 and 12.

**Accept Assignment**

"Accept Assignment" is a term used in the US healthcare system to indicate whether a healthcare provider agrees to accept the amount of payment set by Medicare or another insurance company as full payment for the services provided to a patient.

**For Example**

If a Medicare payment schedule sets the amount for a particular service at $100, and a healthcare provider agrees to "Accept Assignment," they are agreeing to accept $100 as full payment for that service and cannot bill the patient for any additional amounts.

**Provider who accepts Assignment**

A medical provider who accepts Medicare assignment is considered a participating provider. These providers have agreed to accept Medicare’s fee schedule as payment in full for services they provide to Medicare beneficiaries. Most doctors, hospitals, and other medical providers do accept Medicare assignment.

**Provider who doesn’t accepts Assignment**

Nonparticipating providers are those who have not signed an agreement with Medicare to accept Medicare’s rates as payment in full. However, they can agree to accept assignment on a case-by-case basis, as long as they haven’t opted out of Medicare altogether. If they do not accept assignment, they can bill the patient up to 15% more than the Medicare-approved rate.

**Modifiers**

Modifiers are two-digit codes added to Current Procedural Terminology (CPT) codes in the US healthcare system to provide additional information about the medical service or procedure that was provided. Modifiers are used to indicate that a service was altered by some specific circumstance but was still medically necessary.

**Advantages of Using Modifiers**

The use of modifiers in medical billing helps in

* Avoiding claim denials by submitting clean and accurate claims
* [Submitting claims](https://www.medicalbillingwholesalers.com/services/claims-submission-work-edits-and-rejection) with a higher level of coding specificity and obtain the right reimbursements
* Getting improved reimbursements for services that have been rendered concurrently or in an unusual manner depending on the specific nature of the case

**Types of Modifiers**

* **Level I Modifiers**. Level I modifiers or CPT Modifiers comprises of two numeric digits and is copyrighted & updated annually by the American Medical Association (AMA)
* **Level II Modifiers.** Level II modifiers or HCPCS modifiers can be made of either Alphabets or Alphanumeric. These modifiers are copyrighted and updated by the Centre for Medicare & Medicaid Services (CMS)

**Example of Modifiers**

A patient visits a physician for a routine check-up, and during the visit, the physician discovers that the patient has a new health problem and performs an evaluation and management (E/M) service. On the same day, the physician performs a procedure related to the new health problem. In this case, the physician would bill for the E/M service using a modifier to indicate that a significant, separately identifiable service was performed on the same day as the procedure.

The **modifier 25** (significant, separately identifiable E/M service by the same physician on the same day as a procedure) would be added to the E/M service code to indicate that the service was performed on the same day as the procedure and was significant and separately identifiable from the procedure. This modifier helps to ensure that the E/M service is recognized and reimbursed appropriately, as it was not part of the routine check-up but was instead a separately identifiable service related to the patient's new health problem.

**Clearing House**

A clearing house service provider can help a healthcare provider to streamline the billing process by eliminating errors from claims, evaluating details in the claims, enabling the right information about insurance providers.

A clearinghouse evaluates the [medical billing claims](https://sybridmd.com/services/medical-billing-services/) for errors and checks whether they are correctly processed to be accepted by the payers. Basically, a clearinghouse operates as a bridge between insurance payers and healthcare providers. Once the clearinghouse establishes the report for claims, the claims and the associated medical records are sent to the respective organizations.

With this process, it becomes possible for healthcare providers to receive payments timely and manage the revenue cycle effectively.

**What does a clearing house do during a claim’s submission?**

The medical billing software on your desktop creates an electronic file (the claim) also known as the ANSI-X12 - 837 file, which is then uploaded (sent) to your medical billing clearinghouse account. The clearinghouse then scrubs the claim checking it for errors (arguably the most important thing a clearinghouse does); and then once the claim passes inspection, the clearinghouse securely transmits the electronic claim to the specified payer with which it has already established a secure connection that meets the strict standards laid down by a HIPAA. (Medical claims are also known technically as ‘HIPAA Transactions’ and it is because of HIPAA that we cannot send claims for patient billing to insurance payers simply by email.) At this stage, the claim is either accepted or rejected by the payer, but either way, a status message is usually sent back to the clearing house who then updates that particular claim’s status in your control panel. Now you have an accepted or rejected claim. If rejected, you have a chance to make any needed corrections and then re-submit the claim. Ultimately, assuming there are no other corrections required, and the patient’s insurance was verified beforehand, you’ll receive a reimbursement check or Electronic Funds Transfer (EFT) along with an explanation of benefits (EOB).

**What are the Benefits of Using a Clearing House?**

There are many advantages to using a medical billing clearing house for your claim process. Here are just key benefits that come from leveraging this option:

* **Better Legibility**

Doctors and other medical professionals are not known for the clarity of their handwriting. With a system of electronic medical records in place (as administered by a clearinghouse provider), insurance companies can easily read patient data. This ensures that claims won’t be rejected because of a misspelled patient name or other preventable errors.

* **Improved Processes**

Many healthcare providers have to transfer a claim’s information to their billing software, print the claim out as a CMS1500 form, and then mail it to the appropriate insurance company. After the insurer receives the claim, they audit it for errors. If they find any, they send the claim back to the provider; and the billing staff is back to square one.

All of this takes a lot of time and manpower. In contrast, the use of a medical billing clearinghouse can save you and your staff from inputting and re-inputting data, and losing precious time on fixing mistakes. Basically, you’re in a better position to focus on patient care rather than necessary but tedious paperwork.

* **Fewer Errors and Returned Claims**

Medical billing errors and other issues cause healthcare providers to lose an estimated $125 billion each year.

Clearinghouses audit bills and claims for errors such as:

* Missing patient data
* Incorrect patient data (misspelled name, wrong birthdate, etc.)
* Erroneous insurance provider information
* Inaccurate billing codes (incorrect Place of Service, HCPCS, or CPT codes, etc.)

**Patient Demographics**

Patient demographics are a patient’s basic information. Practices collect patient demographics to provide higher-quality care and streamline the [medical billing and coding](https://www.businessnewsdaily.com/16238-medical-billing-coding.html) process.

**What do patient demographics typically include?**

Patient demographics almost always include the following information:

* Full legal name
* Date of birth
* Biological sex
* Gender
* Contact information, including address
* Ethnicity
* Race

**Why are Patient Demographics important?**

Patient demographics matter because they:

* **Guide the billing process**

Patient demographics determine the payers from which you should seek reimbursement. Demographics that include insurance information tell you where to send your final bill and how you can follow up on unpaid claims.

* **Streamline patient communications**

Sending patient statements to an outdated address does your practice no favors. Collecting patient demographics is a surefire way to avoid this issue. Likewise, if you’re calling patients to confirm appointments or seek payment on overdue bills, calling an outdated phone number will prove fruitless.

* **Improve patient care**

Notice that a patient’s demographics answer many of the questions you might ask to determine their risk factors. For example, since [1 in every 5 women at least 50 years old has osteoporosis](https://www.nof.org/preventing-fractures/general-facts/what-women-need-to-know/), you’ll know to check for osteoporosis in patients with corresponding demographics. This preventive approach supports emerging [value-based care models](https://www.businessnewsdaily.com/16239-value-based-care.html) that can improve patient outcomes.

**Electronic Data Interchange (EDI)**

Electronic Data Interchange (EDI) is the automated transfer of data between health care professionals or facilities, sometimes an intermediary clearinghouse, and a payer. These electronic transactions are not specific to UnitedHealthcare. They are standard and routinely used across the health care industry. EDI allows both payers and health care professionals to send and receive information faster, avoiding claim delays and reducing administrative expenses.

**EDI Benefits**

**Send and receive information faster**

Turnaround times are typically quicker than using manual processes. For example, a payer can receive a claim the same day the care provider sends it, and an eligibility inquiry can be received and responded to in seconds.

**Identify submission errors immediately to help avoid claim processing delays**

Electronic claims are automatically checked for HIPAA and payer specific requirements at the vendor, clearinghouse and payer levels. This process decreases the reasons a claim may be rejected. This same level of automated data verification can’t be performed on paper claims.

**Reduce administrative expenses**

EDI cuts down on purchases of paper, forms, supplies and postage. It also saves time faxing, printing, sorting and stuffing envelopes.

**Spend less time on the phone**

EDI reduces calls your staff needs to make to UnitedHealthcare to obtain information on our members, claims, payments, authorizations and referrals.

**Exchange information with multiple payers**

EDI lets you complete transactions for multiple payers at one time. Transactions can be set up to automatically generate in a practice’s daily workflow. For example, a practice management system could perform a claim status inquiry at the same time it sends eligibility inquiries to verify a member’s benefit coverage and copayment.

**Types of EDI transactions**

* **270/271**: Eligibility and benefit inquiry and response
* **276/277**: Claim status inquiry and response
* **278**: Referral request
* **278I**: Prior authorization
* **278N**: Hospital admission notification
* **835**: Electronic remittance advice (ERA)
* **837D**: Dental claim
* **837I**: Institutional claim
* **837P**: Professional claim

**Steps of an EDI transaction**

1. EDI transactions start with an inquiry from the care provider and conclude with a response from the payer

2. The inquiry is submitted by supplying certain required data fields, such as member ID number, date of birth and Payer ID

3. This inquiry can go directly to the payer, but it often goes through a clearinghouse contracted by the care provider

4. The clearinghouse facilitates the inquiry to the payers

5. Once the payer receives the inquiry, they send the response back to the clearinghouse

6. The clearinghouse then sends the data to the care provider’s practice management system

7. If there’s an error in the data, the care provider will correct it and resubmit it to the clearinghouse for a response.

8. EDI transactions can be completed for 1 or more members

**Sample scenario of how EDI works**

A medical group is scheduled to see 100 patients from various payers on a Tuesday. They want to verify coverage and know how much to collect before the appointments. Using the 270 transaction for the inquiry for eligibility and benefit information, the payer returns the 271 transaction as the response. For this example, here’s what would happen:

• The care provider’s practice management system compiles the required information for the patients who have appointments on Tuesday

• The 270-inquiry transaction goes to the clearinghouse, which sends the 270 transaction to each payer

• The payer returns a 271-response transaction with confirmation of coverage/eligibility, copayment, coinsurance and deductible information and other benefit details

• The 271 transaction is returned to the clearinghouse for formatting and transmitted into the care provider’s practice management system

• On Tuesday morning, the care provider staff sees confirmation of coverage and the cost-sharing amounts on their computers before the patient arrives

• If there were errors with any 270 transaction requests, the information can be corrected in the care provider’s practice management system and resubmitted for an immediate response

• If the care provider needs more information than the EDI transaction provides, they can use the UnitedHealthcare Provider Portal to get additional information at UHCprovider.com/portal. Information can also be provided with Application Programming Interface (API), set up by your vendor, clearinghouse or IT department. Visit UHCprovider.com/api for more information on our API solutions.

**What is difference between 837P and 837I?**

**837 Professional**

Professional billing is responsible for billing of claims generated for work performed by physicians, suppliers for both out-patient and in-patient services. Professional charges are billed on CMS-1500 form. The electronic version of the CMS-1500 is called 837-P, the P standing for professional format.

**837 Institutional**

Institutional billing is responsible for the billing of claims generated for work performed by hospitals and skilled nursing facilities.

**What is ANSI-X12 format?**

ANSI X12 is a standardized format for electronic data interchange (EDI) in the United States. In the healthcare industry, ANSI X12 is used to exchange healthcare-related transactions, such as claims, enrollments, and eligibility information, between healthcare providers, payers, and other healthcare entities.

**ANSI X12 Message Structure**

ANSI X12 messages consist of 3 parts typically. The segments that can be used in each of these parts for a particular message type are listed in the related tables defined in the ANSI X12 standards document which follows the structure:

1. Header
2. Detail
3. Summary

An ANSI X12 message always begins with the Transaction Set Header (ST) segment in “1. Header” and always ends with the Transaction Set Trailer (SE) segment in “3. Summary”.

In between the Transaction Set Header (ST) segment and Transaction Set Trailer (SE) segment there are segments with an ID and Title in a desired sequence of segments.

**Why ANSI-X12 is used?**

The use of ANSI X12 in the US healthcare system enables efficient and secure electronic data exchange between healthcare entities, reducing the need for manual data entry and minimizing the risk of errors and inaccuracies. ANSI X12 also helps to ensure that healthcare transactions are processed in a consistent and standardized manner, improving the accuracy and timeliness of claims processing and reducing administrative costs.

**What is REC and INS response in US Healthcare system?**

In the US healthcare system, "REC" and "INS" responses are usually related to the processing of medical insurance claims.

A **"REC" response** could refer to a "Recipient Eligibility Verification" response, which is used to confirm the patient's eligibility for coverage under their insurance plan. This information typically includes the patient's coverage status, effective dates, co-pay amounts, and any limitations on their insurance coverage.

An **"INS" response**, on the other hand, is often used to refer to an "Insurance Payment Response". This is the response that an insurance company gives to the healthcare provider after they have processed a claim for payment. The response includes information on the amount of payment that will be made by the insurance company and any deductions or copayments that the patient will be responsible for. The "INS" response is used by the healthcare provider to reconcile their accounts and determine the amount that they will receive for the services they have provided.

**Conclusion:**

In both cases, the "REC" and "INS" responses play an important role in the medical billing process, as they help healthcare providers to determine the amount of payment that they will receive from insurance companies, and ensure that patients are billed correctly for the medical services they receive.

**What is Prior Authorization?**

Prior Authorization is a management process used by insurance companies to determine if a prescribed product or service will be covered. This means if the product or service will be paid for in full or in part. This process can be used for certain medications, procedures, or services before they are given to the patient.

**For Example:** A patient needs to receive a brand-name drug for the treatment of a chronic condition. The patient's physician writes a prescription for the drug and the patient takes it to the pharmacy. The pharmacist finds that the drug requires prior authorization from the patient's insurance company.

The pharmacist submits a prior authorization request to the insurance company, including the patient's information, the prescription details, and any relevant medical history. The insurance company then evaluates the request, using criteria such as the patient's diagnosis, the drug's clinical effectiveness, and the availability of alternative treatments.

Based on this evaluation, the insurance company may approve, deny, or partially approve the request. If the request is approved, the patient can then purchase the drug and start treatment. If the request is denied or partially approved, the patient and the physician may need to consider alternative treatments or appeal the decision.

**What is Referral Request?**

Referral is the process of sending a patient to another practitioner (ex. specialist) for consultation or a health care service that the referring source believes is necessary but is not prepared or qualified to provide. Your primary care physician will refer you to a participating specialist or a health care service provider if he or she cannot personally provide the care you need. Many referrals do not require an authorization number.

**Essentials for the referral**

* Referrals should be in a written format and not verbally told to you for further acceptance by another doctor.
* It must be officially signed by the practitioner who has given you a referral to show it to the specialist.
* It must mention the date of approval such that a patient can use it within the time period of 18 months.
* The Primary care doctor must specify the treatment in the referral for the specialist to consider it.
* Adequate particulars about the patient’s health condition should be provided in the referral.
* In circumstances of emergency, referrals in a written format is not required.

**Process of Referral**

**Example:**

You have been diagnosed with a chronic kidney disease with abdominal pain and frequent fevers, your family doctor would need to seek an opinion from a nephrologist and depending on the opinion, the family doctor will request the nephrologist to take over the treatment. This request will be reviewed under your healthcare plan to check the approval requirements. Following the approval, the family doctor will be notified.

The patients, before they approach their specialist should have a file containing a record of clinical findings, any treatment if he underwent before the referral and the specific reason for which the referral has been made.

Your doctor will then help to coordinate your visit and the referral provided thereafter will help to make sure you get adequate care when you meet a specialist.

**What is EDIFACT?**

**EDIFACT**is the shorter, sweeter acronym for Electronic Data Interchange for Administration, Commerce and Transport, and it is the international EDI standard developed under the United Nations to help ensure EDI is structured to work for multi-industry and multi-country exchange.

**Who uses EDIFACT?**

Like EDI, [EDIFACT](https://www.goanywhere.com/blog/what-is-edifact) it is used to help organizations – both commercial and governmental - exchange information between each other using a common language. EDIFACT is widely used in Europe and a growing number of organizations with the U.S and the Asia-Pacific (APAC) regions are also adopting this standardized process for exchanging data securely. Outside of North America, EDIFACT is the most popular EDI data standard.

**Differences between CO, OA, PI, PR**

* **CO (Contractual Obligations)** is the amount between what you billed and the amount allowed by the payer when you are in-network with them.  This is the amount that the provider is contractually obligated to adjust.

**For Example:**

Let’s say both the parties have agreed to $100.00 as the max allowable amount that can be billed for a surgery. But post-surgery the provider bills the insurer for $120.00. The additional $20.00 will be marked as Contractual Obligation. $20.00 is described as a contractual adjustment that the provider has to write off.

* **OA (Other Adjustments)** is used when CO (Contractual Obligation) nor PR (Patient Responsibility) apply.  This can be used when the claim is paid in full and there is no contractual obligation or patient responsibility on the claim.

**Examples of other adjustments** may include correcting errors in coding, reducing payment for services that were duplicated, or denying payment for services that were not medically necessary.

* **PI (Payer Initiated Reductions)** Payer initiated reduction is a term used in the US healthcare system to describe a situation where a payer reduces the amount of payment for a service based on their own discretion. This reduction is initiated by the payer and is not based on any agreement between the payer and the provider.

**Examples:**

**Lack of medical necessity:** The payer may determine that a service was not medically necessary and therefore reduce the payment accordingly.

**Non-compliance with coding and billing requirements:** The payer may initiate a reduction if the provider has not followed the payer's coding and billing requirements, such as using incorrect codes or not submitting the necessary documentation.

**Cost containment measures:** The payer may initiate a reduction in payment as a cost containment measure to manage healthcare costs.

**Overpayments:** The payer may initiate a reduction if they have made an overpayment for a service, such as paying for a service twice or paying more than the contracted rate.

* **PR (Patient Responsibility)** is used to identify portions of the bill that are the responsibility of the patient.  These could include deductibles, copays, coinsurance amounts along with certain denials.  If the patient did not have coverage on the date of service, you will also see this code.

**Patient Responsibility denial code list**

Following are the patient responsibility denial code list

* **PR 1 Deductible Amount:** Members plan deductible applied to the allowable benefit for the rendered services
* **PR 2 Coinsurance Amount:** Members plan coinsurance rate applied to allowable benefit for the rendered services.
* **PR 3 Co-Payment Amount:** Copayments members plan copayments applied to the allowable benefit for the rendered services.

**HCFA 1500**

Form CMS-1500 is the standard paper claim form used to bill an insurance for rendered services and supplies. It provides information about the client, their corresponding insurance policy, and their diagnosis and treatment. The HCFA form is made up of 33 boxes

The abbreviation “HCFA” stands for “Health Care Finance Administration.” As you might guess from this name, the HCFA 1500 has official origins. It’s the work of the Centers for Medicare & Medicaid Services (CMS), which initially devised it to facilitate Medicare and Medicaid reimbursements.

Form HCFA is so comprehensive that private insurers have also adopted it as their standard.

**How does the HCFA form work?**

Practitioners like yourself (or, more realistically, your front-office staff or third-party medical billing team) will complete the HCFA form after a patient encounter. A complete HCFA form will include Current Procedural Terminology (CPT) codes for all services provided. It may also include International Classification of Diseases, 10th Revision (ICD-10) codes for diagnoses. These codes standardize services, so payers more easily know what to reimburse.

Your HCFA form should also include your patient’s demographics and basic information. Just as importantly, the form should clearly state your patient’s insurance information. This way, payers know exactly which of your CPT and ICD-10 codes they can and can’t reimburse.

**How to file an HCFA form?**

Once you’ve completed your form, you should run it through a [claim scrubber](https://www.businessnewsdaily.com/16233-claim-scrubber-benefits.html) to check for any errors. These tools are usually available through third-party medical billing service providers. Once you fix the indicated errors, you can resubmit your HCFA form to an appropriate clearinghouse, which will deliver it to the appropriate payer.

**Electronic Remittance Advice (ERA)**

Electronic Remittance Advice is a data file that you receive from an insurance payer that provides you with payment information about a claim you submitted to it. ERA is a HIPAA-compliant electronic substitute for paper-based EOBs.

The 835 is sent to detail the payment for the claim, which was sent by the provider using the 837 transaction set. In medical billing, ERAs detail a patient’s paid and denied [medical claims](https://www.businessnewsdaily.com/16237-medical-claims-how-to.html), adjusted amount owed, and final claim status.

**Benefits of ERA in Medical Billing**

There are many benefits to using ERA in medical billing, including freeing administrations’ time for other tasks and receiving payments faster. These are some ways ERA can support your practice’s medical billing.

* **Saving time:** EOBs are often processed manually. Given the high volume of claims that move through the medical industry, such manual processes quickly become time-consuming and tedious. Since ERAs are electronic, they’re seamless to create and send. The result is invaluable time back for your front-office staff to interact directly with patients and complete other projects.
* **Fewer errors:**When you’re manually working with a high volume of EOBs, it’s easy to list incorrect dollar amounts that cause trouble for you, your patients and your payers. Switching to an ERA medical billing model vastly reduces the frequency of these errors. The result is a more accurate and comprehensive set of patient billing communication.
* **Easier grouping:** With EOBs, you need to send billing and payment details to your patients after each encounter. The digital technology behind ERAs allows you to group all of a patient’s claims into one communication. This grouping keeps a patient’s bill up to date in one place, making the process of receiving patient payments more efficient.
* **Quicker distinctions between paid and unpaid encounters:** When you send out individual EOBs, there’s no easy way to track which patients have and haven’t paid. Since ERAs are electronic, they’re much easier to track. With this tracking comes more accurate accounts receivable records. Plus, since ERA is automated, you don’t need to manually alter your AR books.
* **Reporting and analytics:** Since ERA platforms are electronic, they often include reporting and analytics tools. With these tools, you can review data on how well your practice is or isn’t [collecting patient payments](https://www.businessnewsdaily.com/8989-medical-billing-tips.html). You’ll likely see metrics – such as how quickly your patients pay after receiving ERAs and how much money you earn per period, including months or quarters, from ERAs. You can use these metrics to improve your organization’s performance.
* **Quicker patient collections:** Just because you’ve alerted patients that they need to pay doesn’t mean they’ll do so right away. With EOBs, you have no easy way to determine whether patients have received your bill and acted on them. ERAs, though, are entirely trackable. This makes it easier to get in touch with patients who are behind on payment, and receive the payments sooner.

**Explanations of Benefits (EOB)**

EOB means Explanation of Benefits. It is a manual documentation from your health insurance company providing details on payment for a medical service you received and explains what portion of those services were paid by your insurance plan and what part you're responsible for paying.

**Example:**

When you visit a doctor, dentist, or other health care provider, you will generally be asked whether you want the service to be billed to your insurance. If you do, the medical office should fill out a health insurance claim and submit it to your health insurance company. This is essentially a request for payment to your insurance company to cover the cost of the visit, treatment, or equipment.

When the insurance company gets the claim, they will evaluate the claim, create an Explanation of Benefits (sometimes referred to as an EOB) and send it to you in the mail. They might also make a digital copy available through their website.

**What is included in EOB?**

The EOB contains the following information:

* The name of the person who holds the policy, or the “primary," and the name of the dependent who received the health service
* The health insurance ID or policy number, and the claim number
* The name of the healthcare provider who administered care – doctor, dentist, specialist, laboratory, hospital, clinic, etc.
* The type of service or medical equipment you received and the date on which you received it; for service that lasted more than one day, the date range will be given
* The cost of the service (what your provider billed the insurance company)
* How much of the billed amount your insurance company paid
* The remaining amount to be paid to the provider, which is usually your responsibility

**Insurance Eligibility Verification**

[**Insurance Eligibility Verification**](https://www.capminds.com/medical-billing) is the procedure of verifying a patient’s insurance in terms of three different statuses such as coverage status, active or Inactive status, and eligibility status. Insurance eligibility verification is very important as it is directly linked to claim denials or payment delays of a healthcare practice. To avoid claim rejection, the verification process must be done before the patient is admitted into a hospital, sees a physician or gets services from a medical professional.

**For Example**

An existing patient comes in for his scheduled visit to have a steroid injection for arthritis. The patient has been under your care for five years now. Upon his arrival, the front desk staff members asks him to share his insurance card and then proceeds to contact the insurance carrier for verification. When the front desk staff contacts the insurance carrier, they were informed that the patient no longer has coverage with that carrier. That’s why it’s always important to verify each patient’s insurance.

**Benefits of Insurance Eligibility Verification**

Following are the benefits of insurance eligibility verification

* **Clean Claim Submission**

The accurate eligibility verification process helps the healthcare providers to submit clean claims and helps to avoid claim re-submission, reduces demographic or eligibility-related rejections and denials, increases upfront collections, and results in improved patient satisfaction.

* **Increased Cash Flow**

Updated eligibility verification helps in better claim submission and lesser claim denials. It helps healthcare practices to maintain cash flow through the decrease in write-offs and improved patient care.

* **Efficient Workflow**

Insurance credentialing services help to enhance the entire process of revenue cycle management. An efficient and streamlined workflow will lead to lesser claim denials and an improved patient experience.

* **Increased Self-Pay Revenue**

There will be an increase in the self-pay revenue as patient information is electronically matched with the healthcare database. This helps in helping patients whose “cover” is not known; it helps to submit their claims after cross-checking the eligibility and cover status online, thus streamlining the pay pipeline for self-pay patients.

**5010 HIPAA Transaction Standards**

The 5010 HIPAA transactions standards are a new set of standards that regulates electronic transmission of specific health care transactions. These include eligibility, claims status, referrals, claims and electronic remittance.

**Transactions Specified in the HIPAA 5010 Standard**

* Health care claim (professional, institutional, and dental)
* Health care claim payment/advice
* Benefit enrollment and maintenance
* Payroll deducted and other group premium payment for insurance products
* Authorization request and response
* Claim status request and response
* Eligibility benefit inquiry and response

**What are the Common Code Set Numbers?**

All code set numbers are preceded by the prefix “X12,” to indicate that the HIPAA 5010 format is being used. The two most common code set numbers are 837 and 835. The code number of X12 837 is the code set number used by billers to request reimbursement from a healthcare plan. When a HIPAA covered entity requests information about the patient, the provider, the patient’s health insurance plan, or about procedures and diagnoses, the request is sent using the code set number X12 837. The code set number X12 835 code set number, in contrast, contains payment (remittance) information. This number is sent by the healthcare plan to a provider, to provide information about the healthcare services being paid for. 835 files contain such information as what charges were paid/reduced/denied, deductible/co-insurance/co-pay amounts, and how the payment was made (cash, credit card, etc.).

**Advantages of HIPAA 5010 over HIPAA 4010**

* Obsolete data content has been removed and ability to support new use-cases has been added
* Improved functionality with new changes suggested by the healthcare industry
* Enhanced reporting on claims and more functional transactions
* NPI regulation support
* Transaction formatting clarification
* Usage clarification for ambiguity removal
* Consistent transactions across the board
* Accommodation of ICD-10 values
* Significant improvement in referral transactions and removal of several implementation obstacles

**Patient Statement**

A patient statement in US healthcare is a document that summarizes the charges for medical services received by a patient. It is sent to the patient either by the healthcare provider or the patient's insurance company, and it provides a detailed breakdown of the services that were performed and the costs associated with those services. The patient statement may also show any payments made by the patient or the patient's insurance company, as well as any remaining balance that the patient is responsible for paying.

**What is the purpose of patient statement?**

The purpose of a patient statement is to inform the patient of their financial responsibility for the medical services they have received. The statement is used by the patient to track their healthcare expenses, to help them understand their insurance coverage, and to manage their finances. It is also used by healthcare providers as a tool for collections and to communicate with patients about their outstanding balances.

**Conclusion:**

In short, a patient statement is an important document in the US healthcare system that helps patients understand and manage their healthcare expenses.

**Contractual Adjustment**

A contractual adjustment is a difference between the billing amount and the maximum allowable charge. The hospital faces certain restrictions in the form of contractual agreement. They are prohibited from charging the remaining amount from the patient. However, this will only happen in case the patient has an insurance policy with an insurance company.

**For Example:**

If the total medical bill is $60 and the maximum allowable charge amounted to the patient by the insurance company is $45, the hospital will have to let go of $15.

**What is the role of contractual adjustment in medical billing?**

It is important that patients and hospitals, especially their billing office, understand the role of contractual adjustment and how it works to avoid any legal or ethical issues later. The hospital, under no circumstances, should charge the patient the remaining amount. This, however, should only be the case if the patient already has an existing insurance policy. A lot of times, hospitals do add the remaining amount in the total medical bill of the patient. This can also be an honest mistake on their part due to their limited understanding of the situation and what role the contractual adjustment plays in a medical bill. Patients can always seek professional help and get a medical company to outsource their medical bills and check for any loopholes that they might not be able to catch on their own.

**Crossover Claims**

A crossover claim is a claim for a recipient who is eligible for both Medicare and Medicaid, where Medicare pays a portion of the claim, and Medicaid is billed for any remaining deductible or coinsurance.

**Handling Crossover Claims**

Rules for crossover claims are set by the federal Centers for Medicare & Medicaid Services. Health-care providers submit all crossover claims to Medicare. Medicare assesses the claim, pays its portion of the bill, and then submits the remaining claim to Medicaid. How much Medicaid will pay -- if anything -- depends on the rules in the state where the claim was filed. Once Medicaid has handled its portion of the bill, the claim is closed, and the provider may bill the patient or that patient's supplemental insurers for any unpaid portion.

**Date of Service**

The date of service is the specific time at which a patient has been given medical treatment. It is recorded for billing purposes and as an item in a patient's medical record. It also matters for insurance purposes, since health insurers base their reimbursement or payment on the date of service, along with other billing factors.

**Day Sheet**

A day sheet in the US healthcare system is a document used to record the financial transactions of a medical practice on a daily basis. It typically contains information about patient encounters, payments received, charges made, and balances due. The day sheet is an important tool for financial management in healthcare, as it provides a detailed record of the financial activity of a medical practice over time. This information can be used to reconcile accounts, monitor cash flow, and identify trends and patterns in financial activity. The day sheet is typically reviewed and updated on a daily basis and is used by healthcare providers to make informed decisions about their operations and financial strategies.

**Fee Schedule**

A fee schedule in US healthcare is a predetermined list of fees or reimbursement rates that healthcare providers or insurance companies agree to pay for specific medical services and procedures. These fees can vary by geographic location and may be influenced by factors such as the type of healthcare provider, the complexity of the service provided, and the type of insurance coverage held by the patient. The fee schedule is often used to determine how much a patient will be charged for a particular medical service and how much a healthcare provider will be reimbursed for providing that service.

The Medicare Physician Fee Schedule (MPFS) is designed to provide information for more than 10,000 services, along with fees and various payment policies.

**Who uses the fee schedule?**

The Centers for Medicare and Medicaid Services (CMS) develops fee schedules for:

* Physicians
* Ambulance services
* Clinical laboratory services
* Durable medical equipment suppliers

**What is Revenue Cycle Management (RCM) in Healthcare?**

Revenue cycle management is the process used by healthcare systems in the United States to track revenue from patients from their initial appointment or encounter with the healthcare system to their payment of balance.

Revenue cycle starts with the appointment or hospital visit and ends when the provider or hospital gets paid fully for the services provided.

**Steps of Revenue Cycle Management**

There are eleven steps of revenue cycle management

* 1. **Scheduling Appointments**

In revenue cycle management, scheduling an appointment refers to the process of setting up a date and time for a patient to receive a medical service, such as a consultation, diagnostic test, or treatment.

Scheduling an appointment is an essential part of revenue cycle management because it enables healthcare providers to manage their workflow efficiently and ensure that patients receive timely and appropriate care. A well-designed appointment scheduling process can help reduce no-show rates, optimize resource utilization, and improve patient satisfaction. It can also facilitate the accurate and timely capture of chargeable services, which is critical for revenue cycle management.

* 1. **Registration**

After scheduling, patients go through the pre-registration and registration phase of RCM. This includes collecting all relevant information about the patient, including demographics, medical history and insurance information.

**Difference between Pre-Registration and Registration**

Registration occurs at the time of the patient's first visit to a healthcare provider or facility. It involves the collection of personal and insurance information, as well as other relevant details that are necessary to initiate and manage patient care. Registration typically occurs at the point of care, such as in a clinic, hospital, or other healthcare facility.

Pre-registration, on the other hand, occurs before the patient's actual visit to the healthcare provider or facility. It is a process that allows patients to provide their personal and insurance information in advance, typically online or over the phone. Pre-registration helps to streamline the registration process by reducing the amount of time patients spend in the waiting room and facilitating the scheduling of appointments.

The primary difference between registration and pre-registration is the **timing of the data collection process.**

* 1. **Eligibility**

Once registered, providers can check patient eligibility. Eligibility refers to the process of verifying a patient's insurance coverage and determining their eligibility for medical services.

The eligibility process typically involves contacting the patient's insurance provider to confirm their coverage and any co-payments or deductibles that may apply. The process may also involve checking the patient's insurance plan to ensure that the requested service is covered and to obtain any necessary prior authorizations.

* 1. **Utilization Review**

Often combined with the eligibility phase, utilization review is the process of determining essential health care services. Insurance companies and medical staff perform a utilization review to confirm a patient is not only eligible for insurance coverage, but they need the procedure or treatment they're requesting. A utilization review uses data-backed clinical guidelines to establish what kind of care is necessary, usually prior to the appointment.

* 1. **Initial Payment**

Initial payment refers to the payment that is made by a patient or their insurance provider at the time of service or shortly hereafter.

Patients sometimes pay up-front for their health care costs to later be reimbursed, or pay a copay at the start of their appointment. The initial payments step involves collecting financial information and processing transactions to limit the chance of missed payments or account delinquency as well as track contributions to prevent overcharging.

* 1. **Describing Charges**

Also known as charge capture, this phase is essential for both the health care provider and patient to have accurate, transparent records about why a visit costs a certain amount. Health care providers use a patient's chart notes to itemize the entire visit, including information on length and type of visit and any procedures performed or medications prescribed.

* 1. **Medical Coding**

To process an insurance claim after recording charges on a patient's account, health care providers use medical coding to turn a visit summary into an insurance and billing document. Medical coders interpret a patient's file by assigning codes to each type of procedure. These codes exist for insurers to process different types of health care treatment in their systems. Medical coding helps to reverify patient eligibility, prevent denials and generally speed up the process of an insurer reviewing a claim.

* 1. **Submitting Claims**

Next, the health care provider or patient submits their coded information to an insurer, starting a new case file. This administrative process connects the health care provider's documentation with the insurer's information about a patient. Insurance claims must be properly formatted and meet the insurer's requirements to be approved, even if eligibility was pre-confirmed, making accuracy and organization vital. Providers and patients rely on revenue cycle management systems to provide them with updates about when they can expect approval or payment after opening a claim.

**How claim department work in healthcare insurance companies?**

The claim department in healthcare insurance company is responsible for processing and handling healthcare insurance claims made by policyholders. Here is the general overview of how the claims department works in healthcare.

* 1. **Receiving the Claim:** The claims department receives the claim from the healthcare provider or the policyholder. This can be done through a variety of methods including online portals, fax, mail or electronic data interchange (EDI).
  2. **Verification:** The claims department verifies the patient's eligibility, the policy's coverage, and the validity of the claim. This step may involve cross-checking the claim against the policyholder's health plan, verifying the patient's demographic and insurance information, and ensuring that the service or treatment provided is covered under the policy.
  3. **Adjudication:** The claims department reviews the claim to determine the amount payable based on the policy benefits and the contracted rates with the healthcare provider. This step may involve applying deductibles, coinsurance, and copayments, as well as adjusting the amount payable for services provided outside the network or out of plan.
  4. **Payment:** Once the claim has been adjudicated, the claims department authorizes payment to the healthcare provider or directly to the policyholder if the policy allows. Payment can be made through electronic funds transfer (EFT), checks, or virtual credit card payments.
  5. **Appeals and Disputes:** If a claim is denied or partially paid, the policyholder or healthcare provider can dispute the decision. The claims department is responsible for managing the appeals process and addressing any disputes.
  6. **Reporting and Analytics:** The claims department tracks and reports on claims data to identify trends and patterns that can help improve the claims process, detect fraud, and monitor the financial performance of the plan.

**What is Claim adjudication and how it works?**

The process that every insurance payer goes through to determine how much they owe a provider based upon the claim that they received.

**STEP1: INITIAL PROCESSING REVIEW**

In the initial processing review, claims are checked for simple claim errors or omissions.  Problems identified during the initial processing review include:

* The wrong patient name or incorrect spelling
* The subscriber identification number or plan number is wrong
* The place of service code is wrong
* The date of service is wrong
* The diagnosis code is missing or invalid
* The patient's gender does not match the type of service

When a claim is rejected for any of the above reasons, it can simply be corrected and resubmitted for payment.

**STEP2: AUTOMATED REVIEW**

In the automatic review, claims are checked for more detailed items that apply to the insurance payers payment policies.  Problems identified during the automatic review include:

* The patient is not eligible on the date of service.  This could mean the coverage has termed or is not active.
* Pre-certification or authorization is not present.  This could mean that the pre-certification or authorization was not obtained for the service or that the pre-certification or authorization number was not added to the claim prior to submission.
* Pre-certification or authorization is not valid. This could mean that the diagnosis, procedure, or date of service does not match the information submitted for the pre-certification or authorization.
* The claim submitted is a duplicate claim: This could mean that a claim has already been submitted for the same date or procedure.
* Timely filing deadline has passed. Insurance payers typically have a 90 to 120 day time limit for initial claims to be submitted.  If your original claim has not been submitted by the filing deadline, then the claim cannot be processed for payment.
* The diagnosis or procedure code is invalid.  The payer will cross check the diagnosis codes and procedure codes listed on the claim to determine whether the codes match.
* The services performed are not medically necessary.  This means that the claim does not indicate the patient care was provided at the most appropriate levels and in the most cost effective manner

**STEP3: MANUAL REVIEW**

In the manual review, claims are checked by medical claim examiners.  It is not uncommon for nurses or physicians to also manually review these claims during this process.  Medical records may be requested to compare the claim with the medical documentation.  This can be conducted for any type of procedure but most commonly with an unlisted procedure to determine medical necessity.

**STEP4: THE PAYMENT DETERMINATION**

There are three types of payment determinations:

1. **Paid:** When the claim is considered paid, the payer determines that the claim is reimbursable
2. **Denied:** When the claim is considered denied, the payer determines that the claim is not reimbursable
3. **Reduced:** When it is determined that the service level billed is too high based on the diagnosis, the procedure code can be down coded to a lower level deemed appropriate by the claim’s examiner

**STEP5: PAYMENTS**

The payment submitted to the medical office supplied by the insurance payer is called a remittance advice or explanation of payment.  It details the notice of and explanation reasons for payment, reduction of payment, adjustment, denial and/or uncovered charges of a medical claim.

The remittance advice typically includes the following information:

* Payer Paid Amount
* Approved Amount
* Allowed Amount
* Patient Responsibility Amount
* Covered Amount
* Discount Amount
* Adjudication Date
  1. **Remittance Processing**

Remittance is the actual money that an insurer sends to a health care provider once they approve their claim. The insurer sends a remittance statement to the provider explaining how much of a charge they covered and why they covered it. Health care providers save remittance processing information in their systems as a way to reconcile patient accounts and calculate the remainder of their account balance before sending a final invoice.

* 1. **Denial Management**

In revenue cycle management, denial management refers to the process of identifying and resolving issues related to denied or rejected insurance claims. Insurance claim denials occur when an insurer determines that a claim is not payable based on factors such as incorrect patient information, inaccurate billing codes, or other errors or omissions.

Denial management is a critical aspect of revenue cycle management, as it helps to ensure that healthcare providers receive payment for the services they provide and that patient accounts are properly managed. Denial management typically involves reviewing denied claims, identifying the reasons for the denial, and taking appropriate action to address the issues that led to the denial.

* 1. **Third-Party Follow-Up**

If an insurer doesn't respond to a claim or delays payment, the healthcare provider must follow up with them to collect their payment. When claims are approved but a third-party payer hasn't sent payments, the provider must be able to identify this discrepancy and enforce collections. Third-party follow-up can also involve inquiring about why a claim was denied if a patient was eligible for coverage, fighting the denial and seeking payment.

* 1. **Patient Collections**

In revenue cycle management, patient collections refer to the process of collecting payment for healthcare services directly from patients. Patient collections may involve collecting payment at the time of service, or it may involve following up with patients after services have been provided to request payment.

Finally, health care providers charge patient accounts and attempt to collect payment through online portals, mail or phone transactions. This step can involve developing payment plans, seeking out discounts to make payments manageable or charging credit to patients’ accounts while they continue to receive care. Each health care provider has its own policies for collecting payments from patients, updating their accounts to remove charges and sending out payment receipts.

**Difference Between Rejected and Denial Claim**

A **rejected claim** is one that has not been processed by the insurer because it contains errors or omissions that prevent the claim from being processed. For example, if a claim is missing required information or contains invalid codes, it may be rejected by the insurer. A rejected claim can be corrected and resubmitted to the insurer for processing.

On the other hand, a **denied claim** is a claim that has been processed by the insurer but has been determined to be not payable based on specific factors, such as medical necessity, pre-authorization requirements, or coverage limitations. A denied claim cannot be corrected and resubmitted; instead, it must be appealed and reviewed by the insurer to determine if payment can be made.

**What is Appeal in medical billing?**

A request for your health insurance company to review a decision that denies a benefit or payment

**What is Accounts Receivable Aging report?**

In medical billing, the term A/R aging report refers to the report showing outstanding insurance claims and patient balances. The report not only shows the unpaid invoice but also shows the number of days they were paid in. If the accounts are being received at a slow rate, i.e. over 50+ plus days, then the medical institution must take it as a warning sign. However, if your aging report shows fewer days of unpaid accounts then your revenue managing strategy is working great.

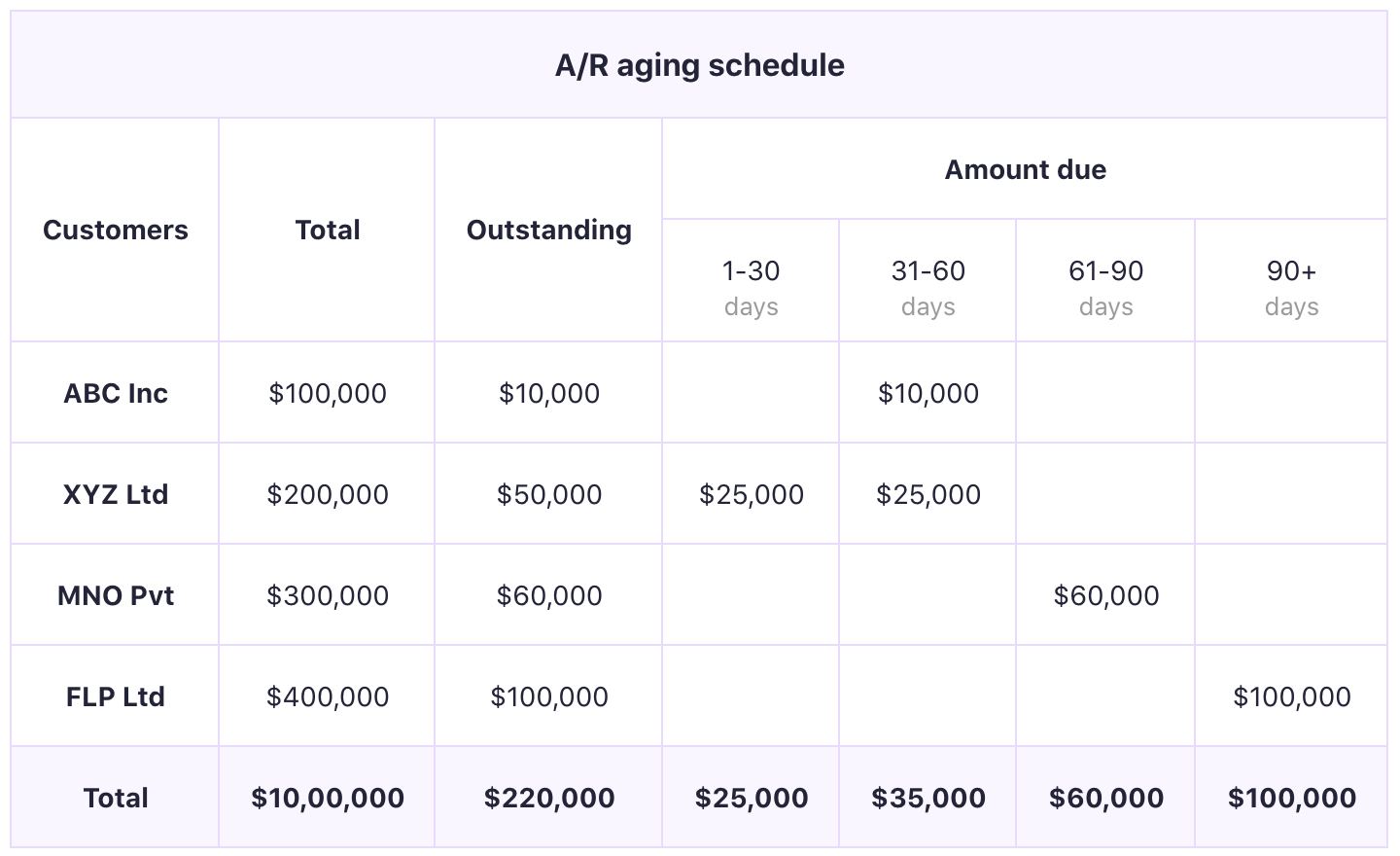
The results of the A/R aging report are measured using certain benchmarks to identify the medical institution’s financial health. The benchmarks are as follows:

* Accounts received in **35 or fewer days** represents good financial health
* Accounts received in **35-50 days** represents average financial health
* Accounts received in **50 or more days** represents poor financial health

To achieve good financial health, the hospital must perform A/R follow-up without any interruption or delay. Following on the pending accounts and reviewing the denied claims is the only way to generate high revenue while ensuring a better aging report.

**Aging Report format/Structure**

There is no specific format or structure of an aging report. However, what’s similar in every aging report is the listing of clients, current A/R, total A/R and division of A/R days. The division of A/R days tends to vary across hospitals. One hospital may show A/R days up to 90 days whereas other hospitals may show A/R days up to 150 days. The division of A/R days reflected in the aging report depends on the length of pending accounts in a particular hospital. If a hospital only has pending accounts with the length of 50 days then the report may not show A/R days above it. But if a hospital has pending accounts for 150 days then the aging report will have a column for 150 days. However, almost every institution tries to maintain a low percentage of A/R days for a better revenue cycle.

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**What is the duration of aging report in case of private and medical?**

The duration of an Accounts Receivable Aging report in the case of private and medical accounts receivable may vary depending on the billing and payment policies of the healthcare provider or facility.

For **private accounts receivable**, the report may cover a period of 30, 60, 90 or more days past due, depending on the provider's policies for following up on overdue balances. Some providers may choose to prioritize the collection efforts for balances that are 90 days or more past due, while others may start following up on overdue balances after 30 or 60 days.

In the case of **medical accounts receivable**, the report may cover a longer period of time, since the billing and payment process can be more complex due to the involvement of insurance companies and government programs. The report may cover a period of 90, 120, or more days past due, depending on the provider's policies and the requirements of the payers.

**Difference between Super-Bill and Charge**

The main differences between a superbill and a charge in medical billing are their purpose and the information they contain. Here is a more detailed explanation of each.

**Superbill:**

A superbill is a document that healthcare providers use to record the services they provide to patients. It typically contains the following information:

* Patient information: Name, date of birth, address, and insurance information.
* Service information: Date of service, service codes (diagnosis and procedure codes), and a description of the service provided.

**Purpose of Superbill:**

The purpose of a superbill is to serve as a record of the services provided during a patient visit. It is not used for billing purposes, but instead is used as a reference document by the medical coder to create the claim form that is submitted to the insurance company for payment. Superbills may also be used by patients to keep track of the services they received for their personal records.

**Example:** A patient visits a primary care physician for a routine checkup. During the visit, the physician conducts a physical examination, reviews the patient's medical history, and provides preventive care counseling. The physician creates a superbill that includes the date of service, service codes for the physical exam and preventive care counseling, and a description of the services provided.

**Charge:**

A charge is the amount of money that a healthcare provider or facility bills for a specific service or procedure. It is based on the provider's fee schedule and the specific services provided during a patient visit. A charge may include the following information:

* Patient information: Name, date of birth, address, and insurance information.
* Service information: Date of service, service codes (diagnosis and procedure codes), and the charge amount for each service provided.

**Purpose of Charge:**

The purpose of a charge is to bill the patient or the insurance company for the services provided. Charges may be used by the provider to track revenue and expenses, and to monitor payment patterns and reimbursement rates.

**Example:** A patient undergoes a knee replacement surgery at a hospital. The hospital bills the patient for the surgery, which includes charges for the surgeon's fee, anesthesia, operating room use, and supplies. The charges are based on the hospital's fee schedule and the specific services provided during the surgery.

**Conclusion:**

In summary, a superbill is a record of the services provided during a patient visit that is used by the medical coder to create the claim form, while a charge is the amount of money that is billed for a specific service or procedure. Superbills are used for record-keeping and reference purposes, while charges are used for billing and revenue tracking.

**Difference between Paper and Electronic Superbill**

The main difference between a paper and electronic superbill in medical billing is the format in which the information is recorded and transmitted. Here's a more detailed explanation of each:

**Paper Superbill**

A paper superbill is a physical document that healthcare providers use to record the services provided to patients during a visit. The provider fills out the superbill by hand, typically with a pen or pencil. The document contains the date of the visit, the patient's name and demographic information, the services provided (including diagnosis and procedure codes), and any other relevant information. The provider can give the paper superbill to the patient to take with them, or use it as a reference when filling out the insurance claim form. Paper superbill is a common method of billing for small practices that may not have electronic billing systems.

**Advantages:**

* Easy to create and use for small practices
* No need for expensive software or equipment
* Can be customized to meet the specific needs of the practice
* Can be given to the patient to take home

**Disadvantages:**

* Prone to errors due to illegible handwriting
* Time-consuming to fill out and manage
* Risk of losing or misplacing the document
* Cannot be easily transmitted to the insurance company for billing

**Electronic Superbill**

An electronic superbill is a digital document that is created and stored on a computer or electronic health record (EHR) system. Providers use software or EHRs to enter the services provided during a patient visit. The electronic superbill contains the same information as a paper superbill, but it is recorded and transmitted digitally. Electronic superbills can be easily generated from templates in the EHR system, and can be automatically populated with patient data from the system. Electronic superbills can be transmitted directly to the insurance company for billing, eliminating the need for manual data entry and reducing errors.

**Advantages:**

* Faster and more efficient than paper superbill
* Can be easily generated from templates in the EHR system
* Automatically populates with patient data from the system
* Can be easily transmitted to the insurance company for billing
* Reduces errors due to illegible handwriting

**Disadvantages:**

* Requires expensive software and equipment
* Can be complex to set up and use
* Data security concerns due to the sensitive nature of patient data
* May require additional training for staff to use effectively

**Payment Types**

The most commonly used payment systems to remunerate healthcare providers are

* **Fee-for-service:** Providers are paid for each individual service or procedure they perform, such as an office visit, lab test, or surgical procedure.
* **Capitation:** Providers are paid a fixed amount per patient per month, regardless of how much care the patient actually receives. For example, a primary care physician might receive a set monthly fee for each patient in their panel.
* **Bundled payments:** Providers are paid a fixed amount for a bundle of related services, such as all of the services associated with a specific surgical procedure. For example, a hospital might receive a fixed payment for a knee replacement surgery that covers all of the pre-operative, intra-operative, and post-operative care.
* **Value-based payments:** Providers are paid based on the quality and outcomes of the care they provide, rather than the volume of services they perform. For example, a hospital might receive a bonus payment for meeting certain quality metrics, such as reducing hospital readmissions or improving patient satisfaction scores.
* **Self-pay:** Patients pay for their healthcare services out of pocket, either because they don't have insurance coverage or because they have a high-deductible health plan. For example, a patient might pay cash for an office visit or lab test.
* **Private insurance:** Private insurance companies pay healthcare providers for the services they provide to patients who are covered by those plans. For example, Blue Cross Blue Shield might pay a hospital for a patient's surgery.
* **Medicare:** The federal health insurance program for people aged 65 and older, as well as people with certain disabilities and medical conditions. For example, a physician might bill Medicare for a patient's office visit.
* **Medicaid:** The joint federal-state health insurance program for people with low income and limited resources. For example, a hospital might bill Medicaid for a patient's hospitalization.
* **Veterans Affairs (VA):** The government-run healthcare system for military veterans. For example, a veteran might receive medical care at a VA hospital or clinic.

**What is Denial Management?**

Denial management in healthcare is the practice of determining why medical claims are denied and developing the most suitable strategies for decreasing the number of denials. It also includes practically applying strategies that can increase the percentage of claims reimbursed first.

How does Denial Management Work?

Denial management works on a systematic technique known as the IMMP process, which stands for Identify, Manage, Monitor, and Prevent.

* 1. **Identify**

The first step to effectively manage denial management is determining the root reasons and causes of the claim denial. An insurer generally indicates the reason behind the claim denial in the explanation of the payment that accompanies the denial. These explanation indicators are generally known as claim adjustment reason codes (CARC).

However, the CARC codes are not as simple as they sound. The primary task is to understand the feedback from the insurer and decipher the reason behind the claim denial. This deciphering process takes considerable time and expert-level skills because some insurers still use non-standard, overly complex legacy codes. But dedicated denial management professionals can handle these codes and determine why a claim was denied and who is responsible for its reimbursement.

* 1. **Manage**

After successfully identifying the claim denial cause, the next step is to manage the denial and get reimbursed. The denial management team can undertake this process through the following steps:

1. **Directly Routing Denials**

The first and foremost action is to expedite and organize the paperwork for denial-related data. This involves using automated tools to direct the denied transactions to worklists.

1. **Sorting the Action**

The denial management team uses complicated and innovative software to organize their worklists by time, amount, reason, and other factors. This allows their work to become more efficient and streamlined than manual systems.

1. **Developing Standardized Workflow**

The third action involves developing a standard action for every claim denial type through:

* Rooting out the insurer’s most typical denial reason
* Determining that denial’s most frequently used code
* Developing a strategic action plan that manages similar claim denials

1. **Using a Checklists**

Checklists can help systemize a denial management process by rendering it error-free. Developing simple do’s, and don’ts can allow your team to avoid typical mistakes that result in stagnant denials or uncollectible bad debts.

* 1. **Monitor**

This step in the [denial management](https://smartclinix.net/what-are-the-top-10-denials-in-medical-billing/) process is crucial to keep all aspects accurate and on track, allowing a seamless compensation of your claim this time. Monitoring involves stacking your denial record according to the received date, type, disposition, and date appealed. It is also important to audit the denial management team’s work by supervising and sampling their appeals.

Lastly, monitoring involves ensuring that your team possesses suitable technologies and resources to perform the job effectively and promptly. This step-in claim denial management extends to the insurer to help your team understand every claim denial better. The objective may be to determine the number, time, source, and type of denial. This information can help your organization conduct internal dialogues with the insurer to decide more convenient ways of conducting business and decreasing future claim denials.

* 1. **Prevent**

After a denial management team gathers all the necessary information regarding the claim denial, the final and most crucial step is to start a prevention campaign. The most common step in this process is to go through the intricacies of your denials another time to identify all aspects where you need to retrain your staff, revise procedures, or manage workflows.

The denial management team also brings together different teams that played a part in the claim denial in one way or the other. For example, in the case of a registration-related denial, the team must bring together the front desk team and debrief them about the prevention program to ensure that they don’t commit errors that can lead to further claim denials. Some other claim denial categories a team should focus on including a lack of authorization, coding systems, and medical necessities.

**What is meant by Provider Notes?**

In US healthcare, provider notes refer to the written documentation created by healthcare providers (such as physicians, nurses, and other clinicians) during patient encounters. These notes are a critical part of a patient's medical record and provide a detailed account of the patient's medical history, examination findings, diagnoses, treatment plans, and other relevant information.

Provider notes can be created in a variety of formats, including electronic health records (EHRs), paper charts, and dictated or transcribed reports. They typically include information such as:

* Patient demographics (name, age, sex, etc.)
* Reason for the visit
* Medical history
* Physical examination findings
* Diagnostic test results
* Diagnoses
* Treatment plans
* Medications prescribed
* Follow-up instructions

Provider notes are used by healthcare providers to document their assessments and treatments of patients, and they also serve as a communication tool among different providers involved in a patient's care. They are also used for billing and coding purposes to ensure that the services provided are accurately documented and billed.

**What is meant by Closing of Accounts in Billing Revenue Cycle?**

In the billing revenue cycle, closing accounts refers to the final step in the process of billing and collecting payment for healthcare services rendered to patients. It involves completing all outstanding claims, resolving any issues or disputes, and closing out the account by reconciling all payments and outstanding balances.

The process of closing accounts typically involves several steps, including:

* **Reviewing outstanding claims**: The billing staff reviews all outstanding claims to ensure that they have been submitted and processed correctly. Any issues or errors are identified and corrected to prevent further delays in payment.
* **Resolving denials and appeals:** Any denials or appeals that are still pending are addressed, and any necessary documentation or information is submitted to the payer to support the claim.
* **Collecting payments:** The billing staff reviews all payments received from payers and patients and reconciles them against the outstanding balances on the account. Any discrepancies are identified and resolved.
* **Adjusting balances:** Any adjustments to the account balance are made, including write-offs for uncollectible amounts and adjustments for contractual allowances or discounts.
* **Closing the account:** Once all outstanding claims have been paid or resolved, and the account balance has been adjusted, the account is closed out, and the patient's file is archived.

**Conclusion**

Closing accounts is a critical part of the billing revenue cycle, as it ensures that all payments have been collected, and all claims have been processed and resolved. It also helps healthcare providers maintain accurate financial records and comply with regulatory requirements.

**Centers for Medicare and Medicaid Services (CMS)**

The Centers for Medicare and Medicaid Services (CMS) is a federal agency that provides health insurance coverage to Americans via Medicare and works with state governments to provide insurance through Medicaid and [**CHIP**](https://blog.definitivehc.com/the-childrens-health-insurance-program-chip-vs.-medicaid). CMS is also responsible for overseeing HIPAA administration, quality standards in [**long-term care facilities**](https://www.definitivehc.com/data-products/long-term-care-view), clinical quality guidelines, and management of HealthCare.gov.

**Why are CMS important in healthcare?**

CMS is the organization responsible for creating health and safety guidelines for U.S. hospitals and healthcare facilities, including introducing and enforcing clinical and quality programs. As a government payor, CMS also reimburses care facilities for the healthcare services its Medicare patients receive.

In addition to regular care costs, CMS penalizes care facilities performing below its clinical and quality standards—usually in the form of fines or lower reimbursement rates. CMS also pays bonuses to high-performing care facilities to incentivize proper care procedures and lower overall care costs.

**Net Collection Ratio**

Net collection ratio is the percentage of payments received out of the total amount you're contractually owed from insurers. The higher your net collection rate, the better you are at collecting reimbursement for services.

**Why does Net Collection Ratio matters?**

A medical practice’s net collection ratio is one of its most significant collections metrics as it provides visibility into what is actually being collected and what your medical practice is actually allowed to collect after factoring in any refunds, write-offs, or any other contractual and non-contractual amounts. As a result, your net collection rate is one of the most important collections metrics as it gives a clear picture of your practice’s benchmark performance.

**How to Calculate Net Collection Ratio (NCR)?**

Calculating net collection rate involves several important steps:

1. Identify the time period that you want to monitor (e.g., 90 or 120 days). Assess data from an earlier period in which the majority of claims would be closed and cleared; ~6 months back is advisable.
2. Calculate total payments (from payers and patients) for the designated time period.
3. Calculate total charges minus approved write-offs (e.g., due to contractual reasons, bad debt, professional courtesy discounts, etc.) for the designated time period.
4. Divide your calculation in step 2 by your calculation in step 3. Then multiply by 100.

The formula looks like this:

**Net Collection Rate = (Payments / (Charges – Contractual Adjustments)) \* 100%**

**How to Increase Net Collection Ratio?**

Here are some ways to increase net collection for your medical practice.

* **Educate patients about the payment process**

Most patients don't understand their financial obligations when consuming medical services.

Accordingly, you should create educational materials to explain the payment process to patients. Consider creating blogs, videos, brochures, and reference sheets that outline patients' duties and roles in the payment process. You should also get a staff member to answer questions and concerns about payments and claims.

**Group Number**

Group number identifies your employer plan. Each employer choses a package for their employees based on price, or types of coverage. This is identified through the group number. If you purchased your insurance through the health exchange you might not have a group number.

**For Example:**

Group number is unique to your company. Everyone who has an insurance from your company will have a same group number. The group number is created when a company first signs up for insurance.

**In-Patient**

Inpatient care is care provided in a hospital or other type of inpatient facility, where you are admitted, and spend at least one night—sometimes more—depending on your condition.

**As an Inpatient**

* You are under the care of doctors, nurses, and other types of health care professionals within a hospital.
* You are often admitted to a particular service, such as Neurology, Cardiology, Orthopedics, Oncology, General Surgery, etc., depending on what you are being treated for.

**For Example:**

* Serious illness such as flu, stroke, heart attack
* Traumatic injury
* Severe burns
* Serious mental health issues, treatment for substance use disorder, and overdoses
* Chronic diseases, such as cancer and chronic obstructive pulmonary disease (COPD), that require specialized treatment and ongoing care
* Some cosmetic procedures requiring extensive plastic surgery or reconstruction

**Out-Patient**

Outpatient care—the kind that you don’t have to stay in a hospital for—can vary greatly. Other than an annual check-up or blood test, almost any other kind of care can be defined as outpatient. These may be diagnostic tests, treatments, or other types of procedures.

Outpatient care may be provided in a hospital, as well as a walk-in clinic, an outpatient surgery center, and even your doctor’s office.

**For Examples**

* Medical screenings such as mammogram, colonoscopy, and endoscopy
* Oral surgeries and other dental procedures, such as extractions, implants, root canal, and gum grafts
* Minor surgeries and procedures that don’t require advanced medical care, such as laser surgery, hand or foot surgery, mole removal, and Lasik eye surgery

**Medicare**

Medicare is the federal government health insurance program for people age 65 and older and younger people living with certain illnesses or disabilities. Its coverage plays an important role in containing [medical costs as you age](https://www.nerdwallet.com/blog/investing/what-will-you-spend-on-health-care-costs-in-retirement/).

**Types of Medicare**

* 1. **Medicare Part A**

Medicare Part A is the part of original Medicare that covers your hospital costs and other inpatient care.

**Coverage**

* inpatient hospital stays
* limited stay in a [skilled nursing facility](https://www.healthline.com/health/medicare/does-medicare-cover-skilled-nursing-facility)
* stay in a long-term care hospital
* nursing home care that is not long-term or custodial
* hospice care

**Ensure That Medicare cover your stay, you must**

* have an official order from your doctor stating that you need the care for an illness or injury
* make sure the facility accepts Medicare
* ensure you have days left in your benefit period to use (for skilled nursing facility stays)
* confirm that Medicare and the facility approve the reason for your stay

**Payment for the Plan**

Under Medicare Part A, [you can expect to pay](https://www.healthline.com/health/medicare/medicare-part-a-cost) the following costs in [2023](https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance):

* no premium if you worked at least 40 quarters (10 years) in your lifetime and paid Medicare taxes (you’ll pay up to $506 per month if you worked less than 40 quarters)
* $1,600 deductible for each [benefit period](https://www.healthline.com/health/medicare/medicare-benefit-period)
* daily coinsurance costs based on the length of your inpatient stay: $0 for days 1 to 60, $400 per day for days 61 to 90, and $800 per day for days 91 and beyond
* all costs if you are in the hospital for more than 90 days in one benefit period and you have exceeded your 60 [lifetime reserve days](https://www.healthline.com/health/medicare/medicare-lifetime-reserve-days)
  1. **Medicare Part B**

Medicare Part B is the part of original Medicare that covers the costs of your outpatient care.

Coverage

* doctors’ visits
* medically necessary medical supplies and services
* [preventive care services](https://www.healthline.com/health/medicare/medicare-preventive-services)
* [emergency ambulance transportation](https://www.healthline.com/health/medicare/does-medicare-cover-ambulance)
* some [medical equipment](https://www.healthline.com/health/medicare/how-to-get-a-medical-device-approved-for-medicare)
* some [outpatient prescription medications](https://www.healthline.com/health/medicare/medicare-part-b-vs-part-d)

**Ensure That Medicare cover your stay**

To be sure Medicare Part B covers your appointment, service, or medical equipment, ask if your doctor or service provider accepts Medicare.

Payment for the Plan

* a premium of at least $164.90 per month (this amount increases if your individual income is above $97,000 per year or $194,000 per year for married couples)
* $226 deductible for the year
* 20 percent of Medicare-approved amounts after your deductible is met for the year
  1. **Medicare Part C**

**Medicare Part C (Medicare Advantage)** is a private insurance product that gives you all the coverage of Medicare parts A and B, plus extra services.

Most of these plans offer [prescription coverage](https://www.healthline.com/health/medicare/medicare-prescription-plans) in addition to inpatient and outpatient services. Benefits like [dental](https://www.healthline.com/health/medicare/does-medicare-cover-dental) and [vision](https://www.healthline.com/health/medicare/does-medicare-cover-eye-exams) coverage can be added too.

**Plan Classifications**

* [**Health Maintenance Organization (HMO)**](https://www.healthline.com/health/medicare/medicare-hmo)plans require that you receive nonemergency care from specific providers within your plan’s network.
* [**Preferred Provider Organization (PPO)**](https://www.healthline.com/health/medicare/medicare-ppo)plans allow you to use providers either within or outside of your network, but you do pay less for in-network care.
* [**Private Fee-for-Service (PFFS)**](https://www.healthline.com/health/medicare/pffs-medicare) plans also allow you to see providers that are either within or outside of the plan’s network; however, the plan sets rates for what it will pay for its member services and what your share will be.
* [**Special Needs Plans (SNPs)**](https://www.healthline.com/health/medicare/medicare-special-needs-plans) are Medicare Advantage plans created for people with certain diseases or conditions. These plans tailor services and coverage to your specific situation.
  1. **Medicare Part D**

**Medicare Part D** is a plan that offers coverage for prescription medications. Prescription medication coverage must be offered at a standard level set by Medicare.

**Coverage**

* formulary, which is a list of prescription medications covered in the plan – typically with at least two choices for each drug class or category
* generic medications that may be substituted for brand-name medications with the same effect
* tiered programs that offer various levels of medications (generic only, generic plus name brand, and so on) for a range of copayments that increase with your medication prices

**Payment for the Plan**

The average Medicare Part D monthly premium is [$31.50 in 2023](https://www.cms.gov/newsroom/news-alert/cms-releases-2023-projected-medicare-basic-part-d-average-premium), but rates can range from $0 to over $150, depending on the plan you choose and your medications.

**Difference between Part A, B, C, D**

|  |  |  |
| --- | --- | --- |
|  | Coverage | Cost |
| **Part A** | Inpatient hospital or skilled nursing facility care | |  | | --- | | Premium: $0 for most people; but up to $506 per month in 2023 for those who don't qualify for premium-free Part A. | | Deductible: $1,600 in 2023. | | |
| **Part B** | Doctor visits and preventive services | |  | | --- | | Premium: Starts at $164.90 per month in 2023. | | Deductible: $226 in 2023. | |
| **Part C** | The same coverage as Part A and B, plus additional benefits that may include cost help with vision, hearing and dental care | |  | | --- | | Premium: Continue to pay Part B premium, plus premium billed by private insurer. (Some plans have $0 premiums.) | | Out-of-pocket limit: As much as $8,300 in 2023. | |
| **Part D** | Generic and brand-name prescription drugs | Premium: Varies by private insurer; average is $31.50 per month in 2023. |

**Medicaid Plan**

Created in 1965, Medicaid is a public insurance program that provides health coverage to low-income families and individuals, including children, parents, pregnant women, seniors, and people with disabilities; it is funded jointly by the federal government and the states.  Each state operates its own Medicaid program within federal guidelines. Because the federal guidelines are broad, states have a great deal of flexibility in designing and administering their programs. As a result, Medicaid eligibility and benefits can and often do vary widely from state to state.

**Who is Eligible for Medicaid?**

Medicaid is an “entitlement” program, which means that anyone who meets eligibility rules has a right to enroll in Medicaid coverage. It also means that states have guaranteed federal financial support for part of the cost of their Medicaid programs.

In order to receive federal funding, states must cover certain “mandatory” populations:

* children through age 18 in families with income below 138 percent of the federal poverty line ($29,974 for a family of three in 2020);
* people who are pregnant and have income below 138 percent of the poverty line;
* certain parents or caretakers with very low income; and
* most seniors and people with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program.

**Coverage**

Federal rules require state Medicaid programs to cover certain “mandatory” services, such as hospital and physician care, laboratory and X-ray services, home health services, and nursing facility services for adults. States are also required to provide a more comprehensive set of services, known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, for children under age 21.

**Provider Network**

A provider network is a group of physicians and specialists of health-care providers who are contracted by an insurance company, and provide medical care to those enrolled in plans offered by that insurance company. The providers in the health insurance plan’s network are called “network providers” or “in-network providers”. This term could apply to doctors, medical facilities, and other types of health-care providers.

**Why does health insurance plan have provider network?**

Many health insurance plan types cut costs for their enrollees by having their networks full of in-network providers, according to America’s Health Insurance Plans (AHIP). These providers charge lower rates in exchange for being part of the provider network of a given insurance company.

Health insurance plans that have in-network providers are referred to as “managed-care” plans. This model has become increasingly popular, with the market now dominated by plans with a list of doctors and facilities for enrollees to choose from.

**Out of Network Provider**

These are providers that do not have a contract with your insurance company. If you receive covered services from an out- of-network provider, the insurance company may pay only a part or none of the charges depending upon the terms of your policy. Also, your copay or coinsurance may be larger than if the services had been provided by an in-network provider.

**Difference between In-Network vs Out-Network Costs**

|  |  |  |
| --- | --- | --- |
|  | **In-Network Hospital – pays 80%** | **Out-of-Network Hospital – pays 60%** |
| **Actual hospital charge** | $22,000 | $22,000 |
| **Amount hospital agrees to pay** | $14,000 (this is the agreed upon discounted rate) | $14,000 (this plan does not agree to pay the $8,000 difference |
| **Medical plan pays** | 80% of the discounted rate:  $14,000 x 80% = $11,200 | $14,000 x 60% = $8,400 |
| **Covered individual pays:** | 20% of the discounted rate:  $14,000 x 20% = $2,800 | 40% of charges ($14,000) in addition to all of the amount that the plan does not agree to pay ($8,000):  $5,600 + $8,000 = $13,600 |

**Primary Care Physician (PCP)**

A primary care physician is a medical doctor who’s trained to prevent, diagnose, and treat a broad array of illnesses and injuries in the general population.

Primary care physicians provide comprehensive care — which means they can address chronic, long-term conditions like diabetes mellitus as well as acute problems like bronchitis, allergic reactions, or colds and flu.

**What do primary care physicians do?**

 Let’s take a closer look at the types of services a primary care physician can provide.

* 1. **Wellness and prevention screenings**

Primary care physicians commonly check for:

* [high blood pressure](https://www.healthline.com/health/high-blood-pressure-hypertension)
* other risk factors for [heart disease](https://www.healthline.com/health/heart-disease)
* [high cholesterol](https://www.healthline.com/health/high-cholesterol)
* developmental disorders
* [depression](https://www.healthline.com/health/depression)
* signs of [domestic violence](https://www.healthline.com/health/domestic-violence-resource-guide#1)
  1. **Acute illness and injury care**

If you visit your primary care doctor because you’re sick, injured, or have symptoms that concern you, your doctor will likely be able to:

* perform lab tests to diagnose your condition
* prescribe appropriate medications for your condition
* check for interactions with other medicines you’re taking

**What to consider when choosing a primary care physician?**

Here are some practical matters to consider when choosing a primary care doctor:

* **Insurance**
* **Location**
* **Hours**
* **Language**
* **Board certification**
* **Online access**

**Place of Service (POS)**

Place of Service Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. The Centers for Medicare & Medicaid Services (CMS) maintain POS codes used throughout the health care industry.

Place of Service Codes

There are 99 place of service codes present (assigned and unassigned).

For Example

* **41 Ambulance –** Land A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
* 43-48 Unassigned N/A

Scenario

If the physician’s face-to-face encounter with a patient occurs in the office, the correct POS code on the claim, in general, reflects the 2-digit POS code 11 for the office. In these instances, the 2-digit POS code (i.e., item 24B on the claim form CMS-1500) will match the address and ZIP entered in the service location (i.e., item 32 on the Form CMS-1500), the physical/geographical location of the physician.

**Durable Medical Equipment (DME)**

Durable medical equipment (DME) describes medical equipment and supplies ordered by a healthcare provider for a patient's routine, long-term use. DME refers to a wide variety of devices to meet all manner of medical needs, including:

* Nebulizers
* Hospital beds
* Wheelchairs
* Blood glucose monitors

**Note:** Expendable medical supplies such as bandages, masks, and rubber gloves are not considered DME under Medicare.

**Why is durable medical equipment being important?**

Durable medical equipment (DME) enables patients with a debilitating medical condition, illness or injury to achieve a higher quality of life while living at home.

DME may be ordered by a healthcare provider to accommodate a patient's temporary disability, as in the case of a wheelchair or crutches for a recovering patient, or as part of a patient's long-term care plan for their chronic or life-limiting condition, such as a mechanical ventilator for a patient with advanced lung disease.

**Process for DME**

Following are the steps being followed

* **Step1:** A medical provider has a DME requirement, which is necessary to provide specialized patient care. Documentation should be prepared to demonstrate medical necessity. We ensure overall ease of claim submission, by compiling all necessary medical review documentation to avoid any delays in the process.
* **Step2:** Once the provider has prescribed a specific DME, the patient is required to get their equipment from a DME supplier. Our team will verify eligibility and obtain prior authorization (if required) to approve the use of DME supplies. Once the paperwork is completed and approved, the DME supplier can provide the patient with the equipment.
* **Step3:** Our team then assigns the correct HCPCS Level II codes and bills the DME claims to the patient’s insurance company. We will ensure every piece and accessory of the equipment is coded for and all necessary paperwork is provided to the payer to get the DME claim paid.
* **Step4:** Our accounts receivable management team then follow-ups on the claims to make sure accurate payments are made in time.

Revenue Codes

Revenue codes are 4-digit numbers that are used on hospital bills to tell the insurance companies either where the patient was when they received treatment, or what type of item a patient might have received as a patient. A medical claim will not be paid if this is missing from a bill. The revenue code tells an insurance company whether the procedure was performed in the emergency room, operating room or another department.

Revenue Codes information

The first digit of the revenue code is zero followed by the other three digits—0110, 0119, and 0276, etc. If there is a zero at the end of the revenue code then it means the service was unspecified and is referred to as general—0110, 0120, and 0130, etc. The number nine is used at the end of a revenue code to represent ‘other’ services in any given category—0119, 0129, and 0149, etc.

Purpose of Revenue Codes

A revenue code is used to indicate that in which department or place the procedure or treatment is performed like an emergency room, operating room, or some other department. This helps the insurance companies to identify the type, place, and supplies used for the procedure while making the payments. Without the revenue codes, the insurance will not pay the claim.

For Example:

* A blood transfusion can be performed either in the emergency room or treatment room. If the blood transfusion is performed in the emergency room then the revenue code 0450 will be used. However, if the blood transfusion is performed in the treatment room then the revenue code 0761 will be used.

**What is CLIA?**

CLIA stands for Clinical Laboratory Improvement Amendments. These are federal regulations established in 1988 in the United States that set standards for laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results.

Under CLIA, all clinical laboratories in the United States that test human specimens for health assessment or to diagnose, prevent, or treat disease must meet certain quality standards. The CLIA program is administered by the Centers for Medicare & Medicaid Services (CMS) in partnership with the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA).

**What is CLIA Quality Requirement?**

CLIA Quality Requirements are a set of standards that laboratories in the United States must meet to ensure the accuracy, reliability, and timeliness of patient test results. These requirements are established under the Clinical Laboratory Improvement Amendments (CLIA) of 1988, which are federal regulations that set standards for laboratory testing.

There are several components to the CLIA Quality Requirements, including:

* **Personnel Qualifications:** Laboratories must employ personnel who are qualified to perform the tests and interpret the results. The personnel must have the appropriate education, training, and experience for the type of testing being performed.
* **Quality Control:** Laboratories must establish and maintain a quality control program to ensure that the tests are accurate and reliable. This includes monitoring the performance of instruments, reagents, and other materials used in the testing process.
* **Proficiency Testing:** Laboratories must participate in proficiency testing programs to assess their performance and ensure that the tests are accurate and reliable. Proficiency testing involves testing samples provided by an external organization and comparing the laboratory's results to the expected results.
* **Quality Assurance:** Laboratories must establish and maintain a quality assurance program to monitor and evaluate the overall quality of the testing process. This includes monitoring the performance of personnel, instruments, and reagents, as well as ensuring that the laboratory's policies and procedures are being followed.
* **Record Keeping:** Laboratories must maintain accurate and complete records of all testing performed, including the results of proficiency testing, quality control, and quality assurance activities.

By meeting these CLIA Quality Requirements, laboratories can ensure that their test results are accurate, reliable, and timely, which is essential for providing high-quality patient care.

**What is CLIA Number?**

A CLIA number is a unique identifier assigned by the Centers for Medicare & Medicaid Services (CMS) to a laboratory that meets the requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988. The CLIA number is used to track and identify laboratories that perform testing on human specimens for health assessment or to diagnose, prevent, or treat disease.

The CLIA number is a ten-digit number that is assigned to a laboratory when it applies for certification under CLIA. The number is composed of three parts:

* The first two digits represent the state in which the laboratory is located.
* The next two digits represent the type of laboratory, such as a physician office laboratory (POL), independent laboratory, or hospital laboratory.
* The final six digits are unique to the laboratory and are assigned by CMS.

**What are Claim Statuses in medical billing?**

Claim statuses in medical billing refer to the different stages of processing a claim for payment from a healthcare payer. When a healthcare provider submits a claim to a payer, the claim goes through several different statuses as it is reviewed and processed.

The following are some of the most common claim statuses in medical billing:

* **Submitted:** This status means that the claim has been submitted to the payer for processing.
* **Pending:** This status means that the claim is still being reviewed and has not yet been processed.
* **Denied:** This status means that the claim has been denied by the payer and will not be paid.
* **Rejected:** This status means that the claim has been rejected by the payer due to errors or missing information.
* **Paid:** This status means that the claim has been processed and the provider has received payment from the payer.
* **Adjusted:** This status means that the payment amount for the claim has been adjusted due to changes made by the payer.
* **In Process:** This status means that the claim is currently being processed and reviewed by the payer.

Tracking claim statuses is an important part of medical billing because it allows healthcare providers to monitor the progress of their claims and identify any issues that need to be addressed. By understanding the different claim statuses and what they mean, providers can take appropriate actions to resolve any issues and ensure that they receive timely and accurate payment for their services.

What is NF 3 form?

NF stands for No Fault Verification Form. A "no fault verification form" is a document used in some states in the United States to confirm that an individual who was injured in an accident was not at fault for the accident. This form is often required by insurance companies or healthcare providers in order to establish liability for the injuries sustained in the accident.

The form typically includes information about the accident, such as the date and location of the accident, the names of the individuals involved, and a description of the injuries sustained. The form may also require a statement from the individual confirming that they were not at fault for the accident.

In some states, such as New York, a "no fault verification form" is required as part of the process for receiving no-fault insurance benefits. No-fault insurance is a type of insurance that provides coverage for medical expenses and lost wages resulting from a motor vehicle accident, regardless of who was at fault for the accident.

Conclusion:

Overall, the purpose of the no fault verification form is to establish that the individual who was injured was not at fault for the accident, and to facilitate the processing of insurance claims and medical billing related to the injuries sustained in the accident.

**What is meant by C 4 form?**

In medical billing, a workers' compensation form is a document used to report an employee's injury or illness that occurred while on the job. Workers' compensation is a type of insurance that provides benefits to employees who are injured or become ill as a result of their job duties.

The workers' compensation form is typically used to gather information about the employee's injury or illness and to begin the process of filing a workers' compensation claim. The form may include details such as the employee's name and contact information, the date and location of the incident, the nature and severity of the injury or illness, and other relevant details.

Once the workers' compensation form is completed, it is submitted to the employer's insurance carrier, who reviews the claim and determines the employee's eligibility for benefits. The insurance carrier may also request additional information, such as medical records, to evaluate the claim.

Once the workers' compensation claim is approved, the insurance carrier will cover the costs of the employee's medical treatment and provide compensation for any lost wages due to the injury or illness. The medical billing process for workers' compensation claims may differ from other types of medical billing, as there may be specific requirements and procedures that must be followed in order to receive payment.

Overall, workers' compensation forms are an important tool in medical billing for healthcare providers who treat patients with work-related injuries or illnesses. By completing and submitting the necessary forms, healthcare providers can help ensure that their patients receive the appropriate medical care and financial support they need to recover from their injuries and return to work.