MEDICAL BILLING TRAINING MANUAL

Medical billing & Coding is the process of submitting and following up on claims to insurance companies in order to receive payment.....

Medical billing translates a health care service into a billing claim. The responsibility of the medical biller in a health care facility is to follow that claim to ensure the practice receives reimbursement for the work the providers perform. A knowledgeable biller can optimize revenue performance for the practice.

Although a medical biller's duties vary with the size of the work facility, the biller typically assembles all data concerning the bill. This can include charge entry, claims transmission, payment posting, insurance follow-up and patient follow-up. Medical billers regularly communicate with physicians and other health care professionals to clarify diagnoses or to obtain additional information. Therefore, the medical biller must understand how to read the medical record and, like the medical coder, be familiar with CPT®, HCPCS Level II and *ICD-10-CM codes.*

INTRODUCTION OF GOVT. INSURANCES

A-Federal Insurance

1. Medicare
2. Medicaid
3. Tricare
4. RR Medicare (RR-Rail Road)

Medicare Eligible

Administrated by administered directly the federal government.

1. People 65 Years above
2. People Under 65 with certain Disabi lities

For People with Disabilities and Illnesses

No matter how old you are, if you have Lou Gehrig's disease, kidney failure, or certain other disabilities, you are eligible for Medicare. But you might have a waiting period before you can get Medicare benefits. Here are the details.

Lou Gehrig's disease (ALS). As soon as you get Social Security Disability benefits for ALS, you should be automatically enrolled in Medicare. There is no waiting period.

Kidney failure. To qualify, you must have end-stage renal disease and need dialysis or a kidney transplant. Usually, you can't get Medicare until three months after you start dialysis. Once

you've been diagnosed with kidney failure, call the Social Security administration at (800) 772-1213 to enroll in Medicare.

Other disabilities for which you get Social Security Disability benefits. You can't get Medicare until two years after you qualify for Social Security Disability. At that point, the Social Security Administration should sign you up automatically.

Note: Patient must be Tax Paid in order to get Medicare benefits.

The Different parts of Medicare

1. Part A
2. Part B
3. Part C
4. Part D

Part A (Hospital Insurance)

Only Covered with Hospital Services. (Ex. Bed Charges & Equipment charges)
Its Cover Inpatient care in Hospital.
Its cover Skilled Nursing facility, hospice and home health care.
Claims billing to UB92 & UB04 forms.

Part B (Medical Insurance)

Its Covered with Doctors' Services, hospital outpatient care and home health care.
Its cover some Preventive services to help maintain your health and to keep certain illness from getting worse
Claims Billing to HCFA-1500 & CMS1500 forms.

Part C (PartA+PartB+PartD)

Medicare Advantage plans (like an HMO or PPO) are health plans run by Medicare-approved private insurance companies. Medicare Advantage plans (also called Part C) include Part A, Part B and usually other coverage like Medicare prescription drug coverage (Part D), sometimes for an extra cost

Part D (Medicare prescription Drug Coverage)

Only Covered with Drug Programme (supply for Medicine) Ex: Sugar Patient.

Medicaid:

It's Covered with below Poverty people (or) Low income people. It's monthly month basic. Administrated by Each State Law.

Dual Eligible Medicare Beneficiary Groups

Dual Eligible Medicare Beneficiary Groups	**Income Criteria**	**Benefits**
QMB	≤ 100% of the Federal Poverty Line (FPL)	Eligible for Medicaid payment of Medicare premium, deductible, coinsurance and copayment amounts (except for Medicare Part D).
*QMB Plus***	* ≤ 100% of the FPL	Entitled to all benefits available to a QMB, as well as all benefits available under the State Medicaid plan.

SLMB Only Specified Low-Income Medicare Beneficiaries*	> 100% of the FPL but < 120% of the FPL	Eligible for payment of Medicare Part B premiums only.
*SLMB Plus***	> 100% of the FPL but < 120% of the FPL	Entitled to all benefits available to an SLMB, as well as all benefits available under the State Medicaid plan.
QI Qualifying Individuals	≥ 120% of the FPL but < 135% of the FPL	Eligible for payment of Medicare Part B premiums only; however, expenditures are 100% federally funded and total expenditures are limited by statute.
QDWI Qualified Disabled Working Individuals	≤ 200% of the FPL	Eligible for Medicaid payment of Medicare Part A premiums only.
FBDE	NA	Eligible for Medicaid either categorically or through optional coverage groups, such as Medically Needy or special income levels for institutionalized or home and community-based waivers.

Tricare:

It's Coved with Army people.

Tricare Two Types:

1. CHAMPVA (Civilian Health and Medical program for Veteran affairs)
2. CHAMPUS (Civilian Health and Medical program for Uniformed services)

RR Medicare:

It's covered with Railway Department, Transport Department & Highway's Department.

Worker's Compensation:

It's covered with Work related injury and work relevant accident.

Auto Accident:

It's Covered with Vehicle Accident.

Two types of Auto Accident:

1. No fault Auto Accident
2. Non-No fault Auto Accident

Managed Care Plans/Commercial Plans:
To provide High quality service at low Cast.

1. HMO (Health Maintenance Organization)

Patient must go to in-network Provider. PCP Must. (Low premiums, low deductible, copay & coins). PCP means Primary care Physician.

Pt goes to PCP first and PCP Issue Referral for specialist visit according to Diagnose.

2. PPO (Preferred Provider Organization)

Patient may go to any Healthcare Provider in listed Panel doctors, anywhere; Include out of Network If benefits are available.

3. EPO (Exclusive Provider Organization)

Similar to an HMO, with an EPO you ***must*** use network providers - doctors, hospitals and other health care providers - that participate in the plan. The only exception is for emergency care. Unlike an HMO, you do not need to select a Primary Care Physician, nor do you need to contact your PCP for referrals to specialists.

4. POS (Point of Services)

It's companied with HMO+PPO
Patient goes to any network provider (In or Out). PCP Must.

POS plans combine elements of both HMO and PPO plans. Like an HMO plan, you may be required to designate a primary care physician who will then make referrals to network specialists when needed. Depending upon the plan, services rendered by your PCP are typically not subject to a deductible and preventive care benefits are usually included. Like a PPO plan, you may receive care from non-network providers but with greater out-of-pocket costs. You may also be responsible for co-payments, coinsurance and an annual deductible.

Traditional Indemnity: Patients are billed and repaid for all or part of each service performed, subject to deductibles and limits on coverage.

HSA:

Health savings accounts (HSAs) are like personal savings accounts, but the money in them is used to pay for health care expenses. You — not your employer or insurance company — own and control the money in your health savings account. The money you deposit into the account is not taxed. To be eligible to open an HSA, you must have a special type of health insurance called a high-deductible plan.

PAR Provider: (Participating Provider)

Who agrees and accept Insurance fees schedule and willing to contract with Insurance company.

Capitation:

1. Fixed Capitation
2. Rolling Capitation

1. Fixed Capitation:

Provider will be get fixed amount for every month/year.

2. Rolling Capitation:

Provider will be get the fixed amount for every patient.

Non-PAR Provider (Non-Participating Provider)

Who does not contract with any Insurance company. (no write off).

Medical Terminolog

Coinsurance
:
Portion/Fixed Percentage of the Allowed amount, insured/subscriber/Patient has to pay to Healthcare Provider.

Copay:
It's fixed amount payable to provider by insured for each visit.

Deductible:
A specified amount of money that the insured must pay before an insurance company starts benefits.
Medicare & Commercial insurance starts in January of each year
Tricare insurance starts in October of each year

Authorization:

Two types of Authorization

1. Prior Authorization
2. Retro Authorization

Prior Authorization:
The process of obtaining permission to perform a service from the insurance carrier before the service is performed is called Pre-authorization. Prior authorization only required for certain type of procedures or specialty. However prior Auth is not guarantee of payment.

Retro Authorization:
After rendered the service provider get approval from the insurance company. It's exceptional only. Mostly insurances do not issue retro Auth.

Referral:

A referral is an authorization provided by the Primary Care Physician referring a patient to a specialist. Submitting a referral along with a claim is necessary to get reimbursement.

ABN: (Advance Beneficiary Notice)
A notice that hospital/Provider gives the patient before they receive services when Medicare/Medicaid is not expected to pay for some or all of the...

AOB: (Assignment of Benefits)
Patient assigned benefits to the provider behalf of the treatment.

COB:
Coordination of Benefits

Its details of Primary and secondary insurance.

SSN: (Social Security Number)
This Number all US Citizen Must. This Number Given by Social Security Administrator. SSN 3-2-4 format. First 3digit-Area Code 2digit-Group no. 4digit-Serial no.

Allowed Amount:
Insurance Company fixed Maximum amount allowed each and every procedure code is called Allowed amount.

Refund or Take Back
Claim wrongly Process and pay to the provider after the insurance company find the amount and ask refund request from the provider.

Offset or Recoupment amount
It the provider not refund the amount in the insurance company bill be adjusted on the next Claim.

Modifier:

Modifiers are codes that are used to "ENHANCE OR ALTER THE DESCRIPTION OF A SERVICE OR SUPPLY" UNDER CERTAIN CIRCUMSTANCES. A modifier provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but has not changed in its definition or code. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance.

Modifiers may be used under the following circumstances:-

· A service or procedure has both a professional and technical component.

· A service or procedure was performed by more than one physician and/or in more than one location.

· A service or procedure has been increased or reduced.

· Only part of a service was performed.

· A bilateral procedure was performed.

· A service or procedure was provided more than once.

· Unusual events occurred.

1. **Information Modifier**
2. **Reimbursement Modifier**

1.Information Modifier:
Does not Vary the payment just intimate the insurance company which part of the organ service was rendered eg.LT, RT, AI, KX, KO
2. Reimbursement Modifier:
Vary the payment who render the service patient (EX) PC, TC, 24,25,26,59,78,79

Commonly User Modifiers:

24 :Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period.

25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure or Other Service.

26: Reading of Reports.

50: Bilateral Procedure.

57: Decision of Surgery.

58: Staged or Related Procedure or Service by the Same Physician During the Postoperative Period.

59: Distinct Procedural Service

76: Repeat Procedure or Service by Same Physician: It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service

77: Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated.

78: Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period

79: Unrelated Procedure by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure:

90: Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier 90 to the usual procedure number.

91: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is require

CMS :
Centers of Medicare and Medicaid Service

HIPAA:
HIPAA is the acronym for the Health Insurance Portability and Accountability Act that was passed by Congress in 1996. HIPAA does the following:

- Provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs;
- Reduces health care fraud and abuse;
- Mandates industry-wide standards for health care information on electronic billing and other processes; and
- Requires the protection and confidential handling of protected health information

POS: (Place of Service)
It's Indicate where the service was rendered. (EX) Hospital, Clinic, Home etc.
Most commonly used POS are mentioned below.

11- Office	12-Home	13-Assisted Living Facility	20-Urgent Care
21-Hospital in Patient		22-Hospital Out Patient	23-Emergencey Room
31-Skilled Nursing Facility		32-Nursing Facility	81-Independent Laboratory

ROI: (Release of Information)
Patients accept agree to release their Medical Information

DX-Codes: (Diagnosis Code) (ICD9 or ICD10 codes)

The identification of the nature of an illness or other problem by examination of the symptoms.

DX-Codes means Diagnosis Code.
3-5 Digit numbers. Ex: 123.45, Fever, Headache

CPT: Current Procedure Terminology

Current Procedural Terminology (CPT) is a code set that is used to report medical procedures and services to entities such as physicians, health insurance companies and accreditation

organizations.

There are three types of CPT codes. Category 1 covers vaccines, Category 2 deals with performance measurement and Category 3 covers emerging technologies, services and procedures. The current version is known as CPT 2010.

HCPCS level-1 codes
CPT Code means Procedure code. 5 digit number
Procedure codes include 6 types of Treatment.

1. E/M (Evaluation Management) Visit. Starting with 99201-99499.
2. Anesthesiology – Starting with 00100-01999, 99100-99140
3. Surgery – Starting with 10021-69990
4. Radiology (Including Nuclear Medicine and Diagnostic Ultrasound)(Ex: Exray, CT, MRI) – Starting with 70010-79999
5. Pathology (Blood test, Urine test) – Starting with 80048-89356
6. Medicine (except Anesthesiology) (EKG (ECG), EMG) – Starting with 90281-99199, 99500-99602

HCPCS Code:
Health Care Financing Administration Common Procedure Coding System. (pronounced "hick-picks"). Three level system of codes.

Level I - American Medical Associations Current Procedural Terminology (CPT) codes.

Level II - The alphanumeric codes which include mostly non-physician items or services such as medical supplies, ambulatory services, prosthesis, etc. These are items and services not covered by CPT (Level I) procedures.

Level III - Local codes used by state Medicaid organizations, Medicare contractors, and private insurers for specific areas or programs.

Pre-Existing Condition:

Patient already suffered from Some disease before enter the policy, Insurance will not cover some duration for that disease, that patient responsible….that period called "Waiting Period". Once the patient will complete their waiting period, insurance starts to pay their services.
Ex: Heart Disease, High blood pressure, Cancer and Asthma.

FECA- Federal Employee's Contribution Act.
The Federal Employees' Compensation Act (FECA) provides federal employees injured in the performance of duty with workers' compensation benefits, which include wage-loss benefits for total or partial disability, monetary benefits for permanent loss of use of a schedule member, medical benefits, and vocational rehabilitation. This Act also provides survivor benefits to eligible dependents if the injury causes the employee's death. The FECA is administered by the Office of Workers' Compensation Programs (OWCP)

Work on claim

1. Eligibility verification
   Pt. id/group number, effective/Termination date, claim mailing address, payer ID or fax, Timely filing limit,
2. Billing entry
3. Reconcile
4. Claim submission… Paper, Electronic, Fax or Online on Web portal
5. Call after appropriate days of filing for claim status
6. If not on file verify eligibility again
7. If deny get denial reason argue them about this denial and try to reprocess if you see any possibility
8. If paid get received date. Paid date, check#, claim# and the address where they mailed the check. Date of check cleared.
9. Payment posting… and work on denial.
10. Appeal on those denials which you feel denied in error/Fault of Insurance company or Medical Necessity.

Skills/Experience:

1. Good communication/Listening Skills.(English)
2-Knowledge of medical billing/collection practices.
3. Knowledge of computer programs and basic office equipment.
4. Knowledge of business office procedures.
5. Knowledge of basic medical coding and third-party operating procedures and Practices.
6. Ability to operate a multi-line telephone system.
7. Skill in answering a telephone in a pleasant and helpful manner.
8. Ability to read, understand and follow oral and written instructions.
9. Ability to establish and maintain effective working relationships with patients, employees and the public.
10. Must be well organized and detail-oriented.

DAILY USE ABBRIVATIONS

NPI - National Provider Identifier
TIN – Tax Identification Number
IVR - Interactive Voice response
EOB - Explanation of Benefits
DME - Durable Medical Equipment
HIPAA - Health insurance Portability and Accountability Act
CLIA- Clinical Laboratory Improvement Amendments.
EDI - Electronic Data Interchange.
EGHP - Employer Group Health Plan.
EIN - Employer Identification Number.
ERISA - Employee Retirement income security Act.
ESRD - End stage Renal Disease.
HCFA - Health Care Financial Administration.
HIC - Health insurance Claim.
HCPCS - Healthcare common procedure coding system.
ICD9CM-International Classification of Disease 9 the revision of clinical modifier
DOS - Date of Service.
OWCP - Office of Worker's Compensation Program.
PIN - Provider Identification number.
PCP - Primary Care Provider.
ERA - Electronic Remittance Advice.
RRB - Railroad Retirement Board.
SSA - Social Security Administration.
SNF - Skilled Nursing Facility.
TPA - Third Party Administrator.
UPIN - Unique Physician Identification Number.

EVALULATION AND MANGMENT CODES (Commonly Used)

POS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL4	LEVEL5	DESCRIPTION
11	*99201 10mins*	*99202 20mins*	*99203 30mins*	*99204 45mins*	*99205 60mins*	**OFFICE** NEW VISIT
	99211 5mins	*99212 10mins*	*99213 20mins*	*99214 30mins*	*99215 45mins*	SUBSEQUENT
	99241 15mins	*99242 30mins*	*99243 40mins*	*99244 60mins*	*99245 80mins*	CONSULT
13	*99324 20mins*	*99325 30mins*	*99326 45mins*	*99327 60mins*	*99328 75mins*	**ASSISTED LIVING HOME** NEW
	99334 15mins	*99335 25mins*	*99336 40mins*	*99337 60mins*		SUBSEQUENT
21	*99221 35mins*	*99222 55mins*	*99223 70mins*			**HOSPITAL** INITIAL VISIT
	99231 15mins	*99232 25mins*	*99233 35mins*			FOLLOW UP
	99237	*99238*	*99239*			DISCHARGE
	99251 20mins	*99252 40mins*	*99253 55mins*	*99254 80mins*	*99255 110mins*	CONSULT
	99291 30-74 mins	*99292 Each Additional 30 mins*				HOSPITAL CRITICAL CARE
22	*99234*	*99235*	*99236*			SAME DAY **OBSERVATION**
	99218	*99219*	*99220*			INITIAL OBSERVATION
	99224	*99225*	*99226*			FOLLOW UPS
	99217					DISCHARGE
23	*99281*	*99282*	*99283*	*99284*	*99285*	**EMERGENCY**
31	*99304 25mins*	*99305 35mins*	*99306 45mins*			**SKILLED NURSING FACILITY** INITIAL VISIT
	99307	*99308*	*99309*	*99310*		SUBSEQUENT

	10mins	*15mins*	*25mins*	*35mins*		
	99215 <30mins	*99216 >30mins*				DISCHARGE
11	*99383 5-11yrs*	*99384 12-17*	*99385 18-39*	*99386 40-64*	*99387 65More*	**PHYSICAL EXM** New
	99393	*99394*	*99395*	*99396*	*99397*	Established

NEW PATIENT VISIST

Required Key Component 3/3	99201	99202	99203	99204	99205
· *Problem-Focused*	X				
· *Expanded Problem-Focused*		X			
· *Detailed*			X		
· *Comprehensive*				X	X
Medical Decision Making (complexity)					
· *Straightforward*	X	X			
· *Low*			X		
· *Moderate*				X	
· *High*					X
Contributory Factors					
Presenting Problem (Severity)					
· *Self-Limited or Minor*	X				
· *Low to Moderate*		X			
· *Moderate*			X		
· *Moderate to High*				X	X

ESTABLISHED PATIENT VISIT

Required Key Component 3/3	99211	99212	99213	99214	99215
· *Problem-Focused*	NA				
· *Expanded Problem-Focused*		X			
· *Detailed*			X		
· *Comprehensive*				X	X
Medical Decision Making (complexity)					
· *Straightforward*	NA	X			
· *Low*			X		
· *Moderate*				X	
· *High*					X
Contributory Factors					
Presenting Problem (Severity)					
· *Self-Limited or Minor*	X				

· *Low to Moderate*		X			
· *Moderate*			X		
· *Moderate to High*				X	X

Collector Must Know(After above short training)

Must Know Basics of Medical Billing.
Must Know Claim Cycle.
Must Know about Timely filing.
Must know E/M codes
Must Know Place of Services.
Must Know about All Boxes of Claim form.
Must Know about Main Windows of Software.
Must Know about Abbreviations.
Must Know about NCCI.
Must know LCD/Medical Necessity.
Must Know BASIC process of Credentialing.
Must Know to work on web portals.
Must Dial 50 calls to Hospital/Provider's, Insurance Companies and Patients.

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