CHAPTER 5
MEDICAL BILLING

LEARNING OBJECTIVES

In this PowerPoint presentation, we will learn about:

- Insurance and types of insurance
- Medical Billing
- Skills of Medical Biller
- Certifying Bodies
- Medical Billing Terms
- Health insurance payer and plan
- Claim form
- Medical billing process
- Pricing

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REVENUE AND BUSINESS

Revenue is the backbone of any business.

In absence of constant cash flow, there lies a threat to the existence of any healthcare facility.

Deficit in the cash flow might force the medical facility to shutdown despite providing the best healthcare service to the patients, therefore, medical billing department is of essence to every healthcare facility.

"Revenue is vanity, cash flow is sanity, but cash is king."

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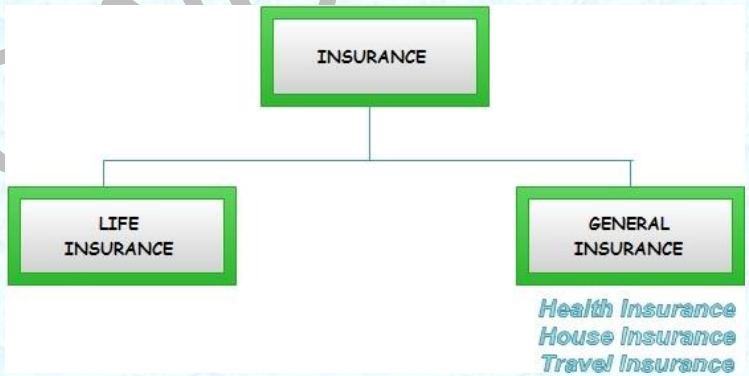
INSURANCE

Insurance is a contractual agreement between an insurance company and an individual or entity to provide compensation or reimbursement against any form of loss for which the individual or entity pays a premium to the insurance company.

There are two most common types of insurance,

- ✓ Life insurance
- ✓ General insurance



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INSURANCE

Life insurance is the contractual agreement between an insurance company and an individual (normally termed as policyholder) to provide predefined financial compensation in case of the death of the insured person or after the maturity period of the policy.

General insurance (non-life insurance) is defined as the insurance coverage given to all other types of risk other than life.

Health insurance is insurance against the risk of incurring medical and surgical expenses to the insured entity.

Health insurance is considered as a subcategory of general insurance in India, but in many countries, it is considered as a different type of insurance all together.

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UNITED STATES HEALTH INSURANCE

In United States, close to 85% of the population is covered under some or the other health insurance schemes.

With the advent of the Patient Protection and Affordable Care Act (PPACA) commonly called as the Affordable Care Act (ACA) or the "Obamacare," a near-universal healthcare insurance coverage to all the US citizens will be achieved.

The premium for the health insurance scheme in US is either paid by the individual or the employer or both the employer and employee contribute equally towards the premium.

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UNITED STATES HEALTH INSURANCE

In order to receive the payment, the healthcare provider needs to submit a claim to the insurance company.

Claim is the bill prepared by the medical biller to be submitted to the insurance company.

The health insurance company will then analyse the claim and release the payment to the healthcare provider if the claim is proper or reject/deny the claim if there is any discrepancy in the claim form.

This is where medical billing comes into play.

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INDIAN HEALTH INSURANCE

In India, only 25 percent of the population has access to any form of health insurance while the rest 75 percent remain uninsured and have to bear the cost of the medical expenses on their own.

Therefore, the healthcare providers (physicians, medical facilities, or hospitals) are in most cases paid directly by the patient.

The Indian government through various government-sponsored health insurance schemes (GSHISs) is trying to ensure that all Indians rich or poor (especially the poor) are covered with some form of health insurance.

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INDIAN HEALTH INSURANCE

The implementation of the famous Rashtriya Swasthya Bima Yojana (RSBY) in various states in India is an example of a commendable work in that direction.

In India, even in cases where the individuals are covered under the health insurance plan (normally termed as Mediclaim in India), the follow-ups with the health insurance company for the payment is done by the policyholder.

Only in case of cashless Mediclaim, the follow-up with the health insurance company is done by the healthcare provider.

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DIFFERENCE BETWEEN INDIAN AND US HEALTH INSURANCE

Some of the common differences between the Indian and US health insurance plans and companies are as follows;

		United States	India
1	Health Insurance Coverage	Almost 85 percent of the US population are covered under health insurance, and with the new Patient Protection and Affordable Care Act (PPACA), it is projected to be almost 100 percent.	Only about 25 percent of the Indian population are covered under health insurance leaving the rest 75 percent uninsured.
2	Coverage Definition	All physician's visit are covered under health insurance plan.	Only the hospitalization (24 hours in hospital) is covered under health insurance. A routine general practitioner's visit is not covered.
3	Premium rates	Health insurance premiums are generally very high.	Health insurance premiums are generally low as compared to US.
4	Medical Service Cost	Medical procedures and treatments are very costly.	Medical procedures and treatments are moderate.
5	Remittance time	After filing the proper claim, the healthcare provider might receive the payment in 10 to 12 days.	After filing the proper claim, the individual might receive the payment in a couple of weeks.

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DIFFERENCE BETWEEN INDIAN AND US HEALTH INSURANCE

		United States	India
6	Fee Structure	There exists a uniform fee schedule for medical procedures and treatments which is followed by most of the health insurance company in US.	There does not exist a uniform fee schedule for medical procedures and treatments and hospitals' charge vary from one hospital to another.
7	Claim submission	Claim submission is done by the healthcare provider.	Claim submission is usually done by the policyholder.
8	Follow-ups	Follow-ups for payments needs to be done by the healthcare provider.	Follow-ups for payments needs to be done by the policyholder.
9	Claim submission format	There exists a uniform format for claim submission (CMS-1500 and UB-04).	There does not exist a uniform format for claim submission and may differ from one health insurnace company to another.
10	Out-of-pocket expense	Only about 15 percent population have to pay out-of-pocket for the healthcare services.	Nearly about 75 percent population have to pay out-of-pocket for the healthcare services.

The difference in the health insurance plans of both the countries are attributed to the fact that India is a developing country whereas US is a developed country.

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MEDICAL BILLING

Medical billing is the process of documentation, submission, and follow-ups on claims with health insurance companies in order to receive payment for services rendered by a healthcare provider.

Oftentimes medical billing is transposed with medical coding as usually medical coding and billing are referred together as one entity.

The job of the medical biller is a little easier than of a medical coder but relies heavily on the performance of the latter.

In the revenue cycle management of healthcare, medical billing is preceded by medical coding.

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MEDICAL BILLING

Medical biller, also known as medical billing specialist, is a person skilled to document, submit, and follow-up on claims with health insurance companies in order to receive payment for services rendered by a healthcare provider.

Professionals who master both medical coding and medical billing are termed as **medical insurance specialist**.

Medical insurance specialist is a person skilled to handle the complete reimbursement cycle.

The medical biller has to look at the codes, find the appropriate fees for these corresponding codes, and prepare a bill to be sent to the health insurance company.

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NEED FOR MEDICAL BILLING

The need for seasoned medical billing specialist is because of the following reasons;

Physicians and hospitalists are occupied the whole day caring for patients, and it is really tiresome at the end of the day for them to sit and file claims to the insurance company for reimbursement of the services rendered to the patients.

Stringent new rules and regulations laid down by the healthcare regulatory bodies require detailed records of procedures/treatment.

Coding standards are developed and updated quarterly or annually and are complex.

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NEED FOR MEDICAL BILLING

If a healthcare provider intends to file claim on his own,

He will have spend a fair amount of time and perform quite a cumbersome task.

He is still unsure that the claim submitted to the insurance company is error-free and will be settled.

If claim is rejected or denied, healthcare provider would then have to resubmit the claim after making the necessary changes or providing appropriate justification.

The whole process of submitting and resubmitting the claims normally would lead to delay in payments thereby increasing the reimbursement cycle to 90 days or even more.

All these factors acts as a deterrent to the provider to file claim manually.

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SKILLS OF MEDICAL BILLER

A medical biller relieves the healthcare professionals from the hassle of filing claims.

These responsibilities can range from gathering the medical and demographic information to responding to adjudicated claims.

Some of the distinct skill sets which every medical biller should possess are as follows:

- **Medical skill**: Medical billers sometimes need to relate the diagnosis and the procedure codes and hence should possess sound knowledge of medical terminology, human anatomy and physiology, and medical coding.

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SKILLS OF MEDICAL BILLER

- **Technical skill**: Computers have become an integral part of the healthcare billing system. Therefore, it is crucial that every medical biller is technically skilled.

- **Eye-for-detail skill**: Medical billing implicates dealing with different kinds of numbers, viz, social security number, preauthorization identification number, tallying medical codes, calculating various kinds of payments, etc. An eye-for-detail is required to spot any type of error to avoid claim rejection or denial.

- **Interpersonal skill**: Medical billers need to possess excellent interpersonal skill since they have to constantly interact with the patients, physicians, medical coders, and health insurance companies.

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SKILLS OF MEDICAL BILLER

- **Transformative skill**: Rules and regulations pertaining to the insurance industry which are developed and implemented by the statutory bodies undergoes constant change, hence medical biller should timely update themselves.

- **Concealment skill**: Medical biller under no circumstances should part or disclose the protected health information, in part or whole, to any unauthorized personnel.

- **Mathematical skill**: Medical biller should have mathematical skill to calculate copay, coinsurance, deductible, various percentages, and to construct financial reports.

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CERTIFICATION

Certification in medical billing is not mandatory.

A certified medical biller is a sound example of an individual who is focused on the career objectives and would go to any length in terms of updating the skill set to achieve career goals.

Certification demonstrates superior level of commitment and dedication by the medical biller on an international level.

Two of the biggest professional organizations that provide the best medical billing training are American Academy of Professional Coders (AAPC) and American Medical Billing Association (AMBA).

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CERTIFICATION

AMERICAN ASSOCIATION OF PROFESSIONAL CODERS (AAPC)

Established in 1988, American Association of Professional Coders (AAPC) provided certification only for medical coders. Gradually, AAPC also started providing training for medical billing professionals.

It offers unique certification for the medical billing professionals called as the Certified Professional Biller (CPB™).

Upon completion of the Certified Professional Biller program, a medical biller would be able to independently and effectively handle claim generation, claim submission, claim follow-up, patient follow-up, and claim rejection resolution.

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CERTIFICATION

AMERICAN MEDICAL BILLING ASSOCIATION (AMBA)

Founded in 1998, American Medical Billing Association (AMBA) is considered as the premier organization to impart medical billing certification all over the globe.

Unlike, AAPC which also provides other types of certifications along with medical billing, AMBA is totally dedicated to cater only the medical billing professionals.

It offers Certified Medical Reimbursement Specialist (CMRS) certification to the medical billing professionals.

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CERTIFICATION

AMERICAN MEDICAL BILLING ASSOCIATION (AMBA)

CMRS is the one of the most rigorous exams and tests the medical biller on all aspects of the medical billing process.

A CMRS is skilled in facilitating the claims paying process and possess a sound knowledge of different types of medical codes, viz, ICD-9, ICD-10, CPT4 and HCPCS along with insurance claims, denials, fraud and abuse, HIPAA, reimbursement process, etc.

The CMRS exam consists of 17 sections and an individual is required to at least score 85% marks in order to earn the CMRS credential designation.

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CERTIFICATION

MEDICAL ASSOCIATION OF BILLERS (MAB)

Apart from AAPC and AMBA, there are several other institutions which offer certifications for medical billing professionals.

One such organization is Medical Association of Billers (MAB).

Founded in 1995, MAB provides medical billing professionals with education and training leading to Certified Medical Billing Specialist® certification.

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MEDICAL BILLING TERMS

There are various jargons used in the medical billing profession and one needs to have a thorough understanding about these to understand the medical billing process.

Let us discuss about some of these jargons:

Capitation: Capitation is an agreement between the healthcare provider and the health insurance payer wherein the health insurance payer pays the healthcare provider a fixed lump sum amount.

This lump sum amount is called capitated payment and is fixed per month per patient based on the patient's health risks, history, etc.

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MEDICAL BILLING TERMS

Co-pay: Co-pay is the amount paid by the patient out of his pocket to the healthcare provider prior to the medical service or procedure.

Co-pay is a fixed amount and is distinct from deductible because it needs to be paid during each visit.

Deductible: Deductible is the amount a patient must pay at the start of every calendar year in order to be eligible for the health insurance plan coverage.

The patient will not be covered under the health insurance plan until the deductible has been paid.

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MEDICAL BILLING TERMS

Out-of-pocket: Out-of-pocket amount is the maximum amount the patient may have to pay for medical service or procedure rendered in a calendar year.

Once the patient has paid the out-of-pocket amount, thereafter nothing needs to be paid, and the health insurance plan will cover the rest of the medical cost.

One important thing to note is that the out-of-pocket amount may or may not include the deductible amount.

Billed amount: Billed amount is the total amount charged a healthcare service or procedure performed by the provider on the patient.

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MEDICAL BILLING TERMS

Co-insurance: Co-insurance is a cost sharing of medical service or procedure between the health insurance company and the patient based on percentage.

This cost sharing is usually 80%/20%, that is, the health insurance company will pay 80% of the medical cost and the patient has to pay the remaining 20% of the medical cost.

Allowed amount: Allowed amount (allowed expense) is the fixed amount an insurance company will pay to the healthcare provider to reimburse a healthcare service or procedure rendered to the patient.

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MEDICAL BILLING TERMS

Write-off amount: Write-off amount is the amount that the healthcare provider deducts from the billed amount and does not expect to collect, thereby "writing it off" the accounts receivables owed by payers or patients.

It is also known as adjustment amount or unpaid insurance claims. The difference between the billed amount and the allowed amount is equal to the write-off.

Offset: Offset is the process of adjusting past excess payments made to the healthcare provider with the current or future claims raised by the healthcare provider.

It is also known as recoupment.

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MEDICAL BILLING TERMS

Demographic entry: Demographic entry also known as face sheets is the process of entering or keying-in the demographic details of the patient into the medical coding and billing software.

Charge Entry: Charge entry is the process of entering/keying-in the insurance details and charges of the medical services and procedures rendered by the healthcare provider to the patient into the medical billing software.

Superbill: Superbill is a form that contains most commonly used subset of codes for procedures (CPT/HCPCS) and diagnoses (ICD-9-CM) based on the specialty of the medical provider.

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MEDICAL BILLING TERMS

Claim adjudication: Claim adjudication is the process of paying the submitted claims or rejecting or denying them after examining the claims to the benefit or coverage requirements.

If the adjudication is done manually it is known as manual adjudication and if it is done with the help of a software it is known as auto-adjudication.

Explanation of Benefits (EOB): Explanation of Benefits is a document sent by the health insurance company to the provider and the patient explaining what medical services or procedures are covered under the plan.

An EOB is not a bill and does not follow a standard format.

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MEDICAL BILLING TERMS

Electronic Remittance Advice (ERA): Electronic Remittance Advice is an electronic version of Explanation of Benefits sent by the health insurance company to the provider explaining what medical services or procedures are covered under the plan.

ERA follows a standard format. The industry format for ERA data is HIPAA ASC X12N 835.

New practice management softwares have the ability to import the details of the ERAs into the system. This is called auto-posting of ERAs.

Collection refers to the outstanding amount due to the medical practice.

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MEDICAL BILLING TERMS

Payment Posting: Payment posting is the process of posting/applying the payments reimbursed by the health insurance company (primary, secondary, or tertiary), patients, or other entities towards settlement of claims to the relevant patient accounts.

Account Receivable: Account receivable is the amount owed to the healthcare provider by the insurance company or the patient for the medical services rendered to the patient.

The account receivable department analyses the reason for delay in submission or settlement of claims and takes appropriate action to ensure that the claims are settled in a timely fashion.

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HEALTH INSURANCE PLAN

A plan that provides insurance against the risk of incurring medical and surgical expenses to the insured entity is called health insurance plan.

It can be an:

Individual health insurance plan (where only the individual and sometimes the immediate family members are covered under the plan)

OR

Group health insurance plan (where a group of individuals are covered under a single plan).

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TYPES OF HEALTH INSURANCE PLAN

Health insurance plans are divided based on the features wherein,

Some health insurance plans cover for certain medical illness and treatments whereas other might not cover those medical illness and treatments.

Some health insurance plans may be flexible than others, which some may be cheaper than others.

All forms of insurance plans can be categorized into the following three types:

(1) Fee-for-service (FFS) health plan,

(2) Managed care organization (MCO) health plan, and

(3) Consumer-driven health plan (CDHP).

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TYPES OF HEALTH INSURANCE PLAN

(1) Fee-for-service (FFS) health plan

In this type of health plan, the healthcare provider delivers the medical service or treatment to the patient and raises the claim (bill) to the health insurance payer.

It is one of the oldest and most basic types of insurance.

In this plan, each and every service rendered by the provider is paid separately and the insured has the liberty to choose any provider for the medical service.

It is also known as indemnity health plan or pay-for-service health plan.

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TYPES OF HEALTH INSURANCE PLAN

(1) Fee-for-service (FFS) health plan

One disadvantage of this plan is that it is too costly because providers tend to perform more procedures (sometimes unnecessary) because the payment is directly proportional to the amount and the services or procedures are unbundled and paid separately.

Since the patients are indemnified by the insurance company against costs of medical services and procedures according to the benefits schedule of the policy, they too are inclined to welcome any service or procedure that the healthcare provider feels would help the patient's condition.

These types of insurance plans are slowly losing market share to the bundled or integrated health plans.

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TYPES OF HEALTH INSURANCE PLAN

(2) Managed care organization (MCO) health plans

It differs from fee-for-service health plan in a sense that this does not provide the liberty to the patient to choose the provider.

The premiums and deductibles are low as compared to fee-for-service health plan and at times are fixed.

The patient has to visit the provider or hospital within the network of the managed care organization.

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TYPES OF HEALTH INSURANCE PLAN

(2) Managed care organization (MCO) health plans

Due to the low cost of health insurance, this type of health plans is more popular among employers and have gained acceptance all over the United States.

It is an umbrella organization that contains different organizations within itself, some of the common ones are as follows:

A) Health maintenance organization (HMO)
B) Preferred provider organization (PPO)
C) Point-of-service plan (POS), etc.

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TYPES OF HEALTH INSURANCE PLAN

(A) Health Maintenance Organization (HMO)

Health Maintenance Organization was introduced to tackle the problem of rising healthcare cost through the Health Maintenance Organization Act of 1973.

The HMOs charge the insured individual a fixed amount and in exchange for that amount would allow the insured individual to receive medical service from any of the healthcare provider or hospitals only within the network of the HMOs.

HMO assigns healthcare provider a group of insured individuals and pays the healthcare provider a fixed amount for the same called the capitated payment.

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TYPES OF HEALTH INSURANCE PLAN

(B) Preferred Provider Organization (PPO)

Preferred provider organization is an organization which enters into contracts with specific healthcare providers and hospitals under the terms that they will be provided the membership of this PPO network and in return the healthcare providers and hospitals would have to provide a significant discount in their regular fees to the insured individual.

In this type of health plan, the insured individual benefits from the discounted rates whereas the healthcare providers and hospitals benefit from getting to see more number of patients than usual.

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TYPES OF HEALTH INSURANCE PLAN

Difference between Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO)

The basic difference between an HMO and a PPO is,

In Health Maintenance Organization (HMO), the insured individual cannot see healthcare provider or hospital outside the network.

In Preferred Provider Organization (PPO), the insured individual has the option of utilizing the service of a healthcare provider and hospital outside the network, however, it would cost more.

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TYPES OF HEALTH INSURANCE PLAN

(C) Point-of-Service Plan (POS)

Point-of-Service Plan is a mix of HMO and FFS health plan.

In this type of health plan, the insured individual has the access of the healthcare providers and hospitals within the organization's network, but at the same time the insured individual has the option of choosing a healthcare provider or hospital which is outside the network.

If the individual chooses a healthcare provider or hospital outside the network, he would have to pay more fees out-of-pocket.

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TYPES OF HEALTH INSURANCE PLAN

(3) Consumer-driven health plans (CDHP)

Consumer-driven health plan is similar to the preferred provider organization health plan except for a small difference that it also provides a savings account to the insured individual.

A certain sum of the untaxed wages of the insured is deposited regularly into the savings account with or without an equal contribution from the employer and this amount is utilized to pay for any out-of-pocket medical expenses that may arise in the future.

These types of plan usually have high deductibles and low premiums and the funds deposited in the savings account is used to meet the high deductibles.

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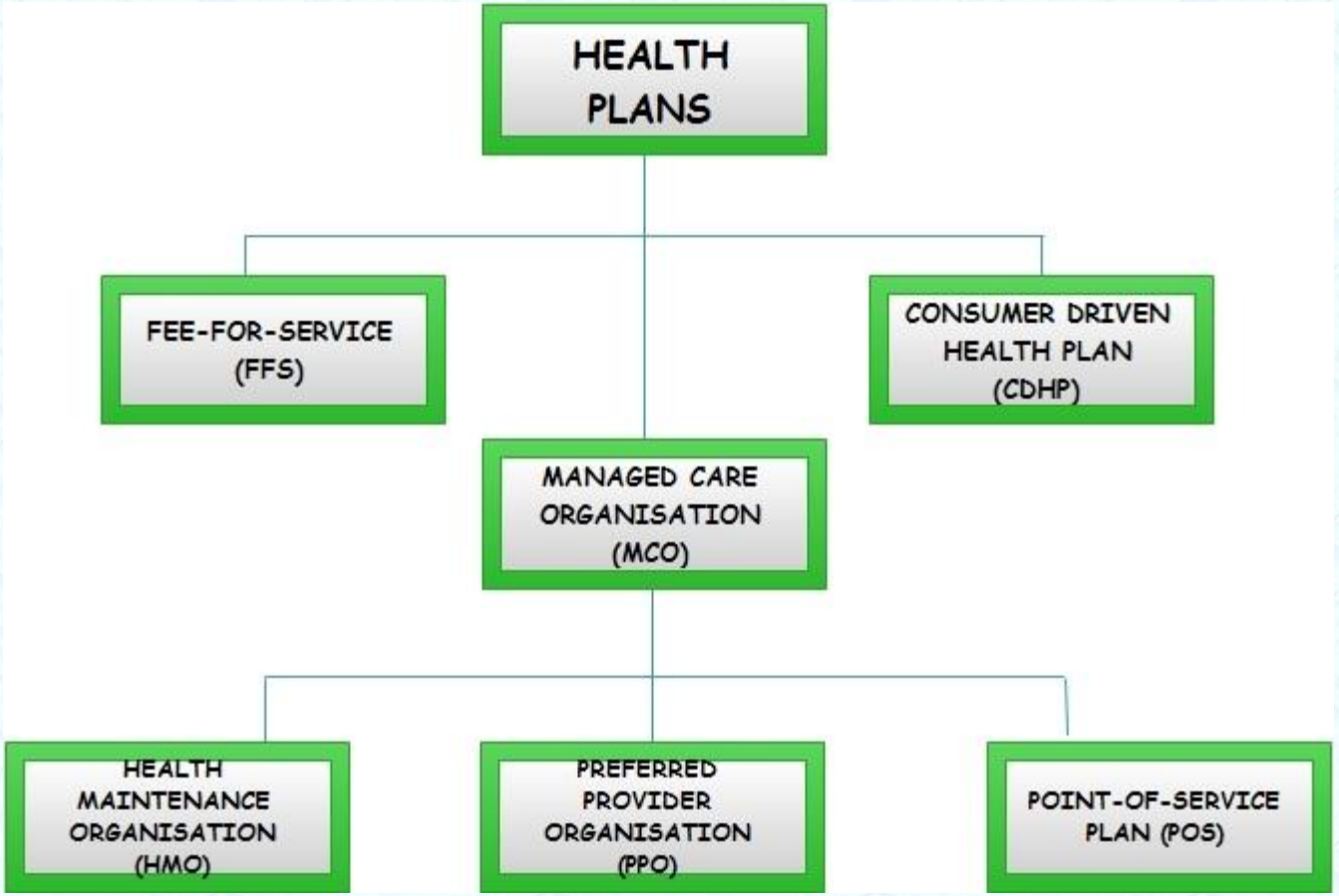
TYPES OF HEALTH INSURANCE PLAN



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HEALTH INSURANCE PAYER

Health insurance payers are the insurance companies which provide coverage to the individuals purchasing one of the various insurance plans from the basket of plans available.

If the individual is self-employed or employed with an employer that does not provide health insurance coverage, then one has to buy an individual health insurance plan.

If the individual is employed and the employer provides health insurance coverage, then the individual will be covered under the group health insurance plan of the employer.

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TYPES OF HEALTH INSURANCE PAYER

The health insurance payers can be segregated into three categories,

1) Public-funded payers.
2) Private-funded payers.
3) Self-funded payers.

One of the above mentioned health insurance payers will provide health plan coverage to an individual or a group of individual for their medical needs.

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TYPES OF HEALTH INSURANCE PAYER

Public-Funded Payers

Public-funded payers are those insurance payers which are financially supported by the US government either state government or federal government.

They are also known as government-funded payers.

In an effort to provide quality and affordable healthcare to all the people, US government has started various insurance programs each having different sets of eligibility and benefits.

Let us look at some of the most common government-funded payers:

- ❑Medicare
- ❑Medicaid
- ❑TRICARE
- ❑Child Health Insurance Programs (CHIP)

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TYPES OF HEALTH INSURANCE PAYER

Public-Funded Payers

Medicare: Founded on July 30, 1965, Medicare is totally federal government funded program. It provides healthcare coverage to individuals who are either above 65 years of age, to individuals who have some kind of disability (total or permanent), end stage renal disease (ESRD) patients, and amyotrophic lateral sclerosis (ALS) patients. Medicare provides health coverage to approximately 54 million individuals in United States.

Medicaid: Also founded on July 30, 1965, Medicaid on the other hand is partly funded by the federal government and partly funded by the state government. It provides healthcare coverage to individuals hailing from low income groups. Since it is partly funded by the state, each state has its own set of rules and regulations, and hence, Medicaid of different states usually has distinct set of features and benefits. Medicaid provides health coverage to approximately 66 million individuals in United States.

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TYPES OF HEALTH INSURANCE PAYER

Public-Funded Payers

TRICARE: TRICARE was formerly known as the CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). TRICARE is a United States Department of Defense healthcare program funded by the federal government which provides medical coverage to the active-duty military personnel, retired military personnel, and the dependents of the military personnel.

Child Health Insurance Programs (CHIP): Child Health Insurance Programs are funded by the state government and provides coverage to the uninsured children of families whose income falls below a certain threshold.

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TYPES OF HEALTH INSURANCE PAYER

Private-Funded Payers

Private-funded payers are group of insurance companies which are funded by private entities.

Generally, the basic intention behind founding a private-funded organization is to earn profit but there are certain not-for-profit private-funded organizations as well.

They provide all types of health plans ranging from individual to group and HMO to PPO.

There are several examples of private-funded payers such as Aetna, Cigna, UnitedHealthcare, Blue Cross Blue Shield, Kaiser Permanente, etc.

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TYPES OF HEALTH INSURANCE PAYER

Private-Funded Payers

Let us see the example of a for-profit private-funded payer (Aetna), a not-for-profit private-funded payer (Kaiser Permanente), and a hybrid Blue Cross Blue Shield Association with both for-profit and not-for-profit private-funded payer.

Aetna: Aetna is a for-profit health insurance payer which offers health plans and insurance solutions to individuals and to small- and big-sized employers to provide coverage to the employees.

It has a wide network of healthcare providers and hospitals and offers both the traditional type of plans as well as the consumer-driven health plan (CDHP) to the members.

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TYPES OF HEALTH INSURANCE PAYER

Private-Funded Payers

Kaiser Permanente: Founded in the late 1930s, Kaiser Permanente is one of the largest not-for-profit health insurance payers. It used to provide industrial healthcare programs to the workers and was later in 1945 opened for the general public. It has introduced many unique features into the US healthcare system since its institution such as prepaid health plan, physician group practice, and organized delivery system of medical services.

Blue Cross Blue Shield Association (BCBSA): Blue Cross Blue Shield Association is a federation of 37 different health insurance organizations. The BCBSA constitutes of both for-profit and not-for-profit health insurance organization under its umbrella, which provides a product mix of health insurance plan to cater the unique needs of different individuals. Some of the most widely known companies which are part of this esteemed association are WellPoint, WellMark, and CareFirst.

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TYPES OF HEALTH INSURANCE PAYER

Self-Funded Payers

Self-funded payers are those big companies which provide the health coverage and disability benefits to its employees.

These companies create a pool of own funds from the partial or total contribution and use this pool of funds to meet any unforeseen medical expenses of the employees.

One of the main disadvantages of this type of plan for the employer is the unlimited risk as the employer is solely responsible to cater all the medical expenses of the employees irrespective of the volume and cost.

Microsoft, Oracle, and Apple are among a few companies that act as self-funded insurance payers.

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CLAIM FORMS

Claim is the bill prepared by the medical biller to be submitted to the insurance company.

Claim forms are either electronic claim form or paper claim form. The paper claim forms are also known as manual claim forms or physical claim forms.

The electronic transaction rule of HIPAA Administrative Simplification and Privacy advocates the use of standard electronic formats for transfer of healthcare information between two parties.

Each and every covered entity is required to utilize the standard formats for processing claims and payments as well as for maintenance and transmission of electronic healthcare data.

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CLAIM FORMS

Adoption of electronic claim form provides several advantages over the traditional paper claim form.

On an average, it is estimated that the error rate is anywhere between 25% and 30% when using paper claims, which can be substantially reduced with the use of electronic claims.

Electronic claims are faster to process which in turn leads to reduction in the reimbursement cycle bringing the collection period down from an average of 60 days to 15 days.

Electronic claims create a paperless and clutter-free environment.

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CLAIM FORMS

Electronic claims are advantageous than paper claims, but there are certain instances where still paper claims are being used.

Paper claim forms are permitted to be used by those providers who have not computerized their medical practice.

Paper claim forms are permitted to be used by those providers who have fewer than 25 FTE (full-time equivalent) employees or a physician, practitioner, facility, or supplier (other than a provider of services) with fewer than 10 FTE (full-time equivalent) employees.

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TYPES OF CLAIM FORMS

There are three different types of claim forms used for the electronic transactions, viz,

- CMS-1500
- UB-04
- ADA J430D

These claim forms are printed with OCR "dropout" red ink. OCR "dropout" red ink is a type of ink designed to be intentionally ignored by OCR machines and just scan the text filled in the data fields.

These claim forms are of same dimension, 8.5 × 11.0 inches.

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TYPES OF CLAIM FORMS

CMS-1500

CMS-1500 claim form (formerly known as HCFA-1500 pronounced "hick-fa") is used as a standard claim form to bill for non-facility services, such as healthcare provider services, transportation, and durable medical equipment.

The CMS-1500 claim form has 33 blocks or data fields marked "Required," "Required if applicable," or "Not required," and details have to be filled accordingly.

These blocks can be broadly divided into two sections, first section (Blocks 1 through 13) contains the insured individual's details and the second section (Blocks 14 through 33) contains the healthcare provider/supplier's details.

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MEDICAL BILLING

TYPES OF CLAIM FORMS

UB-04

UB-04 (formerly known as CMS-1450) is the standard claim form sent to the insurance company to bill the inpatient charges for services and procedures delivered to the patient.

It was introduced as the replacement for the UB-92 form.

The UB-04 claim form has 81 data fields known as form locators on the front side and are marked as "Required," "Situational," "Recommended," or "Not Required," and details have to be filled accordingly.

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MEDICAL BILLING

DIFFERENCE BETWEEN CMS-1500 & UB-04

CMS-1500 is used for non-institutional providers (primary care provider) and UB-04 is used for institutional providers (hospitals).

Structure of the UB-04 form is much more complicated than the CMS-1500, therefore, preparation of UB-04 claim form requires more expertise than preparation of CMS-1500.

CMS-1500 form contains 33 data fields referred to as blocks, whereas UB-04 form contains 81 data fields referred to as form locators (FL).

CHAPTER 5
MEDICAL BILLING

TYPES OF CLAIM FORMS

ADA J430D

ADA J430D is the claim form used by dentists for reporting dental services provided to a patient's dental benefit plan.

It is also known as ADA dental claim form.

It contains 58 data fields in all to be filled to file the dental claim.

This ADA J430D is same as the ADA J430, J431, J432, J433, and J434 forms.

CHAPTER 5
MEDICAL BILLING

MEDICAL BILLING PROCESS

Universally, there are three parties involved in the medical billing process,

- ✓ The patient (insured individual)
- ✓ The healthcare provider (physician/hospital/supplier), &
- ✓ The payer (health insurance company)

The concept of medical billing for an uninsured person remains the same in India and US as well as all over the world.

In this scenario only two parties exist, that is, the patient (uninsured individual) and the healthcare provider.

The healthcare provider examines the patient and provides appropriate treatment plan. The patient in turn of the healthcare provider's service pays a specific amount of fees. This terminates the medical billing process.

CHAPTER 5
MEDICAL BILLING

MEDICAL BILLING PROCESS

The concept of medical billing for an insured person in India is entirely different from the United States medical billing process.

The whole United States billing process can be summed up in seven steps:

1) Registration
2) Demographics & Insurance Verification
3) Medical Documentation
4) Medical Coding
5) Claim Submission
6) Payment Posting
7) A/R & Collections

CHAPTER 5
MEDICAL BILLING

MEDICAL BILLING PROCESS

1) **Registration**: For registration of a new patient, the front-office staff obtains the minimal information required to schedule an appointment. In case of an established patient, the front-office staff will verify the information and schedule an appointment.

2) **Demographics & Insurance Verification**: In this step, verification of demographics and insurance details are performed. Using electronic real-time eligibility, the medical biller can instantly and preemptively determine the eligibility of the patient.

After confirmation about the eligibility of the patient, the medical biller coveys to the patient about the copay (if any under the insurance coverage) that needs be paid to the provider.

CHAPTER 5
MEDICAL BILLING

MEDICAL BILLING PROCESS

If a particular medical service is not covered under the insurance plan of the patient, an Advance Beneficiary Notice of Noncoverage (ABN) needs to be signed by the patient undertaking to pay for the medical service from out-of-pocket expense or to refuse the service altogether.

3) Medical Documentation: In this step, the encounter between the patient and the physician takes place.

4) Medical Coding: The medical coder after reviewing the report extracts all the billable services provided to the patient and assigns a specific code to each of these services. These codes are then entered into the superbills.

CHAPTER 5
MEDICAL BILLING

MEDICAL BILLING PROCESS

5) **Claim Submission**: The medical biller reviews the superbill and ensures that respective charges for each of the billable codes are entered into the claim form (paper or electronic). Claim scrubbing is the process of verifying the claims for any errors and checking its format compatibility with the insurance payer.

6) **Payment Posting**: When the claim is approved or denied an explanation of benefit (EOB) is sent to the healthcare provider. The medical biller has to evaluate the EOB and post it in the medical billing software. The biller also prepares a patient invoice describing the patient's responsibility.

MEDICAL BILLING PROCESS

7) **Accounts Receivable (A/R) & Collections**: Accounts receivable department handles the function of identification, monitoring, and following up on pending payments either from the insurance company or from the patient.

Identification of pending payments is done through generation so reports called aging reports.

If the patient is reluctant to pay the bill, the case is handed over to a collection agency.

CHAPTER 5
MEDICAL BILLING

OUTCOMES OF CLAIM SUBMISSION PROCESS

The claims are accepted, denied, or rejected.

(a) Accept the claims and make the payment. (Rationale: It is a clean claim).

(b) Deny the claim in part or full and request additional information. (Rationale: If the information provided is incomplete or illegible).

(c) Reject the claim. (Rationale: Inconsistent claim format, out-of-network patient, incorrect policy number, etc.).

Clearinghouses are intermediaries between the healthcare practices and insurance payer that help to transmit electronic claims to the insurance payers in a secure way.

CHAPTER 5
MEDICAL BILLING

ERRORS IN MEDICAL BILLING

Some of the common medical billing errors are as follows:

- **Inaccurate or Incomplete Information**: This is a very common type of error in the billing process where the information entered into the billing software is either incomplete or inaccurate.

- **Insurance verification error**: Failing to verify the insurance details in a timely manner leads to these kinds of error.

- **Domino-effect error**: This kind of error arises due to wrong medical reports dictated by the physician or transcribed by the medical transcriptionist or wrong coding by the medical coder will transcend down to the medical biller and will lead to a domino-effect kind of error.

CHAPTER 5
MEDICAL BILLING

ERRORS IN MEDICAL BILLING

Some of the common medical billing errors are as follows:

- **Wrong/Outdated claim format**: If the medical biller uses a wrong claim form or uses an outdated claim form to submit the claim, the insurance payer will straightaway reject the claim.

- **Undercoding/Upcoding/Unbundling error**: If a medical biller on the behest of the healthcare provider intentionally undercodes, upcodes or unbundles a procedure in order to receive any type of financial, taxation, or audit benefit than legitimate, it is considered as a fraudulent practice.

CHAPTER 5
MEDICAL BILLING

PRICING

The pricing structure for coding and billing are almost identical.

Listed below are some of the medical billing pricing strategies adopted by the industry:

❖ **Percentage-based model**: Charging a particular percentage of the total net collections of the healthcare practice is the most preferred method of billing. The medical billing company usually charges between 3% and 4% of the total collection.

❖ **Full-time equivalent model**: An FTE is the equivalent of one medical biller hired as a full-time employee and works full time, that is, 8 hours per day and 5 days per week.

FTEs do not represent the number of employees.

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MEDICAL BILLING

PRICING

❖ **Per Claim Model**: In the per claim model, a rate is negotiated to be paid for each claim processed by the billing department. Average rate for billing per claim usually ranges between $2 and $3.

❖ **A/R & Collections**: There are certain healthcare providers who only need the accounts receivable and collections part of the process to be outsourced to a particular vendor. They either perform the billing services in-house or outsource to another vendor.

In such cases, the vendor needs to provide the rates for only accounts receivable and collections service to the provider which is usually around $15/hour.

CHAPTER 5
MEDICAL BILLING

ELECTRONIC SOFTWARES FOR BILLING

A thorough research in terms of the user need and budget needs to be performed before settling on specific medical billing software.

The use of electronic softwares for billing speeds up the billing process.

These medical billing softwares are available as software-as-a-service (SaaS) model and the user has to pay a monthly or annual charge for their usage.

Listed below are the names of a few electronic medical billing softwares:

- ✓ PracticeSuite
- ✓ AllegianceMD
- ✓ TheraBill
- ✓ NueMD
- ✓ Iridium Suite, etc.