

Chapter 2

Billing and Coding for Health Services

LEARNING OBJECTIVES

After studying this chapter, you should be able to do the following:

1. Describe the revenue cycle for health care firms.
2. Understand the role of coding information in health care organizations in claim generation.
3. Define the two major bill types used in health care firms.
4. Define the basic characteristics of chargemasters.
5. Appreciate the role of claims editing in the bill submission process.

REAL-WORLD SCENARIO

Riley Ilene, the Chief Financial Officer of Campbell Hospital, was concerned by the reduction in revenue during the last three months. The revenue reduction was most pronounced in the outpatient arena and represented a 15 percent reduction from prior year levels. Loss of this revenue had eroded Campbell's already thin operating margins and the hospital was now operating with losses.

Riley's first thought was that volume may be down from prior year levels. She asked her controller, Michael Dean, to report on comparative volumes for last year and this year. Michael's report showed that total numbers of outpatient visits were actually above last year. Furthermore, the increases in volumes appeared relatively uniform across all product line groupings. Riley then directed Michael to review "Revenue and Usage" summaries for the current and prior year. A revenue and usage summary would show the quantity of items billed by charge code and payer. The summaries would also break out the volumes by inpatient and outpatient areas.

After reviewing this data, Michael reported back to Riley with some startling news. Volumes for several procedures in the hospital's "Chargemaster" were well below prior year levels. Specifically, the numbers of drug administration codes that are reported when an injectable or infusible drug is administered were well below prior year levels. This was surprising because the number of injectable and infusible drugs had actually increased.

Riley Ilene thought she had discovered the problem and reported back to her CEO, Meredith Lynn. Meredith, however, asked Riley whether this could have caused the revenue reduction.

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Meredith believed that a heavy percentage of the hospital's payment was related to either case payment for inpatients or APC (Ambulatory Patient Classification) groups for outpatients. Meredith believed that these bundled payments would not be impacted by a failure to document the drug administration procedures.

Riley said that this was a good point and she would do some additional research and report back to Meredith. Riley found that Medicare provides separate payments for the drug administration procedure when performed in outpatient visits. The average loss for the undocumented procedure codes appeared to average about \$120 per occurrence. Riley also found that many of their commercial payers paid on a discount from a billed charge basis. Failure to report these procedures for these payers would result in lost revenue. The only remaining task was to discover why charges for drug administration procedures for outpatient procedures were not being recorded.

Health care firms are for the most part business-oriented organizations. Their ultimate financial survival is dependent upon a consistent and recurring flow of funds from the services that they provide to patients. Without an adequate stream of revenue these firms would be forced to cease operations. In this regard, health care firms are similar to most business entities that sell products or services in our economy. Figure 2–1 depicts the stages involved in the revenue cycle for a health care firm. The critical stages in the revenue cycle for health care firms are the provision of services to the patient, the generation of charges for those services, the preparation of a bill or claim, the submission of the bill or claim to the respective payer, and the collection of payment.

LEARNING OBJECTIVE 1

Describe the revenue cycle for health care firms.

A simple review of the five stages of the revenue cycle in Figure 2–1 hides the significant degree of complexity involved in revenue generation for health care providers. There is no other industry in our nation's economy that experiences the same level of billing complexity that most health care firms face. Part of this complexity is related to the nature and importance of the services provided. Regulation is also a factor that further complicates documentation and billing for health care services. Finally, the existence of different payment methods and rates for multiple

payers further complicates the revenue cycle for most health care firms. Payment complexity is a topic that will be addressed in Chapter 3.

GENERATING HEALTH CARE CLAIMS

Figure 2–2 provides more detail on the steps and processes involved in the actual generation of a health care bill or claim. The process and steps mirror those in Figure 2–1, except additional detail unique to health care firms is included. The process often begins with the collection of information about the patient in the patient registration function, prior to the delivery of services. Information about the patient including address, date of birth, and insurance data is collected to facilitate bill preparation after services are provided. Once services have been provided, data from that encounter(s) flow into two areas: medical documentation and charge capture.

While the primary purpose of the data accumulated in the medical record may relate to clinical decision-making, a substantial proportion of the information may also be linked to billing. For example, the assignment of diagnosis and procedure codes within the medical record by physicians plays a key role in DRG (Diagnosis Related Group) assignment. Many health care payers provide payment for inpatient care based upon DRG assignment. Data in the medical record is also the primary source for documenting the provision of services. For example, if a patient's bill listed a series of drugs used by the patient, but the medical record did not show those drugs as being used, the claim would not be supported. The primary linkage between the claim and the medical record is related to the

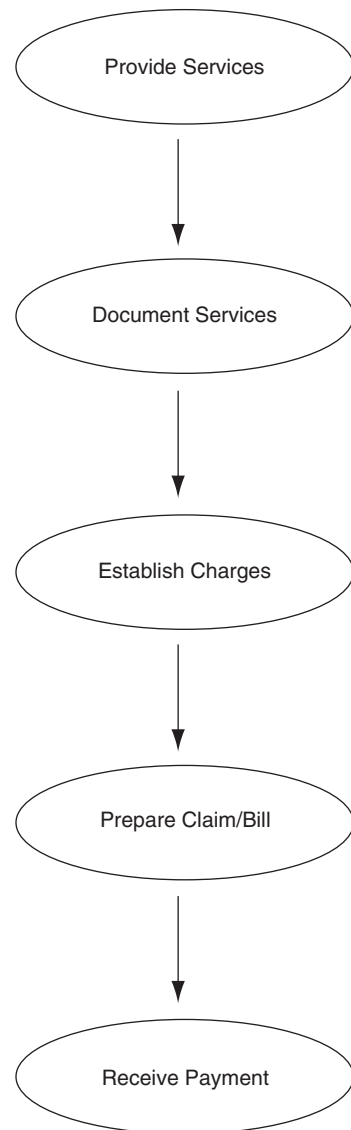


Figure 2–1 Revenue Cycle

documentation of specific services provided and their reporting in a series of clinical codes. We will explore the categories of coding and their importance to billing shortly.

Data from the provision of services also flow directly to billing indirectly through the capture of charges. The posting of charges to a patient's account is usually accomplished through the issuance and collection of "charge slips" in a manual mode, or through direct order entry or bar code readers in an automated system. The critical link here is the firm's price list, often referred to as its "chargemaster." The chargemaster is simply a list of all the items that the firm has

established specific prices for. In a hospital setting it is not unusual to find more than 20,000 items on a chargemaster.

Information from the medical record and the chargemaster then flow into the actual claim. For most health care firms, there are two basic categories of claims: the Uniform Bill(UB)–92 and the Center for Medicare and Medicaid Services(CMS)–1500. The UB–92 is the claim form that is used for most hospitals to report claims for both inpatient and outpatient services. The CMS–1500 is used primarily for physician and professional claims. Samples of these two claim forms are included in the Appendix to this chapter.

The final step before actual claim submission is claims editing. While this step may not be performed by all health care firms, it is a critical step for many. In this editing process, several key areas are reviewed. First, does the claim have enough information to trigger payment by the patient's payer? For example, perhaps the claim is missing the patient's social security number or health care plan identification number. Second, does the claim meet logical standards and is it complete? For example, a claim may have a charge for laboratory panel, but there may be no charge for a blood draw to collect the sample. Editing is critical to accurate and timely payment by third-party payers.

REGISTRATION

In most cases, a patient or their representative will provide a basic set of patient information prior to the actual delivery of services. In a physician's office this may be done just prior to medical service performance. For an elective hospital inpatient admission, it may be done a week or more prior to admission. A number of clinical and financial sets of information are collected at this point. From the financial perspective, three activities are especially important in the billing and collection process.

Perhaps the most important activity is insurance verification. If the patient has indicated that they have third-party insurance coverage, it is important to have this coverage verified by the payer. The patient may also have secondary coverage from another health plan. Verification of that coverage is also critical to accurate and timely billing. The critical piece of information to collect from the patient in this regard is their health plan identification number, which may sometimes be their social security number. Queries addressed to the

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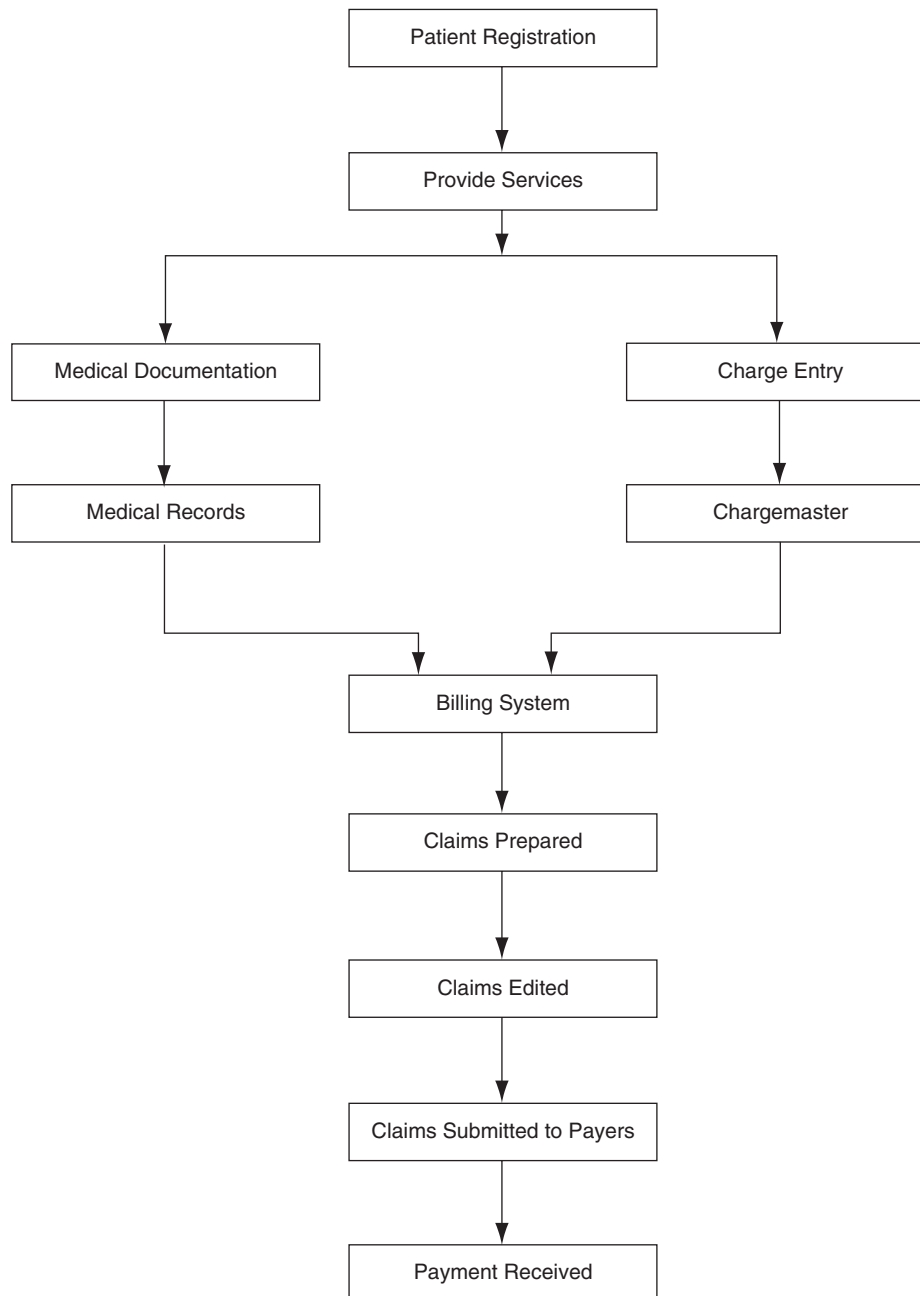


Figure 2–2 Detailed Revenue Cycle

third-party insurance company prior to service can validate the type of coverage provided by the health plan and the eligibility of the patient for the scheduled service. In today's current environment insurance verification is often done online. Sometimes prior approval for elective services is required by the health plan before a claim can be submitted. This prior verification is often referred to as pre-certification. Information regarding

coverage for large governmental programs such as Medicare and Medicaid is not often needed because the benefit structure is standardized. It is important however to verify the existence of current coverage.

The second activity in registration is often related to the computation of co-payment or deductible provisions that may be applicable for the patient. Once insurance coverage has been determined, it is usually

possible to calculate the required amount that may still be due from the patient. For example, a Medicare patient without supplemental coverage may report to a hospital for a scheduled CT scan. It is possible for the registration staff to calculate the amount of co-payment that will be due by the patient. The registration staff can then advise the patient regarding the amount of payment due and try to make arrangements for payment at the point of service.

The third activity in this registration process relates to financial counseling. Patients who have no coverage may be eligible for some discount through the health care firm's charity care policy. Any residual that may still be due can be discussed with the patient and financing may be arranged prior to the point of service. It is also possible that an uninsured patient may be eligible for some governmental programs, especially Medicaid. Staff at the health care firm can advise the patient regarding eligibility and help them to complete the necessary documents required for coverage.

LEARNING OBJECTIVE 2

Understand the role of coding information in health care organization claims generation.

MEDICAL RECORD/CODING

Information regarding the services provided to the patient is recorded in the patient's medical record. Critical pieces of information contained in that record are utilized in the billing process and are communicated to the payers to trigger payment. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 designated two specific coding systems to be used in reporting to both public and private payers:

- International Classification of Diseases 9th Revision—Clinical Modification
- Healthcare Common Procedure Coding System

HIPAA requires that two categories of information be reported to payers: diagnosis codes and procedure codes. The International Classification of Diseases 9th Revision—Clinical Modification (ICD-9-CM) has sets of codes that provide information for both diagnosis and procedures. The Healthcare Common Procedure Coding System (HCPCS) provides information in the procedure area, but does not provide information regarding diagnosis. HIPAA therefore requires that ICD-9 codes be used for diagnosis reporting for all health care providers including hospitals and physicians. ICD-9 procedure codes are required for procedure reporting for hospital inpatients, while HCPCS codes are used for procedure reporting by hospitals for outpatient services and also by physicians (See Table 2-1).

ICD-9 diagnosis codes are three digits, which may be followed by a decimal point with two additional digits. For example, all ICD-9 codes that have 428 as their first three digits refer to the primary diagnosis of heart failure. Additional digits following a 428 would further specify the patient's exact condition. For example, 428.1 would refer to left heart failure. Table 2-2 provides a listing of the top ten inpatient diagnoses reported by Medicare in Fiscal Year 2004.

ICD-9 procedure codes are used to report hospital inpatient procedures. These codes may be up to four digits in length, with a decimal point following the first two digits. For example, a code with 37 as the first two digits would refer to procedures on the heart and pericardium. A code of 37.23 would refer to a combined right and left heart cardiac catheterization. Table 2-3 shows a listing of the top ten inpatient ICD-9 procedure codes reported by Medicare in Fiscal Year 2004.

Table 2-1 HIPAA-Designated Coding

Provider	Inpatient		Outpatient	
	Diagnosis	Procedure	Diagnosis	Procedure
Physician	ICD-9-CM	CPT	ICD-9-CM	CPT
Facility	ICD-9-CM	ICD-9-CM	ICD-9-CM	HCPCS (CPT and HCPCS Level II)

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Table 2–2 2004 Public Data—Primary Diagnosis Frequency

<i>Dx1</i>	<i>Definition</i>	<i>Frequency</i>	<i>% of Total</i>
4280	Congestive Heart Failure	698,697	5.1
486	Pneumonia, Organism Unspecified	606,396	4.5
41401	Coronary Atherosclerosis of Native Coronary Artery	517,405	3.8
49121	Obstructive Chronic Bronchitis, with Acute Exacerbation	355,457	2.6
V5789	Care Involving Other Specified Rehabilitation Procedure	337,664	2.5
41071	Subendocardial Infarction, Initial Episode of Care	231,249	1.7
5990	Urinary Tract Infection, Site Not Specified	229,076	1.7
42731	Atrial Fibrillation	207,119	1.5
78659	Other Chest Pain	193,757	1.4
2765	Volume Depletion Disorder	190,991	1.4

ICD–9 diagnosis and procedure codes are very important in the assignment of a Diagnosis Related Group (DRG). DRG payment is widely used by many payers, especially Medicare. Coding therefore has a critical link to provider payment.

HCPCS codes are used for reporting procedures by physicians for both inpatient and outpatient procedures. They are also used by facilities for reporting outpatient procedures, but they use ICD–9 procedure codes for reporting inpatient procedures. There are two tiers used in HCPCS coding, Level I and Level II. Level I codes are referred to as CPT (Current Procedure Terminology) codes that have been developed and maintained by the American Medical Association. Level I and CPT are used interchangeably to describe these sets of codes. Six main categories of CPT codes are currently used:

- Evaluation & Management (99201 to 99499)
- Anesthesia (01000 to 01999)
- Surgery (10040 to 69979)
- Radiology (70010 to 79999)

- Pathology and Laboratory (80002 to 89399)
- Medicine (90701 to 99199)

The five digit CPT code may also contain a “modifier,” which is a two digit numeric or alphanumeric that may provide additional information essential to process a claim. For example, modifier 91 is used to indicate that a laboratory procedure was repeated. Table 2–4 provides a list of the top ten hospital outpatient CPT codes reported to Medicare in Fiscal Year 2004.

Level II HCPCS codes were developed by CMS to report services, supplies, or procedures that were not present in the Level I (CPT) codes. There are two groups within the Level II HCPCS codes: permanent and temporary. Permanent codes are five digit codes that begin with an alpha character. Table 2–5 provides a list of the top ten Level II permanent HCPCS codes reported to Medicare in Fiscal Year 2004 for hospital outpatients.

Level II temporary HCPCS codes are used to meet a temporary need for a new code. These codes are also five digit codes that begin with an alpha character.

Table 2–3 2004 Public Data—Primary Procedure Frequency

<i>Px1</i>	<i>Definition</i>	<i>Frequency</i>	<i>% of Total</i>
36.01	Ptca-1 Ves/Ath w/o Agent	292,085	3.9
99.04	Packed Cell Transfusion	285,906	3.8
37.22	Left Heart Cardiac Cath	257,270	3.4
81.54	Total Knee Replacement	241,381	3.2
45.16	Egd With Closed Biopsy	230,779	3.1
38.93	Venous Cath Nec	218,295	2.9
39.95	Hemodialysis	207,926	2.8
45.13	Sm Bowel Endoscopy Nec	142,572	1.9
81.51	Total Hip Replacement	116,364	1.5
96.71	Cont Mech Vent < 96 Hrs	113,965	1.5

Table 2-4 2004 Public Data—CPT Frequency

<i>CPT</i>	<i>Definition</i>	<i>Frequency</i>	<i>% of Total</i>
85025	Automated hemogram	8,988,187	4.7
93005	Electrocardiogram, tracing	5,820,832	3.1
71020	Chest x-ray	5,223,746	2.7
80048	Basic metabolic panel	4,855,852	2.5
80053	Comprehen metabolic panel	4,646,886	2.4
99213	Office/outpatient visit, est	4,202,313	2.2
85610	Prothrombin time	4,148,100	2.2
99283	Emergency dept visit	3,623,782	1.9
99211	Office/outpatient visit, est	2,790,103	1.5
88305	Tissue exam by pathologist	2,706,423	1.4

These codes can exist for a long time, but they may be replaced with a permanent code. Table 2-6 provides a list of the top ten Level II temporary HCPCS codes reported to Medicare in Fiscal Year 2004 for hospital outpatients.

HCPCS/CPT codes have a significant effect on provider payment for both facilities and physicians. CPT codes are often linked to fee schedules for many physicians by a large number of payers, which makes coding by medical groups especially critical. CPT and Level II HCPCS codes are also used by Medicare to define payment for many hospital outpatient services in the APC system.

LEARNING OBJECTIVE 3

Define the two major bill types used in health care firms.

CHARGE ENTRY/CHARGEMASTER

Performing actual medical services is the lifeblood of a health care firm's revenue cycle. Without the provision of services there is no revenue, but it is imperative that charges for those services be captured. A service that is performed, but not billed, will not produce revenue. The three greatest concerns in billing are:

- Capture of charges for services performed
- Incorrect billing
- Billing late charges

Charge capture is usually accomplished in one of two ways. For a number of providers actual paper documents or charge slips are used to identify services that are performed. These charge slips are then posted to a patient's account in a batch processing mode by data processing or the business office. Alternatively, an order entry system could be used, which may involve

Table 2-5 2004 Public Data—Level II (Perm) Frequency

<i>Level II (Perm)</i>	<i>Definition</i>	<i>Frequency</i>	<i>% of Total</i>
J3010	Fentanyl citrate injection, .1	1,509,269	8.8
J2250	Inj midazolam hydrochloride	1,321,476	7.7
A4646	Contrast 300-399 MGs iodine	670,868	3.9
J2175	Meperidine hydrochl/100 MG	455,294	2.7
J2405	Ondansetron hcl inj 1 mg	406,727	2.4
A9500	TC 99M sestamibi, per syringe	384,467	2.3
J0690	Cefazolin sodium injection	338,973	2.0
J2550	Promethazine hcl injection	312,201	1.8
J2270	Morphine sulfate injection	302,017	1.8
J1885	Ketorolac tromethamine inj	291,196	1.7

Table 2–6 2004 Public Data—Level II (Temp) Frequency

<i>Level II (Temp)</i>	<i>Definition</i>	<i>Frequency</i>	<i>% of Total</i>
G0001	Drawing blood for specimen	9,823,049	60.8
Q0081	Infusion ther other than che	2,562,493	15.9
Q0136	Non esrd epoetin alpha inj	634,901	3.9
Q0084	Chemotherapy by infusion	467,230	2.9
G0239	Therapeutic procedures	281,637	1.7
G0202	Screening mammography	199,681	1.2
Q0137	Darbepoetin alfa, non esrd	172,803	1.1
Q0083	Chemo by other than infusion	168,884	1.0
G0008	Admin influenza virus vac	143,824	0.9
G0103	Psa, total screening	110,263	0.7

direct entry of charges to the patient’s account through a computer terminal. Scanning of bar codes may also be used.

Sometimes health care firms may use a “charge explosion” system to better organize charge entry for selective services. For example, a specific type of surgery may routinely require a standardized set of supplies. Rather than entering all these supplies, one code may be used that then explodes into the list of supply codes used for that surgery.

LEARNING OBJECTIVE 4

Describe the basic characteristics of chargemasters.

The key link between charge capture and the billing process is the “charge code,” which is reflected in the order entry system or the charge slips and is also represented on the firm’s chargemaster. The chargemaster is the list of services, supplies, and drugs that the firm bills. For hospitals, some chargemasters can have up to 100,000 items. Every chargemaster will usually have the following six common elements:

- Charge code
- Item description
- Department Number
- Charge/Price
- Revenue Code
- CPT/HCPCS code

Table 2–7 provides a sample of selected codes in a hospital’s chargemaster. The first column in the chargemaster is the charge code or item code for the specific service or product that is to be billed. The second column provides a short description of the specific item code. For example, item code 3023001 is “Daily Care Fourth North.” The third column contains the department number and may reference a specific department within the firm, and which might also relate to their accounting system or general ledger. The fourth column is the current price or standard price for the service or product. In some cases, there may be multiple prices for a given code. For example, a hospital might price a laboratory procedure at one rate for inpatient care, and it may have a different price for outpatient care. These differences may reflect differences in cost or competitive price pressure. Competition for outpatient laboratory procedures may be intense and the hospital may believe that it must discount its price if it wants to maintain its market share for outpatient laboratory services. The fifth column is the revenue code. Revenue codes are a required field in any hospital claim that is submitted on a UB–92. The current categories used have been mandated by CMS and the current list is presented in Table 2–8. The last column that is included in many chargemasters is the field for the HCPCS code. In our sample chargemaster not all entries have a HCPCS code. For example, the first two entries that relate to room and board charges do not have a HCPCS code. Also notice that surgery and anesthesia codes do not have a HCPCS code. Most hospitals bill for a great majority of their surgeries on a time/level basis. Someone from Health Information Management (HIM) will assign a CPT code or an

Table 2-7 Partial Chargemaster File

<i>Item Code</i>	<i>Item Description</i>	<i>Dept Num</i>	<i>Standard Price (\$)</i>	<i>Revenue Code</i>	<i>HCPCS</i>
3023001	DAILY CARE FOURTH NORTH	13030	665.50	111	
3120000	DAILY CARE ICU	13120	1,172.50	200	
4156159	MINERAL OIL 30ML	13190	11.50	250	
4400206	SINGLE TOWEL	14430	2.25	270	
4440302	HEP C ANTIBODIES-0288	14440	53.50	300	86803
4470220	HAND XRAY-0183	14470	102.50	320	73130
4472538	C/T PELVIS W & W/O ENHANCEMENT	14302	1,069.75	350	72194
4416000	LASIK SURGERY—PER EYE	13190	2,105.25	360	66999
4416013	O.R. MINOR CHARGE—0.5 HOUR	13190	556.75	360	
4416014	O.R. MINOR CHARGE—1 HOUR	13190	770.75	360	
4416015	O.R. MINOR CHARGE—1.5 HOURS	13190	983.00	360	
4416016	O.R. MINOR CHARGE—2 HOURS	13190	1,197.25	360	
4416017	O.R. MINOR CHARGE—2.5 HOURS	13190	1,409.25	360	
4416018	O.R. MINOR CHARGE—3 HOURS	13190	1,622.25	360	
4520013	ANESTHESIA MINOR—0.5 HOUR	14520	110.25	370	
4520014	ANESTHESIA MINOR—1 HOUR	14520	151.25	370	
4520015	ANESTHESIA MINOR—1.5 HOURS	14520	192.75	370	
4520016	ANESTHESIA MINOR—2 HOURS	14520	233.00	370	
4520017	ANESTHESIA MINOR—2.5 HOURS	14520	274.75	370	
4520018	ANESTHESIA MINOR—3 HOURS	14520	317.00	370	
3167020	BLOOD TRANSFUSION	13160	303.25	391	36430
4532057	MASSAGE <8 MINS	14532	21.00	420	97124
3050717	EVALUATION—OT	13050	130.00	430	97003
3160001	EMERG DEPT OBSERVATION 0-3HRS	13160	241.25	450	99218
3160002	EMERG DEPT OBSERVATION 3-6HRS	13160	406.00	450	99218
3160003	EMERG DEPT OBSERVATION 6-12HRS	13160	492.00	450	99219
3160004	EMERG DEPT OBSERV. OVER 12 HRS	13160	592.75	450	99220
4465350	OUTPAT VISIT LEVEL 1 (NEW)	14465	78.50	510	99201
4465351	OUTPAT VISIT LEVEL 2 (NEW)	14465	92.25	510	99202
4465352	OUTPAT VISIT LEVEL 3 (NEW)	14465	112.50	510	99203
4465353	OUTPAT VISIT LEVEL 4 (NEW)	14465	159.75	510	99204
4465354	OUTPAT VISIT LEVEL 5 (NEW)	14465	\$209.00	510	99205

ICD-9 procedure code to the procedure at a later point in time prior to billing. Where a HCPCS code is present in the chargemaster, less time is required in coding claims at the back end, but care needs to be taken that appropriate charge codes are used at charge entry. Direct coding of HCPCS codes into the chargemaster is referred to as static coding. When codes are left off the chargemaster and entered later by HIM personnel, the process is referred to as dynamic coding. Many ancillary procedures such as laboratory or radiology procedures can be coded statically, that is HCPCS codes can be placed in the chargemaster. In contrast, many surgery codes are dynamically coded and HIM staff

will assign the appropriate HCPCS code after the procedure.

BILLING/CLAIMS PREPARATION

For most health care providers medical claims fall into one of two types:

- CMS-1500
- HCFA-1450 (UB-92)

The CMS-1500 form is used by noninstitutional providers and suppliers to submit claims to Medicare and many other payers. The HCFA-1450 or UB-92 is

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Table 2–8 Revenue Code Categories

<i>Accommodation Revenue Codes</i>	
010X	All-Inclusive Rate
011X	R&B–Private (Medical or General)
012X	R&B–Semiprivate (2 Beds) (Medical or General)
013X	Semiprivate (3 and 4 Beds)
014X	Private (Deluxe)
015X	R&B–Ward (Medical or General)
016X	Other R&B
017X	Nursery
018X	LOA
019X	Subacute Care
020X	Intensive Care
021X	Coronary Care
<i>Ancillary Services Revenue Codes</i>	
022X	Special Charges
023X	Incremental Nursing Care Rate
024X	All-Inclusive Ancillary
025X	Pharmacy (See also 063X, an extension of 025X)
026X	IV Therapy
027X	Medical/Surgical Supplies and Devices (See also 062X, an extension of 027X)
028X	Oncology
029X	DME (Other than Renal)
030X	Laboratory
031X	Laboratory Pathological
032X	Radiology–Diagnostic
033X	Radiology–Therapeutic and/or Chemotherapy Administration
034X	Nuclear Medicine
035X	Computed Tomographic TCPScans
036X	Operating Room Services
037X	Anesthesia
038X	Blood
039X	Blood and Blood Component Administration, Processing and Storage
040X	Other Imaging Services
041X	Respiratory Services
042X	Physical Therapy
043X	Occupational Therapy
044X	Speech-Language Pathology
045X	Emergency Room
046X	Pulmonary Function
047X	Audiology
048X	Cardiology
049X	Ambulatory Surgical Care
050X	Outpatient Services
051X	Clinic
052X	Freestanding Clinic
053X	Osteopathic Services
054X	Ambulance
055X	Skilled Nursing
056X	Medical Social Services

Table 2–8 *continued**Ancillary Services Revenue Codes*

057X	Home Health—Home Health Aide
058X	Home Health—Other Visits
059X	Home Health—Units of Service
060X	Oxygen (Home Health)
061X	Magnetic Resonance Technology (MRT)
062X	Medical/Surgical Supplies (Extension of 027X)
063X	Pharmacy—Extension of 025X
064X	Home IV Therapy Services
065X	Hospice Service
066X	Respite Care
067X	Outpatient Special Residence Charges
068X	Trauma Response
069X	Not Assigned
070X	Cast Room
071X	Recovery Room
072X	Labor Room/Delivery
073X	EKG/ECG (Electrocardiogram)
074X	EEG (Electroencephalogram)
075X	Gastrointestinal Services
076X	Treatment or Observation Room
077X	Preventive Care Services
078X	Telemedicine
079X	Extra-Corporeal Shock Wave Therapy
080X	Inpatient Renal Dialysis
081X	Acquisition of Body Components
082X	Hemodialysis—Outpatient or Home
083X	Peritoneal Dialysis—Outpatient or Home
084X	CAPD—Outpatient or Home
085X	CCPD—Outpatient or Home
086X	Reserved for Dialysis (National Assignment)
087X	Reserved for Dialysis (State Assignment)
088X	Miscellaneous Dialysis
089X	Reserved for National Assignment
090X	Behavioral Health Treatments/Services (See also 091X, an extension of 090X)
091X	Behavioral Health Treatments/Services—extension of 090X
092X	Other Diagnostic Services
093X	Medical Rehabilitation Day Program
094X	Other Therapeutic Services
095X	Other Therapeutic Services—Extension of 094X
096X	Professional Fees (See also 097X and 098X)
097X	Professional Fees (Extension of 096X)
098X	Professional Fees (Extension of 096X and 097X)
099X	Patient Convenience Items
100X	Behavioral Health Accommodations
101X–209X	Reserved for National Assignment
210X	Alternative Therapy Services
211X–300X	Reserved for National Assignment
310X	Adult Care
311X–999X	Reserved for National Assignment

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used by institutional providers to submit claims to Medicare and most other payers. Sample copies of both a CMS-1500 and a UB-92 are shown in the Appendix to this chapter.

Most claims in today's environment are submitted in an electronic format. Usually, claims are submitted directly to the payer, or indirectly to a "clearinghouse" where the claims are grouped and then sent to the appropriate payer. The Health Insurance Portability and Accountability Act (HIPAA) administrative simplification provisions direct the Secretary of Health and Human Services to adopt standards for administrative transactions, code sets, and identifiers, as well as standards for protecting the security and privacy of health data. After October 16, 2003, providers who are not small providers (institutional organizations with fewer than 25 full-time employees or physicians with fewer than ten full-time employees) must send all claims electronically in the HIPAA format.

The electronic format required under HIPAA is 837 I for the UB-92 and 837 P for the CMS-1500. These formats specify both the nature of data exchange, as well as the required data fields. There have been a few additional data elements included in the 837 I and 837 P protocols that were not in the current CM-1500 and UB-92 claim forms.

Two of the primary payment grouping algorithms are DRGs and APCs, both of which are used by Medicare for hospital payment and also many commercial payers. Both DRGs and APCs are assigned based on data in the UB-92. A DRG is often assigned depending upon values found in the UB-92 for ICD-9 procedure codes and ICD-9 diagnosis codes. Surgical procedures require an ICD-9 procedure code and may also require a ICD-9 diagnosis code. A medical DRG will require one or more ICD-9 diagnosis codes. Note that in the UB-92 form in the Appendix, there are allowed spaces for a principal diagnosis code and up to eight additional diagnosis codes. There is also a field for the principal procedure and up to five additional procedures may be coded. Many diagnosis and procedure codes may group to more than one DRG. A complete review of the DRG title is necessary to understand the correct DRG assignment. To illustrate this concept, let's examine the following three related DRGs:

- DRG 320 Kidney and Urinary Tract Infections, Age Greater than 17 with Complications or Comorbidities
- DRG 321 Kidney and Urinary Tract Infections, Age Greater than 17 without Complications or Comorbidities
- DRG 322 Kidney and Urinary Tract Infections, Age 0-17

All three of the above DRGs have a common set of diagnosis codes of which one must be present to assign a patient to one of these DRGs. ICD-9 diagnosis code 599.0 (Infection, urinary tract, site not specified) is one of a list of diagnosis codes that would qualify. If the patient was older than 17 they would be assigned to DRG 320 or 321, depending upon the presence of any complications or comorbidities. Examples of common complications or comorbidities would be congestive heart failure, diabetes, and anemia. If the patient was 17 years of age or younger with an ICD-9 diagnosis code that mapped to DRG 320, they would be assigned to DRG 322 with or without the presence of any complications or comorbidities.

Medicare payment for hospital outpatient services shifted to APC payment in 2000. Each APC is related to one or more HCPCS/CPT codes. The assignment of HCPCS/CPT codes is presented in the UB-92 claim form in field locator (FL) #44 HCPCS/Rates. For many inpatient claims, there may be no HCPCS/CPT codes presented. The sample claim in the Appendix is for an inpatient claim and no HCPCS codes are presented. Items are aggregated at the revenue code level. For example, all laboratory procedures are grouped under Revenue Code 300. Outpatient claims will however show detailed procedures and HCPCS/CPT codes will be present. For example, APC 0005 (Level II Needle Biopsy/Aspiration Except Bone Marrow) may be assigned if one of the following CPT codes is present: 19100, 19102, 20206, 32400, 38505, 42400, 47011, 47399, 48511, 48999, 50021, 54500, and 62269. The key point to remember is that for an APC to be assigned, a HCPCS code must be present. Multiple HCPCS codes may map to one APC code, but any given HCPCS code will map to one and only one APC.

LEARNING OBJECTIVE 5

Appreciate the role of claims editing in the bill submission process.

CLAIMS EDITING

Both providers and payers will employ claims editing software to detect possible errors in claim submission. From the provider's perspective, two major objectives are of interest. First, they want to ensure that they receive the maximum payment for the medical services delivered to their patients. Second, providers want to shorten the amount of time from claim submission to actual payment. Payers have a similar set of incentives except they are reversed. Payers do not want to make payment in an amount that is greater than the amount of their obligation. In addition, payers prefer to delay payment as long as possible without violating state payment laws or contract discount terms.

Most large providers use some type of automated software for editing claims that are to be submitted to payers. These software packages check for a large number of possible errors. First, the software will determine if the requisite information for submitting a "clean claim" is present in the claim. Is the patient's name spelled correctly? Is the social security or health care plan identification present? Are diagnosis and procedure codes present? Is the date of service included? And so on. The second set of conditions that are often tested deal with the internal validity of the claim. Is the procedure consistent with the gender of the patient? Was there an injection procedure included in the claim, but no injectable drug listed? Many of these edit checks may be internally developed, but a large number of them may also be related to uniform claim edits developed by Medicare.

The Center for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B health insurance claims. The coding policies developed are based on coding conventions defined in the American Medical Association's CPT codes, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of correct coding practice.

The National Correct Coding Initiative edits identify pairs of services that normally should not be billed by the same physician for the same patient on the same day. The NCCI includes two types of edits: comprehensive/component edits and mutually exclusive edits.

- Comprehensive/Component edits identify code pairs that should not be billed together because one service inherently includes the other.
- Mutually Exclusive edits identify code pairs that, for clinical reasons, are unlikely to be performed on the same patient on the same day. For example, a mutually exclusive edit might identify two different types of testing that yield equivalent results.

CMS has designated a series of specific edit checks that are used in determining hospital outpatient claim status. These edit checks are referred to as Outpatient Code Edits (OCE) and at the time of this writing included 73 specific edit checks.

The OCE utilizes claim level and line item level information in the editing process. The claim level information includes such data elements as "from" and "through" dates, ICD-9-CM diagnosis codes, type of bill, age, sex, etc. The line level information includes such data elements as HCPCS codes with up to two modifiers, revenue code, service units, etc.

Each OCE edit results in one of six different dispositions. The dispositions help to ensure that all fiscal intermediaries are following similar procedures. There are four claim level dispositions, which include:

- Rejection—Claim must be corrected and resubmitted
- Denial—Claim cannot be resubmitted, but can be appealed
- Return to provider (RTP)—Problems must be corrected and claim resubmitted
- Suspension—Claim requires further information before it can be processed

There are two line item level dispositions which include:

- Rejection—Claim is processed, but line item is rejected and can be resubmitted later
- Denial—Claim is processed, but line item is rejected and cannot be resubmitted

This area of coding edits is very complex, but extremely important to the provider's ultimate payment. Sometimes the code edits do not appear to be consistent. For example, OCE edit #43 specifies that when a blood transfusion procedure code is present in the claim but there was no related blood product present, the claim will be returned to the provider. There is no related OCE edit to detect the reverse situation, that is

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when a blood product may be present but no transfusion procedure is included. In this situation, Medicare would pay for the blood product, but the provider would have lost payment for the transfusion procedure. This is an example of an edit that is most likely added to many hospital claims editor programs.

SUMMARY

Accurate billing and coding are essential to a health care firm's financial survival. This is a very complex area that requires the input of billing and coding professionals. In many health care firms, the billing and coding functions may report to the chief financial officer because of their integral relation to revenue generation. Failure to capture all charges associated with a patient encounter can result in significant revenue loss. Some estimates of lost charges run as high as five per-

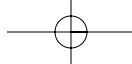
cent of total charges. Given the relatively low margins for most health care firms, this could be a catastrophic loss. Most claims are submitted electronically to payers and must now be consistent with HIPAA provisions that govern EDI (Electronic Data Interchange) submissions. Health care claims are unique in many respects, but coding is an area of special importance. In most other business settings, a bill would simply list the items purchased or services rendered. In health care firms, the charge codes describing the services or products must be related to standard procedure codes and supplemented with diagnosis codes to document the legitimacy of the services. These codes can and do play a major role in not only the amount of payment received, but also the timeliness of that payment. Claims editing software is widely used by health care providers to ensure the accuracy of their claims prior to submission.

ASSIGNMENTS

1. A hospital submitting an outpatient claim would use a UB-92 claim form. What source of coding information would be used to report diagnosis codes? What source of coding information would be used to report procedures?
2. Elective procedures often require prior approval from the patient's insurance company. What is this approval process often called?
3. From what types of coding information must the following codes be derived?
 - 453.41 Venous embolism and thrombosis of deep vessels of proximal lower extremity
 - 84.55 Insertion of bone void filler
 - 69090 Ear Piercing
 - A4646 Supply of Low Osmolar Contrast Material
4. Including a HCPCS/CPT code directly in the chargemaster is called what?
5. Many DRGs are in pairs that differ by the term with complications or comorbidities (cc), or without cc. The DRG that has the cc is usually paid at a higher rate. What can cause a DRG "without cc" to be changed to a DRG "with cc"?
6. A payer may delay or deny payment because of inaccurate or missing information in a submitted claim. Many contracts require payment within a specified period of time, e.g. 30 days from submission of a "clean claim." How can health care service providers avoid claims rejections?
7. The Medicare intermediary has returned a claim to a hospital because of Outpatient Code Edit (OCE) violation Number 1—invalid diagnosis code. This would imply that the procedure performed is not supported by the diagnosis code. What action can the provider take to ensure payment?

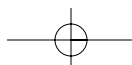
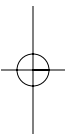
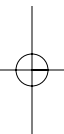
SOLUTIONS AND ANSWERS

1. ICD–9 diagnosis codes would be used to report diagnosis information on a UB–92 for both hospital inpatient and outpatient claims. HCPCS codes would be used to report procedure codes for hospital outpatient claims.
2. Pre-certification.
3. 453.41 (ICD–9 Diagnosis Code), 84.55 (ICD–9 Procedure Code), 69090 (Level I HCPCS/CPT Code), A4646 (Level II HCPCS Code).
4. Static coding.
5. While there are a number of factors that may lead to the designation of “with cc,” the presence of additional diagnosis codes, such as anemia or diabetes can often change the coding to a “with cc” designation. This illustrates the importance of good physician documentation in the medical record and accurate transcription from the medical record to the claim form.
6. Insuring a clean claim submission often starts at registration. Accurate collection of patient and related insurance information is critical in the claims submission process. Claims editing software can also check for issues that may result in claims denial prior to submission.
7. Because this is an OCE violation where the claim is returned to the provider, the provider can correct the diagnosis code and resubmit for payment. Ideally, a good claims editing system would have caught this problem prior to submission.



Appendix

Sample UB-92 Form and Sample CMS-1500 Form



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SAMPLE UB-92 FORM

ABC Medical Center PO Box 1713 Columbus OH 43210 614-722-9614		2		3 PATIENT CONTROL NO. 13504295		4 TYPE OF BILL 111					
5 FED. TAX NO. 311054871		6 STATEMENT COVERS PERIOD FROM 080906 THROUGH 081406		7 COV D. 5	8 N-C D.	9 C-I D.	10 L-R D.	11			
12 PATIENT NAME Brutus Buckeye				13 PATIENT ADDRESS 00 Buckeye Lane, Columbus OH 43210							
14 BIRTHDATE 01301960	15 SEX M	16 MS S	17 DATE 080906	ADMISSION 18 HR 19 TYPE 20 SRC 06 3 1		21 D HR 14	22 STAT 01	23 MED. RECORD NO. 404390000003	CONDITION CODES 24 25 26 27 28 29 30		31
32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE		35 OCCURRENCE CODE DATE		36 OCCURRENCE SPAN CODE FROM THROUGH		37	
38 Brutus Buckeye 00 Buckeye Lane Columbus OH 43210					39 VALUE CODES CODE AMOUNT 01 444.00		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT		
42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49				
110	Room board, pvt	447.00		5	2,235.00	15.00					
250	Pharmacy			61	674.87						
253	Drugs, take home			65	88.75	88.75					
259	Other pharmacy			27	151.38						
270	Medsur supplies			40	1,603.82						
278	Supply implants			5	2,969.55						
300	Laboratory			3	228.50						
310	Path lab			6	569.00						
360	OR services			29	7,662.00						
370	Anesthesia			3	1,108.05						
410	Respiratory services			1	8.65						
710	Recovery room			2	391.00						
999	Pt convenience			1	7.20	7.20					
001	Total				17,697.77	110.95					
50 PAYER Central Benefits		51 PROVIDER NO. 230147		52 REL. INFO Y	53 ASG BEN Y	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56	
57 DUE FROM PATIENT ▶											
58 INSURED'S NAME Brutus Buckeye		59 P. REL. 08	60 CERT. - SSN - HIC. - ID NO. 000 00 000			61 GROUP NAME		62 INSURANCE GROUP NO.			
63 TREATMENT AUTHORIZATION CODES		64 ESC	65 EMPLOYER NAME			66 EMPLOYER LOCATION					
57 PRIN. DIAG. CD. 52469		OTHER DIAG. CODES 68 CODE 5180 69 CODE 52461 70 CODE 72210 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE					76 ADM. DIAG. CD. 52469	77 E-CODE	78		
79 P.C. 9	80 PRINCIPAL PROCEDURE CODE DATE 765 081406		81 OTHER PROCEDURE CODE DATE 247 081406		OTHER PROCEDURE CODE DATE		82 ATTENDING PHYS. ID T Z AC 198x				
OTHER PROCEDURE CODE DATE							OTHER PROCEDURE CODE DATE		83 OTHER PHYS. ID		
OTHER PROCEDURE CODE DATE							OTHER PROCEDURE CODE DATE		OTHER PHYS. ID		
84 REMARKS						85 PROVIDER REPRESENTATIVE X		86 DATE			

