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MEDICAL BILLING 101

second edition

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Michelle M. Rimmer, CMRS, CBCS

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Dedication

This book is dedicated to our past, present, and future students.
It is for you that we write and because of you that we are able to live
our passion to teach.

Contents

Preface

Medical billing is an important function of a provider's office. If billing is not performed accurately, reimbursement can be negatively affected. *Medical Billing 101*, Second Edition, provides step-by-step instructions for your success as a medical biller. The material presented in this text is on an introductory level, intended to be easily comprehended by those students who are new to allied health courses and the medical field.

Medical Billing 101 is designed for the allied health student who is enrolled in a medical billing, medical coding, medical office specialist, or medical assisting program. While it can be used as a stand-alone text for a medical billing program, it can also be used to supplement other required texts in other allied health programs. Additionally, it can serve as a reference guide for medical billers on the job, both in providers' offices and in medical billing companies. Frequently, billing texts contain information on many subject areas, leaving students feeling overwhelmed or overloaded. *Medical Billing 101* maintains its focus on billing only, to support the beginning biller and enhance the learning process.

Organization of Text

The chapter order and flow of this text are designed to outline the job duties of a medical biller in the order they are performed in the provider's office setting. Chapter 1 discusses the duties required of the medical biller and the importance of maintaining certification. Chapters 2 through 5 introduce readers to the health insurance identification card, the code sets, and the various forms used to gather the data necessary for completing the medical billing function. Chapters 6 through 8 describe the types of billing the provider-based biller will be performing. Chapters 9 through 12 guide students through the processes that occur once medical claims have been submitted.

Features of the Text

- Each chapter opens with learning objectives and a list of key terms, to help orient readers to the material.
- A margin glossary defines bolded key terms for reference during the reading; all the key terms are also compiled into an end-of-book glossary.
- Many examples of real-world forms are included throughout, such as explanation of benefit (EOB) forms, aging reports, and denied claims.

- An end-of-chapter summary provides an opportunity to assess learning before moving on to the next chapter.
- Chapter review questions provide an opportunity to test learning.
- Case studies written to be completed on the CMS-1500 form allow students to practice billing for different provider service situations, including office visits and inpatient provider services.
- Space is provided in the text for students to record their answers, and blank CMS-1500 forms are included for practice.
- Appendix I contains 25 case studies (with both ICD-9 and ICD-10 codes) for CMS-1500 form completion. SimClaim software, located online at the Premium Web Site, can be used to complete the CMS-1500 form electronically or manually.
- Appendix II contains examples of several real-world forms commonly used in the billing world, including the UB-04.
- Appendix III offers a list of medical abbreviations and acronyms.
- Appendices IV and V include a state-by-state listing of Medicare carriers and insurance commissioners.

Supplements

The following supplements are available to enhance the use of *Medical Billing 101*, Second Edition.

Resources for the Student

- Free Online SimClaim Software contains 25 case studies designed to help students practice and understand how to complete the CMS-1500 form. These case studies provide billing practice for different provider service situations, including office visits and inpatient provider services.
- A 59-day free trial of OptumInsight's *EncoderPro.com—Expert* is provided as a bind-in card in the front of the text. This software will allow students to look up ICD-9-CM, ICD-10-CM, CPT, and HCPCS Level II codes quickly and accurately across all code sets.

Resources for the Instructor

The **Instructor Resources** are housed online at the Instructor Companion Web Site found at www.cengagebrain.com, and include:

- The *Instructor's Manual*, which contains lecture notes, classroom participation activities, homework, and answer keys to chapter review questions and to the SimClaim case studies in Appendix I.
- The *Test Bank*, which offers more than 500 questions in the powerful Cognero platform.
- Microsoft *PowerPoint* presentations, with more than 300 slides, which serve as a great teaching and lecture tool.

Feedback

We welcome your feedback and success stories on *Medical Billing 101*, Second Edition. Crystal Clack can be contacted at clackc@gmail.com. Linda Renfroe can be contacted at renfroelinda@yahoo.com.

Acknowledgments

Crystal Clack would like to thank the following people:

Mary Beth, for her patience over the course of this exciting project.

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A loving heart-felt gratitude for my mother, grandmother, grandfather, and father.

Linda Renfroe would like to thank the following people:

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Robert, my husband, for cooking dinner for us when my writing took longer than I expected.

My family and friends who were always interested in how the book was coming along.

Rhonda Dearborn, who gave me the chance in the first place.

About the Authors

Crystal Clack, MS, RHIA, CCS, has over 25 year's experience working in a variety of health care settings. In the beginning, Crystal worked as a student health aid at a college clinic after graduating from high school, followed later by positions in billing, scheduling, admitting, release of information and coding. More recently, Crystal has served as HIM manager and HIPAA privacy officer for a hospital in rural Washington, and a Coding and Charge Capture manager for a multi-system health care provider in Oregon. She has taught adjunct coding classes for 7 years, with 4 of those years spent teaching at Lane Community College in Eugene, Oregon. Crystal's degrees in Health Information Informatics Managements and IT Leadership were earned through the College of St. Scholastica in Duluth, MN. In her spare time, Crystal is actively involved with Oregon Health Information Management as the Director of Education. Crystal enjoys raising and showing purebred rabbits, camping, gardening, and exploring the great outdoors with her husband Scott.

Linda Renfroe, RHIT, CPC-P, has spent the last 26 years gaining knowledge about the health information management field. As a coder, she has worked in both large and small hospitals, long-term care, and home health. Linda gained additional leadership training when working at Swedish Medical Center in Seattle, Washington, which opened the door to move her beyond the coder role. Linda returned to school after years in the health care field to earn a BA at the University of Washington. This increased education allowed Linda to be hired at several Seattle-area community colleges as an adjunct instructor, teaching medical billing, coding, and medical terminology.

In her spare time, Linda works as a volunteer for a nonprofit organization focusing on teaching young people to be leaders in their community. She has organized several local teen mission trips and helped others begin tutoring and mentoring sites for children's reading help and English as a second language.

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How to Use SimClaim CMS-1500 Software

SimClaim software is an online educational tool designed to familiarize you with the basics of the CMS-1500 claims completion. Because in the real world there are many rules that can vary by payer, facility, and state, the version of SimClaim that accompanies the second edition of this textbook maps to the specific instructions found in your *Medical Billing 101* textbook.

How to Access SimClaim

To access the SimClaim student practice software program online, please refer to the information on the printed access card found in the front of this textbook. The SimClaim case studies are also available for reference in Appendix I of this textbook.

Main Menu

From the Main Menu, you can access the SimClaim program three different ways: Study Mode, Test Mode, and Blank Form Mode. You can now save your work in all three modes and return to it later.

- Click on **Study Mode** to get feedback as you fill out claim forms for the case studies. If you need help entering information in a block of the form, you may click on Block Help for block-specific instructions while in Study Mode.
- Click on **Test Mode** to fill out claim forms for the case studies to test yourself. The completed claim is graded and can be printed and e-mailed to your instructor.
- Use **Blank Form Mode** if you wish to utilize the SimClaim program to fill out a blank CMS-1500 form with another case study in the textbook.

You can access SimClaim support documentation from the Menu as well, including Block Help, a glossary, and a list of abbreviations.

General Instructions and Hints for Completing CMS-1500 Claims in SimClaim

Please read through the following general instructions before beginning work in the SimClaim program:

- **Certain abbreviations are allowed in the program—**for example, 'St' for Street, 'Dr' for Drive, 'Rd' for Road, 'Ct' for Court. No other abbreviations will be accepted as correct by the program.
- **Only one Diagnosis Pointer in Block 24E per line—**though SimClaim allows for more than one Diagnosis Pointer to be entered, only one diagnosis pointer is allowed in Block 24E for each line item.
- **No Amount Paid Indicated—**If there is no amount paid indicated on the case study, *leave the field blank*.
- **Secondary Insurance Claims—**If a Case Study indicates that a patient's Primary Insurance carrier has paid an amount, fill out a second claim for the Secondary Insurance that reflects the amount reimbursed by primary insurance when indicated.
- **Fill out Block 32** only when the facility is other than the office setting, as indicated on the Case Study.
- **Enter all dates** as listed on the Case Study.
- **For additional help using SimClaim, refer to the Block Help within SimClaim or to the specific carrier guidelines found in your textbook**.

How to Use the *EncoderPro.com—Expert* 30-Day Free Trial

With the purchase of this textbook you receive free 59-day access to *EncoderPro.com—Expert*, the powerful online medical coding solution from OptumInsight©. With *EncoderPro.com—Expert*, you can simultaneously search across all code sets.

How to Access the Free Trial of *EncoderPro.com—Expert*

Information about how to access your 59-day trial of *EncoderPro.com—Expert* is included on the printed tear-out card bound into this textbook; the card contains a unique user access code and password. Once you log in, scroll down to the bottom of the License Agreement page, and click the "I Accept" link. Then, click the "I Accept" link on the Terms of Use page. Be sure to check with your instructor before beginning your free trial because it will expire 59 days after your initial login.

Features and Benefits of *EncoderPro.com—Expert*

EncoderPro.com—Expert is the essential code lookup software from OptumInsight© for CPT, HCPCS (level II), ICD-9-CM Vol. 1, ICD-9-CM Vol. 3, ICD-10-CM, and ICD-10-PCS code sets. It gives users fast searching capabilities across all code sets. *EncoderPro.com—Expert* can greatly reduce the time it takes to build or review a claim, and it helps improve overall coding accuracy.

During your free trial period to *EncoderPro.com—Expert*, the following tools will be available to you:

- **Powerful CodeLogic™ search engine.** Search all code sets simultaneously using lay terms, acronyms, abbreviations, and even misspelled words.
- **Lay descriptions for thousands of CPT® codes.** Enhance your understanding of procedures with easy-to-understand descriptions.
- **Color-coded edits.** Understand whether a code carries an age or sex edit, is covered by Medicare, or contains bundled procedures.

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- **ICD-10 Mapping Tool.** Crosswalk from ICD-9-CM codes to the appropriate ICD-10 code quickly and easily.
- **Great value.** Get the content from over 20 code and reference books in one powerful solution.

For more information about EncoderPro.com—Expert or to become a subscriber beyond the free trial, email us at **esales@cengage.com.**

Chapter 1

Working as a Provider-Based Medical Biller

Learning Objectives

Upon completion of this chapter, the student should be able to:

- Explain the tasks and responsibilities of a medical biller.
- Explain the work environment.
- Discuss the importance of certification and maintaining CEUs.
- Define key terms.

Key Terms

Accounts Receivable
American Academy of Professional Coders (AAPC)
American Health Information Management Association (AHIMA)
Certification
Certified Billing and Coding Specialist (CBCS)
Certified Coding Associate (CCA)
Certified Medical Reimbursement Specialist (CMRS)
Certified Professional Biller (CPB)
Certified Professional Coder
Continuing Education Unit (CEU)
Home-Based Billing
Medical Biller
Medical Billing Company
National Healthcareer Association (NHA)
Outsource
Provider-Based
Revenue Cycle

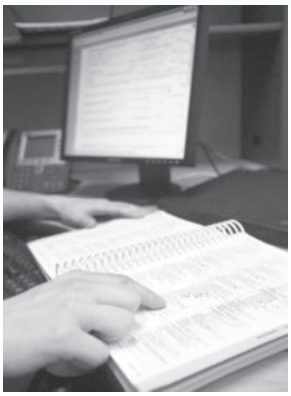

FIGURE 1-1 Medical billers are knowledgeable about insurance payers, billing procedures, and reimbursement for services.

Medical biller

the person responsible for submitting a provider's charges to the appropriate party.

What is a Medical Biller?

Medical billers contribute critical knowledge and subject expertise to a constantly changing health care reimbursement system, which impacts how providers are paid, and, ultimately, the cost of providing health care to the patient. Medical billers assist providers with submitting correct and compliant patient claims for reimbursement, and they have an understanding of local, state, and federal billing rules and regulations, which ensures the overall integrity of their provider's **accounts receivable** practices (Figure 1-1). Medical billers may also serve as subject matter experts to their provider on biller- and coding-related questions. In addition to the above skillset, highly marketable medical billers display important professional skills such as: critical thinking, superb customer service, positive attitude, team player ability, and excellent communication skills with providers and colleagues.

Revenue Cycle

A medical biller provides important knowledge and best practices to a provider's **revenue cycle** process (Figure 1-2). A revenue cycle starts when a patient calls to schedule an appointment with a provider and ends when payment is appropriately posted to the patient's account.

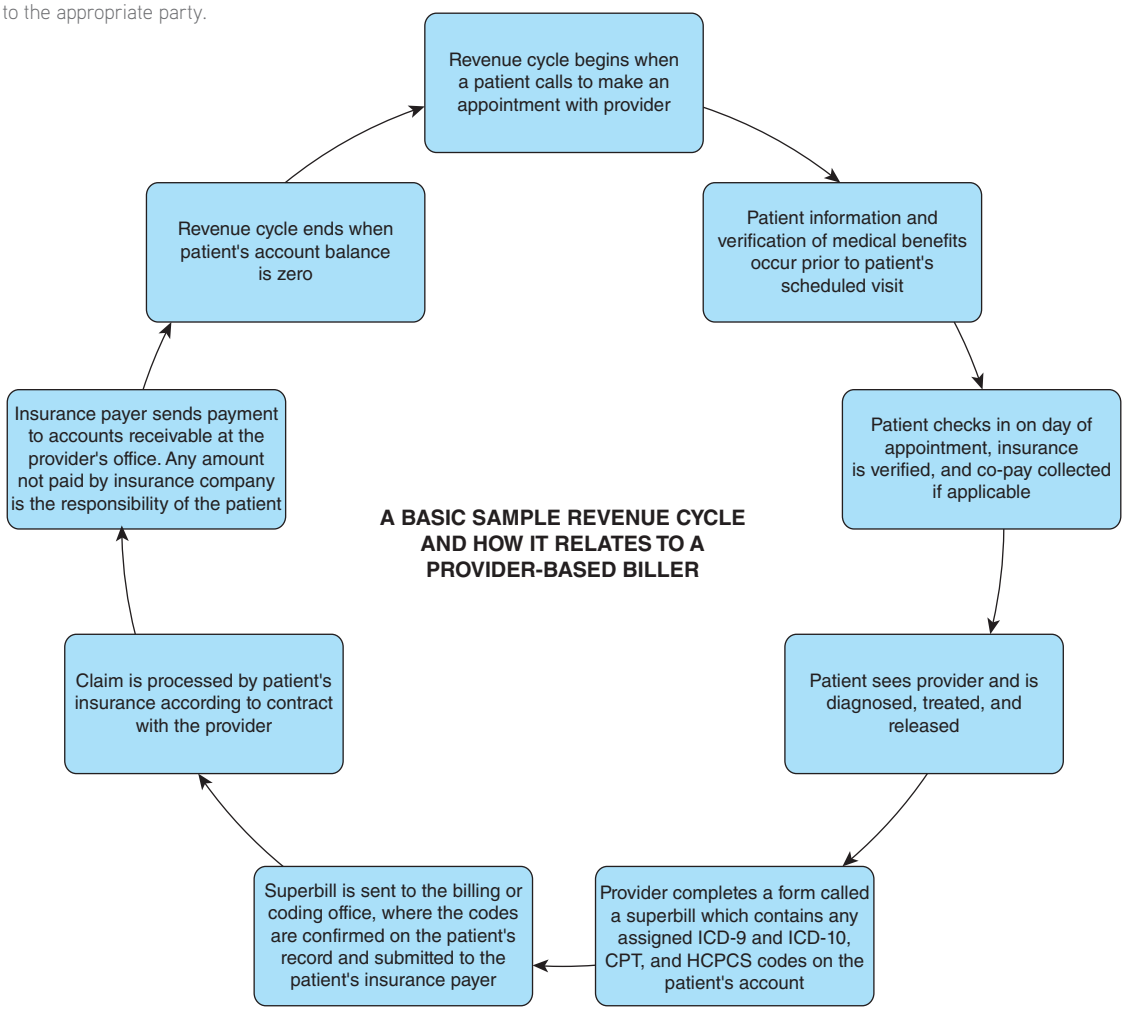

FIGURE 1-2 A sample revenue cycle and how it relates to a **provider-based** biller.

Accounts receivable

monies owed to a provider for his or her services.

Revenue cycle

complete patient billing cycle that starts at the time patient makes appointment and ends when patient's account is paid in full.

Provider-based

pertaining only to a provider such as physician, nurse practitioner, physician's assistant and other clinical providers.

Skills and Attributes of a Successful Biller

A medical biller must, above all, have a strong attention to detail. Working with numbers, forms, contracts, and insurance guidelines requires a medical biller's succinct ability to identify errors and correct them prior to submitting a patient claim for reimbursement. Additionally, a successful medical biller should have the following skillset:

1. Critical thinking
2. Active listening
3. Reading comprehension
4. Integrity and diplomacy
5. Phone etiquette
6. Working knowledge of computers and software
7. Team player ability
8. Ability to provide excellent customer service to a variety of patient types
9. Ability to communicate with providers, and other office staff
10. Professionalism

A medical biller must be aware of current local, state, and federal billing guidelines, and must know what to do when a claim is denied.

Work Environments

Medical billing company

an offsite company hired to process medical bills for the provider.

Home-based billing

the ability for an experienced biller to work from their home office.

Outsource

send work offsite.

An experienced and certified medical biller may work in many environments that include the following settings: hospitals, private medical practice, laboratory services, radiology departments, specialty clinics, insurance companies, attorney's offices, or a **medical billing company**. For those with the entrepreneurial drive and years of billing experience, a **home-based billing** company may be an option. With a home-based business, provider practices can **outsource** their billing to billers across the country who work remotely from the comforts of home. Regardless of a medical biller's working environment, all billers are encouraged to maintain their billing or coding certification and love of lifelong learning!

Importance of Certification

Certification

a professional status or level earned by successful completion of an examination; a person who is certified may subsequently list the designated credentials after her or his name.

Obtaining a medical biller or coding **certification** demonstrates dedication to the profession, skills, and knowledge. A certification increases the opportunity for employment and career advancement. It can also be the deciding factor for being hired over an equally qualified non-certified candidate!

In order to pursue certification, one must successfully pass an examination given by a sponsoring organization. Some exams are offered online, while others must be taken at an exam site predetermined by the sponsoring organization. Some organizations may provide study guides for use prior to taking the exam, but the majority may not. They will, however, indicate what is on the exam and what acceptable materials are allowed while taking the exam. This may include the use of ICD-9 or ICD-10-CM/PCS, CPT-4, and HCPCS coding books. Coding systems and methodologies will be further addressed in Chapter 3.

Membership in an Organization

Before one can take a certification exam, s/he is usually required to become a member of the certification exam's sponsoring organization. Membership is an important step toward demonstrating professionalism and knowledge of billing practices. Sponsoring organizations' websites are often packed with relevant information pertaining to current billing and coding trends. Furthermore, membership will expose the biller to timely profession news and trends on the organization's corresponding communications (i.e., newsletters, magazines, blogs, or virtual bulletin boards). A biller should take advantage of opportunities to network with peers and utilize the organization's resources on rules, regulations, and other guidelines more specific to medical billing and coding. Once a decision is made on which organization to join, the new member can take the credentialing examination. Credentialed billers and coders must maintain **continuing education units (CEUs)** in order to prove knowledge of current trends and changes within the medical billing profession.

Continuing Education Unit (CEU)

a level of measurement of non-credited education.

Certified Billing and Coding Specialist (CBCS)

a certification offered by the National Healthcareer Association.

National Healthcareer Association (NHA)

organization that specializes in the certification of healthcare professionals, including coders.

Certified Coding Associate (CCA)

an entry-level coding certification offered by AHIMA.

American Health Information Management Association (AHIMA)

organization of professionals dedicated to advancing the field of health information management and coding.

Certified Medical Reimbursement Specialist (CMRS)

a certification offered by the American Medical Billing Association.

Certified Billing and Coding Specialist (CBCS)

The **Certified Billing and Coding Specialist (CBCS)** exam is offered through the **National Healthcareer Association (NHA)**. A Certified Billing and Coding Specialist is mainly responsible for assigning medical diagnoses and procedures on a patient's record, and then submitting them to the insurance payer on an electronic or paper claim for reimbursement.

Certified Coding Associate (CCA)

The **Certified Coding Associate (CCA)** exam is offered through the **American Health Information Management Association (AHIMA)**. A Certified Coding Associate is responsible for assigning basic ICD codes and CPT codes to a patient's record.

Certified Medical Reimbursement Specialist (CMRS)

The **Certified Medical Reimbursement Specialist** exam is a credential created with the medical billing professional in mind. The American Medical Billing Association created this certification ten years ago to demonstrate (to providers, employers, and peers) the billing professionals' credibility and dedication to advancement of their career through education, knowledge, and skills. The exam is administered online through a secure login and contains over 800 questions. One may have up to 45 days to access and complete the exam and must pass with an 85% accuracy rate or higher to earn the CMRS credential. Sections included in the exam are:

- Medical Terminology
- Anatomy and Physiology
- Information Technology
- Web and Information Technology
- ICD-9/10-CM Coding
- CPT 4 Coding
- Clearinghouses
- CMS-1500
- Compliance
- Insurance and Insurance Carriers

- Acronyms
- Fraud and Abuse
- Managed Care
- General
- Case Study

Certified Professional Biller (CPB)

American Academy of Professional Coders (AAPC)

organization of professionals dedicated to educating physician-based coders.

Certified Professional Biller (CPB)

offered through the American Academy of Professional Coders.

The **American Academy of Professional Coders (AAPC)** has recently added a new credential to their list of professional certifications: **Certified Professional Biller**. According to the AAPC website, a CPB certified biller should be knowledgeable about the following:

- Comprehension of different types of insurance plans
- Understanding and correctly applying payer policies; Knowledge of Local Coverage Determination (LCD) and National Coverage Determination (NCD)
- Knowledge of ICD-9/10-CM, CPT-4 and HCPCS Level II coding guidelines
- Different applicable health care rules and regulations including the Health Information Portability Accountability Act (HIPAA), False Claims Act, Fair Debt Collections Act, and Stark
- Revenue life cycle
- Expertise in claims and patient follow-up, as well as denial resolution

The CPB is a proctored exam. It contains 200 multiple-choice questions, and the candidate has five hours and forty minutes to complete the exam.

Certified Professional Coder (CPC)

Certified Professional Coder

coding certification exam offered by the American Academy of Professional Coders.

The American Academy of Professional Coders offers a coding certification exam: **Certified Professional Coder**. According to their website, the CPC's medical billing abilities include:

- Expertise in reviewing and assigning accurate medical codes for diagnoses, procedures, and services performed by providers
- Proficiency across a wide range of services to include evaluation and management, anesthesia, surgery, radiology, pathology, and medicine
- Knowledge of ICD-9/10-CM, CPT-4 and HCPCS Level II coding guidelines
- Knowledge of compliance and reimbursement to include medical necessity, claims denials, bundling, and charge capture

The CPC is a proctored exam. It contains 150 multiple-choice questions, and the candidate has five hours and forty minutes to complete the exam.

Continuing Education Units (CEUs) and Certification

Once certification is obtained, it's critical to stay on top of the required continuing education units (CEUs) in the certifying organization. Each organization's requirements are different, and the costs to maintain CEUs will vary. CEUs help maintain certifications and provide important, time-sensitive, information needed for a biller to maintain success in their chosen field.

Summary

There are many job opportunities for the provider-based medical biller. A person in this position may be physically located in a provider's office, may work for a medical billing company, or even have their own home-based business. It is important to understand that the job must be performed accurately, ethically, and diplomatically.

In order to increase the opportunity for advancement in the field of billing, certification is recommended. Obtaining certification shows dedication and professionalism to prospective employers. It also places the medical biller a step ahead of those applicants who lack certification.

REVIEW QUESTIONS

1. What are the primary job duties of a medical biller?
   a. file claims
   b. answer phones
   c. tell the provider how to assign correct codes
   d. review and submit patient visit claims to the patient's insurance payer for appropriate reimbursement

2. Provider-based billing refers to:
   a. durable medical equipment billing
   b. hospital room charges
   c. charges for a provider's services
   d. charges for copies of patient medical records

3. Professionalism is not important to a medical biller
   a. True
   b. False

4. What is the advantage of obtaining a billing or coding certification?
   a. Displays billing knowledge to an employer
   b. Shows the ability to network with peers
   c. A medical biller is told how to bill by a professional association biller
   d. Both a & b

5. Which exam is offered online?
   a. CHRS
   b. CHP
   c. CMRS
   d. none of the above

6. What does the acronym CEU stand for?
   a. continuous education understanding
   b. comprehensive evaluation unit
   c. critical evaluation understanding
   d. continuing education unit

7. Which designation is not based on passing an examination?
   a. CAP
   b. CHP
   c. CMRS
   d. none of the above

8. The _____ recently added a new credential to their certifications called Certified Professional Biller.
   a. American Academy of Professional Coders (AAPC)
   b. American Health Information Management Association (AHIMA)
   c. National Healthcareer Association (NHA)
   d. American Medical Association (AMA)

Chapter 2

Overview of the Health Insurance Payment System

Learning Objectives

Upon completion of this chapter, the student should be able to:

- Understand the Affordable Care Act and its impact on health care.
- Describe the types of health insurance and identification cards associated with the health care plans.
- Explain the difference between co-insurance and co-payments.
- Discuss how health insurance differs from a medical discount card.
- Define key terms.

Key Terms

Affordable Care Act (ACA)
Allowed Amount
Beneficiary
Carriers
Centers for Medicare and Medicaid Services (CMS)
Co-insurance
Commercial
Contract
Co-payment
Coverage
Deductible
Dependents
Disability Insurance
Eligibility Category
Emergency Room Visits
Employee
Employee/ Significant Other (E/S) Coverage
Family Coverage
Fee Schedule
Fiscal Agent
Government Plan
Group Number
Health Insurance
Health Insurance Identification Card
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Health Maintenance Organization (HMO)
Husband/Wife (H/W) Coverage
Identification Number
Indemnity Plan
Individual
In Network
Insured
Managed Care Plan
Medicaid
Medicare
Medicare Advantage
Medicare Part B
Medicare Part C (also known as Medicare Advantage)
Medigap
Military Treatment Facility (MTF)
Original Medicare
Out of Network

Out of Pocket
Outpatient
Parent/Child Coverage
Plan type
Point-of-Service (POS) Plan
Policyholder
Preferred Provider Network (PPN)
Preferred Provider Organization (PPO)
Prescription Drugs
Primary
Primary Care Provider (PCP)
Referral
Secondary
Self-pay
Specialist
Subscriber
Supplemental
Traditional
Tricare
Tricare Extra
Tricare Prime
Tricare Standard

A Bit of History

Prior to 1920, the delivery of professional medical services in the United States was very basic. House calls were made by providers to patients ill in their homes. This kept the prices of providing health care low for the patient. Those patients unable to work lost wages and struggled to maintain their lifestyle. For a patient to have two weeks without pay because of an illness was a big financial hardship. Fortunately, a newly incorporated program called **disability insurance** evolved, and helped workers cover lost wages due to illness.

Progression in the twentieth century led to many changes in the practice of health care. Now, instead of visiting a patient's home, practitioners perform treatments on patients in hospitals or medical offices. This shift created a need for **health insurance** to cover the rising costs associated with the delivery of health care in a more costly setting and increased liabilities.

Over the years, insurance in the United States developed into a highly regulated, complex, multitiered payment system. Recently, in an effort to encourage affordable health care, the **Affordable Care Act (ACA)** was signed into place by President Barack Obama in 2010 and was implemented on January 1, 2014. The ACA allows access to affordable, preventative health care for millions of Americans that otherwise would not have access to health insurance coverage.

Disability insurance
insurance providing income to a policyholder who is disabled and cannot work.

Health insurance
a contract between the subscriber and the insurance company to pay for medical care and preventive services.

Affordable Care Act (ACA)
landmark health reform legislation intended to lower health care costs and provide health care coverage to millions of uninsured Americans. It was signed into law by President Barack Obama in March 2010.

Health insurance identification card
card given to subscriber as proof of insurance.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
mandates government regulations that govern patient privacy, security, and electronic record transactions.

Self-pay
a patient with no health insurance who must pay out of pocket for medical care.

Primary
the insurance plan that is billed first for medical services.

Health Insurance

Most patients seen in a provider's office have health insurance, which covers the majority of costs for their personal medical care. When a patient presents for an appointment at his or her provider's office, the patient checks in at the front desk, where a receptionist asks the patient to present a **health insurance identification card** and complete other important paperwork. The **Health Insurance Portability and Accountability Act (HIPAA)** strongly suggests a photo identification confirmation prior to the patient's visit with their provider. The insurance card provides valuable information for the office staff. The photo identification, such as a driver's license or state-issued identification card, helps prevent medical fraud and abuse by confirming that the patient's identity and health insurance plans match. The patient without health insurance must pay for the entire visit out of his or her own pocket. This is known as **self-pay**.

The first insurance billed for the patient's care is called the **primary** insurance. Once the primary insurance pays on the claim, the claim's balance is submitted to the patient's **secondary** or **supplemental** insurance (called **Medigap** for patients whose primary insurance is Medicare). If there is a question as to which insurance is primary

Secondary

the insurance plan that is billed after the primary has paid or denied payment.

Supplemental

another name for secondary insurance. A supplemental plan usually picks up the patient's deductible and/or co-insurance.

Medigap

supplemental insurance for patients with Medicare as their primary. These plans may pick up the Medicare deductible and co-insurance.

Contract

an agreement between two or more parties.

Identification number

the number listed on the identification card that identifies the patient to the insurance company.

Group number

the number on the identification card that identifies the patient's employer group health plan.

Plan type

a specific name assigned by the insurance company designating a specific plan for that type of insurance. For example, Oxford has a "liberty" plan.

Policyholder

the person who has (carries) the health insurance.

Subscriber

another term for policyholder.

Insured

another term for policyholder or subscriber.

Beneficiary

term used for a patient who has Medicare coverage.

Co-payment

a flat fee the patient pays each time for medical services. This is associated with managed care plans.

for a patient who presents two cards upon registration, the biller must contact both insurance companies to verify who should be primary. This should not occur frequently, as patients are usually well informed regarding the order (priority) of their insurance and the benefits of each. One rule of thumb: if a patient has insurance through an employer and is also covered through a spouse's employer, the *patient's* insurance is *always* primary.

The Identification Card

The health insurance identification card will list the name and address of the insurance company. It is the responsibility of the biller or patient scheduler to verify insurance eligibility to ensure the office is **contracted** with the insurance plan. Once a patient checks in at the front desk, the staff member signing in the patient should confirm the following information on the patient's identity card:

- **patient's identification number**
- **group number**
- **plan type**
- **policyholder**, also known as **subscriber**, **insured**, or **beneficiary**
- **co-payment**
- **co-insurance**
- **deductible**

The receptionist or biller must scan both sides of the health insurance identification card. Because a single insurance company may have many different addresses, never assume different patients with the same insurance will have the same claims submission address and phone number.

Types of Health Insurance Plans

There are many different types of health insurance plans to choose from. It is not the *most* important job duty of a medical biller to memorize these types of plans; however, it is important to have a familiarity with the different types to ensure the medical office staff collects the correct co-payment or co-insurance amount at the time of a patient's visit.

Indemnity Plan

An **indemnity plan** is a type of health insurance plan that allows the participant to select his or her own provider. The insurance company usually pays 80 percent of the **allowed amount** based on an insurance company's **fee schedule**. The patient is responsible for paying the remaining 20 percent. These monies are paid only after the patient's deductible has been met. The 20 percent the patient is responsible to pay is called co-insurance. In the field of medical billing and health insurance, a biller might also hear this type of plan referred to as a **traditional** or **commercial** health insurance plan. See Figure 2-1.

Government Plan

A **government plan** is a health insurance plan that is funded by the federal or state government. These plans are regulated by the **Centers for Medicare and Medicaid Services (CMS)**. Coverage may be dependent on state and federal laws, national

Co-insurance

a percentage the patient is responsible to pay of the cost of medical services. This is associated with indemnity, traditional, and commercial health insurance plans.

Deductible

the amount the patient is responsible to pay before any reimbursement is issued by the insurance company. This is usually associated with indemnity, traditional, or commercial plans.

Indemnity plan

a type of insurance plan in which reimbursement is made at 80 percent of the allowed amount, and the patient pays the remaining 20 percent.

Allowed amount

the dollar amount an insurance company deems fair for a specific service or procedure.

Fee schedule

a list of allowed amounts for all services and procedures payable by the insurance company.

Traditional

another term for indemnity or commercial health insurance plans.

Commercial

another term for indemnity or traditional health insurance plans.

Government plan

a health insurance plan funded by the government.

Centers for Medicare and Medicaid Services (CMS)

a government agency that oversees the Medicare and Medicaid programs.

Medicare

a government health insurance plan primarily covering persons aged 65 and older.

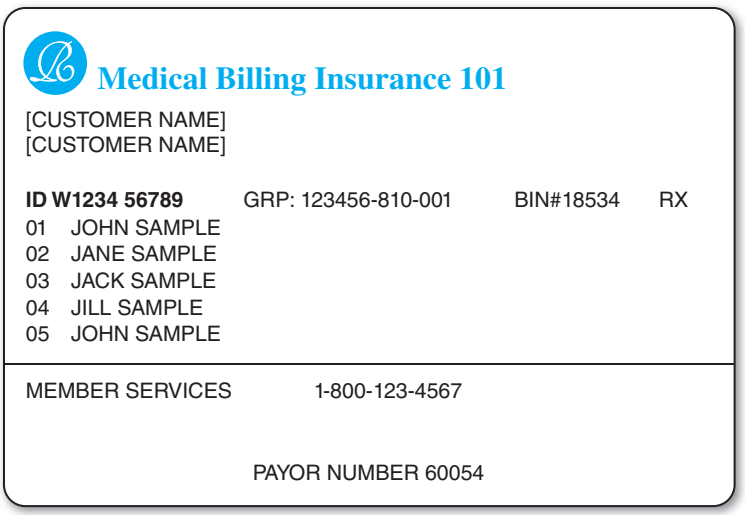

FIGURE 2-1 Sample indemnity card.

Medicare coverage decisions, and local coverage decisions (LCDs). LCDs are managed by individual companies who process Medicare claims. Each state or groups of states have different LCDs, and they must follow their guidelines on medical necessity for that patient's state. There are two types of plans that fall into the government plan category: **Medicare** and **Medicaid**.

Medicare

The Medicare health insurance coverage referred to in this text is **Medicare Part B**. This coverage is for provider and **outpatient** services, clinical research, durable medical equipment, mental health, and ambulance services. A person who has Medicare coverage is always referred to as a *beneficiary.* A person may become eligible for Medicare in several ways. Some include:

- Patient is 65 years of age or older
- Patient is disabled
- Patient has end-stage renal disease
- Patient has Medicare through spouse

Medicare billers must understand the rules and regulations regarding submission of these claims, not the reason for the patient's Medicare insurance. These rules are covered in detail in Chapter 5. There is more than one type of Medicare plan; the plan discussed in this section is called **Original Medicare**. Because CMS contracts with various **carriers** to pay Part B claims, the address to which these claims are submitted is different for each state. See Figure 2-2.

In addition to Medicare Part B, medical billers need to be aware of three other Medicare plans:

1. **Medicare Part A** – covers inpatient care in hospitals, services such as surgeries, laboratory tests, supplies and provider visits that meet medical necessity for that patient's diagnosis
2. **Medicare Part C** – Medicare Advantage Plans approved by Medicare but managed by private entities which cover all Medicare services.
3. **Medicare Part D** – Prescription drug coverage

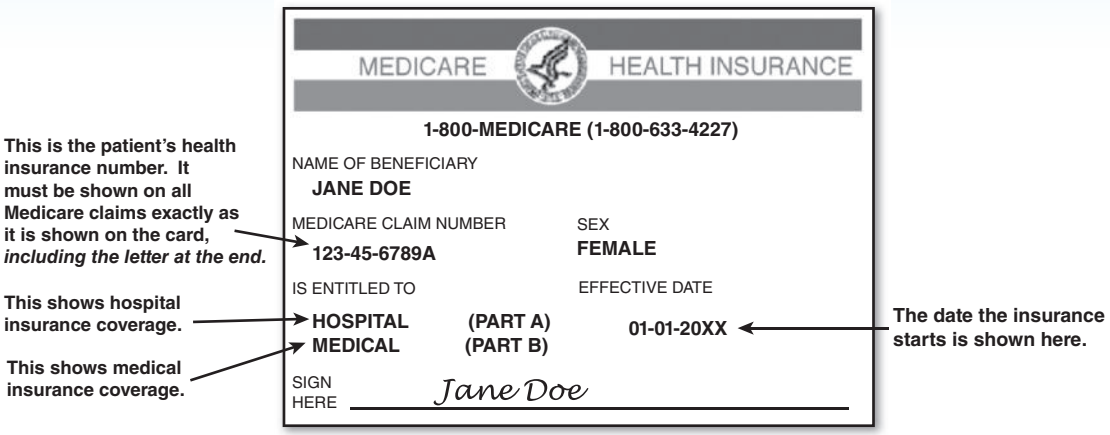

FIGURE 2-2 Sample Medicare card.

Medicaid
a government plan for financially indigent people.

Medicare Part B
covers services such as provider exams, surgeries, lab and radiology tests, durable medical equipment supplies (such as canes, oxygen and wheelchairs) considered medically necessary to treat a patient's condition.

Outpatient
services performed at a facility where the patient stays less than 24 hours and is not admitted to the facility; also, the term for the patient receiving such services.

Original Medicare
healthcare coverage managed by the federal government.

Carrier
a company that has contracted with CMS to pay Part B claims.

Fiscal agent
a company that contracts with CMS to pay Medicaid claims.

Eligibility category
a category listing requirements for a person to be covered by a specific plan.

Managed care plan
a health insurance plan that includes financing, management, and delivery of health care services.

Medicaid

Medicaid is for a patient who is unable to pay for medical costs due to limited financial income. Medicaid is funded by both the federal government and state governments. Medicaid claims are paid through a **fiscal agent**. To become eligible for Medicaid, a person must fall into an **eligibility category**. Each state has its own guidelines; therefore, it is imperative to research the rules of the state in which the patient lives to become familiar with that state's Medicaid guidelines. Some states require that an eligible person register with a Medicaid managed care plan.

Managed Care Plans

Managed care plans are among the most common type of health insurance plans a biller will come across. With these health insurance plans, the patient is responsible for paying a co-payment at each provider encounter. Co-payment amounts vary within an insurance plan depending on the type of service that is provided. There is a co-payment for a **primary care provider (PCP)**, a **specialist**, **prescription drugs**, **emergency room visits**, and other various procedures, treatments, and testing that may occur. Co-payment amounts may increase at the beginning of a calendar year. The patient will be sent a replacement health insurance identification card that lists the new co-payment amounts if there is a change in a co-payment amount.

The number and types of managed care plans can be overwhelming and confusing. This text helps students cover the basics of currently managed care plans seen from a billing perspective. These five plans are:

- health maintenance organization (HMO)
- preferred provider organization (PPO)
- point-of-service (POS) plan
- Medicare managed care plan
- Medicaid managed care plan

The HMO

With a **health maintenance organization (HMO)**, the patient must remain **in network** for services to be covered. If the patient goes **out of network** to receive medical care, the patient is responsible to pay the entire cost of the services rendered.

Primary Care Provider (PCP)

a provider (or other health care provider) who is responsible for a patient's main health care.

Specialist

a provider who specializes in a particular area of medicine.

Prescription drugs

medications prescribed by a provider (or other licensed prescriber).

Emergency room visits

an encounter in the emergency room.

Health Maintenance Organization (HMO)

a prepaid medical service plan that provides services to plan members.

In network

medical care sought from participating providers within a managed care plan.

Out of network

medical care sought from nonparticipating providers; those providers who have not contracted with specific managed care plans.

Preferred Provider Organization (PPO)

this type of plan offers discounts to insurance company clients in exchange for more members.

Out of pocket

the patient's share of the cost of health care services. This can include co-payment, co-insurance, or a deductible.

Point-Of-Service (POS)

plan a health insurance plan in which the patient pays a co-payment when staying in network.

Medicare Advantage

a private company that contracts with Medicare to offer and manage a plan for Part A and B Medicare health insurance benefits.

The PPO

A **preferred provider organization (PPO)** is a group of providers and hospitals that offer insurance discounts to company clients in order to encourage more members. For example, if a person works for sporting goods company A, the insurance company, Sandy Sails PPO, wants sporting goods company A as a client. Sandy Sails PPO is willing to reduce the premiums and will pay for the company's employees' health insurance coverage, *if* a large number of the employees choose the Sandy Sails PPO plan and the preferred providers in it. The co-payment amount the patient pays is minimal. If the patient goes out of network, however, reimbursement by the insurance company is at a lower rate; therefore, going out of network increases the patient's **out-of-pocket** cost.

The POS Plan

The **point-of-service (POS) plan** is one in which a member can choose to stay in network and pay the designated co-payment amount, or go out of network and pay a deductible and co-insurance for the services rendered. If the patient goes out of network in a POS plan, reimbursement to the provider is still very good, and the patient's co-insurance amount is usually between 20 to 30 percent. If offered by their employer, many employees choose this type of plan because of its flexibility.

Medicare Managed Care Plans

When a person becomes eligible for Medicare benefits, that person has an option to choose a Medicare managed care plan, known as **Medicare Advantage** or **Medicare Part C**. Medicare managed care plans are offered by the same insurance companies that offer managed care plans to non-Medicare patients. When a person chooses this plan, s/he is responsible for the monthly Medicare Part B premiums. If selected, the Medicare managed care plan is the patient's primary insurance. Original Medicare is *not billed* if a patient opts for a Medicare managed care plan.

The advantages of these plans vary. Some do not charge their members monthly premiums, while others do not require the patient to obtain a **referral** to see a specialist or to have certain testing or procedures done. With this kind of plan, the patient does not pay a 20 percent co-insurance of the allowed amount, as required with Original Medicare, but does pay a flat co-payment for each medical encounter. This is financially beneficial to the patient who may have several procedures or services done in the office during a single visit. See Figure 2-3.

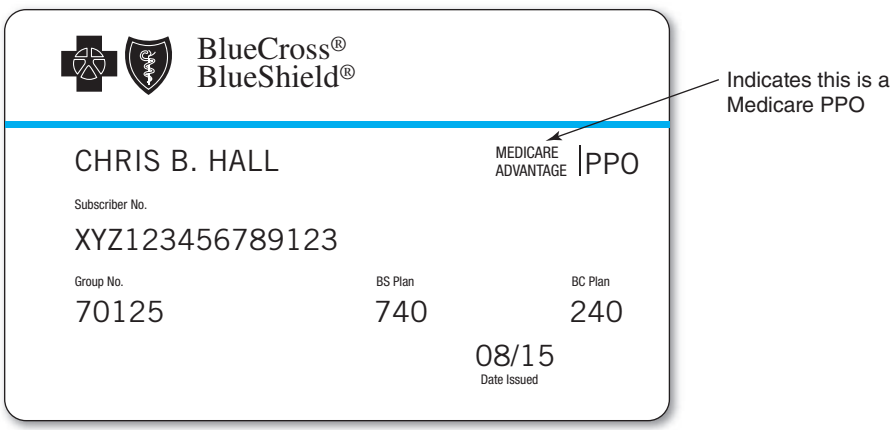

FIGURE 2-3 Sample Medicare managed care plan card.

Medicare Part C

plans run by private companies that combine coverage for both hospital and provider visits for an out-of-pocket fee.

Referral

permission from the primary care provider to seek services from a specialist for an evaluation, testing, and/or treatment. Managed care plans require this.

Tricare

health insurance provided for retired military personnel, active military personnel, and their dependents.

Medicaid Managed Care Plan

Because Medicaid guidelines vary by state, it's important for the medical biller to refer to the state's rules and regulations regarding a Medicaid managed care plan. If a state requires eligible Medicaid recipients to choose from a variety of managed care plans, then the state's Medicaid website will list the managed care plans to choose from. The income guidelines determining monthly premiums and co-payment amounts will be listed as well.

Tricare

Tricare is health insurance provided for retired military personnel, active military personnel, and their dependents. There are three Tricare regions throughout the United States: West, North, and South. Tricare-eligible beneficiaries have the opportunity to choose from three Tricare plans:

- Tricare Prime
- Tricare Standard
- Tricare Extra

Tricare Prime

Tricare Prime

the only Tricare plan offering coverage for active-duty service members. Retired members may also select this plan.

Military Treatment Facility (MTF)

a place where Tricare members receive medical treatment.

Preferred Provider Network (PPN)

a group of civilian medical providers that has contracted with Tricare.

With the **Tricare Prime** plan, active-duty service members are not required to pay an enrollment fee. Medical services for this plan are given at a **military treatment facility (MTF)**. Members receive treatment at these facilities from a Tricare-contracted civilian medical provider that is a **preferred provider network (PPN)**. Tricare Prime members also have a POS option, as described earlier in the managed care section. If members use the POS option under this plan, there is a deductible to meet and additional charges may apply.

Tricare Prime advantages include:

- No enrollment fee for active-duty service members or their families
- Small co-payment for a visit to civilian providers and no fee for active-duty service members
- Guaranteed appointments
- Away-from-home emergency coverage
- POS option

Tricare Prime disadvantages include:

- Enrollment fee for retirees and their families
- Limited provider choice
- Specialty care by referral only
- Not universally available

Tricare Standard

Tricare Standard

a Tricare plan available only to retired military service members and their families. This plan is available both in the United States and overseas.

The **Tricare Standard** plan is available only to retired military service members and their families. This plan option is considered the most flexible of the three plans. It is a fee-for-service plan that gives beneficiaries the opportunity to see any Tricare-authorized provider. The Standard plan covers most of the costs of medical care received from civilian providers when care from an MTF is unavailable.

Tricare Standard advantages include:

- Broadest choice of providers

- Wide availability
- No enrollment fee
- Members may also use Tricare Extra

Tricare Standard disadvantages include:

- No primary care provider
- Members must pay a deductible and 25 percent of the allowed charges for service
- If provider is nonparticipating, members may pay an additional 15 percent of fees if the bill exceeds the allowed charges
- Members may have to file their own health insurance claims

Tricare Extra

Tricare Extra

a Tricare plan available only to retired military service members and their families. This plan is not available overseas.

Like the Standard plan, the **Tricare Extra** plan is also available only to retired military service members and their families. The deductible and cost-sharing rules are similar to those of the Tricare Standard plan. Tricare Extra, however, is not available overseas. This plan may also be used on a case-by-case basis by Tricare Standard members.

Tricare Extra advantages include:

- Co-payment is 5 percent less than that of Tricare Standard
- No enrollment fee
- No deductible when using a retail pharmacy network
- No form to file
- Members may also use Tricare Standard

Tricare Extra disadvantages include:

- No primary care provider
- Limited provider choice
- Patient pays deductible and co-payment
- Not universally available

Types of Coverage

Regardless of whether a patient has health insurance through a job or has to pay out of pocket for health insurance premiums, the **coverage** falls into one of four types:

Coverage

existence and scope of the existing health insurance.

- Individual or employee coverage
- Husband/wife or employee/significant other coverage
- Parent/child coverage
- Family coverage

Individual or Employee Coverage

Individual

the one and only person covered under a health insurance plan.

Employee

a person employed who is covered under an employer's group health plan.

Individual or employee coverage is usually for a single person. The person may or may not have a child, but if s/he does, and the child is not covered under the plan, the coverage is under an **individual** or **employee** coverage. The individual is the only person covered under the plan.

Husband/Wife (H/W) coverage

health insurance covering both the husband and wife.

Employee/Significant other (E/S) coverage

health insurance covering the employee and the employee's significant other.

Parent/Child coverage

health insurance coverage for a parent and child.

Family coverage

health insurance coverage for the individual employee, the employee's spouse, and the employee's children.

Dependents

persons covered under the policyholder's plan.

Husband/Wife or Employee/Significant Other Coverage

When an individual has health insurance that covers himself and his spouse, or himself and a significant other, the coverage is called **husband/wife (H/W)** or **employee/significant other (E/S) coverage**.

Parent/Child Coverage

The single parent who insures both her/himself and her/his children through a health insurance plan has **parent/child coverage**. This coverage is very common for men who are divorced and required by the divorce decree to carry insurance coverage for their children.

Family Coverage

Family coverage is health insurance that covers the individual employee, the employee's spouse, and the employee's children. For the most part, health insurance premiums will remain the same regardless of how many children are covered or added to the policy. The only time this may not be true is in a Medicaid managed care plan. Depending on the state and the size of the family, premiums may increase as the family size increases. Most family coverage plans now include adopted children and stepchildren. Persons covered under the policyholder's plan are called **dependents**.

Summary

The health insurance identification card contains important information that is needed for a biller to verify a patient's health care coverage. It is always necessary to confirm current eligibility and benefits prior to a patient's visit. When the health insurance identification card is presented, a biller or receiving staff member must scan both the front and back of the card.

Because there are so many different types of health insurance plans, a biller is not expected to memorize them all. A biller is expected to know the difference between indemnity, government, and managed care plans and the difference between co-insurance and co-payment. A co-payment is a flat fee the patient pays for each provider encounter. Co-payments are used in managed care plans. Co-insurance is defined as a percentage the patient is responsible for paying at each provider visit. Co-insurance relates to indemnity plans and Original Medicare. Medicaid is for the low-income patient who has limited funds to pay for their health care expenses. Depending on the state in which a patient lives, Medicaid may require the patient to use a managed care plan. Active and retired military personnel have health insurance through Tricare. Three types of Tricare plans are offered; eligibility depends on the patient's status as active or retired military, and on family coverage.

Lastly, it's a biller's responsibility not to confuse health insurance identification cards with medical discount cards. It is wise for the provider to determine in advance whether to accept discount cards.

REVIEW QUESTIONS

1. It is not important to copy/scan both the front and back of the health insurance identification card.
   a. True
   b. False

2. A patient who has no health insurance is called a/an:
   a. self-referral
   b. indigent
   c. dependent
   d. self-pay

3. The insurance that is billed first for the patient is called:
   a. principal
   b. primary
   c. presenting
   d. none of the above

4. Another name for secondary insurance is:
   a. duplicate
   b. supplemental
   c. co-insurance
   d. primary

5. A nongovernmental plan that usually pays 80 percent and makes the patient responsible for 20 percent is called a(n) ____ plan.
   a. PPO
   b. HMO
   c. POS
   d. self-pay

6. The acronym ACA stands for:
   a. Accountable Care Association
   b. American Care Act
   c. Affordable Care Act
   d. Affordable Care Association

7. CMS stands for:
   a. Centers for Medical Supervisors
   b. Centers for Medical Services
   c. Centers for Medicare and Medicaid Services
   d. none of the above

8. The Health Information Portability and Accountability Act strongly suggests seeing _____ prior to the patient's visit with their provider.
   a. consent
   b. identification
   c. authorization
   d. photo id

9. _____ is a type of health insurance plan that allows the participant to select his or her own provider.
   a. Government plan
   b. Medicaid
   c. PPO
   d. Indemnity plan

10. Medicare Part B is for provider and _____ services.
   a. inpatient
   b. outpatient
   c. rehabilitation
   d. surgical

Chapter 3

The Codes (ICD-9, ICD-10, CPT, HCPCS Level II, and Modifiers)

Learning Objectives

Upon completion of this chapter, the student should be able to:

- Recognize an ICD-9 and ICD-10 code.
- Differentiate between a CPT code and a HCPCS national code.
- Explain modifier usage.
- Define key terms.

Key Terms

Audit
Codes
Current Procedural Technology (CPT)
CPT Modifier
E codes
HCPCS
HCPCS Modifier
HCPCS National Codes
ICD-9-CM
ICD-10-CM
Modifier
Place of Service (POS)
Superbill
V Codes

Learning a New Language

Codes

assigned letters, numbers, or a combination of both used to report procedures, services, supplies, durable medical equipment, and diagnoses.

Understanding the terms associated with medical billing is similar to learning a new language. A huge part of medical billing lingo is comprised primarily of numbers and letters called **codes**. These codes represent descriptions of:

- Services
- Diagnoses

- Procedures
- Supplies
- Medicine
- Durable Medical Equipment (DME)

Fluency in any language requires practice; the language of medical billing is no different.

ICD-9-CM Coding System

Volume 1 (Tabular List)

ICD-9-CM

International Classification of Diseases, 9th Revision, Clinical Modification. The ICD-9 codes are used to report diagnoses, signs, and symptoms of a patient's illness or disease.

V codes

used exclusively in ICD-9 for conditions and factors influencing a patient's health and subsequent care with a health services agency.

E codes

used exclusively in ICD-9 to explain causes of patient injuries and poisonings.

Codes in Volume 1 of the **ICD-9-CM** manual are listed numerically, according to diseases and disorders of the body systems. This volume also contains **V codes**, which are used for Supplementary Classification of Factors Influencing Health Status and Contact with Health Service Codes and **E codes**, which are Supplementary Classification of External Causes of Injury and Poisoning Codes. Because Volume 1 contains the fourth-digit subcategories and fifth-digit subclassification descriptions, the coder in the provider's office should always refer to this volume to be certain whether an ICD-9-CM code requires further subdivision.

V Codes (V01–V91)

V codes are assigned when a patient is seen in the office for a reason other than injury or disease. Preventive medicine for both children and adults is always designated with a V code as a diagnosis. For example, the ICD-9-CM code for a well-baby checkup is V20.2, and the ICD-9-CM code for an annual physical examination is V70.0.

E Codes (E000–E999)

E codes are assigned to describe external causes of injury, poisoning, or other adverse reactions affecting the patient's health. When a code from this section is applicable, it is intended to be used *in addition to* the main numeric ICD-9-CM code indicating the nature of the condition. This means that E codes are never listed as primary codes.

For example, a child falls while running around the bases at his baseball game. He is diagnosed with a closed fracture of the wrist (814.00). The additional E code E849.4 would follow to indicate the location where the injury occurred.

Volume 2 (Index to Diseases)

This volume of the ICD-9-CM manual is an alphabetical listing of diseases and injuries. The novice medical biller may at first experience some difficulty when looking for an ICD-9-CM code in this section, because diagnoses with more than one word are not always listed alphabetically by the first term.

For example, a patient is diagnosed with back pain. When searching in Volume 2 of the ICD-9-CM manual under the letter B, the main term "back" is located. The biller will find the following words, "*see condition*." This means that the ICD-9-CM code is listed by the condition first. In this example, the condition is "pain." Once the main term for the condition "pain" is located, the subterm is found directly under the main term. Here the ICD-9 code for back pain is 724.5.

Volume 2 of the ICD-9-CM manual is usually referenced first, followed by verifying in Volume 1 to see if the code requires further subdivision. If it does, an

additional fourth or fifth digit must be included in order to accurately assign a diagnosis.

Because this text is not an instructional coding text, information given on the ICD-9-CM, ICD-10-CM, and CPT coding manuals are very basic. To see a complete list of codes and appendices in these manuals, check with the course instructor, or visit the local library if copies are not available.

ICD-10-CM/PCS Coding System

A new coding system called ICD-10-CM and ICD-10-PCS will replace the ICD-9-CM and ICD-9 Volume 3 coding systems in the near future. ICD-10-CM allows for code expansion in response to newly discovered diseases and treatments. It also embraces a greater level of specificity and laterality, which means that the ability to code is more specific to a body part and/or side of the body. This change is due to ICD-9-CM's inability to accommodate an increased need for updated diagnostic and procedural codes. Currently, ICD-9-CM contains 3–5 digit placeholders and over 14,000 codes. ICD-10-CM contains 3–7 character spaces and over 68,000 codes!

ICD-10-CM and ICD-10-PCS Codes

ICD-10-CM

International Classification of Diseases, 10th Revision, Clinical Modification. The ICD-10 codes are used to report diagnoses, signs, and symptoms of a patient's illness or disease.

ICD-10-CM codes are used to report a patient's diagnosis and health status. ICD-10 codes can be found in ICD-10-CM and ICD-10-PCS coding manuals. The manuals are arranged in sections as follows:

- ICD-10-CM Index to Diseases and Injuries
- ICD-10-CM Tabular List of Diseases and Injuries
- ICD-10-PCS Index
- ICD-10-PCS Tables

Medical billing performed in the provider's office uses only ICD-10-CM codes. ICD-10-PCS codes are used in hospitals for procedures, and they will not be addressed in this book.

To further explain, an ICD-10-CM code book is a combination of alphanumeric code sections divided into the Index and the Tabular List. The Index contains the Index to Diseases and Injuries and the Index to External Causes of Injuries, a Neoplasm Table, and a Table of Drug and Chemicals. The Tabular List contains the alphanumeric codes and their descriptions. The first character of the code is a letter followed by numbers or alpha characters. Codes may be between three and seven characters in length. Some codes use X as a fifth character placeholder. The X allows for further expansion of codes without interrupting the six-character structure.

Superbill

a form listing CPT, HCPCS, and ICD-10 codes used to record services performed for the patient and the patient's diagnosis(es) for a given visit.

A provider's office will track patient visits and consequential diagnostic and CPT codes on a form called a **superbill** that contains the most common ICD-10-CM and CPT codes for the provider's specific practice and specialty. After a patient is seen, the provider will mark the correct diagnosis associated with the documentation that the provider has written on the patient's chart. It is critical that a definitive diagnosis is supported by provider documentation and is recorded in the patient's medical record. See Figure 3-1.

ENCOUNTER FORM

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OFFICE VISITS	NEW	EST
❑ Level I	99201	99211
❑ Level II	99202	99212
❑ Level III	99203	99213
❑ Level IV	99204	99214
❑ Level V	99205	99215

OFFICE PROCEDURES	
❑ EKG with interpretation	93000
❑ Oximetry with interpretation	94760

LABORATORY TESTS	
❑ Blood, occult (feces)	82270
❑ Skin test, Tb, intradermal (PPD)	86580

INJECTIONS	
❑ Influenza virus vaccine	____
❑ Admin of Influenza vaccine	G0008
❑ Pneumococcal vaccine	90732
❑ Admin of pneumococcal vaccine	G0009
❑ Hepatitis B vaccine	90746
❑ Admin of Hepatitis B vaccine	G0010
❑ Tetanus toxoid vaccine	90703
❑ Immunization administration	90471

DIAGNOSIS

❑ Abnormal heart sounds	R00.9	❑ Chronic ischemic heart disease	I25.9	❑ Hypertension	I10
❑ Abdominal pain	R10.8__	❑ Chronic obstructive lung disease	J44.9	❑ Hormone replacement	Z79.890
❑ Abnormal feces	R19.5	❑ Congestive heart failure	I50.9	❑ Hyperlipidemia	E78.5
❑ Allergic rhinitis	J30.9	❑ Cough	R05	❑ Hyperthyroidism	E05.9__
❑ Anemia, pernicious	D51.0	❑ Depressive disorder	F32.9	❑ Influenza	J11.1
❑ Anxiety	F41.9	❑ Diabetes mellitus, type 2	E11.____	❑ Loss of weight	R63.4
❑ Asthma	J45.909	❑ Diarrhea	R19.7	❑ Nausea	R11.0
❑ Atrophy, cerebral	G31.9	❑ Dizziness	R42	❑ Nausea with vomiting	R11.2
❑ B-12 deficiency	D51.9	❑ Emphysema	J43.__	❑ Pneumonia	J18.__
❑ Back pain	M54.9	❑ Fatigue	R53.83	❑ Sore throat	J02.9
❑ Bronchitis	J40	❑ Fever	R50.9	❑ Vaccine, hepatitis B	Z23
❑ Cardiovascular disease	I25.1__	❑ Gastritis	K29.50	❑ Vaccine, influenza	Z23
❑ Cervicalgia	M54.2	❑ Heartburn	R12	❑ Vaccine, pneumococcus	Z23
❑ Chest pain	R07.9	❑ Hematuria	R31.9	❑ Vaccine, tetanus toxoid	Z23
❑ _____		❑ _____		❑ _____	

PATIENT IDENTIFICATION	
PATIENT NAME:	
PATIENT NUMBER:	
DATE OF BIRTH:	

ENCOUNTER DATE	
DATE OF SERVICE:	/ /

RETURN VISIT DATE	
DATE OF RETURN VISIT:	/ /

FINANCIAL TRANSACTION DATA	
INVOICE NO.	
ACCOUNT NO.	
TOTAL FOR SERVICE:	$
AMOUNT RECEIVED:	$
PAID BY:	❑ Cash ❑ Check ❑ Credit Card
CASHIER'S INITIALS:	

FIGURE 3-1 Sample superbill using ICD-10-CM codes.

When reviewing diagnosis codes, the Diagnosic Coding and Reporting Guidelines for Outpatient Services, found in the beginning of an ICD-10 coding book, are important guidelines for correct diagnostic coding practices. The ICD-10 codes are updated October 1 of each year. While it is unnecessary to memorize the ICD-10 codes, it is very important to know and understand the coding guidelines, and how to look up a code. Some offices may have encoders,

which are automated coding software programs, which a biller may also have to learn as a new employee.

Current Procedural Terminology (CPT) Coding System

Current Procedural Technology (CPT)

codes used to report services and procedures. These are level I codes under HCPCS.

Current Procedural Terminology (CPT) codes, also known as *level I codes*, are five-digit numeric codes. They are used to describe procedures and services provided by a health care professional. These codes are used in conjunction with the diagnostic codes previously explained in order to communication what has happened during a patient's visits, and any consequential treatment. Used together, these codes are submitted to a contracted payor for reimbursement.

Like the ICD-9-CM and the ICD-10-CM manuals, the CPT manual contains an index and a table of contents for the following services and procedures:

- Evaluation and Management (E/M) (99201–99499)
- Anesthesia (00100–01999, 99100–99140, 00100–01999)
- Surgery (10021–69990)
- Radiology (70010–79999)
- Pathology and Laboratory (81099–88299, 88399–88398, 80047–89398)
- Medicine (90281–91299, 92002–92014, 92015–92140, 99225–99607)

Evaluation and management (E/M) codes are "visit" codes that are used extensively in outpatient settings. Billers may encounter these codes and need to identify a New versus Established patient, which quantifies the amount of time and resources used to help diagnose and treat a patient's concern. Other things that billers should be aware of is the place of services, such as office or hospital, and the type of visit, such as office visit or inpatient admissions. These codes are very important to providers. Their reimbursement can be impacted by incorrect coding practices.

Anesthesia codes are used primarily by anesthesiologists who perform procedures in an ambulatory surgery center or in a hospital operating room.

The surgery section of the CPT book is divided into subsections based on body systems, and while many of the procedures indicated are performed in an ambulatory surgery center or hospital operating room, some of the procedures may be performed in a provider's office.

Radiology CPT codes are used for diagnostic and screening exams such as x-rays, ultrasound, MRI, CT scans, and mammography. Additionally, they may be used for administration of contrast materials used in conjunction with MRI or CT scans. These CPT codes are also used for radiation treatment management.

Pathology and Laboratory are used for any specimen, or disease-oriented testing. This may include testing for drugs, diseases, or in reproductive medicine.

The Medicine section contains many services. Some examples of services included in the medicine section are immunizations, vaccinations, psychiatry, dialysis, ophthalmology, and cardiovascular.

The CPT manual containing these codes is updated and published every year on January 1 by the American Medical Association.

Modifiers

There are occasions in medical billing when a code description does not contain all of the information needed to describe the service completely. When specific or additional information is needed to be able to accurately bill with a CPT or

HCPCS

a coding system used to report procedures, services, supplies, medicine, and durable medical equipment. Comprised of CPT (level I) and national (level II) codes.

Modifier

a two-character alphabetic, numeric, or alphanumeric descriptor used to signify that a procedure or service has been altered by an unusual or specific circumstance, although the code itself has not changed. Additional use includes referencing a specific body site.

CPT modifier

a two-character numeric descriptor used only with CPT codes.

HCPCS national code, a CPT or HCPCS **modifier** may be added to the CPT or HCPCS codes. In these instances, the medical biller must attach a modifier to the appropriate code.

Modifiers are used when:

- A service or procedure has a technical component
- A service or procedure has a professional component
- A service or procedure was performed by more than one provider
- A service or procedure was increased or reduced
- Only part of a service was performed
- An additional service was performed
- A bilateral procedure was performed more than once
- Referencing a specific body site
- Unusual events occurred

CPT Modifiers

It is extremely important that the medical biller use the most accurate **CPT modifier** in a given situation. Incorrect modifier usage can result in denial of the claim or, worse, an **audit** by the insurance company. Each provider's office should have a CPT manual on hand for the medical biller to refer to. See Table 3-1.

TABLE 3-1 CPT Modifiers

22	Unusual procedural service—Surgeries for which services performed are significantly greater than usually required; may be billed with the 22 modifier added to the CPT code. Include a concise statement about how the service differs from the usual. Supportive documentation (e.g., operative reports, pathology reports, etc.) must be submitted with the claim.
23	Unusual anesthesia.
24	Unrelated evaluation and management (E&M) service by the same provider during a postoperative period.
25	Significant, separately identifiable E&M service by the same provider on the same day of the procedure or other therapeutic service that has a 0- to 10-day global period. A separate diagnosis is not needed. This modifier is used on the E&M service.
26	Professional component—Certain procedures that are combined with a provider's professional component may be identified by adding the modifier 26 to the usual procedure number. All diagnostic testing with a technical or professional component, whether done in an outpatient or inpatient setting, must reflect the 26 modifier. The fiscal intermediary (Part A Medicare) will reimburse the facility for the technical component.
50	Bilateral procedure—*Bilateral services* are procedures performed on both sides of the body during the same operative session or on the same day. Medicare will approve 150 percent of the fee-schedule amount for those services.
51	Multiple procedures—For internal use by carrier only.
52	Reduced services—Use modifier 52 (reduced service) to indicate a service or procedure that was partially reduced or eliminated at the provider's election. If claims are submitted electronically with modifier 52, the insurer or payor will request medical records from the provider before processing the claims.
53	Discontinued procedure—Under certain circumstances, the provider may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. If claims are

Continues

TABLE 3-1 CPT Modifiers (Continued)

	submitted electronically with modifier 53, the insurer or payor will request medical records from the provider before processing the claims. One of the most common examples of the use of modifier 53 is when an incomplete colonoscopy is performed. Add modifier 53 to CPT code 45378. No documentation is required (this is an exception to the rule).
54	Surgical care only—When one provider performs a surgical procedure and another provider provides preoperative and/or postoperative management, the surgical service should be identified by adding modifier 54 to the usual procedure code.
55	Postoperative management only—Used for a provider's postoperative services when one provider performs the postoperative management and another provider has performed the surgical procedure.
57	Initial decision for surgery (90-day global period)—This modifier is used on E&M service, the day before or the day of surgery, to exempt it from the global surgery package.
58	Staged or related procedure or service by the same provider during the postoperative period—If a less extensive procedure fails and a more extensive procedure is required, the second procedure is payable separately. Modifier 58 must be reported with the second procedure.
59	Distinct procedural service—The provider may need to indicate that a procedure or service was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate lesion, or separate injury. However, when another already established modifier is appropriate, it should be used rather than modifier 59.
62	Two surgeons (co-surgery)—Under certain circumstances, the skills of two surgeons (usually different skills) may be required in the management of a specific surgical procedure. Adding modifier 62 to the procedure code used by each surgeon should identify the separate service.
66	Surgical team—Under some circumstances, highly complex procedures requiring the accompanying services of several providers, often of different specialties, plus other highly skilled or specially trained personnel, and also various types of complex equipment, are carried out under the surgical team concept. Claims with modifier 66 cannot be processed without a copy of the operative report.
73	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia.
74	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia.
76	Repeat procedure by same provider—Indicate the reason or the different times for the repeat procedure in item 19 of the CMS-1500 form or the electronic equivalent.
77	Repeat procedure by another provider—Indicate the reason or the different times for the repeat procedure in item 19 of the CMS-1500 form or the electronic equivalent.
78	Return to the operating room for a related procedure during the postoperative period—The provider may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires use of the operating room, it should be reported by adding modifier 78 to the related procedure.
79	Unrelated procedure or service by the same provider during the postoperative period—The provider may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure.
80	Assistant surgeon—Add modifier 80 to the usual procedure in a nonteaching setting to identify surgical assistant services.
82	Assistant surgeon when qualified resident surgeon not available in a teaching setting.

Continues

TABLE 3-1 CPT Modifiers (Continued)

90	Reference (outside) laboratory—When laboratory procedures are performed by a party other than the treating or reporting provider, the procedure may be identified by adding the modifier 90 to the usual procedure number. For the Medicare program, this modifier is used by independent clinical laboratories when referring tests to a reference laboratory for analysis.
91	Repeat clinical diagnostic lab tests performed on same day to obtain subsequent reportable test value(s)—This modifier is used to report a separate specimen(s) taken at a separate encounter.
99	The Multi-Carrier System (MCS) now allows the biller to send up to four modifiers per line of service on claims, for both electronically submitted and paper claims. Please indicate the pricing modifiers in the first two positions and processing or informational modifiers in the third and fourth positions. Use modifier 99 when more than four modifiers are needed on a line of service. In situations that require five or more modifiers, indicate modifier 99 in the first modifier field on the line of service and enter the remaining modifiers in the narrative field of an EMC claim or item 19 of a CMS-1500 claim form. For example: 79, RT, LT, QU, GA—99 in the first modifier field on the line of service, and 79, RT, LT, QU, GA in the narrative field of an EMC claim or item 19 of a CMS-1500 claim form.

Audit

a formal examination of an individual's or organization's accounts.

HCPCS national codes

alphanumeric codes used to identify categories not included in HCPCS level I codes. These codes are considered level II codes.

HCPCS modifier

a two-character alphabetic or alphanumeric descriptor used with both CPT level I and level II national codes.

HCPCS National Coding System

HCPCS national codes, or *level II codes*, are five-digit alphanumeric codes. The codes always begin with a letter followed by four numbers. Level II codes cover:

- Supplies
- Durable medical equipment
- Materials
- Injections/drugs
- Services

The **HCPCS modifier** can be used with both a CPT level I and level II national code. It is in this list of modifiers that the biller will find reference to specific body sites. See Table 3-2.

TABLE 3-2 HCPCS Modifiers

AA	Anesthesia services personally furnished by an anesthesiologist.
AD	Medical supervision by provider: more than four concurrent anesthesia services.
AQ	Provider providing a service in a health professional shortage area (HPSA) (for dates of service on or after January 1, 2006).
AR	Provider providing services in a provider scarcity area.
AS	Provider assistant, nurse practitioner, or clinical nurse specialist service for assistant at surgery.
AT	Acute or chronic active/corrective treatment (effective October 1, 2004).
CB	Services ordered by a dialysis-facility provider as part of the ESRD (end-stage renal disease) beneficiary's dialysis benefit; this is not part of the composite rate and is separately reimbursable.
CC	Procedure code change (the carrier uses CC when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed).

Continues

TABLE 3-2 HCPCS Modifiers (Continued)

CR	Catastrophe-/disaster-related.
EJ	Subsequent claim for EPO (epoetin alfa) course of therapy.
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	Advance Beneficiary Notification on file.
GC	This service has been performed in part by a resident under the direction of a teaching provider.
GE	This service has been performed by a resident without the presence of a teaching provider, under the primary care exception.
GG	Performance and payment of screening mammogram and diagnostic mammogram on the same patient, same day (effective for dates of service on or after January 1, 2002).
GJ	"OPT OUT" provider or practitioner emergency or urgent service.
GM	Multiple patients on one ambulance trip.
GN	Service delivered under an outpatient speech-language pathology plan of care.
GO	Service delivered under an outpatient occupational therapy plan of care.
GP	Service delivered under an outpatient physical therapy plan of care.
GQ	Via asynchronous telecommunications system.
GT	Via interactive audio and video telecommunications system.
GV	Attending provider not employed or paid under arrangement by the patient's hospice provider (effective for dates of service on or after January 1, 2002).

Continues

TABLE 3-2 HCPCS Modifiers (Continued)

GW	Service not related to the hospice patient's terminal condition (effective for dates of service on or after January 1, 2002).
GY	Item or service statutorily excluded or does not meet the definition of any Medicare benefit.
GZ	Item or service expected to be denied as not reasonable and necessary and Advance Beneficiary Notification has not been signed.
J1	Competitive acquisition program (CAP) no-pay submission for a prescription number.
J2	CAP restocking of emergency drugs after emergency administration.
J3	CAP drug not available through CAP as written; reimbursed under average sales price methodology.
KD	Infusion drugs furnished through implanted durable medical equipment (effective January 1, 2004).
KX	Claims for therapy services that have exceeded therapy caps (either by automatic exception or by approved request), for which specific required documentation is on file.
KZ	New coverage not implemented by managed care.
LC	Left circumflex coronary artery.
LD	Left anterior descending coronary artery.
LR	Laboratory round trip.
LT	Left side (use to identify procedures performed on the LEFT side of the body).
QA	FDA investigational device exemption.
QB	Provider providing service in a rural HPSA.
QC	Single-channel monitoring (recording device for Holter monitoring).
QD	Recording and storage in solid-state memory by a digital recorder (digital recording/storage for Holter monitoring).
QJ	Services/items provided to a prisoner or patient in state or local custody. However, the state or local government, as applicable, meets the requirements in 42 C.F.R. § 411.4.
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
QL	Patient pronounced dead after ambulance called.
QP	Documentation is on file showing that the laboratory test(s) was ordered individually or ordered as a CPT-recognized panel other than automated profile codes.
QR	Services that are covered under a clinical study/trial.
QS	Monitored anesthesia care service.

Continues

TABLE 3-2 HCPCS Modifiers (Continued)

QT	Recording and storage on tape by an analog tape recorder.
QU	Provider providing services in an urban HPSA (for dates of service prior to January 1, 2006).
QV	Item or service provided as routine care in a Medicare qualifying clinical trial.
QW	CLIA waived test.
QX	Certified registered nurse anesthetist (CRNA) service with medical direction by a provider.
QY	Medical direction of one CRNA by an anesthesiologist.
QZ	CRNA service without medical direction by a provider.
Q3	Live kidney donor surgery and related services.
Q5	Service furnished by a substitute provider under a reciprocal billing arrangement.
Q6	Service furnished by a locum tenens provider.
Q7	One class "A" finding.
Q8	Two class "B" findings. Class "B" findings: Absent posterior tibial pulse; advanced tropic changes (hair growth, nail changes, pigmentary changes, or skin texture—three required); absent dorsalis pedis pulse.
Q9	One class "B" and two class "C" findings. Class "C" findings: Claudication; temperature changes, edema, paresthesias; burning.
RC	Right coronary artery.
RT	Right side (use to identify procedures performed on the RIGHT side of the body).
SG	Ambulatory surgical center (ASC) facility charges. This modifier is used only by the ASC for identifying the facility charge. It should not be reported by the provider when reporting the provider's professional service rendered in an ASC.
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.

Continues