**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, and making arrangements for EFT – electronic funds transfer.

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?**

Healthcare providers are supposed to install medical billing software where they upload their claims electronically to be checked and evaluated by the clearinghouse. Clearinghouse scrubbed the claims for coding and billing errors and transferred the claims to respective insurance providers for further processing. The whole billing and claiming procedure is processed over an electronic medium that is secured through provided guidelines across the healthcare system.

**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 in healthcare is a secure way of transmitting data between healthcare institutions, insurers, and patients using established message formats and standards.  Healthcare EDI software transmits details like the coordination of benefits, claims status and information, insurance data, payment data and eligibility forms among healthcare providers, professionals and institutions, clearinghouses, insurance companies and government entities like Medicare.

**How Healthcare EDI Works?**

Healthcare EDI transactions usually occur in five steps. Let’s use an inquiry from a medical provider to a payer as an example:

* The medical provider initiates the inquiry by supplying specific data, like member ID number and date of birth.
* The inquiry goes to a clearinghouse contracted by the provider.
* The clearinghouse sends the inquiry to the payer.
* The payer responds to the clearinghouse.
* The clearinghouse transmits the response to the medical provider.

**Note:** All involved parties transmit the information using codes laid out in ANSI ASC X12 protocol  ensures the [**security and accuracy of medical data**](https://demigos.com/blog-post/data-security-in-healthcare-importance-challenges-solutions/), the general standard that governs all EDI transaction codes, including electronic healthcare transactions.

What is the importance of EDI in Healthcare?

**EDI standards for healthcare are related to HIPAA, the national health privacy law enacted in 1996. The importance of EDI in healthcare cant be overstated - without it, data errors , security, breaches and payment would be much more common.**

**The Benefits of EDI in Healthcare**

As mentioned earlier, healthcare EDI streamlines the transmission of patient medical records and related data. Healthcare professionals can share details more efficiently and quickly with EDI. Other benefits include:

* Enhanced security
* Better accuracy
* Improved productivity

**Healthcare EDI Transaction Sets**

The benefits of healthcare EDI are related to the wide variety of transaction sets available for use by healthcare professionals. These sets cover all the different types of information transmitted among medical providers, clearinghouses and payers. The sets cover EDI healthcare transactions like:

* Healthcare claim
* Healthcare claim payment/advice
* Benefits enrollment and maintenance
* Healthcare eligibility/benefit inquiry
* Healthcare eligibility/benefit response
* Healthcare service review information

**HCFA 1500**

The HCFA form, also known as Form HCFA 1500 or Form CMS-1500, is what non-institutional practitioners file to payers (insurance companies). They often comprise the basis of [medical claims](https://www.businessnewsdaily.com/16237-medical-claims-how-to.html).

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.