Centralized Billing Unit Refresher For Clerical Staff

October 11, 2018
2:00 PM – 3:30 PM
Arnita Shepherd, Director, CBU
Jennifer McNeel, State Clerical Director
LaTonya Jackson, MPA,CPM
Cindy Ashley, BSN, RN, CPC-A
Justin Tyson, BBA

1

This video presentation was created to assist with coding accuracy for services rendered to patients seen at the ADPH county health departments only. It is the responsibility of the clinician to use his or her professional discretion to document and bill for appropriate services rendered.

Disclaimer

2

Upon completion of this presentation, Administrative Support Staff will have an Understanding of documentation and coding Guidelines used for billing at the Alabama Department of Public Health

Objective

3

- **At the conclusion of this presentation, participants should be able to:**
  - **Outline variables that can affect reimbursement**
    - **Global Fee**
    - **Medicaid requirements**

Conclusion

4

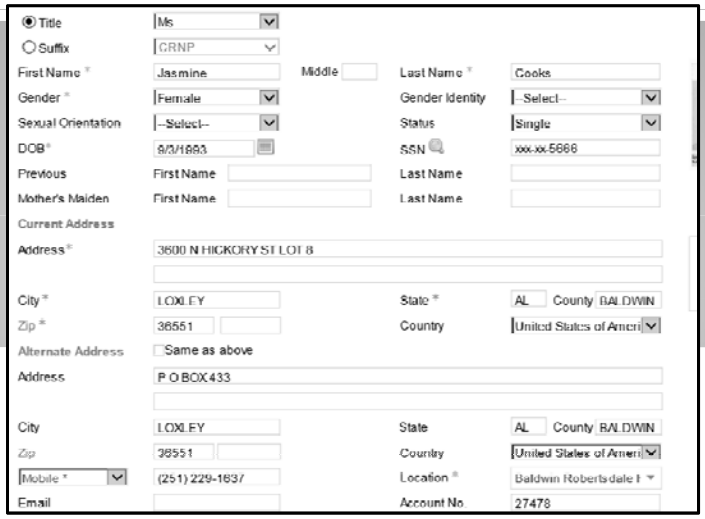
- Illustrate how the documentation of a patient encounter is converted into revenue
- Utilize common coding/billing terms
- List common reasons claims are denied

Conclusion

5

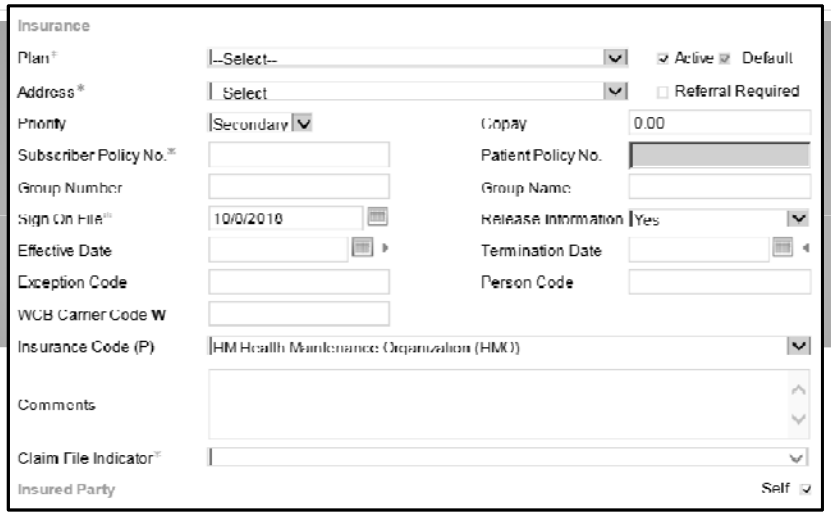
Patient Registration

6



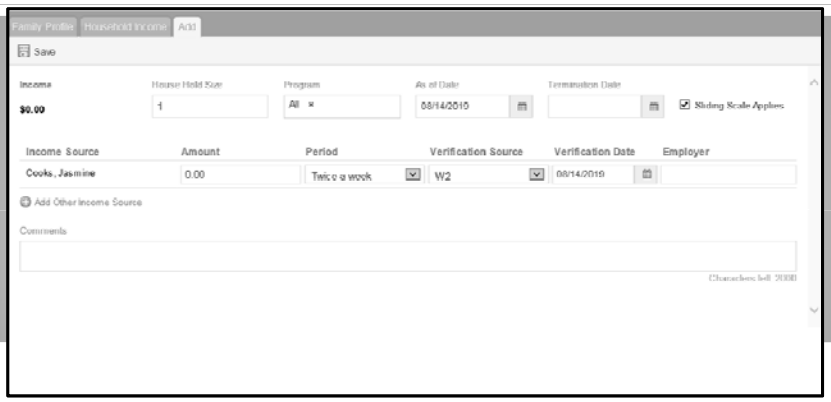
Profile

7



Insurance

8



Income Assessment

9

Coding

10

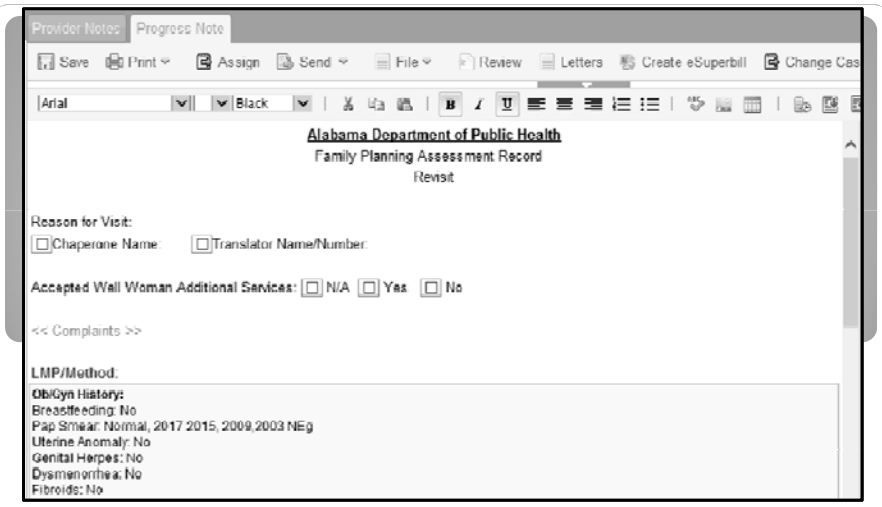
- **A process of transforming descriptions of medical encounters, diagnoses, procedures, diagnostic tests and supplies provided to a patient into universal code numbers, often referred to as CPT (Current Procedural Terminology)**
- **For every ailment, injury, diagnosis, and medical procedure, there is a corresponding code.**

What is Coding?

11

Forms Used In Billing Review

12



Provider Note
Documentation for all services and additional notes rendered during the encounter

13

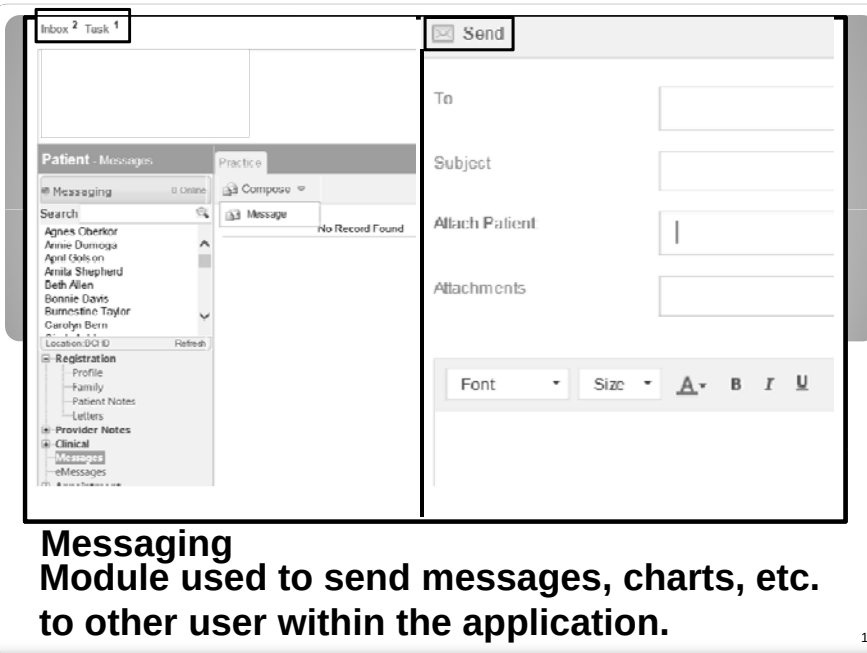
eSuperbill
Summary of all services rendered, based on documentation (CPT Codes) from the Provider Note.

14

Charge Screen

Billing component used in creating a bill file to submit to payer source

15



Messaging

Module used to send messages, charts, etc. to other user within the application.

16

Common Problems on the Provider Note

17

FP Documentation:
Documentation:
Counseling
PT: 3 Yes
Counseling done/protocolYes
Topics Indicated
1) Key Topic Areas: Discussed s/s of method
2) Key Topic Areas: discussed risk of STD's
3) Key Topic Areas: Discussed importance of calcium and Vit D intake daily
Supplies Given:
Details:
Previous documentation/record reviewed No contraindication noted Order for medication in chart
Medication:Depo Provera
Site: Left Deltoid
Patient Tolerated WellYes, RTC for FPS depo Oct 5- 19

☑ Required Consent(s) reviewed and signed by patient

Prescription:
MedroxyPROGESTERone Acetate 150 MG/ML Intramuscular Suspension: 150 Milligram(s) every 12 weeks , Start 07/20/2018, Qty 1 Vial For 90 Day(s), ICD: Z30.42

Diagnoses:
Encounter for surveillance of injectable contraceptive - Z30.42

Procedures:
MEDROXYPROGESTERONE ACETATE (CPT-J1050), Units: 1
INJECTION SUBQ/IM (CPT-96372), Units: 1

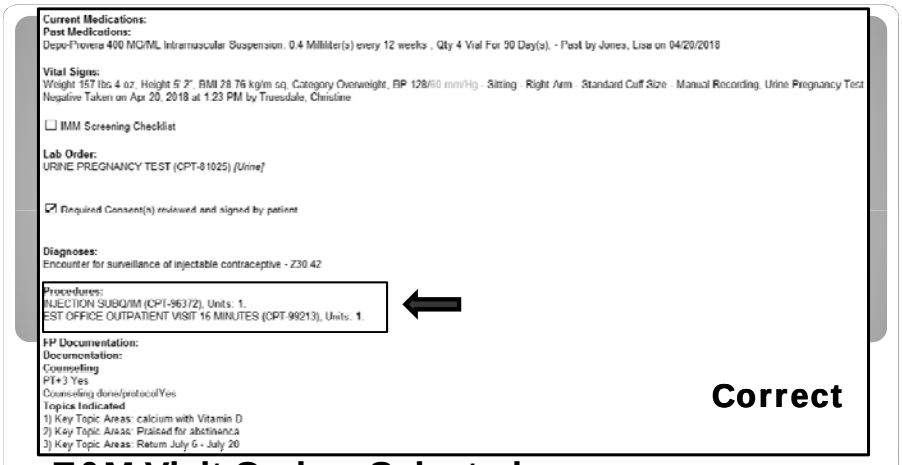
Incorrect

Patient / Guardian Education:
Patient verbalizes understanding for ADPH Depo Provera Shots Fact Sheet Nov 16. Provided by Peggy McGraw on 07/20/2018 10:39 AM

E&M Visit Code – Not Selected as a Procedure Code

E/M codes MUST be selected under "Procedures" on the provider note in order to bill for the visit.

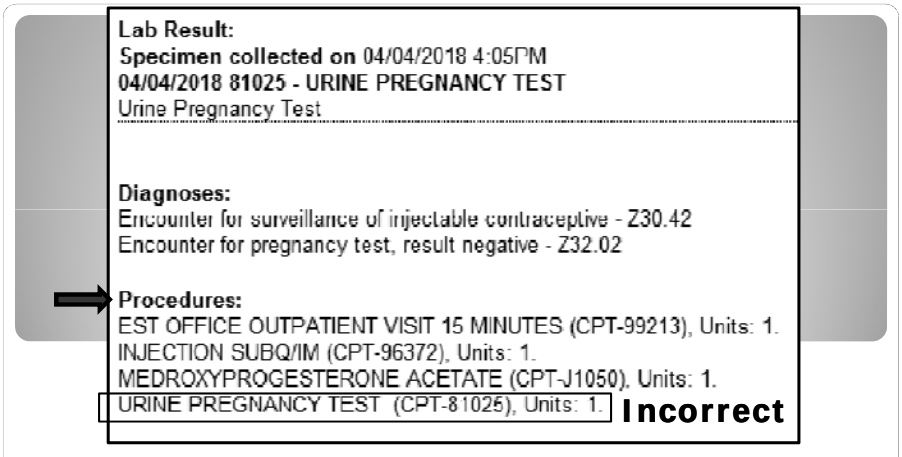
18



E&M Visit Code – Selected as a Procedure Code

E/M codes MUST be selected under "Procedures" on the provider note in order to bill for the visit.

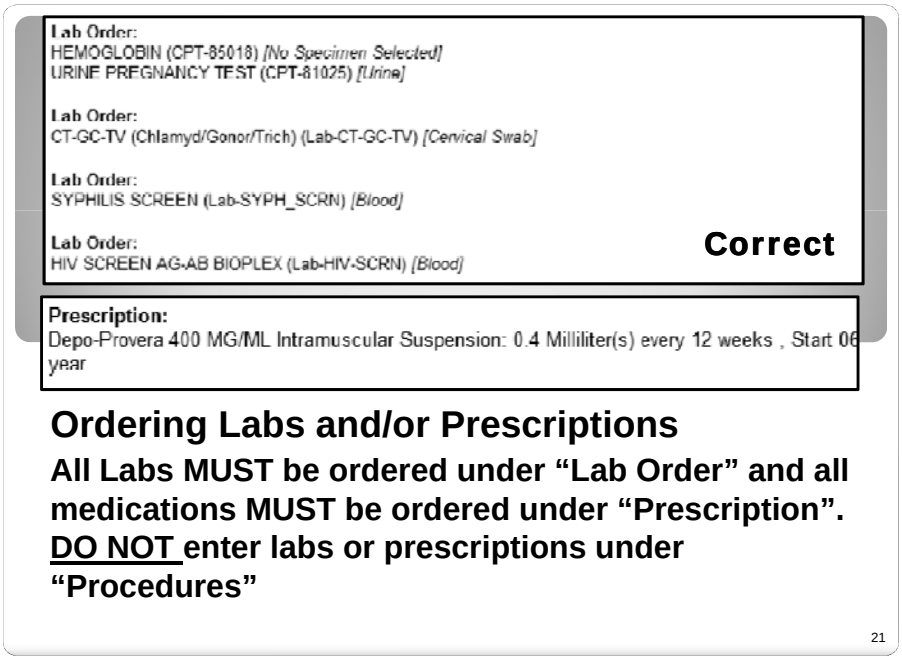
19



Ordering Labs and/or Prescriptions

All Labs MUST be ordered under "Lab Order" and all medications MUST be ordered under "Prescription".
<u>DO NOT</u> enter labs or prescriptions under "Procedures"

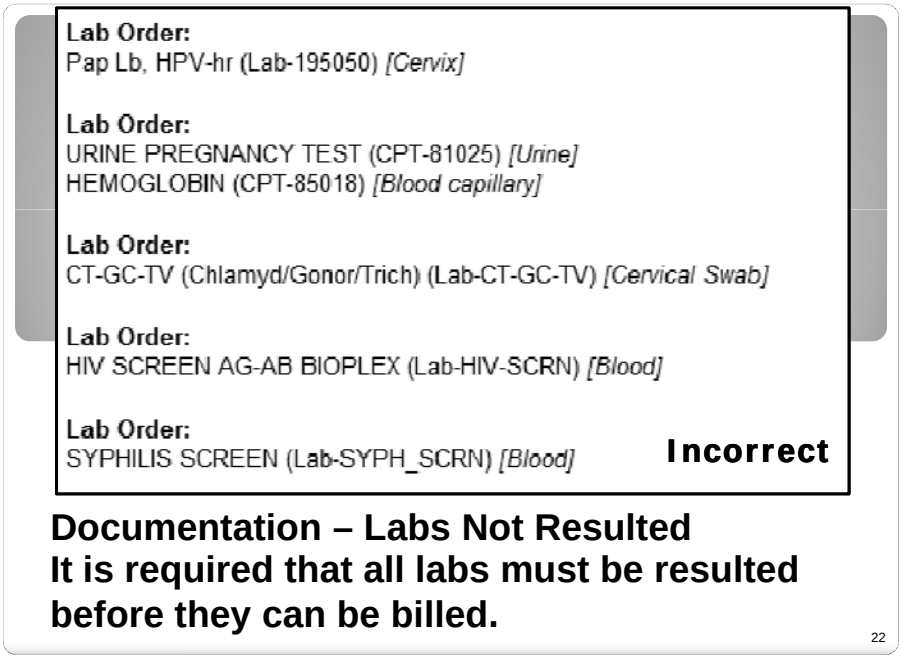
20



Ordering Labs and/or Prescriptions

All Labs MUST be ordered under "Lab Order" and all medications MUST be ordered under "Prescription". DO NOT enter labs or prescriptions under "Procedures"

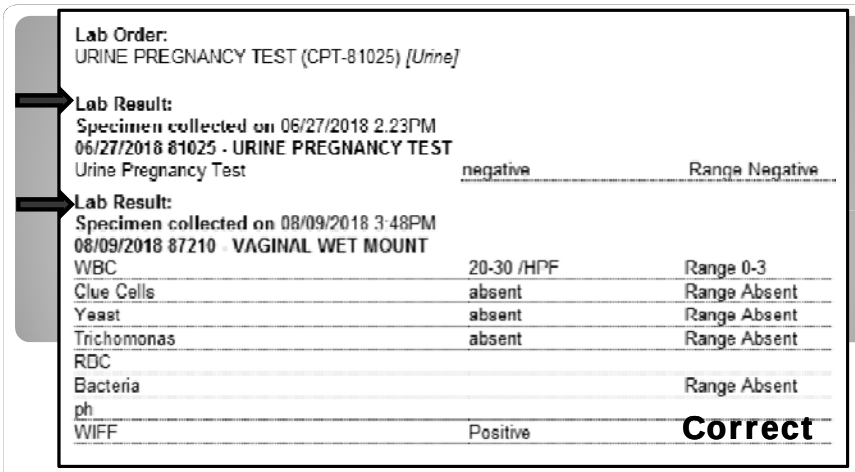
21



Documentation – Labs Not Resulted

It is required that all labs must be resulted before they can be billed.

22



Lab Order:
URINE PREGNANCY TEST (CPT-81025) *[Urine]*

Lab Result:
Specimen collected on 06/27/2018 2:23PM
06/27/2018 81025 - URINE PREGNANCY TEST

Urine Pregnancy Test	negative	Range Negative

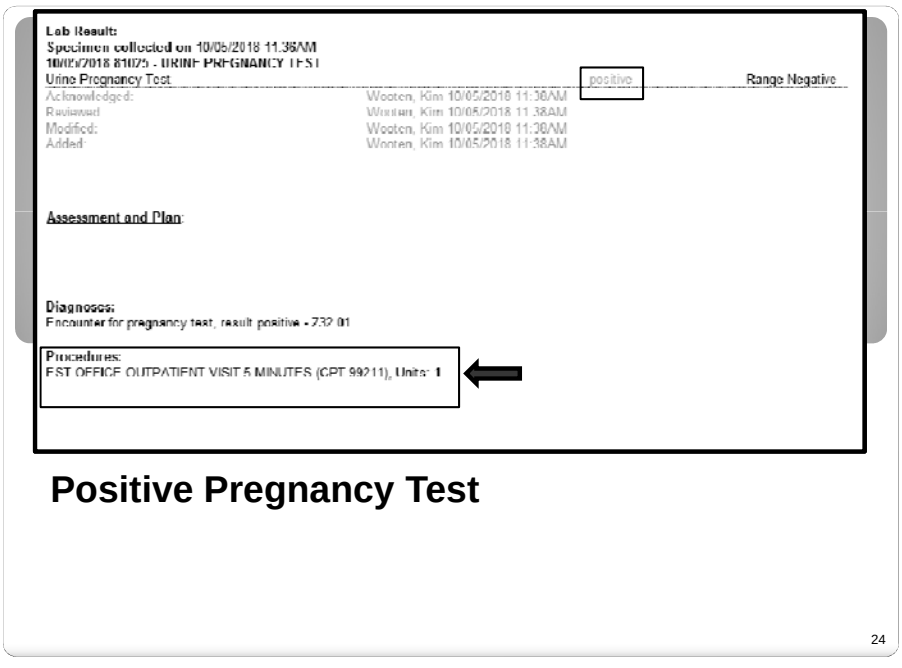
Lab Result:
Specimen collected on 08/09/2018 3:48PM
08/09/2018 87210 - VAGINAL WET MOUNT

WBC	20-30 /HPF	Range 0-3
Clue Cells	absent	Range Absent
Yeast	absent	Range Absent
Trichomonas	absent	Range Absent
RBC		
Bacteria		Range Absent
ph		
WIFF	Positive	**Correct**

Documentation – Labs Resulted

It is required that all labs must be resulted before they can be billed.

23



Lab Result:
Specimen collected on 10/05/2018 11:36AM
10/05/2018 81025 - URINE PREGNANCY TEST

Urine Pregnancy Test		positive	Range Negative
Acknowledged:	Wooten, Kim 10/05/2018 11:36AM		
Reviewed:	Wooten, Kim 10/05/2018 11:38AM		
Modified:	Wooten, Kim 10/05/2018 11:36AM		
Added:	Wooten, Kim 10/05/2018 11:38AM		

Assessment and Plan:

Diagnoses:
Encounter for pregnancy test, result positive - Z32.01

Procedures:
EST OFFICE OUTPATIENT VISIT 5 MINUTES (CPT 99211), Units: 1

Positive Pregnancy Test

24

Family Planning				Additional Family Planning Diagnoses	
Contraceptive Pills	**CPT**	**MOD**	**ICD-10**	**Breast Conditions**	
Annual	99214	FP	Z30.41	Mastitis without abcess	N61.0
Def Physical / Revisit	99213	FP	Z30.41	Abcess of the breast and nipple	N61.1
Initial Visit	99205	FP	Z30.41	Unspecified lump or mass in breast	N63.0
Injectable Contraceptive	**CPT**	**MOD**	**ICD-10**	Galactorrhea (not assoc. w/childbirth)	N64.3
Annual	99214	FP	Z30.42	Nipple discharge	N64.52
Def Physical / Revisit	99213	FP	Z30.42	Retraction of nipple	N64.53
Initial Visit	99205	FP	Z30.42	Mastitis, postpartum, unspecified	O91.20
Checking of Intrauterine Contraceptive Devi		**MOD**	**ICD-10**	Mastodynia	N64.4
Annual	99214	FP	Z30.431		
Def Physical / Revisit	99213	FP	Z30.431		
Initial Visit	99205	FP	Z30.431	**Cervix**	
Insertion of Intrauterine Device	**CPT**	**MOD**	**ICD-10**	Cervical Polyp	N84.1
Annual	99214	FP	Z30.430	AGC cytology	R87.619
Initial Visit	99205	FP	Z30.430	ASC-US cytology	R87.610
Revisit	99213	FP	Z30.430	ASC-H cytology	R87.611
Removal of Intrauterine Device		**MOD**	**ICD-10**	LSIL cytology	R87.612
Annual	99214	FP	Z30.432	High Risk HPV DNA positive	R87.810
Initial Visit	99205	FP	Z30.432	Cytologic evidence of malignancy	R87.614
Revisit	99213	FP	Z30.432	Unsatisfactory cytology	R87.615
Removal & Reinsertion	**CPT**	**MOD**	**ICD-10**	Lacking transformation zone	R87.616
Annual	99214	FP	Z30.433	**Chlamydia**	
Initial Visit	99205	FP	Z30.433	Chlamydia, unspecified	A56.00

CPT Codes with Diagnosis (Dx) Codes

The Coding Guide should be used to reference Dx that correspond to the correct CPT code(s)

25

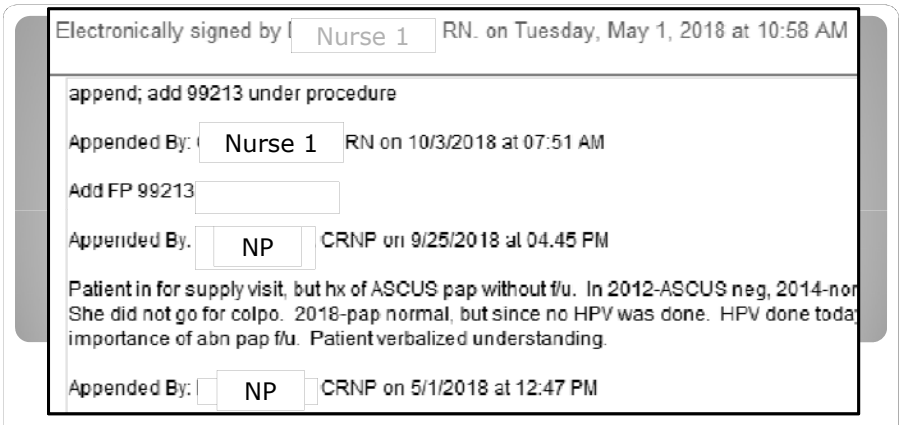
Diagnoses:
Encounter for surveillance of injectable contraceptive - Z30.42
Encounter for pregnancy test, result negative - Z32.02

Procedures:
INJECTION SUBQ/IM (CPT-96372), Units: 1.
EST OFFICE OUTPATIENT VISIT 15 MINUTES (CPT-99213), Units: 1.

Administration Code

Whenever an injection is administered, document the appropriate administration code shown on the ADPH Coding Guide

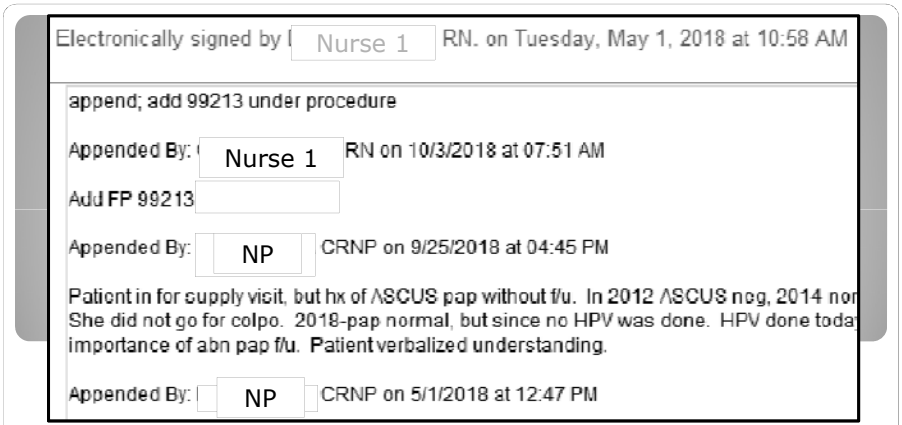
26



Wrong Provider Signing the Note

The highest level clinician providing services should sign the provider note and create the superbill

27



Addendum – Wrong Person Appending the Record

Only the Clinician that created the Provider Note or eSuperbill can append it.

28

DO NOT:

- **Delete**
- **Remove**
- **Copy and Paste documentation into a patient's record**

Terminology NOT to Use When Appending

29

YOU CAN USE:

- **Add CPT code**
  - **Ex: Add CPT code 99211, as 99213 was used in error**
- **Add Dx code**
  - **Ex: Add Dx code Z32.02**

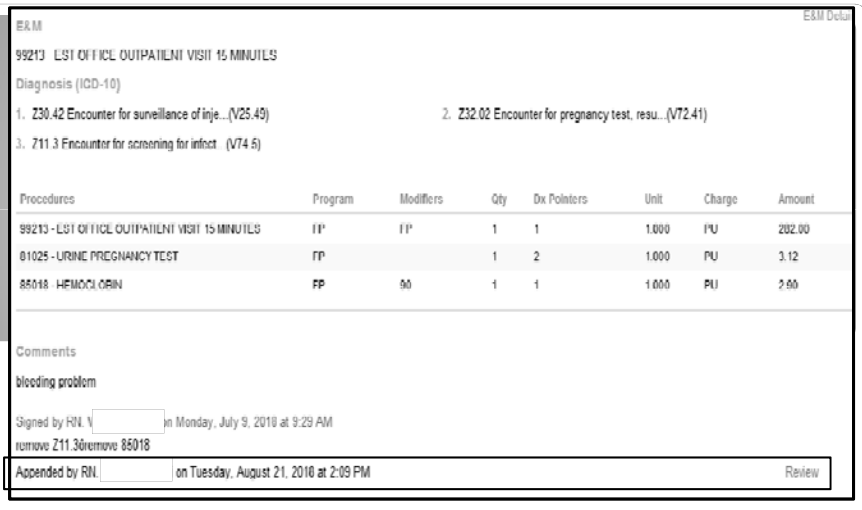
Terminology to Use When Appending

30

eSuperbill

Summary of all services rendered, based on documentation (CPT Codes) from the Provider Note.

31


E&M

E&M Detail

99213 - EST OFFICE OUTPATIENT VISIT 15 MINUTES

Diagnosis (ICD-10)

1. Z30.42 Encounter for surveillance of inje...(V25.49)
2. Z32.02 Encounter for pregnancy test, resu...(V72.41)
3. Z11.3 Encounter for screening for infect (V74.5)

Procedures	Program	Modifiers	Qty	Dx Pointers	Unit	Charge	Amount
99213 - EST OFFICE OUTPATIENT VISIT 15 MINUTES	FP	FP	1	1	1.000	PU	202.00
81025 - URINE PREGNANCY TEST	FP		1	2	1.000	PU	3.12
85018 - HEMOGLOBIN	FP	90	1	1	1.000	PU	2.60

Comments

bleeding problem

Signed by RN [redacted] on Monday, July 9, 2018 at 9:29 AM

remove Z11.3&remove 85018

Appended by RN [redacted] on Tuesday, August 21, 2018 at 2:09 PM Review

eSuperbill

When a clinician appends the eSuperbill, the system will request that the appended note is reviewed, typically by the clerk that is creating/submitting the charges."

32

Charge Screen

Billing component used in creating a bill file to submit to payer source

33

- **Alabama Medicaid Agency (AMA)**
- **Blue Cross Blue Shield (BCBS)**
- **Different payers have different rules.**
- **Different health departments programs have different rules.**
- **Coding only applies to services provided in the Health Department.**

Alabama Medicaid Agency Medicaid

Blue Cross Blue Shield

All Payers Are Not Alike

34

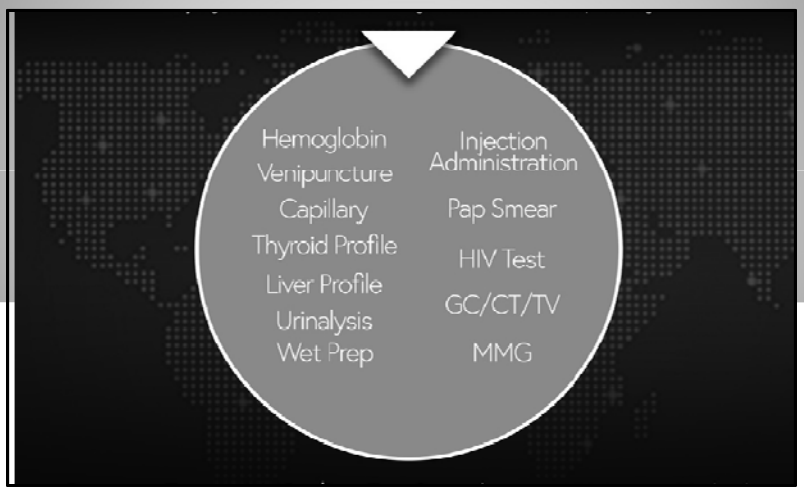
- **Certain services are included in the global fee for Medicaid.**
- **Health Department is not considered a pharmacy provider therefore we can not bill certain birth control methods to BCBS.**
- **Patients are unique and coding should reflect this.**

All Payers Are Not Alike

Alabama Medicaid Agency Medicaid

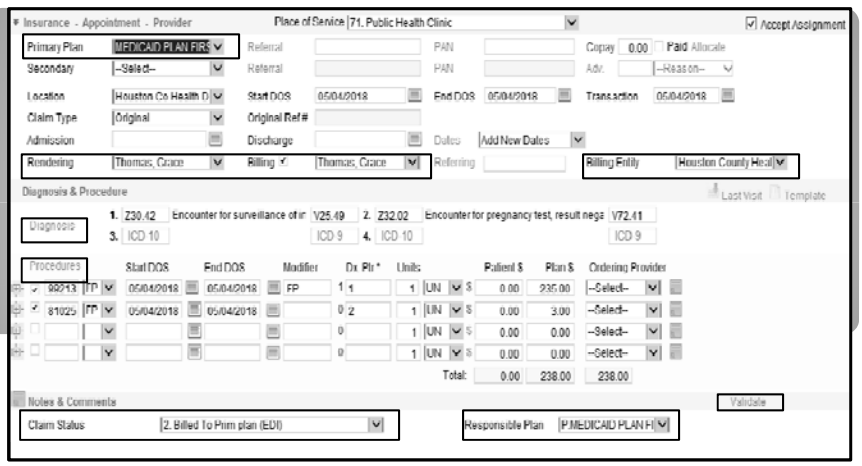
Blue Cross BlueShield

35



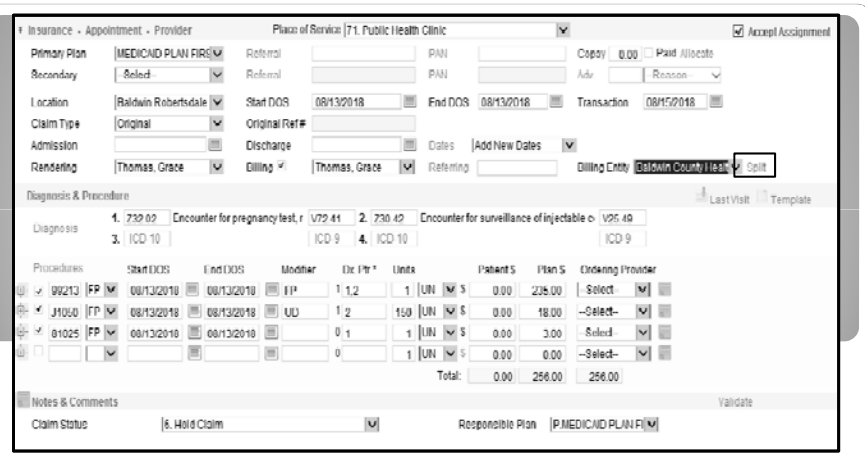
Medicaid Family Planning Global Fee

36



Key Elements of the Charge Screen

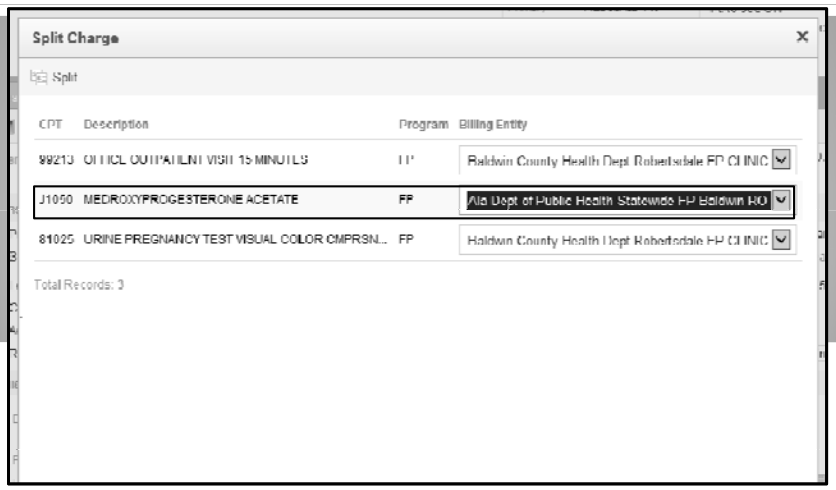
37



Splitting of Charges

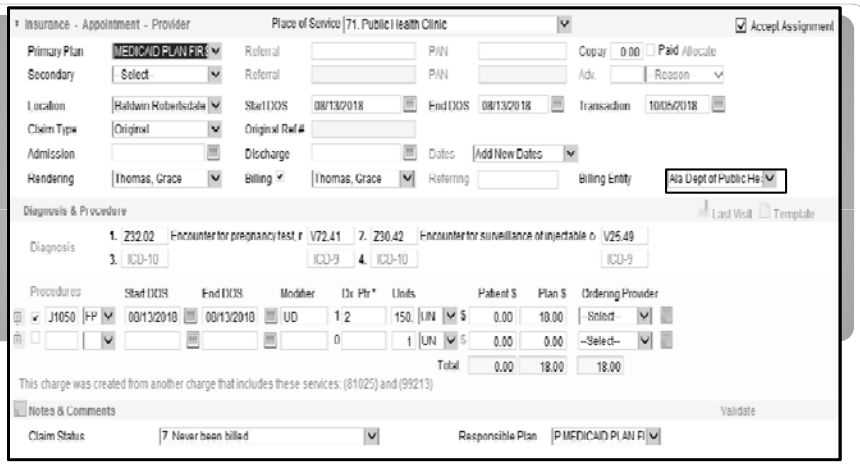
You should <u>ONLY</u> split charges if the method is billed back to the family planning state level NPI (ex. Rings, depo, IUDS)

38



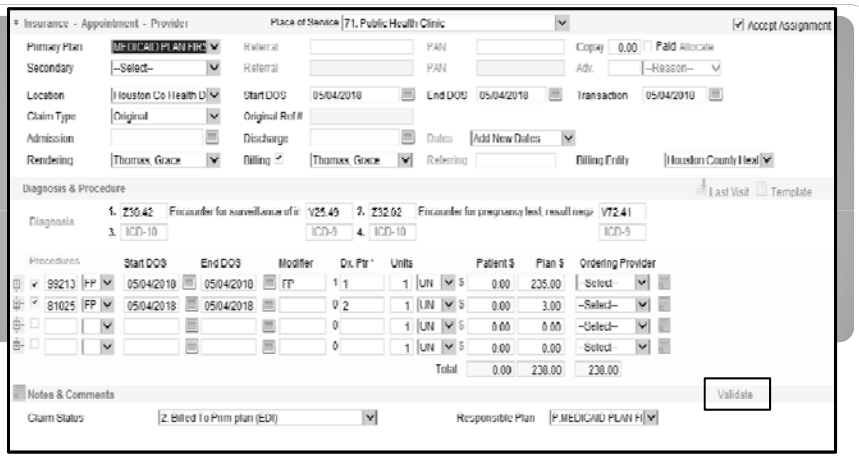
Splitting of Charges

39

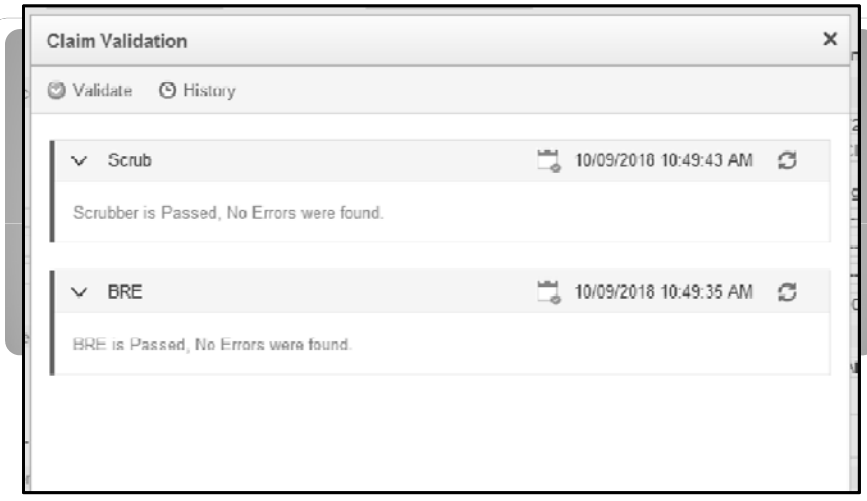


Splitting of Charges

40

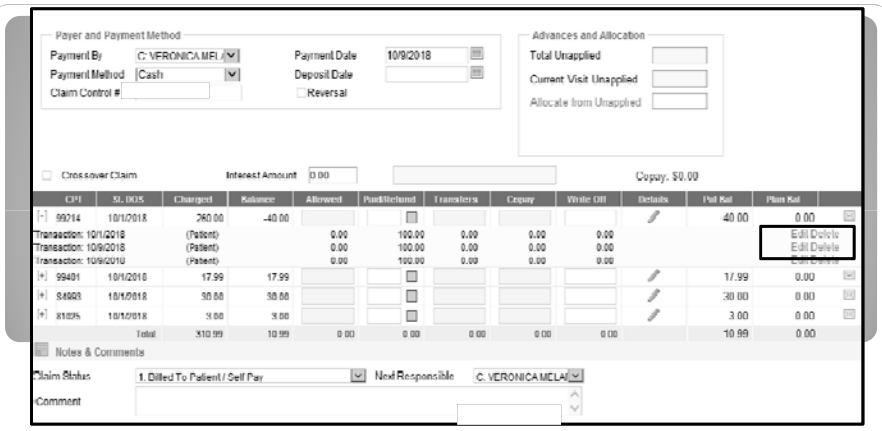


Validate Button



Validate Button

Two green bars as shown above, indicated charge is ready to be billed, based on info on charge screen



Double Payment Charges

Problem Lists

Claims that have been flagged for errors in demographics or Billing Rules Engine

- Located in the Billing Module
- Used to communicate billing issues with designated district and county staff
- Ex. Demographics, eligibility, patient has undocumented insurance, claims flagged of billing error, etc.
  - Messages that identifies the issue will be found in CureMD

Problem Lists

45

Recap for Clerks

46

CAN	CAN'T
• Update units on the charge screen, if correct on the provider note and/or eSuperbill • Add/Delete modifiers • Update diagnosis pointers • Utilize training materials for coding, provided by **CBU Only** • Make sure correct primary plan is selected • Make sure correct Billing Entity is selected based on the service	• Can not add, delete, or change CPT code selections on charge screen • Can not add, delete, or change diagnosis codes on charge screen • Can not append eSuperbill or documentation • Ex: The clinician must append eSuperbill if changes need to be made before a charge is created and submitted.

Recap for Clerks

47

- **Clear and accurate documentation**
- **Reviewing Provider Documentation**
  - **Documentation must match the billed services – every billed service and its corresponding diagnosis code must be clearly documented in the medical record**
  - **Services must be medically necessary for the treatment of the patient's condition**
  - **If it wasn't documented – it did not happen and can not be coded or billed**

Recap for Clerks

48

- Select the “Zip Code” hyperlink to populate the address properly. If you do not, your address will not save
- Enter all accurate patient demographics
- Ensure that the Sliding Scale Fee is checked and that programs show ALL

Quick Tips

49

- Review Provider Note thoroughly
- Refresh Charges. Make sure that the appropriate insurance carrier is selected, if any. Then add your modifiers. Lastly, tab through each line of the eSuperbill and the charge screen to ensure the system is pulling in the correct rate and/or activating the sliding fee scale.

Quick Tips

50

- Highest level provider MUST sign the provider note and the eSuperbill
- Be sure that we are using the ALFP1 for Emergency Contractive not S4993
- Refer to the policy for correcting documentation for retired/separated employees

Quick Tips

51

- Incomplete exams are not to be billed to a payer.
- Questions? Contact your District or CBU Representative

Quick Tips

52

Questions

53