Chapter 5

The Hospital Billing Process

The purpose of this chapter is to provide an overview of the hospital billing process. The billing process includes submitting charges to third-party payers and patients, posting patient transactions, and following-up on outstanding accounts. As discussed in the previous chapter, information collected during the patient visit is utilized to complete the tasks required to bill for services rendered. A review of the purpose of the billing process will provide an understanding of how vital billing functions are for the hospital to maintain a sound financial base.

The role of hospital billing and coding professionals is complicated because of the ever-changing health insurance environment and variations in payer guidelines. It is essential for billing and coding professionals to understand payer guidelines in order to ensure that proper reimbursement is obtained and to be compliant with payer guidelines. A review of several elements of the participating provider agreement "payer contract" will illustrate how payer guidelines vary and the significant impact they have on the billing process. A discussion of how charges are captured, coding systems, and claim forms will provide a basis for an understanding of the billing process. The chapter will close with an overview on the hospital billing process from patient admission to collections. Many of the concepts presented in this chapter are described briefly. More detailed discussion will be provided in later chapters.

Outline

PURPOSE OF THE BILLING PROCESS

PAYER GUIDELINES
Participating Provider Agreements
Claim Forms
Clean Claim
Reimbursement Methods
Reimbursement Methods by Service Category
Reimbursement Methods by Payer Category

CHARGE DESCRIPTION MASTER (CDM)
Services and Items Billed by the Hospital
Hospital Categories of Services and Items
Content of the Charge Description Master (CDM)
Chargemaster Maintenance

CODING SYSTEMS
Procedure Coding Systems
Diagnosis Coding Systems
Coding Systems for Outpatient and Inpatient

UNIVERSALLY ACCEPTED CLAIM FORMS
CMS-1500
CMS-1450 (UB-92)
Detailed Itemized Statement
Manual versus Electronic Claim Submission

THE HOSPITAL BILLING PROCESS
Patient Admission and Registration
Patient Care Order Entry
Charge Capture
Chart Review and Coding
Charge Submission
Reimbursement
Accounts Receivable (A/R) Management

Chapter Objectives

- Define terms, phrases, abbreviations, and acronyms related to the hospital billing and claims process.
- Demonstrate an understanding of the billing process and its purpose.
- Discuss the relationship among participating provider agreements, claim forms, reimbursement methods, and the billing process.
- Explain the significance of submitting a clean claim.
- Demonstrate understanding of the variations in claim requirements by payer type and type of service
- Explain the purpose of the chargemaster and its relationship to billing.
- List and explain data elements in the chargemaster and discuss maintenance of the chargemaster.
- Provide an overview of categories of services and items billed by the hospital.
- Differentiate between coding systems utilized for outpatient services versus those used for inpatient services.
- Discuss the purpose of the detailed itemized statement.
- Briefly discuss the purpose of a claim form and provide a brief outline of information recorded on a claim form.
- Demonstrate an understanding of all elements and phases in the hospital billing process.
- Explain the significance of A/R management.
- Discuss claims that do not meet clean claim status.

Key Terms

Accounts receivable (A/R) management
Ambulatory payment classifications (APC)
Ambulatory surgery
Batch
Billing process
Capitation
Case mix
Case rate
Charge Description Master (CDM)
Claims process
Clean claim
Clearinghouse
CMS-1450 (UB-92)
CMS-1500
Collections
Contract rate
Detailed itemized statement
Diagnosis Related Group (DRG)
Electronic data interchange (EDI)
Electronic media claim (EMC)
Encoder
Facility charges
Fee-for-service
Fee schedule
Flat rate
Form locator (FL)
GROUPER
Health Care Common Procedure Coding System (HCPCS)
Inpatient Prospective Payment System (IPPS)
Outpatient Prospective Payment System (OPPS)
Participating provider agreement
Patient invoice
Patient statement
Per diem
Percentage of accrued charges
Professional charges
Prospective Payment System (PPS)
Reimbursement
Relative value scale (RVS)
Resource-based relative value scale (RBRVS)
Revenue code
Third-party payer
Usual, customary, and reasonable
UB-92

Acronyms and Abbreviations

APC—Ambulatory payment classification
CMS-—Centers for Medicare and Medicaid Services
CDM-—Charge Description Master
DRG-—Diagnosis Related Group
EDI-—electronic data interchange
EMC-—electronic media claim
FL-—form locator
HCPCS-—Health Care Common Procedure Coding System
IPPS-—Inpatient Prospective Payment System
NUBC-—National Uniform Billing Committee
OPPS-—Outpatient Prospective Payment System (OPPS)
RBRVS-—resource-based relative value scale
RVS-—Relative value scale

PURPOSE OF THE BILLING PROCESS

The purpose of the hospital billing process is to obtain reimbursement for services and items rendered by the hospital. Reimbursement is received from patients, insurance carriers, and government programs. The hospital billing process begins when a patient arrives at the hospital for diagnosis and treatment of an injury, illness, disease, or condition. The patient's demographic and insurance information is obtained and registered in the hospital's information system. Physician's orders or a requisition outlines the patient care services required. Patient care services and items provided during the patient's stay are recorded on the patient's account. Charges are posted to the patient's account by various departments. When the patient leaves the hospital, all information and charges are prepared for billing. The **billing process** involves all the functions required to prepare charges for submission to patients and third-party payers in order for the hospital to obtain reimbursement. It includes patient registration, posting charges to the patient's account, chart review and coding, preparing claim forms and patient invoices or statements for charge submission, and monitoring and follow-up of outstanding accounts. The term **claims process** refers to the portion of billing that involves preparing claims for submission to payers. An extension of the billing process is **collections**, also known as A/R management, which involves monitoring accounts that are outstanding and pursuing collection of those balances from patients and third-party payers. The hospital billing process is illustrated in Figure 5-1.

The complexity of the hospital billing process is a result of the health care industry's evolution. The history of hospitals explains how medicine changed over the years and how hospitals evolved as a result of that change. It also shows the relationship among advances in medicine, hospital evolution, and rising health care costs. Health insurance and government-funded health

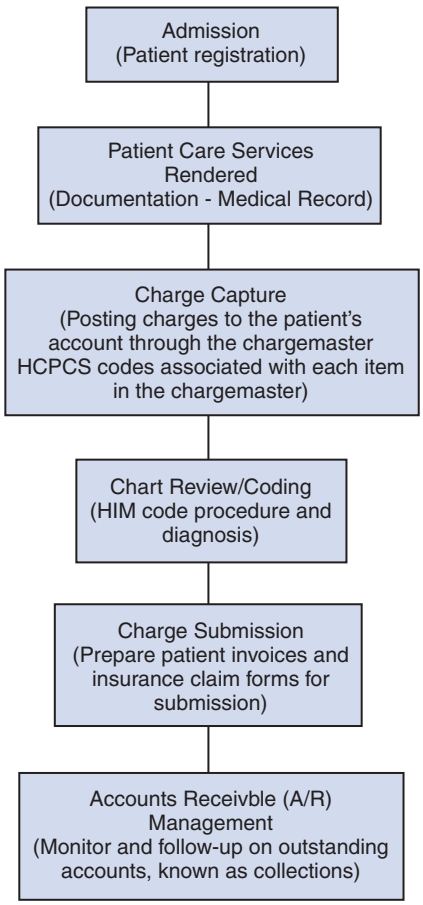


Figure 5-1 The hospital billing process. Begins with registration during the patient admission process.

care benefit programs were born. Over the years, more insurance companies and government programs came into existence. Regulation of the health care industry was enhanced. Contracts between providers and payers were initiated. The process of submitting charges became more involved than providing services and collecting a fee from the patient. It now involves authorizations and certifications, medical record documentation, coding, participating provider agreements, various payer guidelines, and different reimbursement systems (Figure 5-2). Because of the complexity of this system, hospital billing and coding professionals are required to have knowledge of all these elements to ensure that appropriate reimbursement is obtained and is in compliance with payer guidelines.

PAYER GUIDELINES

Variations in payer guidelines contribute significantly to the complexity of the billing process. Guidelines for the provision of patient care services and claim submission and reimbursement vary from payer to payer. Hospitals are required to comply with all provisions in their participating provider agreements. Compliance with these guidelines is a condition for receiving reimbursement, and legal consequences may result from noncompliance. A review of some common provisions in a participating provider agreement will contribute to an understanding of the relationship between the agreements and the billing process.

Participating Provider Agreements

The hospital's payer mix highlights the various payers that provide coverage to patients seen at the hospital. Medicare, Medicaid, TRICARE, Blue Cross/Blue Shield, Worker's Compensation, automobile insurance, and various managed care plans are generally part of the

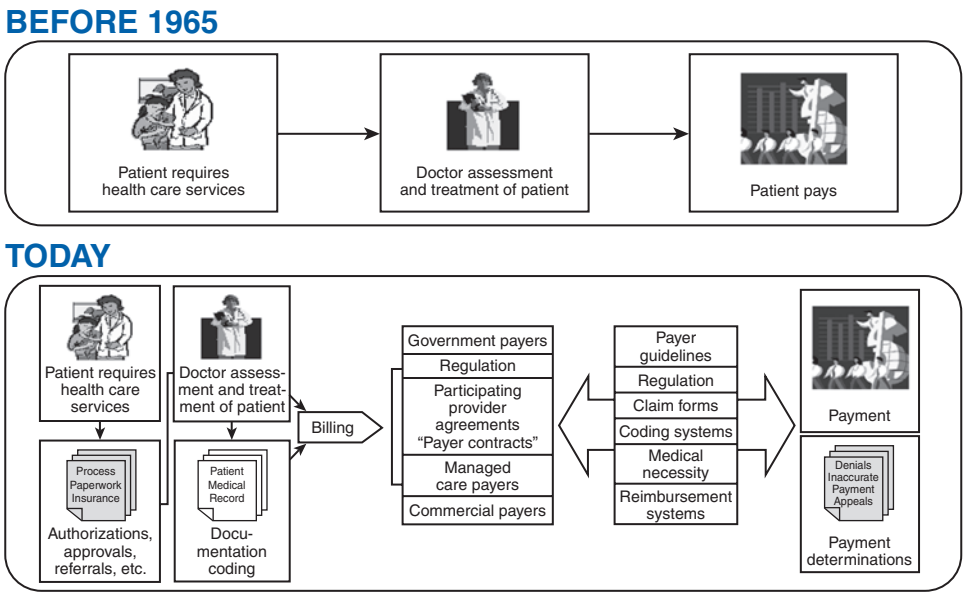


Figure 5-2 The evolution and complexity of the billing process from 1965 to today.

Participating Provider Agreement

This Agreement is entered into by and between **Community Hospital,** contracting on behalf of itself, **ABC Health Insurance,** Inc. and the other entities that are ABC Affiliates (collectively referred to as "ABC") and Community ("Hospital").

This Agreement is effective on the later of the following dates (the "Effective Date"):
i) December 31, 2006 or the first day of the first calendar month that begins at least thirty days after the date when this Agreement has been executed by all parties. Through contracts with physicians and other providers of health care services, ABC maintains one or more networks of providers that are available to Customers. Hospital is a provider of health care services. ABC wishes to arrange to make Hospital's services available to Customers. Hospital wishes to provide such services, under the terms and conditions set forth in this Agreement. The parties therefore enter into this Agreement.

Article I. Definitions

The following terms when used in this Agreement have the meanings set forth below:

1.1 "Benefit Plan" means a certificate of coverage or summary plan description, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 "Covered Service" is a health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

1.3 "Customary Charge" is the fee for health care services charged by Hospital that does not exceed the fee Hospitals would ordinarily charge another person regardless of whether the person is a Customer.

1.4 "Customer" is a person eligible and enrolled to receive coverage from a Payer for Covered Services.

1.5 "Hospital" is a duly licensed and qualified under the laws of the jurisdiction in which Covered Services are provided, who practices as a shareholder, partner, or employee of Hospital, or who practices as a subcontractor of Hospital.

Article II. Representations and Warranties

2.1 Representations and Warranties of Hospital. Hospital, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

(a) Hospital is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

(b) Hospital has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement.

(c) The execution, delivery and performance of this Agreement by acknowledges the **Hospital do not and will not violate or conflict with** (i) the organizational documents of Hospital, (ii) any material agreement or instrument to which Hospital is a party or by which Hospital or any material part of its property is bound, or (iii) **applicable law.**

(d) Hospital has reviewed the Protocols and Payment Policies and acknowledges it is bound by the Protocols and that claims under this Agreement will be paid in accordance with the Payment Policies.

(f) **Each submission of a claim** by Hospital pursuant to this Agreement shall be deemed to constitute the representation and warranty by it to ABC that (i) the representations and warranties of it set forth in this section 2.1 and elsewhere in this Agreement are true and correct as of the date the claim is submitted, (ii) it has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of such claim, (iii) the charge amount set forth on the claim is the Customary Charge and (iv) the claim is a valid claim.

Article III. Applicability of this Agreement

3.1 Hospital's Services. This Agreement applies to services that are medically necessary and reasonable to diagnose and treat customer's condition.

3.2 Services not covered under a Benefit Plan. This Agreement does not apply to services not covered under the applicable Benefit Plan. Hospital may seek and collect payment from a Customer for such services, provided that the Hospital first obtains the Customer's written consent. This section does not authorize Hospital to bill or collect from Customers for Covered Services for which claims are denied or otherwise not paid. That issue is addressed in section 7 of this Agreement.

–1–

Figure 5-3 A participating provider agreement, highlighting provisions regarding patient care services, patient responsibility, billing, and reimbursement.

hospital's payer mix. Hospitals and other providers may elect to enter into a written agreement to participate with several different payers, known as the participating provider agreement. A **participating provider agreement** is a written agreement between the hospital and a payer that outlines the terms and specifications of participation for the hospital and the payer. The next section provides a brief overview of some of the key elements of a participating provider agreement. Figures 5-3 and 5-4 highlight common provisions related to patient care services, patient financial responsibility, billing requirements, and reimbursement.

Patient Care Services

The participating provider agreement outlines the services that are covered for plan members. Participating providers are encouraged to refer patients to providers within the network for the plan. All payers include provisions regarding medical necessity and utilization management protocols that must be followed to ensure that the appropriate reimbursement is received.

Medical Necessity

Providers are statutorily obligated to provide patient care services that are considered medically necessary. All payers have medical necessity guidelines that must

Participating Provider Agreement

3.4 Health Care. Hospital acknowledges that this Agreement does not dictate the health care provided by Hospital or Hospital Professionals, or govern Hospital's or Hospital Professional's determination of what care to provide their patients, even if those patients are Customers. The decision regarding what care is to be provided remains with Hospital and Hospital Professionals and with Customers, and not with ABC or any Payer. Hospital will not allow coverage decisions to determine or influence treatment decisions.

Article V. Duties of Hospital

5.1 Provide Covered Services. Hospital will provide Covered Services that are considered Medically Necessary to Customers at the location specified in section 3.1.

5.2 Cooperation with Protocols. Hospital will cooperate with and be bound by ABC's and Payers' Protocols. The Protocols include but are not limited to all of the following:

1. Hospital will use reasonable commercial efforts to direct Customers only to other providers that participate in ABC's network, except as otherwise authorized by ABC or Payer.
2. Hospital will follow Utilization Management protocols and provide notification for certain Covered Services as defined by ABC or Payer, including the following requirements:
   (a) Provide notification, as further described in the Protocols, prior to a scheduled inpatient admission of a Customer, by telephone, at least five (5) business days prior to the admission; in cases in which the admission is scheduled less than five business days in advance, Hospital will give notice at the time the admission is scheduled.
   (b) With regard to the inpatient admission of a Customer, provide notification, as further described in the Protocols, no later than the next business day, by telephone, if a Customer is admitted on an emergency basis or for observation.
   (c) Obtain required authorizations and certifications and authorizations as outlined in Appendix B.
3. Hospital will obtain customer consent to release Medical Record information.
4. Hospital will follow ABC protocols and fulfill responsibility for the collection of deductible, co-payment or co-insurance amounts outlined in Appendix C as the customer's responsibility.

Article VII. Submission, Processing and Payment of Claims

7.1 Form and content of claims. Hospital must submit claims for Covered Services in a manner and format prescribed by ABC, as further described in the Protocols. Unless otherwise directed by ABC, Hospital shall submit claims using current CMS-1500 or CMS-1450 (UB-92) forms, whichever is appropriate, with applicable coding including, but not limited to, ICD, CPT, Revenue and HCPCS coding. Hospital shall comply with all claim form completion guidelines as outlined in Appendix C.

7.2 Electronic filing of claims. Within six months after the Effective Date of this Agreement, Hospital will use electronic submission for all of its claims under this Agreement that ABC is able to accept electronically

7.3 Time to file claims. All information necessary to process a claim must be received by ABC no more than 90 days from the date that Covered Services are rendered. Payment to the hospital may be denied if the Hospital does not comply with Timely Filing Protocols in Appendix D and does not file a timely claim

7.4 Denial of Claims. Hospitals may appeal claim denials in accordance with Protocols outlined in Appendix E.

7.5 Reimbursement - Payment of claims. **ABC** will pay claims for Covered Services according to the lesser of, the Hospital's Customary Charge or the applicable fee schedule, as provided in Appendix F. Payment determinations are subject to the Payment Policies, and minus any co-payment, deductible, or coinsurance as applicable under the Customer's Benefit Plan. The obligation for payment under this Agreement is solely that of ABC.

7.6 Timely payment. In accordance with provisions in this agreement and legal statutes, ABC is obligated to process claims and remit payment or explanation of non-payment within 30 days of the date the claim is received.

–2–

Figure 5-4 A participating provider agreement, highlighting provisions regarding patient care services, patient responsibility, billing, and reimbursement. *(Modified from National Uniform Billing Committee: UB-04 Proofs, www.nubc.org/public/whatsnew/UB-04Proofs.pdf, 2005.)*

be met as a condition of receiving payment for those services. Medically necessary services are those that are considered reasonable and medically necessary to address the patient's condition based on standards of medical practice. Interpretations of medical necessity based on standards of medical practice vary by payer.

BOX 5-1 ■ KEY POINTS

Medical Necessity

Medically necessary services are those that are considered reasonable and medically necessary in order to address the patient's condition based on standards of medical practice.

Utilization Management

Utilization management involves monitoring and managing health care resources for the purpose of controlling cost and ensuring that quality care is provided. In

BOX 5-2 ■ KEY POINTS

Patient Responsibility

The amount the patient is required to pay in accordance with their health care plan:

- Deductible—Annual amount determined by the payer that the patient must pay before the plan pays benefits
- Co-insurance—A percentage of the approved amount that the patient is required to pay
- Co-payment—A fixed amount determined per service that the patient must pay

accordance with the participating provider agreement, providers are required to follow utilization management requirements outlined in the payer contract. Precertification, prior authorization, and second surgical opinions are examples of utilization management requirements.

Patient Financial Responsibility

Participating provider agreements include information regarding the patient's financial responsibility under the plan. The patient's responsibility is the amount that the patient is required to pay in accordance with his or her health care plan. All health care plans require the patient to pay some portion of the charges for services rendered. As outlined in the patient's plan, the patient's responsibility amount may represent a deductible, coinsurance, or a co-payment amount. The agreement further specifies the participating provider's contractual obligation to collect a specified amount from the patient and the consequences if the provider does not make every attempt to collect the patient's share.

Billing Requirements

Billing requirements are outlined in each participating provider agreement. Billing requirements vary according to plan. Most plans outline provisions in the participating provider agreement regarding documentation, coding, claim form requirements, timely filing, and the appeals process.

Reimbursement

Participating provider agreements contain provisions regarding timely processing of claims and reimbursement. Reimbursement is provided for services covered under the patient's plan that are considered medically necessary. The agreement also explains how payment determinations are made and what reimbursement method will be utilized to calculate payment for covered services.

It is important to remember that reimbursement for services provided to plan members is contingent on the provider's compliance with plan terms and specifications. It is critical for hospital personnel involved in the billing process to have an understanding of the terms in the provider agreement to ensure compliance with program specifications and to optimize reimbursement. Participating provider agreements will be discussed further in Chapters 11 to 13. To enhance our understanding of the complexity of the billing process, the following section provides a basic review of the payer variations in claim form requirements and reimbursement methods utilized to determine payments to the hospital.

Claim Forms

The purpose of the claim form is to submit charges to third-party payers. A **third-party payer** is an organization or other entity that provides coverage for medical services, such as insurance companies, managed care plans, Medicare, and other government programs. All the information collected and recorded on the patient account and in the patient record is utilized to complete the claim form.

FOR IMMEDIATE RELEASE

NUBC Announces 45-day Public Comment Period, ending February 1, 2005, for the New UB-04 Data Set and Form

December 17, 2004

The National Uniform Billing Committee (NUBC) announced today the opening of a 45-day public comment period, ending February 1, 2005, for the new UB-04 data set and form to replace the UB-92. The UB-04 contains a number of improvements and enhancements that resulted from nearly four years of research. The NUBC is conducting this final survey to better understand the timelines and transition issues surrounding the implementation of the UB-04. Those wishing to comment on the UB-04 are encouraged to visit the NUBC website http://www.nubc.org/ for further information.

There, you will find the survey, a copy of the UB-04 form, and other supporting information that explains the differences between the current UB-92 and the new UB-04. The NUBC will review the survey results at its next meeting in Baltimore, Maryland on February 22nd and 23rd, and will deliberate on an implementation schedule for the UB-04.

The NUBC maintains the billing data set known as the Uniform Bill (UB) designed for the institutional health care provider. The NUBC is one of four organizations named in the 1996 HIPAA Administrative Simplification legislation for a consultative role in establishing administrative standards for health care. The NUBC is a signatory to a Memorandum of Understanding with five other organizations to collectively serve as the Designated Standard Maintenance Organizations (DSMO) to the HIPAA Transaction Standard Implementation Guides as designated by the Department of HHS.

The National Uniform Billing Committee (NUBC) is a voluntary organization founded in 1975. The members of the NUBC include representatives from major provider, payer, health researchers, and other organizations representing vendors, billing professionals, and electronic standard developers.

http://www.nubc.org/public/whatsnew/NUBC%20ANNOUNCES%20APPROVAL%20OF%20UB.pdf

NUBC ANNOUNCES APPROVAL OF UB-04

Following the close of a public comment period and careful review of comments received, the National Uniform Billing Committee approved the UB-04 as the replacement for the UB-92 at its February 2005 meeting.

Receivers (health plans and clearinghouses) need to be ready to receive the new UB-04 by March 1, 2007.

Submitters (health care providers such as hospitals, skilled nursing facilities, hospice, and other institutional claim filers) can use the UB-04 **beginning March 1, 2007,** however, they will have a transitional period between March 1, 2007 and May 22, 2007 where they can use the UB-04 or the UB-92.

Starting May 23, 2007 all institutional paper claims must use the UB-04; the UB-92 will no longer be acceptable after this date.

The final image of the UB-04 form, a summary of the public comments/NUBC responses, and information on how to obtain a beta version of the UB-04 Data Specifications Manual will be posted to the NUBC website by the end of March 2005.* *Note: Still in process as of 4/8/05.

Figure 5-5 The National Uniform Billing Committee announces replacement of the CMS-1450 (UB-92) with the UB-04 in 2007.

There are two universally accepted claim forms utilized for submission of charges to various payers– the CMS-1500 and the CMS-1450 (UB-92). These forms were formerly called the HCFA-1500 and the HCFA-1450 (UB-92). The Health Care Financing Administration (HCFA) changed their name to the Centers for Medicare and Medicaid Services (CMS), and the forms are now referred to as the CMS-1500 and CMS-1450.

The CMS-1450 (UB-92) is scheduled to be replaced by the UB-04. The National Uniform Billing Committee (NUBC) announced the period for public comment, the process that will be followed after all comments are in, and finally the scheduled implementation dates (Figure 5-5). The release indicates that

Following the close of a public comment period and careful review of comments received, the National Uniform Billing Committee approved the UB-04 as the replacement for the UB-92. Receivers (health plans and clearinghouses) need to be ready to receive the new UB-04 by March 1, 2007. Submitters (health care providers such as hospitals) can use the UB-04 beginning March 1, 2007; however, they will have a transitional period between March 1, 2007 and May 22, 2007 where they can use the UB-04 or the UB-92.*

*From NUBC Web page: http://www.nubc.org/public/whatsnew/UB-04Proofs.pdf.

BOX 5-3 ■ KEY POINTS

NUBC Announces UB-04 Scheduled to Replace the CMS-1450 (UB-92)

Receivers

Health plans and clearinghouses need to be ready to receive the new UB-04 by March 1, 2007

Submitters

Health care providers such as hospitals can use the UB-04 beginning March 1, 2004; however, they will have a transitional period between March 1, 2007 and May 22, 2007 in which they can use the UB-04 or the UB-92

This chapter will discuss the CMS-1450 (UB-92) as it relates to the hospital billing process. Claim forms will be discussed further in Chapter 10.

Claim form requirements vary by payer, and the participating provider agreement defines what claim form should be used to submit charges. The CMS-1500 is generally required for submission of charges related to physician and outpatient services (Figure 5-6). The CMS-1450 (UB-92) is generally used to submit facility charges for services provided in the hospital. This form is commonly referred to as the UB-92 or just UB (Figure 5-7). Payers specify the claim form required for submission of charges based on the following service categories: outpatient, inpatient, and non-patient. The following section provides an overview of which claim

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EXAMPLE ONLY

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Figure 5-6 CMS-1500 is the universally accepted claim form utilized for submission of charges for physician and outpatient services.

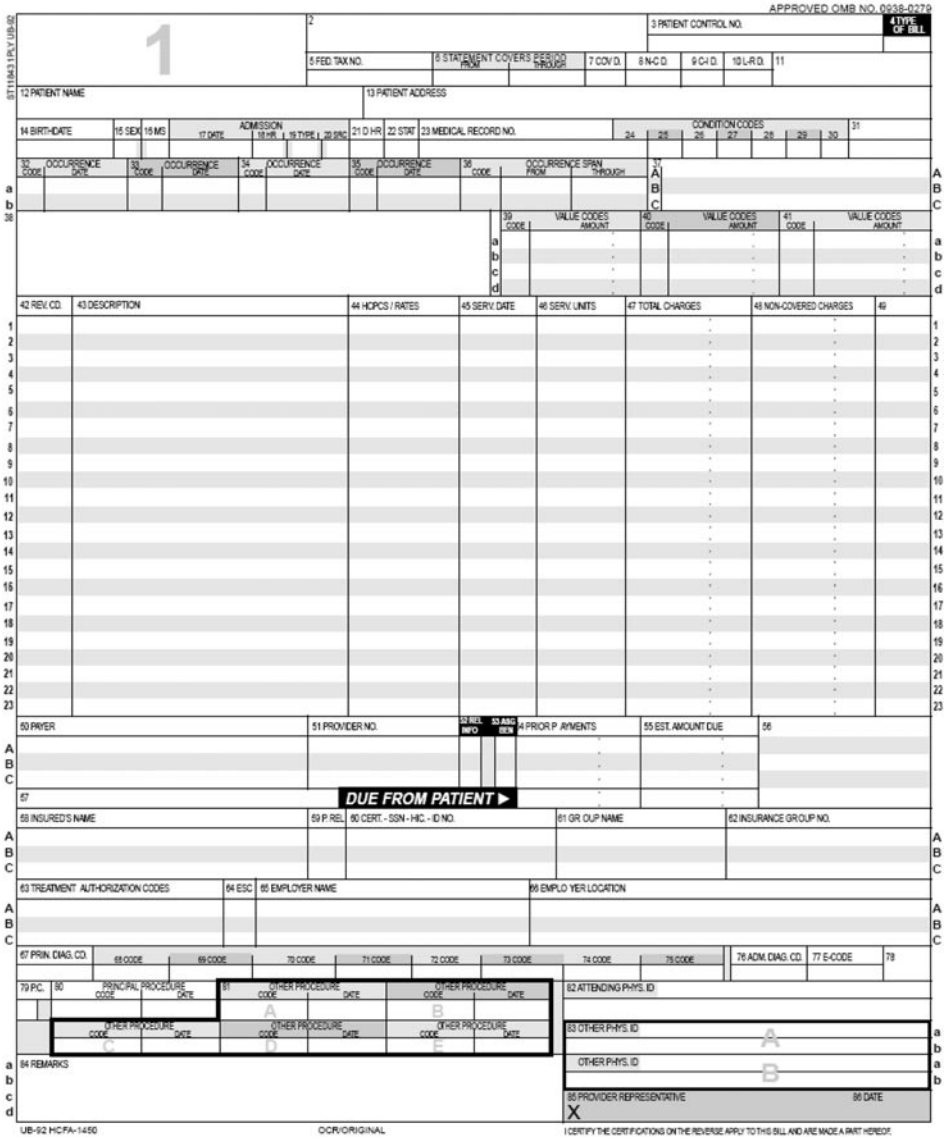


Figure 5-7 UB-92 is the universally accepted claim form utilized for submission of facility charges.

form is required for these service types, as shown in Table 5-1.

Outpatient

Hospital outpatient services are generally submitted to payers utilizing the UB-92; however, some payers may require the CMS-1500. Outpatient services include Ambulatory Surgery, Emergency Department, other outpatient department services, and clinic services.

Ambulatory Surgery

Ambulatory surgery may be performed in a hospital Ambulatory Surgery Department or in a hospital-based certified Ambulatory Surgery Center (ASC). Ambulatory surgery is considered an outpatient service because the patient is released the same day the procedure is performed. Ambulatory surgery services performed in a hospital are generally submitted utilizing the UB-92. Some payers may require ambulatory surgery services performed in a certified ASC to be submitted utilizing the CMS-1500.

Emergency Department

Facility charges for Emergency Department visits are generally submitted utilizing the UB-92. Again, some payers may require the CMS-1500. Emergency Room (ER) physician charges are not billed by the hospital. The ER physician will submit charges for services he or she provides on the CMS-1500. Emergency Department charges are included on the inpatient claim utilizing the UB-92 when the patient is admitted as an inpatient from the ER.

Ancillary Departments

Charges for services provided by ancillary departments such as Radiology, Laboratory, or Physical, Occupa-

TABLE 5-1 Claim Form Variations

Hospital Service Categories of "Facility Charges"	CMS-1500	UB-92	Variations
Outpatient			
Ambulatory surgery performed in a hospital outpatient surgery department		X	Some payers require ambulatory surgery charges to be submitted on the CMS-1500
Ambulatory surgery performed in a certified ambulatory surgery center (ASC)		X	
Emergency Department		X	Some payers require outpatient department charges to be submitted on the CMS-1500
Ancillary departments: Radiology; Laboratory; Physical, Occupational and Speech Therapy		X	Some payers require outpatient department charges to be submitted on the CMS-1500
Other outpatient services: Infusion Therapy and Observation		X	
Durable medical equipment: provided on an outpatient or inpatient basis	X		
Hospital-based primary care office	X		Physician services may be included if employed by the hospital
Other hospital-based clinic	X		Physician services may be included if employed by the hospital
Inpatient			
All services and items provided by the hospital during the inpatient stay			Emergency Department charges are included on the inpatient claim when the patient is admitted from the ER
Non-patient		X	
A specimen received and processed; the patient is not present		X	Some payers require outpatient department charges to be submitted on the CMS-1500

UB-92 is utilized to submit charges to Medicare Part A.
CMS-1500 is utilized to submit charges to Medicare Part B.

tional, and Speech Therapy on an outpatient basis are generally submitted utilizing the UB-92. Infusion therapy and observation services are also submitted on the UB-92.

Hospital-Based Primary Care Office or Hospital-Based Clinic

Charges for services provided in a hospital-based primary care office are generally submitted on the CMS-1500. These charges will include the physician services if the physician is an employee of or under contract with the hospital. Charges for services provided in a hospital-based clinic are generally submitted on the CMS-1450. These charges do not include the physician services unless the physician is an employee of the hospital.

Inpatient

Inpatient charges are submitted on a UB-92. It is important to remember that if the patient is seen in the Emergency Department and later admitted to the hospital as an inpatient, the Emergency Department charges will be included on the UB-92 for the inpatient claim.

Non-patient

Non-patient services are those required by a laboratory when a specimen is received and processed when the patient is not present. Non-patient services are generally submitted on a UB-92.

Some payers define claim form requirements based on the part of the plan that covers specific services. For example, the UB-92 is used to submit charges covered under Medicare Part A. The CMS-1500 is used to submit charges covered under Medicare Part B. Durable medical equipment is covered under Medicare Part B; therefore, charges for these items are submitted on the CMS-1500.

Payer guidelines also dictate required methods of submission and claim completion requirements. Claims can be submitted manually by sending a paper claim or via electronic data interchange (EDI). Claim form elements will be discussed later in this chapter. The

BOX 5-4 ■ KEY POINTS

Medicare Claim Form Requirement

CMS-1500

Charges submitted for payment under Medicare Part B

UB-92

Charges submitted for payment under Medicare Part A

purpose of this section is to show the relationship between payer guidelines and the billing process.

Clean Claim

The hospital's major goal when submitting claims to third-party payers is to submit a clean claim the first time. A **clean claim** is one that does not need to be investigated by the payer. A clean claim passes all internal billing edits and payer-specific edits, and is paid without need for additional intervention.

Examples of claims that do not meet the clean claim status include:

- Claims that need additional information
- Claims that need Medicare secondary payer (MSP) screening information
- Claims that need information to determine coverage
- Claims that do not pass payer edits

Hospital billing and coding professionals carefully review claim information to ensure submission of a clean claim. It is necessary for hospital billing and coding professionals to have an understanding of payer guidelines in order to ensure compliance and prevent delay in payments. Payer guidelines outline the reimbursement method utilized to determine payment for services.

Reimbursement Methods

Reimbursement is the term used to describe the amount paid to the hospital by patients and third-party payers for services rendered. The purpose of the billing process is to obtain the appropriate reimbursement within a reasonable period after the services are rendered. Most reimbursement for hospital services is received from third-party payers. Payers utilize various reimbursement methods to determine the payment amount for a service or item. Reimbursement methods can be categorized as traditional methods, fixed payment methods, and Prospective Payment Systems (PPS). Table 5-2 provides definitions for the various payment methods.

BOX 5-5 ■ KEY POINTS

Clean Claim

A claim that does not need to be investigated by the payer. A clean claim passes all internal billing edits and payer-specific edits and is paid without need for additional intervention.

Traditional Methods

Historically, payments for health care services were primarily based on charges submitted. Insurance companies and government programs processed payments for services utilizing four reimbursement methods—fee-for-service, fee schedule, percentage of accrued charges, and usual, customary, and reasonable.

Fee-for-service

Fee-for-service is a reimbursement method that provides payment for hospital services based on an established fee schedule for each service.

Fee Schedule

Fee schedule is a listing of established, allowed amounts for specific medical services and procedures.

Percentage of Accrued Charges

Percentage of accrued charges is a reimbursement method that calculates payment for charges accrued during a hospital stay. Payment is based on a percentage of accrued charges.

Usual, Customary, and Reasonable (UCR)

Reimbursement is based on a review of the usual and customary fee to determine the fee that is considered reasonable.

1. Usual fee—the fee usually submitted by the provider for a service or item
2. Customary fee: —the fee that providers of the same specialty in the same geographic area charge for a service or item
3. Reasonable fee: —the fee that is considered reasonable

(Figure 5-8) illustrates examples of payment calculations utilizing traditional payment methods—fee-for-service, percentage of accrued charges, fee schedule, and UCR.

Efforts to control the rising costs of health care changed reimbursement methods to systems involving predetermined amounts paid to hospitals. The advent of managed care also brought with it fixed payment methods. The following are reimbursement methods in which the payment is a fixed amount: capitation, case rate, contract rate, flat rate, per diem, and relative value scale.

Fixed Payment Methods

Capitation

Capitation is a reimbursement method utilized that provides payment of a fixed amount, paid per member

TABLE 5-2 Reimbursement Methods Defined

Traditional	
Fee-for-service	A reimbursement method where hospitals are paid for each service provided, based on an established fee schedule
Fee schedule	A listing of established allowed amounts for specific medical services and procedures.
Percentage of accrued charges	A reimbursement method that calculates payment for charges accrued during a hospital stay. Payment is based on a percentage of approved charges.
Usual, customary, and reasonable (UCR)	Reimbursement is based on review of 3 fees: (1) usual fee, the fee usually submitted by the provider a service or item; (2) customary fee, fees that providers of the same specialty in the same geographic area charge for a service or item; (3) reasonable fee, the fee that is considered reasonable
Fixed Payment	
Capitation	Reimbursement method where payment is a fixed amount paid per member per month. Capitation methods are generally utilized to provide reimbursement for primary care physician services and other specified outpatient services provided to managed care plan members.
Case rate	A set rate is paid to the hospital for the case. The payment rate is based on the type of case and resources utilized to treat the patient.
Contract rate	Reimbursement to the hospital is a set rate as agreed to in the contract between the hospital and the payer.
Flat rate	Reimbursement is a set rate for a hospital admission regardless of charges accrued.
Per diem	The hospital is paid a set rate per day rather than payment based on total accrued charges.
Relative value scale (RVS)	A relative value that represents work, practice expense, and cost malpractice insurance assigned to professional services.
Prospective Payment System (PPS)	
Ambulatory payment classification (APC)	An Outpatient Prospective Payment System (OPPS) that is utilized by Medicare and other government programs to provide reimbursement for hospital outpatient services including ambulatory surgery performed in a hospital outpatient department. The hospital is paid a fixed fee based on the procedure(s) performed.
Diagnosis Related Group (DRG)	An Inpatient Prospective Payment System (OPPS) that is utilized by Medicare and other government programs to provide reimbursement for hospital inpatient cases. The hospital is paid a fixed fee based on the patient's condition and relative treatment.
Resource-based relative value scale (RBRVS)	A reimbursement method implemented under PPS for Medicare and other government programs to provide reimbursement for physician and outpatient services. A unit value is assigned to each procedure. The unit value represents physician time, skill, practice overhead, and malpractice.

BOX 5-6 ■ KEY POINTS

Traditional Payment Methods

Fee-for-service
Fee schedule
Percentage of accrued charges
Usual, customary, and reasonable (UCR)

per month. Capitation methods are generally utilized to provide reimbursement for primary care physician services and other specified outpatient services provided to managed care plan members.

Case Rate

For case rate, reimbursement is a set rate paid to the hospital for the case. The payment rate is based on the type of case and resources utilized for the case.

Fee-for-Service

Charges Submitted		Established Fee (Reimbursement)
Level IV ER Visit	$575.00	$475.00
Chest X-Ray	$135.00	$110.00
CBC	$95.00	$95.00

Payer determines payment for each charge

Fee Schedule

Charges Submitted		Allowed Amount (Reimbursement)
Level IV ER Visit	$575.00	$500.00
Chest X-Ray	$135.00	$120.00
CBC	$95.00	$65.00

Payer determines payment for services based on a fee schedule

Percentage of Accrued Charges

Accrued Charges Submitted		Approved/ Eligible Amount	Payment 80%
Level IV ER Visit	$575.00	$475.00	$380.00
Chest X-Ray	$135.00	$110.00	$88.00
CBC	$95.00	$95.00	$76.00

Payer determines payment based on a percentage of approved amounts for charges accrued

Usual, Customary, and Reasonable (UCR)

Charges Submitted		Usual	Customary
MRI	$575.00	$475.00	$380.00
Payment Amount (Reasonable Fee)			$380.00

Payer formula for reasonable amount varies (in this case the reasonable amount is lower than the usual and customary charges)

Figure 5-8 Examples of traditional payment methods.

Contract Rate

For contract rate, reimbursement to the hospital is a set rate as agreed to in a contract between the hospital and the payer.

Flat Rate

For flat rate, reimbursement is a set rate for the hospital admission regardless of charges accrued.

Per Diem

For per diem, the hospital is paid a set rate per day rather than payment based on the total of accrued charges.

Relative Value Scale (RVS)

RVS is a relative value that represents work, practice expense, and the cost of malpractice insurance is assigned to professional services.

Figure 5-9 illustrates examples of some of the most common fixed payment methods utilized to reimburse hospitals for services (case rate, contract rate, flat rate, and per diem).

BOX 5-7 ■ KEY POINTS

Fixed Payment Methods

Capitation
Case rate
Contract rate
Flat rate
Per diem
Relative value scale (RVS)

The government became one of the largest payers of health care services with the establishment of the Medicare and Medicaid programs in 1965. Over the following 30 years, due to the continued growth in the aged population and the rising cost of health care, the government found it necessary to devise reimbursement methods that provided fixed payment amounts for health care services. **Prospective Payment Systems (PPS)** were implemented to provide reimbursement for inpatient, outpatient and professional services provided to members of government health care programs. A PPS is a method of determining reimbursement to health care providers based on predetermined factors, not on individual services. Today, members of govern-

BOX 5-8 ■ KEY POINTS

Prospective Payment Systems (PPS)

Ambulatory payment classification (APC)
Diagnosis Related Group (DRG)
Resource-based relative value scale (RBRVS)

Case Rate

Charges Submitted		Case Rate (Reimbursement)
Arthroscopic Surgery	$3,913.23	$2,500.00

Payer reimbursement based on a rate for the arthroscopy case

Contract Rate

Charges Submitted		Contract Rate (Reimbursement)
Hospital Inpatient Stay 3 days Peripheral Vascular Shunt	$27,780.19	$23,613.16

Payer determines payment for services based on a fee schedule

Flat Rate

Charges Submitted		Flat Rate (Reimbursement)
Hospital Inpatient Inpatient Days 9 Respiratory Failure Obstructive Chronic Bronchitis	$22,548.11	$19,750.00

Payer determines payment based on flat rate

Per Diem

Charges Submitted	Per Diem Rate $5,450 per day	(Reimbursement)
Hospital Inpatient Stay 3 days Peripheral Vascular Shunt	$27,780.19	$16,350.00

Payer determines payment based on a per diem rate of $5,450.00 per day

Figure 5-9 Examples of fixed payment methods.

ment sponsored plans who are provided with hospital services are paid based on different prospective payment systems.

Prospective Payment Systems

The Inpatient Prospective Payment System (IPPS) was established as mandated by the Tax Equity and Fiscal Responsibility Act (TEFRA) in 1983 to provide reimbursement for acute hospital inpatient services. The system implemented under IPPS is known as Diagnosis Related Groups (DRG).

Diagnosis Related Group

DRG is the IPPS utilized by Medicare and other government programs to provide reimbursement for hospital inpatient services. Under the DRG system, the hospital is paid a fixed fee based on the patient's condition and relative treatment. DRG assignment is determined based on the principal diagnosis, secondary diagnosis, significant procedures, complications and comorbidities, age and sex of the patient, and discharge status of the patient.

Resource-based relative value scales (RBRVSs) were implemented over a 5-year period beginning January 1992 to provide reimbursement for services provided by physicians.

BOX 5-9 ■ KEY POINTS

Inpatient Prospective Payment Systems (IPPS)

Implemented in 1983 to provide reimbursement for hospital inpatient services

- Diagnosis Related Group (DRG)

BOX 5-10 ■ KEY POINTS

Other Prospective Payment Systems

Implemented over a 5-year period beginning January 1992 to provide reimbursement for physician and outpatient services

- Resource-based relative value scale (RBRVS)

BOX 5-11 ■ KEY POINTS

Outpatient Prospective Payment Systems (OPPS)

Implemented in 2000 to provide reimbursement for hospital outpatient services

- Ambulatory payment classification (APC)

Resource-Based Relative Value Scale (RBRVS)

RBRVS is a payment method utilized by Medicare and other government programs to provide reimbursement for physician and some outpatient services. The RBRVS system consists of a fee schedule of approved amounts calculated based on relative values. A relative value unit (RVU) is assigned to each procedure. The RVU represents physician time and skill, practice overhead, and malpractice insurance. The RVU is used in a formula that multiplies the RVU by a geographic adjustment factor (GAF) and a monetary conversion factor (CF).

CMS implemented the Outpatient Prospective Payment System (OPPS), effective August 2000. The OPPS provides reimbursement for hospital outpatient services. The system implemented under OPPS is known as ambulatory payment classification (APC).

Ambulatory Payment Classification (APC)

APC is the OPPS utilized by Medicare and other government programs to provide reimbursement for hospital outpatient services. Under the APC system, the hospital is paid a fixed fee based on the procedure(s)

Ambulatory Payment Classification (APC)

Procedures Reported	APC Group	Payment Rate
#1 Cystourethroscopy	0160	$375.39
#2 MRA, Neck with contrast	0284	$388.28
#3 Emergency Department Visit Complex	0612	$226.30

Payer determines reimbursement based on payment rate for APC Group assigned to each procedure

Diagnosis Related Group (DRG)

Inpatient admission

Principal diagnosis	Skull Fracture
Secondary diagnosis	None
Principal procedure	Craniotomy
Age	18
Gender	Male
Length of stay	3 days
Charges submitted	$9,684.32

DRG	Payment Rate
2	$6,782.45

Payer determines reimbursement based on the payment rate for DRG Group assigned

Figure 5-10 Examples of APC and DRG, both of which are PPS reimbursement methods.

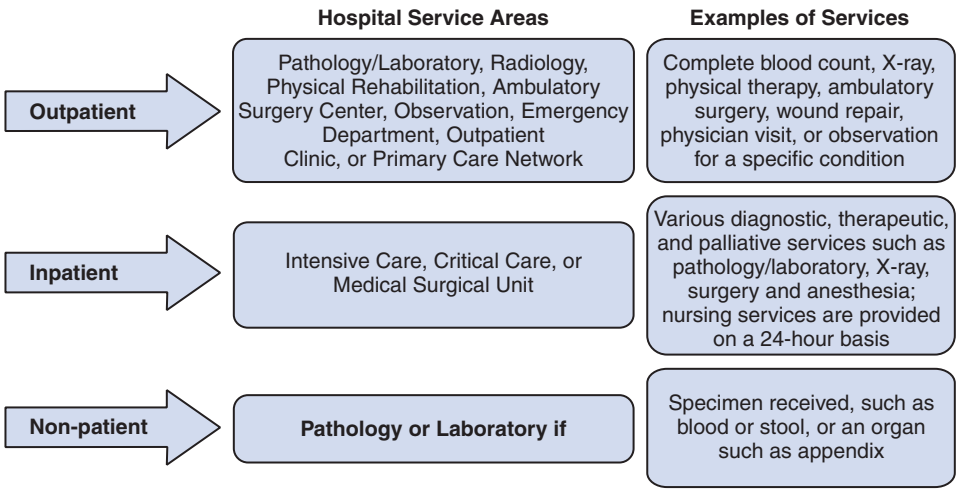


Figure 5-11 Hospital services are provided on an outpatient, inpatient, or non-patient basis. Note that professional services are not billed by the hospital unless the provider is employed by the hospital.

BOX 5-12 ■ KEY POINTS

Payer Types

Government Programs

Medicare, TRICARE, and Medicaid

Commercial Payers

BC/BS, Aetna, Cigna, and other insurance plans that do not have a contract with the provider

Managed Care Plans

Plans offered by various payers

performed. Services reimbursed under APC include ambulatory surgical procedures, chemotherapy, clinic visits, diagnostic services and tests, Emergency Department visits, implants, and other outpatient services.

PPSs were implemented to provide a preestablished payment amount for reimbursement to providers for services rendered to members of government health care programs. Figure 5-10 illustrates payment determination utilizing the DRG and APC reimbursement systems. PPSs will be discussed further in Chapter 13.

As discussed previously, hospitals provide various services including outpatient, inpatient, non-patient, and professional services, as illustrated in Figure 5-11. Reimbursement methods vary based on many factors, such as payer category and the type of services provided. Hospital billing professionals strive to achieve an understanding of the various reimbursement methods utilized to ensure that appropriate payment is provided for services rendered. It is also important to understand guidelines relating to each of the different payment methods. Three major categories of third-party payers are government programs, commercial payers, and managed care plans. Each of the payer types listed utilizes various methods of reimbursement for outpatient, inpatient, non-patient, and professional services.

Reimbursement Methods by Service Category

Outpatient Services

Outpatient services are those that are performed on the same day the patient is released or sent home. Examples of outpatient services are ambulatory surgery and various diagnostic and therapeutic procedures performed by hospital departments such as Radiology and Laboratory.

Ambulatory Surgery

Ambulatory surgery services can be performed in a hospital outpatient surgery department or in a certified ambulatory surgery center (ASC). The surgery is performed and the patient is discharged the same day. Ambulatory surgery services are provided in accordance with physician orders. Charges related to the ambulatory surgery are submitted to the payers for reimbursement. Ambulatory surgery services are reimbursed utilizing various methods including APC, case rate, contract rate, fee-for-service, fee schedule, and percentage of accrued charges.

Inpatient Services

Inpatient services are provided when a patient is admitted to the hospital with the expectation that he or she will be in the hospital for more than 24 hours. Inpatient admissions and services required are provided in accordance with the admitting physician's orders. All charges incurred during the hospital stay are submitted to the payers for reimbursement. Inpatient services are reimbursed utilizing various methods including DRG, case rate, contract rate, fee-for-service, flat rate, percentage of accrued charges, or per diem.

Non-Patient Services

Non-patient services are provided when a specimen is received by the Laboratory or Pathology Department for processing. Specimens from within the hospital as

well as provider offices are received for testing. A specimen may be blood or other body fluid, stool, or tissue. Non-patient services are reimbursed utilizing various methods including RBRVS, fee-for-service, fee schedule, relative value scale, UCR, capitation, or a contract rate.

Professional Services

Professional services are patient care services provided by physicians and other non-physician clinical providers such as a physician assistant. Evaluation and management, surgery, and the professional component of a radiology procedure are examples of professional services. Hospitals do not bill professional services unless the physician providing the service is employed by the hospital. Professional services are reimbursed utilizing various methods including RBRVS, fee-for-service, fee schedule, relative value scale, UCR, capitation, or a contract rate.

Some of the most common reimbursement methods utilized by government programs, commercial payers, and managed care plans are outlined in Table 5-3 for outpatient, inpatient, non-patient, and professional services. Reimbursement methods will be discussed further as they relate to each of the payer categories later in this text.

Reimbursement Methods by Payer Category

Government Programs

Medicare, TRICARE, Medicaid, and other government payers utilize reimbursement methods implemented under PPS: RBRVS, APCs, and DRGs. The following is an outline of common reimbursement methods used by government payers for outpatient, inpatient, professional, and non-patient services.

Outpatient Services

APCs provide payment for outpatient services performed in the hospital, such as ambulatory surgery performed in a hospital outpatient surgery department, X-rays, and laboratory procedures.

Inpatient Services

DRGs are utilized to reimburse hospitals for inpatient cases.

Professional and Non-Patient Services

RBRVS is a reimbursement method to pay for professional services performed by physicians and non-patient services.

Commercial Payers

Blue Cross/Blue Shield, Aetna, Metropolitan, Cigna, and other payers with whom the providers are not participating are considered commercial payers. Commercial payers utilize various reimbursement methods, including fee schedule, UCR, case rate, per diem, and contract rate. The following is an outline of common reimbursement methods used by commercial payers for outpatient, inpatient, professional, and non-patient services.

TABLE 5-3 Reimbursement Methods by Payer Category*

	Service Level and Reimbursement Methods		
Payer Category	**Hospital Outpatient Services**	**Hospital Inpatient Services**	**Hospital Professional and Non-Patient Services**
Government programs Medicare, TRICARE, Medicaid (implemented under Prospective Payment	Ambulatory payment classification (APC)	Diagnosis Related Group (DRG)	Resource-based relative value scale (RBRVS)
PPS method basis	Hospital is reimbursed a set fee based on the APC payment rate for the procedure performed	Hospital is reimbursed a set fee based on DRG payment rate for the patient's condition and related treatment.	A relative value is assigned to each CPT code, which represents physician time, skill, and overhead
Commercial and other third-party payers Blue Cross/Blue Shield, Aetna, Humana, Worker's compensation	Case rate Contract rate Fee-for-service Fee schedule Percentage of accrued charges	Case rate Contract rate Fee-for-service Flat rate Percentage of accrued charges Per diem	Fee-for-service Fee schedule Relative value scale (RVU) Usual, customary, and reasonable (UCR)
Managed care plans	Case rate Contract rate	Case rate Contract rate	Capitation Contract Fee schedule

*Many payers are adopting prospective payment–type reimbursement methods.

Outpatient Services

Outpatient services performed in a hospital are reimbursed utilizing one of the following reimbursement methods—case rate, contract rate, fee-for-service, fee schedule, or percentage of accrued charges.

Inpatient Services

All charges accrued during the inpatient hospital stay are submitted to payers, and reimbursement is determined utilizing various reimbursement methods such as case rate, contract rate, fee-for-service, flat rate, percentage of accrued charges, and per diem.

Professional and Non-Patient Services

Services performed by physicians, other health care professionals, and non-patient services are reimbursed using a fee-for-service, fee schedule, relative value scale, or UCR. Two of the most common are fee schedule and UCR.

Managed Care Plans

Government programs and many insurance carriers offer managed care plans. Managed care plans are designed to provide health care services efficiently through the application of utilization management techniques to monitor and control the utilization of health care services by their members. Utilization management techniques will be discussed in later chapters. Managed care plans utilize various reimbursement methods such as contract rate and capitation. The managed care contract between the payer and the provider will outline the method of payment utilized to determined reimbursement for services or items.

Outpatient Services

Services provided on an outpatient basis such as ambulatory surgery, X-rays, and laboratory services are also reimbursed utilizing case rate or contract rate methods to determine payment.

Inpatient Services

Inpatient services are often reimbursed utilizing case rate and contract rate reimbursement methods.

Professional and Non-Patient Services

Professional and non-patient services may be reimbursed by managed care plans utilizing a capitation, contract rate, or fee schedule method for reimbursement.

CHARGE DESCRIPTION MASTER (CDM)

A critical component of the entire billing process in the hospital environment is the CDM. Hospitals provide a wide range of services and items to patients on an outpatient, inpatient, and non-patient basis in various areas of the hospital such as the Radiology or Laboratory Department or on the floor or unit (Figure 5-11). From the time a patient arrives at the hospital, a complex network of highly specialized personnel within the hospital becomes involved in the patient's stay in a clinical and/or administrative capacity.

As discussed in Chapter 4, the collection of information, assessment of the patient's condition, and provision of diagnostic and therapeutic services require a system designed to allow storage, maintenance, and access to the data. The data collected include services and items provided to the patient during the visit. The system must also accommodate an inventory of charges for procedures, services, items, and drugs provided during the patient's stay. Information regarding the patient's condition, diagnostic and therapeutic treatments, and responses are recorded in the patient record. Services and items are also recorded in the patient record.

The CDM, also known as the chargemaster, is the computerized system utilized by hospitals to inventory and record services and items provided in various locations in the hospital during a patient stay. The chargemaster is designed to capture charges for all services and items provided for the purpose of posting charges to the patient's account and billing those charges on the claim form. The chargemaster is usually automated and linked with the billing system. Items in the chargemaster are generally organized by department. Each item in the chargemaster is associated with the appropriate procedure code, revenue code, service or item description, charge, and other information required for the submission of the hospital's facility charges. To provide a better understanding of items in the chargemaster, we will first explore categories of service provided in the hospital.

Services and Items Billed by the Hospital

The hospital provides a variety of services and items during a patient's visit. It is critical for the hospital's financial stability to capture charges for services and items provided during the patient stay. An outline of hospital facility charges that are captured through the chargemaster is provided in Figure 5-12. It is important for hospital personnel to understand the difference between facility and professional charges.

Facility Charges

Hospitals submit facility charges for patient care services provided on an outpatient basis such as laboratory tests, X-rays, or ambulatory surgery. **Facility charges** represent cost and overhead for providing patient care services, which include space, equipment, supplies, drugs and biologicals, and technical staff. Facility charges

TEST YOUR Knowledge

BOX 5-1

PURPOSE OF THE BILLING PROCESS

1. Provide a definition of the hospital billing process and explain the purpose of the process.
2. List the functions involved in the billing process.
3. Discuss the claims process and its relationship to the billing process.
4. Participating provider agreements outline the terms and specifications of participation for hospitals and payers. List four common provisions covered in these agreements that relate to the billing process.
5. Define medical necessity.
6. The amount the patient is responsible to pay may represent a _____, _____, or _____.
7. What is the purpose of a claim form?
8. Identify two claim forms that are currently utilized by a hospital to submit charges to various payers.
9. Provide an explanation of what claim form is generally used for hospital outpatient and inpatient services.
10. Outline four examples of claims that do not meet clean claim status.
11. Define reimbursement.
12. List four examples of traditional reimbursement methods.
13. Describe the percentage of accrued charges reimbursement method.
14. Explain the difference between traditional and fixed payment methods.
15. Discuss what IPPS is, when it was implemented, and why.
16. State what OPPS is, when it was implemented, and why.
17. Explain the difference between the APC and DRG reimbursement methods.
18. Provide a listing of the reimbursement methods utilized by government programs to pay hospitals for outpatient and inpatient services.
19. Identify six reimbursement methods commonly used by commercial payers for inpatient services.
20. Outline reimbursement methods commonly utilized by managed care plans for outpatient and inpatient hospital services.

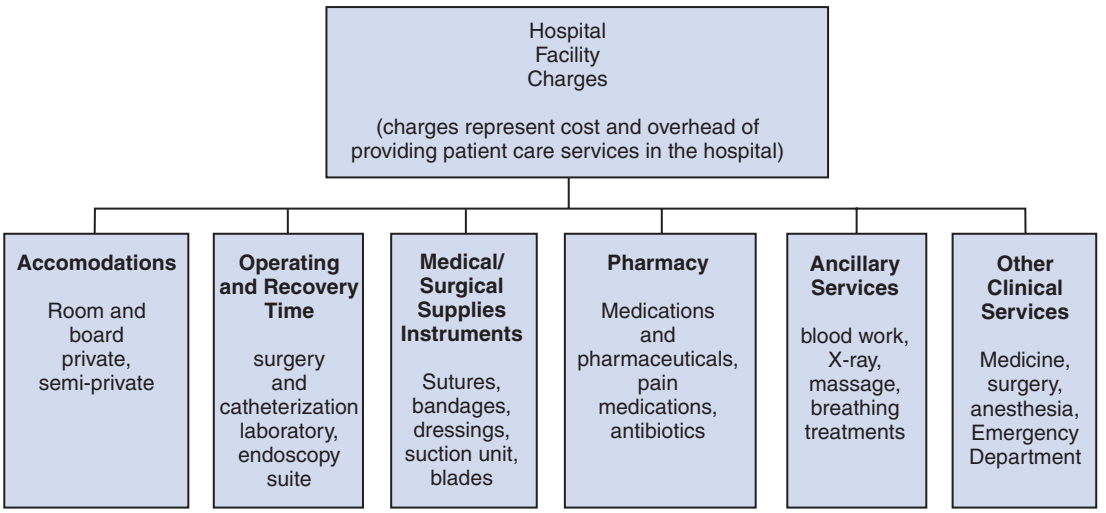


Figure 5-12 Categories of hospital facility charges.

represent the technical component of the services. They are captured through the chargemaster and submitted on the UB-92.

Professional Charges

Professional charges represent the professional component of patient care services performed by physicians and other non-physician clinical providers. The professional component of surgery, anesthesia administration, interpretation of an X-ray, or office visit is billed by the physician. Professional services may be billed by the hospital if the physician is an employee or under contract with the hospital. Professional charges are submitted on the CMS-1500.

TABLE 5-4 Hospital Service Categories

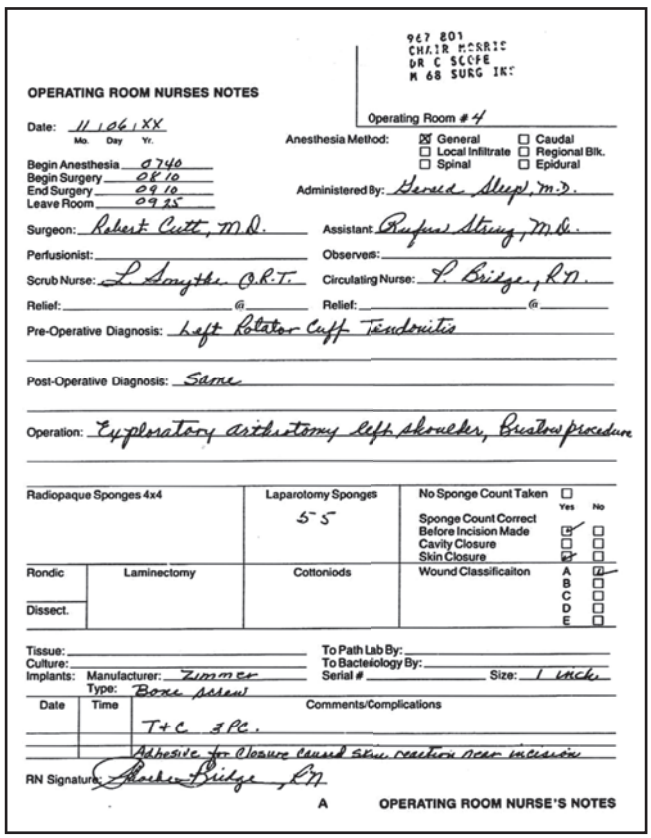
Service Category	Description
Accommodations (room and board)	Inpatient admission—Room/bed assigned to the patient on admission. Rooms may be private or semi-private (more than one bed). Rooms are assigned on various units or wards: medical, surgical, OB/GYN, oncology, psychiatric, intensive care, coronary care, or nursery. **Nursing services are included in overhead charges.**
Operating room (OR) suite, operating room, recovery room	Patients requiring surgery are placed in an OR suite before surgery. Surgery is performed in the operating room. The patient is generally moved to the recovery room after surgery. Some procedures are performed in other areas such as the catheterization laboratory or the endoscopy suite.
Medical surgical supplies	Materials, supplies, and instruments supplied by various departments such as Central Supply. Items include bandages, splints, instruments, and bed pans.
Pharmacy	Medications ordered by the physician are supplied by the Pharmacy Department.
Ancillary services	Diagnostic and therapeutic services ordered by the physician are provided by various clinical departments such as Pathology/Laboratory,
Other clinical services	Various medical departments coordinate and provide services required as outlined in the physician's orders such as Surgery, Medicine, Anesthesia, Pulmonology, and Cardiology.

Hospital Categories of Services and Items

As discussed in the previous chapter, hospital services and items can be categorized as follows: accommodations; operating and recovery room; medical surgical supplies; pharmacy; ancillary services; and other clinical services. Charges for services and items provided are captured at various points in the patient care process, as outlined below (Table 5-4).

Accommodations (Room and Board)

An inpatient admission requires the assignment of a room/bed to accommodate the patient overnight. The admitting physician orders the patient admission and room assignment is performed in accordance with the physician's orders. Rooms are available on various units or wards in the hospital such as the medical, surgical, OB/GYN, oncology, intensive care, coronary care, or nursery ward. The patient is charged for the accommodations, commonly referred to as room and board. Hospital personnel take a census around 12:00 P.M. each evening to identify which patients occupy specific rooms and beds. Charges for room and board are posted to the patient's account daily.


967 801
CHAIR MORRIS
DR C SCOPE
M 68 SURG INT

OPERATING ROOM NURSES NOTES

Date: 11 06 XX (Mo. Day Yr.)

Operating Room # 4

Anesthesia Method: ☒ General ☐ Caudal ☐ Local Infiltrate ☐ Regional Blk. ☐ Spinal ☐ Epidural

Begin Anesthesia 0740
Begin Surgery 0810
End Surgery 0910
Leave Room 0935

Administered By: Gerard Slupe, M.D.

Surgeon: Robert Cutt, M.D. Assistant: Rufus Stone, M.D.

Perfusionist: Observer:

Scrub Nurse: L. Smythe O.R.T. Circulating Nurse: P. Bridge, R.N.

Relief: @ Relief: @

Pre-Operative Diagnosis: Left Rotator Cuff Tendonitis

Post-Operative Diagnosis: Same

Operation: Exploratory arthrotomy left shoulder, Bristow procedure

Radiopaque Sponges 4x4	Laparotomy Sponges	No Sponge Count Taken	Yes	No
	5 5	Sponge Count Correct Before Incision Made	☑	☐
		Cavity Closure	☐	☐
		Skin Closure	☑	☐
Rondic / Dissect.	Laminectomy / Cottoniods	Wound Classificaiton	A ☑	
			B ☐	
			C ☐	
			D ☐	
			E ☐	

Tissue: To Path Lab By:
Culture: To Bacteiology By:
Implants: Manufacturer: Zimmer Serial # Size: 1 inch
Type: Bone screw

Date	Time	Comments/Complications
		T+C 3 Pc.
		Adhesive for closure caused skin reaction near incision

RN Signature: Rhonda Bridge, RN

A OPERATING ROOM NURSE'S NOTES

Figure 5-13 Sample operating room record used to capture OR charges. *(Modified from Brooks ML, Gillingham ET: Health unit coordinating, ed 5, St Louis, 2004, Saunders.)*

Operating and Recovery Room

When a patient is scheduled for a surgical procedure, an operating and recovery room is assigned for use during the patient's surgery. The rooms are furnished with highly specialized equipment required for the surgery. Surgical services are performed in accordance with the physician's orders. Specially trained nursing personnel are available to perform required functions related to the surgery and recovery of the patient. Charges are captured for operating and recovery room services based on the amount of time the patient occupied the room. Various forms are utilized by hospitals to capture these charges such as the operating room records, illustrated in Figure 5-13. Charges are posted to the patient's account after the procedure is performed.

Medical/Surgical Supplies

The Central Supply Department or other similar department issues charges for medical and surgical supplies required during the hospital stay. Medical and surgical supplies and instruments are provided in accordance with providing patient care services as outlined in the physician's orders. Supplies and items are issued to the respective patient care area. Departmental personnel post charges for the items through the chargemaster.

Pharmacy

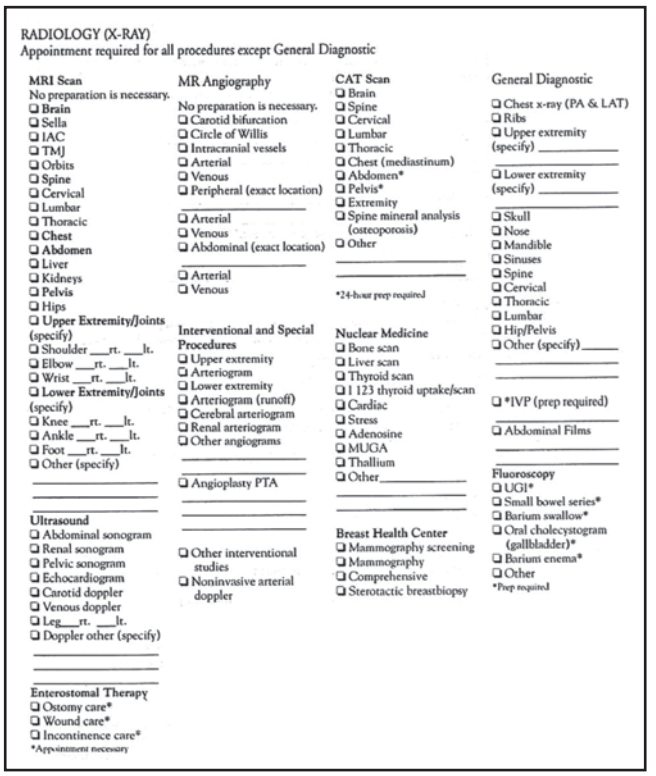
Drugs and biologicals required during the hospital stay are issued by the Pharmacy Department in accordance with providing patient care services as outlined in the physician's orders. Drugs and biologicals are issued to the respective patient care area. Departmental personnel post charges for pharmacy items through the chargemaster.

Ancillary Services

Various ancillary services are provided to patients during the hospital stay. Hospital departments such as Radiology, Pathology/Laboratory, and Physical Rehabilitation provide services in accordance with the physician's orders or a requisition. As discussed in the previous chapter, the physician's orders are entered into the hospital's information systems and distributed to various departments. Outpatient services are provided in accordance with the physician's orders or a requisition. A sample radiology requisition is illustrated in Figure 5-14. Charges for ancillary services are posted through the chargemaster by the department performing the services..

Other Clinical Services

Services provided by various clinical departments within the hospital such as the Emergency Department are provided in accordance with the ER physician's orders. Department personnel post charges through the



RADIOLOGY (X-RAY)
Appointment required for all procedures except General Diagnostic

MRI Scan
No preparation is necessary.
- ❑ Brain
- ❑ Sella
- ❑ IAC
- ❑ TMJ
- ❑ Orbits
- ❑ Spine
- ❑ Cervical
- ❑ Lumbar
- ❑ Thoracic
- ❑ Chest
- ❑ Abdomen
- ❑ Liver
- ❑ Kidneys
- ❑ Pelvis
- ❑ Hips
- ❑ Upper Extremity/Joints (specify)
- ❑ Shoulder ___rt. ___lt.
- ❑ Elbow ___rt. ___lt.
- ❑ Wrist ___rt. ___lt.
- ❑ Lower Extremity/Joints (specify)
- ❑ Knee ___rt. ___lt.
- ❑ Ankle ___rt. ___lt.
- ❑ Foot ___rt. ___lt.
- ❑ Other (specify)

Ultrasound
- ❑ Abdominal sonogram
- ❑ Renal sonogram
- ❑ Pelvic sonogram
- ❑ Echocardiogram
- ❑ Carotid doppler
- ❑ Venous doppler
- ❑ Leg___rt. ___lt.
- ❑ Doppler other (specify)

Enterostomal Therapy
- ❑ Ostomy care*
- ❑ Wound care*
- ❑ Incontinence care*

*Appointment necessary

MR Angiography
No preparation is necessary.
- ❑ Carotid bifurcation
- ❑ Circle of Willis
- ❑ Intracranial vessels
- ❑ Arterial
- ❑ Venous
- ❑ Peripheral (exact location)
- ❑ Arterial
- ❑ Venous
- ❑ Abdominal (exact location)
- ❑ Arterial
- ❑ Venous

Interventional and Special Procedures
- ❑ Upper extremity
- ❑ Arteriogram
- ❑ Lower extremity
- ❑ Arteriogram (runoff)
- ❑ Cerebral arteriogram
- ❑ Renal arteriogram
- ❑ Other angiograms
- ❑ Angioplasty PTA
- ❑ Other interventional studies
- ❑ Noninvasive arterial doppler

CAT Scan
- ❑ Brain
- ❑ Spine
- ❑ Cervical
- ❑ Lumbar
- ❑ Thoracic
- ❑ Chest (mediastinum)
- ❑ Abdomen*
- ❑ Pelvis*
- ❑ Extremity
- ❑ Spine mineral analysis (osteoporosis)
- ❑ Other

*24-hour prep required

Nuclear Medicine
- ❑ Bone scan
- ❑ Liver scan
- ❑ Thyroid scan
- ❑ I 123 thyroid uptake/scan
- ❑ Cardiac
- ❑ Stress
- ❑ Adenosine
- ❑ MUGA
- ❑ Thallium
- ❑ Other

Breast Health Center
- ❑ Mammography screening
- ❑ Mammography
- ❑ Comprehensive
- ❑ Sterotactic breastbiopsy

General Diagnostic
- ❑ Chest x-ray (PA & LAT)
- ❑ Ribs
- ❑ Upper extremity (specify)
- ❑ Lower extremity (specify)
- ❑ Skull
- ❑ Nose
- ❑ Mandible
- ❑ Sinuses
- ❑ Spine
- ❑ Cervical
- ❑ Thoracic
- ❑ Lumbar
- ❑ Hip/Pelvis
- ❑ Other (specify)
- ❑ *IVP (prep required)
- ❑ Abdominal Films

Fluoroscopy
- ❑ UGI*
- ❑ Small bowel series*
- ❑ Barium swallow*
- ❑ Oral cholecystogram (gallbladder)*
- ❑ Barium enema*
- ❑ Other

*Prep required

Figure 5-14 Sample Radiology Department requisition used to indicate patient care services required.

chargemaster. Emergency Department charges do not represent the professional services performed by the Emergency Department physician. The ER physician will submit charges for his or her professional services separately.

Hospital-Based Clinic or Primary Care Office

Many hospitals provide patient care services in a clinic or primary care office. Physician services provided in the clinic or primary care office are recorded on the encounter form. Charges are posted to the patient's account for each visit. The hospital submits professional charges for these services when the physician is employed by or is under contract with the hospital. Professional charges are submitted on the CMS-1500, as discussed previously.

Services and items provided by a hospital are determined by the hospital's specialization and case mix. **Case mix** is a term used to describe the type of patient cases treated by the hospital. For example, a trauma center will treat different types of patient cases than those treated by a burn center. Chargemasters vary by hospital as a result of the variation in the type of cases seen by the hospital. Because of the wide variety of services and items provided by the hospital, a chargemaster will typically have thousands of entries.

Community General Hospital

Charge Description Master (CDM)

Chargemaster Number/ Department #/ General Ledger #	Item/Service Description	Procedure/ Item Code HCPCS/ NDC and Modifier	Revenue Code	Quantity/ Dose	Charge
100/977	Room C532		0110	1	1042
200/164	Cefepime inj 2 G	J0692	0250	2 g	133
300/116	Tray hyperal dre	A4550	0270	1	33
300/169	ABD/KUB flatplat	74470	0320	1	148
400/137	Oximeter	S8105	0410	1	49
700/138	Prothrombin time	85210	0300	1	57
700/138	CBC with diff	85025	0300	1	68
700/139	Blood culture	87040	0300	1	121
700/140	Basic metabolic	80048	0300	1	53
700/167	Dopp-venous lowe	93303	0400	1	583
700/169	X-ray chest	71020	0320	1	185
700/169	X-ray chest fluoroscopy	71090	0320	1	185

Figure 5-15 sample hospital Charge Description Master (CDM) illustrating common data elements of a CDM.

Content of the Charge Description Master

Services, procedures, and items provided by the hospital are listed in the chargemaster with various data elements required for charging patient accounts and billing services and items on the claim form. Chargemaster data elements vary by hospital; however, basic information will include the chargemaster number, department number, item and service description, HCPCS and modifier, general ledger codes, and quantity or dose and will be charged as outlined in Figure 5-15.

Chargemaster Number

The chargemaster number is an internal control number assigned to each service or item provided by the hospital. This number may be referred to by other names, such as charge description number, internal control number, or service code number. Many hospitals also include a general ledger number for accounting purposes.

Department Number

Each service and item in the chargemaster is assigned a number representing the department that provides the service or item. Many departments further specify services. For example, the Radiology Department may be department number 700. Within the Radiology Department, nuclear medicine and radiation oncology services may be assigned numbers such as 710 and 720. Department numbers are utilized to track procedures and items provided by that department.

Item or Service Description

All services and items are given a written statement that describes the service or item within the chargemaster. Descriptions vary by hospital. Some hospitals assign a clinical description, and others may utilize a billing description. The billing description appears on the detailed itemized statement. Many hospitals use the HCPCS or NDC code descriptions.

Procedure or Item Code

Each item in the chargemaster is assigned the appropriate code from the HCPCS coding system or a National Drug Code (NDC). The appropriate HCPCS Level I CPT or HCPCS Level II Medicare National Code is assigned according to payer specifications. Modifiers are also recorded in the chargemaster where appropriate. The NDC may be assigned to various drugs provided by the hospital in accordance with payer specifications.

SERVICE	REVENUE CODES
Room and Board	0110
Nursery	0170
Intensive Care	0200
Coronary Care	0210
Pharmacy	0250
IV Therapy	0260
Medical Surgical Supplies	0270
Laboratory, Clinical	0300
Radiological Services	0320
Operating Room	0360
Anesthesia	0370
Blood	0380
Respiratory Services	0410
Physical Therapy	0420
Occupational Therapy	0430
Speech/Language Therapy	0440
Emergency Room	0450
Cardiology	0480
Recovery Room	0710
Labor/Delivery Room	0720
EKG/ECG and EEG	0730
Gastrointestinal Services	0750
Treatment or Observation Room	0760
Lithotripsy	0790
Inpatient Renal Dialysis Services	0800
Organ Acquisition	0810
Professional Fees	0960

Figure 5-16 Sample revenue code list for various categories of services.

Revenue Code

A **revenue code** is a four-digit number assigned to each service or item provided by the hospital that designates the type of service or where the service was performed. For example, general pharmacy charges are assigned revenue code number 0250, and ER services are assigned revenue code number 0450. Figure 5-16 provides a listing of some of the most common general revenue codes.

The National Uniform Billing Committee (NUBC) defines revenue code categories, and they are required for completion of the UB-92. Information regarding revenue codes can be obtained from many sources such as the CMS Web site at www.cms.gov or the NUBC Web site at www.nubc.org.

Quantity or Dose

A quantity, unit, or dose is assigned to each service or item in the chargemaster. HCPCS Level I CPT and Level II Medicare National Codes represent a specific quantity that indicates the number of times the service was performed or the number of items that were provided. Codes for drugs have an associated quantity that represents the specific dose or quantity of the drug provided.

Charge

The amount charged for each service or item is listed on the chargemaster. Some hospitals may designate a different charge for services or items based on whether the service was provided on an inpatient versus outpatient basis. However, many hospitals assign the same charge regardless of whether the service or item was provided on an inpatient or outpatient basis.

BOX 5-13 ■ KEY POINTS

Charge Description Master (CDM) Data Elements

Chargemaster number
Department number
Item or service description
Procedure or item code
Revenue code
Quantity or dose
Charge

TEST YOUR Knowledge

BOX 5-2

CHARGE DESCRIPTION MASTER (CDM)

1. What is a CDM?
2. Explain the purpose of the chargemaster.
3. How is the chargemaster utilized within the hospital?
4. List six categories of services for which hospitals submit facility charges.
5. List seven data elements generally contained in a CDM.
6. What description on the chargemaster is used by many hospitals for services and items?
7. Name the procedure or item codes that are utilized on the chargemaster.
8. Explain the purpose of revenue codes.
9. State the role of the National Uniform Billing Committee (NUBC) with regard to revenue codes.
10. Why does the chargemaster require regular updating and what department is generally responsible for chargemaster maintenance?

Chargemaster Maintenance

The challenge for hospitals is to develop and maintain a chargemaster that incorporates required information for claim preparation, for monitoring of resource utilization, and obtaining appropriate reimbursement. The HIM Department is generally responsible for the maintenance and updating of the chargemaster, which involves changes, revisions and deletions of codes, and incorporation of changes in payer guidelines. The appropriate revenue codes must be assigned to each HCPCS code utilized. As a result, hospital billing and coding professionals are becoming more involved in chargemaster functions. Many hospitals assign a committee to perform updating and auditing functions to identify discrepancies in the chargemaster.

Procedure Coding Systems
(Services or Items)

HCPCS Level I
Current Procedural Terminology (CPT-4)

HCPCS Level II
Medicare National Codes

International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM)
Volume III (Alphabetical and numerical listing of procedures)

Diagnosis Coding Systems
(Conditions, disease, illness, injury, or other)

International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM) – Volume I & II (alphabetical and numerical listing of diseases, signs and symptoms, encounters and external causes of injury)

Figure 5-17 Coding systems utilized by hospital for submission of charges.

CODING SYSTEMS

Historically, providers submitted a written description of conditions, services, and items on claims. Coding systems were developed to standardize descriptions of conditions, services, and items for the purpose of consistent reporting and tracking of conditions and procedures. Coding systems consist of numeric and alphanumeric codes that represent a translation of the written descriptions of conditions, services, or items provided as documented in the patient's medical record. Services and items provided are submitted to third-party payers utilizing two distinct coding systems—a procedure coding system and a diagnosis coding system (Figure 5-17).

BOX 5-14 ■ KEY POINTS

Procedure Coding Systems

Health Care Common Procedure Coding System (HCPCS)
- Level I: CPT-4
- Level II: Medicare National Codes

International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM), Volume III, Procedures

BOX 5-15 ■ KEY POINTS

Diagnosis Coding Systems

International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM), Volumes I and II

TABLE 5-5 Coding System Variations

Hospital Service Categories of Facility Charges	Procedures HCPCS Level		Procedures ICD-9-CM	Diagnosis ICD-9-CM Volume I & II	Variations
	I CPT	II Medicare National			
Outpatient					
Ambulatory surgery	X	*	*	X	Some payers may require ICD-9-CM Volume III procedures for ambulatory surgery claim submitted on the UB-92
Emergency Department	X	*	*	X	†
Ancillary departments: Radiology; Laboratory; Physical, Occupational, and Speech Therapy	X	*	*	X	†
Other outpatient services: Infusion; Therapy and Observation	X	*	*	X	†
Durable medical equipment: provided on an outpatient or inpatient basis	X	*	*	X	†
Hospital-based primary care office	X	*	*	X	†
Other hospital-based clinic	X	*	*	X	†
Inpatient					
Inpatient services	X	*		X	†
Non-patient					
A specimen received and processed — the patient is not present	X	*		X	†

*Varies by payer; generally required to report significant procedures on the UB-92 claim form.
†CPT codes are generally utilized to describe services and some items. Medicare National Codes are utilized when a CPT code cannot be found that adequately describes the service or item or when the payer requires a Level II code.

Procedure Coding Systems

Procedure coding systems are utilized to provide descriptions of procedures, services, and items provided. Procedure codes are listed on the claim form to describe the charges submitted. Payer guidelines regarding procedure codes vary. The standard procedure coding system utilized today to submit charges to payers is referred to as the **Health Care Common Procedure Coding System (HCPCS)**, which consists of two levels of codes—Level I CPT Codes and Level II Medicare National Codes.

Another coding system utilized for report procedures is ICD-9-CM Volume III Procedure Codes. The ICD-9-CM Volume III procedure coding system is commonly referred to as the ICD-9-PC. This coding system is utilized for reporting significant procedures on the claim form.

Diagnosis Coding Systems

Diagnosis coding systems are utilized to describe the patient's injury, illness, condition, disease, or other reason for hospital visit. They are used describe the reason why services or items were provided. ICD-9-CM Volume I and II is the diagnosis coding system currently utilized for coding the reason for services or items that were provided. An explanation of the patient's condition or other reason for the service is essential to establishing medical necessity.

Coding Systems for Outpatients and Inpatients

Coding systems utilized vary by payer according to whether the services are provided on an outpatient or inpatient basis, as illustrated in Table 5-5.

TEST YOUR *Knowledge*

BOX 5-3

CODING SYSTEMS

1. Why were coding systems developed?
2. What are coding systems?
3. Explain the relationship between coding systems and the claim form.
4. Name two coding systems utilized to code services rendered and reasons why they were rendered.
5. Explain what coding system is utilized to describe the reason why services were rendered.
6. Outline and describe coding systems utilized for outpatient claims.
7. Describe coding systems utilized for inpatient claims.
8. State two levels of the HCPCS coding system.
9. List the coding system that is utilized to submit charges for items and medications on outpatient claims.
10. Provide an explanation of the relationship between diagnosis codes and medical necessity.

Outpatient

Outpatient is the term used to describe patient care services or items provided on the same day the patient is released. Hospitals perform various services on an outpatient basis, such as radiology, laboratory, physical and occupational therapy, ER, observation, and ambulatory surgery services. Coding systems utilized for outpatient services are HCPCS and ICD-9-CM. HCPCS and ICD-9-CM Volume I and II codes are reported on the CMS-1500 to report patient conditions and services provided to evaluate and treat those conditions. HCPCS and ICD-9-CM procedures codes will be discussed further in Chapters 7 and 8.

Inpatient

Hospitals perform a variety of services on patients who are admitted as inpatients. Inpatient services are performed on patients who are admitted to the hospital for more than 24 hours. A wide range of services and items are provided during the patient's hospital visit. They are coded utilizing the HCPCS and the ICD-9-CM Volume III procedure coding systems. Conditions, diseases, illnesses, injuries, and other reasons for the hospital stay are coded utilizing the ICD-9-CM Volume I and II diagnosis coding system. The codes are listed on the claim form to describe services and items provided and the medical reason why they were provided. ICD-9-CM Volume I and II codes are utilized to report diagnoses on the UB-92. ICD-9-CM Volume III codes are required to report significant procedures on the UB-92. Some payers require the Volume III codes when the UB-92 is required for submission of ambulatory surgery services. HCPCS codes are utilized to post charges for services, procedures, and items through the chargemaster for inpatient claims.

Hospital billing and coding professionals are involved in the coding process and submission of charges for payment to patients and payers. It is essential for hospital billing and coding professionals to understand coding system requirements in order to ensure coding compliance and to obtain the proper reimbursement. Billing professionals are required to understand coding and related guidelines for various payers to ensure that the claim form is completed accurately and that proper reimbursement is obtained. Coding professionals are required to understand and apply coding principals and guidelines outlined by payers to ensure that accurate descriptions of services, items, and reasons for the hospital stay are submitted. A detailed discussion of each of these coding systems follows in later chapters.

BOX 5-16 ■ KEY POINTS

Claim Submission Methods

Manual

Paper claim sent by mail

Electronic Media Claim (EMC)

Claim sent by electronic data interchange (EDI)

UNIVERSALLY ACCEPTED CLAIM FORMS

Claim forms are utilized to submit charges for services and items rendered to third-party payers. There are two universally accepted claim forms used for submission of charges to payers— CMS-1500 and UB-92. A detailed discussion of claim form completion will be provided in Chapter 10. The following section provides an outline of the claim form information required for the CMS-1500 and the UB-92. It is important to remember that payer guidelines define what claim form is required for outpatient, inpatient, and non-patient services.

CMS-1500

The CMS-1500 is used to submit charges to payers for professional and specified outpatient services provided by physicians and other providers to payers. As discussed previously, hospitals do not submit charges for physician services unless the physician is employed by or under contract with the hospital. The CMS-1500 consists of 33 fields, referred to as blocks, utilized to record information regarding the patient visit. The payer requires four areas of information—patient and insurance information, diagnosis code(s), and charge information including appropriate code(s), and provider information. Figure 5-18 highlights the four sections of information on the CMS-1500.

CMS-1450 (UB-92)

The CMS-1450 is also referred to as the UB-92 because it is the universal bill accepted by most payers. The UB-92 is used to submit hospital facility charges for patient care services rendered during a patient visit. The UB-92 consists of 86 fields, which are referred to as **form locators (FLs).** As illustrated in Figure 5-19, the claim form can be viewed in four sections in which information regarding the facility, patient, charges, and payer are recorded.

Detailed Itemized Statement

The detailed itemized statement includes information collected and posted to the patient's account throughout the patient's stay. The **detailed itemized statement** is a listing of all charges incurred during the patient visit. The statement and its content vary from

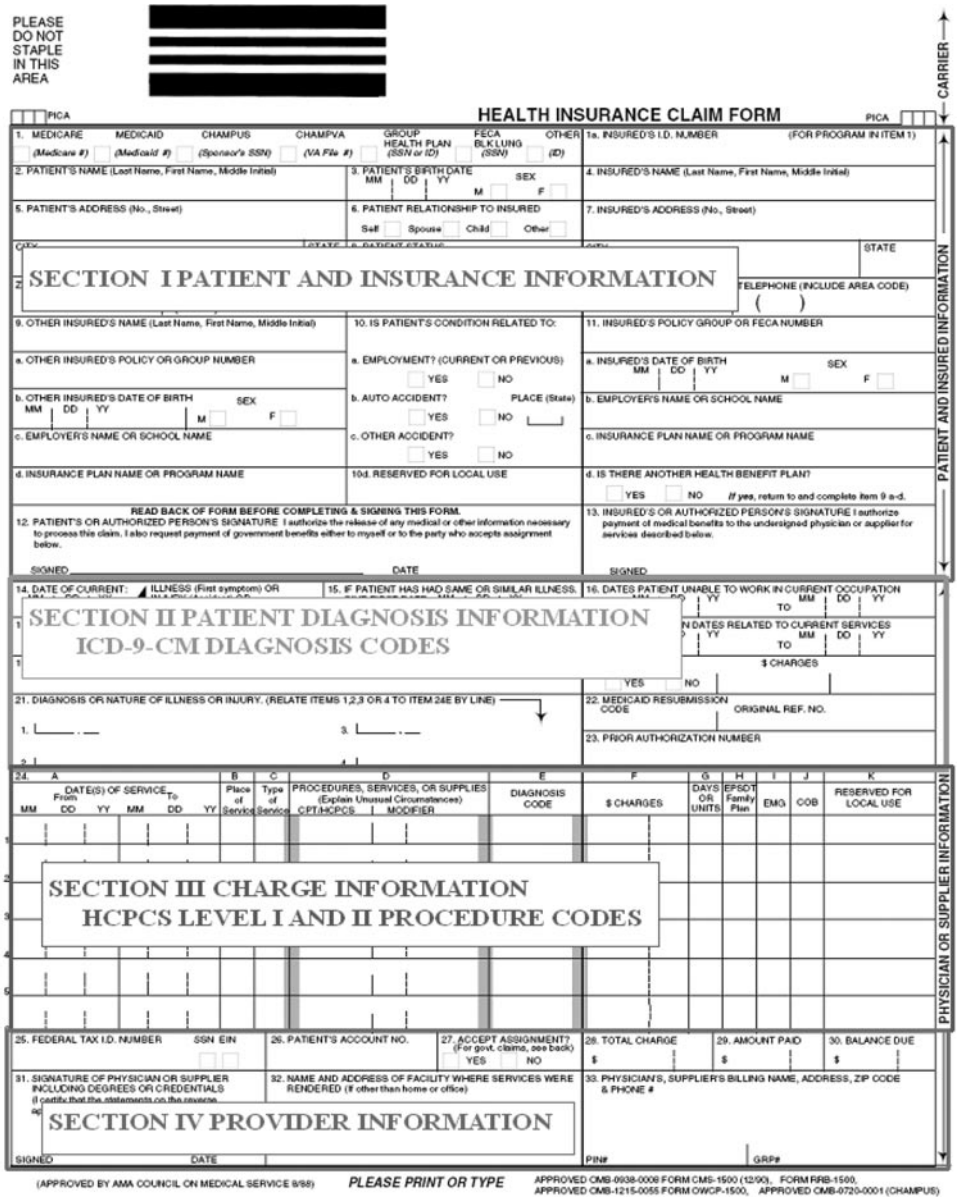


Figure 5-18 CMS-1500 highlighting sections of required information.

hospital to hospital. The basic information included on a detailed itemized statement is patient's name and address, hospital name and address, patient account and medical record number, admit and discharge date, and all information describing the services and items charged. The data outlined on the detailed itemized statement is obtained throughout the patient care process. Charges are posted and maintained through the chargemaster during the patient's visit. Figure 5-20 illustrates a detailed itemized statement highlighting the following four sections of information outlined:

1. Facility, patient, and insurance information.
2. Detailed information for each charge.
3. Revenue code for each charge.
4. Procedure code, description, quantity, dose, and total for each charge.

Detailed Itemized Statement Section 1

Section 1 of the detailed itemized statement contains information regarding the facility, patient, and insurance, including hospital name, address, phone number, and tax identification number, patient and medical record number, bill date, admission and discharge dates, and bill type. The patient and insurance information is obtained during the admission process. This information is registered on the hospital's system, and a patient account number and medical record number is assigned.

Detailed Itemized Statement Section 2

Section 2 is utilized to record charge detail for services and items provided during the patient stay, including date of service, chargemaster number, and department number. This information is captured throughout the

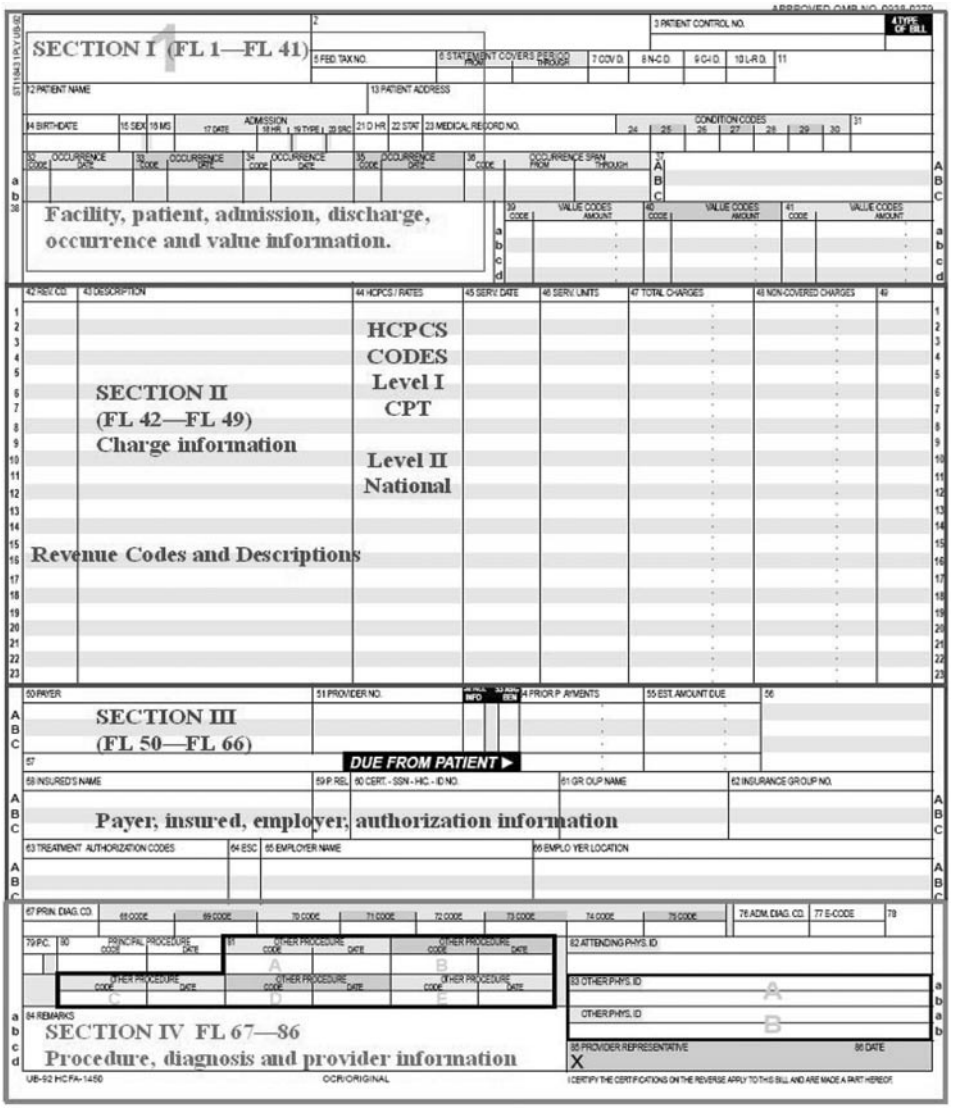


Figure 5-19 UB-92 highlighting sections of required information.

patient visit as charges are posted through the chargemaster by various departments. Services and items listed on the detailed itemized statement are documented in the patient's medical record and are provided in accordance with the physician's orders.

Detailed Itemized Statement Section 3

Section 3 highlights the revenue code column. A revenue code is assigned to each service or item provided by the hospital. Revenue codes are associated with HCPCS codes listed in the chargemaster. When hospital departments post charges to the patient's account, all the associated data such as revenue codes are recorded on the patient's account with the charge.

Detailed Itemized Statement Section 4

Section 4 contains a procedure or item code, description, quantity, and total charge for each charge. All services and items provided by the hospital are assigned a numerical or alphanumerical procedure or item code and a charge. As discussed previously, coding systems utilized for procedures and items are HCPCS Level I CPT or HCPCS Level II Medicare National code. Some payers require that a National Drug Code (NDC) be used to identify drugs and biologicals. A written description of the item or service is listed in the description line. The quantity or dose and total amount charged is listed in the next columns for each code.

Many payers require submission of a detailed itemized statement with the claim. Payers that do not require submission of the detailed itemized statement with the claim form may request one after initial review of the claim. A patient may also request a detailed itemized statement after review of the summary statement or invoice.

Manual versus Electronic Claim Submission

Claim forms can be submitted manually or via electronic media. Manual claim form submission involves

Community General Hospital
TAX ID # 62–1026428

8192 South Street
Mars, Florida 37373
(747) 722-1800

Section 1
Facility/patient/insured information

Detailed Itemized Statement

Patient no: 3611869
Med rec no: 17933398411
Patient: Smith, John

Bill date 12/1/06 Page 1
Admit date 11/27/06 Discharged 11/28/06
Bill type: Admit through discharge

Bill to:
Smith, John
7272 54th Street

Insurance: BC/BS P.O. Box 7272, Tampa, FL 34677

Section 2
Charge detail–date of service, chargemaster, and dept #

Section 3
Charge detail–revenue code

Section 4
Charge detail–procedure and item codes, description, quantity, and total charges

Date of Service	Charge-master #	Dept #	Revenue Code	HCPCS	Description	Qty/ Dose	Total Charges
11/27/2006	35466	0750	0250	33880551	Vistaril 25-100 mg inj	6	109.50
11/27/2006	35150	0750	0250	33820891	Docusate sodium	3	8.25
11/27/2006	32558	0750	0250	J3590	Cepacol loz	2	4.50
11/27/2006	35126	0750	0250	J1110	Diphenhydramine HCL	1	2.35
11/27/2006	34439	0750	0250	J2715	Demerol	2	21.70
11/27/2006	32444	0750	0250	J2250	Versed 1 mg/ml	1	19.50
11/28/2006	35422	0750	0250	Q0179	Zofran vial (inj) 2 mg	1	66.35
11/28/2006	35700	0750	0250	J3590	Percocet	14	63.00
11/28/2006	90850	0718	0270		Mini synder hemovac (JP)	1	31.00
11/28/2006	27907	0713	0300	80007	PA surgical profile	1	104.75
11/28/2006	27969	0713	0300	80058	PA liver profile	1	97.75
11/28/2006	59920	0780	0314	88304	P-gross & micro, diag sm	1	40.75
11/27/2006	2067	0770	0330	76000	XR fluro C-arm initial	2	464.00
11/27/2006	60006	0719	0360		OR time group VI	75	2514.00
11/27/2006	47070	0721	0370		Anesthesia	1	200.00
11/27/2006	85625	0720	0710		R-time recovery rm	60	346.80

Figure 5-20 Sample detailed itemized statement highlighting four sections of information generally reported on the statement. *(Courtesy of Sandra Giangreco.)*

printing a paper claim and/or a detailed itemized statement. Both are reviewed for accuracy and submitted to the appropriate third-party payer via mail or fax transmission when the claim must be resubmitted. Electronic claims are submitted via **electronic data interchange (EDI),** which is the term used to describe the process of sending information from one place to another via computer. The claim form sent via EDI is called an **electronic media claim (EMC)**. EMCs are submitted to payers electronically. Many hospitals utilize a clearinghouse to submit claims electronically. The **clearinghouse** receives claim form information from hospitals and other providers in various formats. The clearinghouse also reviews the claim for completeness and verification of accuracy. The claim is converted to the required format for each specific payer and submitted electronically.

CMS-1500 and CMS-1450 claim form requirements vary by payer. Payers receiving the UB-92 have specific requirements based on the type of facility submitting the claim and whether service was provided on an outpatient or inpatient basis. A detailed discussion of the UB-92 and completion instructions is provided later in the text.

The complex process of billing is difficult to understand without knowledge of the purpose of billing, the chargemaster, coding systems, claim forms, and the detailed itemized statement. The process is similar to a puzzle, and hospital billing and coding professionals need to know all the pieces of the puzzle in order to fit them together for the purpose of obtaining accurate reimbursement and maintaining compliance with all billing and coding guidelines. Now that we have an understanding of the elements of the process, we will review the entire process from the time the patient is admitted to collection of accounts receivable.

BOX 5-17 ■ KEY POINTS

Universally Accepted Claim Forms

CMS-1500

Charges for physician and outpatient services

UB-92

Hospital facility charges for inpatient and outpatient services

THE HOSPITAL BILLING PROCESS

The hospital billing process begins with patient registration at admission, and it ends when payment is received for hospital services. The next section will review the billing process in order to provide a complete "big picture" understanding of how all the elements are related and how this relationship is critical to obtaining proper reimbursement and ensuring compliance. Figure 5-21 illustrates the billing process and indicates the departments involved in the process. The billing process consists of all functions required for claim submission and obtaining reimbursement. It includes patient admission/registration, patient care/order entry, charge capture, chart review and coding, charge submission, reimbursement, and accounts receivable management.

Patient Admission and Registration

Patients are received at the hospital on an inpatient or outpatient basis. Non-patient services may be provided when a specimen is received for processing and the patient is not present. The process followed by the Admitting Department for each type of admission includes collection of demographic and insurance information. Patient registration involves entering all information into the hospital system. This information is utilized throughout the patient stay for the purpose of providing patient care services and posting charges for those services. The admission process is critical to ensure that accurate information is obtained that will be used for charge submission.

TEST YOUR Knowledge

BOX 5-4

UNIVERSALLY ACCEPTED CLAIM FORMS

1. Explain the purpose of a claim form.
2. List four sections of the CMS-1500 and provide a brief description of information in each section.
3. Provide an explanation of the difference in format between the CMS-1500 and UB-92.
4. Outline the type of services reported on the UB-92 versus those reported on the CMS-1500 claim forms.
5. Discuss four sections of the UB-92 and provide a brief explanation of information in each.
6. Identify the section where procedure and diagnosis codes are listed on the UB-92 and explain what a form locator is.
7. What section of the UB-92 is used to provide information about the charges to be submitted?
8. State the difference between a manual claim and electronic claim submission.
9. Explain the purpose of the detailed itemized statement and describe where information on the statement comes from.
10. What is the term that describes the process of sending information from one party to another via computer?

Patient Care Order Entry

Patient care services are rendered in accordance with the physician's orders. The physician's orders are entered into the hospital's information system and distributed to the appropriate departments. During the patient stay, hospital personnel from various clinical and ancillary departments are involved in providing care to the patient. Diagnostic and therapeutic services are provided by departments such as Radiology, Pathology/Laboratory, and Rehabilitation. All patient care activities are recorded in the patient's medical record.

Charge Capture

All services and items provided during the patient stay are documented in the patient's record. Departments involved in providing patient care are responsible for posting charges to the patient's account through the chargemaster. Other departments such as Pharmacy and Sterile Supplies also post charges to the patient's account for items utilized for patient care, such as medications and supplies. As discussed previously, the chargemaster lists all services, procedures, items, and drugs that the hospital may provide. The items listed in the chargemaster are organized by department. Each item in the chargemaster is associated with the appropriate revenue code, procedure or item code, description, quantity, and charge.

Chart Review and Coding

The patient is released from the hospital when the attending physician provides written discharge orders

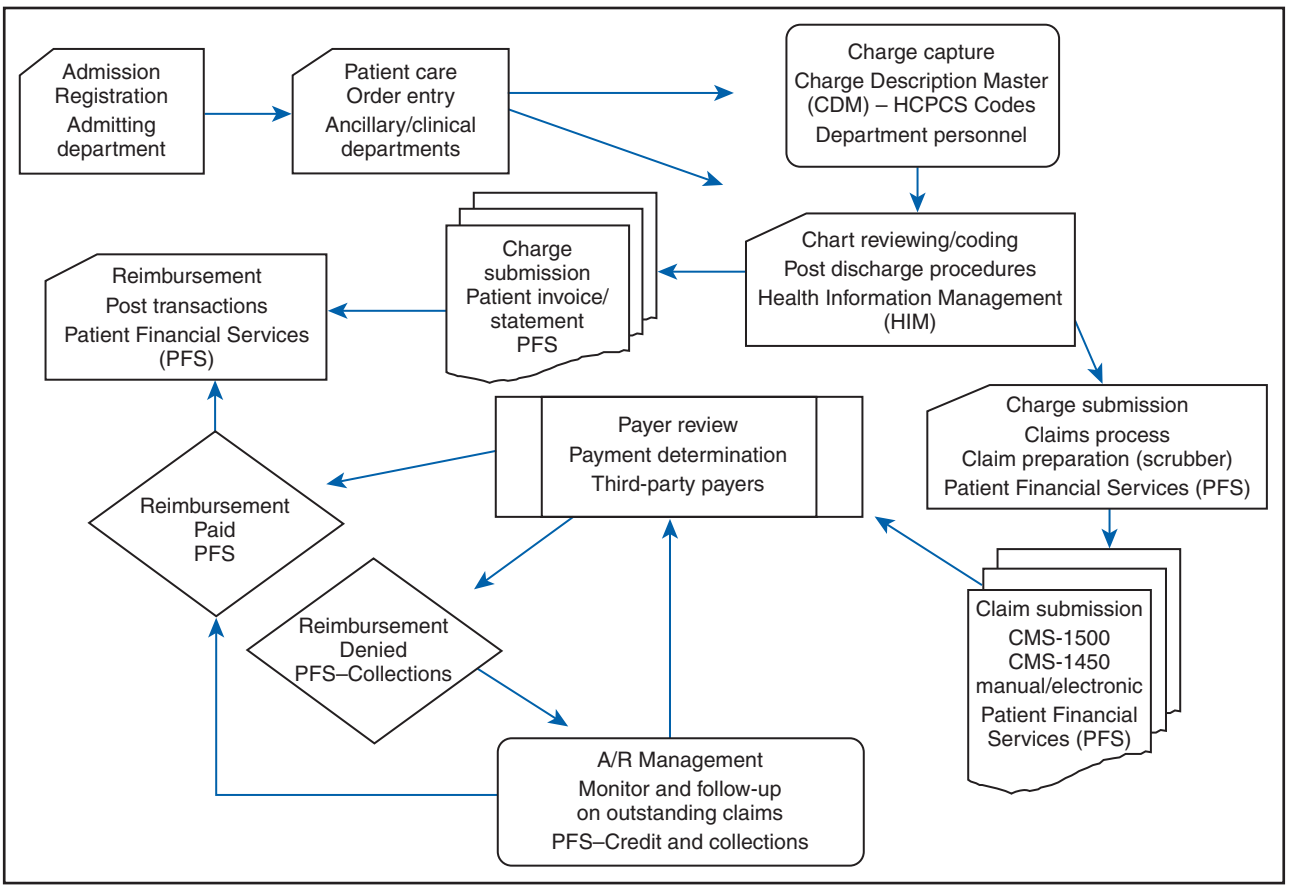


Figure 5-21 The hospital billing process: key functions and the primary departments involved in performing those functions.

and instructions. Once the patient is discharged, the completed medical record is forwarded to the HIM. HIM coding professionals review the patient's medical record for purposes of identifying and verifying charges. The coder then analyzes the medical record to abstract the patient's diagnosis(es) and significant procedure(s) from the record for the purpose of assigning procedure and diagnosis codes. A computer program called an **Encoder** may be utilized to assist with code assignment. A program called the **Grouper** is utilized for the assignment of a DRG or APC based on the information entered such as diagnosis, procedure, and other patient information such as age, sex, and length of stay.

Community General Hospital
TAX ID # 62–1026428

8192 South Street
Mars, Florida 37373
(747) 722-1800

Patient Statement

Patient no: 3611869 Bill date 12/1/06 Page 1
Med rec no: 17933398411 Admit date 11/27/06 Discharged 11/27/06
Patient: Smith, John

Bill to:
Smith, John
7272 54th Street

Date of Service	Description	Total
11/27/2006	Laboratory	4.00
11/27/2006	Chemistry	60.00
11/27/2006	Immunology	34.25
11/27/2006	Hematology	20.75
11/27/2006	Bacteriology & microbiology	92.25
11/27/2006	Urinalysis/stool/body fluid	19.25
	TOTAL CHARGES	$230.50
	BALANCE DUE	$230.50

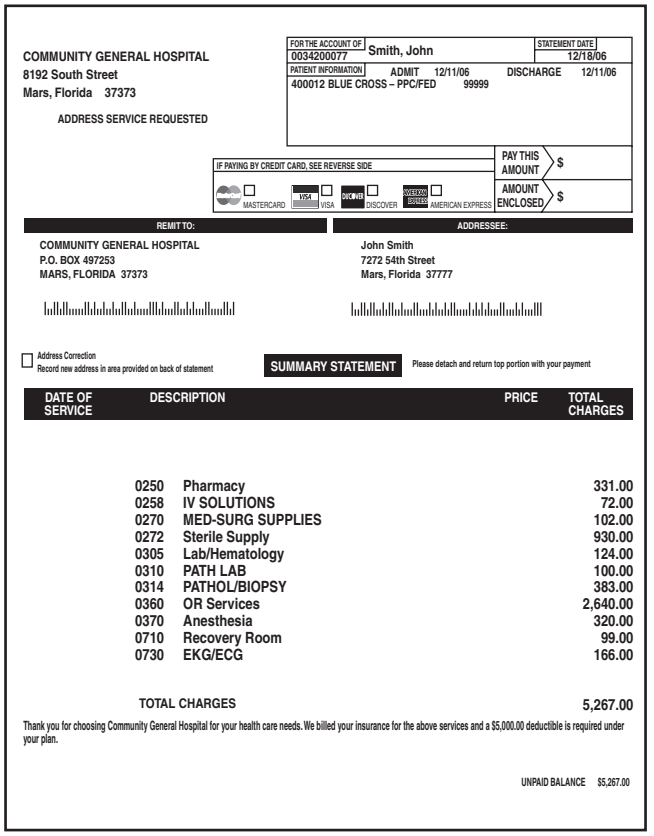
Figure 5-22 Sample hospital patient statement.

Charge Submission

The Patient Financial Services (PFS) Department utilizes information gathered during the patient stay to prepare appropriate documents required for charge submission. The patient invoice or statement is utilized to submit charges to the patient. Claim forms are utilized to submit charges to third-party payers.

Patient Invoice and Patient Statement

An invoice or statement is prepared and sent to advise the patient of an outstanding balance. A **patient invoice** is a document prepared by the hospital to advise the patient of an outstanding balance that includes details



COMMUNITY GENERAL HOSPITAL
8192 South Street
Mars, Florida 37373

ADDRESS SERVICE REQUESTED

FOR THE ACCOUNT OF: 0034200077 Smith, John
STATEMENT DATE: 12/18/06
PATIENT INFORMATION: ADMIT 12/11/06 DISCHARGE 12/11/06
400012 BLUE CROSS – PPC/FED 99999

IF PAYING BY CREDIT CARD, SEE REVERSE SIDE
MASTERCARD VISA DISCOVER AMERICAN EXPRESS
PAY THIS AMOUNT $
AMOUNT ENCLOSED $

REMIT TO:
COMMUNITY GENERAL HOSPITAL
P.O. BOX 497253
MARS, FLORIDA 37373

ADDRESSEE:
John Smith
7272 54th Street
Mars, Florida 37777

Address Correction
Record new address in area provided on back of statement

SUMMARY STATEMENT

Please detach and return top portion with your payment

DATE OF SERVICE	DESCRIPTION	PRICE	TOTAL CHARGES
0250	Pharmacy		331.00
0258	IV SOLUTIONS		72.00
0270	MED-SURG SUPPLIES		102.00
0272	Sterile Supply		930.00
0305	Lab/Hematology		124.00
0310	PATH LAB		100.00
0314	PATHOL/BIOPSY		383.00
0360	OR Services		2,640.00
0370	Anesthesia		320.00
0710	Recovery Room		99.00
0730	EKG/ECG		166.00
	TOTAL CHARGES		5,267.00

Thank you for choosing Community General Hospital for your health care needs. We billed your insurance for the above services and a $5,000.00 deductible is required under your plan.

UNPAID BALANCE $5,267.00

Figure 5-23 Sample hospital summary statement.

regarding current services, and it is generally sent out the first time a balance is billed to the patient, as illustrated in Figure 5-22. A **patient statement** is a document prepared by the hospital that provides details regarding account activity, including the previous balance, recent charges, payments, and the current balance. Hospitals generally send a patient statement monthly to notify the patient of a balance due.

A summary statement may also be sent to advise the patient of charges submitted to his or her insurance company or government program. The summary statement is a listing of charges posted during the patient stay, organized by revenue code category. Summary statements include the hospital name and address, patient name and account number, admission and discharge dates, a summary of charges, payments, and adjustments, and the unpaid balance, as illustrated in Figure 5-23.

Patient invoices or statements are run in batches and sent to patients. A **batch** is a specified group of invoices or statements processed at one time. For example, invoices and statements for patient last names beginning with A through M may be run in the first batch. Invoices and statements for patient last names ning with N through Z may be run in another batch.

BOX 5-18 ■ KEY POINTS

Computer Edits

Computer edits are designed to detect potential claim problems.

- Procedure versus patient's sex: to verify that the procedure is appropriate for the patient's sex
- Procedure versus patient's age: to ensure the procedure is age appropriate
- Procedure versus patient's diagnosis: to ensure the procedure is appropriate based on the patient's condition

BOX 5-19 ■ KEY POINTS

Payer Payment Determination

Payment determination is conducted by the payer after the claim passes all computer edits and can result in one of the following actions:

- Payment is processed for the claim
- The claim is put in a pending status until information requested is received The claim may be denied

Claim Forms

Claim forms are utilized to submit charges to third-party payers, as outlined previously. The UB-92 is generally used to submit most hospital facility charges. The CMS-1500 is used to submit charges for professional services and other specified outpatient services. Claim forms are also prepared in batches, usually by payer type. Claim forms can be printed manually and sent to the payer by mail or fax or they can be submitted electronically. Most payers do not allow faxed claims unless they are resubmissions. Most hospital computer billing systems have computerized checks referred to as edits that are performed prior to submission of a claim. These edits are designed to detect potential claim problems. The computer system checks specific data against other data on the claim. Computer edits will vary by hospital.

All computer edits are run for the purpose of identifying problems that can result in denial or inaccurate payment of a claim. The computer system will provide a report that outlines potential problems with the claim. Hospital billing and/or HIM staff will review the problem areas and make corrections prior to submission of the claim. The claim may be held while more information is requested.

Reimbursement

The purpose of the billing process is to submit hospital charges to patients and third-party payers for payment. As outlined in Chapter 4, payments are received and posted to the patient's account by the PFS Department.

MEDICARE PART A

P.O. BOX 167953 TEMPE AR 72207 TEL# 800 660 4235 VER# 4010–A1

PROV #69542A PROVIDER NAME: Dr Martin Samerston PART A PAID DATE: 06/26/2006 REMIT#: 7654 PAGE:1

PATIENT NAME / HIC NUMBER / FROM DT THRU DT / CLMSTATUS	PATIENT CNTRL NUMBER ICN / NUMBER NACHG HICHG TOB / COST COVDY NCOVDY	RC REM DRG# / RC REM OUTCD CAPCD / RC REM PROF COMP / RC REM DRG AMT	DRG OUT AMT / NEW TECH / MSP PAYMT / DEDUCTIBLES	COINSURANCE / COVDCHGS / NCOVD CHGS / DENIED CHGS	PAT REFUND / ESRD NET ADJ / INTEREST / PRE PAY ADJ	CONTRACT ADJ / PER DIEM RTE / PROC CD AMT / NET REIMB
Smith John	7 9 4076922738872 / 084327777A / 00					
109876543210			6,895.72	1,463.72	.00	4556.00
06/01/2005 06/05/2006	3 111					
6		149				
		M 45	.00	.00	.00	.00
		M 138	.00	.00	.00	.00
SUBTOTAL FISCAL YEAR-$000		45.03	876.00	5,432.00	.00	4,556.00
			.00	.00	.00	.00
			.00	.00	.00	.00
SUBTOTAL PART A		.00	.00	.00	.00	.00
			876.00	5,432.00	.00	4556.00
TOTAL PART A						

Figure 5-24 Sample remittance advice (RA), a document used by payers to communicate the payment determination on a claim to the provider.

Patient payments are posted and balances owed are printed on a statement and sent to the patient until the balance is paid. Claims received by payers are processed after computer edits and manual review of the claim are performed. Payment determination is conducted by the payer after claim review edits are performed and can result in the following actions: the claim may be paid, the claim may be pended, or the claim may be denied.

Claim Paid

Payments received from a payer are accompanied by a document that explains the charges submitted, deductible, co-insurance, co-payment, allowed charges, and amount paid on the claim. The term for the document sent with payment is remittance advice. The **remittance advice (RA)** provides an explanation of the charges submitted and details regarding the payer's payment determination (Figure 5-24). Payers may use a variety of other names for this document, such as explanation of benefits, explanation of Medicare benefits, or Medicare summary notice. Payments are processed by the hospital as follows:

- Payment is posted to the patient's account
- Contractual adjustment is applied where applicable
- The balance is billed to the patient or to a secondary or tertiary payer where applicable

The payment is reviewed to determine whether the correct amount was paid. Payer payments will vary based on the specific guidelines for the policy or plan under which the patient is covered. Payments will also vary based on the participating provider agreements between the hospital and the payer, as discussed previously in this chapter. If the payment is not correct, the hospital billing professional will gather information regarding the incorrect payment and pursue payment of the correct amount from the payer. Contact is made with the payer, generally in writing, to outline the details of the incorrect payment and to request the payment be corrected.

Claim Pended

When payers identify a potential problem with medical necessity or coverage based on the claim review, they may request additional information and put the claim in a pending status. The claim is put on hold until the requested information is received. The request for additional information is communicated on the RA that is sent to the provider along with an indication that payment cannot be processed until the requested information is received. Many payers send a notification to the patient to inform the patient about the pended status and the reason for nonpayment of the claim.

Claim Denied

A claim submitted to a payer may be denied entirely, or a specific charge on the claim may be denied. Claim denials are communicated on the RA that is sent to the provider. An explanation of the reason for denial is provided through the use of codes referred to as reason codes. A claim may be denied for many reasons:

- The patient's identification number and name may not match any in the payer file
- Coverage for the patient may not be in effect
- The plan may not provide coverage for a particular service or item
- The service or item may not be considered medically necessary
- Service may be included in a package and therefore not separately billable
- Services may be considered duplicate
- The hospital may not be a network provider through the plan

BOX 5-20 ■ KEY POINTS

Common Reasons for Claim Denials

Patient's identification number and name are incorrect
Coverage terminated prior to date of service
Service not covered under the plan
Service not considered medically necessary
Service included in a package
Duplicate services
Non-network provider

BOX 5-21 ■ KEY POINTS

Accounts Receivable (A/R) Management

Performs functions required to monitor and follow-up on outstanding accounts In order to ensure that reimbursement is received in a timely manner

Accounts Receivable (A/R) Management

It is critical for hospitals to have accounts receivable management functions in place to ensure that payment of reimbursement is received in a timely manner.

Accounts receivable (A/R) management refers to functions required for the monitoring and follow-up of outstanding accounts. A division under the PFS Department, commonly called Credit and Collections, is responsible for A/R management functions. Accounts are monitored by payer type, aging categories, and amount due. Computer-generated reports such as an aging report or a financial class report are printed to identify outstanding accounts based on specified criteria such as payer type or age of the accounts. Credit and collection personnel utilize these reports to identify accounts that require follow-up for the purpose of pursing payment. A/R management is discussed further in Chapter 6.

TEST YOUR *Knowledge* BOX 5-5

THE HOSPITAL BILLING PROCESS

1. Explain when the billing process begins and ends.
2. List five functions in the hospital billing process required to submit charges to third-party payers for reimbursement. Indicate which department is responsible for those functions.
3. Name the phase that starts the process of and is critical to obtaining information required to submit claims to payers and bill patients.
4. Explain the role of the chargemaster in charge capture.
5. Name functions performed by the HIM Department relative to the billing process.
6. State the purpose of encoder and grouper programs.
7. Provide an explanation of the difference between billing patients and third-party payers.
8. What purpose does the patient summary statement serve?
9. Explain what it means to run invoices and claim forms in batches.
10. Describe the document prepared by payers that is sent with payment.

CHAPTER SUMMARY

The hospital billing process involves all functions performed to prepare and submit charges for services rendered. Services and items rendered are posted to the patient's account through the chargemaster. Charges are submitted to patients utilizing invoices and statements. Claim forms are utilized to submit charges to third-party payers such as insurance carriers or government programs. Claims may be submitted via mail, fax, or electronic data interchange (EDI). Coding systems are utilized to translate written descriptions of services and items into codes. Procedure and diagnosis codes are reported on the claim form to describe what services were performed and why they were performed. Third-party claims are reviewed and payment is determined based on the patient's coverage and the outcome of the claim form edits, or the claim can be denied or pended. Payers utilize various reimbursement methods to pay for services rendered. Outstanding accounts are monitored and hospital collection representatives pursue outstanding balances based on the account's age.

The purpose of the process is to obtain the appropriate reimbursement for services and items rendered. Hospital billing and coding professionals are required to have an understanding of the hospital's billing process, billing guidelines, payer specifications, and coding principles and guidelines. The insurance billing and coding industry is in constant motion, with changes in policies, procedures and guidelines occurring on a daily basis. As a result of the constant change, billing and coding professionals need to maintain a current knowledge base on payer guidelines and specifications.

CHAPTER REVIEW 5-1

True/False

1. The purpose of the hospital billing process is to obtain appropriate reimbursement for services rendered. T F
2. Accurate completion of the claim helps to ensure accurate reimbursement. T F
3. Patients are considered third-party payers. T F
4. The detailed itemized statement is an outline of all services and items posted to the patient's account during the patient stay. T F
5. The Charge Description Master does not include procedure codes. T F

Fill in the Blanks

6. A claim that can be processed the first time without failing payer edits and specifications is called a _____.
7. The portion of a claim that the patient must pay is referred to as _____ _____.
8. Two claim forms used to submit claims to third-party payers are _____ and _____.
9. The process of counting the number of days a claim is outstanding is known as _____.
10. Coding systems used to describe diagnosis and procedures on the UB-92 are _____, _____ and _____.

Match the Following Definitions with the Terms Below

11. Reimbursement to the hospital is a set rate as agreed to by the hospital and the payer.
12. The hospital is paid the total amount of charges accrued for the patient admission.
13. A reimbursement method used to determine payment for inpatient cases.
14. A reimbursement method used to determine payment for ambulatory surgery cases.
15. A percentage of the total accrued charges are paid to the facility.

A. DRG
B. Fee for service
C. Percentage of accrued charges
D. Contract rate
E. APC

Research Project

Utilize the participating provider agreement in Figures 5-3 and 5-4, the hospital billing process information in this chapter, and research aspects, as required, through the Internet or by contacting a local hospital and perform a side-by-side comparison of the agreement to the process and discuss how the hospital billing process is designed to meet provisions in the participating provider agreement.

GLOSSARY

Accounts receivable (A/R) management Refers to functions required for the monitoring and follow-up on outstanding accounts to ensure that reimbursement is received in a timely manner.

Ambulatory payment classification (APC) The OPPS utilized by Medicare and other government programs to provide reimbursement for hospital outpatient services. Under the APC system, the hospital is paid a fixed fee based on the procedure(s) performed.

Ambulatory surgery Surgery is performed in a free-standing or hospital-based ambulatory surgery setting. Surgery is performed and the patient is discharged the same day.

Batch A specified group of invoices or statements processed at one time.

Billing process Involves all the functions required to prepare charges for submission to patients and third-party payers to obtain reimbursement.

Capitation A reimbursement method utilized that provides payment of a fixed amount, paid per member per month.

Case mix A term used to describe type of patient cases treated by the hospital.

Case rate A reimbursement method utilized that provides a set payment rate to the hospital for a case. The payment rate is based on the type of case and resources utilized to treat the patient.

Charge Description Master (CDM) Computerized system used by the hospital to inventory and record services and items provided by the hospital. The CDM is commonly referred to as the chargemaster.

Claims process The portion of billing that involves preparing claims for submission to payers.

Clean claim A claim that does not need to be investigated by the payer. A clean claim passes all internal billing edits and payer specific edits and is paid without need for additional intervention.

Clearinghouse A company that receives claim information from hospitals and other providers in various formats for conversion to a required format for submission to various payers.

Collections Involves monitoring accounts that are outstanding and pursuing payment from patients and third party payers. Collections is also referred to as accounts receivable (A/R) management.

Contract rate A reimbursement method utilized that provides a set payment rate to the hospital as agreed to by the hospital and payer.

Detailed itemized statement A listing of all charges incurred during the patient visit.

Diagnosis Related Group (DRG) The IPPS utilized by Medicare and other government programs to provide reimbursement for hospital inpatient services. Under the DRG system, the hospital is paid a fixed fee based on the patient's condition and relative treatment.

Electronic data interchange (EDI) Term used to describe the process of sending information from one place to another via computer.

Electronic media claim (EMC) Term used to describe the claim form that is sent via EDI.

Encoder A computer program utilized to assist with code assignment.

Facility charges Charges that represent cost and overhead for providing patient care services, including space, equipment, supplies, drugs and biologicals, and technical staff. Facility charges represent the technical component of the services.

Fee-for-service A reimbursement method that provides payment for hospital services based on an established fee schedule for each service.

Fee schedule A listing of established allowed amounts for specific medical services and procedures.

Flat rate A reimbursement method whereby the hospital is paid a set rate for a hospital admission regardless of charges accrued.

Form locator (FL) The name used to refer to each of the 86 fields (form locator 1 through 86) on the UB-92.

GROUPER A computer program utilized for the assignment of a DRG or APC based on the information entered such as diagnosis, procedure, and other patient information like age, sex, and length of stay.

Health Care Common Procedure Coding System (HCPCS) The standard coding system used to report services and items to various payers. HCPCS consists of two levels: Level I, CPT codes, and Level II, Medicare National Codes.

Inpatient Prospective Payment System (IPPS) A Prospective Payment System established as mandated by the Tax Equity and Fiscal Responsibility Act (TEFRA) in 1983 to provide reimbursement for acute hospital inpatient services. The system implemented under IPPS is known as Diagnosis Related Group (DRG).

Outpatient Prospective Payment System (OPPS) Prospective Payment System implemented (effective August 2000) by CMS that provides reimbursement for hospital outpatient services. The system implemented under OPPS is known as ambulatory payment classification (APC).

Participating provider agreement A written agreement between the hospital and a payer that outlines the terms and specifications of participation for the hospital and the payer.

Patient invoice A document prepared by the hospital to advise the patient of an outstanding balance that includes details regarding current services. It is generally sent out the first time a balance is billed to the patient.

Patient statement A document prepared by the hospital that provides details regarding account activity, including the previous balance, recent charges, payments, and the current balance. The patient statement is generally sent monthly to notify the patient of a balance due.

Per diem A reimbursement method that provides payment of a set rate, per day to the hospital, rather than payment based on total charges.

Percentage of accrued charges A reimbursement method that calculates payment for charges accrued during a hospital stay. Payment is based on a percentage of approved charges.

Professional charges Charges that represent the professional component of patient care services performed by physicians and other non-physician clinical providers.

Prospective Payment System (PPS) A method of determining reimbursement to health care providers based on predetermined factors, not on individual services.

Reimbursement Term used to describe amount paid to the hospital by patients or third-party payers for services rendered.

Relative value scale A reimbursement method that assigns a relative value to each procedure. It represents work, practice expense, and cost of malpractice insurance and is assigned to professional services.

Resource-based relative value scale (RBRVS) A payment method utilized by Medicare and other government programs to provide reimbursement for physician and some outpatient services. The RBRVS system consists of a fee schedule of approved amounts calculated based on relative values assigned to each procedure.

Revenue code A four-digit number assigned to each service or item provided by the hospital that designates the type of service or where the service was performed.

Third-party payer An organization or other entity that provides coverage for medical services, such as insurance companies, managed care plans, Medicare, and other government programs.

Usual, customary, and reasonable A reimbursement method whereby payment is determined by reviewing three fees: (1) the usual fee—the fee usually submitted by the provider of a service or item; (2) the customary fee—the fee that providers of the same specialty in the same geographic area charge for a service or item; and (3) the reasonable fee—the fee that is considered reasonable