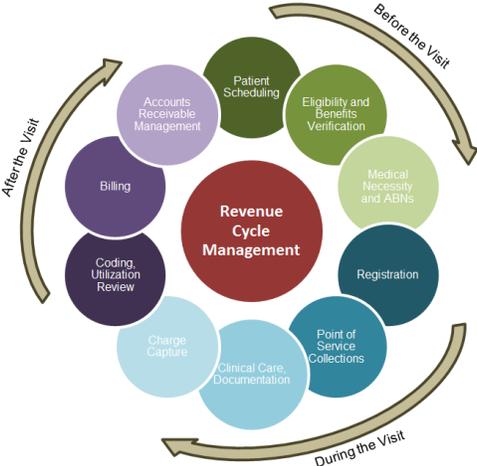


Billing and Coding Manual for Title X Family Planning Clinics

Updated March 1, 2016



Family Planning Program
Prevention Services Division



RT Welter
& Associates, Inc.

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Introduction

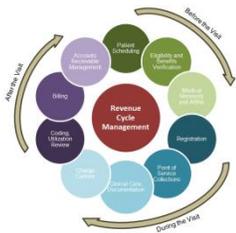
About the Guide

ABOUT THE GUIDE

This billing manual is meant for use by Title X grantees and service sites across the state of Colorado, and will function as an interactive web based tool to understand the revenue cycle management process with descriptions, sample documents, and best practices, and will link to resources to help you develop your agency's revenue management structure and processes,

The major components of the revenue cycle management process are broken down by section, and within each section you will find a brief overview followed by detailed instructions and best practices for each component. As you use this guide it is important to consider your agency's capacity to successfully implement each component of the revenue cycle management process.

Look for the following: **AGENCY CAPACITY ASSESSMENT CHECKLIST** in the resource section for a downloadable/printable version to keep track of your agency's capacity at each step.



When you see the revenue cycle management wheel, click on any of the titles to jump to the section you wish to review.

SPECIFIC LEARNING OBJECTIVES

- Identify vital components of revenue cycle management that take place before, during, and after the client's visit.
- Implement an effective workflow process for all components of revenue cycle management.
- Utilize communication tips to request information and payment from clients.
- Apply the steps involved in coding, claims submission, and follow up to ensure that reimbursement is received for services provided.
- Identify the necessary resources for financial management based on clinic capacity.
- List the initial steps required to develop a third party payer contracting strategy.
- Understand the key components to look for in reviewing a third party payer contract.
- Identify the common principles for fee schedule development.
- Describe the process of provider credentialing and explain why it is necessary.
- Assess your agency's level of capacity to effectively carry out each of the components of revenue cycle management.
- Understand the difference between private (commercial) insurance and public health plans (such as Medicare and Medicaid).
- Understand the basics of the Health Insurance Portability and Accountability Act (HIPAA) and how to ensure compliance.
- Identify outsourcing options; be able to assess the benefits or necessity in outsourcing certain functions.



Definitions

DEFINITIONS & ACRONYMS

For the purposes of this guide, the following definitions and acronyms have been provided for your reference.

- *Advance Beneficiary Notice (ABN)*: also known as a waiver of liability; a notice that suppliers and other medical providers are required to give the client when they offer services or items they know or have reason to believe Medicare will deem medically unnecessary and therefore will not pay for.
- *Assignment of Benefits*: form signed by the patient appointing the provider as the authorized representative to receive payment for medical claims.
- *Client: Patient*: interchangeable – in the public health setting “client” is used to refer to individuals receiving services in agencies; in the private sector “patient” is used more often; for this guide the two will be interchangeable.
- *Copayment*: the out of pocket portion of the cost of the visit the insured individual is required to pay at the time of the visit.
- *Covered Entities*: organizations that are engaged in electronic transmission of PHI (protected health information).
- *CPT*: Current procedure terminology; report the medical services and procedures provided to the patient.
- *EFT*: Electronic Funds Transfer.
- *Explanation of Benefits (EOB)*: a statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid or denied
- *Federal Poverty Level (FPL) or Federal Poverty Guidelines*: Issued by the Department of Health and Human Services (HHS) as a simplification of the US Census based poverty thresholds for use for administrative purposes to determine financial eligibility for certain federal programs. Click here to access the [Federal Register notice of the HHS 2015 poverty guidelines](#).
- *Health Insurance Portability and Accountability Act (HIPAA)*: Passed into law in 1996, HIPAA requires the establishment of national standards for electronic health transactions and national identifiers for providers, health insurance plans, and employers, and addresses the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in the US healthcare system.
- *ICD-9*: International classification of diseases 9th revision identify the particular diagnosis. These ICD-9 codes describe a disease or condition.
- *ICD-10*: International classification of diseases 10th revision identify the particular diagnosis. These ICD-10 codes describe a disease or condition. The 10th revision will be utilized in the United States effective October 1st 2015.
- *Office of Population Affairs (OPA)*: The Office of Population Affairs (OPA) administers the federal Title X program and serves as the focal point to advise the Secretary and the Assistant Secretary for Health on a wide range of reproductive health topics, including family planning, adolescent pregnancy, sterilization and other population issues.
- *Payer; Insurer; Third party; Health plan; Insurance company*: interchangeable - a company that covers health insurance benefits (includes all insurance companies, including public plans such Medicare, Medicaid, and CHP+).
- *Pre-visit*: from the time a client calls to schedule an appointment up until the time the client's clinical care is rendered by a clinician.
- *Protected Health Information (PHI)*: any information concerning health status, provision of health care, or payment for health care that can be linked to an individual.



- *Revenue cycle management*: a combination of the many different strategies and processes required in order for a facility or provider to receive payment for services
- *Superbill; Encounter Form*: provides a one to two page snapshot of the client visit and should include services provided and basic information such as the client name, date of appointment, may include insurance information, the co-payment amount, and balance due and may be available in electronic format through electronic health records

Overview: Revenue Cycle Management Process

WHAT IS REVENUE CYCLE MANAGEMENT?

Revenue Cycle Management is a combination of many different strategies, components and processes required by payers in order for a facility or provider to receive payment for services provided. Components of the revenue cycle management you might be most familiar with include: reviewing the patient's financial situation, assigning a sliding fee schedule category, and determining the amount due for services rendered; issuing invoices and collecting payment when able; and perhaps even submitting claims to insurance companies; however, the complete revenue cycle management process actually begins at the time the patient calls to make or walks in for an appointment. Each component of the cycle that occurs before, during, and after the patient visit is crucial to the financial viability your organization, and sound business practices must be implemented to ensure sustainability.

WHO NEEDS THIS GUIDE?

The Intended users include local public health agencies, state health departments, nonprofit organizations, federally qualified health centers, federal agencies, and others. This guide is meant for Title X grantees and service sites as a resource to assist in implementing a structure for managing the entire revenue cycle that will contribute to the long term sustainability of the agency in the changing healthcare environment.

WHY IS THIS GUIDE NECESSARY?

The Patient Protection and Affordable Care Act (ACA) include a number of provisions that will impact your agency. The provisions of the ACA that are predicted to impact the populations you currently served include:

- **Contraceptives:** Most health plans will be required to cover contraceptive services without cost-sharing.
- **Dependent Coverage:** Requires most private health plans that cover dependents to continue to cover young adult children under the age of 26.
- **Medicaid Expansion:** With financial support from the federal government, many states, including Colorado, has expanded Medicaid to include most non-elderly, non-pregnant individuals with income below 133% of the Federal Poverty Level (FPL), effectively 138% of FPL with a 5% income disregard.
 - States were given the option to provide targeted Medicaid family planning services and supplies to certain individuals who would otherwise be ineligible for Medicaid.
 - All state Medicaid programs are mandated to include family planning services and supplies in their benefit packages (with no cost-sharing). For those in the new eligibility group, the federal government will pay 100% of Medicaid expenditures 2014-2016, including family planning expenditures, gradually declining to 90% in 2020 and thereafter. For all other Medicaid enrollees, the federal government pays 90% of Medicaid family planning expenditures.
 - On May 13, 2013 Governor Hickenlooper signed into law Colorado's plan for health insurance alignment and Medicaid expansion, as authorized by the ACA. The expansion of Medicaid in Colorado will allow more than 160,000 Coloradans to gain access to Medicaid. Expanded coverage began January 2014 and there is no deadline to apply. The expansion allows



Coloradans earning up to 138% of the Federal Poverty Level (\$33,465 per year for a family of four or \$16,242 per year for an individual).

In Colorado, it is estimated that 510,000 Coloradans – nearly one of every 10 residents – will become newly insured between 2014 and 2016 ([“A Half Million Newly Insured is Colorado Ready.”](#) The Colorado Trust).

- **Health Insurance Exchanges (Marketplaces):** Provide eligible individuals and small businesses with access to a marketplace to shop for and purchase private health insurance and will subsidize premium costs for qualified individuals.

[Source: Congressional Research Service, Title X \(Public Health Service Act\) Family Planning Program](#)

The Title X Family Planning Program Priorities (FY2012) for The Office of Population Affairs (OPA) has identified the need for tools to assist Title X service sites with revenue cycle management:

“Identifying specific strategies for addressing the provisions of health care reform and for adapting delivery of family planning and reproductive health services to a changing health care environment, and assisting clients with navigating the changing health care system. This includes, but is not limited to enhancing the ability of Title X clinics to bill third party payers, private insurance, and Medicaid.”

[Source: HHS OPA Title X Family Planning Program Priorities](#)

ABOUT THE MARKET PLACE

Beginning on January 1st 2014 states are required to operate health marketplaces – which are marketplaces where individual or small businesses can compare the costs of various health plans and different types of health coverage benefits. If a state decides not to operate its own health insurance marketplace, the state will be required to participate in the federally run marketplace. Health plans participating in these marketplaces are referred to as qualified health plans.

For Colorado’s health marketplace, click here: [Connect for Health Colorado](#)

For the federally run marketplace, click here: [Healthcare.gov](#)

TITLE X GUIDELINES RELEVANT TO REVENUE CYCLE MANAGEMENT

While you are encouraged to implement best business practices at your organization for revenue cycle management, it is important to understand and continue to comply with Title X guidelines.

Your agency is required to have policies and procedures in place to outline how you will *make a reasonable effort* to verify the client's insurance and income status.

- Individuals with incomes below 100% of the federal poverty level (FPL) cannot be charged for services **unless** they have insurance. **42 CFR 59.5 (a) (7)**
- Individuals with incomes between 100% and 250% FPL must be charged discounted fees based on a sliding fee scale and if insured, the insurance company must be billed the non-discounted amount. **42 CFR 59.5 (a) (8)**
- Individuals with incomes over 250% FPL must be charged based on reasonable cost of providing services **42CFR 59.5 (a) (8)**



- Reasonable efforts to collect charges without jeopardizing confidentiality must be made.

Keep in mind that if they are not filing a claim for a minor under their parents' insurance, discounts are calculated based on the minor's income, and that clients must not be denied services based on inability to pay.

For a complete list of Title X Regulations and Federal and Colorado State Laws click [here](#).

Confidentiality: Federal regulations require that your agency protect information. Clients with insurance coverage may request that you not bill the insurance due to confidentiality concerns. The client may be concerned that an Explanation of Benefits (EOB) or other documents about their medical care will be mailed to their address. While honoring requests for confidential services is necessary, it is important to explore options for how best to handle this situation. Your agency should address options for protecting confidentiality such as EOB suppression with payers at the time of contracting [*to jump to the contracting section of this guide, [click here](#)*]. The payer may agree to withhold EOBs and other communication regarding services, however, you should be aware that the policyholder, e.g. the client's spouse or parent, may still have access to claims information. Your Agency should establish a process for how requests for confidential services will be handled, and should be sure to enforce the policy across all clients.

EOB suppression is a challenge and will most likely become more of an issue as more uninsured individual (including minors) become insured through healthcare reform. The willingness of health plans to suppress EOBs varies across health plans and across the country. Your agency should be proactive as healthcare reform is implemented. Some service sites are making a shift by asking clients to request confidential services, rather than assuming this is a necessity for all clients.

[For information on Title X in Colorado, click here.](#)

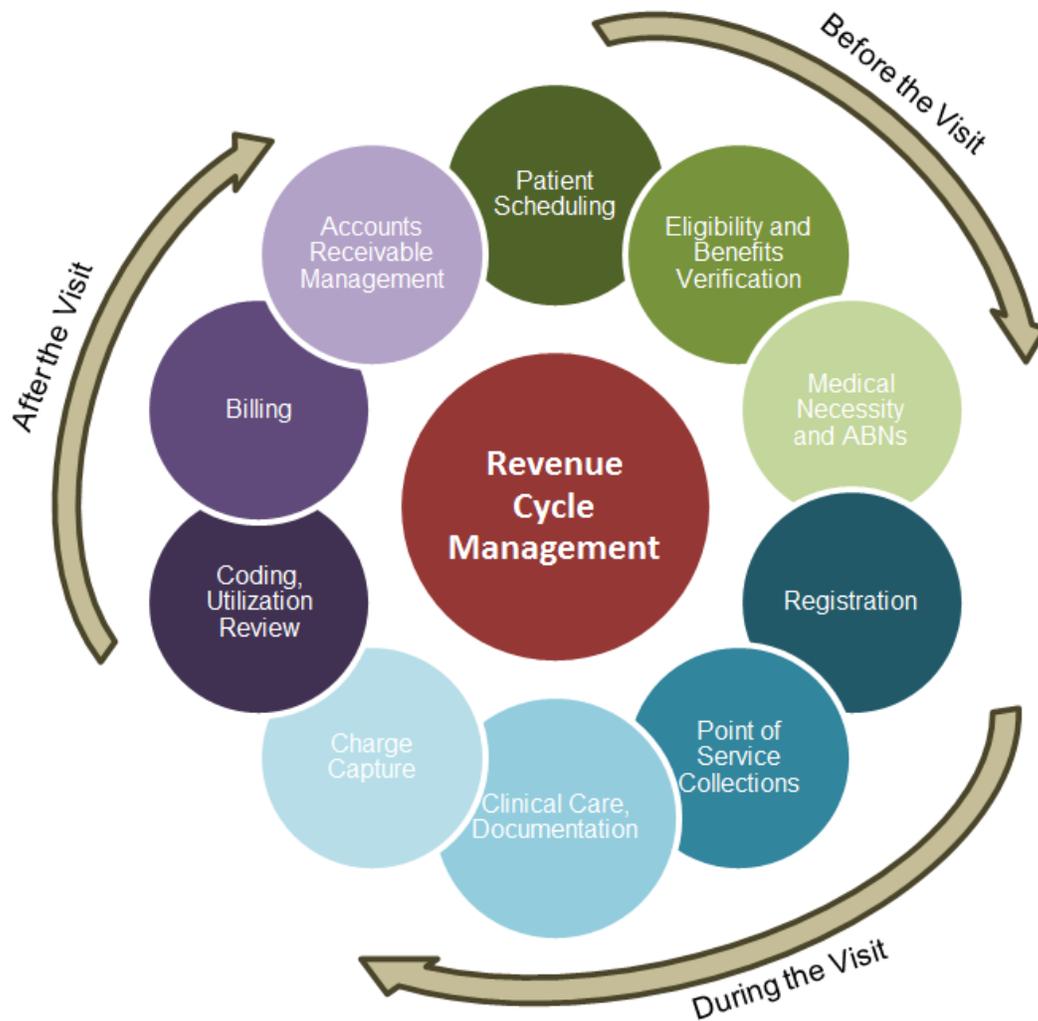
[For information on health care reform in Colorado, click here.](#)

With regards to EOB suppression, there was a recent update to Colorado's Department of Regulatory Affairs (DORA), Division of Insurance (DOI) policies: Regulation 4-2-35 now includes increased HIPAA protections with an additional Section 6 "Protected Health Information." All of the proposed changes have been accepted, effective January 1 2014. For final regulation language, [click here](#).



COMPONENTS OF REVENUE CYCLE MANAGEMENT

The image below demonstrates the components of the revenue cycle management process. Each of these components will be covered and discussed in detail in this guide. You may jump to different sections by selecting any portion of the graphic (or by clicking on any subject on the left hand navigation menu).

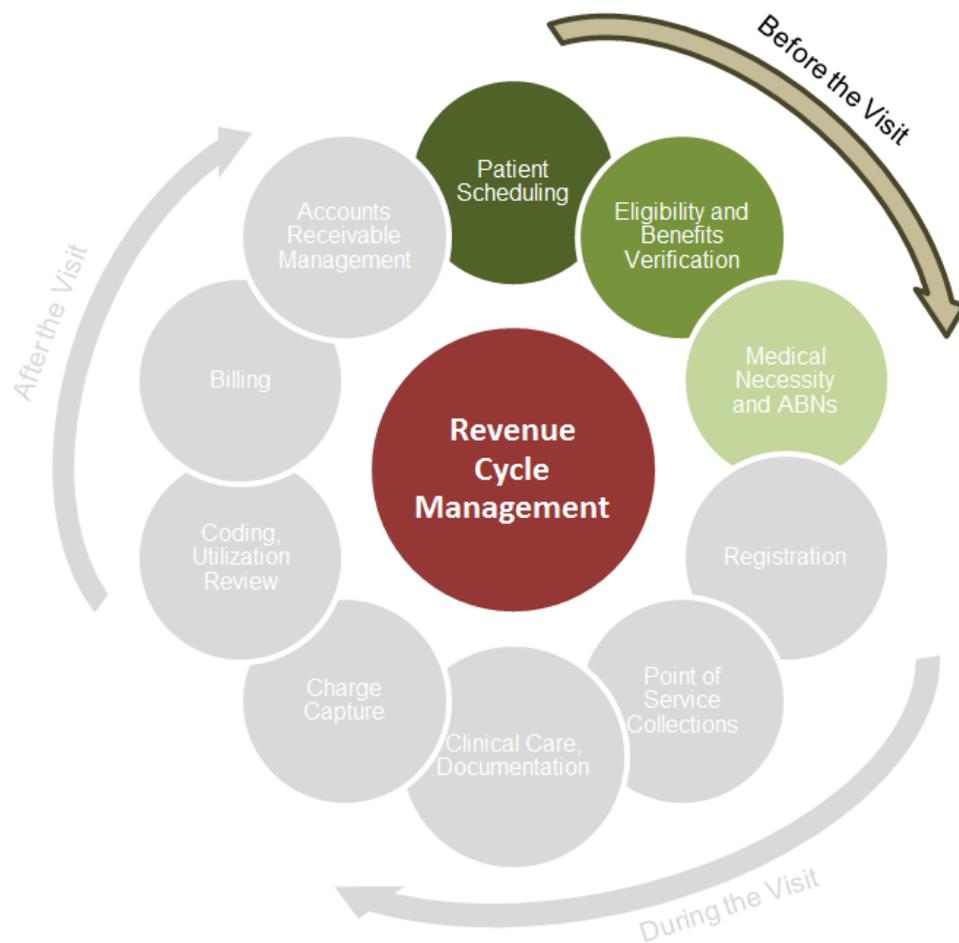


Source: Health Data Management: "Revenue Cycle Management" June 2008:
http://www.healthdatamanagement.com/media/pdfs/RevCycle_Supplement_June.pdf



Before the Visit

Before the Visit (Scheduling, Eligibility/Benefit Verification, Medical Necessity)



OVERVIEW

This section will cover the key components of the revenue cycle management process that should take place **before** the client's appointment, which include:

- Patient scheduling
- Eligibility, benefits verification
- Medical necessity, ABNs

SPECIFIC LEARNING OBJECTIVES

- Identify the vital components of revenue cycle management that take place before the client visit
- Assess your agency's level of capacity to effectively carry out these components of revenue cycle management
- Tools to implement an effective workflow process for those components of revenue cycle management
- Utilize communication tips to request information from your clients



WARNING: COMMON MISSTEP

Before we begin, a common misstep before (and during) the client visit can result in significant revenue loss, and is detrimental to ensuring financial sustainability. While claims submission, billing, and collections are often considered the key components to receiving reimbursement, the steps involved in collecting the pertinent information and ensuring that appropriate documentation is in place prior to claims submission are just as critical to making sure reimbursement is received.

Be sure to collect current client information, do not fail to collect the previous balance, and be sure there are no inconsistencies or failures in collecting copayments. It is imperative that all the T's are crossed and I's are dotted in order to receive payment from commercial and public payers.

APPOINTMENT SCHEDULING

When you are scheduling an appointment, be sure to collect as much information as possible by phone at the time of scheduling, such as:

- Demographics: Complete name, date of birth, telephone number
- Insurance information: Payer name, insurance ID
- Reason for visit

[Click here](#) for a sample registration form that highlights essential demographic, insurance, and visit information you should collect from clients.

There are many reasons why it may be challenging for your agency to collect comprehensive information from the client at time of scheduling. Some of these reasons include language barriers, time constraints, hesitancy to ask as the information gathering may not be a part of the agencies culture or practice.

However, as the number of insured clients increases over the next few years, as referenced earlier in this guide ([click here to jump to the ACA section of this guide](#)), it will become even more imperative to **collect as much information as possible in advance**.

If possible your agency should implement an automated scheduling system, and should ideally develop the capacity to enter detailed information at the time of scheduling directly into the system. Systems may range from scheduling software, to practice management systems, to electronic medical records, but at a **minimum** your agency should be able to enter basic demographics, insurance information, and the client's clinical needs at the time of scheduling.

[What information should we record when our clients are scheduling an appointment?](#)

PREVISIT REGISTRATION AND APPOINTMENT REMINDERS

At the time of scheduling, clients should be asked whether or not they have any type of insurance coverage, and this information should be entered into the practice management system prior to the visit if possible. As mentioned above, clients should be reminded to bring their insurance cards to the appointment (regardless of whether or not the insurance will be billed later, or whether or not services will be covered).

After collecting as much information as possible from the client at the time of scheduling, it is important to follow up afterwards with confirmation and appointment reminders. For appointments scheduled in advance, the client should receive a confirmation phone call (or text message) as a reminder within 24 hours of the appointment. Texting is favored for teenage clients, however, the agency should obtain permission from the client prior to texting. Appointment confirmation clearly does not apply for same day or next day scheduling.

It is strongly suggested that your agency mail or email registration forms to clients to complete prior to arriving for the appointment – this will increase efficiency for the clinic.

It is also at this point that a conversation should also take place to review the [agency's financial policy](#) – if possible, clients should be provided with a cost estimate for the services.



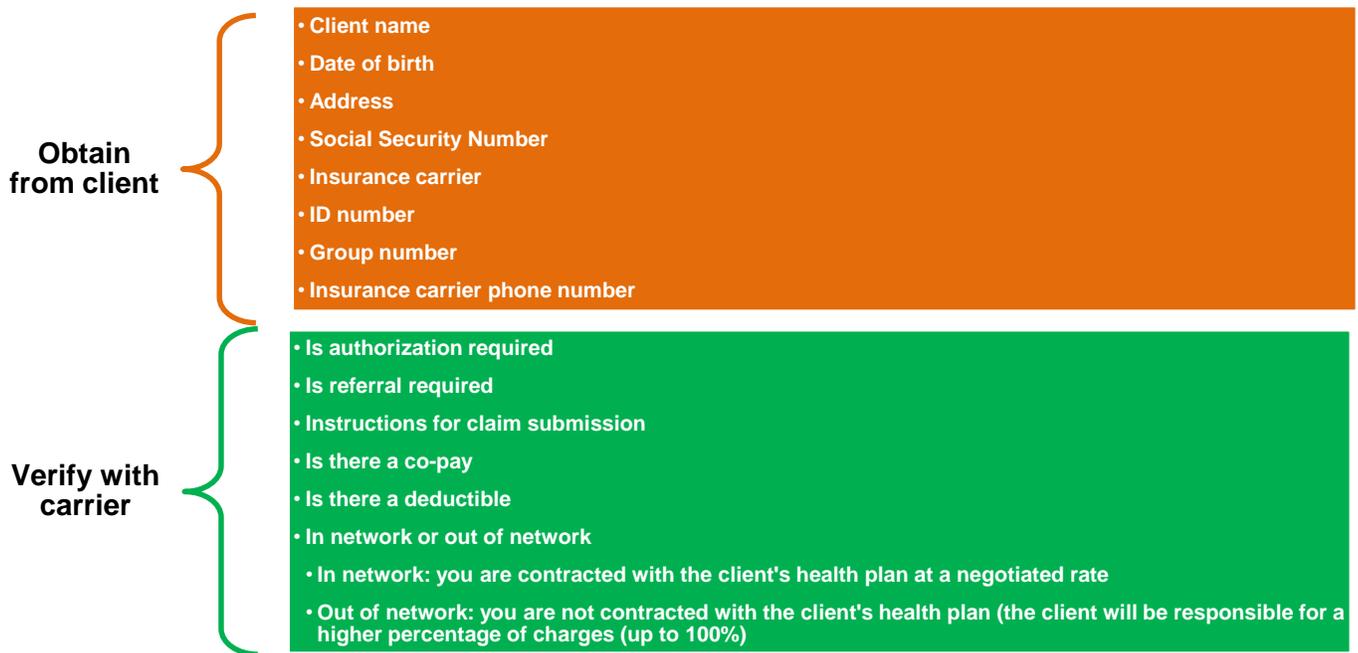
VERIFICATION OF ELIGIBILITY AND BENEFITS

In addition to collecting information from the client, agencies should conduct eligibility verification to confirm the client's insurance status and whether or not the services will be covered. To conduct eligibility verification, you will need to:

1. Gather pertinent information (see list below) and have the information ready.
2. Contact the insurance company. You can either call the insurance company using the contact information listed on the back of the member ID card, or log into the insurance company's website using your provider login. Most commercial insurance companies provide a web based verification process for providers.
3. Verify eligibility. This is the time to ask the representative if a patient is covered. What day did coverage become effective? Has the policy terminated? Were there any breaks in coverage for the patient?
4. Verify benefits. Ask the representative if a specific procedure or medication is covered. Does this plan have routine-care benefits? Are prior authorizations for a procedure needed?

Another option for carrying out this process is to pay a fee to utilize an automated benefits verification software solution. Most clearinghouses (*to jump to the clearinghouse section of the manual [click here](#)*) offer this service.

Information Necessary for Eligibility/Benefit Verification



Clients seeking care at your agency may be covered by insurance plans that the agency has not contracted with – in which case the agency may be considered an **“out of network”** provider.

Some health plans will not reimburse out of network providers at all, which means that if services are provided, the client will be responsible for the full amount of charges. Some health plans offer partial coverage for out of network providers, but the client usually pays a higher amount than if you were in-network. Out of network care is generally more expensive for the client, and it is essential to discuss this with the client prior to the visit.

If this situation arises, make sure to:



- Discuss your agency's [financial policy](#) with the client prior to providing services and have the client sign a financial agreement documenting that he/she understands the financial responsibility.
- This process should be outlined in your agency's financial policies and procedures – and you should follow this same process consistently across all clients.
- Ask the patient to assign benefits to your agency. Typically, in this scenario, the insurance company will not reimburse out of network providers and therefore may issue any payment for the services directly to the patient. You may ask to the client to assign benefits (by filling out an [Assignment of Benefits form](#)) to your agency, making you the authorized representative to receive payment for medical claims. While some health plans will recognize the assignment of benefits and issue payment directly to the out of network provider, some will not – in which case the client will receive the payment and will need to make a payment to your agency.

MEDICAL NECESSITY (MEDICARE)

Before the visit (or this may come up during the visit), there may be instances when you believe Medicare might not pay for an item or services when it usually covers the item or service and Medicare might not consider the item or service medically reasonable and necessary for this patient in this particular instance. If this happens, you must issue an **Advance Beneficiary Notice (ABN)**. An ABN, **Form CMS-R-131**, is a standardized notice that you or your designee must issue to a Medicare beneficiary before providing certain Medicare Part B (outpatient), or Part A (limited to hospice and religious nonmedical healthcare institutions only) items or services. The ABN thus allows the beneficiary to make an informed decision about whether to get services and accept financial responsibility for those services if Medicare does not pay, and also serves as proof that the beneficiary knew prior to getting the item/service that Medicare might not pay. If you do not issue a valid ABN to the beneficiary when Medicare requires, you will not be able to bill the beneficiary for the service and your clinic may be financially viable. An ABN can also serve as an optional/voluntary notice used to forewarn beneficiaries of their financial liability prior to providing care that Medicare never covers anyway.

For a detailed report and instructions from HHS and CMS (2012), click [here](#).

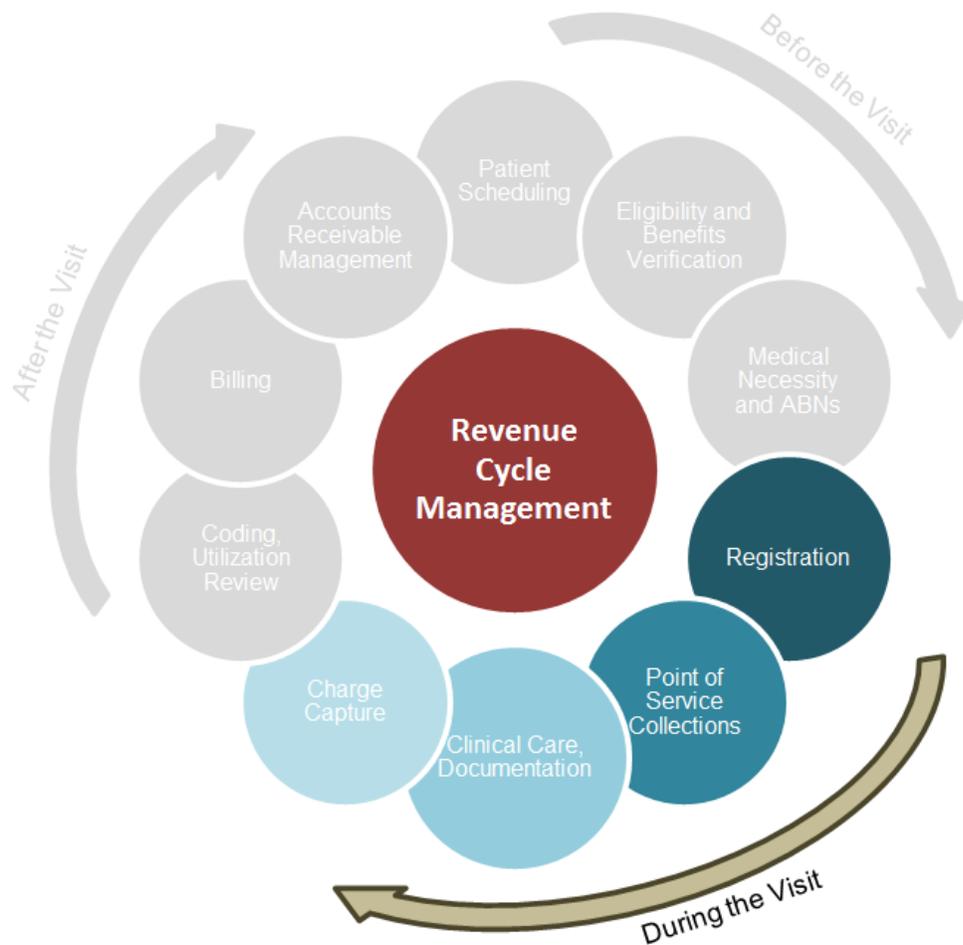
Click to jump to the [Medicare](#) or [Medicaid](#) section of this guide.

Click to download ABN form [CMS-4-131](#)



During the Visit

During the Visit (Registration, Collection, Clinical Care/Documentation, Charge Capture)



OVERVIEW

This section will cover the key components of revenue cycle management process that should take place during the client's visit, which include:

- Registration
- Collections
- Clinical Care/Documentation
- Charge Capture

After completing this section you will be able to:

- Identify the vital elements of revenue cycle management that take place during the client's visit
- Assess level of capacity to effectively carry out these components of revenue cycle management
- Implement an effective workflow process for those components of revenue cycle management
- Utilize communication tips to request payment from clients



REGISTRATION

During the registration/check-in process you should obtain and confirm the following information from the client:

- Client Name
- Date of birth
- Address
- Social security number
- Primary Insurance carrier
- ID number
- Group Number
- Insurance Carrier Phone number
- Co –pay/Co-insurance amount
- Secondary Insurance information (if any)
- Copy of insurance card

Click here for a sample client [registration](#) form:

When checking a patient in, if the agency is using paper charts, you should make a copy of the insurance card (front and back). If the agency has an automated practice management system and electronic medical records, the insurance card should be scanned directly into the system if possible. An Optical Character Recognition (OCR) card reader is the most efficient, because it automatically detects the fields on the card and inputs it in the system. At this time, the patient should also be required to:

In addition to the information above you should have your client acknowledge and sign off on some of your agency's policies including.

- [Financial Policy](#) (outlining the client's financial obligation)
- [Assignment of benefits \(which could be included in your financial policy\)](#)
- [Notice of Privacy Policies and Practices](#)

Once this information and signed forms have been collected the next step is to generate (either through a practice management software or manually) a [superbill](#) or charge slip that is pre-populated with the client's information.

HIPAA: If you are not familiar with The Health Insurance and Portability and Accountability Act (HIPAA), you should become familiar with it as soon as possible (*to jump to the HIPAA section of this guide [click here](#)*). HIPAA became effective in 1996 and has had many different rules and clarifications since that you should be familiar and comply with.

*Changing your agency's financial policies to ensure that you consistently obtain insurance information, file insurance claims, require copayments at the time of the visit, collect balances due at the time of the visit, and collect previous balances could be a **major** change for your agency's staff, clients, and your community.*

Agencies can set policies and procedures for income verification as long as those policies are consistently applied to all clients. If a client is unable (rather than unwilling) to provide income or insurance verification, they cannot be denied services.

[Click here](#) for more instructions that address income verification from the Office of Population Affairs (OPA) program instructions:

Be sure to review financial obligations and obtain payment (or provide estimate for collection at check out)



POINT OF SERVICE COLLECTIONS

The check-in area should be inviting, accessible, and [HIPAA compliant](#); credit card machine and/or scanning equipment should be within easy access.

Collecting co-payments may not be a common practice in your agency. As discussed earlier in this guide, the number of insured Americans is increasing in the coming years due to a number of provisions in the Affordable Care Act ([click here](#) for more), through Medicaid expansion ([click here](#) for more), insurance marketplaces ([Connect for Health Colorado](#)), and other programs. Your agency will need to start collecting these funds **up front**, at the time of the patient visit, from insured clients whose insurance policies require co-payments.

Click [here](#) for a valuable resource that explains the different types of funds that need to be collected.

Keep in mind:

- Billing for copayments is costly and seldom results in collection
- Failure to collect copayments required by payers is an insurance contract violation
- Collection of copayments is standard business practice (most services are paid for at time of service)

For convenience, you should make sure there is a credit card machine and scanning equipment available within easy access to the front desk. If the receptionist has to leave the front area to walk to another location to run a credit card for co-payment or to scan an insurance card, this can cause delays and bottlenecks during check in and registration.

TIPS FOR REQUESTING PAYMENT FROM CLIENTS

First, communicate the expectations to the client in advance. You could, for example:

- Display tasteful signage in the clinic, “your insurance company requires that we collect your copayment”
- Send a letter outlining your [financial policy](#) to each client
- Create a brochure or flyer outlining the financial policy and display it in the waiting room or checkout area
- Post your agency’s financial policy on your website
- Include an announcement about financial policy on recorded telephone messages
- Upon check in, have clients read and sign a financial agreement
- Remind clients of the policy when they call to make appointments, and provide estimates of what they will owe if feasible

At check out, you should:

- Ask how they wish to pay the amount due
- Keep it personal, address client by name, be professional, do not try to use humor
- Stay calm, polite, and in control - pass the client to a colleague if necessary to change the tone
- Get the client to commit to a date to pay the amount due
 - Try not to go beyond 30 days
 - Document and follow up
 - Without a firm commitment and follow up, once the client leaves the clinic chances of getting paid are reduced by 50%, and after the 60 day mark the chances decrease drastically



CLINICAL CARE DOCUMENTATION

Clinical care provided to your clients must be documented. The documentation should be detailed enough so that the appropriate **CPT** and **ICD-9** (soon to be **ICD-10**) code can be assigned to the visit and submitted to the insurance for reimbursement.

If the services provided are not documented it's as if those services were never provided and they cannot be billed.

The Superbill

A superbill, also known as the “encounter form” or “charge slip” provides a one page snapshot of a client visit and should include (and sometimes printed in duplicate to provide to the patient as a receipt). The superbill should be pre-populated with client information (and loaded into practice management software, if available). Click [here](#) for an example superbill from a Title X agency.

Basic information	Additional information
<ul style="list-style-type: none"> • Client name • Date of appointment • Insurance information • Co-payment amount • Balance due 	<ul style="list-style-type: none"> • A list of common codes used in the clinic • The CPT (procedure) codes - for new, established, and comprehensive visits • The ICD-9 (diagnosis) codes

*Although many agencies still use paper superbills, some have transitioned to **electronic versions** (available through practice management and electronic health systems), which potentially eliminates legibility challenges and errors – and can include a greater number of codes.*

The provider uses the superbill to select the appropriate codes to bill the insurance for the documented visit. For best practice the superbill should be completed during the client visit and, if on paper, submitted to personnel immediately following the visit for entry into the billing system.

Most electronic health record systems, give you the option of setting up pre-populated superbills with basic client demographics – which alleviates the need to complete them by hand – or you can at least print the most pertinent information on an automated label. Not all agencies are able to set up these systems currently, but it is strongly recommended that you begin **moving toward electronic forms** and **away from manual processes**.



CHARGE CAPTURE

Make sure you capture all of the charges so to avoid loss of revenue. The diagram below provides a summary of the steps you should take at the conclusion of the visit.

CHECK OUT

Provide private area for financial conversations to protect client privacy, and a credit card machine/check scanning devices should be within easy reach of check out area

CONFIRM INSURANCE TO BE BILLED, AND BALANCE DUE

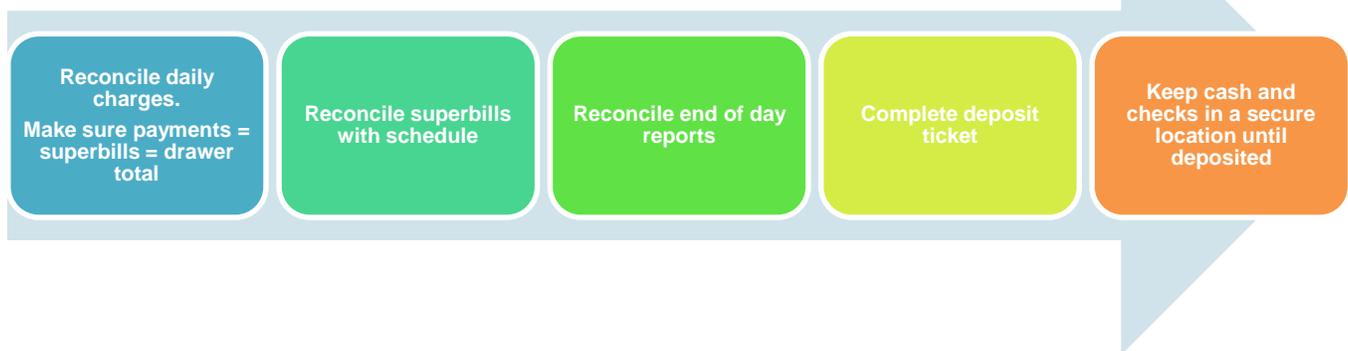
Notify the client of the amount they will owe today (if any) and/or that you will be submitting a claim to their insurance

CHARGE CAPTURE - COLLECT PAYMENT, AND PROVIDE RECEIPT

Be sure to collect this **before** the client leaves, record the payment in your system immediately, and provide a copy of the superbill as a receipt.

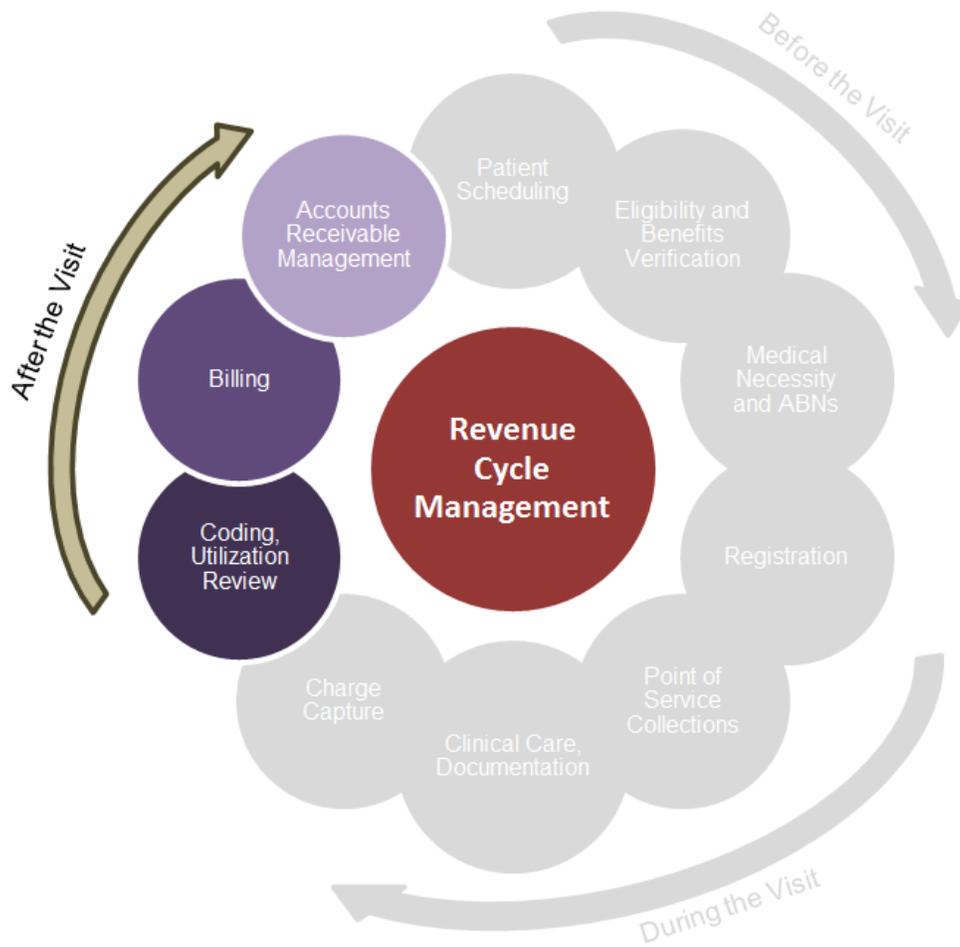
END OF DAY CHARGE CAPTURE

Be sure to have a written Policy and Procedure for your agency to explicitly outline the end of day reconciliation process, and in that process include checks and balances (as well as separation of duties among staff) to prevent risk.



After the Visit

After the Visit (Coding)



WHAT HAPPENS AFTER THE PATIENT VISIT?

This section will discuss the basics of coding and documentation.

CODING AND DOCUMENTATION

Medical coding is the transformation of services, diagnoses, and supplies into alphanumeric codes.

Primary medical code sets

The primary medical code sets are:

- CPT
- ICD-9 (ICD-10 in 2015)
- HCPCS LEVEL II

CPT codes report the medical services and procedures that are provided to the patient such as diagnostic, radiology, laboratory, surgical, and many others. They identify the type of visit or encounter (office visit,

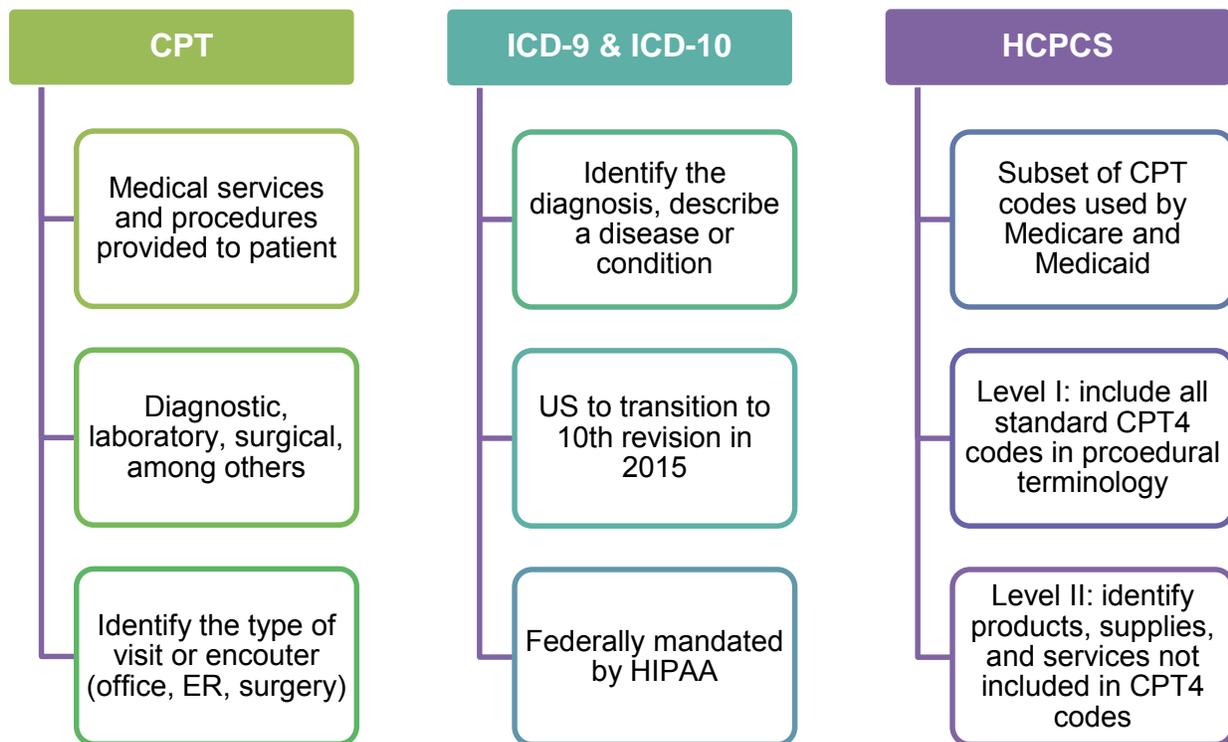


emergency room visit, and surgery, for example). The CPT manual is published by the American Medical Association, and can be purchased from them.

ICD-9 codes identify the particular diagnosis. These codes describe a disease or condition. In the United States we currently use the 9th revision, but many countries are using the 10th revision (the US will transition on October 1st, 2015). The ICD book is published by the World Health Organization, but can also be purchased from the American Medical Association.

HCPCS codes are a subset of CPT codes, and are also used by Medicare and Medicaid.

When coding a patient visit, ICD-9 codes must match the CPT codes. The diagnosis must justify the procedure or services. More than one ICD-9 code can be listed per CPT code.



CODING: CPT (CURRENT PROCEDURE TERMINOLOGY)

- Developed by American Medical Association in 1966
- Five character, alphanumeric codes
- Updated annually, effective January 1 each year
- Provides a uniform language to describe services
- Effective means of reliable communication
- Used to report services to payers for reimbursement
- Used as a basis for payment
- Used for data collection
- Includes evaluation/management (E/M) codes

CPT codes are owned by the American Medical Association (AMA), and are a registered trademark of the AMA. The current edition is the fourth, published in 1977 – at the time they reflected significant updates in medical terminology. They were created to be a uniform language to describe medical, surgical, and diagnostic services.



CODING: ICD-9-CM (INTERNATIONAL CLASSIFICATION OF DISEASES)

- Used internationally to track diseases and mortality
- Initially adopted by International Statistical Institute in 1893
- Current version developed by the World Health Organization, adopted in the United States in 1979
- Updated annually, effective October 1 each year
- Use of ICD-9 is federally mandated by HIPAA

The Centers for Disease Control (CDC), National Center for Health Statistics (NCHS) and Centers for Medicare and Medicaid Services (CMS) are the United States governmental agencies responsible for overseeing all changes and modifications to ICD-9. ICD-9 was federally mandated by the Health Insurance Portability and Accountability Act (HIPAA) in 2003. HIPAA mandates that the healthcare industry use standard formats for electronic claims and related transactions. The implementation of ICD-10 to replace ICD-9 was also mandated by HIPAA (final rule in January 2009).

For resources related to ICD-9 and ICD-10 use the following links:

<http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10/>
http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html

Although CPT and ICD-9 codes are typically updated annually, currently both are on a code freeze requirement, which means that no revisions will be made to these code sets prior to implementation of ICD-10 in October of 2015. To learn more about the code freeze, click [here](#).

CODING: ICD-10-CLINICAL MODIFICATION (CM)

- Replaces ICD-9 effective October 1, 2015

Why change?

Change can be difficult, and the transition to ICD-10 will certainly be challenging for payers and providers. However there are certainly some key benefits and improvements with ICD-10. **First of all**, ICD-9 is 30 years old and is based on medical knowledge from the late 1970s – it consists of outdated and obsolete terminology and is inconsistent with current medical practice. **Secondly**, ICD-9 hampers the ability to compare costs and outcomes of different medical technologies, and cannot support the United States in transitioning to an interoperable health data exchange. **Lastly**, ICD-10 provides better data for:

- Measuring patient care outcomes
- Designing payment systems
- Processing claims
- Making clinical decisions
- Tracking public health
- Identifying fraud and abuse
- Conducting research



CODING: NUMBER OF CODES COMPARISON

This table provides a comparison of the number of codes for ICD-9 to ICD-10. There are tools available to assist providers with converting or mapping codes from ICD-9 to ICD-10 (click [here](#) for a crosswalk developed by CMS explaining the conversion process). NOTE: This resource is not a substitute for being trained to code with ICD-10.

	Diagnoses	Procedures
ICD-9-CM	14,315	3838
ICD-10-CM	69,099	71797

There are training opportunities available and all providers are encouraged to begin preparing for the transition now. Clearinghouses, software vendors, and billing companies are available to assist in the transition as well.

For some information on training opportunities, follow this [link](#) to the CMS website.

Additionally, the American Medical Association has a report to help agencies prepare for ICD-10 implementation, with best practices and suggestions for what you should be doing now. Click [here](#) for the report.

CODING: HCPCS (HEALTHCARE COMMON PROCEDURE CODING SYSTEM)

HCPCS codes

These are standard codes required for Medicare and Medicaid reimbursement, and are monitored and approved by the Centers for Medicare and Medicaid Services (CMS). These codes were mandated for use for all health care transactions by HIPAA.

HCPCS Level I

Level I codes include all of the standard CPT codes included in the AMA's current procedural terminology discussed earlier in this guide.

HCPCS Level II

Level II codes are standardized for use primarily to identify products, supplies, and services not included in the CPT4 codes such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside of a physician's office. Examples of Level II codes for family planning include:

- J 1050 depo-provera
- J 7307 implanon
- J 7300 paragard
- J 7302 mirena
- J 0696 injection, ceftriaxone sodium

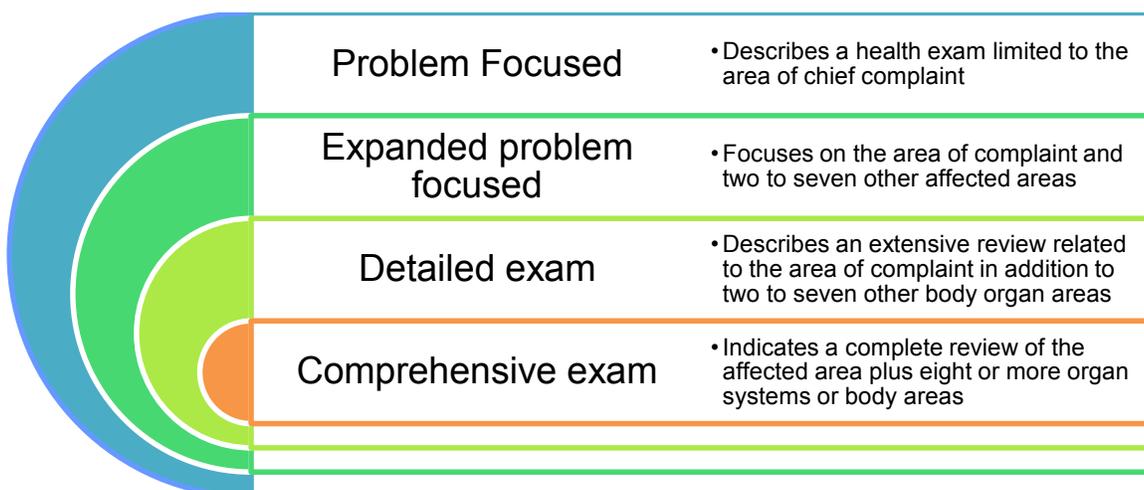
Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, so Level II HCPCS codes were established in order to submit claims for those items.



CODING: EVALUATION AND MANAGEMENT (E/M) CODES

Subset of CPT codes used for office related visits
Five digits, starting with 99
99201-99205: describe services to new patients
99211-99215: visits by established patients
99241-99245: identify office consultations
99354-99360: describe prolonged services
80% of claims in family planning are for E/M services

The key components of E/M documentation are: history, exam, and medical decision making. E/M exams fall in one of four categories:



Other factors that are used to determine which E/M code best describes the services provided include:

- The patient's chief complaint
- How long symptoms have been present
- Consideration of a patient's past medical, family, and social history
- The amount of time taken for the office visit

NOTE:

The Affordable Care Act now required an increase in Medicaid reimbursement for E/M codes and vaccine administration – up to 100% of the Medicare rate for certain qualified providers in 2013 and 2014 (click [here](#) for a detailed explanation).



LIST OF SPECIFIC CODES

For a list of the CPT codes family planning agencies typically use, [click here](#).

NOTE: Billing for well visit codes (99381-99397): Per Colorado Medicaid, there is currently a systemic glitch impacting the billing of these codes for agencies designated with the Family Planning (FP) provider type. Agencies with this provider designation are advised to only submit claims with regular E/M codes (99201-99215), using the FP modifier, regardless of whether or not a wellness service was provided.

Providers are encouraged to document the intent of the E/M service and the medical necessity for oral contraceptives (e.g. prevention of pregnancy, acne, menstrual regulation).

NEW PATIENT VS ESTABLISHED PATIENT

A new patient is a patient who **has not** received any professional services from the agency's family planning program within the past three years.

An established patient is a patient who **has** received professional services from the agency's family planning program within the past three years.

For revisits or visits of a more medical nature, consider the following codes. All visits listed below include counseling and/or coordination of care, including anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.

NEW PATIENT VISITS

CPT CODE	DESCRIPTION	COMPONENTS	EXAMPLE
99201	New patient focused visit: presenting problems are self-limited or minor . Physicians typically spend 10 minutes face to face with patient. Office or other outpatient visit for the evaluation and management of a new patient	<ul style="list-style-type: none"> Problem focused history Problem focused examination Straightforward medical decision making 	Counseling and treatment for male contact to positive Ct/GC
99202	New patient expanded visit: presenting problems are low to moderate . Physicians typically spend 20 minutes face to face with patient. Office or other outpatient visit for the evaluation and management of a new patient	<ul style="list-style-type: none"> Expanded problem focused history Expanded problem focused examination Straightforward decision making 	Initial evaluation of a new client with UTI)
99203	New patient detailed visit: presenting problems are of moderate severity .	<ul style="list-style-type: none"> Detailed history Detailed examination 	Initial evaluation of female with STD or vaginitis



	Physicians typically spend 30 minutes face-to-face with patient. Office or other outpatient visit for the evaluation and management of a new patient	<ul style="list-style-type: none"> Medical decision making of low complexity 	
99204	<p>New patient comprehensive visit; presenting problems are of moderate to high severity.</p> <p>Physicians typically spend 45 minutes face to face with patient. Office or other outpatient visit for the evaluation and management of a new patient.</p>	<ul style="list-style-type: none"> Comprehensive history Comprehensive examination Medical decision making of moderate complexity 	<p>Initial evaluation of pelvic/testicular pain to rule out PID/epididymitis</p> <p><i>It would be very unusual in typical family planning clinic settings to use this code.</i></p>

ESTABLISHED PATIENT VISITS

CPT CODE	DESCRIPTION	COMPONENTS	EXAMPLE
99211	<p>Established patient minimal visit: usually, the presenting problems are minimal and may not require the presence of a physician or mid-level provider.</p> <p>Typically, a total of 5 minutes are spent with patient.</p>		RN visit, delayed exam, blood pressure recheck established client
99212	<p>Established patient focused visit: presenting problems are self-limited or minor.</p> <p>Physicians typically spend 10 minutes face to face with patient. Office or other outpatient visit for the evaluation and management of an established patient.</p>	<p>(2/3 required)</p> <ul style="list-style-type: none"> Problem focused history Problem focused examination Straightforward medical decision making 	Brief medical visit with practitioner for evaluation of vaginitis or STD
99213	<p>Established patient expanded visit: presenting problems are of low to moderate severity.</p> <p>Physicians typically spend 15 minutes face to face with patient. Office or other outpatient visit for the evaluation and management of an established patient.</p>	<p>(2/3 required)</p> <ul style="list-style-type: none"> Expanded problem focused history Expanded problem examination Medical decision making of low complexity 	Evaluation of established client with pelvic/testicular pain to rule out PID/epididymitis
99214	<p>Established patient detailed visit: presenting problems are of moderate to high severity.</p> <p>Physicians typically spend 25 minutes face to face with patient. Office or other outpatient visit for the evaluation and management of an established patient.</p>	<p>(2/3 required)</p> <ul style="list-style-type: none"> Detailed history Detailed examination Medical decision making of moderate complexity 	<p>Evaluation of lower quadrant pain to rule out ectopic pregnancy</p> <p><i>It would be uncommon in typical family planning clinic settings to use this code</i></p>



Preventive counseling visit codes: When face to face visit is for the purpose of promoting health, preventing illness or risk factor reduction, may be more appropriate to use the following counseling codes - used for new and established patients - can be provided by any qualified health care professional. Counseling codes include the visit, so an additional visit code should not be charged.

CPT CODE	DESCRIPTION	EXAMPLE
99401	Preventive medicine counseling: provided to an individual, approximately 15 minutes.	3 month method evaluation with no problems and not requiring a physical exam
99402	Preventive medicine counseling: provided to an individual, approximately 30 minutes.	Delayed exam to initiating contraceptive method or pregnancy testing and options counseling

*The following is a list of common procedure codes, which include the decision for the procedure. An additional E/M code should not be billed unless there is a significant and separately identifiable evaluation and management service rendered on the same day. **For example:** The patient would like her IUD removed (58301) due to excessive cramping and bleeding, but would like to try Lutera. This is an instance where a separate E/M would be warranted.*

CPT CODE	DESCRIPTION
11981	Insertion of implantable contraceptive capsules
11976	Removal of implantable contraceptive capsules
57170	Diaphragm fitting (with instructions)
58300	Insertion of intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)
11980	Subcutaneous hormone pellet implantation
11982	Removal, non-biodegradable drug delivery implant
11983	Removal w reinsertion, non-biodegradable drug delivery implant

*The following is a list of codes for contraceptive and other supplies. For implantable contraceptives, IUDs, Depo-Provera, etc, charge CPT code for procedure and CPT code for device/supply. *Medicaid does not cover female condoms or spermicide.*

CPT CODE	DESCRIPTION
A4266	Diaphragm
A4267	Condom, male
A4268	Condom, female*
A4269	Spermicide (e.g. foam, gel) - each*
J1050	Contraceptive injectable - per 3-month dose (i.e. Depo Provera) (Injection, medroxyprogesterone acetate per 1 mg (Depo Provera). The appropriate dosage (measured in units) should be reported based on the specific needs of the patient.
J7300	Intrauterine device, copper T380A (Paragard)
J7302	Intrauterine device, levonorgestrel releasing, LNG-IUS (Mirena)
J7303	Hormone releasing vaginal ring (i.e. Nuvaring) – each
J7304	Hormone containing patch (i.e. Ortho Evra) (each individual patch provided should be billed as a unit).
J7307	Etonogestrel implant, 68 mg. (Implanon)

**Please note: female condoms are a covered benefit under Medicaid.*



J3490	(Drugs which are not otherwise classified) Medications related to family planning services. If billing this code to insurance, including Medicaid, the name of the medication must be specified. Including, but not limited to: <ul style="list-style-type: none"> • Metrogel • Monistat • Monistat Dual Pack • Sultrin • Terazol 3, Terazol 7, Terazol Cream
J0696	Rocephin*
Q0144	Zithromax

Please note: J0696 should be billed in combination with the injection code 96372.

S4993	Oral contraceptives (per cycle), all brands, including Plan B
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NOTE: Billing for EC on same day as OC: Per Colorado Medicaid, you must submit billing for these services in the following manner: S4993 on a single line item, attach both the OC and EC diagnoses to that line item (V25.03, V25.01), and change the quantity of the pills. Remember if the client has exhausted their benefit, that may be the cause for denial.

The following are lab codes, for labs typically done in the clinic. Labs that are not performed in the clinic are not billed to third parties by the clinic. The lab performing the test(s) should bill insurance for the test(s).

CPT CODE	DESCRIPTION
81000	Urinalysis, non-automated with microscopy (by dipstick or tablet reagent)
82948	Glucose, blood reagent strip
85013	Spun MicroHematocrit
85018	Hemoglobin (Hgb)
86701	Rapid HIV 1
87210	Smear, Wet Mount
Q0111	Smear, Wet Mount with preparations
99000	Handling and/or conveyance of specimen for transfer from clinic to a laboratory (e.g., Chlamydia or Pap smear specimens). This can only be billed once even if there are multiple specimens.
36415	Collection of venous blood by venipuncture
36416	Collection of capillary blood specimen (e.g. finger, heel, ear stick)

The following are some other procedure related codes – specifically for the male genital system.

CPT CODE	DESCRIPTION
54050	Destruction of lesion(s) on penis (e.g. condyloma, papilloma) chemical
54056	Destruction of lesion(s) on penis- cryosurgery
55250	Vasectomy, unilateral or bilateral (includes post-op semen examination)

As previously mentioned, ICD-9-CM codes describe the reason for the visit. All claims submitted to third party insurers for family planning services must include an appropriate diagnosis code from the International



Classification of Diseases, Clinical Modifications (ICD-9-CM) coding structure as well as a CPT code. The codes most likely to be used in family planning clinics, corresponding to the appropriate CPT code include:

ICD-9 Code	UPDATED ICD-10 Code	Technical Description
V25.01	Z30.011	Encounter for initial prescription of contraceptive pills
V25.02	Z30.012	Encounter for prescription of emergency contraception
V25.03	Z30.013	Encounter for initial prescription of injectable contraceptive
V25.04	Z30.014	Encounter for initial prescription of intrauterine contraceptive device
V25.09	Z30.018	Encounter for initial prescription of other contraceptives
V25.11	Z30.019	Encounter for initial prescription of contraceptives, unspecified
V25.12	Z30.02	Counseling and instruction in natural family planning to avoid pregnancy
V25.13	Z30.09	Encounter for other general counseling and advice on contraception
V25.2	Z30.2	Encounter for sterilization
V25.4	Z30.40	Encounter for surveillance of contraceptives, unspecified
V25.40	Z30.41	Encounter for surveillance of contraceptive pills
V25.41	Z30.42	Encounter for surveillance of injectable contraceptive
V25.42	Z30.430	Encounter for insertion of intrauterine contraceptive device
V25.43	Z30.431	Encounter for routine checking of intrauterine contraceptive device
V25.49	Z30.432	Encounter for removal of intrauterine contraceptive device
V25.5	Z30.433	Encounter for removal and reinsertion of intrauterine contraceptive device
V25.8	Z30.49	Encounter for surveillance of other contraceptives
V25.9	Z30.8	Encounter for other contraceptive management
	Z30.9	Encounter for contraceptive management, unspecified
	Z31.69	Encounter for other general counseling and advice on procreation
	Z31.89	Encounter for other procreative management
	Z31.9	Encounter for procreative management, unspecified
939.2	T19.2XXA	Foreign body in vulva and vagina, initial encounter
	T19.2XXD	Foreign body in vulva and vagina, subsequent encounter
	T19.2XXS	Foreign body in vulva and vagina, sequela

When the reason for the visit (ICD-9 code) is other than contraceptive in nature (example – follow up to abnormal Paps, vaginitis, etc.), other ICD-9 codes may need to be used to file insurance claims. The above list is not meant to be an exhaustive list. Please refer to the resource referenced below for more complete coding information.

More information and/or resources on CPT and ICD-9 coding can be purchased from the American Medical Association. Phone: (800) 621-8335 & [Website](#).

For a snapshot of codes [click here](#).

These code lists in the above section were pulled from the document titled *Financial Management*: [download](#)



CODING: TOP TEN E/M CODING ERRORS

1 Upcoding	6 Test billed but not ordered
2 Downcoding	7 Documentation of medications is unclear
3 No chief complaint	8 Incorrect diagnosis
4 Unclear assessment	9 Documentation missing
5 Documentation is not signed	10 Illegible

CODING: DOCUMENTATION BASICS

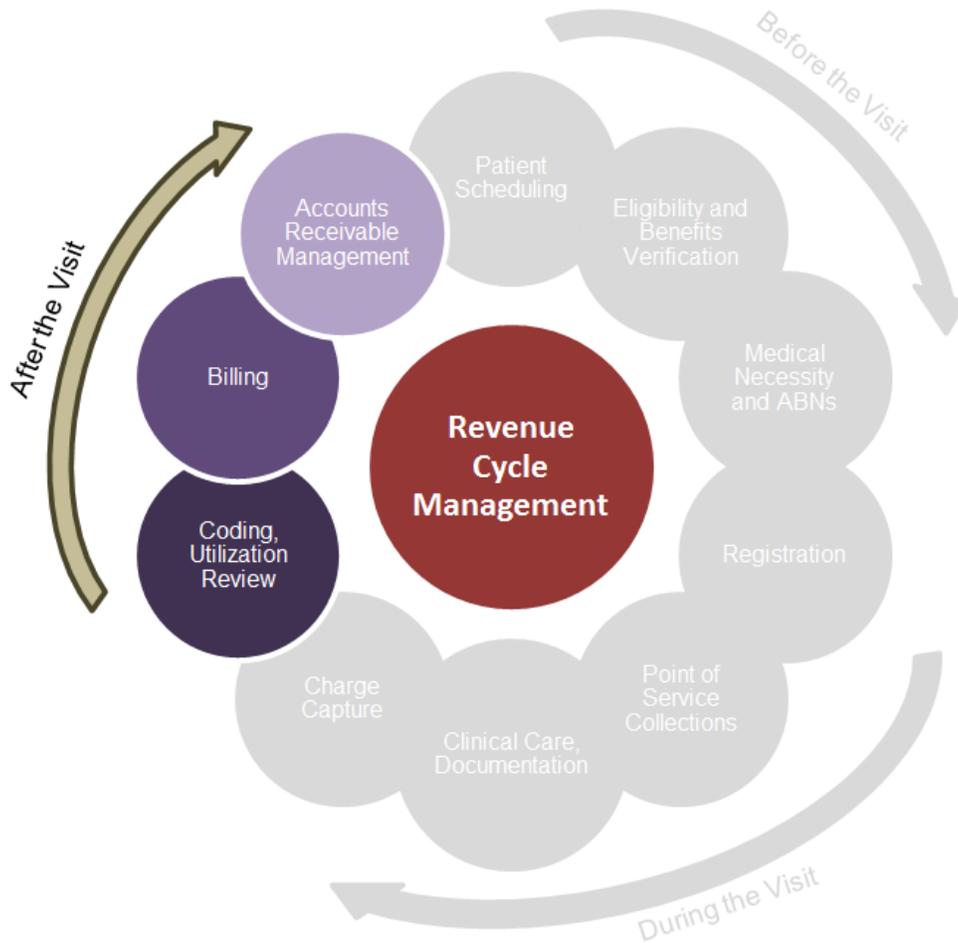
- If it isn't documented, it didn't happen
- Documentation must be clear, concise, and substantiate medical necessity
- Coding for services not provided is fraud
- The medical record provides documentation of assessment, decision making, and general management of the patient

Because the medical record is a legal document, it may be used to recreate events of care in the event of a professional liability action and may be used as a definitive piece of evidence in legal action.



After the Visit

After the Visit (Billing, Accounts Receivable Management)



WHAT HAPPENS AFTER THE PATIENT VISIT?

This section will cover key components of the revenue cycle management process that should take place after the client visit, which include:

- Billing
- Accounts Receivable
- Collections and claims follow up (Accounts Receivable Management)
- Revenue Cycle Management Performance Measures

In addition to discussing the listed components we have provided you with a few case studies to help you apply this information in your agency.

After completing this section you will be able to:

- Describe the components of the revenue cycle management process that occur after the client visit
- Apply the steps involved in coding, claims submission, and follow up to ensure that reimbursement is received for the services provided



- Identify the necessary resources for financial management in Title X agencies, based on clinic capacity
- Assess the agency's level of capacity to effectively carry out these components of revenue cycle management

BILLING: CLAIMS SUBMISSION

Today, most payers require electronic claims submission, which means the claim is transmitted electronically via HIPAA compliant, secure, and encrypted data transmission. Faxing a claim form to the payer does not count as an electronic claim submission. Your agency should have appropriate mechanisms in place to complete claim forms to ensure cost effectiveness and efficient use of personnel time. There are many systems and software programs available to enable any sized clinical practice to implement electronic claims submission, and many at a reasonable cost.

Your agency would benefit from utilizing a clearinghouse for their claims submission processes. Most electronic medical record vendors recommend the use of a preferred clearinghouse, but there many effective, reputable clearinghouse on the market.

In most agencies like yours, claims are submitted on the CMS 1500 [form](#); for instructions about the CMS form, follow this [link](#). Make sure all required information is complete.

THE CLAIMS CLEARINGHOUSE

A claims clearinghouse is a third party that already has established a secure electronic connection with the payer's claims processing system. While your agency can establish direct data entry with payers the cost is prohibitive and the process is inefficient. A clearinghouse offers the following benefits:

- Claim standardization for clean claim submission.
- Prevents claims submission with errors and allows you to catch and correct errors within minutes rather than days or weeks
- Fewer claims are delayed or rejected
- Reduces reimbursement time
- Submits electronic claims in batch all at once, rather than submitting separately to each individual payer
- Provides a single location to manage all claims

THE CLAIMS CLEARINGHOUSE - DO I NEED ONE?

Does your agency bill (or plan to soon bill), electronically?

Many payers today require that you submit claims electronically, and very few insurance companies will accept paper claims. If you do not have the capacity to bill electronically, you will need to implement the necessary technology to do so in order to successfully and effectively submit claims and receive reimbursement. A basic practice management system will allow you to create an electronic claim and submit it to a clearinghouse.

Does your agency bill a number of health plans, or just one?

If your agency is only planning to contract ([click here](#) to jump to the Contracting section of this guide) with one payer (Medicaid, for example) using a clearinghouse does not make sense. However, if you are billing multiple payers, getting set up with each new payer may involve a long and involved testing/certification process that can take weeks while you send multiple test claims (and then attempt to send live claims) which may get rejected until the details unique to that payer are worked out. Billing directly to each payer would mean repeating this process each time you want to add a new payer.

Is your staff experienced at electronic billing?



Submitting claims directly to more than one single entity also puts an extra burden on billing staff, who are required to keep track of multiple transmission methods, multiple logins and passwords, multiple file names and file types, and to learn each payer's error code and interpret payer's claim status reports. If your staff is not experienced with electronic billing, using a clearinghouse provides a safeguard to make sure claims are completed appropriately for submission. Even if your staff members are experienced with electronic billing, the clearinghouse can provide you with a cost effective option for outsourcing all or part of this process. Many clearinghouses offer services ranging from claims submission to reporting, eligibility verification, and sending out patient statements.

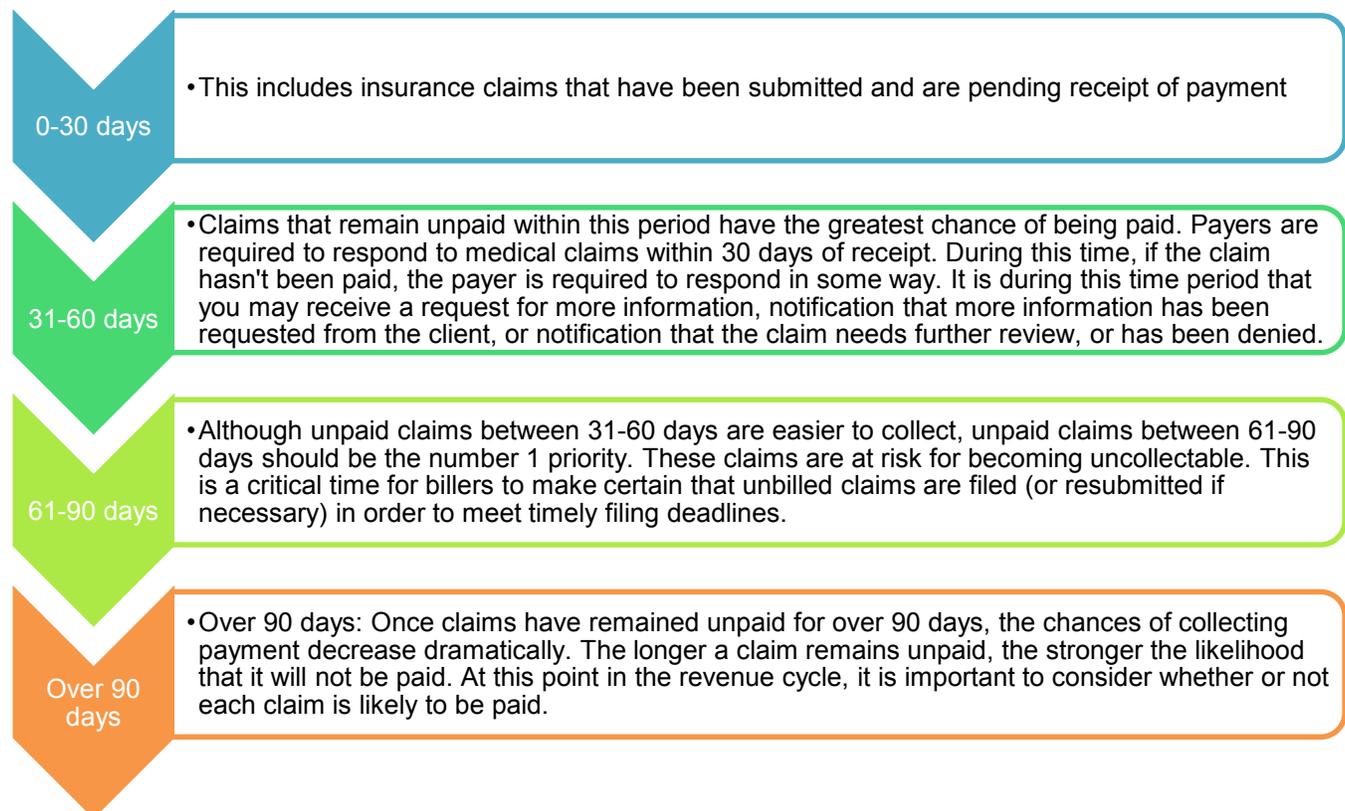
What is your claim volume?

Clearinghouses may charge a monthly flat fee or a claim transaction fee based on volume. Usually, the higher the volume, the lower fee per transaction. When assessing potential clearinghouses, it is important to know your anticipated claims volume and the fee structure offered. If you have a fairly low volume of claims (less than 200 per month) a fee per transaction may be more cost effective.

COLLECTIONS: ACCOUNTS RECEIVABLE

"Accounts receivable" refers to money owed to the clinic either by an insurance company or by the client. In general, account aging is broken down as demonstrated in the diagram below. In order to insure sustainability in a medical clinic, common business practices involve reviewing accounts receivable on a regular basis, which helps to analyze the financial health of an organization.

The Accounts Receivable report calculates the length of time it takes for claims to be paid. Medical claims are unique to accounts receivable in other industries because of timely filing restrictions set by insurance companies. Depending on the insurer, your agency may have as little as 60 days up to a year to file a claim (120 days for Colorado Medicaid). If the claim is identified as uncollectable, it should be written off to prevent valuable time from being spent that could be used pursuing collectable accounts. Accounts receivable is categorized in "aging buckets" as depicted below.



COLLECTIONS: ACCOUNTS RECEIVABLE MANAGEMENT

CLAIMS FOLLOW UP

Depending on the payer, you should expect to receive payment within 10-15 days of a clean claim submission. This timeframe is assuming that your agency has streamlined the process of claim submission by utilizing a practice management system to complete the claim form and a clearinghouse to submit the claim to the insurance company. Additionally, you should ask payers to automatically deposit reimbursement to the agency's account rather than issuing and mailing a check to you, that is enroll in the EFT program).

Regardless of how claims are submitted (through a clearinghouse, electronically in house, or on paper) it is imperative that clinics follow up with payers to obtain claim status. The first step to follow up is to make sure that the claim has been received and "accepted for processing" by the payer. Once the clinic receives confirmation that the claim has been received by the insurance company, you do not have to wait patiently at the mercy of the payer to get paid in a timely manner. **You can, and should be, proactive.** For those claims that are not paid within 15 days of being accepted, you should implement a process for claim follow up (also known as working a claim or A/R follow up).

*You do not have to wait patiently at the mercy of the payer to get paid in a timely manner.
You can, and should be, proactive*

The most common reasons for payment delays include:

- Never received
- Denied
- Pending additional information

The claim was never received: This mainly happens with paper claims getting mysteriously lost - another reason to send electronic claims. However, even electronic claims can sometimes be "lost". If the claim hasn't been followed up in a timely manner by you, it could be a month or longer before you realize the payer hasn't received the claim. For paper claims, you should allow at least 10 business days before contacting the payer to confirm that the claim has been received. For electronic claims, if you use a clearinghouse, you will receive confirmation within a day or two that the claim was received and accepted by the payer for processing. If you file the electronic claim in house, you should call within 5 business days to confirm. The sooner you confirm that the claim has not been received, the sooner you can resubmit the claim, and the sooner you will be paid.

The claim has been denied: If you find out the claim has been denied by the payer, you should correct the issue (if correctible) and resubmit the claim as soon as possible. If the denial reason is not something that can be corrected but you believe the payer should reimburse you, you should write an appeal as soon as possible. Each insurance company has different requirements for appeals or request for reconsideration so be sure to ask your provider representative.

The claim is pending for additional information: claims may be categorized as pending for a certain amount of time while additional information is requested from the member (or insured individual). Even if the payer has sent the client a letter by mail requesting the information, you may also notify the client that the information is needed in order to expedite the process.

TIPS FOR DENIAL MANAGEMENT: APPEALS

When claims are denied, and the issue is not something you can correct in order to resubmit the claim, you may want to consider appealing the claim denial. However, it is important to determine whether or not it is worth the time and effort to file the appeal.

Set a dollar amount for claims to be appealed: You should set a minimum dollar amount for claims to be appealed – some providers choose to only appeal claims higher than a certain amount, such as \$9.99 or \$99.99.



Review the denial reason: Review the reason for the denial. If you believe the payer wrongfully denied your claim, then you should definitely make an attempt to appeal the decision. One common reason for denial that is easily appealed is “no prior authorization” – for a procedure or service for which prior authorization is required. Oftentimes the authorization received for the particular treatment was not documented correctly on the claim form. This can be easily resolved if the insurance company provided the authorization, as they will have a record of providing it.

Submit the appeal within 7 days of receiving the denial notice: You should always file the appeal quickly. Try to submit it within seven days from receiving the denial notice, because the longer you take to resolve the denial, the lower a chance of approval of the appeal due to filing deadlines.

Ask the client for assistance: It is in the client’s best interest to get the claim paid (since denial may result in more out of pocket costs), so ask for their help during the appeal process. The client may be willing to call the insurance company on the clinic’s behalf to pursue or follow up with the appeal.

Review the conditions of your contract with the payer: Be sure to review the terms of the contract because some denials may actually be against the conditions of your contract. This information can be useful in appealing claims that should never have been denied in the first place.

TIPS FOR COLLECTING FROM CLIENTS

Your agency may not have experience in collecting unpaid balances from clients, but it is common practice for some – in particular, those agencies that provide a wide range of services in addition to family planning. The collections process applies to clients with outstanding balances after payment has been received from the insurance company and you have already determined the clients’ income level at the time of the visit, and applied the amount owed to the sliding fee scale. Then you will collect any out of pocket balance due from the patient. This is when it is important to have clear [financial policies](#) and procedures in place to outline how the clinic will handle collecting outstanding balance. As you know, if the client receiving Title X services is below 100% of the Federal Poverty Level, the client cannot be charged for services – but if they are covered by insurance such as Medicaid you can bill their insurance and write off any amount that the payer determined to be “patient responsibility”.

The collections process kicks in when:

1. The primary insurance has processed the claim and determined the client’s financial obligation.
2. There is still an outstanding balance that needs to be collected from the client.
3. And that you are able to collect – based on any guidelines or regulations (i.e. the client is above 100% of FPL).

Monthly vs. Cycle billing

Monthly billing: Most medical practices send out statements at the same time each month.

Cycle billing: Allows you to print statements every few days, or weekly. Cycle billing reduces the time between the encounter and the delivery of the statement, thus improving your ability to collect payment.

1, 2, 3 strikes you're out

A common practice when collecting from clients is the 3 strikes and you’re out rule – which means you send out three statements, and if payment is not received after the third statement the account is written off or turned over to a collections agency. You may want to consider implementing a rule like this as you move forward in



developing standard business practices for clients who do not fall into low income brackets of the sliding fee scale, and/or are insured and have outstanding balances due to deductibles, copays, and out of pocket expenses.

It is common in private medical practices to give the patient three chances (billing cycles) to pay the balance due or be sent over to collections. There is nothing in Title X guidelines or regulations that prohibit clinics from turning accounts over to collection agencies.

Debt collection laws and guidelines

It is extremely important to adhere to federal and state guidelines that govern debt collection practices, and to develop a written policy and procedure for collections and write offs.

Click [here](#) for Colorado Fair Debt Collection Practices Act:

Other debt collection resources

Collection Agencies and Debt Collection

www.coloradoattorneygeneral.gov/ca

Colorado Revised Statute Title 12, Article 14, Section 101, et seq. (12-14-101), Go to:

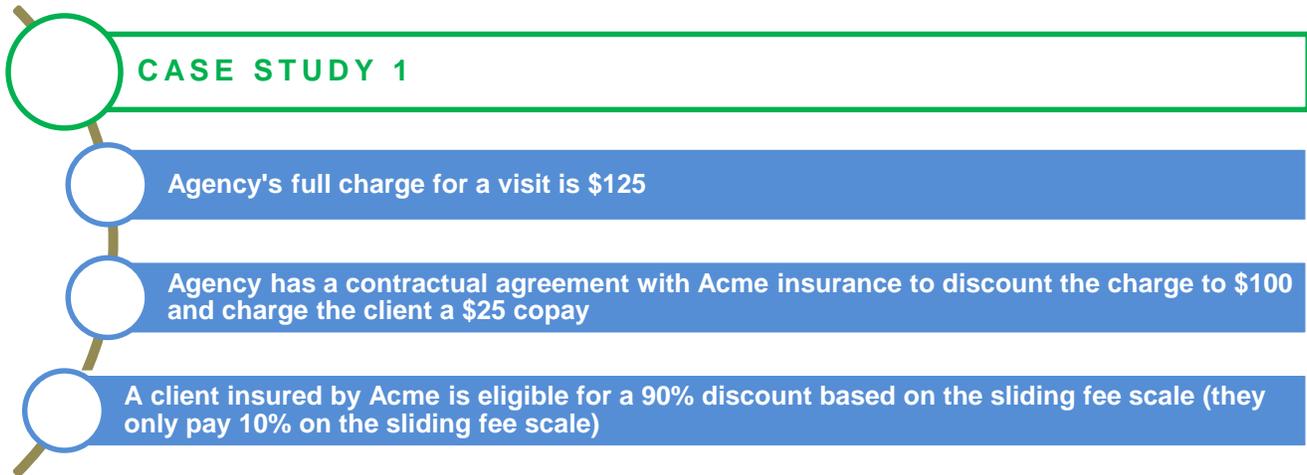
www.lexisnexis.com/hottopics/Colorado/(NOTE: To access (1) agree to terms (2) select revised statutes (3) search term "debt collector")



CASE STUDIES

The following is a series of case studies designed to help you understand specific client visit situations. While reviewing these scenarios, keep these three points in mind, based on Title X Guidelines:

- The client pays the lower of what he or she owes on a sliding fee scale or the copay
- The client does not pay out of pocket more than what he or she owes on a sliding fee scale (even those who are insured)
- When clients request confidential services, agencies should have collection policies that are consistent with Title X rules and those rules and policies should be applied equally to all clients



Do the math:

Total Fee	Sliding Fee Scale	Co Pay
\$125.00	\$12.50	\$25.00

How much can the agency collect from the client?

- **\$12.50**
- The client **cannot** be charged for more than what they owe on the sliding fee scale (10% of the agency's full \$125 charge)

What charge amount is submitted to Acme insurance?

- **\$125**
- The agency should submit the full charge to the insurance company, even though the obligation of the insurance company is to pay the discounted rate of \$100 minus the co-pay to be collected by the agency (\$25)
- Since the clinic collected the \$12.50 per the sliding fee scale, the agency will "lose" \$12.50 and the intent of Title X grant funding is to cover this difference.



CASE STUDY 2

The full charge for a visit is \$125.

The agency has a contractual agreement with Acme insurance that they will discount the charge to \$100 and charge the client a \$25 copay.

A client insured by Acme is eligible for a 50% discount based on the sliding fee scale (they pay 50% of the agency's \$125 charge).

Do the math:

Total Fee	Sliding Fee Scale	Co Pay
\$125.00	\$62.50	\$25.00

How much does the agency collect from their client?

- **\$25**
- The client **cannot** be charged more than their copay

What charge amount is submitted to the insurance company?

- **\$125**
- The agency should submit the full charge to the insurance company, even though the obligation of the insurance company is to pay \$75.00 (The discounted rate of \$100 minus the copay to be collected by the agency \$25)

CASE STUDY 2.5

The full charge for a visit is \$125.

The agency has a contractual agreement with Acme insurance that they will discount the charge to \$100 and charge the client a \$25 copay.

A client insured by Acme is eligible for a 50% discount based on the sliding fee scale (they pay 50% of the agency's \$125 charge).

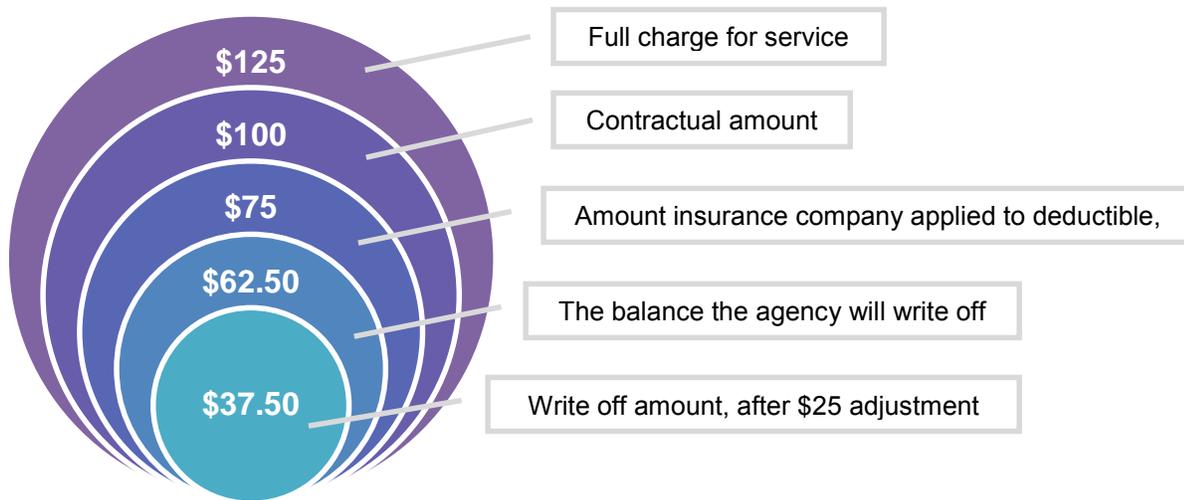
You verified the client's benefit prior to their arrival and the insurance company informed you that the client hasn't met the deductible on their health insurance plan.

What can you collect from the client?

- You can collect from the client for a total of **\$62.50** (including the co-pay)
- The client never pays more than what they owe on the sliding fee scale



- In this scenario the client pays 50% of the sliding fee scale of the \$125 charge
- The agency should still file a claim with the insurance company for the full \$125. The insurance company will process that claim and apply \$75.00 to the client's deductible and \$25.00 for co-pay.
- The agency will make two adjustments and collect payments as follows:
 - Contractual adjustment for \$25.00
 - Sliding Fee Scale adjustment for \$37.50
 - Collect \$62.5 from the client



In this last scenario for Case Study 2, the insurance company will send an Explanation of Benefits (EOB) that states that the insurance company applied \$75 to the deductible (the co-pay does not get applied to the deductible). The agency will write off the balance of \$62.50. The full charge on the fee schedule for this service was \$125, and the contractual amount was \$100. Therefore, an adjustment will be made on the account in the amount of the difference (\$25 is adjusted). The write off amount is \$37.50

Now that you have reviewed these examples, remember to follow these recommended best practices that relate to the above scenarios.

- You should always try to verify coverage and benefits prior to seeing the patient, or discuss the deductible with the patient prior to the visit
- Ask the patient (when they come in for their visit) the amount of the deductible and whether the patient has met their deductible
- Be sure to follow state law – check with your grantee if they know about specific laws/statutes. Click here for [Title X Guidelines and Colorado State Law](#), and here for the [Colorado Department of Public Health & Environment Family Planning](#) landing page.
- Follow state laws as long as it does not conflict with federal Title X guidelines



CASE STUDY 3

A client is above 250% FPL on the sliding fee scale and is insured.

Your full charge for the visit is \$125

The contracted rate with the insurance company for the visit is \$100

You verified benefits and found out that the client has not met the deductible and needs to pay for the visit.

Do the math:

Total Fee	Sliding Fee Scale	Co Pay	Deductible
\$125.00	\$125	\$25.00	\$75.00

What do you charge?

- **\$100 (including the co-pay of \$25)**
- File a claim with the insurance company for \$125
- Insured clients pay the contracted rate for services
- When the agency does not know if the client has met their deductible, the insurance company should be billed and the agency should apply their collections policies to collect any balance due from the client
- Try to collect the full payment at the time of the visit.

CASE STUDY 4

A teen is covered through his parents' insurance and requests confidential services.

He does not want an Explanation of Benefits (EOB) to be sent home.

He has a copay of \$25 and is willing to pay it.

What do you do?

- Unless you have a specific agreement with the insurance company to suppress the EOB, you **cannot** bill insurance
- If you are **not** billing the insurance company, any donation or payment you collect would not be considered a co-pay



- The co-pay is a contractual agreement with the insurance company for a portion of their contracted rate
- You can ask the client if they can pay on the sliding fee scale, and if the client cannot pay, you **still provide services**

Sometimes even an agreement to suppress the EOB is not adequate.

Remember that the policy holder will have access to all claims history, so if the amount of the claim is applied to the deductible the parents (policy holder) will know the amount, location and details of the claim. The amount might show up as payment toward deductibles.

Unless it is Medicaid where reimbursement is individual, it is best not to bill the insurance company.

With regards to EOB suppression, there was a recent update to Colorado's Department of Regulatory Affairs (DORA), Division of Insurance (DOI) policies: Regulation 4-2-35 now includes increased HIPAA protections with an additional Section 6 "Protected Health Information." All of the proposed changes have been accepted, effective January 1 2014. For final regulation language, click [here](#).

SUMMARY FOR CASE STUDIES

As highlighted before all the case studies, remember the following:

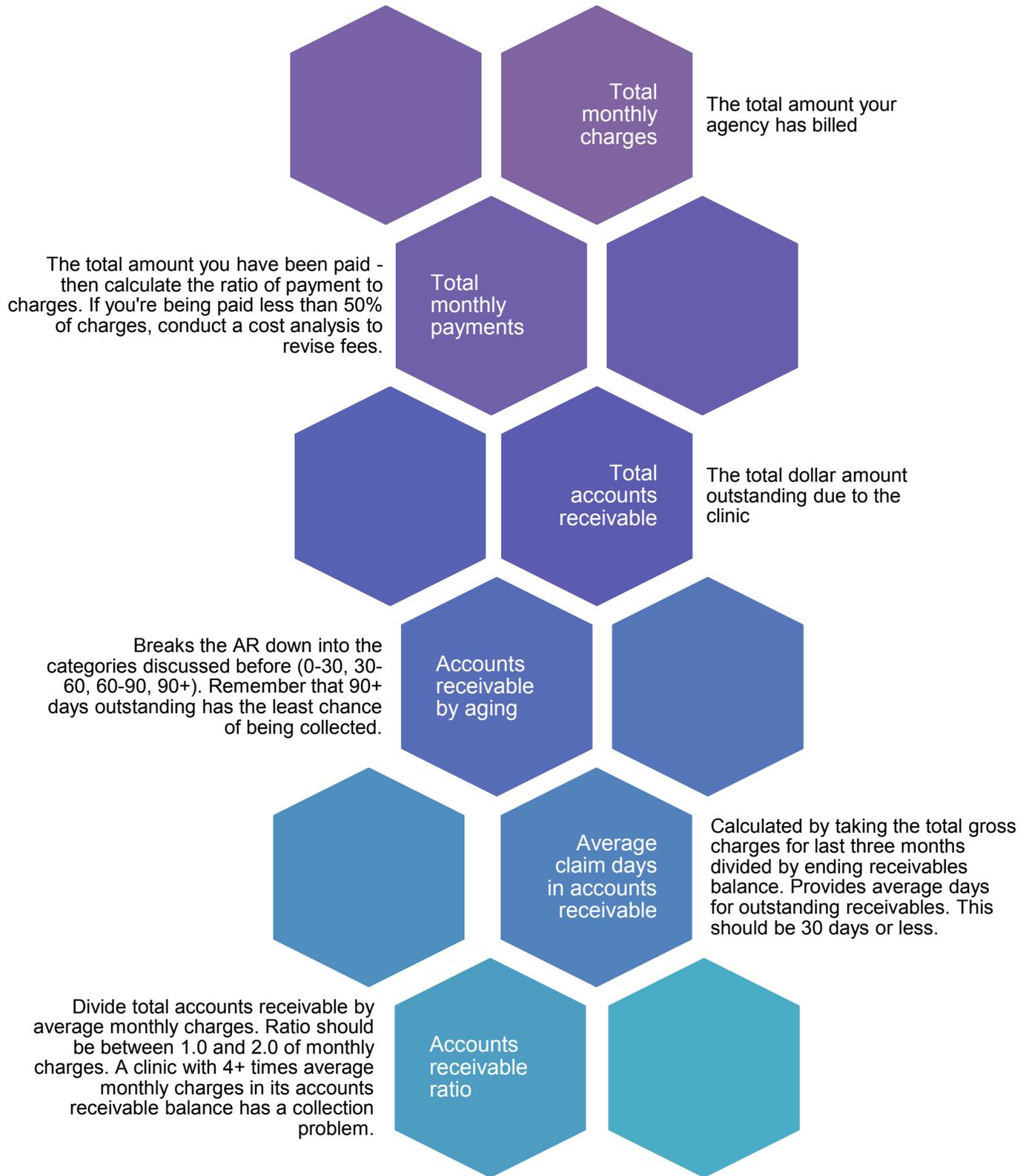
- The client pays the lower of what she/he owes on the sliding fee scale or the co-pay
- The client does not pay more than what she/he owes on the sliding fee scale (even insured clients)
- When clients request confidential services, agencies should have collection policies that are consistent with Title X rules and applied equally to all clients

Thank you to the Office of Population Affairs for helping create the above case studies!



REVENUE CYCLE MANAGEMENT PERFORMANCE MEASURES

The following are examples of common performance measures used to track the financial health of an agency based on successfully managing the revenue cycle process:



Payer Contracting and Credentialing

Commercial Payer Contracting and Credentialing

TRAINING OBJECTIVES

This section will guide you through the process of negotiating fee schedules and executing contracts with third party payers. After completing this section, you will be able to:

- List the initial steps required to develop a third party payer contracting strategy.
- Understand what key components to look for in a third party payer contract.
- Identify the common principles for fee schedule development.
- Describe the process of provider credentialing and explain why it is necessary.
- Assess your agency's level of capacity to carry out the third party payer contracting components of revenue cycle management.

Managed Care: For the purposes of this guide, “managed care” contracting refers to contracting with third party payers, including commercial insurance, Medicare, Medicaid, and other payers. The term “managed care” is commonly used to describe all types of health plans intended to reduce the cost of providing health benefits and improve the quality of care, or to describe systems of financing and delivering healthcare through managed delivery systems. Also, for the purposes of this guide, the terms health plan, insurance company, and insurer are used interchangeably. All of these terms are acceptable and correct. The terms payer and third party are also used and have the same meaning. All of these terms are used because it is important for you to become familiar with the variety of names.

FIRST STEPS TO DEVELOP A THIRD PARTY PAYER CONTRACTING STRATEGY

Identify health plans you should consider

Research and understand the health plan(s), once identified

Recognize your leveraging power

IDENTIFY HEALTH PLANS YOU SHOULD CONSIDER

The first step in payer contracting is to determine which health plans you should or should not contract with. In many cases, especially in today's environment, the health plans may be approaching you. They may ask you to contract or participate in their networks because they need you to help meet the needs of their members and to ensure that they have broad coverage across the market. Rather than signing any contract that comes in the mail, you should do some background work first.

Each state has an agency responsible for insurance regulation. [The National Association of Insurance Commissioners \(NAIC\)](#) supports a national system of state based insurance regulation in the United States.

For Colorado, the [State of Colorado Department of Regulatory Affairs \(DORA\)](#), Division of Insurance offers links, resources, and information about health insurers and insurance topics. You can also contact individual insurance companies to find out about their network coverage in your area, find their provider directories, and speak with provider services representatives about application processes and the insurance company's activities in your area.



Some of the major insurance providers in Colorado include:

COMPANY	WEBSITE
Cigna	http://www.cigna.com/healthcare-professionals/ http://www.cigna.com/healthcare-professionals/join-our-network
Humana	https://www.humana.com/provider/ https://www.humana.com/provider/medical-providers/network/
UnitedHealthCare	http://www.uhc.com/physicians.htm http://www.uhc.com/physicians/join_our_network.htm
Anthem BlueCross BlueShield	https://www.anthem.com/health-insurance/home/overview http://www.anthem.com/home-providers.html
Aetna	http://www.aetna.com/healthcare-professionals/ http://www.aetna.com/healthcare-professionals/join-aetna-network/join-provider-network.html

An effective way to learn about the health plans in your community would be to contact other local providers, hospitals and medical societies and talk to them about their experience with the payers.

You have the option of outsourcing the third party payer contracting process to an expert. There are consultants available with extensive expertise in developing contracting strategies and carrying out the contracting, fee schedule negotiation, and credentialing processes. It is important to remember as well, that even if you outsource this process and receive advice from an expert, you are still the final decision maker regarding accepting the terms of a contract and you are the responsible party who will actually sign and comply with the agreement.

RESEARCH THE HEALTH PLAN

Negotiating contracts with health plans is time consuming and can be frustrating for medical providers. The health plans have dedicated legal departments, advanced technology, and staff experienced in financial analysis and actuaries who evaluate benefit plan costs, reimbursement levels, and contract provisions in order to ensure that they keep their advantage. Most providers do not have this capacity and are at a disadvantage.

As a provider, if you find yourself reviewing a health plan contract, remember that **information is power**. It is to your benefit to gather as much information as possible about the health plan and its strategy for developing a network in your community, such as which employers are under contract with the health plan to purchase employee insurance coverage.

From the health plan you should research its:

- Mission, vision, and values
- Existing provider network (clinicians, facilities, ancillaries)
- Number of covered lives in your community



- Local employers who offer the plan
- [Performance](#)

Ask the following questions to understand the plan:

- What is the health plan's strategy for developing a network in your community?
- Do they need additional providers?
- Are they bidding to provide coverage to a local employer group?
- Are you already serving a particular segment of the population that is or will be covered by the health plan?

The best way to find answers to these questions is to contact the provider enrollment specialist in your area for the health plan and either meet in person or schedule a conference call.

There may be questions the health plans will be unable (or unwilling) to answer. Be aware that due to significant changes happening right now with health reform, some plans (especially those contracting with the health insurance marketplace) have contracting processes that are still under development. Once you receive a contract from a plan, if there is anything in the contract you do not fully understand, ***ask!*** And if you do not get an answer, ***do not sign it.***

There are **many** types of health plan products on the market today. The table below demonstrates a few of the most common.

TYPES OF PRODUCTS	DESCRIPTION
INDEMNITY	Reimburses the patient and/or provider as expenses are incurred, regardless of where the medical services are provided, or who the provider is. These types of plans have the most flexibility as far as where the services are received. Reimbursement under indemnity plans may be based on a percentage (for example, the plan may cover 80% of the charges), or a total per day (per diem) amount.
HEALTH MAINTENANCE ORGANIZATION (HMO)	Assumes both financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility of health care delivery in a particular geographic area to HMO members (usually in return for a fixed, prepaid fee). One of the most widely known HMOs is Kaiser Permanente.
PREFERRED PROVIDER ORGANIZATION (PPO)	Indemnity plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). Enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher co-payments, or non-discounted charges from the providers.
POINT OF SERVICE (POS)	HMO/PPO hybrid, sometimes referred to as an open ended HMO. When offered by an HMO, POS plans resemble HMOs for in network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans (provider reimbursement based on a fee schedule or usual, customary and reasonable charges, for example).
PRIVATE FEE FOR SERVICES (PFFS)	Through PFFS providers are reimbursed negotiated payment amounts based on volume. In addition, there are performance based FFS plans through which payments are negotiated based on volume plus additional incentives for managing cost, quality, and patient experience. The Medicare Pay for Performance program is an example (click here for more info).



There are many different types of contracts with providers, and health plans may vary greatly with regard to the options they offer for contracting. Some plans may offer a group contract for the entire agency and all services provided to covered members will be billed under one contract and one provider number and will include a list of licensed providers as an addendum or attachment. This can be of great benefit to a local public health agency staffed by RNs because it makes it easier to bill for nursing visits. However, many health plans will only agree to contract with licensed, individual providers. In this case, each physician or advanced practice nurse in the agency would hold a contract with the health plan.

RECOGNIZE YOUR LEVERAGING POWER

Title X agencies provide unique services such as care coordination, case management, patient navigator services, or wellness/screening programs. These services are of benefit to health plan members and could help to keep the costs down for the health plan. Title X agencies typically serve young, relatively healthy clients. Commercial insurance companies target this demographic because they are less expensive to cover.

Your agency already has an established relationship with these clients and they are comfortable receiving care from you. In other words, you already reach a population that commercial insurance companies are seeking. Comprehensive family planning services, especially services such as pap smears and breast exams (preventive women's health services), are a core function of your Title X clinic, so when working with the health plans, build upon this strength and the fact that your clinic is already the place where many young adults prefer to access care.

Other benefits you bring to the health plan include reducing the health plan's maternity/newborn expenses by preventing unintended pregnancies, and improving performance in chlamydia screening, cervical cancer screening, BMI, and smoking cessation. These services help health plans reduce cost and improve performance measures. A large portion of a health plan's budget goes toward supporting maternity and newborn care. They will be very interested to learn how many pregnancies are unintended and how your agency's work can help reduce their costs in this area, as well as other areas.

Just as providers are increasingly being monitored for performance measurement and improvement, health plan performance is being measured as well. This information is important to employers and consumers who are purchasing health insurance – and to regulators who are striving to ensure patient safety and reduce the cost of care. Performance measures for health plans may be related to services such as:

- Medication administration
- Health screening
- Preventive care
- Immunizations
- Workplace wellness programs

For more information about health plan performance measures, click [here](#).

Essential Community Providers

The Affordable Care Act requires qualified health plans participating in [health insurance marketplaces](#) to include a sufficient number and geographic distribution of providers that serve predominantly low-income, medically underserved individuals, referred to as Essential Community Providers (ECPs) in their networks. Please keep in mind that while qualified health plans are required to include ECPs in their networks, they are not required to contract with all ECPs. The Centers for Medicare and Medicaid Services (CMS) has posted a list of essential community providers which consists of agencies that serve underserved and/or low income populations: click [here](#) for the list. Most Title X agencies should be listed, but you should double check to make sure your agency is on the list. This list is **not exhaustive** and CMS has recognized that other agencies may be added at the state level. Some states have a statutory definition of an essential community provider and an application process.

The types of providers include, among others, the following:

- Title X

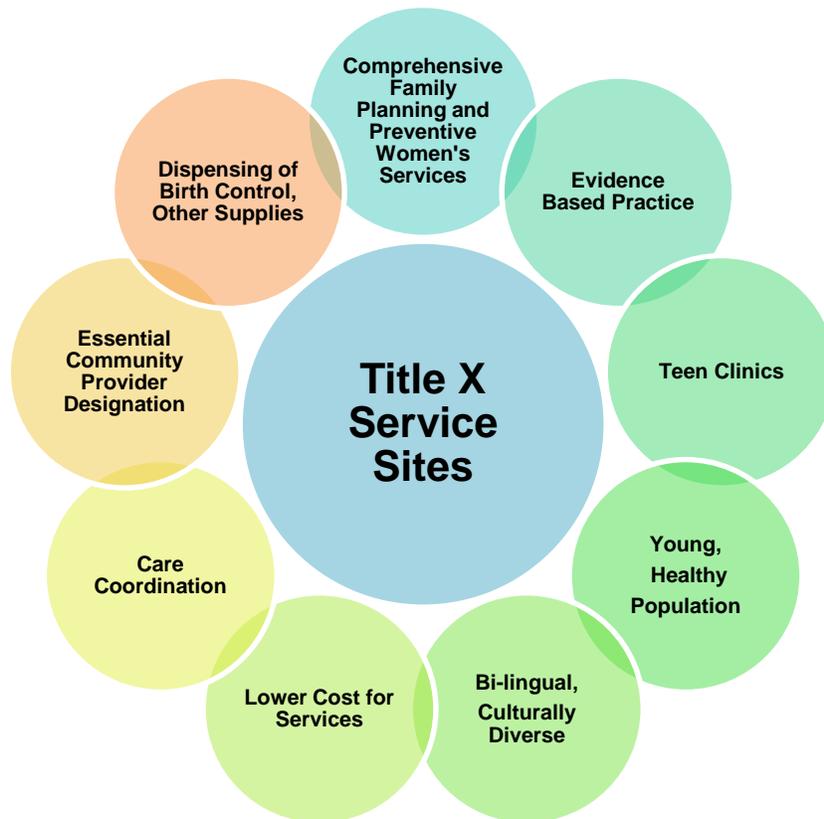


- Ryan White HIV/AIDS
- STD clinics
- Indian health services
- FQHCs

Please note that network criteria or essential community provider criteria may vary from state to state, and from qualified health plan to qualified health plan.

[More about becoming designated as an essential community provider in Colorado.](#)

VALUABLE SERVICES PROVIDED BY TITLE X AGENCIES



The above diagram highlights just some of the benefits your agency brings to the table that are of interest to health plans.

Your clinic is in a unique position to partner with health plans to help improve the health plan's performance in these areas and to contribute to reducing costs and providing education and coordinated care. After you initially approach a plan, they might respond that they have evaluated their network and do not need additional providers. Don't take that "No" as a final answer, write and request they reconsider. This gives you a chance to list all of the benefits you bring to them. Focus on how your services will save them money.

Be sure to approach contracting from a position of strength – they need you, they just might not realize it yet.



KEY COMPONENTS OF A CONTRACT: DEFINITIONS & TIPS

At the beginning of a contract, a number of terms used throughout the contract are defined. Below is a list of terms and tips for each one:

CONTRACT TERMS AND TIPS

Clean Claim

- A clean claim should be very basic and defined as a standardized claim form with required fields completed.
- Anything in addition to this may be a red flag and result in rejected claims or payment delays.

Contracting Payer

- The contracting payer definition should cover exactly who (which health plans, employer groups or third party administrators) will have access to your negotiated discounts under the contract.
- This is important and prevents health plans from being able to rent its provider network to other entities without your knowledge.

Covered Services

- Review the definition of "covered services" as well as "health care services" if it is included.
- You want to make sure you are required to accept health plan discounts only for covered services rather than all health care services.

Notification of Policy Changes

- The contract should require advance written notification of policy changes (30 days is reasonable).



KEY COMPONENTS OF A CONTRACT: HEALTH PLAN OBLIGATIONS

The following list represents items that you should try to negotiate during the contracting process:

1. Provide member ID cards

- The health is to provide its members with ID cards and should provide you with sample cards

2. Provide fee schedules

- Fee schedules should be included as attachments (including a sample of your codes) and the contract should address how fee schedule changes are implemented in the future

3. Do not include "most favored nation" clause

- The contract should not include the term "most favored nation.This would require you to offer the health plan the lowest, most favorable rate of any health plan

4. Prompt payment provision

- The health plan should be contractually obligated to process payment at least within 30 days from your submission of a clean claim

5. Written consent for additional benefit plans

- In order to prevent health plan from requiring you to participate in all benefit plans offered, you should insist on your written consent so you can consider each plan (product) separately.

6. Electronic capabilities

- Are electronic business solutions available? Like claims submissions, referrals, eligibility/benefits verification

7. Credentialing

- If you have sent the health plan the information that they need for credentialing, the timeframe for completion should be 90 days or less.

8. Privacy protection

- Title X guidelines require that you must make reasonable efforts to collect charges without jeopardizing confidentiality, if clients request confidential services. **

****This is something you can address with the health plan and some health plans may be willing to agree to suppress the Explanation of Benefits (EOB), or prevent the EOB and other communication to be sent to the client's home address. You should be aware, however, that there may be issues with compliance with this request, depending on the insurance company's systems. In addition, if the client is a minor and is covered under a parent's insurance policy, or is an adult covered under a spouse or family member, it would be extremely difficult, if not impossible, to maintain privacy protection if a claim is filed because the policy holder would have access to claims history.**



KEY COMPONENTS OF A CONTRACT: PROVIDER OBLIGATIONS

The following list represents items that you should expect the plan to negotiate during the contracting process:

1. OFFICE HOURS/AFTER-HOURS CARE	What office hours are required? Are weekend/evening hours addressed? On call coverage?
2. TIMELY FILING	Timely filing should be reasonable (90 days or more)
3. CLAIM SUBMISSION	Claims submission requirements should be standard (no special or non-standard requirements). Make sure this language is included.
4. NON-DISCRIMINATION	Discrimination language may be included in the contract, but you should make sure you are allowed to manage your payer mix (no longer accepting new patients should not be considered discrimination).
5. MEDICAL RECORDS	What does the health plan expect in relation to accessing medical records information?
6. POLICY MANUAL	Review the policy manual before signing the contract.
7. PROVIDER DIRECTORY	Health plans typically expect that all credentialed providers will be listed in the provider directory which contains information about the plan's current provider network. Provider directories are usually available online with search capabilities by location, specialty, and provider type. You will want to find out how your agency/providers will be listed and be aware that this will help to drive individuals covered by the plan to your agency as a network provider.
8. CO-PAY COLLECTION	If a co-payment (also called cost-share) is required from the insured individual, usually the provider is contractually required to collect the copay at the time of the visit. If you have questions about collecting copayments from clients in relation to Title X guidelines refer to the "Billing/Coding" section of the manual.
9. LIABILITY INSURANCE	Your agency should have the appropriate liability insurance coverage for the services that you provide. The health plan may have different, more stringent requirements than the minimum state requirements. Contact your insurance agent for more information.

KEY COMPONENTS OF A CONTRACT: TERM AND TERMINATION

Health plans offer contracts with a termination without cause provision that does not allow termination of the contract during the initial term (which is usually for multiple payers). You can request that the initial term be limited to **one year** and that the termination without cause provision allow termination with a 90 day written notice regardless of the initial term. If you agree to a **multi-year** term, you can also ask for an accelerator clause that guarantees fee schedule increases each year of the initial **multi-year** term. In this case, the health plan agrees to increase the fee schedule at a predetermined percentage each year, or to adjust the fee schedule each year based on economic indicators and other factors.



KEY COMPONENTS OF A CONTRACT: GENERAL PROVISIONS

Reciprocity

Equal reciprocity for both parties for all provisions

Amendment Process

Make sure contract amendments required signed execution by both parties

Indemnification

The contract should include equal and mutual indemnification language

Legal Proceedings

The contract should make it clear that any arbitration hearings will take place in the provider's community rather than the location of the health plan's corporate office, and that appeal processes must be exhausted before initiating arbitration. The contract should not resist or limit the provider's ability to pursue or participate in class action lawsuits.

UNACCEPTABLE PROVISIONS

1. Restricted access to fee schedules
2. Fee schedule applies to non covered services
3. Lack of clarification regarding entities with access to contract and discounts
4. Payer prohibits provider from establishing panel limits and practice parameters.
5. Any reference to most favored nation
6. Nonstandard coding, billing, or claims submission requirements
7. Cumbersome (or manual) referral or prior authorization process
8. Timely filing less than 90 days
9. Health plan able to amend the contract without your signature

FEE SCHEDULE

All medical practices need to establish a charge master or price list for services (a fee schedule) just as other industries establish their price list for their goods or services. The term fee schedule is also common for insurance companies to use.

NOTE:

To an insurance company the fee schedule is the price they will pay you for your services (based on the contract terms agreed). The name for your internal, comprehensive list of all services the clinic provides with pricing is called the charge master, fee schedule or price list.

Your agency should establish a fee schedule based on the cost of providing services and the value added and profit. [Click here for more about fee schedules, and sample schedules and analysis.](#)



MEDICARE RESOURCE-BASED RELATIVE VALUE SCALE

There are many ways to determine your agency's cost to provide services. But the most common method is to utilize the Centers for Medicare and Medicaid services (CMS) resource based relative value scale (RBRVS).

In 1992 Medicare significantly changed the way it pays for physicians' services. Instead of basing payments on charges, the federal government established a standardized physician payment schedule based on a resource based relative value scale (RBRVS). In the RBRVS system, payments for services are determined by the resource costs needed to provide them. The cost of providing each service is divided into three components:

- Physician work
- Practice expense, and
- Professional liability insurance

Payments are calculated by multiplying the combined costs of a service by a conversion factor (a monetary amount that is determined by CMS).

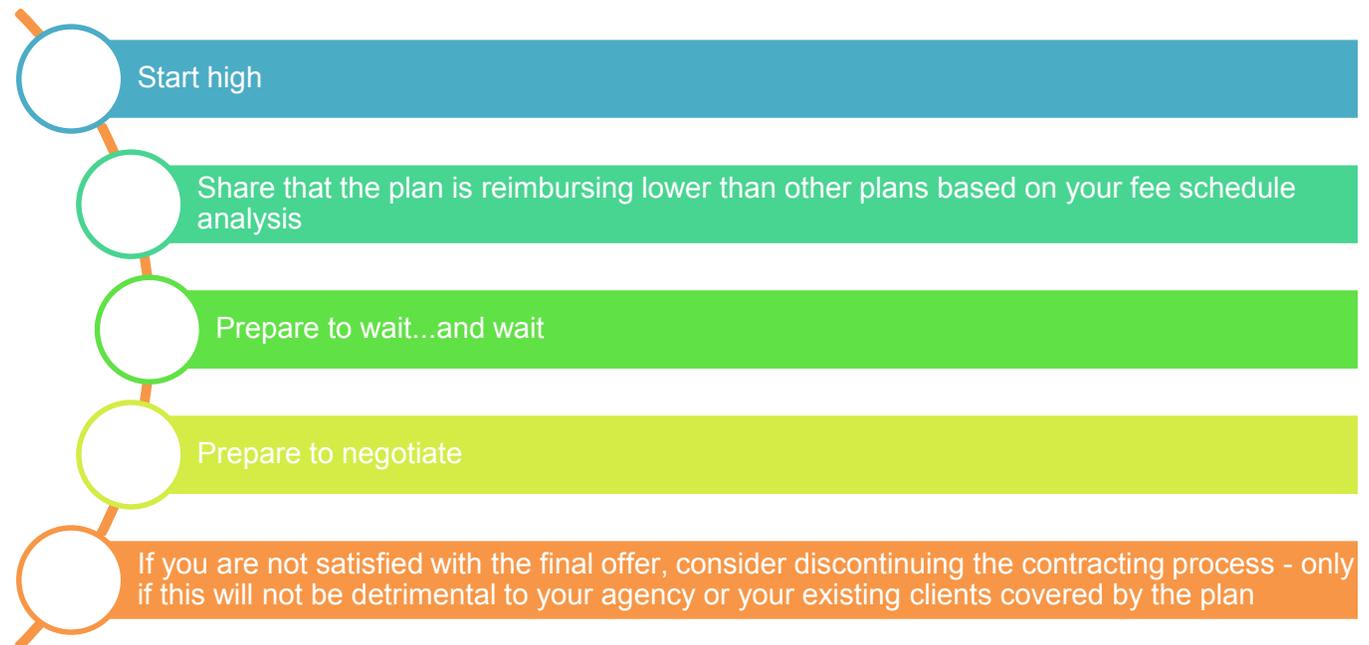
$$\text{Payment} = \text{relative value} \times (\text{geographic practice cost index}) \text{ GPCI} \times \text{conversion}$$

The relative value of each service is multiplied by Geographic Practice Cost Indices (GPCIs) for each Medicare locality in the United States and then translated into a dollar amount by an annually adjusted conversion factor, which means that the payments are adjusted for geographical differences in resource costs.

Commercial insurers use a fixed fee schedule that is roughly based on the Medicare fee schedule.

For more about the RBRVS from the American Medical Association's website, click [here](#).

TIPS FOR NEGOTIATING FEES



CREDENTIALING

Credentialing is **not** contracting. Credentialing is the process of verifying and validating background and qualifications for providers (education, training, licensure, certifications, and experience).

- Allow at least 3-6 months to complete the process
- The Council for Affordable Quality Healthcare (CAQH): centralized database used by most commercial health plans: www.caqh.org
- Direct enrolment required for Medicare and Medicaid

You should know that every payer has a slightly different process for credentialing your providers. The key to credentialing is to be proactive and follow up with the payer!

ITEMS TYPICALLY NECESSARY FOR CREDENTIALING

Physical address	Telephone/fax number
Medical license	National provider identifier (NPI) number
Drug enforcement agency (DEA) number	Start date
W-9 form	Curriculum vitae
Board certification	Professional liability certificate
Unique physician identification number (UPIN)	Tax ID
Birth date	Social security number
Voided bank check	IRS form CP575A

CONTRACTING AND CREDENTIALING ARE ONGOING PROCESSES

- Review contracts and fee schedules at least every 2-3 years
- CAQH requires quarterly attestation for credentialing
- Make sure new providers are credentialed and affiliated with health plans
- Make sure re-credentialing requirements are met



Medicare

Medicare

MEDICARE COVERAGE

Medicare insures people 65 or older, people under 65 with certain disabilities, people of any age with end stage renal disease (ESRD, permanent kidney failure requiring dialysis or a kidney transplant). Click [here](#) for more information. Medicare is a public health plan administered by the United States Department of Health & Human Services, [Centers for Medicare and Medicaid Services](#).

MEDICARE AND TITLE X

Based on the fact that the majority of Medicare covered individuals are age 65 or older, Title X agencies typically do not provide family planning services to Medicare beneficiaries, yet there is a small percentage of Medicare insured individuals that your agency may serve. According to the [Title X Family Planning Annual Report](#) national summary, in 2011 revenue from Medicare for the delivery of Title X-funded family planning and related preventive health services accounted for less than 1% of total national program revenue.

General information about Medicare is provided in this manual as an overview for the benefit of your agency. In particular, this information may be of interest to you if:

- Your agency is a federally qualified health center or other type of non-profit safety net clinic;
- Your clinicians are enrolled as Medicare providers and deliver comprehensive primary care services; or
- Your agency is a local public health agency participating in Title X and offering immunizations covered by Medicare.

WHAT ARE THE DIFFERENT PARTS OF MEDICARE?

Medicare Part A (hospital insurance) helps cover:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care

The patient usually doesn't pay a monthly premium for Part A coverage if the patient or a spouse paid Medicare taxes while working, sometimes referred to as "Premium Free Part A." If the patient isn't eligible for premium free Part A, she/he may be able to buy Part A and pay a premium. Click [here](#) for more information.

Medicare Part B (medical insurance) helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment
- Some preventive services

Most Part B enrollees pay a monthly standard Part B [premium](#).

Medicare Part C (Medicare Advantage):



- Run by Medicare-approved private insurance companies
- Includes all benefits and services covered under Part A and B
- Usually includes Medicare prescription drug coverage (Part D) as part of the plan
- Usually includes extra benefits and services, in some cases for an extra cost

Medicare Part D (Medicare prescription drug coverage):

- Run by Medicare-approved private insurance companies
- Helps cover cost of prescription drugs
- May help lower prescription drug costs and help protect against higher costs in the future

MEDICARE ADMINISTRATIVE CONTRACTORS

The Centers for Medicare and Medicaid Services (CMS) selects multi-state regional Medicare Administrative Contractors (MACs) to serve as the primary operational contact between Medicare Fee-For-Service program, and approximately 1.5 million health care providers enrolled in the program. MACs enroll health care providers in the Medicare program and educate providers on Medicare billing requirements, in addition to answering provider and beneficiary inquiries. Collectively, MACs and other Medicare claims administration contractors process nearly 4.9 million Medicare claims each business day, and disburse more than \$365 billion annually in program payments.

Colorado's MAC is [Novitas Solutions](#).



Medicaid

Medicaid

WHAT IS MEDICAID?

Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid may also cover services not normally covered by Medicare, like long term supports and services and personal care services. Each state has different rules about eligibility and applying for Medicaid. If someone qualifies for Medicaid in their state, they automatically qualify for extra help paying Medicare prescription drug coverage (Part D).

Medicaid eligibility may depend on age, if the person is pregnant, blind, or has other disabilities, and if the person is a U.S. citizen. Certain legal immigrants may be eligible. If Medicaid covers a woman's labor and delivery, the baby may be covered for up to one year without needing to apply. People with Medicaid who are disabled or elderly also may get coverage for services like nursing or home care, or home- and community- based services.

Colorado Medicaid – Department of Health Care Policy and Financing

The Colorado Department of Health Care Policy and Financing (HCPF) administers Medicaid, Child Health PlanPlus and the Colorado Indigent Care Program for Coloradans who qualify. Colorado Medicaid is free or low cost public health insurance for Coloradans who qualify. Medicaid can cover doctor visits, emergency care, preventative care such as screenings and immunizations, and other procedures or treatments.

Medicaid Expansion

Starting in 2014, Colorado Medicaid covers individuals and families with up to 133% of the Federal Poverty Level. This means more adults without children and parents are now able to qualify for free or low cost coverage through Medicaid. Those with higher incomes **may** still qualify for Medicaid.

APPROXIMATE MONTHLY INCOME to qualify for Medicaid beginning January 2014	
Individual	Up to \$1250
Family of 2	Up to \$1700
Family of 3	Up to \$2150
Family of 4	Up to \$2600

Medicaid Resources

The following are just a few of the resources on the HCPF Medicaid website. There are billing manuals, resources, FAQs, and links to learn more about the different programs.

Follow this link to find current HIPAA fact sheets and companion guides: <http://www.colorado.gov/pacific/hcpf/health-insurance-portability-and-accountability-act-hipaa-0>

For a Provider Enrollment Application Checklist and Instructions for a Family Planning Clinic: <http://www.colorado.gov/pacific/sites/default/files/Family%20Planning%20070813.pdf>



For standard provider application enrollment for a variety of applications (including FQHC prenatal plus participation form, or organized health clinic prenatal plus program participation form):

<https://www.colorado.gov/pacific/hcpf/provider-enrollment>

Follow this link for the landing site for all billing manuals under the “Provider Services” section of HCPF:

<https://www.colorado.gov/hcpf/billing-manuals>

- Here you will find all general provider information, appendices, Colorado 1500 information, CMS 1500, dental, HCBS, pharmacy, transportation, and UB-04.

Within the appendices you will find updated information about the Colorado Medical Assistance program, county departments of human and social services, denial codes, revenue codes, the community mental health services program, and a variety of useful forms, for example.

Colorado Medical Assistance Program, 1500 Specialty Manuals (managed care programs, obstetrical care, school health, etc.):

https://www.colorado.gov/pacific/sites/default/files/CO1500_Specialty_Manuals_100114_mm_2.pdf

- “Family planning” specifically referenced on pages 3 and 13.
- Colorado Medical Assistance Program enrolled women may receive family planning services during and after pregnancy. Colorado Medical Assistance Program generally covers most methods of birth control. Prior authorization not required for family planning.”
- Required fields for Colorado 1500 paper claim form for Obstetrical Care claims and for School Health Services
 - Field label: 19K family planning
 - Special instructions: conditional, complete if the service is rendered for family planning

340B DRUG PRICING PROGRAM AND PHARMACY AFFAIRS

The 340B drug pricing program requires drug manufacturers to provide outpatient drugs to eligible health care organizations and covered entities at significantly reduced prices. It enables covered entities to stretch their resources, reach more potentially eligible patients, and provide more comprehensive services. To participate in the program, eligible organizations and covered entities must register and be enrolled with the 340B program and comply with all program requirements (which can be found by [clicking here](#)).

Generally, the 340B program covers the following outpatient drugs:

- FDA approved prescription drugs
- Over the counter drugs written on a prescription
- Biological products that can be dispensed only by a prescription (other than vaccines)
- FDA approved insulin

Medicaid Exclusion

[42 USC 256b\(a\)\(5\)\(A\)\(i\)](#) prohibits duplicate discounts – manufacturers are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug. Covered entities must have processes in place to prevent duplicate discounts. Upon enrollment into the 340B program, covered entities must decide whether they will use the 340B drugs for their patients (carve-in) or whether they will purchase drugs through other mechanisms (carve-out). When utilizing 340B drugs for patients and when billing Medicaid for these drugs, use the 340B purchase price with billing and **NOT** the fee schedule pricing.

Source: <http://www.hrsa.gov/opa/programrequirements/medicaidexclusion/>

Orphan Drug Exclusion

Orphan drugs are those pharmaceuticals or biological products that receive special status to treat a rare disease or condition upon request of a sponsor – this designation qualifies the sponsor of the drug for development incentives, and an extended period of market exclusivity following approval. 340B hospitals that are subject to the



orphan drug exclusion (such as critical access hospitals, free standing cancer hospitals, sole community hospitals, and rural referral centers) are responsible for making sure that any orphan drugs purchased through the 340B program are not transferred, prescribed, sold, or otherwise used for the rare condition or disease for which the orphan drug was designated.

Orphan Drug Act Final Rule: <http://www.gpo.gov/fdsys/pkg/FR-2013-07-23/pdf/2013-17547.pdf>

REGISTERED NURSES

Registered Nurses (RNs) are defined as other qualified healthcare professionals (OQHPs) by Medicaid as they are designated as eligible “rendering providers.” They are required by state regulation to have on premise supervision. This includes an advanced practice nurse or physician. The only exception for this supervision requirement is for RNs who are employees of a certified health agency. With proper enrollment and documentation to support these services, RNs of certified health agencies can provide services without on premise supervision. When billing, claims must identify the RN as the rendering provider.

RNs can provide the following services independently:

- Injections (96372)
- Vaccinations (90476)
- Administration (90471)
- Counseling (99401)
- Nurse visits (99211)

The code of primary use will be 99211 which is designated as “the nurse visit” code. The indication of this service is provided in the code description, “May not require the presence of a physician”. RNs can also provide preventative medicine counseling (99401-99404) services; however this must be directly related to issues such as healthy diet, exercise, STD prevention, family problems, etc. These services should not be used exclusively for delayed exams.

RNs can provide delayed exams to both new/established patients. However, they can only bill as if the patient were established to the practice, meaning RNs can never charge for new patient visit codes (99201-99205).

RNs can never bill new patient codes, even 99201, as this service falls outside of their scope of practice.

DUAL ELIGIBILITY

Some people who are eligible for both Medicare and Medicaid are called "dual eligibles." If someone has Medicare and full Medicaid coverage, most of the health care costs are likely covered.

MEDICARE, MEDICAID + TITLE X

To obtain additional resources other than this guide, including Medicaid maximum allowed rates, contact the administrative consultant in the Women’s Health Unit (WHU) at 303-692-2493.

When billing Medicaid for family planning services, the CPT codes must include the family planning modifier “fp.” For example, 99212-fp. Upon receipt of appropriate documentation, HCPF will base reimbursement by Medicaid on the maximum allowable fees set for family planning services. Payment is subject to conditions, exclusions, and limitations set forth by the department. The payment will be the lower of the following:

- The amount specified in the departments fee schedule (maximum allowable reimbursement information for specific services available from the WHU upon request)
- The agency’s usual and customary fee (in the case of the sliding fee schedule, the 100% charge for the service)



Previously, Medicaid only approved the office visit codes for family planning billing (99201-99204 for new clients, and 99211-99214 for established clients). However, now family planning programs can bill using the preventive medicine service codes (codes are age based and are inclusive of all initial or periodic comprehensive exam, counseling, anticipatory guidance, and risk factor reduction intervention). **Click here to jump to the coding section of this manual.**

Source: Section IX Financial Management, CDPHE.

On the following page is guidance provided by the Colorado Department of Health Care Policy and Financing, for Colorado's Medical Assistance Program, Billing for Family Planning Services (June 2014).



Colorado's Medical Assistance Program, Billing for Family Planning Services

June 2014 update

In this summary, the Colorado Department of Health Care Policy and Financing (HCPF) has identified Family Planning (FP) clinical services that are applicable and covered under Colorado's Medical Assistance Program and in compliance with Federal guidelines.

Definition: Federal guidelines define family planning services as services and supplies provided to individuals of childbearing age which either **prevent or delay pregnancy**. Examples of Medicaid covered family planning clinical services include: contraception or sterilization procedures such as, contraception counseling (including natural family planning), provision of contraceptive prescriptions, methods, devices and supplies, and sterilization counseling, procedures and supplies (The following codes are examples of these services: S4993, J1050, A4266, J7300, J7301 and A4264).

STD/HIV Evaluations: STD/HIV evaluations/diagnosis/testing and treatment are coverable as family planning services because prevention of these infections protect an individuals' reproductive health and future fertility. STD prevention *counseling* is considered a family planning service **only** when provided in conjunction with a family planning visit. If not associated with a family planning visit, STD counseling would be covered under Medicaid's preventive services or in a separate evaluation and management service and should **not** have an associated family planning (FP) modifier used when billing.

Coding: Only the following Evaluation and Management Office visit codes are appropriate for Medicaid family planning clinical service billing: 99201–99205 and 99211–99215. These codes should be associated with a FP diagnostic code and the FP modifier. Preventive Medicine E & M codes (99381-99386 / 99391-99396), Risk Factor Reduction Counseling codes (individual or group / 99401-99404 or 99411, 99412), and Behavior Change Intervention (99406-99409) codes can be used by family planning agencies but should not have an associated family planning (FP) modifier used when billing. FP agencies can use these codes, they just cannot report with the FP modifier. Preventative codes are used for their GYN exams and paps.

Family Planning Modifier: All Medicaid enrolled providers are requested to document the primary purpose or intent of a family planning procedure in the client's medical records. If a contraceptive method or device is prescribed primarily for a medical reason other than for family planning, the FP modifier should **not** be used. For example, when the contraceptive pill (S4993) is prescribed for a medical reason such as to stabilize the uterine lining, the intent of this prescription is not to prevent pregnancy, therefore, the FP modifier should **not** be included on the claim. According to the Centers for Medicare and Medicaid Services (CMS), the use of contraceptive pills for reasons other than pregnancy prevention, is **not** considered a family planning service.

At this time Colorado's Medical Assistance Program does not cover infertility treatment, counseling or testing nor does it cover sterilization reversal procedures.

To receive reimbursement for Medicaid family planning clinical services, providers should:

1. Identify and record an appropriate family planning diagnosis code associated with the family planning clinical visit.
2. Identify and record the appropriate procedure code(s) [Current Procedural Terminology (CPT) or HCPCS] associated with the family planning visit. And,
3. Include the FP modifier.

Additional Resources: A current list of family planning diagnosis codes and examples of procedure codes can be found on HCPF's Provider Services website.

http://www.colorado.gov/pacific/sites/default/files/Family_Planning_Diagnosis_Codes_0.pdf



HIPAA

HIPAA

WHAT IS HIPAA?

If you are not familiar with HIPAA, you should become familiar with HIPAA as soon as possible. The [Health Insurance Portability and Accountability Act](#) became effective in 1996 and has had many different rules and clarifications since.

THE PRIVACY RULE

The Privacy Rule of 2003 regulates the use and disclosure of Protected Health Information (PHI) held by “covered entities.” PHI is any information concerning health status, provision of health care, or payment for health care that can be linked to an individual. Covered entities are organizations that are engaged in electronic transmission of PHI.

If you file a claim form to a payer, you are considered a “covered entity” and you must comply with HIPAA privacy and security rules.

The US [Office of Civil Rights](#) enforces the Privacy Rule and will investigate potential violations. HIPAA requires that you take certain measures to protect PHI and that you disclose information about your HIPAA policies to your clients. If you haven't, you should engage in an assessment to determine your level of compliance with HIPAA and correct any non-compliant findings as soon as possible.

THE HITECH ACT

The HITECH Act is part of the American Reinvestment & Recover Act of 2009. HITECH defines the requirements for being compatible with the security and privacy regulations of the Privacy Rule. HITECH also facilitates the expansion of Electronic Medical Record (EMR) standards that aid in electronic exchange of health information on a national basis. HITECH also put forth incentives for covered entities that adopt Electronic Health Records (EHR), also known as [Meaningful Use](#).

The Privacy Rule lays down the standards that should be followed to become HIPAA-compliant but it is the HITECH Act that elaborates on the criticality of following these norms and lays down enforcement, accountability, penalty and persecution-related guidelines for those involved in sharing or accessing PHI.

If you have not had an assessment to evaluate your compliance with HIPAA, contact one of the agencies listed below (or the Colorado Family Planning Initiative) as soon as possible to find out more.

Helpful HIPAA Resources:

Priva Plan Associates:

- <http://www.privaplan.com/>

HIPAA Solutions:

- <http://www.hipaasolutions.org/index.htm>

HIPAA Compliance Services:

- http://www.hipaacomplianceservices.com/?page_id=272

U.S. Health Care Compliance:

- <http://www.ushealthcarecompliance.com>



Outsourcing

Options for Outsourcing

REVENUE CYCLE MANAGEMENT: BUILD IT OR BUY IT? OPTIONS FOR OUTSOURCING

Any and all components of the revenue cycle management process may be outsourced to professionals who provide these services on a contract basis. Billing companies provide comprehensive revenue cycle management services and will take over the process from claims submission to collections. Most clearinghouses not only provide claims submission services, but also provide:

- Outsourced eligibility verification
- Claims rejection analysis
- Patient statement services

In order to determine whether or not to outsource or keep the services in house, a [cost/benefit analysis](#) should be conducted to weigh the cost to the agency in personnel, training, technology and other resources – versus the cost of contracting with an outside organization.

Often with a small volume of claims, it makes sense to outsource rather than developing the internal capacity.

DECISION MAKING FACTORS - WHEN TO OUTSOURCE

Number of providers – physicians, advance practice nurses, physician assistants

Number of billing personnel

Total monthly salary and benefits for billing personnel

Number of coding personnel

Total monthly salary and benefits for coding personnel

Total monthly salary and benefits for management personnel – providing oversight for coding/billing process

Number of claims filed monthly

Average cost per claim

Average days in Accounts Receivable (AR)

Accounts Receivable ratio – A/R monthly gross production

Total revenue billed monthly

Total revenue collected monthly

Practice management system

Electronic claims submission capability

Adequate hardware – number of computer stations

Experienced staff with coding and billing expertise



It is difficult to calculate internal costs and to accurately estimate the potential for increased revenue using a contracted billing service, therefore, the decision to outsource is challenging. The above list has been compiled as a starting point to help your clinic identify the key factors that are important to consider in the decision-making process. Once you have looked at these factors you can perform a cost benefit analysis to determine whether outsourcing is prudent.

COSTS FOR OUTSOURCING

Clearinghouse

- Set up fee plus flat fee per provider per month **\$50-\$250**
- Per claim fee based on average daily claim volume with volume discounts **<\$1.00/claim**

Outsourced billing

- Price per claim **\$5-\$10 per claim**
- Percentage of collections **7-9%**

Patient statements

- **.55-.69** cents per statement (sometimes this service is included as a part of a percentage fee)

OUTSOURCED BILLING COMPARISON: PRIMARY CARE PRACTICE WITH THREE PHYSICIANS (IN HOUSE VERSUS OUTSOURCED)

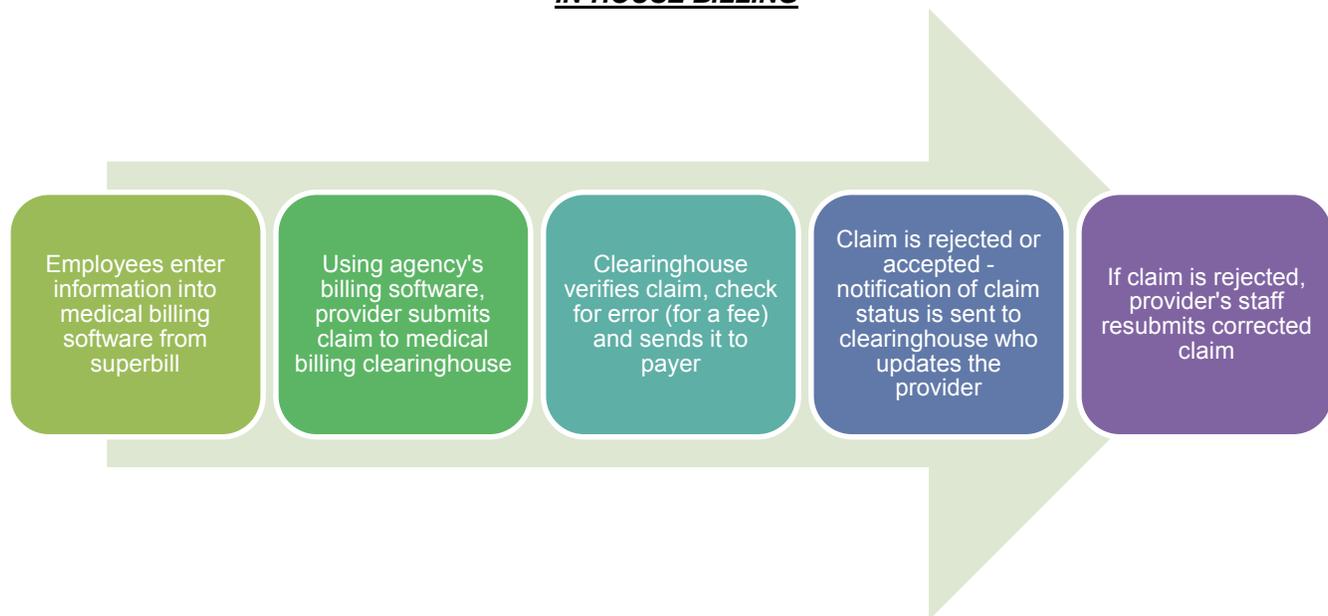
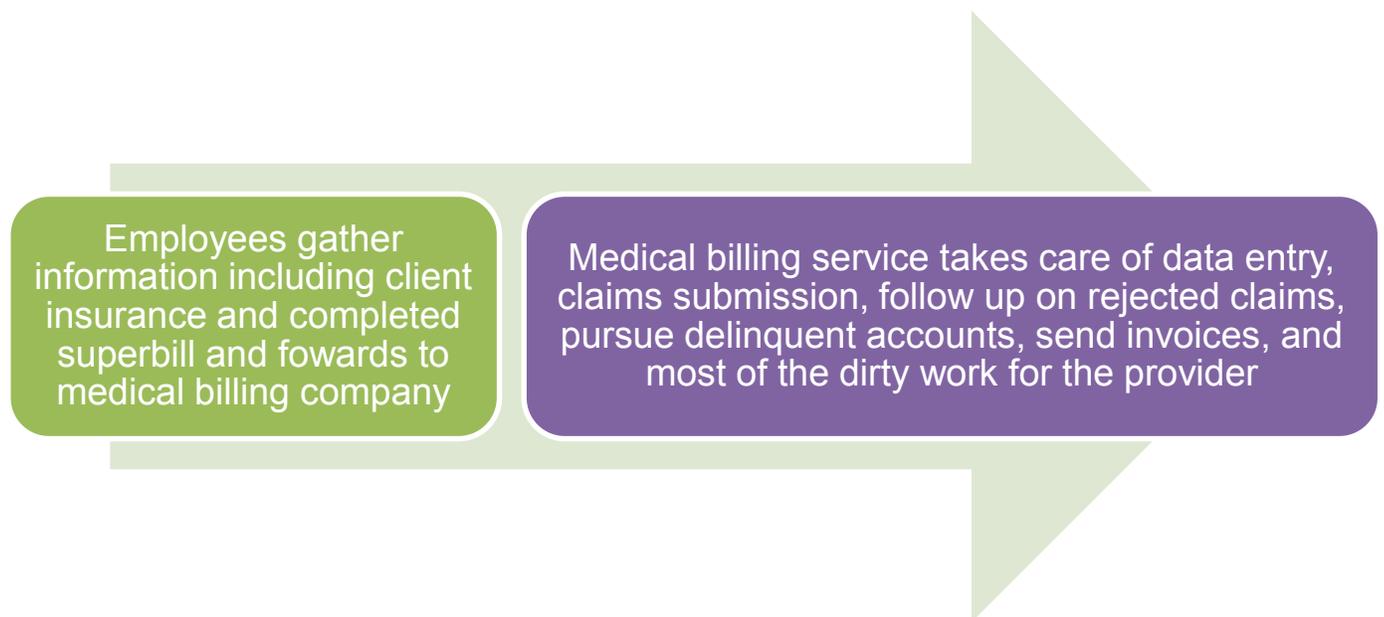
The in-house procedure for processing insurance claims involves steps that are universal to every agency.

First, *employees enter information into the medical billing software program including client insurance and charge information* (to jump to the “during the visit” section, [click here](#)). The charge information is gathered from the superbill which contains particular diagnosis and treatment codes (to jump to the “coding” section of the manual, [click here](#)), among other patient information, which the insurance company uses for reimbursement purposes.

Then, *using the same billing software the provider submits the claim to the payer via a medical billing clearinghouse* which verifies the claim, checks it for errors (for a fee) and forwards it to the payer. Checking for errors saves the provider time, money, and lowers their claim rejection rates. Once the *claim is rejected or accepted by the payer, notification of the claim status is sent to the clearinghouse, who then updates the provider on the status. If the claim is rejected, the provider’s staff resubmits the claim* with whatever additional information is required.

EHR software (especially those with an integrated practice management system), has the potential to make in house billing easier for an agency – it can populate both system’s data fields. Diagnosis codes and other information needed for billing doesn’t need to be keyed into another system. This eliminates a second round of data entry. This tighter integration may be a factor that helps keep billing in house.



*Process Comparison***IN-HOUSE BILLING****OUTSOURCED**

The process for outsourcing billing is more straightforward for practice staff. *Superbills and other documents can be scanned and electronically sent or mailed to the medical claim billing service.* The medical billing service takes care of most of the “administrative work” for the provider, such as data entry, claims submission, pursues delinquent accounts, following up on rejected claims, and sending invoices. The convenience factor is a major reason that providers choose to outsource.

This process is even easier if the practice is using EHR software.

Information from a patient's superbill is stored into the EHR and electronically transmitted to the billing service. This eliminates the need to send paper records to the billing service, and because the EHR software eliminates an extra round of data entry, accuracy is improved. One possible issue here is data integration between the EHR software and the billing service. The type of data being exchanged between the provider and the billing service



will need to match, or else the data will need to be converted to a different format. Depending on the billing service, data conversion may be an option.

Costs Comparison

	IN HOUSE	OUTSOURCED	
Billing department costs	\$118,000	\$4,000	<p><i>This example is based on having three primary care physicians, two medical billing specialists, 80 insurance claims filed per day (approximately 20,000 per year), \$125 billed per claim on average (approximately \$2.5 million per year), and we assume that the billing service has a high collection rate on claims.</i></p> <p>Source: <u>The Profitable Practice. Should you outsource your medical billing, March 2010.</u></p>
Software and hardware costs	\$7,500	\$500	
Direct claim processing costs	\$3,600	\$122,500	
Software and hardware costs	\$5,500	\$2,000	
% of billings collected	60%	70%	
Collections	\$1,370,900	\$1,623,000	
Collections costs	\$129,100	\$127,000	
Collections, net of costs	\$1,241,800	\$1,496,000	

Pros and Cons for In-House versus Outsourcing

	PROS	CONS
IN-HOUSE	Retaining control	Higher costs
	Return on investment	Liabilities
	Close proximity	Lack of Support
OUTSOURCED	Less expensive	Less control
	Experienced Staff	Variable cost
	Knowledge base	Off Site

Source: [Power Your Practice, In-House vs. Outsourced Medical Billing](#)

Other Questions to Ask

- Is your billing process inefficient?
- Do you have high staff turnover?
- Are you tech savvy?
- Are you a new provider?
- Do you have different priorities?



Resources

The following document contains resources referenced in the Title X Billing and Coding Manual. The resources include links, sample documents, and other useful information Title X agencies may want to use.

- [Questions to Ask](#)
- [Sample Financial Policy](#)
- [Explanation of Insurance](#)
- [Assignment of Benefits Form](#)
- [Cost Benefit Analysis](#)
- [Essential Community Providers](#)
- [Sample Client/Patient Registration](#)
- [Sample Notice of Privacy](#)
- [Superbill](#)
- [Agency Capacity Checklist](#)
- [E/M Codes Snapshot](#)

For a downloadable version of all of the above resources that you can print and use, please download the complete resource packet.



What information should we record when clients are scheduling an appointment?

Type of appointment/service: _____ Date of Appointment: _____

Client Name: _____ Telephone: _____

DOB: _____ SSN: _____

Address: _____

Do you have insurance coverage? Yes No

Do you need confidential services? Yes No,

Who is the Payer:
What is you Member ID:
What is your group ID:
Co Payment:



Sample Financial Policy

Financial Policies and Information

Our commitment is to provide the very best care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's health care and financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies, or your insurance coverage and your responsibilities.

Professional fees: Our fees for medical services are comparable to other similarly trained providers in the community and reflect the complexity of your specific needs, the provider time dedicated to your care, the specialized nature of the provider's training and education, supplies, and support costs associated with providing and coordinating your care.

Patient Payments/Balances: Co-payment, deductibles, services not covered by your insurance plan or outstanding balances are due at the time of your appointment. **ALL ACCOUNT BALANCES MUST BE PAID WITHIN 90 DAYS OF RECEIVING YOUR FIRST STATEMENT. PAYMENTS ON ACCOUNT MUST EQUAL NO LESS THAN 1/3 OF THE TOTAL AMOUNT DUE.** Payment may be made by: cash, Visa or MasterCard. After 90 days your account may be turned over to a collection agency. **If your balance is not paid within 90 days, you agree to authorize the balance to be paid on your credit card as follows:**

Card Type _____ Card # _____ Exp. Date _____

Card Holder's Name (print) _____ Signature _____

Insurance Payments: We participate in assignment of payment with **specific** insurance plans in the area. When the correct insurance information is provided, we will submit your claims as a courtesy to you, our patient. Your insurance coverage is a contract between you and your insurance plan. You are responsible for unpaid balances left on your account regardless of the amount your insurance coverage.

Additional Fees

Missed appointments: Please understand your appointment is time that has been reserved for your needs and that your lack of attendance at that visit prevents others from receiving care at that particular time. To assist patients with access to our physicians, we will charge a fee of **\$50.00** for any office appointment not canceled 24 hours in advance.

Medical Forms: The completion of disability forms, attending physician statements and other supplemental insurance forms require additional physician and staff time. The first form will be no charge to you. A recurring fee of **\$25.00** will be charged for additional forms.



Collection Agencies: If it becomes necessary to place your account with a third party collection agency due to your non- payment, the account of the person responsible will be turned over to collections, and the patient will be dismissed from our practice.

Bounced Checks: A \$50.00 charge will be applied for each check returned by the bank.

Your signature on this page constitutes an agreement to this policy.

I have read and agree to the above policies and authorize payment directly to _____, PC, for medical benefits.

Signature of Person Responsible for Account/Patient _____

Date _____

Printed Name _____



Explanation of Insurance

For Our Patient's Information: An Explanation of Medical Insurance

Misunderstandings about medical insurance have become increasingly common since “managed care” revolutionized the medical insurance industry. At one time it was not unusual for insurance to cover 100% of the cost of services provided during a medical visit. However, this is rarely the case at the current time. The discussion that follows will help you evaluate your insurance coverage for treatment obtained through this office.

Your Insurance Contract

A claim from our office for all services provided to you (office visits, procedures, surgery, etc.) will be sent to your insurance company. The amount that your insurance pays to the physician (provider) as reimbursement for these services – **and the amount that must be paid by you** – is determined by the contractual agreement between you and your insurance company. That agreement most likely states that you, the insured, are responsible for several types of payments. These include:

- **Copayment**

Copayment is the amount that your insurance company requires you to pay to the physician at the time of the service (office visit). Depending on the type of service being rendered, you may be required to pay a copay with each visit.

- **Deductible (per calendar year)**

The deductible is the amount that your insurance requires **you to pay** for services rendered before the insurance company will begin paying for benefits.

- **Co-Insurance (per calendar year)**

After your deductible has been met, your insurance company will pay for all or part of the expenses according to your agreement with the insurance company. The amount that your insurance company pays will vary from 0% to 100%, with common options being 90% / 10% and 80% / 20%. This means that you (the patient) will be responsible for a percentage of the expenses (up to a maximum) beyond the deductible and your insurance company will be responsible for a percentage. The percentage amount is determined by your contract with your insurance company.

The terms under which insurance policies establish these limitations on reimbursement vary widely among policies and depend on your individual contract and plan benefits. We will contact your insurance company and verify your individual plan benefits (copay, deductible, co-insurance) and inform you of these benefits. We also encourage you to contact your insurance company to verify your plan benefits.

EFFECTIVE IMMEDIATELY – IT IS OUR OFFICE POLICY TO COLLECT YOUR COPAY WHEN YOU CHECK-IN FOR YOUR APPOINTMENT.



Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to (Agency) rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Signature of Person Responsible for Account/Patient _____

Date _____

Printed Name _____



Cost Analysis

The National Training Center recently hosted a Cost Analysis webinar series. This series described in detail how to establish the cost for services you provide. If you were unable to participate in the original webinar, follow the links provided below to download materials containing detailed information about cost analysis.

[Webinar 1: How to Get Started with a Cost Analysis](#)

[Webinar 2: All About Relative Value Units](#)

[Webinar 3: Putting the Pieces Together for an Effective Cost Analysis](#)



Essential Community Provider

In order to be designated as an **Essential Community Provider** in Colorado, a provider must demonstrate that it meets the requirements of **Section 25.5-5-403 C.R.S. (2006)**. These regulations require that the ECP:

- Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population or, in the case of a sole community provider, serves the medically indigent patients within its medical capability; and
- Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations.

The Department of Health Care Policy and Financing (HCPF) designates ECPs.

The Colorado Division of Insurance holds the all-inclusive list of Essential Community Providers for the State of Colorado. This list contains those providers listed in the CMS Non-Exhaustive List of ECPs (above) as well as those HCPF designated ECPs in Colorado. [Click here](#) for the list.

For an application to be designated as an ECP, [click here](#).

All this information can also be found on: <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251568596003>



*Sample Client Registration Form***PATIENT REGISTRATION**

Patient Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

SS# _____ Date of Birth _____ Sex _____

Marital Status _____

Employers Name _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION**Primary Insurance**

Insurance Name _____ Policy # _____ Phone _____

Name of Insured _____ Relationship _____

SS# _____ Date of Birth _____

Employers Name _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

Secondary Insurance

Insurance Name _____ Policy # _____ Phone _____

Name of Insured _____ Relationship _____

SS# _____ Date of Birth _____

Employers Name _____ Phone _____



Employer Address _____ City _____ State _____ Zip _____

PCP Name _____ Phone _____

Emergency Contact _____ Phone _____

I hereby authorize (agency) _____ and its providers to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency.

Signature of Patient / Authorized Person _____ Date _____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims.

Signature of Patient / Authorized Person _____ Date _____



Sample Notice of Privacy Policy

**NOTICE OF PRIVACY POLICIES AND PRACTICES
FOR
(AGENCY)**

DEAR PATIENT:

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At **AGENCY** we are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD / HEALTH INFORMATION

Each time you visit (**AGENCY**) a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication with other health professionals involved in your care
- Legal document outlining and describing the care you received
- A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided
- An education tool for medical health providers
- A source for medical research
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A source of data for planning and / or marketing
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment



- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

OUR RESPONSIBILITIES

AGENCY is required to:

- Maintain the privacy of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and/ locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according procedures included in the authorization.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations. Your health information may be used as necessary to support the day-to-day activities and management of Matthew A. Metz, MD, PC For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates. In some instances, we have contracted separate entities to provide services for us. These “associates” require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these “business associates” might be a billing service, collection agency, answering services and computer software/hardware provider.

Communication with family. Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.



Research / Teaching / Training. We may use your information for the purpose of research, teaching, and training.

Healthcare Oversight. Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public health reporting. Your health information may be disclosed to public health agencies as required by law.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Appointment reminders. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail in a closed envelope, or, a brief, non-specific message may be left on your answering machine. If you don't approve of these methods, or, if you prefer alternative methods (i.e., email) please inform the practice.

Other uses and disclosures. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of **AGENCY** please contact:

AGENCY
ADDRESS
ADDRESS

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C., 20201



Sample Superbill

EVALUATION MANAGEMENT	Code	Fee	Amt
New- Ann Exam (12-17)	99384		
New- Ann Exam (18-39)	99385		
New -Ann Exam (40-64)	99386		
Est.- Ann Exam (12-17)	99394		
Est.- Ann Exam (18-39)	99395		
Est.- Ann Exam (40-64)	99396		
New - O.V. Minimal	99201		
New - O.V. Straight-forward	99202		
New - O.V. Low comp	99203		
Est-Nurse Visit	99211		
Est.-O.V. Minor Problem	99212		
Est- O.V. Low Complex	99213		
Est.-O.V. Mod Complex	99214		
Prev. Med/Counseling 15 mins	99401		
Prev. Med/Counseling 30 mins	99402		
Prev. Med/Counseling 45 mins	99403		
Supply Pickup	00000		

Last Name		First Name		Social Security Number	
Birthdate		Age		Home Phone/ Msg. Phone	
Work Phone					
PROCEDURES			HEALTH STATUS V CODES		
	Code	Fee	Amount		Code
BP Check	93770			Annual Gyn. Exam	V72.31
Diaphragm or Cervical Cap Fit	57170			Clinical Breast Exam	V76.1
HPV—Fem ale	56501			Contraceptive Mgmt.	V25.9
HPV—Male	54050			Depo Injection	V25.49
Injection	96372			Couns. & Advice for contraceptives	V25.09
IUD Insertion	58300			Diaphragm Fit	V25.02
IUD Removal	58301			Hct/HG	V78
Implanon Insertion	11981			IUD Check/Removal	V25.42
Implanon Removal	11976			OCP Refill	V25.41
LABORATORY			DIAGNOSTIC CODES		
Blood Draw	36415			OCP Rx	V25.01
CT/GC	87491			PG Test	V72.4
Hep B/ + Draw	86704			Implantable sub dermal contraceptives	V25.43
Hep C/ + Draw	86803			Repeat Pap	V76.2
Syphilis/ + Draw	86592			STI Screening	V74.5
HIV/ +Draw	87390			ERC	V25.03
Lipid Panel/ + Draw	80061			Other:	
Pap Smear	88164			Other:	
TSH/ + Draw	84443			DIAGNOSTIC CODES	
UA Dip or Spun	81000			Abnormal Pap Smear	795.00
Hematocrit	85013			Abnormal Weight Gain	783.1
Glucose—FS	82948			Anemia	285.9
hCG P/N	81025			Breast—Fibrocystic	610.1
Wet Prep	87210			Breast Mass	611.72
Other:				Breast, Pain	611.71
SUPPLIES AND MEDICATIONS			FOR PROVIDER'S USE ONLY		
Condoms (Male) X _____	A4267			PP	MD
Depo Provera	J1050			WWC	NB
Diaphragm	A4266			TANF	
OCP X _____ Cycles	S4993			SERVICES PROVIDED BY _____	
Seasonique X _____	S4993			FOR OFFICE USE ONLY	
Nuvaring X _____	J7303			BILLED PATIENT	MC
Spermicides X _____	A4269			BILLED MD	CE
ER Contraceptive	S4993			BILLED RMHP	Order #
IUD Paragard	J7300			BILLED CWCCI	
IUD Mirena	J7302				
Implanon	J7307				
Other:					

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Mailing Address	City	State	Zip Code
Street Address	City	State	Zip Code
Primary Insurance (please attach card)	Medicaid (please attach card)	Name of Insured /Responsible Party	



☑ AGENCY CAPACITY ASSESSMENT CHECKLIST

	Staffing structure/expertise to support developing the payer contracting strategy or decision to outsource
	Knowledge of your state's status in creating a health insurance marketplace and your potential role
	Understand the value proposition of your agency in today's environment
	Staffing structure and expertise to support the contract review process or outsourcing
	Legal counsel
	Staffing structure and expertise to support the fee schedule development process
	Microsoft Excel or other software for creating basic spreadsheets
	Clinic charge master and cost analysis for common CPT codes
	Staffing structure and expertise to support the initial and ongoing credentialing process
	Access to CAQH
	Access to provider and agency NPI numbers and other pertinent provider information
	Staffing structure to support data collection at the time of appointment scheduling
	Mechanism for confirmation calls/texts
	Practice management or scheduling software
	Process for emailing or mailing forms prior to appointment
	Resources in place for electronic eligibility/benefit verification
	Policies and procedures to outline financial process
	Financial policy and agreement signed by clients
	HIPAA compliance policies and procedures
	Staffing structure and technology in place to support efficient check in and check out processes
	Card readers in check in and check out areas
	Pre-populated or electronic superbills
	End of day process in place to reconcile payments
	Cash policies in place
	Staff trained in effective communication regarding payment collection
	Access to current ICD-9 and CPT coding resources
	Strategy for training providers and staff on ICD-10
	Coding audits and education/updates for providers and staff at least annually
	Staffing structure and expertise to support claims submission
	Technology to carry out electronic claims submission
	Access to clearinghouse services



GENERAL MULTI SYSTEM Evaluation & Management Guidelines

New Out Patient (Meet 3 of 3)		99201 (time 10 min)	99202 (time 20 min)	99203 (time 30 min)	99204/05 (204=45 / 205=60)
Estab. Out Patient (Meet 2 of 3)	99211 (time 5 min)	99212 (time 10 min)	99213 (time 15 min)	99214 (time 25 min)	99215 (time 40 min)
Out Pt. Consultation (Meet 3 of 3) <i>*Not valid w/MCR - Contact Individual Payers*</i>		99241 (time 15 min)	99242 (time 30 min)	99243 (time 40 min)	99244/245 (244=60 / 245=80)
Initial Hospital Care (Meet 3 of 3)				99221 (time 30 min)	99222/223 (222=50 / 223=70)
Subsequent Inpt. (Meet 2 of 3)		99231 (time 15 min)	99232 (time 25 min)	99233 (time 35 min)	
Inpt. Consultation (Meet 3 of 3) <i>*Not valid w/MCR - Contact Individual Payers*</i>		99251 (time 20 min)	99252 (time 40 min)	99253 (time 55 min)	99254/255 (254=80 / 255=110)
CHIEF COMPLAINT	Required	Required	Required	Required	Required
HISTORY HISTORY OF PRESENT ILLNESS: <ul style="list-style-type: none"> • Location • Quality • Severity • Duration • Timing • Context • Modifying Factors • Associated Signs/Symptoms 	N/A	Status of 1-2 Chronic Cond. Brief 1-3 Elements	Status of 1-2 Chronic Cond. Brief 1-3 Elements	Status of 3 Chronic Cond. Extended 4+ Elements	Status of 3 Chronic Cond. Extended 4+ Elements
REVIEW OF SYSTEMS: <ul style="list-style-type: none"> • Constitutional • Eyes • Ears, Nose, Mouth, Throat • Cardiovascular • Respiratory • Gastrointestinal • Genitourinary • Musculoskeletal • Integumentary • Neurological • Psychiatric • Endocrine • Hematologic/Lymphatic • Allergic/Immunologic 	N/A	N/A	Pertinent to Problem 1 System	2-9 Systems	10+ Systems
PAST, FAMILY & SOCIAL HISTORY: <ul style="list-style-type: none"> • Past (illnesses, operations, etc) • Family (medical events in the pts family) • Social (review of past & current activities) 	N/A	N/A <i>Prob Focused</i>	N/A <i>Exp Prob Foc</i>	One from any <i>Detailed</i>	New/Consults = one from each Established Pts = Two from any <i>Comprehensive</i>
PHYSICAL EXAMINATION Perform & Document: (Bullets listed on back)	1997 N/A 1995	1 - 5 Elements 1 body area or organ system <i>Prob Focused</i>	At least 6 Elements 2-7 body areas and/or organ systems <i>Exp Prob Foc</i>	At least 12 items in 2 or more areas 2-7 body areas and/or organ systems <i>Detailed</i>	At least 2 items from each of 9 areas/systems 8+ Organ systems Not body areas <i>Comprehensive</i>
MEDICAL DECISION MAKING (2 of 3 for all patients)		99201,99202 99241, 99242 99221,99231 99251,99252 99212	99203,99213 99243,99221 99231,99253	99204, 99214 99244,99222 99232,99254	99205, 99215 99245,99223 99233,99255
<u># of Dx and/or Mgmt Options</u>	N/A	Minimal (1)	Limited (2)	Multiple (3)	Extensive (4)
<u>Amt or Complexity-Data Review</u>		Minimal/None (1)	Limited (2)	Multiple (3)	Extensive (4)
<u>Risk (Refer to Table of Risk)</u>		Minimal <i>Straightforward</i>	Low <i>Low</i>	Moderate <i>Moderate</i>	High <i>High</i>

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GENERAL MULTI-SYSTEM EXAMINATION

<u>SYSTEM/AREA</u>	<u>ELEMENTS OF EXAMINATION</u>	<u>SYSTEM/AREA</u>	<u>ELEMENTS OF EXAMINATION</u>
Constitutional *Organ System*	<ul style="list-style-type: none"> • Measurement of any 3 of the following vital signs: sitting or standing blood pressure, supine blood pressure, pulse rate & regularity, respiration, temperature, height, weight. (May be measured & recorded by staff) • General appearance of patient (nutrition, development, body habitus, deformities, attention to grooming) 	Gastrointestinal *Organ System*	<ul style="list-style-type: none"> • Examination of abdomen with notation of presence of masses or tenderness • Examination for presence or absence of hernia • Examination of liver and spleen • Examination of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses • Obtain stool sample for occult blood test (when indicated)
Eyes Organ System*	<ul style="list-style-type: none"> • Inspection of conjunctivae and lids • Examination of pupils & irises (reaction to light & accommodation, size & symmetry) • Ophthalmoscopic exam of optic discs (size, C/D ratio, appearance) and posterior segments (vessel changes, exudates, hemorrhages) 	Genitourinary *Organ System*	<p>MALE:</p> <ul style="list-style-type: none"> • Examination of scrotal contents (hydrocele, spermatocele, tenderness of cord, testicular mass) • Examination of penis • Digital rectal exam of prostate gland (size, symmetry, nodularity, tenderness) <p>FEMALE:</p> <p>Pelvic exam (with or without specimen collection for smears & cultures), including:</p> <ul style="list-style-type: none"> • Exam of external genitalia (general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Exam of urethra (masses, tenderness, scarring) • Exam of bladder (fullness, masses, tenderness) • Cervix (general appearance, lesions, discharge) • Uterus (size, contour, position, mobility, tenderness, descent or support) • Adnexa/parametria (masses, tenderness, organomegaly)
Ears, Nose, Mouth and Throat *Organ System*	<ul style="list-style-type: none"> • External inspection of ears & nose (scars, lesions, masses, overall appearance) • Otoscopic exam of external auditory canals & tympanic membranes • Assessment of hearing (whispered voice, finger rub, tuning fork) • Inspection of nasal mucosa, septum and turbinates • Inspection of lips, teeth and gums • Examination of oropharynx: oral mucosa, salivary glands, hard & soft palates, tongue, tonsils and posterior pharynx. 	Musculoskeletal *Organ System*	<ul style="list-style-type: none"> • Examination of gait and station • Inspection and/or palpation of digits and nails (clubbing, cyanosis, inflammatory conditions, infections, nodes) <p>Examination of joints, bones & muscles of one or more of the following 6 areas: 1) head and neck; 2) spine, ribs, pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; 6) left lower extremity. The examination of a given area includes:</p> <ul style="list-style-type: none"> • Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses • Assessment of range of motion with notation of any pain, crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements
Neck	<ul style="list-style-type: none"> • Examination of neck (masses, overall symmetry, tracheal position, crepitus) • Examination of thyroid (enlargement, tenderness, mass) 	Respiratory *Organ System*	<ul style="list-style-type: none"> • Assessment of respiratory effort (use of accessory muscles, intercostal retractions, diaphragmatic movement) • Percussion of chest (dullness, flatness, hyperresonance) • Palpation of chest (tactile fremitus) • Auscultation of lungs (breath sounds, adventitious sounds, rubs)
Respiratory *Organ System*	<ul style="list-style-type: none"> • Assessment of respiratory effort (use of accessory muscles, intercostal retractions, diaphragmatic movement) • Percussion of chest (dullness, flatness, hyperresonance) • Palpation of chest (tactile fremitus) • Auscultation of lungs (breath sounds, adventitious sounds, rubs) 	Cardiovascular *Organ System*	<ul style="list-style-type: none"> • Palpation of heart (location, size, thrills) • Auscultation of heart with notation of abnormal sounds and murmurs <p>Examination of:</p> <ul style="list-style-type: none"> • carotid arteries (pulse amplitude, bruits) • abdominal aorta (size, bruits) • femoral arteries (pulse amplitude, bruits) • pedal pulses (pulse amplitude) • extremities for edema or varicosities
Cardiovascular *Organ System*	<ul style="list-style-type: none"> • Palpation of heart (location, size, thrills) • Auscultation of heart with notation of abnormal sounds and murmurs <p>Examination of:</p> <ul style="list-style-type: none"> • carotid arteries (pulse amplitude, bruits) • abdominal aorta (size, bruits) • femoral arteries (pulse amplitude, bruits) • pedal pulses (pulse amplitude) • extremities for edema or varicosities 	Neurologic *Organ System*	<ul style="list-style-type: none"> • Test cranial nerves with notation of any deficit • Exam of deep tendon reflexes with notation of pathological reflexes (Babinski) • Exam of sensation (by touch, pin, vibration)
Chest (Breasts)	<ul style="list-style-type: none"> • Inspection of breasts (symmetry, nipple discharge) • Palpation of breasts & axillae (masses or lumps, tenderness) 	Psychiatric *Organ System*	<ul style="list-style-type: none"> • Description of patient's judgement & insight • Brief assessment of mental status, including: <ul style="list-style-type: none"> • Orientation to time, place & person • Recent and remote memory
Lymphatic *Organ System*	<p>Palpation of lymph nodes in 2 or more areas:</p> <ul style="list-style-type: none"> • Neck • Axillae • Groin • Other 		
Skin *Organ System*	<ul style="list-style-type: none"> • Inspection of skin & subcutaneous tissue (rashes, lesion, ulcers) • Palpation of skin & subcutaneous tissue (induration, tightening) 		

