Indian Health Service

Briefing Topic

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What is a Medical Billing?

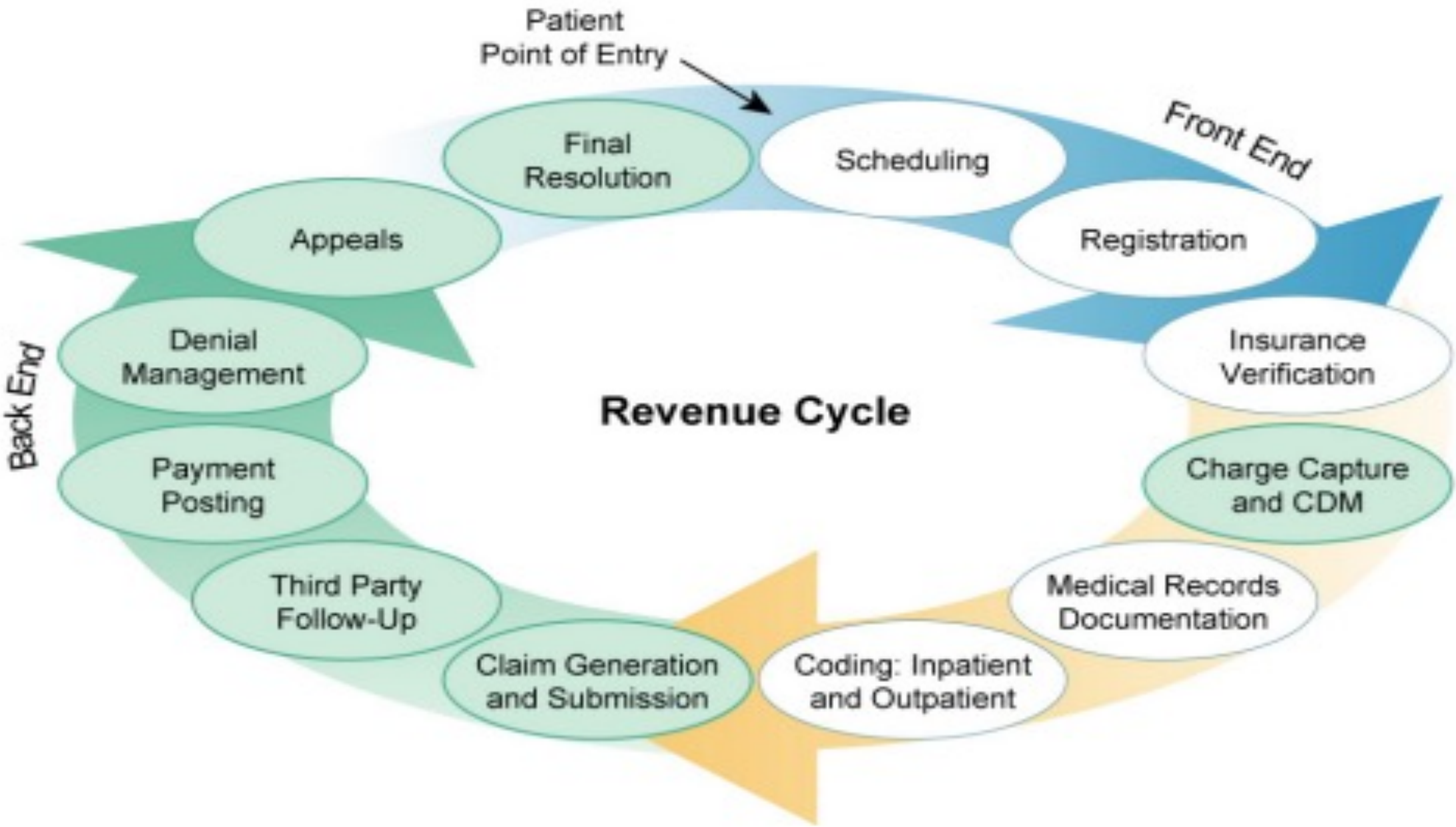
MEDICAL BILLING IS THE PROCESS OF GENERATING HEALTHCARE CLAIMS TO SUBMIT TO INSURANCE COMPANIES FOR THE PURPOSE OF OBTAINING PAYMENT FOR MEDICAL SERVICES RENDERED BY PROVIDERS AND PROVIDER OGRANIZATIONS.

What Medical Billers Do?

- MEDICAL BILLERS NAVIGATE BETWEEN PATIENTS, HEALTHCARE PROVIDER AND INSURANCE COMPANIES TO ARRANGE FOR REIMBURSEMENT OF HEALTHCARE SERVICES.

Medical Billing Process

Accurate billing and timely follow up is the No. 1 priority.


Patient
Point of Entry
Front End
Scheduling
Registration
Insurance
Verification
Charge Capture
and CDM
Medical Records
Documentation
Coding: Inpatient
and Outpatient
Claim Generation
and Submission
Third Party
Follow-Up
Payment
Posting
Denial
Management
Appeals
Final
Resolution
Back End
Revenue Cycle

Front End – Revenue Cycle

Pre-Registration and Registration:

To start, when a patient arranges an appointment, administrative staff must handle the scheduling, insurance eligibility verification, and patient account establishment.

Insurance Verification Process:

Our ability to enter the correct insurance, verify accurate demographics for the patient, and collect the patient's financial responsibility at the front end all reduces rework throughout the revenue cycle and ultimately reduces potential denials

Encounter Forms (PCC):

After a patient visit is complete, the healthcare provider must create a claims submission and complete charge capture duties (Health Information Management).

The provider or coder identifies the ICD-10-CM, CPT, HCPCS Level II code(s) that corresponds with the treatment, selecting the most appropriate code for services can help prevent claim denials.

Back End – Revenue Cycle

Communicating with physicians to clarify any discrepancies or to obtain additional information about patient encounter is the back end process.

Medical biller must know how to read the medical record and be familiar with ICD-10-CM, CPT and HCPCS Level II codes.

Back End – Revenue Cycle

Charge Entry:

The charge capture process documents the services into billable fees.

Claim Generation:

This involves compiling charges, revenue codes, ICD-10-CM, CPT, HCPCS Level II codes. Once all information is translated into a claim then claim is sent to third party payers for reimbursement.

Claim Scrubber:

Ensure all procedure, diagnosis, modifier codes, revenue codes are present and accurate. Ensuring patient, provider visit information is completed. Clearinghouse: scrub claims for any additional errors.

Claim forms:

Biller primarily use claims forms to obtain payment from insurers.

Claim Submission:

Submit claims electronically or directly which meet filing requirement as established by HIPAA claims standards.

Third Party Billing System:

Claim Editor Menu:

- Add/Edit Claim Menu
  - Edit Claim Generator, One Patient
  - Claim Data
  - Add New Claim (manual entry)
  - Rebuild Items from PCC
  - Check Eligibility for a visit

Third Party Billing System:

- Claim/Bill Management Menu
  - Cancel Claim
  - Cancel an approved bill
  - Inquire about an Approved bill
  - Add a new Bill that was manually submitted
  - Open/Close claim
  - Split claim

Third Party Billing System:

- Reports Menu
  - Brief Claim Listing
  - Employee Productivity Report
  - Bills Listing
  - View PCC Visit
  - Cancelled Claims Report
  - Closed Claims Report
  - Pending Claims Status Report

Third Party Billing System:

Set Site

- Enter your facility name: Jumping from site to site within your Service Unit

Claim Editor Menu

Clinic Type:

- Know your Clinic Types/Clinic Codes:

➢ Emergency Medicine 30

➢ Dental 56

➢ Dietary 67

➢ Family Practice 08

➢ General 01

➢ Gynecology 10

➢ Immunization 12

Get familiar with your Clinics and clinic codes. Know what type of services are provided in those clinic areas.

Hint: Place double question mark (??) on line 1 and display all the Clinic type/codes in RPMS.

Visit Type

Visit types

- 111 – Inpatient
- 121 – Ancillary (MCR Part B Only)
- 131 – Outpatient
- 500 Series – Telehealth/Telemedicine
- 989 – Emergency Room
- 998 – Dental
- 999 – Professional Component

Hint: Place double question mark (??) display a list of all Visit Types in RPMS

Bill Types:

- This four-digit alphanumeric code provides three specific pieces of information after a leading zero. CMS ignores the leading zero. This three-digits alphanumeric codes gives three specific pieces of information.

- ***First Digit =*** Leading zero. Ignored by CMS

- ***Second Digits =*** Type of Facility 1-9

  - 1 Hospital
  - 2 Skilled Nursing Facility
  - 3 Home Health
  - 7 Clinic or Hospital based End Stage Renal Disease (ESRD) facility

Bill Types

Third Digit = Type of Care 1-9

- 1 Inpatient Part A, Rural Hospital Center, Hospice
- 2 Inpatient (Part B), Hospital Based, Hospice
- 3 Outpatient, ASC

Fourth Digit = Frequency 1-9, Alpha Characters.

- 0 Non payment
- 1 Admit Through Discharge
- 7 Replace for Prior Claim

Billing From Date & Billing Thru Date

This displays your dates of service:

Outpatient = 1 date of service

ex: Billing From date: 01/01/2023

Billing Thru date: 01/01/2023

Inpatient = date of admission

ex: Billing From date: 01/01/2023

Billing Thru date: 01/05/2023

Mode of Export/Claim Forms:

Paper Format:

24 NCPDP-P = Pharmacy

28 UB-04

34 ADA-2012 ADA Claim

35 CMS-1500 (02/12)

36 ADA-2019 ADA Claim

Electronic Format:

31 837I (UB) 5010 = 837 5010 Institutional

32 837P(HCFA) 5010 = 837 5010 Professional

33 837D(ADA) 5010 = 837 5010 Dental

Insurers

- Medicare
  - Medicare Part C (Medicare Advantage Plan)
- Medicaid
  - AHCCCS
  - New Mexico Medicaid
  - Utah Medicaid
  - Colorado
  - Managed Care Organizations: Western Sky, Presbyterian Centennial, etc.
- Private Insurance
  - BCBS
  - Cigna
  - United Health Care
- Veteran's Administration
- Other

Insurer Information

Any information on the Insurer page come from Patient Registration.

Active Payer

Primary or who you will be billing

Pending Payer

Other listed insurer from patient demographics

Biller should understand the different in payer:

- Primary
- Secondary
- Tertiary

Ex: Medicare Primary and Medicaid secondary

Provider Data

Enter providers that are credentialed with your facility:

- A = Attending
- O = Operating
- R= Rendering

Should not bill out services for provider if they have not received their provider number with Medicare and Medicaid. Enrollment process has to be completed and assigned provider number will be provided. Without assigned provider obtained and entered into RPMS, claims will deny.

Diagnosis Page

Biller should be familiar with code sets: CPT, ICD-10-CM, HCPCS Level II, CDT (Dental).

Current Procedural Terminology (CPT) = uniform language for coding medical services and procedures.

International Classification of Diseases, Tenth Revision (ICD-10) = system used by physicians to classify and code all diagnoses, symptoms and procedures for claims processing.

Healthcare Common Procedure Coding System (HCPCS Level II) = developed by Center for Medicare and Medicaid Services (CMS) to help code procedures and medial equipment.

Current Dental Terminology = standard code sets for dental diagnoses and treatments (oral health and dentistry). Each procedural codes is an alphanumeric code beginning with the letter “D” (the procedure code) and followed by four numbers (the nomenclature).

Revenue Code

Revenue codes are descriptions and dollar amounts charged for hospitals services provided to a patient. The revenue code tells an insurance company whether the procedure was performed in the emergency room, operating room or another department. A valid procedure code must be accompanied by a Revenue Code for it to be accepted by the insurance provider. Every item in a hospital's chargemaster (catalog of all services performed by that hospital) must have one revenue code attached to it.

11x = Room and board

17x = Nursery

25x = Pharmacy

26x = Therapy

30x = Laboratory

37x= Anesthesia

40x = Physical Therapy

45x = Emergency Room

50x = Outpatient Services

Hint: Place two question marks (??) will display all Revenue Codes in RPMS.

Clearinghouse

An institution that electronically transmits different types of medical claims data to insurance carriers.

1. Prescreen and clean medical claims data
2. Search for errors and inaccuracies

Once it passes the edits

1. Securely transmits the electronic data to the specified payor over a secure connection that meets strict standards outlined by HIPAA.

Various Types of Clearinghouse:

Inovolon (My Ability) and Change Healthcare

National Correct Coding Initiative (NCCI)

Medicare National Correct Coding Initiative (NCCI) promote correct coding methodologies and for improper coding/payment. Improper payment for certain codes that are submitted together for Part B covered services.

Medically Unlikely Edits (MUEs) is a maximum number of Units of Services (UOS) allowable under most circumstances for a single HCPCS/CPT codes billed by the provider on a date of service for a single beneficiary.

1. Denial based on NCCI/MUEs may not be billed to Medicare beneficiaries.
2. Provider cannot utilize an Advance Beneficiary Notice of Noncoverage to seek payment from a Medicare Beneficiary.
3. NCCI does not include all possible combinations of correct coding edits or type of unbundling.

https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

National Coverage Determination (NCD) Local Coverage Determination (LCD)

A national coverage determination (NCD) is a general outline of coverage which is applicable regardless to which MAC (Medicare Administrative Contractor) is administering claims for a region. LCDs (Local Coverage Determinations) are specific to a Medicare Administrative Contractor (MAC).

MAC – Novitas Solutions

https://www.novitas-solutions.com/webcenter/portal/NovitasSolutions

Global Period/Days

A global period is a period of time starting with a surgical procedure and ending some period of time after the procedure.

Minor procedures are relatively simple and may have either a 0-day or 10-day global period. A 0-day global means there is no pre-operative period and no post-operative days. Apply only the day of the procedure or service.

A 10-global has more resource intensive, require a longer recovery for the patient and have a 90-day global period. The global package for a major procedure begins one day before the procedure or service and includes the day of service plus 90 days that follow (a total of 92 days).

You may separately report an E/M service during a global period if the E/M service is unrelated to the global package procedure or service.

The E/M service is for treatment of a problem unrelated to the surgery

The E/M service is for treatment of the underlying condition that prompted the procedure

Modifier Usage

Modifiers indicate that a service was altered in some way from the stated descriptor without changing definition. The American Medical Association (AMA) modifiers are two-digit alpha/numeric codes listed after a procedure or supply code and separate from the code by a hyphen. The modifier provides additional information:

- Services has professional and technical components
- More than one provider performing procedure
- More than one location
- Increase and decrease of services
- Repeated services

Proper use of modifiers is important both for accurate coding and impact reimbursement for providers. Using the wrong modifier may cause claim denials which will cause rework, payment delays or reimbursement loss.

https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xe-xp-xs-and-xu.pdf

Value Codes

Value codes are required on an institutional claim to identify data elements.

Example:

Medicare lifetime reserve, no-fault payment and number of days not covered by the primary payer.

- 80 – covered days
- 81 – Non covered days

Physical Therapy

- 50 – Physical Therapy
- 51 – Occupational Therapy
- 52 – Speech Therapy

Condition Codes

Condition codes are 2 digit numerical or alphanumeric representation of aspects of a patient, services provided, the type of service venue and/or billing situation that can impact the processing of an institutional claim by a payer.

Medicare

- A6 – Pneumocccal pneumonia and influenza vaccines paid at 100%.
- 44 – used when inpatient admission is being changed to outpatient.
- B4 – to indicate services are not related/unrelated repeat admission

Occurrence Codes

The code that identifies a significant event relating to an institutional claim that may affect payer processing:

- M1 – the from/through dates of a period of non-covered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable – No Pay Bill Medicare Claims.
- 21 – Billing for no-payment claims (billing for denial notice)
- A3 – Benefits have exhausted

Occurrence Span Codes

Occurrence span codes are similar to occurrence codes. They display on institutional claims to identify a specific event related to a claim, which occurred from a certain span of time:

- 71 Hospital prior stay dates
- 72 First/last visit
- 73 Benefit eligibility period
- 74 – Non covered level of care: dates represent the period at a non-covered level of care in an otherwise covered stay excluding any period reported by occurrence span code 76, 77, or 79.
- 75 the from/thru dates of SNF level of care during IP hospital stay
- 76 Patient liability
- 77 Provider liability (utilization charged)
- 78 SNF prior stay dates
- 79 Provider Liability (non-utilization)

Discharge Status Codes

The claim must include the discharge status code that most accurately reflects the discharge of the patient.

- 01 – Discharge to home or self care
- 02 – Discharged/transferred to a short term general hospital for inpatient care.
- 07 – Left against medical advice or discontinued care.
- 20 – Expired (report only when the patient dies).

Fraud

Fraud is an intentional representation that an individual knows to be false or does not believe to be true and makes, knowing that the representation could result in some unauthorized benefit to himself/herself or some other person. The most frequent kind of fraud arises from a false statement or representation that is material to entitlement or payment under the Medicare program. The violator may be a practitioner, physician supplier, contractor employee or beneficiary.

Examples of fraud include, but are not limited to the following:

- Billing for services or supplies that weren't provided
- Altering claims to obtain higher payments
- Soliciting, offering or receiving a kickback, bribe or rebate (example: Paying for referral of clients)
- Provider completing Certificates of Medical Necessity (CME) for patients not known to the provider
- Suppliers completing CMEs for the physician
- Using another person's Medicare card to obtain medical care

Abuse

Abuse is the practices may, directly or indirectly, result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or which are medically unnecessary.

Examples of abuse include, but are not limited to the following:

- Excessive charges for services or supplies
- Claims for services that aren't medically necessary
- Breach of the Medicare participation or assignment agreements
- Improper billing practices

Medicare Secondary Payer -Objectives-

1. What is Medicare Secondary Payer MSP
2. Eligibility
3. Other Types of Insurance and Medicare
4. Billing Sequence of Other Insurance and Medicare
5. Examples
6. Analyzing and Reconciling 999 / 277CA Reports

What is Medicare Secondary Payer ?

Define

Medicare Secondary Payer, MSP, occurs when a patient has another type of primary insurance and is entitlement to Medicare as a secondary payer.

Medicare does not have primary payment responsibility.

What is Medicare Secondary Payer ?

Example

Patient has Group Health Insurance like Blue Cross Blue Shield as primary and Medicare Part B as secondary.

Why is it important?

Preserve the Medicare Trust Fund and generates revenue for the Service Unit which in return is utilized to enhance patient care.

What is Medicare Secondary Payer ?

History

1965 The “Medicare Bill”

1972 Social Security Amendment

1980 The Medicare Secondary Payer Act

2003 Medicare Identifies Self-Insured entities

MSP Now

Eligibility

Resources - Websites and Customer Service Call Center

These resources facilitate proper and efficient verification of coverage

1. Novitasphere
2. State Medicaid Portals
3. Clearing House
4. Customer Service Call Center

Usage further facilitates proper and timely billing of MSP Claims

Eligibility

Navigating Novitasphere and Tabs

1. The Beneficiary tab informs Patient Demographics and the Medicare number, MBI

2. The Eligibility tab informs Effective dates for Part A and Part B

3. The MSP tab informs who is primary to Medicare and what the insurance type code is, (12,13,14 etc.)

Eligibility

Navigating State Medicaid websites (Navajo Area)

1. Arizona Medicaid - AHCCCS portal
2. New Mexico Medicaid – Conduent portal
3. Utah Medicaid - Eligibility Look up Tool and/or PRISM
4. Colorado Medicaid – GainWell Technologies portal

Eligibility – Other Resources

Clearing House applications support eligibility, billing, and accounts receivable functions

- Coverage Discovery with Inovalon
- Individual Eligibility request via EDI 270 Health Care Eligibility Benefit Inquiry Transaction

Customer Call Centers

- Customer Service Lines
- Interactive Voice Response IVR

Eligibility – Other Resources

MSP Contractor (formerly known as the Benefits Coordination and Recovery Center BCRC)

1-855-798-2627 to report changes

The patient must be present and is the only individual that can update the Common Working File

- The common working file houses a Medicare beneficiary's Demographic Information.
  - Who pays first
  - Insurance Type Code (12, 13, 14, etc.)

Eligibility

Screening the Medicare Beneficiary

1. Upon patient check-in, query the patient
2. Medicare Secondary Payer Questionnaire, MSPQ
   - Format is a flow sheet
   - Answers of NO = Medicare is Primary
   - Answers of YES = Medicare is Secondary
     - Aids a Patient Registration end user in determining which insurance type to assign to a Medicare Beneficiary's profile

Eligibility

2. Medicare Secondary Payer Questionnaire, MSPQ continued

Examples

- 12 Working Aged Employed or Retired (date) Group Health Insurance Self/Spouse
- 15 Workers' Compensation Accepted Conditions or Diagnoses
- 14 No Fault Insurer Automobile Insurance PIP
- 47 Liability Insurer claims related to the Accident
- 43 Disability
- 13 ESRD

Billing Sequence of Other Insurance and Medicare

Group Health Insurance and Medicare

1. Bill Group Health/Private Insurance, Once Adjudicated…

2. Bill Medicare, include all claims adjustment reason codes (CARC) from the primary payer

- Blue Cross Blue Shields and Medicare
- Cigna and Medicare

Billing Sequence of Other Insurance and Medicare

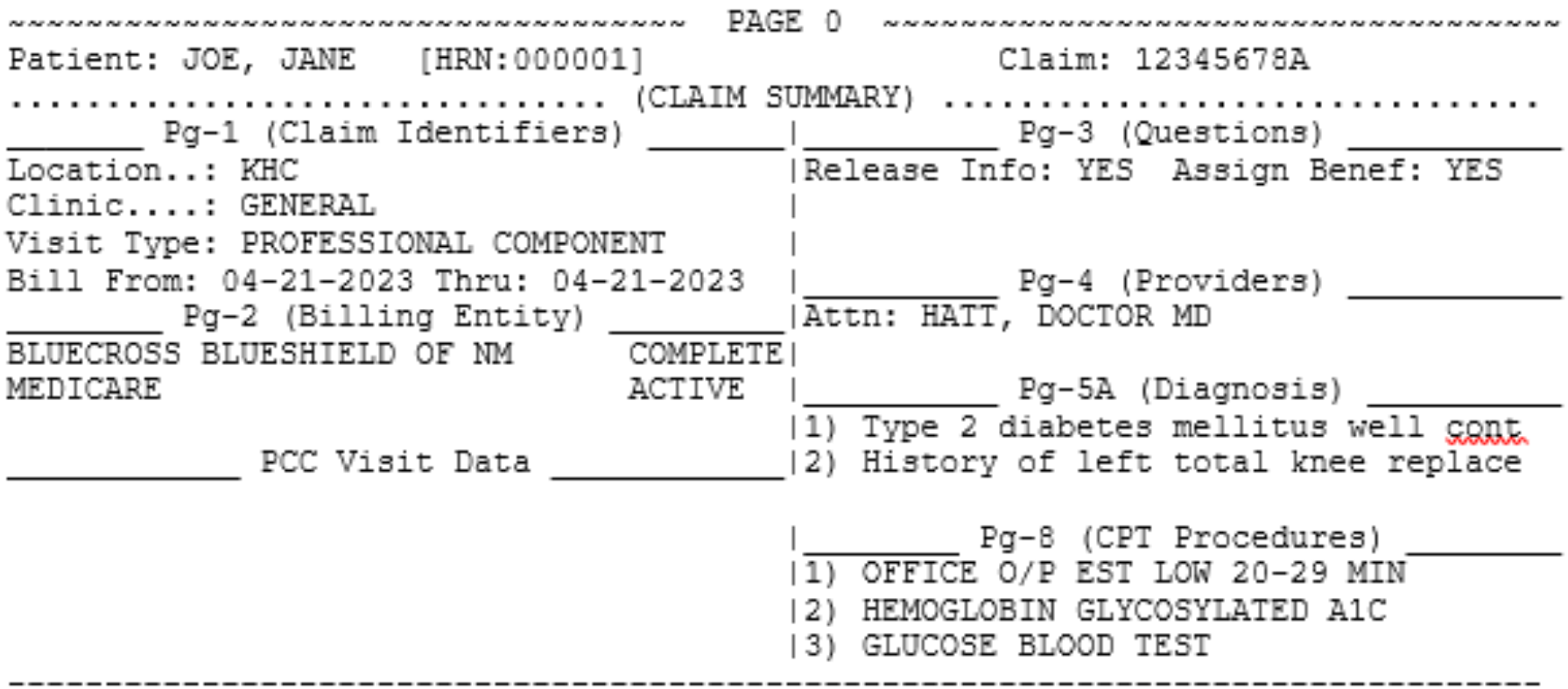
Tribal Self Funded and Medicare

1. Bill Medicare and submit a reconsideration (work around)
   - Justification: Patient is entitled to Tribal Self-Funded Insurance
   - Add Attachment Ex. EOB, Letter of Coverage
2. Bill Tribal Self-Funded then Bill Medicare.
   - This process is our ultimate goal.

Why is the billing sequence important?

- Claims are processes efficiently and accurately. No further follow-up.

RPMS Third Party EDIT



RPMS Accounts Receivable VIEW

```
Claims for JOE, JANE  from 04/21/2023 to 04/21/2023          Page: 1

                                          Billed     Current   Current    Current
LN#  DOS      Claim #                    Amount     Payments  Adjust.    Balance
-------------------------------------------------------------------------------
10 04/21/23 12345678A                  244.00       0.00      0.00       0.00

List of Transactions for Bill 12345678A

Patient: JOE, JANE                                  Beg DOS : APR 21, 2023
Address: PO BOX 999999                              End DOS : APR 21, 2023
GALLUP, NEW MEXICO 87305                            LST STMT:

Phone #: 928 000 0000                              Insurer: BLUECROSS BLUESHIELD OF NM
                                                   Balance: 0.00

Trans Dt    By  Trans Type                                    Amount       Balance
                A/R Account                    Batch                    Item
-------------------------------------------------------------------------------
05/17/2023      BILL NEW                                       244.00        244.00
                BLUECROSS BLUESHIELD OF NM     NO BATCH                 0
07/11/2023 PPP  DEDUCTIBLE/Deductible                        (244.00)        0.00
                BLUECROSS BLUESHIELD OF AZ     PI  -06/14/2023-3        1
                NONPAYMENT
```

RPMS Third Party EDIT

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: JOE, JANE   [HRN:000001]                    Claim: 12345678A
..........................  (PRIOR PAYMENTS/ADJUSTMENTS)  ..........................
Payment Amount....:          0.00          ORIGINAL BILL AMOUNT:      244.00
Deductible Amount :        244.00          Current Charges.....:      244.00
Co-pay/ins Amount :          0.00          Current Bill Amount.:      244.00
Write Off.........:          0.00
Non-Covered Amount:          0.00
Penalty Amount....:          0.00
Grouper Allowance.:          0.00
Refund..........  :          0.00
Payment Credits...:          0.00
[1] INSURER: BLUECROSS BLUESHIELD OF NM PRIORITY ORDER: 1     STATUS: COMPLETED
             COVERAGE TYPE: MEDICAL
   ADJUSTMENT:      244.00  [13] DEDUCTIBLE     [29] Deductible              [1]
[2] INSURER: MEDICARE                    PRIORITY ORDER: 2     STATUS: ACTIVE
             COVERAGE TYPE: PART A, PART B
-------------------------------------------------------------------------------
**Use the EDIT option to populate the Standard Adjustment Reason Code**
Desired ACTION (Add/Edit/Quit): Q// E
Which insurer are you editing:  (1-2): 1
Ok, let's edit BLUECROSS BLUESHIELD OF NM
CLAIM CHECK OR REMIT DATE: JUL 11,2023// 07112023
  [1] ADJUSTMENT      244.00    [13]DEDUCTIBLE    [29]Deductible
Which transaction:  (1-1): 1
AMOUNT:  (-99999.99-99999.99): 244// 244
ADJUSTMENT CATEGORY: 13//   DEDUCTIBLE
ADJUSTMENT REASON: 29//   Deductible
Desired ACTION (Add/Edit/Quit): Q// ENTER to APPROVE the claim.

Do You Wish to APPROVE this Claim for Billing? YES
Transferring Data....
Bill Number 12345678B Created.  (Export Mode: 837P (HCFA) 5010)
```

RPMS Accounts Receivable VIEW

```
Claims for (msg) JOE, JANE  from 04/21/2023 to 04/21/2023          Page: 1

                                          Billed     Current   Current    Current
LN#  DOS      Claim #                    Amount     Payments  Adjust.    Balance
-------------------------------------------------------------------------------
1 04/21/23 12345678A                      244.00       0.00      0.00       0.00
2 04/21/23 12345678B                      244.00       0.00      0.00     244.00

Line #: 2
Select Command (Line # 2) :

List of Transactions for Bill 12345678B-KA

Patient: JOE, JANE                              Beg DOS : APR 21, 2023
Address: PO BOX 999999                          End DOS : APR 21, 2023
GALLUP, NEW MEXICO 87305                        LST STMT:

Phone #: 928 000 0000                           Insurer: MEDICARE
                                                Balance: 244.00

Trans Dt   By  Trans Type                                    Amount       Balance
               A/R Account                      Batch                    Item
-------------------------------------------------------------------------------
07/12/2023     BILL NEW                                      244.00        244.00
               MEDICARE
```

Trouble Shooting

What happened?

1. According to the EDI Transaction file 277CA, a file or claim was not accepted by Medicare.

2. Utilize your Medicare Contractor's self-service tools.

3. Review the Raw Data and Interpret the Claim Status Category Code(s) and Claim Status Code(s).

Trouble Shooting

Analyze the Raw Data on the 277CA

HL*4*3*PT~

NM1*QC*1*JOE*JANE***MI*1XX1QXXXXXX~

TRN*2*12345678B-KA~

STC*A6:578:L*20230803*U*244~

STC*A6:286*20230803*U*244~

DTP*472*D8*20230421~

Trouble Shooting

CSCC A6 CSC 286

Description Acknowledgment/Rejected for Missing Information. The claim/encounter is missing the information specified in the Status details and has been rejected. Other Payer's Explanation of Benefits/Payment Information.

CSCC A6 CSC 578

Description Acknowledgment/Rejected for Missing Information. The claim/encounter is missing the information specified in the Status details and has been rejected. Insurance Type Code.

Trouble Shooting

CSCC A6 CSC 286

- Primary Payer Adjudication was added successfully to the claim

```
SBR*P*18*131******BL~
CAS*PR*1*244*1~     Adjudication from Primary Payer (CARC)
AMT*EAF*244~        Patient Responsibility
OI***Y***Y~
```

- Primary Payer Adjudication is missing

```
SBR*P*18*131******BL~
OI***Y***Y~
```

Trouble Shooting

CSCC A6 CSC 578

- Claim <u>WITH</u> the Insurance Type Code

HL*3*1*22*0~

SBR*S*18***12****MB~

Subscriber ; Secondary ; Person Code ; Insurance Type Code ; Payer Source

- Claim <u>WITHOUT</u> the Insurance Type Code

HL*3*1*22*0~

SBR*S*18*******MB~

Trouble Shooting

If you are unable to reconcile - contact your IT Department

- Service Now Ticket at your Local Service Unit
- Escalate to the Area Office
- Escalate to OIT

Thank you

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INDIAN HEALTH SERVICE
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