Physician Practice Billing
From A to Z

Charlotte L. Kohler, RN, CPA, CVA, CRCE-I, CPC, ACS, CHBC
and Kohler HealthCare Consulting, Inc., associates

Physician Practice Billing From A to Z is a comprehensive, user-friendly guide to billing requirements, with particular emphasis on Medicare. This resource will help physician practice billers understand the relevant regulations, code sets, compliance issues, and myriad other factors that affect the billing process.

From ABNs to ZPICs, this valuable reference book addresses, defines, and explains more than 100 topics in alphabetical order, including the following:

» Billing Compliance
» Codes—CPT and HCPCS
» Deductibles, Copayments, and Coinsurance
» Denial of Related Part B Services When Inpatient Service Denied by Medicare
» Evaluation and Management and Procedure—Same Day
» HCPCS vs. CPT: G (Temporary) Code Assignment
» Laboratory Billing and Modifiers -91 and -59
» Local Coverage Determinations and National Coverage Determinations

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Introduction

The greatest challenge faced by billers of professional services is the complexity of the area’s many rules that must be met. The first responsibility includes managing the data and related supporting medical records, thereby ensuring the accuracy of bills being submitted to Medicare and other payers. Numerous regulations, standards, and guidelines govern this function, and professional service billers are expected to maintain up-to-date knowledge of these requirements. Professional services cover a broad spectrum of providers/suppliers, such as physicians, nurse practitioners, physician assistants, physical therapists, nurses and ethicists, certified nurse midwives, psychologists, other behavioral health professionals, and others. Much of this knowledge is acquired by on-the-job training, working through issues, and looking for resources to support the tasks.

This book is a high-level reference guide designed to help professional service billing professionals meet these Medicare and other insurance billing requirements. Its approach is topical to help readers find the answers to their questions quickly. The 107 chapters are brief, addressing only one topic each, and are arranged alphabetically. Resources at the end of chapters provide URLs to the ever-changing nature of Medicare rules and regulations to assist in quickly locating the source of the rule, regulation, or guidance from Medicare as well as other payers.

Submitting inaccurate bills to Medicare and other payers carry many potential consequences. These consequences can be long-term or short-term and can affect patients, practitioners, and the staff responsible for billing. Federal and state governments are systematically reviewing claims submitted to its payers to verify that any payments made are only for services that are necessary and appropriate and that they are accurately billed. There has been an overall increase by commercial insurance companies concerned with an escalation of inappropriate billing.

A review of the U.S. Department of Health and Human Services Office of Inspector General illustrates the vast number of compliance audits and settlements with professional fee providers/suppliers. Size is not an indication of being under scrutiny. Other payers, including Medicaid, commercial insurance companies, and benefit programs, are also reviewing billing. The overall use of analytics to find those who appear to be billing differently than others in the same specialty is one of the ways that Medicare, Medicaid, and the commercial payers are finding those to be reviewed. Medical necessity has become an overriding issue in many of these reviews. Although it comes back as a “pended claim,” and, therefore, billers need to deal with these held or denied claims, much of billing is highly dependent on complete and accurate medical record documentation. Demands are being made for any amount
deemed over-billed. All these activities point to the need for a solid understanding of the range of issues affecting claims accuracy.

This book will help professional service billing staff understand the variety of requirements that can affect the accuracy of hospital bills to all payers. It also provides information that can help mitigate payer audits and repayments.
1500 Form Definitions

The CMS-1500 form is the standard claim form used by physicians and suppliers for claim billing. The Centers for Medicare & Medicaid Services (CMS) developed the form, and it has become the standard form used by other insurance carriers. The National Uniform Claim Committee controls the process for the form update.

There are two ways to use the CMS-1500 form:

- **Paper**—The Standard CMS-1500 is the paper form to bill Medicare and other carriers when a paper claim is allowed.
- **Electronic**—The 837P (Professional) is the electronic form to transmit healthcare claims electronically. The data elements in the electronic version are consistent with the hard copy.

The CMS-1500 form is comprised of three sections with a total of 33 blocks:

- **Carrier/Payer Section**—The upper section of the form is where the name and address of the carrier information is provided so the claim can be directed to the specific carrier.

- **Patient and Insured Section**—The middle section of the form is identified by items 1–13, which include patient and insured information. See example below:
  
  - **Item 1a (Insured’s ID Number)**—This section is where the ID number is provided as shown on the insured’s ID card.

- **Physician or Supplier Information Section**—The bottom section of the form (Items 14–33) is where procedural, diagnostic services, and specific provider billing information is located. See example below:
  
  - **Item 17 (Name of Referring Provider or Other Source)**—This section is where the name of the referring provider, ordering provider, or supervising provider who referred, ordered, or supervised the service(s) or supply(ies) is located.

Complete detailed instructions and filed locater definitions for the CMS-1500 form can be found in Chapter 26 of the *Medicare Claims Processing Manual*, “Completing and Processing Form CMS-1500 Data Set.”
Resources

Centers for Medicare & Medicaid Services, Professional Paper Claim Form (CMS-1500)

Centers for Medicare & Medicaid Services, Medicare Learning Network, Medicare Billing:
837P and Form CMS-1500
downloads/form_cms-1500_fact_sheet.pdf

Form CMS-1500

National Uniform Claim Committee, Resources for Implementing the 02/12 1500 Claim Form
http://www.nucc.org

National Uniform Claim Committee, 1500 Health Insurance Claim Form Reference
Instruction Manual
Accountable Care Organizations Overview

Accountable Care Organizations (ACO) are collaborative organizations often including groups of physicians, hospitals, and other healthcare providers. Their overall goal is to reduce costs of healthcare, coordinate and improve services, and obtain financial rewards for those results.

Although in some ways ACOs are similar to Health Maintenance Organizations (HMO), the term and model introduced by the Affordable Care Act (ACA) are very different. The ACA encouraged the creation of ACOs as one way to meet its goals of improving the healthcare delivery system through incentives designed to enhance quality, improve beneficiary outcomes, and increase value of care. ACOs facilitate coordination and cooperation among providers, which should improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. However, unlike HMOs, the patient is not assigned to a practice or physician and can move from one to another without any notification to anyone.

In Medicare’s traditional fee-for-service payment system, physicians and hospitals generally are paid for each test and procedure. This traditional Medicare model can increase cost by rewarding providers for providing care that is not necessary or efficient. Fee-for-service reimbursement has not been eliminated for ACOs, but there is an incentive to be more efficient by offering bonuses when providers reduce costs. Physicians and hospitals must meet specific quality benchmarks, focusing on prevention and carefully managing patients with chronic diseases. An ACO may also have to pay a penalty if it doesn’t meet performance and savings benchmarks.

Other payers have established incentives similar to the Medicare ACO approach.

Consult the Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov for additional information about ACOs, or go to www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO.
Admitting Versus Attending Physicians

The admitting physician is the clinical provider who arranges and admits a patient to a hospital or other inpatient healthcare facility, also referred to as the “physician of record.” Physicians are granted admitting privileges by a hospital clinical board to provide direct patient care in the hospital. The board will verify and check the admitting physician’s medical credentials, license, scope of clinical services, and malpractice history.

Each admission has specific criteria the admitting physician is responsible for accurately documenting in the patient’s medical record, such as the following:

- Diagnosis for the admission
- Admission order (furnished at or before the time of admission)
- Admission date
- Chief complaint

Please note the admitting physician admits the patient to the facility; however, the admitting physician may not be responsible for the patient’s care during the course of the inpatient hospital stay. The patient’s actual care is provided by the attending physician who regularly visits and treats patients during the course of a patient’s hospital visit. In this case, the physician of record changes to the attending physician. This distinction is critical when considering the liability to bill for observation services.

CMS has created Healthcare Common Procedure Coding System (HCPCS) modifier -AI to identify the physician of record. When CMS eliminated the use of consultation codes for Medicare, it needed a mechanism to distinguish which of the physicians submitting claims with evaluation and management (E/M) codes for the same date of service were providing a consultative service and which one was the attending. Modifier -AI provides this distinction.
Resources


http://wpsmedicare.com/j5macpartb/resources/modifiers/hospicemodifier.shtml

http://www.wpsmedicare.com/j5macpartb/resources/modifiers/modifier-ai.shtml

http://www.ecfr.gov/cgi-bin/text-idx?SID=a129db8a7075d0210edfd7f234b72ce3&node=se42.2.412_13&rgn=div8
An Advanced Beneficiary Notice (ABN) is a Centers for Medicare & Medicaid Services (CMS) form (CMS-R-31) used before a Medicare beneficiary receives Part A (Hospital) or Part B (Outpatient) services or charges that may not be covered by Medicare. The patient may not be under duress when making the decision to be held responsible for payment.

ABNs advise and inform Medicare beneficiaries that they may be responsible for payment regarding services that are expected or known to be denied by Medicare because they are not reasonable or considered not medically necessary under Medicare regulations. The signed ABN becomes part of the patient’s record.

ABNs serve multiple purposes:

- Provide Medicare beneficiaries the option to receive services and take financial responsibility if Medicare does not pay for the specific service
- Validate when the Medicare beneficiaries were informed prior to receiving services that Medicare may not pay
- Offer protection to Medicare beneficiaries and give them the right to appeal Medicare’s decision

Please note, an ABN is not required if services are not or are never covered as a Medicare benefit. Some examples of excluded items are hearing aids, eye exams, and dental services.

**Billing Requirements**

There are certain billing requirements when a procedure is provided that requires an ABN. Providers must utilize the following Medicare modifiers:

- **-GA modifier**—Waiver of liability statement issued as required by payer policy. This modifier indicates that an ABN is on file and allows the provider to bill the patient if not covered by Medicare.
- **-GX modifier**—Notice of liability issued, voluntary under payer policy. Report this modifier only to indicate that a voluntary ABN was issued for services that are not covered.
• **-GY modifier**—Notice of liability not issued, not required under payer policy. This modifier is used to obtain a denial on a non-covered service. Use this modifier to notify Medicare that you know this service is excluded.

• **-GZ modifier**—Item or service expected to be denied as not reasonable and necessary. When an ABN may be required but was not obtained, this modifier should be applied.

This is a Medicare concept and form, although some providers use it to inform patients if their insurance will not cover an item/service.

**Resources**


Ancillary Services

The term *ancillary services* refers to “services provided by a professional healthcare provider for clients on an outpatient basis as an adjunct to basic medical or surgical services.” Ancillary services are classified under three categories:

- Diagnostic
- Therapeutic
- Custodial

Diagnostic ancillary services include audiology, radiology, pulmonary testing services, and clinical lab services. Most often, they are provided in the referring physician's office and are utilized to support the determination of the patient's diagnosis or to manage a chronic condition. They can also be provided at a hospital, an ambulatory surgical center (ASC), or freestanding testing center, often called an IDTF (independent diagnostic testing facility).

Therapeutic ancillary services include physical therapy, occupational therapy, speech therapy, radiation therapy, nutrition therapy, and weight management. Most therapeutic services are restorative.

Custodial ancillary services focus on hospice, home health, and nursing home care and are provided as indicated by the type of service (e.g., home healthcare would be provided at the patient's home).

It is important for providers to understand the “in-office ancillary service exception” contained in the Stark Law. For the exception to apply, provision of ancillary services may not be the primary reason the patient comes into contact with the physician or the physician’s group practice. Providers are encouraged to contact the Government Accountability Office at (202) 512-7114 for more information.

**Resources**

Centers for Medicare & Medicaid Services, Physician Self-Referral  
[https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral](https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral)

Social Security Administration, Limitation on Certain Physician Referrals  
[http://www.socialsecurity.gov/OP_Home/ssact/title18/1877.htm](http://www.socialsecurity.gov/OP_Home/ssact/title18/1877.htm)
Appeals—Rights and Requirements

Under the Patient Protection and Affordable Care Act, consumers have the right to appeal health plan decisions made after March 23, 2010. The law governs how insurance companies handle initial appeals and how consumers can request a reconsideration of a decision to deny payment. If an insurance company upholds its decision to deny payment, the law provides consumers the right to appeal the decisions to an outside, independent decision-maker, regardless of the type of insurance or state in which the individual resides.

**Appeal Rights**

In an effort to offer healthcare consumers more transparency, the following rights are afforded to beneficiaries:

- Right to information about why a claim or coverage has been denied
- Right to appeal to the insurance company
- Right to an independent review

Beneficiaries may appoint any individual, attorney, or uninvolved provider or supplier to act as their representative during the processing of a claim or claims and/or any appeals of claims.

The law prohibits Medicare carriers from extending appeal rights for claims that contain incomplete or invalid information. No notice of appeal rights will be furnished in connection with a rejected claim, because no initial determination on the claim was made. No beneficiary Explanation of Medicare Benefits (EOMB) will be issued for a rejected claim. Beneficiaries may not be billed for the services. Claims must be corrected and resubmitted through the normal claim filing procedures.

**Appeal Requirements**

Once an initial claim determination is made, beneficiaries, providers, and suppliers have the right to appeal Medicare coverage and payment decisions. With Medicare, the individual filing the appeal (appellant) must file the request for redetermination with the contractor within 120 days from the
date of receipt of the initial determination or denial decision. Refer to Medicare Appeals Process on the Centers for Medicare & Medicaid Services’ (CMS) website (www.cms.gov), which describes all specific requirements for standard and expedited timelines, content, and form. An abbreviated chart of requirements and timelines is included in Figure A.1, for reference.

If there is disagreement or dissatisfaction with an appeal decision, the appellant may request a second-level appeal. This second level of appeal includes a quality reconsideration process, allowing for an independent review of the initial determination and initial appeal decision.

Other payers may follow different timelines and requirements that should be determined by researching payer websites, calling the payer representative, or analyzing payer contracts. Maintain careful notes of all activities.

**Resources**

Centers for Medicare & Medicaid Services (CMS), Regulations and Guidance

CMS, Medicare Learning Network, Medicare Appeals Process

CMS, Medicare Claims Processing Manual, Chapter 29-Appeals of Claims Decisions
CMS, *Original Medicare* (Fee-for-service) Appeals

CMS, *Original Medicare* (Parts A & B – Fee-for-Service): Initial Determination/Appeals Process
AppealsProcessFlowchart-FFS.pdf

Appeals Process
Assignment of Benefits

Assignment of Benefits (AOB) is an authorization by the insured (patient/insurance holder) to the insurer to pay a claim directly to a third-party provider or supplier when the provider or supplier does not have a contract (often called non-participating) directly with the payer/insurer.

Medical providers have the right to refuse or not offer AOB if they prefer to bill their patients directly and hold their patients responsible. For Medicare, however, there are specific limitations and requirements for AOB.

An AOB is a legally binding agreement between the insured and the insurance company that requires payment to be sent directly to the provider. (The insured is always responsible for the payment of medical expenses.)

When an AOB is obtained for a participating provider, the insurance company sends payment for the covered service (less any applicable copayment, coinsurance, or deductible amounts) directly to the participating provider. If there is a difference between the participating provider’s charge and the insurance company’s allowed amount, the contractual agreement between the participating provider and the insurance company will outline what additional payment the participating provider can collect from the patient.

Payment also goes directly to a non-participating provider with an AOB. If there is a difference between a non-participating provider’s charge and the insurance company’s allowed amount, the patient is liable for paying the balance of the bill. Problems can occur depending on the geographic location of the provider, patient, and payer. Regardless of whether an AOB is obtained for a non-participating provider, the patient/insured is still liable for paying the bill balance.

The agreement and instructions for accepting assignment of benefits can be found at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS460.pdf. Completed agreements need to be filed with the Medicare Administrative Contractor (MAC)/carrier. For other insurers, it is important to check with state laws.
Resources

Centers for Medicare & Medicaid Services (CMS), Lower costs with assignment

CMS, Medicare Claims Processing Manual, Chapter 1 – General Billing Requirements
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- Medicare Beneficiary Numbers—Health Insurance Claim Number Prefixes and Suffixes
- Medicare Coverage Overview
- Modifier Overview
- National Provider Identifier
- Observation—Billing Codes and Requirements
- Rejected and Denied Claims
- Split/Shared Visits
- Split Payment