**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.

**What information is protected under HIPAA?**

The HIPAA Privacy Rule protects all individually identifiable health information that is held or transmitted by a covered entity. This information including [digital](https://www.techtarget.com/whatis/definition/digital), [paper](https://www.techtarget.com/whatis/definition/hard-copy-printout) or oral.

PHI includes the following:

* a patient's name, address, birth date, Social Security number, biometric identifiers or other personally identifiable information (PII);
* an individual's past, present or future physical or mental health condition;
* any care provided to an individual
* information concerning the past, present or future payment for the care provided to the individual that identifies the patient or information for which there is a reasonable basis to believe could be used to identify the patient.

**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.

**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. |
| [Pre-approval](http://www.insurance.ca.gov/01-consumers/110-health/10-basics/terms.cfm#preauth) | You will need pre-approval from your health plan before you can get many health services. | You may be able to get many health services without pre-approval. | You will need pre-approval from your health plan before you can get any services. |
| [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 Affect Insurance Premiums?**

A premium is an amount paid for an insurance policy. In most cases, plans with relatively high premiums are likely to have low co-pays, while plans with low premiums are more likely to have high co-pays.

**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

**Family Practice & Internal Medicine Physicians**

* Family practice physicians are also called family medicine physicians. The training for family practice physicians focuses on caring for the whole family. This includes children, also called pediatrics, and OB/GYN care, which is for girls and women.
* Internal medicine training focuses only on adults and the conditions they face. Both types of physicians must take ongoing medical education courses throughout their careers.

**Obstetricians and Gynecologists**

Obstetricians and gynecologists, or OB/GYNs, are experts in the female reproductive system. Some women use their OB/GYN as their primary care provider. OB/GYNs are physicians trained to care for women during pregnancy and childbirth, as well as manage any disorders of the female reproductive system. If you want your OB/GYN to be your primary care provider, make sure to ask if they will serve that role as well. Some OB/GYNs prefer to have a family practice or internal medicine physician follow patients for medical issues not related to the reproductive system.

**Pediatricians**

Pediatricians are physicians trained to care for newborns, infants, children and adolescents. They also attend four years of medical school followed by three years of residency training. They provide preventive care for healthy children and treat children who are injured or ill. They specialize in childhood diseases, growth and emotional health.

**M.D.s and D.O.s**

Medical Doctors, known as M.D.s, and Doctors of Osteopathy, or D.O.s, are physicians who are licensed to practice medicine. The main difference is in the type of four-year medical school they attend (medical or osteopathic). Following medical school, both obtain graduate medical education through internships and residencies.

**Nurse Practitioners**

Many primary care physicians also use Advanced Practice Providers, or APPs, to help take care of their patients. Advanced Practice Provider is a term used to describe nurse practitioners and physician assistants who are trained to care for patients under the supervision of a physician. They are licensed to provide primary care, as well as order diagnostic tests or prescribe many medications.

**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 sole proprietors, 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 consists of two medical code sets

* ICD-10-PCS
* ICD-10-CM

**ICD-10-PCS**

ICD-10-PCS stands for the International Classification of Diseases, Tenth Revision, Procedure Coding System. As indicated by its name, ICD-10-PCS is a procedural classification system of medical codes. It is used in hospital settings to report inpatient procedures.

**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.

**Difference Between ICD-10-CM & ICD-10-PCS**

Both ICD-10-CM and ICD-10-PCS came into effect for medical claims reporting on Oct.1, 2015. But the two code sets differ vastly. The primary distinctions are:

* **ICD-10-CM**—diagnosis code set used for all healthcare settings
* **ICD-10-PCS**—procedure code set used only in hospital inpatient settings

**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**

* The Tabular List is organized into 21 chapters according to body system or condition, with diagnosis codes listed alphanumerically in each chapter.

**ICD-10-CM Chapters and Code Ranges**

|  |  |  |
| --- | --- | --- |
| **Chapter** | **Code Range** | **Description** |
| **1** | [A00-B99](https://www.aapc.com/codes/icd-10-codes-range/A00-B99) | Certain Infectious and Parasitic Diseases |
| **2** | [C00-D49](https://www.aapc.com/codes/icd-10-codes-range/C00-D49) | Neoplasms |
| **3** | [D50-D89](https://www.aapc.com/codes/icd-10-codes-range/D50-D89) | Diseases of the Blood and Blood-Forming Organs and Certain Disorders  Involving the Immune Mechanism |
| **4** | [E00-E89](https://www.aapc.com/codes/icd-10-codes-range/E00-E89) | Endocrine, Nutritional and Metabolic Diseases |
| **5** | [F01-F99](https://www.aapc.com/codes/icd-10-codes-range/F01-F99) | Mental, Behavioral and Neurodevelopmental Disorders |
| **6** | [G00-G99](https://www.aapc.com/codes/icd-10-codes-range/G00-G99) | Diseases of the Nervous System |
| **7** | [H00-H59](https://www.aapc.com/codes/icd-10-codes-range/H00-H59) | Diseases of the Eye and Adnexa |
| **8** | [H60-H95](https://www.aapc.com/codes/icd-10-codes-range/H60-H95) | Diseases of the Ear and Mastoid Process |
| **9** | [I00-I99](https://www.aapc.com/codes/icd-10-codes-range/I00-I99) | Diseases of the Circulatory System |
| **10** | [J00-J99](https://www.aapc.com/codes/icd-10-codes-range/J00-J99) | Diseases of the Respiratory System |
| **11** | [K00-K95](https://www.aapc.com/codes/icd-10-codes-range/K00-K95) | Diseases of the Digestive System |
| **12** | [L00-L99](https://www.aapc.com/codes/icd-10-codes-range/L00-L99) | Diseases of the Skin and Subcutaneous Tissue |
| **13** | [M00-M99](https://www.aapc.com/codes/icd-10-codes-range/M00-M99) | Diseases of the Musculoskeletal System and Connective Tissue |
| **14** | [N00-N99](https://www.aapc.com/codes/icd-10-codes-range/N00-N99) | Diseases of the Genitourinary System |
| **15** | [O00-O9A](https://www.aapc.com/codes/icd-10-codes-range/O00-O9A) | Pregnancy, Childbirth and the Puerperium |
| **16** | [P00-P96](https://www.aapc.com/codes/icd-10-codes-range/P00-P96) | Certain Conditions Originating in the Perinatal Period |
| **17** | [Q00-Q99](https://www.aapc.com/codes/icd-10-codes-range/Q00-Q99) | Congenital Malformations, Deformations, and Chromosomal  Abnormalities |
| **18** | [R00-R99](https://www.aapc.com/codes/icd-10-codes-range/R00-R99) | Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not  Elsewhere Classified |
| **19** | [S00-T88](https://www.aapc.com/codes/icd-10-codes-range/S00-T88) | Injury, Poisoning, and Certain Other Consequences of External Causes |
| **20** | [V00-Y99](https://www.aapc.com/codes/icd-10-codes-range/V00-Y99) | External Causes of Morbidity |
| **21** | [Z00-Z99](https://www.aapc.com/codes/icd-10-codes-range/Z00-Z99) | Factors Influencing Health Status and Contact with Health Services |

**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) |

**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 The codes in red above are examples of what have been identified by the CDC as header codes, 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. We will deny header codes with the following CORE (Committee on Operating Rules for Information Exchange) approved messages:

**Claim Adjustment Reason Code (CARC) 16**: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

**Remittance Advice Remark Code (RARC) M76**: Missing/incomplete/invalid diagnosis or condition.

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:

* A00.0 Cholera due to Vibrio cholerae 01, biovar cholerae
* A00.1 Cholera due to Vibrio cholerae 01, biovar eltor
* 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

**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**

It is important to remember that the primary reason for the patient’s visit indicates the primary diagnosis code pointer that should be used on the claim. Diagnosis code pointers are used to indicate the appropriate order of importance in relation to the service being performed. The first pointer designates the primary diagnosis for the service line. Remaining diagnosis pointers indicate declining level of importance to service line.

**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 an agreement between Medicare and medical providers (doctors, hospitals, medical equipment suppliers, etc.) in which the provider agrees to accept Medicare’s fee schedule as payment in full when Medicare patients are treated.

**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**

According to the AMA and the CMS, a modifier provides the means to report or indicate that a service or procedure has been performed and altered by some specific circumstance but not changed in definition.  It may also provide more information about the service that has been performed more than one time or services that have occurred unusually.

**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)

**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:

* **Greater Convenience**

The majority of healthcare claims are now processed electronically instead of through the mail. Medicare and other large insurance payers prefer to use electronic clearinghouses to sift through and audit claims. Electronic submissions make the entire claims process quicker and smoother.

* **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.

* **More Accurate Documentation**

The American Medical Association has estimated that approximately 42% of physicians will face a medical malpractice claim at some point in their career. While there’s not much you can do to speed up the legal process around a malpractice suit once initiated, a medical billing clearinghouse provider can ease some of your burden by providing detailed and accurate information on the claim in question. In addition, you’ll be able to quickly access that information as circumstances dictate.

* **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.)
* Incomplete data related to procedures or diagnostics performed
* “Double-billing” for the same service

**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**: Authorization and referral request
* **278I**: Prior authorization and notification inquiry
* **278N**: Hospital admission notification
* **835**: Electronic remittance advice (ERA)
* **837D**: Dental claim
* **837I**: Institutional claim
* **837P**: Professional claim or vision 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.

**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 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 dose 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.

**Who fills out an HCFA form?**

Any of these kinds of individual practitioner can complete and file HCFA forms:

* Physicians
* Specialists
* Nurse practitioners
* Nurse-midwives
* Certified nurse anesthetic practitioners
* Physician assistants
* Clinical psychologists
* Clinical social workers
* Ambulance services
* Laboratory services

**What is included in HCFA form?**

The HCFA form is made up of 33 boxes. If that seems like an overwhelming number, each box requires little information

* 1. **Insurance information**
  2. **Patient’s name**
  3. **Patient’s sex and date of birth**
  4. **Insured’s name**
  5. **Patient’s address and phone number**
  6. **Patient’s relationship to insured**
  7. **Insured’s address**
  8. **Patient status**
  9. **Other insurance information**
  10. **Patient’s signature etc.**

**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.

**An EOB is not a Bill**

The Explanation of Benefits tells you how much of the doctor's charges you are responsible for, but it is not a bill. The EOB is for your reference only. If you owe money for the service beyond what your insurer or health accounts pay, you may receive a bill directly from your provider.

**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

**How does HIPAA 5010 Actually Works?**

HIPAA requires all providers and billers covered by HIPAA to submit claims electronically using the ASC X12 Version 5010, or HIPAA 5010. HIPAA 5010 transactions are best thought of visually as a series of cars. Each car looks the same on the outside. The colors are the same, the tires are the same, the number of doors is the same. This universe of cars that all appear the same on the outside can be thought of as transactions in the HIPAA 5010 universe. In the HIPAA 5010 universe, all code sets must be identical. The same number must be used to denote the same procedure, for every transaction there is.

Within each car, there are different features inside. One car may have an antilock braking system, a cupholder and reclining bucket seats, while another may only have antilock brakes.  Just as each component of the car has a part number, each claim within a 5010 transaction has a code set number.

**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**

Patient statements are medical bills that help the healthcare providers collect the medical fees more efficiently with lower administration. The patient needs to understand what services they are paying.

**What do our Patient Statement Services include?**

* Patient-friendly statement generation
* Statement printing
* Statement mailing to the mentioned address (online and offline).

**Why choose our Patient Statement Services?**

* Avoid bad debts and unnecessary third-party cost collection
* Prompt and precise low-risk statements for faster clearance of payment
* Additional revenue saving
* Transparent billing procedure
* Speedy turnaround
* On-time delivery of the patient statement

**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**

“Day of Show” or DOS or Day Sheet and this simply put is the schedule for the day and the contact numbers for all the players involved.

**For Example:**

6:00 am – Venue opens to production  
7:30 am – Loading dock clear for artist arrival.  
12noon – Lunch Break in Conference Rm  
2:00 pm – Hospitality room setup  
3:00 pm – Sound Check  
5:00 pm – Venue cleared  
6:00 pm – Security Meeting  
7:00 pm – Doors  
8:00 pm – Support Band  
8:30 pm – Set Change  
9:00 pm – Headliner  
11:00 pm – Venue Clear and Strike

**Fee Schedule**

A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis.

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

**Status indicators used by CMS**

* **A**= **Active code**. These codes are separately paid under the physician fee schedule, if covered.
* **B**=**Bundled code**. Payment for covered services is always bundled into payment for other services not specified.
* **C**= **MACs priced code**. MACS will establish RVUs and payment amounts for these services, generally on an individual case-by-case basis following review of documentation such as an operative report.
* **E**=**Excluded from physician fee schedule by regulation.** These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation.
* **I**=**Not valid for Medicare purposes**. Medicare uses another code for reporting of, and payment for, these services. (Code is NOT subject to a 90-day grace period.)
* **M** = **Measurement codes**. Used for reporting purposes only.
* **N** = **Non-covered service**.
* **P** = **Bundled/excluded codes**. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule.
* **R** = **Restricted coverage**. Special coverage instructions apply.
* **T** = **Paid as only service**. These codes are paid only if there are no other services payable under the physician fee schedule billed on the same date by the same provider.
* **X** = **Statutory exclusion**. These codes represent an item or service that is not in the statutory definition of ‘physician services’ for fee schedule payment purposes.

**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.