

LEARN MORE ABOUT MEDICAL BILLING



WHY WE BILL

- **Billing is one third** of a three-part cycle
 - **Patient:** The person who receives the medical services
 - **Provider:** The person who provides the medical service for the patient
 - **Payer:** The insurance company (or Medicaid/Medicare)

WHY WE BILL

- The **biller** arranges payments between these three parties
- Specifically, the biller makes sure the provider is **reimbursed** (by the patient and the payer) for their services

HOW WE BILL

- Billers collect information from the coder/provider
 - Called the “superbill”
 - Includes procedures, diagnosis, patient information, provider information, and more
- Billers create ‘claims’
 - Claims include all of the information in the superbill, along with the prices of procedures
 - Claims ask payers to pay a percentage (or all, in certain cases) of the cost of the procedures, depending on the payer’s contract with the patient

MORE ABOUT INSURANCE

- Individuals who have contracts with insurance companies (or other payers) are called “subscribers” or, in some cases “the insured”
- There are three main types of private insurance
 - Indemnity
 - Managed Care
 - Consumer-Driven Healthcare Plans

INDEMNITY

- Pay-for-service
- Patient may see any provider that accepts their insurance
- Typically more expensive
- More flexible
- Becoming less and less popular

MANAGED CARE ORGANIZATIONS (MCO)

- “Manages” care by reducing cost, but also reducing options for service
 - Emphasis on quality and cost control
- Includes Health Management Organizations (HMOs), Preferred Provider Organizations (PPO)

MANAGED CARE ORGANIZATIONS (MCO)

- MCOs establish a network of providers that subscribers may see
- Fewer options for service, but lower cost
- Still most popular form of insurance in the United States

CONSUMER-DRIVEN HEALTHCARE PLAN (CDHP)

- Similar to a PPO
- Features high deductibles and co-pays, but low premiums
- Also features a “savings account,” into which subscribers can put money to pay down their deductibles
- Small but growing in popularity



MORE ABOUT CLAIMS

- Claims have *a who, a what, a when, a why, a where, and a how much*
- The Who: the provider, documented in the National Provider Index (NPI)
- The What: the procedure code (CPT or HCPCS)
- The When: information on the procedure in the superbill, including the date of the procedure

MORE ABOUT CLAIMS

- The Why: the diagnosis code (ICD-9-CM), which demonstrates medical necessity
- The Where: also included in the NPI
- The How Much: The cost of the procedure, as laid out by the provider

MORE ABOUT CLAIMS

- The Biller must ensure the claim is compliant
 - It is factually correct
 - It has the right diagnosis codes to go with the procedure codes, lists the right information on the patient and provider, lists the correct price
 - It is formatted correctly for the payer
 - Many payers have their own preferred/required format for submitting claims

MORE ABOUT CLAIMS

- If the claim is approved by the payer, the payer sends back how much of the cost they're willing to pay
 - This amount will depend on the subscriber's contract with the payer
- The biller then subtracts that from the total cost and sends the balance on to the patient

DAY-TO-DAY ACTIVITIES

- Working with patients
- Working with computers
- Creating claims
- Notification and Communication
- Collections

WORKING WITH PATIENTS

- Billers create bills for patients by looking at their **insurance agreements** and charging them **(the patients)** for any **co-pays** or **deductibles**
- Billers also send final bills to patients (after the payer has reimbursed the provider, the patient **owes the balance**)
- Billers work with **medical records & reports**
 - This involves abstracting/extracting information from dense medical documents

WORKING WITH COMPUTERS

- Most provider offices today use some form of **billing/practice management software** to perform or assist in their billing
- This software
 - Keeps track of **patient records**
 - Can be used to **generate reports** and requests for information on claims
 - **Record payments** and **create statements**

CREATING CLAIMS

- Billers
 - Create claims
 - Format them correctly
 - Adjust them for a patient's specific insurance agreement
 - Check that claims are compliant
 - Work with insurance clearinghouses

NOTIFICATION AND COMMUNICATION

- Billers communicate with insurance companies
 - Follow up on claims
- Communicate with patients
 - Issue Explanation of Benefits (EOBs)
 - Explain how much of a procedure is covered and why
- Follow up with patients on late payments

COLLECTIONS

- If a patient has not paid a bill for a certain amount of time, a biller may have to arrange for a **collections service**
- Not a common occurrence, but worth noting