Billing and Collections Knowledge Assessment

Message to the manager who may use this assessment tool:
All or portions of the following questions can be used for interviewing/assessing candidates for open positions in various reimbursement related functions in the practice and with existing employees to assess their understanding of topics. If used for existing employees important to stress that it is a knowledge assessment tool to determine where more training or better position placement is needed, not a "test."

Coding

1. Explain the difference between a CPT code and an ICD-10-CM code.
2. A CPT code has _____ characters while an ICD-10-CM code has _____ characters.
3. What are Evaluation and Management (E/M) codes?
4. Name three types, or categories, of E/M codes applicable to your specialty.
5. If a physician performs a consultation in the emergency room on a non-Medicare patient then admits the patient to the hospital on the same day, can the physician bill both the consultation code *and* the admission code?
6. What is the difference between the office consultation and new patient codes, according to CPT?
7. List the major payors that do not recognize consultation codes.
8. True or false: CPT says there are 90 days in the postoperative global period for major procedures.
9. What CPT codes are used for joint injections and how do they differ?
10. How are drugs for joint injections billed? What about units?
11. What is "unbundling"?
12. Can an E/M visit be billed with a minor procedure?
13. If an E/M visit is denied because the patient is being seen in a post-operative period for a different problem, what might be missing from the claim?

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Billing and Collections Knowledge Assessment

Follow-Up and Posting

14. Which 3 payor websites do you find the easiest to use and why?

15. List all of the individual insurance companies that you know of who have their own on-line appeals forms.

16. Name three types of *non-contractual* adjustments/write offs.

17. How is the posting of an insurance payment from a non-contracted payor different than the posting of a payment from a PPO with whom the practice is contracted?

18. Describe the difference between pre-certification, prior authorization and determination of benefits.

19. What does it mean to post payments by *line item?* Why is it so important?

20. A Medicare "clean" claim should be paid within _____ days after electronic submission.

21. A non-Medicare unpaid "clean" claim should be followed up by billing staff at ____ days after claim submission.

22. How would you handle the following EOB rejections, or "$0 pays", and how could these payment denials be avoided?
    a. "Procedure not a covered benefit"
    b. "Patient not eligible on date of service"
    c. "Contract number does not match information on file"
    d. "Applied to deductible"
    e. "Bundled service"

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Collections and Interactions with Patients

23. Which payor or clearing house online claims estimator do you have the most familiarity with? Which features are the most beneficial? In what ways is it lacking?

24. Is it appropriate to offer a cash discount to an uninsured patient who is paying cash for services?

25. Describe your experience with collecting patient responsibility portions *prior* to surgery. About what percentage of the patient responsibility do you typically collect *prior* to surgery? How do you ensure payment for the remainder?

26. If you were discussing the status of a patient's overdue balance with him or her on the telephone, and the patient said, "I can pay you, but not until I get my paycheck next week." How would you respond?

27. What's the best method for determining if a Medicare patient has traditional Medicare coverage or a Medicare Advantage/Replacement plan?

Overall A/R

28. True or false: The accounts receivables (A/R) greater than 90 days should be a much *smaller* percentage of the total A/R than the A/R less than 90 days old.

29. True or false: A/R should be aged based on the date of service rather than the date of charge entry.

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Billing and Collections Knowledge Assessment: *Answer Key*

1. Explain the difference between a CPT code and an ICD-10-CM code.
   CPT code is used to describe a service or procedure (what was done to the patient), and ICD-10-CM is used to describe the diagnoses (why the service or procedure was done).

2. A CPT code has _____ digits while an ICD-10-CM code has _____ characters.
   CPT code has **5** digits while an ICD-10-CM code has **3-7 characters** (depending on the level of specificity).

3. What are Evaluation and Management (E/M) codes?
   Evaluation and Management codes describe various types of visit such as office, emergency department, consultation or hospital.

4. Name three types, or categories, of E/M codes applicable to your specialty.
   There are several types, or categories, of E/M codes. Examples are 9920x (new patient), 9921x (established patient), 9924x (office or other outpatient consultation), 9922x (initial hospital care), 9923x (subsequent hospital care), 9925x (inpatient consultation), and 9928x (emergency department visit).

5. If a physician performs a consultation in the emergency room on a non-Medicare patient then admits the patient to the hospital on the same day, can the physician bill both the consultation code *and* the admission code?
   No. Both the consultation code (9924x) and the initial hospital care code (9922x) may not be billed on the same day when the service provided is continuous as in this example. In this example, either the consultation code or the initial hospital care code is billed – but not both codes.

6. What is the difference between the office consultation and new patient codes, according to CPT?
   Consultation codes (99241-99245): A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit. The written or verbal request for a consult may be made by a physician or other appropriate source and documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source. New patient codes (99201-99205): Usually a self-referred patient or a consultation on a Medicare patient (or patient whose insurance company does not recognize the consultation codes (9924x)."

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Billing and Collections Knowledge Assessment: *Answer Key*

7. List the major payors that do not recognize consultation codes.
   Medicare does not recognize consultation codes. There may be additional carriers listed as an answer to this depending on local carriers' position on consultations. Confirm the answer locally. The answer "all" is most likely incorrect.

8. True or false: CPT says there are 90 days in the postoperative global period for major procedures.
   False. This is an example of where coding guidelines (as defined by CPT) differ from payor reimbursement rules. CPT states that the postoperative period includes the "typical postoperative follow-up care" while Medicare's rules are 0-10 days in the postoperative follow-up period for minor procedures and 90 days for major procedures.

9. What CPT codes are used for joint injections and how do they differ?
   20600-20611. The codes differ by the size of the joint (small, intermediate, and major) and whether ultrasound guidance is used. The purpose of this question is to determine whether one knows the difference in the main codes submitted for many office procedures. Failure to bill the right code can lead to missed reimbursement.

10. How are drugs for joint injections billed? What about the units?
    The drugs used for joint injections are billed using HCPCS II "J codes." The codes have specific dosages listed in the descriptors, so units are used to report the appropriate amount of the drug injected. For example if a patient has 16 mg of Synvisc injected into the right knee, code J7325 should be billed with 16 units as this code is billed per 1 mg. The codes for the drugs can only be billed if the practice paid for the medication and needs reimbursement. The purpose of this question is to determine that one understands how to bill properly for medications. If drugs are billed with improper units, the practice can be losing reimbursement and actually losing money on drugs.

11. What is "unbundling"?
    "Unbundling" is reporting more than one CPT code that should actually be reported using one CPT code.

    As an example, CPT meniscectomy codes 29880 and 29881 are defined to include chondroplasty in the same knee. Reporting 29877 for chondroplasty separately in the same knee represents unbundling of 29880 and 29881. Today's insurance companies have software that edits submitted code combinations to quickly identify unbundling issues on a claim. Sometimes the software edits are accurate and sometimes they are not. Billing staff must be knowledgeable about CPT codes to understand when two codes are truly unbundled and when they are not.

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12. Can an E/M visit be billed with a minor procedure?
    Sometimes. If a significant, separately identifiable service is documented, then and E/M visit may be billed on the same visit as a minor procedure with modifier 25. This questions tests knowledge of coding guidelines. If an E/M is billed with a minor procedure and denied, the medical record should be pulled and evaluated to see if the documentation supports both services. If it does, then an appeal may be necessary.

13. If an E/M visit is denied because the patient is being seen in a post-operative period for a different problem, what might be missing from the claim?
    Modifier 24. Modifier 24 is used to indicate the patient is seen for an unrelated problem during a postoperative global period. This question is used to test understanding of modifiers that may affect reimbursement.

Follow-Up and Posting

14. Which 3 payor websites do you find the easiest to use and why?
    Answer will vary. Check out answer against payor websites and/or follow up on this answer. **A detailed answer here demonstrates that one is familiar with and regularly uses payor websites** rather than just saying they do and using the telephone, which is a much less efficient/effective way to follow up with payors.

15. List all of the individual insurance companies that you know of who have their own on-line appeals forms.
    Answer will vary. Verify the answer on the internet. Here again, looking for bona fide experience with pertinent, effective internet experience.

16. Name 3 types of *non-contractual* adjustments/write offs.
    Possible answers include: Bad debt, bankruptcy, deceased patient, missed appeal deadline, timely filing, no precertification, no referral authorization, noncovered service, NSF check, payment plan default, pre-existing condition, recovered from collection agency, small balance write off, charity care, financial hardship, professional courtesy, cash discount, Medicaid secondary.

17. How is the posting of an insurance payment from a non-contracted payor different than the posting of a payment from a PPO with whom the practice is contracted?
    For non-contracted payors, the difference between what the insurance company pays and the practice's fee can be transferred to the patient's responsibility, and a statement sent to the patient. For contracted payors, you must adjust off the difference between the contracted payment and the practice's fee.

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Billing and Collections Knowledge Assessment: *Answer Key*

18. Describe the difference between pre-certification, prior authorization and determination of benefits?
    Pre-certification means the plan said, "Yes, you can do that specific procedure." This does not guarantee payment. Prior authorization means the plan said, "You will be paid for this specific procedure." Typically prior authorization is requested, and provided, in writing. Written prior authorization from the payor is a guarantee for reimbursement. Determination of benefits means you've confirmed with the payor the patient's specific insurance benefits available. This is no guarantee of payment for a specific procedure.

19. What does it mean to post payments by *line item?* Why is it so important?
    Posting by line item means you post payments and adjustments to the actual CPT code that was billed; as opposed to posting payments to the oldest outstanding invoice balance on the account, or the entire "claim." If payments are not posted in line item fashion, you have no way of knowing if you have received correct payment by CPT code or of retrieving historical payment information by CPT code.

20. A Medicare "clean" claim should be paid within _____ days after electronic submission.
    Medicare "clean" claim should be paid by **14** days after electronic submission.

21. A non-Medicare unpaid "clean" claim should be followed up by billing staff at ____days after claim submission.
    Non-Medicare "clean" claim should be followed up by billing staff at **30-45 days after claim submission, depending on the contract's terms for timeliness of payment.**

22. How would you handle the following EOB rejections, or "$0 pays", and how could these payment denials be avoided?

    a. "Procedure not a covered benefit"
       Check the plan guidelines. If this rejection is accurate, transfer the balance to the patient and send a statement. This type of rejection could be avoided if good determination of benefits were done prior to surgery – then payment prior to surgery would be expected from the patient.

    b. "Patient not eligible on date of service"
       Verify accuracy of this information, if true, then call the patient to see if s/he is covered under a different insurance plan. If so, obtain that information and submit a claim to the new plan. If not, then explain to the patient that s/he is responsible for the charge and obtain credit card information to charge the visit at this time. This type of rejection could be avoided if verification of insurance eligibility had been performed prior to the service.

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c. "Contract number does not match information on file"
Call patient to obtain correct information and file a corrected claim to the insurance company. Make sure corrected number is in patient record.

d. "Applied to deductible"
Transfer balance to patient responsibility and send a statement. This type of rejection could be avoided by knowing the patient's unpaid deductible information prior to surgery and collection of a surgery scheduling deposit.

e. "Bundled service"
Analyze the CPT code denied and determine whether or not the code is indeed bundled or if the payor's software editing system has inappropriately bundled the code into another code billed. If the denial is appropriate, then adjust off the balance. If the denial is not accurate, then file an appeal for payment.

Collections and Interactions with Patients

23. Which payor or clearing house online claims estimator do you have the most familiarity with? Which features are the most beneficial? In what ways is it lacking?
Answer will vary. Purpose is to solicit examples of experience using online claims estimators. Looking for details and description here so demonstrate an understanding and experience having used a claims estimator.

24. Is it appropriate to offer a cash discount to an uninsured patient who is paying cash for services?
Yes. Typically practices offer a 10-30% cash discount to uninsured patients who pay cash for services. The discount is in exchange for the practice not incurring the associated costs to bill an insurance company for the service. Be sure your discounted fee is still above Medicare's allowable as you do not want to offer services below this rate.

25. Describe your experience with collecting patient responsibility portions *prior* to surgery. About what percentage of the patient responsibility do you typically collect *prior* to surgery? How do you ensure payment for the remainder?
Answers will vary. You are looking for indications that someone has had success talking with patients *and collecting prior* to surgery. Perhaps the answer will describe collecting half of the patient responsibility prior to the procedure, and the remaining half at the first postoperative visit. Some answers may describe collecting the entire patient responsibility prior to surgery. Some answers may describe that the doctors did not want the staff to collect prior to surgery – this is an indication that the individual has no training or experience in talking with patients about money and collecting *prior* to surgery.

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26. If you were discussing the status of a patient's overdue balance with him or her on the telephone, and the patient said, "I can pay you, but not until I get my paycheck next week." How would you respond?
"That's fine. I'll make a note to myself to watch for that payment from you Mr. Jones, and be sure it is processed immediately. We appreciate you taking care of your account." Make a note to be sure the check really arrives. If it doesn't, place another call.

27. What's the best method for determining if a Medicare patient has traditional Medicare coverage or a Medicare Advantage/Replacement plan?
Answers may vary. Trying to determine methods they have come up with or training they have received on the topic. Possible answers: Asking the patient to show ALL of the insurance cards they have. Asking the (Medicare) patient if they have prescription drug coverage. Verifying eligibility online.

Overall A/R

28. True or false: The accounts receivables (A/R) greater than 90 days should be a much *smaller* percentage of the total A/R than the A/R less than 90 days old.
True. The A/R>90 days *should* be a smaller percentage of the total A/R than unpaid balances <90 days old.

29. True or false: A/R should be aged based on the date of service rather than the date of charge entry.
True. The A/R should be aged based on the date of service rather than the date of charge entry. The lag time between date of service and date of charge entry is controllable by the practice and the practice should be motivated to get charges in quickly.

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