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Medical Insurance

A Revenue Cycle Process Approach

Eighth Edition

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MEDICAL INSURANCE: A REVENUE CYCLE PROCESS APPROACH, EIGHTH EDITION

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Preface

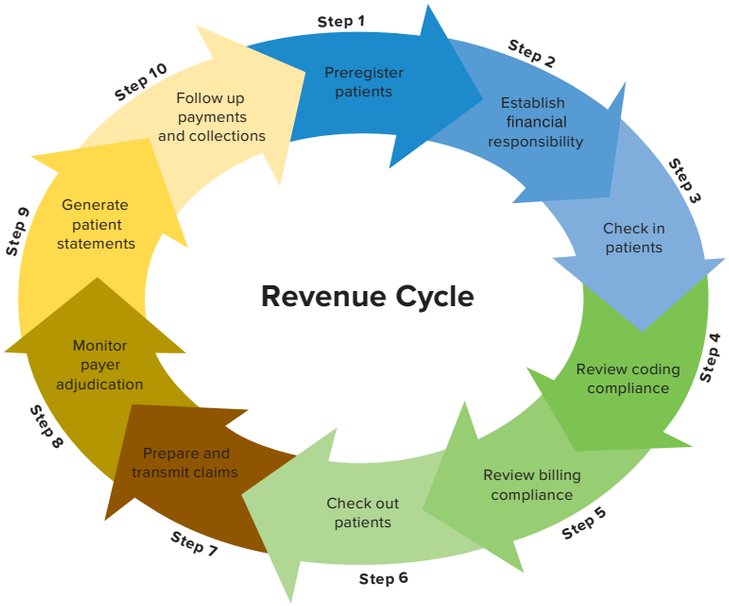
Follow the Money!

Medical insurance plays an important role in the financial well-being of every healthcare business. The regulatory environment of medical insurance is now evolving faster than ever. Changes due to healthcare reform require medical office professionals to acquire and maintain an in-depth understanding of compliance, electronic health records, medical coding, and more.

The eighth edition of *Medical Insurance: A Revenue Cycle Process Approach* emphasizes the **revenue cycle**—ten steps that clearly identify all the components needed to successfully manage the medical insurance claims process. The cycle shows how administrative medical professionals "follow the money."

Medical insurance specialists must be familiar with the rules and guidelines of each health plan in order to submit proper documentation. This ensures that offices receive maximum, appropriate reimbursement for services provided. Without an effective administrative staff, a medical office would have no cash flow!

The following are some of the key skills covered for you and your students in *Medical Insurance, 8e:*



Skills	Coverage
Procedural	**Learning** administrative duties important in medical practices as well as how to bill both payers and patients
Communication	**Working** with physicians, patients, payers, and others using both written and oral communication
Health information management	**Using** practice management programs and electronic health records technology to manage both patient records and the billing/collections process, to electronically transmit claims, and to conduct research
Medical coding	**Understanding** the ICD-10, CPT, and HCPCS codes and their importance to correctly report patients' conditions on health insurance claims and encounter forms as well as the role medical coding plays in the claims submission process
HIPAA/HITECH	**Applying** the rules of HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Economic and Clinical Health act) to ensure compliance, maximum reimbursement, and the electronic exchange of health information

Medical Insurance is available with McGraw-Hill Education's revolutionary adaptive learning technology, McGraw-Hill SmartBook®! You can study smarter, spending your valuable time on topics you don't know and less time on the topics you have already mastered. Succeed with SmartBook. . . . Join the learning revolution and achieve the success you deserve today!

Organization of *Medical Insurance, 8e*

An overview of the book's parts, including how they relate to the steps of the revenue cycle, follows:

Part	Coverage
1: Working with Medical Insurance and Billing	Covers Steps 1 through 3 of the revenue cycle by introducing the major types of medical insurance, payers, and regulators, as well as the steps of the cycle. Also covers HIPAA/HITECH Privacy, Security, and Electronic Health Care Transactions/Code Sets/Breach Notification rules.
2: Claim Coding	Covers Steps 4 through 6 of the revenue cycle while building skills in correct coding procedures, using coding references, and complying with proper linkage guidelines.
3: Claims	Covers Step 7 of the revenue cycle by discussing the general procedures for calculating reimbursement, how to bill compliantly, and preparing and transmitting claims.
4: Claim Follow-Up and Payment Processing	Covers Steps 8 through 10 of the revenue cycle by describing the major third-party private and government-sponsored payers' procedures and regulations along with specific filing guidelines. Also explains how to handle payments from payers, follow up and appeal claims, and correctly bill and collect from patients. This part includes two case studies chapters that provide exercises to reinforce knowledge of completing primary/secondary claims, processing payments from payers, and handling patients' accounts. The case studies in Chapter 15 can be completed using Connect for simulated exercises. The case studies in Chapter 16 can be completed using the CMS-1500 form.
5: Hospital Services	Provides necessary background in hospital billing, coding, and payment methods.

New to the Eighth Edition

Medical Insurance is designed around the revenue cycle with each part of the book dedicated to a section of the cycle followed by case studies to apply the skills discussed in each section. The revenue cycle now follows the overall medical documentation and revenue cycle used in practice management/electronic health records environments and applications.

Medical Insurance offers several options for completing the case studies at the end of Chapters 8–12 and throughout Chapter 15:

- **Paper Claim Form:** If you are gaining experience by completing a paper CMS-1500 claim form, use the blank form supplied to you (from the back of *Medical Insurance*) and follow the instructions in the text chapter that is appropriate for the particular payer to fill in the form by hand.
- **Connect Simulations:** The ability to understand and to use Electronic Health Records (EHR) systems are critical job skills and competencies required for employment in a Medical Office or Hospital. In the past, teaching students the hows and whys of using an EHR has been challenging. Live software solutions require complex installation and support, and often don't translate well into the classroom. Simulated educational solutions often fall short in giving students the realistic experience of working in real world scenarios.

  McGraw-Hill Education is proud to introduce **EHRclinic,** the educational EHR solution that provides the best of both worlds, both the experience of working in a

live, modern EHR application, along with the convenience and reliability of simulated educational solutions.

EHRclinic is integrated into **Connect, McGraw-Hill's** digital teaching and learning environment that saves students and instructors time while improving performance over a variety of critical outcomes.

For *Medical Insurance,* Connect provides simulated, auto-graded exercises in multiple modes to allow the student to use EHRclinic to complete the claims. If assigned this option, students should read the User Guide at www.mhhe.com/valerius as the first step, and then follow the instructions with each chapter's case studies. Note: some data may be prepopulated to allow students to focus on the key tasks of each exercise.

- **Connect CMS-1500 Form Exercises:** Another way to complete the claims exercises is by using the CMS-1500 form exercises in Connect if directed by your instructor. These exercises allow you to complete the necessary fields of the form in an auto-graded environment.
- Please note that starting with this edition, we will no longer be offering live Medisoft® or Medisoft simulations as part of the options.

Key content features include the following.

- **Pedagogy**
  - Learning Outcomes reflect the range of difficulty levels to teach and assess critical thinking about medical insurance and coding concepts and continue to reflect the revised version of Bloom's Taxonomy.
  - Objective end-of-chapter questions cover all Learning Outcomes.
- **HIPAA-Related Updates**
  - 2018 ICD-10-CM and CPT/HCPCS codes are included.
  - The new Notice of Privacy Practices (NPP) that addresses disclosures in compliance with HITECH is illustrated.
- **Key Chapter Changes**
  - **Chapter 1:** *New:* Thinking It Through 1.7. *Revised:* Thinking It Through 1.2. *Updated:* statistics and data in Figures 1.1 and 1.4; Compliance Guideline on ICD-10-CM implementation.
  - **Chapter 2:** *New:* two HIPAA/HITECH Tips on Texting and Plans Mandated; PHI on the cloud. *Updated:* four WWW features on HHS, Medical Notice of Privacy Practices, HHS Breach Notifications, and CMS HIPAA Enforcement. *Deleted:* old Figures 2.1, 2.2, and 2.6; information on the National Health Information Network.
  - **Chapter 3:** *Deleted:* old Figure 3.7.
  - **Chapter 4:** *Updated:* all ICD-10-CM codes and conventions for 2018; Figures 4.1 and 4.3; Case 4.1 in Applying Your Knowledge. *Deleted:* key term ICD-9-CM.
  - **Chapter 5:** *New:* Billing Tips on Category III Code Sunsets and Revised Guidelines Coming; symbol for telemedicine. *Updated:* all CPT codes, conventions, and modifiers for 2018; WWW features on CPT Updates, AMA Vaccine Code Updates, and Category II and III Updates; all cases in Applying Your Knowledge; Tables 5.2, 5.3, and 5.6; structure of E/M section. *Deleted:* symbol for moderate sedation.
  - **Chapter 6:** *New:* image for Figure 6.3. *Revised:* Figures 6.1 and 6.2. *Updated:* Case 6.1 in Applying Your Knowledge.
  - **Chapter 7:** *New:* key terms 5010A1 version and Healthcare Provider Taxonomy Code (HPTC); text for 5010A1 Version and the CMS-1500. *Revised:* Figure 7.1; art in Cases 7.2, 7.3, and 7.4. *Updated:* all conventions for completing the CMS-1500 and all Item Numbers; WWW features on POS Codes, Current Taxonomy Code Set, and All Administrative Code Sets for HIPAA Transactions. *Deleted:* old Figures 7.2, 7.3, 7.4, 7.5, 7.6, and 7.8; old Table 7.1; Billing Tip on How Many Pointers?

- **Chapter 8:** *New:* item in Thinking It Through 8.9. *Revised:* Figures 8.5, 8.7, 8.9, and 8.10; Case 8.4 introduction and art. *Updated:* high-deductible health plan deductibles; out-of-pocket limits for metal plans in section 8.5.
- **Chapter 9:** *New:* key terms Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Medicare Beneficiary Identifier (MBI), Quality Payment Program (QPP); Figure 9.1; WWW features on New Medicare Card Information and QPP; Medicare coverage text in section 9.3; Medicare incentives text in section 9.4. *Revised:* WWW feature on Beneficiary Preventive Services; Figures 9.7 and 9.9; Applying Your Knowledge introduction; Cases 9.1, 9.2, and 9.3. *Updated:* Billing Tips on Medicare Part A and Part B; WWW features on Medicare FFS Provider Web Pages Bookmark and Medicare Physician Fee Schedule; Thinking It Through 9.8. *Deleted:* key terms Medicare health insurance claim number (HICN), Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBPM); WWW feature on MPFS Online.
- **Chapter 10:** *New:* Thinking It Through 10.7. *Revised:* Figure 10.5; Applying Your Knowledge introduction; Cases 10.1 and 10.2. *Updated:* Medicaid info in intro; Medicaid changes in section 10.1; WWW feature on CHIP; websites in Table 10.1; covered services in section 10.5.
- **Chapter 11:** *New:* key terms Prime Service Area, TRICARE For Life, TRICARE Select; section 11.3 on TRICARE Prime; section 11.4 on TRICARE Select; Figure 11.1. *Revised:* Figure 11.2; Review Questions section; Applying Your Knowledge Introduction; Cases 11.1, 11.2, and 11.3. *Updated:* TRICARE regions in section 11.6. *Deleted:* key terms catchment area, nonavailability statement (NAS), TRICARE Extra, TRICARE Prime Remote, TRICARE Reserve Select, TRICARE Standard, TRICARE Young Adult (TYA); old Figures 11.1, 11.2, 11.3; Compliance Guideline on Preauthorization.
- **Chapter 12:** *Revised:* Figure 12.2; Applying Your Knowledge introduction; Cases 12.1 and 12.2.
- **Chapter 13:** *Revised:* Figures 13.1 and 13.8; Thinking It Through 13.3 and 13.5. *Updated:* key term claim adjustment group code (CAGC); Medicare appeals costs in section 13.6. *Deleted:* question D in Case 13.2.
- **Chapter 14:** Revised: chart in section 14.2; Thinking It Through 14.2; Figures 14.3 and 14.4. *Deleted:* old Figures 14.3a, 14.3b, and 14.3c; relating statements to the PMP section.
- **Chapter 15:** *Updated:* all CPT codes, conventions, and modifiers for 2018; *Updated:* Patient Account Number section so students no longer assign patient chart numbers; *Updated:* Dates for each case study.
- **Chapter 16:** *Updated:* Dates for each case study.
- **Chapter 17:** *New:* Figure 17.3; WWW feature on Medicare Secondary Payer Questionnaire; NUBC information on electronic claim submission. *Updated:* Compliance Guideline What Determines the Correct Code Set for Hospital Coding?

For a detailed transition guide between the seventh and eighth editions, visit the Instructor Resources in *Connect*.

Workbook for Use with Medical Insurance: A Revenue Cycle Process Approach, Eighth Edition (1-260-48914-0, 978-1-260-48914-9)

The *Workbook for Use with Medical Insurance* has excellent material for reinforcing the text content, applying concepts, and extending understanding. It combines the best features of a workbook and a study guide. Each workbook chapter enhances the text's strong pedagogy through:

- Assisted outlining—reinforces the chapter's key points
- Key terms—objective questions
- Critical thinking—questions that stimulate process understanding
- Guided web activities—exercises to build skill in locating and then evaluating information on the Internet
- Application of concepts—reinforcements and extensions for abstracting insurance information, calculating insurance math, and using insurance terms

The workbook matches the text chapter by chapter. It reinforces, applies, and extends the text to enhance the learning process.

Medical Coding Workbook for Physician Practices and 2018–2019 Edition (1-259-63002-1, 978-1-259-63002-6)

The *Medical Coding Workbook* provides practice and instruction in coding and using compliance skills. Because medical insurance specialists verify diagnosis and procedure codes and use them to report physicians' services, a fundamental understanding of coding principles and guidelines is the basis for correct claims. The coding workbook reinforces and enhances skill development by applying the coding principles introduced in *Medical Insurance, 8e,* and extending knowledge through additional coding guidelines, examples, and compliance tips. It offers more than seventy-five case studies that simulate real-world application. Also included are inpatient scenarios for coding that require compliance with *ICD-10-CM Official Guidelines for Coding and Reporting* sequencing rule as explained in Chapter 17 of the text.

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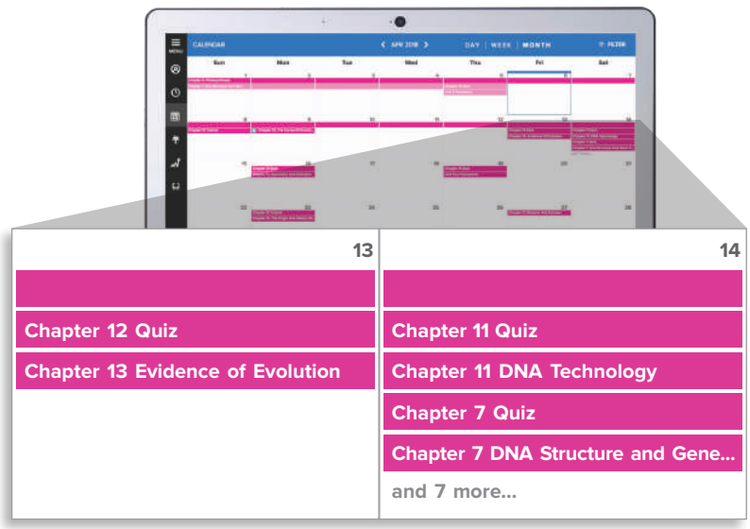

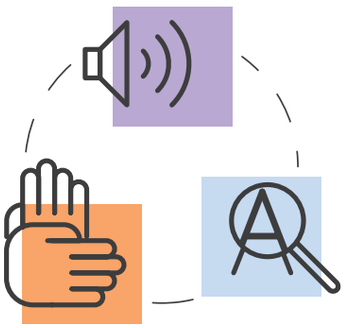

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- All end-of-chapter questions
- Interactive exercises, such as matching, sequencing, and labeling activities
- Testbank questions
- Simulated CMS-1500 exercises for Chapters 8–12 and 15
- Simulated EHRclinic exercises for Chapters 8–12 and 15

INSTRUCTORS' RESOURCES

You can rely on the following materials to help you and your students work through the material in the book; all are available in the Instructor Resources under the library tab in *Connect* (available only to instructors who are logged in to *Connect*).

Supplement	Features
Instructor's Manual (organized by Learning Outcomes)	• Lesson Plans • Answer Keys for all exercises
PowerPoint Presentations (organized by Learning Outcomes)	• Key Terms • Key Concepts • Accessible
Electronic Testbank	• Computerized and *Connect* • Word Version • Questions tagged for Learning Outcomes, Level of Difficulty, Level of Bloom's Taxonomy, Feedback, ABHES, CAAHEP, CAHIIM, and Estimated Time of Completion.
Tools to Plan Course	• Correlations of the Learning Outcomes to Accrediting Bodies such as ABHES, CAAHEP, and CAHIIM • Sample Syllabi • Conversion Guide between seventh and eighth editions • Asset Map—recap of the key instructor resources as well as information on the content available through *Connect*
EHRclinic Simulated Exercises Resources	• Implementation Guide • Technical Support Information • Steps for students completing the simulated exercises in Connect
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Part 1

WORKING WITH MEDICAL INSURANCE AND BILLING

chapter 1
Introduction to the Revenue Cycle

chapter 2
Electronic Health Records, HIPAA, and HITECH: Sharing and Protecting Patients' Health Information

chapter 3
Patient Encounters and Billing Information

1 INTRODUCTION TO THE REVENUE CYCLE

KEY TERMS

accounts payable (AP)
accounts receivable (AR)
adjudication
benefits
capitation
cash flow
certification
coinsurance
compliance
consumer-driven health plan (CDHP)
copayment
covered services
deductible
diagnosis code
electronic health record (EHR)
ethics
etiquette
excluded services
fee-for-service
healthcare claim
health information technology (HIT)
health maintenance organization (HMO)
health plan
indemnity plan
managed care
managed care organization (MCO)
medical coder
medical insurance
medical insurance specialist
medical necessity
network
noncovered services
out-of-network
out-of-pocket
participation
patient ledger
payer
per member per month (PMPM)
PM/EHR
policyholder
practice management program (PMP)
preauthorization
preferred provider organization (PPO)
premium

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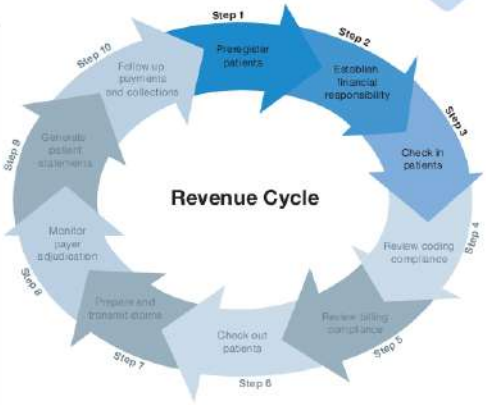

Learning Outcomes

After studying this chapter, you should be able to:

1.1 Identify three ways that medical insurance specialists help ensure the financial success of physician practices.

1.2 Differentiate between covered and noncovered services under medical insurance policies.

1.3 Compare indemnity and managed care approaches to health plan organization.

1.4 Discuss three examples of cost containment employed by health maintenance organizations.

1.5 Explain how a preferred provider organization works.

1.6 Describe the two elements that are combined in a consumer-driven health plan.

1.7 Define the three major types of medical insurance payers.

1.8 Explain the ten steps in the revenue cycle.

1.9 Analyze how professionalism, ethics, and etiquette contribute to career success.

1.10 Evaluate the importance of professional certification for career advancement.

KEY TERMS *(continued)*

preventive medical services
primary care physician (PCP)
procedure code
professionalism
provider
referral
revenue cycle
schedule of benefits
self-funded (self-insured) health plan
third-party payer

Patients who come to physicians' practices for medical care are obligated to pay for the services they receive. Some patients pay these costs themselves, while others have medical insurance to help them cover medical expenses. Administrative staff members help collect the maximum appropriate payments by handling patients' financial arrangements, billing insurance companies, and processing payments to ensure both top-quality service and profitable operation.

1.1 Working in the Medical Insurance Field

A major trend in the trillion-dollar healthcare industry is a shift of payment responsibility from employers and insurance companies to patients. To remain profitable, as this trend accelerates, physicians must carefully manage the business side of their practices. Knowledgeable medical office employees are in demand to help.

Administrative Complexity Increases Career Opportunities

The healthcare industry offers many rewarding career paths for well-qualified employees. Providers must compete in a complex environment of various health plans, managed care contracts, and federal and state regulations. The average practice works with nearly twenty different health plans, and some with more than eighty of them. Employment in positions that help providers handle these demands is growing, as are opportunities for career development. According to *The Physician's Advisory*, a healthcare journal:

> " . . . good, experienced billing/coding specialists are in short supply; to retain good workers in these very important positions, going up in salary is a bargain compared to risking their going to another employer . . . the work of insurance specialists is an increasingly complex job."

Figure 1.1 describes the rapidly growing employment possibilities in the healthcare administrative area.

Helping to Ensure Financial Success

Medical insurance specialists' effective and efficient work is critical for the satisfaction of the patients—the physician's customers—and for the financial success of the practice. To maintain a regular **cash flow**—the movement of monies into or out of a business—specific tasks must be completed on a regular schedule before, during, and after a patient visit. Managing cash flow means making sure that sufficient monies flow into the practice from patients and insurance companies paying for medical services, referred to as **accounts receivable (AR)**, to pay the practice's operating expenses, such as for rent, salaries, supplies, and insurance—called **accounts payable (AP)**.

cash flow movement of monies into or out of a business

accounts receivable (AR) monies owed to a medical practice

accounts payable (AP) a practice's operating expenses

Tracking AR and AP is an accounting job. *Accounting*, often referred to as "the language of business," is a financial information system that records, classifies, reports on, and interprets financial data. Its purpose is to analyze the financial condition of a business following generally accepted accounting principles (GAAP). The accountant of the practice sets up accounts such as AR, AP, and patient accounts for all aspects of running

U.S. Department of Labor
Bureau of Labor Statistics

Occupational Outlook Handbook

Medical Records and Health Information Technicians

- Employment of medical records and health information technicians is projected to grow faster than the average for all occupations.
- Job prospects for those with a certification in health information will be best. As electronic health record (EHR) systems continue to become more common, technicians with computer skills will be needed to use them. Employment of medical records and health information technicians is expected to grow faster than the average for all occupations through 2026, due to an aging national population and rapid growth in the number of medical tests, treatments, and procedures that will be increasingly scrutinized by third-party payers, regulators, courts, and consumers.
- Most technicians will be employed in hospitals, but job growth will be faster in offices and clinics of physicians, nursing homes, and home health agencies. Technicians who achieve additional qualifications through professional organizations or who obtain a bachelor's or master's degree will be particularly successful.

Medical Assistants

- Employment of medical assistants is expected to grow much faster than the average for all occupations through 2026 as the health services industry expands due to technological advances in medicine and a growing and aging population. It is one of the fastest-growing occupations.
- Employment growth will be driven by the increase in the number of group practices, clinics, and other healthcare facilities that need a high proportion of support personnel, particularly the flexible medical assistant who can handle both administrative and clinical duties so that physicians can see more patients. Medical assistants work primarily in outpatient settings, where much faster than average growth is expected. As more and more physicians' practices switch to EHRs, medical assistants' job responsibilities will continue to change. They will need to become familiar with EHR computer software, including maintaining EHR security and analyzing electronic data, to improve healthcare information.
- Job prospects should be best for medical assistants with formal training or experience, particularly those with certification. The medical assistants who are expected to excel are those best fit to deal with the public through a courteous, pleasant manner and a professional demeanor.

Medical Administrative Support

- Growth in the health services industry will spur faster than average employment growth for medical support staff.
- Medical administrative support employees may transcribe dictation, prepare correspondence, and assist physicians or medical scientists with reports, speeches, articles, and conference proceedings. They also record simple medical histories, arrange for patients to be hospitalized, and order supplies. Most medical administrative support staff need to be familiar with insurance rules, billing practices, the use of EHRs, and hospital or laboratory procedures.
- As with medical records and health information technicians and medical assistants, medical administrative support employees with advanced qualifications and degrees will excel.

FIGURE 1.1 Employment Opportunities

the practice and then prepares financial statements that show whether the cash flow is adequate. These statements are monitored regularly to see whether revenues are sufficient or need improving.

revenue cycle all administrative and clinical functions that help capture and collect patient

Having adequate cash flow is the purpose of managing the **revenue cycle,** which is made up of all administrative and clinical functions which ensure that sufficient monies flow

into the practice from patients and insurance companies paying for medical services to pay the practice's bills.

Medical insurance specialists have an important role in revenue cycle management. They help to ensure financial success by (1) carefully following procedures, (2) communicating effectively, and (3) using health information technology—medical billing software and electronic health records—to improve efficiency and contribute to better health outcomes.

Following Procedures

Medical billing requires a set of procedures. Some procedures involve administrative duties, such as entering data and updating patients' records. Other procedures are done to comply with government regulations, such as keeping computer files secure from unauthorized viewing. In most offices, policy and procedure manuals that describe how to perform major duties are available.

For most procedures, medical insurance specialists work in teams with both licensed medical professionals and other administrative staff members. Providers include physicians and nurses as well as physician assistants (PAs), nurse-practitioners (NPs), clinical social workers, physical therapists, occupational therapists, speech therapists, audiologists, and clinical psychologists. Administrative staff may be headed by an office manager, practice manager, or practice administrator to whom medical assistants, patient services representatives or receptionists, and billing, insurance, and collections specialists report.

Communicating

Communication skills are as important as knowing about specific forms and regulations. A pleasant tone, a friendly attitude, and a helpful manner when gathering information increase patient satisfaction. Having interpersonal skills enhances the billing and reimbursement process by establishing professional, courteous relationships with people of different backgrounds and communication styles. Effective communicators have the skill of empathy; their actions convey that they understand the feelings of others.

Equally important are effective communications with physicians, other professional staff members, and all members of the administrative team. Conversations must be brief and to the point, showing that the speaker values the provider's time. People are more likely to listen when the speaker is smiling and has an interested expression, so speakers should be aware of their facial expressions and should maintain moderate eye contact. In addition, good listening skills are important.

Using Health Information Technology

Medical insurance specialists use **health information technology (HIT)**—computer hardware and software information systems that record, store, and manage patient information—in almost all physician practices.

health information technology (HIT) computer information systems that record, store, and manage patient information

Practice Management Programs **Practice management programs (PMPs),** which are accounting software used in almost all medical offices for scheduling appointments, billing, and financial record keeping, are good examples of HIT. They streamline the process of creating and following up on healthcare claims sent to payers and on bills sent to patients.

practice management program (PMP) accounting software used for scheduling appointments, billing, and financial record keeping

Expertise in the use of practice management programs is an important skill in the medical practice. Medical insurance specialists use them to:

- Schedule patients
- Organize patient and insurance information
- Collect data on patients' diagnoses and services

- Generate, transmit, and report on the status of healthcare claims
- Record payments from insurance companies
- Generate patients' statements, post payments, and update accounts
- Create financial and productivity reports

Electronic Health Records

Another HIT application is rapidly becoming critical in physician practices: electronic health records, or EHRs. While patients' financial records have been electronic for more than a decade, clinical records—the information about a patient's health entered by doctors, nurses, and other healthcare professionals—until recently, have been stored in paper charts. An **electronic health record (EHR)** is a computerized lifelong healthcare record for an individual that incorporates data from all sources that provide treatment for the individual. Note that EHRs are not the same as *electronic medical records*, or *EMRs*, which are a single provider's records of patients.

electronic health record (EHR) computerized lifelong healthcare record for an individual that incorporates data from all sources

EHR systems are set up to gather patients' clinical information using the computer rather than paper. Most EHR systems are designed to exchange information with—to "talk" to—the PMP and to eliminate the need for many paper forms. Electronic health record systems are discussed further in the chapter on EHRs, Health Insurance Portability and Accountability Act (HIPAA), and Health Information Technology for Economic and Clinical Health (HITECH) Act.

PM/EHRs Some software programs combine both a PMP and an EHR in a single product called an integrated **PM/EHR**. Data entered in either the PMP or the EHR can be used in all applications, such as scheduling, billing, and clinical care. For example, if a receptionist enters basic information about a patient in the electronic health record during the patient's first visit to the practice, those data are available for the medical insurance specialist to use in the billing program. Facts such as the patient's identifying information, type of health insurance, and previous healthcare records must be entered only once rather than in both programs. PM/EHRs greatly improve administrative efficiency.

PM/EHR software program that combines both a PMP and an EHR into a single product

A Note of Caution: What Health Information Technology Cannot Do

Although computers increase efficiency and reduce errors, they are not more accurate than the individual who is entering the data. If people make mistakes while entering data, the information the computer produces will be incorrect. Computers are very precise and very unforgiving. While the human brain knows that *flu* is short for *influenza*, the computer regards them as two distinct conditions. If a computer user accidentally enters a name as *ORourke* instead of *O'Rourke*, a human might know what is meant; the computer does not. It might respond with the message "No such patient exists in the database."

THINKING IT THROUGH 1.1

1. In your opinion, will employment opportunities for medical insurance specialists in physician practices continue to grow?

1.2 Medical Insurance Basics

medical insurance a written policy stating the terms of an agreement between a policyholder and a health plan

policyholder person who buys an insurance plan

health plan individual or group plan that provides or pays for medical care

Understanding how to work with the revenue cycle begins with medical insurance basics. **Medical insurance,** which is also known as *health insurance*, is a written policy that states the terms of an agreement between a **policyholder**—an individual—and a **health plan**—an insurance company. The policyholder (also called the *insured*, the *member*, or

the *subscriber*) makes payments of a specified amount of money. In exchange, the health plan provides **benefits**—defined by the America's Health Insurance Plans (AHIP) as payments for covered medical services—for a specific period of time. Because they pay for medical expenses, health plans are often referred to as **payers**.

benefits health plan payments for covered medical services

payer health plan or program

BILLING TIP

Third-Party Payers

There are actually three participants in the medical insurance relationship. The patient (policyholder) is the first party, and the physician is the second party. Legally, a patient–physician contract is created when a physician agrees to treat a patient who is seeking medical services. Through this unwritten contract, the patient is legally responsible for paying for services. The patient may have a policy with a health plan, the third party, which agrees to carry some of the risk of paying for those services and therefore is called a **third-party payer.**

third-party payer private or government organization that insures or pays for healthcare on behalf of beneficiaries

Health plans create a variety of insurance products that offer different levels of coverage for various prices. In each product, they must manage the risk that some individuals they insure will need very expensive medical services. They do that by spreading that risk among many policyholders.

Healthcare Benefits

The medical insurance policy contains a **schedule of benefits** that summarizes the payments that may be made for medically necessary medical services that policyholders receive. The payer's definition of **medical necessity** is the key to coverage and payment. A medically necessary service is reasonable and is consistent with generally accepted professional medical standards for the diagnosis or treatment of disease, illness, or injury.

Payers scrutinize the need for medical procedures, examining each bill to make sure that it meets their medical necessity guidelines. The **provider** of the service must also meet the payer's professional standards. Providers include physicians, nurse-practitioners, physician assistants, therapists, hospitals, laboratories, long-term care facilities, and suppliers such as pharmacies and medical supply companies.

schedule of benefits list of medical expenses covered by a health plan

medical necessity payment criterion that requires medical treatments to be appropriate and provided in accordance with generally accepted standards

provider person or entity that supplies medical or health services and bills for, or is paid for, the services in the normal course of business

Covered Services

Covered services are listed on the schedule of benefits. These services may include primary care, emergency care, medical specialists' services, and surgery. Coverage of some services is mandated by state or federal law; others are optional. Some policies provide benefits only for loss resulting from illnesses or diseases, while others also cover accidents or injuries. Many health plans also cover **preventive medical services,** such as annual physical examinations, pediatric and adolescent immunizations, prenatal care, and routine screening procedures such as mammograms.

Not all services that are covered have the same benefits. A policy may pay less of the charges for specialty care than for primary care, for example. Many services are also limited in frequency. A payer may cover just three physical therapy treatments for a condition or a certain screening test every five years, not every year.

covered services medical procedures and treatments that are included as benefits in a health plan

preventive medical services care provided to keep patients healthy or prevent illness

Noncovered Services

The medical insurance policy also describes **noncovered services**—those for which it does not pay. Such **excluded services** or exclusions may include any of the following:

- Most medical policies do not cover dental services, eye examinations or eyeglasses, employment-related injuries, cosmetic procedures, or experimental or investigational procedures.
- Policies may exclude specific items such as vocational rehabilitation or surgical treatment of obesity.
- Many policies do not have prescription drug benefits.

noncovered services medical procedures that are not included in a plan's benefits

excluded services services not covered in a medical insurance contract

Group or Individual Medical Insurance Policies

Either groups or individuals may be insured. In general, policies that are written for groups cost policyholders less than those written for individuals. Group plans are bought by employers or organizations. The employer or the organization agrees to the contract and then offers the coverage to its group members. People who are not eligible for group insurance from employers—for example, independent contractors, temporary or part-time employees, or unemployed people—may purchase individual policies directly from health plans, either private, government, or state sponsored. In either a group or an individual plan, the policyholder's dependents, customarily the spouse and children, may sometimes also be covered for an additional cost.

Disability and Automotive Insurance and Workers' Compensation

Other types of health-related insurance are available. A patient may have disability insurance that provides reimbursement for income lost because of the person's inability to work. Automotive insurance policies cover specific vehicle-related situations. Disability insurance is discussed in the chapter about workers' compensation.

Workers' compensation insurance is purchased by employers to pay benefits and provide medical care for employees who are injured in job-related accidents or develop illnesses from their jobs and to pay benefits to employees' dependents in the event of work-related death. State laws determine the coverage that is required.

THINKING IT THROUGH 1.2

1. Describe the type of medical insurance coverage you have. If you are not insured, describe the policy held by someone you know, or access the website of the Medicare program (Medicare.gov) and click the tab "What Medicare Covers" before answering the following questions: According to the plan's policy information (often printed in a pamphlet that accompanies the policy itself or available online at the plan's website), what benefits does the policy cover? Are some services excluded from coverage? Are any preventive medical services included?

1.3 Healthcare Plans

Although there are many variations, all insurance plans are based on one of the two essential types of plans, indemnity and managed care.

BILLING TIP

Filing Claims for Patients

The practice usually handles the process of billing the insurance company for patients; patients are generally more satisfied with their office visits when this is done for them, and the practice receives payment more quickly.

indemnity plan health plan that reimburses a policyholder for medical services under the terms of its schedule of benefits

healthcare claim electronic transaction or a paper document filed to receive benefits

Indemnity

An indemnity is protection against loss. Under an **indemnity plan**, the payer indemnifies the policyholder against costs of medical services and procedures as listed on the benefits schedule. Patients choose the providers they wish to see. The physician usually sends the **healthcare claim**—a formal insurance claim in either electronic or hard copy format that reports data about the patient and the services provided by the physician—to the payer on behalf of the patient.

Conditions for Payment

For each claim, four conditions must be met before the insurance company makes a payment:

1. The medical charge must be for medically necessary services and covered by the insured's health plan.
2. The insured's payment of the **premium**—the periodic payment the insured is required to make to keep the policy in effect—must be up-to-date. Unless the premium is current, the insured is not eligible for benefits and the insurance company will not make any payment.
3. If part of the policy, a **deductible**—the amount that the insured pays on covered services before benefits begin—must have been met (paid) by the insured. Deductibles range widely, usually from $200 to thousands of dollars annually. Higher deductibles generally mean lower premiums.
4. Any **coinsurance**—the percentage of each claim that the insured pays—must be taken into account. The coinsurance rate states the health plan's percentage of the charge, followed by the insured's percentage, such as 80-20. This means that the payer pays 80 percent of the covered amount and the patient pays 20 percent after the premiums and deductibles are paid.

premium money the insured pays to a health plan for a policy

deductible amount the insured must pay for healthcare services before a health plan's payment begins

coinsurance portion of charges an insured person must pay for covered healthcare services after the deductible

The formula is as follows:

Charge − Deductible − Patient Coinsurance = Health Plan Payment.

Example

An indemnity policy states that the deductible is the first $200 in covered annual medical fees and that the coinsurance rate is 80-20. A patient whose first covered medical charge of the year was $2,000 would owe $560:

Charge	$2,000
Patient owes the deductible	$ 200
Balance	$1,800
Patient also owes coinsurance (20% of the balance)	$ 360
Total balance due from patient	$ 200 + $360 − $560

In this case, the patient must pay an **out-of-pocket** expense of $560 this year before benefits begin. The health plan will pay $1,440, or 80 percent of the balance:

out-of-pocket expenses the insured must pay prior to benefits

Charge	$2,000
Patient payment	−$560
Health plan payment	$1,440

If the patient has already met the annual deductible, the patient's benefits apply to the charge, as in this example:

Charge	$2,000
Patient coinsurance (20%)	$ 400
Health plan payment (80%)	$1,600

BILLING TIP

Out-of-pocket Maximum

Health plans state the out-of-pocket maximum for a given year. Premium payments do not count toward this figure.

Fee-for-Service Payment Approach

fee-for-service payment method based on provider charges

Indemnity plans usually reimburse medical costs on a fee-for-service basis. The **fee-for-service** payment method is retroactive: The fee is paid after the patient receives services from the physician (see the following Figure 1.2).

Managed Care

managed care system combining the financing and delivery of healthcare services

managed care organization (MCO) organization offering a managed healthcare plan

Managed care offers a more restricted choice of (and access to) providers and treatments in exchange for lower premiums, deductibles, and other charges than traditional indemnity insurance. This approach to insurance combines the financing and management of healthcare with the delivery of services. **Managed care organizations (MCOs)** establish links between provider, patient, and payer. Instead of only the patient having a policy with the health plan, both the patient and the provider have agreements with the MCO. This arrangement gives the MCO more control over what services the provider performs and the fees for the services.

Managed care plans, first introduced in California in 1929, are now the predominant type of insurance. More than 90 percent of all insured employees are enrolled in some type of managed care plan, and thousands of different plans are offered. The basic types are:

- Health maintenance organizations
- Point-of-service plans
- Preferred provider organizations
- Consumer-driven health plans

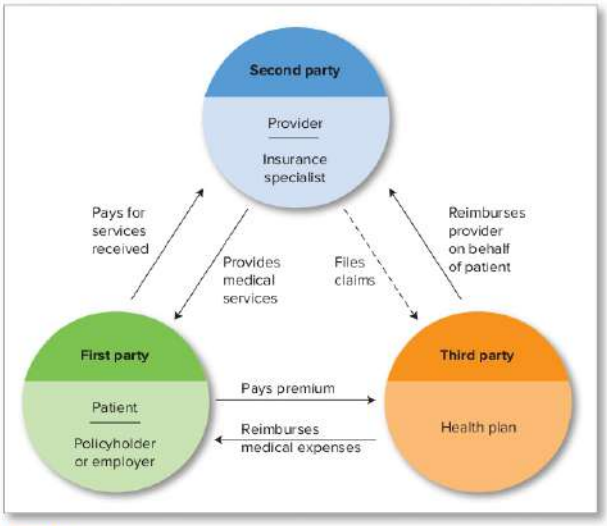

FIGURE 1.2 Payment Under Fee-for-Service

BILLING TIP

Participation as a Provider

Participation means that a provider has contracted with a health plan to provide services to the plan's beneficiaries. Being a participating (PAR) provider brings advantages, such as more patients, as well as contractual duties and, usually, reduced fees.

participation contractual agreement to provide medical services to a payer's policyholders

THINKING IT THROUGH 1.3

1. Which types of health plans, indemnity or managed care, are likely to offer patients more selection in terms of which physicians patients can visit?

1.4 Health Maintenance Organizations

A **health maintenance organization (HMO)** combines coverage of medical costs and delivery of healthcare for a prepaid premium. The HMO creates a network of physicians, hospitals, and other providers by employing or negotiating contracts with them. The HMO then enrolls members in a health plan under which they use the services of those network providers. In most states, HMOs are licensed and are legally required to provide certain services to members and their dependents. Preventive care is often required as appropriate for each age group, such as immunizations and well-baby checkups for infants and screening mammograms for women.

health maintenance organization (HMO) managed healthcare system in which providers offer healthcare to members for fixed periodic payments

Capitation in HMOs

Capitation (from *capit*, Latin for *head*) is a fixed prepayment to a medical provider for all necessary contracted services provided to each patient who is a plan member (see Figure 1.3). The capitated rate is a prospective payment—it is paid *before* the patient visit. It covers a specific period of time. The health plan makes the payment whether the patient receives many or no medical services during that specified period.

capitation a fixed prepayment covering provider's services for a plan member for a specified period

In capitation, the physician agrees to share the risk that an insured person will use more services than the fee covers. The physician also shares in the prospect that an insured person will use fewer services. In fee-for-service, the more patients the provider sees, the more charges the health plan reimburses. In capitation, the payment per patient remains the same, and the provider risks receiving lower per-visit revenue.

Example

A family physician has a contract for a capitated payment of $30 a month for each of a hundred patients in a plan. This $3,000 monthly fee ($30 × 100 patients = $3,000) covers all office visits for all the patients. If half of the patients see the physician once during a given month, the provider in effect receives $60 for each visit ($3,000 divided by 50 visits). If, however, half of the patients see the physician four times in a month, the monthly fee is $3,000 divided by 200 visits, or $15 for each visit.

A patient is enrolled in a capitated health plan for a specific time period, such as a month, a quarter, or a year. The capitated rate, which is called **per member per month (PMPM)**, is usually based on the health-related characteristics of the enrollees, such as age and gender. The health plan analyzes these factors and sets a rate based on its prediction of the amount of healthcare each person will need. The capitated rate of prepayment covers only services listed on the schedule of benefits for the plan. The provider may bill the patient for any other services. ◂

per member per month (PMPM) periodic capitated prospective payment to a provider that covers only services listed on the schedule of benefits

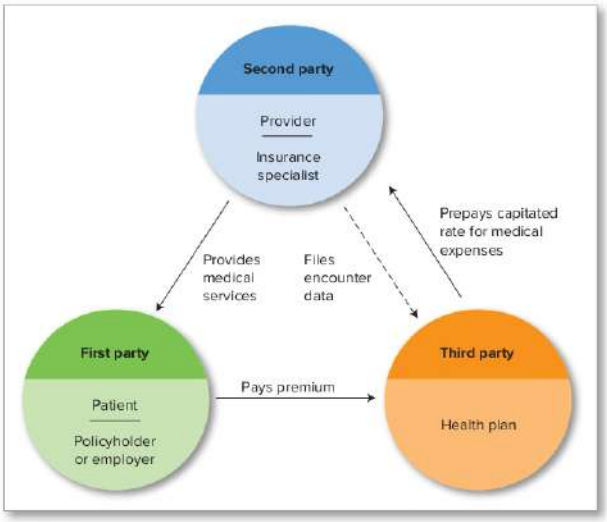

FIGURE 1.3 Payment Under Capitation

Medical Management Practices in HMOs

Health maintenance organizations seek to control rising medical costs and at the same time improve healthcare.

Cost Containment An HMO uses the following cost-containment methods:

- *Restricting patients' choice of providers:* After enrolling in an HMO, members must receive services from the **network** of physicians, hospitals, and other providers who are employed by or under contract to the HMO. Visits to **out-of-network** providers are not covered except for emergency care or urgent health problems that arise when the member is temporarily away from the geographical service area.
- *Requiring preauthorization for services:* HMOs often require **preauthorization** (also called *precertification* or *prior authorization*) before the patient receives many types of services. The HMO may require a second opinion—the judgment of another provider that a planned procedure is necessary—before authorizing service. Services that are not preauthorized are not covered. Preauthorization is almost always needed for non-emergency hospital admission, and it is usually required within a certain number of days after an emergency admission.
- *Controlling the use of services:* HMOs develop medical necessity guidelines for the use of medical services. The HMO holds the provider accountable for any questionable service and may deny a patient's or provider's request for preauthorization.

  For example, a patient who has a rotator cuff shoulder injury repair can receive a specific number of physical therapy sessions. More sessions will not be covered unless additional approval is obtained. Emergency care is particularly tightly controlled because it is generally the most costly way to deliver services. These guidelines are also applied to hospitals in the network, which, for instance, limit the number of days patients can remain in the hospital following particular surgeries.

network a group of healthcare providers, including physicians and hospitals, who sign a contract with a health plan to provide services to plan members

out-of-network provider who does not have a participation agreement with a plan

preauthorization prior authorization from a payer for services to be provided

- *Controlling drug costs:* Providers must prescribe drugs for patients only from the HMO's list of selected pharmaceuticals and approved dosages, called a *formulary*. Drugs that are not on the list require the patient to have preauthorization, which is often denied.
- *Cost-sharing:* At the time an HMO member sees a provider, he or she pays a specified charge called a **copayment** (or copay). A lower copayment may be charged for an office visit to the primary care physician, and a higher copayment may be required for a visit to the office of a specialist or for the use of emergency department services.
- *Requiring referrals:* HMOs may require a patient to select a **primary care physician (PCP)**–also called a *gatekeeper*–from the HMO's list of general or family practitioners, internists, and pediatricians. A PCP coordinates patients' overall care to ensure that all services are, in the PCP's judgment, necessary. In gatekeeper plans, an HMO member needs a medical **referral** from the PCP before seeing a specialist or a consultant and for hospital admission. Members who visit providers without a referral are directly responsible for the total cost of the service.

copayment specified amount a beneficiary must pay at the time of a healthcare encounter

primary care physician (PCP) physician in a health maintenance organization who directs all aspects of a patient's care

referral transfer of patient care from one physician to another

Historically, the first HMOs used all of these cost-containment methods and reduced operating costs. However, both physicians and patients became dissatisfied with the policies. Physicians working under managed care contracts complained that they were not allowed to order needed treatments and tests. Patients often reported that needed referrals were denied. In response, the medical management practices of HMOs increasingly emphasize the quality of healthcare as well as the cost of its delivery. Just as providers must demonstrate that their services are both effective and efficient, HMOs must demonstrate that they can offer these services at competitive prices while improving the quality of healthcare.

Healthcare Quality Improvements The quality improvements made by HMOs are illustrated by these features, which most plans contain:

- *Disease and case management:* Some patients face difficult treatments, such as for high-risk pregnancies, and others need chronic care for conditions such as congestive heart failure, diabetes, and asthma. HMOs often assign case managers to work with these patients. Some conditions require case managers who are healthcare professionals. Others are assigned to people who are familiar with the healthcare system, such as social workers. The goal of case managers is to make sure that patients have access to all needed treatments. For example, physician case managers coordinate appropriate referrals to consultants, specialists, hospitals, and other services. Other types of case managers provide patient education, special equipment such as a blood glucose meter for a diabetic, and ongoing contact to monitor a patient's condition.
- *Preventive care:* Preventive care, which seeks to prevent the occurrence of conditions through early detection of disease, is emphasized through provisions for annual check-ups, screening procedures, and inoculations.
- *Pay-for-performance (P4P):* HMOs collect and analyze large amounts of data about patients' clinical treatments and their responses to treatment. In this way, the HMOs can establish the most effective protocols–detailed, precise treatment regimens that work best. HMOs use financial incentives to encourage their providers to follow these protocols.

Point-of-Service Plans and Exclusive Provider Organizations

Many patients dislike HMO rules that restrict their access to physicians. In order to better compete for membership, a *point-of-service (POS) plan*, also called an open HMO, reduces restrictions and allows members to choose providers who are not in the HMO's network.

Members must pay additional fees that are set by the plan when they use out-of-network providers. Typically, the patient must pay 20 to 30 percent of the charge for out-of-network service, and the deductible can be very high. The HMO pays out-of-network providers on a fee-for-service basis.

An exclusive provider organization (EPO) plan is similar. EPOs generally do not cover care outside the plan's provider network. These plans, though, do not usually require referrals to specialists.

THINKING IT THROUGH 1.4

1. Managed care organizations often require different payments for different services. Table 1.1 shows the copayments for an HMO health plan. Study this schedule and answer these questions:
   - **A.** Does this health plan cover diabetic supplies? Dental exams? Emergency services?
   - **B.** Is the copayment amount for a PCP visit higher or lower than the charge for specialty care?

Table 1.1 Example of Benefits Under an HMO

	Copayments
Primary Care Physician Visits	
Office Hours	$20
After Hours and Home Visits	$20
Specialty Care	
Office Visits	$30
Diagnostic Outpatient Testing	$20
Phys, Occ, Speech Therapy	$20
SPU Surgery	$250
Hospitalization	$250
Emergency Room (copay waived if admitted)	$35
Maternity	
First OB Visit	$30
Hospital	$250
Mental Health	
Inpatient	$250, 60 days
Outpatient	$30
Substance Abuse	
Detoxification	$250
Inpatient Rehab (combined with mental health coverage)	$250
Outpatient Rehabilitation	$30
Preventive Care	
Routine Eye Exam	Not covered
Routine GYN Exam	$30
Pediatric Preventive Dental Exam	Not covered
Chiropractic Care (20 visits per condition)	$20
Prescriptions	$15/$20/$30
	$150 deductible/calendar year
Contraceptives	Covered
Diabetic Supplies	Covered
31–90 Day Supply	$30/$40/$60
Durable Medical Equipment	No copay

1.5 Preferred Provider Organizations

A **preferred provider organization (PPO)** is another healthcare delivery system that manages care. PPOs are the most popular type of insurance plan. They create a network of physicians, hospitals, and other providers with whom they have negotiated discounts from the usual fees. For example, a PPO might sign a contract with a practice stating that the fee for a brief appointment will be $60, although the practice's physicians usually charge $80. In exchange for accepting lower fees, providers—in theory, at least—see more patients, thus making up the revenue that is lost through the reduced fees.

preferred provider organization (PPO) managed care organization in which a network of providers supplies discounted treatment for plan members

A PPO requires payment of a premium and often of a copayment for visits. It does not require a primary care physician to oversee patients' care. Referrals to specialists are also not required. Premiums and copayments, however, are higher than in HMO or POS plans. Members choose from many in-network generalists and specialists. PPO members also can use out-of-network providers, usually for higher copayments, increased deductibles, or both.

Example

A PPO member using an in-network provider pays a $20 copayment at the time of service (the visit), and the PPO pays the full balance of the visit charge. A member who sees an out-of-network provider usually pays a deductible and a coinsurance that is a higher percentage than in-network visits.

As managed care organizations, PPOs also control the cost of healthcare by:

- *Directing patients' choices of providers:* PPO members have financial incentives to receive services from the PPO's network of providers.
- *Controlling use of services:* PPOs have guidelines for appropriate and necessary medical care.
- *Requiring preauthorization for services:* PPOs may require preauthorization for nonemergency hospital admission and for some outpatient procedures.
- *Requiring cost-sharing:* PPO members are also required to pay copayments for general or specialist services. ◂

THINKING IT THROUGH 1.5

1. In your opinion, why are PPOs the most popular type of insurance plan?

1.6 Consumer-Driven Health Plans

Consumer-driven health plans (CDHPs), also known as high-deductible health plans, combine two elements. The first element is a health plan, usually a PPO, that has a high deductible (such as $5,000) and low premiums. The second element is a special "savings account" that is used to pay medical bills before the deductible has been met. The savings account, similar to an individual retirement account (IRA), lets people put aside untaxed wages that they may use to cover their out-of-pocket medical expenses. Some employers contribute to employees' accounts as a benefit.

consumer-driven health plan (CDHP) medical insurance that combines a high-deductible health plan with a medical savings plan

Cost containment in consumer-driven health plans begins with consumerism—the idea that patients who themselves pay for healthcare services become more careful consumers. Both insurance companies and employers believe that asking patients to pay a larger portion of medical expenses reduces costs. To this are added the other controls typical of a PPO, such as in-network savings and higher costs for out-of-network visits.

The major types of plans are summarized in Table 1.2.

Table 1.2 Comparison of Health Plan Options

Plan Type	Provider Options	Cost-Containment Methods	Features
Indemnity Plan	Any provider	• Little or none • Preauthorization required for some procedures	• Higher costs • Deductibles • Coinsurance • Preventive care coverage limited
Health Maintenance Organization (HMO)	Only HMO network providers	• Primary care physician manages care; referral required • No payment for out-of-network nonemergency services • Preauthorization required	• Low copayment • Limited provider network • Covers preventive care
Point-of-Service (POS) and Exclusive Provider Organizations (EPOs)	Network providers or out-of-network providers	• Within network, primary care physician manages care	• Lower copayments for network providers • Higher costs for out-of-network providers • Covers preventive care
Preferred Provider Organization (PPO)	Network or out-of-network providers	• Referral not required for specialists • Fees are discounted • Preauthorization for some procedures	• Higher cost for out-of-network providers • Preventive care coverage varies
Consumer-Driven Health Plan (CDHP)	Usually similar to PPO	• Increases patient awareness of healthcare costs • Patient pays directly until high deductible is met	• High deductible/low premium • Savings account

THINKING IT THROUGH 1.6

1. What two elements are combined in a consumer-driven health plan?

COMPLIANCE GUIDELINE

Unpaid Healthcare

Under the federal Emergency Medical Treatment and Active Labor Act, or EMTALA, hospital emergency departments must provide care for all patients in need of medical services, regardless of their ability to pay. More than $100 billion in unpaid healthcare is provided annually for uninsured and underinsured patients.

1.7 Medical Insurance Payers

Based on the 2017 U.S. Census Bureau data, 91.2 percent of people in the United States have medical coverage through private payers, self-funded health plans, or government programs. Just over 28 million people that year had no insurance. See Figure 1.4 for a breakdown of the types of insurance held.

Private Payers

A small number of large insurance companies dominate the national market and offer all types of health plans. There are also a number of nonprofit organizations, such as Kaiser Permanente, which is the largest nonprofit HMO. Some organizations, such as the Blue Cross and Blue Shield Association, have both for-profit and nonprofit parts.

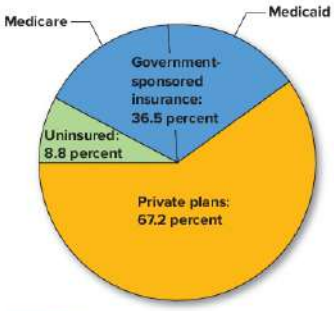

FIGURE 1.4 Types of Insurance Held

Source: U.S. Census Bureau, "Health Insurance Coverage: 2017," www.census.gov/hhes.

Private payers have contracts with businesses to provide benefits for their employees. These may be large-group or small-group healthcare plans. Payers may also offer individual insurance coverage.

Self-Funded Health Plans

Most large employers that offer insurance have established themselves as **self-funded (self-insured) health plans.** Rather than paying premiums to an insurance carrier, the organization "insures itself." It assumes the risk of paying directly for medical services and sets up a fund from which it pays for claims. The organization establishes the benefit levels and the plan types it will offer. Self-funded health plans may set up their own provider networks or, more often, buy the use of existing networks from managed care organizations.

self-funded (self-insured) health plan organization pays for health insurance directly and sets up a fund from which to pay

Most self-funded health plans are set up as PPOs; fewer than 10 percent are set up as HMOs. As discussed in the chapter about private payers, being self-insured changes the regulations under which a plan works, giving the employer some financial advantages over paying for coverage through a typical insurance company.

Government-Sponsored Healthcare Programs

The four major government-sponsored healthcare programs offer benefits for which various groups in the population are eligible:

1. Medicare is a 100 percent federally funded health plan that covers people who are sixty-five and over and those who, regardless of age, are disabled or have permanent kidney failure (end-stage renal disease, or ESRD).
2. Medicaid, a federal program that is jointly funded by federal and state governments, covers low-income people who cannot afford medical care. Each state administers its own Medicaid program, determining the program's qualifications and benefits under broad federal guidelines.
3. TRICARE, a Department of Defense program, covers medical expenses for active-duty members of the uniformed services and their spouses, children, and other dependents; retired military personnel and their dependents; and family members of deceased active-duty personnel. (This program replaced CHAMPUS, the Civilian Health and Medical Program of the Uniformed Services, in 1998.)

4. CHAMPVA, the Civilian Health and Medical Program of the Department of Veterans Affairs, covers the spouses and dependents of veterans with permanent service-related disabilities. It also covers surviving spouses and dependent children of veterans who died from service-related disabilities.

These government programs are covered in the chapters about Medicare, Medicaid, TRICARE, and CHAMPVA.

THINKING IT THROUGH 1.7

1. In your opinion, should having medical insurance be mandated? Is it fair to charge monetary penalties for people who do not have insurance?

1.8 The Revenue Cycle

medical insurance specialist staff member who handles billing, checks insurance, and processes payments

In this text, the job title **medical insurance specialist** encompasses all the tasks that are completed by administrative staff members during the revenue (*medical billing*) cycle. Typically, *front office* staff members handle duties such as reception (registration) and scheduling. *Back office* staff duties are related to billing, insurance, and collections. Job titles in common use are billing clerk, insurance specialist, reimbursement specialist, and claims specialist. The broad picture of the medical insurance specialist is presented in *Medical Insurance*, Eighth Edition, to provide the widest background for future employment.

The main job functions of medical insurance specialists are:

- To understand patients' responsibilities for paying for medical services
- To analyze charges and insurance coverage to prepare accurate, timely claims
- To collect payment for medical services from health plans and from patients

These functions entail:

- Verifying patient insurance information and eligibility before medical services are provided
- Collecting payments that are due, such as copayments, at the time of service
- Maintaining up-to-date information about health plans' billing guidelines
- Following federal, state, and local regulations on maintaining the confidentiality of information about patients
- Abstracting information from patients' records for accurate billing
- Billing health plans and patients, maintaining effective communication to avoid problems or delayed payments
- Assisting patients with insurance information and required documents
- Processing payments and requests for further information about claims and bills
- Maintaining financial records
- Updating the forms and computer systems that the practice uses for patient information and healthcare claims processing

To complete their duties and contribute to financial success, medical insurance specialists follow the series of steps in the revenue cycle that leads to maximum, appropriate, timely payment for patients' medical services (see Figure 1.5).

BILLING TIP

The Revenue Cycle

Study the revenue cycle in Figure 1.5 as you read the steps. Refer to the cycle as you read the text's chapters; it serves as your path toward expertise in medical insurance.

BEFORE THE ENCOUNTER	Step 1	Preregister patients
DURING THE ENCOUNTER	Step 2	Establish financial responsibility
	Step 3	Check in patients
	Step 4	Review coding compliance
	Step 5	Review billing compliance
	Step 6	Check out patients
AFTER THE ENCOUNTER	Step 7	Prepare and transmit claims
	Step 8	Monitor payer adjudication
	Step 9	Generate patient statements
	Step 10	Follow up payments and collections

FIGURE 1.5 The Revenue Cycle

Step 1 Preregister Patients

The first step in the revenue cycle is to preregister patients. It involves two main tasks:

- Schedule and update appointments
- Collect preregistration demographic and insurance information

New patients who call for appointments provide basic personal and insurance information to the scheduler. Both new and returning patients are asked about the medical reason for the visit so appropriate visits can be scheduled for them.

Step 2 Establish Financial Responsibility

The second step is very important: determine financial responsibility for visits. For insured patients, these questions must be answered:

- What services are covered under the plan? What medical conditions establish medical necessity for these services?
- What services are not covered?
- What are the billing rules of the plan?
- What is the patient responsible for paying?

Knowing the answers to these questions is essential to correctly bill payers for patients' covered services. This knowledge also helps medical insurance specialists ensure that patients will pay their bills when benefits do not apply.

To determine financial responsibility, these procedures are followed:

- Verify patients' eligibility for their health plan.
- Check the health plan's coverage.
- Determine the first payer if more than one health plan covers the patient (this is the payer to whom the first claim will be sent).
- Meet payers' conditions for payment, such as preauthorization, ensuring that the correct procedures are followed to meet them.

The practice's financial policy—which defines when bills have to be paid—is explained so that patients understand the revenue cycle. Patients are told that they are responsible for paying charges that are not covered under their health plans. Uninsured patients are

informed of their responsibility for the entire charge. Payment options are presented if the bill will be large.

Step 3 Check In Patients

The third step is to check in individuals as patients of the practice. When new patients arrive for their appointments, detailed and complete demographic and medical information is collected at the front desk. Returning patients are asked to review the information that is on file for them, making sure that demographics and medical data are accurate and up-to-date. Their financial records are also checked to see whether balances are due from previous visits.

COMPLIANCE GUIDELINE

ICD-9-CM versus ICD-10-CM

ICD-9-CM was required until October 1, 2015, after which ICD-10-CM must be used for medical coding.

Both the front and back of insurance cards and other identification cards, such as driver's licenses, are scanned or photocopied and stored in the patient's record. If the health plan requires a copayment, the correct amount is noted for the patient. Copayments should always be collected at the time of service. Some practices collect copayments before the patient's encounter with the physician, others after the encounter.

A number of other important forms may need to be completed by patients. These forms are part of the process of recording administrative and clinical facts about patients. Often, they involve authorizing planned procedures and payments to the practice from the health plan.

During the office visit, a physician evaluates, treats, and documents a patient's condition. These notes include the procedures performed and treatments provided, as well as the physician's determination of the patient's complaint or condition.

Steps 1–3 are covered in later chapters of this text.

Step 4 Review Coding Compliance

medical coder staff member with specialized training who handles diagnostic and procedural coding

diagnosis code number assigned to a diagnosis

To bill for the visit, the medical diagnoses and procedures must be assigned medical codes. In some practices, physicians assign these codes; in others, a **medical coder** or a medical insurance specialist handles this task. The medical insurance specialist may verify the codes with data in the patient's medical record.

The patient's primary illness is assigned a **diagnosis code** from the *International Classification of Diseases*, 10th Revision, *Clinical Modification* (ICD-10-CM) (see the chapter about diagnostic coding).

Example

The ICD-10-CM code for Alzheimer's disease is G30.9.

The ICD-10-CM code for frostbite with tissue necrosis of the left wrist is T34.512A. ◂

procedure code code that identifies medical treatment or diagnostic services

Similarly, each procedure the physician performs is assigned a **procedure code** that stands for the particular service, treatment, or test. This code is selected from the *Current Procedural Terminology* (CPT) (see the chapter about procedural coding). A large group of codes covers the physician's evaluation and management of a patient's condition during office visits or visits at other locations, such as nursing homes. Other codes cover groups of specific procedures, such as surgery, pathology, and radiology. Another group of codes covers supplies and other services.

Example

99460 is the CPT code for the physician's examination of a newborn infant.

27130 is the CPT code for a total hip replacement operation.

The physician identifies the patient's diagnoses and procedures. The medical insurance specialist uses this information after the encounter to update the patient's account in the PMP. The transactions for the visit, which include both the charges and any

payment the patient has made, are entered in the **patient ledger** (the record of a patient's financial transactions; also called the *patient account record* when stored in the PMP), and the patient's balance is updated. Following is an example of the account for one patient's recent series of visits:

patient ledger record of a patient's financial transactions

Date/Procedure		Charge	Payment		Balance
7/2/2029	OV	200.00		200.00	—
7/3/2029	OV	150.00			
7/4/2029	INS	—		—	150.00
7/13/2029	PMT		Insurance	120.00	30.00
7/25/2029	STM	—		—	30.00
7/30/2029	PMT		Patient	30.00	0.00

This formula is followed to calculate the current balance:

Previous Balance + Charge − Payment = Current Balance.

In this example, on 7/2, the patient's office visit (OV) resulted in a $200 charge. The patient paid this bill, so there is no current balance. The patient's next office visit, 7/3, resulted in a charge of $150. The medical insurance specialist sent a healthcare claim to the health plan (INS for insurance) the next day, and the payer paid $120 (PMT) on 7/13. This payment is subtracted from the charge to equal the current balance of $30.

As noted on the account, then a statement (STM) (a bill) was sent to the patient on 7/25 showing the current balance now owed. The patient sent a payment of $30 (PMT) received on 7/30, which reduced the patient's current balance to zero. ◂

At the time of the visit, patients may owe a previous balance, coinsurance, deductibles, and/or fees for noncovered services. Payments may be made by cash, check, or credit or debit card. When a payment is made, a receipt is given to the patient. Patients' follow-up visits are also scheduled.

Coding Compliance

Compliance means actions that satisfy official requirements. In the area of coding, compliance involves following official guidelines when codes are assigned. Also, after diagnosis and procedure codes are selected, they must be checked for errors. The diagnosis and the medical services that are documented in the patient's medical record should be logically connected (linked), so that the payer understands the medical necessity of the charges.

compliance actions that satisfy official requirements

Step 5 Review Billing Compliance

Each charge, or fee, for a visit is related to a specific procedure code. The provider's fees for services are listed on the medical practice's fee schedule. Most medical practices have standard fee schedules listing their usual fees.

Although a separate fee is associated with each code, each code is not necessarily billable. Whether a code can be billed depends on the payer's rules. Following these rules when preparing claims results in billing compliance. Some payers combine certain physician work in the payment for another code. Medical insurance specialists apply their knowledge of payer guidelines to analyze what can be billed on healthcare claims.

Step 6 Check Out Patients

Checkout is the last step that occurs while the patient is still in the office. The medical codes have been assigned and checked, and the amounts to be billed have also been verified according to payers' rules. The charges for the visit are calculated and discussed

with the patient. Payment for these types of charges is usually collected at the time of service:

- Previous balances
- Copayments or coinsurance
- Noncovered services
- Charges of nonparticipating providers
- Charges for self-pay patients
- Deductibles

A receipt is prepared for the payments made by the patients, and follow-up work is scheduled as ordered by the physician.

Steps 4, 5, and 6 are covered in Chapters 4–6.

Step 7 Prepare and Transmit Claims

A major step in the revenue cycle is the preparation of accurate, timely healthcare claims. Most practices use the PMP to prepare claims for their patients and send them to the payer electronically. A claim communicates information about the diagnosis, procedures, and charges to a payer. A claim may be for reimbursement for services rendered or to report an encounter to an HMO. The practice has a schedule for transmitting claims, such as daily or every other day, which is followed.

General information on claims found in the chapters about healthcare claim preparation and transmission, private payers, and workers' compensation explains how to prepare correct claims for each major payer group:

- Private payers or Blue Cross and Blue Shield
- Medicare
- Medicaid
- TRICARE and CHAMPVA
- Workers' compensation and disability
- A related topic, hospital coding and billing, is covered in Chapter 17.

Step 8 Monitor Payer Adjudication

Once healthcare claims have been sent to health plans, it is important to collect payments as soon as possible. The money due from the plans, as well as payments due from patients, adds up to the practice's accounts receivable (AR)—the money that is needed to run the practice.

adjudication health plan process of examining claims and determining benefits

Payers review claims by following a process known as **adjudication.** This term means that the payer puts the claim through a series of steps designed to judge whether it should be paid. What the payer decides about the claim—to pay it in full, to pay some of it, to *pend* it for further information to arrive, or to deny it—is explained on a report sent back to the provider with the payment. Common reasons that claims are not paid in full include factual errors and failure to satisfy the payer's medical necessity guidelines. When patients are covered by more than one health plan, the additional plans are then sent claims based on the amounts still due.

The amount of the payment depends on the practice's contract with the payer. Seldom do the practice's fee and the payer's fee match exactly. Most payers have their own fee schedules for providers with whom they have contractual arrangements. The medical insurance specialist compares each payment with the claim to check that:

- All procedures that were listed on the claim also appear on the payment transaction.
- Any unpaid charges are explained.
- The codes on the payment transactions match those on the claim.
- The payment listed for each procedure is correct according to the contract with the payer.

If discrepancies are found, an appeal process may be started. In this process, the medical insurance specialist follows payers' or state rules to seek full appropriate reimbursement for a claim.

When a patient is covered by more than one health plan, the second and any other plans must be sent claims.

Step 8 is covered in Chapter 13.

Step 9 Generate Patient Statements

Payers' payments are applied to the appropriate patients' accounts. In most cases, these payments do not fully pay the bills, and patients will be billed for the rest. The amount paid by all payers (the primary insurance and any other insurance) plus the amount to be billed to the patient should equal the expected fee. Bills that are mailed to patients list the dates and services provided, any payments made by the patient and the payer, and the balances now due.

Step 10 Follow Up Payments and Collections

Patient payments are regularly analyzed for overdue bills. A collection process is often started when patient payments are later than permitted under the practice's financial policy.

Patient medical records and financial records are stored and retained according to the medical practice's policy. Federal and state regulations govern what documents are kept and for how long.

Steps 9 and 10 are covered in Chapter 14.

THINKING IT THROUGH 1.8

1. In your opinion, is each of the following procedures likely to be considered medically necessary by a payer's healthcare claims examiner? Why?

   A. Diagnosis: deviated septum

   _____ Procedure: nasal surgery

   B. Diagnosis: mole on a female patient's cheek, questionable nature

   _____ Procedure: surgical removal and biopsy

   C. Diagnosis: male syndrome hair loss

   _____ Procedure: implant hair plugs on scalp

   D. Diagnosis: probable broken wrist

   _____ Procedure: comprehensive full-body examination, with complete set of lab tests, chest X-ray, and electrocardiography (ECG)

1.9 Achieving Success

In addition to working in physicians' practices, medical insurance specialists work in clinics, for hospitals or nursing homes, and in other healthcare settings such as in insurance companies as claims examiners, provider relations representatives, or benefits analysts. The majority of these employees work for small- to medium-sized practices that range from solo doctors to multi-physician practices. Positions are also available in government and public health agencies. Employment with companies that offer billing or consulting services to healthcare providers is an option, as is self-employment as a claims assistance professional who helps consumers with medical insurance problems or as a billing service for providers.

In small physician practices, medical insurance specialists handle a variety of billing and collections tasks. In larger medical practices, duties may be more specialized. Billing, insurance, and collections duties may be separated, or a medical insurance specialist may work exclusively with claims sent to just one of many payers, such as Medicare or workers' compensation. Practice size varies by specialty. Seventy-five percent of physicians

provide care in small settings, usually in practices with one to three physicians. Specialties that require a lot of technology, such as radiology, tend to have large single-specialty medical groups.

professionalism acting for the good of the public and the medical practice

Regardless of the size of the practice, the most important characteristic that medical insurance specialists should evidence is **professionalism**, always acting for the good of the public and the medical practice they serve. Professional staff members act with honor and integrity to ensure a high quality of service. They are internally motivated to do their best. They aim for a professional image in their appearance, their actions, and their oral communications.

Requirements for Success

A number of skills and attributes are required for successful mastery of the tasks of a medical insurance specialist.

Skills

Knowledge of medical terminology, anatomy, physiology, and medical coding: Medical insurance specialists must analyze physicians' descriptions of patients' conditions and treatments and relate these descriptions to the systems of diagnosis and procedure codes used in the healthcare industry.

Communication skills: The job of a medical insurance specialist requires excellent oral and written communication skills. For example, patients often need explanations of insurance benefits or clarification of instructions such as referrals. Courteous, helpful answers to questions strongly influence patients' willingness to continue to use the practice's services. Memos, letters, telephone calls, and e-mails are used to research and follow up on changes in health plans' billing rules. Communication skills also are needed to create and send collection letters that are effective and claim attachments that explain special conditions or treatments so as to obtain maximum reimbursement.

Attention to detail: Many aspects of the job involve paying close attention to detail, such as correctly completing healthcare claims, filing patients' medical records, recording preauthorization numbers, calculating the correct payments, and posting payments for services.

Flexibility: Working in a changing environment requires the ability to adapt to new procedures, handle varying kinds of problems and interactions during a busy day, and work successfully with different types of people with various cultural backgrounds.

BILLING TIP

Keeping Up-to-Date: The Internet

The Internet is frequently used for research about government regulations, payer billing updates, and code updates. Ignorance of new instructions, rules, or codes is not an excuse for incorrect billing. Experienced medical insurance specialists make it a habit to regularly check the websites that are most important for their billing environment. Many are provided throughout this text and summarized in Appendix C.

Health information technology (HIT) skills: Most medical practices use computers to handle billing and process claims. Many also use or plan to use computers to keep patients' medical records. General computer literacy is essential, including working knowledge of an operating system, a word-processing program, a medical billing program, Internet-based research, and use of social media. Data-entry skills are also necessary. Many human errors occur during data entry, such as pressing the wrong key on the keyboard. Other errors are a result of a lack of computer literacy—not knowing how to use a program to accomplish tasks. For this reason, proper training in data-entry techniques and in using computer programs are essential for medical insurance specialists.

Honesty and integrity: Medical insurance specialists work with patients' medical records and with finances. It is essential to maintain the confidentiality of patient information and communications as well as to act with integrity when handling these tasks.

Ability to work as a team member: Patient service is a team effort. To do their part, medical insurance specialists must be cooperative and must focus on the best interests of the patients and the practice.

Attributes

A number of attributes are also very important for success as a medical insurance specialist. Most have to do with the quality of professionalism, which is key to getting and keeping employment. These factors include the following:

Appearance: A neat, clean, professional appearance increases other people's confidence in your skills and abilities. When you are well groomed, with clean hair, nails, and clothing, patients and other staff members see your demeanor as businesslike. Many employers do not permit visible piercings or tattoos, and following their guidelines is critical for being hired and keeping the job.

Attendance: Being on time for work demonstrates that you are reliable and dependable.

Initiative: Being able to start a course of action and stay on task is an important quality to demonstrate.

Courtesy: Treating patients and fellow workers with dignity and respect helps build solid professional relationships at work.

Medical Ethics and Etiquette in the Practice

Licensed medical staff and other employees working in physicians' practices share responsibility for observing a code of ethics and for following correct etiquette.

Ethics

Medical **ethics** are standards of behavior requiring truthfulness, honesty, and integrity. Ethics guide the behavior of physicians, who have the training, the primary responsibility, and the legal right to diagnose and treat human illness and injury. All medical office employees and those working in health-related professions share responsibility for observing the ethical code.

ethics standards of conduct based on moral principles

Each professional organization has a code of ethics that is to be followed by its membership. In general, this code states that information about patients and other employees and confidential business matters should not be discussed with anyone not directly concerned with them. Behavior should be consistent with the values of the profession. For example, it is unethical for an employee to take money or gifts from a company in exchange for giving the company business.

Etiquette

Professional **etiquette** is also important for medical insurance specialists. Correct behavior in a medical practice is generally covered in the practice's employee policy and procedure manual. For example, guidelines establish which types of incoming calls must go immediately to a physician or to a nurse or assistant and which require a message to be taken. Of particular importance are guidelines about the respectful and courteous treatment of patients and all others who interact with the practice's staff.

etiquette standards of professional behavior

THINKING IT THROUGH 1.9

1. Dorita McCallister, the office manager of Clark Clinic, ordered medical office supplies from her cousin, Gregory Hand. When the supplies arrived, Gregory came to the office to check on them and to take Dorita out to lunch. Is Dorita's purchase of supplies from her cousin ethical? Why?
2. George McGrew is a medical insurance specialist in the practice of Dr. Sylvia Grets. Over the past few weeks, Dr. Grets has consistently assigned procedure codes that stand for lengthy, complex appointments to visits that were actually for the administration of flu shots—a brief procedure. Is it ethical for George to report these codes on healthcare claims?

1.10 Moving Ahead

Completion of a medical insurance specialist program, coding specialist program, or medical assisting or health information technology program at a postsecondary institution provides an excellent background for many types of positions in the medical insurance field. Another possibility is to earn an associate degree or a certificate of proficiency by completing a program in a curriculum area such as healthcare business services. Further baccalaureate and graduate study enables advancement to managerial positions.

certification recognition of a superior level of skill by an official organization

Moving ahead in a career is often aided by membership in professional organizations that offer certification in various areas. **Certification** by a professional organization provides evidence to prospective employers that the applicant has demonstrated a superior level of skill on a national test. Certification is the process of earning a credential through a combination of education and experience followed by successful performance on a national examination.

CMA

American Association of Medical Assistants (AAMA)
20 N. Wacker Drive, Suite 1575
Chicago, IL 60606-2903
312-899-1500
www.aama-ntl.org

Medical Assisting Certification

Two organizations offer tests in the professional area of medical assisting. After earning a diploma in medical assisting from an accredited program (or having five years' work experience [for the RMA only]), medical assistants may sit for the Certified Medical Assistant (CMA) title from the American Association of Medical Assistants or the Registered Medical Assistant (RMA) designation from the American Medical Technologists.

RMA

American Medical Technologists (AMT)
10700 West Higgins Road, Suite 150
Rosemont, IL 60018
847-823-5169
www.AmericanMedTech.org

Health Information Certification

Students who are interested in the professional area of health information (also known as *medical records*) may complete an associate degree from an accredited college program and pass a credentialing test from the American Health Information Management Association (AHIMA) to be certified as a Registered Health Information Technician, or RHIT. An RHIT examines medical records for accuracy, reports patient data for reimbursement, and helps with information for medical research and statistical data.

RHIT, RHIA, CCS, CCS-P, CCA

American Health Information Management Association (AHIMA)
233 N. Michigan Ave., 21st Floor
Chicago, IL 60601-5809
800-335-5535
www.ahima.org

Also offered is the Registered Health Information Administrator (RHIA), requiring a baccalaureate degree and national certification. RHIAs are skilled in the collection, interpretation, and analysis of patient data. Additionally, they receive the training necessary to assume managerial positions related to these functions. RHIAs interact with all levels of an organization—clinical, financial, and administrative—that employ patient data in decision making and everyday operations.

RHITs and RHIAs enjoy job placements in a broad range of settings that span the continuum of healthcare, including office-based physician practices, nursing homes, home health agencies, mental health facilities, and public health agencies. The growth of managed care has created additional job opportunities in HMOs, PPOs, and insurance companies. Prospects are especially strong in these settings for RHIAs who possess advanced degrees in business or health administration and informatics.

CPC, CIC, CPC-P, CPC-A

American Academy of Professional Coders (AAPC)
2233 S. Presidents Dr., Suite F
Salt Lake City, Utah 84120
800-626-2633
www.aapc.com

Coding Certification

Medical coders are expert in classifying medical data. They assign codes to physicians' descriptions of patients' conditions and treatments. For employment as a medical coder, employers typically prefer—or may require—certification. AHIMA offers three coding certifications: the Certified Coding Associate (CCA), intended as a starting point for entering a new career as a coder; the Certified Coding Specialist (CCS); and the Certified Coding Specialist-Physician-based (CCS-P). The American

Academy of Professional Coders (AAPC) grants the Certified Professional Coder (CPC) and the CPC-A, an apprentice level for those who do not yet have medical coding work experience.

BILLING TIP

Moving Ahead in Your Career

Professional certification, additional study, and work experience contribute to advancement to positions such as medical billing manager and medical office manager. Billers may also advance through specialization in a field, such as radiology billing management. Some become medical coders or coding managers.

Advanced Professional Certification

Professional organizations such as AHIMA and AAPC also have professional certification that can be earned following work experience and additional education. For example, AHIMA offers the Certified Documentation Improvement Practitioner (CDIP) recognition, and AAPC offers the Certified Professional Medical Auditor (CPMA) certification.

Continuing Education

Most professional organizations require certified members to keep up-to-date by taking annual training courses to refresh or extend their knowledge. Continuing education sessions are assigned course credits by the credentialing organizations, and satisfactory completion of a test on the material is often required for credit. Employers often approve attendance at seminars that apply to the practice's goals and ask the person who attends to update other staff members.

THINKING IT THROUGH 1.10

1. Why is it important for administrative medical office employees to become certified in their area of expertise? At this point, what are your personal goals relating to certification?

Chapter 1 Summary

Learning Outcomes	Key Concepts/Examples
1.1 Identify three ways that medical insurance specialists help ensure the financial success of physician practices.	• Following all procedures carefully. • Communicating effectively with patients and with those who work in the practice. • Using health information technology skills to work with practice management programs and electronic health records.
1.2 Differentiate between covered and noncovered services under medical insurance policies.	Covered services: • May include primary care, emergency care, medical specialists' services, and surgery • Are eligible for members • Are listed under the schedule of benefits of an insurance policy Noncovered services: • Are identified by the insurance policy as services for which it will not pay

Learning Outcomes	Key Concepts/Examples
1.3 Compare indemnity and managed care approaches to health plan organization.	• All insurance plans are based on one of the two essential types of plans, indemnity and managed care. • Under an indemnity plan, the payer protects the member against loss from the costs of medical services and procedures. • Managed care offers a more restricted choice of providers and treatments in exchange for lower premiums, deductibles, and other charges.
1.4 Discuss three examples of cost containment employed by health maintenance organizations.	Health maintenance organizations (HMOs) control healthcare costs by: • Creating a restricted number of physicians for members • Requiring preauthorization of services • Controlling the use of services • Controlling drug costs • Using cost-sharing methods
1.5 Explain how a preferred provider organization works.	• Create a network of hospitals and other providers for members to use at negotiated, reduced fees. • Are the most popular type of healthcare. • Generally require the payment of premiums and copayments from patients.
1.6 Describe the two elements that are combined in a consumer-driven health plan.	• Consumer-driven health plans (CDHPs) combine a high-deductible, low-premium PPO with a pretax savings account to cover out-of-pocket medical expenses up to the amount of the deductible.
1.7 Define the three major types of medical insurance payers.	• Private payers of health benefits are either insurance companies or self-insured employers. • Most private health insurance is employer sponsored. • Government-sponsored healthcare programs include Medicare, Medicaid, TRICARE, and CHAMPVA.
1.8 Explain the ten steps in the revenue cycle.	The ten steps in the revenue cycle are: 1. Preregister patients 2. Establish financial responsibility 3. Check in patients 4. Review coding compliance 5. Review billing compliance 6. Check out patients 7. Prepare and transmit claims 8. Monitor payer adjudication 9. Generate patient statements 10. Follow up payments and collections
1.9 Analyze how professionalism, ethics, and etiquette contribute to career success.	• It is vitally important for all members of the medical office to possess these traits. • Office members acquire the proper skills and develop the necessary attributes in order to perform their work successfully. • Pair these characteristics with a strong code of ethics and correct etiquette.
1.10 Evaluate the importance of professional certification for career advancement.	• Medical staff personnel advance their careers through membership in a professional organization and by receiving a certification by that organization. • Certifications are earned through a combination of education, experience, and an exam.

Review Questions

Match the key terms with their definitions.

1. **LO 1.4** health maintenance organization (HMO)
2. **LO 1.9** etiquette
3. **LO 1.2** schedule of benefits
4. **LO 1.3** fee-for-service
5. **LO 1.3** coinsurance
6. **LO 1.10** certification
7. **LO 1.4** copayment
8. **LO 1.1** electronic health record (EHR)
9. **LO 1.5** preferred provider organization (PPO)
10. **LO 1.3** indemnity
11. **LO 1.8** compliance
12. **LO 1.6** consumer-driven health plan (CDHP)
13. **LO 1.7** self-funded (self-insured) health plans

A. A list of the medical services covered by an insurance policy

B. A computerized lifelong healthcare record for an individual that incorporates data from all sources that provide treatment for the individual

C. A managed care network of providers under contract to provide services at discounted fees

D. An amount that an insured person pays at the time of a visit to a provider

E. The percentage of each claim that an insured person must pay

F. Standards of professional behavior

G. Payment method based on provider's charges

H. An organization that contracts with a network of providers for the delivery of healthcare for a prepaid premium

I. Recognition of a superior level of skill by an official organization

J. Health plan that protects beneficiaries against losses

K. A method by which organizations pay for health insurance directly and set up a fund from which to pay

L. Actions that are performed to satisfy official requirements

M. Type of medical insurance combining a high-deductible health plan and a medical savings plan

Select the answer choice that best completes the statement or answers the question.

14. **LO 1.4** In an HMO with a gatekeeper system, a(n) _____ coordinates the patient's care and provides referrals.
    A. PPO **C.** PCP
    B. EPO **D.** NPP

15. **LO 1.6** Which of the following combines a health plan that has a high deductible and low premiums with a special "savings account" that is used to pay medical bills before the deductible has been met?
    A. CDHP **C.** PPO
    B. HMO **D.** EHR

16. **LO 1.2** Health plans pay for _____ services.
    A. indemnity **C.** coded
    B. covered **D.** out-of-network

17. **LO 1.4** In an HMO, securing _____ may be required before services are provided.
    A. preauthorization **C.** gatekeeper
    B. utilization **D.** formulary

18. **LO 1.7** A self-insured health plan may use its own
    A. physician-employees **C.** gatekeepers
    B. funds **D.** primary care physicians

19. **LO 1.5** Unlike an HMO, a PPO permits its members to use _____ providers, but at a higher cost.
    A. subcapitated **C.** nonphysician practitioner
    B. out-of-network **D.** primary care

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20. **LO 1.7** The major government-sponsored health programs are
    - **A.** TRICARE, CHAMPVA, Medicare, and Medicaid
    - **B.** HEDIS, Medicare, Medicaid, and CHAMPUS
    - **C.** Medicare and Medicaid
    - **D.** Medicare and TRICARE

21. **LO 1.3** Coinsurance is calculated based on
    - **A.** the number of policyholders in a plan
    - **B.** a fixed charge for each visit
    - **C.** a capitation rate
    - **D.** a percentage of a charge

22. **LO 1.8** When a patient has insurance coverage for which the practice will create a claim, the patient bill is usually done
    - **A.** before the encounter
    - **B.** during the encounter
    - **C.** after the encounter when the healthcare claim is transmitted
    - **D.** after the encounter and after the payer's payment is posted

23. **LO 1.8** If a patient's payment is later than permitted under the financial policy of the practice, the _____ may be started.
    - **A.** copayment process
    - **B.** appeal process
    - **C.** coding process
    - **D.** collection process

Complete the following.

24. **LO 1.8** List the ten steps in the revenue cycle.

    Step 1

    Step 2

    Step 3

    Step 4

    Step 5

    Step 6

    Step 7

    Step 8

    Step 9

    Step 10

25. **LO 1.8** List at least four important skills of medical insurance specialists.

    A.

    B.

    C.

    D.

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Applying Your Knowledge

Case 1.1 Abstracting Insurance Information

A patient shows the following insurance identification card to the medical insurance specialist:

Connecticut HealthPlan

I.D.#:	1002.9713
Employee:	DANIEL ANTHONY
Group #:	A0000323
Eff. date:	03/01/2029
Status:	Dependent Coverage? F
In-network:	$10 Co-Pay
Out-of-network:	$250 Ded; 80%/20%

Front of card

IMPORTANT INFORMATION
Notice to Members and Providers of Care

To avoid a reduction in your hospital benefits, you are responsible for obtaining certification for hospitalization and emergency admissions. The review is required regardless of the reason for hospital admission. For specified procedures, Second Surgical Opinion is may be mandatory.

For certification, call Utilization Management Services at 800 827-8808:

- At least 7 days in advance of Scheduled Surgery of Hospital Admissions.
- Within 48 hours after Emergency Admissions or on the first business day following weekend or holiday Emergency Admissions.

CONNECTICUT HEALTHPLAN C/O

WEISS

Robert S. Weiss
& Company
Silver Hill Business Center
500 S. Broad Street
P.O. Box 1034
Meriden, CT 06450
(800) 466-7500

THIS CARD IS FOR IDENTIFICATION ONLY AND DOES NOT ESTABLISH ELIGIBILITY FOR COVERAGE BY CONNECTICUT HEALTH PLAN. Please refer to your insurance booklet for further details.

Back of card

A. **LO 1.4, 1.5** What copayment is due when the patient sees an in-network physician?

B. **LO 1.4, 1.5** What payment rules apply when the patient sees an out-of-network physician?

C. **LO 1.4, 1.5** What rules apply when the patient needs to be admitted to the hospital?

Case 1.2 Calculating Insurance Math

Calculate the payment(s) billed in each of the following situations:

A. **LO 1.3** The patient's health plan has a $100 annual deductible. At the first visit of the year, the charges are $95. What does the patient owe?

B. **LO 1.3** The patient's coinsurance percentage is stated as 75-25 in the insurance policy. The deductible for the year has been met. If the visit charges are $1,000, what payment should the medical insurance specialist expect from the payer? What amount will the patient be billed?

C. **LO 1.3** The patient's coinsurance percentage is stated as 80-20 in the insurance policy. The deductible for the year has been met. If the visit charges are $420, what payment should the medical insurance specialist expect from the payer? What amount will the patient be billed?

D. **LO 1.4** The patient is enrolled in a capitated HMO with a $10 copayment for primary care physician visits and no coinsurance requirements. After collecting $10 from the patient, what amount can the medical insurance specialist bill the payer for an office visit?

E. **LO 1.3, 1.8** The patient has a policy that requires a $20 copayment for an in-network visit due at the time of service. The policy also requires 30 percent coinsurance from the patient. Today's visit charges total $785. After subtracting the copayment collected from the patient, the medical insurance specialist expects a payment of what amount from the payer? What amount will the patient be billed?

F. **LO 1.3** A patient's total surgery charges are $1,278. The patient must pay the annual deductible of $1,000, and the policy states a 80-20 coinsurance. What does the patient owe?

G. **LO 1.3, 1.6** A patient has a high-deductible consumer-driven health plan. The annual deductible is $2,500, of which $300 has been paid. After a surgical procedure costing $1,890, what does the patient owe? Can any amount be collected from a payer? Why?

H. **LO 1.3, 1.5, 1.6** A patient with a high-deductible consumer-driven health plan has met half of the $1,000 annual deductible before requiring surgery to repair a broken ankle while visiting a neighboring state. The out-of-network physician's bill is $4,500. The PPO that takes effect after the deductible has been met is an 80-20 in-network plan and a 60-40 out-of-network plan. How much does the patient owe? How much should the PPO be billed?

Case 1.3 Using Insurance Terms

Read the following information from a medical insurance policy.

Policy Number 054351278
Insured Jane Hellman Brandeis
Premium Due Quarterly $1,414.98

AMOUNT PAYABLE
Maximum Benefit Limit, per *covered person* $2,000,000
Stated Deductible per *covered person*, per *calendar year* $2,500
EMERGENCY ROOM DEDUCTIBLE (for each visit for *illness* to an emergency room when not directly admitted to the *hospital*) $50
Note: After satisfaction of the emergency room deductible, *covered expenses* are subject to any applicable *deductible amounts* and coinsurance provisions.
PREFERRED PROVIDER COINSURANCE PERCENTAGE, per *calendar year*
For *covered expenses* in excess of the applicable stated deductible, payer pays 100%

A. **LO 1.3, 1.4, 1.5** What type of health plan is described: HMO, PPO, or indemnity?

B. **LO 1.3, 1.4, 1.5** What is the *annual* premium?

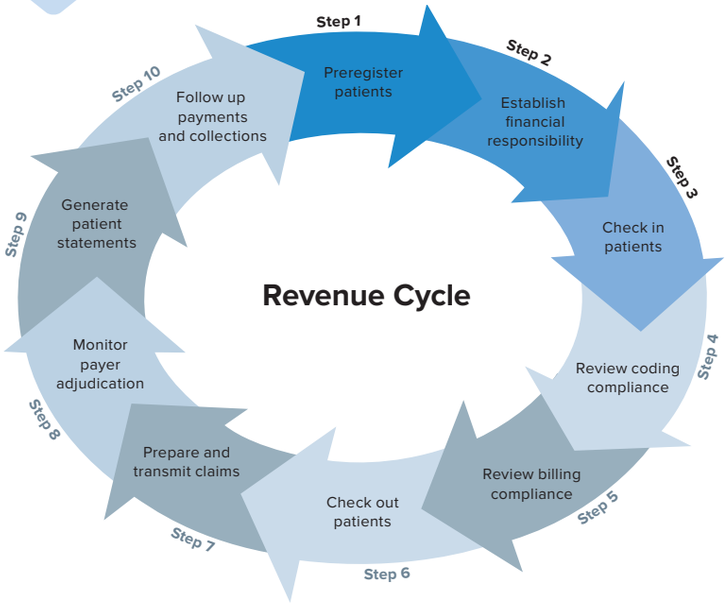
C. **LO 1.3, 1.4, 1.5** What is the annual deductible?

D. **LO 1.3, 1.4, 1.5** What percentage of preferred provider charges does the patient owe after meeting the deductible each year?

E. **LO 1.3, 1.4, 1.5** If the insured incurs a $6,000 in-network medical bill after the annual deductible has been paid, how much will the health plan pay?

ELECTRONIC HEALTH RECORDS, HIPAA, AND HITECH: SHARING AND PROTECTING PATIENTS' HEALTH INFORMATION

2



Learning Outcomes

After studying this chapter, you should be able to:

2.1 Explain the importance of accurate documentation when working with medical records.

2.2 Compare the intent of HIPAA, HITECH, and ACA laws.

2.3 Describe the relationship between covered entities and business associates.

2.4 Explain the purpose of the HIPAA Privacy Rule.

2.5 Briefly state the purpose of the HIPAA Security Rule.

2.6 Explain the purpose of the HITECH Breach Notification Rule.

2.7 Explain how the HIPAA Electronic Health Care Transactions and Code Sets standards influence the electronic exchange of health information.

2.8 Describe the four final rules in the Omnibus Rule.

2.9 Explain how to guard against potentially fraudulent situations.

2.10 Assess the benefits of a compliance plan.

KEY TERMS

abuse
accountable care organization (ACO)
accounting of disclosure
Affordable Care Act (ACA)
audit
authorization
breach
breach notification
business associate (BA)
Centers for Medicare and Medicaid Services (CMS)
clearinghouse
code set
compliance plan
covered entity (CE)
de-identified health information
designated record set (DRS)
documentation
electronic data interchange (EDI)
encounter
encryption
evaluation and management (E/M)
fraud
Health Care Fraud and Abuse Control Program
health information exchange (HIE)
Health Information Technology for Economic and Clinical Health (HITECH) Act
Health Insurance Portability and Accountability Act (HIPAA) of 1996
HIPAA Electronic Health Care Transactions and Code Sets (TCS)
HIPAA National Identifiers
HIPAA Privacy Rule
HIPAA Security Rule
informed consent
malpractice
meaningful use
medical documentation and revenue cycle
medical record
medical standards of care
minimum necessary standard
National Provider Identifier (NPI)
Notice of Privacy Practices (NPP)
Office for Civil Rights (OCR)
Office of E-Health Standards and Services (OESS)

Continued

KEY TERMS *(continued)*

Office of the Inspector General (OIG)
Omnibus Rule
operating rules
password
protected health information (PHI)
relator
transaction
treatment, payment, and healthcare operations (TPO)

Medical insurance specialists work with important clinical data as well as demographic data. Health plans need patient clinical information to assess the medical necessity of claims sent for payment. To provide the right level of care, other physicians need to know the results of tests and examinations that patients have already had. Keeping all patient data safe and secure is the job of everyone on the healthcare team. But it is no longer a job of managing stacks of paper files. Like shopping, buying tickets, banking, and sharing photos online, healthcare records are moving to a digital platform. Working in this environment requires knowledge of electronic health records and of the federal rules that regulate access to them.

2.1 Medical Record Documentation: Electronic Health Records

medical record file containing the documentation of a patient's medical history and related information

A patient's **medical record** contains facts, findings, and observations about that patient's health history. The record also contains communications with and about the patient. In a physician practice, the medical record begins with a patient's first contact and continues through all treatments and services. The record provides continuity and communication among physicians and other healthcare professionals who are involved in the patient's care. Patients' medical records are also used in research and for education.

Medical Records

Medical records, or charts, contain documentation of patients' conditions, treatments, and tests that are created and shared by physicians and other providers to help make accurate diagnoses and to trace the course of care.

COMPLIANCE GUIDELINE

Medical Standards of Care and Malpractice

Medical standards of care are state-specified performance measures for the delivery of healthcare by medical professionals. Medical **malpractice** can result when a provider injures or harms a patient because of failure to follow the standards.

malpractice failure to use professional skill when giving medical services that results in injury or harm

A patient's medical record contains the results of all tests a primary care physician (PCP) ordered during a comprehensive physical examination. To follow up on a problem, the PCP could refer the patient to a cardiologist, also sending the pertinent data for that doctor's review. By studying the medical record, the specialist treating a referred patient learns the outcome of previous tests and avoids repeating them unnecessarily.

documentation recording of a patient's health status in a medical record

medical standards of care state-specified performance measures for the delivery of healthcare

Documentation means organizing a patient's health record in chronological order using a systematic, logical, and consistent method. A patient's health history, examinations, tests, and results of treatments are all documented. Complete and comprehensive documentation is important to show that physicians have followed the **medical standards of care** that apply in their state. Healthcare providers are liable (that is, legally responsible) for providing this level of care to their patients. The term *medical professional liability* describes this responsibility of licensed healthcare professionals.

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Patient medical records are legal documents. Good medical records are a part of the physician's defense against accusations that patients were not treated correctly. They clearly state who performed what service and describe why, where, when, and how it was done. Physicians document the rationale behind their treatment decisions. This rationale is the basis for medical necessity—the clinically logical link between a patient's condition and a treatment or procedure.

COMPLIANCE GUIDELINE

Documentation and Billing: A Vital Connection

The connection between documentation and billing is essential: If a service is not documented, it cannot be billed.

Advantages of Electronic Health Records

Because of their advantages over traditional paper records, electronic health records are now used by the majority of physician practices. *Electronic health records (EHRs)* are computerized lifelong healthcare records for an individual that incorporate data from all sources that treat the individual.

EHRs are different from electronic *medical* records (EMRs), which are computerized records of one physician's encounters with a patient over time that are the physician's legal record of patient care. EHRs are also different from a third type of electronic record, *personal health records (PHRs),* which are private, secure electronic files that are created, maintained, and controlled by patients and contain data such as their current medications, health insurance information, allergies, medical test results, family medical history, and more.

BILLING TIP

Medical Necessity

Services are medically necessary when they are reasonable and essential for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Such services must also be consistent with generally accepted standards of care.

Documents in electronic health records may be created in a variety of ways, but they are ultimately viewed on a computer screen. For example, one general practice uses a number of medical-history-taking templates for gathering and recording "consistent history and physical information from patients." The computer-based templates range in focus from abdominal pain to depression, with from ten to twenty questions each. The on-screen templates are filled out in the exam rooms. Responsible providers then sign the entries, using e-signature technology that verifies the identity of the signer.

EHRs offer both patients and providers significant advantages over paper records:

- *Immediate access to health information:* The EHR is simultaneously accessible from computers in the office and in other sites such as hospitals. Compared to sorting through papers in a paper folder, an EHR database can save time when vital patient information is needed. Once information is updated in a patient record, it is available to all who need access, whether across the hall or across town.
- *Computerized physician order entry management:* Physicians can enter orders for prescriptions, tests, and other services at any time. This information is then transmitted to the staff for implementation or directly to pharmacies linked to the practice.
- *Clinical decision support:* An EHR system can provide access to the latest medical research on approved medical websites to help medical decision making.
- *Automated alerts and reminders:* The system can provide medical alerts and reminders for office staff to ensure that patients are scheduled for regular screenings and other preventive practices. Alerts can also be created to identify patient safety issues, such as possible drug interactions.
- *Electronic communication and connectivity:* An EHR system can provide a means of secure and easily accessible communication between physicians and staff and in some offices between physicians and patients.
- *Patient support:* Some EHR programs allow patients to access their medical records and request appointments. These programs also offer patient education on health topics and instructions on preparing for common medical tests, such as an HDL cholesterol test.
- *Administration and reporting:* The EHR may include administrative tools, including reporting systems that enable medical practices to comply with federal and state reporting requirements.
- *Error reduction:* An EHR can decrease medical errors that result from illegible chart notes because notes are entered electronically on a computer or a handheld device.

BILLING TIP

Hybrid Record Systems

Although the majority of physician practices use EHRs, most also still have paper records. The use of electronic along with paper records is called a *hybrid record system*.

Nevertheless, the accuracy of the information in the EHR is only as good as the accuracy of the person entering the data; it is still possible to click the wrong button or enter the wrong letter.

Documenting Encounters with Providers

Every patient **encounter**—the meeting, face-to-face or via telephone or emessaging, between a patient and a provider in a medical office, clinic, hospital, or other location—should be documented with the following information:

encounter visit between a patient and a medical professional

- Patient's name
- Encounter date and reason
- Appropriate history and physical examination
- Review of all tests that were ordered
- Diagnosis
- Plan of care, or notes on procedures or treatments that were given
- Instructions or recommendations that were given to the patient
- Signature of the provider who saw the patient

In addition, a patient's medical record must contain:

- Biographical and personal information, including the patient's full name, date of birth, full address, marital status, home and work telephone numbers, and employer information as applicable
- Records of all communications with the patient, including letters, telephone calls, faxes, and e-mail messages; the patient's responses; and a note of the time, date, topic, and physician's response to each communication
- Records of prescriptions and instructions given to the patient, including refills
- Scanned records or original documents that the patient has signed, such as an authorization to release information and an advance directive
- Drug and environmental allergies and reactions, or their absence
- Up-to-date immunization record and history if appropriate, such as for a child
- Previous and current diagnoses, test results, health risks, and progress
- Records of referral or consultation letters
- Hospital admissions and release documents
- Records of any missed or canceled appointments
- Requests for information about the patient (from a health plan or an attorney, for example), and a detailed log of to whom information was released

Medicare's general documentation standards are shown in Table 2.1.

Evaluation and Management Services Reports

evaluation and management (E/M) provider's evaluation of a patient's condition and decision on a course of treatment to manage it

When providers evaluate a patient's condition and decide on a course of treatment to manage it, the service is called **evaluation and management (E/M).** Evaluation and management services may include a complete interview and physical examination for a new patient or a new problem presented by a person who is already a patient. There are many other types of E/M encounters, such as a visit to decide whether surgery is needed or to follow up on a patient's problem. An E/M service is usually documented with chart notes.

BILLING TIP

SOAP Format

A common documentation structure is the *problem-oriented medical record (POMR)* that contains *SOAP* notes—*S*ubjective information from the patient, and three elements the provider enters: *O*bjective data such as examination and/or test results, *A*ssessment of the patient's diagnosis, and *P*lan, the intended course of treatment, such as surgery or medication.

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Table 2.1 Documentation Pointers

1.	Medicare expects the documentation to be generated at the time of service or shortly thereafter.
2.	Delayed entries within a reasonable time frame (twenty-four to forty-eight hours) are acceptable for purposes of clarification, error correction, and addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.
3.	The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference about their origin. Corrections or additions must be dated, preferably timed, and legibly signed or initialed.
4.	Every note stands alone—that is, the performed services must be documented at the outset.
5.	Delayed written explanations will be considered for purposes of clarification only. They cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For that, the medical record must stand on its own, with the original entry corroborating that the service was rendered and was medically necessary.
6.	All entries must be legible to another reader to a degree that a meaningful review can be conducted.
7.	All notes should be dated, preferably timed, and signed by the author.

History and Physical Examination A complete history and physical (H&P) is documented with four types of information: (1) the chief complaint, (2) the H&P examination, (3) the diagnosis, and (4) the treatment plan.

The provider documents the patient's reason for the visit, often using the patient's own words to describe the symptom, problem, condition, diagnosis, or other factor. For clarity, the provider may restate the reason as a "presenting problem," using medical terminology.

The provider also documents the patient's relevant medical history. The extent of the history is based on what the provider considers appropriate. It may include the history of the present illness (HPI), past medical history (PMH), and family and social history. There is usually also a review of systems (ROS), in which the provider asks questions about the function of each body system considered appropriate to the problem.

COMPLIANCE GUIDELINE

Informed Consent

If the plan of care involves significant risk, such as surgery, state laws require the provider to have the patient's **informed consent** in advance. The provider discusses the assessment, risks, and recommendations with the patient and documents this conversation in the patient's record. Usually, the patient signs either a chart entry or a consent form to indicate agreement.

informed consent process by which a patient authorizes medical treatment after a discussion with a physician

The provider performs a physical examination and documents the diagnosis—the interpretation of the information that has been gathered—or the suspected problem if more tests or procedures are needed for a diagnosis. The treatment plan, or plan of care, is described. It includes the treatments and medications that the provider has ordered, specifying dosage and frequency of use.

Other Chart Notes Many other types of chart notes appear in patients' medical records. Progress reports document a patient's progress and response to a treatment plan. They explain whether the plan should be continued or changed. Progress reports include:

- Comparisons of objective data with the patient's statements
- Goals and progress toward the goals
- The patient's current condition and prognosis
- Type of treatment still needed and for how long

Discharge summaries are prepared during a patient's final visit for a particular treatment plan or hospitalization. Discharge summaries include:

- The final diagnosis
- Comparisons of objective data with the patient's statements
- Whether goals were achieved
- Reason for and date of discharge
- The patient's current condition, status, and final prognosis
- Instructions given to the patient at discharge, noting any special needs such as restrictions on activities and medications

Procedural Services Documentation

Other common types of documentation are for specific procedures done either in the office or elsewhere:

- Procedure or operative reports for simple or complex surgery
- Reports for laboratory tests
- Radiology reports for the results of X-rays
- Forms for a specific purpose, such as immunization records, preemployment physicals, and disability reports

Using PM/EHRs: An Integrated Medical Documentation and Billing Cycle

The increased use of electronic health records in physician practices has changed office workflow. In a medical office, a flow of work that provides medical care to patients and collects payment for these services must be in place. When PM/EHRs are used, previous paper-based tasks, such as pulling file folders and making photocopies, are replaced by efficient electronic processes. The **medical documentation and revenue cycle** explains how using EHRs is integrated with practice management programs as the ten-step revenue cycle billing process is performed. This cycle is illustrated in Figure 2.1. The inner circle represents the revenue cycle, as explained in Chapter 1; the outer circle contains the medical documentation cycle.

medical documentation and revenue cycle circle that explains how using EHRs is integrated with practice management programs

As the illustration shows, the two cycles are interrelated. For example, a new patient phones for an appointment. During preregistration, both billing and clinical information must be collected during the phone call. From a billing perspective, the office wants to know whether the patient has insurance that will cover some or all of the cost of the visit or whether the patient will pay for the visit. From a health or medical perspective, the staff wants to know the reason the person needs to see the doctor, known as the *chief complaint,* or CC.

Following the revenue cycle billing steps that establish financial responsibility and handle check-in, the professional medical staff gather clinical information. Often a medical assistant inputs vital signs, such as the patient's temperature, pulse, respiration, blood pressure, height, and weight, in the EHR. The physician then documents the results of the physical examination, relevant history, and planned treatments.

As the medical documentation and billing cycle continues, so does the interaction between the two types of information. The physician or a medical coder assigns medical codes to the patient's diagnosis and procedures, and the charges for those procedures are determined. Based on this information, the biller reviews coding and billing compliance and checks out the patient. When the biller prepares and transmits claims, then documentation may be studied to support medical necessity during claim creation and later during adjudication if a payer requires it. During the steps of claim follow-up, patients' statements and payment and collections are documented, and the process of managing and retaining patient data according to regulations is carried out.

Medical insurance specialists are knowledgeable about this PM/EHR cycle so that they can access the clinical information they need as they complete claims and provide documentation in support of their medical necessity.

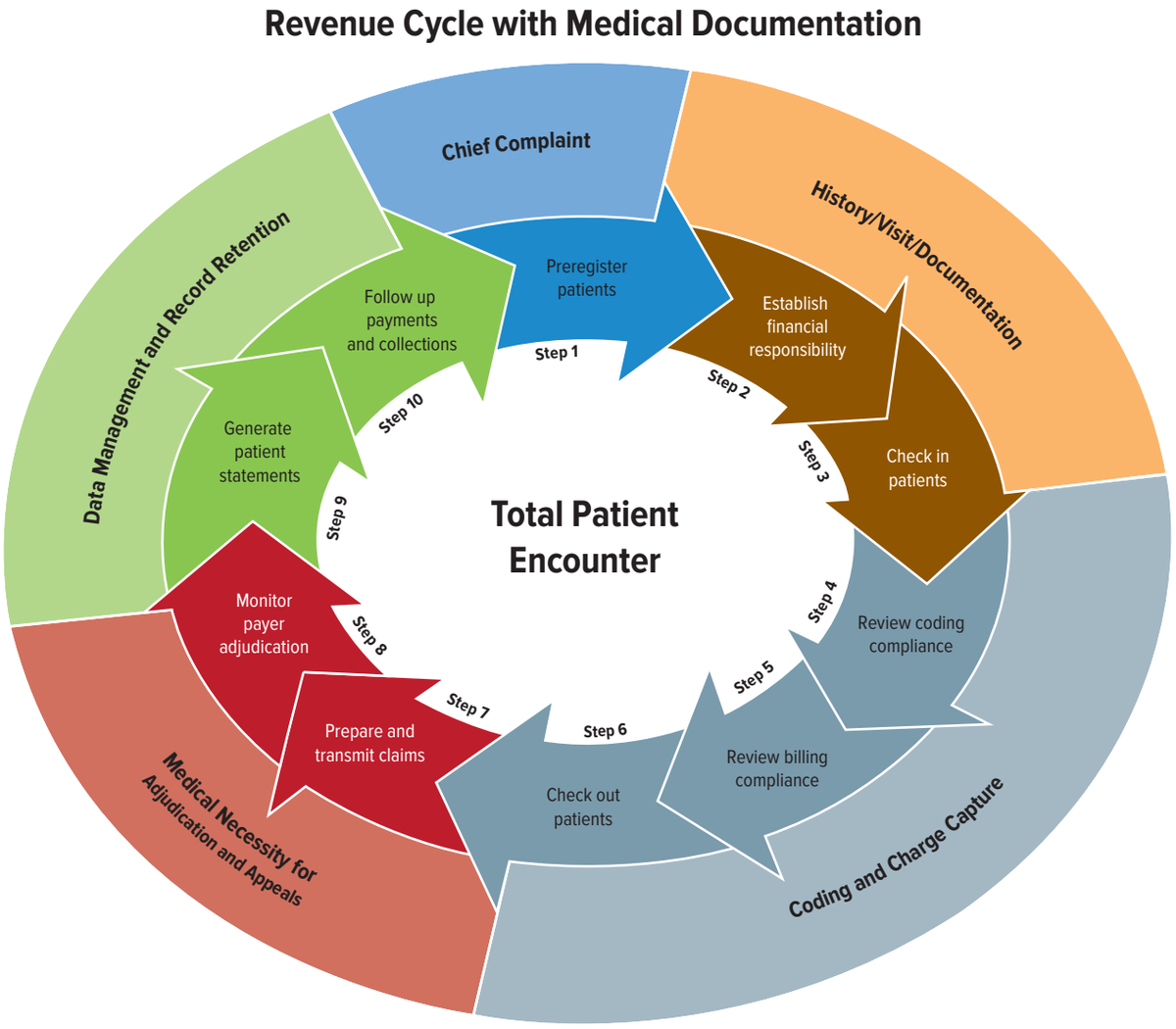

FIGURE 2.1 The Revenue Cycle with Medical Documentation

Source: Susan M. Sanderson, *Practice Management and EHR: A Total Patient Encounter For Medisoft® Clinical*, 1/e. © 2012 McGraw-Hill Companies, Inc. Reprinted with permission.

THINKING IT THROUGH 2.1

1. Review the following letter that is in the patient medical record of John W. Wu.

   Nicholas J. Kramer, MD
   2200 Carriage Lane
   Currituck, CT 07886
   Consultation Report
   on John W. Wu
   (Birth date 12/06/1949)
   Dear Dr. Kramer:

(continued)

(concluded)

At your request, I saw Mr. Wu today. This is a seventy-seven-year-old male who stopped smoking cigarettes twenty years ago but continues to be a heavy pipe smoker. He has had several episodes of hemoptysis; a small amount of blood was produced along with some white phlegm. He denies any upper respiratory tract infection or symptoms on those occasions. He does not present with chronic cough, chest pain, or shortness of breath. I reviewed the chest X-ray done by you, which exhibits no acute process. His examination was normal.

A bronchoscopy was performed, which produced some evidence of laryngitis, tracheitis, and bronchitis, but no tumor was noted. Bronchial washings were negative.

I find that his bleeding is caused by chronic inflammation of his hypopharynx and bronchial tree, which is related to pipe smoking. There is no present evidence of malignancy.

Thank you for requesting this consultation.

Sincerely,

Mary Lakeland Georges, MD

A. What is the purpose of the letter?

B. How does it demonstrate the use of a patient medical record for continuity of care?

2. Consider the process of switching to EHRs from paper records in a practice having 2,000 patients. What are the pros and cons of moving all past patient records to the EHR at once versus doing so gradually?

CMS Home Page
www.cms.gov

2.2 Healthcare Regulation: HIPAA, HITECH, and ACA

To protect consumers' health, both federal and state governments pass laws that affect the medical services that must be offered to patients. To protect the privacy of patients' health information, additional laws cover the way healthcare plans and providers exchange this information as they conduct business.

Federal Regulation

Centers for Medicare and Medicaid Services (CMS) federal agency that runs Medicare, Medicaid, clinical laboratories, and other government health programs

The main federal government agency responsible for healthcare is the **Centers for Medicare and Medicaid Services,** known as **CMS** (formerly the Health Care Financing Administration, or HCFA). An agency of the Department of Health and Human Services (HHS), CMS administers the Medicare and Medicaid programs to more than 90 million Americans. CMS implements annual federal budget acts and laws such as the Medicare Prescription Drug, Improvement, and Modernization Act that has created help in paying for drugs and for an annual physical examination for Medicare beneficiaries.

CMS also performs activities to ensure the quality of healthcare, such as:

- Regulating all laboratory testing other than research performed on humans
- Preventing discrimination based on health status for people buying health insurance
- Researching the effectiveness of various methods of healthcare management, treatment, and financing
- Evaluating the quality of healthcare facilities and services

CMS policy is often the model for the healthcare industry. When a change is made in Medicare rules, for example, private payers often adopt a similar rule.

BILLING TIP

State-Mandated Benefits

States may require benefits that are not mandated in federal regulations. For example, some states mandate coverage of infertility treatments for women, and many states mandate chiropractic services coverage.

State Regulation

States are also major regulators of the healthcare industry. Operating an insurance company without a license is illegal in all states. State commissioners of insurance investigate consumer complaints about the quality and financial aspects of healthcare. State laws ensure the solvency of insurance companies and managed care organizations so that they will be able to pay enrollees' claims. States may also restrict price increases on premiums and other charges to patients, require that policies include a guaranteed renewal provision, control the situations in which an insurer can cancel a patient's coverage, and require coverage of certain diseases and preventive services.

BILLING TIP

Any Willing Provider

Many states have "any willing provider" laws that require a managed care organization to accept all qualified physicians who wish to participate in its plan. This regulation helps reduce the number of patients who have to switch physicians if they change from one plan to another.

HIPAA

The foundation legislation for the privacy of patients' health information is called the **Health Insurance Portability and Accountability Act (HIPAA) of 1996.** HIPAA contained five provisions called *titles* that focused on various aspects of healthcare:

Health Insurance Portability and Accountability Act (HIPAA) of 1996 federal act with guidelines for standardizing the electronic data interchange of administrative and financial transactions, exposing fraud and abuse, and protecting PHI

Title I: Healthcare Access, Portability and Renewability

Title II: Preventing Healthcare Fraud and Abuse; Administrative Simplification

Title III: Tax-Related Health Provisions

Title IV: Application and Enforcement of Group Health Plan Requirements

Title V: Revenue Offsets

This law is designed to:

- Protect people's private health information
- Ensure health insurance coverage for workers and their families when they change or lose their jobs
- Uncover fraud and abuse
- Create standards for electronic transmission of healthcare transactions

HITECH

The *American Recovery and Reinvestment Act (ARRA) of 2009,* also known as the *Stimulus Package,* contains additional provisions concerning the standards for electronic transmission of healthcare data. The most important rules are in the **Health Information Technology for Economic and Clinical Health (HITECH) Act,** which is Title XIII of the ARRA. This law guides the use of federal stimulus money to promote the adoption and meaningful use of health information technology, mainly using EHRs. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of HIPAA rules.

Health Information Technology for Economic and Clinical Health (HITECH) Act law promoting the adoption and meaningful use of health information technology

Meaningful Use

HITECH provides financial incentives to physicians, hospitals, and other healthcare providers. Physicians who adopt and use EHRs have been eligible for bonus payments.

To be eligible, providers must do more than simply purchase EHRs; they must demonstrate meaningful use of the technology. **Meaningful use** is the utilization of certified EHR technology to improve quality, efficiency, and patient safety in the healthcare system. Incentives for achieving meaningful use are divided into three stages. The government has specified a series of objectives that determine whether meaningful use requirements have been met. Table 2.2 lists the criteria for the first stage.

meaningful use utilization of certified EHR technology to improve quality, efficiency, and patient safety

Regional Extension Centers

Even with government financial incentives, successful implementation of EHRs is not expected to be quick or easy. Small practices, where most primary care is delivered, may

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Table 2.2 Meaningful Use Objectives

Core Set
Use computerized physician order entry for medications
Implement drug-drug and drug-allergy interaction checks
Generate and transmit permissible prescriptions electronically
Record patient demographics
Maintain up-to-date problem list of current and active diagnoses
Maintain active medication list and active medication allergy list
Record and chart vital signs
Record smoking status
Implement one clinical decision support rule and have the ability to track compliance with rule
Calculate and transmit Centers for Medicare & Medicaid Services Quality Measure
Protect electronic copy of health information
Provide clinical summaries
Exchange key clinical information
Ensure privacy and security
Menu Set
Implement drug formulary checks
Incorporate clinical laboratory test results into EHR system as structured data
Generate patient lists
Send patient reminders
Provide timely electronic access to health information
Identify patient-specific information
Perform medication reconciliation
Provide summary of care
Submit electronic immunization data to registries or information systems
Submit laboratory results to public health agencies
Submit electronic syndromic surveillance data to public health agencies

lack the expertise and resources required to purchase, install, and use the new technology. Recognizing the challenges associated with implementing HIT, the HITECH Act called for the creation of *regional extension centers (RECs).* Patterned after the agriculture extension service the government created almost a century ago, the RECs offer information, guidance, training, and support services to primary care providers who are in the process of making the transition to an EHR system.

Health Information Exchanges

To meet meaningful use criteria, providers must also be able to exchange clinical information outside the organization. One of the ways that providers share information is

through the use of local, state, and regional health information networks. A **health information exchange (HIE)** enables the sharing of health-related information among provider organizations according to nationally recognized standards. Examples of the use of an HIE include sharing patient records with physicians outside the physician's own medical group, transmitting prescriptions to pharmacies, and ordering tests from an outside lab. The goal of an HIE is to facilitate access to clinical information for the purpose of providing quality care to patients.

health information exchange (HIE) enables the sharing of health-related information among provider organizations

Patient Protection and Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act, known as the **Affordable Care Act (ACA),** has had a number of impacts since its adoption in 2010. Reducing the number of people without health insurance has been a major result, as explained in the chapter on private payers. The ACA also fostered the formation and operation of **accountable care organizations (ACOs).** An ACO is a network of doctors and hospitals that shares responsibility for managing the quality and cost of care provided to a group of patients. A network could include primary care physicians, specialists, hospitals, home healthcare providers, and so on. By making this group of providers jointly accountable for the health of their patients, the program provides incentives to coordinate care in a way that improves quality and saves money by avoiding unnecessary tests and procedures.

Affordable Care Act (ACA) health system reform legislation that offers improved insurance coverage and other benefits

accountable care organization (ACO) network of doctors and hospitals that shares responsibility for managing the quality and cost of care provided to a group of patients

THINKING IT THROUGH 2.2

1. Discuss the purpose of HITECH as it relates to electronic health records.

BILLING TIP

Notices of Proposed Rulemaking

The process of transforming acts of Congress into law involves first a proposed rule, followed by a specified period of time for the public to comment, and then, at last, a Final Rule. This process can span a number of years from mandate to regulation to enforcement.

2.3 Covered Entities and Business Associates

Patients' medical records—the actual progress notes, reports, and other clinical materials—are legal documents that belong to the provider who created them. But the provider cannot withhold the information in the records unless providing it would be detrimental to the patient's health. The information belongs to the patient.

Patients control the amount and type of information that is released except for the use of the data to treat them or to conduct the normal business transactions of the practice. Only patients or their legally appointed representatives have the authority to authorize the release of information to anyone not directly involved in their care.

Medical insurance specialists handle issues, such as requests for information from patients' medical records. They need to know what information about patients' conditions and treatments can be released. What information can be legally shared with other providers and health plans? What information must the patient specifically

authorize to be released? The answers to these questions are based on HIPAA Administrative Simplification provisions and their expansion under HITECH and the ACA.

Congress passed the Administrative Simplification provisions partly because of rising healthcare costs. A significant portion of every healthcare dollar is spent on administrative and financial tasks. These costs can be controlled if the business transactions of healthcare are standardized and handled electronically.

Electronic Data Interchange

electronic data interchange (EDI) computer-to-computer exchange of data in a standardized format

transaction electronic exchange of healthcare information

The Administrative Simplification provisions encourage the use of **electronic data interchange (EDI).** EDI is the computer-to-computer exchange of routine business information using publicly available standards. Practice staff members use EDI to exchange health information about their practices' patients with payers and clearinghouses. Each electronic exchange is a **transaction,** which is the electronic equivalent of a business document.

EDI transactions are not visible in the same way as an exchange of paperwork, such as a letter. An example of a nonmedical transaction is the process of getting cash from an ATM. In an ATM transaction, the computer-to-computer exchange is made up of computer language that is sent and answered between the machines. This exchange happens behind the scenes. It is documented on the customer's end with the transaction receipt that is printed; the bank also has a record at its location.

HIPAA/HITECH TIP

Staying Current with HIPAA

HIPAA laws have a lengthy review process before being released as final rules. Future changes are expected. Medical insurance specialists need to stay current with those that affect their areas of responsibility.

The Three Administrative Simplification Provisions

The three parts of the *Administrative Simplification* provisions are:

1. *HIPAA Privacy Rule:* The privacy requirements cover patients' health information.
2. *HIPAA Security Rule:* The security requirements state the administrative, technical, and physical safeguards that are required to protect patients' health information.
3. *HIPAA Electronic Transaction and Code Sets Standards:* These standards require every provider who does business electronically to use the same healthcare transactions, code sets, and identifiers.

Complying with HIPAA

covered entity (CE) health plan, clearinghouse, or provider who transmits any health information in electronic form

Healthcare organizations that are required by law to obey HIPAA regulations are called **covered entities (CEs).** A covered entity is an organization that electronically transmits any information that is protected under HIPAA. Other organizations that work for the CEs must also agree to follow HIPAA rules.

Covered Entities

Under HIPAA, three types of CEs must follow the regulations:

- *Health plans:* The individual or group plan that provides or pays for medical care
- *Healthcare* **clearinghouses:** Companies that convert nonstandard transactions into standard transactions and transmit the data to health plans, and the reverse process
- *Healthcare providers:* People or organizations that furnish, bill, or are paid for healthcare in the normal course of business

clearinghouse company that converts nonstandard transactions into standard transactions and transmits the data to health plans, and the reverse process

Many physician practices are included under HIPAA. Exempt providers are only those who do not send any claims (or other HIPAA transactions) electronically *and* do not employ any other firm to send electronic claims for them. Because CMS requires practices to send Medicare claims electronically unless they employ fewer than ten full-time or equivalent employees, practices have moved to electronic claims. Electronic claims have the advantage of being paid more quickly, too, so practices may use them even when they are not required.

HHS HIPAA Home Page
www.hhs.gov/hipaa

COMPLIANCE GUIDELINE

Business Associate Contracts

Contracts with BAs should specify how they are to comply with HIPAA/HITECH in handling the practice's PHI.

Business Associates

Business Associates (BAs) are people or organizations that work for CEs but are not themselves CEs. Examples of BAs include law firms; outside medical billers, coders, and transcriptionists; accountants; collection agencies; and vendors of PHRs. BAs are as responsible as CEs for following HIPAA rules.

business associate (BA) person or organization that performs a function or activity for a covered entity

THINKING IT THROUGH 2.3

1. Describe the responsibilities of BAs.

2.4 HIPAA Privacy Rule

The HIPAA Standards for Privacy of Individually Identifiable Health Information rule is known as the **HIPAA Privacy Rule.** It was the first comprehensive federal protection for the privacy of health information. Its national standards protect individuals' medical records and other personal health information. Before the HIPAA Privacy Rule became law, the personal information stored in hospitals, physicians' practices, and health plans was governed by a patchwork of federal and state laws. Some state laws were strict, but others were not.

The Privacy Rule says that covered entities must:

- Have a set of privacy practices that are appropriate for its healthcare services
- Notify patients about their privacy rights and how their information can be used or disclosed
- Train employees so that they understand the privacy practices
- Appoint a privacy official responsible for seeing that the privacy practices are adopted and followed
- Safeguard patients' records

HIPAA Privacy Rule law regulating the use and disclosure of patients' protected health information

BA Agreements

All BAs that transmit, create, receive, or maintain PHI must sign business associate agreements (BAAs) to safeguard it.

Protected Health Information

The HIPAA Privacy Rule covers the use and disclosure of patients' **protected health information (PHI).** PHI is defined as individually identifiable health information that is transmitted or maintained by electronic media, such as over the Internet, by computer modem, or on magnetic tape or compact disks. The rule also covers PHI that is sent via the Internet to "the cloud," remote servers used to store and manage data. This information includes a person's:

protected health information (PHI) individually identifiable health information transmitted or maintained by electronic media

- Name
- Address (including street address, city, county, ZIP code)
- Names of relatives and employers
- Birth date
- Telephone numbers
- Fax number
- E-mail address
- Social Security number
- Medical record number
- Health plan beneficiary number
- Account number

- Certificate or license number
- Serial number of any vehicle or other device
- Website address
- Fingerprints or voiceprints
- Photographic images
- Genetic information

Use and Disclosure for Treatment, Payment, and Healthcare Operations

Patients' PHI under HIPAA can be used and disclosed by providers for treatment, payment, and healthcare operations. *Use of PHI* means sharing or performing analysis *within* the entity that holds the information. *Disclosure of PHI* means the release, transfer, and provision of access to or divulging of PHI *outside* the entity holding the information.

Both use and disclosure of PHI are necessary and permitted for patients' **treatment, payment, and healthcare operations (TPO).** *Treatment* means providing and coordinating the patient's medical care; *payment* refers to the exchange of information with health plans; and *healthcare operations* are the general business management functions.

treatment, payment, and healthcare operation (TPO) legitimate reason for the sharing of patients' protected health information without authorization

Minimum Necessary Standard When using or disclosing PHI, a covered entity must try to limit the information to the minimum amount necessary for the intended purpose. The **minimum necessary standard** means taking reasonable safeguards to protect PHI from incidental disclosure. *Incidental use* or *disclosure* is a secondary use of patient information that cannot reasonably be prevented, is limited, and usually occurs as the result of another permitted use.

minimum necessary standard principle that individually identifiable health information should be disclosed only to the extent needed

HIPAA/HITECH TIP

Privacy Officers

The privacy official at a small physician practice may be the office manager who also has other duties. At a large health plan, the position of privacy official may be full time.

Examples of HIPAA Compliance

A medical insurance specialist does not disclose a patient's history of cancer on a workers' compensation claim for a sprained ankle. Only the information the recipient needs to know is given.

- A physician's assistant faxes appropriate patient cardiology test results before scheduled surgery.
- A physician sends an e-mail message to another physician requesting a consultation on a patient's case.
- A patient's family member picks up medical supplies and a prescription. ◀

Designated Record Set A covered entity must disclose individuals' PHI to them (or to their personal representatives) when they request access to, or an accounting of disclosures of, their PHI. Patients' rights apply to a **designated record set (DRS).** For a provider, the DRS means the medical and billing records the provider maintains. It does not include appointment and surgery schedules, requests for lab tests, and birth and death records. It also does not include mental health information, psychotherapy notes, and genetic information. For a health plan, the DRS includes enrollment, payment, claim decisions, and medical management systems of the plan.

Within the DRS, patients have the right to:

- Access, copy, and inspect their PHI
- Request amendments to their health information
- Obtain accounting of most disclosures of their health information
- Receive communications from providers via other means, such as in Braille or in foreign languages
- Complain about alleged violations of the regulations and the provider's own information policies

designated record set (DRS) covered entity's records that contain protected health information (PHI); for providers, the medical/financial patient record

Notice of Privacy Practices Covered entities must give each patient a notice of privacy practices at the first contact or encounter. To meet this requirement, physician practices give patients their **Notice of Privacy Practices (NPP)** (Figure 2.2) and ask them to sign an

Notice of Privacy Practices (NPP) description of a covered entity's principles and procedures related to the protection of patients' health information

HIPAA/HITECH TIP

HIPAA Exemptions

Certain benefits are always exempt from HIPAA, including coverage only for accident, disability income coverage, liability insurance, workers' compensation, automobile medical payment and liability insurance, credit-only insurance (such as mortgage insurance), and coverage for on-site medical clinics.

Valley Associates, PC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PRIVACY OBLIGATIONS

The law requires us to maintain the privacy of certain health information called "Protected Health Information" ("PHI"). Protected Health Information is the information that you provide us or that we create or receive about your healthcare. The law also requires us to provide you with this Notice of our legal duties and privacy practices. When we use or disclose (share) your Protected Health Information, we are required to follow the terms of this Notice or other notice in effect at the time we use or share the PHI. Finally, the law provides you with certain rights described in this Notice.

WAYS WE CAN USE AND SHARE YOUR PHI WITHOUT YOUR WRITTEN PERMISSION (AUTHORIZATION)

In many situations, we can use and share your PHI for activities that are common in many offices and clinics. In certain other situations, which we will describe below, we must have your written permission (authorization) to use and/or share your PHI. We do not need any type of permission from you for the following uses and disclosures:

A. Uses and Disclosures for Treatment, Payment and Healthcare Operations

We may use and share your PHI to provide "Treatment," obtain "Payment" for your Treatment, and perform our "Healthcare Operations." These three terms are defined as:

Treatment:

We use and share your PHI to provide care and other services to you—for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment options. We may tell you about other health-related benefits and services that might interest you. We may also share PHI with other doctors, nurses, and others involved in your care.

Payment:

We may use and share your PHI to receive payment for services that we provide to you. For example, we may share your PHI to request payment and receive payment from Medicare, Medicaid, your health insurer, HMO, or other company or program that arranges or pays the cost of some or all of your healthcare ("Your Payer") and to confirm that Your Payer will pay for healthcare. As another example, we may share your PHI with the person who you told us is primarily responsible for paying for your Treatment, such as your spouse or parent.

Healthcare Operations:

We may use and share your PHI for our healthcare operations, which include management, planning, and activities that improve the quality and lower the cost of the care that we deliver. For example, we may use PHI to review the quality and skill of our physicians, nurses, and other healthcare providers.

B. Your Other Healthcare Providers

We may also share PHI with other healthcare providers when they need it to provide Treatment to you, to obtain Payment for the care they give to you, to perform certain Healthcare Operations, such as reviewing the quality and skill of healthcare professionals, or to review their actions in following the law.

C. Disclosure to Relatives, Close Friends, and Your Other Caregivers

We may share your PHI with your family member/relative, a close personal friend, or another person who you identify if we

(1) First provide you with the chance to object to the disclosure and you do not object;
(2) Infer that you do not object to the disclosure; or
(3) Obtain your agreement to share your PHI with these individuals. If you are not present at the time we share your PHI, or you are not able to agree or disagree to our sharing your PHI because you are not capable or there is an emergency circumstance, we may use our professional judgment to decide that sharing the PHI is in your best interest. We may also use or share your PHI to notify (or assist in notifying) these individuals about your location and general condition.

D. Public Health Activities

We are required or are permitted by law to report PHI to certain government agencies and others. For example, we may share your PHI for the following:

FIGURE 2.2 Example of a Notice of Privacy Practices (*Continues on the following pages*)

HIPAA/HITECH TIP

PHI and Release of Information Document

A patient release of information document is not needed when PHI is shared for TPO under HIPAA. However, state law may require authorization to release data, so many practices continue to ask patients to sign releases.

HIPAA/HITECH TIP

Healthcare Providers and the Minimum Necessary Standard

The minimum necessary standard does not apply to any type of disclosure—oral, written, phone, fax, e-mail, or other— among healthcare providers for treatment purposes.

HIPAA/HITECH TIP

Posting and Amending the NPP

The NPP should be posted on the practice's website.
When the NPP is updated or changed, all patients who received the previous version must be notified.

(1) To report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability;
(2) To report abuse and neglect to the state Department of Children and Family Services, the state Department of Human Services, or other government authorities, including a social service or protective services agency, that are legally permitted to receive the reports;
(3) To report information about products and services to the U.S. Food and Drug Administration;
(4) To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of developing or spreading a disease or condition;
(5) To report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; and
(6) To prevent or lessen a serious and imminent threat to a person for the public's health or safety, or to certain government agencies with special functions such as the State Department.

E. Health Oversight Activities

We may share your PHI with a health oversight agency that oversees the healthcare system and ensures the rules of government health programs, such as Medicare or Medicaid, are being followed.

F. Judicial and Administrative Proceedings

We may share your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

G. Law Enforcement Purposes

We may share your PHI with the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a subpoena.

H. Decedents

We may share PHI with a coroner or medical examiner as authorized by law.

I. Organ and Tissue Procurement

We may share your PHI with organizations that facilitate organ, eye, or tissue procurement, banking, or transplantation.

J. Research

We may use or share your PHI in related research processes.

K. Workers' Compensation

We may share your PHI as permitted by or required by state law relating to workers' compensation or other similar programs.

L. As Required by Law

We may use and share your PHI when required to do so by any other law not already referred to above.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN PERMISSION (AUTHORIZATION)

A. Use or Disclosure with Your Permission (Authorization)

For any purpose other than the ones described above, we may only use or share your PHI when you grant us your written permission (authorization). For example, you will need to give us your permission before we send your PHI to your life insurance company.

B. Marketing

We must also obtain your written permission (authorization) prior to using your PHI to send you any marketing materials. However, we may communicate with you about products or services related to your Treatment, case management, or care coordination, or alternative treatments, therapies, healthcare providers, or care settings without your permission. For example, we may not sell your PHI without your written authorization.

C. Uses and Disclosures of Your Highly Confidential Information

Federal and state law requires special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including any portion of your PHI that is:
(1) Kept in psychotherapy notes;
(2) About mental health and developmental disabilities services;
(3) About alcohol and drug abuse prevention, treatment and referral;
(4) About HIV/AIDS testing, diagnosis or treatment;
(5) About sexually transmitted disease(s);
(6) About genetic testing;

FIGURE 2.2 (*Continued*)

HIPAA/HITECH TIP

Patient Complaints

Patients who observe privacy problems in their providers' offices can complain either to the practice or to the Office for Civil Rights of the Department of HHS. Complaints must be put in writing, either on paper or electronically, and sent to OCR within 180 days.

Medical Notice of Privacy Practices

www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html

(7) About child abuse and neglect;
(8) About domestic abuse of an adult with a disability;
(9) About sexual assault; or
(10) In vitro Fertilization (IVF). Before we share your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written permission.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

A. For Further Information; Complaints

If you want more information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact our Compliance Officer. You may also file written complaints with the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services. When you ask, the Compliance Officer will provide you with the correct address for the OCR. We will not take any action against you if you file a complaint with us or with the OCR.

B. Right to Receive Confidential Communications

You may ask us to send papers that contain your PHI to a different location than the address that you gave us, or in a special way. You will need to ask us in writing. We will try to grant your request if we feel it is reasonable. For example, you may ask us to send a copy of your medical records to a different address than your home address.

C. Right to Revoke Your Written Permission (Authorization)

You may change your mind about your authorization or any written permission regarding your PHI by giving or sending a written "revocation statement" to the Compliance Officer. The revocation will not apply to the extent that we have already taken action where we relied on your permission.

D. Right to Inspect and Copy Your Health Information

You may request access to your medical record file, billing records, and other records used to make decisions about your Treatment and payment for your Treatment. You can review these records and/or ask for copies. Under limited circumstances, we may deny you access to a portion of your records. If you want to access your records, you may obtain a record request form and return the completed form to the registration desk. If you request copies, we will charge you the amount listed on the rate sheet. We will also charge you for our postage costs, if you request that we mail the copies to you. For a copy of records, material, or information that cannot routinely be copied on a standard photocopy machine, such as x-ray films or pictures, we may charge for the reasonable cost of the copy.

E. Right to Amend Your Records

You have the right to request that we amend PHI maintained in medical record files, billing records, and other records used to make decisions about your Treatment and payment for your Treatment. If you want to amend your records, you may submit an amendment request form to the Compliance Officer. We will comply with your request unless we believe that the information that would be amended is correct and complete or that other circumstances apply. In the case of a requested amendment concerning information about the Treatment of a mental illness or developmental disability, you have the right to appeal to a state court our decision not to amend your PHI.

F. Right to Receive an Accounting of Disclosures

You may ask for an accounting of certain disclosures of your PHI made by us on or after April 14, 2003. These disclosures must have occurred before the time of your request, and we will not go back more than six (6) years before the date of your request. If you request an accounting more than once during a twelve (12) month period, we will charge you based on the rate sheet. Direct your request for an accounting to the Compliance Officer.

G. Right to Request Restrictions

You have the right to ask us to restrict or limit the PHI we use or disclose about you for treatment, payment, or healthcare operations. With one exception, we are not required to agree to your request. If we do agree, we will comply unless the information is needed to provide emergency treatment. Your request for restrictions must be made in writing and submitted to the Compliance Officer. We must grant your request to a restriction on disclosure of your PHI to a health plan if you have paid for the healthcare item in full out of pocket.

H. Right to Receive Paper Copy of this Notice

If you ask, you may obtain a paper copy of this Notice, even if you have agreed to receive the notice electronically.

You may contact the compliance officer at:
Valley Associates, PC
ATTN: Compliance Officer
1400 West Center Street
Toledo, OH 43601-0123
555-321-0987

PHI and Medical Office Staff

Be careful not to discuss patients' cases with anyone outside the office, including family and friends. Avoid talking about cases, too, in the practice's reception areas where other patients might hear. Close charts on desks when they are not being worked on. Position computer screens so that only the person working with a file can view it.

Questions and Answers on HIPAA Privacy Policies
www.hhs.gov/ocr/privacy

acknowledgment that they have received it (see the chapter about patient encounters and billing information). The notice explains how patients' PHI may be used and describes their rights.

Practices may choose to use a layered approach to giving patients the notice. On top of the information packet is a short notice, like the one shown in Figure 2.2, that briefly describes the uses and disclosures of PHI and the person's rights. The longer notice is placed beneath it.

PHI and Accounting for Disclosures Patients have the right to an **accounting of disclosure** of their PHI other than for TPO. When a patient's PHI is accidentally disclosed, the disclosure should be documented in the individual's medical record because the individual did not authorize it and it was not a permitted disclosure. An example is faxing a discharge summary to the wrong physician's office.

Also, under HITECH, patients can request an accounting of all disclosures—not just those other than for TPO—for the past three years if their PHI is stored in an EHR.

Charging for Copying

Practices may charge patients a fee for supplying copies of their records but cannot hold records "hostage" while awaiting payment.

accounting of disclosure documentation of the disclosure of a patient's PHI in that person's medical record in unauthorized cases

authorization (1) document signed by a patient to permit release of medical information; (2) health plan's system of approving payment of benefits for appropriate services

Authorizations for Other Use and Disclosure

For use or disclosure other than for TPO, the covered entity must have the patient sign an **authorization** to release the information. Information about substance (alcohol and drug) abuse, sexually transmitted diseases (STDs) or human immunodeficiency virus (HIV), and behavioral/mental health services may not be released without a specific authorization from the patient. The authorization document must be in plain language and include the following:

- A description of the information to be used or disclosed
- The name or other specific identification of the person(s) authorized to use or disclose the information
- The name of the person(s) or group of people to whom the covered entity may make the use or disclosure
- A description of each purpose of the requested use or disclosure
- An expiration date
- The signature of the individual (or authorized representative) and the date

In addition, the rule states that a valid authorization must include:

- A statement of the individual's right to revoke the authorization in writing
- A statement about whether the covered entity is able to base treatment, payment, enrollment, or eligibility for benefits on the authorization
- A statement that information used or disclosed after the authorization may be disclosed again by the recipient and may no longer be protected by the rule

A sample authorization form is shown in Figure 2.3.

Uses or disclosures for which the covered entity has received specific authorization from the patient do not have to follow the minimum necessary standard. Incidental use and disclosure are also allowed. For example, the practice may use reception-area sign-in sheets.

Marketing

PHI can be used for marketing—communications that influence others to use or purchase a product. In most cases, no patient authorization is needed.

Exceptions

There are a number of exceptions to the usual rules for release:

- Emergencies
- Court orders
- Workers' compensation cases
- Statutory reports
- Research
- Self-pay (patient rather than insurance pays for the service) requests for restrictions

All these types of disclosures must be logged, and the release information must be available to the patient who requests it.

Patient Name: _____

Health Record Number: _____

Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure: _____

What specific information can be released

3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)

- ☐ problem list
- ☐ medication list
- ☐ list of allergies
- ☐ immunization records
- ☐ most recent history
- ☐ most recent discharge summary
- ☐ lab results (please describe the dates or types of lab tests you would like disclosed): _____
- ☐ x-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed): _____
- ☐ consultation reports from (please supply doctors' names): _____
- ☐ entire record
- ☐ other (please describe): _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

To whom

5. The information identified above may be used by or disclosed to the following individuals or organization(s):

Name: _____

Address: _____

Name: _____

Address: _____

For what purpose

6. This information for which I'm authorizing disclosure will be used for the following purpose:

- ☐ my personal records
- ☐ sharing with other healthcare providers as needed/other (please describe): _____

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

For how long

8. This authorization will expire (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal representative: _____ Date: _____

If signed by legal representative, relationship to patient

Signature of witness: _____ Date: _____

Distribution of copies: Original to provider; copy to patient; copy to accompany use or disclosure

Note: This sample form was developed by the American Health Information Management Association for discussion purposes. It should not be used without review by the issuing organization's legal counsel to ensure compliance with other federal and state laws and regulations.

FIGURE 2.3 Example of an Authorization to Use or Disclose Health Information

PHI and Authorization to Release

To legally release PHI for purposes other than treatment, payment, or healthcare operations, a signed authorization document is required.

Emergencies Emergency guidance from HHS states that CEs may disclose PHI without the patient's consent for the following reasons:

- To treat the patient or another patient, which includes coordinating and managing care and services by one or more healthcare providers and others, or for consultation between providers and referrals
- To grant public health authorities (e.g., the Centers for Disease Control and Prevention) access to PHI that is critical to carrying out its public health mission
- To provide information for the patient's family members, relatives, friends, or other persons identified by the patient as involved in the patient's care
- As necessary to identify or locate a patient and notify his or her family, guardians, or anyone else responsible for the patient's care of the patient's location, general condition, or death
- To prevent or lessen a serious and imminent threat to the health and safety of a person or the public

Release Under Court Order If the patient's PHI is required as evidence by a court of law, the provider may release it without the patient's approval if a judicial order is received. In the case of a lawsuit, a court sometimes decides that a physician or medical practice staff member must provide testimony. The court issues a *subpoena,* an order of the court directing a party to appear and testify. If the court requires the witness to bring certain evidence, such as a patient medical record, it issues a *subpoena duces tecum,* which directs the party to appear, testify, and bring specified documents or items.

PHI and Practice Policy

The release of protected health information must follow the practice's policies and procedures. The practice's privacy official trains medical insurance specialists on how to verify the identity and authority of a person requesting PHI.

Workers' Compensation Cases State law may provide for release of records to employers in workers' compensation cases (see the chapter about workers' compensation). The law may also authorize release to the state workers' compensation administration board and to the insurance company that handles these claims for the state.

Statutory Reports Some specific types of information are required by state law to be released to state health or social services departments. For example, physicians must make statutory reports for patients' births and deaths and for cases of abuse. Because of the danger of harm to patients or others, communicable diseases, such as tuberculosis, hepatitis, and rabies, must usually be reported.

A special category of communicable disease control is applied to patients with diagnoses of HIV infection and acquired immunodeficiency syndrome (AIDS). Every state requires AIDS cases to be reported. Most states also require reporting of the HIV infection that causes the syndrome. However, state law varies concerning whether just the fact of a case is to be reported or if the patient's name must also be reported. The practice guidelines reflect the state laws and must be strictly observed, as all these regulations should be, to protect patients' privacy and to comply with the regulations.

Research Data PHI may be made available to researchers approved by the practice. For example, if a physician is conducting clinical research on a type of diabetes, the practice may share information from appropriate records for analysis. When the researcher issues reports or studies based on the information, specific patients' names may not be identified.

Self-Pay Requests for Restrictions Under HITECH, patients can restrict the access of health plans to their medical records if they pay for the service in full out of pocket at the time of the visit.

De-Identified Health Information

de-identified health information medical data from which individual identifiers have been removed

There are no restrictions on the use or disclosure of **de-identified health information** that neither identifies nor provides a reasonable basis to identify an individual. For example, these identifiers must be removed: names, medical record numbers, health plan beneficiary numbers, device identifiers (such as pacemakers), and biometric identifiers, such as fingerprints and voiceprints.

Psychotherapy Notes

Psychotherapy notes have special protection under HIPAA. According to the Department of HHS,

> Under the HIPAA Privacy Rule, psychotherapy notes are notes recorded by a mental health professional documenting or analyzing the contents of a conversation and that are separate from the rest of a patient's medical record. Psychotherapy notes are treated differently because they contain particularly sensitive information and are not typically useful for treatment, payment, or health care operations purposes. Therefore, the Privacy Rule generally requires CEs to obtain patient authorization for any kind of disclosure except in cases where disclosure is required by another law. (Available online at www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html)

State Statutes

Some state statutes are more stringent than HIPAA specifications. Areas in which state statutes may differ from HIPAA include the following:

- Designated record set
- Psychotherapy notes
- Rights of inmates
- Information compiled for civil, criminal, or administrative court cases

Each practice's privacy official reviews state laws and develops policies and procedures for compliance with the HIPAA Privacy Rule. The tougher rules are implemented.

THINKING IT THROUGH 2.4

Based on the information in Figure 2.2:

1. Is permission needed to share a patient's PHI with his or her life insurance company?
2. Is written authorization from a patient needed to use or disclose health information in an emergency?
3. What is the purpose of an "accounting of disclosures"?

2.5 HIPAA Security Rule

The **HIPAA Security Rule** requires covered entities to establish safeguards to protect PHI. The security rule specifies how to secure such protected health information on computer networks, the Internet ("cloud storage"), and storage disks such as CDs.

Encryption Is Required

Information security is needed when computers exchange data over the Internet. Security measures rely on **encryption,** the process of encoding information in such a way that only the person (or computer) with the key can decode it. Practice management programs (PMPs) encrypt data traveling between the office and the Internet so that the information is secure.

Security Measures

A number of other security measures help enforce the HIPAA Security Rule. These include:

- Secure Internet connections
- Access control, passwords, and log files to keep intruders out
- Backups to replace items after damage
- Security policies to handle violations that do occur

HIPAA/HITECH TIP

PHI and Answering Machines

If possible, ask patients during their initial visit whether staff members may leave messages on answering machines or with friends or family. If this is not done, messages should follow the minimum necessary standard; the staff member should leave a phone number and a request for the patient to call back. For example: "This is the doctor's office with a message for Mr. Warner. Please call us at 203-123-4567."

HIPAA/HITECH TIP

PHI and Reports

The Association for Healthcare Documentation Integrity (AHDI) (formerly the American Association for Medical Transcription) advises against using a patient's name in the body of a medical report. Instead, place identification information only in the demographic section, where it can be easily deleted when the report data are needed for research.

HIPAA Security Rule law requiring covered entities to establish safeguards to protect health information

encryption method of converting a message into encoded text

BILLING TIP

Internet Security Symbol

On the Internet, when an item is secure, a small padlock appears in the status bar at the bottom of the browser window.

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Access Control, Passwords, and Log Files

Most practices use role-based access, meaning that only people who need information can see it. Once access rights have been assigned, each user is given a key to the designated databases. Users must enter a user ID and a **password** (the key) to see files to which they have been granted access rights.

password confidential authentication information

For example, receptionists may view the names of patients coming to the office on one day, but they should not see those patients' medical records. However, the nurse or physician needs to view the patient records. Receptionists are given individual computer passwords that let them view the day's schedule but that deny entry to patient records. The physicians and nurses possess computer passwords that allow them to see all patient records.

The PMP also creates activity logs of who has accessed—or tried to access—information, and passwords prevent unauthorized users from gaining access to information on a computer or network.

COMPLIANCE GUIDELINE

Don't Share!

Never share your log-in or passwords. Sharing makes *you* responsible if someone else access and breaches HIPAA information with your identification.

Internet Security

Information is exchanged over the Internet between the practice and those outside of the office in a number of ways, especially by e-mail, the most important business communication method. Additionally, practices may have their own websites and patient portals for access to the physicians and for marketing purposes; take calls from patients' mobile phones; and send medical records to health plans via attachments. HIPAA, HITECH, and many states have laws for data security that require the use of antivirus software programs and encrypting confidential patient data that are transmitted.

HIPAA/HITECH TIP

Texting

Physicians and other providers can text patient data if a secure messaging platform is used.

Backups

Backing up is the activity of copying files to another medium so that they will be preserved in case the originals are no longer available. A successful backup plan is critical in recovering from either a minor or major security incident that jeopardizes critical data. To be secure, backups must also be encrypted.

THINKING IT THROUGH 2.5

1. Imagine that you are employed as a medical insurance specialist for Family Medical Center. Make up a password that you will use to keep your files secure.
2. As an employee, how would you respond to another staff member who asked to see your latest claim files in order to see how you handled a particular situation?

Security Policy

Practices have security policies that inform employees about their responsibilities for protecting electronically stored information. Many practices include this information in handbooks distributed to all employees. These handbooks contain general information about the organizations, their structures, and their policies as well as specific information about employee responsibilities.

2.6 HITECH Breach Notification Rule

The HITECH Act requires covered entities to notify affected individuals following the discovery of a breach of unsecured health information. A **breach** is an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of PHI.

breach impermissible use or disclosure of PHI that could pose significant risk to the affected person

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Guidance on Securing PHI

The HITECH Act refers to *unsecured PHI* as unprotected health information that is not secured through the use of technologies or methods that HHS has specified. These methods involve either encrypting or destroying the data. If PHI has not been secured through one or more of these methods and there is a breach, covered entities are required to follow the provision's breach notification procedures.

Although covered entities do not have to follow the guidance on acceptable methods, if the encryption and destruction methods specified are used to secure data, covered entities may be exempt from the breach notification requirements for breaches of that data. In addition, the rule notes several exceptions to the definition of "breach," including certain good faith uses and disclosures among a company's workforce members, as long as the private information is not further acquired, accessed, used, or disclosed without authorization.

Breach Notification Procedures

Following the discovery of a breach of unsecured PHI, a covered entity must notify each individual whose unsecured PHI has been, or is reasonably believed to have been, inappropriately accessed, acquired, or disclosed in the breach. Additionally, following the discovery of a breach by a business associate, the business associate must notify the covered entity of the breach and identify for the covered entity the individuals whose unsecured PHI has been, or is reasonably believed to have been, breached. If not going ahead with notification, the covered entity must document the reason this was not done. The act requires the notifications to be made within 60 calendar days after discovery of the breach. An exception may be made to the 60-calendar-day deadline only in a situation in which a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security.

HITECH specifies the following:

- Notice to patients of breaches "without reasonable delay" within 60 days
- Notice to covered entities by BAs when BAs discover a breach
- Notice to "prominent media outlets" on breaches involving more than 500 individuals
- Notice to "next of kin" on breaches involving patients who are deceased
- Notice to the secretary of HHS about breaches involving 500 or more individuals without reasonable delay
- Annual notice to the secretary of HHS about breaches of "unsecured PHI" involving less than 500 individuals that pose a significant financial risk or other harm to the individual, such as reputation

The document notifying an individual of a breach, called the **breach notification,** must include the following points: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known; (2) a description of the types of unsecured PHI that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code); (3) the steps individuals should take to protect themselves from potential harm resulting from the breach; (4) a brief description of what the covered entity involved is doing to investigate the breach, to mitigate losses, and to protect against any further breaches; and (5) contact procedures for individuals to ask questions or learn additional information, which include a toll-free telephone number, an e-mail address, website, or postal address.

In addition, as part of the rule, the secretary of HHS must annually prepare and submit to Congress a report regarding the breaches for which the secretary was notified and all enforcement actions taken. This means that covered entities must maintain a log of breaches involving fewer than 500 individuals, which they submit annually to HHS. HHS must post the report on the HHS public website.

HIPAA/HITECH TIP

Selecting Good Passwords

- Security experts suggest a combination of letters, numbers, and symbols that are at least 12 characters long, that are not real words, and that are not obvious (like a birth date).
- Do not use a user ID (logon, sign-on) as a password. Even if an ID has both numbers and letters, it is not secret.
- Select a mixture of uppercase and lowercase letters if the system permits, and include special characters, such as @, $, or &, if possible.
- Change passwords periodically, but not too often. Forcing frequent changes can actually make security worse because users are more likely to write down passwords.
- Electronically stored passwords should be encrypted.

COMPLIANCE GUIDELINE

Federal Versus State Regulations

State insurance departments may have additional, more stringent breach notification regulations.

breach notification document notifying an individual of a breach

HHS Breach Notifications Website

www.hhs.gov/hipaa/for-professionals/breach-notification/index.html

HHS Health Data Privacy and Security Resources
www.hhs.gov/ocr/privacy/

THINKING IT THROUGH 2.6

1. Review the HITECH specifications regarding breaches and business associates. If a business associate causes a breach, who is responsible for notifying the individuals affected?

2.7 HIPAA Electronic Health Care Transactions and Code Sets

HIPAA Electronic Health Care Transactions and Code Sets (TCS) rule governing the electronic exchange of health information

The **HIPAA Electronic Health Care Transactions and Code Sets (TCS)** standards make it possible for physicians and health plans to exchange electronic data using a standard format and standard code sets.

CMS eHealth
www.cms.gov/eHealth
Website for health information technology and electronic standards programs

Standard Transactions

The HIPAA transactions standards apply to the electronic data that are regularly sent back and forth between providers, health plans, and employers. Each standard is labeled with both a number and a name. Either the number (such as "the 837") or the name (such as the "HIPAA Claim") may be used to refer to the particular electronic document format.

Number	*Official Name*
X12 837	Healthcare Claims or Equivalent Encounter Information/Coordination of Benefits—*coordination of benefits* refers to an exchange of information between payers when a patient has more than one health plan
X12 276/277	Healthcare Claim Status Inquiry/Response
X12 270/271	Eligibility for a Health Plan Inquiry/Response
X12 278	Referral Certification and Authorization
X12 835	Healthcare Payment and Remittance Advice
X12 820	Health Plan Premium Payments
X12 834	Health Plan Enrollment and Disenrollment

BILLING TIP

Healthcare Claims

The X12 837 is usually referred to just as "Healthcare Claims," dropping the "or Equivalent Encounter Information," for short.

Medical insurance specialists use the first five transactions in performing their jobs. Each of these is covered in later text chapters.

Operating Rules

operating rules rules that improve interoperability between the data systems of different entities

The ACA requires the adoption of **operating rules** for each of the HIPAA standard transactions. The operating rules improve interoperability between the data systems of different entities, such as health plans and providers, and so increase their usefulness. They define the rights and responsibilities of those who are conducting the transactions, setting forth the security requirements, EDI transmission formats, response times, and error resolution.

Standard Code Sets

code set alphabetic and/or numeric representations for data

Under HIPAA, a **code set** is any group of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnosis codes, or medical procedure codes. Medical code sets used in the healthcare industry include coding systems for diseases; treatments and procedures; and supplies or other items used to perform these actions. These standards, listed in Table 2.3, are covered in later text chapters.

Table 2.3 HIPAA Standard Code Sets

Purpose	Standard
Codes for diseases, injuries, impairments, and other health-related problems	Before October 1, 2015: *International Classification of Diseases,* 9th Revision, *Clinical Modification* (ICD-9-CM), Volumes 1 and 2 After October 1, 2015: *International Classification of Diseases,* 10th Revision, *Clinical Modification*
Codes for procedures or other actions taken to prevent, diagnose, treat, or manage diseases, injuries, and impairments	Physicians' Services: *Current Procedural Terminology* (CPT) Before October 1, 2015: Inpatient Hospital Services: *International Classification of Diseases, 9th Revision, Clinical Modification,* Volume 3: *Procedures* After October 1, 2015: *International Classification of Diseases, Procedure Coding System*
Codes for dental services	*Current Dental Terminology* (CDT-4)
Codes for other medical services	Healthcare Common Procedures Coding System (HCPCS)

HIPAA National Identifiers

HIPAA National Identifiers are for:

- Employers
- Healthcare providers
- Health plans
- Patients

HIPAA National Identifiers identification systems for employers, healthcare providers, health plans, and patients

Identifiers are numbers of predetermined length and structure, such as a person's Social Security number. They are important because the unique numbers can be used in electronic transactions. These unique numbers can replace the many numbers that are currently used. Two identifiers have been set up, and two—health plans and patients—are to be established in the future.

Employer Identification Number (EIN)

The employer identifier is used when employers enroll or disenroll employees in a health plan (X12 834) or make premium payments to plans on behalf of their employees (X12 820). The Employer Identification Number (EIN; also called the *tax identification number*) issued by the Internal Revenue Service is the HIPAA standard.

National Provider Identifier (NPI)

The **National Provider Identifier (NPI)** is the standard for the identification of providers when filing claims and other transactions. The NPI has replaced other identifying numbers that had been used, such as the UPIN (Unique Physician Identification Number) for Medicare and the numbers that have been assigned by each payer to the provider. The older numbers are known as *legacy numbers.*

National Provider Identifier (NPI) unique ten-digit identifier assigned to each provider

The NPI has nine numbers and a check digit, for a total of ten numbers. The federal government assigns the numbers to individual providers, such as physicians and nurses, and to provider organizations such as hospitals, pharmacies, and clinics. CMS maintains NPIs as they are assigned in the National Plan and Provider Enumerator System (NPPES), a database of all assigned numbers. Once assigned, the NPI will not change; it remains with the provider regardless of job or location changes.

All healthcare providers who transmit health information electronically must obtain NPIs, even if they use business associates to prepare the transactions. Most health plans, including Medicare, Medicaid, and private payers, and all clearinghouses, must accept and use NPIs in HIPAA transactions. This includes small health plans as well.

BILLING TIP

Physician and Group NPIs

If a physician is in a group practice, both the individual doctor and the group have NPIs.

THINKING IT THROUGH 2.7

1. Gloria Traylor, an employee of National Bank, called Marilyn Rennagel, a medical insurance specialist who works for Dr. Judy Fisk. The bank is considering hiring one of Dr. Fisk's patients, Juan Ramirez, and Ms. Traylor would like to know if he has any known medical problems. Marilyn, in a hurry to complete the call and get back to work on this week's claims, quickly explains that she remembers that Mr. Ramirez was treated for depression some years ago but that he has been fine since that time. She adds that she thinks he would make an excellent employee.

   A. In your opinion, did Marilyn handle this call correctly?

   B. What problems might result from her answers?

COMPLIANCE GUIDELINE

HPID

A ten-digit "health plan identifier" is assigned to covered entities such as health plans.

BILLING TIP

OEID

An "other identity" identifier is assigned to entities that are not required to have NPIs but need to be identified in the standard transactions, such as third-party administrators who work for health plans.

2.8 Omnibus Rule and Enforcement

Omnibus Rule set of regulations enhancing patients' privacy protections and rights to information and the government's ability to enforce HIPAA

The **Omnibus Rule** contains regulations that enhance patients' privacy protections, provide individuals new rights to their health information, and strengthen the government's ability to enforce HIPAA in an increasingly digital period. All major parts of this rule were included in the appropriate sections earlier in this chapter, and that content is up-to-date. This brief section outlines the four final rules:

1. Strengthening previous HIPAA/HITECH rules, such as making BAs directly liable for compliance with privacy and security law
2. Increasing the civil monetary penalties for violations
3. Restating the standard that determines when to report breaches with more objective measures
4. Prohibiting health plans from using or disclosing genetic information for determining insurance coverage

Enforcement and Penalties

Enforcing HIPAA is the job of a number of government agencies. Which agency performs which task depends on the nature of the violation.

Office for Civil Rights (OCR) government agency that enforces the HIPAA Privacy Act

OCR Compliance and Enforcement

www.hhs.gov/hipaa/for-professionals/compliance-enforcement/index.html

Office for Civil Rights

Civil violations (those that are based on *civil law,* such as trespassing, divorce cases, and breech of contract proceedings) of the HIPAA privacy and security standards are enforced by the **Office for Civil Rights (OCR),** an agency of HHS. OCR has the authority to receive and investigate complaints as well as to issue subpoenas for evidence in cases it is investigating. It is charged with enforcing the privacy standards because privacy and security of one's health information are considered a civil right. It is important to note, though, that individuals themselves do not have the right to sue a covered entity that may have disclosed their PHI inappropriately; OCR must take action on individuals' behalf.

Department of Justice

Criminal violations (those that involve crimes, such as kidnapping, robbery, and arson) of HIPAA privacy standards are prosecuted by the federal government's. Department

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of Justice, which is America's "law office" and central agency for enforcement of federal laws.

Office of E-Health Standards and Services

The other standards are enforced by the **Office of E-Health Standards and Services (OESS),** part of CMS. In addition to its major task of administering the Medicare and Medicaid programs, HHS has also authorized CMS to investigate complaints of noncompliance and enforce these HIPAA standards:

- The Electronic Health Care Transaction and Code Set Rule (TCS)
- The National Employer Identifier Number (EIN) Rule
- The National Provider Identifier Rule

Office of E-Health Standards and Services (OESS) part of CMS that helps to develop and coordinate the implementation of a comprehensive e-health strategy

Office of Inspector General

The Office of Inspector General was directed by the original HIPAA law to combat fraud and abuse in health insurance and healthcare delivery.

Most billing-related accusations under the False Claims Act are based on the guideline that providers who *knew or should have known* that a claim for service was false can be held liable. The intent to commit fraud does not have to be proved by the accuser in order for the provider to be found guilty. Actions that might be viewed as errors or occasional slips might also be seen as establishing a pattern of violations, which constitute the knowledge meant by "providers knew or should have known."

OIG has the authority to investigate suspected fraud cases and to **audit** the records of physicians and payers. In an audit, which is a methodical examination, investigators review selected medical records to see whether the documentation matches the billing. The accounting records are often reviewed as well. When problems are found, the investigation proceeds and may result in charges of fraud or abuse against the practice.

Although OIG says that "under the law, physicians are not subject to civil, administrative, or criminal penalties for innocent errors, or even negligence," decisions about whether there are clear patterns and inadequate internal procedures can be subjective at times, making the line between honest mistakes and fraud very thin. Medical practice staff members must avoid any actions that could be perceived as noncompliant.

CMS HIPAA Enforcement
www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html

audit formal examination of a physician's or a payer's records

Monetary Penalties

Many privacy complaints have been settled by voluntary compliance. But if the covered entity does not act to resolve the matter in a way that is satisfactory, the enforcing agency can impose *civil money penalties (CMPs).* Fines of up to $50,000 for "willful neglect" and $1.5 million (per provision) for multiple violations of identical provisions may be imposed.

COMPLIANCE GUIDELINE

Ongoing Compliance Education

As explained in Section 2.10, many medical office staff members receive ongoing training and education in current rules so that they can avoid even the appearance of fraud.

THINKING IT THROUGH 2.8

1. Mary Kelley, a patient of the Good Health Clinic, asked Kathleen Culpepper, the medical insurance specialist, to help her out of a tough financial spot. Mary's medical insurance authorized her to receive [illegible] radiation treatments for her condition, one every thirty-five days. Because she was out of town, she did not schedule her appointment for the last treatment until today, which is one week beyond the approved period. The insurance company will not reimburse Mary for this procedure. She asks Kathleen to change the date on the record to last Wednesday so that it will be covered, explaining that no one will be hurt by this change and, anyway, she pays the insurance company plenty.

   A. What type of action is Mary asking Kathleen to do?

   B. How should Kathleen handle Mary's request?

OIG Home Page
http://oig.hhs.gov

2.9 Fraud and Abuse Regulations

Almost everyone involved in the delivery of healthcare is trustworthy and is devoted to patients' welfare. However, some people are not. Healthcare fraud and abuse laws help control cheating in the healthcare system. Is this really necessary? The evidence says that it is. The National Health Care Anti-Fraud Association has projected that of the estimated $2 trillion spent on healthcare every year, at least 3 percent—or $50 billion—is lost to fraud.

The Health Care Fraud and Abuse Control Program

Health Care Fraud and Abuse Control Program government program to uncover and prosecute fraud and abuse in federal healthcare programs

Office of the Inspector General (OIG) government agency that investigates and prosecutes fraud

HIPAA's Title II required the **Health Care Fraud and Abuse Control Program** to uncover and prosecute fraud and abuse. The HHS **Office of the Inspector General (OIG)** has the task of detecting healthcare fraud and abuse and enforcing all laws relating to them. OIG works with the U.S. Department of Justice (DOJ), which includes the Federal Bureau of Investigation (FBI), under the direction of the U.S. attorney general to prosecute those suspected of medical fraud and abuse.

False Claims Act, Fraud Enforcement and Recovery Act, and State Laws

relator person who makes an accusation of fraud or abuse

The federal False Claims Act (FCA) (31 USC § 3729), a related law, prohibits submitting a fraudulent claim or making a false statement or representation in connection with a claim. It also encourages reporting suspected fraud and abuse against the government by protecting and rewarding people involved in *qui tam,* or whistle-blower, cases. The person who makes the accusation of suspected fraud is called the **relator.** Under the law, the relator is protected against employer retaliation. If the lawsuit results in a fine paid to the federal government, the whistle-blower may be entitled to 15 to 25 percent of the amount paid. People who blow the whistle are current or former employees of insurance companies or medical practices, program beneficiaries, and independent contractors.

The federal *Fraud Enforcement and Recovery Act (FERA)* of 2009 strengthens the provisions of the FCA. Also enforced by DOJ, FERA extends whistle-blower protection to agents and contractors of an employer as well as to employees. It also makes it illegal to knowingly keep an overpayment received from the government. (Handling such overpayments correctly is covered in the chapter about payments, appeals, and secondary claims.)

The ACA further strengthened the tools that DOJ and HHS have to pursue fraud investigations. The act provides additional funding so that providers can be subject to fingerprinting, site visits, and criminal background checks before they are allowed to bill the Medicare and Medicaid programs.

Nearly half of the states also have passed versions of the federal False Claims Act. These laws allow private individuals to bring an action alone or by working with the state attorney general against any person who knowingly causes the state to pay a false claim. These laws generally provide for civil penalties and damages related to the cost of any losses sustained because of the false claim.

COMPLIANCE GUIDELINE

The False Claims Act

The U.S. Department of Justice (DOJ) recovered a record-breaking $5.69 billion in False Claims Act settlements in fiscal year (FY) 2014.

Extending Laws to Private Payers

HIPAA extended existing laws governing fraud in the Medicare and Medicaid programs to all health plans.

Additional Laws

Additional laws relating to healthcare fraud and abuse control include:

- An antikickback statute that makes it illegal to knowingly offer incentives to induce referrals for services that are paid by government healthcare programs. Many financial actions are considered to be incentives, including illegal direct payments to other physicians and routine waivers of coinsurance and deductibles.
- Self-referral prohibitions (called *Stark rules*) that make it illegal for physicians (or members of their immediate families) to have financial relationships with clinics to which they refer their patients, such as radiology service clinics and clinical laboratory services. (Note, however, that there are many legal exceptions to this prohibition under various business structures.)

- The Sarbanes-Oxley Act of 2002 that requires publicly traded corporations to attest that their financial management is sound. These provisions apply to for-profit healthcare companies. The act includes whistle-blower protection so that employees can report wrongdoing without fear of retaliation.

Definition of Fraud and Abuse

Fraud is an intentional act of deception used to take advantage of another person. For example, misrepresenting professional credentials and forging another person's signature on a check are fraudulent. Pretending to be a physician and treating patients without a valid medical license are also fraudulent. Fraudulent acts are intentional; the individual expects an illegal or unauthorized benefit to result.

fraud intentional deceptive act to obtain a benefit by taking advantage of another person

Claims fraud occurs when healthcare providers or others falsely report charges to payers. A provider may bill for services that were not performed, overcharge for services, or fail to provide complete services under a contract. A patient may exaggerate an injury to get a settlement from an insurance company or may ask a medical insurance specialist to change a date on a chart so that a service is covered by a health plan.

In federal law, **abuse** means an action that misuses money that the government has allocated, such as Medicare funds. Abuse is illegal because taxpayers' dollars are misspent. An example of abuse is an ambulance service that billed Medicare for transporting a patient to the hospital when the patient did not need ambulance service. This abuse—billing for services that were not medically necessary—resulted in improper payment for the ambulance company. Abuse is not necessarily intentional. It may be the result of ignorance of a billing rule or of inaccurate coding.

abuse action that improperly uses another's resources

Examples of Fraudulent or Abusive Billing Acts

A number of billing practices are fraudulent or abusive. Investigators reviewing physicians' billing work look for patterns like these:

- Intentionally billing for services that were not performed or documented
  Example A lab bills Medicare for two tests when only one was done.
  Example A physician asks a coder to report a physical examination that was just a telephone conversation.
- Reporting services at a higher level than were carried out
  Example After a visit for a flu shot, the provider bills the encounter as a comprehensive physical examination plus a vaccination.
- Performing and billing for procedures that are not related to the patient's condition and therefore not medically necessary
  Example After reading an article about Lyme disease, a patient is worried about having worked in her garden over the summer, and she requests a Lyme disease diagnostic test. Although no symptoms or signs have been reported, the physician orders and bills for the *Borrelia burgdorferi* (Lyme disease) confirmatory immunoblot test. ◀

BILLING TIP

Fraud Versus Abuse

To bill when the task was not done is fraud; to bill when it was not necessary is abuse. Remember the rule: If a service was not documented, in the view of the payer, it was not done and cannot be billed. To bill for undocumented services is fraudulent.

THINKING IT THROUGH 2.9

1. Discuss the difference between fraud and abuse. Which is likely to create the most severe punishment?

2.10 Compliance Plans

Because of the risk of fraud and abuse liability, medical practices must be sure that all staff members follow billing rules. In addition to responsibility for their own actions, physicians are liable for the professional actions of employees they supervise. This responsibility is a result of the law of *respondeat superior,* which states that an employer

Plans Mandated

Under the ACA, practices are now required to have compliance plans in place.

is responsible for an employee's actions. Physicians are held to this doctrine, so they can be charged for the fraudulent behavior of any staff member.

compliance plan a medical practice's written plan for complying with regulations

A wise slogan is that "the best defense is a good offense." For this reason, medical practices write and implement **compliance plans** to uncover compliance problems and correct them to avoid risking liability. A compliance plan is a process for finding, correcting, and preventing illegal medical office practices. It is a written document prepared by a compliance officer and committee that sets up the steps needed to (1) audit and monitor compliance with government regulations, especially in the area of coding and billing, (2) have policies and procedures that are consistent, (3) provide for ongoing staff training and communication, and (4) respond to and correct errors.

The goals of the compliance plan are to:

- Prevent fraud and abuse through a formal process to identify, investigate, fix, and prevent repeat violations relating to reimbursement for healthcare services
- Ensure compliance with applicable federal, state, and local laws, including employment and environmental laws as well as antifraud laws
- Help defend the practice if it is investigated or prosecuted for fraud by substantiating the desire to behave compliantly and thus reduce any fines or criminal prosecution

Having a compliance plan demonstrates to outside investigators that the practice has made honest, ongoing attempts to find and fix weak areas.

Compliance plans cover more that just coding and billing. They also cover all areas of government regulation of medical practices, such as Equal Employment Opportunity (EEO) regulations (for example, hiring and promotion policies) and Occupational Safety and Health Administration (OSHA) regulations (for example, fire safety and handling hazardous materials such as blood-borne pathogens).

Parts of a Compliance Plan

Model Compliance Programs
https://oig.hhs.gov/compliance/compliance-guidance/index.asp

Generally, according to OIG, plans should contain seven elements:

1. Consistent written policies and procedures
2. Appointment of a compliance officer and committee
3. Training
4. Communication
5. Disciplinary systems
6. Auditing and monitoring
7. Responding to and correcting errors

Following OIG's guidance can help in the defense against a false claims accusation. Having a plan in place shows that efforts are made to understand the rules and correct errors. This indicates to OIG that the problems may not add up to a pattern or practice of abuse but may simply be errors.

Compliance Officer and Committee

To establish the plan and follow up on its provisions, most medical practices appoint a compliance officer who is in charge of the ongoing work. The compliance officer may be one of the practice's physicians, the practice manager, or the billing manager. A compliance committee is also usually established to oversee the program.

Code of Conduct

The practice's compliance plan emphasizes the procedures that are to be followed to meet existing documentation, coding, and medical necessity requirements. It also has a code of conduct for the members of the practice, which covers:

- Procedures for ensuring compliance with laws relating to referral arrangements
- Provisions for discussing compliance during employees' performance reviews and for disciplinary action against employees, if needed

- Mechanisms to encourage employees to report compliance concerns directly to the compliance officer to reduce the risk of whistle-blower actions

Promoting ethical behavior in the practice's daily operations can also reduce employee dissatisfaction and turnover by showing employees that the practice has a strong commitment to honest, ethical conduct.

Ongoing Training

Physician Training

Part of the compliance plan is a commitment to keep physicians trained in pertinent coding and regulatory matters. Often, the medical insurance specialist or medical coder is assigned the task of briefing physicians on changed codes or medical necessity regulations. The following guidelines are helpful in conducting physician training classes:

- Keep the presentation as brief and straightforward as possible.
- In a multispecialty practice, issues should be discussed by specialty; all physicians do not need to know changed rules on dermatology, for example.
- Use actual examples, and stick to the facts when presenting material.
- Explain the benefits of coding compliance to the physicians, and listen to their feedback to improve job performance.
- Set up a way to address additional changes during the year, such as an office newsletter or compliance meetings.

Staff Training

An important part of the compliance plan is a commitment to train medical office staff members who are involved with coding and billing. Ongoing training also requires having the current annual updates, reading health plans' bulletins and periodicals, and researching changed regulations. Compliance officers often conduct refresher classes in proper coding and billing techniques.

THINKING IT THROUGH 2.10

1. As a medical insurance specialist, why would ongoing training be important to you?

COMPLIANCE GUIDELINE

Medical Liability Insurance

Medical liability cases for fraud often result in lawsuits. Physicians purchase professional liability insurance to cover such legal expenses. Although they are covered under the physician's policy, other medical professionals often purchase their own liability insurance. Medical coders and medical insurance specialists who perform coding tasks are advised to have professional liability insurance called error and omission (E&O) insurance, which protects against financial loss due to intentional or unintentional failure to perform work correctly.

COMPLIANCE GUIDELINE

Have It in Writing!

Do not code or bill services that are not supported by documentation, even if instructed to do so by a physician. Instead, report this kind of situation to the practice's compliance officer.

Chapter 2 Summary

Learning Outcomes	Key Concepts/Examples
2.1 Explain the importance of accurate documentation when working with medical records.	• Medical records are created based on a variety of different types of documentation for patient encounters to provide the best possible care. • Both EHRs and paper records are forms of medical documentation. EHRs offer several advantages: • Immediate access to health information • Computerized physician order management • Clinical decision support • Automated alerts and reminders • Electronic communication and connectivity • Patient support • Administration and report • Error reduction

Learning Outcomes	Key Concepts/Examples
2.2 Compare the intent of HIPAA, HITECH, and ACA laws.	HIPAA is a law designed to: • Protect people's private health information • Ensure health insurance coverage for workers and their families when they change or lose their jobs • Uncover fraud and abuse • Create standards for electronic transmission of healthcare transactions The HITECH Act: • Contains additional provisions concerning the standards for electronic transmission of healthcare data • Guides the use of federal stimulus money to promote the adoption and meaningful use of health information technology, mainly using EHRs The ACA: • Reduces the number of people without health insurance • Fosters the formation and operation of ACOs
2.3 Describe the relationship between covered entities and business associates.	• Under HIPAA, a covered entity is a health plan, healthcare clearinghouse, or healthcare provider who transmits any health information in electronic form in connection with an HIPAA transaction. • A business associate, such as a law firm or billing service that performs work for a covered entity, must agree to follow applicable HIPAA regulations to safeguard PHI. • Electronic data interchange is used to facilitate transactions of information.
2.4 Explain the purpose of the HIPAA Privacy Rule.	• It regulates the use and disclosure of patients' PHI. • Both use and disclosure of PHI are necessary and permitted for patients' TPO. • PHI may also be released in some court cases, workers' compensation cases, statutory reports, and research. • Providers are responsible for protecting their patients' PHI, following the minimum necessary standard in releasing it, and creating procedures to follow in regard to PHI.
2.5 Briefly state the purpose of the HIPAA Security Rule.	• The rule requires covered entities to establish administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of health information. • Providers follow this rule through the use of encryption, access control, passwords, log files, backups to replace items after damage, and by developing security policies to handle violations when they do occur.
2.6 Explain the purpose of the HITECH Breach Notification Rule.	• The rule requires covered entities to notify affected individuals following the discovery of a breach of unsecured health information. • Covered entities have specific breach notification procedures that they must follow in the event of a breach. • When a breach occurs, covered entities must send the corresponding individual a breach notification, which must include five key points of information.
2.7 Explain how the HIPAA Electronic Health Care Transactions and Code Sets standards influence the electronic exchange of health information.	• TCS establishes standards for the exchange of financial and administrative data among covered entities. • The standards require the covered entities to use common electronic transaction methods and code sets. • The four National Identifiers are for employers, healthcare providers, health plans, and patients.

Learning Outcomes	Key Concepts/Examples
2.8 Describe the four final rules in the Omnibus Rule.	• The rule strengthens previous HIPAA/HITECH rules. • It increases the civil monetary penalties for violations. • The rule restates the standard for reporting breaches. • It prohibits health plans from using or disclosing genetic information for determining insurance coverage.
2.9 Explain how to guard against potentially fraudulent situations.	• Fraud and abuse regulations have been enacted to prevent fraud and abuse in healthcare billing. • OIG has the task of detecting healthcare fraud and abuse and related law enforcement. • The FCA prohibits submitting a fraudulent claim or making a false statement or representation in connection with a claim. • FERA strengthens the provisions of the FCA.
2.10 Assess the benefits of a compliance plan.	Compliance plans include: • Consistent written policies and procedures • Appointment of a compliance officer and committee • Training plans • Communication guidelines • Disciplinary systems • Ongoing monitoring and auditing of claim preparation • Response to and correction of errors • A formal process that is a sign that the practice has made a good-faith effort to achieve compliance

Review Questions

Match the key terms with their definitions.

1. **LO 2.4** HIPAA Privacy Rule
2. **LO 2.6** breach
3. **LO 2.4** minimum necessary standard
4. **LO 2.3** business associate
5. **LO 2.3** clearinghouse
6. **LO 2.4** Notice of Privacy Practices
7. **LO 2.7** code set
8. **LO 2.5** HIPAA Security Rule
9. **LO 2.3** covered entity

A. Law under the Administrative Simplification provisions of HIPAA requiring covered entities to establish administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of health information

B. The systematic, logical, and consistent recording of a patient's health status—history, examinations, tests, results of treatments, and observations—in chronological order in a patient's medical record

C. A person or organization that performs a function or activity for a covered entity but is not part of its workforce

D. The principle that individually identifiable health information should be disclosed only to the extent needed to support the purpose of the disclosure

E. Under HIPAA, a health plan, healthcare clearinghouse, or healthcare provider who transmits any health information in electronic form in connection with a HIPAA transaction

F. Law under the Administrative Simplification provisions of HIPAA regulating the use and disclosure of patients' protected health information—individually identifiable health information that is transmitted or maintained by electronic media

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10. **LO 2.1** documentation
11. **LO 2.2** CMS
12. **LO 2.8** Omnibus Rule
13. **LO 2.10** compliance plan
14. **LO 2.9** OIG

G. A HIPAA-mandated document that presents a covered entity's principles and procedures related to the protection of patients' protected health information

H. A coding system used to encode elements of data

I. A company that offers providers, for a fee, the service of receiving electronic or paper claims, checking and preparing them for processing, and transmitting them in proper data format to the correct carriers

J. Impermissible use or disclosure of PHI that could pose significant risk to the affected person

K. Agency that investigates and prosecutes fraud

L. Regulations that enhance privacy protections, rights to information, and the government's ability to enforce HIPAA

M. A practice's written plan for complying with regulations

N. Agency that runs Medicare, Medicaid, clinical laboratories, and other government health programs

Select the answer choice that best completes the statement or answers the question.

15. **LO 2.2** Which of the following laws is designed to uncover fraud and abuse?
    A. Fraud and Abuse Act
    B. ARRA
    C. HIPAA
    D. HITECH Act

16. **LO 2.4** A Notice of Privacy Practices is given to
    A. a practice's patients
    B. a practice's business associates
    C. the health plans with which a practice contracts
    D. all physicians who refer patients to the practice

17. **LO 2.4** Patients' PHI may be released without authorization to
    A. local newspapers
    B. employers in workers' compensation cases
    C. social workers
    D. family and friends

18. **LO 2.4** Which government group has the authority to enforce the HIPAA Privacy Rule?
    A. CIA
    B. OIG
    C. OCR
    D. Medicaid

19. **LO 2.4** Patients always have the right to
    A. withdraw their authorization to release information
    B. alter the information in their medical records
    C. block release of information about their communicable diseases to the state health department
    D. restrict the release of all de-identified health information associated with them

20. **LO 2.4** The authorization to release information must specify
    A. the number of pages to be released
    B. the Social Security number of the patient
    C. the entity to whom the information is to be released
    D. the name of the treating physician

21. **LO 2.4** Health information that does not identify an individual is referred to as
    A. protected health information
    B. authorized health release
    C. statutory data
    D. de-identified health information

22. **LO 2.6** Analyze the following scenarios to determine which would likely warrant a breach notification.
    A. De-identified health information is accessed by an outside provider.
    B. A company's workforce members use information in good faith.
    C. The database of a large insurance company is accessed by a hacker.
    D. Information is released to the government for statistical purposes.

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23. **LO 2.5** The main purpose of the HIPAA Security Rule is to

A. regulate electronic transactions

B. protect research data

C. control the confidentiality and integrity of and access to protected health information

D. protect medical facilities from criminal acts such as robbery

24. **LO 2.10** A compliance plan contains

A. consistent written policies and procedures

B. medical office staff names

C. the practice's main health plans

D. a list of all the practice's patients

25. Define the following abbreviations:

A. **LO 2.8** **OCR**

B. **LO 2.4** **PHI**

C. **LO 2.7** **TCS**

D. **LO 2.4** **DRS**

E. **LO 2.1** **EHR**

F. **LO 2.1** **CC**

G. **LO 2.7** **NPI**

H. **LO 2.4** **NPP**

I. **LO 2.9** **OIG**

Applying Your Knowledge

Case 2.1 Working with HIPAA

In each of these cases of release of PHI, was the HIPAA Privacy Rule followed? Why or why not?

A. **LO 2.4** A laboratory communicates a patient's medical test results to a physician by phone.

B. **LO 2.4** A physician mails a copy of a patient's medical record to a specialist who intends to treat the patient.

C. **LO 2.4** A hospital faxes a patient's healthcare instructions to a nursing home to which the patient is to be transferred.

D. **LO 2.4** A doctor discusses a patient's condition over the phone with an emergency room physician who is providing the patient with emergency care.

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E. **LO 2.4** A doctor orally discusses a patient's treatment regimen with a nurse who will be involved in the patient's care.

F. **LO 2.4** A physician consults with another physician by e-mail about a patient's condition.

G. **LO 2.4** A hospital shares an organ donor's medical information with another hospital treating the organ recipient.

H. **LO 2.4** A medical insurance specialist answers questions from a health plan over the phone about a patient's dates of service on a submitted claim.

Case 2.2 Applying HIPAA

LO 2.4 Rosalyn Ramirez is a medical insurance specialist employed by Valley Associates, PC, a midsized multispecialty practice with an excellent record of complying with HIPAA rules. Rosalyn answers the telephone and hears this question:

"This is Jane Mazloum, I'm a patient of Dr. Olgivy. I just listened to a phone message from your office about coming in for a checkup. My husband and I were talking about this. Since this is my first pregnancy and I am working, we really don't want anyone else to know about it yet. Has this information been given to anybody outside the clinic?" How do you recommend that she respond?

Patient Name: Angelo Diaz

Health Record Number: ADI00

Date of Birth: 10-12-1945

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure: Dr. L. Handlesman

3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)

- ☐ problem list
- ☐ medication list
- ☐ list of allergies
- ☐ immunization records
- ☑ most recent history
- ☐ most recent discharge summary
- ☐ lab results (please describe the dates or types of lab tests you would like disclosed): _____
- ☑ x-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed): _____
- ☐ consultation reports from (please supply doctors' names): _____
- ☐ entire record
- ☑ other (please describe): Progress notes

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. The information identified above may be used by or disclosed to the following individuals or organization(s):

Name: Blue Cross & Blue Shield

Address: _____

Name: _____

Address: _____

6. This information for which I'm authorizing disclosure will be used for the following purpose:

- ☐ my personal records
- ☐ sharing with other healthcare providers as needed/other (please describe): _____

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal representative: *Angelo Diaz* Date: 3-1-2029

If signed by legal representative, relationship to patient

Signature of witness: _____ Date: _____

Distribution of copies: Original to provider; copy to patient; copy to accompany use or disclosure

Note: This sample form was developed by the American Health Information Management Association for discussion purposes. It should not be used without review by the issuing organization's legal counsel to ensure compliance with other federal and state laws and regulations.

Case 2.3 Handling Authorizations

LO 2.4 Angelo Diaz signed the authorization form on the preceding page. When his insurance company called for an explanation of a reported procedure that Dr. Handlesman performed to treat a stomach ulcer, George Welofar, the clinic's registered nurse, released copies of his complete file. On reviewing Mr. Diaz's history of treatment for alcohol abuse, the insurance company refused to pay the claim, stating that Mr. Diaz's alcoholism had caused the condition. Mr. Diaz complained to the practice manager about the situation.

Should the information have been released?

Case 2.4 Working with Medical Records

The following chart note contains typical documentation abbreviations and shortened forms for words.

> 65-yo female; hx of right breast ca seen in SurgiCenter for bx of breast mass. Frozen section reported as benign tumor. Bleeding followed the biopsy. Reopened the breast along site of previous incision with coagulation of bleeders. Wound sutured. Pt adm. for observation of post-op bleeding. Discharged with no bleeding recurrence.
>
> Final Dx: Benign neoplasm, left breast.

Research the meaning of each abbreviation (see the Abbreviations list at the end of the text) and write their meanings:

A. **LO 2.1** yo

B. **LO 2.1** hx

C. **LO 2.1** ca

D. **LO 2.1** bx

E. **LO 2.1** Pt

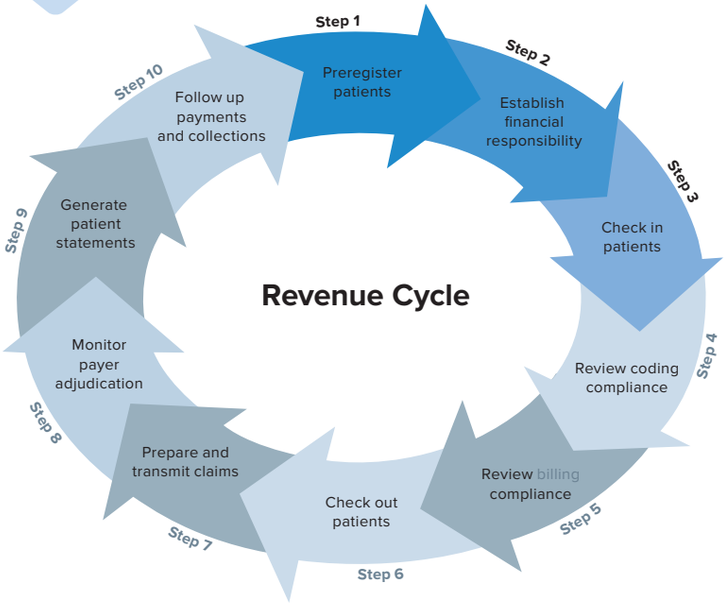
F. **LO 2.1** adm.

G. **LO 2.1** op

H. **LO 2.1** dx

PATIENT ENCOUNTERS AND BILLING INFORMATION

3



Learning Outcomes

After studying this chapter, you should be able to:

3.1 Explain the method used to classify patients as new or established.

3.2 Discuss the five categories of information required of new patients.

3.3 Explain how information for established patients is updated.

3.4 Verify patients' eligibility for insurance benefits.

3.5 Discuss the importance of requesting referral or preauthorization approval.

3.6 Determine primary insurance for patients who have more than one health plan.

3.7 Summarize the use of encounter forms.

3.8 Identify the eight types of charges that may be collected from patients at the time of service.

3.9 Explain the use of real-time adjudication tools in calculating time-of-service payments.

KEY TERMS

accept assignment
Acknowledgment of Receipt of Notice of Privacy Practices
assignment of benefits
birthday rule
certification number
charge capture
chart number
coordination of benefits (COB)
credit card on file (CCOF)
direct provider
electronic eligibility verification
encounter form
established patient (EP)
financial policy
gender rule
guarantor
HIPAA Coordination of Benefits
HIPAA Eligibility for a Health Plan
HIPAA Referral Certification and Authorization
indirect provider
insured/subscriber
new patient (NP)
nonparticipating provider (nonPAR)
partial payment
participating provider (PAR)
patient information form
portal
primary insurance
prior authorization number
real-time adjudication (RTA)
referral number
referral waiver
referring physician
secondary insurance
self-pay patient
supplemental insurance
tertiary insurance
trace number

From a business standpoint, the key to the financial health of a physician practice is billing and collecting fees for services. To maintain a regular cash flow—the movement of monies into or out of a business—specific medical billing tasks must be completed on a regular schedule. Processing encounters for billing purposes makes up the pre-claim section of the revenue cycle. This chapter discusses the important aspects of these steps:

- Information about patients and their insurance coverage is gathered and verified.
- The encounter is documented by the provider, and the resulting diagnoses and procedures are posted.
- Time-of-service payments are collected.

Patient charges represent an increasing percentage of practice revenues. Patients must leave the encounter with a clear understanding of their financial responsibilities and the next steps in the revenue cycle: filing claims, insurance payments, and paying bills they receive for balances they owe.

BILLING TIP

Defining "Provider"

The *provider* is defined as either a physician or a qualified healthcare professional, such as a physician assistant.

3.1 New Versus Established Patients

To gather accurate information for billing and medical care, practices ask patients to supply information and then double-check key data. Patients who are new to the medical practice complete many forms before their first encounters with their providers. A **new patient (NP)** is someone who has not received any services from the provider (or another provider of the same specialty/subspecialty) who is a member of the same practice within the past three years. A returning patient is called an **established patient (EP).** This patient has seen the provider (or another provider in the practice who has the same specialty) within the past three years. Established patients, review and update the information that is on file about them. Figure 3.1 illustrates how to decide which category fits the patient.

new patient (NP) patient who has not seen a provider within the past three years

established patient (EP) patient who has seen a provider within the past three years

THINKING IT THROUGH 3.1

1. Why is it important to determine whether patients are new or established in the practice?

3.2 Information for New Patients

When the patient is new to the practice, five types of information are important:

1. Preregistration and scheduling information
2. Medical history
3. Patient or guarantor and insurance data
4. Assignment of benefits
5. Acknowledgment of Receipt of Notice of Privacy Practices

Preregistration and Scheduling Information

The collection of information begins before the patient presents at the front desk for an appointment. Most medical practices have a preregistration process to check that patients' healthcare requirements are appropriate for the medical practice and to schedule appointments of the correct length.

Preregistration Basics

When new patients call for appointments, basic information is usually gathered:

- Full legal name as it appears on the patient's insurance card
- Telephone number

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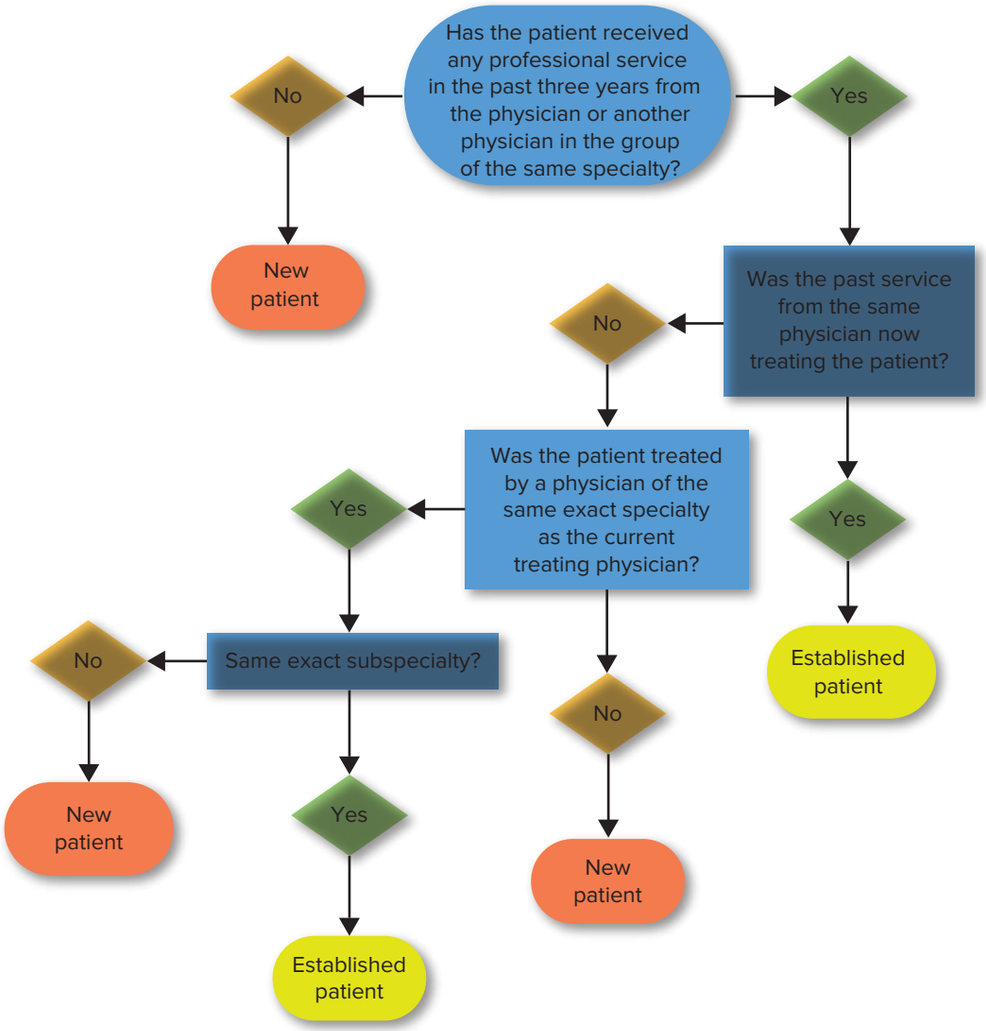

FIGURE 3.1 Decision Tree for New Versus Established Patients

- Address
- Date of birth
- Gender
- Reason for call or nature of complaint, including information about previous treatment
- If insured, the name of the health plan and whether a copay or coinsurance payment at the time of service is required
- If referred, the name of the referring physician

BILLING TIP

Referring Physician

A **referring physician** sends a patient to another physician for treatment.

referring physician physician who transfers care of a patient to another physician

Scheduling Appointments

Front office employees handle appointments and scheduling in most practices and may also handle prescription refill requests. Patient-appointment scheduling systems are often used; some permit online scheduling. Scheduling systems can be used to automatically

send reminders to patients, to trace follow-up appointments, and to schedule recall appointments according to the provider's orders. Some offices use open-access scheduling that allows patients to see providers without having made advance appointments; follow-up visits are scheduled.

BILLING TIP

MCOs and Appointments

Many managed care organizations (MCOs) require participating physicians to see enrolled patients within a short time of their calling for appointments. Some also require primary care physicians (PCPs) to handle emergencies in the office, rather than sending patients to the emergency department.

Provider Participation

New patients, too, may need information before deciding to make appointments. Most patients in preferred provider organizations (PPOs) and health maintenance organizations (HMOs) must use network physicians to avoid paying higher charges. For this reason, patients check whether the provider is a **participating provider, or PAR,** in their plan. When patients see **nonparticipating, or nonPAR, providers,** they must pay more—a higher copayment, higher coinsurance, or both—so a patient may choose not to make an appointment because of the additional expense.

participating provider (PAR) provider who agrees to provide medical services to a payer's policyholders according to a contract

nonparticipating provider (nonPAR) provider who does not join a particular health plan

Medical History

New patients complete medical history forms. Some practices give printed forms to patients when they come in. Others make the form available for completion ahead of time by posting it online or mailing it to the patient. Practices may also enable the patient to complete the medical history electronically in the reception area using portable check-in devices such as a tablet or wireless clipboard.

An example of a patient medical history form is shown in Figure 3.2. The form asks for information about the patient's personal medical history, the family's medical history, and the social history. Social history covers lifestyle factors such as smoking, exercise, and alcohol use. Many specialists use less-detailed forms that cover the histories needed for treatment.

The physician reviews this information with the patient during the visit. The patient's answers and the physician's notes are documented in the medical record.

BILLING TIP

Social Security Numbers (SSNs)

Although claim completion does not require SSNs, many practices still use these numbers as identifiers and request them on their patient information forms. Some patients may not provide SSNs. When the Health Insurance Portability and Accountability Act (HIPAA) national patient identifier rule is enacted, the numbering system the law will create will replace the use of SSNs in healthcare.

BILLING TIP

Know Plan Participation

Administrative staff members must know what plans the providers participate in. A summary of these plans should be available during patient registration.

Patient or Guarantor and Insurance Data

patient information form form that includes a patient's personal, employment, and insurance company data

A new patient arriving at the front desk for an appointment completes a **patient information form** (see Figure 3.3). It is used to collect the following demographic information about the patient:

- First name, middle initial, and last name
- Gender (*F* for female or *M* for male)
- Race and ethnicity
- Primary language
- Marital status (*S* for single, *M* for married, *D* for divorced, *W* for widowed)
- Birth date, using four digits for the year
- Home address and telephone numbers (area code with seven-digit number)

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PATIENT HEALTH SURVEY

NAME PLATE

NAME _____ AGE_____ M_____ F_____ DATE_____

ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Have you had

Childhood:
- ☐ Measles ☐ Mumps ☐ Chicken Pox
- ☐ Congenital Abnormalities ☐ Rheumatic fever or heart disease

Adult:
- ☐ Asthma ☐ High Blood Pressure ☐ Cancer (Site_____)
- ☐ Diabetes ☐ Ulcer or Gastritis ☐ Thyroid Problems
- ☐ Tuberculosis ☐ Kidney Problem ☐ Liver Problems
- ☐ Blood Problem ☐ Venereal Disease ☐ Heart Failure
- ☐ Heart Attack ☐ Abnormal Heart Rhythm

Have you had any serious illness? No Yes
Have you ever had a transfusion? No Yes
Have you ever been hospitalized or been under medical care for very long? No Yes

If Yes, for what reason? _____

Most recent immunizations:

Hepatitis B_____(date) Flu Vaccine_____(date)

Pneumovax_____(date) Tetanus_____(date)

OPERATIONS:

Have you ever had any surgery? No Yes

List: ☐ Appendectomy ☐ Hysterectomy (If so, reason_____)
☐ Ovaries Removed ☐ Joint Replacement
☐ Gallbladder ☐ Bypass (If so, what_____)
☐ Other _____

ALLERGIES:

MEDICATIONS:

INJURIES:

Have you ever been seriously injured in a motor vehicle accident? No Yes
Have you had any head concussions or injuries? No Yes
Have you ever been knocked unconscious? No Yes

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed Significant Other

With whom do you live? _____

Recreational Drug Usage? No Yes
Do you have any problems with sexual function? No Yes

Foreign travel within last year_____

Coffee_____ Tea_____ Cola's_____ (per day)

Alcoholic Beverages: Never_____ < 1 per week_____
1-5 per week_____ Other_____

Tobacco: ☐ Never Smoked ☐ Quit _____years ago
☐ Years smoked_____ ☐ Packs per day_____

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SOCIAL HISTORY: (continued)

Are you employed? Full Time_____ Part Time_____

What is your job? _____

Are you exposed to fumes, dusts or solvents? _____

How much time have you lost from work because of your health during the past?

Six Months_____ One Year_____ Five Years_____

Education: (Years)

Grade School_____ College_____ Postgraduate_____

Do you wear seatbelts? ☐ Always ☐ Sometimes ☐ Never

FAMILY HISTORY:	Age	Health	If Deceased, Age at Death	Cause of Death
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has either parent, sister, brother, child or grandparent ever had?

Stroke	No	Yes	Heart Trouble	No	Yes
Tuberculosis	No	Yes	High Blood Pressure	No	Yes
Diabetes	No	Yes			

Has any blood relative ever had?

Cancer	No	Yes	Bleeding Tendancy	No	Yes
Type:			Gout or other crippling arthritis		
Suicide	No	Yes		No	Yes
Mental Illness	No	Yes	Hereditary Defects	No	Yes

FIGURE 3.2 Medical History Form

- E-mail address
- Employer's name, address, and telephone number
- For a married patient, his or her employer's name or the name and employer of the spouse
- A contact person for the patient in case of a medical emergency
- If the patient is a minor (under the age of majority according to state law) or has a medical power of attorney in place (such as a person who is handling the medical

PATIENT HEALTH SURVEY

NAME PLATE

CIRCLE NO OR YES FOR THOSE THAT APPLY

SYSTEMIC REVIEW: Do you have any of the following?
General: Maximum weight_____ Minimum weight_____
Recent weight change? . . . . . No Yes
Have you been in good general health most of your life? . . . . No Yes
Have you recently had?
☐ Weakness ☐ Fever ☐ Chills ☐ Night Sweats
☐ Fainting ☐ Problems Sleeping

Skin:
Skin Disease . . . . . No Yes
Jaundice . . . . . No Yes
Hives, eczema or rash . . . . . No Yes

Head-Eyes-Ears-Nose-Throat (cont'd):
Dry eyes or mouth. . . . . No Yes
Bleeding Gums - Frequent or Constant. . . . . No Yes
Blurred Vision. . . . . No Yes
Date of Last Eye Exam _____
Sneezing or runny nose . . . . . No Yes
Nosebleeds - Frequent. . . . . No Yes
Chronic sinus trouble . . . . . No Yes
Ear disease. . . . . No Yes
Impaired hearing . . . . . No Yes
Dizziness or sensation of room spinning. . . . . No Yes
Frequent or severe headaches. . . . . No Yes

Respiratory:
Asthma or Wheezing . . . . . No Yes
Difficulty breathing. . . . . No Yes
Any trouble with lungs . . . . . No Yes
Pleurisy or Pneumonia . . . . . No Yes
Cough up Blood (ever). . . . . No Yes

Cardiovascular:
Chest pain, pressure, or tightness . . . . . No Yes
Shortness of breath with walking or lying down. . . . . No Yes
Difficulty walking two blocks . . . . . No Yes
Palpitations. . . . . No Yes
Swelling of hands, feet or ankles . . . . . No Yes
Awakening in the nights smothering . . . . . No Yes
Heart murmur. . . . . No Yes

Gastrointestinal:
Vomiting blood or food . . . . . No Yes
Gallbladder disease . . . . . No Yes
Change in appetite . . . . . No Yes
Hepatitis/Jaundice. . . . . No Yes
Painful bowel movements . . . . . No Yes
Bleeding with bowel movements . . . . . No Yes
Black stools . . . . . No Yes
Hemorrhoids or piles. . . . . No Yes
Recent change in bowel habits. . . . . No Yes
Frequent diarrhea . . . . . No Yes
Heartburn or indigestion. . . . . No Yes
Cramping or pain in the abdomen . . . . . No Yes
Does food stick in throat. . . . . No Yes

Endocrine:
Hormone therapy. . . . . No Yes
Any change in hat or glove size . . . . . No Yes
Any change in hair growth. . . . . No Yes
Have you become colder than before -
or skin become dryer. . . . . No Yes

Neck:
Stiffness. . . . . No Yes
Enlarged glands. . . . . No Yes

Genitourinary:
Loss of urine. . . . . No Yes
Blood in urine . . . . . No Yes
Frequent urination. . . . . No Yes
Burning or painfu . . . . . No Yes
Night time urinating . . . . . No Yes
Kidney trouble . . . . . No Yes
Problem stopping/starting flow of urine . . . . . No Yes
Testicular mass . . . . . No Yes
Testicular pain . . . . . No Yes
Prostate problem . . . . . No Yes
Sexual Dysfunction . . . . . No Yes
STD / AIDS Risk . . . . . No Yes

Gynecological:
First day of last period _____
Age periods started_____
How long do periods last?_____Days
Frequency of periods every _____ Days
Pain with periods . . . . . No Yes
Number of pregnancies _____
Number of miscarriages _____
Date of last cancer smear and results _____
Breast Lump. . . . . No Yes
Abnormal Vaginal Discharge. . . . . No Yes
Breast Discharge. . . . . No Yes
Pain with Intercourse . . . . . No Yes
Skin change of Breast. . . . . No Yes
Nipple retraction. . . . . No Yes

Locomotor-Musculoskeletal:
Stiffness or pain in joints (check all that apply)
☐Finger ☐Hands ☐Wrist ☐Elbows ☐Shoulders ☐Neck ☐Back
☐Hip ☐Knee ☐Toes ☐Foot ☐Temporomandibular Joint
Weakness of muscles or joints . . . . . No Yes
Any difficulty in walking. . . . . No Yes
Any pain in calves or buttocks on walking
relieved by rest. . . . . No Yes

Neuro-Psychiatric:
☐Transient blindness ☐Tremor ☐Numbness in fingers ☐ Weakness
Have you ever had counselling for your mental health?. . . No Yes
Have you ever been advised to see a psychiatrist? . . . . . No Yes
Do you ever have, or have had, fainting spells? . . . . . No Yes
Convulsions . . . . . No Yes
Paralysis . . . . . No Yes
Problem with coordination . . . . . No Yes
Domestic violence . . . . . No Yes
Depression Symptoms (difficulty sleeping, loss of appetite
loss of interest in activities, feelings of hopelessness). . . . No Yes

Hematologic:
Are you slow to heal after cuts? . . . . . No Yes
Anemia . . . . . No Yes
Phlebitis or Blood Clots in veins . . . . . No Yes
Have you had difficulty with bleeding excessively
after tooth extraction or surgery? . . . . . No Yes
Have you had abnormal bruising or bleeding?. . . . . No Yes

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Provider Date Signature of Patient

FIGURE 3.2 *(continued)*

decisions of another person), the responsible person's name, gender, marital status, birth date, address, e-mail address, telephone number, and employer information are collected. If a minor, the child's status if a full-time or part-time student is recorded. In most cases, the responsible person is a parent, guardian, adult child, or other person acting with legal authority to make healthcare decisions on behalf of the patient.

- The name of the patient's health plan

VALLEY ASSOCIATES, PC
1400 West Center Street
Toledo, OH 43601-0213
555-967-0303

PATIENT INFORMATION FORM

THIS SECTION REFERS TO PATIENT ONLY

Name:	Sex:	Marital Status: ☐S ☐M ☐D ☐W Birth Date:
Address:	E-mail Address:	
City: State: Zip:	Employer:	Phone:
Home Phone:	Employer's Address:	
Work Phone:	City: State: Zip:	
Spouse's Name:	Spouse's Employer:	
Emergency Contact:	Relationship:	Phone #:
Race: ☐White ☐Native Hawaiian ☐Asian ☐Other Pacific Islander ☐Black or African American ☐Undefined ☐American Indian or Alaskan Native ☐Refused to report/ unreported ☐More than one	Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Undefined ☐Refused to report/ unreported	Preferred Language: ☐English ☐Spanish ☐Other_____ ☐Refused to report/ unreported

FILL IN IF PATIENT IS A MINOR

Parent/Guardian's Name:	Sex:	Marital Status: ☐S ☐M ☐D ☐W Birth Date:
Phone:	E-mail Address:	
Address:	Employer:	Phone:
City: State: Zip:	Employer's Address:	
Student Status:	City: State: Zip:	

INSURANCE INFORMATION

Primary Insurance Company:	Secondary Insurance Company:
Subscriber's Name: Birth Date:	Subscriber's Name: Birth Date:
Plan:	Plan:
Policy #: Group #:	Policy #: Group #:
Copayment/Deductible:	

OTHER INFORMATION

Reason for visit:	Allergy to medication (list):
Name of referring physician:	If auto accident, list date and state in which it occurred:

I authorize treatment and agree to pay all fees and charges for the person named above. I agree to pay all charges shown by statements, promptly upon their presentation, unless credit arrangements are agreed upon in writing.

I authorize payment directly to VALLEY ASSOCIATES, PC of insurance benefits otherwise payable to me. I hereby authorize the release of any medical information necessary in order to process a claim for payment in my behalf.

_____ (Patient's Signature/Parent or Guardian's Signature) _____ (Date)

I plan to make payment of my medical expenses as follows (check one or more):

_____Insurance (as above) _____Cash/Check/Credit/Debit Card _____Medicare _____Medicaid _____Workers' Comp.

FIGURE 3.3 Patient Information (Registration) Form

- The health plan's policyholder's name (the policyholder may be a spouse, guardian, or other relation), birth date, plan type, policy number or group number, telephone number, and employer
- If the patient is covered by another health plan, the name and policyholder information for that plan

BILLING TIP

Subscriber, Insured, or Guarantor?

Other terms for *policyholder* are **insured** *or* **subscriber.** This person is the holder of the insurance policy that covers the patient and is not necessarily also a patient of the practice. The **guarantor** is the person who is financially responsible for the bill.

insured/subscriber policyholder of a health plan

guarantor person who is financially responsible for the bill

Insurance Cards

For an insured new patient, the front and the back of the insurance card are scanned or photocopied. All data from the card that the patient has written on the patient information form are double-checked for accuracy.

Most insurance cards have the following information (see Figure 3.4):

- Group identification number
- Date on which the member's coverage became effective
- Member name
- Member identification number
- The health plan's name, type of coverage, copayment/coinsurance requirements, and frequency limits or annual maximums for services; sometimes the annual deductible
- Optional items, such as prescription drugs that are covered, with the payment requirements

BILLING TIP

Matching the Patient's Name

Payers want the name of the patient on a claim to be exactly as it is shown on the insurance card. Do not use nicknames, skip middle initials, or make any other changes. Compare the patient information form carefully with the insurance card, and resolve any discrepancies before the encounter.

Photo Identification

Many practices also require the patient to present a photo ID card, such as a driver's license, which the practice scans or copies for the chart.

Assignment of Benefits

Physicians usually submit claims for patients and receive payments directly from the payers. This saves patients paperwork; it also benefits providers because payments are faster. The policyholder must authorize this procedure by signing and dating an **assignment of benefits** statement. This may be a separate form, as in Figure 3.5, or an entry on the patient information form, as in Figure 3.3. The assignment of benefits statement is filed in both the patient medical and billing records.

assignment of benefits authorization allowing benefits to be paid directly to a provider

Acknowledgment of Receipt of Notice of Privacy Practices

Under the HIPAA Privacy Rule (see the chapter about EHRs, HIPAA, and HITECH), providers do not need specific authorization in order to release patients' protected health information (PHI) for treatment, payment, and healthcare operations (TPO) purposes. These uses are defined as:

1. *Treatment:* This purpose primarily consists of discussion of the patient's case with other providers. For example, the physician may document the role of each member of the healthcare team in providing care. Each team member then records actions and observations so that the ordering physician knows how the patient is responding to treatment.
2. *Payment:* Practices usually submit claims on behalf of patients; this involves sending demographic and diagnostic information.
3. *Healthcare operations:* This purpose includes activities such as staff training and quality improvement.

BILLING TIP

Smart Cards

Smart cards are being introduced by health plans. These have embedded data and a required PIN for access. The goal is to reduce the likelihood of identity theft, fraud, and abuse.

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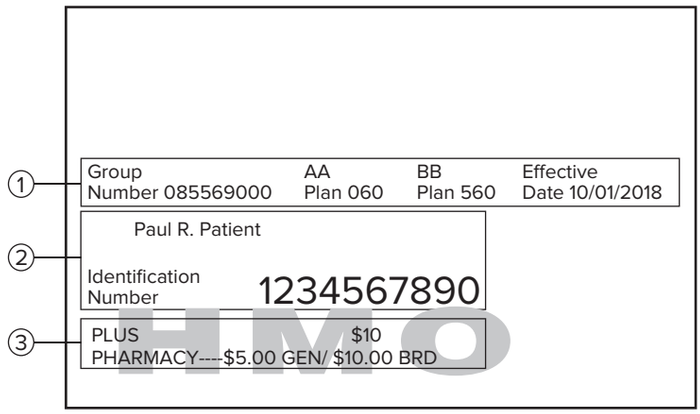

1. ***Group identification number***
   The 9-digit number used to identify the member's employer.

   Plan codes
   The numbers used to identify the codes assigned to each plan; used for claims submissions when medical services are rendered out-of-state.

   Effective date
   The date on which the member's coverage became effective.
2. ***Member name***
   The full name of the cardholder.

   Identification number
   The 10-digit number used to identify each plan member.
3. ***Health plan***
   The name of the health plan and the type of coverage; usually lists any copayment amounts, frequency limits, or annual maximums for home and office visits; may also list the member's annual deductible amount.

   Riders
   The type(s) of riders that are included in the member's benefits (DME, Visions).

   Pharmacy
   The type of prescription drug coverage; lists copayment amounts.

FIGURE 3.4 An Example of an Insurance Card

Providers must have patients' authorization to use or disclose information that is not for TPO purposes. For example, a patient who wishes a provider to disclose PHI to a life insurance company must complete an authorization form (see Figure 2.3 in the chapter about EHRs, HIPAA, and HITECH) to do so.

BILLING TIP

Release Document

State law may be more stringent than HIPAA and demand an authorization to release TPO information. Many practices routinely have patients sign release of information statements.

Under HIPAA, providers must inform each patient about their privacy practices one time. The most common method is to give the patient a copy of the medical office's

COMPLIANCE GUIDELINE

State Law on Assignment of Benefits

Many states have laws mandating that the payer must pay the provider of services (rather than the patient) if a valid assignment of benefits is on file and the payer has been notified of the assignment of benefits.

Assignment of Benefits

I hereby assign to Valley Associates, PC, any insurance or other third-party benefits available for healthcare services provided to me. I understand that Valley Associates has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Valley Associates, I agree to forward to Valley Associates all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian: _____

Date: _____

FIGURE 3.5 Assignment of Benefits Form

Who is Requesting PHI?

Although the HIPAA Privacy Rule permits sharing PHI for TPO purposes without authorization, it also requires verification of the identity of the person who is asking for the information. The person's authority to access PHI must also be verified. If the requestor's right to the information is not certain, the best practice is to have the patient authorize the release of PHI.

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that the providers of Valley Associates, PC, may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand that Valley Associates has the right to change this notice at any time. I may obtain a current copy by contacting the practice's office or by visiting the website at yourvalleyassociates.com.

My signature below constitutes my acknowledgment that I have been provided with a copy of the notice of privacy practices.

_____

Signature of Patient or Legal Representative Date

If signed by legal representative,
relationship to patient:_____

FIGURE 3.6 Acknowledgment of Receipt of Notice of Privacy Practices

Acknowledgment of Receipt of Notice of Privacy Practices form accompanying a covered entity's Notice of Privacy Practices for the patient's signature, indicating that the NPP has been read

direct provider clinician who treats a patient face-to-face

indirect provider clinician who does not interact face-to-face with the patient

privacy practices to read and then to have the patient sign a separate form called an **Acknowledgment of Receipt of Notice of Privacy Practices** (see Figure 3.6). This form states that the patient has read the privacy practices and understands how the provider intends to protect the patient's rights to privacy under HIPAA.

The provider must make a good-faith effort to have patients sign this document. The provider must also document—in the medical record—whether the patient signed the form. The format for the acknowledgment is up to the practice. Only a **direct provider,** one who directly treats the patient, is required to have patients sign an acknowledgment. An **indirect provider,** such as a pathologist, must have a privacy notice but does not have to secure additional acknowledgments.

If a patient who has not received a privacy notice or signed an acknowledgment calls for a prescription refill, the recommended procedure is to mail the patient a copy of the

privacy notice, along with an acknowledgment of receipt form, and to document the mailing to show a good-faith effort that meets the office's HIPAA obligation in the event that the patient does not return the signed form.

THINKING IT THROUGH 3.2

1. Why is it important to verify a patient's insurance coverage before an office visit?

HIPAA/HITECH TIP

Keeping Acknowledgments on File

Providers must retain signed acknowledgments as well as documentation about unsuccessful attempts to obtain them for six years.

3.3 Information for Established Patients

When established patients present for appointments, the front desk staff member asks whether any pertinent personal or insurance information has changed. This update process is important because different employment, marital status, dependent status, or plans may affect patients' coverage. Patients may also phone in changes, such as new addresses or employers.

To double-check that information is current, most practices periodically ask established patients to review and sign off on their patient information forms when they come in. This review should be done at least once a year. A good time is an established patient's first appointment in a new year. The file is also checked to be sure that the patient has been given a current Notice of Privacy Practices.

If the insurance of an established patient has changed, both sides of the new card are copied, and all data are checked. Many practices routinely scan or copy the card at each visit as a safeguard.

HIPAA/HITECH TIP

PHI and Minors

A covered entity may choose to provide or deny a parent access to a minor's PHI if doing so is consistent with state or other applicable law and provided that the decision is made by a licensed healthcare professional. These options apply whether or not the parent is the minor's personal representative.

Entering Patient Information in the Practice Management Program

A practice management program (PMP) is set up with databases about the practice's income and expense accounting. The provider database has information about physicians and other health professionals who work in the practice, such as their medical license numbers, tax identification numbers, and office hours. A database of common diagnosis and procedure codes is also built in the PMP. After these databases are set up, the medical insurance specialist can enter patients' demographic and visit information to begin the process of billing.

The database of patients in the practice management program must be continually kept up-to-date. For each new patient, a new file and a new **chart number** are set up. The chart number is a unique number that identifies the patient. It links all the information that is stored in other databases—providers, insurance plans, diagnoses, procedures, and claims—to the case of the particular patient.

chart number unique number that identifies a patient

Usually, a new *case* or record for an established patient is set up in the program when the patient's chief complaint for an encounter is different than the previous chief complaint. For example, a patient might have had an initial appointment for a comprehensive physical examination. Subsequently, this patient sees the provider because of stomach pain. Each visit is set up as a separate case in the PMP.

Communications with Patients

Service to patients—the customers of medical practices—is as important as, if not more important than, billing information. Satisfied customers are essential to the financial health of every business, including medical practices. Medical practice staff members must be dedicated to retaining patients by providing excellent service.

The following are examples of good communication:

- Established and new patients who call or arrive for appointments are always given friendly greetings and are referred to by name.
- Patients' questions about forms they are completing and about insurance matters are answered with courtesy.
- When possible, patients in the reception area are told the approximate waiting time until they will see the provider.
- Fees for providers' procedures and services are explained to patients.
- The medical practice's guidelines about patients' responsibilities, such as when payments are due from patients and the need to have referrals from primary care physicians, are prominently posted in the office (see Figure 3.11, where financial policies are explained).
- Patients are called a day or two before their appointments to remind them of appointment times.

Like all businesses, even the best-managed medical practices have to deal with problems and complaints. Patients sometimes become upset over scheduling or bills or have problems understanding lab reports or instructions. Medical insurance specialists often handle patients' questions about benefits and charges. They must become good problem solvers, willing to listen to and empathize with the patient while sorting out emotions from facts to get accurate information. Phrases such as these reduce patients' anger and frustration:

"I'm glad you brought this to our attention. I will look into it further."

"I can appreciate how you would feel this way."

"It sounds like we have caused some inconvenience, and I apologize."

"I understand that you are angry. Let me try to understand your concerns so we can address the situation."

"Thank you for taking the time to tell us about this. Because you have, we can resolve issues like the one you raised."

Medical insurance specialists need to use the available resources and to investigate solutions to problems. Following through on promised information is also critical. A medical insurance specialist who says to a patient "I will call you by the end of next week with that information" must do exactly that. Even if the problem is not solved, the patient needs an update on the situation within the stated time frame.

HIPAA/HITECH TIP

Observing HIPAA Privacy and Security Requirements

Front office staff members follow HIPAA requirements in dealing with patients. They use reasonable safeguards, such as speaking softly and never leaving handheld dictation devices unattended, to prevent others from hearing PHI. Computer monitors, medical records, and other documents are not visible to patients who are checking in or to others in the waiting room.

THINKING IT THROUGH 3.3

1. Review these multiple versions of the same name:

   Ralph Smith

   Ralph P. Smith

   Ralph Plane Smith

   R. Plane Smith

   R. P. Smith

   If "Ralph Plane Smith" appears on the insurance card and his mother writes "Ralph Smith" on the patient information form, which version should be used for the medical practice's records? Why?

2. Refer to the following patient information form. According to the information supplied by the patient, who is the policyholder? What is the patient's relationship to the policyholder?

PATIENT INFORMATION FORM			
THIS SECTION REFERS TO PATIENT ONLY			
Name: **Mary Anne C. Kopelman**	Sex: **F**	Marital status: ☐ S ☒ M ☐ D ☐ W	Birth date: **08/24/1992**
Address: **45 Mason Street**	E-mail address: **makopelman@gmail.com**		
City: **Hopewell** State: **OH** Zip: **43800**	**Employer:**		
Home phone: **555-427-6019**	Employer's address:		
Work phone:	City: State: Zip:		
Spouse's name: **Arnold B. Kopelman**	Spouse's employer: **U.S. Army, Fort Tyrone**		
Emergency contact: **Arnold B. Kopelman**	Relationship: **husband**	Phone #: **555-439-0018**	
INSURANCE INFORMATION			
Primary insurance company: **TriCare**	**Secondary insurance company:**		
Policyholder's name: **Arnold B. Kopelman** Birth date: **04/10/1995**	**Policyholder's name:** **Birth date:**		
Plan: **TriCare**	**Plan:**		
Policy #: **230-56-9874** Group #: **USA9947**	**Policy #:** **Group #:**		

3.4 Verifying Patient Eligibility for Insurance Benefits

To be paid for services, medical practices need to establish financial responsibility. Medical insurance specialists are vital employees in this process. For insured patients, they follow three steps to establish financial responsibility:

1. Verify the patient's eligibility for insurance benefits
2. Determine preauthorization and referral requirements
3. Determine the primary payer if more than one insurance plan is in effect

BILLING TIP

Plan Information

Be aware of the copayments, preauthorization and referral requirements, and noncovered services for plans in which the practice participates.

The first step is to verify patients' eligibility for benefits. Medical insurance specialists abstract information about the patient's payer or plan from the patient's information form (PIF) and the insurance card. They then contact the payer to verify three points:

1. Patients' general eligibility for benefits
2. The amount of the copayment or coinsurance required at the time of service
3. Whether the planned encounter is for a covered service that is medically necessary under the payer's rules

These items are checked before an encounter except in a medical emergency when care is provided immediately and insurance is checked after the encounter.

BILLING TIP

Payers' Rules for Medical Necessity

Medicare requires patients to be notified if their insurance is not going to cover a visit, as detailed in the Medicare chapter. Other payers have similar rules.

Factors Affecting General Eligibility

General eligibility for benefits depends on a number of factors. If premiums are required, patients must have paid them on time. For government-sponsored plans for which income is the criterion, such as Medicaid, eligibility can change monthly. For patients with employer-sponsored health plans, employment status can be the deciding factor:

- Coverage may end on the last day of the month in which the employee's active full-time service ends, such as for disability, layoff, or termination.
- The employee may no longer qualify as a member of the group. For example, some companies do not provide benefits for part-time employees. If a full-time employee changes to part-time employment, the coverage ends.
- An eligible dependent's coverage may end on the last day of the month in which the dependent status ends, such as reaching the age limit stated in the policy.

BILLING TIP

Getting Online Information About Patients

A **portal** is a website that is an entry point to other websites. Many insurers have portals to be used to check patient eligibility for coverage, get information on copayments and deductibles, process claims, and submit preauthorization requests.

portal website that serves as an entry point to other websites

If the plan is an HMO that requires a PCP, a general or family practice must verify that (1) the provider is a plan participant, (2) the patient is listed on the plan's enrollment master list, and (3) the patient is assigned to the PCP as of the date of service.

The medical insurance specialist checks online with the payer to confirm whether the patient is currently covered. Based on the patient's plan, eligibility for these specific benefits may also need checking:

- Office visits
- Lab coverage
- Diagnostic X-rays
- Maternity coverage
- Pap smear coverage
- Coverage of psychiatric visits
- Physical or occupational therapy
- Durable medical equipment (DME)
- Foot care

BILLING TIP

Check the Lab Requirements

Because many MCOs specify which laboratory must be used, patients should be notified that they are responsible for telling the practice about their plans' lab requirements so that if specimens are sent to the wrong lab, the practice is not responsible for the costs.

Checking Out-of-Network Benefits

If patients have insurance coverage but the practice does not participate in their plans, the medical insurance specialist checks the out-of-network benefit. When the patient has out-of-network benefits, the payer's rules concerning copayments or coinsurance and coverage are followed. If a patient does not have out-of-network benefits, as is common when the health plan is an HMO, the patient is responsible for the entire bill.

Verifying the Amount of the Copayment or Coinsurance

The amount of the copayment or coinsurance, if required at the time of service, must be checked. It is sometimes the case that the insurance card is out of date and a different amount needs to be collected.

Determining Whether the Planned Encounter Is for a Covered Service

The medical insurance specialist also must attempt to determine whether the planned encounter is for a covered service. If the service will not be covered, that patient can be informed and made aware of financial responsibility in advance.

The resources for covered services include knowledge of the major plans held by the practice's patients, information from the provider representative and payer websites, and the electronic benefit inquiries described in the next section. Medical insurance specialists are familiar with what the plans cover in general. For example, most plans cover regular office visits, but they may not cover preventive services or some therapeutic services. Unusual or unfamiliar services must be researched, and the payer must be queried.

Electronic Benefit Inquiries and Responses

If the practice sends the HIPAA standard transaction, the payer must, under HIPAA rules, return the answering **electronic eligibility verification.** When an eligibility benefits transaction is sent, the computer program assigns a unique **trace number** to the inquiry. Often, eligibility transactions are sent the day before patients arrive for appointments. If the PMP has this feature, the eligibility transaction can be sent automatically.

The health plan responds to an eligibility inquiry with this information:

- Trace number as a double check on the inquiry
- Benefit information, such as whether the insurance coverage is active
- Covered period—the period of dates that the coverage is active
- Benefit units, such as how many physical therapy visits
- Coverage level—that is, who is covered, such as spouse and family or individual

The following information may also be transmitted:

- The copay amount
- Premium amount and status
- The yearly deductible amount and payment status
- The out-of-pocket expenses
- The health plan's information on the first and last names of the insured or patient, dates of birth, and identification numbers
- Primary care provider

Procedures When the Patient Is Not Covered

If an insured patient's policy does not cover a planned service, this situation is discussed with the patient. Patients should be informed that the payer does not pay for the service and that they are responsible for the charges.

HIPAA/HITECH TIP

X12 270/271 Eligibility for a Health Plan Inquiry/Response

The **HIPAA Eligibility for a Health Plan** transaction is also called the X12 270/271. The number 270 refers to the inquiry that is sent, and 271 to the answer returned by the payer.

HIPAA Eligibility for a Health Plan HIPAA X12 270/271 transaction in which a provider asks for and receives an answer about a patient's eligibility for benefits

electronic eligibility verification required payer response to the HIPAA standard transaction

trace number number assigned to a HIPAA 270 electronic transaction

BILLING TIP

Double-Checking Patients' Information

Review the payer's spelling of the insured's and the patient's first and last names as well as the dates of birth and identification numbers. Correct any mistakes in the record, so that when a healthcare claim is later transmitted for the encounter, it will be accepted for processing.

BILLING TIP

Processing the Patient Financial Agreement

Patients should be given copies of their financial agreements. A signed original is filed in the patient's record.

Service to be performed: _____
Estimated charge: _____
Date of planned service: _____
Reason for exclusion: _____
_____

I, _____, a patient of _____, understand the service described above is excluded from my health insurance. I am responsible for payment in full of the charges for this service.

FIGURE 3.7 Sample Financial Agreement for Patient Payment of Noncovered Services

Some payers require the physician to use specific forms to tell the patient about uncovered services. These financial agreement forms, which patients must sign, prove that patients have been told about their obligation to pay the bill *before* the services are given. For example, the Medicare program provides a form, called an *advance beneficiary notice (ABN),* that must be used to show patients the charges. The signed form, as explained in the Medicare chapter, allows the practice to collect payment for a provided service or supply directly from the patient if Medicare refuses reimbursement. Figure 3.7 is an example of a form used to tell patients in advance of the probable cost of procedures that are not going to be covered by their plan and to secure their agreement to pay.

THINKING IT THROUGH 3.4

1. What is the advantage of using electronic transactions for verifying a patient's eligibility for benefits?

3.5 Determining Preauthorization and Referral Requirements

Preauthorization

A managed care payer often requires preauthorization before the patient sees a specialist, is admitted to the hospital, or has a particular procedure. The medical insurance specialist may request preauthorization over the phone, by e-mail or fax, or by an electronic transaction. If the payer approves the service, it issues a **prior authorization number** that must be entered in the practice management program so it will be stored and appear later on the healthcare claim for the encounter. (This number may also be called a **certification number.**)

prior authorization number identifying code assigned when preauthorization is required

certification number identifying code assigned when preauthorization is required

To help secure preauthorization, best practice is to:

- Be as specific as possible about the planned procedure when exchanging information with a payer
- Collect and have available all the diagnosis information related to the procedure, including any pertinent history
- Query the provider and then request preauthorization for all procedures that may potentially be used to treat the patient

Referral Form

Label with Patient's Personal & Insurance Information

Physician referred to _____

Referred for:

☐ Consult only
☐ Follow-up
☐ Lab
☐ X-ray
☐ Procedure
☐ Other

Reason for visit _____

Appointment requested: Please contact patient; phone: _____

Primary care physician

Name _____

Signature _____

Phone _____

FIGURE 3.8 Referral

Referrals

Often, a physician needs to send a patient to another physician for evaluation and/or treatment. For example, an internist might send a patient to a cardiologist to evaluate heart function. If a patient's plan requires it, the patient is given a **referral number** and a referral document, which is a written request for the medical service. The patient is usually responsible for bringing these items to the encounter with the specialist.

A paper referral document (see Figure 3.8) describes the services the patient is certified to receive. (This approval may instead be communicated electronically using the HIPAA referral transaction.) The specialist's office handling a referred patient must:

- Check that the patient has a referral number
- Verify patient enrollment in the plan
- Understand restrictions to services, such as regulations that require the patient to visit a specialist in a specific period of time after receiving the referral or that limit the number of times the patient can receive services from the specialist

Two other situations arise with referrals (but always verify the payer's rules):

1. A managed care patient may "self-refer"—come for specialty care without a referral number when one is required. The medical insurance specialist then asks the patient to sign a form acknowledging responsibility for the services. A sample form is shown in Figure 3.9a.
2. A patient who is required to have a referral document does not bring one. The medical insurance specialist then asks the patient to sign a document such as that shown in Figure 3.9b. This **referral waiver** ensures that the patient will pay for services received if in fact a referral is not documented in the time specified.

HIPAA Referral Certification and Authorization

If an electronic transaction is used for referrals and preauthorizations, it must be the **HIPAA Referral Certification and Authorization** transaction, also called the X12 278.

HIPAA Referral Certification and Authorization HIPAA X12 278 transaction in which a provider asks a health plan for approval of a service and gets a response

referral number authorization number given to the referred physician

referral waiver document a patient signs to guarantee payment when a referral authorization is pending

Member Self-Referral Acknowledgment

I, _____, understand that I am seeking the care of this specialty physician or healthcare provider, _____, without a referral from my primary care physician. I understand that the terms of my Plan coverage require that I obtain that referral, and that if I fail to do so, my Plan will not cover any part of the charges, costs, or expenses related to this specialist's services to me.

Signed,

_____ _____
(member's name) (date)

****
Specialty physician or other healthcare provider:

Please keep a copy of this form in your patient's file

(a)

Referral Waiver

I did not bring a referral for the medical services I will receive today. If my primary care physician does not provide a referral within two days, I understand that I am responsible for paying for the services I am requesting.

Signature: _____

Date: _____

(b)

FIGURE 3.9 (a) Self-referral Document, (b) Referral Waiver

BILLING TIP

Billing Supplemental Plans

Supplemental insurance held with the same payer can be billed on a single claim. Claims for supplemental insurance held with other than the primary payer are sent after the primary payer's payment is posted, just as secondary claims are.

THINKING IT THROUGH 3.5

1. What is the difference between a referral and a preauthorization requirement?

3.6 Determining the Primary Insurance

The medical insurance specialist also examines the patient information form and insurance card to see whether other coverage is in effect. A patient may have more than one health plan. The specialist then decides which is the **primary insurance**—the plan that pays first when more than one plan is in effect—and which is the **secondary insurance**—an additional policy that provides benefits. **Tertiary insurance,** a third payer, is possible. Some patients have **supplemental insurance,** a "fill-the-gap" insurance plan that covers parts of expenses, such as coinsurance, that they must otherwise pay under the primary plan.

primary insurance health plan that pays benefits first

secondary insurance second payer on a claim

tertiary insurance third payer on a claim

supplemental insurance health plan that covers services not normally covered by a primary plan

As a practical matter for billing, determining the primary insurance is important because this payer is sent the first claim for the encounter. A second claim is sent to the secondary payer after the payment is received for the primary claim.

Deciding which payer is primary is also important because insurance policies contain a provision called **coordination of benefits (COB).** The coordination of benefits guidelines ensures that when a patient has more than one policy, maximum appropriate benefits are paid, but without duplication. Under the law, to protect the insurance companies, if the patient has signed an assignment of benefits statement, the provider is responsible for reporting any additional insurance coverage to the primary payer.

coordination of benefits (COB) explains how an insurance policy will pay if more than one policy applies

Coordination of benefits in government-sponsored programs follows specific guidelines. Primary and secondary coverage under Medicare, Medicaid, and other programs is discussed in the chapters on these topics. Note that COB information can also be exchanged between provider and health plan or between a health plan and another payer, such as auto insurance.

Guidelines for Determining the Primary Insurance

How do patients come to have more than one plan in effect? Possible answers are that a patient may have coverage under more than one group plan, such as an employer-sponsored insurance and a policy from union membership. A person may have primary insurance coverage from an employer but also be covered as a dependent under a spouse's insurance, making the spouse's plan the person's additional insurance.

General guidelines for determining the primary insurance are shown in Table 3.1.

Guidelines for Children with More than One Insurance Plan

A child's parents may each have primary insurance. If both parents cover a dependent on their plans, the child's primary insurance is usually determined by the **birthday rule.** This rule states that the parent whose day of birth is earlier in the calendar year is primary. For example, Rachel Foster's mother and father both work and have employer-sponsored insurance policies. Her father, George Foster, was born on October 7, 1983, and her mother, Myrna, was born on May 15, 1984. Because the mother's date of birth is earlier in the calendar year (although the father is older), her plan is Rachel's primary insurance. The father's plan is secondary for Rachel. Note that if a dependent child's primary insurance does not provide for the complete reimbursement of a bill, the balance may usually be submitted to the other parent's plan for consideration.

birthday rule guideline stating that the parent whose day of birth is earlier in the calendar year is primary

Another, much less common, way to determine a child's primary coverage is called the **gender rule.** When this rule applies, if the child is covered by two health plans, the father's plan is primary. In some states, insurance regulations require a plan that uses the gender rule to be primary to a plan that follows the birthday rule.

gender rule guideline that states when a child is covered by two health plans, the father's plan is primary

The insurance policy also covers which parent's plan is primary for dependent children of separated or divorced parents. If the parents have joint custody, the birthday rule usually applies. If the parents do not have joint custody of the child, unless

Table 3.1 Determining Primary Coverage

- If the patient has only one policy, it is primary.
- If the patient has coverage under two group plans, the plan that has been in effect for the patient for the longest period of time is primary. However, if an active employee has a plan with the present employer and is still covered by a former employer's plan as a retiree or a laid-off employee, the current employer's plan is primary.

- If the patient has coverage under both a group and an individual plan, the group plan is primary.
- If the patient is also covered as a dependent under another insurance policy, the patient's plan is primary.

- If an employed patient has coverage under the employer's plan and additional coverage under a government-sponsored plan, the employer's plan is primary. For example, if a patient is enrolled in a PPO through employment and is also on Medicare, the PPO is primary.

- If a retired patient is covered by a spouse's employer's plan and the spouse is still employed, the spouse's plan is primary, even if the retired person has Medicare.

- If the patient is a dependent child covered by both parents' plans and the parents are not separated or divorced (or if the parents have joint custody of the child), the primary plan is determined by the birthday rule, which will be defined in a subsequent section.

- If two or more plans cover dependent children of separated or divorced parents who do not have joint custody of their children, the children's primary plan is determined in this order:
  —The plan of the custodial parent
  —The plan of the spouse of the custodial parent if remarried
  —The plan of the parent without custody

- Dependent coverage can be determined by a court decision, which overrules these guidelines.

HIPAA TIP

HIPAA Coordination of Benefits

The **HIPAA Coordination of Benefits** transaction is used to send the necessary data to payers. This transaction is also called the X12 837—the same transaction used to send healthcare claims electronically—because it goes along with the claim.

HIPAA Coordination of Benefits
HIPAA X12 837 transaction sent to a secondary or tertiary payer

otherwise directed by a court order, usually the primary benefits are determined in this order:

- The plan of the custodial parent
- The plan of the spouse of the custodial parent, if the parent has remarried
- The plan of the parent without custody

Entering Insurance Information in the Practice Management Program

The practice management program contains a database of the payers from whom the medical practice usually receives payments. The database contains each payer's name and the contact's name; the plan type, such as HMO, PPO, Medicare, Medicaid, or other; and telephone and fax numbers. Like the patient database, the payer database must be updated to reflect changes, such as new participation agreements or a new payer representative's contact information.

The medical insurance specialist selects the payer that is the patient's primary insurance coverage from the insurance database. If the particular payer has not already been entered, the PMP is updated with the payer's information. Secondary coverage is also selected for the patient as applicable. Other related facts, such as policy numbers, effective dates, and referral numbers, are entered for each patient.

Communications with Payers

Communications with payers' representatives—whether to check on eligibility, receive referral certification, or resolve billing disputes—are frequent and are vitally important to the medical practice. Getting answers quickly means faster payment

for services. Medical insurance specialists follow these guidelines for effective communication:

- Learn the name, telephone number/extension, and e-mail address of the appropriate representative at each payer. If possible, invite the representative to visit the office and meet the staff.
- Use a professional, courteous telephone manner or writing style to help build good relationships.
- Keep current with changing reimbursement policies and utilization guidelines by regularly reviewing information from payers. Usually, the medical practice receives Internet or printed bulletins or newsletters that contain up-to-date information from health plans and government-sponsored programs.

All communications with payer representatives should be documented in the patient's financial record. The representative's name, the date of the communication, and the outcome should be described. This information is sometimes needed later to explain or defend a charge on a patient's insurance claim.

COMPLIANCE GUIDELINE

Payer Communications

Payer communications are documented in the financial record rather than the medical (clinical) record.

THINKING IT THROUGH 3.6

1. When a patient has secondary insurance, the claim for that payer is sent after the claim to the primary payer is paid. Why is that the case? What information do you think the secondary payer requires?

3.7 Working with Encounter Forms

After the registration process is complete, patients are shown to rooms for their appointments with providers. Typically, a clinical medical assistant documents the patient's vital signs. Then the provider conducts and documents the examination. After the visit, the medical insurance specialist uses the documented diagnoses and procedures to update the practice management program and to total charges for the visit.

Encounter Forms

During or just after a visit, an **encounter form**—either electronic or paper—is completed by a provider to summarize billing information for a patient's visit. This may be done using a device such as a laptop computer, tablet PC, or PDA (personal digital assistant), or by checking off items on a paper form. Physicians should sign and date the completed encounter forms for their patients.

encounter form list of the diagnoses, procedures, and charges for a patient's visit

Encounter forms record the services provided to a patient, as shown in the completed office encounter form in Figure 3.10. These forms (also called *superbills, charge slips,* or *routing slips*) list the medical practice's most frequently performed procedures with their procedure codes. It also often has blanks where the diagnosis and its code(s) are filled in. (Some forms include a list of the diagnoses that are most frequently made by the practice's physicians.)

Other information is often included on the form:

- A checklist of managed care plans under contract and their utilization guidelines
- The patient's prior balance due, if any
- Check boxes to indicate the timing and need for a follow-up appointment to be scheduled for the patient during checkout

BILLING TIP

Encounter Forms for Hospital Visits

Specially designed encounter forms (sometimes called *hospital charge tickets*) are used when the provider sees patients in the hospital. These forms list the patient's identification and date of service, but they may show different diagnoses and procedure codes for the care typically provided in the hospital setting.

Paper Preprinted or Computer-Generated Encounter Forms

The paper encounter form may be designed by the practice manager and/or physicians based on analysis of the practice's medical services. It is then printed, usually with carbonless copies available for distribution according to the practice's policy. For

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VALLEY ASSOCIATES, PC
Christopher M. Connolly, MD - Internal Medicine
555-967-0303
NPI 8877365552

PATIENT NAME	APPT. DATE/TIME
Deysenrothe, Mae J.	10/4/2029 9:30 am
PATIENT NO.	**DX**
DD001	1. Z00.00 Exam, Adult 2. 3. 4.

DESCRIPTION	✓	CPT	FEE	DESCRIPTION	✓	CPT	FEE
OFFICE VISITS				**PROCEDURES**			
New Patient				Diagnostic Anoscopy		46600	
LI Problem Focused		99201		ECG Complete	✓	93000	70
LII Expanded		99202		I&D, Abscess		10060	
LIII Detailed		99203		Pap Smear		88150	
LIV Comp./Mod.		99204		Removal of Cerumen		69210	
LV Comp./High		99205		Removal 1 Lesion		17000	
Established Patient				Removal 2-14 Lesions		17003	
LI Minimum		99211		Removal 15+ Lesions		17004	
LII Problem Focused		99212		Rhythm ECG w/Report		93040	
LIII Expanded		99213		Rhythm ECG w/Tracing		93041	
LIV Detailed		99214		Sigmoidoscopy, diag.		45330	
LV Comp./High		99215					
				LABORATORY			
PREVENTIVE VISIT				Bacteria Culture		87081	
New Patient				Fungal Culture		87101	
Age 12-17		99384		Glucose Finger Stick		82948	
Age 18-39		99385		Lipid Panel		80061	
Age 40-64	✓	99386	180	Specimen Handling		99000	
Age 65+		99387		Stool/Occult Blood		82270	
Established Patient				Tine Test		85008	
Age 12-17		99394		Tuberculin PPD		86580	
Age 18-39		99395		Urinalysis	✓	81000	17
Age 40-64		99396		Venipuncture		36415	
Age 65+		99397					
				INJECTION/IMMUN.			
CONSULTATION: OFFICE/OP				Immun. Admin.	✓	90471	25
Requested By:				Ea. Addl.		90472	
LI Problem Focused		99241		Hepatitis A Immun		90632	
LII Expanded		99242		Hepatitis B Immun		90746	
LIII Detailed		99243		Influenza Immun	✓	90661	68
LIV Comp./Mod.		99244		Pneumovax		90732	
LV Comp./High		99245					
				TOTAL FEES			360

FIGURE 3.10 Completed Encounter Form

example, the top copy may be filed in the medical record; the second copy may be filed in the financial record; and the third copy may be given to the patient.

Alternatively, the form may be printed for each patient's appointment using the practice management program. A customized encounter form lists the date of the appointment, the patient's name, and the identification number assigned by the medical practice. It can also be designed to show the patient's previous balance, the day's fees, payments made, and the amount due.

BILLING TIP

Numbering Paper Encounter Forms

Encounter forms should be prenumbered to make sure that all the day's appointments agree with the day's encounter forms. This provides a check that all visits have been entered in the practice management program for accurate **charge capture.**

charge capture procedures that ensure billable services are recorded and reported for payment

Communications with Providers

At times, medical insurance specialists find incorrect or conflicting data on encounter forms. It may be necessary to check the documentation and, if it is still problematic, to communicate with the physician to clear up the discrepancies. In such cases, it is important to remember that medical practices are extremely busy places. Providers often have crowded schedules, especially if they see many patients, and have little time to go over billing and coding issues. Questions must be kept to those that are essential.

Also, encounter forms (and practice management programs) list procedure codes and, often, diagnosis codes that change periodically. Medical insurance specialists must be sure that these databases are updated when new codes are issued and old codes are modified or dropped (see the chapters about diagnostic and procedural coding). They also bring key changes in codes or payers' coverage to the providers' attention. Usually the practice manager arranges a time to discuss such matters with the physicians.

THINKING IT THROUGH 3.7

Review the completed encounter form shown in Figure 3.10.

1. What is the age range of the patient?
2. Is this a new or an established patient?
3. What procedures were performed during the encounter?
4. What laboratory tests were ordered?

3.8 Understanding Time-of-Service (TOS) Payments

Routine Collections at the Time of Service

Up-front collection—money collected before the patient leaves the office—is an important part of cash flow. Practices routinely collect the following charges at the time of service:

1. Previous balances
2. Copayments
3. Coinsurance
4. Noncovered or overlimit fees
5. Charges of nonparticipating providers
6. Charges for self-pay patients
7. Deductibles for patients with consumer-driven health plans (CDHPs)
8. Charges for supplies and copies of medical records

BILLING TIP

Collecting TOS payments

- Many offices tell patients who are scheduling visits what copays they will owe at the time of service.
- Keep change to make it easier for cash patients to make TOS payments.
- Ask for payment. "We verified your insurance coverage, and there is a copay that is your responsibility. Would you like to pay by cash, check, or credit or debit card?"

COMPLIANCE TIP

Never refuse to provide medical record copies because a patient has a balance due; this is unethical and, in many states, illegal.

Billing for Medical Record Copies

Under HIPAA, it is permissible to bill patients a reasonable charge for supplying copies of their medical records. Costs include labor, supplies, postage, and time to prepare record summaries. Practices must check state laws, however, to see if there is a per-page charge limit.

Previous Balances

Practices routinely check their patient financial records and, if a balance is due, collect it at the time of service.

Copayments

Copayments are always collected at the time of service. In some practices, they are collected before the encounter; in others, right after the encounter.

The copayment amount depends on the type of service and on whether the provider is in the patient's network. Copays for out-of-network providers are usually higher than for in-network providers. Specific copay amounts may be required for office visits to PCPs versus specialists and for lab work, radiology services such as X-rays, and surgery.

When a patient receives more than one covered service in a single day, the health plan may permit multiple copayments. For example, copays both for an annual physical exam and for lab tests may be due from the patient. Review the terms of the policy to determine whether multiple copays should be collected on the same day of service.

Coinsurance

As healthcare costs have risen, employers have to pay more for their employees' medical benefit plans. As a result, employers are becoming less generous to employees, demanding that employees pay a larger share of those costs. Annual health insurance premiums are higher, deductibles are higher, and in a major trend—a shift from copayments to coinsurance—many employers have dropped the small, fixed-amount copayment requirements and replaced them with a coinsurance payment that is often due at the time of service.

BILLING TIP

Copayment Reminder

Many practice management programs have a copayment reminder feature that shows the copayment that is due.

Charges for Noncovered/Overlimit Services

Insurance policies require patients to pay for noncovered (excluded) services, and payers do not control what the providers charge for noncovered services. Likewise, if the plan has a limit on the usage of certain covered services, patients are responsible for paying for visits beyond the allowed number. For example, if five physical therapy encounters are permitted annually, the patient must pay for any additional visits. Practices usually collect these charges from patients at the time of service.

Charges of Nonparticipating Providers

accept assignment participating physician's agreement to accept allowed charge as full payment

As noted earlier in this chapter, when patients have encounters with a provider who participates in the plan under which they have coverage—such as a Medicare-participating provider—that provider has agreed to **accept assignment** for the patients—that is, to accept the allowed charge as full payment. Nonparticipating physicians usually do not accept assignment and require full payment from patients at the time of service. They also do not file claims on patients' behalf. An exception is Medicare, which requires all providers to file claims for patients as a courtesy.

Charges for Services to Self-Pay Patients

self-pay patient patient with no insurance

Patients who do not have insurance coverage are called **self-pay patients.** Because many Americans do not have insurance, self-pay patients present for office visits daily. Medical insurance specialists follow the practice's procedures for informing patients of their responsibility for paying their bills. Practices may require self-pay patients to pay their bills in full at the time of service.

Deductibles for Patients with CDHPs

Patients who have CDHPs must meet large deductibles before the health plan makes a payment. Practices are responsible for determining and collecting those deductibles at the time of service.

Billing for Supplies and Other Services

Many practices bill for supplies and for other services, such as making copies of medical records, at the time of service.

Other TOS Collection Considerations

In the typical revenue cycle, after the routine up-front collections are handled, a claim for insured patients is created and sent. The practice then waits to receive insurance payments, post the amount of payment to the patient's account in the PMP, and bill the patient for the balance. This process is followed because until the claim is adjudicated by the payer, the patient's actual amount due is not known. The adjudication process often results in a change to the amount due initially calculated. Of course, how much of an annual deductible the patient has paid affects that amount. Differences in participation contracts with various payers also may reduce the physician's fee for a particular service (this topic is covered in the chapter about visit charges and compliant billing).

However, following this process creates a problem for the practice in that it delays receipt of funds, reducing cash flow. For this reason, many practices are changing their billing process to increase TOS collections.

For example, a practice may decide to collect patients' unmet deductibles or to adopt the policy of estimating the amount the patient will owe and collecting a **partial payment** during the checkout process. For example, if the patient is expected to owe $600 and practice policy is to collect 50 percent, the patient is asked to pay $300 today and to expect to be billed $300 after the claim is processed.

COMPLIANCE GUIDELINE

Collecting Charges

Some payers (especially government programs) do not permit providers to collect any charges except copayments from patients until insurance claims are adjudicated. Be sure to comply with the payer's rules.

partial payment payment made during checkout based on an estimate

THINKING IT THROUGH 3.8

1. Why is collecting balances from patients at the time of service an important part of revenue cycle management?

3.9 Calculating TOS Payments

What patients owe at the time of service for the medical procedures and services they received depends on the practice's financial policy and on the provisions of their health plans.

Financial Policy and Health Plan Provisions

Patients should always be informed of their financial obligations according to the credit and collections policy of the practice. This **financial policy** on payment for services is usually either displayed on the wall of the reception area or included in a new patient information packet. A sample of a financial policy is shown in Figure 3.11.

financial policy practice's rules governing payment from patients

The policy should explain what is required of the patient and when payment is due. For example, the policy may state the following:

- *For unassigned claims:* Payment for the physician's services is expected at the end of your appointment unless you have made other arrangements with our practice manager.
- *For assigned claims:* After your insurance claim is processed by your insurance company, you will be billed for any amount you owe. You are responsible for any part of the charges that are denied or not paid by the carrier. All patient accounts are due within thirty days of the date of the invoice.
- *Copayments:* Copayments must be paid before you leave the office.

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We sincerely wish to provide the best possible medical care. This involves mutual understanding between the patients, doctors, and staff. We encourage, you, our patient, to discuss any questions you may have regarding this payment policy.

Payment is expected at the time of your visit for services not covered by your insurance plan. We accept cash, check, AMEX, Visa, MasterCard, and Discover.

Credit will be extended as necessary.

Credit Policy
Requirements for maintaining your account in good standing are as follows:

1. All charges are due and payable within 30 days of the first billing.
2. For services not covered by your health plan, payment at the time of service is necessary.
3. If other circumstances warrant an extended payment plan, our credit counselor will assist you in these special circumstances at your request.

We welcome early discussion of financial problems. A credit counselor will assist you.

An itemized statement of all medical services will be mailed to you every 30 days. We will prepare and file your claim forms to the health plan. If further information is needed, we will provide an additional report.

Insurance
Unless we have a contract directly with your health plan, we cannot accept the responsibility of negotiating claims. You, the patient, are responsible for payment of medical care regardless of the status of the medical claim. In situations where a claim is pending or when treatment will be over an extended period of time, we will recommend that a payment plan be initiated. Your health plan is a contract between you and your insurance company. We cannot guarantee the payment of your claim. If your insurance company pays only a portion of the bill or denies the claim, any contact or explanation should be made to you, the policyholder. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

Insufficient Funds Payment Policy
We may charge an insufficient funds processing fee for all returned checks and bankcard charge backs. If your payment is dishonored, we may electronically debit your account for the payment, plus an insufficient funds processing fee up to the amount allowed by law. If your bank account is not debited, the returned check amount (plus fee) must be replaced by cash, cashier's check, or money order.

FIGURE 3.11 Example of a Financial Policy

However, a health plan may have a contract with the practice that prohibits physicians from obtaining anything except a copayment until after adjudication. Medicare has such a rule; the provider is not permitted to collect the deductible or any other payment until receiving data on how the claim is going to be paid. In this case, the health plan protects patients from having to overpay the deductible amount, which could occur if multiple providers collected the deductible within a short period of visits.

Estimating What the Patient Will Owe

Many times, patients want to know what their bills will be. For practices that collect patient accounts at the time of service and for high-deductible insurance plans, the physician practice also wants to know what a patient owes.

To estimate these charges, the medical insurance specialist verifies:

- The patient's deductible amount and whether it has been paid in full, the covered benefits, and coinsurance or other patient financial obligations
- The payer's allowed charges for the planned or provided services

Based on these facts, the specialist calculates the probable bill for the patient.

Other tools can be used to estimate charges. Some payers have a swipe-card reader (like a credit card processing device) that can be installed in the reception area and used by patients to learn what the insurer will pay and what the patient owes. Most practice management programs have a feature that permits estimating the patient's bill, as shown below:

		Est. Resp.
Policy 1: Aetna Choice (EMC)		$116.00
Policy 2: Medicare Nationwide		$0.00
Policy 3:		$0.00
Guarantor: Williams, Vereen		−$15.00
Adjustment:		$0.00
Policy Copay: 15.00	OA:	
Annual Deductible:	0.00 YTD:	$0.00

Charges:	$116.00
Adjustments:	$0.00
Subtotal:	$116.00
Payment:	−$15.00
Balance:	$101.00
Account Total:	$101.00

Real-Time Adjudication

The ideal tool for calculating charges due at the time of service is the transaction called **real-time adjudication (RTA).** Offered to practices by many health plans, RTA allows the practice to view, at the time of service, what the health plan will pay for the visit and what the patient will owe. The process is to (1) create the claim while the patient is being checked out, (2) transmit the claim electronically to the payer, and (3) receive an immediate ("real-time") response from the payer. This response

real-time adjudication (RTA) process used to generate the amount owed by a patient

- Informs the practice if there are any errors in the claim, so these can be fixed and the claim immediately resent for adjudication
- States whether the patient has met the plan's deductible
- Provides the patient's financial responsibility
- Supplies an explanation of benefits for this patient, so that any questions the patient has about denial of coverage or payment history can be immediately answered.

Note that RTA does not generate a "real-time" payment—that follows usually within twenty-four hours. This brief waiting period is also a great improvement over the time it normally takes payers to send payments.

BILLING TIP

RTA Versus Estimates

The RTA process generates an actual amount due from the patient, not an estimate of that amount.

Credit Card on File Policy

Many practices have instituted a policy of collecting and retaining patients' credit card information. Known as a **credit card on file (CCOF)** policy, it protects the practice in the event of delays in payment or failures to pay. Patients complete the practice's form (see Figure 3.12) by providing their credit card information and signature to authorize payment for outstanding balances. The practice must keep this information private, in compliance with HIPAA regulations, and may stipulate other conditions, such as billing fees and additional charges.

credit card on file (CCOF) policy of collecting and retaining patients' credit card information

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CREDIT CARD ON FILE POLICY

At Valley Associates, PC, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of [$X] will be added to your account for any balances that we must attempt to collect of through mailing monthly statement. Furthermore, an "outstanding balance" change of 1.5 percent of the total bill will change for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Valley Associates, PC to change the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Visa ☐ Mastercard ☐ Discover

Credit Card Number _____

Expiration Date _____/ _____ / _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State _____ Zip _____

I (we), the undersigned, authorize and request Valley Associates, PC to change my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Valley Associates, PC.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to [practice name] in writing and the account must be in good standing.

Patient name (Print): _____

Patient signature: _____

Date: _____/_____/_____

FIGURE 3.12 Credit Card on File Policy

Financial Arrangements for Large Bills

If patients have large bills that they must pay over time, a financial arrangement for a series of payments may be made (see Figure 3.13). The payments may begin with a prepayment followed by monthly amounts. Such arrangements usually require the approval of the practice manager. They may also be governed by state laws. Payment plans are covered in greater depth in the chapter about patient billing and collections.

BILLING TIP

Use of Credit and Debit Cards

Accepting credit or debit cards requires paying a fee to the credit card carrier. It is generally considered worth the cost because payments are made immediately and are more convenient for the patient.

THINKING IT THROUGH 3.9

1. Read the financial policy shown in Figure 3.11. If a patient presents for noncovered services, when is payment expected? Does the provider accept assignment for plans in which it is nonPAR?

Patient Name and Account Number

Total of All Payments Due

FEE	$_____	
PARTIAL PAYMENT	$_____	
UNPAID BALANCE	$_____	
AMOUNT FINANCED	$_____	(amount of credit we have provided to you)
FINANCE CHARGE	$_____	(dollar amount the interest on credit will cost)
ANNUAL PERCENTAGE RATE	$_____	(cost of your credit as a yearly rate)
TOTAL OF PAYMENTS DUE	$_____	(amount paid after all payments are made)

Rights and Duties

I (we) have reviewed the above fees. I agree to make _____ payments in monthly installments of $ _____, due on the _____ day of each month payable to _____, until the total amount is paid in full. The first payment is due on _____. I may request an itemization of the amount financed.

Delinquent Accounts

I (we) understand that I am financially responsible for all fees as stated. My account will be overdue if my scheduled payment is more than 7 days late. There will be a late payment charge of $_____ or _____% of the payment, whichever is less. I understand that I will be legally responsible for all costs involved with the collection of this account including all court costs, reasonable attorney fees, and all other expenses incurred with collection if I default on this agreement.

Prepayment Penalty

There is no penalty if the total amount due is paid before the last scheduled payment.

I (we) agree to the terms of the above financial contract.

_____ _____
Signature of Patient, Parent or Legal Representative Date

_____ _____
Witness Date

_____ _____
Authorizing Signature Date

FIGURE 3.13 Financial Arrangement for Services Form

Chapter 3 Summary

Learning Outcomes	Key Concepts/Examples
3.1 Explain the method used to classify patients as new or established.	• Practices gather accurate information from patients to perform billing and medical care. • New patients are those who have not received any services from the provider within the past three years. • Established patients have seen the provider within the past three years. • Established patients review and update the information that is on file about them.

Learning Outcomes	Key Concepts/Examples
3.2 Discuss the five categories of information required of new patients.	Five types of information collected: • Basic personal preregistration and scheduling information • The patient's detailed medical history • Insurance data for the patient or guarantor • A signed and dated assignment of benefits statement by the policyholder • A signed Acknowledgment of Receipt of Notice of Privacy Practices authorizing the practice to release the patient's PHI for TPO purposes
3.3 Explain how information for established patients is updated.	• Patient information forms are reviewed at least once per year by established patients. • Patients are often asked to double-check their information at their encounters. • The PMP is updated to reflect any changes as needed, and the provider strives for good communication with the patient to provide the best possible service.
3.4 Verify patients' eligibility for insurance benefits.	To verify patients' eligibility, the provider: • Checks the patient's information form and medical insurance card (except in medical emergency situations) • Contacts the payer to verify the patient's general eligibility for benefits and the amount of copayment or coinsurance that is due at the encounter, and to determine whether the planned encounter is for a covered service that is considered medically necessary by the payer
3.5 Discuss the importance of requesting referral or preauthorization approval.	• Preauthorization is requested before a patient is given certain types of medical care. • In cases of referrals, the provider often needs to issue a referral number and a referral document in order for the patient to see a specialist under the terms of the medical insurance. • Providers must handle these situations correctly to ensure that the services are covered if possible.
3.6 Determine primary insurance for patients who have more than one health plan.	• Patient information forms and insurance cards are examined to determine whether more than one health insurance policy is in effect. • If so, the provider determines which policy is the primary insurance based on coordination of benefits rules. • This information is then entered into the PMP and all necessary communications with the payers are performed.
3.7 Summarize the use of encounter forms.	• Encounter forms are lists of a medical practice's most commonly performed services and procedures and often its frequent diagnoses. • The provider checks off the services and procedures a patient received, and the encounter form is then used for billing.
3.8 Identify the eight types of charges that may be collected from patients at the time of service.	• Practices routinely collect up-front money from patients at the time of their office visit as an important source of cash flow. Eight different types of charges may be collected from patients at the time of service: 1. Previous balances 2. Copayments 3. Coinsurance 4. Noncovered or overlimit fees 5. Charges of nonparticipating providers 6. Charges for self-pay patients 7. Deductibles for patients with CDHPs 8. Charges for supplies and copies of medical records

Learning Outcomes	Key Concepts/Examples
3.9 Explain the use of real-time adjudication tools in calculating time-of-service payments.	Real-time adjudication tools: • Allow the practice to view, at the time of service, what the health plan will pay for the visit and what the patient will owe • Provide valuable information and checks so that the practice and patients are aware of the expected costs and coverage • Inform or remind patients of the financial policy and give estimates of the bills they will owe

Review Questions

Match the key terms with their definitions.

1. **LO 3.2** direct provider
2. **LO 3.2** assignment of benefits
3. **LO 3.1** new patient
4. **LO 3.6** secondary insurance
5. **LO 3.7** encounter form
6. **LO 3.1** established patient
7. **LO 3.2** insured/subscriber
8. **LO 3.6** coordination of benefits
9. **LO 3.3** primary insurance
10. **LO 3.2** patient information form
11. **LO 3.9** credit card on file (CCOF)
12. **LO 3.5** referral waiver
13. **LO 3.4** trace number
14. **LO 3.8** partial payment

A. Form used to summarize the treatments and services patients receive during visits

B. Policyholder

C. Authorization by a policyholder that allows a payer to pay benefits directly to a provider

D. The insurance plan that pays benefits after payment by the primary payer when a patient is covered by more than one medical insurance plan

E. The provider who treats the patient

F. A clause in an insurance policy that explains how the policy will pay if more than one insurance policy applies to the claim

G. A patient who has received professional services from a provider or another provider in the same practice with the same specialty in the past three years

H. Form completed by patients that summarizes their demographic and insurance information

I. A patient who has not received professional services from a provider, or another provider in the same practice with the same specialty, in the past three years

J. The insurance plan that pays benefits first when a patient is covered by two medical insurance plans

K. The document a patient signs to guarantee payment when a referral authorization is pending

L. A policy of collecting and retaining patients' credit card information

M. The number assigned to a HIPAA 270 electronic transaction

N. A payment made during checkout based on an estimate

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Select the answer choice that best completes the statement or answers the question.

15. **LO 3.2** A patient's group insurance number written on the patient information or update form must match
A. the patient's Social Security number
B. the number on the patient's insurance card
C. the practice's identification number for the patient
D. the diagnosis codes

16. **LO 3.4** If a health plan member receives medical services from a provider who does not participate in the plan, the cost to the member is
A. lower
B. higher
C. the same
D. negotiable

17. **LO 3.2** What information does a patient information form gather?
A. the patient's personal information, employment data, and insurance information
B. the patient's history of present illness, past medical history, and examination results
C. the patient's chief complaint
D. the patient's insurance plan deductible and/or copayment requirements

18. **LO 3.6** If a husband has an insurance policy but is also eligible for benefits as a dependent under his wife's insurance policy, the wife's policy is considered _____ for him.
A. primary
B. participating
C. secondary
D. coordinated

19. **LO 3.5** A certification number for a procedure is the result of which transaction and process?
A. claim status
B. healthcare payment and remittance advice
C. coordination of benefits
D. referral and authorization

20. **LO 3.9** A practice's rules for payment for medical services are found in its
A. coordination of benefits
B. documentation
C. financial policy
D. compliance plan

21. **LO 3.7** The encounter form is a source of _____ information for the medical insurance specialist.
A. billing
B. treatment plan
C. third-party payment
D. credit card

22. **LO 3.9** Under Medicare, what must a provider receive before it is permitted to collect a deductible or any other payment?
A. the patient's coinsurance
B. the patient's copayment
C. authority to accept assignment
D. data on how the claim is going to be paid

23. **LO 3.8** Which charges are usually collected at the time of service?
A. copayments, lab fees, and therapy charges
B. copayments, noncovered or overlimit fees, charges of nonparticipating providers, and charges for self-pay patients
C. deductibles and lab fees
D. coinsurance

24. **LO 3.6** The tertiary insurance pays
A. after the first and second payers
B. after the first payer
C. after receipt of the claim
D. before all other payers

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Answer the following questions or provide the information required.

25. Define the following abbreviations:

A. **LO 3.2** nonPAR

B. **LO 3.6** COB

C. **LO 3.2** PAR

D. **LO 3.1** NP

E. **LO 3.1** EP

Applying Your Knowledge

Case 3.1 Abstracting Insurance Information

LO 3.1 Carol Viragras saw Dr. Alex Roderer, a gynecologist with the Alper Group, a multispecialty practice of 235 physicians, on October 24, 2027. On December 3, 2029, she made an appointment to see Dr. Judy Fisk, a gastroenterologist also with the Alper Group. Did the medical insurance specialist handling Dr. Fisk's patients classify Carol as a new or an established patient?

Case 3.2 Documenting Communications

LO 3.3 Harry Cornprost, a patient of Dr. Connelley, calls on October 25, 2029, to cancel his appointment for October 31 because he will be out of town. The appointment is rescheduled for December 4. How would you document this call?

Case 3.3 Coordinating Benefits

Based on the information provided, determine the primary insurance in each case.

A. **LO 3.6** George Rangley enrolled in the ACR plan in 2018 and in the New York Health plan in 2016.

George's primary plan:

B. **LO 3.6** Mary is the child of Gloria and Craig Bivilaque, who are divorced. Mary is a dependent under both Craig's and Gloria's plans. Gloria has custody of Mary.

Mary's primary plan:

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C. **LO 3.6** Karen Kaplan's date of birth is 10/11/1985; her husband Carl was born on 12/8/1986. Their child Ralph was born on 4/15/2015. Ralph is a dependent under both Karen's and Carl's plans.

Ralph's primary plan:

D. **LO 3.6** Belle Estaphan has medical insurance from Internet Services, from which she retired last year. She is on Medicare but is also covered under her husband Bernard's plan from Orion International, where he works.

Belle's primary plan:

E. **LO 3.6** Jim Larenges is covered under his spouse's plan and has medical insurance through his employer.

Jim's primary plan:

Case 3.4 Calculating Insurance Math

A. **LO 3.8, 3.9** A patient's insurance policy states:

Annual deductible: $300.00

Coinsurance: 70-30

This year the patient has made payments totaling $533 to all providers. Today the patient has an office visit (fee: $80). The patient presents a credit card for payment of today's bill. What is the amount that the patient should pay?

B. **LO 3.8, 3.9** A patient is a member of a health plan with a 15 percent discount from the provider's usual fees and a $10 copay. The day's charges are $480. What are the amounts that the HMO and the patient each pay?

C. **LO 3.8, 3.9** A patient is a member of a health plan that has a 20 percent discount from the provider and a 15 percent copay. If the day's charges are $210, what are the amounts that the HMO and the patient each pay?

Part 2

CLAIM CODING

chapter 4
Diagnostic Coding: ICD-10-CM

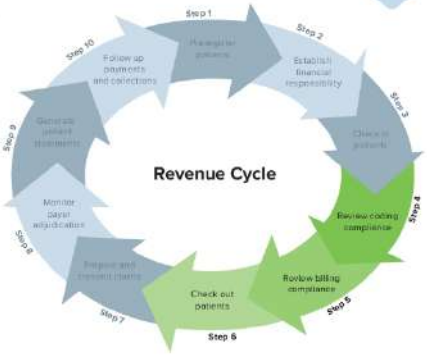
chapter 5
Procedural Coding: CPT and HCPCS

chapter 6
Visit Charges and Compliant Billing

4 DIAGNOSTIC CODING: ICD-10-CM

KEY TERMS

acute
Alphabetic Index (AI)
category
chief complaint (CC)
chronic
code
coexisting condition
combination code
convention
default code
diagnostic statement
eponym
etiology
excludes 1
excludes 2
exclusion notes
external cause code
first-listed code
GEMs
ICD-10-CM
ICD-10-CM *Official Guidelines for Coding and Reporting*
inclusion notes
Index to External Causes
laterality
main term
manifestation
NEC (not elsewhere classifiable)
Neoplasm Table
nonessential modifier
NOS (not otherwise specified)
placeholder character (x)
primary diagnosis
principal diagnosis
sequelae
seventh-character extension
subcategory
subterm
Table of Drugs and Chemicals
Tabular List (TL)
Z code



Learning Outcomes

After studying this chapter, you should be able to:

4.1 Discuss the purpose of ICD-10-CM.
4.2 Describe the organization of ICD-10-CM.
4.3 Summarize the structure, content, and key conventions of the Alphabetic Index.
4.4 Summarize the structure, content, and key conventions of the Tabular List.
4.5 Apply the rules for outpatient coding that are provided in the ICD-10-CM *Official Guidelines for Coding and Reporting*.
4.6 Briefly describe the content of Chapters 1 through 21 of the Tabular List.
4.7 Assign correct ICD-10-CM diagnosis codes.
4.8 Differentiate between ICD-9-CM and ICD-10-CM.

Scientists and medical researchers have long gathered information from hospital records about patients' illnesses and causes of death. In place of written descriptions of the many different symptoms and conditions people have, standardized diagnosis codes have been developed for recording them. A coding system provides an accurate way to collect statistics to keep people healthy and to plan for needed healthcare resources as well as to record morbidity (disease) and mortality (death) data.

Diagnosis codes are used to report patients' conditions on claims. Physicians determine the diagnosis. The physicians, medical coders, insurance or billing specialists, or medical assistants may be responsible for assigning the codes for those diagnoses. Expertise in diagnostic coding requires knowledge of medical terminology, pathophysiology, and anatomy, as well as experience in correctly applying the guidelines for assigning codes.

Mandated Use of ICD-10-CM

ICD-10-CM is the mandated code set for diagnoses under the HIPAA Electronic Health Care Transactions and Code Sets standard starting on October 1, 2015. Previously, ICD-9-CM was the required code set.

4.1 ICD-10-CM

Under HIPAA, the diagnosis codes that must be used in the United States starting on October 1, 2015, are based on the *International Classification of Diseases (ICD)*, 10th Revision. The ICD-10 lists diseases and codes according to a system copyrighted by the World Health Organization of the United Nations. ICD has been revised a number of times since the coding system was first developed more than a hundred years ago.

The federal government has used ICD-10 to categorize mortality data from death certificates since 1999. An expanded version of this tenth revision was published prior to the mandated compliance date for the healthcare community to review. A committee of healthcare professionals from various organizations and specialties prepared this version, which is called the ICD-10's *Clinical Modification*, or **ICD-10-CM.** It is used to code and classify morbidity data from patient medical records, physician offices, and surveys conducted by the National Center for Health Statistics (NCHS). Codes in ICD-10-CM describe conditions and illnesses more precisely than does the World Health Organization's ICD-10 because the codes are intended to provide a more complete picture of patients' conditions.

ICD-10-CM HIPAA-mandated diagnosis code set as of October 1, 2015

Code Makeup

In ICD-10-CM, a **code** is a three- to seven-character alphanumeric representation of a disease or condition. The system is built on categories for diseases, injuries, and symptoms. A category has three characters. Most categories have subcategories of either four- or five-character codes. Valid codes themselves are either three, four, five, six, or seven characters in length, depending on the number of subcategories provided. For example, the code for the first visit for a closed and displaced fracture of the right tibial spine requires seven characters:

code three- to seven-character alphanumeric representation of a disease or condition

Category S82 **Fracture of lower leg, including ankle**

Subcategory S82.1 **Fracture of upper end of tibia**

Subcategory S82.11 **Fracture of tibial spine**

Code S82.111- **Displaced fracture of right tibial spine**

Code S82.111A **Displaced fracture of tibial spine, initial encounter for closed fracture**

This variable structure enables coders to assign the most specific diagnosis that is documented in the patient medical record. A sixth character code is more specific than one with only fourth or fifth characters, and the seventh character extension can provide additional specific information about the health-related condition. When they are available for assignment in the ICD-10-CM code set, sixth and seventh characters are not optional but must be used. For example, Centers for Medicare and Medicaid Services (CMS) rules state that a Medicare claim will be rejected when the most specific code available is not used.

THINKING IT THROUGH 4.3

1. The following entry appears in the Alphabetic Index: Pompe's disease (glycogen storage) E74.02
   A. What type of term is Pompe's disease?

   _____

   B. What type of term is shown in parentheses?

   _____

2. Locate the following main terms in the Alphabetic Index. List and interpret any cross-references you find next to the entries.
   A. Stieda's disease _____
   B. Atrophia _____
   C. Branchial _____
3. Are see cross-references in the Alphabetic Index followed by codes? Why or why not?

   _____

4.4 The Tabular List

The Tabular List received its name from the language of statistics; the word *tabulate* means to count, record, or list systematically. The diseases and injuries in the Tabular List are organized into chapters according to etiology, body system, or purpose. See Table 4.1 for the organization of the Tabular List and the ranges of codes each part covers.

Placeholder Character Requirement

placeholder character (x) character "x" inserted in a code to fill a blank space

ICD-10-CM uses a **placeholder character** (also known as the "dummy placeholder") designated as "x" in some codes when a fifth-, sixth-, or seventh-digit character is required but the digit space to the left of that character is empty.

For example, the subcategory T46.1 Poisoning by, adverse effect of and underdosing of calcium-channel blockers, uses the *sixth* digit to describe whether the poisoning was accidental (unintentional), was intentional self-harm, was caused by assault, was undetermined, or was related to an adverse effect or underdosing. Because there is no fifth digit assigned, an x is used to hold that fifth space.

T46.1X2A Poisoning by calcium-channel blockers, intentional self-harm, initial encounter

Seventh-Character Extension

seventh-character extension necessary assignment of a seventh character to a code; often for the sequence of an encounter

ICD-10-CM requires assigning a seventh character in some categories, usually to specify the sequence of the visit (for example, the initial encounter for the problem, the subsequent encounter for the problem, or sequela–the problem results from a previous disease or injury; the plural is *sequelae*). The **seventh-character extension** requirement is contained in a note at the start of the codes it covers. The seventh character must always be in position seven of the alphanumeric code, so if the code is not at least six characters long, the placeholder character "x" must be used to fill that empty space.

For example, category S64, Injury of nerves at wrist and hand level, leads off with this note:

The appropriate seventh character is to be added to each code from category S64.

A for an initial encounter

D for a subsequent encounter

S for sequela

Cross-References

Some entries use cross-references. If the cross-reference *see* appears after a main term, the coder *must* look up the term that follows the word *see* in the index. The *see* reference means that the main term where the coder first looked is not correct; another category must be used. In Figure 4.1, for example, to code the subterm snow under *blind,* the term *Photokeratitis* must be found.

See also, another type of cross-reference, points the coder to additional, related index entries. The *see also* category indicates that the coder should review the additional categories that are mentioned. For example, in Figure 4.1, the *see also* note at Blind directs the coder to check *Blindness* as well.

The Abbreviations NEC and NOS

Not elsewhere classifiable, or NEC, appears with a term when there is no code that is specific for the condition. This abbreviation means that no code matches the exact situation. For example:

Hemorrhage, hemorrhagic, eye NEC H57.8

Another abbreviation, **NOS,** or **not otherwise specified,** means *unspecified.* This term or abbreviation indicates that the code to be located in the Tabular List should be used when a condition is not completely described in the medical record. For example:

Enteritis, bacillary NOS A03.9

NEC (not elsewhere classifiable) abbreviation indicating the code to use when a disease or condition cannot be placed in any other category

NOS (not otherwise specified) term that indicates the code to use when no information is available for assigning the disease or condition a more specific code; unspecified

Multiple Codes, Connecting Words, and Combination Codes

Some conditions may require two codes, one for the etiology and a second for the **manifestation,** the disease's typical signs, symptoms, or secondary processes. This requirement is indicated when two codes, the second in brackets, appear after a term:

Pneumonia in rheumatic fever I00 [J17]

This entry indicates that the diagnostic statement "pneumonia in rheumatic fever" requires two codes, one for the etiology (rheumatic fever, I00) and one for the manifestation (pneumonia, J17). The use of brackets in the Alphabetic Index around a code means that it cannot be the **first-listed code** in coding this diagnostic statement; these codes are listed after the codes for the etiology.

The use of connecting words, such as *due to, during, following,* and *with,* may also indicate the need for two codes or for a single code that covers both conditions. For example

Cramp(s), muscle, R25.2

due to immersion T75.1

When the Alphabetic Index indicates the possible need for two codes, the Tabular List entry is used to determine whether in fact they are needed. In some cases, a **combination code** describing both the etiology and the manifestation is available instead of two codes. For example:

Influenza due to identified novel influenza A virus with gastrointestinal manifestations J09.X3

Combination codes that classify two diagnoses or a diagnosis with an associated complication may also exist.

manifestation characteristic sign or symptom of a disease

first-listed code code for diagnosis that is the patient's main condition; in cases involving an underlying condition and a manifestation, the underlying condition is the first-listed code

combination code single code describing both the etiology and the manifestation(s) of a particular condition

Blind (*see also* Blindness)
bronchus (congenital) Q32.4
loop syndrome K90.2
congenital Q43.8
sac, fallopian tube (congenital) Q50.6
spot, enlarged—*see* Defect, visual field, localized, scotoma, blind spot area
tract or tube, congenital NEC—*see* Atresia, by site
Blindness (acquired) (congenital) (both eyes) H54.0X-
blast S05.8x-
color—*see* Deficiency, color vision
concussion S05.8x-
cortical H47.619
left brain H47.612
right brain H47.611
day H53.11
due to injury (current episode) S05.9-
sequelae—code to injury with seventh character S
eclipse (total)—*see* Retinopathy, solar
emotional (hysterical) F44.6
face H53.16
hysterical F44.6
legal (both eyes) (USA definition) H54.8
mind R48.8
night H53.60
abnormal dark adaptation curve H53.61
acquired H53.62
congenital H53.63
specified type NEC H53.69
vitamin A deficiency E50.5
one eye (other eye normal) H54.40
left (normal vision on right) H54.42-
low vision on right H54.12-
low vision, other eye H54.10
right (normal vision on left) H54.41-
low vision on left H54.11-
psychic R48.8
river B73.01
snow—*see* Photokeratitis
sun, solar—*see* Retinopathy, solar
transient—*see* Disturbance, vision, subjective, loss, transient
traumatic (current episode) S05.9-
word (developmental) F81.0
acquired R48.0
secondary to organic lesion R48.0

FIGURE 4.1 Format of the Alphabetic Index

Common Terms

Many terms appear more than once in the Alphabetic Index. Often, the term in common use is listed as well as the accepted medical terminology. For example, there is an entry for *flu*, with a cross-reference to *influenza*.

Eponyms

eponym name or phrase formed from or based on a person's name

An **eponym** (pronounced êp'-o-nim) is a condition (or a procedure) named for a person, such as the physician who discovered or invented it; some are named for patients. An eponym is usually listed both under that name and under the main term *disease* or *syndrome*. For example, Morvan's disease appears as a subterm under *disease* and as a main term. The Alphabetic Index is the guide for coding other syndromes, such as battered child syndrome or HIV infection; if the syndrome is not identified, its symptoms or the conditions that are exhibited are assigned codes.

Indention: Turnover Lines

If the main term or subterm is too long to fit on one line, as is often the case when many nonessential modifiers appear, turnover (or carryover) lines are used. Turnover lines are always indented farther to the right than are subterms. It is important to read carefully to distinguish a turnover line from a subterm line. For example, under the main term *blindness* (Figure 4.1) and the subterm *transient*, the information under "*See*" is long enough to require a turnover line. Without close attention, it is possible to confuse a turnover entry with a subterm.

This process must be followed when assigning all codes. A code followed by a hyphen in the Alphabetic Index is a clear reminder of this rule. The hyphen means that the coder will need to drill down to select the right code. For example, the index entry for otitis media is H66.9-. The coder turns to the Tabular List and reviews these entries:

H66.90 Otitis media, unspecified, unspecified ear

H66.91 Otitis media, unspecified, right ear

H66.92 Otitis media, unspecified, left ear

H66.93 Otitis media, unspecified, bilateral

Based on the documentation, one of these must be selected for compliant coding; only H66.9 is not sufficient.

THINKING IT THROUGH 4.2

1. Why is it important to use current ICD codes?

4.3 The Alphabetic Index

The Alphabetic Index contains all the medical terms in the Tabular List classifications. For some conditions, it also lists common terms that are not found in the Tabular List. The index is organized by the *condition,* not by the body part (anatomical site) in which it occurs.

The term *wrist fracture* is located by looking under *fracture, traumatic* (the condition) and then, below it, *wrist* (the location), rather than under *wrist* to find *fracture.*

Main Terms, Subterms, and Nonessential Modifiers

The assignment of the correct code begins by looking up the medical term that describes the patient's condition based on the diagnostic statement. Figure 4.1 illustrates the format of the Alphabetic Index. Each **main term** appears in boldface type and is followed by its **default code,** the one most frequently associated with it. For example, if the diagnostic statement is "the patient presents with blindness," the main term *blindness* is located in the Alphabetic Index (see Figure 4.1); the default code shown is H54.0X-.

Below the main term, any **subterms** with their codes appear. Subterms are essential in the selection of correct codes. They may show the **etiology** of the disease—its cause or origin—or describe a particular type or body site for the main term. For example, the main term *blindness* in Figure 4.1 includes more than twenty subterms, each indicating a different etiology or type—such as color blindness—for that condition.

Any **nonessential modifiers** for main terms or subterms are shown in parentheses on the same line. Nonessential modifiers are supplementary terms that are not essential to the selection of the correct code. They help point to the correct term, but they do not have to appear in the physician's diagnostic statement for the coder to correctly select the code. In Figure 4.1, for example, any of the supplementary terms *acquired, congenital,* and *both eyes* may modify the main term in the diagnostic statement, such as "the patient presents with blindness acquired in childhood," or none of these terms may appear.

main term word that identifies a disease or condition in the Alphabetic Index

default code ICD-10-CM code listed next to the main term in the Alphabetic Index that is most often associated with a particular disease or condition

subterm word or phrase that describes a main term in the Alphabetic Index

etiology cause or origin of a disease or condition or describe a particular type or body site for the main term

nonessential modifier supplementary word or phrase that helps define a code in ICD-10-CM

ICD-10-CM Updates
www.cdc.gov/nchs/icd/icd10cm.htm
www.cms.gov/ICD10

Updates

The National Center for Health Statistics and CMS release ICD-10-CM updates called *addenda*. The major new, invalid, and revised codes are posted on the appropriate websites, such as the National Center for Health Statistics and CMS websites.

New codes must be used as of the date they go into effect, and invalid (deleted) codes must not be used. The U.S. Government Printing Office (GPO) publishes the official ICD-10-CM on the Internet and in CD-ROM format every year. Various commercial publishers include the updated codes in annual coding books that are printed soon after the updates are released. The current reference must always be used for the date of service of the encounter being coded.

THINKING IT THROUGH 4.1

1. Each time an update is released, ICD-10-CM has many new categories, in part for diseases that have been discovered since the previous revision. What are examples of diseases that have been diagnosed in the last two decades?

4.2 Organization of ICD-10-CM

ICD-10-CM has two major parts:

ICD-10-CM Index to Diseases and Injuries: The major section of this part, known as the **Alphabetic Index,** provides an index of the disease descriptions in the second major part, the Tabular List. Many descriptions are listed in more than one manner.

ICD-10-CM Tabular List of Diseases and Injuries: The **Tabular List** is made up of twenty-one chapters of disease descriptions and their codes.

Alphabetic Index part of ICD-10-CM listing diseases and injuries alphabetically with corresponding diagnosis codes

Tabular List part of ICD-10-CM listing diagnosis codes in chapters alphanumerically

ICD-10-CM's first part also has three additional sections that provide resources for researching correct codes:

ICD-10-CM Neoplasm Table: The **Neoplasm Table** provides code numbers for neoplasms by anatomical site and divided by the description of the neoplasm.

ICD-10-CM Table of Drugs and Chemicals: The **Table of Drugs and Chemicals** provides in table format an index of drugs and chemicals that are listed in the Tabular List.

ICD-10-CM Index to External Causes: The **Index to External Causes** provides an index of all the external causes of diseases and injuries that are listed in the related chapter of the Tabular List.

Neoplasm Table summary table of code numbers for neoplasms by anatomical site and divided by the description of the neoplasm

Table of Drugs and Chemicals index in table format of drugs and chemicals that are listed in the Tabular List

Index to External Causes index of all external causes of diseases and injuries classified in the Tabular List

The process of assigning ICD-10-CM codes begins with the physician's **diagnostic statement,** which contains the medical term describing the condition for which a patient is receiving care. For each encounter, this medical documentation includes the main reason for the patient encounter. It may also provide descriptions of additional conditions or symptoms that have been treated or that are related to the patient's current illness.

diagnostic statement physician's description of the main reason for a patient's encounter

In each part of ICD-10-CM, **conventions,** which are typographic techniques that provide visual guidance for understanding information, help coders understand the rules and select the right code. The primary rule is that both the Alphabetic Index and the Tabular List are used sequentially to pick a code. The coder first locates the description and code in the Alphabetic Index and then verifies the proposed code selection by turning to the Tabular List and studying its entries.

convention typographic technique that provides visual guidance for understanding information

Etiology and Manifestation Coding

The convention that addresses multiple codes for conditions that have both an underlying etiology and manifestations is indicated in the Tabular List by some phrases that contain instructions about the need for additional codes. The phrases point to situations in which more than one code is required. For example, a statement that a condition is "due to" or "associated with" may require an additional code.

Use an Additional Code

The etiology code may be followed by the instruction *use an additional code* or a note saying the same thing. The order of the codes must be the same as shown in the Alphabetic Index: the etiology comes first followed by the manifestation code.

Code First Underlying Disease

The instruction *code first underlying disease* (or similar wording) appears below a manifestation code that must not be used as a first-listed code. These codes are for symptoms only, never for causes. At times, a specific instruction is given, such as in this example:

F07 Personality and behavioral disorders due to known physiological condition

Code first the underlying physiological condition

Assign Required Other "Use Additional Code"

The "use additional code" note also appears when ICD-10-CM requires assignment of codes for health factors such as tobacco use and alcohol use.

Laterality

laterality use of ICD-10-CM classification system to capture the side of the body that is documented; the fourth, fifth, or sixth characters of a code specify the affected side(s)

The Tabular List provides a coding structure based on the concept of **laterality.** In ICD-10-CM, this is the idea that the classification system should capture the side of the body that is documented for a particular condition. The fourth, fifth, or sixth characters specify the affected side, such as right arm, left wrist, both eyes. (In general usage, *laterality* means a preference for one side of the body, such as left-handedness.) When the affected side of the condition is not known, an unspecified code is assigned. If a condition is documented as bilateral but there is no appropriate code for bilaterality (that is, both), two codes for the left and right sides are assigned.

THINKING IT THROUGH 4.4

Provide the following information about codes found in the Tabular List.

1. What condition is excluded from category B58, Toxoplasmosis?
2. What is the meaning of the phrase that follows the entry J44.0?
3. What is the meaning of the note that follows category S80, Superficial injury of knee and lower leg?
4. What types of diabetes are included in category E11, Type 2 diabetes mellitus?
5. Review the instructions for category H67, Otitis media in diseases classified elsewhere. Can any of the codes be first-listed?

ICD-10-CM *Official Guidelines for Coding and Reporting* general rules, inpatient (hospital) coding guidance, and outpatient (physician office/clinic) coding guidance from the four cooperating parties (CMS advisers and participants from the AHA, AHIMA, and NCHS)

4.5 ICD-10-CM Official Guidelines for Coding and Reporting

Assigning HIPAA-mandated diagnosis codes follows both the conventions that are incorporated in the Alphabetic Index/Tabular List as well as a separate set of rules called **ICD-10-CM *Official Guidelines for Coding and Reporting*.** Known as the

letters, although currently the second character is usually (but not always) a number. A valid code has to have at least three characters. If it has more than that, a period is placed following the third character:

L03.042 Acute lymphangitis of left toe

Each character beyond the category level provides greater specificity to the code's meaning.

Inclusion Notes

Inclusion notes are headed by the word *includes* and refine the content of the category appearing above them. For example, in ICD-10-CM's tabular list section on neoplasms, category D49 is annotated to include all not otherwise specified "growths," neoplasms, new growths, or tumors.

inclusion notes Tabular List entries addressing the applicability of certain codes to specified conditions

Exclusion Notes

Exclusion notes are headed by the word *excludes* and indicate conditions that are not classifiable to the preceding code. Two types of exclusion notes are used. **Excludes 1** is used when two conditions could not exist together, such as an acquired and a congenital condition; it means "not coded here." **Excludes 2** means "not included here," but a patient could have both conditions at the same time. An example occurs in Figure 4.2 under the entry L03.01. This *excludes 1* note states that herpetic Whitlow cellulitis is not included.

exclusion notes Tabular List entries limiting applicability of particular codes to specified conditions

excludes 1 exclusion note used when two conditions could not exist together, such as an acquired and a congenital condition; means "not coded here"

excludes 2 exclusion note meaning that a particular condition is not included here, but a patient could have both conditions at the same time

Punctuation

Colons

A colon (:) indicates an incomplete term. One or more of the entries following the colon is required to make a complete term. Unlike terms in parentheses or brackets, when the colon is used, the diagnostic statement must include one of the terms after the colon to be assigned a code from the particular category. For example, the *excludes* note after the information for chorioretinal disorders is as follows:

H32 Chorioretinal disorders in diseases classified elsewhere

Excludes 1: chororetinitis (in):

toxoplasmosis (acquired) (B58.01)

tuberculosis (A18.53)

For the *excludes* note to apply to *chororetinitis*, "acquired toxoplasmosis" or "tuberculosis" must appear in the diagnostic statement.

Parentheses

Parentheses ( ) are used around descriptions that do not affect the code—that is, nonessential, supplementary terms. For example, the subcategory G24.1, Genetic torsion dystonia, is followed by the entry "Idiopathic (torsion) dystonia NOS."

Brackets

Brackets [ ] are used around synonyms, alternative wordings, or explanations. They have the same meaning as parentheses. For example, category E52 is described as "Niacin deficiency [pellagra]."

Abbreviations: NEC versus NOS

NEC and NOS are used in the Tabular List with the same meanings as in the Alphabetic Index.

subcategory four- or five-character code number

2. A **subcategory** is a four- or five-character alphanumeric subdivision of a category. It provides a further breakdown of the disease to show its etiology, site, or manifestation. For example, the L03 category has six subcategories:

   L03 Cellulitis and acute lymphangitis

   - L03.0 Cellulitis and acute lymphangitis of finger and toe
   - L03.1 Cellulitis and acute lymphangitis of other parts of limb
   - L03.2 Cellulitis and acute lymphangitis of face and neck
   - L03.3 Cellulitis and acute lymphangitis of trunk
   - L03.8 Cellulitis and acute lymphangitis of other sites
   - L03.9 Cellulitis and acute lymphangitis, unspecified

3. A *code*, the smallest division, has either three, four, five, six, or seven alphanumeric characters. For example, Figure 4.2 shows the entries under the first subcategory of the L03 category.

Note that the first character in a code is always a letter. The complete alphabet, except for the letter U, is used. The second and third characters may be either numbers or

L03.0 **Cellulitis and acute lymphangitis of finger and toe**
Infection of nail
Onychia
Paronychia
Perionychia

L03.01 **Cellulitis of finger**
Felon
Whitlow

Excludes 1 *herpetic whitlow (B00.89)*

L03.011 **Cellulitis of right finger**
L03.012 **Cellulitis of left finger**
L03.019 **Cellulitis of unspecified finger**

L03.02 **Acute lymphangitis of finger**

Hangnail with lymphangitis of finger

L03.021 **Acute lymphangitis of right finger**
L03.022 **Acute lymphangitis of left finger**
L03.029 **Acute lymphangitis of unspecified finger**

L03.03 **Cellulitis of toe**
L03.031 **Cellulitis of right toe**
L03.032 **Cellulitis of left toe**
L03.039 **Cellulitis of unspecified toe**

L03.04 **Acute lymphangitis of toe**

Hangnail with lymphangitis of toe

L03.041 **Acute lymphangitis of right toe**
L03.042 **Acute lymphangitis of left toe**
L03.049 **Acute lymphangitis of unspecified toe**

FIGURE 4.2 Format of Tabular List Subcategory

Table 4.1 ICD-10-CM Chapter Structure

Chapter	Code Range	Title
1	A00-B99	Certain infectious and parasitic diseases
2	C00-D49	Neoplasms
3	D50-D89	Diseases of the blood and blood-forming organs
4	E00-E89	Endocrine, nutritional and metabolic diseases
5	F01-F99	Mental, behavioral and neurodevelopmental disorders
6	G00-G99	Diseases of the nervous system
7	H00-H59	Diseases of the eye and adnexa
8	H60-H95	Diseases of the ear and mastoid process
9	I00-I99	Diseases of the circulatory system
10	J00-J99	Diseases of the respiratory system
11	K00-K95	Diseases of the digestive system
12	L00-L99	Diseases of the skin and subcutaneous tissue
13	M00-M99	Diseases of the musculoskeletal system and connective tissue
14	N00-N99	Diseases of the genitourinary system
15	O00-O9A	Pregnancy, childbirth and the puerperium
16	P00-P96	Certain conditions originating in the perinatal period
17	Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities
18	R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
19	S00-T88	Injury, poisoning and certain other consequences of external causes
20	V00-Y99	External causes of morbidity
21	Z00-Z99	Factors influencing health status and contact with health services

Subcategory S64.22, Injury of radial nerve at wrist and hand level of left arm, has no sixth digit but requires the seventh, so the correct code for an initial encounter would be:

S64.22xA Injury of radial nerve at wrist and hand level of left arm, initial encounter

Depending on the publisher of ICD-10-CM, a section mark (§) or other symbol (such as a number enclosed in a circle) appears next to a chapter, a category, a subcategory, or a code that requires a fifth, sixth, or seventh digit to be assigned. These are important reminders to assign the appropriate characters.

Categories, Subcategories, and Codes

Each Tabular List chapter is divided into categories, subcategories, and codes.

1. A **category** is a three-character alphanumeric code that covers a single disease or related condition. For example, the category L03 covers cellulitis and acute lymphangitis.

category three-character code for classifying a disease or condition

O. Routine outpatient prenatal visits

See Section I.C.15. Routine outpatient prenatal visits.

P. Encounters for general medical examinations with abnormal findings

The subcategories for encounters for general medical examinations, Z00.0- and encounter for routine child health examination, Z00.12-, provide codes for with and without abnormal findings. Should a general medical examination result in an abnormal finding, the code for general medical examination with abnormal finding should be assigned as the first-listed diagnosis. An examination with abnormal findings refers to a condition/diagnosis that is newly identified or a change in severity of a chronic condition (such as uncontrolled hypertension, or an acute exacerbation of chronic obstructive pulmonary disease) during a routine physical examination. A secondary code for the abnormal finding should also be coded.

Q. Encounters for routine health screenings

See Section I.C.21. Factors influencing health status and contact with health services, Screening.

(c)

FIGURE 4.3 *(concluded)*

Source: "ICD-10-CM Official Guidelines for Coding and Reporting," Centers for Disease Control and Prevention, Sep 30, 2018. https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf

Example

Chart Note: Mrs. Mackenzie, whose previous encounter was for her regularly scheduled blood pressure check to monitor her hypertension, presents today with a new onset of psoriasis.

Primary Diagnosis: L40.9 Psoriasis, unspecified ◂

Coding Acute Versus Chronic Conditions

acute illness or condition with severe symptoms and a short duration

chronic illness or condition with a long duration

The reasons for patient encounters are often **acute** symptoms—generally, relatively sudden or severe problems. Acute conditions are coded with the specific code that is designated acute, if listed. Many patients, however, receive ongoing treatment for **chronic** conditions—those that continue over a long period of time or recur frequently. For example, a patient may need a regular injection for the management of rheumatoid arthritis. In such cases, the disease is coded and reported for as many times as the patient receives care for the condition.

In some cases, an encounter covers both an acute and a chronic condition. Some conditions do not have separate entries for both manifestations, so a single code applies. If both the acute and the chronic illnesses have codes, the acute code is listed first.

Example

Acute kidney failure, unspecified N17.9
Chronic kidney disease, unspecified N18.9 ◂

Coding Sequelae

sequelae conditions that remain after an acute illness or injury has been treated and resolved

Sequelae are conditions that remain after a patient's acute illness or injury has ended. Often called residual effects or late effects, some happen soon after the disease is over, and others occur later. The diagnostic statement may say:

- Due to an old . . . (for example, swelling due to old contusion of knee)
- Late . . . (for example, nausea as a late effect of radiation sickness)
- Due to a previous . . . (for example, abdominal mass due to a previous spleen injury)
- Traumatic (if not a current injury); including scarring or nonunion of a fracture (for example, malunion of fracture, left humerus)

G. ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit

List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

H. Uncertain diagnosis

Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

I. Chronic diseases

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

J. Code all documented conditions that coexist

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

K. Patients receiving diagnostic services only

For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z01.89, Encounter for other specified special examinations. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the Z code and the code describing the reason for the non-routine test.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Please note: This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.

L. Patients receiving therapeutic services only

For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy or radiation therapy, the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

M. Patients receiving preoperative evaluations only

For patients receiving preoperative evaluations only, sequence first a code from subcategory Z01.81, Encounter for pre-procedural examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

N. Ambulatory surgery

For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

(b)

FIGURE 4.3 *(continued)*

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

These coding guidelines for outpatient diagnoses have been approved for use by hospitals/ providers in coding and reporting hospital-based outpatient services and provider-based office visits. Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-10-CM Tabular List (code numbers and titles), can be found in Section IA of these guidelines, under "Conventions Used in the Tabular List." Section I.B. contains general guidelines that apply to the entire classification. Section I.C. contains chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Information about the correct sequence to use in finding a code is also described in Section I. The terms encounter and visit are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other. Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:

The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis does not apply to hospital-based outpatient services and provider-based office visits.

Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

A. Selection of first-listed condition

In the outpatient setting, the term *first-listed diagnosis* is used in lieu of *principal diagnosis*. In determining the first-listed diagnosis the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines. Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.

1. Outpatient Surgery
   When a patient presents for outpatient surgery (same day surgery), code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.
2. Observation Stay
   When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis.
   When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses.

B. Codes from A00.0 through T88.9, Z00-Z99

The appropriate code(s) from A00.0 through T88.9, Z00-Z99 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

C. Accurate reporting of ICD-10-CM diagnosis codes

For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all of these.

D. Codes that describe symptoms and signs

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings Not Elsewhere Classified (codes R00-R99), contain many, but not all codes for symptoms.

E. Encounters for circumstances other than a disease or injury

ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (Z00-Z99) are provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

See Section I.C.21. Factors influencing health status and contact with health services.

F. Level of Detail in Coding

1. ICD-10-CM codes with 3, 4, 5, 6 or 7 characters.
   ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity.
2. Use of full number of characters required for a code
   A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

(a)

FIGURE 4.3 Section IV of the *Official Guidelines*

"*Official Guidelines*," these rules are developed by a group known as the four cooperating parties made up of CMS advisers and participants from the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), and the NCHS.

The *Official Guidelines* has sections for general rules, inpatient (hospital) coding, and outpatient (physician office/clinic) coding:

- Section I, *Conventions, general coding guidelines, and chapter-specific guidelines*, first reviews the Alphabetic Index and Tabular List conventions and broad coding rules and then discusses key topics affecting the use of codes in each of the twenty-one chapters.
- Section II, *Selection of Principal Diagnosis*, and Section III, *Reporting Additional Diagnoses*, explain the guidelines for establishing the diagnosis or diagnoses for inpatient cases.
- Section IV, *Diagnostic Coding and Reporting Guidelines for Outpatient Services*, explains the guidelines for establishing the diagnosis or diagnoses for all outpatient encounters. Figure 4.3 presents Section IV. The key points from this section can be summarized as follows:

  1. Code the **primary diagnosis** first, which is the first-listed diagnosis, followed by current coexisting conditions.
  2. Code to the highest level of certainty.
  3. Code to the highest level of specificity.

ICD-10-CM Official Guidelines
www.cdc.gov/nchs/icd/icd10cm.htm

primary diagnosis first-listed diagnosis

Code the Primary Diagnosis First, Followed by Current Coexisting Conditions

ICD-10-CM code for the primary diagnosis is listed first.

Example

Diagnostic Statement: Patient is an elderly female complaining of back pain. For the past five days, she has had signs of pyelonephritis, including urinary urgency, urinary incontinence, and back pain. Has had a little hematuria, but no past history of urinary difficulties.

Primary Diagnosis: N12 Tubulo-interstitial nephritis, not specified as acute or chronic ◂

After the first-listed diagnosis, additional codes may be used to describe all current documented coexisting conditions that must be actively managed because they affect patient treatment or that require treatment during the encounter. **Coexisting conditions** may be related to the primary diagnosis, or they may involve a separate illness that the physician diagnoses and treats during the encounter.

coexisting condition additional illness that either has an effect on the patient's primary illness or is also treated during the encounter

Example

Diagnostic Statement: Patient, a forty-five-year-old male, presents for complete physical examination for an insurance certification. During the examination, patient complains of occasional difficulty hearing; wax is removed from the left ear canal.

Primary Diagnosis: Z02.6 Encounter for examination for insurance purposes

Coexisting Condition: H61.22 Impacted cerumen, left ear ◂

It is important to note that patients may have diseases or conditions that do not affect the encounter being coded. Some physicians add notes about previous conditions to provide an easy reference to a patient's history. Unless these conditions are directly involved with the patient's current treatment, they are not considered in selecting codes. Also, conditions that were previously treated and no longer exist are not coded.

F01–F99 Mental, Behavioral, and Neurodevelopmental Disorders

Codes in Chapter 5 of ICD-10-CM classify the various types of mental disorders, including conditions of drug and alcohol dependency, Alzheimer's disease, schizophrenic disorders, and mood disturbances. Most psychiatrists use the terminology found in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* for diagnoses, but the coding follows ICD-10-CM.

G00–G99 Diseases of the Nervous System

Codes in Chapter 6 classify diseases of the central nervous system and the peripheral nervous system.

H00–H59 Diseases of the Eye and Adnexa

Codes in Chapter 7 classify diseases of the eye and adnexa.

H60–H95 Diseases of the Ear and Mastoid Process

Codes in Chapter 8 classify diseases of the ear and mastoid process.

I00–I99 Diseases of the Circulatory System

Because Chapter 9 addresses the circulatory system, which involves so many interrelated components, the disease process can create interrelated, complex conditions. The notes and *code also* instructions must be carefully observed to code circulatory diseases accurately.

J00–J99 Diseases of the Respiratory System

Codes in Chapter 10 of ICD-10-CM classify respiratory illnesses such as influenza, pneumonia, chronic obstructive pulmonary disease (COPD), and asthma. Pneumonia, a common respiratory infection, may be caused by one of a number of organisms. Many codes for pneumonia include the condition and the cause in a combination code, such as J15.21, pneumonia due to Staphylococcus aureus.

K00–K95 Diseases of the Digestive System

Codes in Chapter 11 of ICD-10-CM classify diseases of the digestive system. Codes are listed according to anatomical location, beginning with the oral cavity and continuing through the intestines, liver, and related organs.

L00–L99 Diseases of the Skin and Subcutaneous Tissue

Codes in ICD-10-CM's Chapter 12 classify skin infections, inflammations, and other diseases.

M00–M99 Diseases of the Musculoskeletal System and Connective Tissue

Codes in Chapter 13 of ICD-10-CM classify conditions of the bones and joints–arthropathies (joint disorders), dorsopathies (back disorders), rheumatism, pathological fractures, and other diseases. In this huge chapter, codes are provided for both site and laterality. The site represents the bone, joint, or muscle that is affected. Many codes cover conditions affecting multiple sites, such as osteoarthritis.

N00–N99 Diseases of the Genitourinary System

Codes in Chapter 14 of ICD-10-CM classify diseases of the male and female genitourinary (GU) systems, such as infections of the urinary tract, renal disease, conditions of the prostate, and problems with the cervix, vulva, and breast.

O00–O9A Pregnancy, Childbirth, and the Puerperium

Codes in Chapter 15 of ICD-10-CM classify conditions that are involved with pregnancy, childbirth, and the puerperium (the six-week period following delivery).

4.6 Overview of ICD-10-CM Chapters

A00–B99 Certain Infectious and Parasitic Diseases

Codes in Chapter 1 of ICD-10-CM's Tabular List classify communicable infectious and parasitic diseases. Most categories describe a condition and the type of organism that causes it.

C00–D49 Neoplasms

Neoplasms are coded from Chapter 2 of ICD-10-CM. Neoplasms (tumors) are growths that arise from normal tissue. Note that this category does not include a diagnosis statement with the word *mass*, which is a separate main term. The Alphabetic Index also contains a Neoplasm Table that points to codes for neoplasms. The table lists the anatomical location in the first column. The next six columns relate to the behavior of the neoplasm, as follows:

- One of these three types of malignant tumor, each of which is progressive, rapid-growing, life-threatening, and made of cancerous cells:

  Malignant Primary: The neoplasm that is the encounter's main diagnosis is found at the site of origin.

  Malignant Secondary: The neoplasm that is the encounter's main diagnosis metastasized (spread) to an additional body site from the original location.

  Carcinoma in situ: The neoplasm is restricted to one site (a noninvasive type); this may also be referred to as *preinvasive cancer.*
- Benign—slow-growing, not life-threatening, made of normal or near-normal cells
- Uncertain behavior—not classifiable when the cells were examined
- Unspecified behavior—no documentation of the nature of the neoplasm

As an example, the following entries are shown in the Neoplasm Table for a neoplasm of the colon:

	MALIGNANT				UNCERTAIN	
	Primary	Secondary	Cancer in situ	BENIGN	BEHAVIOR	UNSPECIFIED
Intestine, intestinal; large; colon; and rectum	C19	C785	D011	D127	D375	D490

M Codes

In the regular Alphabetic Index entries, the pointers for neoplasms also show morphology codes, known as M codes. M codes contain the letter M followed by four digits, a slash, and a final digit. Pathologists use M codes to report on and study the prevalence of various types of neoplasms. They are not used in physician practice (outpatient) coding. However, pathologists' reports help in selecting the correct code for a neoplasm.

D50–D89 Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism

Codes in this brief ICD-10-CM chapter classify diseases of the blood and blood-forming organs, such as anemias and coagulation defects, as well as some immune mechanism deficiencies.

E00–E89 Endocrine, Nutritional and Metabolic Diseases

Codes in Chapter 4 of ICD-10-CM classify a variety of conditions. The most common disease in this chapter is diabetes mellitus, which is a progressive disease of either type 1 or type 2, the predominant disease.

Category L03 **Cellulitis and acute lymphangitis** (three characters)

Subcategory L03.0 **Cellulitis and acute lymphangitis of finger and toe** (four characters)

Subcategory L03.01 **Cellulitis of finger** (five characters)

Code L03.011 **Cellulitis of right finger** (six characters)

Code L03.012 **Cellulitis of left finger** (six characters)

Code L03.019 **Cellulitis of unspecified finger** (six characters)

However, note that the last code, L03.019, is considered less specific than the other six-character codes because it indicates that the affected finger is not known. Appropriate documentation should provide this level of detail.

Other (or Other Specified) Versus Unspecified

In the Tabular List, the coder may need to choose between a code described as the core condition, *other* (or *other specified*) versus *unspecified*. For example:

L70.8 Other acne

L70.9 Acne, unspecified

If the documentation mentions a type or form of the condition that is not listed, the coder chooses "other" because a type is indicated but not found. If no type is mentioned, the documentation is not complete enough to assign a more specific code, and so the least-specific choice, "unspecified," is assigned. If there is no "other" versus "unspecified" coding option, select the "other specified," which in this situation represents both "other" and "unspecified."

THINKING IT THROUGH 4.5

Provide the diagnosis code(s) for the following cases, and explain the coding guideline that you applied to the case.

1. A thirty-six-year-old female patient presents to the physician's office for her yearly checkup. During the exam, the physician identifies a palpable, solitary lump in the upper outer quadrant of the left breast. The physician considers this significant and extends the exam to gather information for diagnosing this problem.

   _____

2. A forty-five-year-old male patient presents to the office complaining of headaches for the past twenty-four hours. Based on the examination, the physician orders a magnetic resonance imaging (MRI) to investigate a possible brain tumor.

   _____

3. An eighty-six-year-old female patient who has a chronic laryngeal ulcer presents for treatment of a painful episode.

   _____

4. A fifty-eight-year-old female patient has muscle weakness due to poliomyelitis in childhood.

   _____

5. A sixty-four-year-old male patient's diagnosis is degenerative osteoarthritis.

   _____

In general, the main term *sequela* is followed by subterms that list the causes. Two codes are usually required. First reported is the code for the specific effect (such as muscle soreness), followed by the code for the cause (such as the late effect of rickets). The code for the acute illness that led to the sequela is never used with a code for the late effect itself.

Code to the Highest Level of Certainty

Diagnoses are not always established at a first encounter. Follow-up visits over time may be required before the physician determines a primary diagnosis. During this process, although possible diagnoses may appear in the physician's documentation as diagnostic work is progressing, these inconclusive diagnoses are not used to determine the first-listed codes reported for reimbursement of service fees.

Signs and Symptoms

Instead of inconclusive diagnoses, the specific signs and symptoms are coded and reported. A *sign* is an objective indication that can be evaluated by the physician, such as weight loss. A *symptom* is a subjective statement by the patient that cannot be confirmed during an examination, such as pain.

The following case provides an example of how symptoms and signs are coded:

Example

Diagnostic Statement: Middle-aged male presents with abdominal pain and weight loss. He had to return home from vacation due to acute illness. He has not been eating well because of a vague upper-abdominal pain. He denies nausea, vomiting. He denies changes in bowel habit or blood in stool. Physical examination revealed no abdominal tenderness.

Primary Diagnosis: R10.13 Epigastric pain

Coexisting Condition: R63.4 Abnormal weight loss ◄

Suspected Conditions

Similarly, possible but not confirmed diagnoses, such as those preceded by "rule out," "suspected," "probable," or "likely," are not coded in the outpatient (physician practice) setting. Instead, the reported symptoms are coded.

Note that in the inpatient setting, however, the guidance is different. For hospital coding, the first-listed diagnosis is referred to as the **principal diagnosis** and is defined as the condition established after study to be chiefly responsible for the admission. "After study" means at the patient's discharge from the facility. If a definitive condition has not been established, then, at discharge, the inpatient coder codes the condition that matches the planned course of treatment most closely as if it were established.

principal diagnosis in inpatient coding, the condition established after study to be chiefly responsible for the admission of the patient to a hospital

Coding the Reason for Surgery

Surgery is coded according to the diagnosis that is listed as the reason for the procedure. In some cases, the postoperative diagnosis is available and is different from the physician's primary diagnosis before the surgery. If so, the postoperative diagnosis is coded because it is the highest level of certainty available. For example, if an excisional biopsy is performed to evaluate mammographic breast lesions or a lump of unknown nature, and the pathology results show a malignant neoplasm, the diagnosis code describing the site and nature of the neoplasm is used.

Code to the Highest Level of Specificity

The more characters a code has, the more specific it becomes; the additional characters add to the clinical picture of the patient. Using the most specific code possible is referred to as *coding to the highest level of specificity.* In the following example, the most specific code has six characters.

FIGURE 4.4 Diagnosis Code Assignment Flowchart

Step 2: Abstract the Medical Conditions from the Visit Documentation

The code will be assigned based on the physician's diagnosis or diagnoses. This information may be located on the encounter form or elsewhere in the patient's medical record, such as in a progress note. For example, a medical record reads:

> CC: Chest and epigastric pain; feels like a burning inside. Occasional reflux. Abdomen soft, flat without tenderness. No bowel masses or organomegaly.
>
> Dx: Peptic ulcer.

The diagnosis is peptic ulcer.

Step 3: Identify the Main Term for Each Condition

If needed, decide which is the main term or condition of the diagnosis. For example, in the diagnosis above, the main term or condition is *ulcer*. The word *peptic* describes what type of ulcer it is. Here are other examples:

> Dx: Complete paralysis.

BILLING TIP

Use Z Codes to Show Medical Necessity

Z codes such as family history or a patient's previous condition help demonstrate why a service was medically necessary.

GO TO CODING WORKBOOK PART 2

Your successful completion of this chapter is the basis for gaining additional coding experience. If assigned by your instructor, complete Part 2, pages 55–134, of the *Medical Coding Workbook for Physician Practices and Facilities*, by Cynthia Newby, CPC, CPC-P, to reinforce and expand your knowledge and skill in ICD-10-CM coding.

THINKING IT THROUGH 4.6

1. Are external cause codes ever primary codes? Why or why not?

4.7 Coding Steps

The correct procedure for assigning accurate diagnosis codes has six steps, as shown in Figure 4.4.

Step 1: Review Complete Medical Documentation

In outpatient settings, diagnosis coding begins with the patient's **chief complaint (CC).** The chief complaint is the medical reason that the patient presents for the particular visit. This is documented in the patient's medical record. The physician then examines the patient and evaluates the condition or complaint, documenting the diagnosis, condition, problem, or other reason that the documentation shows as being chiefly responsible for the services that are provided. This primary diagnosis provides the main term to be coded first. Documentation will also mention any coexisting complaints that should be coded.

chief complaint (CC) patient's description of the symptoms or other reasons for seeking medical care

Example

If a patient has cancer, the disease is probably the patient's major health problem. However, if that patient sees the physician for an ear infection that is not related to the cancer, the primary diagnosis for that particular claim is the ear infection.

A patient's examination might be documented as follows:

CC: Diarrhea X five days with strong odor and mucus, abdominal pain and tenderness, no meds.

Dx: Ulcerative colitis.

The notes mean that the patient has had symptoms for five days and has taken no medication. The chief complaint is noted after the abbreviation *CC*. The diagnosis, listed after the abbreviation *Dx*, is ulcerative colitis.

Assume that another patient's record indicates a history of heavy smoking and includes an X-ray report and notes such as these:

CC: Hoarseness, pain during swallowing, dyspnea during exertion.

Dx: Emphysema and laryngitis.

The physician listed emphysema, the major health problem, first; it is the primary diagnosis. Laryngitis is a coexisting condition that is being treated.

the accident, circumstance, or event that caused the injury. Codes are verified in Chapter 20 of the Tabular List.

External cause codes are often used in collecting public health information. They capture cause, intent, place, and activity. As many external cause codes as needed to describe these factors should be reported. Note, however, that these codes are not needed if the external cause and intent are already included in a code from another chapter.

Z00–Z99 Factors Influencing Health Status and Contact with Health Services

Z code abbreviation for codes from the 21st chapter of the ICD-10-CM that identify factors that influence health status and encounters that are not due to illness or injury

Chapter 21 contains **Z codes** that are used to report encounters for circumstances other than a disease or injury, such as factors influencing health status, and to describe the nature of a patient's contact with health services. There are two chief types:

- Reporting visits with healthy (or ill) patients who receive services other than treatments, such as annual checkups, immunizations, and normal childbirth. This use is coded by a Z code that identifies the service, such as:

  Z00.01 Encounter for general adult medical examination with abnormal findings

- Reporting encounters in which a problem not currently affecting the patient's health status needs to be noted, such as personal and family history. For example, a person with a family history of breast cancer is at higher risk for the disease, and a Z code is assigned as an additional code for screening codes to explain the need for a test or procedure, as is shown here:

  Z80.3 Family history of malignant neoplasm of breast

A Z code can be used as either a primary code for an encounter or as an additional code. It is researched in the same way as other codes, using the Alphabetic Index to point to the term's code and the Tabular List to verify it. The terms that indicate the need for Z codes, however, are not the same as other medical terms. They usually have to do with a reason for an encounter other than a disease or its complications. When found in diagnostic statements, the words listed in Table 4.2 often point to Z codes.

Table 4.2 Terminology Associated with Z Codes

Term	Example
Contact/exposure	Z20.1 Contact with and (suspected) exposure to tuberculosis
	Z30.01 Encounter for initial prescription of contraceptives
Counseling	Z31.5 Encounter for procreative genetic counseling
	Z00.110 Health examination for newborn under 8 days old
	Z46.51 Encounter for fitting and adjustment of gastric lap band
	Z08 Encounter for follow-up examination after completed treatment for malignant neoplasm
	Z92.23 Personal history of estrogen therapy
	Z11.51 Encounter for screening for human papillomavirus (HPV)
Status	Z67.10 Type A blood, Rh positive
Supervision (of)	Z34.01 Encounter for supervision of normal first pregnancy, first trimester
Vaccination/inoculation	Z23 Encounter for immunization

P00–P96 Certain Conditions Originating in the Perinatal Period

Codes in Chapter 16 of ICD-10-CM classify conditions of the fetus or the newborn infant, the neonate, up to twenty-eight days after birth. These codes are assigned only to conditions of the infant, not of the mother.

Q00–Q99 Congenital Malformations, Deformations and Chromosomal Abnormalities

Codes in ICD-10-CM Chapter 17 classify anomalies, malformations, and diseases that exist at birth. Unlike acquired disorders, congenital conditions are either hereditary or due to influencing factors during gestation.

R00–R99 Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified

Codes in this eighteenth chapter of ICD-10-CM classify patients' signs, symptoms, and ill-defined conditions for which a definitive diagnosis cannot be made. In physician practice (outpatient) coding, these codes are always used instead of coding "rule out," "probable," or "suspected" conditions.

S00–T88 Injury, Poisoning and Certain Other Consequences of External Causes

Codes in Chapter 19 of ICD-10-CM classify injuries and wounds (fractures, dislocations, sprains, strains, internal injuries, and traumatic injuries), burns, poisoning, and various consequences of external causes. Often, additional codes from Chapter 20 are used to identify the cause of the injury or poisoning.

The Table of Drugs and Chemicals in the Alphabetic Index lists for each drug the codes for accidental poisoning, intentional poisoning, poisoning from assault or undetermined cause, adverse effects, and underdosing. *Adverse effects,* which are unintentional, harmful reactions to a proper dosage of a drug properly taken, are different from *poisoning,* which refers to the medical result of the incorrect use of a substance, or *underdosing,* taking less of a medication than is prescribed by a provider or the manufacturer.

Most categories in Chapter 19 need the seventh-character extension to capture one of these three episodes of care:

A for an initial encounter

D for a subsequent encounter

S for sequela

For example, ICD-10-CM code S31.623A, Laceration with foreign body of abdominal wall, right lower quadrant with penetration into peritoneal cavity, initial encounter, shows a seventh character used with a laceration code.

COMPLIANCE GUIDELINE

U

The letter U is not used as a chapter in the current ICD-10-CM.

V00–Y99 External Causes of Morbidity

Codes in Chapter 20 of ICD-10-CM classify **external cause codes,** which report the cause of injuries from various environmental events, such as transportation accidents, falls, and fires. External cause codes are not used alone or as first-listed codes. They always supplement a code that identifies the injury or condition itself.

external cause code
ICD-10-CM code for an external cause of a disease or injury.

Many blocks of accident and injury codes in this chapter require additional external cause codes for

- The encounter (A = initial, D = subsequent, or S = sequela)
- The place of occurrence (category Y92)
- The activity (category Y93)
- The status (category Y99)

External cause codes are located by first using the third section of the Alphabetic Index, Index to External Causes. This index is organized by main terms describing

Learning Outcomes	Key Concepts/Examples
4.2 Describe the organization of ICD-10-CM.	• ICD-10-CM has two major parts that are used in medical practices, the Tabular List and the Alphabetic Index. • The Alphabetic Index has three additional sections: the Neoplasm Table, the Table of Drugs and Chemicals, and the Index to External Causes. • Conventions must be followed to select the correct code.
4.3 Summarize the structure, content, and key conventions of the Alphabetic Index.	• It contains in alphabetic order the main terms that describe all diseases classified in the Tabular List. • Main terms may be followed by related subterms or supported by supplementary terms. Several conventions apply to using the Alphabetic Index correctly, including: • Turnover lines are indented farther to the right than are subterms. • *See* cross-references direct a coder to another term; *see also* cross-references point to related index entries; *see also category* cross-references indicate that additional categories should be reviewed. • Notes provide information on code selection. • The abbreviation NEC is the code to be used when the diagnosis does not match any other available code, and the abbreviation NOS is the one to indicate the code to use when a condition is not completely described. • Multiple codes are required when two codes, the second in brackets, appear after a main term. • Brackets around a code mean that it cannot be the first-listed code.
4.4 Summarize the structure, content, and key conventions of the Tabular List.	• It contains the codes, which are organized into twenty-one chapters, according to etiology, body system, or purpose and are listed in numerical order. • Code categories consist of three-character alphanumeric listings that cover a single disease or related condition. • Subcategories listed in a four- or five-character alphanumeric format provide further breakdown of a disease's etiology, site, or manifestation. • Codes have either three, four, five, six, or seven alphanumeric characters. Several conventions are used in the Tabular List, including: • The first character in a code is always a letter. • Placeholder characters are designated as "x" in some codes. • The seventh-character extension requirement. • Inclusion and exclusion notes. • Colons indicate an incomplete term. • Parentheses indicate supplementary terms. • Brackets are used around synonyms, alternative wordings, or explanations. • The abbreviation NEC is the code to be used when the diagnosis does not match any other available code, and the abbreviation NOS indicates the code to use when a condition is not completely described. • Phrases for multiple code requirements include codes that are not used as primary appear in italics and are usually followed by an instruction to *use an additional code* or *code first underlying disease*. • The concept of laterality.
4.5 Apply the rules for outpatient coding that are provided in the ICD-10-CM *Official Guidelines for Coding and Reporting*.	The *Official Guidelines* has four sections containing general coding rules. Three key points are made in Section IV: • Code the primary diagnosis first followed by current coexisting conditions. • Code to the highest level of certainty. • Code to the highest level of specificity.

ICD-10-CM	ICD-9-CM
S72.001A Fracture of unspecified part of neck of right femur, initial encounter for closed fracture	820.8 Fracture of unspecified part of neck of femur, closed
S72.002A Fracture of unspecified part of neck of left femur, initial encounter for closed fracture	
S72.009A Fracture of unspecified part of neck of femur, initial encounter for closed fracture	

Similarities

It is useful to note that two major similarities exist: The two major sections of the ICD-9-CM and the ICD-10-CM code sets are the Alphabetic Index and the Tabular list, and the same steps covered earlier in this chapter apply to ICD-9-CM.

ICD-10-CM to ICD-9-CM Conversion Tool
www.aapc.com/icd-10/codes/

GENERAL EVIDENCE MAPPINGS (GEMs)

In some situations, coders will be called upon to research an ICD-9-CM code. Perhaps an old claim has resurfaced, or an audit forces a review of pre-2015 codes that were reported. Workers' compensation (WC) claims may also specify a non-ICD-10-CM code set because WC is not regulated by HIPAA law and therefore use of ICD-10-CM is not required.

The federal government has prepared **GEMs,** an acronym that stands for general equivalence mappings. Although imperfect, GEMs may be helpful in these situations. Both files of equivalent codes and a conversion tool may be located via an Internet search. Particularly useful is the translator tool located on the American Association of Professional Coders (AAPC) website.

GEMs acronym for general equivalence mappings, reference tables of related ICD-10-CM and ICD-9-CM codes

Note that confusion may result if the coder mixes up the ICD-9-CM codes that start with the capital letter E with those in ICD-10-CM that also start with E. A number of codes are the same in both systems but have different meanings. Being clear on which system is used will help the coder avoid these problems.

BILLING TIP

Ongoing Usage of ICD-9-CM

Not all types of insurance claims fall under HIPAA—including workers' compensation, liability insurance, and disability insurance claims—and therefore do not require ICD-10-CM. Medical coders may need to know ICD-9-CM well into the future.

THINKING IT THROUGH 4.8

1. Access the online database and research the ICD-10-CM codes for the following conditions:
   - **A.** Urinary tract infection
   - **B.** COPD
   - **C.** CVA with right hemiplegia
   - **D.** Electrocution, initial episode

Chapter 4 Summary

Learning Outcomes	Key Concepts/Examples
4.1 Discuss the purpose of ICD-10-CM.	• As of October 1, 2015, ICD-10-CM must be used for diagnostic coding in the United States. • Codes are made up of between three and seven alphanumeric characters. • Addenda to codes are released regularly and must be followed as of the date they go into effect.

THINKING IT THROUGH 4.7

1. Why is it important to use the Alphabetic Index and then the Tabular List to find the correct code? Work through this coding process, and then comment on your result.
   - **A.** Double-underline the main term and underline the subterm: Patient complains of abdominal cramps.
   - **B.** Find the term in the Alphabetic Index, and list its code.

     _____
   - **C.** Verify the code in the Tabular List, reading all instructions. List the code you have determined to be correct.

     _____
   - **D.** Did the result of your research in the Tabular List match the main term's code in the Alphabetic Index? Why?
2. Place a double underline below the main terms and a single underline below any subterms in each of the following statements, and then determine the correct codes.
   - **A.** cerebral atherosclerosis
   - **B.** spasmodic asthma with status asthmaticus
   - **C.** congenital night blindness
   - **D.** recurrent inguinal hernia with obstruction
   - **E.** bilateral non-palpable testicles
   - **F.** acute bacterial food poisoning
   - **G.** malnutrition following gastrointestinal surgery
   - **H.** skin test for hypersensitivity
   - **I.** frequency of urination disturbing sleep

Differences and Similarities Between ICD-9 and ICD-10-CM

Differences in chapter structure, chapter order, and code structure are important to note.

Differences

ICD-10-CM contains twenty-one chapters versus ICD-9-CM's seventeen chapters and two supplemental classifications, V codes and E codes. ICD-9-CM has a single chapter Diseases and Disorders of the Nervous System and Sense Organs whereas ICD-10-CM places these conditions in three separate chapters. ICD-10-CM groups injuries by anatomical site rather than injury category. Postoperative complications in ICD-10-CM are found in procedure-specific body system chapters. Disorders of the immune mechanism are included with diseases of the blood and blood-forming organs, whereas the immunity disorders are found in the ICD-9-CM chapter for endocrine, nutritional, and metabolic diseases.

The order of chapters differs. Furthermore, ICD-10-CM codes are alphanumeric and have five, six, or seven digits, making them more specific, whereas ICD-9-CM codes have three to five characters. Compare these codes for a closed fracture of an unspecified part of the neck of the femur:

The main term is *paralysis*, and the supplementary term is *complete*.

Dx: Heart palpitation.

The main term is *palpitation*, and the supplementary term is *heart*.

Dx: Panner's disease.

This condition can be found in either of two ways: by looking up the main term *disease*, followed by *Panner's*, or by looking up *Panner's disease*.

Step 4: Locate the Main Term in the Alphabetic Index

The main term for the patient's primary diagnosis is located in the Alphabetic Index. These guidelines should be observed in choosing the correct term:

- Use any supplementary terms in the diagnostic statement to help locate the main term.
- Read and follow any notes below the main term.
- Review the subterms to find the most specific match to the diagnosis.
- Read and follow any cross-references.
- Note a two-code (etiology and/or manifestation) indication.

Step 5: Verify the Code in the Tabular List

The code for the main term is then located in the Tabular List. These guidelines are observed to verify the selection of the correct code:

- Read *includes* or *excludes* notes, checking back to see whether any apply to the code's category, section, or chapter.
- Be alert for and follow instructions for additional digit requirements.
- Follow any instructions requiring the selection of additional codes (such as "code also" or "code first underlying disease").
- List multiple codes in the correct order.

Step 6: Check Compliance with Any Applicable *Official Guidelines* and List Codes in Appropriate Order

The final step is to review ICD-10-CM *Official Guidelines for Coding and Reporting* to check for applicable points. Coders should be sure not to include suspected conditions (for outpatient settings) and to report the primary diagnosis as the first-listed code followed by any coexisting conditions and external source codes.

4.8 ICD-10-CM and ICD-9-CM

ICD-10-CM, as the name implies, is the tenth version of the diagnostic code set. The previous version is called ICD-9-CM. The major advantages that ICD-10-CM provides are many more categories for disease and other health-related conditions and much greater flexibility for adding new codes in the future. It is a larger code set, having about 70,000 codes versus ICD-9-CM's approximately 14,000. It also offers a higher level of specificity and additional characters and extensions for expanded detail. There are also many more codes that combine etiology and manifestations, poisoning and external cause, or diagnosis and symptoms.

B. LO 4.7

Physician's notes, 2/24/2029, patient George Kadar, DOB 10/11/1954:

Subjective: This seventy-five-year-old patient complains of voiding difficulties, primarily urinary incontinence. No complaints of urinary retention.

Objective: Rectal examination: enlarged prostate. Patient catheterized for residual urine of 200 cc. Urinalysis is essentially negative.

Assessment: Prostatic hypertrophy, benign.

Plan: Refer to urologist for cystoscopy.

The following code was reported: N40.1.

C. LO 4.7

Patient: Gloria S. Diaz:

Subjective: This twenty-five-year-old female patient presents with pain in her left knee both when she moves it and when it is inactive. She denies previous trauma to this area but has had right-knee pain and arthritis in the past.

Objective: Examination revealed the left knee to be warm and slightly swollen compared to the right knee. Extension is 180 degrees; flexion is 90 degrees. Some tenderness in area.

Assessment: Left-knee pain probably due to chronic arthritis.

Plan: Daypro 600 mg 2-QD 3 1 week; recheck in one week.

The following codes were reported: M25.562, M19.90.

Applying Your Knowledge

Case 4.1 Coding Diagnoses

Supply the correct ICD-10-CM codes for the following diagnoses:

A. **LO 4.7** Brewer's infarct

B. **LO 4.7** Parinaud's conjunctivitis

C. **LO 4.7** seasonal allergic rhinitis due to pollen

D. **LO 4.7** cardiac arrhythmia

E. **LO 4.7** sundowning

F. **LO 4.7** sebaceous cyst

G. **LO 4.7** adenofibrosis of left breast

H. **LO 4.7** psychosocial religious problem

I. **LO 4.7** normal delivery, single live birth

J. **LO 4.7** stage 2 pressure ulcer of right ankle

K. **LO 4.7** acute myocarditis due to influenza

L. **LO 4.7** acute otitis media, bilateral

M. **LO 4.7** endocarditis due to Q fever

N. **LO 4.7** influenza vaccination

O. **LO 4.7** Heartland virus disease

P. **LO 4.7** antineoplastic chemotherapy induced anemia

Q. **LO 4.7** muscle spasms, right thigh

R. **LO 4.7** influenza with acute respiratory infection

S. **LO 4.7** pneumonia due to Streptococcus, Group B

T. **LO 4.7** systemic vasculitis

Case 4.2 Auditing Code Assignment

Audit the following cases to determine whether the correct codes have been reported in the correct order. If a coding mistake has been made, state the correct code and your reason for assigning it.

A. **LO 4.7**

Chart note for Henry Blum, date of birth 11/4/64:

Examined patient on 12/6/2029. He was complaining of a facial rash. Examination revealed generalized pustular psoriasis and extensive seborrheic dermatitis over his upper eyebrows, nasolabial fold, and extending to the subnasal region.

The following codes were reported: L40.1, L21.

Multiple-Choice Questions

Select the answer choice that best completes the statement or answers the question.

15. **LO 4.2** The _____ provides an index of the disease descriptions that are found in the second major part of ICD-10-CM.
A. Tabular List
B. Index to External Causes
C. Neoplasm Table
D. Alphabetic Index

16. **LO 4.1** The ICD-10-CM updates released by the National Center for Health Statistics are called _____.
A. sequelae
B. addenda
C. eponyms
D. conventions

17. **LO 4.8** The ICD-10-CM code set contains approximately _____ codes, making it much larger than ICD-9-CM.
A. 13,000
B. 57,000
C. 70,000
D. 3,250,000

18. **LO 4.6** _____ are used to report encounters for circumstances other than a disease or injury in ICD-10-CM.
A. V codes
B. Z codes
C. E codes
D. A codes

19. **LO 4.5** A(n) _____ is an objective indication that can be evaluated by a physician.
A. sign
B. sequela
C. symptom
D. eponym

20. **LO 4.4** ICD-10-CM uses _____ to indicate an incomplete term.
A. parentheses
B. brackets
C. colons
D. abbreviations

21. **LO 4.4** Which of the following is *not* a further breakdown of a disease that may be provided by a subcategory?
A. manifestation
B. etiology
C. site
D. sequela

22. **LO 4.2** Typographic techniques that provide visual guidance for understanding information and that help coders to understand rules and select the right code are known as _____ in ICD-10-CM.
A. inclusion notes
B. conventions
C. manifestations
D. sequelae

23. **LO 4.3** Tay-Sachs disease is an example of a(n) _____.
A. eponym
B. etiology
C. manifestation
D. convention

24. **LO 4.3** The abbreviation _____ is used with a term when there is no code that is specific for the condition.
A. CC
B. NOS
C. NEC
D. GEM

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Learning Outcomes	Key Concepts/Examples
4.6 Briefly describe the content of Chapters 1 through 21 of the Tabular List.	• ICD-10-CM contains twenty-one chapters that cover every body system and part, as well as diseases related to pregnancy and childbirth, symptoms and signs, injury and poisoning, external causes of morbidity, and other factors that influence health status. • Z codes are used to report encounters for circumstances other than a disease or injury. • Expanded sections exist to help coders classify neoplasms, drugs and chemicals, and external causes of injuries.
4.7 Assign correct ICD-10-CM diagnosis codes.	• Step 1. Review complete medical documentation. • Step 2. Abstract the medical conditions from the visit documentation. • Step 3. Identify the main term for each condition. • Step 4. Locate the main term in the Alphabetic Index. • Step 5. Verify the code in the Tabular List. • Step 6. Check compliance with any applicable *Official Guidelines* and list codes in appropriate order.
4.8 Differentiate between ICD-9-CM and ICD-10-CM.	• ICD-10-CM offers major advantages because many more categories for disease and other health-related conditions are available, and it allows for much more flexibility for adding new codes in the future. • The federal government has prepared GEMs to help coders' transition from ICD-9-CM to ICD-10-CM.

Review Questions

Matching Questions

Match the key terms with their definitions.

1. **LO 4.4** excludes 1
2. **LO 4.4** excludes 2
3. **LO 4.3** subterm
4. **LO 4.3** main term
5. **LO 4.7** chief complaint
6. **LO 4.3** eponym
7. **LO 4.3** etiology
8. **LO 4.5** chronic
9. **LO 4.5** acute
10. **LO 4.5** sequelae
11. **LO 4.1** ICD-10-CM
12. **LO 4.8** GEMs
13. **LO 4.6** Z code
14. **LO 4.2** convention

A. An illness or condition with a long duration.

B. Exclusion note used when two conditions could not exist together, such as an acquired and a congenital condition; means "not coded here."

C. Patient's description of the symptoms or other reasons for seeking medical care.

D. An illness or condition with severe symptoms and a short duration.

E. Exclusion note meaning that a particular condition is not included here, but a patient could have both conditions at the same time.

F. A cause or origin of a disease or condition.

G. Conditions that remain after an acute illness or injury has been treated and resolved.

H. Word that identifies a disease or condition in the Alphabetic Index.

I. Word or phrase that describes a main term in the Alphabetic Index.

J. A name or phrase formed from or based on a person's name.

K. An acronym for reference tables of related ICD-10-CM and ICD-9-CM codes.

L. A typographic technique that provides visual guidance for understanding information.

M. HIPAA-mandated diagnosis code set as of October 1, 2015.

N. Abbreviation for ICD-10-CM codes that identify factors that influence health status and encounters that are not due to illness or injury.

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Category II and Category III codes are prereleased on the AMA website and can be used on their implementation date even before they appear in the printed books.

THINKING IT THROUGH 5.1

1. Which organization owns and maintains the CPT code set?

5.2 Organization

CPT is made up of the main text—sections of codes—followed by appendixes and an index. The main text has the following six sections of Category I procedure codes:

- Evaluation and Management — Codes 99201–99499
- Anesthesia — Codes 00100–01999
- Surgery — Codes 10021–69990
- Radiology — Codes 70010–79999
- Pathology and Laboratory — Codes 80047–89398
- Medicine — Codes 90281–99607

Table 5.1 summarizes the types of codes, organization, and guidelines of these six sections of Category I codes. These codes are followed in CPT by the Category II and Category III code sections.

Table 5.1 CPT Category I Code Sections

Section	Definition of Codes	Structure	Key Guidelines
Evaluation and Management	Physicians' services that are performed to determine the best course for patient care	Organized by place and/or type of service	New/established patients; other definitions Unlisted services, special reports Selecting an evaluation and management (E/M) service level
Anesthesia	Anesthesia services by or supervised by a physician; includes general, regional, and local anesthesia	Organized by body site	Time based Services covered (bundled) in codes Unlisted services/special reports Qualifying circumstances codes
Surgery	Surgical procedures performed by physicians	Organized by body system and then body site, followed by procedural groups	Surgical package definition Follow-up care definition Add-on codes Separate procedures Subsection notes Unlisted services/special reports
Radiology	Radiology services by or supervised by a physician	Organized by type of procedure followed by body site	Unlisted services/special reports Supervision and interpretation (professional and technical components)
Pathology and Laboratory	Pathology and laboratory services by physicians or by physician-supervised technicians	Organized by type of procedure	Complete procedure Panels Unlisted services/special reports
Medicine	Evaluation, therapeutic, and diagnostic procedures by or supervised by a physician	Organized by type of service or procedure	Subsection notes Multiple procedures reported separately Add-on codes Separate procedures Unlisted services/special report

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00730	Anesthesia for procedures on upper posterior abdominal wall
32552	Removal of indwelling tunneled pleural catheter with cuff
70100	Radiologic examination, mandible; partial, less than 4 views
80400	ACTH stimulation panel; for adrenal insufficiency
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour

Although the codes are grouped into sections, such as Surgery, codes from all sections can be used by all types of physicians. For example, a family practitioner might use codes from the Surgery section to describe an office procedure such as the incision and drainage of an abscess.

Category II Codes

Category II codes are used to track performance measures for a medical goal such as reducing tobacco use. These codes are optional; they are not paid by insurance carriers. They help in the development of best practices for care and improve documentation. These codes have alphabetic characters for the fifth digit:

3271F	Low risk of recurrence, prostate cancer (PRCA)
4000F	Tobacco use cessation intervention, counseling

Category II codes optional CPT codes that track performance measures

Category III Codes

Category III codes are temporary codes for emerging technology, services, and procedures. These codes also have alphabetic characters for the fifth digit:

0468T	Removal of chest wall respiratory sensor electrode or electrode array

A temporary code may become a permanent part of the regular Category I codes if the service it identifies proves effective and is widely performed.

BILLING TIP

Category III Code Sunsets

Per CPT guidelines, Category III codes have a five-year life span. If a Category III code is not revised or replaced by a Category I code within five years, that code will "sunset," meaning it will be archived unless it is demonstrated that a temporary code is still needed.

Category III codes temporary codes for emerging technology, services, and procedures

Updates

CPT is a proprietary code set, meaning that it is not available for free to the public. Instead, the information must be purchased, either in print or electronic format, from the AMA, which publishes the revised CPT codes.

During the year, practicing physicians, medical specialty societies, and state medical associations send their suggestions for revision to the AMA. This input is reviewed by the AMA's Editorial Panel, which includes physicians as well as representatives from America's Health Insurance Plans (AHIP), CMS, the American Health Information Management Association (AHIMA), the American Hospital Association (AHA), and BlueCross BlueShield. The panel decides what changes will be made in the annual revision of the printed reference book.

BILLING TIP

Defining Provider in CPT

The term *provider* means either a physician or another type of qualified healthcare professional, such as a physician assistant.

BILLING TIP

Updating Vaccine Codes and Category III Codes

Both vaccine product codes and Category III codes are released twice a year and have a six-month period for implementation. Offices billing these services should check for updates at the CPT website.

The annual changes for Category I codes are announced by the AMA on October 1 and are in effect for procedures and services provided after January 1 of the following year. The code books can be purchased in different formats, which range from a basic listing to an enhanced edition. The AMA also reports the new codes on its website.

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Procedure codes, like diagnosis codes, are an important part of the revenue cycle. Physicians use standard procedure codes to report the medical, surgical, and diagnostic services they provide. Payers use these reported codes to determine payments. Accurate procedural coding ensures that providers receive the maximum appropriate reimbursement.

Procedure codes are also used to establish guidelines for the delivery of the best possible care for patients. Medical researchers track various treatment plans for patients with similar diagnoses and evaluate patients' outcomes. The results are shared with physicians and payers so that best practices can be implemented. For example, this type of analysis has shown that a patient who has had a heart attack can reduce the risk of another attack by taking a class of drugs called *beta blockers*.

In the practice, usually the physicians, medical coders, or medical insurance specialists assign procedure codes. Medical insurance specialists verify the procedure codes and use them to report physicians' services to payers. This chapter provides a fundamental understanding of how to assign procedure codes so that medical insurance specialists can work effectively with claims. Knowledge of procedural coding—and of how to stay up-to-date—is the baseline for compliant billing.

Mandated Code Set

CPT is the mandated code set for physician procedures and services under HIPAA Electronic Health Care Transactions and Code Sets.

5.1 Current Procedural Terminology (CPT), Fourth Edition

The procedure codes for physicians' and other healthcare providers' services are selected from the ***Current Procedural Terminology*** code set, called **CPT,** which is owned and maintained by the American Medical Association (AMA).

***Current Procedural Terminology* (CPT)** contains the standardized classification system for reporting medical procedures and services

History

The AMA first produced CPT in 1966. Its wide use began in 1983 when the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, or CMS) decided that the CPT codes would be the standard for physician procedures paid by Medicare, Medicaid, and other government medical insurance programs.

CPT lists the procedures and services that physicians across the country commonly perform. There is also a need for codes for items that are used in medical practices but are not listed in CPT, such as supplies and equipment. These codes are found in the Healthcare Common Procedure Coding System, referred to as Healthcare Common Procedure Coding System (HCPCS) and pronounced "hick-picks." Officially, CPT is the first part (called Level I) of HCPCS, and the supply codes are the second part (Level II). Most people, though, refer to the codes in the CPT book as *CPT codes* and the Level II codes as *HCPCS codes*.

Mandated Use of Current Codes

Codes must be current as of the date of service.

Types of CPT Codes

There are three categories of CPT codes:

- Category I codes
- Category II codes
- Category III codes

Category I Codes

Category I codes procedure codes found in the main body of CPT

CPT **Category I codes**—which are the most numerous—have five digits (with no decimals). Each code has a descriptor, which is a brief explanation of the procedure:

99204	Office or other outpatient visit for the evaluation and management of a new patient

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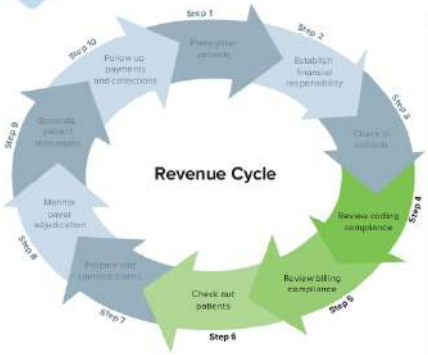
PROCEDURAL CODING: CPT AND HCPCS

5



Learning Outcomes

After studying this chapter, you should be able to:

- **5.1** Explain the CPT code set.
- **5.2** Describe the organization of CPT.
- **5.3** Summarize the use of format and symbols in CPT.
- **5.4** Assign modifiers to CPT codes.
- **5.5** Apply the six steps for selecting CPT procedure codes to patient scenarios.
- **5.6** Explain how the key components are used in selecting CPT Evaluation and Management codes.
- **5.7** Explain the physical status modifiers and add-on codes used in the Anesthesia section of CPT Category I codes.
- **5.8** Differentiate between surgical packages and separate procedures in the Surgery section of CPT Category I codes.
- **5.9** State the purpose of the Radiology section of CPT Category I codes.
- **5.10** Code for laboratory panels in the Pathology and Laboratory section of CPT Category I codes.
- **5.11** Code for immunizations using the Medicine section CPT Category I codes.
- **5.12** Contrast Category II and Category III codes.
- **5.13** Discuss the purpose of the HCPCS code set and its modifiers.

KEY TERMS

add-on code
bundled payment
bundling
Category I codes
Category II codes
Category III codes
consultation
Current Procedural Terminology (CPT)
durable medical equipment (DME)
E/M codes (evaluation and management codes)
fragmented billing
global period
global surgery rule
Healthcare Common Procedure Coding System (HCPCS)
key component
Level II
Level II modifiers
modifier
never event
outpatient
panel
physical status modifier
primary procedure
professional component (PC)
resequenced
section guidelines
separate procedure
special report
surgical package
technical component (TC)
unbundling
unlisted procedure

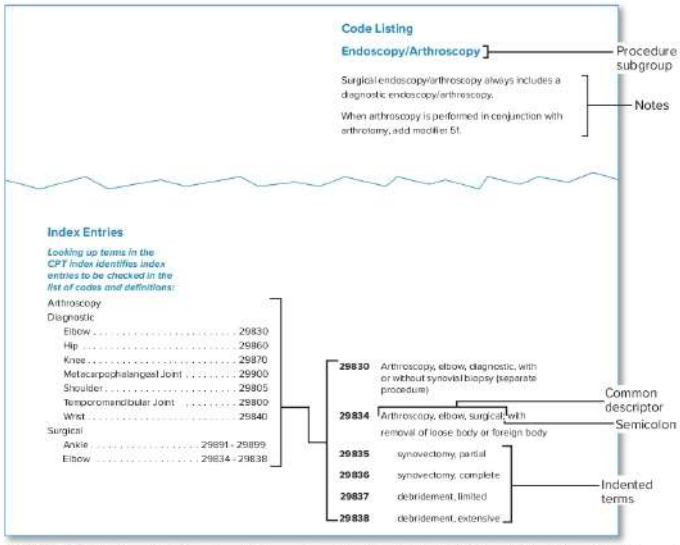


FIGURE 5.2 Codes from the Procedure Subgroup from the Musculoskeletal System Subsection of the Surgery Section

BILLING TIP

Correct Coding Procedure

Never select a code based on only the index entry because the main text may have additional entries and important guidelines that alter the selection.

Guidelines

Each section begins with **section guidelines** for the use of its codes. The guidelines cover definitions and items unique to the section. They also include special notes about the structure of the section or the rules for its use. The guidelines must be carefully studied and followed in order to correctly use the codes in the section. Some notes apply only to specific subsections. The guidelines list the subsections in which these notes occur, and the notes themselves begin those subsections (see Figure 5.2).

section guidelines usage notes at the beginning of CPT sections

Unlisted Procedures

Most sections' guidelines give codes for **unlisted procedures**—those not completely described by any code in the section. For example, in the Evaluation and Management section, this unlisted code is provided:

unlisted procedure service not listed in CPT

99499 Unlisted evaluation and management service

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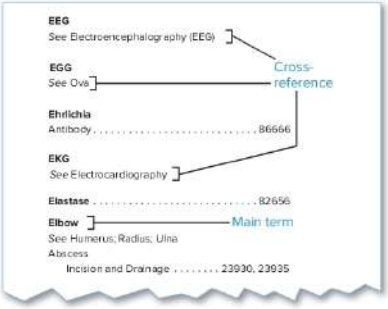

FIGURE 5.1 Example of Index Entries

Cross-References

The cross-reference *See* is a mandatory instruction. It tells the coder to refer to the term that follows it to find the code. It is used mainly for synonyms, eponyms, and abbreviations. For example, the cross-reference "*See* Electrocardiography" follows EKG (see Figure 5.1). Also, under *Elbow*, the cross-reference "*See* Humerus; Radius; Ulna" points to those main terms if the entry is not located under Elbow (see Figure 5.1).

Typographic Conventions

To save space, some connecting words are left out and must be assumed by the reader. For example:

Harvesting
  Cartilage Graft
    Ear 21235

should be read "harvesting a cartilage graft from the ear." The reader supplies the words *a* and *from the*.

The Main Text

After the index is used to point to a possible code, the main text is read to verify the selection of the code (see Figure 5.2).

Each of the six sections of the main text lists procedure codes and descriptors under subsection headings. These headings group procedures or services, such as Therapeutic or Diagnostic Injections or Psychoanalysis; body systems, such as Digestive System; anatomical sites, such as Abdomen; and tests and examinations, such as Complete Blood Count (CBC). Following these headings are additional subheadings that group procedures, systems, or sites. For example, Figure 5.2 illustrates the following structure, in which the body system appears as the subsection followed by a procedure subgroup:

Surgery Section <*The Section*>
  Musculoskeletal System <*The Subsection*>
    Endoscopy/Arthroscopy <*The Procedure Subgroup*>

The section, subsection, and code number range on a page are shown at the top of the page, making it easier to locate a code.

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THINKING IT THROUGH 5.2

Would you expect to locate codes for the following services or procedures in CPT? What range or series of codes would you investigate, Service or Procedure Range or Series?

1. Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
2. Echocardiography
3. Radiologic examination, nasal bones, complete
4. Home visit for evaluation and management of an established patient
5. Drug test for amphetamines
6. Anesthesia for cardiac catheterization

CPT Updates

www.ama-assn.org/practice-management/cpt-current-procedural-terminology

The Index

The assignment of a correct procedure code begins by reviewing the physician's statements in the patient's medical record to determine the service, procedure, or treatment that was performed. Then the index entry is located; it provides a pointer to the correct code range in the main text. Using the CPT index makes the process of selecting procedure codes more efficient. The index contains the descriptive terms that are listed in the sections of codes in the CPT.

Using the Current Codes

Practices must use new CPT codes on the date they are effective. There is no "grace period" or overlapping use of old and new codes. Keep codes on encounter forms and practice management programs up-to-date.

Main Terms and Modifying Terms

The main terms in the index are printed in boldface type. There are five types of main terms:

1. The name of the procedure or service, such as echocardiography, extraction, and cast
2. The name of the organ or other anatomical site, such as stomach, wrist, and salivary gland
3. The name of the condition, such as abscess, wound, and postpartum care
4. A synonym or an eponym for the term, such as Noble Procedure, Ramstedt operation, and Fowler-Stephens orchiopexy
5. The abbreviation for the term, such as CAT scan and ECMO

Many terms are listed more than one way. For example, the kidney biopsy procedure is listed both as a procedure–Biopsy, kidney–and by the site–Kidney, biopsy.

A main term may be followed by subterms that further describe the entry. These additional indented terms help in the selection process.

Code Ranges

A range of codes is shown when more than one code applies to an entry. Two codes, either sequential or not, are separated by a comma:

Cervix

Biopsy 57500, 57520

More than two sequential codes are separated by a hyphen:

Spine

CT Scan

Lumbar 72131-72133

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THINKING IT THROUGH 5.3

1. Find the following codes in the index of CPT. Underline the key term you used to find the code.
   - **A.** Intracapsular lens removal
   - **B.** Direct Coombs test
   - **C.** X-ray of duodenum
   - **D.** Unlisted procedure, maxillofacial prosthetics
   - **E.** DTaP immunization, individuals younger than 7 years
2. Identify the symbol used to indicate a new procedure code, and list five new codes that appear in CPT.
3. Identify the symbol used to indicate a procedure that is usually done in addition to a primary procedure. Locate code 33228, and describe the device that is involved with this add-on code.
4. Identify the symbol that indicates that the code's descriptor has been changed, and list five examples of codes with new or revised descriptors that appear in CPT.
5. Identify the symbols that enclose new or revised text other than the code's descriptor, and list five examples of codes with new or revised text that appear in CPT.
6. Identify the symbol next to a code that indicates a telemedicine code, and list one example from CPT's evaluation and management code section (codes 99201–99499).
7. Identify the symbol next to resequenced code, and list one example from CPT.

5.4 CPT Modifiers

A CPT **modifier** is a two-digit number that may be attached to most five-digit procedure codes (see Table 5.2). Modifiers are used to communicate special circumstances involved with procedures that have been performed. A modifier tells private and government payers that the physician considers the procedure to have been altered in some way. A modifier usually affects the normal level of reimbursement for the code to which it is attached.

modifier number appended to a code to report particular facts

For example, the modifier 76, Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional, is used when the reporting physician repeats a procedure or service after doing the first one. A situation requiring this modifier to show the extra procedure might be:

Procedural Statement: Physician performed a chest X-ray before placing a chest tube and then, after the chest tube was placed, performed a second chest X-ray to verify its position.

Code: **71046 26** Radiologic examination, chest; two views; repeat procedure or service by same physician or other qualified health care professional

The modifiers are listed in Appendix A of CPT. However, not all modifiers are available for use with every section's codes:

- Some modifiers apply only to certain sections. For example, the modifier 23, Unusual Anesthesia, is used only with codes that are located in the Anesthesia section, as its descriptor implies.

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Symbol for Add-on Codes

add-on code procedure performed and reported in addition to a primary procedure

primary procedure most resource-intensive CPT procedure during an encounter

A plus sign (+) next to a code in the main text indicates an **add-on code**. Add-on codes describe *secondary procedures* that are commonly carried out in addition to a **primary procedure**. Add-on codes usually use phrases such as *each additional* or *list separately in addition to the primary procedure* to show that they are never used as stand-alone codes. For example, the add-on code +15003 is used in addition to the code for surgical preparation for a skin graft site (15002) to provide a specific percentage or dimension of body area that was involved beyond the amount covered in the primary procedure.

Symbol for Telemedicine

In CPT, the symbol ★ next to a code indicates telemedicine codes. These services are rendered via a real-time interactive audio and/or video telecommunications system. In order to report these codes, the provider must exchange sufficient information with the patient to meet the key components and/or requirements of the service as if it had been rendered face-to-face.

BILLING TIP

Vaccine Coding Prerelease

Stay up-to-date on approval status for vaccine codes with the lightning bolt symbol. These codes are prereleased every six months on the AMA website and can be used as soon as they appear.

Symbol for Food and Drug Administration (FDA) Approval Pending

Also used is the symbol ⚡ (a lightning bolt). This symbol is used with vaccine codes that have been submitted to the Food and Drug Administration (FDA) and are expected to be approved for use soon. The codes cannot be used until approved, at which point this symbol is removed.

Symbol for Resequenced Codes

As new procedures are developed and widely adopted, CPT has encountered situations in which not enough numbers are left in a particular numerical sequence of codes to handle all new items that need to be included. Also, at times codes need to be regrouped into related procedures for clarity.

Beginning with CPT 2010, the AMA decided to change the way this situation had been accommodated. Previously, if more procedures were to be added than numbers were available, the entire list would be renumbered using *new* numbers and moved to the place in CPT where the list would be in numerical order. This approach often caused large groups of code numbers to have to be renumbered–creating confusion and requiring lots of updating of medical practice forms and databases.

The AMA decided to use the idea of *resequencing* rather than renumbering and moving codes. Resequencing is the practice of displaying the codes outside of numerical order in favor of grouping them according to the relationships among the code descriptors. This permits out-of-sequence code numbers to be inserted under the previous key procedural terms without having to renumber and move the entire list of related codes.

resequenced CPT procedure codes that have been reassigned to another sequence

The codes that are **resequenced** are listed twice in CPT. First, they are listed in their original numeric position with the note that the code is now out of numerical sequence and referring the user to the code range containing the resequenced code and description.

46220 Code is out of numerical sequence. See 46200–46288.

Second, the code and its descriptor appear in the group of codes to which it is related, as shown here:

46220 Excision of single external papilla or tag, anus

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entries, the procedure *partial laryngectomy (hemilaryngectomy)* is the common descriptor. This same descriptor applies to the four unique descriptors after the semicolon–*horizontal, laterovertical, anterovertical,* and *antero-latero-vertical.* Note that the common descriptor begins with a capital letter, but the unique descriptors after the semicolon do not. Also note that after the first listing, the second, third, and fourth descriptors are indented. Indenting visually reinforces the relationship between the entries and the common descriptor.

31370	Partial laryngectomy (hemilaryngectomy); horizontal
31375	laterovertical
31380	anterovertical
31382	antero-latero-vertical

This method shows the relationships among the entries without repeating the common word or words. Follow this case example in Figure 5.2:

Index Entry:	Arthroscopy, Surgical, Elbow 29834–29838
Main Text:	**29838** Arthroscopy, elbow, surgical; debridement, extensive

Cross-References

Some codes and descriptors are followed by indented *see* or *use* entries in parentheses, which refer the coder to other codes. For example:

82239	Bile acids; total
82240	cholylglycine

(For bile pigments, urine, see 81000–81005.)

Examples

Descriptors often contain clarifying examples in parentheses (sometimes with the abbreviation *e.g.*, meaning for example). These provide further descriptions, such as synonyms or examples, but they are not essential to the selection of the code. Here are examples:

87040	Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)
50400	Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; simple
86592	Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART) ◂

AMA Vaccine Code Updates

www.ama-assn.org/practice-management/category-i-vaccine-codes

Symbols for Changed Codes

These three symbols have the following meanings when they appear next to CPT codes:

- ● A bullet (a solid circle) indicates a new procedure code. The symbol appears next to the code only in the year that it is added.
- ▲ A triangle indicates that the code's descriptor has changed. It, too, appears only in the year the descriptor is revised.
- ▸◂ Facing triangles (two triangles that face each other) enclose new or revised text other than the code's descriptor.

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Unlisted procedure codes are used for new services or procedures that have not yet been assigned either Category I or III codes in CPT. When an unlisted code is reported to a payer, documentation of the procedure should accompany the claim. Often the operative report or a letter from the physician describing the procedure meets this need.

Special Reports

special report note explaining the reasons for a new, variable, or unlisted procedure or service

Some section guidelines suggest the use of **special reports** for rare or new procedures, especially unlisted procedure codes. These reports, which are mandatory, permit payers to assess the medical appropriateness of the procedures. The guidelines cover the information that should be in the report, such as a description of the nature, extent, and need for the procedure plus additional notes on the symptoms or findings.

BILLING TIP

Unlisted Procedure Codes

Unlisted procedures require special reports that delay claims because they must be processed manually. Check with the payer to find out whether a Category III code has been assigned. If so, that code should be used. If not, use the unlisted code, and supply the payer-required documentation.

The Appendixes

The sixteen appendixes in the American Medical Association publication of CPT contain information helpful to the coding process:

1. *Appendix A–Modifiers:* A complete listing of all modifiers used in CPT with descriptions and, in some cases, examples of usage
2. *Appendix B–Summary of Additions, Deletions, and Revisions:* A summary of the codes added, revised, and deleted in the current version
3. *Appendix C–Clinical Examples:* Case examples of the proper use of the codes in the Evaluation and Management section
4. *Appendix D–Summary of CPT Add-on Codes:* List of supplemental codes used for procedures that are commonly done in addition to the primary procedure
5. *Appendix E–Summary of CPT Codes Exempt from Modifier 51:* Codes to which the modifier showing multiple procedures cannot be attached because they already include a multiple descriptor
6. *Appendix F–Summary of CPT Codes Exempt from Modifier 63*
7. *Appendix G–Summary of CPT Codes That Include Moderate (Conscious) Sedation*
8. *Appendix H–Alphabetical Clinical Topics Listing*
9. *Appendix I–Genetic Testing Code Modifiers*
10. *Appendix J–Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves*
11. *Appendix K–Product Pending FDA Approval*
12. *Appendix L–Vascular Families*
13. *Appendix M–Renumbered CPT Codes–Citations Crosswalk*
14. *Appendix N–Summary of Resequenced CPT Codes*
15. *Appendix O–Multianalyte Assays with Algorithmic Analyses*
16. *Appendix P–CPT Codes That May Be Used for Synchronous Telemedicine Services*

5.3 Format and Symbols

Format

Semicolons and Indentions

To save space in the book, CPT uses a semicolon and indentions when a common part of a main entry applies to entries that follow. For example, in the following

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Step 1. Review Complete Medical Documentation

The first step is to review the documentation of the patient's visit and decide which procedures and/or services were performed and where the service took place (the *place of service*, which may be an office, a facility, or another healthcare setting).

Step 2. Abstract the Medical Procedures from the Visit Documentation

Then, based on knowledge of CPT and of the payer's policies, a decision is made about which services can be charged and are to be reported.

Step 3. Identify the Main Term for Each Procedure

The next step is to identify the main term for each procedure. Main terms may be based on the:

- Procedure or service (such as repair, biopsy, evaluation and management, or extraction)
- Organ or body part (such as chest wall, prostate, or bladder)
- Condition or disease being treated (such as facial nerve paralysis)
- Common abbreviation (such as ECG or CT)
- Eponym (such as Cotte operation)
- Symptom (for example, fracture)

Step 4. Locate the Main Terms in the CPT Index

Next, locate the procedures in the index at the back of CPT. For each term a listing of a code or a code range identifies the appropriate heading and procedure code(s) in CPT. Some entries have a *See* cross-reference or a *See also* to point to another index entry.

Example

Code Range Index Entry
Graft
Ear
Skin Substitute Graft. 15275–15278

When a code range is listed, read the code descriptors for all codes within the range indicated in the index in order to select the most specific code.

If the main term cannot be located in the index, the medical insurance specialist reviews the main term selection with the physician for clarification. In some cases, a better or more common term can be used. ◄

Step 5. Verify the Code in the CPT Main Text

The next step is to review the possible codes in the CPT section that the index entries point to. Check section guidelines and any notes directly under the code, within the code descriptor, or after the code descriptor. Items that cannot be billed separately because they are covered under another, broader code are eliminated.

The codes to be reported for each day's services are ranked in order of highest to lowest rate of reimbursement. The actual order in which they were performed on a

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(concluded)

CASE C
Patient was scheduled for a total diagnostic colonoscopy, but the patient went into respiratory distress during procedure; surgeon stopped the procedure.

CASE D
Puncture aspiration of a cyst in the left breast and a cyst in the right breast.

CASE E
A neurological surgeon and an orthopedic surgeon worked as cosurgeons.

HIPAA/HITECH TIP

CPT Assistant

The American Medical Association's monthly publication *CPT Assistant* is the authoritative guide to the correct use of CPT codes.

5.5 Coding Steps

The correct process for assigning accurate procedure codes has six steps, as shown in Figure 5.3.

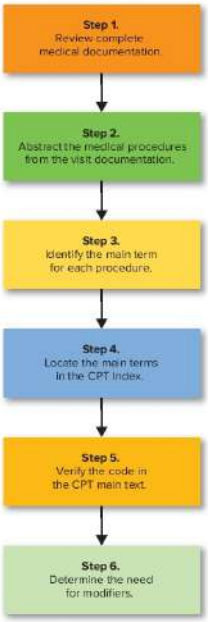

FIGURE 5.3 Procedure Code Assignment Flow Chart

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- Add-on codes cannot be modified with 51, Multiple Procedures, because the add-on code is used to add increments to a primary procedure, so the need for multiple procedures is replaced by procedures added on.
- Codes that begin with ⊘ (a circle with a backslash) also cannot be modified with 51, Multiple Procedures.

What Do Modifiers Mean?

The use of a modifier means that a procedure was different from the description in CPT but not in a way that changed the definition or required a different code. Modifiers are used mainly when:

- A procedure has two parts—a **technical component (TC)** performed by a technician, such as a radiologist, and a **professional component (PC)** that the physician performs, usually the interpretation and reporting of the results
- A service or procedure has been performed more than once, by more than one physician, and/or in more than one location
- A service or procedure has been increased or reduced
- Only part of a procedure has been done
- A bilateral or multiple procedure has been performed
- Unusual difficulties occurred during the procedure

Assigning Modifiers

Modifiers are shown by adding a space and the two-digit code to the CPT code. For example, a physician providing radiologic examination services in a hospital would report the modifier 26, Professional Component, as follows:

73090 26

This format means professional component only for an X-ray of the forearm. (In effect, it means that the physician who performed the service did not own the equipment used, so the fee is split between the physician and the equipment owner.)

Two or more modifiers may be used with one code to give the most accurate description possible. The use of two or more modifiers is shown by reporting 99, Multiple Modifiers, followed by the other modifiers, with the most essential modifier listed first.

Procedures: Multitrauma patient's extremely difficult surgery after a car accident; team surgery by orthopedic surgeon and neurosurgeon. The first surgical procedure carries these modifiers:

27236 99, 66, 51, 22

BILLING TIP

Professional Component Modifier 26

The professional component modifier tells the payer that the physician did not perform all the work, just the professional part, so only part of the fee is due. The other part of the fee, associated with the modifier TC, is paid to the technician.

technical component (TC) reflects the technician's work and the equipment and supplies used in performing it

professional component (PC) represents a physician's skill, time, and expertise used in performing it

BILLING TIP

Modifier 22

Many payers consider modifier 22 overused (abused). When it is used, the need for the increased service or procedure should be well documented.

THINKING IT THROUGH 5.4

1. In CPT, what is the meaning of the symbol in front of code 93503?
2. Based on Appendix A of CPT, what modifiers would you assign in each of the following cases? Why?

CASE A

Patient has recurrent cancer; surgeon performed a colectomy, which took forty-five minutes longer than the normal procedure due to dense adhesions from the patient's previous surgery.

CASE B

Surgeon operating on an ingrown toenail administers a regional nerve block.

(continued)

GO TO CODING WORKBOOK
Modifiers

Table 5.2 CPT Modifiers: Description and Common Use in Main Text Sections

Code	Description	E/M	Anesthesia	Surgery	Radiology	Pathology	Medicine
22	Increased Procedural Services	Never	Yes	Yes	Yes	Yes	Yes
23	Unusual Anesthesia	Never	Yes	—	—	—	Never
24	Unrelated E/M Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period	Yes	Never	Never	Never	Never	Never
25	Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of the Procedure or Other Service	Yes	Never	Never	Never	Never	Never
26	Professional Component	—	—	Yes	Yes	Yes	Yes
32	Mandated Services	Yes	Yes	Yes	Yes	Yes	Yes
33	Preventive Services	Yes	Never	Yes	Yes	Yes	Yes
47	Anesthesia by Surgeon	Never	Never	Yes	Never	Never	Never
50	Bilateral Procedure	—	—	Yes	—	—	—
51	Multiple Procedures	—	Yes	Yes	Yes	Never	Yes
52	Reduced Services	Yes	—	Yes	Yes	Yes	Yes
53	Discontinued Procedure	Never	Yes	Yes	Yes	Yes	Yes
54	Surgical Care Only	—	—	Yes	—	—	—
55	Postoperative Management Only	—	—	Yes	—	—	Yes
56	Preoperative Management Only	—	—	Yes	—	—	Yes
57	Decision for Surgery	Yes	—	—	—	—	Yes
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	—	—	Yes	Yes	—	Yes
59	Distinct Procedural Service	—	Yes	Yes	Yes	Yes	Yes
62	Two Surgeons	Never	Never	Yes	Yes	Never	—
63	Procedure Performed on Infants Less Than 4 kgs	—	—	Yes	Yes	—	Yes
66	Surgical Team	Never	Never	Yes	Yes	Never	—
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	—	—	Yes	Yes	—	Yes
77	Repeat Procedure or Service by Another Physician or Other Qualified Health Care Professional	—	—	Yes	Yes	—	Yes
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	—	—	Yes	Yes	—	Yes
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	—	—	Yes	Yes	—	Yes
80	Assistant Surgeon	Never	—	Yes	Yes	—	—
81	Minimum Assistant Surgeon	Never	—	Yes	—	—	—
82	Assistant Surgeon (When Qualified Resident Surgeon Not Available)	Never	—	Yes	—	—	—
90	Reference (Outside) Laboratory	—	—	Yes	Yes	Yes	Yes
91	Repeat Clinical Diagnostic Laboratory Test	—	—	Yes	Yes	Yes	Yes
92	Alternative Laboratory Platform Testing	—	—	Yes	Yes	Yes	Yes
95	Synchronous Telemedicine Service Rendered via a Real-Time Interactive Audio and Video Telecommunications System						
96	Habilitative Services						
97	Rehabilitative Services						
99	Multiple Modifiers	—	—	Yes	Yes	—	Yes

Source: CPT 2018.
Note: Physician in this table denotes either a physician or a qualified healthcare professional.
Key: Yes = commonly used
— = not usually used with the codes in that section
Never = not used with the codes in that section

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Preventive Medicine Service
Non-Face-to-Face Services
Special E/M Services
Newborn Care Services
Delivery/Birthing Room Attendance and Resuscitation Services
Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services
Cognitive Assessment and Care Plan Services
Care Management Services
Psychiatric Collaborative Care Management Services
Transitional Care Management Services
Advanced Care Planning
General Behavioral Health Integration Care Management
Other E/M Services

A New or Established Patient?

Many subsections of E/M codes assign different code ranges for new patients and established patients. A new patient (NP) has not received any professional services from the provider (or from another provider of the exact same specialty/subspecialty in the same group practice) within the past three years. An established patient (EP) has received professional services under those conditions (see Figure 3.1 for a decision tree for determining patient status as NP or EP). The distinction is important because new patients typically require more effort by the provider and practice staff, who should therefore be paid more.

The term *any professional services* in the definitions of new and established patients means that the established category is used for a patient who had a face-to-face encounter with a physician. The same rule applies to a patient of a physician who moves to another group practice. If the patient then sees the physician (or another of the same specialty) in the new practice, the patient is established. In other words, the patient is new to the practice but established to the provider.

BILLING TIP

New and Established Patients

Be familiar with payers' guidelines on new and established patients because some payers have special rules for deciding on the patient's status when the specialty group has subspecialties (for example, a hand surgeon in a surgery practice).

A Consultation or a Referral?

To understand the subsection of E/M codes on consultations, review the difference between a consultation and a referral in coding terminology. A **consultation** occurs when a second physician, at the request of the patient's physician, examines the patient. The second physician usually focuses on a particular issue and reports a written opinion to the first physician. The physician providing a consultation ("consult") may perform a service for the patient but does not independently start a full course of treatment (although the consulting physician may recommend one) or take charge of the patient's care. Consultations require use of the E/M consultation codes (the range from 99241 to 99255). Consultation requests and reports must be written documents that are placed in the medical records. Under most managed care guidelines, the reports should be reviewed and initialed by the primary care physician with documentation of follow-up plans.

consultation service in which a physician advises a requesting physician about a patient's condition and care

BILLING TIP

Consults: Three Rs

Coders remember the three Rs of consults: request opinion, render service, report back.

On the other hand, when the patient is referred to another physician, either the total care or a specific portion of care is transferred to that provider. The patient becomes a new patient of that doctor for the referred condition and may not return to the care of

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Table 5.3 E/M Categories and Subcategories *(concluded)*

Category	Subcategory	Code Range
Home services	New patient	99341–99345
	Established patient	99347–99350
Prolonged services	Direct patient contact	99354–99357
	Without direct patient contact	99358–99359
	With physician supervision	99415–99416
	Standby services	99360
Case management services	Anticoagulant management	99363–99364
	Medical team conferences	99366–99368
Care plan oversight		99374–99380
Preventive medicine	New patient	99381–99387
	Established patient	99391–99397
	Individual counseling	99401–99409
	Group counseling	99411–99412
	Other	99429
Non-face-to-face services	Telephone services	99441–99443
	Online medical evaluation	99444
	Interprofessional consultations	99446–99449
Special E/M services		99450–99456
Newborn care		99460–99463
Delivery/birthing room attendance		99464–99465
Neonatal and pediatric critical care services	Pediatric patient transport	99466–99467 99485–99486
	Inpatient neonatal critical care services	99468–99469
	Inpatient pediatric critical care services	99471–99476
	Initial and continuing intensive care services	99477–99480
Cognitive assessment and care plan		99483
Care management services		99487–99490
Psychiatric collaborative care management		99492–99494
Transitional care management services		99496–99495
Advance care planning		99497–99498
General behavioral health integration care management		99484
Other E/M services		99499

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Structure

Most codes in the E/M section are organized by the place of service, such as the office, the hospital, or a patient's home. A few (for example, prolonged) are grouped by type of service. The subsections, detailed in Table 5.3, are as follows:

Office or Other Outpatient Services
Hospital Observation Services
Hospital Inpatient Services
Consultations
Emergency Department Services
Critical Care Services
Nursing Facility Services
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services
Domiciliary, Rest Home (e.g., Assisted Living Facility), or Home Care Plan Oversight Home Services
Prolonged Services
Case Management Services
Care Plan Oversight Services

Table 5.3 E/M Categories and Subcategories

Category	Subcategory	Code Range
Office/other outpatient services	New patient	99201–99205
	Established patient	99211–99215
Hospital observation services	Discharge services	99217
	Initial services	99218–99220
	Subsequent Observation Care	99224–99226
Hospital inpatient services	Initial hospital care	99221–99226
	Subsequent hospital care	99231–99233
	Observation or inpatient care	99234–99236
	Discharge services	99238–99239
Office or outpatient consultations	Initial consultations	99241–99245
Hospital consultations	Initial consultations	99251–99255
Emergency department services		99281–99288
Critical care services	Timed services	99291–99292
Nursing facility services	Initial care	99304–99306
	Subsequent care	99307–99310
	Discharge services	99315–99316
	Other	99318
Domiciliary, rest home, custodial	New patient	99324–99328
	Established patient	99334–99337
Domiciliary, rest home, home care	Oversight services	99339–99340

(continued)

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particular day is not important. When reporting, the earliest date of service is listed first followed by subsequent dates of service. For example:

Date	*Procedure*	*Charge*
11/17/2029	99204	$202
11/20/2029	43215	$355
11/20/2029	74235	$75

Step 6. Determine the Need for Modifiers

The circumstances involved with the procedure or service may require the use of modifiers. The patient's diagnosis may affect this determination.

THINKING IT THROUGH 5.5

List all possible index entries for locating the service, and then assign the code. The first item is completed as an example.

Index Entry Code

1. Excision of mucous cyst of a finger: Excision, Cyst, Finger _____ 26160
2. Endoscopic biopsy of the nose: _____
3. Arthroscopic medial meniscectomy of the knee joint: _____
4. Drainage of a sublingual salivary gland abscess: _____
5. Cystoscopy with fragmentation of ureteral calculus: _____

5.6 Evaluation and Management Codes

E/M codes (evaluation and management codes) codes that cover physicians' services performed to determine the optimum course for patient care

The codes in the Evaluation and Management section (**E/M codes,** or **evaluation and management codes**) cover physicians' services that are performed to determine the best course for patient care. The E/M codes are listed first in CPT because they are used so often by all types of physicians. Often called the *cognitive codes,* the E/M codes cover the complex process a physician uses to gather and analyze information about a patient's illness and to make decisions about the patient's condition and the best treatment or course of management. The actual treatments—such as surgical procedures and vaccines—are covered in the CPT sections that follow the E/M codes, such as the Surgery and Medicine sections.

Although CPT was first published in 1966, the Evaluation and Management section was not introduced until 1992. The E/M coding method came from a joint effort by CMS and the AMA to define ranges of services from simple to very complicated. Patients' conditions require different levels of information gathering, analysis, and decision making by physicians. For example, on the low end of a range might be a patient with a mild case of poison ivy. On the opposite end is a patient with a life-threatening condition. The E/M codes reflect these different levels. There are five codes to choose from for an office visit with a new patient, for example, and another five for office visits with established patients. A financial value (fee or prospective payment) is assigned by a payer to each code in a range. To justify the use of a higher-level code in the range—one that is tied to a higher value—the physician must perform and document specific clinical facts about the patient encounter.

BILLING TIP

Assigning E/M Levels

In many practices, because of their complexity, physicians assign the E/M code levels, and then medical coders or insurance specialists check them against documentation.

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The examination that the physician documents is categorized as one of four types on a scale from lesser to greater extent:

1. *Problem-focused:* A limited examination of the affected body area or system
2. *Expanded problem-focused:* A limited examination of the affected body area or system and other related areas
3. *Detailed:* An extended examination of the affected body area or system and other related areas
4. *Comprehensive:* A general multisystem examination or a complete examination of a single organ system

Step 4. Determine the Complexity of Medical Decision Making That Is Documented

The complexity of the medical decisions that the physician makes involves how many possible diagnoses or treatment options were considered; how much information (such as test results or previous records) was considered in analyzing the patient's problem; and how serious the illness is, meaning how much risk there is for significant complications, advanced illness, or death.

The decision-making process that the physician documents is categorized as one of four types on a scale from lesser to greater complexity:

1. *Straightforward:* Minimal diagnoses options, a minimal amount of data, and minimum risk
2. *Low complexity:* Limited diagnoses options, a small amount of data, and low risk
3. *Moderate complexity:* Multiple diagnoses options, a moderate amount of data, and moderate risk
4. *High complexity:* Extensive diagnoses options, an extensive amount of data, and high risk

Step 5. Analyze the Requirements to Report the Service Level

The descriptor for each E/M code explains the standards for its selection. For office visits and most other services to new patients and for initial care visits, all three of the **key components** must be documented. If two are at a higher level and a third is below that level, the standard is not met. This is stated in CPT as follows:

key component factor documented for various levels of evaluation and management services

99203 Office or other outpatient visit for the evaluation and management of a new patient, which require these three key components:

- **A detailed history**
- **A detailed examination**
- **Medical decision making of low complexity**

BILLING TIP

Three Key Components

This means that to select code 99203, the medical record must show that a detailed history and examination were taken and that medical decision making was at least at the level of low complexity.

For most services for established patients and for subsequent care visits, two of three of the key components must be met. For example:

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- **An expanded problem-focused history**
- **An expanded problem-focused examination**
- **Medical decision making of low complexity**

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System Review (Review of Systems [ROS]) The review of systems is an inventory of body systems. These systems are:

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular (CV)
- Respiratory
- Gastrointestinal (GI)
- Genitourinary (GU)
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/lymphatic
- Allergic/immunologic

BILLING TIP

Military History

The patient's military history should be documented as appropriate.

Past History The past history of the patient's experiences with illnesses, injuries, and treatments contains data about other major illnesses and injuries, operations, and hospitalizations. It also covers current medications the patient is taking, allergies, immunization status, and diet.

Family History (FH) The family history reviews the medical events in the patient's family. It includes the health status or cause of death of parents, brothers and sisters, and children; specific diseases that are related to the patient's chief complaint or the patient's diagnosis; and the presence of any known hereditary diseases.

Social History (SH) The facts gathered in the social history, which depend on the patient's age, include marital status, employment, and other factors.

The histories documented after the HPI are sometimes referred to as PFSH for past, family, and social history. This history is then categorized as one of four types on a scale from lesser to greater extent of amount of history obtained:

1. *Problem-focused:* Determining the patient's chief complaint and obtaining a brief history of the present illness
2. *Expanded problem-focused:* Determining the patient's chief complaint and obtaining a brief history of the present illness plus a problem-pertinent system review of the particular body system that is involved
3. *Detailed:* Determining the chief complaint; obtaining an extended history of the present illness; reviewing both the problem-pertinent system and additional systems; and taking pertinent PFSH
4. *Comprehensive:* Determining the chief complaint and taking an extended history of the present illness, a complete review of systems, and a complete past, family, and social history

Step 3. Determine the Extent of the Examination That Is Documented

The physician may examine a particular body area or organ system or may conduct a multisystem examination. The body areas are divided into the head, face, and neck; chest, including breasts and axilla; abdomen; genitalia, groin, and buttocks; back; and each extremity.

The organ systems that may be examined are the eyes; the ears, nose, mouth, and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; skin; neurologic; psychiatric; and hematologic/lymphatic/immunologic.

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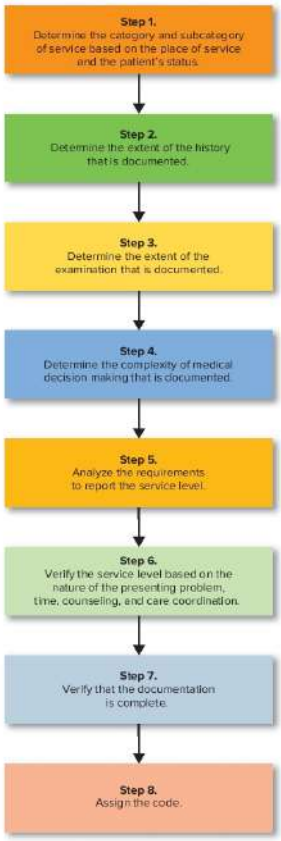

FIGURE 5.4 Evaluation and Management Code Assignment Flow Chart

- Timing (time of day the pain or symptom occurs)
- Context (any situation related to the pain or symptom, such as "occurs after eating")
- Modifying factors (any factors that alter the pain or symptom)
- Associated signs and symptoms (things that also happen when the pain or symptom occurs)

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the referring physician until the completion of a course of treatment. Referrals require use of the regular office visit E/M service codes.

COMPLIANCE GUIDELINE

Medicare Does Not Pay Consult Codes

Because of fraudulent use of consult codes by some physicians—billing consults for what are new visits—Medicare does not pay for them; providers must report these visits using regular office visit E/M codes.

Although people sometimes use these terms to mean the same thing, a referral and a consultation are different. This distinction is important to medical insurance specialists because the amounts that can be charged for the two types of service are different. Under a referral, the primary care physician (PCP) or other provider is sending the patient to another physician for specialized care. If the sending provider requests a consultation, this is asking for the opinion of another physician regarding the patient's care. The patient will be returned to the care of the original provider with the specialist's written consultation report containing an evaluation of the patient's condition and/or care.

E/M Code Selection

To select the correct E/M code, follow eight steps (see Figure 5.4).

Step 1. Determine the Category and Subcategory of Service Based on the Place of Service and the Patient's Status

The list of E/M categories—such as office visits, hospital services, and preventive medicine services—is used to locate the appropriate place or type of service in the index. In the main text of the selected category, the subcategory, such as new or established patient, is then chosen.

Documentation: initial hospital visit to established patient

Index: **Hospital Services**

Inpatient Services

Initial Care, New or Established Patient

Code Ranges: 99221–99233

For most types of service, from three to five codes are listed. To select an appropriate code from this range, consider three key components: (1) the history the physician documented, (2) the examination that was documented, and (3) the medical decisions the physician documented. (The exception to this guideline is selecting a code for counseling or coordination of care when in some situations the amount of time the physician spends may be the only key component.)

Step 2. Determine the Extent of the History That Is Documented

History is the information the physician received by questioning the patient about the chief complaint and other signs or symptoms, about all or selected body systems, and about pertinent past history, family background, and other personal factors.

The history is documented in the patient medical record as follows:

History of Present Illness (HPI) The history of the illness is a description of its development from the first sign or symptom that the patient experienced to the present time. These points about the illness or condition may be documented:

- Location (body area of the pain or symptom)
- Quality (type of pain or symptom, such as sudden or dull)
- Severity (degree of pain or symptom)

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Table 5.5 General Multi-System Examination *(concluded)*

System/Body Area	Elements of Examination
Lymphatic	Palpation of lymph nodes in **two or more** areas: • Neck • Axillae • Groin • Other
Musculoskeletal	• Examination of gait and station • Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes) Examination of joints, bones and muscles of **one or more of the following six** areas: 1) head and neck; 2) spine, ribs, and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: • Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions • Assessment of range of motion with notation of any pain, crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements
Skin	• Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers) • Palpation of skin and subcutaneous tissue (e.g., induration, subcutaneous nodules, tightening)
Neurologic	• Test cranial nerves with notation of any deficits • Examination of deep tendon reflexes with notation of pathological reflexes (e.g., Babinski) • Examination of sensation (e.g., by touch, pin, vibration, proprioception)
Psychiatric	• Description of patient's judgment and insight Brief assessment of mental status, including: • Orientation to time, place and person • Recent and remote memory • Mood and affect (e.g., depression, anxiety, agitation)
	Content and Documentation Requirements
	Perform General Multi-System Examination
Level of Exam	**Perform and Document**
Problem Focused	**One to five** elements identified by a bullet
Expanded Problem Focused	**At least six** elements identified by a bullet
Detailed	**At least two** elements identified by a bullet **from each of six areas/systems** or **at least 12** elements identified by a bullet **in two or more areas/systems.**
Comprehensive	**At least two** elements identified by a bullet **from each of nine areas/systems.**

Office and Hospital Services

Office and other outpatient services are the most often reported E/M services. A patient is an **outpatient** unless admitted to a healthcare facility, such as a hospital or nursing home, for a twenty-four-hour period or longer.

outpatient patient who receives healthcare in a hospital setting without admission

- When a patient is evaluated and then admitted to a healthcare facility, the service is reported using the codes for initial hospital care (the range 99221–99223).
- The admitting physician uses the initial hospital care services codes. Only one provider can report these services; other physicians involved in the patient's care, such as a surgeon or radiologist, use other E/M service codes or other codes from appropriate sections.
- Codes for initial hospital observation care (99218–99220), initial hospital care (99221–99223), and initial inpatient consultations (99251–99255) should be reported by a physician only once for a patient admission.

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Table 5.5 General Multi-System Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of any three of the following seven vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (may be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Eyes	• Inspection of conjunctivae and lids • Examination of pupils and irises (e.g., reaction to light and accommodation, size and symmetry) • Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth, and Throat	• External inspection of ears and nose (e.g., overall appearance, scars, lesions, masses) • Otoscopic examination of external auditory canals and tympanic membranes • Assessment of hearing (e.g., whispered voice, finger rub, tuning fork) • Inspection of nasal mucosa, septum, and turbinates • Inspection of lips, teeth, and gums • Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils, and posterior pharynx
Neck	• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (e.g., dullness, flatness, hyperresonance) • Palpation of chest (e.g., tactile fremitus) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

Cardiovascular	• Palpation of heart (e.g., location, size, thrills)
	• Auscultation of heart with notation of abnormal sounds and murmurs
	Examination of:
	  • carotid arteries (e.g., pulse, amplitude, bruits)
	  • abdominal aorta (e.g., size, bruits)
	  • femoral arteries (e.g., pulse, amplitude, bruits)
	  • pedal pulses (e.g., pulse amplitude)
	  • extremities for edema and/or varicosities

Chest (Breasts)	• Inspection of breasts (e.g., symmetry, nipple discharge) • Palpation of breasts and axillae (e.g., masses or lumps, tenderness)
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Examination for presence or absence of hernia • Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses • Obtain stool sample for occult blood test when indicated
Genitourinary	**Male:** • Examination of the scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass) • Examination of the penis • Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness) **Female:** Pelvic examination (with or without specimen collection for smears and cultures) including: • Examination of external genitalia (e.g., general appearance, hair distribution, lesions) • Examination of urethra (e.g., masses, tenderness, scarring) • Examination of bladder (e.g., fullness, masses, tenderness) • Cervix (e.g., general appearance, lesions, discharge) • Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent, or support) • Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)

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BILLING TIP

Two of Three Key Components

This means that to select code 99213, the medical record must show that two of the three factors are documented.

BILLING TIP

The Time Factor

When a patient's visit is mainly about counseling and/or coordination of care regarding symptoms or illness, the exact length of time the physician spends and documents is the controlling factor. If over 50 percent of the visit is spent counseling or coordinating care, time is the main factor. If an established patient's visit is thirty minutes, for example, and twenty minutes are spent counseling, the E/M code is 99214.

The severity of the presenting problem helps determine medical necessity. Even if a physician documented comprehensive history and exam with complex decision making, treating a minor problem such as removal of uncomplicated sutures would not warrant a high E/M level.

Counseling Counseling is a discussion with a patient regarding areas such as diagnostic results, instructions for follow-up treatment, and patient education. It is mentioned as a typical part of each E/M service in the descriptor, but it is not required to be documented as a key component.

Concurrent Care and Transfer of Care Coordination of care with other providers or agencies is also mentioned. When coordination of care is provided but the patient is not present, codes from the case management and care plan oversight services subsections are reported.

Step 7. Verify That the Documentation Is Complete

The documentation must contain the record of the physician's work in enough detail to support the selected E/M code. The history, examination, and medical decision making must be sufficiently documented so that the medical necessity and appropriateness of the service could be determined by an independent auditor.

Step 8. Assign the Code

The code that has been selected is assigned. The need for any modifiers, based on the documentation of special circumstances, is also reviewed.

Reporting E/M Codes on Claims

Documentation Guidelines for Evaluation and Management

CMS and the AMA have published two sets of guidelines for documenting evaluation and management codes: the *1995 Documentation Guidelines for Evaluation and Management Services* and the 1997 version. CMS and most payers permit providers to use either the 1995 or the 1997 E/M guidelines. Table 5.5 shows the items that can be documented to satisfy the general multisystem examination requirements under the 1997 Documentation Guidelines, which are most commonly used. There are guidelines similar to those in Table 5.5 for each major medical specialty.

BILLING TIP

Revised Guidelines Coming

CMS has said that the two sets of guidelines will be revised following national surveys. Stay up-to-date.

BILLING TIP

Which Guidelines?

The medical practice should be clear about which set of guidelines, the 1995 or the 1997, it generally follows for E/M coding and reporting.

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Table 5.4 Evaluation and Management Code Selection Tool: Office Visits

	NEW PATIENTS					ESTABLISHED PATIENTS				
CPT Codes=	99201 NP Level 1	99202 NP Level 2	99203 NP Level 3	99204 NP Level 4	99205 NP Level 5	99211 EP Level 1	99212 EP Level 2	99213 EP Level 3	99214 EP Level 4	99215 EP Level 5
Key Components										
History:						*Minimal*				
Problem-focused	Y						Y			
Expanded problem-focused		Y						Y		
Detailed			Y						Y	
Comprehensive				Y	Y					Y
Examination:						*Minimal*				
Problem-focused	Y						Y			
Expanded problem-focused		Y						Y		
Detailed			Y						Y	
Comprehensive				Y	Y					Y
Medical Decision Making:						*Minimal*				
Straightforward	Y	Y					Y			
Low complexity			Y					Y		
Moderate complexity				Y					Y	
High complexity					Y					Y
NUMBER OF KEY COMPONENTS REQUIRED	**3**	**3**	**3**	**3**	**3**	**2**	**2**	**2**	**2**	**2**

Table 5.4 shows the type of decision tool that many medical coders use to assign the correct E/M code for office visits with new and established patients.

Step 6. Verify the Service Level Based on the Nature of the Presenting Problem, Time, Counseling, and Care Coordination

Nature of Presenting Problem Many descriptors mention two additional components: (1) how severe the patient's condition is, referred to as the *nature of the presenting problem*, and (2) how much time the physician typically spends directly treating the patient. These factors, while not key components, help in selecting the correct E/M level. For example, the following wording appears in CPT after the 99214 code (office visit for the evaluation and management of an established patient):

> Usually, the presenting problem(s) is (are) of moderate to high severity. Typically, twenty-five minutes are spent face-to-face with the patient and/or family.

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COMPLIANCE GUIDELINE

The 1998 Women's Health and Cancer Rights Act requires all health plans that provide coverage for mastectomies to also provide coverage for associated treatments, such as breast reconstruction after surgery.

an integral part of a surgical package—usually a larger procedure—but that in some situations it is not. If a separate procedure is performed alone or along with other procedures but for a separate purpose, it may be reported separately. For example:

42870 Excision or destruction lingual tonsil, any method (separate procedure)

Lingual tonsil excision is a separate procedure. It is usually a part of a routine tonsillectomy and so cannot be reported separately when a tonsillectomy is performed. When it is done independently, however, this code can be reported.

Structure

Most of the Surgery section's subsections are organized by body system and then divided by body site. Procedures are grouped next, under headings followed by specific procedures. For example:

Subsection:	DIGESTIVE SYSTEM
Site:	Lips
Heading—type of procedure:	Excision
Description—specific procedure:	40490 Biopsy of lip

The exceptions to the usual subsection structure are the Laparoscopy/Hysteroscopy subsection, which groups those operative procedures, and the Maternity Care and Delivery subsection, organized by type of service, such as postpartum care.

Modifiers

A number of modifiers are commonly used to indicate special circumstances involved with surgical procedures.

- 22 *Increased procedural services:* Used with rare, unusual, or variable surgery services; requires documentation.
- 26 *Professional component:* Used to report the professional components when a procedure has both professional and technical components.
- 32 *Mandated services:* Used when the procedure is required by a payer or is a government, legislative, or regulatory requirement.
- 33 *Preventive services:* Used to indicate that the primary purpose of a service is the delivery of an evidence-based preventive services.
- 47 *Anesthesia by surgeon:* Used when the surgeon (rather than an anesthesiologist) administers regional or general anesthesia (local/topical anesthesia is bundled in the surgical code).
- 50 *Bilateral procedure:* Used when identical bilateral procedures were performed during the same operation, either through the same incision or on separate body parts, such as left and right bunion correction. Attach the bilateral modifier to the code for the first procedure to indicate that the procedure was done bilaterally. For example, to report a puncture aspiration of one cyst in each breast:

  19000 50 Puncture aspiration of cyst of breast

  The trend in annual updates is to replace bilateral codes with unilateral codes to which modifier 50 is attached if needed. However, a few codes are defined as bilateral procedures. For example:

  32853 Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass)

- 51 *Multiple procedures:* Used to identify a second procedure or multiple procedures during the same operation. The additional procedures are the same type and done to the same body system. Attach the modifier to the second procedure code. For

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5.8 Surgery Codes

The codes in the Surgery section are used for the many hundreds of surgical procedures performed by physicians. This is the largest procedure code section with codes ranging from 10021 to 69990.

Surgical Package

As defined in CPT, surgical package codes include all the usual services in addition to the operation itself:

- Evaluation and Management (E/M) service(s) subsequent to the decision for surgery on the day before and/or day of surgery (including history and physical)
- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians and other qualified health care professionals
- Writing orders
- Evaluating the patient in the postanesthesia recovery area
- Typical postoperative follow-up care

A complete procedure includes the operation, the use of a local anesthetic, and postoperative care, all covered under a single code.

Example

Procedural Statement: Procedure conducted eight days ago in office to correct hallux valgus (bunions) on both feet; local nerve block administered, correction by simple exostectomy. The global period for this procedure is ten days. Saw patient in office today for routine follow-up; complete healing. ◂

Code:	28292 50	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method

BILLING TIP

Global Period

Some payers are dropping the global period. Verify the payer's rules.

In the Surgery section, the grouping of related work under a single procedure code is called a **surgical package** or **global surgery rule.** Government and private payers assign a fee to a surgical package code that reimburses all the services provided under it. The period of time that is covered for follow-up care is referred to as the **global period.** After the global period ends, additional services that are provided can be reported separately for additional payment. For most payers, there are two possible global preoperative periods—zero days and one day. Usually, there are three possible postoperative global periods: zero days, ten days, and ninety days.

surgical package combination of services included in a single procedure code

global surgery rule combination of services included in a single procedure code

global period days surrounding a surgical procedure when all services relating to the procedure are considered part of the surgical package

Two types of services are not included in surgical package codes. These services are billed separately and are reimbursed in addition to the surgical package fee:

- Complications or recurrences that arise after therapeutic surgical procedures.
- Care for the condition for which a diagnostic surgical procedure is performed. Routine follow-up care included in the code refers only to care related to recovery from the diagnostic procedure itself, not the condition. For example, a diagnostic colonoscopy is performed to examine a growth in the patient's colon. An office visit after the surgery to evaluate the patient for chemotherapy because the tumor is cancerous is billed separately, not with code 99024 for a postoperative follow-up visit included in global service.

Separate Procedures

Some procedural code descriptors in the Surgery section are followed by the words *separate procedure* in parentheses. **Separate procedure** means that the procedure is usually done as

separate procedure descriptor used for a procedure that is usually part of a surgical package but may also be performed separately

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CASE C

Office visit by established patient for regularly scheduled blood test to monitor long-term effects of Coumadin; nurse spends five minutes, reviews the test, confirms that the patient is feeling well, and, after speaking with the physician on the medications, states that no change in the dosage is necessary.

3. If a physician sees a patient in the hospital and the patient comes to the office for a follow-up visit, is the follow-up encounter coded for a new or established patient?

Preventive Medicine Services Preventive medicine services are used to report routine physical examinations in the absence of a patient complaint. These codes, in the range 99381 to 99397, are divided according to the age of the patient. Counseling is coded from code range 99401 to 99429. Immunizations and other services, such as lab tests that are normal parts of an annual physical, are reported using the appropriate codes from the Medicine and the Pathology and Laboratory sections (see Section 5.10).

5.7 Anesthesia Codes

The codes in the Anesthesia section are used to report anesthesia services performed or supervised by a physician. These services include general and regional anesthesia as well as supplementation of local anesthesia. Each anesthesia code includes the complete usual services of an anesthesiologist:

- Usual preoperative visits for evaluation and planning
- Care during the procedure, such as administering fluid or blood, placing monitoring devices or IV lines, laryngoscopy, interpreting lab data, and nerve stimulation
- Routine postoperative care

Example

Anesthesiologist Report: Initial meeting with seven-year-old patient in good health, determined good candidate for required general anesthesia for tonsillectomy. Surgical procedure conducted April 4, 2029; patient in the supine position; administered general anesthesia via endotracheal tube. Routine monitoring during procedure. Following successful removal of the right and left tonsils, the patient was awakened and taken to the recovery room in satisfactory condition.

00170 P1 Anesthesia for intraoral procedures, including biopsy; not otherwise specified

(A discussion of the modifier P1 follows.)

Postoperative critical care and pain management requested by the surgeon are not included and can be billed in addition to the main anesthesia code by the anesthesiologist.

Anesthesia codes are reimbursed according to time. The American Society of Anesthesiologists assigns a base unit value to each code. The anesthesiologist also records the amount of time spent with the patient during the procedure and adds this to the base value. Difficulties, such as a patient with severe systemic disease, also add to the value of the anesthesiologist's services. ◄

Structure

The Anesthesia section's subsections are organized by body site. Under each subsection, the codes are arranged by procedures. For example, under the heading *Neck*, codes for

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Emergency Department Services An emergency department is hospital-based and is available to patients twenty-four hours a day. When emergency services are reported, whether the patient is new or established is not applicable. Time is not a factor in selecting the E/M service code. The code ranges are 99281 to 99288.

BILLING TIP

Modifier 25

During an annual physical examination, an illness or clinical sign of a condition may be found that requires the physician to conduct an additional evaluation. In this case, the preventive medicine service code is reported first, followed by the appropriate E/M code for the new problem, adding the 25 modifier, Significant, Separate E/M Service.

THINKING IT THROUGH 5.6

1. In which category—problem focused, expanded problem focused, detailed, or comprehensive—would you place these statements concerning patient history? Why?

CASE A

Patient seen for follow-up of persistent sinus problems including pain, stuffiness, and greenish drainage over the past twenty days. She continues to have left-sided pain in the forehead and maxillary areas and feels that her symptoms are worse around dust. She gets drainage into her throat, which causes her to cough. Review of systems reveals no history of diabetes or asthma. She has thyroid problems for which she takes Synthroid.

CASE B

Patient presents with a mild case of poison ivy on face and both hands contracted four days ago while gardening; has never been bothered by poison ivy before.

2. Using the office visit E/M codes, which code would you select for each of these cases?

CASE A

Chart note for established patient:

S: Patient returns for removal of stitches I placed about seven days ago. Reports normal itching around the wound area, but no pain or swelling. _____

O: Wound at lateral aspect of the left eye looks well healed. Decision made to remove the 5-0 nylon sutures, which was done without difficulty. _____

A: Laceration, healed. _____

P: Patient advised to use vitamin E for scar prophylaxis

_____

CASE B

Initial office evaluation by oncologist of a sixty-five-year-old female with sudden unexplained twenty-pound weight loss. Comprehensive history and examination performed with medical decision making of high complexity.

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Unlisted Procedures and Special Reports

New procedures are common in the area of radiology services. There are codes for nearly twenty unlisted code areas, such as:

78299 Unlisted gastrointestinal procedure, diagnostic nuclear medicine

When unlisted codes are reported, a special report must be attached that defines the nature, extent, and need for the procedure and describes the time, effort, and equipment necessary to provide it.

Contrast Material

For some radiological procedures, the physician decides whether it is best to perform the procedure with or without contrast material, a substance administered in the patient's blood vessels that helps highlight the area under study. For example, computerized tomography (CT) and magnetic resonance imaging (MRI) provide different types of information about body parts and may be performed with or without contrast material. The term *with contrast* means only contrast materials given in the patient's veins or arteries. Contrast materials administered orally or rectally are coded as *without contrast* since oral and/or rectal contrast administration alone does not qualify as a study with contrast.

Structure and Modifiers

The diagnostic radiology, diagnostic ultrasound, and nuclear medicine subsections of the Radiology section are structured by type of procedure followed by body sites and then specific procedures. For example:

Type:	Diagnostic ultrasound
Body site:	Chest
Procedure:	Ultrasound, chest (includes mediastinum), real time with image documentation

BILLING TIP

Modifier 26

If the physician does not own the equipment used for the radiology procedure, the modifier 26 is appended to the code, such as:

76511 26 Ophthalmic ultrasound, diagnostic; quantitative A-scan only

The radiation oncology subsection is organized somewhat differently. The first group of codes covers the planning services oncologists perform to set up a patient's radiation therapy treatment for cancer.

The following modifiers are commonly used in the Radiology section: 22, 26, 32, 51, 52, 53, 58, 59, 62, 66, 76, 77, 78, 79, 80, 90, and 99. Table 5.2 has a brief description of each modifier.

Reporting Radiology Codes

GO TO CODING WORKBOOK
Codes 70010–79999 Radiology Section

Most radiology services are performed and billed by radiologists working in hospital or clinic settings. Medical practices usually do not have radiology equipment but instead refer patients to these specialists. In many cases, the radiologist performs both the technical and the professional components. Codes are selected based on body part, and the number/type of views.

THINKING IT THROUGH 5.9

1. Why are special reports frequently used when filing radiology claims?

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often pay reduced percentages of the subsequent procedures. For maximum payment when multiple procedures are reported, the most complex or highest-level code–the procedure with the highest reimbursement value–should be listed first. The subsequent procedures are listed with the modifier 51 (indicating multiple procedures).

When warranted, to avoid reduced payment for multiple procedures, the modifier 59 is used to indicate distinct procedures rather than multiple procedures. This is usually done when the surgeon performs procedures on two different body sites or organ systems, such as the excision of a lesion on the chest as well as the incision and drainage (I & D) of an abscess on the leg.

GO TO CODING WORKBOOK
10021–69990 Surgery Section

BILLING TIP

Lesion Excision

The choice of the correct code for the surgical removal of a lesion depends on the pathology report. There are different code ranges for benign lesions and malignant lesions. Coders should wait for a pathology report before coding lesion excisions from the benign or malignant code ranges.

THINKING IT THROUGH 5.8

1. Rank the following codes in order from highest to lowest reimbursement level, and explain your rationale.

   44950 51

   44950 59

   44950 53

2. Review CPT code 44180 and determine whether it is correct to report a diagnostic laparoscopy (CPT code 49320) with a surgical laparoscopy.

5.9 Radiology Codes

The codes in the Radiology section are used to report radiological services performed by or supervised by a physician. Radiology procedures have two parts:

1. *The technical component:* The technologist, the equipment, and processing, including preinjection and postinjection services such as local anesthesia, placement of needle or catheter, and injection of contrast material
2. *The professional component:* The reading of the radiological examination and the written report of interpretation by the physician

Radiology codes follow the same types of guidelines as noted in the Surgery section. For example, some radiology codes are identified as separate procedure codes. These codes are usually part of a larger, more complex procedure and should not be reported as separate codes unless the procedure was done independently. Also, some codes are add-ons, such as those covering additional vessels that are studied after the basic examination. These codes are used with the primary codes, not alone.

BILLING TIP

Professional Component Requirement

Billing the professional component of a radiological procedure requires a written interpretation from the physician. This documentation contains the patient's identifying information, the clinical indications for the procedure, the process followed, and the physician's impressions of the findings.

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- 80 *Assistant surgeon:* Used when a physician assists another during a surgical procedure. Each physician reports the services using the same code, but the assistant surgeon appends the modifier to the code.
- 81 *Minimum assistant surgeon:* Used when an assistant surgeon assists another during only part of a surgical procedure.
- 82 *Assistant surgeon (when qualified resident surgeon not available):* Used in teaching hospitals where residents usually assist with surgery but none was available during the reported procedure, so a surgeon performed the assistant's work.
- 90 *Reference (outside) laboratory:* Used when laboratory procedures are done by someone other than the reporting physician.
- 91 *Repeat clinical diagnostic laboratory test:* Used when laboratory procedures are repeated.
- 92 *Alternative laboratory platform testing:* Used when laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single-use, disposable analytical chamber.
- 95 *Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system:* Used when a real-time interaction between a physician or other qualified health care professional and a patient is performed to a degree that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.
- 96 *Habilitative Services:* Used when a service or procedure that is either habilitative or rehabilitative in nature is provided for habilitative purposes.
- 97 *Rehabilitative Services:* Used when a service or procedure that is either habilitative or rehabilitative in nature is provided for rehabilitative purposes.
- 99 *Multiple modifiers:* Used when more than one modifier is required; the 99 modifier is appended to the basic procedure, followed by the other modifiers in descending order.

Reporting Surgical Codes

bundled payment single payments to multiple providers involved in an episode of care, in which accountability is shared among providers

bundling using a single payment for two or more related procedure codes

Surgical package codes often are "bundled" *episode payments,* by payers. **Bundling** is using a single payment for two or more related procedure codes. **Bundled payments,** also known as episode payments, are single payments to multiple providers involved in an episode of care with accountability shared among providers. Payments are based on the expected costs for the episode of care rather than for individual services provided. The episode may take place in multiple settings (inpatient, outpatient, etc.) over a period of time. Bundled payment combinations are based on payers' judgment of the correct value for the physician's work. As an example of a bundled code, CPT 27370 codes an injection procedure for knee arthrography. If this code is billed, payers will not also pay for any of these codes on the same day of service:

20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g. shoulder, hip, knee, subacromial bursa); without ultrasound guidance
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time
+77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)

Because 27370 is bundled, neither 20610, 76000, nor 77003 should be billed with it; payment for each of these codes is already included in the payment rate.

unbundling incorrect billing practice of breaking a panel or package of services/procedures into component parts

fragmented billing incorrect billing practice in which procedures are unbundled and separately reported

When such services are billed, physicians must report the bundled code rather than each of the other codes separately. Reporting anything that is included in the bundled code is considered **unbundling,** or **fragmented billing.** Doing so causes denied claims and may result in an audit.

Reporting Sequence

When payers reimburse multiple surgical procedures performed on the same day for the same patient, they pay the full amount of the first listed surgical procedure, but they

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example, to report two procedures, a bunionectomy on the great toe and, in the same session, correction of a hammertoe on the fourth toe:

28292	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method
28285 51	Correction, hammertoe (e.g., interphalangeal fusion, partial or total phalangectomy)

- 52 *Reduced services:* Used when a procedure is less extensive than described. The modifier is attached to the procedure code. It is not used to identify a reduced or a discounted fee. Instead, usually, the normal fee is listed, and the payer determines the amount of the reduction.
- 53 *Discontinued procedure:* Used when the procedure is discontinued due to circumstances that threaten the patient's well-being—for example, surgery discontinued because the patient went into shock during the operation.
- 54 *Surgical care only:* Added to the surgery code when the surgeon performs only the surgery itself, without preoperative or postoperative services. The payer will reduce the fee to reflect only that part of the surgical package.
- 55 *Postoperative management only:* Added to the surgery code when the physician provides only the follow-up care in the global period after another physician has done the surgery. The payer will reduce the fee to reflect only that part of the surgical package.
- 56 *Preoperative management only:* Added to the surgery code when the physician provides only preoperative care. The payer will reduce the fee to reflect only that part of the surgical package.
- 58 *Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period:* Used when the physician performs a postoperative procedure (1) as planned during the surgery to be done later, (2) that is more extensive than the original procedure, or (3) for therapy after diagnostic surgery.
- 59 *Distinct procedural service:* Used for a different encounter or procedure for the same patient on the same day. A different patient encounter, an unrelated procedure, a different body site or system, or a separate incision or injury must be involved. The modifier may also be used to describe the requirement for critical care and nonroutine pain management. If a separate procedure is performed with other procedures, the 59 modifier is added to the separate code to show that it is a distinct, independent procedure, not part of a surgical package.
- 62 *Two surgeons:* Used when a specific surgical procedure requires two surgeons, usually of different specialties; each appends the modifier to the surgical code. Usually each surgeon performs a distinct part of the procedure and dictates a separate operative report. If each surgeon reports different surgical procedure codes, the modifier is not used.
- 63 *Procedure performed on infants less than 4 kgs:* Used when the patient is an infant weighing less than 4 kgs.
- 66 *Surgical team:* Used in very complex procedures that usually require the simultaneous services of physicians of different specialties. Usually used to report transplant-type procedures only.
- 76 *Repeat procedure or service by same physician or other qualified healthcare professional:* Used when a physician repeats a procedure performed earlier.
- 77 *Repeat procedure or service by another physician or other qualified healthcare professional:* Used when a physician repeats a procedure done by another physician.
- 78 *Unplanned return to the operating/procedure room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period:* Used when the patient develops a complication during the postoperative period that requires an additional procedure by the same physician.
- 79 *Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period:* Used when a second, unrelated surgical procedure is performed by the same physician during the postoperative period.

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Level II Codes

A Level II code is made up of five characters beginning with a letter followed by four numbers, such as J7631. The HCPCS Tabular List of codes has more than twenty sections, each of which covers a related group of items. For example, the E section covers **durable medical equipment (DME),** reusable medical equipment ordered by physicians for patients' use at home, such as walkers and wheelchairs. Durable medical equipment:

- Can withstand repeated use
- Is primarily and customarily used for a medical purpose
- Generally is not useful to a person in the absence of an illness or injury
- Is appropriate for use in the home

durable medical equipment (DME) reusable physical supplies ordered by the provider for home use

HCPCS Level II codes can be used in conjunction with the CPT codes on bills for patients and on claims for Medicare, Medicaid, and other payers. As with CPT codes, reporting HCPCS codes does not guarantee payment. Each payer's coverage and payment decisions apply. Also, decisions regarding the addition, deletion, and revision of HCPCS codes are made independent of the adjudication process. Table 5.6 details these sections and provides examples of entries.

Mandated Code Set

HCPCS is the mandated code set for reporting supplies, orthotic and prosthetic devices, and durable medical equipment under HIPAA Electronic Health Care Transactions and Code Sets.

BILLING TIP

DME MACs

CMS has four *Durable Medical Equipment Medicare Administrative Contractors (DME MACs)* that process Medicare claims for *durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).*

Permanent Versus Temporary Codes

The *CMS HCPCS Workgroup* is a code advisory committee made up of representatives from CMS and other government agencies. Its role is to identify services for which new codes are needed. Temporary codes may later be given permanent status if they are widely used.

Permanent Codes

The CMS HCPCS Workgroup maintains the *permanent national codes* that are available for use by all government and private payers. No code changes can be made unless all panel members agree. Advisers from private payers provide input to the Workgroup.

Some codes are *miscellaneous* or *not elsewhere classified (NEC)* (as in ICD-10-CM codes). All payers use these codes to bill for items or services that do not have permanent national codes. Many of these codes are given permanent national status in the updating process.

BILLING TIP

Attachments for Claims with Miscellaneous Codes

Claims with miscellaneous codes are manually reviewed for medical necessity. Their use should be infrequent because it may delay payment and increase chances of denied claims.

Before using a miscellaneous code on a claim form, the medical insurance specialist should check with the payer to determine whether there is a specific code that should instead be used. For Medicare claims sent to one of the DME MACs, the medical insurance specialist should check with the *Pricing, Data Analysis, and Coding (PDAC) contractors* under contract to CMS. The PDAC is responsible for providing assistance in determining which HCPCS codes describe DMEPOS items for Medicare billing purposes.

PDAC Toll-free Helpline
(877) 735-1326
The helpline is operational between 8.30 A.M. and 4 P.M. (CST)

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Categories II and III Updates

www.ama-assn.org/practice-management/category-ii-codes

www.ama-assn.org/practice-management/category-iii-codes

- Patient History
- Physical Examination
- Diagnostic/Screening Processes or Results
- Therapeutic, Preventive, or Other Interventions
- Follow-up or Other Outcomes
- Patient Safety
- Structural Measures
- Nonmeasure Code Listing

The Category III code set contains temporary codes for emerging technology, services, and procedures. If a Category III code is available for a new procedure, this code must be reported instead of a Category I unlisted code.

BILLING TIP

Categories II and III Code Updates

Categories II and III codes are released twice a year, on January 1 and July 1.

Level III Codes Phased Out

Before December 31, 2003, HCPCS had a third level of codes. Level III consisted of local codes used by state Medicaid agencies, Medicare, and private payers, which determined the codes. HIPAA does not allow non-national codes, so the Level III codes have been phased out.

The codes in this section are not like CPT Category I codes, which require that the service or procedure be performed by many healthcare professionals in clinical practice in multiple locations and that FDA approval, as appropriate, has already been received. For these reasons, temporary codes for emerging technology, services, and procedures have been placed in a separate section of the CPT book. When a temporary service or procedure does meet these requirements, it is listed as a Category I code in the appropriate section of the main text.

Category III codes are four digits followed by an alphabetical character.

Note that the standard CPT modifiers can be used with Category III codes but not with Category II codes for which specific Category II modifiers can be used.

THINKING IT THROUGH 5.12

1. What source is used to verify that CPT Categories II and III codes are current?

5.13 HCPCS

The national codes for products, supplies, and those services not included in CPT are in the HCPCS Level II code set. HCPCS codes permit physician practices to bill for items provided to patients in Medicare, Medicaid, and many private payers' plans. Payers need to understand the medical necessity of these items for reimbursement, just as they do for CPT codes.

Healthcare Common Procedure Coding System (HCPCS) procedure codes for Medicare claims

The **Healthcare Common Procedure Coding System,** referred to as **HCPCS,** was set up to give healthcare providers a coding system that describes specific products, supplies, and services that patients receive. HCPCS codes provide uniformity in medical services reporting and enable the collection of statistical data on medical procedures, products, and services. In the early 1980s, the use of HCPCS codes for claims was optional. With the implementation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, HCPCS has become mandatory for coding and billing.

Level II HCPCS national codes

HCPCS is technically made up of two sections of procedural codes. Level I is the CPT *(Current Procedural Terminology)* maintained by the AMA. The second section is the HCPCS **Level II** codes that identify supplies, products, and services not in Level I. The Centers for Medicare and Medicaid Services (CMS) is responsible for maintaining the HCPCS code set.

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makes a second, brief visit to a patient in the hospital and provides psychoanalysis, these services are reported separately:

99231	Subsequent hospital care, problem focused/straightforward or low complexity decision making
90845	Psychoanalysis

- Immunizations require two codes, one for administering the immunization and the other for the particular vaccine or toxoid that is given. For example, when a patient receives an MMRV vaccine, these two codes are used:

90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use

- The descriptors for injection codes also require two codes, one for the injection and one for the substance that is injected (the exception is allergy shots, which have their own codes in the Allergy and Clinical Immunology subsection). For example, to report the intravenous administration of an anti-emetic:

96374	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)

BILLING TIP

Immunizations and Office Visits

To report a patient's visit for just an immunization, some medical practices use E/M 99211 along with a code for the immunization. This is a misuse of the E/M code, which requires some significant, separate E/M service. Code only the immunization.

Some commercial payers and Medicare use an HCPCS code, instead of CPT 99070, for the material that is injected.

GO TO CODING WORKBOOK
Codes 90281–99607 Medicine Section

THINKING IT THROUGH 5.11

1. Which of these codes, 93000, 93005, or 93010, is used to report only the technical component of a routine ECG? Defend your decision.

5.12 Categories II and III Codes

GO TO CODING WORKBOOK
Categories II and III Codes

The Category II code set contains supplemental tracking codes to help collect data regarding services, such as prenatal care and tobacco use cessation counseling, that are known to contribute to good patient care. Having codes available reduces the amount of administrative time needed to gather these data from documentation.

The use of these codes is optional and does not affect reimbursement. The codes are not required for correct coding and are not a substitute for Category I codes.

Category II codes are four digits followed by an alphabetical character. They are arranged according to the following categories:

- Composite Codes
- Patient Management

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List of Waived Tests and PPM Procedures
www.cms.gov/clia

Codes 80047–89398 Pathology and Laboratory Section

Reporting Pathology and Laboratory Codes

Some medical practices have laboratory equipment and perform their own testing. In-office labs are guided by federal safety regulations from OSHA (the Occupational Safety and Health Administration), and the tests that can be performed are regulated by CLIA (the Clinical Laboratory Improvement Amendment of 1988). The CLIA certification program awards one of two levels of certification: (1) waived tests and provider-performed microscopy (PPM) procedures and (2) moderate- or high-complexity testing. The in-office lab with the first level can perform common tests, such as dipstick urinalysis and urine pregnancy, and PPM procedures such as nasal smears for eosinophils and pinworm exams.

If the medical practice does not have an in-office lab, the physician may either take the specimen, reporting this service only (e.g., using code 36415 for venipuncture to obtain a blood sample), and send it to an outside lab for processing or refer the patient to an outside lab for the complete procedure.

THINKING IT THROUGH 5.10

1. If a test for ferritin and a comprehensive metabolic panel are both performed, can both be reported?
2. Is it correct to report a comprehensive metabolic panel and an electrolyte panel for the same patient on the same day?

5.11 Medicine Codes

The Medicine section contains the codes for the many types of evaluation, therapeutic, and diagnostic procedures that physicians perform. (Codes for the Evaluation and Management section described earlier in the chapter, 99201 to 99499, fall numerically at the end of this section, but they appear first in CPT because they are the most frequently used codes.) Medicine codes may be used for procedures and services done or supervised by a physician of any specialty. They include many procedures and services provided by family practice physicians, such as immunizations and injections. The services of many specialists, such as allergists, cardiologists, and psychiatrists, are also covered in the Medicine section. Some Medicine section codes are for *ancillary services* that are used to support diagnosis and treatment, such as rehabilitation, occupational therapy, and nutrition therapy.

Codes from the Medicine section may be used with codes from any other section. Add-on codes and separate procedure codes are included in the Medicine section. Their use follows the guidelines described for previous sections.

Structure and Modifiers

The subsections are organized by type of service. Many subsections have notes containing usage guidelines and definitions. Some services, for example, have subcategories for new and established patients.

The following modifiers are commonly used with codes in the Medicine section: 22, 26, 32, 51, 52, 53, 55, 56, 57, 58, 59, 76, 77, 78, 79, 90, 91, and 99. Table 5.2 has a brief description of each modifier.

Reporting Medicine Codes

- Some of the services in the Medicine section are considered Evaluation and Management services, even though they are not listed in the E/M section. For these codes, the 51 modifier, Multiple Procedures, may not be used. For example, if a physician

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5.10 Pathology and Laboratory Codes

The codes in the Pathology and Laboratory section cover services provided by physicians or by technicians under the supervision of physicians. A complete procedure includes:

- Ordering the test
- Taking and handling the sample
- Performing the actual test
- Analyzing and reporting on the test results

Panels

Certain tests are customarily ordered together to detect particular diseases or malfunctioning organs. These related tests are grouped under laboratory **panels** for reporting convenience. When a panel code is reported, all the listed tests must have been performed (otherwise, just the individual tests are billed). For example, the electrolyte panel requires these tests:

panel single code grouping laboratory tests frequently done together

80051	Electrolyte panel
	This panel must include the following:
	Carbon dioxide (bicarbonate) (82374)
	Chloride (82435)
	Potassium (84132)
	Sodium (84295)

Panels are bundled codes, so when a panel code is reported, no individual test within it may be additionally billed. Other tests that were performed outside that panel may also be billed.

BILLING TIP

Laboratory Work

Medicare does not permit a physician who does not perform the lab work to bill for it. However, other payers allow it. When the physician orders the lab test and then pays the lab (called the *reference lab*) for the service, the physician may then report that test. The modifier 90 is attached to the code for the lab test.

Unlisted Procedures and Special Reports

New developments are frequent in pathology and laboratory services. There are codes for twelve unlisted code areas, such as:

86486	Skin test; unlisted antigen, each

Any unlisted code must be submitted with a special report that defines the nature, extent, and need for the procedure and describes the time, effort, and equipment necessary to provide it.

Structure and Modifiers

Procedures and services are listed in the index under the following types of main terms:

- Name of the test, such as urinalysis, HIV, skin test
- Procedure, such as hormone assay
- Abbreviation, such as TLC screen
- Panel of tests, such as Complete Blood Count

The following modifiers are commonly used with pathology and laboratory codes: 22, 26, 32, 52, 53, 59, 90, and 91. Table 5.2 has a brief description of each modifier.

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provider for them. Noncoverage encompasses all related services provided in the operating room when the error occurs, including those separately performed by other physicians, and all other services performed during the same hospital visit.

Following the surgery, however, any reasonable and necessary services are covered regardless of whether they are or are not related to the surgical error.

CMS created three new HCPCS Level II modifiers for practitioners, ambulatory surgical centers (ASCs), and hospital outpatient facilities to use to report erroneous surgeries.

Append one of the following HCPCS Level II modifiers to the CPT procedure codes for the surgery:

PA Surgical or other invasive procedure on wrong body part

PB Surgical or other invasive procedure on wrong patient

PC Wrong surgery or other invasive procedure on patient

HCPCS Billing Procedures

There are specific procedures to be followed for Medicare and Medicaid patients and for patients with private insurance. Some procedures require both a CPT code and a HCPCS code, such as reporting both the administration of an injection and the material that was injected.

Medicare and Medicaid Billing

When medical insurance specialists are processing claims for patients who have Medicaid or Medicare, they should consult HCPCS code books to identify services reimbursable under HCPCS Level II. Symbols direct the biller or coder to Medicare billing rules that are reprinted in the appendixes of the HCPCS code books. For example, here are the symbols from one publication:

- ♦ Not Covered by or Valid for Medicare
- ✢ Special Coverage Instructions Apply
- ❋ Carrier Discretion

When the symbol for Special Coverage Instructions Apply appears, Medicare resources must be checked online.

Private Payer Billing

When commercial payers want participating practices to use HCPCS codes instead of the corresponding CPT codes, they inform the practices. For example, plans from the BlueCross BlueShield Association send customers a monthly publication that outlines CPT and HCPCS changes, deletions, and additions as they relate to billing for services, procedures, and equipment.

BILLING TIP

HCPCS Anesthesia Modifiers

Medicare uses additional HCPCS modifiers for anesthesia services. These modifiers help clarify special situations when Medicare patient services are reported. For example, –AA is used when the anesthesiologist provides the anesthesia service directly instead of overseeing an assistant anesthetist.

GO TO CODING WORKBOOK
HCPCS

THINKING IT THROUGH 5.13

Assign the correct modifiers for the following situations.

1. Right hand, fourth digit
2. Left foot, great toe
3. Ambulance service furnished directly by a service provider

Using HCPCS Level II, assign the appropriate codes.

4. Ambulance service, basic life support, nonemergency transport
5. Breast pump, manual, any type
6. Injection, zidovudine, 10 mg
7. Wet mounts, including preparations of vaginal, cervical, or skin specimens
8. Hospital bed, total electric, with any type side rails, with mattress

BILLING TIP

Keep HCPCS Updates

Retain HCPCS updates from private payers and keep them where they can be readily accessed when preparing claims.

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of each page. The following example shows the symbols for new and revised codes used in one HCPCS code book:

New and Revised Text Characters

●	New
▲	Revised
~~supply~~	Deleted

COMPLIANCE GUIDELINE

Brand and Trade Names

To avoid the appearance of endorsing particular products, HCPCS does not use brand or trade names to describe products represented by codes.

Reporting Quantities

The coder should carefully review the description of quantities associated with HCPCS codes. Drug descriptions should be carefully checked to note the method of administration and the dosage. The selected code must match the administration method and dose that are documented in the medical record or on the encounter form.

The administration methods common in offices include:

- *IV:* Intravenous injection
- *IM:* Intramuscular injection
- *IA:* Intraarterial injection
- *SC:* Subcutaneous injection
- *INH:* Inhalant
- *Oral:* Taken by mouth
- *Nasal Spray:* Sprayed into the nostril

The dosage is described in appropriate quantities, such as milligrams (mg) or milliliters (ml). For example, the listing for Prednisone is:

J7510 Prednisone, oral, per 5 mg

If a patient's dosage is 10 mg, the code to report is:

J7510 X2

The HCPCS code is followed by the quantity 2. If the patient has been administered 12 mg, the unit indicator is 3.

Multiple units of other items are also reported by the HCPCS code followed by the units. Five surgical stockings would be coded as:

A4495 **X5**

HCPCS Modifiers

Level II modifiers HCPCS national code set modifiers

Like CPT, HCPCS Level II uses modifiers, called **Level II modifiers,** to provide additional information about services, supplies, and procedures. For example, a UE modifier is used when an item identified by a HCPCS code is used equipment, and an NU modifier is used for new equipment. HCPCS Level II modifiers are made up of either two letters or one letter and one number:

F5 Right hand, thumb

HS Family/couple without client present

GO TO CODING WORKBOOK
Healthcare common procedure coding system: Level II codes and modifiers

Payers may require the use of both Level II modifiers and CPT modifiers on claims. The modifiers in Table 5.7 are among the most prevalent.

HCPCS Modifiers for Never Events

The Medicare and Medicaid programs administered by CMS do not cover a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs:

1. The correct procedure but on the wrong body part
2. The correct procedure but on the wrong patient
3. The wrong procedure on the patient

never event situation for which a policy never pays a provider

Each of these situations is called a **never event** because they are preventable events that should never occur in healthcare and therefore the policy is never to pay the healthcare

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- *H codes:* For state Medicaid agencies to identify mental health services (alcohol and drug treatment)
- *T codes:* For state Medicaid agencies when there are not permanent national codes; can be used for private insurers but not for Medicare

HCPCS Updates

HCPCS Level II is a public code set. Information about the codes and updates is located on the CMS HCPCS website. Many publishers also print easy-to-use HCPCS reference books.

HCPCS Level II permanent national codes are released on January 1 of each year and are reviewed continuously throughout the year. Any supplier or manufacturer can ask CMS to make changes. Requests must be submitted in writing and must describe the reason for the proposed changes. CMS must receive requests by January 3 of the current year for the changes to be considered for the next January 1 release. Revisions received after the deadline are considered for the next annual update.

Temporary national codes are updated quarterly. Once established, temporary codes are usually implemented within ninety days to provide enough time to inform physician practices and suppliers about them via bulletins and newsletters.

The HCPCS website lists current HCPCS codes, has an alphabetical index of HCPCS codes by type of service or product, and has an alphabetical table of drugs for which there are Level II codes. The newly established temporary codes and effective dates for their use are also posted to allow for quick dissemination of coding requests and decisions.

HCPCS Website
www.cms.gov/HCPCSReleaseCodeSets/

HCPCS Coding Procedures

To look up codes in HCPCS Level II, follow the same coding conventions that are used to assign ICD-10-CM and CPT codes. When using ICD-10-CM, the coder first uses the Alphabetic Index to locate the appropriate diagnosis and then verifies the code selection using the Tabular List. Just as for coding using the CPT, the Index–arranged alphabetically and located at the end of the text–is used to find the main term, which is then verified in the code sections that are arranged numerically.

BILLING TIP

Researching HCPCS Codes

Publishers' features vary for HCPCS code books, and the index, which is not a standard element because it is for both ICD-10-CM and CPT, is not always complete or helpful. Coders may need to look up a desired item by scanning through a probable listing if the item is not an indexed entry.

Coding Steps

To assign HCPCS Level II codes, first look up the name of the supply or item in the index. The index is arranged alphabetically with the main term in bold print followed by the HCPCS Level II code. Verify the code selection in the appropriate Tabular List section of the HCPCS Level II code book.

Assigning drug codes is made easier by the Table of Drugs in the HCPCS code book. It presents drugs in alphabetical order, followed by the dosage, the way the drug is administered (such as intravenously), and the HCPCS code.

Kanamycin sulfate, up to 500 mg	IM, IV	J1840
Kanamycin sulfate, up to 75 mg	IM, IV	J1850

Also to be checked are symbols next to some codes. Publishers use various symbols in HCPCS code books, but their meaning is always explained in the legend on the bottom

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Table 5.6 HCPCS Level II Detailed Code Ranges and Examples

Section	Code Range	Example
Transportation services including ambulance	A0021–A0999	A0210 Nonemergency transportation: ancillary: meals, escort
Medical and surgical supplies	A4206–A8004	A4211 Supplies for self-administered injections
Administrative, miscellaneous, and investigational	A9150–A9999	A9282 Wig, any type, each
Enteral and parenteral therapy	B4000–B9999	B4082 Nasogastric tubing without stylet
Outpatient PPS	C1300–C9899	C1731 Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes)
Durable medical equipment	E0100–E9999	E0250 Hospital bed, fixed height, with any type side rails, with mattress
Procedures/professional services (temporary)	G0008–G9977	G0008 Administration of influenza virus vaccine
Alcohol and drug abuse treatment services	H0001–H2037	H0006 Alcohol and/or drug services; case management
J codes drugs	J0120–J8999	J0120 Injection, tetracycline, up to 250 mg
J codes chemotherapy drugs	J9000–J9999	J9212 Injection, interferon Alfacon-1, recombinant, 1 mcg
Temporary codes	K0000–K9999	K0001 Standard wheelchair
Orthotic procedures and devices	L0000–L4999	L1812 Knee orthosis, elastic with joints, prefabricated, off-the-shelf
Prosthetic procedures and devices	L5000–L9999	L5050 Ankle, Syme, molded socket, SACH foot
Medical services	M0000–M0301	M0075 Cellular therapy
Pathology and laboratory services	P0000–P9999	P3000 Screening Papanicolaou smear, cervical or vaginal, up to 3 smears, by technician under physician supervision
Q codes (temporary)	Q0035–Q9989	Q0035 Cardiokymography
Diagnostic radiology services	R0000–R5999	R0070 Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen
Temporary national codes (non-Medicare)	S0000–S9999	S0187 Tamoxifen citrate, oral, 10 mg
National T codes established for state Medicaid agencies	T1000–T9999	T1001 Nursing assessment/evaluation
Vision, hearing, speech-language pathology services	V0000–V59999	V2020 Frames, purchases

Source: "HCPCS A-Codes." Centers for Medicare and Medicaid Services, 2018. https://hcpcs.codes/a-codes/.

Temporary Codes

All payers may also use the *temporary national codes*. When temporary codes become permanent national HCPCS Level II codes, the coding reference indicates the change.

- *C codes:* Valid only on Medicare claims and used specifically for the hospital outpatient prospective payment system
- *G codes:* For the professional component of services and procedures not found in the CPT
- *Q codes:* For drugs, medical equipment, and services that have not been given CPT codes and are not identifiable in the Level II codes but are needed to process a billing claim
- *K codes:* Used when no permanent national codes exist for the product or supply
- *S codes:* For private insurers to identify drugs, services, supplies, and procedures; used by the Medicaid program but not reimbursable under Medicare

PDAC product classification list of individual items and their code categories
www.dmepdac.com

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Review Questions

Match the key terms with their definitions.

1. **LO 5.10** panel
2. **LO 5.4** professional component
3. **LO 5.8** separate procedure
4. **LO 5.1** Category III codes
5. **LO 5.8** global period
6. **LO 5.1** packaged code
7. **LO 5.1** Category II codes
8. **LO 5.3** add-on code
9. **LO 5.13** HCPCS
10. **LO 5.4** modifier
11. **LO 5.2** section guidelines
12. **LO 5.7** physical status modifier
13. **LO 5.6** consultation

A. The physician's skill, time, and expertise used in performing a procedure
B. Temporary codes for emerging technology, services, and procedures
C. Procedure code that groups related procedures under a single code
D. Code set providing national codes for supplies, services, and products
E. The inclusion of pre- and postoperative care for a specified period in the charges for a surgical procedure
F. CPT codes that are used to track performance measures
G. In CPT, a single code that groups laboratory tests that are frequently done together
H. A procedure performed in addition to a primary procedure
I. A secondary procedure that is performed with a primary procedure and that is indicated in CPT by a plus sign (+) next to the code
J. A two-digit number indicating that special circumstances were involved with a procedure, such as a reduced service or a discontinued procedure
K. A service in which a physician advises a requesting physician about a patient's condition and care
L. Usage notes at the beginning of CPT sections
M. Code used with anesthesia codes to indicate a patient's health status

Select the answer choice that best completes the statement or answers the question.

14. **LO 5.12** Identify the correct structure of Category II codes in CPT.
    A. an alphabetical character followed by three digits
    B. an alphabetical character followed by four digits
    C. three digits followed by an alphabetical character
    D. four digits followed by an alphabetical character

15. **LO 5.6** When a physician asks a patient questions to obtain an inventory of constitutional symptoms and of the various body systems, the results are documented as the
    A. past medical history
    B. family history
    C. review of systems
    D. comprehensive examination

16. **LO 5.13** Temporary codes for drugs and medical equipment are what type of HCPCS codes?
    A. Q codes
    B. D codes
    C. T codes
    D. V codes

17. **LO 5.2, 5.6** The examination that the physician conducts is categorized as
    A. straightforward, low complexity, moderate complexity, or high complexity
    B. problem-focused, expanded problem-focused, detailed, or comprehensive
    C. straightforward, problem-focused, detailed, or highly complex
    D. low risk, moderate risk, or high risk

18. **LO 5.6** The three key factors in selecting an E/M code are
    A. time, severity of presenting problem, and history
    B. history, examination, and time
    C. past history, history of present illness, and chief complaint
    D. history, examination, and medical decision making

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Learning Outcomes	Key Concepts/Examples
5.6 Explain how the key components are used in selecting CPT Evaluation and Management codes.	Key components for selecting Evaluation and Management codes are: • The extent of the history documented • The extent of the examination documented • The complexity of the medical decision making The steps for selecting correct E/M codes are: Step 1. Determine the category and subcategory of service based on the place of service and the patient's status. Step 2. Determine the extent of the history that is documented. Step 3. Determine the extent of the examination that is documented. Step 4. Determine the complexity of medical decision making that is documented. Step 5. Analyze the requirements to report the service level. Step 6. Verify the service level based on the nature of the presenting problem, time, counseling, and care coordination. Step 7. Verify that the documentation is complete. Step 8. Assign the code.
5.7 Explain the physical status modifiers and add-on codes used in the Anesthesia section of CPT Category I codes.	• The patient's health has a considerable effect on the relative difficulty of anesthesia services. • Therefore, one of these physical status modifiers is added to the anesthesia code: P1 Normal healthy patient P2 Patient with mild systemic disease P3 Patient with severe systemic disease P4 Patient with severe systemic disease that is a constant threat to life P5 Moribund patient who is not expected to survive without the operation P6 Declared brain-dead patient whose organs are being removed for donor purposes
5.8 Differentiate between surgical packages and separate procedures in the Surgery section of CPT Category I codes.	• Many codes in the Surgery section represent all the usual services in addition to the operation itself, a concept referred to as the *surgical package*. • These usual services are not coded in addition to the surgery code that includes them. • Codes that are called *separate procedures* in their descriptors, however, can be reported when that procedure is done alone rather than as part of a surgical package.
5.9 State the purpose of the Radiology section of CPT Category I codes.	• The Radiology section of CPT contains codes reported for radiology procedures either performed by or supervised by a physician.
5.10 Code for laboratory panels in the Pathology and Laboratory section of CPT Category I codes.	• Laboratory panels located in the Pathology and Laboratory section of CPT are single codes that represent a specific battery of tests. • To report a panel code, all the indicated tests must have been done, and any additional test is coded separately.
5.11 Code for immunizations using the Medicine section CPT Category I codes.	• Immunizations require two codes from the Medicine section, one for administering the immunization and the other for the particular vaccine or toxoid that is given.
5.12 Contrast Category II and Category III codes.	• Category II and Category III codes both have five characters—four numbers and a letter. • Category II codes are for tracking performance measures to improve patients' health. • Category III codes are temporary codes for new procedures that may or may not enter the Category I code set if they become widely used in the future.
5.13 Discuss the purpose of the HCPCS code set and its modifiers.	• The HCPCS code set provides a coding system for specific products, supplies, and services that patients receive in the delivery of their care.

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Chapter 5 Summary

Learning Outcomes	Key Concepts/Examples
5.1 Explain the CPT code set.	• CPT contains the HIPAA-mandated system of codes for physicians' medical, evaluation and management, and procedural services. The CPT code set contains: • Category I codes for physician work • Category II codes for tracking performance measures • Category III codes for temporary assignment to emerging technologies, services, and procedures
5.2 Describe the organization of CPT.	• CPT has an index that is used first in the process of selecting a code. It contains alphabetic descriptive main terms and subterms for the procedures and services contained in the main text. CPT contains the main text, which has six sections of Category I codes: • Evaluation and Management • Anesthesia • Surgery • Radiology • Pathology and Laboratory • Medicine as well as Category II and Category III codes • Codes are listed in the main text and are generally grouped by body system or site or by type of procedure. • The AMA publication of CPT has fifteen appendixes that are organized by topic.
5.3 Summarize the use of format and symbols in CPT.	• Each coding section of CPT begins with section guidelines that discuss definitions and rules for the use of codes, such as for unlisted codes, special reports, and notes for specific subsections. • When a main entry has more than one code, a semicolon follows the common part of a descriptor in the main entry, and the unique descriptors that are related to the common description are indented below it. Seven symbols are: 1. • (a bullet or black circle) indicates a new procedure code 2. ▲ (a triangle) indicates that the code's descriptor has changed 3. ►◄ (facing triangles) enclose new or revised text other than the code's descriptor 4. + (a plus sign) before a code indicates an add-on code that is used only along with other codes for primary procedures 5. ★ (a star) indicates a telemedicine code 6. ⚡ (a lightning bolt) is used for codes for vaccines that are pending FDA approval 7. # (a number sign) indicates a resequenced code
5.4 Assign modifiers to CPT codes.	• A CPT modifier is a two-digit number that may be attached to most five-digit procedure codes to indicate that the procedure is different from the listed descriptor but not in a way that changes the definition or requires a different code. • Two or more modifiers may be used with one code to give the most accurate description possible.
5.5 Apply the six steps for selecting CPT procedure codes to patient scenarios.	Six general steps are followed to assign correct CPT codes: • Step 1. Review complete medical documentation. • Step 2. Abstract the medical procedures from the visit documentation. • Step 3. Identify the main term for each procedure. • Step 4. Locate the main terms in the CPT Index. • Step 5. Verify the code in the CPT main text. • Step 6. Determine the need for modifiers.

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Table 5.7 Selected HCPCS Level II (National) Modifiers

Modifier	Description
CA	Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
GA	Waiver of liability statement issued as required by payer policy, individual case
GG	Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day
GY	Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit
GZ	Item or service expected to be denied as not reasonable and necessary
LC	Left circumflex coronary artery
LD	Left anterior descending coronary artery
RC	Right coronary artery
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)
QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by a provider of services
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit
TC	Technical component

Source: "HCPCS A-Codes." Centers for Medicare and Medicaid Services, 2014. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/AQ2125.pdf; and https://www.connecticare.com/provider/commercial/providermanual/Billing/Modifiers.aspx.

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COMPLIANCE GUIDELINE

Why Compliant Billing?

The possible consequences of billing incorrectly include:

- Denied claims
- Delays in processing claims and receiving payments
- Reduced payments
- Fines and other sanctions
- Loss of hospital privileges
- Exclusion from payers' programs
- Prison sentences
- Loss of the physician's license to practice medicine

Although physicians have the ultimate responsibility for proper documentation, correct coding, and compliance with billing regulations, medical insurance specialists help ensure maximum appropriate reimbursement by submitting correct, accurate healthcare claims. The process used to generate claims must comply with the rules imposed by federal and state laws as well as with payer requirements. Correct claims help reduce the chance of an investigation of the practice for fraud and the risk of liability if an investigation does occur.

6.1 Compliant Billing

In the revenue cycle, after patients' encounters, physicians prepare and sign documentation of the visit. The next step is to post the medical codes and transactions of the patient's visit in the practice management program (PMP) and to prepare claims.

Correct claims report the connection between a billed service and a diagnosis. The diagnosis must support the billed service as necessary to treat or investigate the patient's condition. Payers analyze this connection, called **code linkage,** to decide whether the charges are for medically necessary services. Figure 6.1 shows a completed healthcare claim that correctly links the diagnosis and the procedure. Review the information on the lower left of the claim to see the diagnosis code and the procedure code. This chapter covers basic information about billing; the next chapter presents the mechanics of preparing and sending claims.

code linkage connection between a service and a patient's condition or illness

THINKING IT THROUGH 6.1

1. Research the meaning of the diagnosis code and the procedure code shown on the claim in Figure 6.1 and explain how they demonstrate linkage that establishes medical necessity for the payer.

6.2 Knowledge of Billing Rules

To prepare correct claims, it is important to know payers' billing rules that are stated in patients' medical insurance policies and in participation contracts. Because contracts change and rules are updated, medical insurance specialists also rely on payer bulletins, websites, and regular communications with payer representatives to keep up-to-date.

In this chapter, basic claim compliance is discussed. Chapters 8 through 12 cover the specific rules for these types of payers:

- Chapter 8 Private Payers/ACA Plans
- Chapter 9 Medicare
- Chapter 10 Medicaid
- Chapter 11 TRICARE and CHAMPVA
- Chapter 12 Workers' Compensation and Disability

Medicare Regulations: The Correct Coding Initiative

Correct Coding Initiative (CCI) computerized Medicare system that controls improper coding that would lead to inappropriate payment for Medicare claims

Correct Coding Initiative Updates
www.cms.gov/NationalCorrectCodInitEd/

The rules from the Centers for Medicare and Medicaid Services (CMS) about billing Medicare are published in the *Federal Register* and in CMS manuals such as the *Medicare Carriers Manual* and *Coverage Issues Manual* (see the previous chapter and the CMS website). Especially important for billing is Medicare's national policy on correct coding, the Medicare National **Correct Coding Initiative (CCI)** (also known as NCCI). CCI controls improper coding that would lead to inappropriate payment for Medicare claims. It has coding policies that are based on:

- Coding conventions in CPT
- Medicare's national and local coverage and payment policies
- National medical societies' coding guidelines
- Medicare's analysis of standard medical and surgical practice

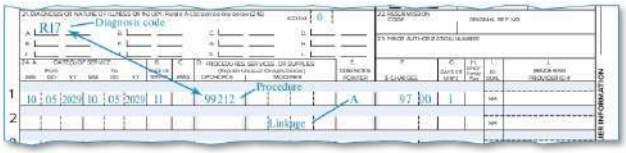

FIGURE 6.1 Example of a Correct Healthcare Claim Showing the Linkage Between the Diagnosis and the Billed Service

CCI, updated every quarter, has many thousands of *Current Procedural Terminology,* or CPT code combinations called CCI **edits** that are used by computers in the Medicare system to check claims. The CCI edits are available on a CMS website. CCI edits apply to claims that bill for more than one procedure performed on the same patient (Medicare beneficiary), on the same date of service, by the same performing provider. Claims are denied when codes reported together do not "pass" an edit.

edits computerized system that identifies improper or incorrect codes

CCI prevents billing two procedures that, according to Medicare, could not possibly have been performed together. Here are examples:

- Reporting the removal of an organ both through an open incision and with laparoscopy
- Reporting female- and male-specific codes for the same patient

CCI edits also test for unbundling. A claim should report a bundled procedure code instead of multiple codes that describe parts of the complete procedure. For example, because a single code is available to describe removal of the uterus, ovaries, and fallopian tubes, physicians should not use separate codes to report the removal of the uterus, ovaries, and fallopian tubes individually.

CCI requires physicians to report only the more extensive version of the procedure performed and disallows reporting of both extensive and limited procedures. For example, only a deep biopsy should be reported if both a deep biopsy and a superficial biopsy are performed at the same location.

Complete CCI Files: Medicare Claims Processing Manual (Publication 100-04), Chapter 23, Section 20.9

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Organization of the CCI Edits

CCI edits are organized into the following basic categories:

- Column 1 and column 2 code pair edits
- Mutually exclusive code edits
- Modifier indicators

Additional explanations for other edits also appear in the CCI edit table.

Column 1 and Column 2 Code Pairs In the **CCI column 1 and column 2 code pair edits,** two columns of codes are listed. Most often, the edit is based on one code being a component of the other. This means that the column 1 code includes all the services described by the column 2 code(s), so the column 2 code(s) cannot be billed together with the column 1 code for the same patient on the same day of service. Medicare pays for the column 1 code only; the column 2 code(s) are considered bundled into the column 1 code.

CCI column 1 and column 2 code pair edit Medicare code edit where CPT codes in column 2 will not be paid if reported on the same day as the column 1 code

Example

Column 1	Column 2
27370	20610, 76000

If 27370 is billed, neither 20610 nor 76000 should be billed with it because the payment for each of these codes is already included in the column 1 code. ◂

Mutually Exclusive Code Edits **CCI mutually exclusive code (MEC) edits** are also listed in the two columns. According to CMS regulations, both services represented by these codes could not have reasonably been done during a single patient encounter, so they cannot be billed together. If the provider reports both codes from both columns for a patient on the same day, Medicare pays only the lower-paid code.

CCI mutually exclusive code (MEC) edit both services represented by MEC codes that could not have been done during one encounter

CCI modifier indicator number showing whether the use of a modifier can bypass a CCI edit

BILLING TIP

Resubmit Claims with Modifier Indicator of 9

If the CCI modifier indicator 9 appears on a claim denial, this means that the original edit was a mistake and is being withdrawn; resubmit it for payment if appropriate.

medically unlikely edits (MUEs) units of service edits used to lower the Medicare fee-for-service paid claims error rate

Medically Unlikely Edits

www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

OIG Work Plan OIG's annual list of planned projects

advisory opinion opinion issued by CMS or OIG that becomes legal advice

excluded parties individuals or companies not permitted to participate in federal healthcare programs

BILLING TIP

Software for Edits

Many vendors sell computer programs to check claims against the edits before submitting them to Medicare. For example, one program identifies any mutually exclusive or column 1 and column 2 codes and indicates whether a modifier is required for payment.

Modifier Indicators In CPT coding, modifiers show particular circumstances related to a code on a claim. The **CCI modifier indicators** control modifier use to "break," or avoid, CCI edits. CCI modifier indicators appear next to items in the CCI list. A CCI modifier indicator of 1 means that a CPT modifier *may* be used to bypass an edit (if the circumstances are appropriate). A CCI modifier indicator of 0 means that use of a CPT modifier will not change the edit, so the column 2 codes or mutually exclusive code edits will not be bypassed.

Example

Flu vaccine code 90656 includes bundled flu vaccine codes 90655 and 90657–90660. It has a CCI indicator of 0. No modifier will be effective in bypassing these edits; so in every case, only CPT 90656 will be paid. ◂

Medically Unlikely Edits

Also important for billing and compliance are the units of service (UOS) edits that CMS uses, which are called **medically unlikely edits (MUEs).** A MUE is related to a specific CPT or HCPCS code and applies to the services that a single provider (or supplier, for supplies such as durable medical equipment) provides for a single patient on the same date of service. The MUE value is based on the maximum units of service that would be reported for a code on the vast majority of correct claims.

MUEs are designed to reduce errors on claims due to clerical entries. They also correct coding mistakes based on anatomic considerations, CPT/HCPCS code descriptors, CPT coding instructions, Medicare policies, or unlikely services. An example is a MUE edit that rejects a claim for a hysterectomy on a male patient. The goal is to reduce the number of healthcare claims that are sent back simply because of a data entry error. The MUE system is set up to allow reporting of appropriate extra units of services when the situation warrants it. For example, the use of modifier 76 would be reported when a physician had to repeat a procedure for a medically necessary reason. Most MUEs are publicly available on the CMS website, but some are confidential and known only to CMS.

Other Government Regulations

Other government billing regulations are issued by the Office of Inspector General (OIG). Annually, as part of a Medicare Fraud and Abuse Initiative, OIG announces the **OIG Work Plan** for the coming year. The Work Plan lists projects for sampling particular types of billing to determine whether there are problems. Practices study these initiatives and make sure their procedures comply with billing regulations. When regulations seem contradictory or unclear, OIG issues **advisory opinions** on its OIG website. These opinions are legal advice only for the requesting parties, who, if they act according to the advice, cannot be investigated on the matter. However, they are good general guidelines for all practices to follow to avoid fraud and abuse.

The OIG website as shown in Figure 6.2 also has:

- Audit reports that summarize OIG findings after problems have been investigated.
- The List of Excluded Individuals/Entities (LEIE), a database that provides information about **excluded parties.** If employees, physicians, or contractors have been found guilty of fraud, they may be excluded from work for government programs, and their names appear on the LEIE. An OIG exclusion has national scope and is important because knowingly hiring excluded people or companies is illegal.

Private Payer Regulations

CCI edits apply to Medicare claims only. Private payers, however, develop code edits similar to those of the CCI. Although private payers give information about payment policies in their contracts, handbooks, and bulletins, the exact code edits may not be released. At times, their claim-editing software does not follow CPT guidelines and bundles distinct procedures or does not accept properly used modifiers. In such cases, medical insurance specialists must follow up with the payer for clarification and possible appeal of denied claims.

FIGURE 6.2 OIG Website Home Page

OIG Home Page
http://oig.hhs.gov

THINKING IT THROUGH 6.2

1. What type of code edit could be used for the following rule?

   Medicare Part B covers a screening Pap smear for women for the early detection of cervical cancer but will not pay for an evaluation and management (E/M) service for the patient on the same day.

   An OIG fraud project found that during one month in a single state, there were 23,000 billings for an E/M service with the modifier 25 reported with one of these CPT codes: 11055, 11056, 11057, and 11719, and with HCPCS code G0127 (trimming of dystrophic nails).

   A. Look up the descriptors for the CPT codes. Do you think the procedures appear to be simple or complicated?

   _____

   B. Why do you think that this billing combination continues to be under scrutiny by CMS?

   _____

PHI and the Minimum Necessary Standard

Protected health information (PHI) from the patient's medical record must be available for the payer to review if it is requested. Be sure to release only the minimum necessary information to answer the payer's questions.

59 and that must be used instead of 59 when the situation applies. The group of new modifiers is collectively referred to as *X[EPSU]* modifiers by CMS. The **X modifiers** are as follows:

X modifiers (X[EPSU]) HCPCS modifiers that define specific subsets of modifier 59

- XE: Separate Encounter: A Service That Is Distinct Because It Occurred During a Separate Encounter
- XS: Separate Structure: A Service That Is Distinct Because It Was Performed On a Separate Organ/Structure
- XP: Separate Practitioner: A Service That Is Distinct Because It Was Performed By a Different Practitioner
- XU: Unusual Non-Overlapping Service: The Use of a Service That Is Distinct Because It Does Not Overlap Usual Components of the Main Service

These new modifiers will provide more specific information regarding why the two services are appropriately reported and, therefore, if one of them applies, it should be reported rather than modifier 59.

Modifier 91: Repeat Clinical Diagnostic Laboratory Test

Modifier 91 should be appended to a laboratory procedure or service to indicate a repeat test or procedure performed on the same day for patient management purposes. This modifier indicates that the physician or provider had to perform a repeat clinical diagnostic laboratory test that was distinct or separate from a lab panel or other lab services performed on the same day and that it was performed to obtain medically necessary subsequent reportable test values. This modifier should not be used to report repeat laboratory testing due to laboratory errors, quality control, or confirmation of results.

Example

A patient undergoing chemotherapy for lung carcinoma has a complete blood count (CBC) with automated platelet count performed prior to receiving chemotherapy. The patient has a very low platelet count and receives a platelet transfusion. The automated platelet count is repeated after the transfusion to determine that the platelet count is high enough for the patient to be sent home.

CPT codes on the claim are 85027 (covers automated CBC with automated platelet count) and 85049 91 (covers repeat automated platelet count). ◂

In general, clarify coding and billing questions with physicians, and be sure that the physician adds any needed clarification to the documentation. Use the information from claims that are denied or paid at a lesser rate to modify procedures as needed.

BILLING TIPS

Professional Courtesy

- Medicare and most private payers do not permit a physician to bill for the treatment of immediate family or household members.
- If professional courtesy is extended to a patient, no one is billed—neither the person receiving it nor the insurance carrier.

BILLING TIP

Check the Documentation

Check the documentation to uncover billing information for frequently billed services. For example, if immunizations are often billed, make it standard procedure to research the quantity of the vaccine administered for correct billing.

Be Clear on Professional Courtesy and Discounts to Uninsured and Low-Income Patients

Professional Courtesy

Professional courtesy means that a physician has chosen to waive (not collect) the charges for services to other physicians and their families. Although this has been common practice in the past, many federal and state laws now prohibit professional courtesy. The routine waiver of deductibles and copays is unlawful because it results in false claims and violates antikickback rules.

professional courtesy providing free services to other physicians and their families

Many physician practices study OIG's *Compliance Program Guidance for Individual and Small Group Physician Practices* and then consult an attorney to clarify their professional courtesy arrangements. The resulting guidelines should be explained to the administrative staff regarding the practice's billing policies and procedures.

COMPLIANCE GUIDELINE

Compliant Encounter Forms

To provide the opportunity to review all appropriate codes in a practice's most frequently assigned E/M code ranges before selecting a code, the complete ranges, not just the most usually assigned codes, should be listed on encounter forms.

Benchmark the Practice's Evaluation and Management (E/M) Codes with National Averages

Comparing the E/M codes that the practice reports with national averages is a good way to monitor upcoding. Medical coding consulting firms as well as CMS and other payers have computer programs to profile average billing patterns for various types of codes. For example, reporting only the top two of a five-level E/M code range for new or established patient office visits would not fit a normal pattern and might appear fraudulent.

Use Modifiers Appropriately

CPT modifiers can eliminate any impression of duplicate billing or unbundling. Modifiers 25, 59, and 91 are especially important for compliant billing.

Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

When a procedure is performed, the patient's condition may require the physician to perform an E/M service above and beyond the usual pre- and postoperative care associated with that procedure. In this case, modifier 25 is appended to the *evaluation and management* (E/M) code reported with the procedure code. The modifier 25 says that this was a significant, clearly separate E/M service by the same physician on the same day as the procedure. Note that a different diagnosis does not have to be involved.

Example

An established patient is seen in a physician's office for a cough, runny nose, and sore throat that started five days ago. During examination, the patient also reports right and left earaches. The physician performs an expanded history and examination with a medical decision making of low complexity. The physician also examines the patient's ears and performs earwax removal from the left and right ears. The patient is discharged home on antibiotics with the following diagnoses and procedures: common cold, impacted cerumen, and removal of impacted cerumen.

CPT codes on the claim are 99213 25 (covers office visit portion) and 69210 (covers removal of impacted cerumen). ◄

Modifier 59: Distinct Procedural Service

Modifier 59 is used to indicate a procedure that was distinct or independent from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).

Example

A physician performs a simple repair (2.5 centimeters in size) of a superficial wound to the right arm and performs a partial thickness skin debridement of another site on the same arm.

CPT codes on the claim are 12001 (covers the repair of the superficial wound) and 11042 59 (covers skin debridement). ◄

Modifier 59 has often been used inappropriately to override bundling edits in the CCI. For this reason, CMS has mandated new HCPCS modifiers that are a subset of modifier

- Unbundling
- Using an inappropriate modifier or no modifier when one is required
- Always assigning the same level of E/M service
- Billing a consultation instead of an office visit
- Billing invalid/outdated codes
- **Upcoding**—using a procedure code that provides a higher reimbursement rate than the correct code—may lead to the payer **downcoding**—using a lower-level code
- Billing without proper signatures on file

COMPLIANCE GUIDELINE

Fraudulent Code Changes

It is fraudulent to change a code for reimbursement purposes. Only the codes that are supported by the documentation, regardless of payer policy, should be reported.

upcoding use of a procedure code that provides a higher payment

downcoding payer's review and reduction of a procedure code

THINKING IT THROUGH 6.3

1. Botox injections have been approved by the Food and Drug Administration (FDA) as a procedure to treat spasms of the flexor muscles in the elbow, wrist, and fingers. Should a payer reject a claim for this use of Botox based on lack of medical necessity?

6.4 Strategies for Compliance

Sending claims that generate payment at the highest appropriate level is a critical goal, but regulations can be unclear or can even conflict with each other. Compliant billing can be a difficult and complex assignment; the strategies discussed in this section are helpful.

Carefully Define Packaged Codes and Know Global Periods

Coders and medical insurance specialists must be clear on what individual procedures are contained in codes and what the global periods are for surgical procedures. Many practices use Medicare's CCI for deciding what is included in a procedure code; they inform their other payers that they are following this system of edits. If the payer has a unique set of edits, coders and billers need to have access to it.

Currently, Medicare uses global periods based on the complexity of the procedure performed. Global periods for minor procedures have a postoperative period of zero or ten days, and their preoperative period is just the day of the procedure. Major procedures have global periods containing a ninety-day postoperative period with a one-day preoperative period. Each CPT code in the CCI has a corresponding global period status indictor that identifies its global period. The global period status indicators used by Medicare are:

- **000** Used for endoscopies or minor procedures without a preoperative and postoperative period
- **010** Used for minor procedures with a same-day preoperative period and a ten-day postoperative period
- **090** Used for major procedures with a one-day preoperative period and a ninety-day postoperative period
- **MMM** Used for maternity codes for which the global period concept does not apply
- **XXX** Used for codes for which the global period concept does not apply
- **YYY** Used for unlisted codes that are subject to individual pricing
- **ZZZ** Used for add-on codes that are related to another service and included in the global period of that primary service

Note, however, that in 2019, CMS is expected to change all ten- and ninety-day global packages to zero-zero day global codes. Medicare will pay separately for visits after the date of service and revalue the surgical codes.

BILLING TIP

Unrelated Work During the Global Period

Visits during a postoperative period that are not related to the patient's surgical procedures are billable; use modifier 79 to indicate this situation.

6.3 Compliance Errors

Healthcare payers often base their decisions to pay or deny claims only on the diagnosis and procedure codes. The integrity of the request for payment rests on the accuracy and honesty of the coding and billing. Incorrect work may simply be an error, or it may represent a deliberate effort to obtain fraudulent payment. Some compliance errors are related to medical necessity; others are a result of incorrect code selection or billing practices.

BILLING TIP

Query Physicians About Unspecified Diagnosis Codes

Unspecified diagnosis codes indicate that some characteristic of the condition was not documented and are usually rejected by payers as being too vague to support medical necessity.

Errors Relating to Code Linkage and Medical Necessity

Claims are denied for lack of medical necessity when the reported services are not consistent with the diagnosis or do not meet generally accepted professional medical standards of care. Each payer has its own list of medical necessity edits. In general, codes that support medical necessity meet these conditions:

- The CPT procedure codes match the ICD-10-CM diagnosis codes.

Example

A procedure to drain an abscess of the external ear or auditory canal should be supported by a diagnosis of disorders of the external ear or an ear carbuncle or cyst. ◂

- The procedures are not elective, experimental, or nonessential.

BILLING TIP

Teamwork

When medical coding and billing are handled by separate departments or employees, they must work as a team to prepare correct claims. The medical insurance specialist contributes knowledge of the items that must be present for payment, and the medical coder presents the codes that are supported by the documentation.

Example

Cosmetic nasal surgery performed to improve a patient's appearance is typically excluded. However, a cosmetic procedure may be considered medically necessary when it is performed to repair an accidental injury or to improve the functioning of a malformed body member. A diagnosis of deviated septum, nasal obstruction, acquired facial deformity, or late effects of facial bone fracture supports medical necessity for cosmetic nasal surgery. ◂

- The procedures are furnished at an appropriate level.

Example

A high-level E/M code for an office visit (such as 99204/99205 and 99214/99215) must be matched by a serious, complex condition such as a sudden, unexplained large loss of weight. ◂

Errors Relating to the Coding Process

These coding problems may cause rejected claims:

truncated coding diagnoses not coded at the highest level of specificity

assumption coding reporting undocumented services that the coder assumes have been provided due to the nature of the case or condition

- **Truncated coding**—using diagnosis codes that are not as specific as possible
- Mismatch between the gender or age of the patient and the selected code when the code involves selection for either criterion
- **Assumption coding**—reporting items or services that are not actually documented but that the coder assumes were performed
- Altering documentation after services are reported
- Coding without proper documentation
- Reporting services provided by unlicensed or unqualified clinical personnel
- Coding a unilateral service twice instead of choosing the bilateral code
- Not satisfying the conditions of coverage for a particular service, such as the physician's direct supervision of a physician assistant's work

Errors Relating to the Revenue Cycle

A number of errors are related to the revenue cycle. These are the most frequent errors:

- Billing noncovered services
- Billing overlimit services

THINKING IT THROUGH 6.5

1. Should internal audits be conducted on a regular basis? Why or why not?

6.6 Physician Fees

Patients often have questions like "How much will my insurance pay?" or "How much will I owe?" "Why are these fees different from my previous doctor's fees?" Medical insurance specialists handle these questions based on their knowledge of the provider's current fees and their estimates of what patients' insurance plans will pay. Both to prepare compliant claims and to estimate what patients will owe, medical insurance specialists must be prepared to answer these key questions:

- What services are covered under the plan? Which services are not covered and therefore cannot be billed to the plan but should be billed to the patient?
- What are the billing rules, fee schedules, and payment methods of the plan?
- In addition to noncovered services, what is the patient responsible for paying?

Sources for Physician Fee Schedules

Physicians establish a list of their **usual fees** for the procedures and services they frequently perform. Usual fees are defined as those that they charge to most of their patients most of the time under typical conditions. There are exceptions to the physician's fee schedule. For example, workers' compensation patients often must be charged according to a state-mandated fee schedule.

usual fee normal fee charged by a provider

The typical ranges of physicians' fees nationwide are published in commercial databases. For example, Figure 6.3 shows the fees for a group of CPT codes from the surgical section. The first and second columns list the CPT codes and brief descriptions of the services. The third, fourth, and fifth columns show the following amounts:

- *Column 3:* Half (50 percent) of the reported fees were higher than this fee, and the other half were lower. This is called the *midpoint* of the range.
- *Column 4:* One-quarter (25 percent) of the fees were higher than this fee, and three-quarters (75 percent) were lower.
- *Column 5:* Ten percent of the fees were higher than this fee, and 90 percent were lower.

For example, in Figure 6.3, CPT 29010, Apply body cast, Risser jacket, columns 3, 4, and 5 show the values $376, $485, and $591. This means that half of the reporting providers charged less than $376 for this service, and half charged more. Three-quarters of the reporting providers charged less than $485 for this service, and 25 percent charged

(1) CODE	(2) SHORT DESCRIPTION	(3) 50TH	(4) 75TH	(5) 90TH	(6) MFS	(7) RVU
APPLICATION OF CASTS AND STRAPPING						
29000	APPLICATION OF BODY CAST, HALO TYPE	478	617	753	151	4.12
29010	APPLY BODY CAST, RISSER JACKET	376	485	591	167	4.56
29015	APPLY BODY/HEAD CAST, RISSER JACKET	439	567	692	179	4.87
29035	APPLY BODY CAST, SHOULDER TO HIPS	255	329	401	143	3.98
29040	APPLY BODY CAST, SHOULDER TO HIPS	339	438	534	160	4.36
29044	APPLY BODY CAST, SHOULDER TO HIPS	299	386	471	160	4.37
29046	APPLY BODY CAST, SHOULDER TO HIPS	324	419	511	176	4.80

FIGURE 6.3 Sample Physician Fee Database

practices set up an "audit log" to track requests for documents, demand letters from CMS, appeal deadlines, and final determinations. As covered later in this text, RAC-based denials may be appealed using a specific process; thus, documenting the response to requests is important so an appeal can be properly supported.

Internal Audits

internal audit self-audit conducted by a staff member or consultant

To reduce the chance of an investigation or an external audit and to reduce potential liability when one occurs, most practices' compliance plans require **internal audits** to be conducted regularly by the medical practice staff or by a hired consultant. These audits are routine and are performed periodically without a reason to think that a compliance problem exists. They help the practice determine whether coding is being done appropriately and whether all performed services are being reported for maximum revenue. The goal is to uncover problems so that they can be corrected. They also help:

- Determine whether new procedures or treatments are correctly coded and documented
- Analyze the skills and knowledge of the personnel assigned to handle medical coding in the practice
- Locate areas where training or additional review of practice guidelines is needed
- Improve communications among the staff members involved with claims processing—medical coders, medical insurance specialists, and physicians

prospective audit internal audit of claims conducted before transmission

retrospective audit internal audit conducted after claims are processed and RAs have been received

Internal audits are done either prospectively or retrospectively. A **prospective audit** (also called a *concurrent audit*), like a prepayment audit, is done before the claims are sent. Some practices audit a percentage of claims each day. Others audit claims for new or very complex procedures. These audits reduce the number of rejected or downcoded claims by verifying compliance before billing.

Retrospective audits are conducted after the claims have been sent and the remittance advice (RA) has been received. Auditing at this point in the process has two advantages: (1) The complete record, including the RA, is available, so the auditor knows which codes have been rejected or downcoded, and (2) there are usually more claims to sample. Retrospective audits are helpful in analyzing the explanations of rejected or reduced charges and making changes to the coding approach if needed.

COMPLIANCE GUIDELINE

Importance of Documentation

According to CMS, E/M codes are the most frequently audited because of continual findings of poor documentation. Some physicians even use lower codes than warranted to avoid an audit, but often their documentation does not justify even the lower code levels, so their actions reduce legitimate revenue and still do not protect them from investigation.

BILLING TIPS

Guidelines May Cross Over

E/M codes may use the 1997 documentation guidelines for an extended HPI along with other elements from the 1995 guidelines.

Auditing Tools to Verify E/M Code Selection

As explained in the previous chapter, the key components for selecting E/M codes are the extent of the history documented, the extent of the examination documented, and the complexity of the medical decision making. The 1995 and the 1997 versions of the CMS/AMA *Documentation Guidelines for Evaluation and Management Services* reduce the amount of subjectivity in making judgments about E/M codes, such as one person's opinion of what makes an examination extended. These guidelines do this by describing the specific items that may be documented for each of the three key E/M components. They also explain how many items are needed to place the E/M service at the appropriate level.

The documentation guidelines have precise number counts of these items, and these counts can be used to audit as well as to initially code services. The audit double-checks the selected code based on the documentation in the patient medical record. The auditor looks at the record and independently analyzes the services that are documented. The auditor then compares the code that should be selected with the code that has been reported. When the resulting codes are not the same, the auditor has uncovered a possible problem in interpreting the documentation guidelines.

Many practices use this type of audit tool to help them conduct audits in a standard way. These tools are distributed to physicians and staff members to develop internal audits, not to make initial code selections. An experienced medical insurance specialist may be responsible for using the audit tool to monitor completed claims and to audit selected claims before they are released.

An important compliance activity involves audits. An **audit** is a formal examination or methodical review. An income tax audit is performed to find out whether a person's or a firm's income or expenses were misreported. Similarly, compliance audits judge whether the practice's physicians and coding and billing staff comply with regulations for correct coding and billing.

audit formal examination or methodical review

An audit does not involve reviewing every claim and document. Instead, a representative sample of the whole is studied to reveal whether erroneous or fraudulent behavior exists. For instance, an auditor might make a random selection, such as a percentage of the claims for a particular date, or a targeted selection, such as all claims in a period that have a certain procedure code. An auditor who finds indications of a problem in the sample usually reviews, more documents and more details.

External Audits

In an **external audit,** private payers or government investigators review selected records of a practice for compliance. Coding linkage, completeness of documentation, and adherence to documentation standards, such as the signing and dating of entries by the responsible healthcare professional, may all be studied. The accounting records are often reviewed as well.

external audit audit conducted by an outside organization

Payers use computer programs of code edits to review claims before they are processed. This process is referred to as a *prepayment audit*. For example, the Medicare program performs computer checks before processing claims. Some prepayment audits check only to verify that documentation of the visit is on file, rather than investigating the details of the coding.

Audits conducted after payment has been made are called *postpayment audits*. Most payers conduct routine postpayment audits of physicians' practices to ensure that claims correctly reflect performed services, that services are billed accurately, and that the physicians and other healthcare providers who participate in the plan comply with the provisions of their contracts.

Private Payer Postpayment Audits

In a routine private payer audit, the payer's auditor usually makes an appointment in advance and may conduct the review either in the practice's office or by taking copies of documents back to the payer's office. Often, the auditor requests the complete medical records of selected plan members for a specified period. The claims information and documentation might include all office and progress notes, laboratory test results, referrals, X-rays, patient sign-in sheets, appointment books, and billing records. When problems are found, the investigation proceeds further and may result in charges of fraud or abuse against the practice.

Recovery Audit Contractor Initiative

The Medicare **Recovery Audit Contractor (RAC)** initiative audits Medicare claims and determines where there are opportunities to recover incorrect payments from previously paid but noncovered services (including services that were not medically necessary), erroneous coding, and duplicate services.

Recovery Audit Contractor (RAC) program designed to audit Medicare claims

RACs use a software program to analyze a practice's claims, looking for:

- Obvious "black and white" coding errors (such as a well-woman exam billed for a male patient)
- Medically unnecessary treatment or wrong setting of care when information in the medical record does not support the claim
- Multiple or excessive number of units billed

Offices should respond to all RAC inquiries because requests for information must be answered within 45 days, or an error is declared and penalties may result. Most

COMPLIANCE GUIDELINE

Compliant Tools

Encounter forms, job reference aids, and documentation templates should never link diagnoses and procedures. This could give the appearance of basing coding on reimbursement rather than on the patient's condition.

Discounts to Uninsured, Low-Income, and Self-Pay Patients

Many physician practices consider ability to pay when they bill patients. It is also legal to offer discounts to patients who do not have insurance coverage and are paying their bills directly. Under OIG guidelines, physicians may offer discounts to their uninsured and low-income patients. The practice's method for selecting people to receive discounts should be documented in the compliance plan and in its policies and procedures information.

Maintain Compliant Job Reference Aids and Documentation Templates

job reference aid list of a practice's frequently reported procedures and diagnoses

Many medical practices use computerized **job reference aids** to help in the billing and coding process. These aids usually list the procedures and CPT codes that are most frequently billed by the practice. Some also list frequently used diagnoses with ICD codes.

Job reference aids can help select correct codes, but their use may also lead to questions about compliance. Are codes assigned by selecting those that are close to patients' conditions rather than by researching precise codes based on the documentation?

computer-assisted coding (CAC) feature that allows a software program to assist in assigning codes

documentation template form used to prompt a physician to document a complete review of systems (ROS) and a treatment's medical necessity

If the practice uses an electronic health record (EHR) system, various coding tools are likely to be available. For example, **computer-assisted coding (CAC)** is a typical feature. This capability means that the software program has resources that assist the provider or the medical coder in assigning codes based on the EHR documentation of a visit.

EHRs have **documentation templates** to assist physicians as they document examinations. The template prompts the physician to document the review of systems (ROS) that was done and to note medical necessity. Like other forms used in medical coding, these templates must be compliant and must clearly record the work done.

EHR TIP

Coding Aids

When adopting an EHR, practices must ensure that any computer-assisted coding aids do not lead the user to a coding decision—especially to a higher level E/M code than was initially documented.

THINKING IT THROUGH 6.4

1. Medical necessity must be shown for emergency department visits for physicians' patients. If a four-year-old wakes at 3 AM with an earache and a temperature of 103°, in what order should the diagnosis codes be listed to show the urgent reason for an emergency department visit with the child's pediatrician?
2. The following diagnosis and procedure codes were rejected for payment. What is the probable reason for the payer's decision in each case?
   A. O35.0XX0
   B. Z41.3, 69090
   C. B00.89, 69145
   D. Z00.00, 80050, 80053

6.5 Audits

Monitoring the coding and billing cycle for compliance is done either by the practice's compliance officer, a staff member who is knowledgeable about coding and compliance regulations, or an outside consultant. The responsible person establishes a system for monitoring the process and performing regular compliance checks to ensure adherence to established policies and procedures.

THINKING IT THROUGH 6.8

1. The following are sample relative value units and geographic practice cost indices from a Medicare Fee Schedule. The conversion factor for this particular year is $34.7315.

Sample RVUs

CPT/HCPCS	Description	Work RVU	Practice Expense RVU	Malpractice Expense RVU
33500	Repair heart vessel fistula	25.55	30.51	4.07
33502	Coronary artery correction	21.04	15.35	1.96
33503	Coronary artery graft	21.78	26	4.07
99203	OV new detailed	1.34	0.64	0.05
99204	OV new comprehensive	2.00	0.96	0.06

Sample GPCIs

Locality	Work GPCI	Practice Expense GPCI	Malpractice Expense GPCI
San Francisco, CA	1.067	1.299	0.667
Manhattan, NY	1.093	1.353	1.654
Columbus, OH	0.990	0.939	1.074
Galveston, TX	0.988	0.970	1.386

Calculate the expected payments for:

A. Office visit, new patient, detailed history/examination, low-complexity decision making, in Manhattan, NY _____

B. Coronary artery graft in San Francisco, CA _____

C. Repair of heart vessel fistula in Columbus, OH _____

D. Coronary artery correction in Galveston, TX _____

6.9 Fee-Based Payment Methods

In addition to setting various fee schedules, payers use one of three main methods to pay providers:

1. Allowed charges
2. Contracted fee schedule
3. Capitation

Allowed Charges

Many payers set an **allowed charge** for each procedure or service. This amount is the most the payer will pay any provider for that CPT code. Whether a provider actually receives the allowed charge depends on three things:

1. *The provider's usual charge for the procedure or service:* The usual charge on the physician's fee schedule may be higher than, equal to, or lower than the allowed charge.
2. *The provider's status in the particular plan or program:* The provider is either participating or nonparticipating. Participating (PAR) providers agree to accept allowed charges that are lower than their usual fees. In return, they are eligible for incentives, such as quicker payments of their claims and more patients.
3. *The payer's billing rules:* These rules govern whether the provider can bill a patient for the part of the charge that the payer does not cover.

When a payer has an allowed charge method, it never pays more than the allowed charge to a provider. If a provider's usual fee is higher, only the allowed charge is paid. If a provider's usual fee is lower, the payer reimburses that lower amount. The payer's payment is always the lower of the provider's charge or the allowed charge.

allowed charge maximum charge a plan pays for a service or procedure

BILLING TIP

Allowed Charge: Other Terms

The allowed charge is also called *a maximum allowable fee, maximum charge, allowed amount, allowed fee, or allowable charge.*

Note that when RBRVS fees are used, payments are considerably lower than when UCR fees are used. On average, according to a study done by the Medicare Payment Advisory Commission, a nonpartisan federal advisory panel, private health plans' fees are about 15 percent higher than Medicare fees. (For example, compare columns 3, 4, and 5 with column 6 in Figure 6.3.)

THINKING IT THROUGH 6.7

1. Does the conversion factor remain the same from year to year?

6.8 Calculating RBRVS Payments

Medicare Physician Fee Schedule (MPFS) the RBRVS-based allowed fees

Each year, CMS updates each part of the RBRVS—the relative values, the GPCI, and the conversion factor. CMS publishes the year's **Medicare Physician Fee Schedule (MPFS)** in the *Federal Register*, and it is available on the CMS website.

Medicare Fee Schedule
www.cms.gov/PfsLookup/

See Figure 6.4 for the formula for calculating a Medicare payment. These steps are followed to apply the formula:

1. Determine the procedure code for the service.
2. Use the Medicare Fee Schedule to find the three RVUs—work, practice expense, and malpractice—for the procedure.
3. Use the Medicare GPCI list to find the three geographic practice cost indices (also for work, practice expense, and malpractice).
4. Multiply each RVU by its GPCI to calculate the adjusted value.
5. Add the three adjusted totals, and multiply the sum by the conversion factor to determine the payment.

Work RVU x Work GPCI = *W*
Practice-Expense RVU x Practice-Expense GPCI = *PE*
Malpractice RVU x Malpractice GPCI = *M*
Conversion Factor = *CF*

($W + PE + M$) x CF = Payment

Example:

Work RVU = 6.39
Work GPCI = 0.998
6.39 x 0.998 = W = 6.37

Practice-Expense RVU = 5.87
Practice-Expense GPCI = 0.45
5.87 x 0.45 = PE = 2.64

Malpractice RVU = 1.20
Malpractice GPCI = 0.721
1.20 x 0.721 = M = 0.86

Conversion Factor = 34.54

(6.37 + 2.64 + 0.86) x 34.54 = $340.90 Payment

FIGURE 6.4 Medicare Physician Fee Schedule Formula

Relative Value Scale (RVS)

Another method, originally created in California, is the **relative value scale (RVS).** In an RVS, each procedure in a group of related procedures is assigned a *relative value* in relation to a *base unit.* For example, if the base unit is 1 and these numbers are assigned—limited visual field examination 0.66; intermediate visual field examination 0.91; and extended visual field examination 1.33—the first two procedures are less difficult than the unit to which they are compared. The third procedure is more difficult. The relative value that is assigned is called the **relative value unit,** or **RVU.**

To calculate the price of each service, the relative value is multiplied by a **conversion factor,** which is a dollar amount that is assigned to the base unit. The conversion factor is increased or decreased each year so that it reflects changes in the cost-of-living adjustments (COLA) index.

relative value scale (RVS) system of assigning unit values to medical services based on their required skill and time

relative value unit (RVU) factor assigned to a medical service based on the relative skill and required time

conversion factor amount used to multiply a relative value unit to arrive at a charge

Example

The year's conversion factor is $35.27.

The relative value of an extended visual field examination is 1.33.

This year's price for the extended visual field examination is $35.27 × 1.33 = $46.90.

The *California Relative Value Studies* eventually came under federal scrutiny and ceased to be published. It was accused of being a price-fixing book created by providers for providers. Despite the problems with this study, the relative value scale is a useful concept. Unlike providers, software companies and publishers are not restricted from gathering and publishing fee information, so the national fee databases they produce now list both UCR fees and a relative value for each procedure. Payers and providers may use the RVS factor in setting their fees.

Resource-Based Relative Value Scale (RBRVS)

The payment system used by Medicare, which builds on the RVU system, is called the **resource-based relative value scale (RBRVS).** The RBRVS establishes relative value units for services. It replaces providers' consensus on fees—the historical charges—with a relative value that is based on resources—what each service really costs to provide.

resource-based relative value scale (RBRVS) relative value scale for establishing Medicare charges

There are three parts to an RBRVS fee:

1. *The nationally uniform RVU:* The relative value is based on three cost elements—the physician's work, the practice cost (overhead), and the cost of malpractice insurance. Another way of stating this is that every $1.00 of charge is made up of x cents for the physician's work, x cents for office expenses, and x cents for malpractice insurance. For example, the relative value for a simple office visit, such as to receive a flu shot, is much lower than the relative value for a complicated encounter such as the evaluation and management of uncontrolled diabetes in a patient. (Column 7 in Figure 6.3 lists the RVUs for procedures in column 1.)
2. *A geographic adjustment factor:* A geographic adjustment factor called the **geographic practice cost index (GPCI)** is a number that is used to multiply each relative value element so that it better reflects a geographic area's relative costs. For example, the cost of the provider's work is affected by average physician salaries in an area. The cost of the practice depends on things such as office rental prices and local taxes. Malpractice expense is also affected by where the work is done. The factor may either reduce or increase the relative values. For example, the GPCI lowers relative values in a rural area where all costs of living are lower. A GPCI from a major city, where everything costs more, raises the relative values. In some states, a single GPCI applies; in others, different GPCIs are listed for large cities and for other areas.
3. *A nationally uniform conversion factor:* A uniform conversion factor is a dollar amount used to multiply the relative values to produce the full Medicare allowable rate for a given service. Medicare uses it to make adjustments according to changes in the cost of living index. CMS recommends annual changes to the conversion factor, but Congress enacts them.

geographic practice cost index (GPCI) Medicare factor used to adjust providers' fees in a particular geographic area

more. Ninety percent of the reporting providers charged less than $591 while only 10 percent charged more. (The sixth and seventh columns contain Medicare data, which are discussed in the following resource-based relative value scale [RBRVS] section. That section also describes reasonable fees.)

BILLING TIP

Setting Fees

Most practices set their fees slightly above those paid by the highest reimbursing plan in which they participate.

How Physician Fees Are Set and Managed

In every geographic area, there is a normal range of fees for commonly performed procedures. Different practices set their fees at some point along this range. They analyze the rates charged by other providers in the area, what government programs pay, and the payments of private carriers to develop their list of fees. Most try to set fees that are in line with patients' expectations to be competitive in attracting patients.

To keep track of whether the practice's fees are correctly set, reports from the practice management program are studied. These reports indicate the most frequently performed services (say, the top twenty procedures) and the providers' fees for them. This list is compared to the amounts that payers pay. If the providers' fees are always paid in full, the fees may be set too low—below payers' maximum allowable charges. If all fees are reduced by payers, the fees may be set too high. When the practice feels that fees are regularly too high or too low, the usual fee structure can be adjusted accordingly.

Medical insurance specialists update the practice's fee schedules when new codes are released. When new or altered CPT codes are among those the practice reports, the fees related to them must be updated, too. For example, if the definition of a surgical package changes, a surgeon's fees need to be altered to tie exactly to the revised elements of the package, or a new procedure may need to be included. Providers may refer to the national databases or, more likely, review those databases and the Medicare rate of pay to establish the needed new fees.

THINKING IT THROUGH 6.6

Based on Figure 6.3:

1. Fifty percent of surveyed providers charged less than what amount for CPT 29044?
2. If 4,000 providers were surveyed about their charges for CPT 29000, how many reported that they charged more than $617?

6.7 Payer Fee Schedules

charge-based fee structure fees based on typically charged amounts

resource-based fee structure setting fees based on relative skill and time required to provide similar services

Payers, too, must establish the rates they pay providers. There are two main methods: charge based and resource based. **Charge-based fee structures** are based on the fees that providers of similar training and experience have charged for similar services. **Resource-based fee structures** are built by comparing three factors: (1) how difficult it is for the provider to do the procedure, (2) how much office overhead the procedure involves, and (3) the relative risk that the procedure presents to the patient and to the provider.

Usual, Customary, and Reasonable (UCR) Payment Structures

usual, customary, and reasonable (UCR) setting fees by comparing usual fees, customary fees, and reasonable fees

Payers that use a charge-based fee structure also analyze charges using one of the national databases. They create a schedule of **UCR (usual, customary, and reasonable)** fees by determining the percentage of the published fee ranges that they will pay. For example, a payer may decide to pay all surgical procedures reported in a specific geographical area at the midpoint of each range.

These UCR fees, for the most part, accurately reflect prevailing charges. However, fees may not be available for new or rare procedures. Lacking better information, a payer may set too low a fee for such procedures.

Provider Withholds

Some managed care plans may also require a **provider withhold** from their participating providers. Under this provision of their contract with the provider, the plan withholds a percentage, such as 20 percent, from every payment to the provider. The amount withheld is supposed to be set aside in a fund to cover the plan's unanticipated medical expenses. At the close of a specified period, such as a year, the amount withheld is returned to the provider if the plan's financial goals have been achieved. Some plans pay back withholds depending on the overall goals of the plan, and some pay according to the individual provider's performance against goals.

provider withhold amount withheld from a provider's payment by a managed care organization (MCO)

THINKING IT THROUGH 6.10

1. In Table 6.1, which category of plan member does the plan consider likely to use the most medical services in a given period? The fewest services?
2. If the capitation schedule in Table 6.1 is used to calculate an average payment per patient, what is the average cap rate?

6.11 Collecting Time-of-Service (TOS) Payments and Checking Out Patients

The practice management program records the financial transactions that result from patients' visits:

- Charges—the amounts that providers bill for services performed
- Payments—monies the practice receives from health plans and patients
- **Adjustments**—changes, positive or negative, such as returned check fees, to correct a patient's account balance

adjustment change to a patient's account

Information from the encounter form is entered in the program to calculate charges. The program also records patients' payments, prints receipts, and computes patients' outstanding account balances.

After the patient's encounter, the medical insurance specialist posts (that is, enters in the PMP) the patient's case information and diagnosis. Then the day's procedures are posted, and the program calculates the charges. Payments from the patient are entered, and the account is brought up-to-date.

Payment Methods: Cash, Check, or Card

The medical insurance specialist handles patients' payments as follows:

- *Cash:* If payment is made by cash, a receipt is issued.
- *Check:* If payment is made with a check, the amount of the payment and the check number are entered in the PMP, and a receipt is offered.
- *Credit or debit card:* If the bill is paid with a credit or debit card, the card is passed through the card reader. A transaction authorization number is received from the card issuer, and the approved card slip is signed by the person paying the bill. The patient is usually offered a receipt in addition to the copy of the credit card sales slip. Telephone approval may be needed if the amount is over a specified limit.

Many practices have CCOF (Credit Card on File; see the chapter on patient encounters and billing information) programs in place to enable credit and debit cards to be used.

If the practice accepts credit and debit cards, it must follow Payment Card Industry Data Security Standards (PCI DSS). Similar to the rules for security under HIPAA, PCI DSS set requirements to safeguard payment card numbers, expiration dates, verification codes, and other personal data.

6.10 Capitation

capitation rate (cap rate)
periodic prepayment to a provider for specified services to each plan member

The fixed prepayment for each plan member in a capitation contract, called the **capitation rate** or **cap rate,** is determined by the managed care organization that contracts with providers.

Setting the Cap Rate

To determine the cap rate, the plan first decides on the allowed charges for the contracted services and then analyzes the health-related characteristics of the plan's members. The plan calculates the number of times each age group and gender group of members is likely to use each of the covered services. For example, if the primary care provider (PCP) contract covers obstetrics and a large percentage of the group's members is young women who are likely to require services related to childbirth, the cap rate is higher than for a group of members containing a higher percentage of men or of women in their forties or fifties who are not as likely to require obstetrics services.

The plan's contract with the provider lists the services and procedures that the cap rate covers. For example, a typical contract with a primary care provider might include the following services:

- Preventive care: well-child care, adult physical exams, gynecological exams, eye exams, and hearing exams
- Counseling and telephone calls
- Office visits
- Medical care: medical care services such as therapeutic injections and immunizations, allergy immunotherapy, electrocardiograms, and pulmonary function tests
- Local treatment of first-degree burns, application of dressings, suture removal, excision of small skin lesions, removal of foreign bodies or cerumen from external ear

These services are covered in the per-member charge for each plan member who selects the PCP. This cap rate, usually a prepaid monthly payment (per member per month, or PMPM), may be a different rate for each category of plan member, as shown in Table 6.1, or an average rate. To set an average rate, the monthly capitation rate for each member profile is added, and the total is divided by the number of member profiles.

Noncovered services can be billed to patients using the provider's usual rate. Plans often require the provider to notify the patient in advance that a service is not covered and to state the fee for which the patient will be responsible.

Table 6.1 Example of a Capitation Schedule

Member Profile	Monthly Capitation Rate
0–2 Years, M/F	$30.10
2–4 Years, M/F	$ 8.15
5–19 Years, M/F	$ 7.56
20–44 Years, M	$ 8.60
20–44 Years, F	$16.66
45–64 Years, M	$17.34
45–64 Years, F	$24.76
Over 65 Years, M, Non-Medicare	$24.22
Over 65 Years, F, Non-Medicare	$27.32
Over 65, M, Medicare Primary	$10.20
Over 65, F, Medicare Primary	$12.05

Coinsurance provisions in many private plans provide for patient cost-sharing. Rather than paying the provider the full allowed charge, for example, a plan may require the patient to pay 25 percent, and the plan pays 75 percent. In this case, if a provider's usual charges are higher than the plan's allowed charge, the patient owes more for a service from a nonparticipating provider than from a participating provider. The calculations are explained next.

Example

Payer policy: A policy provides a benefit of 75 percent of the provider's usual charges, and there is a maximum allowed charge for each procedure. The patient is responsible for 25 percent of the maximum allowed charge. Balance billing is not permitted for plan participants.

Provider A is a participating provider, and Provider B is a nonparticipant in the plan. Provider A and Provider B both perform total abdominal hysterectomies (CPT 58150). The policy's allowed charge for this procedure is $2,880.00.

Provider A (PAR)	
Usual charge	$3,100.00
Policy pays 75% of its allowed charge	$2,160.00 (75% of $2,880.00)
Patient pays 25% of the allowed charge	$ 720.00 (25% of $2,880.00)
Provider writes off the difference between the usual charge and the allowed charge:	$ 220.00 $3,100 − $2,880)
Provider B (nonPAR)	
Usual charge	$3,000.00
Policy pays 75% of its allowed charge	$2,160.00 (75% of $2,880.00)
Patient pays for:	
(1) 25% of the allowed charge +	$ 720.00 (25% of $2,880.00)
(2) the difference between the usual charge and the allowed charge:	$ 120.00 ($3,000.00 − $2,880.00)
Patient pays $840.00 ($720.00 + $120.00)	

The provider has no write-off. ◂

Contracted Fee Schedule

Some payers, particularly those that contract directly with providers, establish fixed fee schedules with participating providers. They first decide what they will pay in particular geographical areas and then offer participation contracts with those fees to physician practices. If the practice chooses to join, it agrees by contract to accept the plan's fees for its member patients.

The plan's contract states the percentage of the charges, if any, that its patients owe and the percentage the payer covers. Participating providers can typically bill patients their usual charges for procedures and services that are not covered by the plan.

THINKING IT THROUGH 6.9

1. A Medicare-participating surgeon in Galveston, TX, reports a normal charge of $6,282.00 to repair a heart vessel fistula. Using the Medicare Fee Schedule RVUs and GPCIs shown in Figure 6.4, calculate the following:
   - **A.** The allowed charge _____
   - **B.** The provider's expected write-off _____

Example

The payer's allowed charge for a new patient's evaluation and management (E/M) service (CPT 99204) is $160.

Provider A Usual Charge = $180	Payment = $160
Provider B Usual Charge = $140	Payment = $140 ◂

balance billing the difference between a provider's usual fee and a payer's lower allowed charge

write off to deduct an uncollectible amount from a patient's account

Whether a participating provider can bill the patient for the difference between a higher physician fee and a lower allowed charge—called **balance billing**—depends on the terms of the contract with the payer. Payers' rules may prohibit participating providers from balance billing the patient. Instead, the provider must **write off** the difference, meaning that the amount of the difference is subtracted from the patient's bill as an adjustment and never collected.

For example, Medicare-participating providers may not receive an amount higher than the Medicare allowed charge from the Medicare Physician Fee Schedule. Medicare is responsible for paying 80 percent of this allowed charge (after patients have met their annual deductibles). Patients are responsible for the other 20 percent.

Example

A Medicare PAR provider has a usual charge of $200 for a diagnostic flexible sigmoidoscopy (CPT 45330), and the Medicare allowed charge is $84. The provider must write off the difference between the two amounts. The patient is responsible for 20 percent of the allowed charge, not of the provider's usual charge:

Provider's usual fee	$200.00
Medicare allowed charge	$ 84.00
Medicare pays 80%	$ 67.20
Patient pays 20%	$ 16.80

The total the provider can collect is $84. The provider must make an adjustment to the patient's account to write off the $116 difference between the usual fee and the allowed charge. ◂

BILLING TIP

Contractual Adjustment

In many practices, the term *contractual adjustment* is preferred to *write off*.

A provider who does not participate in a private plan can usually balance bill patients. In this situation, if the provider's usual charge is higher than the allowed charge, the patient must pay the difference. However, Medicare and other government-sponsored programs have different rules for nonparticipating providers, as explained later in this text.

Example

Payer policy: There is an allowed charge for each procedure. The plan provides a benefit of 100 percent of the provider's usual charges up to this maximum fee. Provider A is a participating provider; Provider B does not participate and can balance bill. Both Provider A and Provider B perform abdominal hysterectomies (CPT 58150). The policy's allowed charge for this procedure is $2,880.

Provider A (PAR)

Provider's usual charge	$3,100.00
Policy pays its allowed charge	$2,880.00
Provider writes off the difference between the usual charge and the allowed charge:	$ 220.00

Provider B (nonPAR)

Provider's usual charge	$3,000.00
Policy pays its allowed charge	$2,880.00
Provider bills patient for the difference between the usual charge and the allowed charge; there is no write-off:	$ 120.00 ($3,000.00 − $2,880.00) ◂

Learning Outcomes	Key Concepts/Examples
6.11 Outline the process of patient checkout.	After a patient encounter: • The practice posts the patient's case information and diagnosis in the practice management program (PMP). • The practice then posts the day's procedures, and the program calculates the charges. • The practice collects payments from the patient and enters them at this time, and the account is brought up-to-date. • Upon leaving, the patient is given a walkout receipt summarizing the services and charges for the encounter as well as any payments the patient has made.

Review Questions

Match the key terms with their definitions.

1. **LO 6.2** edits
2. **LO 6.3** downcoding
3. **LO 6.10** capitation rate
4. **LO 6.6** usual fee
5. **LO 6.9** allowed charge
6. **LO 6.5** prospective audit
7. **LO 6.11** adjustment
8. **LO 6.9** write-off
9. **LO 6.7** conversion factor
10. **LO 6.2** Office of Inspector General (OIG) Work Plan
11. **LO 6.1** code linkage
12. **LO 6.8** Medicare Physician Fee Schedule (MPFS)
13. **LO 6.4** X modifiers

A. Fee for a service or procedure that is charged by a provider for most patients under typical circumstances

B. The maximum charge allowed by a payer for a specific service or procedure

C. A change to a patient's account

D. The amount that a participating provider must deduct from a patient's account because of a contractual agreement to accept a payer's allowed charge

E. The contractually set periodic prepayment amount to a provider for specified services to each enrolled plan member

F. An internal audit conducted before claims are reported to payers

G. A payer's review and reduction of a procedure code to a lower value than reported by the provider

H. The OIG's annual list of planned projects under the Medicare Fraud and Abuse Initiative

I. A computerized system that identifies improper or incorrect codes

J. Dollar amount used to multiply a relative value unit to arrive at a charge

K. The RBRVS-based allowed fees

L. Connection between a service and a patient's condition or illness

M. HCPCS modifiers that define specific subsets of modifier 59

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Learning Outcomes	Key Concepts/Examples
6.7 Compare the methods for setting payer fee schedules.	Fee structures for providers' services are either charge based or resource based: • Charge based structures, such as usual, customary, and reasonable (UCR), are based on the fees that many providers have charged for similar services. • Relative value scales (RVSs) account for the relative difficulty of procedures by comparing the skill involved in each of a group of procedures. • An RVS is charge based if the charges that are attached to the relative values are based on historical fees. • Both charge-based and resource-based fee structures are affected by the geographic area in which the service is provided. Resource-based relative value scales (RBRVSs), such as the Medicare Physician Fee Schedule (MPFS), are built by comparing three cost factors: 1. How difficult it is for the provider to do the procedure 2. How much office overhead the procedure involves 3. The relative risk that the procedure presents to the patient and the provider
6.8 Calculate RBRVS payments under the Medicare Fee Schedule.	The following steps are used to calculate the RBRVS payments under the Medicare Physician Fee Schedule (MPFS): 1. Determine the procedure code for the service. 2. Use the MPFS to find three relative value units (RVUs)—work, practice expense, and malpractice—for the procedure. 3. Use the Medicare geographic practice cost index (GPCI) list to find the three geographic practice cost indices. 4. Multiply each RVU by its GPCI to calculate the adjusted value. 5. Add the three adjusted totals, and multiply the sum by the annual conversion factor to determine the payment.
6.9 Compare the calculation of payments for participating and nonparticipating providers, and describe how balance billing regulations affect the charges that are due from patients.	Most payers use one of three provider payment methods: allowed charges, contracted fee schedules, or capitation: • When a maximum allowed charge is set by a payer for each service, a provider does not receive the difference from the payer if the provider's usual fee is higher. • If the provider participates in the patient's plan, the difference is written off; if the provider does not participate, the plan's rules on balance billing determine whether the patient is responsible for the amount. • Under a contracted fee schedule, the allowed charge for each service is all that the payer or the patient pays; no additional charges can be collected. Payments to participating providers are limited to the allowed charge: • Some part of that amount is paid by the payer and some part by the patient according to the coinsurance provisions of the plan. • Nonparticipating providers in most private plans can collect their usual fees by receiving the specified part of an allowed charge from the payer and the rest of the allowed charge, plus the balance due resulting from a lower allowed charge and a higher usual charge, from the patient.
6.10 Differentiate between billing for covered versus noncovered services under a capitation schedule.	• Under capitation, the healthcare plan sets a capitation rate that pays for all contracted services to enrolled members for a given period. • Noncovered services can still be billed to patients.

Chapter 6 Summary

Learning Outcomes	Key Concepts/Examples
6.1 Explain the importance of code linkage on healthcare claims.	• Diagnoses and procedures must be correctly linked on healthcare claims so payers can analyze the connection and determine the medical necessity of charges. • Correct claims comply with all applicable regulations and requirements. • Codes should be appropriate and documented as well as compliant with each payer's rules.
6.2 Describe the use and format of Medicare's Correct Coding Initiative (CCI) edits and medically unlikely edits (MUEs).	• The Medicare National Correct Coding Initiative (CCI) edits are computerized screenings designed to deny claims that do not comply with Medicare's rules on claims for more than one procedure performed on the same patient, on the same date of service, by the same performing provider. The three basic types of edits are: 1. Column 1 and column 2 pair codes 2. Mutually exclusive edits 3. Modifier indicators
6.3 Discuss types of coding and billing errors.	Claims are rejected or downcoded because of: • Medical necessity errors • Coding errors • Errors related to billing
6.4 Appraise major strategies that help ensure compliant billing.	Major strategies to ensure compliant billing are to: • Carefully define bundled codes and know global periods. • Benchmark the practice's E/M codes with national averages. • Keep up-to-date through ongoing coding and billing education. • Be clear on professional courtesy and discounts to uninsured and/or low-income patients. • Maintain compliant job reference aids and documentation templates. • Audit the billing cycle.
6.5 Discuss the use of audit tools to verify code selection.	Types of audit tools: • Payer audits are routine external audits that are conducted to ensure practice compliance with coding and billing regulations. • Prospective internal audits help the practice reduce the possibility that coding compliance errors will cause claims to be rejected or downcoded. • Retrospective internal audits are used to analyze feedback from payers, identify problems, and address problems with additional training and better communication. E/M codes and audits: • E/M codes are frequently used and have an ongoing audit focus. • Practices should conduct internal audits of their E/M claims using audit tools based on the joint CMS/AMA *Documentation Guidelines for Evaluation and Management Services*.
6.6 Describe the fee schedules that physicians create for their services.	• Physicians set their fee schedules in relation to the fees that other providers charge for similar services.

Valley Associates, PC
1400 West Center Street
Toledo, OH 43601-0123
555-321-0987

Page: 1 | 10/09/2029

Patient: Walter Williams
17 Mill Rd
Brooklyn, OH 44144-4567

Chart #: FF5033
Case #: 8

Instructions:
Complete the patient information portion of your insurance claim form. Attach this bill, signed and dated, and all other bills pertaining to the claim. If you have a deductible policy, hold your claim forms until you have met your deductible. Mail directly to your insurance carrier.

Date	Description	Procedure	Modify	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
10/09/2029	EP LII Problem Focused	99212		110	R53.1			1	46.00
10/09/2029	ECG Complete	93000		110	R53.1			1	70.00
10/09/2029	Aetna Copayment	AETCPAY						1	-15.00

Provider Information
Provider Name: Christopher Connelly MD
License: 3704629
Insurance PIN:
SSN or EIN: 161234567

Total Charges:	$ 116.00
Total Payments:	-$ 15.00
Total Adjustments:	$ 0.00
Total Due This Visit:	**$ 101.00**
Total Account Balance:	$ 101.00

Assign and Release: I hereby authorize payment of medical benefits to this physician for the services described above. I also authorize the release of any information necessary to process this claim.

Patient Signature: _____ Date: _____

FIGURE 6.5 Walkout Receipt

Walkout Receipts

walkout receipt list of the diagnoses, services provided, fees, and payments received and due after an encounter

If the patient makes a payment at the time of an office visit, the amount is entered into the PMP, which generates a walkout receipt. The **walkout receipt** summarizes the services and charges for that day as well as any payment the patient made (see Figure 6.5).

If the provider has not accepted assignment and is not going to file a patient's claim, the walkout receipt is the document the patient will use to do so. Practices generally handle unassigned claims in one of two ways:

1. The payment is collected from the patient at the time of service (at the end of the encounter). The patient then uses the walkout receipt to report the charges and payments to the insurance company. The insurance company repays the patient (or insured) according to the terms of the plan.
2. The practice collects payment from the patient at the time of service and then sends a claim to the plan on behalf of the patient. The insurance company sends a refund check to the patient with an explanation of benefits.

Identity Theft

To avoid the risk of identity theft, the HIPAA Security Rule requires medical practices to protect patients' credit and debit card information.

THINKING IT THROUGH 6.11

1. Why are up-front collections important to the practice?

Part 3

CLAIMS

chapter 7
Healthcare Claim Preparation and Transmission

chapter 8
Private Payers/ACA Plans

chapter 9
Medicare

chapter 10
Medicaid

chapter 11
TRICARE and CHAMPVA

chapter 12
Workers' Compensation and Disability/Automotive Insurance

A. **LO 6.6–6.9** Insurance Plan: Mountville Health Plan; patient has met annual deductible of $250; 80-20 coinsurance
Services: CPT 99203, 90700
Payer Reimbursement: _____ Patient Charge: _____

B. **LO 6.6–6.9** Insurance Plan: Mountville Health Plan; patient has paid $125 toward an annual deductible of $500; 80-20 coinsurance
Services: CPT 99215, 93040, 94010
Payer Reimbursement: _____ Patient Charge: _____

C. **LO 6.6–6.9** Insurance Plan: Ringdale Medical Plan A; no deductible or coinsurance; copayment of $5/PAR; $25/NonPAR
Services: CPT 99212
Payer Reimbursement: _____ Patient Charge: _____

D. **LO 6.6–6.9** Insurance Plan: Ringdale Medical Plan B; patient has met annual deductible of $300; 80-20 coinsurance
Services: CPT 99215
Payer Reimbursement: _____ Patient Charge: _____

E. **LO 6.6–6.9** Insurance Plan: Medicare; annual deductible has been met by patient
Services: 99213, 93040
Payer Reimbursement: _____ Patient Charge: _____

Case 6.4 Determining Global Periods for Compliant Billing

LO 6.4 Using the file named PPRRVU10_U22 found on the CMS website, look up and record the global period for the CPT codes that follow.

To access the file:

- Go to www.cms.gov and click on the Medicare tab at the top left of the screen.
- Click the Physician Fee Schedule link found in the Medicare Fee-for-Service Payment section.
- Select the PFS Relative Value Files link from the list on the left-hand side of the page. The file can be found by clicking the 2010 link that corresponds to the RVU10C_PCT22 listed on this page. (Note that you may need to scroll through the results to access this file.)
- Download the RVU10C_PCT22 zip file by clicking the Accept button for the user terms and thereby saving the file.
- Double-click the zip file to open it, and then double-click the first of the two files titled PPRRVU10_U22 to open the correct spreadsheet.
- In the spreadsheet that loads, CPT codes will be listed on the left, and a GLOB DAYS column will contain their corresponding global periods.

A. 11010
B. 17106
C. 20931
D. 28005
E. 31238
F. 33933
G. 42330
H. 54318
I. 58321
J. 66155

Applying Your Knowledge

Case 6.1 Auditing Linkage

A. **LO 6.1, LO 6.3** Are the following procedure and diagnostic codes appropriately linked? If not, what is (are) the error(s)?

	CPT	ICD-10-CM	LINKED?
1.	77067	Z12.31	
2.	99214	H61.21	
3.	57284	N41.1, B95.61	
4.	96365	Z51.11 D05.90	
5.	99203, 72040, 73590	S82.51XA, S13.8XXA, W18.01XA, Y92.838	

B. **LO 6.4** A forty-year-old established female patient is having an annual checkup. During the examination, her physician identifies a lump in her left breast. The physician considers this a significant finding and performs the key components of a problem-focused E/M service. These four codes and modifier should be reported. To which code is the modifier appended?

CPT codes: 99212, 99396

ICD codes: Z00.00, N63.20

Modifier: 25

Case 6.2 Calculating Expected Charges

Using the sample relative value units and GPCIs shown in Thinking It Through 6.8 and a conversion factor of $34.7315, calculate the expected charge for each of the following services:

A. **LO 6.6, LO 6.7** CPT 99204 in Galveston, TX

B. **LO 6.6, LO 6.7** CPT 33502 in Manhattan, NY

C. **LO 6.6, LO 6.7** CPT 99203 in Columbus, OH

Case 6.3 Calculating Insurance Math

Dr. Mary Mandlebaum is a PAR provider in Medicare and in Mountville Health Plan, which has allowed charges for services and does not permit balance billing of plan members. She is not a PAR provider in the Ringdale Medical Plan. Based on the following table of charges, calculate the charges that the payer and the patient will pay in each of the situations. Show your calculations.

Service	CPT	Usual Charge	Mountville Health Plan Allowed Charge	Medicare Allowed Charge
Office/Outpatient Visit, New, Min.	99201	$54	$48	$43
Office/Outpatient Visit, New, Low	99202	$73	$65	$58
Office/Outpatient Visit, New, Mod.	99203	$100	$89	$80
Office/Outpatient Visit, New, Mod.	99204	$147	$129	$116
Office/Outpatient Visit, New, High	99205	$190	$168	$151
Office/Outpatient Visit, Est., Min.	99211	$29	$26	$22
Office/Outpatient Visit, Est., Low	99212	$44	$39	$35
Office/Outpatient Visit, Est., Mod.	99213	$60	$54	$48
Office/Outpatient Visit, Est., Mod.	99214	$87	$78	$70
Office/Outpatient Visit, Est., High	99215	$134	$119	$107
Rhythm ECG with Report	93040	$30	$36	$30
Breathing Capacity Test	94010	$83	$69	$58
DTAP Immunization	90700	$102	$87	$74

Select the answer choice that best completes the statement or answers the question.

14. **LO 6.2** The OIG Work Plan describes
- **A.** planned projects for investigating possible fraud in various billing areas
- **B.** legislative initiatives under HIPAA
- **C.** the FBI's investigations
- **D.** the current cases that are being prosecuted by OIG's attorneys

15. **LO 6.2** The goal of MUEs is to
- **A.** create billing mistakes
- **B.** reduce clerical billing errors
- **C.** show what modifiers can break an edit
- **D.** show what codes cannot be billed together

16. **LO 6.8** In the example in Figure 6.4, the lowest cost element in the Medicare RBRVS fees is
- **A.** malpractice expense
- **B.** practice expense
- **C.** work expense
- **D.** customary expense

17. **LO 6.7, 6.8** In calculations of RBRVS fees, the three relative value units are multiplied by
- **A.** their respective geographic practice cost indices
- **B.** the neutral budget factor
- **C.** the national conversion factor
- **D.** the UCR factor

18. **LO 6.9** Medicare typically pays for what percentage of the allowed charge?
- **A.** 50 percent
- **B.** 60 percent
- **C.** 70 percent
- **D.** 80 percent

19. **LO 6.9** If a participating provider's usual fee is $400 and the allowed amount is $350, what amount is written off?
- **A.** zero
- **B.** $25
- **C.** $50
- **D.** $75

20. **LO 6.9** If a nonparticipating provider's usual fee is $400, the allowed amount is $350, and balance billing is permitted, what amount is written off?
- **A.** zero
- **B.** $25
- **C.** $50
- **D.** $75

21. **LO 6.9** If a nonparticipating provider's usual fee is $400, the allowed amount is $350, and balance billing is not permitted, what amount is written off?
- **A.** zero
- **B.** $25
- **C.** $50
- **D.** $75

22. **LO 6.6** Physicians establish a list of their usual fees for
- **A.** the charges they have written off
- **B.** workers' compensation patients
- **C.** their Medicare patients
- **D.** the procedures and services they frequently perform

23. **LO 6.4** An encounter form containing E/M codes should list
- **A.** the most frequently billed codes
- **B.** just blanks, so the correct E/M code can be entered
- **C.** the complete ranges of codes for each type or place of service listed
- **D.** the practice's professional courtesy policies

Answer the following questions.

24. **LO 6.8** What is the formula for calculating an RBRVS charge using the Medicare Physician Fee Schedule?

25. Define the following abbreviations:

- **A.** **LO 6.2** CCI
- **B.** **LO 6.7** GPCI
- **C.** **LO 6.8** MPFS
- **D.** **LO 6.7** UCR
- **E.** **LO 6.7** RVS
- **F.** **LO 6.7** RBRVS
- **G.** **LO 6.2** MUE
- **H.** **LO 6.5** RAC

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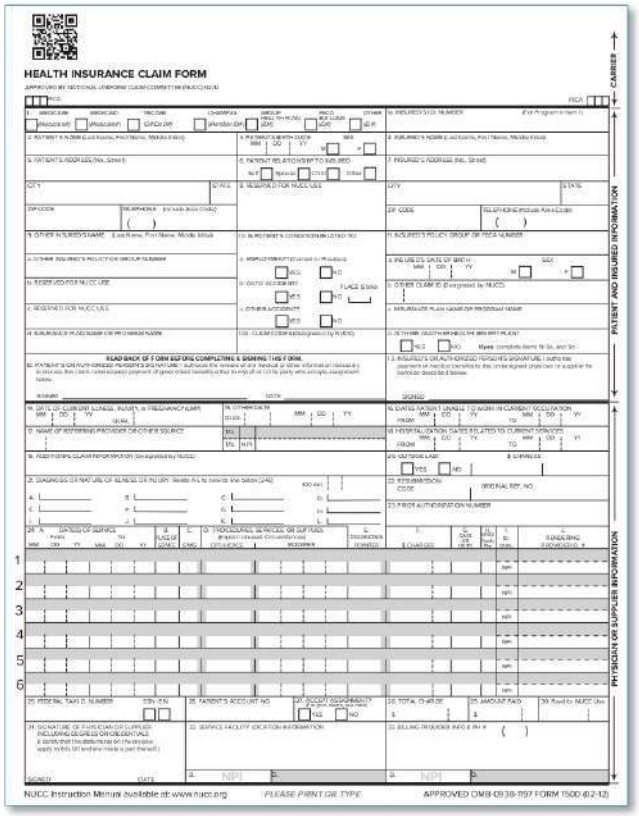


HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO: YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. $ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #

1 NPI

2 NPI

3 NPI

4 NPI

5 NPI

6 NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

FIGURE 7.1 CMS-1500 (02/12) Claim

Item Number 1: Type of Insurance

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

Item Number 1 is used to indicate the type of insurance coverage. Five specific government programs are listed (Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, and Other). If the patient has group contract insurance

5010A1 Version and the CMS-1500

5010A1 Version newest format for EDI transactions

HIPAA, EDI transactions must comply with the **5010A1 version.** This updated format for 837P claims provides enough room for ICD-10-CM codes and additional required data. The NUCC monitors and updates its instructions for the CMS-1500 to move it closer to the data on an electronic claim.

In this text, the general NUCC guidelines are followed for correct completion of paper claims. When the NUCC instructions have removed or modified a data item, this is noted here. However, if the NUCC notes that a particular item is not used in the 5010A1 version, but is valid for paper claims, the text also explains how to complete the item.

On the job, medical insurance specialists using a paper claim—typically, by exception—verify the particular payer requirements, which can vary significantly. Later chapters in the text show the standards of completion for major payor groups such as Medicare.

THINKING IT THROUGH 7.1

1. What advantages can you identify for transmitting electronic claims? Are there any potential disadvantages as well?

NUCC Home Page
www.nucc.org

BILLING TIP

Payer Instructions May Vary

The NUCC instructions do not address any particular payer. Best practice for paper claims is to check with each payer for specific information required on the form.

7.2 Completing the CMS-1500 Claim: Patient Information Section

The CMS-1500 claim has a carrier block and thirty-three Item Numbers (*INs*) as shown in Figure 7.1. The instructions for completing this claim are based on the NUCC publication *1500 Health Insurance Claim Form Reference Instruction Manual for 02/12 Revised Form* available on the NUCC website.

Above the boxes, at the right, the carrier block is used for the insurance carrier's name and address. Item Numbers (INs) 1 through 13 refer to the patient and the patient's insurance coverage. This information is entered in the practice management program based on the patient information form and the patient insurance card. Item Numbers (INs) 14 through 33 contain information about the provider and the patient's condition, including the diagnoses, procedures, and charges. This information is entered from the encounter form and other documentation.

Carrier Block

carrier block data entry area in the upper right portion of the CMS-1500

The **carrier block** is located in the upper right portion of the CMS-1500. At the left is a quick response (QR) code symbol; this block allows for a four-line address for the payer. If the payer's address requires just three lines, leave a blank line in the third position:

ABC Insurance Company
567 Willow Lane

Franklin IL 60605

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a five- or nine-digit ZIP code. Enter the nine-digit ZIP code without the hyphen.

BILLING TIP

Patient Versus Insured

If the patient can be identified by a unique Member Identification Number, the patient is considered to be the "insured." The patient is reported as the insured in the insured data fields, not in the patient fields.

Patient Information

The items in the patient information section of the CMS-1500 identify the patient, the insured, and the health plan and contain other case-related data and assignment of benefits/release information.

Healthcare claims communicate critical data between providers and payers on behalf of patients. Many different types of providers create claims; in this chapter, the focus is on physician claims. Understanding the internal and electronic data interchange (EDI) procedures the practice uses to prepare and transmit claims is important for success as a medical insurance specialist. Claim processing is a major task, and the number of claims can be huge. For example, a forty-physician group practice with fifty-five thousand patients typically processes a thousand claims daily. Technology makes it possible to create, send, and track this volume of claims efficiently and effectively to ensure prompt payment.

7.1 Introduction to Healthcare Claims

The HIPAA-mandated electronic transaction for claims from physicians and other medical professionals is the **HIPAA X12 837 Health Care Claim: Professional (837P).** This electronic transaction is usually called the "837P claim" or the "HIPAA claim." The electronic HIPAA claim is based on the **CMS-1500,** which is a paper claim form. The information on the electronic transaction and the paper form with a few exceptions is the same.

HIPAA X12 837 Health Care Claim: Professional (837P) electronic form used to send a claim for physician services to primary and secondary payers

CMS-1500 paper claim form for physician services

The first sections of this chapter explain filling out a paper claim to introduce the data that claims generally require. Of course, the CMS-1500 is not usually filled out manually by transferring information directly from other office forms, such as the patient information and encounter forms. Instead, claims are created when the medical insurance specialist uses a practice management program (PMP) that captures and organizes databases of claim information. The PMP automates the process of creating correct claims, making it easy to update, correct, and manage the claim process.

The chapter then explains terms and data items that the HIPAA 837P claim may contain in addition to the CMS-1500 information. Some of the data items relate to the capability of electronic claims to provide more detailed information than a paper claim can. Other items are needed to go with various types of information to help the receiver of the claim electronically sort the information.

The third section of the chapter covers clearinghouses and transmission methods. As explained previously, most practices use clearinghouses to take the PMP data and send payers correct claims. The methods of transmitting the HIPAA claim may affect some of the practice's claim procedures, but all methods require close and careful attention to security and protection of patients' protected health information (PHI).

BILLING TIP

Knowledge of Claim Data

Medical insurance specialists become familiar with the information most often required on claims that their practice prepares so that they can efficiently research missing information and respond to payers' questions. Memorization is not required, but good thinking and organizational skills are.

Background

For many years, the CMS-1500 was the universal physician health claim accepted by most payers. The familiar red and black printed form was typed or computer-generated and mailed to payers. However, HIPAA requires electronic transmission of claims, except for practices that have fewer than ten full-time or equivalent employees and never send any kind of electronic healthcare transactions. The HIPAA 837P claim sent electronically is mandated for all other physician practices.

HIPAA has changed the way things work on the payer side, too. Payers may not require providers to make changes or additions to the content of the HIPAA 837P claim. Further, they cannot refuse to accept the standard transaction or delay payment of any proper HIPAA transaction, claims included.

BILLING TIP

Staying Up-to-Date with the CMS-1500

Check the NUCC website for updated instructions.

Claim Content

The **National Uniform Claim Committee (NUCC),** led by the American Medical Association, determines the content of both HIPAA 837P and CMS-1500 claims. The current CMS-1500 form, called the **CMS-1500 (02/12),** is the paper form covered in this chapter. The official guidelines are posted on the NUCC website.

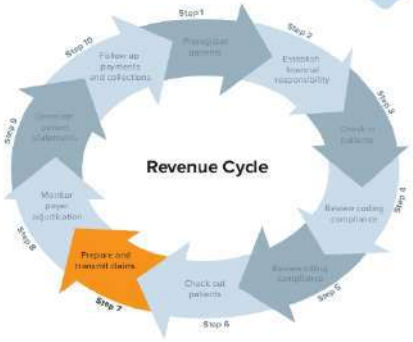
National Uniform Claim Committee (NUCC) organization responsible for claim content

CMS-1500 (02/12) current paper claim form approved by the NUCC

7 HEALTHCARE CLAIM PREPARATION AND TRANSMISSION

KEY TERMS

5010A1 version
administrative code set
billing provider
carrier block
claim attachment
claim control number
claim filing indicator code
claim frequency code (claim submission reason code)
claim scrubber
clean claim
CMS-1500
CMS-1500 (02/12)
condition code
data element
destination payer
Healthcare Provider Taxonomy Code (HPTC)
HIPAA X12 837 Health Care Claim: Professional (837P)
HIPAA X12 276/277 Health Care Claim Status Inquiry/Response
individual relationship code
line item control number
National Uniform Claim Committee (NUCC)
other ID number
outside laboratory
pay-to provider
place of service (POS) code
qualifier
rendering provider
required data element
responsible party
service line information
situational data element



Learning Outcomes

After studying this chapter, you should be able to:

7.1 Distinguish between the electronic claim transaction and the paper claim form.

7.2 Discuss the content of the patient information section of the CMS-1500 claim.

7.3 Compare billing provider, pay-to provider, rendering provider, and referring provider.

7.4 Discuss the content of the physician or supplier information section of the CMS-1500 claim.

7.5 Explain the hierarchy of data elements on the HIPAA 837P claim.

7.6 Categorize data elements into the five sections of the HIPAA 837P claim transaction.

7.7 Evaluate the importance of checking claims prior to submission, even when using software.

7.8 Compare the three major methods of electronic claim transmission.

This information indicates whether the patient's illness or injury is related to employment, auto accident, or other accident. Choosing *Employment* (current or previous) indicates that the condition is related to the patient's job or workplace. *Auto accident* means that the condition is the result of an automobile accident. *Other accident* means that the condition is the result of any other type of accident.

When appropriate, enter an X in the correct box to indicate whether one or more of the services described in IN 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. The state postal code must be shown if Yes is checked in IN 10b for Auto Accident. Any item checked Yes indicates that there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Primary insurance information must then be shown in IN 11.

Item Number 10d: Claim Codes (Designated by NUCC)

10d. CLAIM CODES (Designated by NUCC)

This IN identifies additional information about the patient's condition or the claim. When required by payers to provide a **condition code,** enter it in this field. Use the two-digit **qualifier** BG to indicate that the following is a condition code, and then the code.

In agreement with the NUBC (the organization that controls the hospital claim form, which will be covered in the last chapter), condition codes for abortion and sterilization are approved for use for professional claims and can be reported in field 10d. Condition codes are two-digit numeric or alphanumeric codes used to report a special condition or unique circumstance about a claim.

The following condition codes are valid for the CMS-1500 and 837P claims:

- AA Abortion Performed due to Rape
- AB Abortion Performed due to Incest
- AC Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality
- AD Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising from, or Exacerbated by the Pregnancy Itself
- AE Abortion performed due to Physical Health of Mother that is not Life Endangering
- AF Abortion Performed due to Emotional/Psychological Health of the Mother
- AG Abortion Performed due to Social or Economic Reasons
- AH Elective Abortion
- AI Sterilization

Example of a complete entry:

BGAA

condition code two-digit numeric or alphanumeric code used to report a special condition or unique circumstance

qualifier two-digit code for a type of provider identification number other than the National Provider Identifier (NPI)

Current Condition Codes Listed Under Code Sets
www.NUCC.org

Item Number 11: Insured's Policy Group or FECA Number

11. INSURED'S POLICY GROUP OR FECA NUMBER

Enter the insured's policy or group number as it appears on the insured's healthcare identification card. If IN 4 is completed, this entry should also be completed. The insured's policy group or Federal Employees' Compensation Act (FECA) number refers to the alphanumeric identifier for the health, auto, or other insurance plan coverage. The FECA number is the nine-digit alphanumeric identifier assigned to a patient who is an employee of the federal government claiming work-related condition(s) under the FECA (covered in the chapter about workers' compensation). Do not use a hyphen or space as a separator within the policy or group number.

Item Number 9: Other Insured's Name

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

If IN 11d is marked, complete fields 9, 9a, and 9d; otherwise, leave blank. An entry in the other insured's name box indicates that there is a holder of another policy that may cover the patient. When additional group health coverage exists, enter the other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in IN 2. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

Example: If a husband is covered by his employer's group policy and by his wife's group health plan, enter the wife's name in IN 9.

Item Number 9a: Other Insured's Policy or Group Number

a. OTHER INSURED'S POLICY OR GROUP NUMBER

Enter the policy or group number of the other insurance plan. Do not use a hyphen or a space as a separator within the policy or group number.

Item Number 9b: Reserved for NUCC Use

b. RESERVED FOR NUCC USE

This field is reserved for NUCC use. The NUCC will provide instructions for any use of it. The previous use as "Other Insured's Date of Birth, Sex" has been eliminated.

Item Number 9c: Reserved for NUCC Use

c. RESERVED FOR NUCC USE

This field is reserved for NUCC use. The NUCC will provide instructions for any use of it. The previous use as "Employer's Name or School Name" has been eliminated.

Item Number 9d: Insurance Plan Name or Program Name

d. INSURANCE PLAN NAME OR PROGRAM NAME

Enter the other insured's insurance plan or program name. This box identifies the name of the plan or program of the other insured as indicated in IN 9.

Item Numbers 10a–10c: Is Patient's Condition Related to:

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)
☐ YES ☐ NO

b. AUTO ACCIDENT? PLACE (State)
☐ YES ☐ NO

c. OTHER ACCIDENT?
☐ YES ☐ NO

Item Number 5: Patient's Address

5. PATIENT'S ADDRESS (No., Street)	
CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ( )

Item Number 5 is used to report the patient's address, which includes the number and street, city, state, and ZIP code. The first line is for the street address, the second line for the city and state, and the third line for the ZIP code. Use the two-digit state abbreviation, and use the nine-digit ZIP code if it is available. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a five- or nine-digit ZIP code. Enter the nine-digit ZIP code without the hyphen. If reporting a foreign address, contact payer for specific reporting instructions. Report the patient's information only if it is different from the insured's information.

Do not report the patient's telephone number, per the NUCC.

Note that the patient's address refers to the patient's permanent residence. A temporary address or school address should not be used.

Item Number 6: Patient Relationship to Insured

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

In IN 6, enter the patient's relationship to the insured if IN 4 has been completed. Choosing *Self* indicates that the insured is the patient. *Spouse* indicates that the patient is the husband or wife or qualified partner as defined by the insured's plan. *Child* means that the patient is the minor dependent as defined by the insured's plan. *Other* means that the patient is someone other than self, spouse, or child. *Other* includes employee, ward, or dependent as defined by the insured's plan. If the patient is a dependent but has a unique Member Identification Number that the payer requires on the claim, report *Self* because the patient is reported as the insured.

Item Number 7: Insured's Address

7. INSURED'S ADDRESS (No., Street)	
CITY	STATE
ZIP CODE	TELEPHONE (INCLUDE AREA CODE) ( )

Enter the insured's address. If IN 4 is completed, then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a five- or nine-digit ZIP code. Enter the nine-digit ZIP code without the hyphen. If reporting a foreign address, contact payer for specific reporting instructions. Do not report the insured's telephone number, per the NUCC.

Item Number 8: Reserved for NUCC Use

8. RESERVED FOR NUCC USE

This field is reserved for NUCC use. The NUCC will provide instructions for any use of it. The previous use as "Patient Status" has been eliminated.

with a private payer, Group Health Plan is selected. The Other box indicates health insurance including HMOs, commercial insurance, automobile accident, liability, and workers' compensation. This information directs the claim to the correct program and may establish the primary payer. If a patient can be identified by a unique Member Identification Number, that patient is the *insured* and is reported in the *insured* fields rather than the patient fields.

Item Number 1a: Insured's ID Number

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

Item Number 1a records the insurance identification number that appears on the insurance card of the person who holds the policy, with the payer to whom the claim is being submitted, who may or may not be the patient. If the patient has a unique Member Identification Number assigned by the payer, enter that number.

Item Number 2: Patient's Name

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

The patient's name is the name of the person who received the treatment or supplies, listed exactly as it appears on the insurance card. Do not change the spelling, even if the card is incorrect. Only report the patient's information if it is different from the insured's information. The order in which the name should appear for most payers is last name, first name, and middle initial. Use commas to separate the last name, first name, and middle initial.

If the patient uses a last name suffix (e.g., Jr., Sr.), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. A hyphen can be used for hyphenated names. Do not use periods within the name.

Item Number 3: Patient's Birth Date/Sex

3. PATIENT'S BIRTH DATE SEX
MM DD YY M F

The patient's birth date and sex (gender) help identify the patient by distinguishing among persons with similar names. Enter the patient's date of birth in eight-digit format (MM/DD/YYYY). Note that all four digits for the year are entered, even though the printed form indicates only two characters (YY). Use zeros before single digits. Enter an X in the correct box to indicate the sex of the patient. Leave this box blank if the patient's gender is not known.

Item Number 4: Insured's Name

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

In IN 4, enter the full name of the person who holds the insurance policy (the insured). If the patient is a dependent, the insured may be a spouse, parent, or other person. If the insured uses a last name suffix (e.g., Jr., Sr.), enter it after the last name and before the first name. Use commas to separate the last name, first name, and middle initial. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. A hyphen can be used for hyphenated names. Do not use periods within the name.

Item Number 17a and 17b (split field)

17a.	
17b. NPI	

17a: This field allows for the entry of two characters in the qualifier field and seventeen characters in the Other ID# field. The non-NPI ID number (**Other ID number**) of the referring, ordering, or supervising provider is the unique identifier of the professional. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area.

Other ID number additional provider identification number

The NUCC defines the following qualifiers:

0B State License Number

1G Provider UPIN Number

G2 Provider Commercial Number

LU Location Number (This qualifier is used for Supervising Provider only.)

17b: The NPI number refers to the HIPAA National Provider Identifier number. Enter the NPI number of the referring, ordering, or supervising provider in IN 17b.

Item Number 18: Hospitalization Dates Related to Current Services

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES					
FROM	MM	DD	YY	TO MM	DD YY

The hospitalization dates related to current services refer to an inpatient stay and indicate the admission and discharge dates associated with the service(s) on the claim. If the services are needed because of a related hospitalization, enter the admission and discharge dates of that hospitalization in IN 18. For patients still hospitalized, the admission date is listed in the From box, and the To box is left blank.

Item Number 19: Additional Claim Information (Designated by NUCC)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Refer to instructions from the applicable public or private payer regarding the use of this field. Some payers ask for certain identifiers in this field. (If identifiers are reported, the appropriate qualifiers describing the identifier should be used.) IN 19 may be used to report Supplemental Claim Information, using the qualifier PKW followed by a report-type code, a transmission-type code, and an attachment control.

Item Number 20: Outside Lab? $ Charges

20. OUTSIDE LAB?	$ CHARGES
☐ YES ☐ NO	

Outside lab? $ Charges is used to show that services have been rendered by an independent provider, as indicated in IN 32, and to list the related costs.

Enter an X in No if no lab charges are reported. Complete this item when the physician is billing for laboratory services instead of the lab itself. Enter an X in Yes if the reported service was performed by an **outside laboratory.** If Yes is checked, enter the purchased price under charges. A Yes response indicates that an entity other than the

outside laboratory purchased laboratory services

Item Number 15: Other Date

15. OTHER DATE			
QUAL.		MM DD YY	

Enter an "Other Date" related to the patient's condition or treatment. Enter the date in either six-digit or eight-digit format. The item number is asking whether the patient previously had a related condition. A previous pregnancy is not a similar illness. Leave blank if unknown.

Enter the applicable qualifier to identify which date is being reported.

454 Initial Treatment

304 Latest Visit or Consultation

453 Acute Manifestation of a Chronic Condition

439 Accident

455 Last X-ray

471 Prescription

090 Report Start (Assumed Care Date)

091 Report End (Relinquished Care Date)

444 First Visit or Consultation

Enter the qualifier to the right of the vertical, dotted line.

Item Number 16: Dates Patient Unable to Work in Current Occupation

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION						
FROM	MM DD YY		TO	MM DD YY		

If the patient is employed and is unable to work in his or her current occupation, a six-digit or eight-digit date must be shown for the from–to dates that the patient is unable to work. "Dates patient unable to work in current occupation" refers to the time span the patient is or was unable to work. An entry in this field may indicate employment-related insurance coverage.

Item Number 17: Name of Referring Provider or Other Source

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

The name entered is the referring provider, ordering provider, or supervising provider who referred, ordered, or supervised the service(s) or supply(ies) on the claim. Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim.

If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider
2. Ordering Provider
3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names.

The qualifier indicates the role of the provider being reported. Enter the applicable qualifier to identify which provider is being reported.

DN Referring Provider

DK Ordering Provider

DQ Supervising Provider

Enter the qualifier to the left of the vertical, dotted line.

THINKING IT THROUGH 7.2

A sixty-one-year-old retired female patient is covered by her husband's insurance policy. Her husband is still working and receives health benefits through his employer.

1. What information belongs in IN 2 of the claim?
2. What information belongs in IN 4?
3. What information belongs in IN 11b?

7.3 Types of Providers

Medical insurance specialists working with claims in the 5010A1 format—whether electronic or paper claims—understand that four types of providers may need to be reported: billing provider, pay-to provider, rendering provider, and referring provider.

The **billing provider** is a provider of health services, usually a physician practice. A **pay-to provider,** in contrast, is the person or organization that receives payment for the claim. The billing provider and the pay-to provider are very often the same. However, if a clearinghouse or billing service is authorized by the billing provider to transmit claims and process payments on its behalf, these service organizations are the pay-to providers. A **rendering provider** is a physician or other entity such as a lab that has provided the care. Again, it is possible that the rendering provider is the same as the billing provider.

Finally, when another physician has seen the patient and needs to be identified as the *referring* provider (see Chapter 3), the claim format allows for these data to be reported.

billing provider provider of health services reported on a claim

pay-to provider entity that will receive payment for a claim

rendering provider healthcare professional who provides health services reported on a claim

THINKING IT THROUGH 7.3

1. Why is it important to distinguish between the billing provider and the pay-to provider in physician practices?

BILLING TIP

5010A1 Version: Billing Provider Address

The billing provider's address must be a street address, not a PO box or a lock box. Physicians who want payments sent to another address should use the pay-to address fields.

7.4 Completing the CMS-1500 Claim: Physician/Supplier Information Section

The items in this part of the CMS-1500 claim form identify the healthcare provider, describe the services performed, and give the payer additional information to process the claim.

Physician/Supplier Information

Item Number 14: Date of Current Illness, Injury, or Pregnancy (LMP)

Enter the six-digit or eight-digit date for the first date of the present illness, injury, or pregnancy, if known. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This date refers to the first date of onset of illness, the actual date of injury, or the LMP for pregnancy.

Enter the applicable qualifier to identify which date is being reported.

431 Onset of Current Symptoms or Illness

484 Last Menstrual Period

Enter the qualifier to the right of the vertical, dotted line.

Item Number 11a: Insured's Date of Birth/Sex

a. INSURED'S DATE OF BIRTH MM | DD | YY	SEX M ☐ F ☐

Enter the eight-digit date of birth (MM| DD| YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.

Item Number 11b: Other Claim ID (Designated by NUCC)

b. OTHER CLAIM ID (Designated by NUCC)

This IN is often used to report a claim number assigned by the payer. The NUCC designates applicable claim identifiers.

Item Number 11c: Insurance Plan Name or Program Name

c. INSURANCE PLAN NAME OR PROGRAM NAME

Enter the insurance plan or program name of the insured indicated in IN 1a. Note that some payers require an identification number of the primary insurer rather than the name in this field.

Item Number 11d: Is There Another Health Benefit Plan?

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a and 9d.

Select Yes if the patient is covered by additional insurance. If the answer is Yes, INs 9, 9a, and 9d must also be completed. If the patient does not have additional insurance, select No. If not known, leave blank.

Item Number 12: Patient's or Authorized Person's Signature

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____

Enter "Signature on File," "SOF," or legal signature. When a legal signature is used, enter the date signed in six-digit format (MM/DD/YY) or eight-digit format (MM/DD/YYYY).

This entry means that there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim. If there is no signature on file, leave blank or enter "No Signature on File."

COMPLIANCE GUIDELINE

Signature on File

If a release is required, make certain that the release on file is current (signed within the last twelve months) and that it covers the release of information pertaining to all the services listed on the claim before entering "Signature on File" or "SOF."

Item Number 13: Insured's or Authorized Person's Signature

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

Enter "Signature on File," "SOF," or the legal signature. The insured's or authorized person's signature indicates that there is a signature on file authorizing payment of medical benefits directly to the provider of the services listed on the claim. If there is no signature on file, leave blank or enter "No Signature on File."

"Procedures, Services, or Supplies" identify the medical services and procedures provided to the patient. Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four 2-character modifiers. The specific procedure code(s) must be shown without a narrative description. This field allows for the entry of the following: six characters in the unshaded area of the CPT/HCPCS field and four sets of two characters in the Modifier area.

BILLING TIP

Unlisted Procedure Code

When reporting an unlisted procedure code, include a narrative description in IN 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim.

Item Number 24E: Diagnosis Pointer

The diagnosis pointer refers to the line number from IN 21 that provides the link between diagnosis and treatment. In IN 24E, enter the diagnosis code reference letter (point) A–L as shown in IN 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple diagnoses are related to one service, the reference letter for the primary diagnosis should be listed first; other applicable diagnosis reference letters should follow. The reference letter(s) should be an A, or a B, or a C, or a D or multiple letters as explained. Do not enter diagnosis codes in 24E.

Item Number 24F: $ Charges

Item Number 24F lists the total billed charges for each service line in IN 24D. A charge for each service line must be reported. If the claim reports an encounter with no charge, such as a capitated visit, a value of zero may be used.

Table 7.1 Selected Place of Service Codes

Code	Definition
11	Office
12	Home
21	Inpatient hospital
22	On-campus outpatient hospital
23	Emergency room–hospital
24	Ambulatory surgical center
31	Skilled nursing facility
81	Independent laboratory

Item Number 24C: EMG

POS Codes

www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

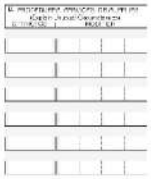
Item Number 24C is EMG, for emergency indicator, as defined by federal or state regulations or programs, payer contracts, or HIPAA claim rules. Generally, an emergency situation is one in which the patient requires immediate medical intervention as a result of severe, life-threatening, or potentially disabling conditions. Check with the payer to determine whether the emergency indicator is necessary. If required, enter "Y" for yes or "N" for no in the bottom unshaded portion of the field.

BILLING TIP

IN 24C

In the past, this Item Number was Type of Service, which is no longer used. Type of service codes have been eliminated from the CMS-1500 02/12 claim.

Item Number 24D: Procedures, Services, or Supplies



Section 24 of the claim reports the **service line information**—that is, the procedures—performed for the patient. Each item of service line information has a procedure code and a charge with additional detailed information.

The six service lines in section 24, which contains INs 24A through 24J, have been divided horizontally to hold both the NPI and a proprietary identifier and to permit the submission of supplemental information to support the billed service. For example, when billing HCPCS codes for products such as drugs, durable medical equipment, or supplies, the payer may require supplemental information using these indicators and codes:

- N4 indicator and the National Drug Codes (NDC)
- VP indicator and Health Industry Business Communications Council (HIBCC) or OZ indicator and Global Trade Item Number (GTIN), formerly Universal Product Codes (UPCs)
- Anesthesia duration: in hours and/or minutes and start and end times

This information is to be placed in the upper shaded section of INs 24C through 24H.

service line information information about procedures performed for the patient

BILLING TIP

Correct Use of Section 24

The top portions of the six service lines are shaded. The shading is not intended to allow the billing of twelve lines of service, just to make it easier to see the lines.

Item Number 24A: Date(s) of Service

Date(s) of service indicate the actual month, day, and year the service was provided. Grouping services refers to a charge for a series of identical services without listing each date of service.

Enter the from and to date(s) of service. If there is only one date of service, enter that date under From, and leave To blank or reenter the From date. When grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in IN 24G.

BILLING TIP

Dates of Service

Dates for the same patient that fall in different years must be reported on separate claims.

Item Number 24B: Place of Service

In 24B, enter the appropriate two-digit code from the place of service code list for each item used or service performed. A **place of service (POS) code** describes the location where the service was provided. The POS code is also called the *facility type code*. Table 7.1 shows typical codes for physician practice claims. A complete list is provided in Appendix A.

BILLING TIP

Place of Service

Payers may authorize different payments for different locations. Higher payments may be made for physician office services, and lower payments for services in ambulatory surgical centers (ASCs) and hospital outpatient departments. When a service is performed in an ASC or outpatient department, check to determine whether it falls under the category of an office service.

place of service (POS) code administrative code indicating where medical services were provided

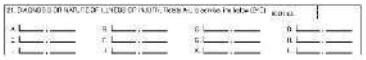
BILLING TIP

Compliant Claims Require Diagnosis Codes

A claim that does not report at least one diagnosis code will be denied.

entity billing for the service performed the laboratory services. When Yes is chosen, IN 32 must be completed. When billing for multiple purchased lab services, each service should be submitted on a separate claim. Enter 00 for cents if the amount is a whole number. Do not use dollar signs, commas, or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Leave the right-hand field blank.

Item Number 21: Diagnosis or Nature of Illness or Injury



BILLING TIP

Primary Diagnosis Codes

An external cause code cannot be used as a primary diagnosis. Some Z codes are also allowed only as secondary diagnoses.

The *ICD Indicator* reports which version of ICD codes is being used, ICD-9-CM (code 9) or ICD-10-CM (code 0). Then the codes that describe the patient's condition are entered in priority order. The code for the primary diagnosis is listed first. Additional codes for secondary diagnoses should be listed only when they are directly related to the services being provided. Up to twelve codes can be entered. In 24E, relate lines A through L to the lines of service (see 24E). Do not include the decimal point in the diagnosis code, because it is implied.

Item Number 22: Resubmission and/or Original Reference Number

BILLING TIP

ICD Indicator

Check to confirm that the NUCC Guideline for this IN remain in place for future years.

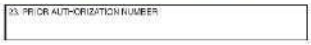
Medicaid *resubmission* means the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter. List the original reference number for resubmitted claims. Please refer to the most current instructions from the applicable public or private payer regarding the use of this field (e.g., code). When resubmitting a claim, enter the appropriate bill frequency code aligned left in the left-hand side of the field.

7 - Replacement of prior claim

8 - Void/cancel of prior claim

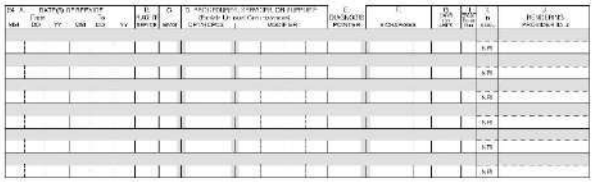
This Item Number is not intended for use for original claim submissions.

Item Number 23: Prior Authorization Number



The prior authorization number refers to the payer-assigned number authorizing the service(s). Enter any of the following: prior authorization number or referral number as assigned by the payer for the current service or the Clinical Laboratory Improvement Amendments (CLIA) number or the mammography precertification number. Do not enter hyphens or spaces within the number.

Section 24



(MM | DD | YY), eight-digit date (MM | DD | YYYY), or alphanumeric date (e.g., January 1, 2003) the form was signed.

Item Number 32, 32a, and 32b: Service Facility Location Information

32 SERVICE FACILITY LOCATION INFORMATION	
a.	b.

If the information in Item Number 33 is different from Item Number 32, enter the name, address, city, state, and nine-digit ZIP code of the location where the services were rendered. In 32a, enter the NPI of the service facility location. In 32b, enter the two-digit qualifier for a non-NPI number.

IN 32 allows for reporting another location for the service, such as a hospital. Physicians who are billing for purchased diagnostic tests or radiology services must identify the supplier's name, address, nine-digit ZIP code, and NPI in IN 32a. Enter the payer-assigned identifying non-NPI number of the service facility in IN 32b with its qualifier. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a nine-digit ZIP code. Enter the nine-digit ZIP code without a hyphen.

Item Number 33, 33a, and 33b: Billing Provider Information and Phone Number

33 BILLING PROVIDER INFO & PH # ( )	
a.	b.

IN 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter the provider's billing name, address, ZIP code, phone number, NPI, non-NPI number, and appropriate qualifier. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a nine-digit ZIP code. Enter the nine-digit ZIP code without a hyphen. The NUCC recommends that a street address or physical location be used. The NPI should be placed in IN 33a. Enter the identifying non-NPI number and its qualifier in IN 33b. If the billing provider is a group, then the rendering provider NPI goes in Item Number 24J. If the billing provider is a solo practitioner, then Item Number 24J is left blank. The referring provider NPI goes in Item Number 17b.

A Note on Taxonomy Codes

The other ID number of the rendering provider may be completed with a **Healthcare Provider Taxonomy Code (HPTC)** as well as a legacy number. (If two numbers are reported, they should be separated by three blank spaces.) A taxonomy code is a ten-digit number that stands for a physician's medical specialty. The type of specialty may affect the physician's pay, usually because of the payer's contract with the physician. For example, nuclear medicine is usually a higher-paid specialty than internal medicine. An internist who is also certified in nuclear medicine would report the nuclear medicine taxonomy code when billing for that service and use the internal medicine taxonomy code when reporting internal medicine claims. Most practice management programs store taxonomy-code databases.

Summary of Claim Information

Table 7.2 summarizes the information that the NUCC requires for correct completion of the CMS-1500 claim both generally and in this text.

Current Taxonomy Code Set

www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40

Administrative Code Sets

The taxonomy codes are one of the nonmedical or nonclinical **administrative code sets** maintained by the NUCC. These code sets are business related. Although the use of an administrative code set is not required by HIPAA, if you choose to report one, it must be on the NUCC list.

administrative code set required codes for various data elements

Healthcare Provider Taxonomy Code (HPTC) administrative code set used to report a physician's specialty

All Administrative Code Sets for HIPAA Transactions

www.hipaa.com/hipaa-administrative-simplification-modifications-to-medical-data-code-set-standards-to-adopt-icd-10-cm-and-icd-10-pcs/

Item Number 25: Federal Tax ID Number

Enter the billing provider's (IN33) Employer Identification Number (EIN) or Social Security number in IN 25. Do not use hyphens in numbers. Mark the appropriate box (SSN or EIN).

Item Number 26: Patient's Account No.

Enter the patient account number used by the practice's accounting system. This information is used primarily to help identify a patient's payments and to post payments when working with remittance advices.

Item Number 27: Accept Assignment?

Enter a capital X in the correct box. "Yes" means that the provider agrees to accept assignment. Only one box can be marked.

Item Number 28: Total Charge

Item Number 28 lists the total of all charges in Item Number 24F, lines 1 through 6. Enter the amount right justified in the left-hand area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the right-hand area if the amount is a whole number. If the claim is to be submitted on paper and there are more services to be billed, put *continued* here, and put the total charge on the last claim form page.

Item Number 29: Amount Paid

BILLING TIP

Address for Service Facility

Do not use a post office (PO) box in the service facility address.

Enter the amount the patient and/or payers paid on the *covered* services listed on this claim in IN 29. If no payment was made, enter none or 0.00. Enter the amount right justified in the left-hand area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the right-hand area if the amount is a whole number.

Item Number 30: Reserved for NUCC Use

This IN is reserved for NUCC use. The previous entry, "Balance Due," has been eliminated.

Item Number 31: Signature of Physician or Supplier Including Degrees or Credentials

Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the six-digit

Item Numbers 24I (ID Qualifier) and 24J (Rendering Provider ID#)

I. ID. QUAL.	J. RENDERING PROVIDER ID.#
NPI	
NPI	
NPI	
NPI	
NPI	
NPI	

Item Number 24I works together with IN 24J. These boxes are used to enter an ID number for the rendering provider–the individual who is providing the service. If the number is an NPI, it goes in IN 24J in the unshaded area next to the 24I label NPI. If the number is a non-NPI (other ID number), the qualifier identifying the type of number goes in IN 24I next to the number in 24J. The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (*locum tenens*) was used, enter that provider's information here. Report the Identification Number in Items 24I and 24J only when it is different from data recorded in items 33a and 33b.

Notes:

- Even though the NPI has been fully implemented, it is assumed that there will always be providers who do not have NPIs and whose non-NPI identifiers need to be reported on claim forms.

BILLING TIP

Medicare NPI Requirements

Medicare fee-for-service claims must include an NPI for the provider in the primary fields (that is, the billing and rendering fields).

Item Number 24: Supplemental Information

Supplemental information can be entered in the shaded areas of IN 24, including the narrative description of unspecified codes, NDCs for drugs, Device Identifiers, contract rates, and tooth numbers and areas of the oral cavity.

The following qualifiers are used when reporting these services:

ZZ	Narrative description of unspecified code
N4	National Drug Codes (NDC)
DI	Device Identifier of the Unique Device Identifier (UDI)
CTR	Contract rate
JP	Universal/National Tooth Designation System
JO	ANSI/ADA/ISO Specification No. 3950-1984 Dentistry Designation System for Tooth and Areas of the Oral Cavity

If required to report supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

To enter supplemental information, begin at IN 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code. More than one supplemental item can be reported. Enter the first qualifier and number/code/information at IN 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information. When reporting dollar amounts in the shaded area, always enter the dollar amount, a decimal point, and cents. Use 00 for the cents if the amount is a whole number. Do not use commas or enter dollar signs.

BILLING TIP

Billing for Capitated Visits

If the claim is to report an encounter under a managed care organization (MCO) capitation contract, a value of zero may be used.

The numbers should be entered without dollar signs, decimals, or commas. Enter 00 in the cents area if the amount is a whole number (for example, 32.00). If the services are for multiple days or units, the number of days or units must be multiplied by the charge to determine the entry in IN 24F. This is done automatically when a practice management program is used to create the claim.

Item Number 24G: Days or Units

The item *days or units* refers to the number of days corresponding to the dates entered in 24A or units as defined in CPT or HCPCS. Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point. Anesthesia services must be reported as minutes. Units may be reported for anesthesia services only when the code description includes a time period (such as "daily management").

Item Number 24H: EPSDT Family Plan

The Item Number for EPSDT Family Plan refers to certain services that may be covered under some stated Medicaid plans. In the bottom unshaded portion of the field, enter the correct alpha referral code if the service is related to early and periodic screening, diagnosis, and treatment (EPSDT). When there is a requirement to report that this is a Family Planning service, enter "Y" for yes in the unshaded area of the field. This field allows for the entry of one character in the unshaded area and two characters right justified in the shaded area. When there is no requirement to report that this is a Family Planning service, leave the field blank.

The following codes for EPSDT are used in 5010A1:

AV Available-Not Used

S2 Under Treatment

ST New Service Requested

NU Not Used

Table 7.3 Crosswalk of the CMS 1500 (02/12) to the HIPAA 837P *(continued)*

CMS Item Number		837 Data Element
	Other Insured's First Name	Other Subscriber First Name
	Other Insured's Middle Initial	Other Subscriber Middle Name
		Other Subscriber Name Suffix
9a	Other Insured's Policy or Group Number	Other Subscriber Primary Identification
9b	Reserved for NUCC Use	NOT USED
9c	Reserved for NUCC Use	NOT USED
9d	Insurance Plan Name or Program Name	Other Payer Organization Name
10	Is Patient's Condition Related To:	Related causes information
10a	Employment (current or previous)	Related causes code
10b	Auto Accident	Related causes code
10b	Place (state)	Auto accident state or province code
10c	Other Accident	Related causes code
11	Insured's Policy Group or FECA number	Subscriber Group or Policy Number
11a	Insured's Date of Birth	Subscriber Date of Birth
	Sex	Subscriber Gender code
11b	Other Claim ID (Designated by NUCC)	NOT USED
11c	Insurance plan name or program name	Subscriber Group Name
11d	Is there another health benefit plan	Entity Identifier code
12	Patient's or authorized person's signature (and date)	Release of Information Code
		Patient signature source code
13	Insured's or authorized person's signature	Benefits assignment Certification indicator
14	Date of Current: Illness, Injury, or Pregnancy (LMP)	Initial treatment date
		Accident/LMP Date
		Last menstrual period
15	Other Date	Other Date related to the patient's condition or treatment
16	Dates patient unable to work in current occupation From/To	Disability From/To Dates
17	Name of Referring Provider or Other Source	Referring Provider Last Name/First Name or Organization
17a/b	ID/NPI of referring physician	Referring Provider NPI
18	Hospitalization dates related to current services From/To	Admission Date/Discharge Date
19	Additional Claim Information (Designated by NUCC)	NOT USED
20	Outside Lab? $ Charges	Purchased Service Charge Amount

(continued)

BILLING TIP

Rejection of Claims Missing Required Elements

Under HIPAA, failure to transmit required data elements can cause a claim to be rejected by the payer.

COMPLIANCE GUIDELINE

Correct Code Sets

The correct medical code sets are those valid at the time the healthcare is provided. The correct administrative code sets are those valid at the time the transaction—such as the claim—is started.

BILLING TIP

Billing Provider Name and Telephone Number

Note that a billing provider contact name and telephone number are required data elements.

7.5 The HIPAA 837P Claim

Most of the information reported on the CMS-1500 is also used on the HIPAA 837P claim. Table 7.3 shows a comparison.

Use of PMPs

PMP vendors are responsible for (1) keeping their software products up to date, (2) receiving certification from HIPAA testing vendors that their software can accommodate HIPAA-mandated transactions, and (3) training office personnel in the use of new features.

Table 7.3 Crosswalk of the CMS 1500 (02/12) to the HIPAA 837P

CMS Item Number		837 Data Element
Carrier Block	Name and Address of Payer	
1	Insurance Plan/Program	Claim Filing Indicator
1a	Insured's ID Number	Subscriber Primary Identifier
2	Patient's Last Name	Patient Last Name
	Patient's First Name	Patient First Name
	Patient's Middle Name	Patient Middle Initial
		Patient Name Suffix
3	Patient's Birth Date	Patient Birth Date
	Sex	Patient Gender code
4	Insured's Last Name	Subscriber Last Name
	Insured's First Name	Subscriber First Name
	Insured's Middle Initial	Subscriber Middle Name
		Subscriber Name Suffix
5	Patient's Address	Patient Address Lines 1, 2
	City	Patient City Name
	State	Patient State Code
	ZIP Code	Patient ZIP Code
	Telephone	NOT USED
6	Patient Relationship to Insured: Self, Spouse, Child, Other	Code for Patient's Relationship to Subscriber
7	Insured's Address	Subscriber Address Lines 1, 2
	City	Subscriber City Name
	State	Subscriber State Code
	ZIP Code	Subscriber ZIP Code
	Telephone	NOT USED
8	Reserved for NUCC Use	NOT USED
9	Other Insured's Last Name	Other Subscriber Last Name

Table 7.2 CMS-1500 Claim Completion *(concluded)*

Item Number	Content
18	**Hospitalization Dates Related to Current Services:** If the services provided are needed because of a related hospitalization, the admission and discharge dates are entered. For patients still hospitalized, the admission date is listed in the From box, and the To box is left blank.
19	**Additional Claim Information (Designated by NUCC):** Refer to instructions from the public or private payer regarding this field.
20	**Outside Lab? $ Charges:** Completed if billing for outside lab services. Enter an X in No if no lab charges are reported on the claim.
21	**Diagnosis or Nature of Illness or Injury:** ICD-9-CM or ICD-10-CM indicator and up to twelve diagnosis codes in priority order.
22	**Resubmission and/or Original Reference Number:** List the original reference number for resubmitted claims.
23	**Prior Authorization Number:** If required by payer, report the assigned number.
24A	**Date(s) of Service:** Date(s) service was provided.
24B	**Place of Service:** A place of service (POS) code describes the location at which the service was provided.
24C	**EMG:** For emergency claims only.
24D	**Procedures, Services, or Supplies:** CPT and HCPCS codes and applicable modifiers for services provided.
24E	**Diagnosis Pointer:** Using the letters (A through L) listed to the left of the diagnosis codes in IN 21, enter the diagnosis for each service listed in IN 24D.
24F	**$ Charges:** For each service listed in IN 24D, enter charges without dollar signs and decimals.
24G	**Days or Units:** The number of days or units.
24H	**EPSDT/Family Plan:** Medicaid-specific. Refer to specific payer instructions.
24I and 24J	**ID Qualifier and Rendering Provider ID Number:** Only report when different from IN 33A and IN 33B.
25	**Federal Tax ID Number:** Billing provider's (IN33) Employer Identification Number (EIN) or Social Security number.
26	**Patient's Account No.:** Patient account number used by the practice's accounting system.
27	**Accept Assignment?** Select Yes.
28	**Total Charge:** Total of all charges in IN 24F.
29	**Amount Paid:** Amount of the payments received for the services listed on this claim from patients and payers.
30	**Reserved for NUCC Use:** LEAVE BLANK.
31	**Signature of Physician or Supplier Including Degrees or Credentials:** Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF."
32	**Service Facility Location Information:** Complete if different from the billing provider information in IN 33.
33	**Billing Provider Information and Phone Number:** Billing office name, address, nine-digit ZIP code, phone number, and ID numbers.

THINKING IT THROUGH 7.4

1. A patient who had a minor automobile accident was treated in the emergency room and released. What place of service code is reported?
2. If a physician practice uses a billing service to prepare and transmit its healthcare claims, which entity is the pay-to provider and which is the billing provider?

BILLING TIP

Follow Payer Guidelines

Always check with the payer for the claim to ensure correct completion.

Table 7.2 CMS-1500 Claim Completion

Item Number	Content
1	**Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other:** Enter the type of insurance.
1a	**Insured's ID Number:** The insurance identification number that appears on the insurance card of the policyholder.
2	**Patient's Name:** As it appears on the insurance card. Report only if different from the insured.
3	**Patient's Birth Date, Sex:** Date of birth in eight-digit format; appropriate selection for male or female.
4	**Insured's Name:** The full name of the person who holds the insurance policy (the insured). If the patient is a dependent, the insured may be a spouse, parent, or other person.
5	**Patient's Address:** Address includes the number and street, city, state, and ZIP code. Report only if different from the insured.
6	**Patient Relationship to Insured:** Self, spouse, child, or other. Self means that the patient is the certificate holder.
7	**Insured's Address:** Address of the insured person listed in IN 4.
8	**Reserved for NUCC Use:** LEAVE BLANK.
9	**Other Insured's Name:** If there is additional insurance coverage, the insured's name.
9a	**Other Insured's Policy or Group Number:** The policy or group number of the other insurance plan.
9b	**Reserved for NUCC Use:** LEAVE BLANK.
9c	**Reserved for NUCC Use:** LEAVE BLANK.
9d	**Insurance Plan Name or Program Name:** Other insured's insurance plan or program name.
10a–10c	**Is Patient's Condition Related To:** To indicate whether the patient's condition is the result of a work injury, an automobile accident, or another type of accident.
10d	**Claim Codes (Designated by NUCC):** Report condition codes when applicable.
11	**Insured's Policy, Group, or FECA Number:** As it appears on the insurance identification card.
11a	**Insured's Date of Birth, Sex:** The insured's date of birth and sex.
11b	**Other Claim ID (Designated by NUCC):** Enter the applicable claim identifier as designated by the NUCC.
11c	**Insurance Plan Name or Program Name:** Of the insured.
11d	**Is There Another Health Benefit Plan?** If the patient is covered by additional insurance. If marked "YES", IN 9, 9a, and 9d must also be completed.
12	**Patient's or Authorized Person's Signature:** If the patient's or authorized person's signature is on file authorizing the release of information, enter "Signature on File," "SOF," or a legal signature. When legal signature, enter date signed in six-digit format (MMDDYY) or eight-digit format (MMDDYYYY). Leave blank or enter "No Signature on File" if there is no signature on file.
13	**Insured's or Authorized Person's Signature:** Enter "Signature on File," "SOF," or legal signature to indicate there is a signature on file authorizing payment of medical benefits. If there is no signature on file, leave blank or enter "No Signature on File."
14	**Date of Current Illness, Injury, or Pregnancy (LMP):** The date that symptoms first began for the current illness, injury, or pregnancy. For pregnancy, enter the date of the patient's last menstrual period (LMP).
15	**Other Date:** Enter an "Other Date" related to the patient's condition or treatment. Leave blank if unknown.
16	**Dates Patient Unable to Work in Current Occupation:** Dates the patient has been unable to work.
17	**Name of Referring Provider or Other Source:** Name and credentials of the physician or other source who referred, ordered, or supervised the service(s) or supply(ies) on the claim.
17a, b	**Other ID Number and NPI Number:** Identifying number(s) for the referring, ordering, or supervising provider.

Other Data Elements

These situational data elements are required if another payer is known to potentially be involved in paying the claim:

- Other Subscriber Birth Date
- Other Subscriber Gender Code (F [female], M [male], or U [unknown])
- Other Subscriber Address

Patient-specific information may be reported in certain circumstances, such as:

- Patient Death Date (required when the patient is known to be deceased and the provider knows the date on which the patient died)
- Weight
- Pregnancy Indicator Code (Y [yes] required for a pregnant patient when mandated by law)

BILLING TIP

Patient Address

The patient's address is a required data element, so "Unknown" should be entered if the address is not known.

Table 7.5 Relationship Codes

Code	Definition
01	Spouse
04	Grandfather or grandmother
05	Grandson or granddaughter
07	Nephew or niece
09	Adopted child
10	Foster child
15	Ward
17	Stepson or stepdaughter
19	Child
20	Employee
21	Unknown
22	Handicapped dependent
23	Sponsored dependent
24	Dependent of a minor dependent
29	Significant other
32	Mother
33	Father
34	Other adult
36	Emancipated minor
39	Organ donor
40	Cadaver donor
41	Injured plaintiff
43	Child where insured has no financial responsibility
53	Life partner
G8	Other relationship

BILLING TIP

Assigning a Claim Control Number

Although sometimes called the *patient account number*, the claim control number should not be the same as the practice's account number for the patient. It may, however, incorporate the account number. For example, if the account number is A1234, a three-digit number might be added for each claim, beginning with A1234001.

responsible party other person or entity who will pay a patient's charges

or someone else. If the subscriber and patient are not the same person, data elements about the patient are also required. The name and address of any **responsible party**—the entity or person other than the subscriber or patient who has financial responsibility for the bill—is reported if applicable.

Claim Filing Indicator Code

claim filing indicator code administrative code that identifies the type of health plan

A **claim filing indicator code** is an administrative code used to identify the type of health plan, such as a PPO. One of the claim filing indicator codes shown in Table 7.4 is reported. These codes are valid until a National Payer ID system is made into law.

Relationship of Patient to Subscriber

individual relationship code administrative code specifying the patient's relationship to the subscriber

The HIPAA 837P claim allows for a more detailed description of the relationship of the patient to the subscriber. When the patient and the subscriber are not the same person, an **individual relationship code** is required to specify the patient's relationship to the subscriber. The current list of choices is shown in Table 7.5.

Table 7.4 Claim Filing Indicator Codes

Code	Definition
09	Self-pay
11	Other nonfederal programs
12	Preferred provider organization (PPO)
13	Point of service (POS)
14	Exclusive provider organization (EPO)
15	Indemnity insurance
16	Health maintenance organization (HMO) Medicare risk plan
AM	Automobile medical
BL	BlueCross BlueShield
CH	CHAMPUS (TRICARE)
CI	Commercial insurance company
DS	Disability
FI	Federal Employees Program
HM	Health maintenance organization
LM	Liability medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
OF	Other federal program
TV	Title V
VA	Department of Veteran's Affairs plan
WC	Workers' compensation health claim
ZZ	Mutually defined

BILLING TIP

Patient Relationship to Insured

Patient information forms and electronic medical records should record the relationship of the patient to the insured according to HIPAA categories, so that these data can be included on the HIPAA 837 claim.

a different way. This organization is efficient for electronic transmission rather than for use on a paper form.

The elements are transmitted in the five major sections, or levels, of the claim:

1. Provider
2. Subscriber (guarantor/insured/policyholder) and patient (the subscriber or another person)
3. Payer
4. Claim details
5. Services

The levels are set up as a hierarchy with the provider at the top, so that when the claim is sent electronically, the only data elements that have to be sent are those that do not repeat previous data. For example, when the provider is sending a batch of claims, provider data are sent once for all of them. If the subscriber and the patient are the same, then the patient data are not needed. But if the subscriber and the patient are different people, information about both is transmitted.

There are four types of data elements:

1. *Required (R) data elements:* For **required data elements,** the provider must supply the data element on every claim, and payers must accept the data element.
2. *Required if applicable (RIA) data elements:* These **situational data elements** are conditional on specific situations. For example, if the insured differs from the patient, the insured's name must be entered.
3. *Not required unless specified under contract (NRUC):* These elements are required only when they are part of a contract between a provider and a payer or when they are specified by state or federal legislation or regulations.
4. *Not required (NR):* These elements are not required for submission and/or receipt of a claim or encounter.

Table 7.6 later in the chapter summarizes all the data elements that can be reported. Review this table after you have read this section.

HIPAA/HITECH TIP

Verifying and Updating Information About Subscribers and Patients

The HIPAA Eligibility for a Health Plan transaction (the provider's inquiry and the payer's response) is used to verify insurance coverage and eligibility for benefits, as noted in the chapter about patient encounters and billing information. If that transaction turns up new or different information, the changes are correctly posted in the PMP.

required data element information that must be supplied on an electronic claim

situational data element Information that must be on a claim in conjunction with certain other data elements

THINKING IT THROUGH 7.5

1. Assume that a patient is a four-year-old minor who lives at home with her father, who has custody. What type of data element is this patient's father?

7.6 Completing the HIPAA 837P Claim

Table 7.6 summarizes the required claim elements.

Provider Information

Like the CMS-1500, the HIPAA 837P claim requires data on these types of providers, as applicable:

- Billing provider
- Pay-to provider
- Rendering provider
- Referring provider

For each provider, an NPI number and possibly non-NPI numbers with the qualifiers shown in Table 7.1 are reported.

Subscriber Information

The HIPAA 837P uses the term *subscriber* for the insurance policyholder or guarantor, meaning the same as *insured* on the CMS-1500 claim. The subscriber may be the patient

HIPAA/HITECH TIP

HIPAA National Plan Identifier

Under HIPAA, the Department of Health and Human Services must adopt a standard health plan identifier system. Each plan's number will be its National Payer ID. The number is also called the *National Health Plan ID.*

Table 7.3 Crosswalk of the CMS 1500 (02/12) to the HIPAA 837P *(concluded)*

CMS Item Number		837 Data Element
21	Diagnosis or nature of illness or injury, diagnosis codes 1 through 4	Diagnosis Codes 1 through 12
22	Resubmission Code/Original Reference Number	Claim Frequency Code/Payer Claim Control Number
23	Prior Authorization Number	Prior Authorization Number
24A	Date(s) of Service (From/To MM DD YY)	Service Date
24B	Place of Service	Place of Service Code
24C	EMG	Emergency Indicator
24D	Procedures, services, or supplies CPT/HCPCS and Modifier	Procedure Codes/Modifiers
24E	Diagnosis Pointers	Diagnosis Code Pointers
24F	$ Charges	Line Item Charge Amount
24G	Days or units	Service Unit Count
24H	EPSDT/Family Plan	EPSDT/Family Planning Indicator
24I	ID Qualifier	Identification Qualifier
24J	Rendering Provider ID#	Rendering Provider ID
25	Federal Tax ID Number	Billing Provider/Pay-to Provider SSN or EIN
26	Patient's Account No.	Patient Control Number
27	Accept Assignment?	Assignment or Plan Participation Code
28	Total Charge	Total Claim Charge Amount
29	Amount Paid	Patient Paid Amount
30	Reserved for NUCC Use	NOT USED
31	Signature of Physician or Supplier Including Degrees or Credentials	NOT USED
32	Service Facility Location Information	Laboratory or Facility Information
33	Billing Provider Info & PH#, NPI/ID (If Not Same as Rendering Provider)	Billing Provider Last/First or Organizational Name, Address, NPI/NonNPI ID (If Not Same as Rendering Provider)

HIPAA/HITECH TIP

X12 837 Health Care Claims/Coordination of Benefits

The HIPAA Health Care Claims/Coordination of Benefits transaction is also called the X12 837. It is used to send a claim to both the primary payer and a secondary payer.

Most PMPs are set up to automatically supply the various items of information that electronic claims need. Some different terms are used with the HIPAA claim, though, and a few additional information items must be relayed to the payer. This section covers those items as it presents the basic organization of the HIPAA 837P claim. When working for physician practices, medical insurance specialists and billers learn the particular elements they need to supply as they process claims.

Claim Organization

data element smallest unit of information in a HIPAA transaction

The HIPAA 837P claim contains many **data elements.** Examples of data elements are a patient's first name, middle name or initial, and last name. Although these data elements are essentially the same as those used to complete a CMS-1500, they are organized in

Line Item Control Number

A **line item control number** is a unique number assigned to each service line by the sender. Like the claim control number, it is used to track payments from the insurance carrier but for a particular service rather than for the entire claim.

Nonspecific Procedure Codes

When "nonspecific procedure codes"–such as unlisted CPT codes or HCPCS codes for some drugs–are reported, the provider must provide a description of the work or the drug and dosage in the service line level.

Claim Attachments

A **claim attachment** is additional data in printed or electronic format sent to support a claim. Examples include lab results, specialty consultation notes, and discharge notes. A HIPAA transaction standard for electronic healthcare claim attachments is under development. When it is adopted, payers will be required to accept all attachments that are submitted by providers according to the standard.

Until then, health plans can require providers to submit claim attachments in the format they specify. The usual options are:

- Available on request at provider site
- By mail
- By e-mail
- By fax

BILLING TIP

Accident Claims

If the reported services are a result of an accident, the claim allows entries for the date and time of the accident; whether it is an auto accident, an accident caused by another party, an employment-related accident, or another type of accident; and the state or country in which the accident occurred.

line item control number unique number assigned by the sender to each service line item reported

claim attachment documentation a provider sends a payer to support a claim

THINKING IT THROUGH 7.6

1. A retiree is covered by his wife's insurance policy. His wife is still working and receives health benefits through her employer, which has a PPO plan.
   A. What code describes the spouse's relationship to the subscriber?
   B. What claim filing indicator code is reported?
   C. What claim filing indicator code is likely to be used if the insurance is TRICARE?
2. What type of code would show whether a claim is the original claim, a replacement, or being cancelled?
3. What is the purpose of a claim control number? Of a line item control number?

HIPAA/HITECH TIP

PHI on Attachments

A payer should receive only data needed to process the claim in question. If an attachment has PHI related to another patient, those data must be marked over or deleted. Information about other dates of service or conditions not pertinent to the claim should also be crossed through or deleted.

7.7 Checking Claims Before Transmission

An important step comes before claim transmittal–checking the claim. Most PMPs provide a way for the medical insurance specialist to review claims for accuracy and to create a record of claims that are about to be sent.

Clean Claims

Although healthcare claims require many data elements and are complex, it is often the simple errors that keep practices from generating **clean claims**–that is, claims that are accepted for adjudication by payers. Following are common errors:

- Missing or incomplete service facility name, address, and identification for services rendered outside the office or home. This includes invalid ZIP codes or state abbreviations.

BILLING TIP

Specialty Claim Service Line Information

Claims for various payers require additional data elements. These include Medicare claims, EPSDT/Medicaid claims, and workers' compensation and disability claims.

clean claim claim accepted by a health plan for adjudication

Table 7.6 HIPAA Claim Data Elements *(concluded)*

CLAIM	
Claim Level	**Rendering Provider**
Claim Control Number (Patient Account Number)	Last or Organization Name
Total Submitted Charges	First Name
Place of Service Code	Middle Name
Claim Frequency Code	Name Suffix
Provider Signature on File	Primary Identifier: NPI
Medicare Assignment Code	Taxonomy Code
Participation Agreement	Secondary Identifiers
Delay Reason Code	
Onset of Current Symptoms or Illness Date	**Referring/PCP Providers**
Similar Illness/Symptom Onset Date	Last or Organization Name
Last Menstrual Period Date	First Name
Admission Date	Middle Name
Discharge Date	Name Suffix
Patient Amount Paid	Primary Identifier: NPI
Claim Original Reference Number	Taxonomy Code
Investigational Device Exemption Number	Secondary Identifiers
Medical Record Number	Proc
Note Reference Code	
Claim Note	**Service Facility Location**
Diagnosis Code 1–12	Type Code
Accident Claims	Last or Organization Name
Accident Cause	Primary Identifier: NPI
Auto Accident	Address 1
Another Party Responsible	Address 2
Employment Related	City Name
Other Accident	State/Province Code
Auto Accident State/Province Code	ZIP Code
Auto Accident Country Code	Country Code
Accident Date	Secondary Identifiers
Accident Hour	
SERVICE LINE INFORMATION	
Procedure Type Code	Shipped Date
Procedure Code	Onset Date
Modifiers 1–4	Similar Illness or Symptom Date
Line Item Charge Amount	Referral/Prior Authorization Number
Units of Service/Anesthesia Minutes	Line Item Control Number
Place of Service Code	Ambulatory Patient Group
Diagnosis Code Pointers 1–4	Sales Tax Amount
Emergency Indicator	Postage Claimed Amount
Copay Status Code	Line Note Text
Service Date Begin	Rendering/Referring/PCP Provider at the Service Line Level
Service Date End	Service Facility Location at the Service Line Level

Service Line Information

The HIPAA 837P has the same elements as the CMS-1500 at the service line level. Different information for a particular service line, such as a prior authorization number that applies only to that service, can be supplied at the service line level.

Diagnosis Code Pointers

A total of four diagnosis codes can be linked to each service line procedure. At least one diagnosis code must be linked to the procedure code. Codes two, three, and four may also be linked, in declining level of importance regarding the patient's treatment, to the service line.

Table 7.6 HIPAA Claim Data Elements

PROVIDER, SUBSCRIBER, PATIENT, PAYER

Billing Provider

Last or Organization Name
- First Name
- Middle Name
- Name Suffix

Primary Identifier: NPI
Address 1
Address 2
City Name
State/Province Code
ZIP Code
Country Code
Secondary Identifiers, such as State License Number
Contact Name
Communication Numbers
- Telephone Number
- Fax
- E-mail
- Telephone Extension

Taxonomy Code
Currency Code

Pay-to Provider

Last or Organization Name
- First Name
- Middle Name
- Name Suffix

Primary Identifier: NPI
Address 1
Address 2
City Name
State/Province Code
ZIP Code
Country Code
Secondary Identifiers, such as State License Number
Taxonomy Code

Subscriber

Insured Group or Policy Number
Group or Plan Name
Insurance Type Code
Claim Filing Indicator Code
Last Name
First Name
Middle Name
Name Suffix
Primary Identifier
- Member Identification Number
- National Individual Identifier
- IHS/CHS Tribe Residency Code

Secondary Identifiers
- IHS Health Record Number
- Insurance Policy Number
- SSN

Patient's Relationship to Subscriber
Other Subscriber Information
Birth Date
Gender Code
Address Line 1
Address Line 2
City Name
State/Province Code
ZIP Code
Country Code

Patient

Last Name
First Name
Middle Name
Name Suffix
Primary Identifier
- Member ID Number
- National Individual Identifier

Address 1
Address 2
City Name
State/Province Code
ZIP Code
Country Code
Birth Date
Gender Code
Secondary Identifiers
- IHS Health Record Number
- Insurance Policy Number
- SSN

Death Date
Weight
Pregnancy Indicator

Responsible Party

Last or Organization Name
First Name
Middle Name
Suffix Name
Address 1
Address 2
City Name
State/Province Code
ZIP Code
Country Code

Payer

Payer Responsibility Sequence Number Code
Organization Name
Primary Identifier
- Payer ID
- National Plan ID

Address 1
Address 2
City Name
State/Province Code
ZIP Code
Secondary Identifiers
- Claim Office Number
- NAIC Code
- TIN

Assignment of Benefits
Release of Information Code
Patient Signature Source Code
Referral Number
Prior Authorization Number

(continued)

Coordination of Benefits

The 837 claim transaction is also used to send data elements regarding coordination of benefits to other payers on the claim.

Payer Information

This section contains information about the payer to whom the claim is going to be sent, called the **destination payer.** A payer responsibility sequence number code identifies whether the insurance carrier is the primary (P), secondary (S), or tertiary (T) payer. This code is used when more than one insurance plan is responsible for payment. The T code is used for the payer of last resort, such as Medicaid (see the Medicaid chapter for an explanation of "payer of last resort").

destination payer health plan receiving a HIPAA claim

Claim Information

The claim information section reports information related to the particular claim. For example, if the patient's visit is the result of an accident, a description of the accident is included. Data elements about the rendering provider–if not the same as the billing provider or the pay-to provider–are supplied. If another provider referred the patient for care, the claim includes data elements about the referring physician or primary care physician (PCP).

BILLING TIP

Mammography Claims

The mammography certification number is required when mammography services are rendered by a certified mammography provider.

Claim Control Number

A **claim control number,** unique for each claim, is assigned by the sender. The maximum number of characters is twenty. The claim control number will appear on payments that come from payers, so it is important for tracking purposes.

claim control number unique number assigned to a claim by the sender

Claim Frequency Code

The **claim frequency code,** also called the **claim submission reason code,** for physician practice claims indicates whether this claim is one of the following:

Code	Definition
1	*Original claim:* The initial claim sent for the patient on the date of service for the procedure
7	*Replacement of prior claim:* Used if an original claim is being replaced with a new claim
8	*Void/cancel of prior claim:* Used to completely eliminate a submitted claim

claim frequency code (claim submission reason code) administrative code that identifies the claim as original, replacement, or void/cancel action

The first claim is always a 1. Payers do not usually allow for corrections to be sent after a claim has been submitted; instead, an entire new claim is transmitted. However, some payers cannot process a claim with the frequency code 7 (replace a submitted claim). In this situation, submit a void/cancel of prior claim (frequency code 8) to cancel the original incorrect claim, and then submit a new, correct claim.

When a claim is replaced, the original claim number (Claim Original Reference Number) is reported.

BILLING TIP

Podiatric, Physical Therapy, and Occupational Therapy Claims

The last-seen date must be reported when (1) a claim involves an independent physical therapist's or occupational therapist's services or a physician's services involving routine foot care and (2) the timing and/or frequency of visits affects payment for services.

Diagnosis Codes

The HIPAA 837P permits up to twelve diagnosis codes to be reported. The order of entry is not regulated. Each diagnosis code must be directly related to the patient's treatment. Up to four of these codes can be linked to each procedure code that is reported.

Claim Note

A claim note may be used when a statement needs to be included, such as to satisfy a state requirement or to provide details about a patient's medical treatment that are not reported elsewhere in the claim.

Learning Outcomes	Key Concepts/Examples
7.6 Categorize data elements into the five sections of the HIPAA 837P claim transaction.	The five sections of the HIPAA 837P claim transaction include: 1. Provider information 2. Subscriber information 3. Payer information 4. Claim information 5. Service line information Additional data elements include: • Claim filing indicator code • Individual relationship code • Claim control number • Claim submission reason code • Line item control number
7.7 Evaluate the importance of checking claims prior to submission, even when using software.	• Clean claims are those claims that are accepted for adjudication by payers. • Clean claims are properly completed and contain all the necessary information.
7.8 Compare the three major methods of electronic claim transmission.	Practices handle the transmission of electronic claims with three major methods: 1. In the direct transmission approach, providers and payers exchange transactions directly without using a clearinghouse. 2. The majority of providers use clearinghouses to send and receive data in correct EDI format. 3. Some payers offer online DDE to providers, which involves using an Internet-based service into which employees key the standard data elements.

Review Questions

Match the key terms with their definitions.

1. **LO 7.3** billing provider
2. **LO 7.7** clean claim
3. **LO 7.6** destination payer
4. **LO 7.6** line item control number
5. **LO 7.3** pay-to provider
6. **LO 7.4** POS code
7. **LO 7.8** claim scrubber
8. **LO 7.4** rendering provider
9. **LO 7.5** subscriber
10. **LO 7.4** Healthcare Provider Taxonomy Code (HPTC)
11. **LO 7.2** carrier block
12. **LO 7.1** CMS-1500

A. Claim accepted by a health plan for adjudication
B. Unique number assigned by the sender to each service line on a claim
C. Software used to check claims
D. Stands for the type of provider specialty
E. Provider of healthcare services reported on a claim
F. Entity that is to receive payment for the claim
G. Stands for the type of facility in which services reported on the claim were provided
H. Insurance carrier that is to receive the claim
I. Entity that is sending the claim to the payer
J. The insurance policyholder or guarantor for the claim
K. Paper claim for physician services
L. The data entry area in the upper right portion of the CMS-1500

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directly to Medicare, Medicaid, and a few other major commercial payers and use a clearinghouse to send claims to other payers.

When the PMP has sent the claims, a summary report provides a review of what was sent. Later, the receiver will send back an electronic response showing that the transmission was received.

Use Direct Data Entry (DDE)

Some payers offer online direct data entry (DDE) to providers. DDE involves using an Internet-based service into which employees key the standard data elements. Although the data elements must meet the HIPAA standards regarding content, they do not have to be formatted for standard EDI. Instead, they are loaded directly into the health plans' computers.

THINKING IT THROUGH 7.8

1. Based on Figure 7.2, what are the key functions of a clearinghouse?

Chapter 7 Summary

Learning Outcomes	Key Concepts/Examples
7.1 Distinguish between the electronic claim transaction and the paper claim form.	• The HIPAA-mandated electronic transaction for claims is the HIPAA X12 837 Health Care Claim or Equivalent Encounter Information. • The electronic transaction is usually called the "837P claim" or the "HIPAA claim" and is based on the CMS-1500, which is a paper claim form. • The information on the electronic transaction and the paper form is the same with a few exceptions.
7.2 Discuss the content of the patient information section of the CMS-1500 claim.	The upper portion of the CMS-1500 claim form (Item Numbers 1-13): • Lists demographic information about the patient and specific information about the patient's insurance coverage • Asks for information based on the patient information form, insurance card, and payer verification data
7.3 Compare billing provider, pay-to provider, rendering provider, and referring provider.	It may be necessary to identify four different types of providers: • It is common to have a physician practice as the pay-to provider—the entity that is paid. • A rendering provider is the doctor who provides care for the patient and is a member of the physician practice that gets the payment. • Practices may use a billing service or a clearinghouse to transmit claims, which is identified as a separate billing provider. • A physician who has sent a patient to another provider needs to be identified as the referring provider.
7.4 Discuss the content of the physician or supplier information section of the CMS-1500 claim.	The lower portion of the CMS-1500 claim form (Item Numbers 14-33): • Contains information about the provider or supplier and the patient's condition, including the diagnoses, procedures, and charges • Asks for information based on the encounter form
7.5 Explain the hierarchy of data elements on the HIPAA 837P claim.	• Required data elements must be provided on the claim and accepted by a payer. • Situational data elements must be provided under certain conditions.

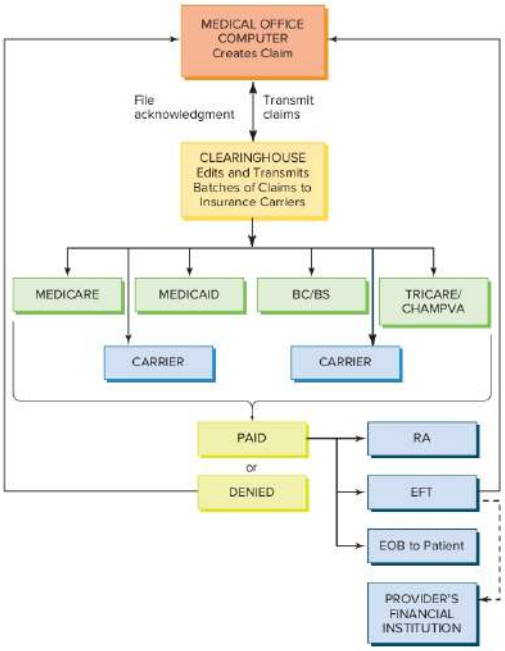

FIGURE 7.2 Claim Flow Using a Clearinghouse

Transmit Claims Directly

In the direct transmission approach, providers and payers exchange transactions directly without using a clearinghouse. To do this requires special technology. The provider must supply all the HIPAA data elements and follow specific EDI formatting rules.

Use a Clearinghouse

The majority of providers use clearinghouses to send and receive data in correct EDI format. Under HIPAA, clearinghouses can accept nonstandard formats and translate them into the standard format. Clearinghouses must receive all required data elements from providers; they cannot create or modify data content. After a PMP-created file is sent, the clearinghouse correlates, or "maps," the content of each IN or data element to the HIPAA 837P transaction based on the payer's instructions.

A practice may choose to use a clearinghouse to transmit all claims, or it may use a combination of direct transmission and a clearinghouse. For example, it may send claims

BILLING TIP

Functional Acknowledgment 997

The EDI term for the acknowledgment of a file transmission is the 997. This is not a standard HIPAA transaction but is used with the HIPAA transaction to report that the payer has received it.

COMPLIANCE GUIDELINE

Disclosing Information for Payment Purposes

Under HIPAA, covered entities such as physician practices may disclose patients' PHI for payment purposes. For example, a provider may disclose a patient's name to a financial institution in order to cash a check or to a clearinghouse to initiate electronic transactions.

BILLING TIP

Clearinghouses

There are many electronic claims and transaction processing firms in the healthcare industry. Most offer services such as claim scrubbing and claim tracking.

BILLING TIP

Editing

Editing software programs called **claim scrubbers** make sure that all required fields are filled, make sure that only valid codes are used, and perform other checks. Some providers use clearinghouses for editing, and others use claim scrubbers in their billing department before they send claims.

claim scrubber software that checks claims to permit error correction

BILLING TIP

"Dropping to Paper"

"Dropping to paper" describes a situation in which a CMS-1500 paper claim needs to be printed and sent to a payer. Some practices, for instance, have a policy of doing this when a claim has been transmitted electronically twice but receipt has not been acknowledged.

- Missing Medicare assignment indicator or benefits assignment indicator.
- Invalid provider identifier (when present) for rendering provider, referring provider, or others.
- Missing part of the name or the identifier of the referring provider.
- Missing or invalid patient birth date.
- Missing payer name and/or payer identifier, required for both primary and secondary payers.
- Incomplete other payer information. This is required in all secondary claims and all primary claims that will involve a secondary payer.
- Invalid procedure codes.

Data Entry Tips

Following are tips for entering data:

- Do not use prefixes for people's names, such as Mr., Ms., or Dr.
- Unless required by a particular insurance carrier, do not use special characters such as dashes, hyphens, commas, or apostrophes.
- Use only valid data in all fields; avoid words such as *same*.
- Do not use a dash, space, or special character in a ZIP code field.
- Do not use hyphens, dashes, slashes, spaces, special characters, or parentheses in telephone numbers.
- Most billing programs or claim transmission programs automatically reformat data such as dates as required by the claim format.

Check with payers for exceptions to these guidelines.

THINKING IT THROUGH 7.7

1. To complete healthcare claims, medical insurance specialists work constantly with numbers—billing software, websites, diagnosis codes, procedure codes, fees and charges, identification numbers, preauthorization numbers, and more. Why is it important to know how to use available resources in the medical office to research or verify information? What role do accurate data entry and proofreading have in this process?

X12 276/277 Health Care Claim Status Inquiry/ Response

The HIPAA X12 276/277 Health Care Claim Status Inquiry/ Response transaction is the electronic format practices use to ask payers about the status of claims. It has two parts: an inquiry and a response. It is also called the X12 276/277. The number 276 refers to the inquiry transaction, and 277 refers to the response that the payer returns.

HIPAA X12 276/277 Health Care Claim Status Inquiry/ Response electronic format used to ask payers about claims.

7.8 Clearinghouses and Claim Transmission

Claims are prepared for transmission after all required data elements have been posted to the practice management program. The data elements that are transmitted are not seen physically as they would be on a paper form. Instead, these elements are in a computer file. The typical flow of a claim ready for transmission is shown in Figure 7.2. Note that in some cases both the sender and the receiver have clearinghouses, so the provider's clearinghouse transmits to the payer's clearinghouse.

Practices handle transmission of electronic claims—which may be called *electronic media claims, or EMC*—in a variety of ways. By far the most common method is to hire outside vendors—clearinghouses—to handle this task. The outside vendor is a business associate under HIPAA that must follow the practice's guidelines to ensure that patients' PHI remains secure and private.

The three major methods of transmitting claims electronically are direct transmission to the payer, clearinghouse use, and direct data entry.

Information About the Insured:

Insured	Raj Shah
Patient Relationship to Insured	Child
Sex	M
Birthdate	02/16/1987
Marital Status	Married
Address	1433 Third Ave Cleveland, OH 44101-1234
Telephone	555-608-9772
Employer	Cleveland Savings Bank
Health Plan	Oxford Freedom PPO
Insurance ID Number	3302112090X
Policy Number	0946582
Group Number	G0904
Copayment/Deductible Amount	$15 copay
Assignment of Benefits	Y
Signature on File	01/01/2029

Condition Unrelated to Employment, Auto Accident, or Other Accident

Questions

A. **LO 7.2–7.5** Are the subscriber and the patient the same person?

B. **LO 7.2–7.5** What is the code for the patient's relationship to the insured?

C. **LO 7.2–7.5** What is the claim filing indicator code?

D. **LO 7.2–7.5** What amount is being billed on the claim?

E. **LO 7.2–7.5** What claim control number would you assign to the claim?

VALLEY ASSOCIATES, PC
Christopher M. Connolly, MD - Internal Medicine
555-967-0303
NPI 8877365552

PATIENT NAME	APPT. DATE/TIME
Shah, Kalpesh	10/4/2029 3:30 pm
PATIENT NO.	**DX**
AA033	1. H61.23 cerumen in ear 2. 3. 4.

DESCRIPTION	✓	CPT	FEE	DESCRIPTION	✓	CPT	FEE
OFFICE VISITS				**PROCEDURES**			
New Patient				Diagnostic Anoscopy			
LI Problem Focused				ECG Complete			
LII Expanded				I&D, Abscess			
LIII Detailed				Pap Smear			
LIV Comp./Mod.				Removal of Cerumen	✓	69210	63
LV Comp./High				Removal 1 Lesion			
Established Patient				Removal 2-14 Lesions			
LI Minimum	✓	99211	30	Removal 15+ Lesions			
LII Problem Focused				Rhythm ECG w/Report			
LIII Expanded				Rhythm ECG w/Tracing			
LIV Detailed				Sigmoidoscopy			
LV Comp.							

Encounter Form for Case 7.3

Assignment of Benefits Y
Signature on File 01/01/2029
Condition Unrelated to Employment, Auto Accident, or Other Accident

Questions

A. **LO 7.2–7.5** What procedure code(s) is (are) being billed on the claim?

B. **LO 7.2–7.5** List the name and the primary identification number of the billing provider for this claim.

C. **LO 7.2–7.5** Are the subscriber and the patient the same person?

D. **LO 7.2–7.5** What copayment is collected?

E. **LO 7.2–7.5** What amount is being billed on the claim?

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Christopher M. Connolly, MD - Internal Medicine
555-967-0303
NPI 8877365552

PATIENT NAME	APPT. DATE/TIME
Porcelli, Jennifer	10/4/2029 12:30 pm
PATIENT NO.	**DX**
AA026	1. J04.0 acute streptococcal laryngitis 2. B95.0 Streptococcus, group A 3. 4.

DESCRIPTION	✓	CPT	FEE	DESCRIPTION	✓	CPT	FEE
OFFICE VISITS				**PROCEDURES**			
New Patient				Diagnostic Anoscopy			
LI Problem Focused				ECG Complete			
LII Expanded				I&D, Abscess			
LIII Detailed				Pap Smear			
LIV Comp./Mod.				Removal of Cerumen			
LV Comp./High				Removal 1 Lesion			
Established Patient				Removal 2-14 Lesions			
LI Minimum				Removal 15+ Lesions			
LII Problem Focused	✓	99212	46	Rhythm ECG w/Report			
LIII E[illegible]				[illegible] ECG w/Tracing			
				[illegible]py, diag.			

Encounter Form for Case 7.2

Case 7.3 From the Patient Information Form:

Information About the Patient:

Name	Kalpesh Shah
Sex	M
Birthdate	01/21/2016
Marital Status	Single
Address	1433 Third Ave Cleveland, OH 44101-1234
Telephone	555-608-9772
Employer	Not Employed
Race	White
Ethnicity	Not Hispanic or Latino
Preferred Language	English

Applying Your Knowledge

Case 7.1 Calculating Insurance Math

LO 7.4 In order to complete the service line information on claims when units of measure are involved, insurance math is required. For example, this is the HCPCS description for an injection of the drug Eloxatin:

J9263 oxaliplatin, 0.5 mg

If the physician provided 50-mg infusion of the drug, instead of an injection, the service line is

J9263 × 100

to report a unit of 50 (100 × 0.5 mg = 50). What is the unit reported for service line information if a 150-mg infusion is provided?

Abstracting Insurance Information

In the cases that follow, you play the role of a medical insurance specialist who is preparing HIPAA claims for transmission. Assume that you are working with the practice's PMP to enter the transactions. The information you enter is based on the patient information form and the encounter form.

- Claim control numbers are created by adding the eight-digit date to the patient account number, as in AA026-10042029.
- A copayment of $15 is collected from each Oxford PPO patient at the time of the visit. A copayment of $10 is collected for Oxford HMO.

Note: For these case studies, do *not* subtract the copayment from the charges; the payer's allowed fees have already been reduced by the amount of the copayment.

Provider Information

Billing Provider	Valley Associates, PC NPI 1476543215
Address	1400 West Center Street Toledo, OH 43601-0213
Telephone	555-967-0303
Employer ID Number	36-1234567
Rendering Provider	Christopher M. Connolly, MD
NPI	8877365552
Oxford PPO Provider Number	1011
Oxford HMO Provider Number	2567
Assignment	Accepts

Answer the questions that follow each case.

Case 7.2 From the Patient Information Form

Name	Jennifer Porcelli
Sex	F
Birthdate	07/05/1982
Marital Status	Married
Address	310 Sussex Turnpike Shaker Heights, OH 44118-2345
Telephone	555-709-0388
Employer	24/7 Inc.
Race	White
Ethnicity	Not Hispanic or Latino
Preferred Language	English
Insured	Self
Health Plan	Oxford Freedom PPO
Insurance ID Number	712340808X
Policy Number	6529436
Group Number	G0119
Copayment/Deductible Amount	$15 copay

Select the answer choice that best completes the statement or answers the question.

13. **LO 7.1** The NPI is used to report the _____ on a claim.
    A. provider identifier
    B. patient identifier
    C. payer identifier
    D. employer identifier

14. **LO 7.5** On HIPAA claims, a required data element
    A. is optional
    B. must be supplied
    C. is entered in capital letters
    D. must be entered in italics

15. **LO 7.8** The HIPAA X12 276/277 Health Care Claim Status Inquiry/Response transaction is used to
    A. transmit claims
    B. transmit claim attachments
    C. ask about the status of claims that have been transmitted
    D. transmit paper claims

16. **LO 7.6** How many diagnosis code pointers can be assigned to a procedure code?
    A. one
    B. two
    C. three
    D. four

17. **LO 7.1** The content of claims and the healthcare provider taxonomy codes are set by
    A. HIPAA
    B. NUCC
    C. ICD-10-CM
    D. CPT/HCPCS

18. **LO 7.1** The number of the HIPAA Professional claim transaction is
    A. CMS-1500
    B. HCFA-1500
    C. X12 837P
    D. X12 834

19. **LO 7.3** If a physician practice sends claims directly to a payer and receives payment directly, which of these entities is *not* additionally reported?
    A. referring provider
    B. rendering provider
    C. billing provider
    D. pay-to provider

20. **LO 7.4** The POS code for a military treatment facility is
    A. 12
    B. 26
    C. 42
    D. 72

21. **LO 7.5** Which of the following may be the same person as the patient?
    A. referring provider
    B. subscriber
    C. pay-to provider
    D. destination payer

22. **LO 7.8** Which of the following is *not* a commonly used transmission method for HIPAA claims?
    A. fax
    B. direct data entry
    C. direct transmission
    D. clearinghouse

Provide the information requested.

23. List the five major sections of the HIPAA claim.

    A. **LO 7.5**

    B. **LO 7.5**

    C. **LO 7.5**

    D. **LO 7.5**

    E. **LO 7.5**

24. Define these abbreviations:

    A. **LO 7.4** EMG

    B. **LO 7.4** POS

    C. **LO 7.1** NUCC

    D. **LO 7.8** DDE

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DECISION #1
Deductible

A ☐ $300
B ☐ $600
C ☐ $900
D ☐ $1,500
E ☐ $2,500

DECISION #2
Coinsurance*/out-of-pocket limit

A ☐ 80% / $2,200
B ☐ 80% / $4,400
C ☐ 70% / $5,000
D ☐ 60% / $5,000
E ☐ 70% / $10,000

DECISION #3
Prescription-drug access

A ☐ No formulary
B ☐ Formulary

DECISION #4
Medical access

A ☐ Broad network
B ☐ Select network

*for in-network coverage

FIGURE 8.1 Example of Selecting Benefits During Open Enrollment

can customize the policies by choosing to accept various levels of premiums, deductibles, and other costs.

Federal Employees Health Benefits Program

The largest employer-sponsored health program in the United States is the **Federal Employees Health Benefits (FEHB) program,** which covers more than 8 million federal employees, retirees, and their families through more than 250 health plans from a number of carriers. FEHB is administered by the federal government's Office of Personnel Management (OPM), which receives and deposits premiums and remits payments to the carriers. Each carrier is responsible for furnishing identification cards and benefits brochures to enrollees, adjudicating claims, and maintaining records.

Self-Funded Health Plans

To save money, many large employers cover the costs of employee medical benefits themselves rather than buying insurance from other companies. They create self-funded (or self-insured) health plans that do not pay premiums to an insurance carrier or a managed care organization. Instead, self-funded health plans "insure themselves" and assume the risk of paying directly for medical services, setting aside funds with which to pay benefits.

Self-insured employers cover more than half of all employees in the United States. The employer establishes the benefit levels and the plan types offered to employees. Self-funded health plans may set up their own provider networks or, more often, lease a managed care organization's networks. They may also buy other types of insurance—such as a vision package—instead of insuring the benefit themselves.

In contrast to employer-sponsored "fully insured plans," which are regulated by state laws, self-funded health plans are regulated by the federal **Employee Retirement Income Security Act (ERISA) of 1974.** ERISA is run by the federal Department of Labor's (DOL) Pension and Welfare Benefits Administration. Self-funded plan members receive a **Summary Plan Description (SPD)** from the plan that describes their benefits and legal rights.

Self-funded health plans often hire **third-party claims administrators (TPAs)** to handle tasks such as collecting premiums, keeping lists of members up to date, and processing and paying claims. Often an insurance carrier or managed care organization works as the TPA under an **administrative services only (ASO)** contract.

FEHB
www.opm.gov/healthcareinsurance

HIPAA/HITECH TIP

TPAs Are Business Associates

Third-party claims administrators are business associates of health plans and must satisfy the normal privacy and security requirements during healthcare transactions.

Group Health Plans and PHI

Both employer-sponsored health plans and self-funded health plans are GHPs under HIPAA and must follow HIPAA rules.

Federal Employees Health Benefits (FEHB) program covers employees and retirees and their families of the federal government

Employee Retirement Income Security Act (ERISA) of 1974 law providing incentives and protection for companies with employee health and pension plans

Summary Plan Description (SPD) required document for self-funded plans stating beneficiaries' benefits and legal rights

third-party claims administrators (TPAs) companies that provide administrative services for health plans but are not contractual parties

administrative services only (ASO) contract under which a third-party administrator or insurer provides administrative services to an employer for a fixed fee per employee

KEY TERMS *(continued)*

stop-loss provision
subcapitation
Summary Plan Description (SPD)
third-party claims administrator (TPA)
tiered network
utilization review
utilization review organization (URO)
waiting period

Group Health Plan Regulation

Employer-sponsored group health plans must follow federal and state laws that mandate coverage of specific benefits or treatments and access to care. When a state law is more restrictive than the related federal law, the state law is followed.

Medical insurance specialists must become knowledgeable about the billing rules of the private plans that insure their patients, especially how they affect coverage of services and financial responsibility. This chapter covers procedures for billing under the leading types of private plans. Also covered are plans with funding options controlled by patients, which have become a popular insurance model. Because these consumer-driven health plans (CDHPs) have high deductibles due before benefits start, patients need to understand what their bills will be, and medical insurance specialists need to know how to collect these amounts. In every case, a clear financial policy that describes patients' financial obligations is increasingly important for medical practices.

8.1 Group Health Plans

People who are not covered by entitlement programs such as government-sponsored health insurance are often covered by private insurance. Many employers offer their employees the opportunity to become covered under employee healthcare benefit plans. Sponsorship of medical insurance is an important benefit to employees, and it also gives employers federal income tax advantages.

Employer-Sponsored Medical Insurance

group health plan (GHP) plan of an employer or employee organization to provide healthcare to employees, former employees, or their families

Many employees have medical insurance coverage under **group health plans (GHPs)** that their employers buy from insurance companies. (Note that when an individual is covered under a GHP, the group is the "policyholder" and the individual is a "certificate holder.") Human resource departments manage these healthcare benefits, negotiating with health plans and then selecting a number of products to offer employees.

rider document modifying an insurance contract

Both basic plans and riders are offered. **Riders,** also called *options*, may be purchased by employees to add voluntary benefits such as vision and dental services. Another popular rider is for complementary healthcare, covering treatments such as chiropractic/manual manipulation, acupuncture, massage therapy, dietetic counseling, and vitamin and minerals. Supplemental health products can also be bought that provide lump-sum payments for policyholders diagnosed with cancer, stroke, or heart attack.

carve out part of a standard health plan changed under an employer-sponsored plan

Employers may **carve out** certain benefits—that is, change standard coverage or providers—during negotiations to reduce the price. An employer may do the following:

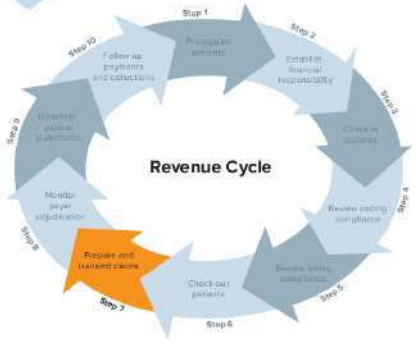
- Omit a specific benefit, such as coverage of prescription drugs
- Use a different network of providers for a certain type of care, such as negotiating with a local practice network for mental health coverage
- Hire a pharmacy benefit manager (PBM) to operate the prescription drug benefit more inexpensively (because PBMs do this work for many employers, they represent a large group of buyers and can negotiate favorable prices with pharmaceutical companies for each employer)

open enrollment period time when a policyholder selects from offered benefits

During specified periods (usually once a year) called **open enrollment periods,** the employee chooses a particular set of benefits for the coming benefit period (see Figure 8.1). The employer provides tools (often web based) and information to help employees match their personal and family needs with the best-priced plans. Employees

PRIVATE PAYERS/ACA PLANS

8



Learning Outcomes

After studying this chapter, you should be able to:

8.1 Describe the major features of group health plans regarding eligibility, portability, and required coverage.

8.2 Discuss provider payment under the various private payer plans.

8.3 Contrast health reimbursement accounts, health savings accounts, and flexible savings (spending) accounts.

8.4 Discuss the major private payers.

8.5 Compare the four ACA metal plans.

8.6 Analyze the purpose of the five main parts of participation contracts.

8.7 Describe the information needed to collect copayments and bill for surgical procedures under contracted plans.

8.8 Discuss the use of plan summary grids.

8.9 Prepare accurate private payer claims.

8.10 Explain how to manage billing for capitated services.

KEY TERMS

administrative services only (ASO)
BlueCard
BlueCross BlueShield Association (BCBS)
carve out
Consolidated Omnibus Budget Reconciliation Act (COBRA)
credentialing
discounted fee-for-service
elective surgery
Employee Retirement Income Security Act (ERISA) of 1974
episode-of-care (EOC) option
essential health benefits (EHB)
family deductible
Federal Employees Health Benefits (FEHB) program
Flexible Blue
flexible savings (spending) account (FSA)
formulary
group health plan (GHP)
health insurance exchange (HIX)
health reimbursement account (HRA)
health savings account (HSA)
high-deductible health plan (HDHP)
home plan
host plan
independent (or individual) practice association (IPA)
individual deductible
individual health plan (IHP)
late enrollee
medical home model
metal plans
monthly enrollment list
narrow network
open enrollment period
parity
pay-for-performance (P4P)
plan summary grid
precertification
repricer
rider
Section 125 cafeteria plan
silent PPO

Continued

Case 7.4 From the Patient Information Form

Name	Josephine Smith
Sex	F
Birthdate	05/04/1994
Marital Status	Married
Address	9 Brook Rd Alliance, OH 44601-1812
Telephone	555-214-3349
Employer	Central Ohio Oil
Race	White
Ethnicity	Not Hispanic or Latino
Preferred Language	English
Insured	Self
Health Plan	Oxford Freedom HMO
Insurance ID Number	610327842X
Policy Number	195803
Group Number	G0404
Copayment/Deductible Amount	$10 copay
Assignment of Benefits	Y
Signature on File	01/01/2029

Condition Unrelated to Employment, Auto Accident, or Other Accident

Questions

A. **LO 7.2–7.5** What diagnosis code is being reported on the claim?

B. **LO 7.2–7.5** What amount is being billed on the claim?

C. **LO 7.2–7.5** What two data elements should be reported because a referral is involved?

D. **LO 7.2–7.5** What claim control number would you assign to the claim?

E. **LO 7.2–7.5** What claim filing indicator code would you assign?

VALLEY ASSOCIATES, PC
Christopher M. Connolly, MD - Internal Medicine
555-967-0303
NPI 8877365552

PATIENT NAME	APPT. DATE/TIME
Smith, Josephine	10/9/2029 1:00 pm
PATIENT NO.	**DX**
AA056	1. I10 benign essential hypertension 2. 3. 4.

DESCRIPTION	✓	CPT	FEE	DESCRIPTION	✓	CPT	FEE
OFFICE VISITS				**PROCEDURES**			
New Patient				Diagnostic Anoscopy			
LI Problem Focused				ECG Complete	✓	93000	70
LIII Expanded				I&D, Abscess			
LIII Detailed				Pap Smear			
LIV Comp./Mod.				Removal of Cerumen			
LV Comp./High				Removal 1 Lesion			
Established Patient				Removal 2-14 Lesions			
LI Minimum				Removal 15+ Lesions			
LII Problem Focused				Rhythm ECG w/Report			
LIII Expanded	✓	99213	62	Rhythm ECG w/Tracing			
LIV Detailed				Sigmoidoscopy, diag.			
LV Comp./High							
				LABORATO			
				Bach			

Encounter Form for Case 7.4

Preferred Provider Organizations

Physicians, hospitals and clinics, and pharmacies contract with the PPO plan to provide care to its insured people. These medical providers accept the PPO plan's fee schedule and guidelines for its managed medical care. PPOs generally pay participating providers based on a discount from their physician fee schedules, called **discounted fee-for-service.**

discounted fee-for-service payment schedule for services based on a reduced percentage of usual charges

Under a PPO, the patient pays an annual premium and often a deductible. A PPO plan may offer either a low deductible with a higher premium or a high deductible with a lower premium. Insured members pay a copayment at the time of each medical service. Coinsurance is often charged for in-network providers.

A patient may see an out-of-network doctor without a referral or preauthorization, but the deductible for out-of-network services may be higher and the percentage the plan will pay may be lower. In other words, the patient will be responsible for a greater part of the fee, as illustrated by the "in-network" versus "out-of-network" columns in Figure 8.2. This encourages people insured by PPOs to use in-network physicians, other medical providers, and hospitals.

Health Maintenance Organizations

An HMO is licensed by the state. For its lower costs, the HMO has the most stringent guidelines and the narrowest choice of providers. Its members are assigned to primary care physicians and must use network providers to be covered, except in emergencies. In an *open-panel HMO,* any physician who meets the HMO's standards of care may join the HMO as a provider. These physicians usually operate from their own offices and see non-HMO patients. In a *closed-panel HMO,* the physicians are either HMO employees or belong to a group that has a contract with the HMO.

Health maintenance organizations were originally designed to cover all basic services for an annual premium and visit copayments. This arrangement is called "first-dollar coverage" because no deductible is required and patients do not make out-of-pocket payments. Because of expenses, however, HMOs may now apply deductibles to family coverage, and employer-sponsored HMOs are beginning to replace copayments with coinsurance for some benefits. HMOs have traditionally emphasized preventive and wellness services as well as disease management.

An HMO is organized around a business model. The model is based on how the terms of the agreement connect the provider and the plan. In all, however, enrollees must see HMO providers in order to be covered.

Staff Model

In a staff HMO, the organization employs physicians. All the premiums and other revenues come to the HMO, which in turn pays the physicians' salaries. For medical care, patients visit clinics and health centers owned by the HMO.

Group (Network) Model

A group (network) HMO contracts with more than one physician group. In some plans, HMO members receive medical services in HMO-owned facilities from providers who work only for that HMO. In others, members visit the providers' facilities, and the providers can also treat nonmember patients.

The practices under contract are paid a per member per month (PMPM) capitated rate for each subscriber assigned to them for primary care services. Practices may hire other providers to handle certain services, such as laboratory tests. The other providers work under a **subcapitation** agreement (a PMPM that covers their services) or an **episode-of-care (EOC) option,** which is a flat fee for all services for a particular treatment. For example, an EOC fee is established for coronary bypass surgery or hip replacement surgery; the fixed rate per patient includes preoperative and postoperative treatment as well as the surgery itself. If complications arise, additional fees are usually paid.

subcapitation arrangement by which a capitated provider prepays an ancillary provider

episode-of-care (EOC) option flat payment by a health plan to a provider for a defined set of services

BILLING TIP

Private Payers

Private payers do not necessarily operate under the same regulations as government-sponsored programs. Each payer's rules and interpretations may vary. The definitions of basic terms (for example, the age range for neonate) differ, as do preauthorization requirements. Research each payer's rules for correct billing and reimbursement.

Standard Benefits

This is a preferred provider organization (PPO) plan. That means members can receive the highest level of benefits when they use any of the more than 5,000 physicians and other healthcare professionals in this network. When members receive covered in-network services, they simply pay a copayment. Members can also receive care from providers that are not part of the network; however, benefits are often lower and covered claims are subject to deductible, coinsurance and charges above the maximum allowable amount. Referrals are not needed from a Primary Care Physician to receive care from a specialist.

PREVENTIVE CARE	In-Network	Out-of-Network
Well child care		
Birth through 12 years	OV Copayment	Deductible & Coinsurance
All others	OV Copayment	Deductible & Coinsurance
Periodic, routine health examinations	OV Copayment	Deductible & Coinsurance
Routine eye exams	OV Copayment	Deductible & Coinsurance
Routine OB/GYN visits	OV Copayment	Deductible & Coinsurance
Mammography	No Charge	Deductible & Coinsurance
Hearing Screening	OV Copayment	Deductible & Coinsurance
MEDICAL CARE	**In-Network**	**Out-of-Network**
PCP office visits	OV Copayment	Deductible & Coinsurance
Specialist office visits	OV Copayment	Deductible & Coinsurance
Outpatient mental health & substance abuse – *prior authorization required*	OV Copayment	Deductible & Coinsurance
Maternity care – *initial visit subject to copayment, no charge thereafter*	OV Copayment	Deductible & Coinsurance
Diagnostic lab, X-ray and testing	No Charge	Deductible & Coinsurance
High-cost outpatient diagnostics – *prior authorization required. The following are subject to copayment: MRI, MRA, CAT, CTA, PET, SPECT scans*	No Charge OR $200 Copayment	Deductible & Coinsurance Deductible & Coinsurance
Allergy Services		
Office visits/testing	OV Copayment	Deductible & Coinsurance
Injections – *80 visits in 3 years*	$25 Copayment	Deductible & Coinsurance
HOSPITAL CARE – Prior authorization required	**In-Network**	**Out-of-Network**
Semi-private room *(General/Medical/Surgical/Maternity)*	HSP Copayment	Deductible & Coinsurance
Skilled nursing facility – *up to 120 days per calendar year*	HSP Copayment	Deductible & Coinsurance
Rehabilitative services – *up to 60 days per calendar year*	No Charge	Deductible & Coinsurance
Outpatient surgery – *in a hospital or surgical center*	OS Copayment	Deductible & Coinsurance
EMERGENCY CARE	**In-Network**	**Out-of-Network**
Walk-in centers	OV Copayment	Deductible & Coinsurance
Urgent care centers – *at participating centers only*	UR Copayment	Not Covered
Emergency care – *copayment waived if admitted*	ER Copayment	ER Copayment
Ambulance	No Charge	No Charge
OTHER HEALTHCARE	**In-Network**	**Out-of-Network**
Outpatient rehabilitative services – *30 visit maximum for PT, OT, and SLP per year. 20 visit maximum for Chiro. per year*	OV Copayment	Deductible & Coinsurance
Durable medical equipment / Prosthetic devices – *Unlimited maximum per calendar year*	No Charge OR 20%	Deductible & Coinsurance
Infertility Services (diagnosis and treatment)	Not Covered	Not Covered
Home HealthCare	No Charge	$50 Deductible & 20% Coinsurance

KEY: Office Visit (OV) Copayment; Emergency Room (ER) Copayment; Urgent Care (UR) Copayment; Hospital (HSP) Copayment; Outpatient Surgery (OS) Copayment

PREVENTIVE CARE SCHEDULES

Well Child Care (including immunizations)
- 6 exams, birth to age 1
- 6 exams, ages 1–5
- 1 exam every 2 years, ages 6–10
- 1 exam every year, ages 11–21

Adult Exams
- 1 exam every 5 years, ages 22–29
- 1 exam every 3 years, ages 30–39
- 1 exam every 2 years, ages 40–49
- 1 exam every year, ages 50+

Mammography
- 1 baseline screening, ages 35–39
- 1 screening per year, ages 40+

Vision Exams
- 1 exam every 2 calendar years

Hearing Exams
- 1 exam per calendar year

OB/GYN Exams
- 1 exam per calendar year

FIGURE 8.2 Example of Range of PPO Benefits for a Popular Plan

BILLING TIP

In- Versus Out-of-Network

To reduce costs, many group health plans are shifting to much more limited networks of physicians and hospitals. Patients may be unaware of possible problems with these **narrow networks**. For example, often emergency room physicians, radiologists, and anesthesiologists are not employees of a hospital and can bill patients their usual charges rather than in-network rates. And narrow networks may limit specialists, such as listing only a general oncologist rather than specialists in hematology or lung cancers.

narrow network payer network of physicians and hospitals with limited choices for patients

THINKING IT THROUGH 8.1

1. If a GHP has a ninety-day waiting period, on what day does health coverage become effective?
2. In terms of enrollment in a health plan, what is the status of an infant born to a subscriber in the plan?
3. A patient pays for a cosmetic procedure that is not medically necessary under the terms of the plan. Does this payment count toward the deductible?
4. Why is it important to verify a patient's eligibility for benefits? Can you think of events, such as job-status change, that might affect coverage?

BILLING TIP

PPOs

About half of all consumers with health insurance are enrolled in a PPO.

8.2 Types of Private Payers

Preferred provider organizations (PPOs) are the most popular type of private plan, followed by health maintenance organizations (HMOs), especially the point-of-service (POS) variety. Few employees choose indemnity plans because they would have to pay more. CDHPs that combine a high-deductible health plan with a funding option of some type are rapidly growing in popularity among both employers and employees. See Table 8.1 for a review of private payer plan types that were introduced earlier in this text. Figure 8.2 presents typical features of a popular PPO plan.

Table 8.1 Types of Private Payer Plans

Plan Type	Participating Provider Payment Method
Preferred Provider Organization (PPO)	Discounted Fee-for-Service
Staff Health Maintenance Organization (HMO)	Salary
Group HMO	Salary or Contracted Cap Rate
Independent Practice Association (IPA)	PCP: Contracted Cap Rate Specialist: Fee-for-Service
Point-of-Service (POS) Plan	PCPs: Contracted Cap Rate Referred Providers: Contracted Cap Rate or Discounted Fee-for-Service
Indemnity	Fee-for-Service
Consumer-Driven Health Plan (Combined High-Deductible Health Plan and Funding Option)	Up to Deductible: Payment by Patient After Deductible: Discounted Fee-for-Service

BILLING TIP

Timely Payments

Group health plans must follow states' Clean Claims Act and/or Prompt Payment Act and pay claims they accept for processing on a timely basis. ERISA (self-funded) plans, under the DOL, do not have similar rates, so the terms of payer contracts apply.

Features of Group Health Plans

Section 125 cafeteria plan employers' health plans structured to permit funding of premiums with pretax payroll deductions

A common way that employers organize employees' choices of plans is by creating a tax structure called a **Section 125 cafeteria plan** (the word *cafeteria* implies that employees may choose from a wide array of options). Under income tax law, the employer can collect an employee's insurance cost through a pretax payroll deduction, and that money is excluded from the income the employee has to pay taxes on. (When a policyholder pays premiums any other way, the policyholder generally pays income tax on that money and can deduct the cost only if the entire year's medical expenses are more than 7.5 percent of his or her income.)

The group health plan specifies the rules for eligibility and the process of enrolling and disenrolling members. Rules cover employment status, such as full-time, part-time, disabled, and laid-off or terminated employees, as well as the conditions for enrolling dependents.

waiting period amount of time that must pass before an employee/dependent may enroll in a health plan

Many plans have a **waiting period,** an amount of time that must pass before a newly hired employee or a dependent is eligible to enroll. The waiting period is the time between the date of hire and the date the insurance becomes effective, and can be up to ninety days.

late enrollee category of enrollment that may have different eligibility requirements

The plan may impose different eligibility rules on a **late enrollee,** an individual who enrolls in a plan at a time other than the earliest possible enrollment date or a special enrollment date. For example, special enrollment may occur when a person becomes a new dependent through marriage.

As explained in the introductory chapter, most plans require annual premiums. Although employers once paid the total premiums as a benefit for employees, currently they pay an average of 80 percent of the cost.

individual deductible fixed amount that must be met periodically by each individual of an insured/dependent group before benefits begin

family deductible fixed, periodic amount that must be met by the combined payments of an insured/dependent group before benefits begin

Many health plans also have a deductible that is due per time period. Noncovered services under the plan that the patient must pay out-of-pocket do not count toward satisfying a deductible. Some plans require an **individual deductible** that must be met for each person—whether the policyholder or a covered dependent—who has an encounter. Others have a **family deductible** that can be met by the combined payments of any covered members of the insured's family.

tiered network network system that reimburses more for quality, cost-effective providers

formulary list of a plan's approved drugs and their proper dosages

Tiered networks reimburse more for providers who are considered of highest quality and cost effectiveness by the plan. The aim of tiered networks is to steer patients toward the best providers (under the plan's performance measurements). Tiered networks are common for prescription drug coverage; medications in the plan's drug **formulary,** a list of approved drugs, have smaller copayments than do nonformulary drugs.

Consolidated Omnibus Budget Reconciliation Act (COBRA) law requiring employers with more than twenty employees to allow terminated employees to pay for coverage for eighteen months

The **Consolidated Omnibus Budget Reconciliation Act (COBRA)** (1985; amended 1986) is a law that gives an employee who is leaving a job the right to continue health coverage under the employer's plan for a limited time at his or her own expense. COBRA participants usually pay more than do active employees because the employer usually pays part of the premium for an active employee but a COBRA participant generally pays the entire premium. Employers are required to inform employees who have left the job that they are eligible for individual health plans.

parity equality with medical/surgical benefits

The Mental Health Parity Act provides for **parity** (equality) with medical/surgical benefits when plans set lifetime or annual dollar limits on mental health benefits (except for substance abuse or chemical dependency).

option and, if there is not enough money, out of pocket. CDHP payment works as follows:

- The group health plan establishes a funding option (HRA, HSA, FSA, or some combination) designed to help pay out-of-pocket medical expenses.
- The patient uses the money in the account to pay for qualified medical services.
- The total deductible must be met before the HDHP pays any benefits.
- Once the deductible has been met, the HDHP covers a portion of the benefits according to the policy. The funding option can also be used to pay the uncovered portion.

Following is an example of payments under a CDHP with an HSA fund of $1,000 and a deductible of $1,000. The HDHP has an 80-20 coinsurance. The plan pays the visit charges as billed.

Office visits for the patient:

First visit charge	$150	$150 paid from HSA (leaving a balance in the fund of $850)
Second visit charge	$450	$450 paid from HSA (leaving a balance in the fund of $400)
Third visit charge	$600	$400 paid from HSA (emptying the HSA fund)
		$160 paid by the HDHP (the balance of $200 on the charge × 80%)
		$40 coinsurance to be paid by the patient (the balance of $200 × 20%)

For medical practices, the best situation is an integrated CDHP in which the same plan runs both the HDHP and the funding options. This approach helps reduce paperwork and speed payment. For example, if an HSA is run by the same payer as the HDHP, a claim for charges is sent to the payer. The payer's remittance advice states what each of the plan and the patient is responsible for paying. If payment is due from the patient's HSA, that amount is withdrawn and paid to the provider. If the patient's deductible has been met, the plan pays its obligation.

BILLING TIP

CDHP Enrollment

Most enrollees in consumer-driven healthcare are in plans that build on insurance carriers' existing provider network and negotiated rates.

Another popular payment method is a credit or a debit card provided by the plan. The patient can use it to pay for health-related expenses up to the amount in the fund. The cards may be preloaded with the member's coverage and copayment data.

Educating patients about their financial responsibility before they leave encounters, extending credit wisely, and improving collections are all key to avoiding uncollectible accounts under CDHPs.

THINKING IT THROUGH 8.3

1. Why do payers consider consumer-driven health plans desirable? Do you agree with the rationale that payers use to support such plans?

plan deductible, copayments, coinsurance, and any medical expenses not covered by the group health plan and may then request reimbursement from the HRA. If the employer authorizes this approach, funds in the account that are left at the end of the benefit period can roll over to the next period's HRA.

Health Savings Accounts

health savings account (HSA) consumer-driven health plan funding option under which funds are set aside to pay for certain healthcare costs.

The most popular type of account is the **health savings account (HSA)** that also is designed to pay for qualified medical expenses of individuals who have HDHPs and are under age sixty-five.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added a section to the Internal Revenue Service (IRS) tax code to permit HSAs. An HSA is a savings account created by an individual. Employers that wish to encourage employees to set up HSAs offer a qualified high-deductible health plan to go with it. Both employee and employer can contribute to the HSA. The IRS sets the maximum amount that can be saved each year. The IRS also sets the maximum out-of-pocket spending under HSA-compatible high-deductible health plans.

The HSA money can be held in an account by an employer, a bank, or a health plan. This holder is referred to as a "custodian" for the account. The federal government decides the limit on the amount of the contribution that is tax sheltered, just as it does for IRAs.

HSAs do not have to be used up at the end of a year. Instead, the account can roll over from year to year and be taken along by an employee who changes jobs or retires. HSAs can earn tax-free interest and can be used for nonmedical purposes after age sixty-five.

Flexible Savings (Spending) Accounts

flexible savings (spending) account (FSA) consumer-driven health plan funding option that has employer and employee contributions.

Some companies offer **flexible savings (spending) accounts (FSAs)** that augment employees' other health insurance coverage. Employees have the option of putting pretax dollars from their salaries in the FSA; they can then use the fund to pay for certain medical and dependent care expenses. The permitted expenses include cost-sharing (deductibles, copayments, coinsurance), medical expenses that are not covered under the regular insurance plan (such as routine physical examinations, eyeglasses, and many over-the-counter medical supplies), and child care. Employers may contribute to each employee's account.

The FSA may be used in one of two ways. In some companies, the employee has to file a claim with the plan after paying a bill. For example, the employee may submit a receipt from a drugstore for a prescription or an Explanation of Benefits (EOB) from the health plan that shows that the patient, not the plan, paid the bill. In the other way, the company gives the employee a credit or debit card to use to pay the bills as they occur, and the employee is responsible for keeping records that prove that the expenses were in the "permitted" category.

Before 2014, the disadvantage of an FSA as compared with an HSA was that unused dollars went back to the employer under the "use it or lose it" rule at the end of the year. Employees had to try to predict their year's expenses to avoid either overfunding or underfunding the account. Current Treasury Department regulations permit employers to change HSA rules so that part of the funds can be carried over into the next year.

Billing Under Consumer-Driven Health Plans

CDHPs reduce providers' cash flow because visit copayments are being replaced by high deductibles that may not be collected until after claims are paid. As more employer-sponsored plan members are covered under CDHPs, physician reimbursement up to the amount of the deductible will come from the patient's funding

8.3 Consumer-Driven Health Plans

Consumer-driven (or consumer-directed) health plans (CDHPs) combine two components: (1) a high-deductible health plan and (2) one or more tax-preferred savings accounts that the patient (the "consumer") directs. The two plans work together: The high-deductible health plan covers catastrophic losses, and the savings account pays out-of-pocket or noncovered expenses. (Note that some payers refer to these plans simply as "high-deductible plans.")

CDHPs empower consumers to manage their use of healthcare services and products. Experts in the healthcare industry believe that people who pay medical expenses themselves will be more careful about how their dollars are spent. CDHPs eliminate most copayment coverage and shift responsibility for managing the dollars in the savings accounts to individuals. The use of CDHPs is growing quickly in popularity with employers: about one-third of large companies offer only CDHPs.

The High-Deductible Health Plan

The first part of a CDHP is a **high-deductible health plan (HDHP),** usually a PPO. The annual deductible for 2019 is $1,350 for an individual and $2,700 for a family. Many of the plan's covered preventive care services, as well as coverage for accidents, disability, dental care, vision care, and long-term care, are not subject to this deductible.

high-deductible health plan (HDHP) health plan that combines high-deductible insurance and a funding option to pay for patients' out-of-pocket expenses up to the deductible

The Funding Options

One of three types of CDHP funding options (Table 8.2) may be combined with high-deductible health plans to form consumer-driven health plans.

Health Reimbursement Accounts

A **health reimbursement account (HRA)** is a medical reimbursement plan set up and funded by an employer. HRAs are usually offered to employees with health plans that have high deductibles. Employees may submit claims to the HRA to be paid back for out-of-pocket medical expenses. For example, an employee may pay a health

health reimbursement account (HRA) consumer-driven health plan funding option that requires an employer to set aside an annual amount for healthcare costs

Table 8.2 Comparisons of CDHP Funding Options

Health Reimbursement Account	Health Savings Account
Contributions from employer	Contributions from individual (regardless of employment status), employer, or both
Rollovers allowed within employer-set limits	Unused funds roll over indefinitely
Portability allowed under employer's rules	Funds are portable (job change, retirement)
Tax-deductible deposits	Tax-deductible deposits
Tax-free withdrawals for qualified expenses	Tax-free withdrawals for qualified expenses
	Tax-free interest can be earned
Flexible Savings (Spending) Account	
Contributions from employer and/or employee	
Unused funds revert to employer	
Employer option to permit $500 to carry over into the next year	
Tax-advantaged deposits	
Tax-free withdrawals for qualified expenses	

Independent Practice Association Model

independent (or individual) practice association (IPA) HMO in which physicians are self-employed and provide services to members and non-members

An **independent (or individual) practice association (IPA)** type of HMO is an association formed by physicians with separately owned practices who contract together to provide care for HMO members. An HMO pays negotiated fees for medical services to the IPA. The IPA in turn pays its physician members by either a capitated rate or a fee. Providers may join more than one IPA and usually see nonmember patients.

Point-of-Service Plans

A POS plan is a hybrid of HMO and PPO networks. Members may choose from a primary or secondary network. The primary network is HMO-like, and the secondary network is often a PPO network. Like HMOs, POS plans charge an annual premium and a copayment for office visits. Monthly premiums are slightly higher than for HMOs but offer the benefit of some coverage for visits to non-network physicians for specialty care. A POS may be structured as a tiered plan, for example, with different rates for specially designated providers, regular participating providers, and out-of-network providers.

COMPLIANCE GUIDELINE

Termination of Patients

HMOs and POSs regulate a primary care physician's decision to terminate a relationship with a patient. The PCP must first ask the payer for permission to do so and must then send a certified letter to the patient, who must sign and return it. The PCP must provide emergency care until the patient has a new PCP.

Indemnity Plans

Indemnity plans require premium, deductible, and coinsurance payments. They typically cover 70 to 80 percent of costs for covered benefits after deductibles are met. Some plans are structured with high deductibles, such as $5,000 to $10,000, in order to offer policyholders a relatively less expensive premium. Many have some managed care features because payers compete for employers' contracts and try to control costs.

BILLING TIP

POS: Two Meanings

POS for claims means place of service; POS relating to health plans means point of service.

Medical Home Model

medical home model care plans that emphasize primary care with coordinated care involving communications among the patient's physicians

A growing number of payers have developed plans that seek to improve patient care by rewarding primary care physicians for coordinating patients' treatments. Called **medical home model** (or *patient-centered medical home model*) plans, these are intended to replace illness-based primary care with coordinated care that emphasizes communications among the patient's physicians. The primary care physician is responsible for arranging a patient's visits to specialists and for proactively planning and managing care.

Payment models vary. As one example, a state program to manage care for children is based on a fee-for-service contract with a physician that is supplemented by a per member per month payment. Generally, medical home model plans are *risk adjusted*—that is, the primary care physician is paid more for sicker or older patients than for healthy ones.

THINKING IT THROUGH 8.2

1. Why is it important for medical insurance specialists to be able to determine the type of plan a patient has?

The program links participating providers and independent BCBS plans throughout the nation with a single electronic claim processing and reimbursement system. It works as follows:

1. A subscriber who requires medical care while traveling outside the service area presents the subscriber ID card to a BCBS participating provider.
2. The provider verifies the subscriber's membership and benefit coverage by calling the BlueCard eligibility number. Only the required copayment can be collected; the provider cannot ask the patient to pay any other fees.
3. After providing treatment, the provider submits the claim to the local BCBS plan in his or her service area, which is referred to as the **host plan.**
4. The host plan sends the claim via modem to the patient's **home plan** (the plan in effect when the patient is at home), which processes the claim and sends it back to the host plan.
5. The host plan pays the provider according to local payment methods, and the home plan sends the remittance advice. For example, if a subscriber from New Jersey requires treatment while traveling in Delaware, the provider in Delaware can treat the patient, file the claim, and collect payment from the Delaware plan.

BlueCard Worldwide is available for BlueCard members who are traveling abroad.

host plan participating provider's local BlueCross BlueShield plan

home plan BlueCross BlueShield plan in the subscriber's community

Flexible Blue Plan

BlueCross BlueShield companies also offer a CDHP called **Flexible Blue.** This plan combines a comprehensive PPO plan with either an HSA, an HRA, or a FSA. Also parts of the CDHP are online decision-support resources.

Flexible Blue BlueCross BlueShield consumer-driven health plan

THINKING IT THROUGH 8.4

1. Given the many different insurance plans with which medical insurance specialists work, what do you think are the most important items of information that should be available about a plan?
2. Review the PPO plan benefits shown in Figure 8.2. How would you summarize the rules for in-network versus out-of-network preventive care? Medical care? Is preauthorization needed for in-network hospital care?

8.5 Affordable Care Act (ACA) Plans

The Patient Protection and Affordable Care Act (ACA) contains numerous changes to improve healthcare in the United States. Included in the 2010 act were many provisions. Some were implemented immediately; others are being implemented or removed in current and future years. Congressional and Supreme Court decisions on the funding for and the legality of the act continue to make aspects of the law uncertain, such as federal subsidies to help cover insurance costs. Medical insurance specialists should stay updated on all aspects of the regulations as they emerge. Improvements that are now in effect for patients with private health insurance are:

- A payer can no longer drop a beneficiary from a plan because of a preexisting illness or a new condition, a practice known as *rescission*.
- A payer cannot discriminate against individuals in providing coverage based on a preexisting medical condition, gender, occupation, or employer size.
- Young adults up to age twenty-six can remain as a dependent on their parents' private health insurance plan.
- Payers cannot impose lifetime financial limits on benefits.
- Insurance plan beneficiaries have expanded rights to appeal denials or cancellation of coverage.

General ACA Information and Plans
www.healthcare.gov

- Subscriber identification number (the subscriber's Social Security number has been replaced with a unique ID) that can be a total of seventeen characters, a three-position alphabetic prefix that identifies the plan, and fourteen alphanumeric characters
- Effective date of coverage
- BCBS plan codes and coverage codes
- Participation in reciprocity plan with other BCBS plans
- Copayments, coinsurance, and deductible amounts
- Information about additional coverage, such as prescription medication and mental healthcare
- Information about preauthorization requirements
- Claim submission address
- Contact phone numbers

Types of Plans

An indemnity BCBS plan has an individual and family deductible and a coinsurance payment. Individual annual deductibles may range from as little as $100 to as much as $2,500 or more. The family deductible is usually twice the amount of the individual deductible. Once the deductible has been met, the plan pays a percentage of the charges, usually 70, 80, or 90 percent, until an annual maximum out-of-pocket amount has been reached. After that, the plan pays 100 percent of approved charges until the end of the benefit year. At the beginning of the new benefit year, the out-of-pocket amount resets, and 100 percent reimbursement does not occur until the out-of-pocket maximum for the new year has been met. Once the cap has been met, charges by nonparticipating providers are paid at 100 percent of the allowed amount. If the charges exceed the allowed amount, the patient must pay the balance to the provider, even though the annual cap has been met.

BILLING TIP

BCBS Participation

Participating providers in BCBS plans are often called *member physicians*.

BCBS plans also offer many types of managed care programs, including the following:

- *HMO:* A patient must choose a primary care physician who is in the BCBS network. HMO has an Away From Home Care Program that provides emergency room coverage if the subscriber needs care when traveling. Many BCBS plans also have a Guest Membership through the Away From Home Care Program. A Guest Membership is a courtesy enrollment for members who are temporarily residing outside of their home HMO service area for at least ninety days.
- *POS:* Members of a POS plan may receive treatment from a provider in the network, or they may choose to see a provider outside the network and pay a higher fee. Depending on the particular plan, a patient may or may not have a primary care provider.
- *PPO:* Physicians and other healthcare providers sign participation contracts with BCBS agreeing to accept reduced fees in exchange for membership in the network. As network members, providers are listed in a provider directory and receive referrals from other network members. PPO subscribers have the PPO on their Blue ID cards. A patient may choose to see a network provider or, for higher fees, a nonnetwork provider.

BlueCard program that provides benefits for subscribers who are away from their local areas and payments for their treating providers

BlueCard Program

The **BlueCard** program is a nationwide program that makes it easy for patients to receive treatment when outside their local service area and for a provider to receive payment when treating patients enrolled in plans outside the provider's service area.

Table 8.3 Plan Accrediting Organizations

- *National Committee for Quality Assurance (NCQA):* An independent nonprofit organization, NCQA is the leader in accrediting HMOs and PPOs. Working with the healthcare industry, NCQA developed a group of performance measures called HEDIS (Health Plan Employer Data and Information Set). HEDIS provides employers and consumers with information about each plan's effectiveness in preventing and treating disease, about policyholders' access to care, about documentation, and about members' satisfaction with care. NCQA's guidelines on the process by which plans select physicians and hospitals to join their networks, called **credentialing,** include performance measures. NCQA requires plans to review the credentials of all providers in their plans every two years to ensure that the providers continue to meet appropriate standards of professional competence.
- *Utilization Review Accreditation Commission (URAC):* URAC, also known as the American Accreditation Healthcare Commission, is another leading accrediting group. Like NCQA, it is a nonprofit organization that establishes standards for managed healthcare plans. URAC has accreditation programs addressing both the security and privacy of health information as required by HIPAA.
- *The Joint Commission (TJC, formerly the Joint Commission on Accreditation of Healthcare Organizations or JCAHO):* TJC sets and monitors standards for many types of patient care. TJC is made up of members from the American College of Surgeons, the American College of Physicians, the American Medical Association, the American Hospital Association, and the American Dental Association. TJC verifies compliance with accreditation standards for hospitals, long-term care facilities, psychiatric facilities, home health agencies, ambulatory care facilities, and pathology and clinical laboratory services. TJC works with NCQA and the American Medical Accreditation Program to coordinate the measurement of the quality of healthcare across the entire healthcare system.
- *American Medical Accreditation Program (AMAP):* AMAP helps alleviate the pressures facing physicians, health plans, and hospitals by reducing cost and administrative effort and simultaneously documenting quality. As a comprehensive program, AMAP measures and evaluates individual physicians against national standards, criteria, and peer performance in five areas: credentials, personal qualifications, environment of care, clinical performance, and patient care.
- *Accreditation Association for Ambulatory Health Care, Inc. (AAAHC):* AAAHC has accredited managed care organizations for more than twenty years. Its program emphasizes an assessment of clinical records, enrollee and provider satisfaction, provider qualifications, utilization of resources, and quality of care.

credentialing periodic verification that a provider or facility meets professional standards and is qualified to be reimbursed

BlueCross BlueShield Association

Founded in the 1930s to provide low-cost medical insurance, the **BlueCross BlueShield Association (BCBS)** is a national organization of independent companies and a federal employee program that insures nearly 100 million people and a number of nonprofit companies. BlueCross was originally hospital coverage, and BlueShield physician/outpatient coverage. The "Blues" offer a full range of health plans, including CDHPs, to individuals, small and large employer groups, senior citizens, federal government employees, and others. In addition to major medical and hospital insurance, the "Blues" also have freestanding dental, vision, mental health, prescription, and hearing plans.

BlueCross BlueShield Association (BCBS) national healthcare licensing association

Subscriber Identification Card

Because BCBS offers local and national programs through many individual plans, subscriber identification cards must be used to determine the type of plan under which a person is covered. Most BCBS cards list the following information:

- Plan name
- Type of plan (A PPO in a suitcase is the logo for BCBS PPO members; the empty suitcase is the logo for Traditional, POS, or HMO members)
- Subscriber name

Blues Companies
www.bcbs.com/about-the-companies/

8.4 Major Private Payers and the BlueCross BlueShield Association

A small number of large insurance companies dominate the national market for commercial insurance and offer employers all types of health plans, including self-funded plans. Local or regional payers are often affiliated with a national plan or with the BlueCross BlueShield Association. Private payers supply complete insurance services, such as:

- Contracting with employers and with individuals to provide insurance benefits
- Setting up physician, hospital, and pharmacy networks
- Establishing fees
- Processing claims
- Managing the insurance risk

Many large insurers own specialty companies that have insurance products in related areas. They may handle behavioral health, dental, vision, and life insurance. Many also work as federal government contractors for Medicare and Medicaid programs and handle prescription management divisions.

Major Payers and Accrediting Groups

The following is a list of major national payers. Note that the BlueCross BlueShield Association (BCBS), which has both for-profit and nonprofit members, is not a payer; it is an association of more than thirty payers. Its national scope, however, means that knowing about its programs is important for all medical insurance specialists.

- *Anthem:* Anthem is one of the nation's largest health insurers. It is also the largest owner of BlueCross BlueShield plans (see the following discussion of the BlueCross BlueShield Association).
- *UnitedHealth Group:* UnitedHealth Group is another large health insurer that runs plans under its UnitedHealthcare subsidiary and owns other major regional insurers.
- *Aetna:* Aetna has a full range of products, including healthcare, dental, pharmacy, group life, behavioral health, disability, and long-term care benefits.
- *CIGNA Health Care:* CIGNA is a large health insurer with strong enrollment in the Northeast and the West.
- *Kaiser Permanente:* The largest nonprofit HMO, Kaiser Permanente is a prepaid group practice that offers both healthcare services and insurance in one package. It runs physician groups, hospitals, and health plans in western, midwestern, and southeastern states plus Washington, D.C.
- *Humana, Inc.:* Humana is particularly strong in the South and Southeast. It offers both traditional and consumer-driven products. Humana handles TRICARE operations in the Southeast.

Outside agencies accredit and rate private payers. The major accrediting organizations are summarized in Table 8.3. Industry groups such as the National Association of Insurance Commissioners also monitor payers.

BILLING TIP

Pay for Performance

BCBS is often a leader in efforts to improve healthcare. One example is **pay-for-performance (P4P)** programs that have financial incentives such as bonuses for excellence in such performance measures as the NCQA HEDIS rating. See Table 8.3.

pay-for-performance (P4P) health plan financial incentives program based on provider performance

Under a capitation plan, the exact covered services (with a list of CPT codes) included in the cap rate should appear. For example, when a provider gives a patient measles, mumps, and rubella (MMR) vaccine, two fees are involved: one for giving the injection (called the administration of the immunization) and a second for the dosage of the vaccine itself. Under a capitated primary care contract, the covered medical services provisions state whether both the fee for injecting vaccines and the cost of injectable materials are included in the cap rate or just the immunization administration.

BILLING TIP

Withdrawing from a Contract

Most participation contracts require physicians to notify patients if the physicians withdraw from the patients' managed care organization.

Physician's Responsibilities

The physician's responsibilities under the plan include the following:

- *Covered services:* The contract should stipulate the services that the provider must offer to plan members.
- *Acceptance of plan members:* The contract states whether providers must see all plan members who wish to use their services or some percentage or a specific number of members. For example, capitated plans often require primary care physicians to accept at least a certain number of patients who are enrolled in the plan. If treating this number of patients means that the plan's enrollees will make up a large part of the practice, providers must decide whether the plan's payment structure is high enough before agreeing to participate.
- *Referrals:* This part of the contract states whether providers must refer patients only to other participating providers. It also covers the conditions under which the referral rules do not apply, such as in an emergency.
- *Preauthorization:* If the provider is responsible for securing preauthorization for the patient, as is the case in most HMOs, this is stated.
- *Quality assurance/utilization review:* Providers typically must agree to allow access to certain records for the payer's quality assurance and utilization review (QA/UR) activities. **Utilization review** refers to the payer's process for determining medical necessity—whether the review is conducted before or after the services are provided.
- *Other provisions:* Providers' credentials, health plan protocols, HIPAA Privacy policies, record retention, and other guidelines from the payer's medical review program are covered.

utilization review payer's process for determining medical necessity

Managed Care Plan Obligations

Managed care plan obligations include the following:

- *Identification of enrolled patients:* The plan's method of identifying enrolled patients should be specified. Usually, this is with an identification card like the one shown in Figure 8.4. In this example, the provider network, the schedule of benefits, the office visit copayment, the name of the policyholder, the group, the type of contract, the patient's identification number, and the patient's dependents are listed.
- *Payments:* A claim turnaround time is specified in the contract. This tells how long it will take for a physician to be paid for services.
- *Other compensation:* This indicates whether any incentives, bonuses, or withholds apply.

Contract Provisions

When a practice's contract evaluation team is considering a participation contract, an experienced medical insurance specialist may be asked to assist. A practice manager or a committee of physicians usually leads the team; an outside attorney typically reviews the contract as well. The managed care organization's business history, accreditation standing, and licensure status are reviewed.

The major question to be answered is whether participation in the plan is a good financial opportunity. All plans pay less than the physicians' fees schedules, so there is less revenue for each procedure. Some plans pay very low fees, and even gaining many more patients who have this plan may not make participation profitable. The evaluation team checks the fees the plan pays for the CPT codes that the practice's providers most often bill. If the plan reduces payment for these services too much, the evaluation team may decide not to join even though doing so would bring in more patients.

Other aspects of the plan, such as its medical necessity guidelines, are also considered. Some physicians do not accept certain plans because, in their view, complying with the plans' healthcare protocols will limit their professional medical judgment in treating patients.

The main parts of participation contracts are the following:

- Introductory section (often called *recitals* and *definitions*)
- Contract purpose and covered medical services
- Physician's responsibilities
- Managed care plan obligations
- Compensation and billing guidelines

Introductory Section

The introductory section is important because it lists the names of the contracting parties and defines the terms used in the contract. Often the contract mentions that the provider's manual is part of the agreement and is to be referred to for specific points. The section also states the ways the plan may use participating physicians' names. Some plans wish to provide lists of participating physicians to plan members. Other plans, however, want to use the providers' names in newspaper, radio, or television advertisements.

This section also specifically indicates who the payer is, such as "First Health Plan, a federally qualified health maintenance organization," or "Golden Gate Insurance Company, a stock company." Payer information must be noted so that claims will be sent to the correct organization. For example, although a self-funded health plan may create the plan, a TPA may be responsible for processing and paying claims.

Contract Purpose and Covered Medical Services

Because MCOs offer multiple products—HMO, PPO, POS, CDHP, and fee-for-service options—a contract may be for one or several of these products. The contract should state the type of plan and the medical services to be provided to its members. In addition to office visits and preventive medical services, which are usual, obstetrician-gynecologist, behavioral health, physical and occupational therapy, emergency and urgent care, and diagnostic laboratory services may be covered.

BILLING TIP

No Copay for Preventive Care

Waiving copays for preventive services is a leading trend in both CDHP and traditional plans.

Private Health Insurance Exchanges

Private exchanges (which had existed in limited numbers before the ACA) are eligible to offer IHPs to individuals and to small businesses, under which employees choose their own plans using a specific amount of money the employer allocates.

THINKING IT THROUGH 8.5

1. Working as a medical insurance specialist, what types of questions and issues might you anticipate from newly insured patients who have bought online plans from an HIX?

8.6 Participation Contracts

Providers, like employers and employees, must evaluate health plans. They judge which plans to participate in based primarily on the financial arrangements that are offered. Because managed care organizations are the predominant healthcare delivery systems, most medical practices have contracts with a number of plans in their area. See Figure 8.3 for the notice of participation posted in an orthopedic specialty.

BILLING TIP

Participation

Most physicians participate in more than twenty health plans.

Welcome to Newton Major Orthopedic Associates, PC

In order to make your visit as pleasant as possible, we have compiled a list of the most commonly asked questions regarding insurance and billing in this office.

With which insurance plans does NMOA participate?

Aetna/US Healthcare Plans
CIGNA
Blue Choice PPO: POS, PPO, Prestige, Select
Focus Workers Compensation PPO
Health Care Value Management, Inc.
Health Choice
Health Direct
Kaiser Permanente
Medicare
Medicaid
MedSpan
MD Health Plan
Oxford Health Plan
Physician Health Services
Prudential Healthcare
POS Plan
Wellcare

What can I expect if NMOA participates with my insurance?

We will file a claim with your insurance company for any charges. Your insurance may require you to pay a copay at the time of services. You are responsible for any deductibles and non-covered services. You may need to obtain a referral from your primary care physician. Failure to obtain a referral may result in rescheduling of your appointment until you can obtain one.

What can I expect if NMOA does not participate with my insurance?

Payment is expected at the time of service. You will receive a statement within two weeks. Use it to file a claim. As a courtesy, NMOA will submit any surgery claims to your insurance carrier, but you are responsible for payment.

FIGURE 8.3 Example of Practice Participation List

- Insurance companies must spend at least 80 cents of every dollar they collect from customers on providing health care, limiting salaries and profits. If this is not the case, health plan subscribers will get a tax-free rebate.
- Preventive services for all patients in new health plans, such as annual physicals and dozens of screening tests, must be completely covered by payers, as long as in-network providers are used. (As opposed to "new" health plans, under certain conditions existing health plans are "grandfathered"—they are exempted from ACA requirements.)

Public Health Insurance Exchanges

individual health plan (IHP) medical insurance plan purchased by an individual

health insurance exchange (HIX) government-regulated marketplace offering insurance plans to individuals

metal plans new health plans created by the ACA named after different types of metals according to the services they cover

A key goal of the ACA is to reduce the number of uninsured citizens and legal residents by providing affordable **individual health plans (IHP).** The ACA required creation of a public government-run online marketplace in each state to offer IHPs to people who do not have employer-based insurance. About half the states chose to run their own **health insurance exchanges (HIX).** Others partnered with the federal government or used a federally run exchange. Commercial payers also join HIXs and offer plans to purchasers.

Metal Plans

The ACA created new designs for health plans that are often referred to as **metal plans** since each is named after a different type of metal (Bronze, Silver, Gold, and Platinum). Each of these metal plan levels covers a different average amount of insurance expenses. The more expensive the metal (and thus the plan's premiums and deductible amounts), the more costs it covers. For example, a platinum plan covers 90 percent of covered medical expenses while a bronze plan covers only 60 percent. A fifth plan called a catastrophic plan is available for individuals who have documentation of financial problems in affording a bronze plan.

In the marketplace, usually a payer charges progressively higher premiums among the plans; bronze plans have the lowest premiums and platinum have the highest premiums. However, one payer's silver plan could be cheaper than another company's bronze plan. All plans have a maximum out-of-pocket amount that enrolled individuals must pay annually before their plan covers the rest of their out-of-pocket expenses. In 2019 the maximum out-of-pocket limit for any individual marketplace plan was $7,900, or $15,800 for a family.

Individual insurance companies are not required to offer plans from all four metal tiers. But payers that choose to participate in a public HIX must offer at least one silver plan and at least one gold plan.

Essential Health Benefits

essential health benefits (EHB) required benefits that must be offered by metal plans as well as some other insurance plans

All metal plans must offer these **essential health benefits (EHB)**:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity care and newborn care
- Mental health services & substance use disorder services—these services include counseling as well as behavioral health treatment for alcohol abuse and drug abuse
- Drug coverage for prescription medications
- Rehabilitative and habilitative services and devices
- Laboratory tests and services
- Preventive and wellness services as well as the management of chronic diseases
- Pediatric medical services (including both oral care and vision care)

States may require additional benefits, so all plans may cover the essential health benefits but cost the member different amounts due to the differences in insurance expenses they pay for.

when the patient visits an office for any procedure or service. Copayment amounts may also vary according to the service performed. Some plans have different copayment amounts for office visits, emergency room visits, ambulance services, and preventive services. When two services, such as an E/M service and a billable procedure, are performed on the same date of service, either one or two copayments may be required, again depending on the payer.

Another variable in collecting copayments involves primary and secondary plans. Medical insurance specialists should verify whether a copayment is to be collected under the secondary plan. Usually it is not, unless the primary plan does not cover the service or if the member is satisfying a deductible for the primary plan.

The payer's rules about copayment calculations also need to be understood. Most plans require the patient's copayment to be subtracted from the amount due to the provider from the payer. This treats the copayment like a deductible or coinsurance payment. The contract (or provider's manual) states the policy in terms such as "All member copayments, deductibles, and coinsurance apply." (The word *apply* means that they should be taken into account when the payer calculates the balance due to the provider.)

The plan is a PPO that pays 75 percent of the provider's usual charge. A $5 copayment is due, and the copayment is applied toward the provider payment.

Provider's usual charge	$100.00
Payer allowed fee ($100 × 75%)	$ 75.00
Patient copay subtracted	$ 5.00
Payer pays	$ 70.00
Provider collects a total of	$ 75.00

Note that a few plans, though, do not deduct the patient's copayment from the usual charge. Instead, the plan has a lower allowed fee for the service, so often the provider collects the same amount in the end. For example:

The plan is a PPO that pays 70 percent of the provider's usual charge. A $5 copayment is due to the provider as well.

Provider's usual charge	$100.00
Payer allowed fee ($100 × 70%)	$ 70.00
Patient copay collected	$ 5.00
Payer pays	$ 70.00
Provider collects a total of	$ 75.00

Both approaches are acceptable. The rules must be clear to the medical insurance specialist for correct calculations of the expected payment from the payer.

COMPLIANCE GUIDELINES

Collect Copays

The practice is obligated to follow payer copayment guidelines. Routinely waiving copays and deductibles may be fraudulent under participation contracts. This should be stated in the financial policy that patients are given.

Consider Secondary Coverage

Check whether the patient's coverage in a secondary plan pays the copay before collecting it from the patient.

BILLING TIP

State Prohibition of Silent PPOs

A number of states (California, Illinois, Louisiana, Minnesota, North Carolina, Oklahoma, and Wisconsin) prohibit silent PPOs, and state insurance commissions in other states may be considering such laws.

Avoiding Silent PPOs

Silent PPOs—also called *network-sharing agreements*—allow a managed care organization to lease its PPO provider network list to another entity, such as a smaller PPO, so the other entity can take advantage of the discounts negotiated by the original PPO. This can cause a practice to accept a PAR payment for a service to a patient who is not enrolled in a plan in which it participates. In most cases, the physician is led to believe that the discount is legitimate. Most experts recommend trying to negotiate a phrase in participation contracts stating that the MCO cannot lease any terms of the agreement—including the physician's discounted services—or assign benefits to another payer.

silent PPO ... an agreement that an MCO can purchase a list of participating providers and pay their enrollees' claims according to the contract's fee schedule despite the lack of a contract

BILLING TIP

When the MPFS Is the Base

If a payer's fee schedule is based on the MPFS, the contract should state which year's schedule is going to be used.

Compiling Billing Data

BILLING TIP

Increasing Covered Services

Keep a record of services that were not paid over a year's billing period. This record provides a basis for negotiating a revised contract in order to cover more services.

Practices generally bill from their normal fee schedules rather than billing the contracted fees, even if they are known. Writing off the differences between normal fees and payments under the participation contract is done when the remittance advice (RA) is processed. Billing this way permits the practice to track how much revenue it loses by participating in a particular contract, which is valuable information for future contract negotiations.

Physician's Fee Schedule for CPT 99211	$25
Contract Fee for Participating Providers (PARs) for CPT 99211	18
Loss of Revenue per Visit for CPT 99211	7
Service Performed × 500 Visits Annually	
Annual Lost Revenue for This CPT Code	3,500

A record of lost revenue per each commonly billed CPT code can be kept. To negotiate higher fees, a practice may compare the difference in payer accounts over a year for its commonly billed procedures and use this comparison when negotiating contract renewal and reviewing fee schedules.

BILLING TIP

Payment for New Procedures

Payment policy for a new procedure may be announced by a payer. If the practice performs this procedure, it should notify its other PAR plans that this procedure will be reported for payment in the future and should request their allowed charge and any other regulations for payment.

Billing for No-Shows

BILLING TIP

Prompt-Payment Discounts

Payers may offer prompt payment in return for higher-than-contracted fees. Acceptance of these offers for expedited review and payment is a matter of practice policy.

The contract determines whether a participating provider can charge a patient for a product used to set up a procedure when the patient cancels. Often, a physician may bill only for a rendered service, not for a service that is not delivered, including cancellations and no-shows. In nonparticipating situations, have patients agree in writing to pay before scheduling procedures. Follow the practice's financial policy for billing for no-shows or cancellations.

COMPLIANCE GUIDELINE

Avoid Price Fixing

Office of Inspector General (OIG) rules prohibit practices from discussing pricing and rates with other practices.

Collecting Copayments

Required copayment(s) vary according to payer. Some plans require a copayment only when an evaluation and management (E/M) service is provided, and others require it

Compensation and Billing Guidelines

The compensation and billing guidelines cover fees, billing requirements, claim filing deadlines, patients' financial responsibilities, and balance-billing rules. The rules for collecting patients' payments are described, as is the way to coordinate benefits when another plan is primary. The contract should also state how far back in time a plan is permitted to go for refunds of overpayments or incorrect payments.

THINKING IT THROUGH 8.6

1. In what section of a participation contract is each of the following phrases located?

   A. Physician has accurately completed the Participating Physician Credentialing Application that accompanies this agreement and has been accepted by the Plan. Physician shall promptly notify Plan of any change in this information, including any change in its principal place of business, within seven days of such change.

   _____

   B. "Members" means enrollees or enrolled dependents covered by a Plan benefit agreement.

   _____

   C. Physician agrees to accept the Plan fee schedule or physician's billed charges, whichever is less, as payment in full for all medical services provided to members.

   _____

   D. Physician agrees to allow review and duplication of any data free of charge and other records maintained on members that relate to this agreement.

   _____

   E. Plan agrees to provide current identification cards for members.

   _____

   F. Plan shall deduct any copayments and deductible amounts required by the Plan benefit agreement from the allowed payment due to the Physician under this agreement.

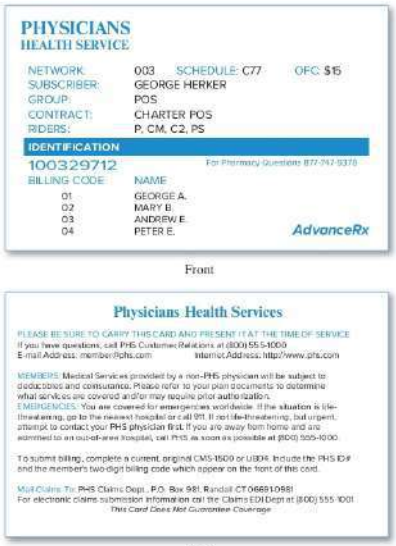
   _____

   G. Plan intends, by entering into this agreement, to make available quality healthcare to Plan members by contracting with Physician. Physician intends to provide such care in a cost-effective manner.

   _____

8.7 Interpreting Compensation and Billing Guidelines

Participation contracts other than for capitated plans often state the basis for the payer's allowed amounts. A payer may base allowed amounts on a percentage of the Medicare Physician Fee Schedule (MPFS) or a discounted fee-for-service arrangement.



PHYSICIANS
HEALTH SERVICE

NETWORK: 003 SCHEDULE: C77 OFC: $15
SUBSCRIBER: GEORGE HERKER
GROUP: POS
CONTRACT: CHARTER POS
RIDERS: P, CM, C2, PS

IDENTIFICATION

100329712 For Pharmacy Questions 877-747-5378

BILLING CODE	NAME
01	GEORGE A.
02	MARY B.
03	ANDREW E.
04	PETER E.

AdvanceRx

Front

Physicians Health Services

PLEASE BE SURE TO CARRY THIS CARD AND PRESENT IT AT THE TIME OF SERVICE
If you have questions, call PHS Customer Relations at (800) 555-1000
E-mail Address: member@phs.com Internet Address: http://www.phs.com

MEMBERS: Medical Services provided by a non-PHS physician will be subject to deductibles and coinsurance. Please refer to your plan documents to determine what services are covered and/or may require prior authorization.
EMERGENCIES: You are covered for emergencies worldwide. If the situation is life-threatening, go to the nearest hospital or call 911. If not life-threatening, but urgent, attempt to contact your PHS physician first. If you are away from home and are admitted to an out-of-area hospital, call PHS as soon as possible at (800) 555-1000.

To submit billing, complete a current, original CMS-1500 or UB04. Include the PHS ID# and the member's two-digit billing code which appear on the front of this card.

Mail Claims To: PHS Claims Dept., P.O. Box 981, Randall CT 06891-0981
For electronic claims submission information call the Claims EDI Dept at (800) 555-1001
This Card Does Not Guarantee Coverage

Back

FIGURE 8.4 Example of an Insurance Card for a POS Plan

stop-loss provision
protection against large losses or severely adverse claims experience

- *Protection against loss:* If the provider is assuming financial risk for the cost of care, as happens under capitation, the contract should have a **stop-loss provision.** This clause limits the provider's costs if there is an unexpectedly high use of services. Stop-loss provisions state a dollar amount over which the provider will be repaid.

Under plans in which providers must refer patients only to other participating providers, the providers' compliance is evaluated by the plan, and incentives or bonuses may be tied to how well a provider observes the referral rules. For this reason, a stated obligation of the plan should be to provide and regularly update the list of participating providers so that providers are sure they are referring their patients correctly.

BILLING TIP

List All NPIs

The contract should list the National Provider Identifiers (NPIs) of all practitioners who will bill under it, not only the NPI for the practice itself.

THINKING IT THROUGH 8.7

1. Read the following referral policy for a payer's HMO plan and answer the questions that follow.

Referral Policy

The following points are important to remember regarding referrals:

- The referral is the way the member's PCP arranges for a member to be covered for necessary, appropriate specialty care and follow-up treatment.
- The member should discuss the referral with his or her PCP to understand what specialist services are being recommended and why.
- If the specialist recommends any additional treatments or tests that are covered benefits, the member needs to get another referral from his or her PCP prior to receiving the services. If the member does not get another referral for these services, the member may be responsible for payment.
- Except in emergencies, all hospital admissions and outpatient surgery require a prior referral from the member's PCP and prior authorization by the plan.
- If it is not an emergency and the member goes to a doctor or facility without a referral, the member must pay the bill.
- In plans without out-of-network benefits, coverage for services from nonparticipating providers requires prior authorization by the plan in addition to a special nonparticipating referral from the PCP. When properly authorized, these services are fully covered, less the applicable cost-sharing.
- The referral provides that, except for applicable cost-sharing, the member will not have to pay the charges for covered benefits as long as the individual is a member at the time the services are provided.

A. In plans with out-of-network benefits, under what three circumstances does this HMO plan require referrals from the plan member's PCP?

B. What two approvals are needed for nonemergency hospital admissions and outpatient surgery?

C. If the plan does not have out-of-network benefits:

(1) Is it possible for a plan member to be covered for services from nonparticipating providers?

(2) What must the plan member do to secure coverage?

(3) What charges apply?

8.8 Private Payer Billing Management: Plan Summary Grids

Organizing job aids, such as the plan summary grid described in Figure 8.8, and following the steps of the billing cycle will provide answers to these essential questions:

- What services are covered under the plan? What conditions establish medical necessity for these services? Are these correctly coded and linked?
- Which services are not covered?
- What are the plan's billing rules—the bundling and global periods?
- What is the patient responsible for paying at the time of the encounter and after adjudication?

Case number: G631000
Procedure: Axillary node dissection

Dear Patient:

As you may know, ABC is a utilization review company that contracts with insurance companies, managed care organizations, and self-insured groups to review the healthcare services provided to people covered under their medical plans and to make recommendations regarding the medical necessity and efficiency of these healthcare services. ABC is not an insurer, and does not make eligibility, benefit, or coverage decisions.

We have received information about the procedure scheduled for 08/12/2029 at Downtown Hospital. Based on review of this information, we find this outpatient procedure to be medically necessary and efficient.

If the treatment plan is changed, or if admission to the hospital is necessary, please contact your insurance company immediately.

ABC's recommendation is not a decision regarding payment of a particular claim. Your medical plan payer is responsible for making final payment and eligibility decisions. Any questions about a claim, deductible, or copayment should be directed to your medical plan.

Sincerely,

ABC Reviewer
Medical Care Coordinator

cc: George Ballister, MD
Downtown Hospital

FIGURE 8.7 Example of Letter from Utilization Review Organization

of planned procedures. When a provider (or a patient) requests preauthorization for a treatment plan, the URO issues a report of its findings. As shown in Figure 8.7, the patient and provider are both notified of the results. If the planned services are not covered, the patient should agree to pay for them before the treatment begins.

BILLING TIP

Out-of-Network Services

Many plans require preauthorization for out-of-network services even though they are covered under the plan.

PRECERTIFICATION FORM

Insurance carrier _____

Certification for [ ] admission and/or [ ] surgery and/or [ ] _____

Patient name _____

Street address _____

City/state/ZIP _____

Telephone _____ Date of birth _____

Subscriber name _____

Employer _____

Member no. _____ Group no. _____

Admitting physician _____

Provider no. _____

Hospital/facility _____

Planned admission/procedure date _____

Diagnosis/symptoms _____

Treatment/procedure _____

Estimated length of stay _____

Complicating factors _____

Second opinion required [ ] Yes [ ] No If yes, [ ] Obtained

Corroborating physician _____

Insurance carrier representative _____

Approval [ ] Yes [ ] No If yes, certification no. _____

If no, reason(s) for denial _____

FIGURE 8.6 Precertification Form for Hospital Admission or Surgery

Some elective surgical procedures are done on an inpatient basis, so the patient is admitted to the hospital; others are done on an outpatient basis. The following are common outpatient surgeries:

- Abdominal hernia
- Bunionectomy
- Carpal tunnel
- Destruction of cutaneous vascular proliferative lesions
- Knee arthroscopy
- Otoplasty
- Sclerotherapy

For a major course of treatment, such as surgery, chemotherapy, and radiation therapy for a patient with cancer, many private payers use the services of a **utilization review organization (URO)**. The payer hires the URO to evaluate the medical necessity

utilization review organization (URO) organization hired by a payer to evaluate medical necessity

precertification preauthorization for hospital admission or outpatient procedures

BILLING TIP

The Term Precertification

Precertification ("precert") is another term for preauthorization. It is usually applied to hospital admissions and outpatient surgery. Both terms have the same meaning.

Billing Surgical Procedures

elective surgery nonemergency surgical procedure

Most managed care plans have rules for authorizing emergency surgical procedures and elective surgery. Emergency surgery usually must be approved within a specified period, such as forty-eight hours, after admission was required. **Elective surgery** is a procedure that can be scheduled ahead of time, but which may or may not be medically necessary. It usually requires preauthorization during a specified period before the service is performed. The preauthorization requirement is usually shown on the patient's insurance card (see Figure 8.5). The practice must send a completed preauthorization form or online application for review in advance of the admission. See Figure 8.6 for an example of a precertification form.

Golden Rule HEALTHChoice OF CONNECTICUT

Certain services require PRECERTIFICATION

Primary Insured: Rachel Bostone
Identification Number:
054360906

Effective Date:
Illness: 03/29/29
Injury: 03/15/29

For maximum benefits, you must call Healthmarc at 1-800-551-1000 7 days prior to treatment or within 24 hours after an emergency admission. Precertification does not guarantee coverage of payment.

Front

HealthChoice of Connecticut Providers

HealthChoice of Connecticut
231 Farmington Ave.
Farmington, CT 06032-1948

All Other Providers

Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, IN 46278-1719

http://www.goldenrule.com
Claims/Benefits: (317) 297-4189
Premium/Other: (317) 297-4149

NEIC
ELECTRONIC CLAIMS PROCESSOR

Back

FIGURE 8.5 Example of an Insurance Card Showing Precertification Requirement

coverage to the primary payer. Review the PIF to determine whether the patient has secondary or supplemental coverage that should be reported on the primary payer's claim.

Meet Preauthorization/Referral Requirements

Additionally, check for and meet the payer's preauthorization and/or referral requirements. Referrals and preauthorizations are examples of the provider's contractual requirement to give the plan notice of services performed. In most cases, payers require data that support clinical necessity if a required preauthorization was not obtained according to plan guidelines.

BILLING TIP

Unbundling

Unbundling for private payers can be complex. Each payer establishes its own billing guidelines, and therefore the definition of *unbundling* can change from payer to payer. Best practice is to require that payers spell out all billing guidelines in participation contracts.

Out-of-Network Billing

Providers that do not participate in patients' plans tell patients this before their encounters and inform them of their responsibility to pay for services they will receive.

If the patient does not have out-of-network benefits, many practices collect either a deposit or full payment at the time of service. In this case, the provider's regular fee schedule is used to calculate the amount due.

However, what fee schedule applies if the patient has out-of-network medical and surgical benefits under a plan? Three of four people covered by group health plans have this option. In this situation, the plan has a role in determining the charge. Often plans have hired a **repricer,** a service company that sets up fee schedules and discounts and processes out-of-network claims.

repricer: vendor that sets up fee schedules and discounts, and processes a payer's out-of-network claims

Another issue that affects billing is some plans' practice of paying their members directly for out-of-network claims they receive from providers. Medical insurance specialists must be aware of the applicable state laws and contract language. When this is the payers' practice or state law, upfront collections are even more important.

Step 3. Check In Patients

Be sure that the correct copayment has been collected from the patient for the planned service. For example, if the plan summary grid for the patient's plan lists an office visit copay and that is the nature of the encounter, collect the copay and post it to the patient's account.

Step 4. Review Coding Compliance

Verify that the diagnosis and procedure codes are current as of the date of service. Check that the codes are properly linked and documented, showing the medical necessity for the services.

Step 5. Check Billing Compliance

Using the plan summary grid, verify that all charges planned for the claim are billable.

Step 6. Check Out Patients

Based on the encounter information, update the practice management program to reflect the appropriate diagnoses, services, and charges. Analyze the patient's financial responsibility, according to the practice's financial policy, for:

Step 1. Preregister Patients

The general guidelines apply to the preregistration process for private health plan patients: Collect and enter basic demographic and insurance information.

Step 2. Establish Financial Responsibility for Visits

The initial information for a new patient's plan is taken from the patient's information form (PIF). Changes in insurance coverage for established patients are noted on an update to the PIF.

Verify Insurance Eligibility

Based on the copies of insurance cards, contact the payer to double-check that the patient is eligible for services. Be sure to accurately enter the patient's name and ID number as it appears on the card.

BILLING TIP

Lab Requirements

Practices should post a notice to patients stating that if patients do not tell them about their plans' lab requirements and the specimen is sent to the wrong lab, the practice is not responsible for the costs.

The payer ID and logo on the insurance card identify the payer. If the card lists multiple PPOs and is not clear, contact the payer to select the correct one for that patient. If the provider is a primary care physician and the plan requires registration of a PCP, the insurance card often lists the correct provider's name.

270/271 Eligibility for Benefits Transaction

The HIPAA 270/271 Eligibility for a Health Plan transaction (the inquiry from the provider and the response from the payer) is the electronic format used to verify benefits.

Check Coverage

Depending on the type of practice, coverage for some of the following services may need to be specifically verified:

- Office visits
- Lab coverage (note that many managed care organizations specify which laboratory must be used for tests)
- Diagnostic X-rays
- Pap smear coverage
- Coverage of psychiatric visits, including the number of visits covered and the coinsurance for each
- Physical or occupational therapy
- Durable medical equipment (DME)
- Foot care

A patient with a self-funded health plan may have an ID card with a familiar plan to which claims should be sent. But that plan is handling the claims processing only; it is not providing the insurance. Do not assume that the patient's coverage is the same as it is for members of that health plan. Locate the actual name of the self-insured plan to verify eligibility and check benefits.

Coordinate Benefits

Next, determine the primary plan for the patient by following the guidelines in Table 3.1. Under coordination of benefits provisions, if the patient has signed an assignment of benefits statement, the provider is responsible for reporting any additional insurance

- The policies for multiple procedure reimbursement (whether the payer fully reimburses multiple procedures performed on the same date of service or pays fully for the first service only and pays the rest at a reduced percentage)
- Verification procedures
- Documentation requirements, such as special reports for unlisted procedure codes or the name of the serum, the dosage, and the route of administration for immunizations
- Appeal procedures

The practice management program (PMP) is also updated with each payer's name and contact information, the plan type, and payment information.

HIPAA/HITECH TIP

278 Referral and Authorization

The HIPAA 278 Referral and Authorization is the electronic format used to obtain approval for preauthorizations and referrals.

BILLING TIP

Consult Versus Referral

Plans often have forms that misuse the terms *refer* and *consult*. A *consultation* occurs when a physician, at the request of another physician, examines the patient and reports an opinion to the requestor. Under a *referral*, care (a portion or all) is transferred to another physician. However, a plan's referral form may in fact be the correct one to use when consultation is required. This usage should be clarified with the plan.

THINKING IT THROUGH 8.8

1. Read the following preauthorization policy from a typical PPO plan and answer the questions that follow:

   Preauthorization is the process of collecting information prior to inpatient admissions and selected ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage, and communication with the physician and/or member. It also allows the PPO to coordinate the member's transition from the inpatient setting to the next level of care (discharge planning), or to register members for specialized programs like disease management, case management, or maternity management programs. In some instances, preauthorization is used to inform physicians, members, and other healthcare providers about cost-effective programs and alternative therapies and treatments.

   Certain healthcare services require preauthorization under this plan. When a service requires preauthorization, the provider is responsible to preauthorize those services prior to treatment. However, if the patient's plan covers self-referred services to network providers or self-referrals to out-of-network providers, and the patient is able to self-refer for covered benefits, it is the member's responsibility to contact the plan to preauthorize those services.

   A. What does the plan state are the purposes of preauthorization?

   B. In your own words, define *self-refer*.

   C. Under what circumstances is it the patient's responsibility to obtain preauthorization approval?

8.9 Preparing Correct Claims

The first seven steps of the standard revenue cycle are followed to complete correct claims and transmit them to private payers. Study these steps. (Chapters 13 and 14 cover the last three steps of the cycle for private payers, covering adjudication and RA, appeals, and patient billing and collections.)

plan summary grid quick-reference table for health plans

Medical insurance specialists organize each plan's benefit and payment information for easy access. For each participation contract and employer, a **plan summary grid** should be prepared or updated. The grid summarizes key items from the contract, such as the payers' names and plans, patient financial responsibility (copayments; which services are subject to deductibles), referral and preauthorization requirements, covered and noncovered services, billing information, and participating labs. Some offices use a form like the one in Figure 8.8.

Other key information includes:

- The major code edits for bundled procedures and services
- The global follow-up times for major and minor surgical procedures

PAYER NAME_____
PLAN NAME _____
PLAN TYPE (PPO, HMO, FFS, OTHER)_____
PAYER WEBSITE_____

PARTICIPATION CONTRACT ACTIVE DATE?_____
Provider Customer Service Phone Contact to check benefits, eligibility, claim status, request verification_____
Correspondence, Claim Appeals, and Reconsiderations to:_____

REQUIRED FACILITIES AND PREAUTHORIZATION FOR: YES NO
Referrals: In Network _____
Out-of-Network_____
Imaging:
CT Scans _____
MRA Scans _____
MRI Scans _____
Nuclear Cardiology Studies _____
PET Scans _____
Other _____

Participating Labs _____
Hospital Admission _____
Known Excluded Services _____

PATIENT FINANCIAL RESPONSIBILITY
Copayments: Office Visit _____
Well Care, age birth to ____ Amount: _____
Well Care, age _____ to _____ Amount: _____
Labs Covered in Office _____
Outside Labs_____
Deductible
No _____Yes ____Amount_____Collect Before or After Service?_____
CDHP Plan?
No _____Yes ____Amount_____Collect Before or After Service?_____
Coinsurance
No _____Yes____Amount_____Collect Before or After Service?_____
Excluded Services Collect Before or After Service?_____

CLAIMS
Electronic Payer ID: _____
Paper Claims to:

Timely Filing: _____

FIGURE 8.8 Plan Summary Grid

THINKING IT THROUGH 8.9

1. Audit the private-payer primary claim shown in Figure 8.10. What problems do you find in the preparation of the claim? List the item number and the problem or question you would raise.

	Item No.	Problem/Question
A.		
B.		
C.		
D.		
E.		
F.		
G.		

8.10 Capitation Management

When the practice has a capitated contract, careful attention must be paid to patient eligibility, referral requirements, encounter reports, claim write-offs, and billing procedures.

Patient Eligibility

Under most capitated agreements with primary care physicians, providers receive monthly payments that cover the patients who chose them as their PCPs for that month. The **monthly enrollment list** that the plan sends with the payment should list the current members. This list, also called a *provider patient listing* or *roster*, contains patients' names, identification numbers, dates of birth, type of plan or program, and effective date of registration to the PCP.

monthly enrollment list document of eligible members of a capitated plan for a monthly period

At times, however, the list is not up-to-date. To be sure that the patient is eligible for services, the insurance coverage is always verified.

Referral Requirements

An HMO may require a PCP to refer a patient to an in-network provider or to get authorization from the plan to refer a patient to an out-of-network provider. Patients who self-refer to nonparticipating providers may be balance-billed for those services. Both PCPs and specialists may be required to keep logs of referral activities.

Encounter Reports and Claim Write-Offs

Most HMOs require capitated providers to submit encounter reports for patient encounters. Some do not require regular procedural coding and charges on the reports; the payer's form may just list "office visit" to be checked off. However, some plans do require the use of a regular claim with CPT codes.

The PMP is set up so that charges for service under capitated plans are written off as an adjustment to the patient's account. The billing staff knows not to expect additional payment based on a claim for a capitated-plan patient. If the service charges were not written off, the PMP would double-count the revenue for these patient encounters—once at the beginning of the month when the capitated payment was entered for a patient, and then again when a claim was created for a patient who has had an encounter during the month. Thus, the regular charges for the services that are included in the cap rate are written off by the biller. Only the monthly capitated payment remains on the patient's account—unless the patient has incurred charges beyond those items.

To avoid major problems, many practices routinely meet with payers to address the practice's specific problems and questions. A meeting should also be held when a new participation contract is signed to discuss the payer's major guidelines, fee schedule, and medical record documentation requirements.

HEALTH INSURANCE CLAIM FORM

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☒ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): AETNA WORLD PLAN

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BELLINI, JIMMY

3. PATIENT'S BIRTH DATE: 03 | 04 | 2018 M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): BELLINI, GEORGE, I

5. PATIENT'S ADDRESS (No., Street): 4144 BARKER AVE

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: JACKSONVILLE STATE: FL

8. RESERVED FOR NUCC USE

ZIP CODE: 35000 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 21B

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

9b. RESERVED FOR NUCC USE

9c. RESERVED FOR NUCC USE

9d. INSURANCE PLAN NAME OR PROGRAM NAME

10a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

10b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

10c. OTHER ACCIDENT? YES ☐ NO ☒

10d. CLAIM CODES (Designated by NUCC)

11a. INSURED'S DATE OF BIRTH: MM DD YY

SEX: M ☒ F ☐

11b. OTHER CLAIM ID (Designated by NUCC)

11c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA WORLD PLAN

11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, complete items 9, 9a and 9d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: George Bellini DATE: 03/15/2029

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP): MM DD YY QUAL.

15. OTHER DATE: QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: QUAL.

17a. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. Z00129 B. Z23 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID.
1	03 15 2029				99382		A	132 00	1		NPI	1212343456
2	03 15 2029				90707		B	82 00	1		NPI	1212343456
3	03 15 2029				90700		B	70 00	1		NPI	1212343456
4	03 15 2029				90471		B	20 00	1		NPI	1212343456
5	03 15 2029				90472		B	20 00	1		NPI	1212343456
6											NPI	

25. FEDERAL TAX ID NUMBER: 234809186 SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: BEIZO

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE: $ 314 00

29. AMOUNT PAID: $ 15 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: SOF DATE:

32. SERVICE FACILITY LOCATION INFORMATION: a. b.

33. BILLING PROVIDER INFO & PH # (555) 9121122

FAMILY GROUP HEALTH
JACKSONVILLE FL 32034

a. 8876427755 b.

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

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FIGURE 8.10 Claim for Thinking It Through 8.9

HEALTH INSURANCE CLAIM FORM

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☒ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): GHJ31240789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): CARUTHERS, ROBIN

3. PATIENT'S BIRTH DATE: MM 03 DD 29 YY 1996 SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 167 CHEVY LANE

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: CLEVELAND STATE: OH

ZIP CODE: 44101 TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒ b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State) c. OTHER ACCIDENT? YES ☐ NO ☒

11. INSURED'S POLICY GROUP OR FECA NUMBER: OH4071

11a. INSURED'S DATE OF BIRTH: MM 03 DD 29 YYYY 1996 SEX: M ☐ F ☒

9a. OTHER INSURED'S POLICY OR GROUP NUMBER:

9b. RESERVED FOR NUCC USE:

9c. RESERVED FOR NUCC USE:

9d. INSURANCE PLAN NAME OR PROGRAM NAME:

11b. EMPLOYER'S OR SCHOOL NAME:

11c. INSURANCE PLAN NAME OR PROGRAM NAME: ANTHEM BCBS PPO

10d. CLAIM CODES (Designated by NUCC):

11d. IS there another health benefit plan? YES ☐ NO ☒ If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: SOF DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: SOF

14. DATE OF CURRENT: ILLNESS (First symp.) OR INJURY (Accident) OR PREGNANCY (LMP): MM DD YY QUAL.

15. OTHER DATE: QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a. QUAL.

17b. NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)): ICD Ind. 0

A. 14891 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE: From MM DD YY To MM DD YY B. Place of Service C. Emergency D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) HCPCS MODIFIER E. DIAGNOSIS POINTER F. $ CHARGES G. Days or Units H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #

1	09 28 2029		11	99213		A	62 00	1		NPI	8877365552
2	09 28 2029		11	93000		A	70 00	1		NPI	8877365552
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 161234567 SSN EIN ☒

26. PATIENT'S ACCOUNT NO.: AA003

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 132 00

29. AMOUNT PAID: $ 15 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): SIGNED: SOF DATE:

32. SERVICE FACILITY LOCATION INFORMATION: a. b.

33. BILLING PROVIDER INFO & PHONE #: (555) 9670303
CHRISTOPHER CONNOLLY MD
1400 WEST CENTER ST
TOLEDO OH 43610112
a. 1286927799 b.

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CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

FIGURE 8.9 CMS-1500 (02/12) Completion for Private Payer, Solo Practitioner

Communications with Payers

Good communication between payers and the medical insurance staff is essential for effective contract and claim management. As claims are processed, questions and requests for information go back and forth between the practice staff and the payer's claim processing group. When claims are long overdue or there are repeated difficulties, however, these problems are the responsibility of the payer's provider representatives.

- Deductibles, especially in CDHPs
- Payment for noncovered services
- Balance due from previous encounters

Apply collected payments to the patient's account and provide a receipt for payment.

BILLING TIP

Payer Instructions May Vary

The NUCC instructions do not address any particular payer. Best practice for paper claims is to check with each payer for specific information required on the form.

Step 7. Prepare and Transmit Claims

Participating providers submit claims to payers on behalf of patients; nonparticipating providers may elect to do this as well. Private payer claims are completed using either the HIPAA 837P claim or the CMS-1500 paper claim. CMS-1500 general completion guidelines are described in Table 7.2 and shown in Figure 8.9. Claims must be submitted according to the plan's guidelines for timely filing. The filing deadline is based on the date of service on the claim, not the sent or received date.

BILLING TIP

Audits

Internal claim audits before transmission are the best way to check claims. During this review, a staff member other than the claim preparer checks the claim's coding and billing compliance for the payer.

Following are some claim preparation tips:

- *Taxonomy codes:* The participation contract may state that certain specialties receive higher rates for various procedures. For example, if a pediatrician is board certified in pediatric cardiology, the correct taxonomy code—either for pediatrician or for pediatric cardiology—would be reported with the associated service.
- *Identifying numbers:* Supply the appropriate NPIs and check with the payer for any other required numbers.
- *Contract information:* The participation contract may require a contract-type code, contract amount, contract percent, contract code, discount percent, or contract version identifier.
- *Description of services for modifiers 22 and 23:* Many plans require a complete description of the services including supporting documentation when these modifiers are used.

The plan's claim submission guidelines are also followed. Contact the payer representative to clarify the procedure for claim attachments or other points.

(Note: Steps 8, 9, and 10 are covered in Chapters 13 and 14.)

BILLING TIP

Secondary Claims and Coordination of Benefits

In covering steps 8, 9, and 10 of the revenue cycle, Chapters 13 and 14 discuss processing RAs/EOBs, secondary claims, coordination of benefits, and appeals for private payers.

20. **LO 8.3** Providers who participate in a PPO are paid
   A. a capitated rate
   B. a discounted fee-for-service
   C. an episode-of-care payment
   D. according to their usual physician fee schedule

21. **LO 8.2** Under a capitated HMO plan, the physician practice receives
   A. an encounter report
   B. precertification for services
   C. a monthly enrollment list
   D. a secondary insurance identification number

22. **LO 8.6** What document is researched to uncover rules for private payers' definitions of insurance-related terms?
   A. ERISA
   B. participation contract
   C. HIPAA Security Rule
   D. rider

23. **LO 8.3** CDHPs have what effect on a practice's cash flow?
   A. A high-deductible payment from the patient takes longer to collect than does a copayment.
   B. The health plan's payment arrives faster than under other types of plans.
   C. There is no effect on cash flow.
   D. The effect is the same as the effect of a capitated plan.

Provide the correct response to the following items.

24. **LO 8.6** List the five main parts of participation contracts.

25. **LO 8.9** List the seven steps of the revenue cycle that lead to completion of correct private payer claims.

Applying Your Knowledge

Case 8.1 Abstracting Insurance Information

LO 8.7, 8.8 Based on the following notes, fill out the precertification form for Betty Sinowitcz.

Encounter Data: 5/4/2029
Patient: Elizabeth R. Sinowitcz
Date of Birth: 8/2/1954
Address: 45 Maple Hill Road, Apt. 12-B, Rangeley, MN 55555
Home Telephone: 555-123-9887
Employer: Argon Electric Company, 238 Industry Way, Rangeley, MN 55554

Betty is on Medicare. She also has insurance coverage through Argon Electric in the Horizon PPO. Her insurance card shows her member number as 65-PO; no group number is shown.

Betty was referred to Dr. Hank R. Ferrara, a Horizon-participating ophthalmologist (PIN 349-00-G), for evaluation of her blurred and dimmed vision. After conducting an examination and taking the necessary history, Dr. Ferrara diagnoses the patient's condition as a cortical age-related cataract of the left eye that is close to mature (ICD-10-CM H25.012). Dr. Ferrara decides to schedule Betty for lens extraction; the procedure is ambulatory care surgery with

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Review Questions

Match the key terms with their definitions.

1. **LO 8.10** monthly enrollment list
2. **LO 8.7** precertification
3. **LO 8.1** rider
4. **LO 8.3** high-deductible health plan
5. **LO 8.1** carve out
6. **LO 8.7** utilization review organization
7. **LO 8.8** plan summary grid
8. **LO 8.4** host plan
9. **LO 8.6** stop-loss provision
10. **LO 8.7** elective surgery
11. **LO 8.5** metal plans
12. **LO 8.2** subcapitation
13. **LO 8.9** repricer

A. Payer preauthorization for elective hospital-based services and outpatient surgeries

B. Insurance plan, usually a PPO, that requires a large amount to be paid before benefits begin; part of a CDHP

C. Quick-reference table for health plans

D. Part of a standard health plan that is changed under a negotiated employer-sponsored plan

E. Document of eligible members of a capitated plan registered with a particular PCP for a monthly period

F. Document that modifies an insurance contract

G. Surgical procedure that can be scheduled in advance

H. In a BlueCard program, the provider's local BCBS plan

I. A company hired by a payer to evaluate the appropriateness and medical necessity of hospital-based healthcare services

J. Contractual guarantee against a participating provider's financial loss due to an unusually large demand for high-cost services

K. Arrangement by which a capitated provider prepays an ancillary provider

L. A vendor that processes a payer's out-of-network claims

M. Term for the new designs of health plans created by the ACA

Select the answer choice that best completes the statement or answers the question.

14. **LO 8.1** The largest employer-sponsored health program in the United States is
    - **A.** Medicare
    - **B.** Medicaid
    - **C.** Federal Employees Health Benefits program
    - **D.** workers' compensation

15. **LO 8.1** In employer-sponsored health plans, employees may choose their plan during the
    - **A.** carve out
    - **B.** open enrollment period
    - **C.** contract period
    - **D.** birthday rule period

16. **LO 8.1** Which laws govern the portability of health insurance?
    - **A.** ERISA and HIPAA
    - **B.** COBRA and HIPAA
    - **C.** PPO and HMO
    - **D.** FEHB and ERISA

17. **LO 8.1** Self-funded health plans are regulated by
    - **A.** PHI
    - **B.** PPO
    - **C.** FEHB
    - **D.** ERISA

18. **LO 8.4** BlueCross BlueShield Association member plans offer
    - **A.** all major types of health plans
    - **B.** indemnity plans only
    - **C.** PPOs only
    - **D.** HMOs only

19. **LO 8.7** Emergency surgery usually requires
    - **A.** a deductible paid to the hospital or clinic
    - **B.** precertification (preauthorization) within a specified time after the procedure
    - **C.** a referral before the procedure
    - **D.** a maximum benefit limit

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Learning Outcomes	Key Concepts/Examples
8.5 Compare the four ACA metal plans.	• The Patient Protection and ACA of 2010 introduced numerous changes to improve healthcare, including providing affordable individual health plans and developing private health insurance exchanges. • The ACA created four new metal plans to cover insurance expenses, ranging in quality from bronze, silver, gold, and platinum.
8.6 Analyze the purpose of the five main parts of participation contracts.	Participation contracts have five main parts: 1. The introductory section provides the names of the parties to the agreement, contract definitions, and the payer. 2. The contract purpose and covered medical services section lists the type and purpose of the plan and the medical services it covers for its enrollees. 3. The third section covers the physician's responsibilities as a participating provider. 4. The fourth section covers the plan's responsibilities to the participating provider. 5. The fifth section lists the compensation and billing guidelines, such as fees, billing rules, filing deadlines, patients' financial responsibilities, and coordination of benefits.
8.7 Describe the information needed to collect copayments and bill for surgical procedures under contracted plans.	• Under participation contracts, most plans require copayments to be subtracted from the usual fees that are billed to the plans. • To bill for elective surgery requires precertification (also commonly called *preauthorization*) from the plan. • Providers must notify plans about emergency surgery within the specified timeline after the procedure.
8.8 Discuss the use of plan summary grids.	• Plan summary grids list key information about each contracted plan and provide a shortcut reference for the billing and reimbursement process. • Grids include information about collecting payments at the time of service and completing claims.
8.9 Prepare accurate private payer claims.	These seven steps of the revenue cycle are followed to prepare correct claims: 1. The general guidelines apply to the preregistration process for private health plan patients when basic demographic and insurance information is collected. 2. The financial responsibility for the visit is established by verifying insurance eligibility and coverage with the payer for the plan, coordinating benefits, and meeting preauthorization requirements. 3. Copayments are collected before the encounter. 4. Coding compliance is checked, verifying the use of correct codes as of the date of service that show medical necessity. 5. Billing compliance with the plan's rules is checked. 6. Any other payments due at the end of the encounter, such as deductible, charges for noncovered services, and balances due, are collected according to the practice's financial policy. 7. Claims are completed, checked, and transmitted in accordance with the payer's billing and claims guidelines.
8.10 Explain how to manage billing for capitated services.	• Under capitated contracts, medical insurance specialists verify patient eligibility with the plan because enrollment data are not always up-to-date. • Encounter information, whether it contains complete coding or just diagnostic coding, must accurately reflect the necessity for the provider's services.

Billing for Excluded Services

Under a capitated contract, providers bill patients for services not covered by the cap rate. Medical insurance specialists need to organize this information for billing. For example, a special encounter form for the capitated plan might list the CPT codes covered under the cap rate and then list the CPT codes that can be billed. The plan's summary grid should indicate the plan's payment method for the additional services to be balance-billed, such as discounted fee-for-service.

THINKING IT THROUGH 8.10

1. Refer to the description of services covered under a PCP's cap rate. Under this agreement, would the provider be permitted to bill the patient for a flu shot? A Pap test? A PSA test?

Chapter 8 Summary

Learning Outcomes	Key Concepts/Examples
8.1 Describe the major features of group health plans regarding eligibility, portability, and required coverage.	Group health plans: • Establish and regulate health plans for employees. • Decide on basic plan coverage and optional riders; eligibility requirements; and premiums and deductibles. • Must observe federal COBRA and HIPAA laws to ensure portability and coverage as required.
8.2 Discuss provider payment under the various private payer plans.	• Preferred provider organizations (PPOs) pay providers under a discounted fee-for-service structure. • In health maintenance organizations (HMOs) and point-of-service (POS) plans, the payment may be a salary or capitated rate, depending on the business model. • Indemnity plans basically pay from the physician's fee schedule.
8.3 Contrast health reimbursement accounts, health savings accounts, and flexible savings (spending) accounts.	Consumer-driven health plans use three types of funding options for out-of-pocket expenses: • A health reimbursement account (HRA) is set up by an employer to give tax-advantaged funds for employees' expenses. • Health savings accounts (HSAs) and flexible savings (spending) accounts (FSAs) both can be funded by employees and employers on a tax-advantaged basis. • HSA funds can be rolled over and taken by the individual to another job or into retirement, like an IRA; FSAs do not roll over.
8.4 Discuss the major private payers.	A small number of large insurance companies dominate the national market: • Anthem • UnitedHealth Group • Aetna • CIGNA Health Care • Kaiser Permanente • Humana, Inc. BlueCross BlueShield Association (BCBS): • BCBS is the national organization of independent companies called *member plans* that insure nearly 100 million people. • BCBS offers the BlueCard program and the Flexible Blue plan.

B. Based on the following patient and encounter information, complete a claim for the patient.

Information About the Patient:

Name	Gwen Remarkey
Sex	F
Birth Date	11/05/1979
Marital Status	Married
Address	9 Sealcrest Dr Brooklyn, OH 44144-6789
Telephone	555-628-9791
Employer	Brooklyn Day Care
Race	White
Ethnicity	Not Hispanic or Latino
Preferred Language	English
Insured	Self
Health Plan	Aetna Choice
Insurance ID Number	BP3333-X89
Policy Number	96248
Group Number	152535C
Copayment/Deductible Amt.	$15 copay
Assignment of Benefits	Y
Signature on File	01/01/2029
Condition Unrelated to Employment, Auto Accident, or Other Accident	

VALLEY ASSOCIATES, PC
David Rosenberg, MD - Dermatology
555-967-0303
NPI 1288560027

PATIENT NAME	APPT. DATE/TIME
Remarkey, Gwen	10/11/2029 11:30 am
CHART NO.	**DX**
A1030	1. L03.030 chronic paronychia, right big toe 2. 3. 4.

DESCRIPTION	✓	CPT	FEE	DESCRIPTION	✓	CPT	FEE
OFFICE VISITS				**PROCEDURES**			
New Patient				Acne Surgery			
LI Problem Focused				I&D, Abscess, Smpl			
LII Expanded				I&D, Abscess, Mult			
LIII Detailed				I&D, Pilonidal Cyst, Smpl			
LIV Comp./Mod.				I&D, Pilonidal Cyst, Compl			
LV Comp./High				I&R, Foreign Body, Smpl			
Established Patient				I&R, Foreign Body, Compl			
LI Minimum				I&D Hematoma			
LII Problem Focused	✓	99212	46	Puncture Aspiration			
LIII Expanded				Debride Skin, To 10%			
Requested P				Remove Skin T			

A. Based on the following patient and encounter information, complete a claim for the patient.

Information About the Patient:

Name	David Belline
Sex	M
Birth Date	01/22/1968
Marital Status	Married
Address	250 Milltown Rd. Alliance, OH 44601-3456
Telephone	555-627-1535
Employer	Kinko's
Race	White
Ethnicity	Not Hispanic or Latino
Preferred Language	English
Insured	Self
Health Plan	Anthem BCBS PPO
Insurance ID Number	35Z29005
Policy Number	87526
Group Number	162537B
Copayment/Deductible Amt.	$20 copay
Assignment of Benefits	Y
Signature on File	06/01/2029
Condition Unrelated to Employment, Auto Accident, or Other Accident	

VALLEY ASSOCIATES, PC
David Rosenberg, MD - Dermatology
555-967-0303
NPI 1288560027

PATIENT NAME	APPT. DATE/TIME
Belline, David R.	10/11/2029 1000 am
CHART NO.	**DX**
AA002	1. E11.9 Type 2 Diabetes mellitus without complications 2. 3. 4.

DESCRIPTION	✓	CPT	FEE	DESCRIPTION	✓	CPT	FEE
OFFICE VISITS				**PROCEDURES**			
New Patient				Acne Surgery			
LI Problem Focused				I&D, Abscess, Smpl			
LII Expanded				I&D, Abscess, Mult			
LIII Detailed				I&D, Pilonidal Cyst, Smpl			
LIV Comp./Mod.				I&D, Pilonidal Cyst, Compl			
LV Comp./High				I&R, Foreign Body, Smpl			
Established Patient				I&R, Foreign Body, Compl			
LI Minimum				I&D Hematoma			
LII Problem Focused				Puncture Aspiration			
LIII Expanded				Debride Skin, TO 10%			
LIV Detailed				Each Addl 10%			
LV Comp./High				Pare Benign Skin Lesion			
				Pare Benign Skin Lesion, 2-4			
CONSULTATION: OFFICE/OP				Pare Benign Skin Lesion, 4+			
Requested By:				Skin Biopsy, Single Les.			
LI Problem Focused				Skin Biopsy, Multi Les.			
LII Expanded				Remove Skin Tags, 1-15			
LIII Detailed				Remove Skin Tags, Addl 10			
LIV Comp./Mod.				Trim Nails			
LV Comp./High				Debride Nails, 1-5			
				Debride Nails, 6+			
CARE PLAN OVERSIGHT				Avulsion of Nail Plate, 1	✓	11730	107
Supervision, 15-29 min.				Avulsion of Nail Plate, Addl 1			
Supervision, 30+ min.				Nail Biopsy			
				Repair Nail Bed			
				Excision, Ingrown Toenail			

B. Using this fee schedule for three different payers for orthopedic procedures, complete the questions that follow.

Code	Description	BCBS	United	Medicare
29871	Knee arthroscopy, surgical; for infection, lavage, and drain	$ 908.95	$1,179.12	$485.06
29876	Knee arthroscopy, surgical; major synovectomy	$1,097.78	$1,356.58	$584.21
29877	Knee arthroscopy, surgical; debridement	$1,031.60	$1,240.64	$549.58
29880	Knee arthroscopy, surgical; with meniscectomy, medial AND lateral	$1,167.23	$1,385.82	$621.21
29881	Knee arthroscopy, surgical; with meniscectomy, medial OR lateral	$1,080.44	$1,292.96	$575.04

1. **LO 8.4-8.7** A patient with BCBS PPO coverage had surgical knee arthroscopy with medial and lateral meniscectomy. The plan has an 80-20 coinsurance with no copayment for surgical procedures. The annual deductible has been met. What will the plan pay, and what amount does the patient owe?
2. **LO 8.4-8.7** A United patient has a high-deductible plan with a $1,200 deductible for this year that has not been met and 75-25 coinsurance. He has surgical knee arthroscopy with debridement. What will the plan pay, and what amount does the patient owe?
3. **LO 8.4-8.7** Another payer offers the practice a contract based on 115 percent of the Medicare Fee Schedule. What amounts are offered for the codes above?

Case 8.4 Completing Correct Claims

connect Go to http://connect.mheducation.com to complete this exercise.

LO 8.2, 8.6–8.8 The objective of these exercises is to correctly complete private payer claims, applying what you have learned in the chapter. Following the information about the provider for the cases are two sections. The first section contains information about the patient, the insurance coverage, and the current medical condition. The second section is an encounter form for Valley Associates, PC.

Data from the first section, the patient information form, have already been entered in the program for you. You must enter information from the second section, the encounter form, to complete the claim. If you are instructed to use the simulation in Connect, follow the steps at the book's website, **www.mhhe.com/valerius** to complete the cases at **http://connect.mheducation.com** on your own once you have watched the demonstration and tried the steps with prompts in practice mode.

If you are gaining experience by completing a paper CMS-1500 claim form, use the blank claim form supplied to you from the back of the book and follow the instructions to fill in the form by hand. Alternatively, your instructor may assign the CMS-1500 exercises through Connect, where you can complete the form electronically and submit it to your instructor as part of an assignment.

The following provider information, which is also preloaded in the database, should be used for Cases 8.4A and 8.4B.

Billing Provider Information

Name	Valley Associates, PC
Address	1400 West Center Street Toledo, OH 43601-0213
Telephone	555-967-0303
Employer ID Number	16-1234567
NPI	1476543215

Rendering Provider Information

Name	David Rosenberg, M.D.
NPI	1288560027
Assignment	Accepts
Signature	On File (1-1-2029)

Assume that all patient copayments are made at the time of the office visit.

same-day admission and discharge. The procedure will be done at Mischogie Hospital's Outpatient Clinic on 5/10/2029. Horizon PPO requires precertification for this procedure (CPT 66984).

Case 8.2 Applying Insurance Rules

Jan Wommelsdorf of Fargo, North Dakota, was on vacation in Portland, Oregon, when she became ill. She has BCBS BlueCard insurance, so she telephoned the BlueCard toll-free number to find a provider near her in Portland. She was examined by Dr. Vijay Sundaram and provided a special diet to follow until she returns home and visits her regular physician.

A. **LO 8.4** Who submits the claim, Jan Wommelsdorf or Dr. Sundaram?

B. **LO 8.4** Is the claim submitted to Jan's local BCBS plan in North Dakota or to Dr. Sundaram's local plan in Oregon?

Case 8.3 Calculating Insurance Math

A. A physician's usual fee for a routine eye examination is $80. Under the discounted fee-for-service arrangement the doctor has with Plan A, the fee is discounted 15 percent for Plan A members. This month, the doctor has seen five Plan A members for routine eye exams.

1. **LO 8.6, 8.7** What is the physician's usual fee for the five patients?
2. **LO 8.6, 8.7** What will the physician be paid for one Plan A member's exam?
3. **LO 8.6, 8.7** What will the physician be paid for the five Plan A eye exams?

PRECERTIFICATION FORM

Insurance carrier _____

Certification for [ ] admission and/or [ ] surgery and/or [ ] _____

Patient name _____

Street address _____

City/State/ZIP _____

Telephone _____ Date of birth _____

Subscriber name _____

Employer _____

Member no. _____ Group no. _____

Admitting physician _____

Provider no. _____

Hospital/facility _____

Planned admission/procedure date _____

Diagnosis/symptoms _____

Treatment/procedure _____

Estimated length of stay _____

Complicating factors _____

Second opinion required [ ] Yes [ ] No If yes, [ ] Obtained

Corroborating physician _____

Insurance carrier representative _____

Approval [ ] Yes [ ] No If yes, certification no. _____

If no, reason(s) for denial _____

BENEFIT MATRIX		
FEMALE PATIENT AGE GROUP	**IN NETWORK**	**OUT OF NETWORK**
35–39 One baseline screening	No charge	20 percent per visit after deductible
40–49 One screening every two years, or more if recommended	No charge	20 percent per visit after deductible
50 and older One screening every year	No charge	10 percent per visit after deductible

- *Initial processing:* The payer's initial claim processing checks that the patient for whom a screening mammogram is reported is a female over age thirty-five.
- *Automated review:* The payer's edits reflect its payment policy for female patients in each of the three age groups. If a claim reports a single screening mammogram for a forty-five-year-old in-network patient within a twenty-four-month period, it passes the edit. If the claim contains two mammograms in fewer than twenty-four months, the edit would flag the claim for manual review by the claims examiner.
- *Manual review:* If two mammograms are reported within a two-year period for a patient in the forty- to forty-nine-year age range, the claims examiner would require documentation that the extra procedure was recommended and then review the reason for the recommendation. If an X-ray is included as a claim attachment, the claims examiner would probably ask a staff medical professional to evaluate the patient's condition and judge the medical necessity for the extra procedure.

BILLING TIP

Medical Necessity Denials

Understand payers' regulations on medical necessity denials. When claims are denied for lack of medical necessity, fees often cannot be recovered from patients. For example, the participation contract may prohibit balance billing when a claim is denied for lack of medical necessity unless the patient agreed in advance to pay.

Determination

For each service line on a claim, the payer makes a payment **determination**—a decision whether to (1) pay it, (2) deny it, or (3) pay it at a reduced level. If the service falls within normal guidelines, it will be paid. If it is not reimbursable, the item on the claim is denied. If the examiner determines that the service was at too high a level for the diagnosis, a lower-level code is assigned. When the level of service is reduced, the examiner has downcoded the service (see also the chapter on visit charges and compliant billing). A **medical necessity denial** may result from a lack of clear, correct linkage between the diagnosis and procedure. A medical necessity denial can also result when a higher level of service was provided without first trying a lower, less invasive procedure. Some payers or policies require a patient to fail less invasive or more conservative treatment before more intense services are covered.

determination payer's decision about the benefits due for a claim

medical necessity denial refusal by a plan to pay for a procedure that does not meet its medical necessity criteria

Payment

If payment is due, the payer sends it to the provider along with a **remittance advice (RA)** or an electronic remittance advice (ERA), a transaction that explains the payment decisions to the provider. In most cases, if the claim has been sent electronically, this transaction is also electronic, but it may sometimes be paper. The **HIPAA X12 835 Health Care Payment and Remittance Advice (HIPAA 835)** is the HIPAA-mandated electronic transaction for payment explanation. An older term that now usually refers to the document a beneficiary receives is **explanation of benefits (EOB)**. EOBs are typically paper documents that are mailed, but electronic transmission via e-mail is increasing. When the general term RA is used in this text, it means both formats.

remittance advice (RA) document describing a payment resulting from a claim adjudication

HIPAA X12 835 Health Care Payment and Remittance Advice (HIPAA 835) electronic transaction for payment explanation

explanation of benefits (EOB) document showing a beneficiary how the amount of a benefit was determined

BILLING TIP

Medicare Claims

Medicare must process "other-than-clean" claims—those that require investigation before payment—within forty-five calendar days of receipt. Clean electronic claims are paid within fourteen days.

4. *Duplicate dates of service:* Is the claim billing for a service on the same date that has already been adjudicated?
5. *Noncovered services:* Are the billed services covered under the patient's policy?
6. *Valid code linkages:* Are the diagnosis and procedure codes properly linked for medical necessity?
7. *Bundled codes:* Have surgical code bundling rules and global periods been followed?
8. *Medical review:* Are there charges for services that are not medically necessary or that exceed the frequency limits of the plan? The payer's medical director and other professional medical staff have a medical review program to ensure that providers give patients the most appropriate care in the most cost-effective manner. The basic medical review edits that are done at this stage are based on the review program's guidelines.
9. *Utilization review:* Are the hospital-based healthcare services appropriate? Are days that services are authorized consistent with services and dates billed?
10. *Concurrent care:* If concurrent care is being billed, was it medically necessary?

concurrent care medical assistance given to a patient who receives independent care from two or more physicians on the same date

Concurrent care refers to extensive independent medical care that the patient receives from two or more providers on the same date of service. For example, both a nephrologist and a cardiologist would attend a hospitalized patient with kidney failure who has had a myocardial infarction. Instead of one provider working under the direction of another, such as the relationship between a supervising surgeon and an anesthesiologist, in concurrent care, each provider has an independent role in treating the patient. When two providers report services as attending physicians rather than as one attending and one consulting provider, a review is performed to determine whether the concurrent care makes sense given the diagnoses and the providers' specialties.

Manual Review

suspended claim status when the payer is developing the claim

development process of gathering information to adjudicate a claim

If the automated review identifies problems, the claim is **suspended** and set aside for **development**—the term payers use to indicate that more information is needed for claim processing. These claims are sent to the medical review department where a claims examiner reviews them. The examiner may ask the provider for clinical documentation to check:

- Where the service took place
- Whether the treatments were appropriate and a logical outcome of the facts and conditions shown in the medical record
- That services provided were accurately reported

Claims examiners are trained in the payer's payment policies, but they usually have little or no clinical medical background. When there is insufficient guidance on the point in question, examiners may have staff medical professionals—nurses or physicians—in the medical review department check it. This step is usually followed, for example, to review the medical necessity of an unlisted procedure.

Example

As an example, the following table shows the benefit matrix—a grid of benefits and policies—for a preferred provider organization's (PPO's) coverage of mammography.

COMPLIANCE GUIDELINE

Documentation Is Essential

If proper and complete documentation is not provided on time when requested during a manual review, claim denial or downcoding may result with the risk for an investigation or audit. Supply both the date-of-service record and any applicable patient or treatment information to support the facts that the service was provided as billed, was medically necessary, and has been correctly coded.

Claim follow-up and payment processing are important procedures in billing and reimbursement. Medical insurance specialists track claims that are due, process payments, check that claims are correctly paid, and file claims with secondary payers. These procedures help generate maximum appropriate reimbursement from payers for providers.

13.1 Claim Adjudication

When a payer receives claims, it issues an electronic response to the sender showing that the transmission has been successful. Each claim then undergoes a process known as *adjudication* (see the introductory chapter) made up of steps designed to judge how it should be paid:

1. Initial processing
2. Automated review
3. Manual review
4. Determination
5. Payment

Initial Processing

A payer's front-end claims processing system checks each claim's data elements. Paper claims and any paper attachments are date stamped and entered into the payer's computer system, either by data-entry personnel or by the use of a scanning system. Initial processing might find problems such as the following:

- The patient's name, plan identification number, or place of service code is wrong.
- The diagnosis code is missing or is not valid for the date of service.
- The patient is not the correct sex for a reported gender-specific procedure code.

The payer rejects claims with errors or simple mistakes and transmits instructions to the provider to correct errors and/or omissions and to rebill the service. The medical insurance specialist should respond to such a request as quickly as possible by supplying the correct information and, if necessary, submitting a clean claim that the payer accepts for processing.

BILLING TIP

Minor Errors on Transmitted Claims

When a practice finds or is notified about a minor error—such as a data-entry mistake or an incorrect place of service—it can usually be corrected by asking the payer to reopen the claim and make the changes.

Automated Review

After identifying problems, payers' computer systems apply edits that reflect their payment policies. For example, a Medicare claim is subject to the Correct Coding Initiative (CCI) edits (see the chapters about visit charges/compliant billing and Medicare). The automated review checks for the following:

1. *Patient eligibility for benefits:* Is the patient eligible for the services that are billed?
2. *Time limits for filing claims:* Has the claim been sent within the payer's time limits for filing claims? The time limit is generally between 90 and 180 days from the date of service.
3. *Preauthorization and/or referral:* Are valid preauthorization or referral numbers present as required under the payer's policies? Some authorizations are for specific dates or number of service, so these data will be checked, too.

BILLING TIP

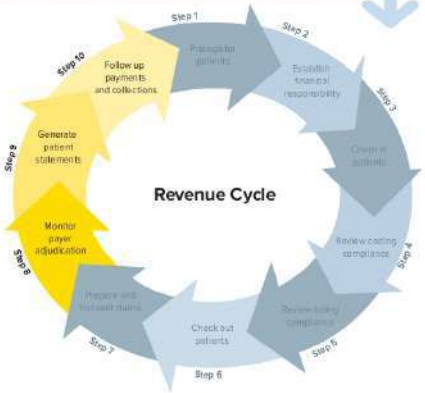
Proof of Timely Filing

- Payers may reduce payment for or deny claims filed after their deadline. Different payers may have different timelines; medical insurance specialists must be familiar with the rules of each payer. Usually, providers cannot bill patients if they have missed the payer's submission deadline.
- Practice management programs (PMPs) create a tamper-proof record of the filing date of every claim that can be used to prove timely filing.

13 PAYMENTS (RAs), APPEALS, AND SECONDARY CLAIMS

KEY TERMS

aging
appeal
appellant
autoposting
claim adjustment group code (CAGC)
claim adjustment reason code (CARC)
claimant
claim status category codes
claim status codes
claim turnaround time
concurrent care
determination
development
electronic funds transfer (EFT)
explanation of benefits (EOB)
grievance
HIPAA X12 835 Health Care Payment and Remittance Advice (HIPAA 835)
HIPAA X12 276/277 Health Care Claim Status Inquiry/Response (HIPAA 276/277)
insurance aging report
medical necessity denial
Medicare Outpatient Adjudication (MOA) remark codes
Medicare Redetermination Notice (MRN)
Medicare Secondary Payer (MSP)
overpayment
pending
prompt-pay laws
reassociation trace number (TRN)
reconciliation
redetermination
remittance advice (RA)
remittance advice remark code (RARC)
suspended



Learning Outcomes

After studying this chapter, you should be able to:

13.1 Explain the claim adjudication process.
13.2 Describe the procedures for following up on claims after they are sent to payers.
13.3 Interpret a remittance advice (RA).
13.4 Identify the points that are reviewed on an RA.
13.5 Explain the process for posting payments and managing denials.
13.6 Describe the purpose and general steps of the appeal process.
13.7 Assess how appeals, postpayment audits, and overpayments may affect claim payments.
13.8 Describe the procedures for filing secondary claims.
13.9 Discuss procedures for complying with the Medicare Secondary Payer (MSP) program.

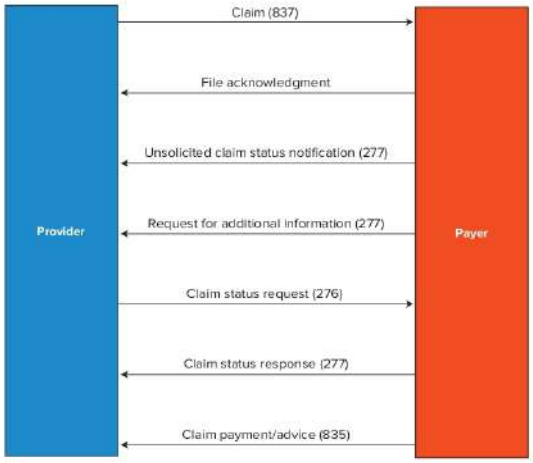


FIGURE 13.2 General Claim Status Request/Response Information Flow

Claim Status Category Codes and Claim Status Codes
www.wpc-edi.com

Table 13.1 Selected Claim Status Codes

1	For more detailed information, see remittance advice.
2	More detailed information in letter.
3	Claim has been adjudicated and is awaiting payment cycle.
4	This is a subsequent request for information from the original request.
5	This is a final request for information.
6	Balance due from the subscriber.
7	Claim may be reconsidered at a future date.
9	No payment will be made for this claim.
12	One or more originally submitted procedure codes have been combined.
15	One or more originally submitted procedure codes have been modified.
16	Claim/encounter has been forwarded to entity.
29	Subscriber and policy number/contract number mismatched.
30	Subscriber and subscriber ID mismatched.
31	Subscriber and policyholder name mismatched.
32	Subscriber and policy number/contract number not found.
33	Subscriber and subscriber ID not found.

HIPAA Health Care Claim Status Inquiry/Response

A medical insurance specialist examines the insurance aging report and selects claims for follow-up. Most practices follow up on claims that are aged less than thirty days in seven to fourteen days. The **HIPAA X12 276/277 Health Care Claim Status Inquiry/Response** is the standard electronic transaction to obtain information on the current status of a claim during the adjudication process. The inquiry is the **HIPAA 276,** and the response returned by the payer is the **HIPAA 277.** Figure 13.2 shows how this exchange is sent between provider and payer.

The HIPAA 277 transaction from the payer uses **claim status category codes** for the main types of responses:

- *A* codes indicate an acknowledgment that the claim has been received.
- *P* codes indicate that a claim is **pending;** that is, the payer is waiting for information before making a payment decision.
- *F* codes indicate that a claim has been finalized.
- *R* codes indicate that a request for more information has been sent.
- *E* codes indicate that an error has occurred in transmission; usually these claims need to be resent.

These codes are further detailed in **claim status codes,** as shown in Table 13.1.

HIPAA X12 276/277 Health Care Claim Status Inquiry/Response (HIPAA 276/277) standard electronic transaction to obtain information on the status of a claim

claim status category codes codes used on a HIPAA 277 to report the status group for a claim

pending claim status when the payer is waiting for information

claim status codes codes used on a HIPAA 277 to provide a detailed answer to a claim status inquiry

HIPAA Claim Status

The HIPAA Claim Status transaction is the 276/277 Health Care Claim Status Inquiry/Response.

Working with Payers

To have claims processed as quickly as possible, medical insurance specialists must be familiar with the payers' claim-processing procedures, including:

- The timetables for submitting corrected claims and for filing secondary claims. The latter is usually a period of time from the date of payment by the primary payer.
- How to resubmit corrected claims that are denied because of missing or incorrect data. Some payers have online or automated telephone procedures or special forms that can be used to resubmit claims after missing information has been supplied.
- How to handle requests for additional documentation if required by the payer.

Requests for information should be answered as quickly as possible, and the answers should be courteous and complete. Medical insurance specialists use correct terms to show that they understand what the payer is asking. For example, a payer often questions an office visit evaluation and management (E/M) service that is reported on the same date of service as a procedure or a preventive physical examination on the grounds that the E/M should not be reimbursed separately. Saying "well, the doctor did do both" is less persuasive than saying "the patient's presenting problems required both the level of E/M as indicated as well as the reported procedure; note that we attached the modifier 25 to indicate the necessity for this separate service."

A payer may fail to pay a claim on time without providing notice that the claim has problems, or the payer may miscalculate payments due. If the problem is covered in the participation contract, the recommended procedure is to send a letter pointing this out to the payer. This notice should be sent to the plan representative identified in the contract.

BILLING TIP

Prompt-Pay Laws for States

The websites of states' insurance commissions or departments cover their prompt-pay laws. Research the law in the state where claims are being sent to determine the payment time frames and the penalty for late payers.

BILLING TIP

Automated Claim Status Requests

Some medical billing programs can be set up to automatically track how many days claims have been unpaid and to send a claim status inquiry after a certain number of days. For example, if a particular payer pays claims on the twentieth day, the program transmits a 276 for unpaid claims aged day twenty-one.

Claim Turnaround Time

Just as providers have to file claims within a certain number of days after the date of service, payers also have to process clean claims within the **claim turnaround time.** The participation contract often specifies a time period of thirty to sixty days from claim submission. States have **prompt-pay laws** that obligate state-licensed carriers to pay clean claims for both participating and nonparticipating providers within a certain time period or incur interest penalties, fines, and lawyers' fees. Claims under Employee Retirement Income Security Act of 1974 (ERISA) (self-funded) plans must follow federal prompt-pay rules.

claim turnaround time time period in which a health plan must process a claim

prompt-pay laws state laws obligating carriers to pay clean claims within a certain time period

Aging

The other factor in claim follow-up is **aging**—essentially, how long a payer has had the claim. The PMP is used to generate an **insurance aging report** that lists the claims transmitted on each day and shows how long they have been in process with the payer. A typical report shown in Figure 13.1 lists claims that were sent fewer than thirty days earlier, between thirty and sixty days earlier, and so on.

aging classifying AR by length of time

insurance aging report report grouping unpaid claims transmitted to payers by the length of time they remain due

Valley Associates, P.C.

Primary Insurance Aging

As of: November 30, 2029

Date of Service	Procedure	Current 0 -	Past 31 - 60	Past 61 - 90	Past 91 - 120	Past 121 --->	Total Balance
Aetna Choice (AET00)							(555)777-1000
AA041 Walter Williams						SSN:401-26-9939	
Claim: 65 Initial Billing Date: 9/2/2029		*Last Billing Date: 9/2/2029*		*Policy: ABC103562239*		*Group: BDC1001*	
9/2/2029	99212			31.00			31.00
9/2/2029	93000			70.00			70.00
	Claim Totals:	0.00	0.00	101.00	0.00	0.00	101.00
	Insurance Totals:	0.00	0.00	101.00	0.00	0.00	101.00
Oxford Freedom (OXF00)							(555)688-1111
AA026 Jennifer Porcelli						SSN:712-34-0808	
Claim: 63 Initial Billing Date: 10/3/2029		*Last Billing Date: 10/3/2029*		*Policy: 712340808X*		*Group: G0119*	
10/3/2029	99211		15.00				15.00
	Claim Totals:	0.00	15.00	0.00	0.00	0.00	15.00
AA035 Josephine Smith						SSN:610-32-7842	
Claim: 64 Initial Billing Date: 10/6/2029		*Last Billing Date: 10/6/2029*		*Policy: 610327842X*		*Group: G0119*	
10/6/2029	99212		36.00				36.00
	Claim Totals:	0.00	36.00	0.00	0.00	0.00	36.00
	Insurance Totals:	0.00	51.00	0.00	0.00	0.00	51.00
Report Aging Totals		$0.00	$51.00	$101.00	$0.00	$0.00	$152.00
Percent of Aging Total		0.0 %	12.9 %	87.1 %	0.0 %	0.0 %	100.0 %

FIGURE 13.1 Example of an Insurance Aging Report

HIPAA 835

HIPAA 835 is the HIPAA-mandated electronic transaction for payment explanation.

THINKING IT THROUGH 13.1

1. A payer's utilization guidelines for preventive care and medical services benefits are shown here.

SERVICE	UTILIZATION
Pediatric: Birth–1 year 1–5 years 6–10 years 11–21 years	 Six exams Six exams One exam every two years One exam
Adult: 22–29 years 30–39 years 40–49 years 50+ years	 One exam every 5 years One exam every 3 years One exam every 2 years One exam every year
Vision Exam	Covered once every 24 months
Gynecological	Covered once every year
Medical Office Visit	No preset limit
Outpatient Therapy	60 consecutive days per condition/year
Allergy Services	Maximum benefit: 60 visits in 2 years

If a provider files claims for each of the following cases, what is the payer's likely response? (Research the CPT codes in the current CPT before answering.) Explain your answers. An example is provided.

PATIENT	AGE	CPT CODE	DOS	PAYER RESPONSE?
Case Example: Patient X	*45*	*99212*	*11/09/2029*	*Pay the claim because unlimited medical office visits are covered*
A. Guy Montrachez	25	92004	11/08/2029	
B. Carole Regalle	58	99385	12/04/2029	
C. Mary Hiraldo	25	99385 and 88150 88150	11/08/2029 12/10/2029	
D. George Gilbert	48	99386 99386	10/20/2028 11/02/2029	

13.2 Monitoring Claim Status

Practices closely track their accounts receivable (AR)—the money that is owed for services rendered—using a PMP. The AR is made up of payments due from payers (insurance AR) and from patients (patient AR). For this reason, after claims have been accepted for processing by payers, medical insurance specialists monitor their status.

Claim Status

Monitoring claims during adjudication requires two types of information. The first is the amount of time the payer is allowed to take to respond to the claim, and the second is how long the claim has been in process.

Table 13.2 Selected Claim Adjustment Reason Codes

1	Deductible amount.
2	Coinsurance amount.
3	Copayment amount.
4	The procedure code is inconsistent with the modifier used, or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Payment adjusted because the submitted authorization number is missing, is invalid, or does not apply to the billed services or provider.
16	Claim/service lacks information that is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury/illness and thus the liability of the workers' compensation carrier.
20	Claim denied because this injury/illness is covered by the liability carrier.
21	Claim denied because this injury/illness is the liability of the no-fault carrier.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
25	Payment denied. Your stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
29	The time limit for filing has expired.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Claim denied. Insured has no dependent coverage.
36	Balance does not exceed copayment amount.
37	Balance does not exceed deductible.
38	Services not provided or authorized by designated (network/primary care) providers.

(continued)

BILLING TIP

Patient Balance Billing

A group code PR with an associated reason code indicates whether a provider may or may not bill a beneficiary for the unpaid balance of the furnished services.

Glossary

The glossary section is the fourth area (see section 4 in Figure 13.3) of an RA. It lists the adjustment codes shown on the transaction with their meanings.

BILLING TIP

Code Updates

Claim adjustment reason codes and remark codes are updated three times each year. Access the website for updated lists.

Adjustments

An adjustment on the RA means that the payer is paying a claim or a service line differently than billed. The adjustment may be that the item is:

- Denied
- Zero pay (if accepted as billed but no payment is due)
- Reduced amount paid (most likely paid according to the allowed amount)
- Less because a penalty is subtracted from the payment

To explain the determination to the provider, payers use a combination of codes: (1) claim adjustment group code, (2) claim adjustment reason code, and (3) RA remark code. Each of these is a HIPAA administrative code set, such as place of service (POS) codes and taxonomy codes.

Claim Adjustment Group Codes

claim adjustment group code (CAGC) code used on an RA to indicate the general type of reason code for an adjustment

Claim adjustment group codes (group codes, abbreviated **CAGC**) are:

- *PR–Patient Responsibility:* Appears next to an amount that can be billed to the patient or insured. This group code typically applies to deductible and coinsurance/copayment adjustments.
- *CO–Contractual Obligations:* Appears when a contract between the payer and the provider resulted in an adjustment. This group code usually applies to allowed amounts. CO adjustments are not billable to patients under the contract.
- *CR–Corrections and Reversals:* Appears to correct a previous claim.
- *OA–Other Adjustments:* Used only when neither PR nor CO applies as when another insurance is primary.
- *PI–Payer Initiated Reduction:* Appears when the payer thinks the patient is not responsible for the charge but there is no contract between the payer and the provider that states this. It might be used for medical review denials.

Remittance Advice Remark Codes

www.wpc-edi.com/codes/remittanceadvice

Claim Adjustment Reason Codes

claim adjustment reason code (CARC) code used on an RA to explain why a payment does not match the amount billed

Payers use **claim adjustment reason codes** (reason codes, abbreviated **CARC**) to provide details about adjustments. Examples of these codes and their meanings are provided in Table 13.2.

Remittance Advice Remark Codes

remittance advice remark code (RARC) code that explains payers' payment decisions

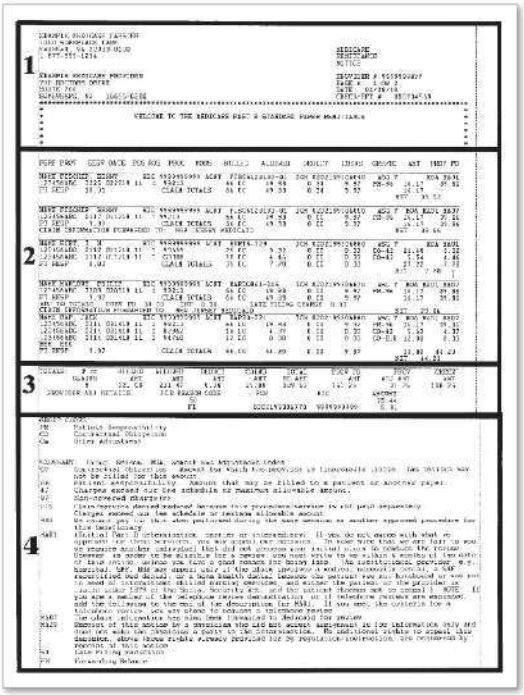
Medicare Outpatient Adjudication (MOA) remark codes codes that explain Medicare payment decisions

Payers may also use **remittance advice remark codes** (remark codes, **RARC**) for more explanation. Centers for Medicare and Medicaid Services (CMS) maintain remark codes that can be used by all payers. (Note that private payers usually maintain their own remittance advice codes, which can be located on their websites.) Codes that start with *M* are from a Medicare code set that was in place before HIPAA but that is still used, including **Medicare Outpatient Adjudication (MOA) remark codes.** Codes that begin with *N* are new. Table 13.3 shows selected remark codes.

PT RESP	Total amount that the beneficiary owes the provider for the claim
CLAIM TOTALS	Total amount for each of these columns: BILLED, ALLOWED, DEDUCT, COINS, AMT, and PROV PD
NET	Amount provider is paid for all the services for the claim

Totals

The third part (see section 3 in Figure 13.3) shows the totals for all the claims on the RA. At the end, the CHECK AMT field contains the amount of the check or EFT payment that the provider receives.



Claim Adjustment Reason Codes

www.wpc-edi.com/codes/claimadjustment

FIGURE 13.3 Sections of the RA

THINKING IT THROUGH 13.2

1. In Figure 13.1, are any of the accounts past due thirty-one to sixty days?

BILLING TIP

Other Names for RA

Payers have various names for the RA, including *explanation of benefits* and *explanation of payments*.

13.3 The RA

The RA summarizes the results of the payer's adjudication process. Whether sent electronically or in a paper format, the basic information in the transaction is the same, although the appearance of the documents is often different.

Content of RAs

An RA covers a group of claims, not just a single claim. The claims paid on a single RA are not consecutive or logically grouped; they are usually for different patients' claims and various dates of service. RAs list claims that have been adjudicated within the payment cycle alphanumerically by the patient account number assigned by provider, alphabetically by client name, or numerically by internal control number. A corresponding EOB sent to the beneficiary (usually the patient), on the other hand, lists just the information for the recipient.

RAs as shown in Figure 13.3 have four types of information, often located in separate sections: header information, claim information, totals, and a glossary (list of definitions for codes used on the form).

Header Information

The header information section (see section 1 in Figure 13.3) contains payer name and address; provider name, address, and National Provider Identifier (NPI); date of issue; and the check or electronic funds transfer (EFT) transaction number. There is a place for "bulletin board" information made up of notes to the provider.

Claim Information

For each claim, section 2 contains the patient's name, plan identification number, account number, and claim control number (CIN) and whether the provider accepts assignment (using the abbreviations ASG = Y or N) if this information applies. Under column headings, these items are shown:

Column Heading	*Meaning*
PERF PROV	Performing provider
SERV DATE	Date(s) of service
POS	Place of service code
NOS	Number of services rendered
PROC	current procedural terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) procedure code
MODS	Modifiers for the procedure code
BILLED	Amount provider billed for the service
ALLOWED	Amount payer allows
DEDUCT	Any deductible the beneficiary must pay to the provider
COINS	Any coinsurance the beneficiary must pay to the provider
GRP/RC	Group and reason adjustment codes
AMT	Amount of adjustments due to group and reason codes
PROV PD	Total amount provider is paid for the service

BILLING TIP

Medicare Allowed Amount

Medicare deductibles are applied from the Medicare allowed amount for a procedure/service, not the amount charged/billed by the provider.

billed on the same date of service as a procedure are always unpaid and should be appealed.

6. Decide whether any items on the RA need clarifying with the payer, and follow up as necessary.

THINKING IT THROUGH 13.4

1. Why is it important to double-check the data on the remittance advice?

BILLING TIP

Matching RAs and EFTs

Many payers transmit RAs and EFTs separately. The RA must be accessed online, printed, and matched with the appropriate EFT by the practice.

13.5 Procedures for Posting

Many practices that receive RAs authorize the payer to provide an **electronic funds transfer (EFT)** of the payment. Payments are deposited directly into the practice's bank account. Regulations under the Affordable Care Act (ACA) mandate a new healthcare funds transfer standard that requires a **reassociation trace number (TRN)** to appear on both the EFT and its ERA, so the documents are easy to match electronically. Otherwise, the payer sends a check to the practice, and the check is taken to the practice's bank for deposit.

COMPLIANCE GUIDELINE

Mandatory EFT Acceptance

The ACA mandates that federal payments to providers be sent only by electronic means.

electronic funds transfer (EFT) electronic routing of funds between banks

reassociation trace number (TRN) identifier that is passed from the payer to the payer's bank, then to the practice's bank, and finally to the practice

Posting and Applying Payments and Adjustments

Payment and adjustment transactions are entered in the PMP. The data entry includes:

- Date of deposit.
- Payer name and type.
- Check or EFT number.
- Total payment amount.
- Amount to be applied to each patient's account, including type of payment. Codes are used for payments, adjustments, deductibles, and other entries.

Some PMPs have an **autoposting** feature. Instead of posting payments manually, this feature automatically posts the payment data in the RA to the correct account. The software allows the user to establish posting rules, such as "post a payment automatically only if the claim is paid at 100 percent," so that the medical insurance specialist can examine claims that are not paid as expected.

autoposting software feature enabling automatic entry of payments on an RA

Reconciling Payments

The process of **reconciliation** means making sure that the totals on the RA check out mathematically. The total amount billed minus the adjustments (such as for allowed amounts and patient responsibility to pay) should equal the total amount paid. For example, study this report for an assigned claim:

reconciliation comparison of two numbers

POS	PROC MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
11	99213	85.00	57.87	0.00	11.57	CO-42 27.13	46.30

RECONCILIATION

Amount Billed	$85.00
(Coinsurance)	−11.57
(GRP/RC Amount)	−27.13
Payment	$46.30

In this case, the allowed amount (ALLOWED) of $57.87 is made up of the coinsurance (COINS) to be collected from the patient of $11.57 plus the amount the payer pays to the provider (PROV PD) of $46.30. The difference between the billed amount (BILLED) of $85.00 and the allowed amount of $57.87 is $27.13. This amount is written off unless it can be billed to the patient under the payer's rules.

THINKING IT THROUGH 13.3

1. Review the RA from Medicare for assigned claims shown in Figure 13.4, locating the highlighted claims that contain these data:
   - **A.** COINS $18.04
   - **B.** GRP/RC AMT PR-96 $162.13
     1. What does the adjustment code mean in the first claim?
     2. What do the adjustment codes mean in the second claim?
     3. In the second claim, the modifier GY is appended to the E/M code 99397. What does this modifier mean? Check the chapter about Medicare if necessary to interpret this information. Who is responsible for payment?

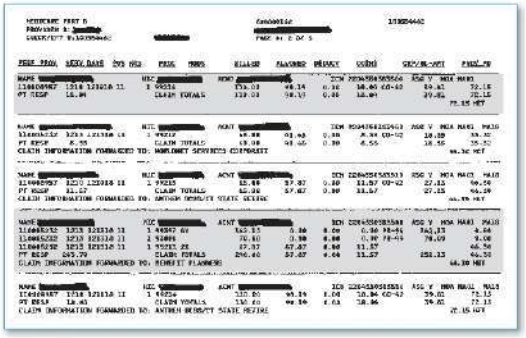


FIGURE 13.4 Medicare RA

13.4 Reviewing RAs

An RA repeats the unique claim control number that the provider assigned to the claim when sending it. As explained in the chapter on claim preparation, this claim control number is the resource needed to match the payment to a claim. To process the RA, each claim is located in the PMP—either manually or automatically by the computer system. The remittance data are reviewed and then posted to the PMP.

This procedure is followed to double-check the remittance data:

1. Check the patient's name, account number, insurance number, and date of service against the claim.
2. Verify that all billed CPT codes are listed.
3. Check the payment for each CPT code against the expected amount, which may be an allowed amount or a percentage of the usual fee. Many PMPs build records of the amount each payer has paid for each CPT code as the data are entered. When another RA payment for the same CPT code is posted, the program highlights any discrepancy for review.
4. Analyze the payer's adjustment codes to locate all unpaid, downcoded, or denied claims for closer review.
5. Pay special attention to RAs for claims submitted with modifiers. Some payers' claim processing systems automatically ignore modifiers so that E/M visits

BILLING TIP

Paper Check Processing

- Because payments may be mailed, the practice's mail should be opened daily and checks deposited according to the office's guidelines.
- All checks that come into the practice should be routed through the staff member who processes claims.

Table 13.2 Selected Claim Adjustment Reason Codes *(concluded)*

152	Payment adjusted because the payer deems that the information submitted does not support this length of service.
155	This claim is denied because the patient refused the service/procedure.
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.
A0	Patient refund amount.
AI	Claim denied charges.
B5	Claim/service denied/reduced because coverage guidelines were not met.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Payment denied because only one visit or consultation per physician per day is covered.
B15	Payment adjusted because this procedure/service is not paid separately.
B16	Payment adjusted because "new patient" qualifications were not met.
B18	Payment denied because this procedure code and modifier were invalid on the date of service.
B22	This payment is adjusted based on the diagnosis.
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.
D8	Claim/service denied. Claim lacks indicator that "X-ray is available for review."
D21	This (these) diagnosis(es) is (are) missing or invalid.
W1	Workers' Compensation State Fee Schedule adjustment.

Table 13.3 Selected Remark Codes

M11	DME, orthotics, and prosthetics must be billed to the DME carrier who services the patient's ZIP code.
M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.
M37	Service not covered when the patient is under age 35.
M38	The patient is liable for the charges for this service, as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
M39	The patient is not liable for payment for this service, as the advance notice of noncoverage you provided the patient did not comply with program requirements.
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
N15	Services for a newborn must be billed separately.
N16	Family/member out-of-pocket maximum has been met. Payment based on a higher percentage.
N210	You may appeal this decision.
N211	You may not appeal this decision.

Table 13.2 Selected Claim Adjustment Reason Codes *(continued)*

39	Services denied at the time authorization/precertification was requested.
40	Charges do not meet qualifications for emergency/urgent care.
41	Discount agreed to in preferred provider contract.
42	Charges exceed our fee schedule or maximum allowable amount.
45	Charges exceed your contracted/legislated fee arrangement.
49	These are noncovered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	These are noncovered services because this is not deemed a medical necessity by the payer.
51	These are noncovered services because this is a preexisting condition.
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56	Claim/service denied because procedure/treatment has not been deemed "proven to be effective" by the payer.
57	Payment denied/reduced because the payer deems that the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.
63	Correction to a prior claim.
65	Procedure code was incorrect. This payment reflects the correct code.
96	Noncovered charge(s).
97	Payment is included in the allowance for another service/procedure.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Payment adjusted as not furnished directly to the patient and/or not documented.
114	Procedure/product not approved by the Food and Drug Administration.
115	Payment adjusted as procedure postponed or canceled.
123	Payer refund due to overpayment.
124	Payer refund amount—not our patient.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
140	Patient/insured health identification number and name do not match.
145	Premium payment withholding.
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
150	Payment adjusted because the payer deems that the information submitted does not support this level of service.
151	Payment adjusted because the payer deems that the information submitted does not support this many services.

CMS

MODEL

Medicare Number of Beneficiary:
111-11-1111 A

MEDICARE APPEAL DECISION

Contact Information
If you questions, write or call:
Contractor Name
Street Address
City, State Zip
Phone Number

MONTH, DATE, YEAR

APPELLANT'S NAME
ADDRESS
CITY, STATE, ZIP

Dear Appellant's Name:

This letter is to inform you of the decision on your Medicare Appeal. An appeal is a new and independent review of a claim. You are receiving this letter because you made an appeal for (insert name of item or service).

The appeal decision is
(Insert either: **unfavorable.** Our decision is that your claim is not covered by Medicare and exclusive EMC remains in effectiveness.
OR **partially favorable.** Our decision is that your claim is partially covered by Medicare, and overturns EMC remains in controversy.)

More information on the decision is provided below. You do not need to take any action. However, if you disagree with the decision, you may appeal to Special an Administrative Law Judge (for Part A), a Hearing Officer (for Part B). You must file your appeal in writing within (insert 6 months (for Part B) or 60 days (for Part A)) of receiving this letter.

A copy of this letter was also sent to (insert Beneficiary Name or Provider Name). (insert Contractor Name) was contacted by Medicare to review your appeal. For more information on how to appeal, see the section titled "Important Information About Your Appeal Rights."

Summary of the Facts
Instructions: You may present this information in this format, or in paragraph form.

Provider	Dates of Service	Type of Service
Insert Provider Name	Insert Dates of Service	Insert Type of Service

- A claim was submitted by (insert kind of services and specific number).
- An initial determination on this claim was made on (insert date).
- The (insert service/item/bill) was denied/partial because (insert reason).
- On (insert date) we received a request for a redetermination.
- (Insert list of documents) was submitted with the request.

Decision
Instructions: Insert a brief statement of the decision, for example "We have determined that the above claim is not covered by Medicare. We have also determined you are responsible for payment for this service."

Explanation of the Decision
Instructions: This is the most important element of the redetermination. Explain the rationale that led to your final determination. Explain what policy (including local medical review policy, regional medical review policy, another national coverage policy, regulations, and/or laws) were used to make the determination. Make sure that the explanation provided in this paragraph is clear and that it includes an explanation of why the claim was or cannot be paid. Statements such as "not medically reasonable and necessary under Medicare guidelines" or "Medicare does not pay for 3rd party liability" are insufficient to meet the requirement of this paragraph.

Who is Responsible for the Bill?
Instructions: Include information on limitation of liability, waiver of recovery, and physician/supplier refund requirements as applicable.

What to Include in Your Request for an Independent Appeal:
Instructions: If the claim was based on medical documentation or a specific type of documentation are necessary to make a favorable decision, please indicate what documentation would be necessary to pay the claim.

Sincerely,

Reviewer Name
Contractor Name
A Medicare Contractor

FIGURE 13.6 Medicare Redetermination Notice

COMPLIANCE GUIDELINE

Patients' Rights Under Medicare

A beneficiary may request an itemized statement from the provider. A provider who does not comply within thirty days may be fined $100 per outstanding request by Medicare. The beneficiary may examine the itemized statement and request review of questionable or unclear charges. The provider is required to work with the enrollee to explain discrepancies.

THINKING IT THROUGH 13.6

1. Create a flowchart based on the five steps in the Medicare appeals process.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM

1. Beneficiary's Name: _____
2. Medicare Number: _____
3. Description of Item or Service in Question: _____
4. Date the Service or Item was Received: _____
5. I do not agree with the determination of my claim. MY REASONS ARE:
6. Date of the initial determination notice _____
   (If you received your initial determination notice more than 120 days ago, include your reason for not making this request earlier.)
7. Additional Information Medicare Should Consider: _____
8. Requester's Name: _____
9. Requester's Relationship to the Beneficiary: _____
10. Requester's Address: _____
11. Requester's Telephone Number: _____
12. Requester's Signature: _____
13. Date Signed: _____
14. ❑ I have evidence to submit. (Attach such evidence to this form.)
    ❑ I do not have evidence to submit.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.

Form CMS-20027 (03/05) [illegible]

FIGURE 13.5 Medicare Request for Redetermination Form

Source: "Medicare Redetermination Request Form — 1st Level of Appeal," U.S. Department of Health and Human Services, 2018. www.cms.gov.

BILLING TIP

Calendar Days, Not Work Days

Note that the timelines for each appeal level are calendar days (including weekends), not work days.

2. *Reconsideration:* The next step is a reconsideration request. This request must be made within 180 days of receiving the redetermination notice. At this level, the claim is reviewed by qualified independent contractors (QICs).
3. *Administrative law judge:* The third level is a hearing by an administrative law judge. The amount in question must be at least $160, and the hearing must be requested within 60 days of receiving the reconsideration notice.
4. *Medicare Appeals Council:* The fourth level must be requested within 60 days of receiving the response from the hearing by the administrative law judge. No monetary amount is specified.
5. *Federal court (judicial) review:* The fifth and final Medicare appeal level is a hearing in federal court. The amount in dispute must be at least $1,600, and the hearing must be requested within 60 days of receiving the department appeals board decision.

13.6 Appeals

After RAs have been reviewed and processed, events that may follow can alter the amount of payment. When a claim has been denied or payment reduced, an appeal may be filed with the payer for reconsideration, possibly reversing the nonpayment. Postpayment audits by payers may change the initial determination. Under certain conditions, refunds may be due to either the payer or the patient. In some cases, the practice may elect to file a complaint with the state insurance commissioner.

The General Appeal Process

An **appeal** is a process that can be used to challenge a payer's decision to deny, reduce, or otherwise downcode a claim. A provider may begin the appeal process by asking for a review of the payer's decision. Patients, too, have the right to request appeals. Under the ACA, payers are required to process appeals, and if payment is still denied, patients can have an independent review organization decide the case. The person filing the appeal is the **claimant** or the **appellant**, whether that individual is a provider or a patient.

appeal request for reconsideration of a claim adjudication

claimant person/entity exercising the right to receive benefits

appellant one who appeals a claim decision

Basic Steps

Each payer has consistent procedures for handling appeals based on their nature. The practice staff reviews the appropriate guidelines and required forms for the particular insurance carrier before starting an appeal and plans its actions according to the rules. Appeals must be filed within a specified time after the claim determination. Most payers have an escalating structure of appeals, such as (1) a complaint, (2) an appeal, and (3) a grievance. The claimant must move through the three levels in pursuing an appeal, starting at the lowest and continuing to the highest, final level. Some payers also set a minimum amount that must be involved in an appeal process to avoid spending much time on a small dispute.

Options After Appeal Rejection

A claimant can take another step if the payer has rejected all the appeal levels on a claim. Because they license most types of payers, state insurance commissions have the authority to review appeals that payers reject. If a claimant decides to pursue an appeal with the state insurance commission, copies of the complete case file—all documents that relate to the initial claim determination and the appeal process—are sent, along with a letter of explanation.

BILLING TIP

Annual Appeal Amounts

Verify the financial amounts that must be involved for each step for the current year.

Medicare Appeals

Medicare-participating providers have appeal rights. Note, though, that appealing a claim is not necessary if it has been denied for minor errors or omissions. The provider can instead ask the Medicare carrier to reopen the claim so the error can be fixed rather than going through the appeals process. However, if a claim is denied because of untimely submission (it was submitted after the specified filing deadline), it cannot be appealed.

BILLING TIP

Late Claims Not Appealable

A claim that is denied because it was not timely filed is not subject to appeal.

The current Medicare appeals process is the result of changes in the law; the Medicare, Medicaid, and Children's Health Insurance Program (CHIP) Benefits and Improvement Act of 2000, known as BIPA, and the Medicare Modernization Act significantly changed these procedures. The Medicare appeal process involves five steps:

1. *Redetermination:* The first step, called **redetermination,** is a claim review by an employee of the Medicare carrier who was not involved in the initial claim determination. The request, which must be made within 120 days of receiving the initial claim determination, is made by completing a form (Figure 13.5) or writing a letter and attaching supporting medical documentation. If the decision is favorable, payment is sent. If the redetermination is either partially favorable or unfavorable, the answer comes as a letter (see Figure 13.6) called the **Medicare Redetermination Notice (MRN).** The decision must be made within 60 days; and the letter is sent to both the provider and the patient.

redetermination first level of Medicare appeal processing

Medicare Redetermination Notice (MRN) communication of the resolution of a first appeal for Medicare fee-for-service claims

BILLING TIP

Auditing Payments per Contract Terms

Verify that payments are correct according to payers' participation contracts. This double-check is particularly important if payments are autoposted. In this case, periodically post a representative number of RAs manually as an audit to uncover any payment problems.

Denial Management

Typical problems and solutions are:

- *Rejected claims:* A claim that is not paid due to incorrect information must be corrected and sent to the payer according to its procedures.
- *Procedures not paid:* If a procedure that should have been paid on a claim was overlooked, another claim is sent for that procedure.
- *Partially paid, denied, or downcoded claims:* If the payer has denied payment, the first step is to study the adjustment codes to determine why. If a procedure is not a covered benefit or if the patient was not eligible for that benefit, typically the next step is to bill the patient for the noncovered amount. If the claim is denied or downcoded for lack of medical necessity, a decision about the next action must be made. The options are to bill the patient, write off the amount as a contractual adjustment, or challenge the determination with an appeal. Some provider contracts prohibit billing the patient if an appeal or necessary documentation has not been submitted to the payer.

To improve the rate of paid claims over time, medical insurance specialists track and analyze each payer's reasons for denying claims. This record may be kept in a denial log or assigned specific denial-reason codes for the PMP to store for reference. Denials should be grouped into categories, such as:

BILLING TIP

Organize Before Calling

Before calling a payer to question a claim determination, prepare by gathering the RA, the patient's medical record, and the claim data. Be ready to explain the situation and to ask politely to speak to a supervisor if necessary.

- Coding errors (incorrect unbundling, procedure codes not payable by plan with the reported diagnosis codes)
- Registration mistakes, such as incorrect patient ID numbers
- Billing errors, such as failure to get required preauthorizations or referral numbers
- Payer requests for more information or general delays in claims processing

The types of denials should be analyzed to identify which procedures can be implemented to fix the problems. For example, educating the staff members responsible for getting preauthorizations about each payer's requirements may be necessary.

THINKING IT THROUGH 13.5

Based on the following RA:

1. What is the total amount paid by check? (Fill in the "Amt paid provider" column before calculating the total.)
2. Were any procedures paid at a rate lower than the claim charge? If so, which?
3. What might be the reason that there is no insurance payment for services for Gloria Vanderhilt?
4. Was payment denied for any claim? If so, for what reason?

Date prepared: 6/22/2029 **Claim number:** 0347914

Patient's name	Dates of service from - thru	POS	Proc	Qty	Charge amount	Eligible amount	Patient liability	Amt paid provider
Kavan, Gregory	04/15/29 - 04/15/29	11	99213	1	$48.00	$48.00	$4.80	_____
Ferrara, Grace	05/11/29 - 05/11/29	11	99212	1	$35.00	$35.00	$3.50	_____
Comprost, Harry	05/12/29 - 05/12/29	11	99214	1	$64.00	$54.00	-0-	_____
Vanderhilt, Gloria	05/12/29 - 05/12/29	11	99212	1	$35.00	$35.00	$35.00	-0-
Dallez, Juan	05/13/29 - 05/13/29	11	99212	1	$35.00	*	*	-0-

******** *Check #1039242 is attached in the amount of* _____ ********

*** Procedure not covered under Medicaid**

Patient's Name: _____ Medicare # _____

- **Medicare Secondary Payer Screening Questionnaire**

1. Are you covered by the Veterans Administration, the Black Lung Program, or Workers Compensation? If so which one? _____ ( ) Yes ( ) No
2. Is this illness or injury due to any type of accident? ( ) Yes ( ) No
3. Are you age 65 or older? ( ) Yes ( ) No
   a. Are you currently employed? ( ) Yes ( ) No
   b. Is your spouse currently employed? ( ) Yes ( ) No
4. Are you age 65 or under? ( ) Yes ( ) No
   a. Are you covered by any employer Group Health Plan? ( ) Yes ( ) No
   b. Or another large Group Health Plan? ( ) Yes ( ) No

- **Authorization Statement and Payment Agreement**

I declare under penalty of perjury that I do not have another primary insurance carrier to pay the medical care rendered to me by _____ and that all information with regard to residence, employment, and income is correct to the best of my knowledge.

I request that payment of authorized Medicare Benefits be made to this health center for any services furnished to me by its physicians or suppliers.

I understand that my signature requests that payment be made and that it authorizes release of medical information necessary to pay the claim(s). If a secondary insurance carrier is involved my signature also authorizes releasing information to the insurer or agency shown.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determined by the Medicare Carrier as full charge, and the patient is responsible only for the deductible (Excluding UCR/Medicare) coinsurance and noncovered services. Coinsurance and deductible are based upon charge determined by the Medicare carrier.

_____ Signature of Patient or Authorized Representative _____ Date

_____ Witnessed by _____ Date

FIGURE 13.8 Medicare Secondary Payer Screening Questionnaire

Source: "Medicare Secondary Payer Questionnaire," Centers for Medicare and Medicaid Services. www.eec-pe.com.

A form such as that shown in Figure 13.8 is used to gather and validate information about Medicare patients' primary plans during the patient check-in process.

Over Age Sixty-Five and Employed

When an individual is employed and is covered by the employer's group health plan, Medicare is the secondary payer. This is the case for employees who are on leaves of absence, even if they are receiving short- or long-term disability benefits. Medicare is also secondary when an individual over age sixty-five is covered by a spouse's employer's group health plan (even if the spouse is younger than sixty-five). On the other hand, Medicare is the primary carrier for:

- An individual who is working for an employer with twenty employees or fewer
- An individual who is covered by another policy that is not a group policy
- An individual who is enrolled in Part B but not Part A of the Medicare program

BILLING TIP

Submit MSP Claims for Zero Balances

Send an MSP claim to Medicare even when the primary payer has fully paid the bill and the patient owes nothing so that the amount paid can be credited to the patient's Medicare Part B annual deductible.

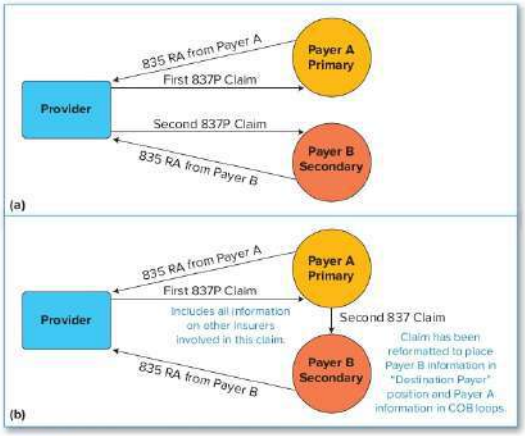


FIGURE 13.7 (a) Provider-to-Payer COB Model, (b) Provider-to-Payer-to-Payer COB Model

THINKING IT THROUGH 13.8

1. In your opinion, is it more efficient to process secondary claims when paper claims are used or when electronic transactions are in place?

13.9 The Medicare Secondary Payer (MSP) Program, Claims, and Payments

Medicare Secondary Payer (MSP) federally mandated program requiring private payers to be the primary payers for Medicare beneficiaries' claims

Benefits for a patient who has both Medicare and other coverage are coordinated under the rules of the **Medicare Secondary Payer (MSP)** program. The Medicare coordination of benefits contractor receives inquiries regarding Medicare as second payer and has information on a beneficiary's eligibility for benefits and the availability of other health insurance that is primary to Medicare.

If Medicare is the secondary payer to one primary payer, the claim must be submitted using the HIPAA 837P transaction unless the practice is excluded from electronic transaction rules. The 837P must report the amount the primary payer paid for the claim or for a particular service line (procedure) in the Allow Amount field. Claims for which more than one plan is responsible for payment prior to Medicare, however, should be submitted using the CMS-1500 claim form. The other payers' RAs must be attached when the claim is sent to Medicare for processing.

Following MSP Rules

The medical insurance specialist is responsible for identifying the situations in which Medicare is the secondary payer and for preparing appropriate primary and secondary claims.

should address these more stringent provisions and help administrative office employees avoid accusations of fraudulent behavior by implementing prompt discovery and repayment of all overpayments.

Grievances

If a medical practice believes that an insurance company has treated it unfairly, it has the right to file a **grievance** with the state insurance commission. The law requires the state to investigate the complaint, and the state can require the insurance company to answer. Grievances, like appeals, require a good deal of staff time and effort. They should be filed when repeated unresolved problems cannot otherwise be worked out with payers. The state insurance commission sets the requirements and steps for pursuing this option.

grievance complaint against a payer filed with the state insurance commission by a practice

THINKING IT THROUGH 13.7

1. In a large practice of forty providers, the staff responsible for creating claims and billing are located in one building, and the staff members who handle RAs work at another location. In your opinion, what difficulties might this separation present? What strategies can be used to ensure the submission of complete and compliant claims?

13.8 Billing Secondary Payers

After the primary payer's RA for a patient who has additional insurance coverage has been posted, the next step is billing the second payer. The primary claim, of course, gave that payer information about the patient's secondary insurance policy. The secondary payer now needs to know what the primary payer paid on the claim in order to coordinate benefits. The primary claim generally crosses over automatically to the secondary payer in many cases–Medicare-Medicaid and Medicare-Medigap claims, as well as others–and no additional claim is filed. For noncrossover claims, the medical insurance specialist prepares an additional claim for the secondary payer and sends it with a copy of the RA.

BILLING TIP

Coordination of Benefits (COB)

When they are the secondary payer, many health plans receive Medicare claims automatically. Do not send a paper claim to the secondary payer upon receipt of the RA; it will be coded as a duplicate claim and rejected. However, billers must still follow up on secondary claims to be sure that the payer has received them.

Electronic Claims

The medical insurance specialist transmits a claim to the secondary payer with the primary RA, sent either electronically or on paper, according to the payer's procedures. The secondary payer determines whether additional benefits are due under the policy's coordination of benefits (COB) provisions and sends payment with another RA to the billing provider. This flow is shown in Figure 13.7a.

The practice does not send a claim to the secondary payer when the primary payer handles the coordination of benefits transaction and the claim crosses over. In this case, the primary payer electronically sends the COB transaction, which is the same HIPAA 837P that reports the primary claim, to the secondary payer. This flow is shown in Figure 13.7b.

When the primary payer forwards the COB transaction, a message appears on the primary payer's RA. For example, on the Medicare RA shown in Figure 13.4 COB is indicated by the phrase "CLAIM INFORMATION FORWARDED TO," followed by the name of the secondary payer, such as Worldnet Services Corporation, Anthem BCBS/CT State Retirement, Benefit Planners, and so forth. Medicare has a consolidated claims crossover process that a special coordination of benefits contractor (COBC) manages. Plans that are supplemental to Medicare sign one national crossover agreement.

PHI on RAs/EOBs

Black out other patients' protected health information (PHI) on printed RAs being sent to secondary payers.

Paper Claims

If a paper RA is received, the procedure is to use the CMS-1500 to bill the secondary health plan that covers the beneficiary. The medical insurance specialist completes the claim form and sends it with the primary RA attached.

13.7 Postpayment Audits, Refunds, and Grievances

Postpayment Audits

Most postpayment reviews are used to build clinical information. Payers use their audits of practices, for example, to study treatments and outcomes for patients with similar diagnoses. The patterns that are determined are used to confirm or alter best practice guidelines.

At times, however, the postpayment audit is done to verify the medical necessity of reported services or to uncover fraud and abuse. The audit may be based on the detailed records about each provider's services that are kept by payers' medical review departments. Some payers keep records that go back for many months or years. The payer analyzes these records to assess patterns of care from individual providers and to flag outliers—those that differ from what other providers do. A postpayment audit might be conducted to check the documentation of the provider's cases or, in some cases, to check for fraudulent practices.

Refunds of Overpayments

overpayment Improper or excessive payment resulting from billing errors

From the payer's point of view, **overpayments** (also called *credit balances*) are improper or excessive payments resulting from billing errors for which the provider owes refunds. Examples are:

- A payer may mistakenly overpay a claim, or pay it twice.
- A payer's postpayment audit may find that a claim that has been paid should be denied or downcoded because the documentation does not support it.
- A provider may collect a primary payment from Medicare when another payer is primary.

In such cases, reimbursement that the provider has received is considered an overpayment, and the payer will ask for a refund (with the addition of interest for Medicare). If the audit shows that the claim was for a service that was not medically necessary, the provider also must refund any payment collected from the patient.

Often, the procedure is to promptly refund the overpayment. Many states require the provider to make the refund payment unless the overpayment is contested, which it may be if the provider thinks it is erroneous. A refund request may also be challenged because:

- Many practices set a time period beyond which they will not automatically issue a refund.
- State law may also provide for a reasonable time limit during which payers can recoup overpayments. For example, Missouri gives insurance companies twelve months from the date they processed the claim to request refunds; Maryland's period is six months.

Overpayment Enforcement Under the Fraud Enforcement and Recovery Act (FERA) and the ACA

COMPLIANCE GUIDELINE

Finding Overpayments Proactively

Part of a practice's compliance plan is a regular procedure to self-audit and discover whether overbilling has occurred—and to send the payer a notice of the situation and a refund.

The Fraud Enforcement and Recovery Act (FERA) of 2009 made major changes to the False Claims Act (FCA) by defining the act of keeping an overpayment from the federal government as fraud. Under these provisions, a person can violate the FCA by merely concealing or avoiding an obligation to repay an overpayment made by the federal government. This violation can be caused not only if the provider makes an error but also if the payer such as Medicare makes the mistake. FERA also encourages *qui tam* lawsuits. It extends the whistle-blower protection to cover both contractors and agents of an entity in addition to employees.

FERA expanded the ACA by defining *reverse false claims*. The ACA classifies overpayments as an obligation under the FCA. Providers that receive Medicare overpayments must report them to the carrier and return the amount within sixty days. Keeping the payment is against the FCA and subject to those penalties. The practice's compliance plan

THINKING IT THROUGH 13.9

1. Ron Polonsky is a seventy-one-year-old retired distribution manager. He and his wife Sandra live in Lincoln, Nebraska. Sandra is fifty-seven and is employed as a high-school science teacher. She has family coverage through a group health insurance plan offered by the state of Nebraska. Ron is covered as a dependent on her plan. The Medicare Part B carrier for Nebraska is Blue Cross and Blue Shield of Kansas.

   Which carrier is Ron's primary insurance carrier? Why?

Chapter 13 Summary

Learning Outcomes	Key Concepts/Examples
13.1 Explain the claim adjudication process.	To adjudicate claims: • Payers first perform initial processing checks on claims, rejecting those with missing or clearly incorrect information During the following adjudication process: • Claims are processed through the payer's automated medical edits • A manual review is performed if required • The payer makes a determination of whether to pay, deny, or reduce the claim • Payment is sent with an RA
13.2 Describe the procedures for following up on claims after they are sent to payers.	• Medical insurance specialists monitor claims by reviewing the insurance aging report and following up at properly timed intervals based on the payer's promised turnaround time. • The HIPAA X12 276/277 Health Care Claim Status Inquiry/Response (276/277) is used to track the claim progress through the adjudication process.
13.3 Interpret a remittance advice (RA).	• The HIPAA X12 835 Health Care Payment and Remittance Advice (HIPAA 835) is the standard transaction that payers use to transmit adjudication details and payments to providers. • Electronic and paper RAs contain the same essential data: a. A heading with payer and provider information b. Payment information for each claim, including adjustment codes c. Total amounts paid for all claims d. A glossary that defines the adjustment codes that appear on the document • These administrative code sets are claim adjustment group codes, claim adjustment reason codes, and remittance advice remark codes.
13.4 Identify the points that are reviewed on an RA.	• The unique claim control number reported on the RA is first used to match claims sent with payments received. • Then basic data are checked against the claim; billed procedures are verified; the payment for each CPT is checked against the expected amount; adjustment codes are reviewed to locate all unpaid, downcoded, or denied claims; and items are identified for follow-up.
13.5 Explain the process for posting payments and managing denials.	• Payments are deposited in the practice's bank account, posted in the practice management program, and applied to patients' accounts. • Rejected claims must be corrected and resent. • Missed procedures are billed again. • Partially paid, denied, or downcoded claims are analyzed and appealed, billed to the patient, or written off.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE ☒ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE ☐ (ID#/DoD #) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): W0N27 M6CC37

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RAMOS, CARLA, D

3. PATIENT'S BIRTH DATE MM 05 DD 13 YY 1939; SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): RAMOS, CARLA, D

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 26 PARK STREET

CITY: | STATE: | ZIP CODE: | TELEPHONE (Include Area Code): ( )

8. RESERVED FOR NUCC USE

CITY: KANSAS CITY | STATE: MO | ZIP CODE: 64110 | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 62DX

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM 05 DD 13 YY 1939; SEX M ☐ F ☒

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: PAINS HEALTH PLAN

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO if yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SOF | DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SOF

14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY; QUAL.

15. OTHER DATE MM DD YY; QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. ID. QUAL.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ NO; $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)): A. I831 B. 001 C. D. E. F. G. H. I. J. K. L.; ICD Ind. 0

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24A. DATES OF SERVICE From MM DD YY	To MM DD YY	24B. PLACE OF SERVICE	24C. EMG	24D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	24E. DIAGNOSIS POINTER	24F. $ CHARGES	24G. DAYS OR UNITS	24H. EPSDT Fam. Plan	24I. ID. QUAL.	24J. RENDERING PROVIDER ID. #
1	10 01 2029		11		99204		A B	126 00			NPI	
2	10 01 2029		11		92002		A	95 00			NPI	
3	10 01 2029		11		92567		A	10 00			NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 016778002 SSN EIN ☒

26. PATIENT'S ACCOUNT NO.: RAMO9

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE: $ 231 00

29. AMOUNT PAID: $ 20 00

30. Reserved for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: SOF | DATE:

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI | b.

33. BILLING PROVIDER INFO & PH # (555) 9999012

RONALD R BERGEN
96 YORK AVE
KANSAS CITY MO 64112-4123

a. 076388865 | b.

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CARRIER | PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION

FIGURE 13.9 CMS-1500 (02/12) Completion for Medicare Secondary Payer (MSP) Claims

15 Workers' Compensation
41 Black Lung
42 Veteran's Administration
43 Disabled Beneficiary Under Age 65 with Large Group Health Plan
47 Other Liability Insurance Is Primary

MSP Claims and Payments

Table 7.2 provides general instructions for completing a CMS-1500. Three formulas are used to calculate how much of the patient's coinsurance will be paid by Medicare under MSP. Of the three amounts, Medicare will pay the lowest. The formulas use Medicare's allowable charge, the primary insurer's allowable charge, and the actual amount paid by the primary payer. Medicare, as the secondary payer, pays 100 percent of most coinsurance payments if the patient's Part B deductible has been paid. See Figure 13.9.

The three formulas are:

1. Primary payer's allowed charge minus payment made on claim
2. What Medicare would pay (80 percent of Medicare allowed charge)
3. Higher allowed charge (either primary payer or Medicare) minus payment made on the claim

Example

A patient's visit-allowed charge from the primary payer is $100, and the primary payer pays $80 with a $20 patient coinsurance. Medicare allows $80 for the service. The patient has met the Part B deductible. The calculations using the three formulas result in amounts of (1) $100 − $80 = $20, (2) $80 × 80 percent = $64, and (3) $100 − $80 = $20. Medicare will pay $20 because this is the lowest dollar amount from the three calculations.

Medicare pays up to the higher of two allowable amounts when another plan is primary. But if the primary payer has already paid more than the Medicare allowed amount, no additional payment is made.◂

TRICARE CMS-1500 Secondary Claims

When TRICARE is the secondary payer, six item numbers on a paper claim are filled in differently than when TRICARE is the primary payer:

Item Number	*Content*
11	Policy number of the primary insurance plan
11a	Birth date and gender of the primary plan policyholder
11b	Employer of the primary plan policyholder if the plan is a group plan through an employer
11c	Name of the primary insurance plan
11d	Select Yes or No as appropriate.
29	Enter all payments made by other insurance carriers. Do not include payments made by the patient.

Medicare and Medicaid

If a patient is covered by both Medicare and Medicaid (a Medi-Medi beneficiary), Medicare is primary. The claim that is sent to Medicare is automatically crossed over to Medicaid for secondary payment.

COMPLIANCE GUIDELINE

Patient Coinsurance When Medicare Is Secondary

Medicare patients should not be charged for the primary insurance's coinsurance until the RA has been received and examined because the patient is entitled to have Medicare pay these charges. A patient who has not met the deductible is, however, responsible for the coinsurance, and that amount is applied toward the deductible.

- An individual who must pay premiums to receive Part A coverage
- An individual who is retired and receiving coverage under a previous employer's group policy

Disabled

If an individual under age sixty-five is disabled and is covered by an employer group health plan (which may be held by the individual, a spouse, or another family member), Medicare is the secondary payer. If the individual or family member is not actively employed, Medicare is the primary payer. Medicare is also the primary payer for:

- An individual and family members who are retired and receiving coverage under a group policy from a previous employer
- An individual and family members who are working for an employer with a hundred or fewer employees
- An individual and family members receiving coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; see the chapter about private payers and BCBS)
- An individual who is covered by another policy that is not a group policy

End-Stage Renal Disease (ESRD)

During a COB period, Medicare is the secondary payer for individuals who are covered by employer-sponsored group health plans and who fail to apply for ESRD-based Medicare coverage. The COB period begins the first month the individual is eligible for or entitled to Part A benefits based on an ESRD diagnosis. This rule is in effect regardless of whether the individual is employed or retired.

Workers' Compensation

If an individual receives treatment for a job-related injury or illness, Medicare coverage (and private insurance) is (are) secondary to workers' compensation coverage (see the chapter about workers' compensation and disability/automotive insurance). Included in this category is the Federal Black Lung Program, a government program that provides insurance coverage for coal miners. When an individual suffers from a lung disorder caused by working in a mine, Medicare is secondary to the Black Lung coverage. If the procedure or diagnosis is for something other than a mining-related lung condition, Medicare is the primary payer.

Automobile, No-Fault, and Liability Insurance

Medicare (and private insurance) is (are) always the secondary payer when treatment is for an accident-related claim whether automobile, no-fault (injuries that occur on private property, regardless of who is at fault), or liability (injuries that occur on private property when a party is held responsible).

Veterans' Benefits

If a veteran is entitled to Medicare benefits, he or she may choose whether to receive coverage through Medicare or through the Department of Veterans Affairs.

Insurance Type Code

For electronic claims, the specialist reports a two-digit insurance type code under the MSP program. This information is not required on CMS-1500 claims. The codes are:

12 Working Aged Beneficiary or Spouse with Employer Group Health Plan

13 End-Stage Renal Disease Beneficiary in the 30-Month Coordination Period with an Employer's Group Health Plan

14 No fault insurance, including auto, is primary

The preceding RA has been received by a provider.

A. **LO 13.5** What is the patient coinsurance *percentage* required under plan R-I?

B. **LO 13.5** What is the patient coinsurance *percentage* required under plan PPO-3?

C. **LO13.5** What is Gloria Ramirez's *balance due* for the two dates of service listed?

Case 13.3 Using Insurance Terms

Read this information from a Medicare carrier and answer the questions that follow.

E&M services rendered in a private residence are correctly billed with CPT codes 99341–99345 (new patients) and CPT codes 99347–99350 (established patients), home services. These CPT codes are payable only in home settings, that is, place of service 12.

National Government Services has seen many instances of providers billing outpatient/office codes in home settings. Home visits should not be reported with E&M codes 99201–99215, which represent office and outpatient services.

A. **LO 13.3** Based on Table 13.2, what claim adjustment reason code will result if this code is billed 99201, POS 12?

B. **LO 13.3** Which Remark Code would appear. N210 or N211?

22. **LO 13.9** Which of the following appears only on secondary claims?
    - **A.** primary insurance group policy number
    - **B.** primary insurance employer name
    - **C.** primary plan name
    - **D.** primary payer payment

Define the following abbreviations.

23. **LO 13.1** RA

24. **LO 13.1** EOB

25. **LO 13.9** MSP

26. **LO 13.5** EFT

27. **LO 13.5** TRN

Applying Your Knowledge

Case 13.1 Auditing Claim Data

The following data elements were submitted to a third-party payer. Using ICD-10-CM, CPT/HCPCS, and place of service codes, audit the information in each case and advise the payer about the correct action.

A. LO 13.4, 13.5
Dx R63.4
CPT 80048
POS 25

B. LO 13.4, 13.5
Dx J96.10
CPT 99241-22

C. LO 13.4, 13.5
Dx O63.2
CPT 54500

Case 13.2 Calculating Insurance Math

Patient ID	Patient Name	Plan	Date of Service	Procedure	Provider Charge	Allowed Amount	Patient Payment (Coinsurance and Deductible)	Claim Adjustment Reason Code	PROV PAY
BBG-88-5267	Ramirez, Gloria B.	R-1	02/13/2029–02/13/2029	99214	$105.60	$59.00	$8.85	2	$50.15
348-99-2537	Finucula, Betty R.	R-1	01/15/2029–01/15/2029	99292	$88.00	$50.00	$7.50	2	$42.50
537-128-5267	Ramirez, Gloria B.	R-1	02/14/2029–02/14/2029	90732	$38.00	0	$38.00	49	0
760-57-5372	Jugal, Kurt T.	R-1	02/16/2029–02/16/2029	93975 99204	$580.00 $178.00	$261.00 $103.00	$139.15 $15.45	12	$121.85 $87.55
1212Zul	Quan, Mary K.	PPO-3	02/16/2029–02/16/2029	20005	$192.00	$156.00	$31.20	2	$124.80
								TOTAL	$426.85

11. **LO 13.3** claim adjustment group code
12. **LO 13.9** MSP

I. Claim status indicating that the payer is waiting for additional information
J. Payer action to gather clinical documentation and study a claim before payment
K. Federally mandated program that requires private payers to be the primary payers for Medicare beneficiaries' claims
L. Code used on an RA to indicate the general type of reason code for an adjustment

Select the answer choice that best completes the statement or answers the question.

13. **LO 13.1, 13.2** A payer's initial processing of a claim screens for
    A. utilization guidelines
    B. medical edits
    C. basic errors in claim data or missing information
    D. claims attachments
14. **LO 13.1** Some automated edits are for
    A. patient eligibility, duplicate claims, and noncovered services
    B. valid identification numbers
    C. medical necessity reduction denials
    D. clinical documentation
15. **LO 13.1** A claim may be downcoded because
    A. it does not list a charge for every procedure code
    B. it is for noncovered services
    C. the documentation does not justify the level of service
    D. the procedure code applies to a patient of the other gender
16. **LO 13.2** Payers should comply with the required
    A. insurance aging report
    B. claim turnaround time
    C. remittance advice
    D. retention schedule
17. **LO 13.8** What is the next step after the primary payer's RA has been posted when a patient has additional insurance coverage?
    A. posting the payment
    B. billing the second payer
    C. filing an appeal
    D. filing a grievance
18. **LO 13.6** Appeals must always be filed
    A. within a specified time
    B. by the provider for the patient
    C. by patients on behalf of relatives
    D. with the state insurance commissioner
19. **LO 13.4** After an RA has been checked for the patient's name, account number, insurance number, and date of service, verification should be made that
    A. the payment for each CPT code matches the expected amount
    B. all billed CPT codes are listed
    C. no further clarification is needed from the payer
    D. no claims have been downcoded
20. **LO 13.9** If a patient has secondary insurance under a spouse's plan, what information is needed before transmitting a claim to the secondary plan?
    A. RA data
    B. 271 data
    C. PPO data
    D. 276 data
21. **LO 13.3** What type of codes explain Medicare payment decisions?
    A. CAGC
    B. CARC
    C. MOA
    D. RARC

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Learning Outcomes	Key Concepts/Examples
13.6 Describe the purpose and general steps of the appeal process.	• An appeal process is used to challenge a payer's decision to deny, reduce, or otherwise downcode a claim. • Each payer determines its policies for providers' appeals, including a graduated level of appeals, deadlines for requesting them, and medical review programs to answer them. • In some cases, appeals may be taken beyond the payer to an outside authority, such as a state insurance commission.
13.7 Assess how appeals, postpayment audits, and overpayments may affect claim payments.	• Filing an appeal may result in payment of a denied or reduced claim. • Postpayment audits are usually used to gather information about treatment outcomes, but they may also be used to find overpayments, which must be refunded to payers. • Refunds to patients may also be requested.
13.8 Describe the procedures for filing secondary claims.	• Claims are sent to patients' additional insurance plans after the primary payer has adjudicated claims. • Sometimes the medical office prepares and sends the claims; in other cases, the primary payer has a COB program that automatically sends the necessary data to secondary payers.
13.9 Discuss procedures for complying with the Medicare Secondary Payer (MSP) program.	Under the MSP program, Medicare is the secondary payer when: a. The patient is covered by an employer group health insurance plan or is covered through an employed spouse's plan. b. The patient is disabled, under age sixty-five, and covered by an employee group health plan. c. The services are covered by workers' compensation insurance. d. The services are for injuries in an automobile accident. e. The patient is a veteran who chooses to receive services through the Department of Veterans Affairs.

Review Questions

Match the key terms with their definitions.

1. **LO 13.1** medical necessity denial
2. **LO 13.7** overpayments
3. **LO 13.6** MRN
4. **LO 13.2** insurance aging report
5. **LO 13.5** autoposting
6. **LO 13.2** pending
7. **LO 13.1** development
8. **LO 13.5** EFT
9. **LO 13.1** concurrent care
10. **LO 13.1** determination

A. Analysis of how long a payer has held submitted claims

B. Software feature enabling automatic entry of payments on an RA

C. Medical situation in which a patient receives extensive independent care from two or more attending physicians on the same date of service

D. A payer's refusal to pay for a reported procedure that does not meet its medical necessity criteria

E. Improper or excessive payments resulting from billing errors for which the provider owes refunds

F. Letter from Medicare to an appellant regarding a first-level appeal

G. A payer's decision regarding payment of a claim

H. A banking service for directly transmitting funds from one bank to another

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Admission

Inpatients are admitted to hospitals in a process called **registration.** Like physician practices, hospitals must keep clear, accurate records of patients' diagnoses and treatments. The record begins at a patient's first admission to the facility or, in some facilities, during a preadmission process used to gather information before actual admission. Having a preadmission process gives staff members time to verify insurance coverage, calculate patients' likely financial responsibilities, work out payment plans if necessary, and handle any ordered preadmission tests.

registration process of gathering information about a patient during admission to a hospital

The HIM department keeps a health record system that permits storage and retrieval of clinical information by patient name or number, by physician, and by diagnosis and procedure. At almost every facility, part or all of the records are computerized (each with a different computer system; the systems are not standardized). Each patient is listed in a patient register under a unique number. These numbers make up the **master patient index (MPI),** the main database that identifies patients. This index contains the patient's:

- Last name, first name, and middle name or initial
- Birth date (eight-digit format)
- Sex
- Address
- Admission and/or treatment date
- Admitting physician
- **Attending physician**—the clinician primarily responsible for the care of the patient from the beginning of the hospital episode
- Health record number

master patient index (MPI) hospital's main patient database

attending physician clinician primarily responsible for a patient's care from the beginning of a hospitalization

More information is gathered for a hospital admission than is required for a visit to a physician practice. For example, in addition to hospital insurance, a patient may have long-term coverage. Special points about the patient's care, such as language requirements, religion, or disabilities, are also entered in the record.

Outpatient department (especially urgent care) and emergency room insurance claims are often delayed because verifying insurance coverage is difficult in these settings. The emergency department may have its own registration system because people who come for emergency and urgent treatment must receive care by the nursing staff first. Both outpatient and emergency room procedures must be set up to collect the minimum information. Many admissions departments join online insurance verification systems so that payers can be contacted during the registration process and verification received in seconds.

HIPAA/HITECH TIP

Treatment, Payment, and Operations (TPO)

In hospital work as well as in physician offices, patients' protected health information (PHI) can be released as necessary for treatment, payment, and operations (TPO).

Consent

As in medical practices, the admission staff in hospitals must be sure that patients give written consent for the medical treatments and procedures they will receive. Figure 17.1 is an example of a consent form used in hospitals. It includes the same kinds of items that patients sign in practices (the consent for medical treatment, acceptance of responsibility for payment, and assignment of benefits) as well as three unique items:

1. A statement covering the conditions under which the facility is responsible for the patient's personal possessions.
2. Advance directives, also called *living wills,* that cover how patients want to receive healthcare, including routine treatments and lifesaving methods if they are too ill to speak for themselves. In the event that a patient cannot make such decisions, he or she may appoint another person to do so with a medical power of attorney.
3. Acknowledgment that Medicare patients have received a copy of the two-page notice "An Important Message from Medicare About Your Rights." The printout, which Centers for Medicare and Medicaid Services (CMS) requires hospitals to give Medicare patients on registration, explains the beneficiary's rights as a hospital patient as well as his or her appeal rights regarding hospital discharge (see Figures 17.2a, 17.2b, and 17.2c).

HIPAA/HITECH TIP

Notice of Privacy Practices

Under the HIPAA Privacy Rule, a hospital must also present a patient with a copy of its privacy practices at registration and have the patient sign an acknowledgment that he or she has received this notice.

at-home recovery care assistance with activities of daily living provided in the home

hospice care care for terminally ill people provided by a public or private organization

occupational therapy, speech therapy, and care by home health aides. **At home recovery care** is a different category; it includes help with the activities of daily living (ADLs), such as bathing and eating. **Hospice care** is a special approach to caring for people with terminal illnesses—that is, people who are not expected to live longer than six months—in a familiar and comfortable place, either a special hospice facility or the patient's home.

Integrated Delivery Systems

An important trend is the development of patient-centered integrated healthcare delivery systems, which are also called *integrated networks*. Healthcare providers from various specialties and healthcare facilities join together to provide patient services. At the center of the system is a single administration. Most integrated systems are locally organized, such as through the merger of local hospitals into large multifacility systems.

Integrated delivery systems change the focus of care from acute care to the continuum of care the patient needs. For example, an acute care hospital, a rehabilitation hospital, a long-term care facility, and a home care program might merge to form one system that can provide services for a stroke patient from the time of the stroke until the resumption of normal activities. The network is set up to move the patient and the patient's record from facility to facility as the patient's treatment and condition require.

THINKING IT THROUGH 17.1

1. When a patient of the practice is admitted to the hospital and the admitting physician first visits the patient there, what current procedural terminology (CPT) code range is used to report that service? What code range is used for subsequent hospital care by this physician? Would the hospital use these same codes?

17.2 Hospital Billing Cycle

Hospitals generally have large departments that are responsible for major business functions. The admissions department records the patient's personal and financial information. In some hospitals, a separate insurance verification department is responsible for double-checking the patient's identity and confirming insurance coverage. The patient accounting department handles billing, and there is often a separate collections department.

health information management (HIM) hospital department that organizes and maintains patient medical records

Organizing and maintaining patient medical records in hospitals are the duties of the **health information management (HIM)** department. Hospitals are also structured into departments for patient care. For example, they have professional services departments, such as laboratory, radiology, and surgery, as well as food service and housekeeping.

The three major steps in a patient's hospital stay from the insurance perspective are:

1. Admission, for creating or updating the patient's medical record, verifying patient insurance coverage, securing consent for release of information to payers, and collecting advance payments as appropriate
2. Treatment during which the various departments' services are provided and charges are generated
3. Discharge from the hospital or transfer to another facility, at which point the patient's record is compiled, claims and/or bills are created, and payment is followed up

HIPAA/HITECH TIP

Verifying Insurance Coverage

The HIPAA standard transaction used to verify patients' insurance is the 270/271 Eligibility for a Health Plan Inquiry/Response.

Although this text focuses on billing and reimbursement in medical practices, medical insurance specialists should be aware of the coding systems and billing cycle used in hospitals. There are many financial agreements between physicians and hospitals; physicians in practices may have staff privileges at hospitals or be associated with hospitals as medical specialists. Physician practice staff members also must bill for the procedures physicians perform in the hospital environment. It is important to distinguish between hospital and physician services for accurate billing.

This chapter provides a brief overview of the types of inpatient and outpatient facilities, the various methods used by payers to pay for these services, and the coding systems that are used to report diagnoses and procedures for reimbursement.

17.1 Healthcare Facilities: Inpatient Versus Outpatient

There are more than 6,500 primarily nonprofit facilities that are known as *acute care hospitals*. Other kinds of healthcare facilities include psychiatric hospitals, rehabilitation facilities, clinics, nursing homes, subacute hospitals, and home healthcare agencies. Hospital size is measured by the number of beds. Hospitals are also classified by the type of facility and services they provide, such as teaching hospital or burn center.

Inpatient Care

Inpatient facilities are equipped for patients to stay overnight. In addition to hospitals, inpatient care may be provided for special populations:

- *Skilled nursing facilities:* A **skilled nursing facility (SNF)** provides skilled nursing and/or rehabilitation services to help patients recover after a hospital stay. Skilled nursing care includes care given by licensed nurses under the direction of a physician, such as intravenous injections, tube feeding, and changing sterile dressings on a wound.
- *Long-term care facilities:* This term describes facilities such as nursing homes that provide custodial care for patients with chronic disabilities and prolonged illnesses.

inpatient person admitted for services that require a stay spanning two midnights

skilled nursing facility (SNF) facility in which licensed nurses provide services under a physician's direction

Outpatient or Ambulatory Care

Hospital emergency rooms (ERs) or departments are the most familiar type of outpatient service. An **emergency** involves a situation in which a delay in treatment would lead to a significant increase in the threat to a patient's life or body part. (Emergency care differs from urgently needed care in which the condition must be treated right away but is not life threatening.) Patients treated in an emergency room are either discharged or admitted as inpatients to the hospital after treatment or observation.

Many hospitals have expanded beyond inpatient and ER services to offer a variety of outpatient services. Outpatient care, often called **ambulatory care,** covers all types of health services that do not require an overnight hospital stay. Most hospitals, for example, have outpatient departments that provide these services. Same-day surgery is performed in two types of facilities where patients do not stay overnight: a separate part of a hospital called an **ambulatory surgical unit (ASU)** and a free-standing facility called an **ambulatory surgical center (ASC).**

Different types of outpatient services are also provided in patients' home settings. **Home healthcare** services include care given at home, such as physical therapy or skilled nursing care. Home healthcare is provided by a **home health agency (HHA),** an organization that provides home care services, including skilled nursing, physical therapy,

emergency situation in which a delay in patient treatment would lead to a significant increase in the threat to life or a body part

ambulatory care outpatient care

ambulatory surgical unit (ASU) hospital department that provides outpatient surgery

ambulatory surgical center (ASC) clinic that provides outpatient surgery

home healthcare care given to patients in their homes

home health agency (HHA) organization that provides home care services

17 HOSPITAL BILLING AND REIMBURSEMENT

KEY TERMS

admitting diagnosis (ADX)
ambulatory care
ambulatory patient classification (APC)
ambulatory surgical center (ASC)
ambulatory surgical unit (ASU)
at-home recovery care
attending physician
case mix index
charge master
CMS-1450
comorbidity
complication
diagnosis-related group (DRG)
emergency
grouper
health information management (HIM)
HIPAA X12 837 Health Care Claim: Institutional (837I)
home health agency (HHA)
home healthcare
hospice care
hospital-acquired condition (HAC)
hospital-issued notice of noncoverage (HINN)
ICD-10-PCS
inpatient
inpatient-only list
Inpatient Prospective Payment System (IPPS)
major diagnostic category (MDC)
master patient index (MPI)
Medicare-Severity DRG (MS-DRG)
never event
observation service
Outpatient Prospective Payment System (OPPS)
present on admission (POA)
principal diagnosis (PDX)
principal procedure
registration
sequencing
skilled nursing facility (SNF)
three-day payment window
UB-92
UB-04
Uniform Hospital Discharge Data Set (UHDDS)

Learning Outcomes

After studying this chapter, you should be able to:

17.1 Distinguish between inpatient and outpatient hospital services.
17.2 List the major steps relating to hospital billing and reimbursement.
17.3 Contrast coding diagnoses for hospital inpatient cases and for physician office services.
17.4 Explain the coding system used for hospital procedures.
17.5 Discuss the factors that affect the rate that Medicare pays for inpatient services.
17.6 Interpret hospital healthcare claim forms.

NOTICE INSTRUCTIONS: THE IMPORTANT MESSAGE FROM MEDICARE

COMPLETING THE NOTICE

Page 1 of the Important Message from Medicare

A. Header

Hospitals must display "DEPARTMENT OF HEALTH & HUMAN SERVICES, Centers for Medicare & Medicaid Services" and the OMB number

The following blanks must be completed by the hospital. Information inserted by hospitals in the blank spaces on the IM may be typed or legibly hand-written in 12-point font or the equivalent. Hospitals may also use a patient label that includes the following information:

Patient Name: Fill in the patient's full name.

Patient ID number: Fill in an ID number that identifies this patient. This number should not be, nor should it contain, the social security number.

Physician: Fill in the name of the patient's physician.

B. Body of the Notice

Bullet # 3 – Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here _____

Hospitals may preprint or otherwise insert the name and telephone number (including TTY) of the QIO.

To speak with someone at the hospital about this notice call: Fill in a telephone number at the hospital for the patient or representative to call with questions about the notice. Preferably, a contact name should also be included.

Patient or Representative Signature: Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents.

Date: Have the patient or representative place the date he or she signed the notice.

Page 2 of the Important Message from Medicare

First sub-bullet—Insert name and telephone number of QIO in BOLD: Insert name and telephone number (including TTY), in bold, of the Quality Improvement Organization that performs reviews for the hospital.

Second sub-bullet—The name of this hospital is: Insert/preprint the name of the hospital, including the Medicare provider ID number (not the telephone number).

Additional Information: Hospitals may use this section for additional documentation, including, for example, obtaining beneficiary initials to document delivery of the follow-up copy of the IM, or documentation of refusals.

FIGURE 17.2c Printout Titled "An Important Message from Medicare About Your Rights" (Provider Instructions)

Source: "AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS," Centers for Medicare and Medicaid Services, 2018. http://www.medicareadvocacy.org/old-site/InfoByTopic/AcuteHospital/Hospital_07.28.02.IMEnglish.rev.pdf.

In these cases, the MSP information must be taken at registration to avoid delays in claim processing. The form used to determine the primary payer is shown in Figure 17.3. In the event of an accident, if the patient does not know what insurance company covers another person involved in it, the hospital may request a police accident report to obtain the information needed to bill the other person's accident insurance that is primary to Medicare.

Beneficiary Notice of Nonpayment (Medicare)

Under Medicare's limitation on liability (LOL) provisions, hospitals are required to provide prior notice in a prescribed form when certain outpatient or inpatient services ordered by a physician do not meet Medicare's medical necessity guidelines for the patient's condition.

Medicare Secondary Payer Questionnaire Visit the website and review the form in its entirety at https://med.noridianmedicare.com/documents/2230703/6501021/MSP+Questionnaire

STEPS TO APPEAL YOUR DISCHARGE

- **STEP 1:** You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information for the QIO:

    Name of QIO *(in bold)*

    Telephone Number of QIO
  - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
  - Ask the hospital if you need help contacting the QIO.
  - The name of this hospital is:

Hospital Name	Provider ID Number

- **STEP 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **STEP 3:** The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **STEP 4:** The QIO will review your medical records and other important information about your case.
- **STEP 5:** The QIO will notify you of its decision within 1 day after it receives all necessary information.
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the QIO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

ADDITIONAL INFORMATION:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 0652. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Office, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

FIGURE 17.2b Printout Titled "An Important Message from Medicare About Your Rights" (Page 2)

Source: "AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS." Centers for Medicare and Medicaid Services, 2018. http://www.medicareadvocacy.org/old-site/InfoByTopic/AcuteHospital/Hospital_07.28.02.IMEnglish.rev.pdf

Coordination of Benefits

As is the case for office visits, health plans require coordination of benefits when more than one insurance policy is in effect for a patient. As an example, many patients are classified as Medicare Secondary Payer (MSP) accounts. These patients are Medicare beneficiaries, but Medicare is the secondary payer. For example, if a patient or a patient's spouse has medical insurance through an employer's plan, that coverage is primary to Medicare.

Patient Name: _____

Patient ID Number: _____

Physician: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT YOU HAVE THE RIGHT TO:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

  _____

  Name of QIO

  _____

  Telephone Number of QIO

  _____

YOUR MEDICARE DISCHARGE RIGHTS

Planning for Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- **Step by step instructions for calling the QIO and filing an appeal are on page 2.**

To speak with someone at the hospital about this notice, call _____.

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative	Date

Form CMS-R-193 (approved 05/02)

FIGURE 17.2a Printout Titled "An Important Message from Medicare About Your Rights" (Page 1)

Source: "AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS," Centers for Medicare and Medicaid Services, 2018. http://www.medicareadvocacy.org/old-site/InfoByTopic/AcuteHospital/Hospital_07.28.02.IMEnglish.rev.pdf.

CONDITION OF ADMISSION / CONSENT FOR TREATMENT
GENESIS HEALTH SYSTEM

Name of Patient: _____

1. REQUEST AND CONSENT FOR HOSPITAL/FACILITY SERVICES

☐ **Consent for Admission to a Genesis Hospital**

I, or my representative acting on my behalf, understand that I am suffering from a condition that requires hospital care and request admission and consent to hospital services for such care including routine diagnostic procedures, administration of drugs, examinations and other care that my attending physician(s) or other hospital medical staff consider necessary including emergency care rendered in the absence of a physician, if needed.

☐ **Consent to Receive Services from a Genesis Hospital or Facility**

I, or my representative acting on my behalf, consent to receive care from a Genesis Hospital or Facility including routine diagnostic procedures, administration of drugs, examinations and other care that my attending physician(s) or other medical staff consider necessary including admission to the hospital.

2. PHYSICIANS ARE INDEPENDENT CONTRACTORS

I understand that many of the physicians on staff at Genesis Health System facilities are not employees or agents of the hospital, but rather are independent contractors who provide specialized services, such as emergency care, cardiology, radiology, hospitalist services and anesthesia. The facility has granted these independent physicians privileges to use the hospital's facilities for the care and treatment of patients. These treating and consulting physicians exercise independent medical judgment and control the patient's care. The hospital staff follows their directions.

Independent Physician Groups that contract to provided services at Genesis Medical Centers include, but are not limited to: Cardiovascular Medicine, P.C.; Radiology Group, P.C.; Cogent, Anesthesia and Analgesia P.C., Acute Care Physicians, and ECHO, P.C.

I have read and understand this: _____
(Initials)

3. OUTCOME OF TREATMENT NOT GUARANTEED

I understand that the practice of medicine is not an exact science; therefore, no guarantees have been made to me as to the result of examination or treatment in this hospital or facility. Further, I understand that diagnosis and treatment may involve risk of injury or even death.

4. INFORMED CONSENT

I understand that it is customary, absent emergency or extraordinary circumstances that no substantial procedures will be performed upon me unless and until I have had an opportunity to discuss a recommended procedure or therapeutic course with my physician or other health professional to my satisfaction. I have the right to consent or refuse to consent to any such proposed procedure or therapeutic course. I understand that I will not be involved in any research or experimental procedure without my full knowledge and consent.

5. FINANCIAL AGREEMENT

I understand whether I sign as agent or patient, that I am directly responsible and will pay for services rendered that are not paid by insurance. I agree that I am responsible for any remaining balance due and that I will pay it in accordance with Genesis policies.

I hereby irrevocably assign, transfer and set over to the hospital (or its affiliate entities), all my rights, title and interest to medical reimbursement under my insurance policy(s), Medicare, Medicaid, or other governmental or insurance program. I further assign payment of all applicable insurance benefits to physicians providing services to me that are billed separately by those physicians. I agree that if I receive any payments directly from my insurance company, I will immediately transfer the payment to Genesis for amounts due. This assignment of benefits shall not be deemed a waiver of Genesis's rights to require payment directly from me.

I understand that any questions, I have regarding my health insurance coverage should be directed to my health insurance provider(s).

I certify that I have received a copy of Genesis Billing Services Options.

6. FINANCIAL ASSISTANCE

I understand that if I am not able to pay for my bill that I can contact a Genesis financial counselor at 563-421-3408. After determining my eligibility for financial assistance, the counselor will work with me to determine a level of financial assistance that best meets my needs including interest-free payment plans, discounted care, or free care.

7. MEDICARE PATIENT CERTIFICATION, ASSIGNMENT, AND RELEASE

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration of its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

8. DISCLOSURE OF HEALTH INFORMATION

I understand that all records concerning my hospitalization, including photographs and digital images, shall remain the property of Genesis. I understand that medical records and billing information generated or maintained by Genesis are accessible to hospital personnel and medical staff, and that this information may be used or disclosed in certain circumstances for payment purposes and to support healthcare operations, as allowable by law. Genesis is authorized to disclose all or any portion of my medical record as set forth in its Notice of Privacy Practices, unless I object in writing. By signing this form, I authorize such disclosures.

9. PATIENT RIGHTS AND RESPONSIBILITIES AND ADVANCE CARE DIRECTIVES

I have received the Patient Rights and Responsibilities form.

_____
(Patient Initials)

I have received the Advance Care Directives/Your right to choose form

_____
(Patient Initials)

10. PERSONAL VALUABLES

I understand and agree that Genesis is not responsible or liable for any loss or damage to my personal property such as jewelry, money, glasses, dentures, documents, or other articles of value. If this consent is for admission to a Genesis Hospital, I understand that the hospital has a safe, which I may use for safekeeping of such property.

11. TELEPHONE CONTACT

I agree that Genesis or any of Genesis' Agents may contact me by telephone, cellular phone and voicemail at the number provided regarding this account or any other accounts.

I have read all sections (1 through 11) of this consent, or if necessary, have had this consent read or explained to me. I have had the opportunity to ask questions and those questions have been answered to my satisfaction. By signing, I acknowledge and agree to the terms as stated above.

Signature of Patient/Representative	Relationship to Patient (if representative)	
Witness Signature/Title	Date	Time (Military)
Witness Signature/Title	Date	Time (Military)
Patient Name (Print)	Account Number	Anticipated Date of Service

FIGURE 17.1 Hospital Consent Form

Courtesy of Genesis Health System, Davenport, Iowa

When patients are transferred between these services, the activity is tracked. In an outpatient or an emergency department encounter, there is no room and bed charge; instead, there is a visit charge. **Observation services** are also billed as an outpatient service. These stays are charged by the hour rather than a per diem (per day) charge. Observation services normally do not extend beyond 23 hours.

observation service assistance provided in a hospital room but billed as an outpatient service

Discharge and Billing

By the time patients are discharged from the hospital, their accounts usually have been totaled and insurance claims or bills created. The goal in most cases is to file a claim or bill within seven days after discharge. A typical bill for a patient contains many items. The items are selected from the hospital's charge description master file, usually called the **charge master,** which is the equivalent of a medical practice encounter form. This master list contains the following information for each item:

charge master hospital's list of codes and charges for its services

- The hospital's code for the service and a brief description of it
- The charge for the service
- The hospital department (such as laboratory)
- The hospital's cost to provide the service
- A procedure code for the service
- Dates of service

The hospital's computer system tracks the services in various departments. For example, if the patient is sent to the intensive care (IC) unit after surgery, the IC billing group reports the specific services the patient received, and these charges are entered on the patient's account.

BILLING TIP

Physician's Fees

The physician rather than the hospital charges for his or her professional fee, such as a surgeon's fee.

THINKING IT THROUGH 17.2

1. What are some of the differences in working for a hospital facility and for a physician practice? Which employment setting is more likely to have specialized job functions?

17.3 Hospital Diagnosis Coding

Inpatient medical coders do the coding as soon as possible after a patient is discharged. Some inpatient coders are generalists; others may have special skills in a certain area, such as surgical coding or Medicare. ICD-10-CM is also used to code inpatient diagnoses; different rules apply for assigning inpatient codes than for physician office diagnoses. These rules—found in sections I, II, and III of the *ICD-10-CM Official Guidelines for Coding and Reporting* and in the *Coding Clinic for ICD-10-CM*, a publication of the American Hospital Association's (AHA) Central Office on ICD-10-CM—were developed by the four groups that are responsible for ICD-10-CM: the AHA, the American Health Information Management Association (AHIMA), CMS, and the National Center for Health Statistics (NCHS). The rules are based on the requirements for sequencing diagnoses and reporting procedures that are part of the **Uniform Hospital Discharge Data Set (UHDDS).** Medicare, Medicaid, and many private payers require the UHDDS rules to be followed for reimbursement of hospital services. The rules are extensive. Three of them are briefly described as follows to illustrate some of the major differences between inpatient and outpatient coding.

Uniform Hospital Discharge Data Set (UHDDS) classification system for inpatient health data

principal diagnosis (PDX) condition established after study to be chiefly responsible for admission

Principal Diagnosis and Sequencing

For diagnostic coding in medical practices, the first code listed is the primary diagnosis, defined as the main reason for the patient's encounter with the provider. Under hospital inpatient rules, the **principal diagnosis (PDX)** is listed first. It is the condition established *after study* to be chiefly responsible for the admission. This principal diagnosis is listed even if the patient has other, more severe diagnoses. In some cases, the

GO TO CODING WORKBOOK

If assigned, complete the inpatient coding exercises in the *Medical Coding Workbook, Part 3, Section B*, to expand your medical coding skill.

hospital-issued notice of noncoverage (HINN)
form used to describe benefit guidelines for inpatient hospital services

In such cases, the advance beneficiary notice of noncoverage (ABN) is the form for outpatient services, and the **hospital-issued notice of noncoverage (HINN)** is used for inpatient services. Limited liability applies when:

- Inpatient services (in whole or part):
  - Are not considered reasonable and necessary
  - May be safely provided in another lower-acuity setting
  - Are custodial in nature
- Some inpatient services ordered during an otherwise covered inpatient stay are not considered reasonable and necessary under a written Medicare policy and are not tied to the reasons justifying that inpatient stay.

When any of these inpatient situations arise, hospitals must provide the appropriate HINN before providing the services in order to reserve the right to bill the beneficiary for these services if Medicare agrees that they are noncovered.

Pretreatment Patient Payment Collection

Most facilities set up pretreatment payment plans to collect at least a deposit before admission and treatment. The following types of payments may be collected in advance:

- Medicare Part A and Part B/private payer deductibles, coinsurance, copayments, and noncovered services.
- Medicare lifetime reserve (LTR) day amounts. Medicare pays for up to ninety days in a hospital per benefit period and an additional sixty days of coverage with a high coinsurance. These sixty LTR days can be used only once during a person's lifetime. For each LTR day, Medicare pays all covered costs except for a daily coinsurance. Patients without additional coverage may be required to make arrangements to pay for this daily amount before admission.
- Estimated amounts for noncovered services.
- Private room differential and fees for extras, such as telephone and television services. Most payers do not pay for any item that is considered a convenience rather than a medical necessity.

COMPLIANCE GUIDELINE

Electronic Health Records

Hospitals are leading the way in the implementation of electronic health records. Although this progress affects the collection, storage, and dissemination of health information, including PHI, the content of the health record remains the same.

Records of Treatments and Charges During the Hospital Stay

The Joint Commission sets standards for hospital patient medical records. The hospital's own bylaws and Medicare regulations for participating hospitals also influence medical record standards. The medical record contains (1) notes of the attending physician and other treating physicians, such as operative reports; (2) ancillary documents such as nurses' notes and pathology, radiology, and laboratory reports; (3) patient data, including insurance information for patients who have been in the hospital before; and (4) a correspondence section that contains signed consent forms and other documents. In line with HIPAA security requirements, the confidentiality and security of patients' medical records are guarded by all hospital staff members. Both technical means, such as passwords and encryption, and legal protections, such as requiring staff members to sign confidentiality pledges, are used to ensure privacy.

Hospitals usually charge patients for the following services:

- Room and board
- Medications
- Ancillary tests and procedures, such as laboratory workups
- Equipment/supplies used during surgery or therapy
- The amount of time spent in an operating room, recovery room, or intensive care unit

Patients are charged according to the type of accommodations and services they receive. For example, the rate for a private room is higher than the rate for a semiprivate room, and intensive care unit or recovery room charges are higher than charges for standard rooms.

noridian
Healthcare Solutions

Medicare Secondary Payer Questionnaire

2. Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)

☐ Yes. Name and address of no-fault insurer(s) and no-fault insurance policy owner:

Insurance claim number(s): _____

☐ No.

3. Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)

☐ Yes. Name and address of liability insurer(s) and responsible party:

Insurance claim number(s): _____

☐ No. NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE ACCIDENT. LIABILITY INSURANCE IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE LIABLITY SETTLEMENT, JUDGMENT, OR AWARD. GO TO PART III.

PART III

1. Are you entitled to Medicare based on:

☐ Age. Go to PART IV. ☐ Disability. Go to PART V. ☐ End-Stage Renal Disease (ESRD). Go to PART VI.

Please note that both "Age" and "ESRD" OR "Disability" and "ESRD" may be selected simultaneously. An individual cannot be entitled to Medicare based on "Age" and "Disability" simultaneously. Please complete ALL "PARTS" associated with the patient's selections.

PART IV – AGE

1. Are you currently employed?

☐ Yes. Name and address of your employer:

☐ No: If applicable, date of retirement: MM/DD/CCYY _____

☐ No. Never Employed.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2097889142-18

A CMS Medicare Administrative Contractor

Noridian Healthcare Solutions, LLC

FIGURE 17.3 Medicare Secondary Payer Determination Form (*continued*)

Source: "Medicare Secondary Payer (MSP) Questionnaire," Centers for Medicare and Medicaid Services, 2018. https://www.cgsmedicare.com/jc/forms/pdf/jc_msp_questionnaire.pdf.

noridian
Healthcare Solutions

Medicare Secondary Payer Questionnaire

Medicare Secondary Payer Questionnaire

Suppliers use the Medicare Secondary Payer Questionnaire model as a guide to help identify other payers that may be primary to Medicare. Per CMS Change Request 5087, effective September 11, 2006, major modifications have been made to the Medicare Secondary Payer Questionnaire. Suppliers should replace previous versions of the form with the revised model information provided by CMS. View Modifications.

PART I

1. Are you receiving Black Lung (BL) Benefits?
   - ☐ Yes; Date benefits began: MM/DD/CCYY _____ BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL.
   - ☐ No.

2. Are the services to be paid by a government research program?
   - ☐ Yes. GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.
   - ☐ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?
   - ☐ Yes. DVA IS PRIMARY FOR THESE SERVICES.
   - ☐ No.

4. Was the illness/injury due to a work-related accident/condition?
   - ☐ Yes; Date of injury/illness: MM/DD/CCYY _____
     Name and address of workers' compensation plan (WC) plan:

     Policy or identification number: _____
     Name and address of your employer:

     WC IS PRIMARY PAYER ONLY FOR CLAIMS FOR WORK-RELATED INJURIES OR ILLNESS, GO TO PART III.
   - ☐ No. GO TO PART II.

PART II

1. Was illness/injury due to a non-work-related accident?
   - ☐ Yes; Date of accident: MM/DD/CCYY _____
   - ☐ No. GO TO PART III

CMS

A CMS Medicare Administrative Contractor

FIGURE 17.3 Medicare Secondary Payer Determination Form

These codes are examples of building from the preceding table:

027004Z	Dilation of Coronary Artery, One Site with Drug-eluting Intraluminal Device, Open Approach
02700DZ	Dilation of Coronary Artery, One Site with Intraluminal Device, Open Approach
02700ZZ	Dilation, Coronary Artery, One Site, Open Approach
027034Z	Dilation, Coronary Artery, One Site with Drug-eluting Intraluminal Device, Percutaneous Approach

Coding Steps and Resources

The index of the ICD-10-PCS Code Tables lists the common procedures. Each entry shows the first three or four characters of the code, which point to the correct table to use to build the code.

After finding the index entry, the coder turns to the correct table, which has those characters in its table header, and selects values from the columns to assign values for the fourth, fifth, sixth, and seventh characters. All the characters must come from the same row (the left-to-right axis). Note that unlike ICD-10-CM, after becoming familiar with the table structure, the coder is not required to first consult the index to build a ICD-10-PCS code.

Coders use both the Code Tables/Index and the ICD-10-PCS Reference Manual, which contains explanatory and reference material. Also available on the CMS website are Coding Guidelines and General Equivalent Mappings (GEMs) that relate new to old codes.

COMPLIANCE GUIDELINE

Inpatient Versus Outpatient Diagnosis Coding

The UHDDS inpatient rules apply only to inpatient services. Hospital-based outpatient services and physician-office services are reported using ICD-10-CM, following the outpatient rules (and CPT/HCPCS).

Principal Procedure

The **principal procedure** that the inpatient medical coder assigns is the one that is most closely related to the treatment of the principal diagnosis. It is usually a surgical procedure.

If no surgery is performed, the principal procedure may be a therapeutic procedure.

principal procedure process most closely related to treatment of the principal diagnosis

THINKING IT THROUGH 17.4

1. Based on the description of ICD-10-PCS, do you think it is easier to build codes using this code set rather than looking them up using ICD-10-CM?

17.5 Payers and Payment Methods

Medicare and Medicaid both provide coverage for eligible patients' hospital services. Medicare Part A, known as *hospital insurance*, helps pay for inpatient hospital care, skilled nursing facilities, hospice care, and home healthcare. Private payers also offer hospitalization insurance. Most employees have coverage for hospital services through employers' programs.

American Hospital Association Clearing House—Information on HCPCS Coding for Outpatient Billing
www.ahacentraloffice.org

Medicare Inpatient Prospective Payment System

Diagnosis-Related Groups

CMS's actions to control the cost of hospital services began with the implementation of **diagnosis-related groups (DRGs)** in 1983. Under the DRG classification system, hospital stays of patients who had similar diagnoses were studied. Groupings were created based on the relative value of the resources that hospitals used nationally for patients with similar conditions. One payment covers one hospitalization for the particular condition.

diagnosis-related group (DRG) system of analyzing conditions and treatments for similar groups of patients

ICD-10-PCS follows a logical, consistent structure. Its codes are built using individual letters and numbers, called *values*, selected in sequence to occupy the seven spaces of the code, called *characters*.

Characters

All codes in ICD-10-PCS are seven characters long. Each character in the seven-character code represents an aspect of the procedure.

Example

In the medical/surgical section, the characters mean the following:

Character 1 = Section
Character 2 = Body System
Character 3 = Root Operation
Character 4 = Body Part
Character 5 = Approach
Character 6 = Device
Character 7 = Qualifier

Values

Possible values of 0 to 34 can be assigned to each character in a code: the numbers 0–9 and the alphabet (except I and O because they are easily confused with the numbers 1 and 0). A finished code looks like the following:

02103D4

This code is built by choosing a specific value for each of the seven characters. The columns specify the allowable values for characters 4–7, and the rows specify the valid combinations of values. As an example, review this table for the medical and surgical root operation dilation of the heart and great vessels body system (027):

0: Medical and Surgical

2: Heart and Great Vessels

7: Dilation: Expanding an orifice or the lumen of a tubular body part

Body Part Character 4	Approach Character 5	Device Character 6	Qualifier Character 7
0 Coronary Artery, One Site	**0** Open	**4** Drug-eluting Intraluminal Device	**6** Bifurcation
1 Coronary Arteries, Two Sites	**3** Percutaneous	**D** Intraluminal Device **T** Radioactive Intraluminal Device	**Z** No Qualifier
2 Coronary Arteries, Three Sites	**4** Percutaneous Endoscopic	**Z** No Device	
3 Coronary Arteries, Four or More Sites			

Because the definition of each character is a function of its physical position in the code, a specific value in one position has a different meaning when it is placed in a different position. For example, the value 0 in the first character means something different than 0 in the second character and 0 in the third character. Details about the procedure performed, values for each character specifying the section, body system, root operation, body part, approach, device, and qualifier are assigned.

THINKING IT THROUGH 17.3

1. A patient is admitted for gastrointestinal bleeding due to diverticulitis. The initial treatment plan is for the patient to undergo a sigmoid resection, but the patient decides to postpone the surgery for personal reasons.

   What is the principal diagnosis in this case? What additional diagnosis code is reported to show that the patient decided not to proceed?

17.4 Hospital Procedure Coding

The UHDDS requires significant procedures to be reported along with the principal diagnosis, comorbidities, and complications. Significant procedures have any of these characteristics:

- They involve surgery.
- Anesthesia (other than topical) is administered.
- The procedure involves a risk to the patient.
- The procedure requires specialized training.

Mandated by HIPAA, as of October 1, 2015, the **ICD-10-PCS** (procedure coding system) code set must be used for inpatient procedural reporting for hospitals and payers. ICD-10-PCS replaced ICD-9-CM volume 3, which had been used previously for facility reporting of hospital inpatient procedures.

ICD-10-PCS mandated code set for inpatient procedural reporting for hospitals and payers as of October 1, 2015

Code Set Structure

ICD-10-PCS has a multiaxial code structure, meaning that a table format is used to present options for building a code. An *axis* is a column or row in a table; columns are vertical, and rows are horizontal. The coder picks the correct values from one of the rows in a table to build a code for each procedure. This approach provides a unique code for every substantially different procedure and allows new procedures to be easily incorporated as new codes.

The code set, which is available both online and in a printed reference, is updated annually. The Code Tables, the main part of the code set, begin with an index to assist in locating common procedures. Then procedures are divided into sixteen sections that identify the general type of procedure, such as medical and surgical, obstetrics, or imaging. The first character of the procedure code always specifies the section:

0 Medical and Surgical
1 Obstetrics
2 Placement
3 Administration
4 Measurement and Monitoring
5 Extracorporeal Assistance and Performance
6 Extracorporeal Therapies
7 Osteopathic
8 Other Procedures
9 Chiropractic
B Imaging
C Nuclear Medicine
D Radiation Oncology
F Physical Rehabilitation and Diagnostic Audiology
G Mental Health
H Substance Abuse Treatment

Each section is made up of a series of tables with columns and rows for valid combinations of codes.

admitting diagnosis (ADX) patient's condition determined at admission to an inpatient facility

sequencing listing the correct order of a principal diagnosis according to guidelines

admitting diagnosis (ADX)—the condition identified by the physician at admission to the hospital—is also reported.

The *ICD-10-CM Official Guidelines for Coding and Reporting* also addresses the correct **sequencing** of a principal diagnosis when various situations are present. Following are major rules and examples:

- If each of two or more related diagnoses meets the definition for a principal diagnosis, either condition can be sequenced first (that is, be the first listed). An example would be the related conditions of congestive heart failure and atrial fibrillation.
- If each of two or more unrelated diagnoses meets this criterion, either can be listed first. A patient hospitalized and treated for both chronic obstructive pulmonary disease (COPD) and atrial fibrillation illustrates this situation.
- If two or more comparative or contrasting conditions are documented, the one that caused the admission is listed first. For example, if a patient is admitted for dizziness and the physician documents benign positional vertigo versus labyrinthitis, either condition could be listed first.
- If an original treatment plan is not carried out, that plan is still the reason for admission and is sequenced as the principal diagnosis.
- If an admission is for treatment of a complication resulting from surgery or other medical care, the complication ICD-10-CM code is sequenced as the principal diagnosis.

COMPLIANCE GUIDELINE

What Determines the Correct Code Set for Hospital Coding?

The dates of discharge/through dates are used to select the correct code set. An inpatient hospital stay is coded based on the patient's date of admission.

Coding Example

Inpatient principal diagnosis after surgery: Acute appendicitis (K35.2)

Inpatient admitting diagnosis: Severe abdominal pain (R10.9)

Suspected or Unconfirmed Diagnoses

When the patient is admitted for workups to uncover the cause of a problem, inpatient medical coders can also use suspected or unconfirmed conditions (rule-outs) if they are listed as the admitting diagnosis. The admitting diagnosis may not match the principal diagnosis once a final decision has been made.

Coding Example

Inpatient principal diagnosis: Diverticulosis of the small intestine (K57.10)

Inpatient admitting diagnosis: Probable acute appendicitis (K35.2)

Comorbidities and Complications

comorbidity admitted patient's coexisting condition that affects the length of hospital stay or course of treatment

complication condition a patient develops after surgery or treatment that affects length of hospital stay or course of treatment

The inpatient coder also lists all other conditions that have an effect on the patient's hospital stay or course of treatment. These conditions at admission are called **comorbidities,** meaning coexisting conditions. Conditions that develop as problems related to surgery or other treatments are coded as **complications.** Comorbidities and complications are shown in the patient medical record with the initials *CC*.

Coding Examples

Comorbidity: The physician's discharge summary stated that the patient needed additional care because of emphysema.

Code: J43.9

Complication: The physician's discharge summary indicates a diagnosis of postoperative hypertension as a postoperative complication.

Codes: Hypertension, I11.9, and I97.89, Cardiac Complications

Coding CCs is important because their presence may increase the hospital's reimbursement level for the care. The hospital insurance claim form discussed later in this chapter allows for up to eighteen additional conditions to be reported.

Medicare Outpatient Prospective Payment Systems

The use of DRGs under a prospective payment system proved to be very effective in controlling costs. In 2000, CMS implemented this type of approach for outpatient hospital services, which previously were paid on a fee-for-service basis. These payment systems are in place:

- *Outpatient Prospective Payment System (OPPS):* The Balanced Budget Act of 1997 authorized Medicare to begin paying for hospital outpatient services under a prospective payment system called the **Outpatient Prospective Payment System (OPPS).** Patients are grouped under an **ambulatory patient classification (APC)** system instead of DRGs. Reimbursement is made according to preset amounts based on the value of each APC group to which the service is assigned.
- *Ambulatory surgical centers (ASCs):* CMS also sets prospective APC rates for facility services provided by Medicare-participating ASCs.
- *Medicaid Ambulatory Patient Groups (APGs):* APGs are gradually being implemented in state Medicaid systems. APGs are a visit-based outpatient classification system designed to explain the amount and type of resources used in the ambulatory setting. Instead of reimbursing providers for outpatient facility costs based on charges or a percentage of charges as is currently done for most outpatient care, a predetermined, fixed reimbursement is made for the outpatient services rendered. The APG reimbursement covers only the facility cost for outpatient services, not the professional (physician) costs. APGs encompass a wide spectrum of outpatient services including ER, same-day surgery unit, hospital clinics, and ancillary service departments. The new system covers a diverse population from pediatrics to geriatrics.

Outpatient Prospective Payment System (OPPS) payment system for Medicare Part B services that facilities provide on an outpatient basis

ambulatory patient classification (APC) Medicare payment classification for outpatient services

Two important guidelines apply to OPPS billing:

- The **inpatient-only list** describes procedures that can be billed only from the inpatient facility.
- Under the **three-day payment window** rule, Medicare bundles all outpatient services that a hospital provided to a patient within three days before admission into the DRG payment for that patient. This has the effect of reducing payments to physicians who are not facility employed because the facility receives the payment for the technical resources and the physician is paid only for the professional component.

Inpatient-only list itemized description of procedures that can be billed from the facility inpatient setting only

three-day payment window rule requiring Medicare to bundle all outpatient services provided by a hospital to a patient within three days before admission into the DRG payment for that patient

Other Medicare Prospective Payment Systems

Long-term care facilities (that is, skilled nursing facilities) are paid under a prospective payment system called the Skilled Nursing Facility Prospective Payment System (SNF PPS). Patients are assessed using information from the minimum data set (MDS) related to staff time and then are categorized into resource utilization groups (RUGs). RUGs are tied to a daily payment amount that Medicare Part A pays.

Home health agencies use data from the Outcomes and Assessment Information Set (OASIS) to categorize patients into payment groups for payments under the Home Health Prospective Payment System (HH PPS).

Inpatient rehabilitation facilities (IRFs) are also paid under a prospective payment system. The IRF PPS pays according to the assessed needs of admitted patients.

BILLING TIP

OCE

Claims for outpatient payments are subject to the outpatients code editor (OCE), which checks that specific codes are payable under OPPS.

Private Payers

Because of the expense involved with hospitalization, private payers encourage providers to minimize the number of days patients stay in the hospital. Most private payers establish the standard number of days allowed for various conditions (called the *estimated length of stay,* or ELOS), and compare the ELOS to the patient's actual stay as a way to control costs.

Many private payers have also adopted the UHDDS format and the DRG method of setting prospective payments for hospital services. Hospitals and the payers, which may include BlueCross BlueShield or other managed care plans, negotiate the rates for each DRG.

- Air embolism (a sudden artery blockage caused by air bubbles introduced during surgery)
- Hospital-related injuries such as fractures, dislocations, head injuries, and burns
- Severe chest infections after surgery
- Blood infections from a catheter
- Surgical site infections following certain elective procedures, including certain orthopedic surgeries, and bariatric surgery for obesity
- Certain manifestations of poor control of blood sugar levels
- Deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures

CMS does not cover a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs (1) the wrong surgery on a patient, (2) the correct procedure but on the wrong body part, or (3) the correct procedure but on the wrong patient.

Noncoverage encompasses all related services provided in the operating room when the error occurs, including those separately performed by other physicians, and all other services performed during the same hospital visit. Following hospital discharge, however, any reasonable and necessary services are covered regardless of whether they are or are not related to the surgical error.

Modifiers for Never Events Physicians, ASCs, and hospital outpatient facilities use one of the following HCPCS Level II modifiers to all codes related to the surgical error:

PA Surgical or other invasive procedure on wrong body part

PB Surgical or other invasive procedure on wrong patient

PC Wrong surgery or other invasive procedure on patient

For hospital inpatient claims, coders assign one of the following modifiers to all codes related to the surgical error:

MX Wrong surgery on patient

MY Surgery on wrong body part

MZ Surgery on wrong patient

Quality Improvement Organizations and Utilization Review

When DRGs were established, CMS also set up peer review organizations (PROs), which were later renamed Quality Improvement Organizations (QIOs). QIOs are made up of practicing physicians and other healthcare experts who are contracted by CMS in each state to review Medicare and Medicaid claims for the appropriateness of hospitalization and clinical care.

QIOs seek to ensure that payment is made only for medically necessary services. In many circumstances, Medicare requires precertification for inpatient or outpatient surgery, as do many private payers. Although the admission or the procedure may be approved, the amount of payment is usually not determined until the QIO reviews the services. When reviewing submitted claims, QIOs may take one of the following actions:

- Review and fully approve a claim
- Review and deny portions of a claim
- Review a claim for a patient's inpatient services and decide that no stay was medically necessary
- Decide to conduct a postpayment audit

QIOs are also resources for investigating quality of care. They review patients' complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. They also contract with private payers to perform these services.

HCPCS/CPT Code Set for APCs

The HCPCS/CPT code set along with selected modifiers is mandated for APCs. Evaluation and management (E/M) codes are used according to a crosswalk the provider develops for its emergency department services.

18 Infectious and Parasitic Diseases (Systemic or Unspecified Sites)
19 Mental Diseases and Disorders
20 Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders
21 Injuries, Poisonings, and Toxic Effects of Drugs
22 Burns
23 Factors Influencing Health Status and Other Contacts with Health Services
24 Multiple Significant Trauma
25 Human Immunodeficiency Virus Infections

Inpatient Prospective Payment System

Hospital inpatient services for Medicare beneficiaries are paid under a prospective payment approach. The Medicare **Inpatient Prospective Payment System (IPPS)** determines the number of hospital days and the hospital services that are reimbursed. If a patient has a principal diagnosis accompanied by comorbidities or complications, such as coma or convulsions, these additional signs are evidence of a more difficult course of treatment, and the MS-DRG reimbursement is raised. If, however, the hospital holds the patient for longer than the MS-DRG specifies without such circumstances, it still receives only the allowed amount and must write off the difference between the reimbursement and its actual costs. Each hospital negotiates a rate for each MS-DRG with CMS based on its geographic location, labor and supply costs, and teaching costs.

Inpatient Prospective Payment System (IPPS) Medicare payment system for hospital services

Present on Admission Indicator

CMS has also put into place the requirement for a **present on admission (POA)** indicator for every reported diagnosis code for a patient upon discharge. *Present on admission* means that a condition existed at the time the order for inpatient admission occurred. This requirement is based on a federal mandate to Medicare to stop paying for conditions that hospitals cause or allow to develop during inpatient stays. Medicare will not assign an inpatient hospital discharge to a higher-paying MS-DRG if a particular **hospital-acquired condition (HAC)** was not POA. HACs are reasonably preventable events. The case will be paid as though the secondary diagnosis was not present.

Five codes are used for POA indicator reporting:

- Y = Diagnosis was present at the time of inpatient admission. (Medicare will continue to assign a discharge to a higher-paying MS-DRG if the selected condition was POA.)
- N = Diagnosis was not present at the time of inpatient admission.
- W = The documentation is insufficient to determine whether the condition was present at the time of inpatient admission.
- U = The provider cannot clinically determine whether the condition was present at the time of admission.
- 1 = Exempt from POA reporting (Medicare).

present on admission (POA) code used when a condition existed at the time the order for inpatient admission occurred

hospital-acquired condition (HAC) condition a hospital causes or allows to develop

Never Events

A halt in payments is designed as an incentive for hospitals to be meticulous about following safety guidelines—from frequent hand-washing to taking careful inventory of surgical objects. Both CMS and many other health plans have announced that they will no longer pay hospitals for treating complications caused by avoidable conditions. The list of so-called **never events**—preventable medical errors that result in serious consequences for the patient—includes:

- Objects left inside a patient during surgery
- Use of the wrong blood type during transfusions
- Urinary tract infections associated with a catheter
- Pressure ulcers (bed sores), Stages III and IV

never event preventable medical error resulting in serious consequences for the patient

grouper software used to calculate the DRG to be paid based on the codes assigned for the patient's stay

BILLING TIP

DRG Grouper

A computer program called a **grouper** calculates the DRG to be paid based on the codes assigned to the patient's stay.

The ICD-10-CM diagnosis and procedure codes are used to calculate the DRG. The calculations combine data about the patient's diagnosis and procedures with factors that affect the outcome of treatment, such as age, gender, comorbidities, and complications. DRGs are ranked by weight. Higher-weighted DRGs use resources more intensively and are therefore paid more. Each hospital's **case mix index** is an average of the DRG weights handled for a specific period of time.

case mix index measure of the clinical severity or resource requirements

MS-DRGs

Medicare-Severity DRG (MS-DRG) type of DRG designed to better reflect the different severity of illness among patients who have the same basic diagnosis

In 2008 Medicare adopted a type of DRG called **Medicare-Severity DRGs (MS-DRGs)** to better reflect the different severity of illness among patients who have the same basic diagnosis. The system recognizes the higher cost of treating patients with more complex conditions.

Hospital admissions are grouped according to their expected use of hospital resources. The groups are based on:

- Principal diagnosis
- Surgical procedure(s)
- Age
- Sex
- Complications
- Comorbidities
- Signs and symptoms (if the diagnosis is not yet known)
- Discharge disposition (routine, transferred, deceased)

major diagnostic category (MDC) classification used to group MS-DRGs

MS-DRGs are grouped into one of the twenty-five **major diagnostic categories (MDCs).** Each MDC is subdivided into medical and surgical MS-DRGs. Most MDCs are based on body site and are defined as:

01	Diseases and Disorders of the Nervous System
02	Diseases and Disorders of the Eye
03	Diseases and Disorders of the Ear, Nose, Mouth, and Throat
04	Diseases and Disorders of the Respiratory System
05	Diseases and Disorders of the Circulatory System
06	Diseases and Disorders of the Digestive System
07	Diseases and Disorders of the Hepatobiliary System and Pancreas
08	Diseases and Disorders of the Musculoskeletal System and Connective Tissue
09	Diseases and Disorders of the Skin, Subcutaneous Tissue, and Breast
10	Endocrine, Nutritional, and Metabolic Diseases and Disorders
11	Diseases and Disorders of the Kidney and Urinary Tract
12	Diseases and Disorders of the Male Reproductive System
13	Diseases and Disorders of the Female Reproductive System
14	Pregnancy, Childbirth, and the Puerperium
15	Newborns and Other Neonates with Conditions Originating in the Perinatal Period
16	Diseases and Disorders of Blood, Blood Forming Organs, and Immunological Disorders
17	Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasm

Table 17.1 UB-04 Form Completion *(continued)*

Form Locator	Description	Medicare Required?
14 Type of Admission/Visit	Required for inpatient bills: 1 = emergency 2 = urgent 3 = elective 4 = newborn 5 = trauma 9 = information not available (rarely used)	Yes
15 Point of Origin for Admission or Visit	Point of origin for IP admission or OP visit: 1 = non-healthcare facility (e.g., home, a physician's office, or workplace) 2 = clinic 3 = reserved 4 = transfer from a hospital (different facility) 5 = transfer from an SNF or ICF 6 = transfer from another healthcare facility 7 = emergency room 8 = court/law enforcement 9 = information not available A = reserved B = transfer from another home health agency C = readmission to same home health agency D = transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the payer E = transfer from ambulatory surgery center F = transfer from hospice and is under a hospice plan of care or enrolled in a hospice program G-Z = reserved Code structure for newborns 1-4 = reserved 5 = born inside this hospital 6 = born outside of this hospital 7-9 = reserved	Yes
16 Discharge Hour	Code indicating the hour patient was discharged from inpatient care. Hour codes are based on military time (see FL 13, Admission Hour).	No
17 Patient Discharge Status	For Part A inpatient, SNF, hospice, home health, and outpatient hospital services: 01 = discharge to home or self-care (routine discharge) 02 = discharge to another short-term general hospital 03 = discharge to SNF 04 = discharge to ICF 05 = discharge to a designated cancer center or children's hospital 06 = discharge to home under care of a home health service organization 07 = left against medical advice or discontinued care 09 = admitted as inpatient (after outpatient services) 20 = expired 30 = still patient or expected to return for outpatient services 40 = expired at home (hospice claims only)	Yes

(continued)

Table 17.1 UB-04 Form Completion

Form Locator	Description	Medicare Required?
1 (Unlabeled Field) (Provider Name, Address, and Telephone Number)	The name, address (service location), and telephone number of the provider submitting the bill.	Yes
2 (Unlabeled Field) (Pay-to Name and Address)	To be used only if the provider would like payments mailed to a different address from that listed in FL 1; for example, a central processing office or a PO box.	Situational
3a Patient Control Number	Patient's unique number assigned by the facility and used to locate the patient's financial record. For example, the patient control number is used to identify payments on RAs.	Yes
3b Medical Record Number	Number assigned by the facility to the patient's medical record and used to locate the patient's treatment history.	Yes
4 Type of Bill	Four-digit alphanumeric code: First digit is a leading 0. (Note: The leading 0 is not included on electronic claims.) Second digit identifies the facility type (e.g., 1 = hospital; 2 = SNF). Third digit identifies the care type (e.g., 1 = inpatient Part A; 2 = inpatient Part B; 3 = outpatient). Fourth digit identifies the billing sequence in this episode of care (e.g., 1 = this bill encompasses entire inpatient confinement or course of outpatient treatment for which provider expects payment from the payer; 2 = this bill is the first bill in an expected series of bills).	Yes
5 Federal Tax Number	Also known as the TIN or EIN; a ten-digit alphanumeric number (XX-XXXXXXXX) reported in the bottom line of FL 5. (Note: The hyphen in the number is not used on electronic claims.) The top line of FL 5 may be used as necessary to report a federal tax sub-ID for an affiliated subsidiary of the hospital, such as a hospital psychiatric pavilion.	Yes
6 Statement Covers Period (From–Through)	The beginning and ending dates (MMDDYY) of the period included on the bill; dates before patient's entitlement are not shown. From date is used to determine timely filing.	Yes
7 (Unlabeled Field)	Reserved for national assignment.	
8a Patient Identifier	May be used if the patient and the insured are not the same; the patient identifier is the number assigned to the patient by the patient's insurance carrier (this number would be different from the Insured's Unique Identifier in FL 60).	Situational
8b Patient Name	Patient's last name, first name, and middle initial. A comma (or space) is used to separate last and first names on the paper claim.	Yes
9 a, b, c, d, e Patient's Address	Patient's full mailing address (a) street number and name, PO Box or RFD; (b) city; (c) state; (d) ZIP Code; and (e) country code (if other than USA).	Yes
10 Patient Birth Date	Patient's birth date (MMDDYYYY); for paper claims, if birth date is unavailable, report eight zeroes.	Yes
11 Patient Sex	For Medicare claims, report M for male; F for female. Other payers may also accept U for Unknown.	Yes
12 Admission, Start of Care Date	Date of admission for inpatient care, or start of care date for home health services (MMDDYY).	Yes
13 Admission Hour	The hour during which the patient was admitted for inpatient care. A two-digit hour code, based on military time, is used to indicate hour (e.g., 3:15 a.m. = 03; 1:40 p.m. = 13).	No

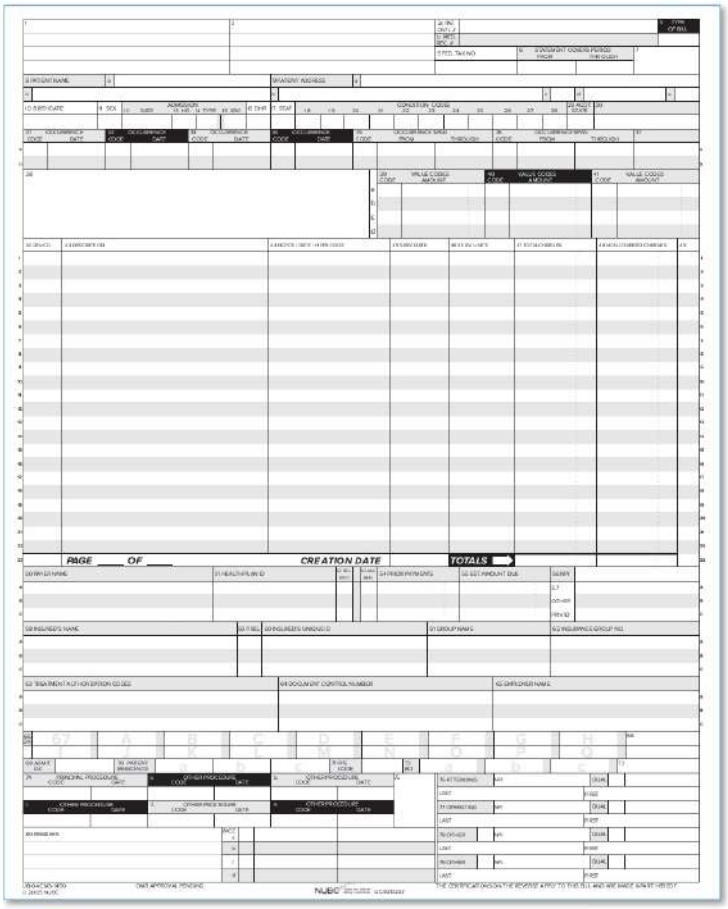

FIGURE 17.4 UB-04 Form

A number of private payers use the DRG to negotiate the fees they pay hospitals. Managed care plans use two other payment methods. Preferred provider organizations (PPOs) often negotiate a discount from the DRG with the hospital and its affiliated physicians. The hospital may have discounted fee structures with a number of PPOs and other managed care plans—each different, depending on what the agreement was agreed to. Health maintenance organizations (HMOs) negotiate capitated contracts with hospitals, too. The hospital agrees to provide care for a set population of prospective patients who are plan members. The HMO in turn pays the hospital a flat rate—a single set fee for each member. This rate may be a per diem rate that pays for each day the patient is in the hospital regardless of the specific services. Like the DRG model, when a patient is held in the hospital for longer than is stated in the agreement between the HMO and the hospital, the hospital has to write off the extra cost.

THINKING IT THROUGH 17.5

1. How are the Medicare Prospective Payment System and the use of capitated rates in managed care organizations similar? How are they different?

17.6 Claims and Follow-Up

HIPAA X12 837 Health Care Claim: Institutional (837I) format for claims for institutional services

UB-04 uniform billing 2004, also known as the CMS-1450 paper claim for hospital billing

UB-92 former paper hospital claim

Hospitals must submit claims for Medicare Part A reimbursement to Medicare Administrative Contractors using the **HIPAA X12 837 Health Care Claim: Institutional (837I)** called 837I. This electronic data interchange (EDI) format, similar to the 837 claim, is called *I* for *Institutional;* the physicians' claim is called 837P *(Professional).* According to the National Uniform Billing Committee (NUBC), 98 percent of hospital claims are submitted electronically to Medicare, and 80 percent of all institutional claims are electronic.

In some situations, payers may accept a paper claim form called the **UB-04** (uniform billing 2004), also known as the **CMS-1450** (see Figure 17.4). The NUBC maintains the UB-04 form, previously called the **UB-92.**

837I Healthcare Claim Completion

The 837I, like the 837P, has sections requiring data elements for the billing and the pay-to provider, the subscriber and patient, and the payer in addition to claim and service level details. Most of the data elements report the same information as summarized in Table 17.1 for the paper claim.

National Uniform Billing Committee (NUBC)

UB-04 Claim Form Completion

The UB-04 claim form has eighty-one data fields, some of which require multiple entries (see Figure 17.3). The information for the form locators often requires choosing from a list of codes. See Table 17.1 for required information and possible choices for a Medicare claim. (In some cases, because the list of code choices is extensive, selected entries are shown as examples.) Private-payer-required fields may be slightly different, and other condition codes or options are often available.

BILLING TIP

Code Sets on the UB-04

Instructions that incorporate ICD-10-CM/PCS are to be released.

Remittance Advice Processing

Hospitals receive a remittance advice (RA) when payments are transmitted by payers to their accounts. The patient accounting department and HIM check that appropriate payment has been received. Unless the software used for billing automatically reports that the billed code is not the same as the paid code, procedures to find and follow up on these exceptions must be set up between the two departments.

Table 17.1 UB-04 Form Completion *(continued)*

Form Locator	Description	Medicare Required?
58 (lines A, B, C) Insured's Name	The name of the insured individual in whose name the insurance, as reported in FL 50 A, B, or C, is listed. The information in FLs 59–62 on the same line all pertains to this person. This name (last name, first name, and middle initial) must correspond to the name on the insured's health insurance card.	Yes
59 (lines A, B, C) Patient's Relationship to Insured	Code for patient's relationship to insured: 01 = spouse 18 = self 19 = child 20 = employee 21 = unknown 39 = organ donor 40 = cadaver donor 53 = life partner G8 = other relationship	Yes
60 (lines A, B, C) Insured's Unique Identifier	The identification number assigned to the insured by the payer organization; for example, in the case of Medicare, the patient's Medicare number.	Yes
61 (lines A, B, C) Insured's Group Name	The name of the group or plan under which the individual is insured; used when available and the group number (FL 62) is not used. For Medicare secondary, the primary payer's insurance group or plan name, if known, is reported in line A.	Situational
62 (lines A, B, C) Insured's Group Number	The number assigned by the insurance company to identify the group or plan under which the individual is insured. For Medicare secondary, the primary payer's insurance group number, if known, is reported in line A.	Situational
63 (lines A, B, C) Treatment Authorization Codes	Number or other indicator that designates that the treatment covered by this bill has been authorized by the payer indicated in FL 50 (lines A, B, C). On Medicare claims, whenever the QIO review is performed for outpatient preadmission, preprocedure, or inpatient preadmission, authorization number is shown.	Situational
64 (lines A, B, C) Document Control Number (DCN)	The internal control number assigned to the original bill by the indicated health plan (FL 50 A, B, C); reported when filing a replacement or cancellation to a previously processed claim.	Situational
65 (lines A, B, C) Employer Name of the Insured	The name of the employer that is providing healthcare coverage for the insured indicated in FL 58 A, B, or C. (*Note:* Not used on electronic claims.)	Situational
66 Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	ICD version indicator. Codes include: 9 = ICD-9-CM 0 = ICD-10-CM	Yes
67 Principal Diagnosis Code and POA Indicator	ICD10-CM diagnosis codes reported to highest level of specificity available. A POA (present on admission) code indicator is required in the eighth position of this FL (shaded area) to indicate whether the diagnosis was present at the time of admission. POA indicators include: Y = yes N = no U = no information in the record W = clinically undetermined 1 or Blank = exempt from POA reporting (1 on electronic claims)	Yes

(continued)

Table 17.1 UB-04 Form Completion *(continued)*

Form Locator	Description	Medicare Required?
46 (lines 1-22) Service Units	Number of units for each applicable service provided, such as number of accommodation days, pints of blood, or number of lab tests.	Yes
47 (lines 1-23) Total Charges	Lines 1-22: Total line item charges. Line 23: On paper claims, the sum total of charges for the billing period is reported in line 23 on final page of bill using revenue code 0001.	Yes
48 (lines 1-23) Noncovered Charges	Lines 1-22: Total of noncovered charges of those listed in FL 42. Line 23: On paper claims, the sum total of noncovered charges is reported in line 23 on final page of bill, using revenue code 0001.	Yes
49 (Unlabeled Field)	Reserved for national assignment.	
50 (lines A, B, C) Payer Name (payers A, B, C)	The name of the payer organization from which the provider is expecting payment; lines A, B, and C are used to report the primary, secondary, and tertiary payer. Information in FLs 51-55 on the same line all pertains to this payer. If Medicare is primary payer, Medicare is entered on line A. If Medicare is secondary or tertiary payer, the primary payer is entered on line A, and Medicare information on line B or C.	Yes
51 (lines A, B, C) Health Plan Identification Number (payers A, B, C)	For reporting the HIPAA national health plan identifier when one is established; otherwise, the provider's six-digit Medicare-assigned number, or legacy number assigned by other payer, is entered on the line corresponding to payer A in FL 50. If other payers are involved, their ID numbers are reported in lines B and C.	Yes
52 (lines A, B, C) Release of Information Certification Indicator (payers A, B, C)	A code indicating whether the provider has obtained release of information authorization from the patient. Codes include: Y = provider has on file a signed statement permitting data release to other organizations in order to adjudicate the claim. (Note: The back of the UB-04 contains this certification.) I = provider has informed consent to release medical information for conditions or diagnoses regulated by federal statutes (to be used when the provider has not collected a signature and state and federal laws do not supersede the HIPAA Privacy Rule).	Yes
53 (lines A, B, C) Assignment of Benefits Certification Indicator (payers A, B, C)	A code indicating whether the provider has obtained a signed form from the patient authorizing the third-party payer to send payments directly to the provider. Codes include: N = no W = not applicable (when patient refuses to assign benefits; for paper claims only) Y = yes (Note: Not required for Medicare claims.)	No
54 (lines A, B, C) Prior Payments—Payer (payers A, B, C)	The amount provider has received to date (from payer A, B, or C) toward payment of this bill.	Situational
55 (lines A, B, C) Estimated Amount Due—Payer (payers A, B, C)	The amount the provider estimates is due from the indicated payer (A, B, or C) toward payment of this bill.	Situational
56 National Provider Identifier—Billing Provider	The billing provider's ten-digit National Provider Identifier (NPI).	Yes
57 (lines A, B, C) Other (Billing) Provider Identifier	For reporting health plan legacy number assigned to provider by the indicated payer in FL 50 (payer A, B, C). No longer a required field on Medicare claims after HIPAA's mandated use of NPIs in FL 56. For non-Medicare claims, required only when there is no NPI in FL 56 and an identification number other than the NPI is necessary for the receiver to identify the provider.	No

Table 17.1 UB-04 Form Completion *(continued)*

Form Locator	Description	Medicare Required?
35, 36 Occurence Span Codes and Dates	Codes and beginning/ending dates (MMDDYY) for specific events relating to the billing period that affect processing, such as: 72 = first/last visit dates (actual dates of first and last visits in this billing period when different from FL 6, Statement Covers Period) 77 = provider liability period (from and through dates of a period of noncovered care for which provider is liable; utilization is charged)	Situational
37 (Unlabeled Field)	Reserved for national assignment	
38 (Unlabeled Field) (Responsible Party Name and Address)	May be used on commercial claims if a window envelope is used for mailing the claim. For Medicare as secondary payer, the address of the primary payer may be shown here	No
39, 40, 41 Value Codes and Amounts	Codes and related dollar amounts required to process the claim; examples include: 08 = Medicare lifetime reserve amount for first calendar year in billing period 09 = Medicare coinsurance amount for first calendar year in billing period 14 = no-fault, including auto/other, when primary payer payments are being applied to covered Medicare charges on this bill 31 = patient liability amount; the amount approved by hospital or the QIO to charge the beneficiary for noncovered services 50 = physical therapy visits; number of visits provided from onset of treatment through this billing period 80 = number of days covered by the primary payer (as qualified by the payer) (*Note:* For paper claims only.) 81 = number of days not covered by the primary payer (*Note:* For paper claims only.) A1, B1, C1 = amounts assumed by provider to be applied to the patient's deductible amount for payer A, B, or C (*Note:* For paper claims only.) A2, B2, C2 = amounts assumed by provider to be applied to the patient's coinsurance amount involving payer A, B, or C (*Note:* For paper claims only.) A3, B3, C3 = amount estimated by provider to be paid by payer A, B, or C D3 = amount estimated by the provider to be paid by the indicated patient	Situational
42 (lines 1-23) Revenue Code	Lines 1-22: For reporting the appropriate four-digit code(s) to identify a specific-accommodation and/or ancillary service. The corresponding narrative description is reported next to the code in FL 43 (Revenue Description). Up to 22 codes (lines 1-22) can be listed on each page. Line 23: On paper claims, code 0001 (total charges) is placed before the total charge amount and reported on line 23 of the final claim page.	Yes
43 (lines 1-22) Revenue Description	Line 1-22: Narrative description for each revenue code used in FL42. (*Note:* Not used on electronic claims.) Line 23: Incrementing page count and total number of pages (Page ___ of ___) is reported on line 23 on each page.	No
44 (lines 1-22) HCPCS/Accommodation/Rates/HIPPS Rate Codes	HCPCS codes for applicable procedures (ancillary and outpatient services); accommodation rates for inpatient bills; or HIPPS rate codes for determining payment for service line item under certain prospective payment systems.	Yes
45 (lines 1-23) Service Date	Lines 1-22: For outpatient claims, the date (MMDDYY) the outpatient service was provided. A single line item date is required for every revenue code. Line 23: The creation date is required in line 23 of this field for all pages of the claim.	Yes

(continued)

Table 17.1 UB-04 Form Completion *(continued)*

Form Locator	Description	Medicare Required?
	41 = expired in a medical facility (hospice claims only) 42 = expired, place unknown (hospice claims only) 50 = hospice—home 51 = hospice—medical facility 70 = discharge to another type of healthcare institution not defined elsewhere in this code list	
18–28 Condition Codes	Codes relating to bill that affect processing; examples include: 02 = condition is employment related 04 = information only bill 05 = lien has been filed 06 = ESRD-patient in first eighteen months of entitlement covered by employer group health insurance 07 = treatment of nonterminal condition for hospice patient 08 = beneficiary would not provide information concerning other insurance coverage 09 = neither patient nor spouse is employed 10 = patient and/or spouse employed, but no employer group health plan coverage exists 31 = patient is student (full-time, day) 40 = same day transfer 50 = product replacement for known recall of a product 67 = beneficiary elects not to use lifetime reserve days A9 = second opinion surgery C3 = partial approval (after review by the QIO or intermediary)	Situational
29 Accident State	State where an accident occurred on claims containing services related to an auto accident; two-digit state abbreviation is reported.	No
30 (Unlabeled Field)	Reserved for national assignment.	
31–34 Occurrence Codes and Dates	Codes and date data (MMDDYY) relating to bill that affect processing; examples include: 01 = accident/medical coverage 04 = accident/employment related 05 = accident/no medical or liability coverage 11 = onset of symptoms/illness 17 = date occupational therapy plan established or reviewed 18 = date of patient/beneficiary retirement 19 = date of spouse retirement 21 = utilization notice received 24 = date insurance denied by primary payer 25 = date benefits terminated by primary payer 31 = date beneficiary notified of intent to bill for inpatient care accommodations 32 = date beneficiary notified of intent to bill for Medicare medically unnecessary procedures or treatments 45 = date treatment started for speech therapy A1 = birthdate—insured A A2 = effective date—insured A policy A3 = benefits for insured A exhausted A4 = split bill date (date patient became Medicaid eligible)	Situational

I.	_____	Patient's sex
J.	_____	Patient's medical record number
K.	_____	Admission hour
L.	_____	Type of admission
M.	_____	Discharge hour
N.	_____	Insured's name
O.	_____	Patient's relationship to insured
P.	_____	Insured's payer ID number
Q.	_____	Payer name
R.	_____	Revenue code(s)
S.	_____	Revenue description
T.	_____	Units
U.	_____	Charges
V.	_____	Principal diagnosis code and POA indicator
W.	_____	Attending provider name and ID

Chapter 17 Summary

Learning Outcomes	Key Concepts/Examples
17.1 Distinguish between inpatient and outpatient hospital services.	Inpatient services: • Involve an overnight stay • Are provided by general and specialized hospitals, skilled nursing facilities, and long-term care facilities Outpatient services: • Are provided by ambulatory surgical centers or units, by home health agencies, and by hospice staff
17.2 List the major steps relating to hospital billing and reimbursement.	The first major step in the hospital claims processing sequence involves: • Admitting (registering) the patient • Entering personal and financial information in the hospital's health record system • Verifying insurance coverage • Signing consent forms by the patient • Presenting a notice of the hospital's privacy policy to the patient • Collecting some pretreatment payments The second step includes: • Tracking and recording the patient's treatments and transfers among the various departments in the hospital The third step involves: • Discharging and billing • Following the discharge of the patient from the facility and the completion of the patient's record
17.3 Contrast coding diagnoses for hospital inpatient cases and for physician office services.	• Diagnostic coding for inpatient services follows the rules of the UHDDS. • Two ways in which inpatient coding differs from physician and outpatient diagnostic coding are: 1. The main diagnosis, called the *principal* rather than the *primary diagnosis*, is established after study in the hospital setting. 2. Coding an unconfirmed (rule-out) as the admitting diagnosis is permitted.

failure, the patient is assigned DRG 87, which has a higher relative value, resulting in an improperly high payment.

OIG has established lists of DRGs that are often the result of upcoding. Patterns of higher-than-normal reporting by a hospital of these DRGs may cause an investigation and possibly an audit of the hospital.

OIG has also used MedPar data over the years to monitor other improper Medicare payments to hospitals. Two problem areas have been improper payments for nonphysician outpatient services and overpayments for patient transfers.

To safeguard against fraud, hospitals:

- Double-check registration information. The admissions department verifies that the patient is being admitted for a medically necessary diagnosis under the payer's rules. If items will not be covered under Medicare Part A, patients must sign the HINN (or an ABN for Part B; see the chapter about Medicare) to acknowledge their responsibility for payment.
- Update their charge masters every year with current HCPCS, ICD-10-CM/PCS, and CPT codes.
- Compare clinical documentation with the patient's bill to make sure reported services are properly documented.
- Conduct postpayment audits to uncover patterns of denied or partially paid codes.

It is also important for the HIM department to respond to requests for additional information from the recovery audit contractor (RAC) program, which is initially focused on hospital billing.

RAC Program

www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/

The goal of the RAC program is to identify and recover improper payments made on claims for Medicare beneficiaries. RACs were created as part of the Medicare Integrity Program (MIP), which mandates that CMS take all possible steps to ensure that claims are correct.

The RACs are independently contracted auditors rather than government employees. RACs receive a percentage of the money that they collect. The contractors audit claims after they have been paid, and they are authorized to look back three years from the date of payment. The contractors use specialized software programs to analyze claims based on the provider's billing patterns. They look for noncompliance with coding guidelines and local and national carrier determinations (LCDs/NCDS) as well as coverage issues. For example, incorrect MS-DRG assignment is considered a coding error.

If an overpayment decision is made, the RAC sends a notification to the provider. Notification is either an automated demand for repayment or, if complex, a demand for medical record review. RACs must request records in writing, and providers have forty-five days to respond. An appeal process has five levels and is more complex than ordinary Medicare appeals. Trained staff must decide whether the appeal process is likely to save enough money to pay for the staff time that will be required.

THINKING IT THROUGH 17.6

1. Based on the guidelines in Table 17.1, assign a form locator (1-23) to each of the following data items. The first has been completed for you.

Form Locator	Data Item
A. 1	Facility name and address
B. _____	Federal tax number
C. _____	Statement covers period (from—through)
D. _____	Patient's name
E. _____	Patient's address
F. _____	Patient birth date
G. _____	Patient's health plan ID
H. _____	Patient control number

Table 17.1 UB-04 Form Completion *(concluded)*

Form Locator	Description	Medicare Required?
78, 79 Other Provider Name and Identifiers	*Line 1:* Provider type qualifier code and NPI of other provider such as a referring or assisting provider. Provider type qualifier codes include: DN = referring provider ZZ = other operating physician 82 = rendering provider On non-Medicare claims, a secondary identifier may be reported in line 1 when an NPI is not used. See FL 76 above. *Line 2:* Last name and first name of other provider.	Situational
80 Remarks	For providing information that is not shown elsewhere on the claim and that is necessary for proper payment; for example, DME and Medicare Secondary Payer information.	Situational
81a, b, c, d Code-Code Field	For reporting FL overflow codes or to report externally maintained codes approved by the NUBC, such as taxonomy codes or public health reporting codes, not used in current form. Report code qualifier followed by code. Code qualifiers for overflow codes (not used on Medicare claims) include: A1 = condition codes A2 = occurrence codes and dates A3 = occurrence span codes and dates A4 = value codes and amounts Other example of code qualifiers: B3 = healthcare provider taxonomy code (billing provider only) (*Note:* Taxonomy code is required for institutional providers submitting Medicare claims; used to identify subparts of facility when provider has chosen not to apply for individual subpart NPIs.)	Situational

Similar to medical practices, hospitals set up schedules when accounts receivable are due and follow up on late payments. The turnaround time for electronic claims is usually from ten to fifteen days faster than for manual paper claims, so the follow-up procedures are organized according to each payer's submission method and usual turnaround time. Payers' requests for attachments such as emergency department reports may delay payment.

Hospital Billing Compliance

Both outpatient and inpatient facilities must comply with federal and state law. In the Medicare program, compliance is as important for Part A claims as it is for Part B claims. To uncover fraud and abuse in Part A payments, the Office of the Inspector General (OIG) directs part of its annual Work Plan at institutional providers. For example, CMS's annual Medical Provider Analysis and Review (MedPar) data show national averages for each DRG group in hospitals. OIG uses these figures in preparing the part of the OIG Work Plan that is directed at hospital coding. A major target has been the upcoding of DRG groups. OIG has sought to uncover fraud when a hospital too often reports codes that result in high-relative-value DRGs.

Example

A patient has a pulmonary edema (fluid in the lungs) that is due to the principal diagnosis of congestive heart failure. The correct ICD-10-CM code order leads to a DRG 127 classification. If the coder instead incorrectly reports pulmonary edema and respiratory

COMPLIANCE GUIDELINE

OIG Guidance

OIG has issued both a 1998 Compliance Program Guidance for Hospitals and a Supplemental Compliance Program Guidance, together presenting effective compliance policies and programs for hospitals.

Table 17.1 UB-04 Form Completion *(continued)*

Form Locator	Description	Medicare Required?
67 A-Q Other Diagnoses Codes with POA Indicators	Codes for additional conditions that coexisted at admission or developed and that had an effect on the treatment or the length of stay. A POA indicator is required in the eighth position of this field (shaded area). See list of POA code indicators in FL 67 above. (*Note:* The UB-04 form provides fields A-Q for up to eighteen additional codes. Medicare allows for up to eight additional codes, reported in the top line in fields A-H)	Yes
68 (Unlabeled Field)	Reserved for national assignment.	
69 Admitting Diagnosis Code	For inpatient claims only. The patient's admitting diagnosis is required if the claim is subject to QIO review.	Yes
70 a, b, c Patient's Reason for Visit	For outpatient claims only. The patient's reason for visit is required for all unscheduled outpatient visits. Up to three diagnosis codes can be reported (a, b, c). (*Note:* May be reported for scheduled outpatient visits, such as for ancillary tests, when this information provides additional support for medical necessity.)	Situational
71 Prospective Payment System (PPS) Code	Used to identify the DRG. Required on IP claims if the hospital's DRG contract with the payer stipulates that this information be provided. (*Note:* Not used for Medicare claims; workers' compensation programs often require this information.)	No
72 a, b, c External Cause of Injury (ECI) Code	The ICD code(s) for an external cause of injury, poisoning, or other adverse effect. (*Note:* Not used for Medicare claims.) POA: FLs 72 a, b, c contain a shaded area for reporting a POA indicator code. (*Note:* Medicare requires only POA codes for ECI codes when they are being reported in FLs 67 A-Q as other diagnosis codes.)	No
73 (Unlabeled Field)	Reserved for national assignment.	
74 Principal Procedure Code and Date	For reporting the ICD procedure code most closely related to principal diagnosis code, along with corresponding date of procedure. (MMDDYY). Required on inpatient claims only. Not to be used on outpatient claims.	Situational
74 a-e Other Procedure Codes and Dates	For reporting up to five additional procedure codes and dates. Required on inpatient claims only. Not to be used on outpatient claims.	Situational
75 (Unlabeled Field)	Reserved for national assignment.	
76 Attending Provider Name and Identifiers	*Line 1:* NPI (primary identifier) of the attending provider. Required for any services received other than nonscheduled transportation services. On non-Medicare claims, a secondary identifier may be reported in line 1 when an NPI has not been obtained and an identification number other than the NPI is necessary for the receiver to identify the provider. Report secondary identifier qualifier followed by ID number. Secondary identifier qualifiers include: 0B = state license number 1G = provider UPIN number G2 = provider commercial number *Line 2:* Last name and first name of attending provider.	Situational
77 Operating Physician Name and Identifiers	*Line 1:* NPI (primary identifier) of physician who also performed principal or surgical procedures; required when a surgical procedure code is reported on the claim. On non-Medicare claims, a secondary identifier may be reported in line 1 when an NPI is not used. See FL 76 above. *Line 2:* Last name and first name of operating physician.	Situational

Case 17.3 Completing Claims

LO 17.6 Based on the guidelines in Table 17.1 and the following data, complete a UB-04 for this hospitalization. Be sure to calculate the total of the charges.

FACILITY INFORMATION

Name:	Hanover Regional Hospital
Address:	2600 Record St.
City/State/Zip:	Hanover, CT 06783
Telephone:	860-376-2000
Federal Tax ID:	07-1282340
NPI:	1213141516

PATIENT INFORMATION

Patient Name:	Marvin Kelly
Patient Address:	46 State St.
City/State/Zip:	Hartford, CT 06516
Patient Control Number:	XZ6518
Medical Record Number:	1825695
Date of Birth:	3/13/2029

INSURANCE INFORMATION

Insured's Name:	Richard G. Kelly
Patient's Relationship to Insured:	Child
Insured's ID Number:	002879366
Health Plan:	HMO Blue Care

PATIENT SERVICES

Date of Service: 3/13/2029, 5:45 P.M. Discharged 3/17/2029, 3:30 P.M.

Services:	REV Codes	Units	Charges
Lab-Hematology	0305	1	72.87
Lab Pathology-Other	0319	1	35.28
Nursery/Newborn Level I	0171	4	@ 552.00
Medical/Surgical Supplies	0270	1	34.44
Lab	0300	1	35.09
Lab-Chemistry	0301	1	517.04

Principal Dx: Single liveborn, born in hospital (Z38.00) POA: 1

Attending Provider: Thomas Wong, NPI 9100016533

Applying Your Knowledge

Case 17.1 Coding Hospital Services

Follow the inpatient coding guidelines for (1) identifying the principal diagnosis, (2) coding suspected conditions, and (3) differentiating between statements of admitting, principal, comorbidity, and complication diagnoses as you analyze these cases.

A. **LO 17.3, 17.4** What is the principal diagnosis for this patient?

Discharge Date: 07/03/2029

Patient: Kellerman, Larry H.

Patient is a 59-year-old male who was recently found to have some evidence of induration of his prostate gland. He was referred for urologic evaluation and admitted to the hospital for further study and biopsy. Under general anesthesia, cystoscopy revealed early prostatic enlargement, and needle biopsy was accomplished. Pathological examination of the tissue removed confirmed the presence of adenocarcinoma of the prostate.

B. **LO 17.3, 17.4** What is the admitting diagnosis for this patient?

Room: S-920

Patient: Koren, Sarah I.

Admission Date: 10/09/2029

Chief Complaint: Severe, right upper abdominal pain radiating to the back.

History of Present Illness: This 38-year-old female reports having this severe pain for two weeks. She has had some nausea and vomiting. Condition worsened by previous treatment with pain medication and Tagamet. Previous ultrasound of her gallbladder showed a very thickened gallbladder wall with a large stone, impacted at the neck of the cystic duct. Her family physician has admitted her to be taken to surgery for a cholecystectomy. She notes diarrhea a few days ago but no other change in bowel habits.

Impression: Probable acute cholecystitis.

C. **LO 17.3, 17.4** Identify the principal diagnosis, the principal procedure, the comorbidity diagnosis, and the complication in the following discharge statement.

Flora Raniculli is a 65-year-old female admitted to the hospital with a three-month history of cough, yellow-sputum production, weight loss, and shortness of breath. Chest X-ray reveals probable bronchiectasis. Patient may also have pulmonary fibrosis. She underwent a bronchoscopy that showed thick secretions in both lower lobes. Postbronchoscopy fever finally cleared up. She is now being discharged and will call me in one week for a progress report.

Case 17.2 Calculating Insurance Math

A hospital has a per diem payment arrangement with an HMO. The plan will pay the hospital $1,200 a day for inpatient care regardless of the services the hospital provides. This month, one member has been hospitalized for three days for observation and tests. The hospital charges for each of the three days are $1,275, $1,330, and $1,200.

A. **LO 17.5, 17.6** What is the total hospital fee for the three days?

B. **LO 17.5, 17.6** How much will the HMO pay the hospital for this patient's care?

C. **LO 17.5, 17.6** How is the balance handled?

Select the answer choice that best completes the statement or answers the question.

11. **LO 17.2** When the hospital staff collects data on a patient who is being admitted for services, the process is called
    - **A.** health information management
    - **B.** registration
    - **C.** MSP
    - **D.** precertification

12. **LO 17.1** Which of the following hospital departments has different procedures for collecting patients' personal and insurance information?
    - **A.** accounting department
    - **B.** surgery department
    - **C.** emergency department
    - **D.** collections department

13. **LO 17.2** Patient charges in hospitals vary according to
    - **A.** their accommodations only
    - **B.** their services only
    - **C.** their accommodations and services
    - **D.** their age and gender

14. **LO 17.4** Which of these rules governs the reporting of hospital inpatient services on insurance claims?
    - **A.** ASC
    - **B.** HIM
    - **C.** APC
    - **D.** UHDDS

15. **LO 17.3** Conditions that arise during the patient's hospital stay as a result of surgery or treatments are called
    - **A.** comorbidities
    - **B.** admitting diagnoses
    - **C.** complications
    - **D.** correlates

16. **LO 17.3** In inpatient coding, the initials *CC* mean
    - **A.** chief complaint
    - **B.** comorbidities and complications
    - **C.** cubic centimeters
    - **D.** convalescent center

17. **LO 17.4** The code 02103D4 is an example of which type of code?
    - **A.** CPT
    - **B.** ICD-10-CM
    - **C.** HCPCS
    - **D.** ICD-10-PCS

18. **LO 17.5** Under a prospective payment system, payments for services are
    - **A.** set in advance
    - **B.** based on the provider's fees
    - **C.** discounts to the provider's usual fees
    - **D.** not required from most patients

19. **LO 17.6** The UB-04 form locator 4 requires the
    - **A.** type of bill
    - **B.** admission hour
    - **C.** revenue code
    - **D.** patient status

20. **LO 17.2** Under Medicare rules for patients in car accidents, the automobile insurance is
    - **A.** primary
    - **B.** secondary
    - **C.** supplemental
    - **D.** tertiary

Define the following abbreviations:

21. **LO 17.5** DRG
22. **LO 17.5** PPS
23. **LO 17.1** SNF
24. **LO 17.1** ASC
25. **LO 17.1** HHA
26. **LO 17.5** POA
27. **LO 17.5** MS-DRG

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Learning Outcomes	Key Concepts/Examples
17.4 Explain the coding system used for hospital procedures.	• ICD-10-PCS (procedure coding system) is used to report hospital procedures. • All codes have seven digits. • The codes are assigned based on the principal diagnosis.
17.5 Discuss the factors that affect the rate that Medicare pays for inpatient services.	• Medicare pays for inpatient services under its Inpatient IPPS, which uses DRGs to classify patients into similar treatment and length-of-hospital-stay units and sets prices for each classification group. • A hospital's geographic location, labor and supply costs, and teaching costs also affect the per-DRG pay rate it negotiates with CMS.
17.6 Interpret hospital healthcare claim forms.	The 837I—the HIPAA standard transaction for the facility claim—or, in some cases, the UB-04 form (CMS-1450), is used to report: • Patient data • Information on the insured • Facility and patient type • The source of the admission • Various conditions that affect payment • Whether Medicare is the primary payer (for Medicare claims) • The principal and other diagnosis codes • The admitting diagnosis • The principal procedure code • The attending physician • Other key physicians • Charges

Review Questions

Match the key terms with their definitions.

1. **LO 17.2** attending physician
2. **LO 17.3** principal diagnosis
3. **LO 17.2** charge master
4. **LO 17.1** inpatient
5. **LO 17.5** DRGs
6. **LO 17.3** comorbidities
7. **LO 17.3** admitting diagnosis
8. **LO 17.4** principal procedure
9. **LO 17.1** ambulatory care
10. **LO 17.6** 837I

A. A person admitted to a hospital for services that require an overnight stay

B. The main service performed for the condition listed as the principal diagnosis for a hospital inpatient

C. The clinician primarily responsible for the care of the patient from the beginning of the hospital episode

D. Outpatient care

E. HIPAA standard transaction for the facility claim

F. A hospital's list of the codes and charges for its services

G. The patient's condition identified by the physician at admission to the hospital

H. A system of analyzing conditions and treatments for similar groups of patients used to establish Medicare fees for hospital inpatient services

I. Conditions in addition to the principal diagnosis that the patient had at hospital admission that affect the length of the hospital stay or the course of treatment

J. The condition that after study is established as chiefly responsible for a patient's admission to a hospital

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