



Overview of Billing Process

What is the Purpose of a Medical Claim?

A medical claim is a method to “Tell the Story” of what condition the patient was experiencing which brought them to the provider AND what services/procedures were performed to address the condition.

A medical claim is the instrument payers utilize in order to administer the appropriate level of benefits covered by the patients medical policy.

Global “Clean Claim” Flow

- Clean Claim is defined as one that can be processed without obtaining additional information from the provider of the service or from a third party
- A medical claim is generated from provider and sent to payer
- The medical claim is processed by payer to determine level of covered/payable benefits
- Payer Payment/Denial is remitted from the payer back to the provider
- Amounts determined by the payer to be due from patient are billed to the patient by the provider (i.e., deductible, coinsurance, non-covered services)

Types of Medical Claim Forms

1. Physician/Professional Billing Form
(CMS I 500)
2. Institutional (Facility) Billing Form
(CMS I 450/UB04)

Institutional (Facility) Billing Form

UB-04/CMS 1450 Fill & Print NPI

File Options Help

Help

1 PATIENT IDENTIFICATION NUMBER		2		3a PAT ENTE #		3b SELECT REC #		4 TYPE OF BILL	
5 FED TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 THROUGH					
8 PATIENT NAME				9 PATIENT ADDRESS					
10 BIRTHDATE		11 SEX	12 DATE		13 HR. 14 TYPE		15 SRC		16 DHR
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31 OCCURRENCE DATE		32 CODE		33 OCCURRENCE DATE		34 CODE		35 OCCURRENCE DATE	
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What are PRIMARY things contained within the Professional Claim(CMS1500)?

- Patient Demographics, i.e., Name, DOB, Address
- Payer Name/Policy Identification Number
- Date(s) of Service
- Procedure(s) Performed – CPT/HCPCS Codes
- Amount Billed for each Procedure
- Provider of Service/Location of where service provided

What are the PRIMARY things contained within the Institutional/Facility Claim (CMSI 450)?

- Patient Demographics, i.e., Name, DOB, Address
- Payer Name/Policy Identification Number
- Date(s) of Service
- Revenue Codes (Categories of Types of Service)
- Quantity/Units
- Billed Amount per Revenue Code
- Total Billed Amount
- Diagnosis Code – ICD10 Code
- Attending/Treating Provider Names

What codes are used and why?

- CPT (Current Procedural Terminology) Codes-numbers that are used on medical claims to identify each service/procedure billed
 - Example: 99213=Midlevel Office Visit
- HCPCS Codes – Medicare uses these codes in place of CPT Codes (Combined there are over 14,000 CPT/HCPCS)
 - Example: G008=Administration of Influenza Virus
- ICD 10 Diagnosis Codes – The International Classification of Diseases Tenth Edition – numbers/letters that are used on medical claims to identify condition(s) the patient had addressed by the provider
 - Example: G44.00=Cluster Headache Syndrome Unspecified
 - ***There are approximately 68,000 ICD 10 Diagnosis Codes

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- Revenue Code – Code which describes the category of hospital services provided
 - Example: Rev Code 270 = Charges for supply items
- There are a lot of, Modifiers, Provider Numbers other types of codes such as Occurrence Codes, Condition Codes, Value Codes

How are claims submitted?

- Electronic Claims (837 Transaction File)
- Paper Claims

Electronic Claims (837 Transaction File)

- A key component of HIPAA is the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans and employers
- The standards are meant to improve the efficiency and effectiveness of the North American health care system by encouraging the widespread use of Electronic Data Interchange (EDI) in the U.S. health care system
- Electronic Claim contains all the data captured on CMSI500 and/or CMSI450 claim format

Are 837 Transaction Files “Standardized” across all payers?

- The format in which to submit all the data elements contained within a claim is “standardized”
- Medicare requires HCPCS codes vs CPT Codes
- Some payers request Rev Code to be modified

Paper Claims

Some payers require submitting claims on paper claims forms (CMSI 500/CMSI 450) via US Postal Service

- Workers Compensation (paper records)
- Some “Secondary Payers”
- Indian Health Services (paper records)
- Local contracts such as Migrant Health, County Detention Center

Corrected Claim (correcting a DOS, etc.)

What happens after claims are sent/why could processing delay?

- Claims process by payer and payable benefits are remitted back to the provider
- Claim is denied – several causes such as not a payable benefit, patient not insured on date(s) of service, service not authorized, etc. Appealing denials may add several days to processing time
- Claim is pended for internal review by payer
- Additional documents are requested from payer, i.e., medical records
- Additional information is needed by Payer from patient, i.e., other coverage questionnaire, accident questionnaire

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- Nothing. Claim reported as not on file with payer, payer requests claim be resubmitted
- Secondary Payer Claim Submission. After primary payer makes payment, claim is then submitted to secondary payer for their benefit determination
- Generally, Billings Clinic claims are submitted within 3 to 16 days from discharge date
- Billings Clinic does not request payment from the patient until all payers have completed processing

Payment is Received from Payer

- Payer Payments (remits) are made in one of two ways
 - EDI Health Care Claim Payment/Advice Transaction Set (835)
 - Paper Check/Explanation of Benefits from Payer

Electronic Remit (835 Transaction Set)

- A key component of HIPAA is the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans and employers
- Standardized use of Claim Adjustment Reason Codes (CARC Codes) and Remittance Advice Reason Codes (RARF Codes) are not standardized across all payers, individual payer use of CARC/RARF Codes occur
- Electronic Remits are not consistently balanced (remit total does not match payment amount)

Why do billed amounts vary for the same procedure?

- Multiple factors can impact the dollar amount of facility claims
 - Health of the patient, are there other comorbid conditions? Impact on length of stay, additional charges
 - Ex-Obesity, Diabetes
 - How is patient responding to recovery, are additional therapy services required?
 - Is patient pain under control-post recovery time impact
 - Once procedure occurs, are other factors discovered at the procedure time? Impact on Operating Room time

Examples

- Four total knee replacement surgeries
 - Same provider performing service within the same month during 2017
 - The same DRG (Diagnostic Related Group) 470
 - Three patients covered by Medicare, one patient covered by commercial payer

DRG 470

Total Knee Replacement

	<u>Patient #1</u>	<u>Patient #2</u>	<u>Patient #3</u>	<u>Patient #4</u>
Total Charges	\$42,023	\$47,105	\$42,715	\$61,585
Facility Charges	\$29,270	\$34,381	\$29,991	\$48,861
Professional Charges	\$12,753	\$12,724	\$12,724	\$12,724
Total Payments	\$15,356	\$15,393	\$35,454	\$15,057
Payment from Primary Insurance	\$13,695	\$13,744	\$32,684	\$14,608
Payment from Secondary Insurance	\$1,660	\$1,649	\$0	\$0
Payment Due from Patient	\$0	\$0	\$2,770	\$449
Payer	Medicare/Commercial Secondary	Medicare/Commercial Secondary	Commercial	Medicare
Length of Stay in Hospital	2 Days	3 Days	2 Days	3 Days
Other factors impacting total dollar amount of facility claim	No comorbid conditions, no medication complexities	No comorbid conditions, but patient experienced post surgical pain requiring additional physical therapy/length of stay. Required one day of isolation room (versus semi private room). Four components of knee being replaced.	No comorbid conditions or medication complexities, however patient did have previous surgery which did require additional work/preparing during surgery, additional pharmacy/IV solutions needed as well as additional time in recovery room.	Multiple comorbid conditions, i.e. obesity, heart conditions, utilizing multiple medications adding to length of stay. Operating Room time increased due to extensive arthritis requiring knee to be built back up as well as seven components of the knee being replaced resulting in higher transplant costs.

Questions?