

Billing Basics: All About Claims

ICAHN Healthcare Billing Webinar Series

Session 1 – March 18th, 2020



Introduction



Lori Zindl
efficientC | OS inc.
President

Learning Objectives

- Overview of UB04 & 1500 Fields and Requirements
- Billing Compliance – Standards of Conduct
- Working Edits
- Secondary Billing/Medicare Crossover Claims
- Overlapping/Conflicting Service Dates
- Illinois Medicaid/MCO Billing
- Helpful Resource Documents

Be Sure to Note & Submit Questions!



What is Revenue Cycle Management?

"All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue."

- *The Healthcare Financial Management Association (HFMA)*

Revenue Cycle Overview



Who Really Bills Claims?

Green

Patient Access

Blue

HIM/Coding

Orange

Charge Master

Yellow

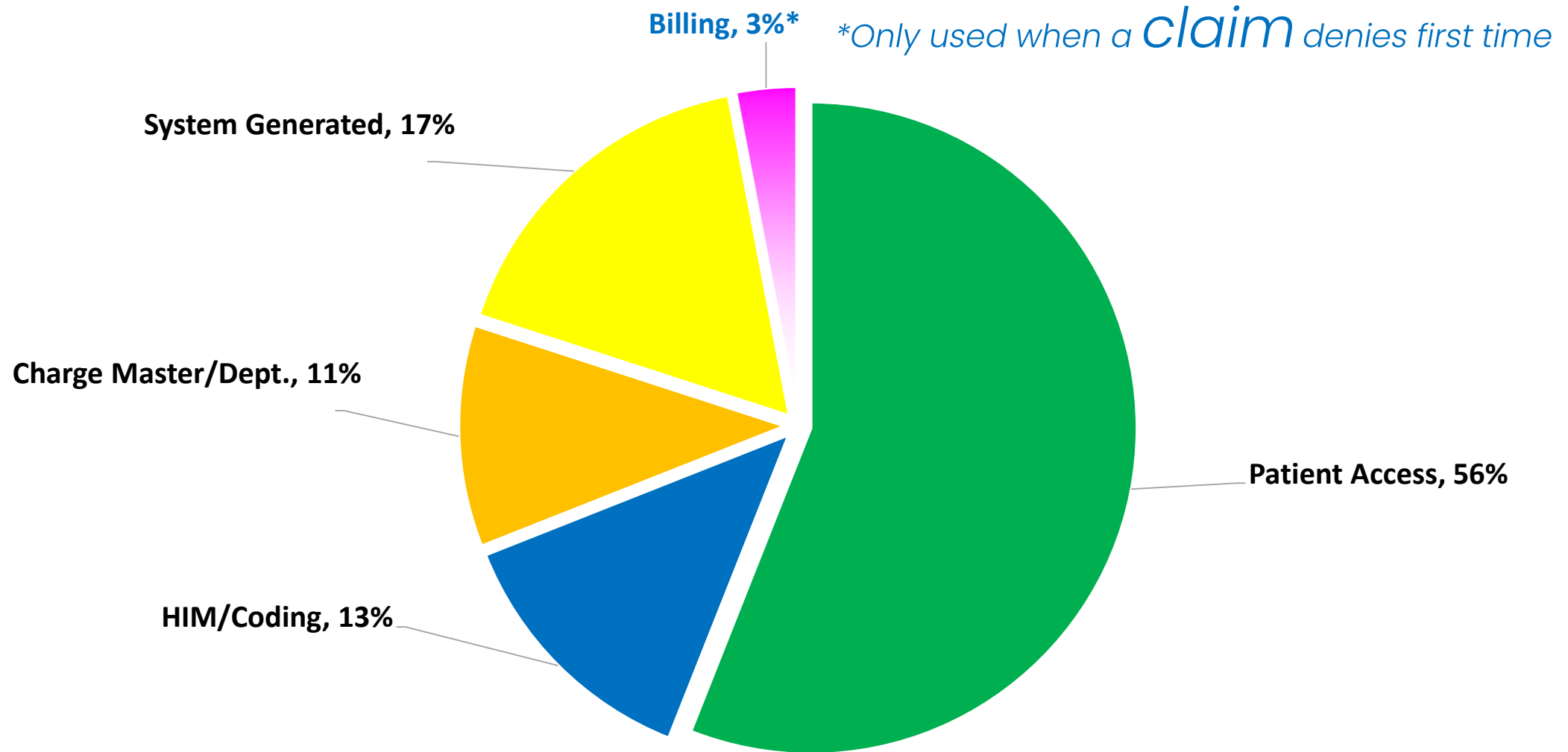
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Billing

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Not the Billing Department



1500

Green

Patient Access

Blue

HIM/Coding

Orange

Charge Master

Yellow

System Generated

Pink

Billing



HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

☐ PICA ☐ PICA

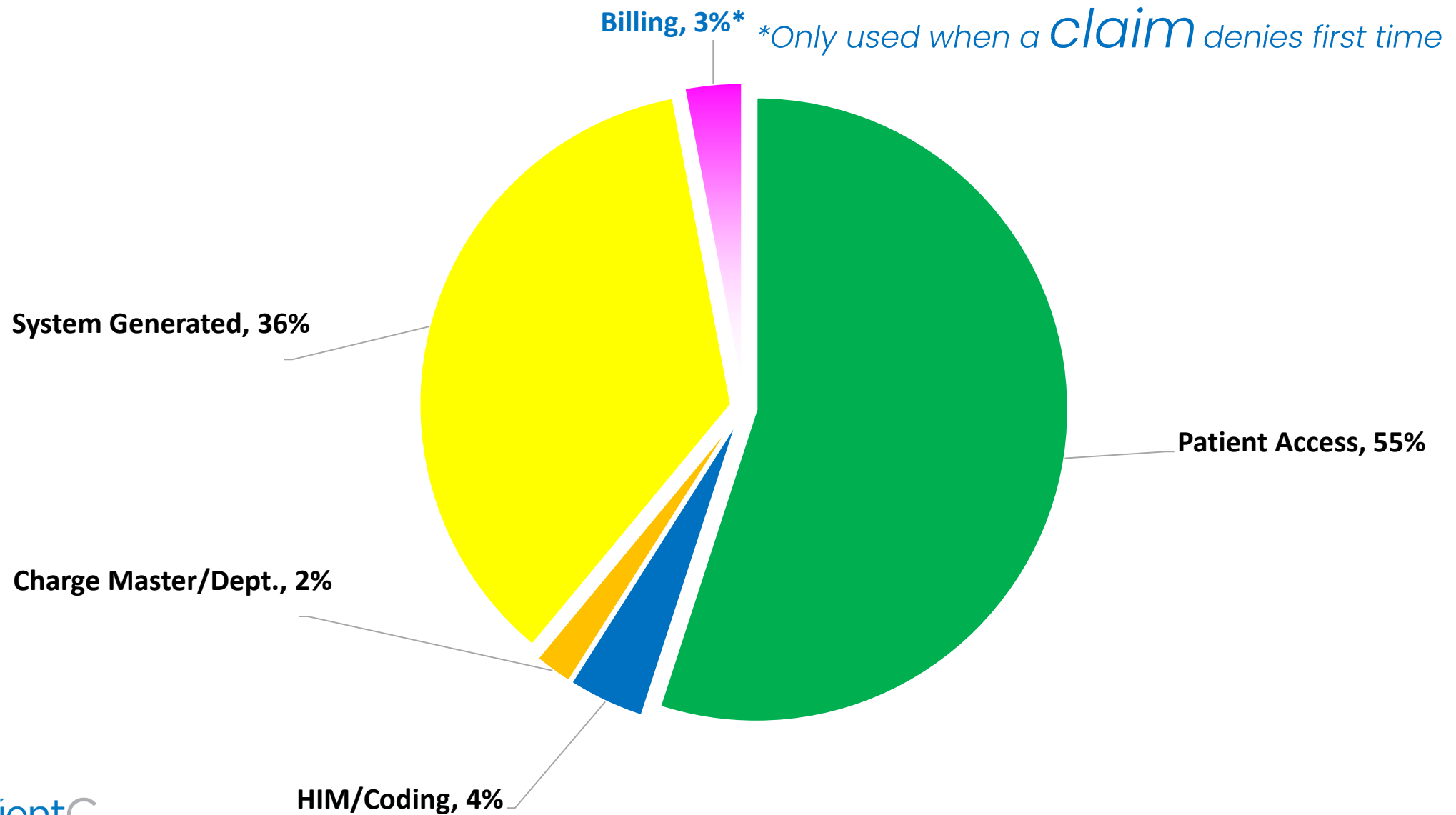
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. INSURED'S ADDRESS (No., Street)	
6. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
8. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		9. RESERVED FOR NUCC USE	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
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.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY QUAL.	
16. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI	
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. PRIOR AUTHORIZATION NUMBER	
22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY - Please A-I to service line below (24E) ICD 10d		23. SUBMISSION CODE ORIGINAL REF. NO.	
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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS ON UNITS H. PCT Family Pen I. ID QUAL J. RENDERING PROVIDER ID #		25. FEDERAL TAX I.D. NUMBER SGN EIN	
26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
28. TOTAL CHARGE \$		29. AMOUNT PAID \$	
30. Revid for NUCC Use		31. BILLING PROVIDER INFO & PH # ()	
32. SERVICE FACILITY LOCATION INFORMATION		33. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	

SIGNED DATE

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

1500



Claim Forms

Institutional

- Typically charges for services in a “facility”
- Room charges, equipment, labs, x-ray’s, supplies, etc.
- Claim form type:
 - 837I Electronic claim
 - UB04 Paper claim

VS

Professional

- Typically billing for a professional’s time
- Services by physicians, suppliers and other non-institutional providers
- Claim form type:
 - 837P Electronic claim
 - CMS 1500 Paper claim

Claim Forms – Illinois Medicaid & MCO's

Institutional

- Inpatient Claims
- Outpatient claims that contain a code from the APL listing
- ER/OBS Claims
- Claim form type:
 - 837I Electronic claim
 - UB04 Paper claim

VS

Professional

- Services by physicians and other non-institutional providers
- Non-APL outpatient charges
- Therapy services
- Rural Health Claims
- Claim form type:
 - 837P Electronic claim
 - CMS 1500 Paper claim

Common Forms- Electronic Claims

- Over 90% of claims are sent electronically to insurance companies in EDI (Electronic Data Interchange) format which is a standard for exchanging information between systems.
- The standard EDI form for healthcare claims is 837 and this is what it looks like.

```
ISA*00*      *00*      *ZZ*BTS-SENDER  *ZZ*RECEIVE-PARTNER*150210*1525*U*00401*002829417*0*T*~GS*HC*BTS-SENDER*RECEIVE-  
APP*20150210*1525*2829414*X*004010X096A1~ST*837*2829412*005010X223A2~BHT*0019*00*00257A1D085336526793*20140614*0853*CH~NM1*41*2*DEMO  
PROVIDER*****46*9999999995~PER*IC**TE*4149616800~NM1*40*2*DEMO PROVIDER*****46*9999999995~HL*1**20*1~PRV*BI*PXC*282N00000X~NM1*85*2*DEMO  
PROVIDER*****XX*9999999995~N3*100 HOSPITAL DRIVE~N4*DEMOTOWN*WI*532121234~REF*EI*392015655~PER*IC*SUE YORK*TE*2624460240*FX*2625444433~NM1*87*2~N3*PO BOX  
1234~N4*MILWAUKEE*WI*532880878~HL*9*1*22*1~SBR*P**702014*****CI~NM1*IL*1*FLINSTONE*FRED*C***MI*860857124~N4*MUSKEGO*WI*531500000~REF*SY*391627445~NM1*PR*2*UNITED  
HEALTHCARE*****PI*999990000~N3*ELECTRONIC CLAIMS*PO BOX  
740800~N4*ATLANTA*GA*303740000~REF*2U*00000~REF*G2*2076664~HL*10*9*23*0~PAT*01~NM1*QC*1*FLINSTONE*WILMA~N3*S72 W19306  
BEDROCK~N4*MUSKEGO*WI*531500000~DMG*D8*19581013*F~CLM*9232406S1C6500*343.3***13:A:1**A*Y*Y~DTP*434*RD8*20140606-20140606~CL1*3*1*01~REF*EA*803-76-  
75~HI*BK:V7263~HI*PR:V7263~HI*BF:V7286~HI*BH:11:D8:20140101~NM1*71*1*WATSON*DOCTOR*E***XX*1790791713~LX*1~SV2*0300*HC:36415::::ROUTINE  
VENIPUNCTURE*20.81*UN*1~DTP*472*D8*20140606~REF*6R*1~LX*2~SV2*0305*HC:86850:90::::RBC ANTIBODY  
SCREEN*254.81*UN*1~DTP*472*D8*20140606~REF*6R*2~LX*3~SV2*0305*HC:86900:90::::BLOOD TYPING ABO*33.84*UN*1~DTP*472*D8*20140606~REF*6R*3~LX*4~SV2*0305*HC:86901:90::::BLOOD  
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Codes Used in Billing

CODES USED IN BILLING



REVENUE CODES

0271 Supplies
0300 Laboratory
0450 Emergency Room



CPT CODES

80050 General Health Panel
99203 New Patient office visit
99285 Emergency Department visit



HCPCS CODES

A0425 Ambulance mileage
E1130 Wheelchair standard
V5261 Hearing aid



DIAGNOSIS CODES

R03.0 Hypertension
S02.2XXB Fracture of nasal bone
W06.XXXA Fall from bed



MODIFIERS

GA Waiver of liability issued
JW Drug amount discarded
TC Technical component

UB Code Definitions

Condition Codes

- Used to identify a condition or conditions relating to the patient or billing process.
- UB04: Box 18-28; 2300: 837I: HI01-02 through HI12-02

Occurrence Codes/Spans

- Code indicating a specific event on a specific date. For an event taking place across multiple days see Occurrence Span codes.
- UB04: Box 31-34; 2300: 837I: HI01-02 through HI12-02
- Spans - UB04: Box 35-36; 837I: 2300: HI01-02 through HI12-02

Value Codes

- Code to identify a monetary amount or value necessary for claim processing.
- UB04: Box 39-41; 837I: 2300: HI01-02 through HI12-02

Billing Compliance

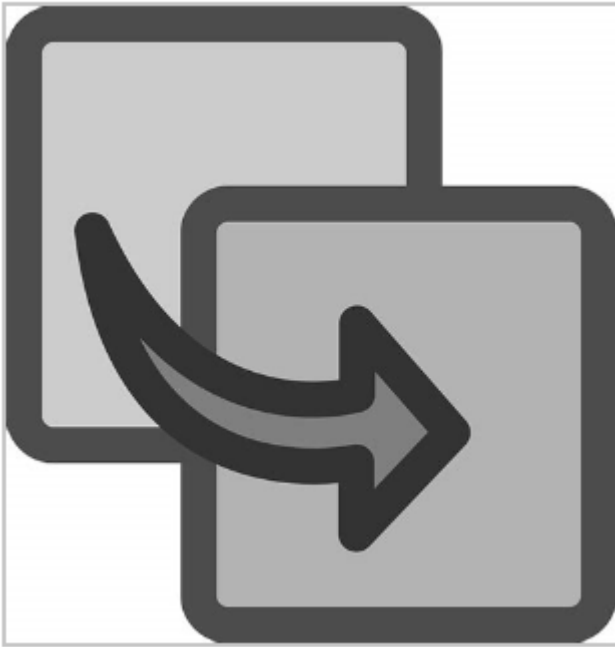
- Revenue Codes
- ICD-10-CM procedure and diagnosis codes
- HCPCS codes
- CPT-4 Codes
- Discharge Status
- Type of Bill
- Place of Service
- Dates of Service
- Modifiers
- Condition Codes
- Occurrence Codes
- Value Codes

Working Edits

- Responsible departments should work their own edits
 - Coding
 - Registration
 - Charge issues
 - Billing – A/R Reps
- efficientC Billing Guide
- Types of edits to work
 - Failed Edits – Hard errors
 - Warnings
 - Conflicting claims (Duplicate, Overlap, 72 hour)



Overlapping Claims



Duplicate claims

The #1 rejection for 75% of providers
In the top 3 of 100% of providers

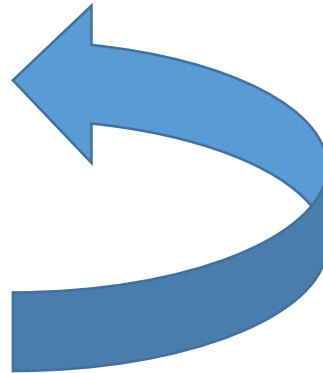
- Work daily reports of patients with multiple visits to move/combine charges
- HIM department involvement for combined coding
- Claim scrubber should have conflict checking prior to billing

Combining Claims - Medicare

Two Outpatient Services in one day (NOT Recurring)

When determining which account to move charges to or combine, use this hierarchy excluding recurring accounts. This means, always move charges up to a higher ranked account.

- Same day surgery
- Observation
- ER
- Clinic
- Lab/diagnostics



If the accounts to combine are from the same level in the hierarchy, and one is already billed, move charges to the one already billed.

Overlapping Services – Recurring Accounts

Services repeated over a span of time and billed with the following revenue codes are defined as repetitive services. Repetitive services are required to be billed monthly or at the end of treatment.

<u>REVENUE CODE (S)</u>	<u>TYPE OF SERVICE</u>
290-299	DME Rental
410, 412, 419	Respiratory Therapy
420-429	Physical Therapy
430-439	Occupational Therapy
440-449	Speech Pathology
550-559	Skilled Nursing
943	Cardiac Rehabilitation Services
820-859	Kidney Dialysis Treatments

Recurring Accounts – When to Combine

- Hospital outpatient services should NOT be combined into recurring claims – EVER
- Recurring accounts containing charges with non-repetitive rev codes can be split around other visits and/or charges transferred off of the recurring account.
- Or report occurrence span code 74 on the recurring claim to encompass any inpatient stay dates, day of outpatient surgery, or outpatient hospital services to avoid denials
- Two recurring accounts with different repetitive rev codes should be billed separately. Example – PT and OT
- Two recurring accounts with the same repetitive rev codes must be combined
- One recurring account with repetitive rev codes and one without repetitive rev codes should be billed separately. Example – PT and Infusion Therapy
- When combining recurring, make sure to look at the From/Thru dates to confirm which “base” account to use.

Illinois Medicaid – MCO Billing

- APL Listing

<https://www.illinois.gov/hfs/SiteCollectionDocuments/APLSortedInCodeOrder1119.pdf>

- Practitioner Fee Schedule & Key

<https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/Practitioner.aspx>

- New complaint procedure for MCO's

<https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/ManagedCareComplaints.aspx>

Secondary Billing - IDPA

- In addition to CAS information for the primary payer, IDPA requires a 5-digit TPL code on EDI claims.
- 3 digits identifying the primary payer
- 2 digits for the payment status
- <https://www.illinois.gov/hfs/SiteCollectionDocuments/8.23.16%20TPL%20Codes.pdf>

The TPL Status Codes are:

01 – TPL Adjudicated – total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.

02 – TPL Adjudicated – patient not covered: TPL Status Code 02 is to be entered when the practitioner is advised **by the third party resource** that the patient was not insured at the time services were provided.

03 – TPL Adjudicated – services not covered: TPL Status Code 03 is to be entered when the practitioner is advised **by the third party resource** that services provided are not covered.

04 – TPL Adjudicated – spenddown met: TPL Status Code 04 is to be entered when the patient's HFS 2432 shows \$0.00 liability.

05 – Patient not covered: TPL Status Code 05 is to be entered when a patient informs the practitioner that the third party resource identified on the Identification Card is not in force.

06 – Services not covered: TPL Status Code 06 is to be entered when the practitioner determines that the identified resource is not applicable to the service provided.

07 – Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment from the TPL have failed.

10 – Deductible not met: TPL Status Code 10 is to be entered when the practitioner has been informed **by the third party resource** that non-payment of the service was because the deductible was not met.

Reference Tools

[Uniform Billing Editor](#)

[National Uniform Billing Committee - Subscription Information](#)

[CMS - MUE Tables](#)

[CMS - LCD Look Up](#)

Questions



Thank you for joining us today!

Don't hesitate to get in touch with any follow up questions. We'll be happy to address them or incorporate responses into the rest of this series.

Please make sure to add the next three sessions of this series to your calendar!

Wednesday, April 29th | 12:00 pm - 1:30 pm Central

[Follow Up: Resolving Unpaid Insurance Balances](#)

Wednesday, May 20th | 12:00 pm - 1:30 pm Central

[Denials: Overview & Resolution Strategies](#)

Wednesday, June 17th | 12:00 pm - 1:30 pm Central

[Collections & Customer Service](#)