Third Party Billing Requirements

Back to Basics-Third Party Billing and Account Management Training

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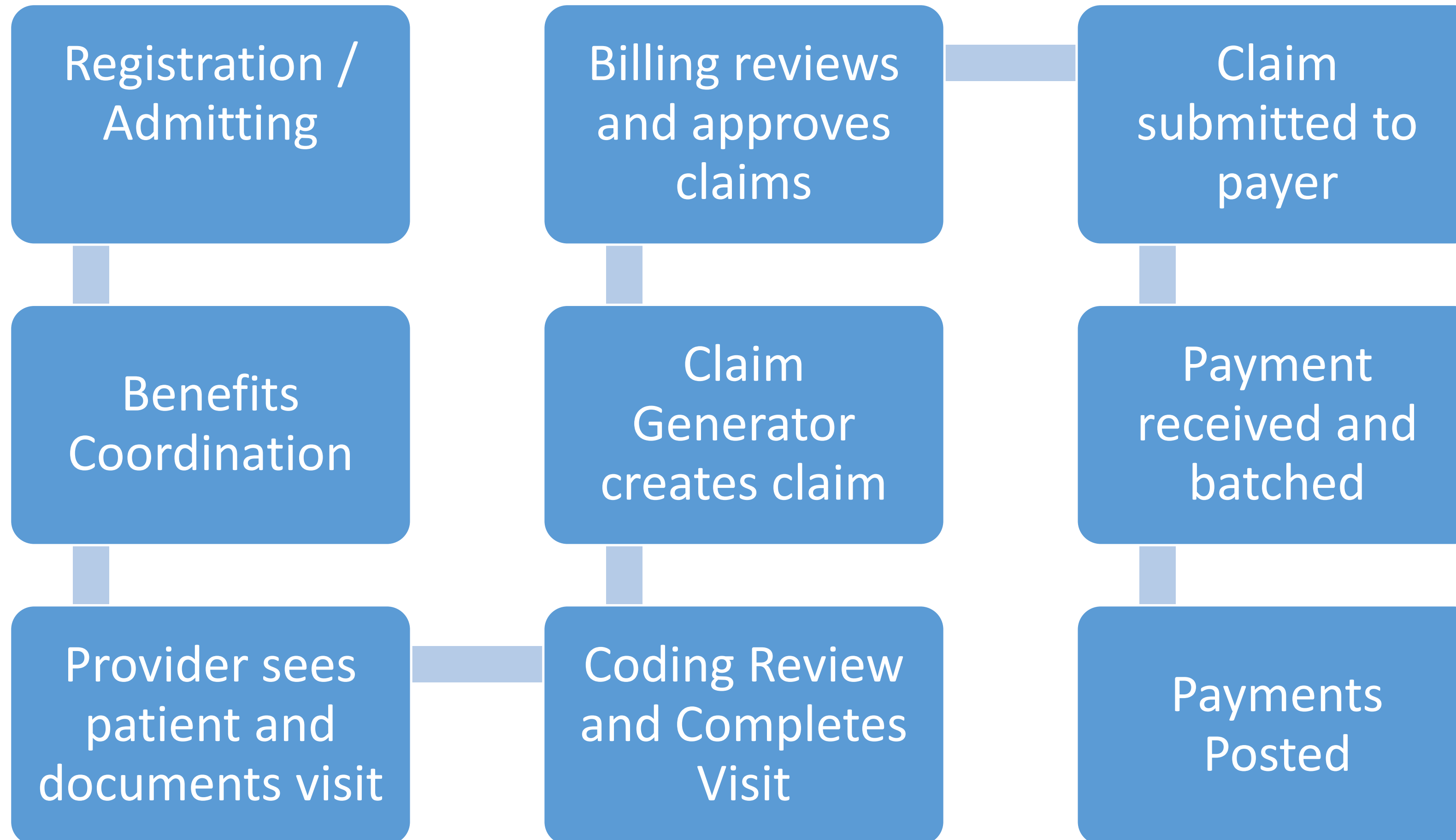
Disclaimer

- Follow your facility process and procedures
- Respectfully agree to disagree – payer requirements are different

Data Flow



Claim Creation - Eligibility for Services

- Eligibility Status
  - **CHS & Direct**
  - **Direct Only**
  - **Pending**
  - **Ineligible**

- Classification/Beneficiary Status
  - 01 - Indian/Alaska Native
  - 03 – Commissioned Officer
  - 04 – Dependents of Comm Officer
  - 18 – Non-Indian Elective
  - 06 – Emergency Case (Non-Indian)

- Urban Facilities

Claim Creation – Visit Components

- Service Categories
  - Billable: Ambulatory, Hospitalization, In Hospital, Day Surgery, Nursing Home, Observation, Telemedicine
  - Unbillable: Chart Review, Event, Not Found, Telecommunications
- Chart Review Status
- Third Party Eligibility
- Unbillable Clinics: Site and/or Insurer
- Unbillable Providers: Site and/or coverage type
- Unbillable Diagnosis: Coverage type only

Claim Generator

- A function built into the Third Party Billing application that automatically creates a claim entry based on information pulled from PCC or from the PCC Coding Queue
  - Uses eligibility from the Patient Registration system
- Uses Date Last Modified to determine if visit will be processed
  - Backbill Check will override this Claim Generator function
- Tasked to run by local RPMS Administrator during off-hours
  - ABMD TSK VISIT option
- Updates PCC Visit with Third Party Billed field

Brief Claims Listing

3P > RPTP > BRRP

- Used to count the number of claims available to be billed in the system
- In BRRP, use option 7 (Report Type) then 3 (Statistical Summary)
- May be generated each morning to monitor claim generation

```
================================================================================
BRIEF LISTING of CLAIMS Flagged as Billable     JUL 9,2024@11:34:03    Page 1
for ALL BILLING SOURCES
Billing Location: INDIAN HOSP
================================================================================
                                Visit                          Number of
Location                        Type                            Claims
--------------------------------------------------------------------------------

INDIAN HEALTH HOSPITAL          INPATIENT                          16
                                OUTPATIENT                        148
                                MULTIPLE VISITS                     4
                                MENTAL HEALTH                       2
                                OBSERVATION                         7
                                PHYSICAL THERAPY                    1
                                EMERGENCY ROOM                      3
                                AMBULATORY SURGERY                 10
                                RADIOLOGY                           1
                                LABORATORY                          2
                                PHARMACY                            4
                                DENTAL                              9
                                PROFESSIONAL COMPONENT             51
                                                                -----
                                                      Total:      258
```

Identifying Billable Claims

- Brief Claims Listing (BRRP)
  - Inclusion Parameters
  - Determines workload
- Claim Editor Loop

```
==============================================================================
BRIEF LISTING of CLAIMS Flagged as Billable     JUL 9,2024@11:31:52    Page 1
for ALL BILLING SOURCES with VISIT DATES from 01/01/2020 to 07/09/2024
Billing Location: INDIAN HOSP
==============================================================================
                                                   Claim      Visit
ST Patient              HRN    Active Insurer      Number     Date      Clinic
------------------------------------------------------------------------------


   Visit Location: INDIAN HEALTH HOSPITAL
       Visit Type: OUTPATIENT
EDT  ACCIDENT,JOSEPH 32423  WORKITOUT AGENCY      31750     08/07/2023 URGENT CA
EDT  BEACH,SANDY     2049   O/P MEDI-CAL  9       31579     05/26/2020 GENERAL
FAB  BEAR,WILLIAM    2543   HUMANA GOLD CHOICE    31691     11/08/2021 GENERAL
EDT  BLACK,HOWARD    654210 NEVERPAY INSURANCE    31713     03/28/2022 GENERAL
EDT  BUWMEN,ROBERT B 34953  VA MEDICAL BENEFIT (  31608     11/14/2020 INTERNAL
EDT  CHAVEZ,HENRIETT 1072   MEDICARE              31739     04/10/2023 GENERAL
EDT  COTTI,MANNY     5103   PARTNERSHIP HEALTHPL  31543     01/15/2020 TRANSPORT
EDT  DEMO,JOHN       123567 BC/BS OF ARIZONA INC  31636     02/14/2021 GENERAL
EDT  DEMO,JOHN       123567 BC/BS OF ARIZONA INC  31653     04/08/2021 GENERAL
```

Looking in the Claim Editor

- Identifying Claim Status
  - Flagged as Billable – Created by Claim Generator and not yet edited/approved
  - Pending – Waiting for additional information prior to being billed
  - In Edit Mode – Created but not approved – may have been edited
  - In Edit Mode – Rolled – Rolled back from AR and re-opened for next payer billing
  - Uneditable (Billed) – Billed and waiting for adjudication
  - Completed – Rolled back from AR and closed
  - Closed – User initiated action that closes a claim if no billing needs to occur
  - Cancelled – User action that determined a claim is no longer needed and will need to be removed

Claim Editor Pages (EDCL)

Claim Page	Category of Data
0	Claim Summary
1	Claim Identifiers
2	Insurers
3	Questions
3A	Ambulance Questions
4	Provider Data
5A	Diagnosis (ICD)
5B	ICD Procedures
6	Dental Services (ADA)
7	Inpatient Data
8A	Medical Services (CPT)
8B	Surgical Procedures (CPT)
8C	Revenue Code
8D	Medications

Claim Page	Category of Data
8E	Laboratory Services (CPT)
8F	Radiology Services (CPT)
8G	Anesthesia Services (CPT)
8H	Misc. Services (CPT)
8I	Inpatient Dental (ADA)
8J	Charge Master
8K	Ambulance Page
9A	Occurrence Codes
9B	Occurrence Span Codes
9C	Condition Codes
9D	Value Codes
9E	Special Program Codes
9F	Remarks
9G	Claim Attachment

Reviewing the Claim Summary

- Claim Editor, Page 0
- Summarizes claim properties
- Watch for error messages which prevent claim from being approved
  - Use <V>iew to view all errors.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 0  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:2]                       SPLT Claim: 31769
.............................. (CLAIM SUMMARY) ..............................
_______ Pg-1 (Claim Identifiers) _______|__________ Pg-3 (Questions) __________
Location..: INDIAN HOSP                 |Release Info: YES  Assign Benef: YES
Clinic....: GENERAL                     |
Visit Type: OUTPATIENT                  |
Bill From: 07-03-2022 Thru: 07-03-2022  |__________ Pg-4 (Providers) __________
________ Pg-2 (Billing Entity) _________|Attn: WELBY,MARCUS
BS OF MASSACHUSETTS INC         ACTIVE  |
O/P MEDI-CAL  9                 UNBILABL|__________ Pg-5A (Diagnosis) _________
NEBRASKA MEDICAID               PENDING |1) FEVER
____________ PCC Visit Data ____________|2) NEUTROPENIA
Prim Visit: 07/03/2022@10:49  Count: 1  |
Srv Cat: A Hsp Loc: <none>              |________ Pg-8 (CPT Procedures) _______
Last Visit: 04/04/2022@10:49  Loc: IHH  |1) APPENDECTOMY
Srv Cat: A Cl:12  Hsp Loc: <none>       |2) OFFICE O/P EST SF 10-19 MIN
                                        |
WARNING:250 - DOS after ICD Indicator Date
-------------------------------------------------------------------------------
     *** Claim File ERRORS exist use the VIEW command to list them. ***

Desired ACTION (View/Appr/Pend/Close/Next/Jump/Quit): N//
```

Basic Claim Properties

- Claim Editor, Page 1 allows the biller to make changes to claim properties
- Changes may impact what the biller sees and what is sent to the payer

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 1  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:2]                              Claim: 31775
............................ (CLAIM IDENTIFIERS) ............................

                 [1] Clinic.............: GENERAL
                 [2] Visit Type.........: OUTPATIENT
                 [3] Bill Type..........: 131
                 [4] Billing From Date..: 04/21/2024
                 [5] Billing Thru Date..: 04/21/2024
                 [6] Super Bill #.......:
                 [7] Mode of Export.....: 837P (HCFA) 5010
                 [8] Visit Location.....: INDIAN HEALTH HOSPITAL

Desired ACTION (Edit/View/Next/Jump/Back/Quit): N//
```

Clinic and Visit Types

- Clinic Type
  - Comes from the PCC visit and is added either when the visit is created (scheduling or admitted)
  - Should not be changed unless is needed for billing – remember this affects reporting
- Visit Type
  - Classifies the visit and is used for reporting
  - Uses the properties from the insurer file to auto-populate certain pages in the Claim Editor

Bill Types

- Type of bill codes are three-digit codes located on the UB-04 claim form that describe the type of bill a provider is submitting to a payer, such as Medicaid or an insurance company
- This code is required on line 4 of the UB-04
- Each digit has a specific purpose and is required on all UB-04 claims in field locator 4
- The codes are published in the National Uniform Billing Committee (NUBC) guidelines

TOB = 13X

- 130 = nonpayment/zero claim (all charges are noncovered)
- 131 = admit through discharge
- 137 = claim adjustment
- 138 = claim cancel

Page 1 - Additional Properties

- Export Mode
  - May be edited based on payer requirements
  - Recent patch allows older export modes to be excluded from list
  - Update in the insurer file, Visit Type to set default
  - Depending on export mode, biller may see certain prompts in the charge pages
- Visit Location
  - Should not be changed unless location has been set up
  - Billing location properties must be set up for division being billed
    - Ex. HOME location, if used, has to have properties set up in RPMS

Insurer Eligibility

- Claim Editor, Page 2 allows the biller to view eligibility for the visit
  - Not all eligibility displays – depends on table maintenance and eligibility dates in Registration
  - Sequencing from Patient Registration is not in place – *the Claim Generator uses rules to determine sequencing*
  - Each listed insurer will display a status
    - ACTIVE – this is the insurer being billed
    - PENDING – insurer that is ready to billed
    - UNBILLABLE – the insurer was considered billable when the claim generated but the status changed – eligibility, table maintenance, backbilling limit, etc.
    - COMPLETED – the insurer was billed, the balance was brought to $0.00 and rolled back from AR
  - The biller may pick the payer to be billed by typing "P" to pick
  - Use "V" to view the insurer and eligibility properties

Claim Editor Page 2 Insurers Display

```
.................................. (INSURERS) ..................................

                         PAGE 2 - INSURER INFORMATION

To: BS OF MASSACHUSETTS INC                 Bill Type...: 131
    100 SUMMER ST                           Proc. Code..: CPT4
    BOSTON, MA  02110                       Export Mode.: CMS-1500 (08/05)
    (617)-956-2785                          Flat Rate...: N/A
..............................................................................

             BILLING ENTITY              STATUS        POLICY HOLDER
     ==============================  ==========  ==============================
[1]  BS OF MASSACHUSETTS INC         ACTIVE      DEMO,JOSEPH
[2]  O/P MEDI-CAL  9                 UNBILLABLE  PATIENT JR,DEMO
[3]  NEBRASKA MEDICAID               PENDING     DEMO,PATIENT
------------------------------------------------------------------------------
WARNING:073 - EMPLOYER NAME UNSPECIFIED
------------------------------------------------------------------------------

Desired ACTION (Add/Del/Pick/View/Next/Jump/Back/Quit): N//
```

MINI QUIZ

- (T/F) It is okay to delete eligibility in the Claim Editor because it deletes the insurer in Patient Registration
- (T/F) All payers that display as Active or Pending are considered billable and must be billed
- (T/F) To bill the Non-Beneficiary (non-Indian) patient, the patient must be added into Patient Registration to show up

Reporting Additional Data

- Claim Editor, Page 3 contains questions that are on the claim form that may be required by the payer
- Question display depends on Mode of Export
- Determines claims processing
- Required fields depend on payer requirement
- Answered fields must have supporting documentation

ROI and AOB

- Release of Information & Assignment of Benefits
  - Signature of the patient *prior to visit* is needed to correctly populate this field
  - ROI - indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim
  - AOB - indicates that there is a signature on file authorizing payment of medical benefits
  - Signature is good unless revoked by the patient

```
[1] Release of Information..: YES    From: 02/09/2009
[2] Assignment of Benefits..: YES    From: 02/09/2009
```

Providers

- The system will 'pull' providers that are considered billable – MD, RN, etc.
- Other provider types may cause the claim to not generate (if entered as the primary provider) and will not show up in the claim editor
- Providers may be added or edited in
  - Page 3 – Questions: Claim Level Provider
  - Page 4 – Providers: Claim Level Provider
  - Pages 8A to 8K – CPT pages: Line Level Provider

Providers – Page 3

REFERRING PHYS (FL17)

The name entered is the provider who referred the service(s) or supply(ies) on the claim

RPMS does not use ordering provider or supervising provider

Populates in Loop 2310A – Referring Provider (DN)

```
 [9] Referring Phys. (FL17)   :

Desired ACTION (Edit/Next/View/Jump/Back/Quit): N// 9

Enter Provider Name: LNAME,FNAME ?? Entry NOT found
Enter Provider NPI: 1039203900
```

```
NM1*DN*1*LNAME*FNAME****XX*1039203900~
```

Providers – Page 3

SUPERVISING PROV (FL19)

Used when the rendering provider is supervised by a physician

Prints in Block 19 on the CMS-1500

Populates in Loop 2310D – Supervising Provider (DQ)

```
[15] Supervising Prov.(FL19).:     NPI:
       Date Last Seen:

Desired ACTION (Edit/Next/View/Jump/Back/Quit): N// 15

[15] Supervising Prov.(FL19): LNAMEFL19,FNAMEFL19
[15] Date Last Seen: -30  (JUN 09, 2024)
[15] NPI: 2039209301
```

```
NM1*DQ*1*LNAMEFL19*FNAMEFL19****XX*2039209301~
```

Page 4 - Provider

- Attending provider required for billing
  - UB/837I – Attending provider
  - 1500/837P/Dental – Rendering provider
- NPI and provider license displayed
- Discipline determines Provider Taxonomy Code

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 4  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:2]                         SPLT Claim: 31769
............................... (PROVIDER DATA) ...............................

                 PROVIDER                 NPI                DISCIPLINE
        ==========================  ============  =============================
(attn)  WELBY,MARCUS                9999329300    CARDIOLOGIST
(other) NURSE,BETTY                 9940349043    CLINIC RN


Desired ACTION (Add/Del/View/Next/Jump/Back/Quit): N//
```

Diagnosis Data

- Page 5A will display all diagnosis data for the visit
- Codes will appear based on how they have been entered into the visit
- Biller may re-sequence codes, if required by payer
  - Re-sequenced codes do not update PCC
- Present on Admission for Inpatient and ER visits

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 5A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:2]                             Claim: 31722
................................ (DIAGNOSIS) ................................

ICD Indicator for BS OF MASSACHUSETTS INC : ICD-10

BIL    ICD
SEQ    CODE    IND   Dx DESCRIPTION                PROVIDER'S NARRATIVE
===  ======== === ========================== ===================================
 1   R50.81    10 Fever presenting with     FEVER
                    conditions classified
                    elsewhere
 2   D70.0     10 Congenital                NEUTROPENIA
                    agranulocytosis


Desired ACTION (Add/Del/Edit/Seq/View/Next/Rfsh/Ind/Jump/Back/Quit): N//
```

CPT Pages – Pages 8A to 8K

- Allows an ordering, rendering or operating provider to be reported on the claim
- One provider may be linked to an individual CPT code

```
 1   CHARGE DATE: 07/03/2022 (UNDER,ANESTASIA-R)
            ****  1,2     44950 APPENDECTOMY                      1      3,249.00

Select SERVICE LINE PROVIDER: UNDER,ANESTASIA       ADU

   SERVICE LINE PROVIDER TYPE: RENDERING// ??

     Choose from:
       R         RENDERING
       D         ORDERING
       O         OPERATING
```

Flat Rate Billing

- Procedure Coding is set to ICD
- Biller will not see Page 8A to 8K
- Default Revenue Code, CPT Code and Billing Rate will be set in the Insurer File within the Visit Type
- User may review and validate providers and diagnosis data

Charges

- CPT and HCPCS are generated on Pages 8A to 8K, depending on category the code falls in to
  - Ex. Laboratory CPT codes typically display on Page 8E
  - With the exception of Chargemaster charges, fees will come from the 3P Fee Table – use the Insurer File to allow zero charges to appear
- Setup is completed in the insurer file by Visit Type
  - CPT procedure coding indicates itemized billing
  - ICD procedure coding indicates flat rate billing
  - ADA procedure coding is used for itemized dental billing
- Sites using M-System Chargemaster may have charges appear on different claim editor pages (ex. Lab on Page 8A)

CPT Pages Properties

- 837P or CMS-1500
  - Must link diagnosis codes to charges
  - Be mindful of payer requirements
- 837I or UB-04
  - Revenue codes are required for each charge
- Modifiers may be added – be careful of modifiers stored in the clinical applications (ex, Chest X-Ray 71001 added with a -26 modifier)
- Avoid changing the charge (ex. Modifier -52) unless specifically needed – policy should be in place when charges may be changed

Additional CPT Properties

- NDC codes may be reported on most CPT pages – logic is built in for the Pharmacy Page (8D)
- Type of Test Result may be reported but will need to be set up by payer and CPT code. This is used for Hemoglobin or Hematocrit results reporting

Reporting Providers Charges

- Professional fees are reported on Pages 8A (Medical) and 8B (Surgical)
  - E&M Codes are usually reported on Page 8A
  - Surgical CPT Codes are reported on Page 8B

Reporting Room and Board

Page 8C – Revenue Codes

- Used to report Revenue Codes CPT codes
- Room and Board charges
- Operating Room
- Emergency Room

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8C  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:2]                          SPLT Claim: 31769
Mode of Export: UB-04
............................... (REVENUE CODE) ...............................

                                                                          TOTAL
     REVENUE CODE                     CPT   CHARGE    DAYS     UNITS      CHARGE
     ================================ ===== ======= ======= ======= ============
[1] CHARGE DATE: 07/05/2022
    0120  ROOM-BOARD/SEMI                   2250.00      4          4     9,000.00
[2] CHARGE DATE: 07/05/2022
    0450  EMERG ROOM                  99282 1500.00      0          1     1,500.00
                                                    =======           ============
                                                         4              $10,500.00

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//
```

Additional Notes Regarding Room and Board

- A default revenue code will always generate and must be validated
- Use VIEW to view ADT movement and determine Revenue codes to bill
- Emergency Room and Observation will not auto populate

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// V

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8C  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:2]                              Claim: 31716
Mode of Export: UB-04
........................... (PAGE 8C - VIEW OPTION) ...........................

Admission Date: 11-25-2021                Bill From Date: 11-25-2021
Discharge Date: 11-29-2021                Bill Thru Date: 11-29-2021

          Covered Days..: 4         Non-Cvd Days..:
--------------------------------------------------------------------------------
                                 ADT MOVEMENT
NUMBER: 380
 DATE/TIME: NOV 25, 2021@19:48              TRANSACTION: ADMISSION
   PATIENT: DEMO,PATIENT                    TYPE OF MOVEMENT: DIRECT
   WARD LOCATION: 7B PCCU                   ROOM-BED: 721-A
   DIAGNOSIS [SHORT]: CHEST PAIN            LENGTH OF STAY: 4
   PASS DAYS: 0                             DAYS ABSENT: 0
   ASIH DAYS: 0                             ADMISSION TYPE-UB-04: EMERGENCY
   ADMISSION SOURCE-UB-04: NON-HEALTH CARE FACILITY POINT OF ORIGIN
```

Page 6 – Dental Services

- Used to identify billable dental services
- ADA codes
- DMTM – Dental Remap Table Maintenance allows for remapping of IHS codes
- Codes with no charge not displayed
- Tooth surface, operative site and area of oral cavity indicators

Cache TRM:6604 (ENSEMBLE)

File Edit Help

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 6  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                              Claim Number: 31287
.............................. (DENTAL SERVICES) ..............................

    VISIT                                                ORAL  OPER
    DATE              DENTAL SERVICE                     CAV   SITE  SURF    CHARGE
    =====  ============================================  ====  ====  =====   ======
[1] 03/11  2330 RESIN-BASED COMPOSITE - ONE SURFACE, AN        I              115.66
[2] 03/11  0120 PERIODIC ORAL EVALUATION - ESTABLISHED                         41.07
                                                                             =======
                                                                             $156.73

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit): N//
```

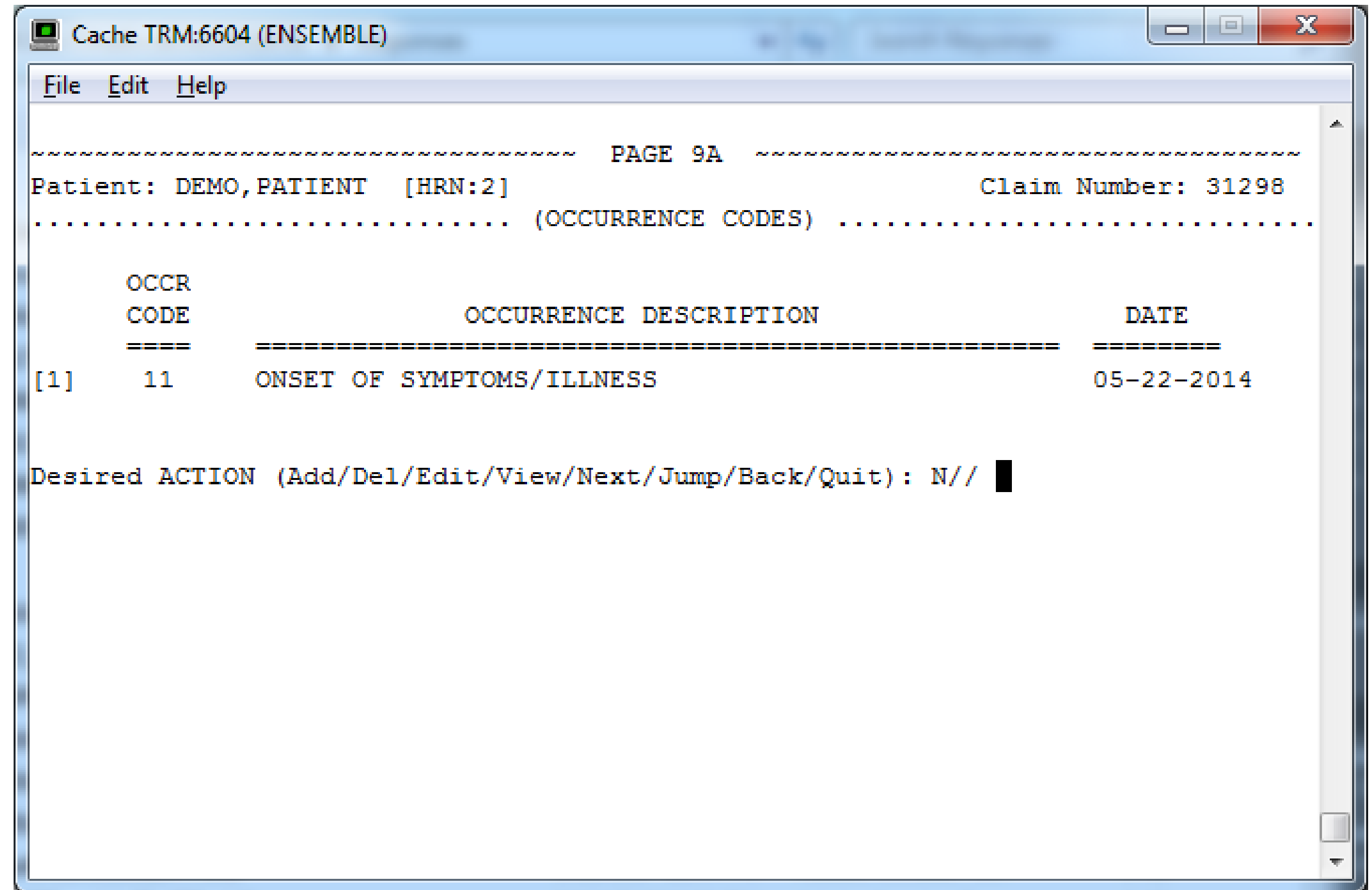
Page 7 – Inpatient Data

- Allows for entry of inpatient or day surgery data
- Admission Source, Type and Discharge status updated
- DRG (#6) will need to be added for VA billing
- Covered/Non-Covered days for Medicare Inpatient
- Prior Authorization submitted on claim

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 7  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:2]                            Claim: 31716
.............................. (INPATIENT DATA) ...............................

[1] Admission Date...: 11-25-2021       [2] Admission Hour....: 19
[3] Admission Type...: 02 (URGENT)
[4] Admission Source.: 02 (CLINIC OR PHYSICIAN'S OFFICE)
--------------------------------------------------------------------------------
[5] Admitting Diag...: R07.1 (Chest pain on breathing)
    Primary Diagnosis: R07.1 (Chest pain on breathing)
[6] DRG..............:
--------------------------------------------------------------------------------
[7] Discharge Date...: 11-29-2021       [8] Discharge Hour....: 09
[9] Discharge Status.:
--------------------------------------------------------------------------------
[10] Service From Date: 11-25-2021      [11] Service Thru Date: 11-29-2021
[12] Covered Days...: 4                 [13] Non-Cvd Days...:

[14] Prior Auth Number.....:
-------------------------------------------------------------------------------
Enter RETURN to continue or '^' to exit:

  ERROR:021 - PATIENT (DISCHARGE) STATUS UNSPECIFIED
WARNING:146 - PSRO AUTHORIZATION NUMBER NOT SPECIFIED
-------------------------------------------------------------------------------


Desired ACTION (Edit/Next/View/Jump/Back/Quit): N//
```

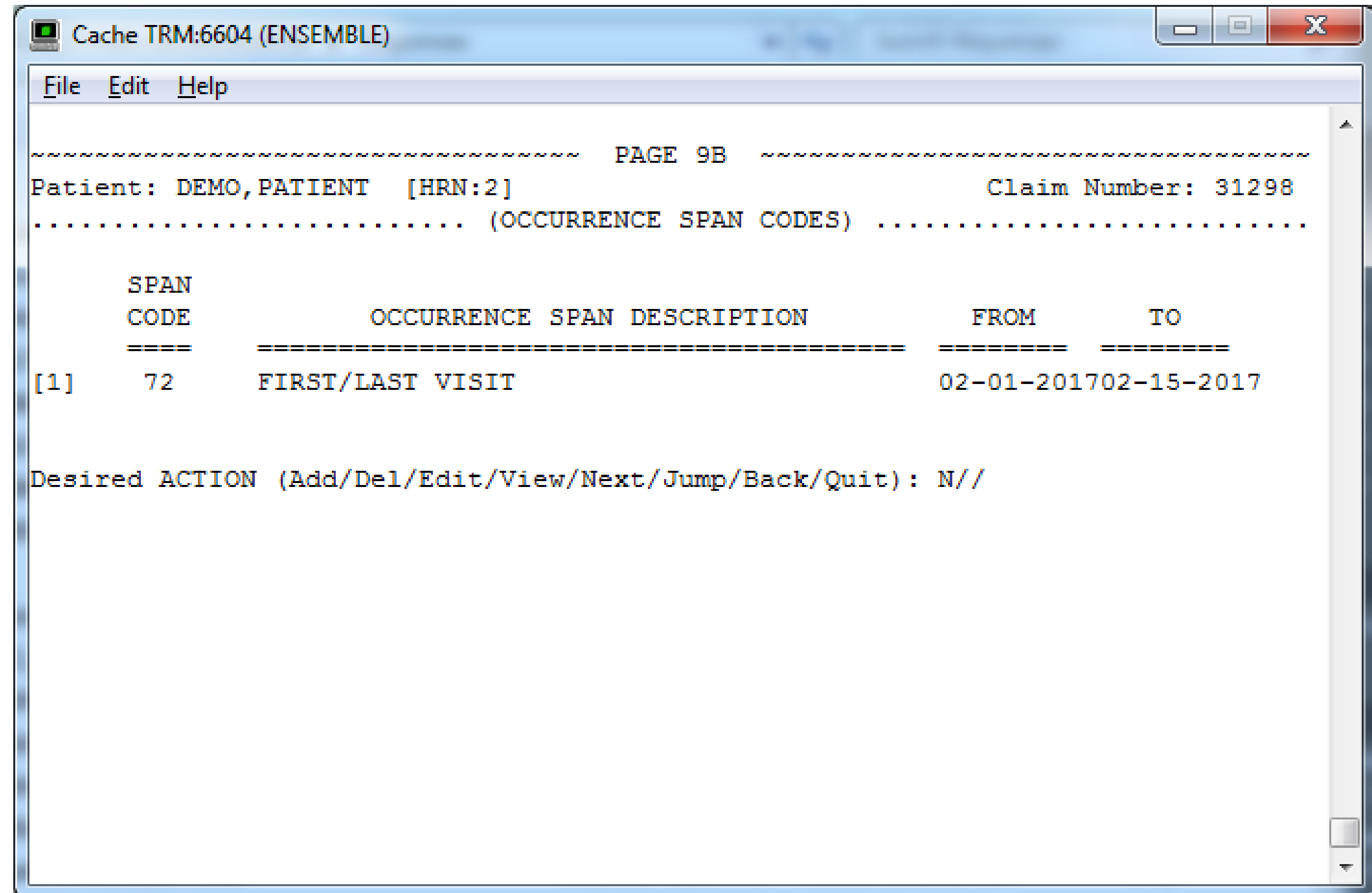
Page 9A – Occurrence Codes

- Occurrence codes help define a specific event that may affect how a medical claim is processed by an insurance company.
- The Occurrence codes are broken down into accident codes, medical condition codes, insurance related codes and service related codes.



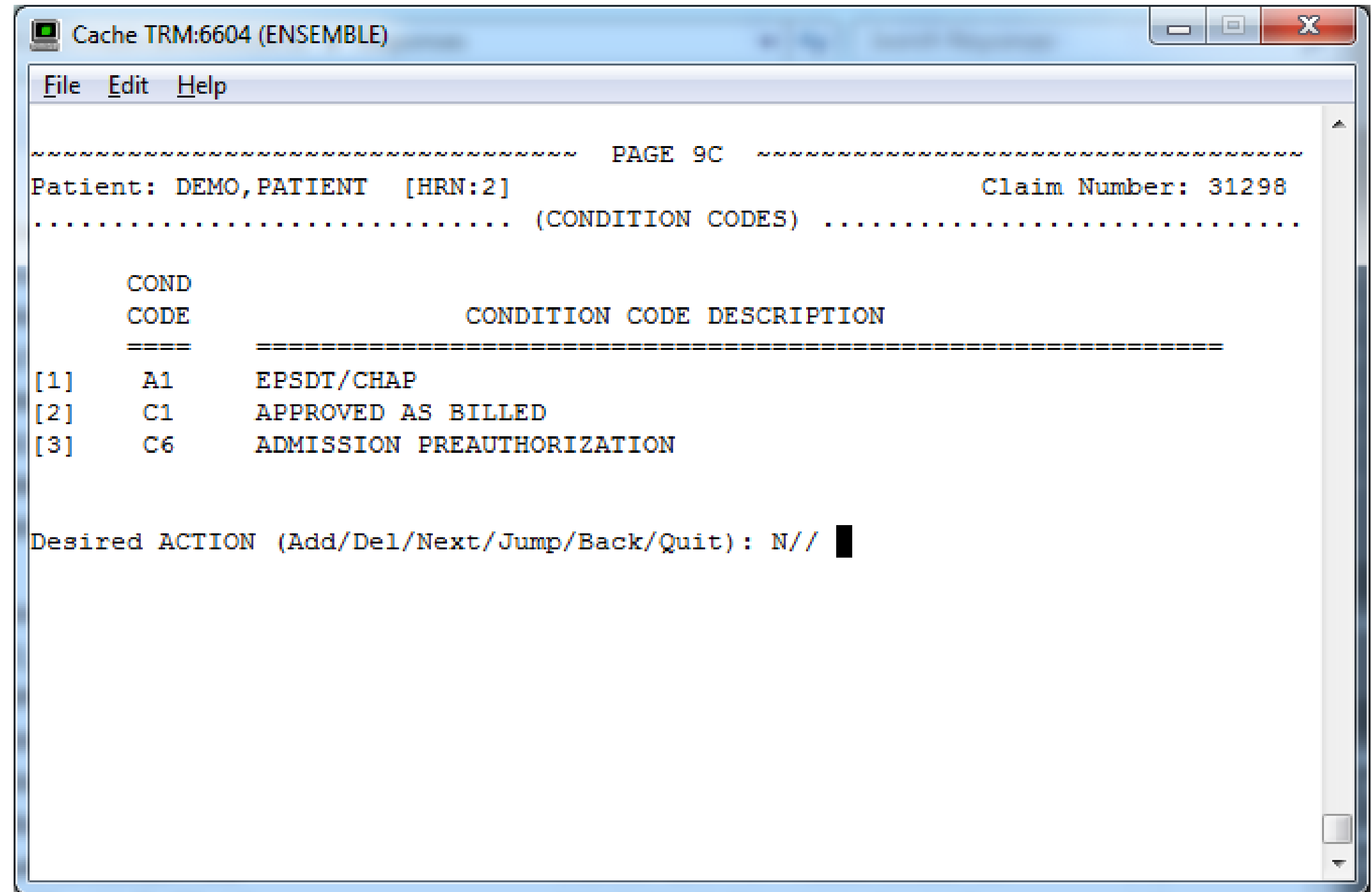
Page 9B – Occurrence Span Codes

- Occurrence Span Codes define a specific event relating to the billing period.
- The event being reported is defined by a date range rather than by a single date.



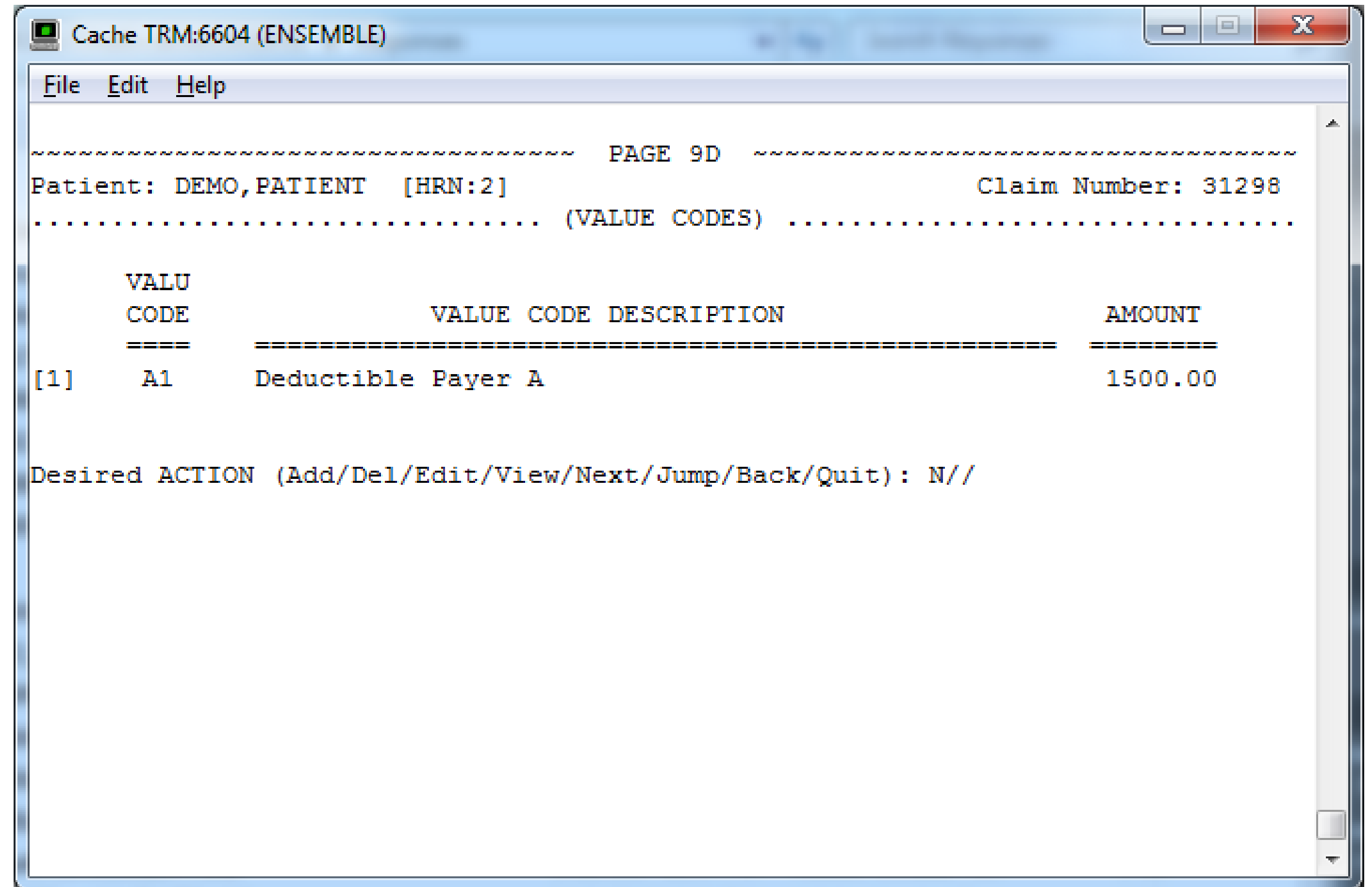
Page 9C – Condition Codes

- Condition Codes indicate a condition applies to the bill that affects processing and payment of the claim
  - Indicates whether coverage exists under another insurance
  - The injury or illness is related to employment
  - Bill is an outlier
  - Medical necessity affects room assignment



Page 9D – Value Codes

- Value Codes help identify data and financial elements about other insurances to the insurance company that is being billed.



Page 9E – Special Program Codes

- Used to explain eligibility for certain programs as required by some State Medicaid plans

```
Cache TRM:6604 (ENSEMBLE)
File  Edit  Help

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9E  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:2]                         Claim Number: 31298
........................... (SPECIAL PROGRAM CODES) ...........................

      PRGM
      CODE                 SPECIAL PROGRAM DESCRIPTION
      ====    ============================================================
[1]    01     EPSDT/CHAP


Desired ACTION (Add/Del/Next/Jump/Back/Quit): N//
```

Page 9F - Remarks

- Comment needed to communicate with the payer to help in adjudicating the claim
- Remarks will display on the 837 formats on the paper claim

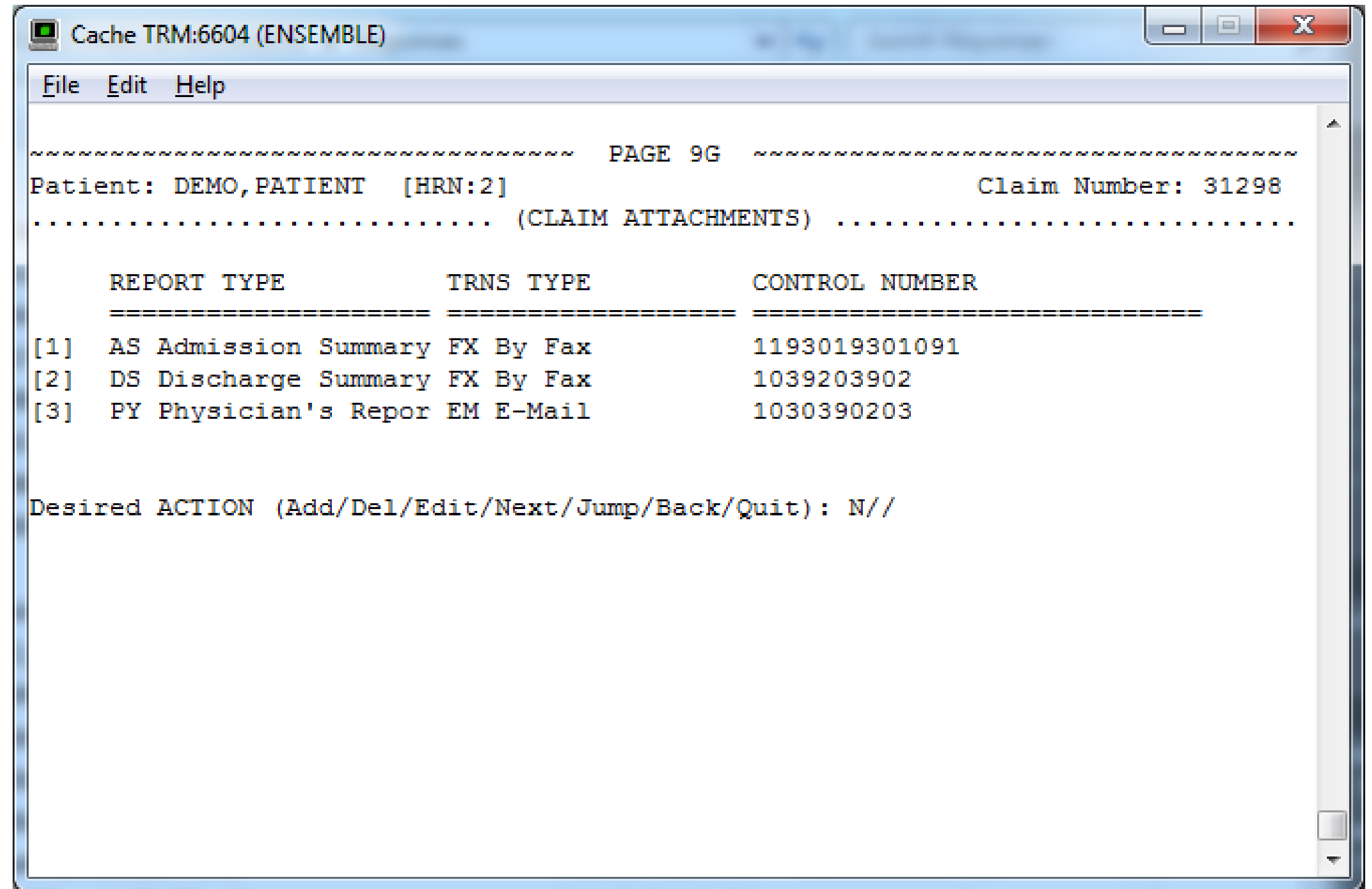
Cache TRM:6604 (ENSEMBLE)

File Edit Help

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9F  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:2]                              Claim Number: 31298
.................................. (REMARKS) ..................................

                   REMARKS
       ========================================
        (19 characters - 1st line; 24 characters x 3 lines max)
      -----------------------------------------------
[1]   PLEASE PAY US!
[2]
[3]
[4]
      -----------------------------------------------

REMARKS:
PLEASE PAY US!

  Edit? NO//
```

Page 9G – Claim Attachments

- Used to indicate if attachments will be sent with the claim
- Supporting documentation to determine medical necessity
- For now, Fax or Mail to send documents



Ambulance Billing

- Page 3A is used to add ambulance indicators needed to adjudicate claim
- Pick up location and drop off location required
- Mileage
- Medical Necessity

Cache TRM:6604 (ENSEMBLE)

File Edit Help

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: LUDERS,LISA  [no HRN]                              Claim Number: 31263
............................ (AMBULANCE QUESTIONS) ............................

   [01] Point of Pickup........: INDIAN HEALTH HOSP
                                 1101 HOMESTEAD ROAD NE
                                 ALBUQUERQUE, NEW MEXICO  87110
        [02] Modifier.........: H  HOSPITAL
   [03] Destination............: WINSLOW LINDBERGH REG AIRPORT
                                 1048 AIRPORT ROAD
                                 WINSLOW, ARIZONA  86047
        [04] Modifier.........: I  TRANS SITE (AIRPORT,ETC)

   [05] Mileage (Covered)......: 22
   [06] Mileage (Non-Covered)..:
   [07] Medical Necessity Ind..: Y
         Condition Indicator...: 60 Transportation was to the nearest facility
   [08] Patient Weight (lbs)...:
   [09] Patient Count..........:

Transfers Only:
   [10] Type of Transport......:
   [11] Transported To/For.....:
```

Page 8K - Ambulance

- Used to report ambulance services
- Usually reported using HCPCS codes
- Mileage
- BLS/ALS reporting

Cache TRM:6604 (ENSEMBLE)

File Edit Help

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8K  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: LUDERS,LISA  [no HRN]                              Claim Number: 31263
Mode of Export: CMS-1500 (02/12)
............................. (AMBULANCE SERVICES) ............................

     REVN                                                     UNIT        TOTAL
     CODE         HCPCS - AMBULANCE SERVICES                 CHARGE QTY  CHARGE
     ==== =============================================      ====== ===  =========
[1]  CHARGE DATE: 12/31/2016@19:50
      540 A0425 Ground mileage                                  5.10 21     107.10
[2]  CHARGE DATE: 12/31/2016@19:50
      540 A0429 BLS-emergency                                2542.00 1    2,542.00
                                                                         ==========
                                                                         $2,649.10

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//
```

Approving the Claim

- Once claims is reviewed, return to Page 0 of the Claim Editor
- Summary of charges will display
- Type “A” to approve the claim

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 0  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:2]                             Claim: 31722
............................... (CLAIM SUMMARY) ...............................
_______ Pg-1 (Claim Identifiers) _______|__________ Pg-3 (Questions) ___________
Location..: INDIAN HOSP                 |Release Info: YES  Assign Benef: YES
Clinic....: GENERAL                     |
Visit Type: OUTPATIENT                  |
Bill From: 07-03-2022 Thru: 07-03-2022  |__________ Pg-4 (Providers) ___________
________ Pg-2 (Billing Entity) _________|Attn: MILLS,CHRISTOPHER P
BS OF MASSACHUSETTS INC        ACTIVE   |
O/P MEDI-CAL  9                UNBILABL|__________ Pg-5A (Diagnosis) __________
NEBRASKA MEDICAID              PENDING  |1) FEVER
____________ PCC Visit Data ____________|2) NEUTROPENIA
Prim Visit: 07/03/2022@10:49  Count: 1  |
Srv Cat: A Hsp Loc: <none>              |_________ Pg-8 (CPT Procedures) ________
Last Visit: 04/04/2022@10:49  Loc: IHH  |1) OFFICE O/P EST SF 10-19 MIN
Srv Cat: A Cl:12  Hsp Loc: <none>       |
                                        |
WARNING:250 - DOS after ICD Indicator Date
--------------------------------------------------------------------------------


Desired ACTION (View/Appr/Pend/Close/Next/Jump/Quit): N// A
```

Claim Editor Charge Summary Page

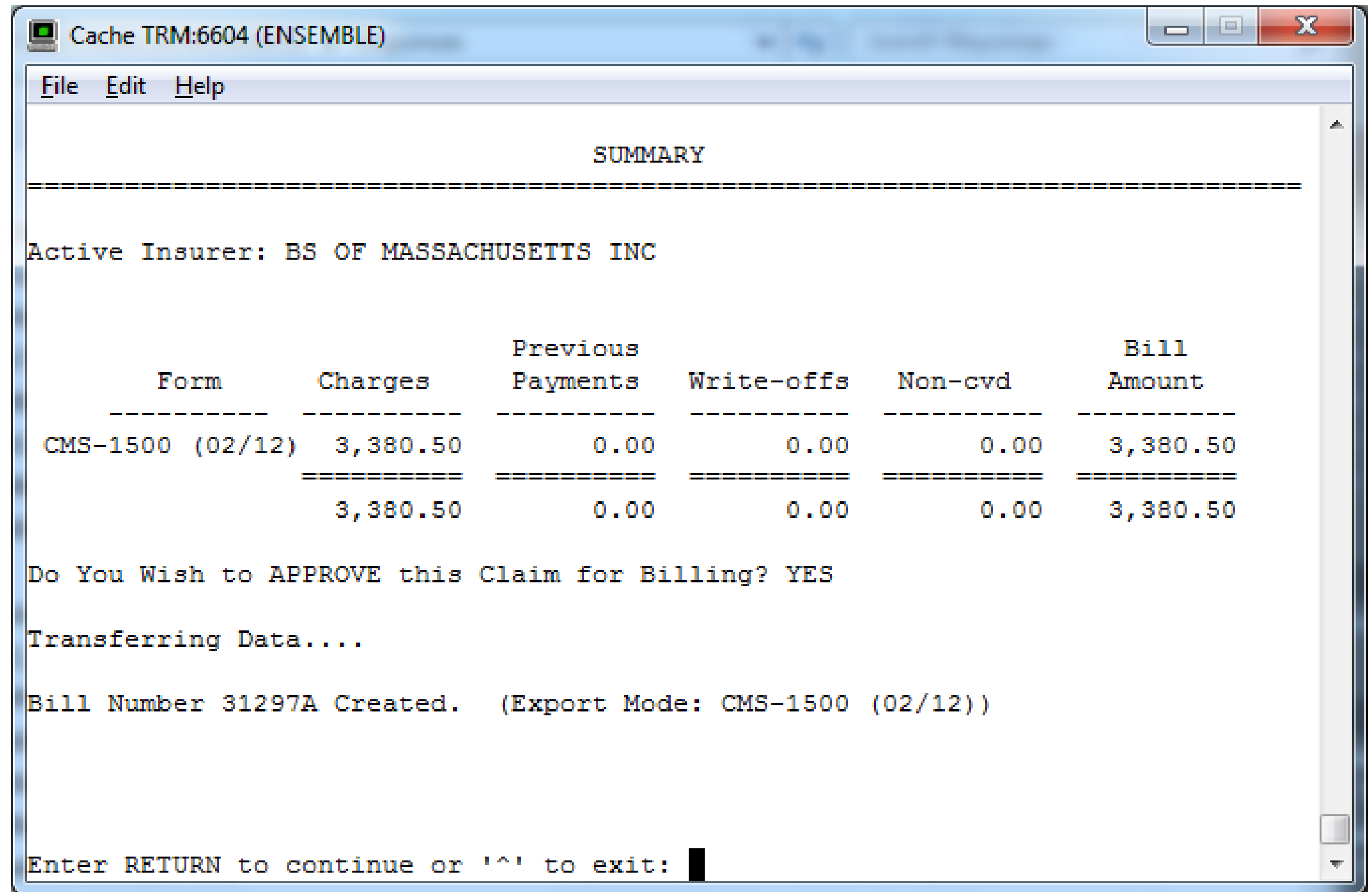
- Displays list of charges
- Last review prior to approving

```
Cache TRM:6604 (ENSEMBLE)
File  Edit  Help

                    ***** CMS-1500 (02/12) CHARGE SUMMARY *****

Active Insurer: BS OF MASSACHUSETTS INC

                                                         Corr
 Charge Date            POS TOS   Description            Diag      Charge       Qty
-------------------------------------------------------------------------------
04-16-2017 04-16-2017 22 2     34842    26                 1     2,650.00         1
04-16-2017 04-16-2017 22 1     99212                       1       166.00         1
04-16-2017 04-16-2017 22 4     71010 LT 26                 1        47.00         1
04-16-2017 04-16-2017 22 7     00520    P1                 1       395.00        45
04-16-2017 04-16-2017 22 1     A6442                       1        90.00        20
04-16-2017 04-16-2017 22 1     J2001                       1        22.50         1
04-16-2017 04-16-2017 22 1     G0010                       1        10.00         1
                                                                 ----------
          TOTAL CHARGE                                           3,380.50

Enter RETURN to continue or '^' to exit:
```

Approval Screen

- If charges appear correct, approve
- Prior payments may appear – verify entry
- Bill created at this time and transferred to Accounts Receivable

<u>Note: REVIEW BILL AMOUNT PRIOR TO APPROVING</u>



Questions?