Medical Billing Specialist

Instruction Pack 4 Lessons 19-22

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Medical Billing Specialist

Instruction Pack 4

0201405LB04A-14

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Lesson 19
Secondary Claims

Step 1: Learning Objectives for Lesson 19

When you complete the instruction in this lesson, you will be trained to:

- Describe the process of coordination of benefits and define terminology involved.
- Explain and demonstrate the process of completing a claim for the secondary carrier.

Step 2: Lesson Preview

At this point, you're familiar with completing claim forms for primary health insurance carriers, and you can review EOBs, as well. Now, it's time to go a step further and learn how to complete secondary claims for patients who have more than one healthcare plan. Let's start by looking at an example.

Kayla Marshall comes in with her mother, Darci Rogers, due to a rash on Kayla's leg. Kayla's parents are divorced and each has insurance coverage for Kayla. How will you determine which insurance is the primary carrier and which is secondary?

Once you determine the primary carrier, you'll complete and submit the CMS-1500 claim form. You'll receive the EOB and interpret the payment, write off and amount due. Now, what do you do if there is a secondary payer? What does the secondary claim look like?

This lesson will answer all of these questions and more. You've learned about the birthday rule, but now you'll discover the details of primary and secondary carriers, along with the associated terminology you'll need to know. Then, you'll review the original claim form and EOB in order to create a secondary claim. The differences are in the details, so be sure to examine claims carefully for a firm understanding of this process.

Step 3: Coordination of Benefits

As you know, some patients have coverage under more than one insurance policy. **Coordination of benefits** (**COB**) applies to a person who has coverage under more than one health plan. The COB provision and regulations require that all health plans coordinate benefits to eliminate duplication of payments, and to assist patients in receiving the maximum benefits to which they are entitled. By adhering to the COB provisions, payers can accurately determine which plan will pay for a claim first. As you recall, the insurance company obligated to pay a claim first is called the primary payer, and the other payer is secondary. Together, the primary and secondary payers coordinate payments for services up to 100 percent of the covered charges at a rate consistent with the benefits plan.

As a medical billing specialist, it's not up to you to determine coverage. However, understanding the general rules will help you assist patients with the billing process. Let's take a closer look at the general rules for distinguishing primary payers from secondary payers for adults and children.

Employee, Member or Subscriber

First, the plan that covers an individual as an employee, member or subscriber is primary over the plan that covers the individual as a dependent.

For example, Dan and Rebecca are married, and they both have insurance coverage through their employers. Dan has Health Services Inc., while Rebecca is insured through Mountain States. Each plan includes dependents; therefore, Health Services Inc. is Dan's primary payer and Mountain States is his secondary payer. On the other hand, Rebecca has Mountain States as primary and Health Services Inc. as secondary insurance.

Dependent Children of Parents Not Separated or Divorced

Dependent children of parents who are married may fall under the birthday or gender rule. You are aware of the birthday rule—the plan covering the parent whose birthday falls earlier in the year is the primary carrier. However, some plans follow the **Gender Rule**, which indicates that the father's coverage is the primary carrier. As mentioned previously, you won't determine the primary and secondary payer in your billing role, but this basic knowledge will help you understand the overall billing process in general.

For instance, Dan and Rebecca have two children, both of whom have coverage under Health Services Inc. and Mountain States. The state law where they live indicates that the birthday rule will determine coverage. Dan's birthday is July 1st and Rebecca's is December 29th. Because Dan's birthday falls earlier in the year, Health Services Inc. is the primary payer and Mountain States is the secondary payer for their children's coverage.

Dependent Children of Parents Separated or Divorced

According to the American Medical Association, "Seeking payment for services provided to dependent children of divorced or separated parents can raise COB issues. States may take different approaches concerning what, if any, COB rules apply when a practice seeks payment for services provided to dependent children of divorced or separated couples."[1]

Insurance plans must pay in the order below if dependent children are covered by more than one payer and the parents are separated or divorced:

1. The plan of the parent with custody of the child
2. The plan of the spouse of the parent with custody of the child
3. The plan of the parent who does not have custody of the child

However, if the terms of a court decree state that one parent is responsible for the healthcare expenses of the child and the insurance company has been advised of the responsibility, that plan is the primary carrier over the plan of the other parent.

Usually, the parents know the order of insurance payers and will provide that information so the claim can be completed accurately.

Now, let's go back to the example. Kayla Marshall comes in with her mother, Darci Rogers, due to a rash on Kayla's leg. Kayla's parents are divorced and each has insurance coverage for Kayla. The new patient questionnaire indicates Eric Marshall is the policy holder on the primary insurance, Blue Cross of Colorado; Darci Rogers is the policy holder on the secondary insurance, TRICARE.

You've completed the CMS-1500 claim form for the primary payer and now know the process for the COB. In this lesson, you'll also learn how the secondary payer's CMS-1500 claim form differs. But first, let's pause to complete the following Practice Exercise.

Step 4: Practice Exercise 19-1

Answer each item as directed, and write your answers on scratch paper.

1. **Bobby lives with his mother and stepfather. Bobby's mother's health plan is with Windy City Benefits. Bobby's father's health plan is with Rocky Road Health. His stepfather's health plan is with Health Benefits of Northern Colorado. What is the order of the payer coverage?**

2. **Sally's parents are Mark and Grace. Since both Mark and Grace have family insurance benefits, you will have to use the birthday rule to determine Sally's primary and secondary policies. Mark's birthday is July 10, 1968, and Grace's birthday is September 5, 1967. Which is the primary payer and why?**

3. **Mark and Grace have divorced, and Grace has custody of Sally; however, the court decree indicates that Mark is responsible for Sally's healthcare expenses. Which is the primary payer and why?**

Step 5: Review Practice Exercise 19-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 6: Processing a Claim for a Secondary Payer

So far, you've discovered the process of completing a claim for a primary payer and explored the variety of EOBs, learning how to interpret them along the way. Now, you're ready for the next step, which is submitting a claim to the secondary payer. You can do this by using an *automatic crossover*, sending an electronic claim or submitting a paper claim. In each case, the secondary carrier needs to know what the primary carrier paid on the claim in order to coordinate benefits.

Automatic Crossover

If the plan has an automatic crossover, it's not necessary to submit a claim to the secondary insurance. In an **automatic crossover**, the primary carrier handles the coordination of benefits transaction by sending the secondary carrier the primary claim information electronically.

You'll see this most often with Medicare claims that have supplemental insurance. Recall that field 9a of the CMS-1500 claim form requires a PAYERID for Medicare claims. A **PAYERID** is a unique, eight-digit number assigned to each healthcare payer; it is used in electronic claims to route the secondary claim automatically.

For example, Joshua has Medicare as his primary insurance and Rocky Mountain Insurance as his supplemental coverage. When Joshua's provider submits a claim to Medicare, Medicare pays its portion of the claim and then forwards the claim information to Rocky Mountain Insurance. Then, that company can process its own portion of the claim.

For a patient with Medicare and Medicaid, the claim will be filed to Medicare as the primary carrier. Medicare will pay the claim, apply a deductible or copayment amount and then automatically forward the claim to Medicaid. The Medicare RA will have an indicator that shows the claim was an automatic crossover to Medicaid, so you'll know not to submit a duplicate claim to Medicaid.

Secondary Claims

At one time, to submit a claim to the secondary payer, you would only have the option of submitting the claim by mail. In addition to the claim, you'd send a copy of the primary payer's EOB to show the reimbursement amount. You would then mail the claim with a copy of the EOB to the secondary carrier for payment.

Net Life
P.O. Box 32
Yampa, CO 80004-0629

KEEP THIS COPY FOR FUTURE REFERENCE AND INCOME TAX PURPOSES

Date: 11/25/XX

CLAIM INFORMATION FORM

PAGE 1

EMPLOYEE:	**GARY T. NILES**
PATIENT:	**BRANDON**
EMPLOYER:	**WESTERN BELL**
GROUP NO:	**629**
ID NO:	**38-40848**
CLM NO:	**0843-03**
PROCESSOR	**SUSAN CLARK**

KEEP THIS STATEMENT FOR TAX PURPOSES
NO OTHER RECORD WILL BE PROVIDED

*IF CODE PRESENT SEE REMARKS BELOW

NATURE	DATE OF SERVICE:		TOTAL	INELIGIBLE		AMOUNT	AMOUNT	AMOUNT	AMOUNT
SERVICE/PROVIDER	FROM	TO	CHARGE	AMOUNT	CODE	@ %	@ %	@ %	@ %
OFFICE VISIT	**11/18/XX**	**11/18/XX**	**50.00**	**15.00**	**A**				
			50.00	**15.00**					
			LESS DEDUCTIBLE						
			BALANCE						
			CO-PAYMENT %						
			BENEFIT				%	%	%
								TOTAL BENEFIT	**35.00**

DESCRIPTION OF REMARKS/BENEFITS

PAYABLE TO	CHECKS ISSUED	AMOUNT	DATE
AUSTIN FREDRICK **24 MOCKINGBIRD LANE** **YAMPA, CO 80004-4791**	**MS 251**	**$35.00**	**11/25/XX**

A Charge is above UCR for this service.

With electronic claims submission, many insurance carriers use automatic crossover, which means that you don't have to submit a secondary claim. The claim will be forwarded to the secondary payer, and the amount paid is provided, as well.

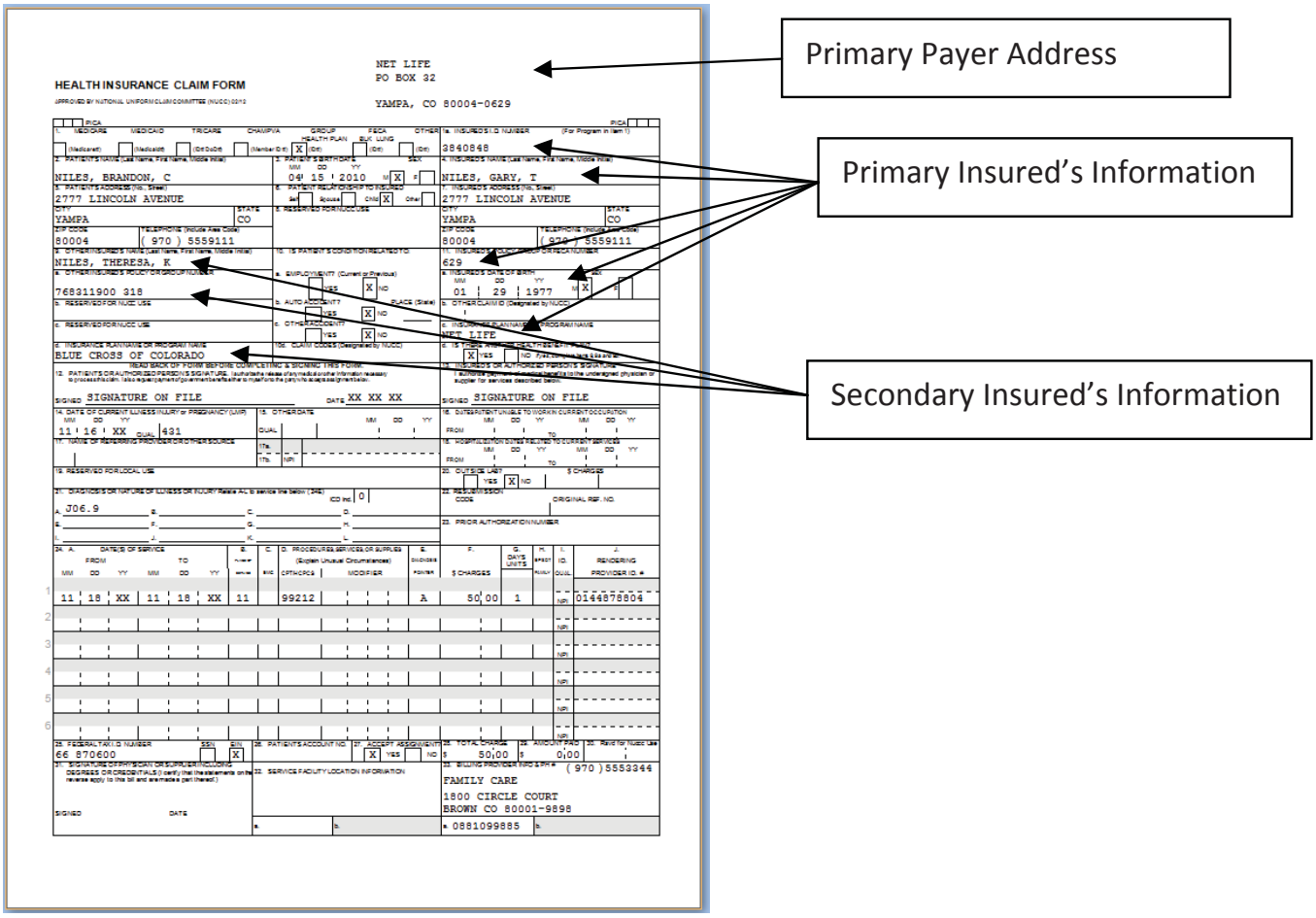
On the other hand, you may find that some carriers don't accept automatic crossovers, but will accept electronic submissions without a copy of the primary EOB.

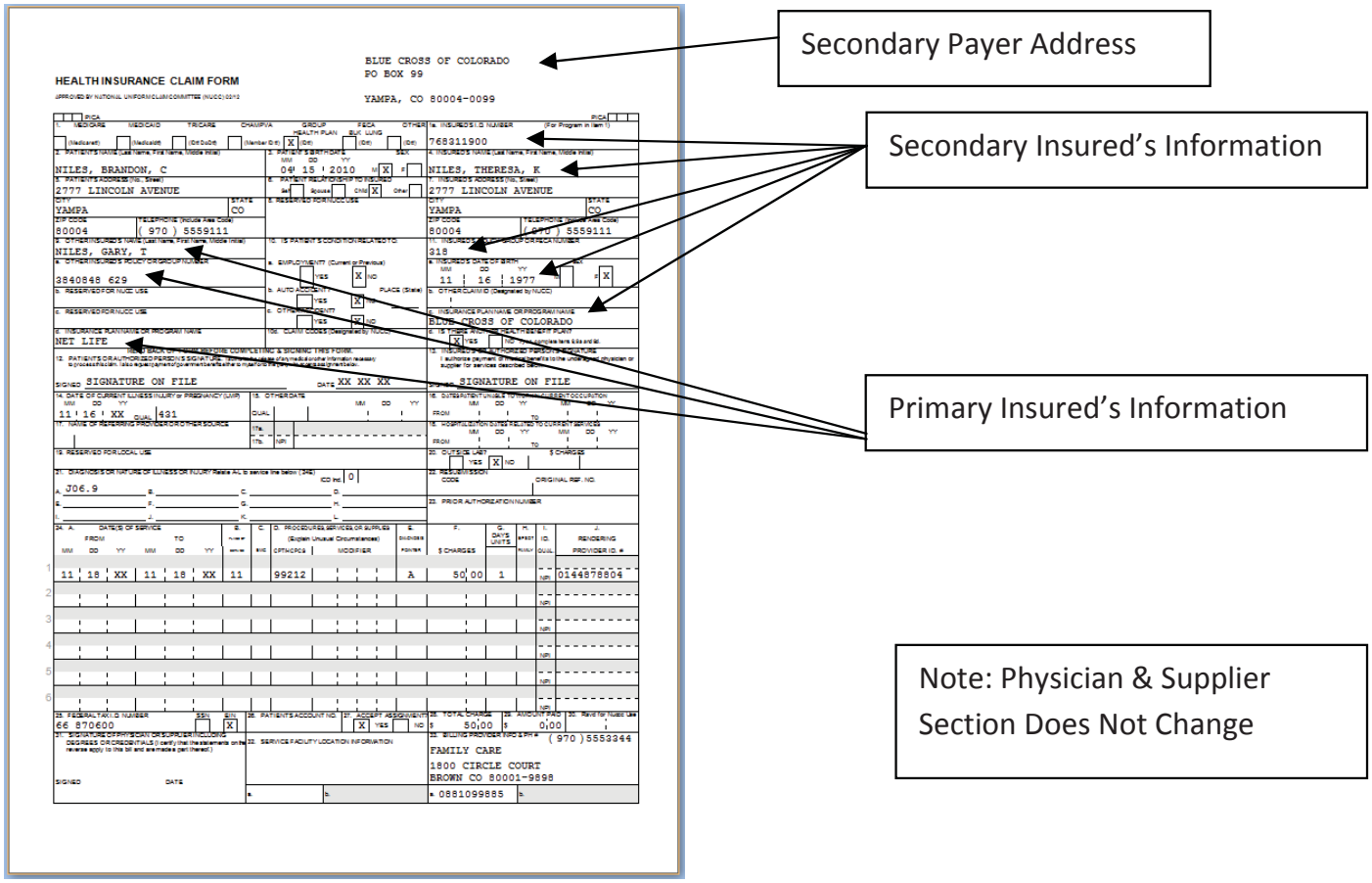
> Participating healthcare plans will not require providers to submit paper EOBs with electronic secondary claims, as long as the primary payer is a commercial insurance company (not Medicare) and the necessary EOB information is included with the claim.
>
> Reference: Group Health Cooperative, at https://provider.ghc.org/open/render.jhtml?item=/open/billingAndClaims/claimsProcedures/claims-secondary.xml

This lesson focuses on submitting paper claims. You will learn more about electronic claims later in this course. You will explore the general standards for completing secondary claims, but it is always a good idea to contact the carrier to verify specifics when you're working as a medical billing specialist.

When submitting a paper claim, you'll complete the CMS-1500 form with the secondary payer in the *Carrier Address* area, and then move the primary insured's information to where the secondary information is usually listed and the secondary insured's information on the right side of the claim.

Let's compare claims for primary and secondary payers.





Essentially, the primary and secondary payers switch places when you submit the claim to the secondary payer for reimbursement. Let's examine the specifics.

The original claim form for Brandon Niles was mailed to Net Life, as it's listed in the *Carrier Section*. You'll see that Gary T. Niles is listed in the primary insured area on the right (fields 1a, 4, 7, 11, 11a and 11c), while Theresa is in the secondary area (fields 9, 9a and 9d).

Now, look at the secondary claim form for Brandon Niles. This time, you'll submit the bill to the secondary insurance, which is Blue Cross of Colorado. Look at the *Carrier Section* of the secondary claim form. Do you see that the address is no longer for Net Life? What else has changed on the secondary claim? You should see that Theresa's insurance information has moved to the right side of the claim, while Gary's insurance information is now in fields 9, 9a and 9d.

Field 29 may also reflect any payments received.

Does that make sense? You'll have a chance to reinforce your understanding with the upcoming Practice Exercise. First, you'll complete a claim for the primary payer. Then, you'll review the EOB from the primary payer. Finally, you'll complete a claim for the secondary payer. This process may seem unnecessary, and you may want to skip it and move on in your studies—but the details are important! Understanding this process is essential to success in the medical billing profession. Be sure to participate in each step to maximize your learning!

Step 8: Practice Exercise 19-2

1. **Complete a CMS-1500 version 02/12 claim form found in your *Assignment Pack* for the primary payer using the following encounter form for Andrew Lee-Carter.**

Christine Jones, MD
1414 Swallow Street
Brown, CO 80001-9898
(970) 555-1514

Physician signature: Christine Jones, MD
EIN: 33-0457789
NPI: 0203048901

☑ 11 Physician Office
☐ 12 Private Residence
☐ 22 Outpatient Hospital
☐ 23 Hospital Emergency Room
Participating Provider ☑Y ☐N

Patient Information

Name Andrew P. Lee-Carter
Address 883 Center Circle
City Avon **State** CO
ZIP 80000
Home Phone 970-555-8812
Date of Birth January 15, 2007
Sex M

Insurance Information

Primary Insurance
Name Blue Cross of Colorado
ID# 630A
Group# BM
Address PO Box 99
City Yampa
State CO **ZIP** 80004-2299
Primary Insured Name Mark K. Carter
Relation to Patient dad
DOB/Sex 07-06-1978 Male
Address 4279 Main Street
Avon CO 80000
Phone 970-555-2289

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Mark K. Carter
Signature of patient (or parent of minor child)

Secondary Insurance
Name CIGNA
ID# 1191031
Group# 488C
Address 1212 Drake
City Cleveland
State OH **ZIP** 44102-1912
Secondary Insured Name Cecelia Lee
Relation to Patient mom
DOB/Sex 10-9-1980 Female
Address Same as patient

Phone Same as patient

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Cecelia Lee
Signature of patient (or parent of minor child)

Date of Service	03/20/XX	Date of Injury	03/18/XX

Diagnosis	Procedure	Charge
S93.421A W21.9XXA	99212 Office visit, Est. Patient	$50.00
Y92.321 Y99.8	73610 X-ray, ankle, complete	$54.00

Today's Charge	$104.00
Cash/Check	$0.00
Balance	$104.00

2. **Review the following EOB for Andrew Lee-Carter to answer as directed, and write your answers on scratch paper.**

THIS IS NOT A BILL

Blue Cross of CO

EXPLANATION OF BENEFITS

CLAIM SUMMARY	Please see lower half of page for itemized details		
Subscriber Name:	MARK K. CARTER		
Subscriber Number:	630A		
Group Number	BM		
Claim Number:	0082345	Page: 1	
Received: 03/23/XX	Processed: 03/30/XX	Report Date: 03/30/XX	
Provider:	CHRISTINE JONES MD		
Participation Status:	PRIME PROVIDER		

Please retain this information for your records. If you have any questions concerning this Explanation, claims activity or benefits, please call Monday - Friday 8:00 a.m. - 4:30 p.m.

Customer Service Telephone Number:

TOLL FREE 1-800-555-XXXX

Patient Name:	ANDREW	Claim Totals	Patient Balance
Total Charge:		$104.00	
Total Not Covered:		$ 19.00	$19.00
Total Allowed:		$ 85.00	
Paid by Other Insurance:		$ 0.00	
Medicare:			
Total Deductible:		$ 0.00	
Coinsurance:		$ 17.00	$17.00
TOTAL BENEFIT AMOUNT:		$ 68.00	
PATIENT TOTAL COST:			$ 17.00
OWED TO:	CHRISTINE JONES MD		

SERVICE DATE/DESCRIPTION	CHARGE	(-) NOT COVERED	SEE MSG	(=) ALLOWED	(-) PAID BY OTHER INS/MEDICARE	SEE MSG	(-) DEDUCTIBLE(D) COINSURANCE(C)	(=) BENEFIT AMOUNT
03/20/XX								
OFFICE VISIT	$50.00	$ 5.00	OV	$45.00			$ 9.00 (C)	$36.00
X-RAY	$54.00	$14.00	OV	$40.00			$ 8.00 (C)	$32.00
TOTALS	$104.00	$19.00		$85.00	$ 0.00		$ 17.00	$68.00

OV THIS CHARGE EXCEEDS THE UCR FOR THE PLAN.

Why is $19.00 not covered?

What is the coinsurance amount for the office visit?

How much did Blue Cross of Colorado pay Christine Jones, MD?

3. **Complete a CMS-1500 version 02/12 claim form found in your *Assignment Pack* for the secondary payer using the previous encounter form, primary payer claim or EOB for Andrew Lee-Carter.**

Step 9: Review Practice Exercise 19-2

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 10: Practice Exercise 19-3

1. **Complete a CMS-1500 version 02/12 claim form found in your *Assignment Pack* for the primary payer using the following encounter form for Brian Harris.**

Family Care
1800 Circle Court
Brown, CO 80001-9898
(970) 555-3344
EIN: 66-6870600

___ Kenneth Miles, MD **NPI:** 02-67679942
___ David Mills, MD **NPI:** 08-10998051
_X_ Roger Small, MD **NPI:** 01-44878804
Group NPI: 08-81099885

☑ 11 Physician Office
☐ 12 Private Residence
☐ 22 Outpatient Hospital
☐ 23 Hospital Emergency Room
Participating Provider ☑Y ☐N

Patient Information

Name Brian D. Harris
Address 3721 Huckle Avenue
City Brown **State** CO
ZIP 80001
Home Phone 970-555-2456
Date of Birth March 17, 2005
Sex M

Insurance Information

Primary Insurance
Name Preferred Coverage
ID# 375-067
Group# 320
Address 729 Clayton Drive
City Brown
State CO **ZIP** 80001-9898
Primary Insured Name Jessica C. Harris
Relation to Patient mother
DOB/Sex 01-30-1971 Female
Address Same as patient

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Jessica C. Harris
Signature of patient (or parent of minor child)

Secondary Insurance
Name CIGNA
ID# 40201
Group# H480
Address 1212 Drake
City Cleveland
State OH **ZIP** 44102-1912
Secondary Insured Name Johnathan R. Harris
Relation to Patient father
DOB/Sex 7-7-1972 Male
Address 928 S. Monroe, Brown CO 80001
970-555-2765

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Johnathan R. Harris
Signature of patient (or parent of minor child)

Physician signature: Roger Small, MD

Date of Service	01/17/XX	Date of Injury	01/07/XX
Diagnosis		**Procedure**	**Charge**
S00.11XD W50.0XXD		99212 Office, Est. Patient	$50.00

Today's Charge	$50.00
Cash/Check	$0.00
Balance	$50.00

2. **Review the following EOB for Brian Harris to answer as directed, and write your answers on scratch paper.**

EXPLANATION OF BENEFITS

Preferred Coverage
729 Clayton Dr.
Brown, CO 80001-9898

Claim: # 0005123
Date: 02-23-XX

Patient	Employee/Subscriber	Group Name	Group Number
Brian Harris	Jessica C. Harris	Preferred Coverage	320

Summary of Payment

Provider: Roger Small, MD

Total Amount Charged	Paid By Other Plan	Paid By Your Plan	Subscriber Responsibility
$50.00	$0.00	$25.00	$0.00

Procedure Code	Date of Service	Amount Charged	Allowed Amount	Not Covered	Applied to Deductible	Coinsurance Copayments	Reason Codes	Amount Paid
99212	01/17/XX	$50.00	$25.00	$25.00	$0.00	$0.00	21	$25.00

Family deductible of $350.00 has been met for year.

21 This charge exceeds the UCR for the plan.

What is the amount of the annual family deductible?

What is the coinsurance amount for the office visit?

How much did Preferred Coverage pay Roger Small, MD?

3. **Complete a CMS-1500 version 02/12 claim form found in your *Assignment Pack* for the secondary payer using the previous encounter form, primary payer claim or EOB for Brian Harris.**

Step 11: Review Practice Exercise 19-3

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 12: Lesson Summary

Wow! You now know a lot more about medical billing! You should feel confident in handling both primary and secondary health insurance claims. You know how to determine the primary and secondary plans for adults and children. You'll learn even more about filing secondary claims electronically later in this course, but you have a good understanding of the overall process at this point.

In the next lesson, you'll switch gears and study the claim form for inpatient hospital billing.

Endnotes

[1] American Medical Association © 2012. Web. 11 October 2013.

Lesson 20
The UB-04 Claim Form

Step 1: Learning Objectives for Lesson 20

When you complete the instruction in this lesson, you will be trained to:

- Describe the fields of the UB-04 claim form.
- Correctly interpret and explain the information included on a completed UB-04 claim form.

Step 2: Lesson Preview

You've already learned how to complete the most common claim form in medical billing, the CMS-1500 form. Now, this lesson will take you through the basic steps you need to follow with another very common claim form—the UB-04 form (sometimes known as the CMS-1450 form).

The UB-04 claim form is primarily used in hospitals and other inpatient settings, in contrast to the CMS-1500 form, which is used by doctors' offices and government programs.

The UB-04 claim form contains many of the same information fields as the CMS-1500 claim form. The main difference is in the layout of each box and the amount of information the form requires. In this lesson, we will guide you through the fields of the UB-04 claim form.

You will not need to complete actual forms in this lesson. In the inpatient setting, the UB-04 form is generally completed with special software that allows various departments to enter information needed for the claim. However, understanding the format of the UB-04 form will prepare you to troubleshoot during the billing process should you work as an inpatient hospital medical billing specialist.

> Beginning with the next chapter, you will complete the CMS-1500 02/12 claim form using **MedLook**, a medical billing software program. Access to a computer, specifically a PC, is required to complete the MedLook lessons. If you do not have access to a computer or have a Mac, you will need to find one to use—you might want to ask a friend or family member. Actual hands-on experience with the software program will be beneficial to you, and it is a requirement of this course.

Step 3: Introduction to Inpatient Billing

It's Wednesday morning at 7:30 a.m. Kate, a Medicare biller for Rocky Mountain Hospital, stops by the coffee cart in the hospital lobby for a cappuccino before beginning her work day. As she walks to her office, Kate pauses to talk with Will, the commercial biller at RMH. Kate knows that her daily edits await her, however, so she only chats for a moment before heading into her office.

Typically, the first few hours of Kate's day consist of what her supervisor calls *daily editing*. Today, Kate reviews all of the Medicare claims that were sent to Medicare electronically yesterday. She logs on to the Medicare Web site and checks to see if Rocky Mountain Hospital has any claims to correct. It looks like several codes were input incorrectly, so she enters the correct codes on those claims. After she finishes editing the incorrect and incomplete claims, Kate resubmits them while logged on to the Medicare Web site.

Once Kate's daily edits are complete, she is ready to process the current day's Medicare claims. These claims were generated on Monday, two days ago, and have made their rounds to all of the various hospital departments that need to fill in portions of the UB-04 claim form. At RMH, after a patient is registered and receives services, each department that provided service for the patient enters charges on that patient's computerized UB-04 form. So, the UB-04 has a great deal of information already completed by the time the patient is discharged and the UB-04 is sent to the billing department. It is Kate's responsibility to edit and submit all Medicare claims. (At RMH, other billers process private insurance and Medicaid claims.)

She sends each claim through a **scrubber**, which is an editing software program that analyzes claims and highlights inaccuracies, errors and missing modifiers. Kate corrects the errors and then submits the claims to Medicare electronically.

After lunch, Kate creates itemized billing statements for patients who do not have insurance or owe the balance of what their insurance plans didn't pay. After she takes the statements to the mail room, she comes back to her office, returns a few phone calls and answers some questions for the new biller down the hall. Feeling good about her productivity for the day, Kate grabs her coat and heads home.

Inpatient billers have various routines depending on the facilities for which they work, but many have very similar responsibilities as Kate does. Some duties differ, but all inpatient billers have one thing in common—they all use the UB-04 form to process claims.

The UB-04 health insurance claim form, also known as the CMS-1450, was originally developed and approved for use in 1992 as the UB-92 form. Starting on October 1, 1993, hospitals, skilled nursing facilities and other providers, such as home health practitioners, began using the UB-92 form to bill Medicare. Other insurance carriers, such as Medicaid and Blue Cross/Blue Shield, began using the UB-94 claim form in 1994. More updates came later, and the current UB-04 form was approved and became the standard in 2007. The original purpose of the UB-04 claim form was to establish uniform billing practices.

Inpatient billers do not use the UB-04 form for billing the professional component of physician services. However, the form is used for billing facility services, such as procedures—especially surgical procedures. Physician services are billed by the physician's office on a CMS-1500 form.

The UB-04 claim form is divided into 81 data fields. The data fields are called **form locators**, or **FLs**. The form is printed in red ink on white paper for processing with optical scanning equipment, and it is designed to be typed or computer printed.

In this lesson, you'll review the general information found in each field of the UB-04 claim form. You will always refer to a hospital medical manual or a UB-04 billing manual should you work as an inpatient hospital biller. Both of these manuals provide billing guidelines that pertain to the specific region where you work. You can access UB-04 billing manuals via the CMS Web site.

A blank UB-04 claim form follows. You will find it helpful to refer to this page as you study the general requirements for successful completion of the UB-04 claim form. The instructions include specifications for each FL on the UB-04 claim form and indicate whether the FL should be completed. The chart of instructions also indicates whether filling in each FL on the UB-04 is required (R), not required (NR), required when applicable (RA) or optional (O).

1 | 2 | 3a PAT. CNTL # | b. MED. REC. # | 4 TYPE OF BILL
5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME a b | 9 PATIENT ADDRESS a b c d e
10 BIRTHDATE | 11 SEX | 12 ADMISSION DATE | 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | 18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES | 29 ACDT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37
a
b

38

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT
a
b
c
d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23		PAGE _____ OF _____	CREATION DATE		TOTALS			

50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI
A
B
C
57 OTHER PRV ID

58 INSURED'S NAME | 59 P. REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.
A
B
C

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME
A
B
C

66 DX | 67 I | A J | B K | C L | D M | E N | F O | G P | H Q | 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Step 4: UB-04 Form Locators

When working with the UB-04, it's important to have access to the UB-04 manual to determine the specific codes for each field. This manual is available at the CMS Web site (www.cms.gov). In this course, you will not be required to have access to the manual. You just need to understand the type of information in each field. Let's begin by looking at the first seven form locators on the UB-04.

	FL	Field Name	Instructions
R	1	Billing Provider Name, Address and Telephone Number	The name and service location of the provider submitting the bill. Enter using the following format: Line 1: Provider name Line 2: Provider address Line 3: City, State, ZIP code Line 4 Telephone with area code
NR	2	Pay-To Name and Address	If payment is to be sent to a different address than that in field 1, complete this field. Line 1: Pay-to name Line 2: Address Line 3: City, State, ZIP code
O	3a	Patient Control Number	Enter patient's unique number if assigned by the provider.
NR	3b	Medical/Health Record Number	Enter the number if assigned by the provider.
R	4	Type of Bill	Enter the 4-digit code to indicate the specific type of bill. Refer to the UB-04 manual for specific code requirements.
R	5	Federal Tax Number	Enter the number assigned to the provider by the federal government for tax reporting purposes. 10 characters, including hyphen: XX-XXXXXXXX
R	6	Statement Covers Period (From–Through)	Enter beginning and ending service dates of the entire period covered in the claim in MMDDYY format. Spaces, slashes, hyphens or dashes are not included.
NR	7	Unlabeled	Leave this field blank.

Review the following for an overview of how to complete the UB-04:

1 ROCKY MOUNTAIN HOSPITAL	2	3a PAT. CNTL #	CB4402B			4 TYPE OF BILL
5454 AUDUBON WAY		b. MED. REC. #	501414AT			0111
BROWN CO 80001		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7	
970 555 5555		55-0000009	1014XX	1015XX		

You'll see that FL 2 is blank, which means the address that the provider submitting the bills intends for payment to be sent to the same address entered in FL 1. The type of bill was determined using the UB-04 manual. In field 4, you'll see the dates 1014XX and 1015XX. Keep in mind that these are invalid numbers that are used only in this course. You will see the current or prior year listed on the actual claim. Now, let's look at another set of form locators.

RA	8a	Patient Name—Identifier	Enter patient identifier as assigned by the payer if different from the subscriber/insured's ID.
R	8b	Patient Name	Enter the patient's last name, first name and middle initial, if provided.
R	9a-e	Patient Address	Enter patient's complete mailing address.
R	10	Patient Birth Date	Enter patient's date of birth in MMDDYYYY (also seen as MMDDCCYY) format. Note that a 4-digit year is required.
R	11	Patient Sex	Enter "M" for male or "F" for female.
R	12	Admission/Start of Care Date	Enter the date the patient was admitted for inpatient services using the MMDDYY format. Note that a 2-digit year is required.
RA	13	Admission Hour	This field is not required by Medicare. If required by a private carrier, enter the hour of admission in military time using 2 numeric characters. For example, 1 a.m. is 01 and 1 p.m. is 13.
RA	14	Type of Admission/Visit	If required, enter the 1-digit code indicating the reason for the admission. Refer to the UB-04 manual for specific code requirements.
RA	15	Point of Origin for Admission or Visit	Enter the 1-digit code indicating the source of the referral for this admission or visit. Refer to the UB-04 manual for specific code requirements.
RA	16	Discharge Hour	This field is not required by Medicare. If required by a private carrier, enter the hour of discharge in military time using 2 numeric characters.
RA	17	Patient Discharge Status	Enter the code indicating the disposition or discharge status of the patient. Refer to the UB-04 manual for specific code requirements.
RA	18-28	Condition Codes	Used to identify conditions or events relating to this bill that may affect processing. For example, 02 means the condition is employment related. Refer to the UB-04 manual for specific code requirements.

NR	29	Accident State	This field is not required by Medicare. If required by carrier, enter the state abbreviation indicating where the accident occurred.
NR	30	Unlabeled	Leave this field blank.

That was a lot of information, so let's pause to carefully examine the UB-04 and explain the process.

8 PATIENT NAME	a		9 PATIENT ADDRESS	a	2419 ZENDT DRIVE															
b HARRISON CATHERINE R			b AVON													c CO	d 80000		e	
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30
08091977	F	1014XX		1	7		01	03												

You'll see that the payer did not assign a different identifier, so FL 8a is blank. The admission date is 10/14/XX, while the admission hour is not completed. The other information indicates the type of admission was an emergency; the patient was admitted by the emergency department physician; and the patient was then discharged to her home. The patient is covered by insurance. This was not an accident; therefore, FL 29 is blank.

Now, you're ready to move on to the next set of form locators.

RA	31-34	Occurrence Codes and Dates	Enter the code and specific date (MMDDYY) noting a specific event relating to the claim that may affect payer processing. Refer to the UB-04 manual for specific code requirements.
NR	35-36	Occurrence Span Codes and Dates	The occurrence span codes and beginning and ending dates (MMDDYY) are entered defining a specific event relating to this billing period. Refer to the UB-04 manual for specific code requirements.
NR	37	Unlabeled	Leave this field blank.
R	38	Responsible Party Name and Address	Enter the name and address of the party responsible for the bill. This is usually the primary insured.
RA	39-41	Value Code and Amount	If applicable, enter the code from the UB-04 manual and the dollar amount associated with the service.

Let's review the form locators you just learned. Remember, various departments will enter much of the information you'll find on the UB-04 form. If an occurrence or occurrence span is necessary, the computer system will prompt you to complete this information with the use of the UB-04 manual for necessary codes.

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a								72	1014XX	1015XX				a
b														b

38 THOMAS E HARRISON 2419 ZENDT DRIVE AVON CO 80000		39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
	a	01	1250 00				
	b						
	c						
	d						

You'll see the occurrence does not apply, but the occurrence span is provided. Thomas Harrison is the primary insured and is entered in FL 38 as the responsible party. The 01 indicates the patient had a semi-private room for the amount of $1250.00. Note that the dollar sign and decimals are not recorded.

Now, let's look at the form locators in the claim that relate to payment for the services.

R	42	Revenue Code	Enter the appropriate numeric code to identify specific accommodations and/or charges for services. Revenue codes are 4-digit codes and can be found in the UB-04 manual.
R	43	Revenue Description	Enter the narrative description of the revenue code found in FL 42.
RA	44	HCPCS/Rate/HIPPS Rate Codes	Enter the accommodation rate for the room and board.
RA	45	Service Dates	Enter the date of service using a 2-digit year (MMDDYY) to indicate when each service was performed.
R	46	Service Units	Indicate the number of units or times a procedure was performed.
R	47	Total Charges	Enter the total charge related to each revenue code listed in FL 42. Indicate the total charge of the claim on the last line with the corresponding 0001 revenue code.
NR	48	Non-Covered Charges	Enter the total non-covered charge related to each revenue code listed in FL 42. Indicate the total non-covered charge of the claim on the last line with the corresponding 0001 revenue code.
NR	49	Unlabeled	Leave this field blank.

Review the following example for a better understanding of form locators 42 through 49.

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	XXXX	SEMIPRIVATE ROOM	125000	1014XX	1	1250 00			1
2	XXXX	FLEXSIGMOIDOSCOPY		1014XX	1	625 00			2
3	XXXX	LABORATORY		1014XX	1	25 00			3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23	0001	PAGE 1 OF 1	CREATION DATE	1015XX	TOTALS	1900 00			23

The revenue code is a four-digit numeric code such as 0001, but you'll see XXXX used in your textbook. The rate of the semi-private room is listed, and you'll note that decimals are not included. At the bottom, the page currently showing, as well as the total number of pages, is provided. In addition, you'll see the date the claim was created. Now, let's take a look at the insurance information and its arrangement on the UB-04 claim form.

R	50	Payer Name	Enter all payers (insurance carrier) in order of their liability (primary, secondary, tertiary).
NR	51	Health Plan ID	Enter the health plan ID if assigned by the payer. Complete for each payer listed, if applicable.
R	52	Release of Information	Enter the appropriate Y or N to indicate whether there is a signed statement permitting the provider to release data for reimbursement. Complete for each payer listed.
R	53	Assignment of Benefits	Enter the appropriate Y or N to indicate whether there is a signed statement authorizing to pay the provider directly for the services. Complete for each payer listed.
RA	54	Prior Payments	Enter any payments, in dollars and cents, received toward payment of the claim prior to billing.
O	55	Estimated Amount Due	Enter the estimated amount due, in dollars and cents, after prior payments are subtracted.

RA	56	National Provider ID	Enter the 10-digit National Provider Identifier for the billing provider.
RA	57	Other Provider ID	Enter the provider number assigned by the payer, if applicable.
R	58	Insured's Name	Enter the name of the person that is primary on the insurance listed in FL 50. List the last name, first name and middle initial.
R	59	Patient's Relationship to Insured	Enter the 2-digit code indicating the relationship of the patient to the insured. The most common are 01 for spouse, 18 for self and 19 for child. Refer to the UB-04 manual for specific code requirements.
R	60	Insured's Unique Identifier	Enter the insured's ID number. Complete for each payer listed.
RA	61	Insured's Group Name	Enter the group name for each payer listed, if applicable.
RA	62	Insured's Group Number	Enter the group number for each payer listed, if applicable.
RA	63	Treatment Authorization Code	Complete with the preauthorization number for each payer, if applicable.
O	64	Document Control Number	Enter the number assigned by the health plan as part of its internal control.
NR	65	Employer Name	Enter the name of the employer for each insured.

There are quite a few fields related to the insurance information. Keep in mind that you can list the names of up to three insureds in form locators 58 through 62, which you'll explore shortly. For now, review the following example to ensure you understand the form locators.

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	6565886565
A BLUE CROSS OF WYOMING		Y	Y			57 OTHER PRV ID	
B							
C							

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A HARRISON THOMAS E	01	6410		GE54002
B				
C				

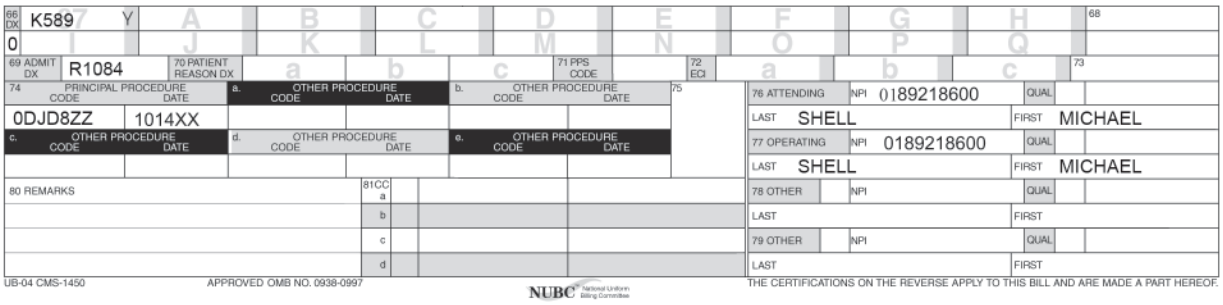
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A AM4415		CHASE AUTO SALES
B		
C		

You'll see that Blue Cross of Wyoming is the only insurance carrier for the patient. There is a signature on file for release of information, as well as an authorization of payment to the provider. Thomas Harrison is the insured, and he's the spouse of the patient. The insured's ID, group number, authorization and employer name are also included. Now, let's wrap up the UB-04 claim form.

NR	66	Diagnosis and Procedure Code Qualifier	This field identifies which ICD version is being used. A “9” indicates ICD-9-CM and “0” indicates ICD-10-CM.
R	67	Principal Diagnosis Code and Present On Admission Indicator	Enter the diagnosis code for the principal diagnosis or chief reason for performing the service. In addition, enter “Y” for yes or “N” for no to identify if the diagnosis was present at the time of admission.
RA	67A-Q	Other Diagnosis Codes	Enter up to 17 diagnosis codes to identify additional conditions.
NR	68	Unlabeled	Leave this field blank.
R	69	Admitting Diagnosis	Enter the diagnosis code describing the condition at the time of admission.
RA	70a-c	Patient’s Reason for Visit	Enter the diagnosis code describing the reason for the visit at the time of registration.
NR	71	Prospective Payment System Code	If required by payer, enter the PPS code assigned to the claim to identify the diagnosis related group (DRG).
RA	72	External Cause of Injury Code	Enter the diagnosis code pertaining to external cause of injuries, poisoning or adverse effect, if applicable. In addition, enter “Y” for yes or “N” for no to identify if the diagnosis was present at the time of admission.
NR	73	Unlabeled	Leave this field blank.
RA	74	Principal Procedure Code/ Date	Enter the procedure code for the principal procedure and the date (MMDDYY) it was performed.
RA	74A-E	Other Procedure Code/ Date	Enter up to 5 additional procedure codes and dates (MMDDYY).
NR	75	Unlabeled	Leave this field blank.
R	76	Attending Provider Name and Identifiers	Enter the following information for the physician who has overall responsibility for the patient’s care: top line includes the 10-digit NPI and legacy ID, if applicable, with qualifier; the provider’s name (last name, first name) on the second line. The qualifier explains the type of legacy ID: 0B for State License Number, 1G for UPIN Number and G2 for Commercial Number
RA	77	Operating Physician Name and Identifiers	If there is a surgical procedure on the claim, you’ll include the operating physician’s name and identifiers, in the same format as FL 76.

RA	78-79	Other Provider Names and Identifiers	If applicable, enter assisting physicians, referring physicians or ordering providers information, in the same format as FL 76.
RA	80	Remarks	Enter any special notations that may be helpful in paying the claim.
RA	81a-e	Code—Code Field	Enter additional codes relating to another FL overflow.

Let's look at an example of the bottom portion of the UB-04 claim form.



The provider is using the *ICD-10-CM*, and has applied *K58.9* (irritable bowel syndrome), a condition that was present on admission. The admitting diagnosis was *R10.84* (generalized abdominal pain). Please note that the codes are recorded without decimal points. To interpret them, you'll place the decimal after the third character.

On 10/14/XX the patient had a flexible sigmoidoscopy (0DJD8ZZ) performed by Dr. Shell, who was also the attending physician.

Remember that, although you don't need it at this time, you can download a complete UB-04 manual from the CMS Web site. The manual provides a complete set of codes for each form locator.

Now, let's review what you've learned so far with a Practice Exercise.

Step 5: Practice Exercise 20-1

Determine the form locator with each field name, and write your answers on scratch paper.

1. **Federal Tax Number**
2. **Health Plan ID**
3. **Insured's Name**
4. **Patient Name**
5. **Payer Name**
6. **Pay-to Name and Address**

7. **Principal Procedure Code/Date**
8. **Responsible Party Name and Address**
9. **Revenue Code**
10. **Service Dates**

Step 6: Review Practice Exercise 20-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 7: Understanding the UB-04 Claim Form

Now, it's time for you to pull all of your new knowledge together! Remember that the UB-04 form is usually completed with specialized computer software, which gathers information from various departments. You'll find the specific code requirements for many of the form locators in the UB-04 manual. Again, you can download this manual from the CMS Web site. However, you do not need to refer to the manual as you work through the lessons in this course.

Following, you'll find a completed UB-04 claim form. Review the claim, and then see if you can locate the information.

1 ROCKY MOUNTAIN HOSPITAL	2	3a PAT. CNTL. # CT1005X	4 TYPE OF BILL
5454 AUDUBON WAY		b. MED. REC. # NE2562UA	0111
BROWN, CO 80001		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH / 7
970 555 5555		55-0000009	0321XX 0322XX

8 PATIENT NAME a	9 PATIENT ADDRESS a 2777 LINCOLN AVENUE				
b NILES BRANDON C	b YAMPA	c CO	d 80004	e	

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
04152010	M	0321XX		1	1		01	03												

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a	05	0321XX							72	0321XX	0322XX				
b															

38 GARY T NILES
2777 LINCOLN AVENUE
YAMPA CO 80004

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	01	1250 00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	XXXX	SEMIPRIVATE ROOM	125000	0321XX	1	1250 00		
2	XXXX	CAT SCAN HEAD		0321XX	1	750 00		
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	0001	PAGE 1 OF 1	CREATION DATE	0322XX	TOTALS	2000 00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 6565886565
A	NET LIFE		Y	Y			57
B	BLUE CROSS OF COLORADO		Y	Y			OTHER
C							PRV ID

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	NILES GARY T	19	3840848		629
B	NILES THERESA K	19	768311900		318
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	NT3605		WESTERN BELL
B	A6666ST		FAMILY CLINIC
C			

66 DX S0601XA Y A B C D E F G H 68
0 I J K L M N O P Q

69 ADMIT DX S098XXA | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI W2107XA b c 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
B020ZZZ	0321XX					
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

	76 ATTENDING	NPI 0203048901	QUAL	
	LAST JONES		FIRST CHRISTINE	
	77 OPERATING	NPI 0203048901	QUAL	
	LAST JONES		FIRST CHRISTINE	
	78 OTHER	NPI	QUAL	
	LAST		FIRST	
	79 OTHER	NPI	QUAL	
	LAST		FIRST	

80 REMARKS	81CC a		
PATIENT HIT WITH SOFTBALL.	b		
NO LIABILITY.	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Who is the patient? Brandon C. Niles

Who is the responsible party? Gary T. Niles

What does the 125000 represent in FL 39? The 01 indicates the patient had a semi-private room for the amount of $1250.00.

What is the total revenue code? 0001

Which insurance is primary? Net Life

What is the amount of the total charges? $2000.00

What is the diagnosis code? S06.01XA

What procedure was performed? B020ZZZ

Who was the attending physician? Christine Jones

Once you're able to break down the form, the UB-04 isn't too overwhelming. Now, it's your turn to evaluate the UB-04 claim form with the next Practice Exercise!

Step 8: Practice Exercise 20-2

Refer to the UB-04 for Samuel Jones that follows to answer the items on scratch paper as directed.

1 ROCKY MOUNTAIN HOSPITAL	2	3a PAT. CNTL # CA4456A	4 TYPE OF BILL
5454 AUDUBON WAY		b. MED. REC. # SP2324AT	0111
BROWN, CO 80001		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH 7
970 555 5555		55-0000009	0512XX 0513XX

8 PATIENT NAME a		9 PATIENT ADDRESS a 3 HWY SOUTH			
b JONES SAMUEL		b AVON	c CO	d 80000	e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
05191982	M	0512XX		2	1		01	03												

CONDITION CODES

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a									72	0512XX	0513XX				a
b															b

38 SAMUEL JONES
3 UNION SQUARE
AVON CO 80000

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	01	1250 00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	XXXX	SEMIPRIVATE ROOM	125000	0512XX	1	1250 00		1
2	XXXX	RADIOLOGY KUB		0512XX	1	188 00		2
3	XXXX	IVP		0512XX	1	278 00		3
4	XXXX	PERCUT NEPHROSTOMY		0512XX	1	1356 00		4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23	0001	PAGE 1 OF 1	CREATION DATE	0513XX	TOTALS	3072 00		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 6565886565
A	BLUE CROSS OF IOWA		Y	Y			57 OTHER PRV ID
B							
C							

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	JONES SAMUEL	18	666006663		VE001
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	A46331215		GREEN FINGER NURSERY
B			
C			

66 DX: N200 Y; A; B; C; D; E; F; G; H; 68
0; I; J; K; L; M; N; O; P; Q

69 ADMIT DX: N23; 70 PATIENT REASON DX: a b c; 71 PPS CODE; 72 ECI: a b c; 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
0TF43ZZ	0512XX					
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 0304851124	QUAL	
LAST ALLEN		FIRST DONALD	
77 OPERATING	NPI 0775811003	QUAL	
LAST ROSE		FIRST JENNIFER	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81 CC		
	a		
	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

1. **The patient's control number in FL 3a is _____.**
2. **The one-digit code indicating the reason for the admission is_____.**
3. **The one-digit code indicating the source of the referral for this admission or visit is _____.**
4. **The occurrence span dates are _____.**
5. **The radiology KUB charge is _____.**
6. **FL 52 is completed "Y" indicating the provider has what?**
7. **The principal procedure code is _____.**
8. **The physician who performed the surgical procedure is _____.**
9. **The attending physician is _____.**
10. **The NPI for Rocky Mountain Hospital is _____.**

Step 9: Review Practice Exercise 20-2

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 10: Lesson Summary

As you've learned, it is primarily hospitals that use the UB-04 claim form for billing facility services, not for professional services. Sometimes known as the CMS-1450 claim form, this form is similar to the CMS-1500, but the fields and required information are presented somewhat differently. The CMS-1500 and the UB-04 are the two most common claim forms in use today.

You're now familiar with the UB-04 claim form! You've explored the fields on the form and will be able to ensure that all of the pertinent information is correct if you should work in an inpatient setting.

In the next lesson, you'll explore medical technology and learn how it applies to medical billing. But first, you'll need to complete the following Quiz to reinforce what you've learned about secondary claims and the UB-04 claim form. Good luck!

Step 11: Quiz 18

Once you have mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the Quiz instructions carefully.

Lesson 21
Medical Billing Technology

Step 1: Learning Objectives for Lesson 21

When you complete the instruction in this lesson, you will be trained to:

- Explain the process of clearinghouses and electronic claims submission.
- Explain the principles of carrier-direct submission and Web-based claims submission.
- Follow instructions to complete a claim form using medical billing software.

Step 2: Lesson Preview

In the last decade, there's been a significant push to contain spiraling healthcare costs. One of the potential solutions lies within new technology. It is estimated that the change from a paper system to an electronic system in health care will eventually provide a cost savings of $120 billion—or more—per year! As you can see, there is a major incentive for the medical profession to move into the electronic age.

Imagine that you are working as a medical billing specialist. Jamie, a patient, comes in to see the doctor. You take the information from Jamie's electronic health record and use it to generate an insurance claim. However, you do not fill out the CMS-1500 claim form—at least, not exactly. Instead, you turn on your computer, start your billing software application and enter the required information. The software uses fields similar to the CMS-1500 fields, and all you have to do is type in the appropriate information. Then, you press a few buttons and, voilà, the claim is filed! Filing claims using medical billing software seems to make the process more efficient, doesn't it?

In this lesson, you will become familiar with electronic claims, Web-based claims submission and medical billing software. You have a lot to learn, so let's get started!

You will complete the CMS-1500 02/12 claim form using MedLook, a medical billing software program. Access to a computer, specifically a PC, is required to complete the MedLook lessons in your course. If you do not have access to a computer or have a Mac, you will need to find one to use—ask a friend or family member. Actual, hands-on experience with the software program will be beneficial to you, and it is a requirement of this course.

Step 3: Clearinghouse and Electronic Claims Submission

In a moment, you will discover the details of filing claims electronically. But first, let's take a look at how electronic claims processing works.

The process starts when a medical billing specialist takes the coded medical record and enters the data into the billing software. Once all codes and charges are entered, the claims are batched together and divided into groups. Typically, one group consists of claims that must be sent to insurance companies; the other consists of bills that will be sent to patients.

Let's take a look at the claims that need to be sent to the insurance company first. If you work as a healthcare professional in a physician's office or hospital, you may file claims to many different insurance companies, or payers. You'll typically find that most companies want to receive these claims electronically. There are several options for filing claims electronically. The provider for whom you work may contract with a **clearinghouse**—a company that facilitates the processing of claims information into standardized formats, then submits the claims to the appropriate insurance companies. Or, alternatively, your provider may file directly to the insurance companies, which is the process known as **carrier-direct submission**. You might also enter the claim information directly into the insurance carrier's Web site as a **Web-based claim submission**.

If you use a clearinghouse, you'll prepare your claims with medical billing software. Then, your program will convert the data you entered into files on your computer. The software exports your files into a format that the clearinghouse can receive. (Keep in mind that you will need to make sure your software is compatible with the clearinghouse your provider uses.) Once the claims are exported into the system, the software sorts them according to payer.

Most clearinghouses have the ability to check for errors. A claim without errors is considered **clean**. If a claim has an error, the clearinghouse will send a report with the required correction. Then, you can make the correction and resubmit the claim. Finally, the clearinghouse will forward the clean claims to the appropriate payers for processing.

If there are claims that you cannot send electronically, you can print and send a paper claim, or the clearinghouse can send the paper claim for you.

The clearinghouse will download reports to indicate how many claims it received and when the claims were forwarded to payers. The insurance payers will also report to the clearinghouse when they receive the claims. These reports are important for timely filing and insurance claim follow-up, topics that you will study later.

After the insurance company receives the claim from the clearinghouse, it processes and pays or rejects that claim. Sometimes, insurance companies notify providers of rejected claims on the payment vouchers they send to the providers. Other times, payers notify providers of rejected claims through the electronic reports that they transmit to the clearinghouse.

By now, you should have a general idea of how the electronic billing cycle works. With that in mind, let's discuss some electronic billing specifics.

Why Submit Electronically?

In past years, most medical insurance claims have been completed by hand or typewriter, and then physically mailed to the insurance company for processing. Although paper claims are still used, the healthcare field is quickly moving away from paper claims and more toward the use of *electronic claims*.

Electronic claims are digitized insurance claims transmitted from a computer, using a modem, to the insurance company or clearinghouse. What does digitized mean? Well, data entered into a computer record is considered **digitized** information. You can digitize data from a healthcare form simply by using software and entering the required information.

Do you wonder how digitizing medical information and using a computer in health care might be beneficial? Consider this: Every year, countless amounts of paper are used to file medical insurance claims. This includes letters and forms that providers use once and then discard. In contrast, digitized information can be stored much more easily; it can also reduce the waste of paper. Additionally, digital submissions are processed much more quickly—ensuring the claims process takes a minimal amount of time. This also means the provider receives payments more quickly, too.

Electronic Transactions Save Money

Every instance in which electronic transactions reduce the time spent processing claims can, of course, translate into cost savings for you and your employer or clients.

For instance, the estimated, per-claim savings of processing claims electronically instead of manually, or on paper, is as follows:

- $1.49 per claim for providers
- $1.00 per claim for health plans
- $0.86 per claim for hospitals

Filing claims electronically can also save valuable time. It takes days for paper claims to be delivered through the mail system—and there is no proof of when you sent a claim. Once the claim is delivered, the insurance company must digitize the information for its system and then process the claim. Finally, the insurance company mails the reimbursement.

In contrast, submitting a claim electronically is comparable to picking up the telephone and calling the insurance company directly. The claim is received instantly, already digitized, and processing can begin immediately. With electronic filing, you have proof of timely filing and can check the status of claims with just a few key strokes on your computer. The provider can receive reimbursement even more quickly with *direct deposit*.

Direct deposit is the process through which money is electronically deposited into a bank account. In regard to filing claims, an insurance company authorizes its bank to transfer funds into a physician's account. This all takes place electronically, via computers, with no actual cash or checks physically changing hands.

The new world of electronic claims presents many opportunities for medical billing specialists. Software helps to eliminate errors, track claims and other medical records, and improves the speed of submission and reimbursement of claims. Electronic claims can make your life as a healthcare professional easier and more efficient!

Claim Submission Routes

As you have learned, there are several routes by which an electronic claim can travel to the insurance company: carrier-direct, Web-based or through a clearinghouse.

Carrier-direct claim submission allows both providers and billing services to transmit insurance claims directly to the insurance company. Insurance carriers who have the ability to receive claims directly provide software to the biller that formats claims data into the required electronic format. Then, the information is entered into the software program and sent directly to the insurance company for processing.

Some carriers even provide Web-based claims submission, in which the medical billing specialist can connect to the Internet, go to the carrier's Web site and upload the claim data directly to the carrier. This does have some disadvantages, as the information must be entered separately into your software for your provider's records, which means that you'll duplicate your efforts.

The third method of submitting claims is via a clearinghouse. Recall that a clearinghouse is a service that takes electronic claims from medical billing specialists all across the country, and files, sorts and forwards them to the appropriate agency or carrier.

A modem enables you, as the medical biller, to use a computer to call the clearinghouse's computer through telephone lines. Then, your computer transmits the data through the phone lines, and the clearinghouse's computer sends back a confirmation that it received the entire transmission.

Clearinghouses charge providers to submit claims to insurance companies. Usually, the clearinghouse charges a one-time, start-up fee for each client. There are various fee schedules. Some clearinghouses charge an annual fee, some charge a per-claim fee and others charge a per-provider fee.

Before you move ahead, take a few moments to review what you've learned to this point. Complete the following Practice Exercise as directed.

Step 4: Practice Exercise 21-1

Match each term with the correct definition, and write your answer on scratch paper.

1. **Clearinghouse**
2. **Carrier-direct submission**
3. **Digitizing**
4. **Paper claims**
5. **Direct deposit**
6. **Web-based claim submission**
7. **Modem**
8. **Clean claim form**

9. **Per-claim charge**

10. **Payers**
    a. The process of entering data into a computer record
    b. A claim form without any errors
    c. Claim submitted via a carrier's Web site
    d. Non-electronic claim forms
    e. A provider files a claim directly to the insurance company
    f. Insurance companies
    g. A method by which a payer can place money into a provider's account
    h. One type of fee that a clearinghouse charges to submit claims
    i. Company that facilitates the processing of claims
    j. Allows you to submit claims electronically via computer

Step 5: Review Practice Exercise 21-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 6: MedLook

As you'll learn, MedLook is one of the most popular medical billing programs in use today. As you become familiar with this program, you should gain a general understanding of any billing software program that you may use, as they do have similarities. MedLook offers many features, including completing and processing insurance claims, which is the focus of this course.

You have been provided with an educational, demonstration version of the MedLook program. In a moment, you will install the software so that you can follow along as you read.

Keep in mind that you will not see a CMS-1500 claim form on the screen when you enter your data in MedLook. Instead, the information you input into each field is organized into various databases. A **database** is a structure that stores organized information. MedLook has 16 different databases—including for patient accounts, referral sources, providers, facilities, fee schedules, procedure codes, place of service, insurance carriers, diagnosis codes, modifiers, type of service, office reports, office labels, billing, appointments and 835. You will not use every single one of the databases in this course, but you will examine a number of the databases in this lesson.

MedLook Support

Your instructor can provide guidance and support regarding items covered in your course materials. You can call or e-mail your instructor for assistance at any time.

However, if you require support due to software technical issues, please contact MedLook directly at (800) 548-6148, or at www.MedLookUSA.com, Monday through Friday from 7:30 a.m. until 5:30 p.m. CST, excluding holidays. The preferred method is through the Web site, at www.MedLookUSA.com, using the ticket system or chat feature.

Follow the steps below when you contact MedLook via the Web site:

- Click *Support* and create a ticket—An e-mail with further assistance will be sent to the e-mail address you provide. You will receive an instant confirmation e-mail when you submit a ticket. If you don't receive this e-mail, check your spam filter.
- Click *Chat* in the upper, right-hand corner to connect to a technician for live instruction—This option is only available during MedLook business hours.

Your MedLook Demonstration Version has all of the features of the full version of the MedLook program; you will be able to work with 50 patients without any restrictions. It is limited to these 50 patients, and you will not be able to use the Demonstration Version for professional purposes. It has been provided to work in conjunction with your course materials.

IMPORTANT NOTE: Do NOT register the MedLook Demonstration Version. Although you will see *Register* as an option, it only applies to the full version—do not click this option! Registering the software will limit your Demonstration Version so that you will not be able to complete the required claims.

MedLook Installation

Your MedLook software is available on a CD or online. To access the software online, go to www.MedLookUSA.com and select *Downloads*. Then select *Student Version ML4.0 Installer*. Follow these steps to install MedLook:

- Load the MedLook CD.
- Cancel the welcome screen.
- Click on *Start*.
- Click on *Computer*.
- Right click on the CD drive and click *Open* or *Explore*.
- Right click on *MedLook_Setup_USCI*.
- Click on *Run as administrator*.
- Click on *No-Questions-Asked Installation*.
- Continue to follow the prompts on the screen.

Some additional windows may appear during installation, depending on your version of Windows. Follow the prompts from these windows, and proceed with the installation.

Each time you open MedLook, you should not just double click on the icon to start it. You should right click on the icon, and then click *Run as administrator*. If you don't run the program as the administrator, you may encounter problems using the software. If you do encounter problems, please close the program and open it again using *Run as administrator* to see if it fixes the issue before contacting an instructor or MedLook for assistance.

In addition, when you open MedLook, you may see a prompt to perform a backup, both daily and weekly. For practice purposes, you should click *No* and continue. However, when you work in the field, you will want to perform a daily backup.

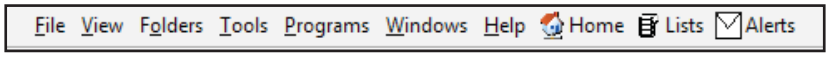
Now, let's take some time to explore your software!

Getting Started

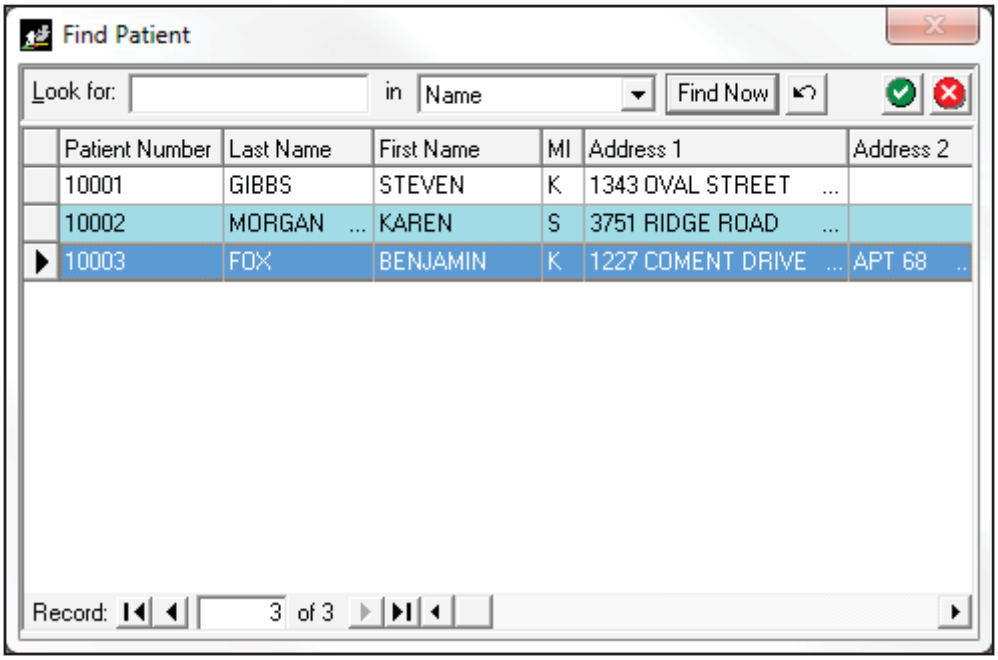
There are two ways to open MedLook:

- Click *Start*, *Programs*, and then right click on *MedLook* to open the box so you can click *Run as administrator*.
- Locate the MedLook icon on your desktop, and then right click to open the box so you can select *Run as administrator*.

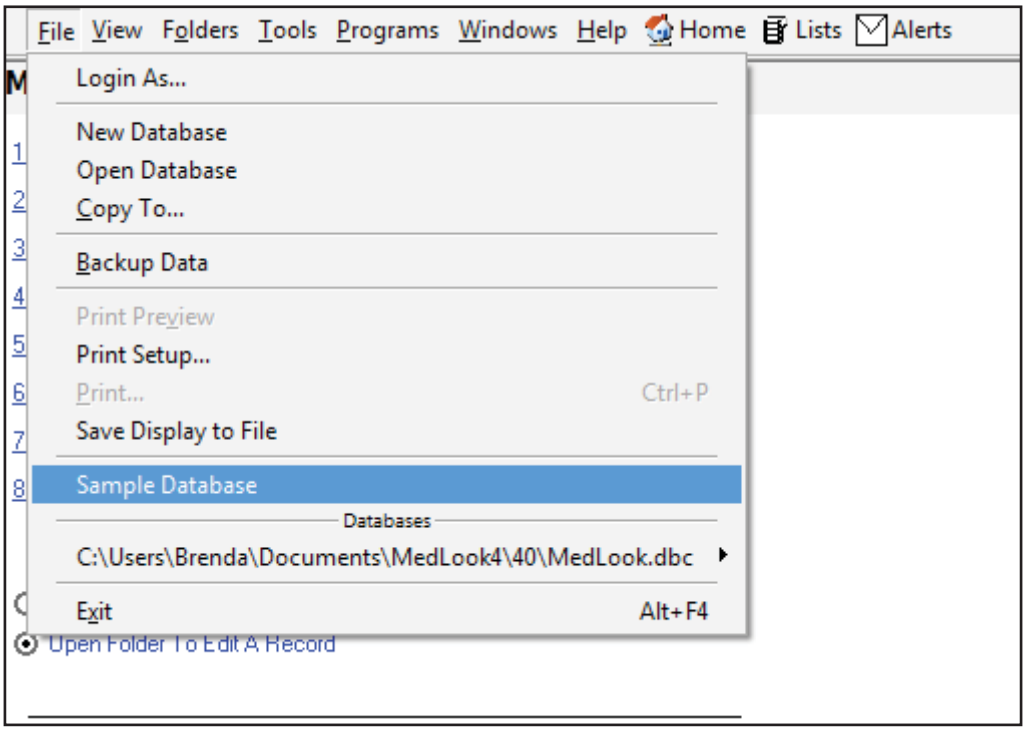
Either way, MedLook will open to the home page, containing the tool bar across the top and links to the various databases. The tool bar lists *File, View, Folders, Tools, Programs, Windows, Help, Home, Lists* and *Alerts*.



The MedLook demo has been preloaded with a sample database that you'll use in this course. Click *Home*, and then click *Patient Accounts*. If a window like the following appears, you'll know you already have access to the sample database. To close the window, click the red circle with an "x" in the upper, right-hand corner.



If this window doesn't appear, click *File* and then *Sample Database.* This database will help you get started with the software. You will add to the database as you complete the examples, Practice Exercises and Quizzes in your materials.



IMPORTANT NOTE: After adding to the sample database, you can clear the information you've entered by clicking *File*, and then *Sample Database*. A box will appear asking if you really want to delete the existing sample database. If you click *Yes*, the sample database will return to the preloaded data, and all of your work will be lost. Use this function cautiously! If you clear the database too often, it will corrupt the existing information in MedLook and you won't be able to access the software.

Also, please keep in mind that you'll see that the information preloaded into the database was entered using all capital letters. It isn't absolutely necessary for you to use all capital letters when you enter new information, but it IS recommended. Again, many insurance carriers request that providers submit claims using all capital letters. For this course, it is preferable that you complete the claims using all capital letters. However, you will not be penalized if you don't follow this preferred method. Either way, accurate spelling is essential on the claims.

You will also see *New Database* as an option. You can create a new database once you've completed the course and you are ready to go to work in the billing field with the full version of MedLook. A billing service may also create a new database for each client, which allows that service to keep practice information separate. However, you will not use this option while completing your course.

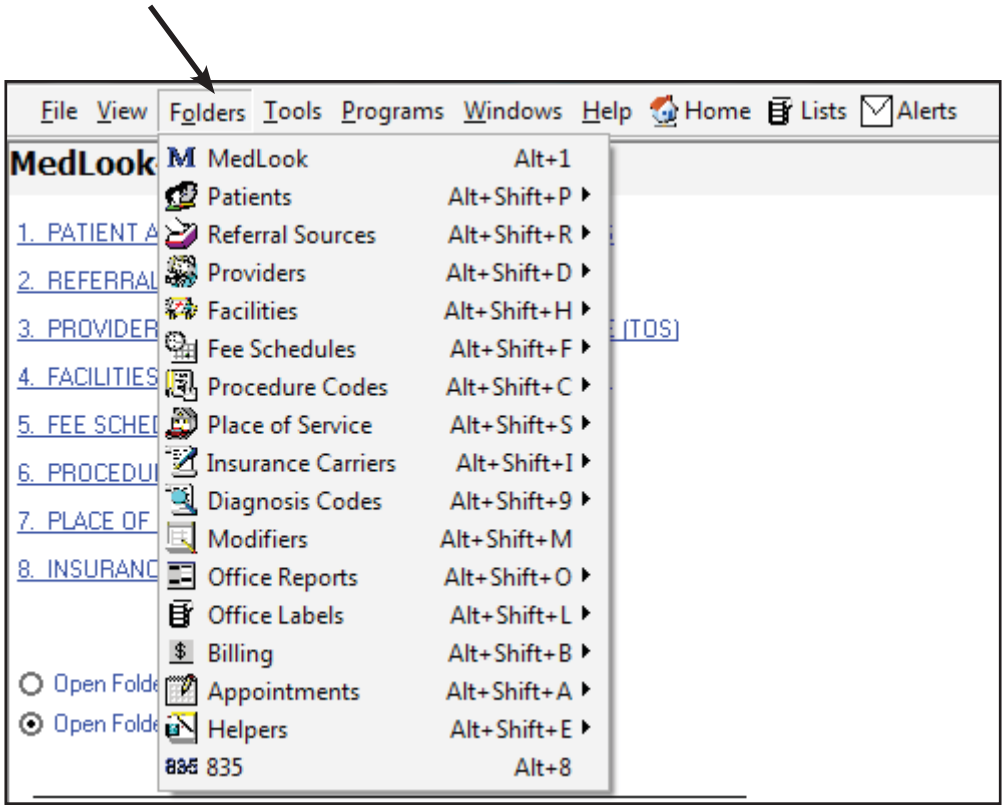
Step 7: Databases

Now that you have a grasp of the basics, you're ready to start looking at each specific database. You'll learn how to edit and add to each database. You will use the information you add to complete your upcoming Practice Exercises and Quizzes. Accurate and complete data entry now will ensure success later in your course!

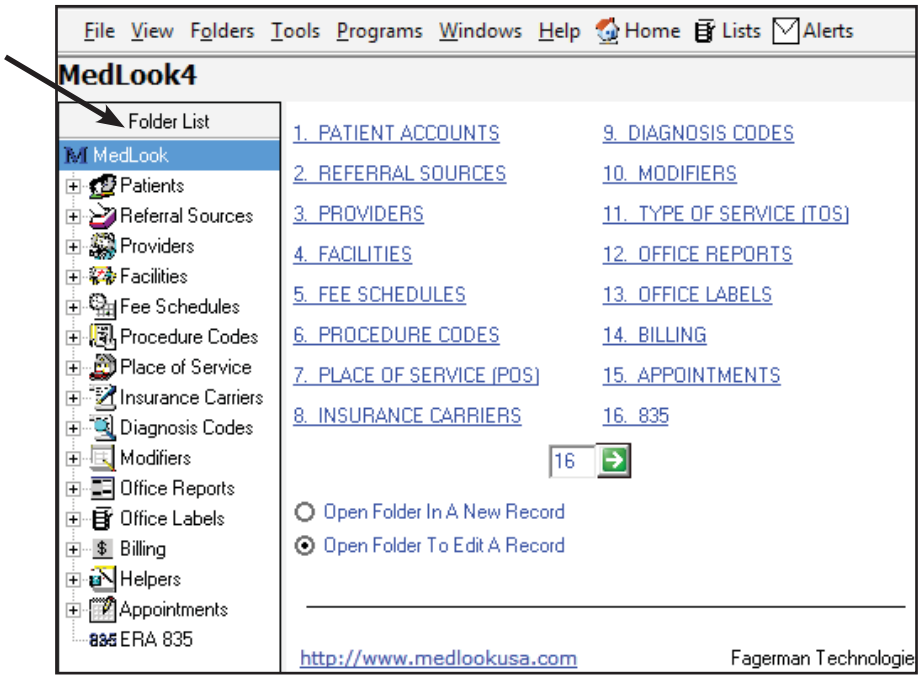
There are three ways to access the database you'd like to use:

1. From the MedLook home page, simply click the link for the specific database you need.

2. Click on *Folders* in the tool bar to display the choices, and then select the specific database you need.



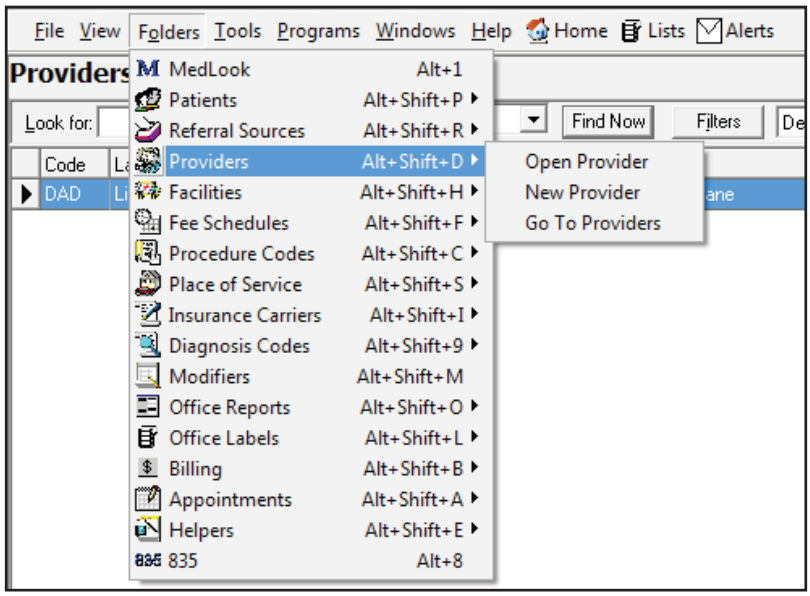
3. Click on *Lists* in the tool bar, which creates a *Folder List* on the left side of the screen. Double click *MedLook* to expand the list and display choices, and then select the specific database you need. To close this view, click on *Lists* again.



Using the home page or *Lists* function allows you to access the current data. To add information, you'll use *Folders* in the tool bar. In this course, you'll often be directed to the *Folders* function. However, as you work more with the billing software, you'll find the system that works best for you.

Provider

The *Providers Table* contains information regarding the physician who provides services. To access the current table, click *Folders*, *Providers* and then decide if you want the option for *Open Provider*, *New Provider* or *Go To Providers*.



If you click on *Go To Providers*, you will open the current *Providers Table*. To open and edit an already existing provider, double click on the name of the desired physician. Doing so will open the window that contains this physician's information; you can then edit the information. (Be sure to click *Save* before you exit the window to save any edits that you make.)

Hands-on Activity

Let's add a physician. Click on *Folders, Providers* and then *New Provider* to add a new physician to the database. At this time, you will add a single practitioner. In a moment, you'll learn how to add a provider that works for a multi-provider practice.

Here is the information you'll need:

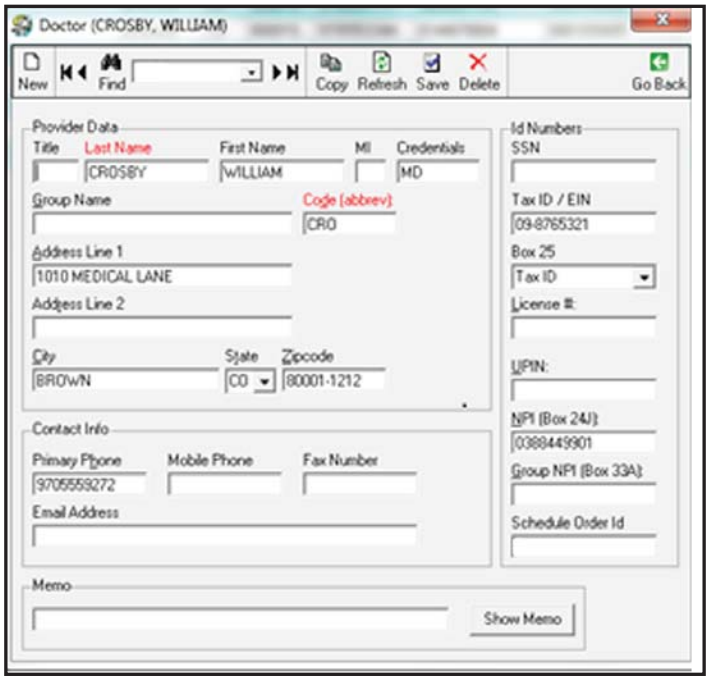
Physician Name: William Crosby, MD
Address: 1010 Medical Lane, Brown CO 80001-1212
Primary Phone: (970) 555-9272
EIN: 09-8765321
NPI: 03-88449901

> To select the state, you can click the arrow and then scroll down until you find the correct state, or type the first letter of the state you need until the correct state appears. For instance, you push the "C" button twice for Colorado. If you enter "CO," you'll see "OH" for Ohio appears.

As you are aware, both Social Security numbers and employer identification numbers have nine digits. SSNs have three numbers, two numbers and four numbers, each separated by a hyphen, while EINs have two numbers and then seven numbers, separated by a hyphen. If you do not include a hyphen in the data entry, MedLook will default to the EIN. Therefore, you will need to use hyphens when you enter the SSN; otherwise, MedLook will always list the number as an EIN.

When entering the NPI, you will not include the hyphen.

Here is how the information should appear on your screen:



Note that MedLook populates the *Code (Abbrev)* once you've entered the provider's last name. You'll learn about the significance of this code later in the course. In addition, you'll list the NPI in *NPI (Box 24J)*, because this entry is for a single provider—not a group practice.

Does your window look the same? If so, click *Save* at the top to save it to the database. If not, make the necessary corrections and then click *Save*. Finally, click *Go Back* in the upper, right-hand corner to close the window. Your *Providers Table* is now updated for Dr. Crosby!

Hands-on Activity

Now, let's walk through the process of adding a provider who works in a multi-provider practice, such as Kenneth Miles, MD. The name of the practice, Family Care, is entered as the *Group Name*.

You will need the following information:

Physician Name: Kenneth Miles, MD
Group Name: Family Care
Address: 1800 Circle Court, Brown, CO 80001-9898
Primary Phone: (970) 555-3344
EIN: 66-6870600
Group NPI: 08-81099885
NPI: 02-67679942

Here is how the information should appear on your screen:

Doctor (MILES, KENNETH)

New | Find | Copy | Refresh | Save | Delete | Go Back

Provider Data
Title | Last Name: MILES | First Name: KENNETH | MI | Credentials: MD
Group Name: FAMILY CARE | Code (abbrev): MIL
Address Line 1: 1800 CIRCLE COURT
Address Line 2:
City: BROWN | State: CO | Zipcode: 80001-9898

Contact Info
Primary Phone: 9705553344 | Mobile Phone: | Fax Number:
Email Address:

Id Numbers
SSN:
Tax ID / EIN: 66-6870600
Box 25: Tax ID
License #:
UPIN:
NPI (Box 24J): 0267679942
Group NPI (Box 33A): 0881099885
Schedule Order Id:

Memo
Show Memo

Does your window look the same? If so, click *Save* at the top to save it to the database. If not, make the necessary corrections and then click *Save*. Finally, click *Go Back* in the upper, right-hand corner to close the window. By entering the group name, the practice name will appear in field 33, while the provider's name appears in field 31 and the provider's NPI in field 24J.

Facilities

Recall that field 32 of the CMS-1500 claim form lists the facility location if the services were provided in a hospital, clinic, laboratory or facility other than the patient's home or physician's office, and if the facility has a separate NPI from the billing provider. You might use this field when a physician has his own practice, but meets a patient in the emergency department or provides services in the hospital.

However, some insurance carriers require you to complete this box even when the services *were* provided at the physician's office. For this course, you will follow the NUCC guidelines and leave the field blank, unless the facility has a separate NPI from the billing provider. Be sure to check with the insurance company when you are working in the field.

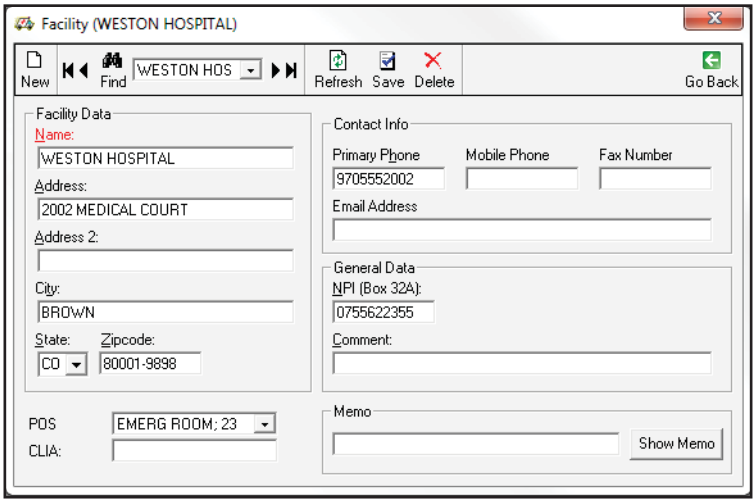
In addition, be sure to set the place of service to the correct code by clicking the arrow to expand the window, and double clicking on the specified place of service.

Hands-on Activity

Now, click *Folders* and then *Facilities*. Again, you'll see the options are *Open Facility*, *New Facility* or *Go To Facilities*. You will select *New Facility* to enter the following information:

Name: Weston Hospital
Address: 2002 Medical Court, Brown CO 80001-9898
POS: Emergency Room (23)
Phone: (970) 555-2002
NPI: 07-55622355

This information should appear the same as follows on your screen:

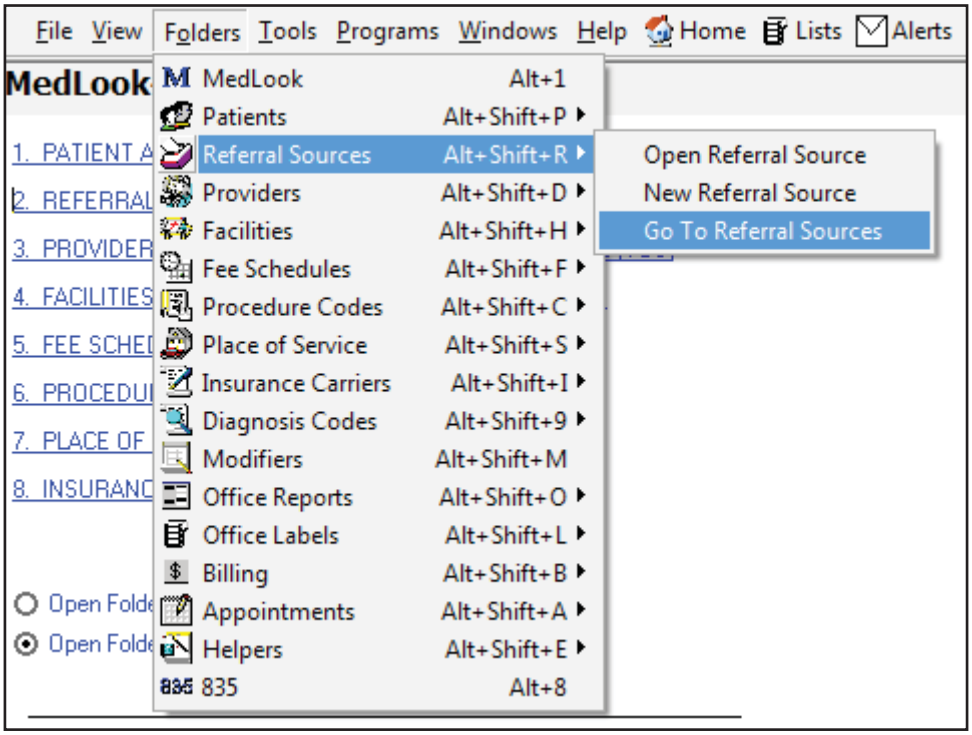


Does your window look the same? If so, click *Save* at the top to save it to the database. If not, make the necessary corrections and then click *Save*. Finally, click *Go Back* in the upper, right-hand corner to close the window. Your *Facilities* database is now updated.

If you click *Folders, Facilities*, *Go To Facilities*, you will open the current *Facilities Table*. To open and edit an already existing facility, double click on the name of the desired facility. Doing so will open the folder that contains this facility's information. Then, you can edit the information. (Be sure to click *Save* before you exit the window to save any edits that you make!)

Referral Sources

When one provider recommends that a patient see another provider for a particular purpose, you will complete the *Referral Source*. The *Referral Source* completes fields 17 and 17a on the CMS-1500 claim form.



Click *Folders* and then *Referral Sources*. Again, you'll see the options are *Open Referral Source*, *New Referral Source* or *Go To Referral Sources*. MedLook does not offer an area for credentials. As you'll recall from your previous lesson, the CMS-1500 form requires that you enter credentials; therefore, you'll enter the provider's credentials right after the last name.

Hands-on Activity

Now, let's add to the database by entering a referring provider. You will select *New Referral Source* to enter the following information:

Referring Provider: Christine Jones, MD
1414 Swallow Street
Brown, CO 80001-9898
(970) 555-1514
NPI: 02-03048901
Provider type: Referring Provider (DN)

Here is how the information should appear on your screen:

Referral (CHRISTINE JONES MD)

New | Find | Refresh | Save | Delete | Go Back

Referral Data
Last Name: JONES MD
First Name: CHRISTINE
MI:
Address: 1414 SWALLOW STREET
City: BROWN
State: CO
Zip Code: 80001-9898

General Data
ID # (Box 17A)
NPI (Box 17B): 0203048901
Cross Reference:
Provider Type: Referring Provider (DN

Contact Info
Primary Phone: 9705551514
Mobile Phone
Fax Number
Email Address

Memo
Show Memo

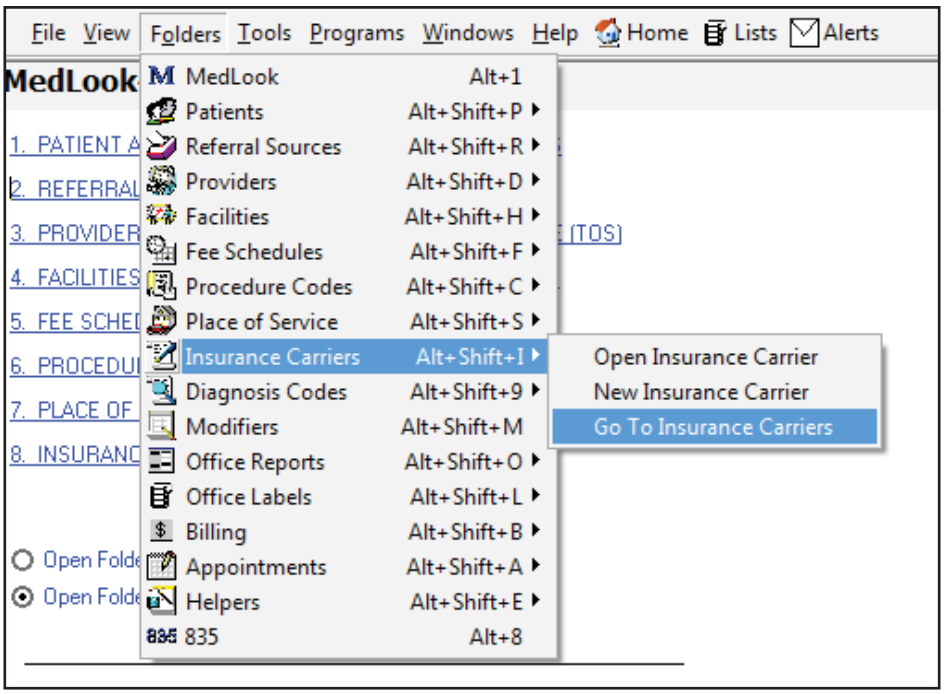
Specialty

Does your window look the same? If so, click *Save* at the top to save it to the database. If not, make the necessary corrections and then click *Save*. Finally, click *Go Back* in the upper, right-hand corner to close the window. Your *Referral Sources Table* is now updated.

If you click *Folders, Referral Sources*, *Go To Referral Sources*, you will open the current *Referral Sources Table*. To open and edit an existing referral source, double click on the name of the desired physician. Doing so will open the folder that contains this physician's information; you can then edit the information. (Be sure to click *Save* before you exit the window to save any edits that you make.)

Insurance Carriers

The *Insurance Carriers Table* contains all information regarding the different insurance coverage. To view the preloaded insurance carriers, click *Folders*, and then *Insurance Carriers*. Again, you'll see the options are *Open Insurance Carrier*, *New Insurance Carrier* or *Go To Insurance Carriers*.



If you click *Go To Insurance Carriers*, you will open the current *Insurance Carriers Table*. A master list of all insurance companies entered into the program will display. As you add insurance carriers, MedLook assigns a *Serial #* or *Insurance Number* based on chronological order; the user cannot change or add this number. You'll see in the example that Mountain States was the first insurance carrier entered into the system, followed by Medicare, Health Plan Inc. and Medicaid. As you add insurance carriers, MedLook completes the field, and the number may vary. This variance is acceptable. Now, double click on Mountain States to view the carrier and examine the details.

Demographics

In this area, you will find the carrier information. MedLook automatically completes the *Code ID (Abbrev)* when entering a new insurance carrier. This helps to identify the carrier in reports and lists that healthcare professionals use. You can enter the name of a contact person, as well as contact information, in the next box. The contact information is for office use only, and you will not transfer it to the CMS-1500 claim form.

Box 11d

As you explored the CMS-1500, you've learned that if 11d is marked *YES*, you will complete fields 9, 9a and 9d. If 11d is marked *NO*, you will leave fields 9, 9a and 9d blank.

This section in MedLook will allow you to account for exceptions, such as to leave blank for Medicare. The default is to mark *Yes* when there is a secondary carrier. To mark *Yes* for the primary carrier, but *No* for the secondary claim, you'll mark the second option.

Type Settings

In the center, you'll see *Claims Submission Mode.* This field determines if you'll print or send the CMS-1500 electronically when you do batch processing of insurance claims. For this course, you will not do any batch processing, so there is no need to change the setting. However, once you begin working in the field, you'll probably send most claims to file for electronic submission.

It's important to be aware of the *Insurance Type*. The default setting is to *7 Other*, which marks an X in the *Other* box in field 1 of the CMS-1500 claim form. Remember, if there is a group number, it is a group health insurance carrier.

The options for this field are as follows:

1 Medicare
2 Medicaid
3 TRICARE
4 CHAMPVA
5 Group Health
6 FECA
7 Other

The *Insurance Type* selection will affect how MedLook processes fields on claims. Please note that the *8 Medicare* option is rarely used in the field, and you will not use it in this course.

Print to File Name, Defaults and Layout File

These functions allow the healthcare professional to change defaults as needed for a specific practice. However, you won't need to change the setting for this course. When you work in the field, MedLook support will be able to assist you with the process if you find the need to change the defaults.

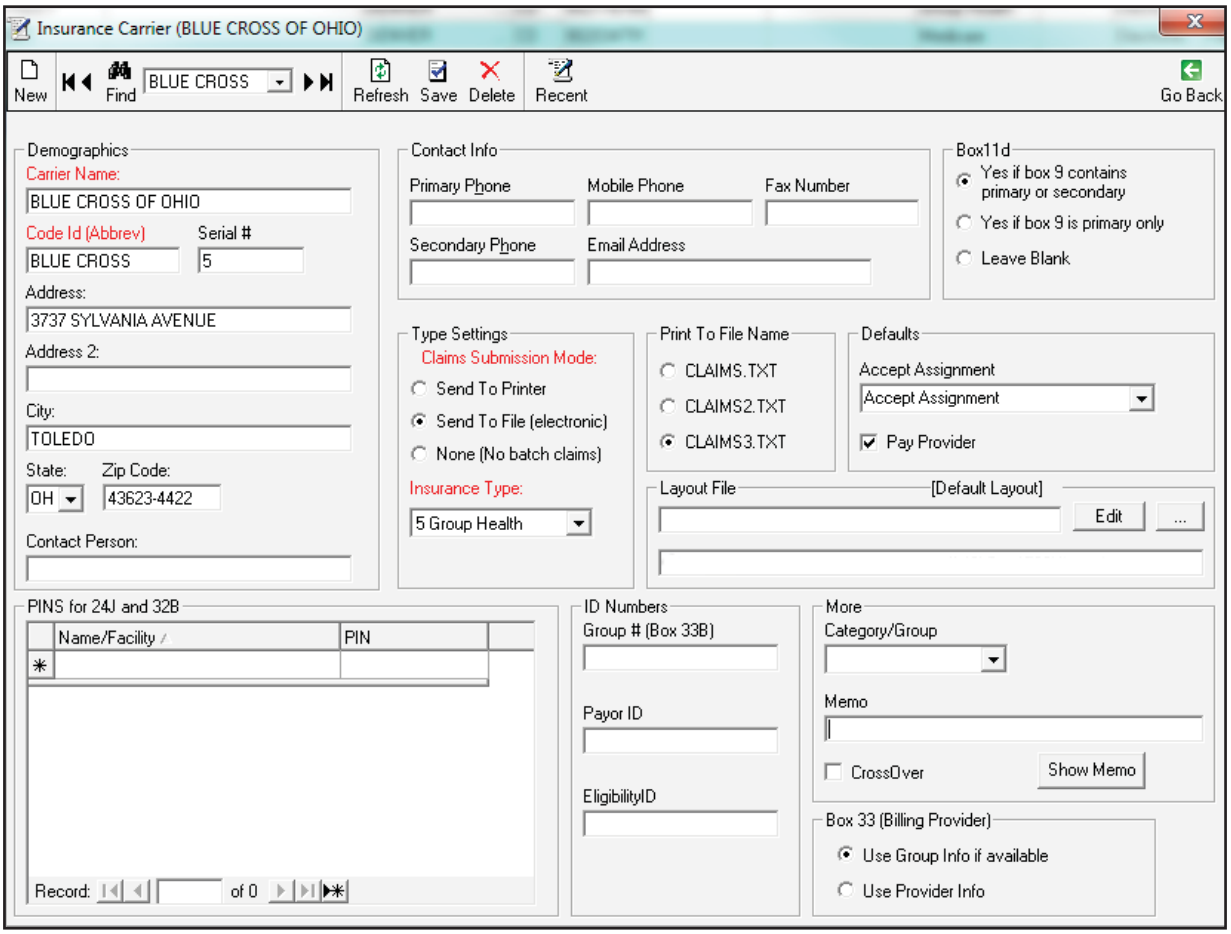
PINS, ID Numbers and More

Previously, you learned about non-NPI ID numbers. MedLook refers to these numbers as PINS. Healthcare professionals have been instructed to use NPIs on all claims, but the PINS section supports legacy PINs that are often required by insurance carriers for both field 24J and 32B. These are carrier specific per facility, group and provider. You may find that older practices still use the legacy PINs, while the newer ones only use the NPI, which is what you'll learn in this course.

Hands-on Activity

Now, you're ready to add a new insurance carrier. You will select *New Insurance Carrier* to enter the following information for a group health plan: Blue Cross of Ohio, 3737 Sylvania Avenue, Toledo OH 43623-4422.

Here is how the information should appear on your screen:

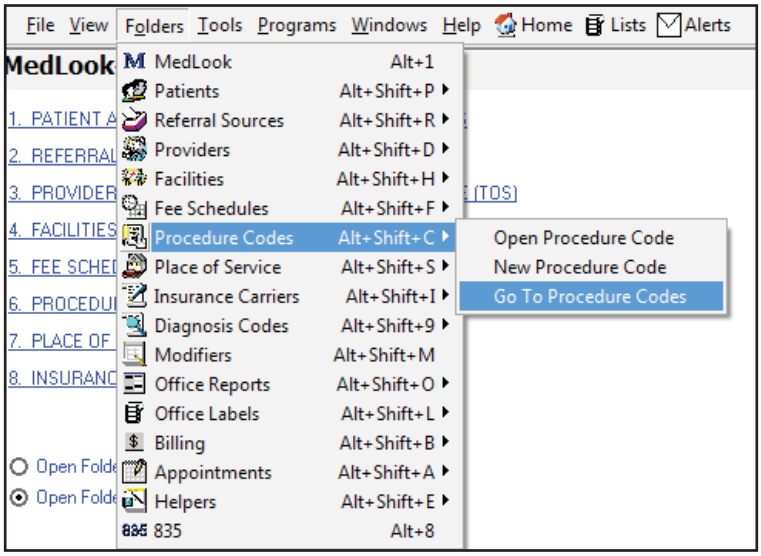


Does your window look the same? Check the *Insurance Type* to verify you've changed it to 5 *Group Health*. Please note that *Print to File Name* appears as *File1*, *File2* and *File3* until you click *Save*. Click *Save* at the top to save it to the database. Finally, click *Go Back* in the upper, right-hand corner to close the window. Your *Insurance Carriers Table* is now updated.

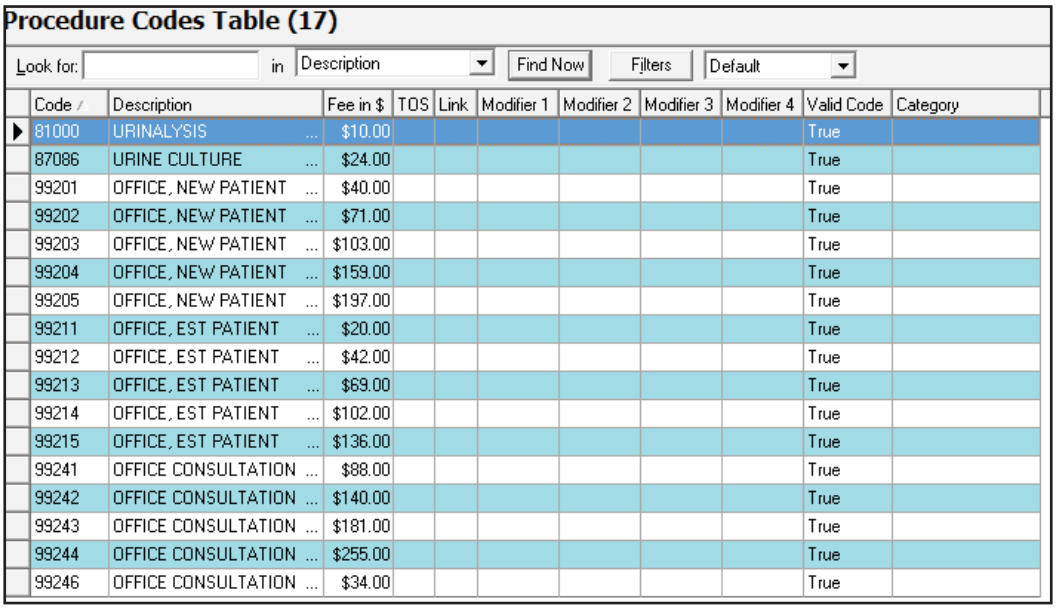
To open and edit an existing insurance carrier, double click on the name of the desired insurance carrier. Doing so will open the folder that contains this insurance information; you can then edit the information. (Be sure to click *Save* before you exit the window to save any edits that you make.)

Procedure Codes

The procedure codes database contains information on procedure codes, including the *Procedure Codes Table, With Fee Schedule, Financials* and *Payments*.



Click *Folders* and then *Procedure Codes*. Again, you'll see the options are *Open Procedure Code*, *New Procedure Code* or *Go To Procedure Codes*. If you click *Go To Procedure Codes*, you will open the *Procedure Codes Table*.



Procedure Codes Table (17)

Look for: in Description Find Now Filters Default

Code	Description	Fee in $	TOS	Link	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Valid Code	Category
81000	URINALYSIS	$10.00							True	
87086	URINE CULTURE	$24.00							True	
99201	OFFICE, NEW PATIENT	$40.00							True	
99202	OFFICE, NEW PATIENT	$71.00							True	
99203	OFFICE, NEW PATIENT	$103.00							True	
99204	OFFICE, NEW PATIENT	$159.00							True	
99205	OFFICE, NEW PATIENT	$197.00							True	
99211	OFFICE, EST PATIENT	$20.00							True	
99212	OFFICE, EST PATIENT	$42.00							True	
99213	OFFICE, EST PATIENT	$69.00							True	
99214	OFFICE, EST PATIENT	$102.00							True	
99215	OFFICE, EST PATIENT	$136.00							True	
99241	OFFICE CONSULTATION	$88.00							True	
99242	OFFICE CONSULTATION	$140.00							True	
99243	OFFICE CONSULTATION	$181.00							True	
99244	OFFICE CONSULTATION	$255.00							True	
99246	OFFICE CONSULTATION	$34.00							True	

IMPORTANT NOTE: If the *Procedure Codes Table* doesn't appear, click *Lists*, and then click the box beside *Procedure Codes* to open the options. Click *Procedure Codes Table* to open the table. Close the folder list by clicking on *Lists* again. Now, click *Folders*, *Procedure Codes*, *Go To Procedure Codes*, and the table should appear.

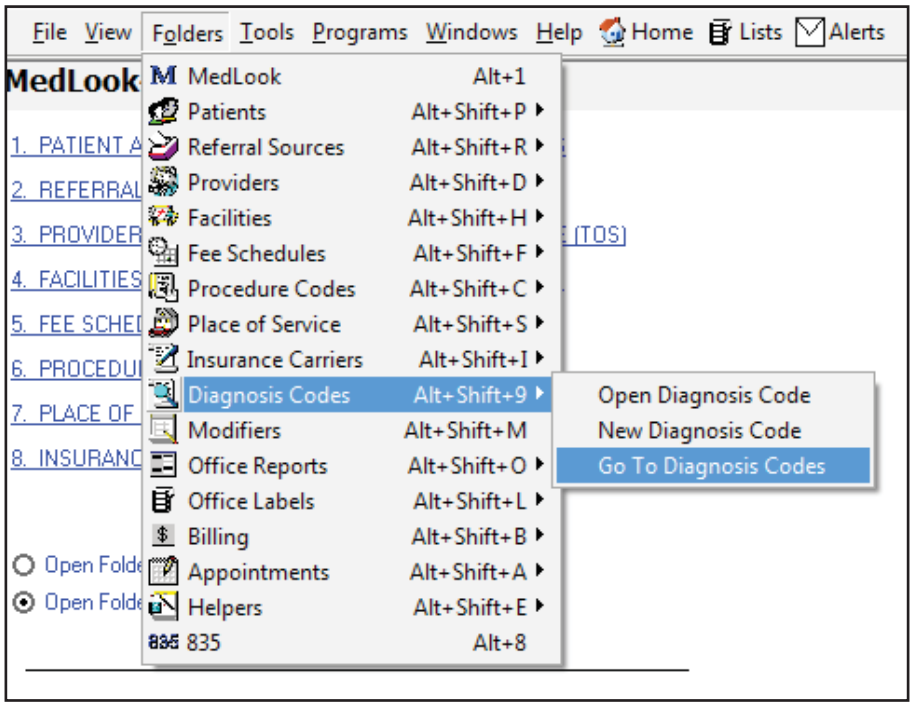
If you have one database for multiple practices, such as the database you're using for this course, you may find one CPT code with different charges. For instance, Dr. Miles may charge $40 for code 99201, while Dr. North charges $37 for the same CPT code. You can either add a separate CPT code to the table, or edit the amount for the code.

To open and edit an existing procedure code, double click on the code. Doing so will open the folder that contains the code information; you can then edit the information. (Be sure to click *Save* before you exit the window to save any edits that you make.)

You will enter more procedure codes to the database in a moment, but first, let's look at diagnosis codes.

Diagnosis Codes

As you would guess, the *Diagnosis Codes* database contains information on diagnosis codes. Click *Folders* and then *Diagnosis Codes*. Again, you'll see the options are *Open Diagnosis Code*, *New Diagnosis Code* or *Go To Diagnosis Codes*. If you click *Go To Diagnosis Codes*, you will open the current list of diagnoses.



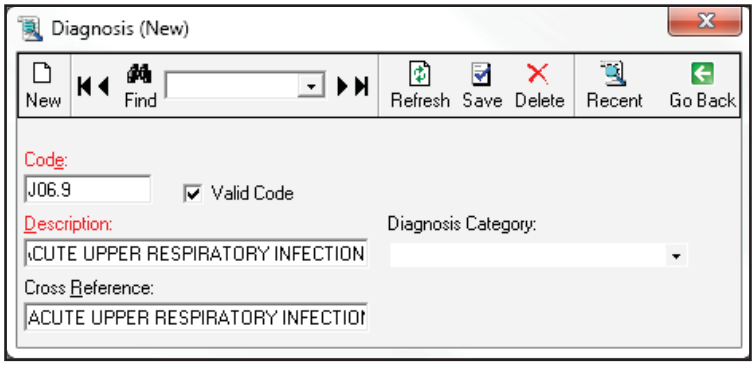
To open and edit an already existing code, double click on the code. Doing so will open the folder that contains the code information; you can then edit the information. (Be sure to click *Save* before you exit the window to save any edits that you make.)

Hands-on Activity

Select *New Diagnosis Code* to enter the following information:

J06.9 Acute upper respiratory infection

Here is how the information should appear on your screen:



Do you see the box below *Diagnosis Category*? If you click the arrow, you'll see groupings to which the diagnosis relates. For instance, code *J06.9* for an acute upper respiratory infection belongs to *Diseases of the respiratory system*. You could select a category, or simply leave this field blank. The purpose of assigning a category is to assist in creating reports for auditing purposes. However, it is not necessary to determine the diagnosis category in this course.

Does your window look the same? If so, click *Save* at the top to save it to the database. If not, make the necessary corrections, and then click *Save*. Finally, click *Go Back* in the upper, right-hand corner to close the window. Your *Diagnosis Code Table* is now updated.

Deleting

Mistakes do happen, and sometimes, you'll need to delete what you've done. To delete a provider, referring physician, insurance carrier, diagnosis or procedure code, you will first open the table. Then, highlight the specific information you want to delete and right click. You will select *Delete*. A box appears to verify that you'd like to delete the selected record. If you want to remove it from your database, click *Yes*. Then, another box appears to make certain you know what you're doing. Click *Yes* again.

One final note: the default option lists the databases as they are entered. However, you can change this order by clicking the top of the database and listing it alphabetically. This may make it easier to locate information when you are using the database later in the course.

At this point, you have covered quite a bit of ground with MedLook! You've had an overview of the many databases found within the billing software. You are able to view, edit and add providers, facilities and referring providers, as well as procedure and diagnosis codes. Now, let's pause to add to the sample database, so that when it's time to create the claims, all necessary information is already there for you.

Step 8: Practice Exercise 21-2

Using MedLook, enter the following information into the *Providers Table*.

1. Christine Jones, MD
   1414 Swallow Street
   Brown, CO 80001-9898
   970-555-1514
   EIN: 33-0457789
   NPI: 02-03048901

2. David Mills, MD
   Family Care
   1800 Circle Court
   Brown, CO 80001-9898
   970-555-3344
   EIN: 66-6870600
   Group NPI: 08-81099885
   NPI: 08-10998051

3. Roger Small, MD
   Family Care
   1800 Circle Court
   Brown, CO 80001-9898
   970-555-3344
   EIN: 66-6870600
   Group NPI: 08-81099885
   NPI: 01-44878804

Using MedLook, enter the following group health insurance carriers into the *Insurance Carriers Table*. Be sure to change the *Insurance Type*!

4. Blue Cross of Wyoming
   PO Box 465
   Casper WY 82002-0456

5. CIGNA
   1212 Drake
   Cleveland OH 44102-1912

6. Country Group Life
   PO Box 37
   Toledo OH 43623-0037

7. MedLink
   PO Box 560
   Brown CO 80001-0560

Using MedLook, enter the following procedure codes and fees into the *Procedure Code Table*.

8.	73610	Ankle x-ray, complete	$54
9.	99281	Emergency department	$68
10.	99282	Emergency department	$92
11.	99283	Emergency department	$125
12.	99284	Emergency department	$205
13.	99285	Emergency department	$269

Using MedLook, enter the following diagnosis codes and fees into the *Diagnosis Code Table*.

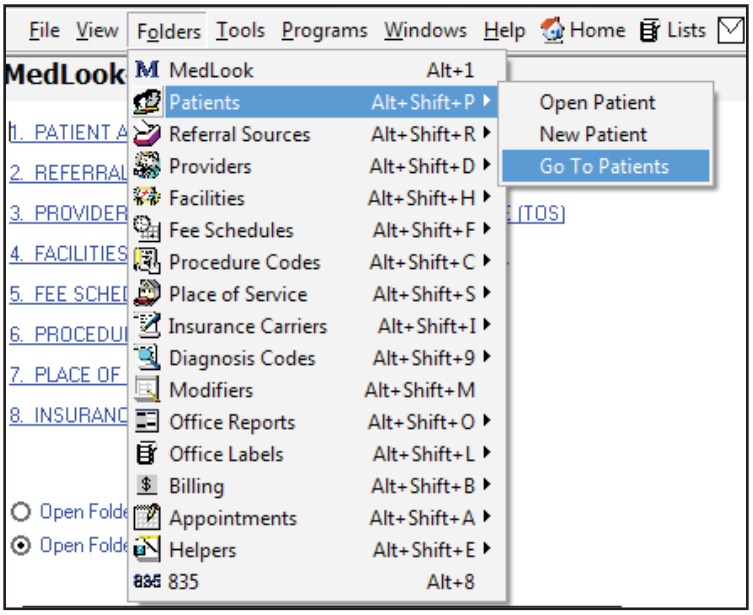
14.	M75.51	Bursitis, right shoulder
15.	S93.421A	Sprain, deltoid ligament, right
16.	W01.0XXA	Tripped over animal
17.	H61.22	Ear wax, left ear
18.	J42	Chronic bronchitis NOS

Step 9: Review Practice Exercise 21-2

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 10: Patient Accounts

The database you'll use most often is *Patient Accounts*. This is the database where you'll add new patients, edit existing patients, enter charges, apply payments and create bills. Let's begin with a patient in the sample database as you learn the details.



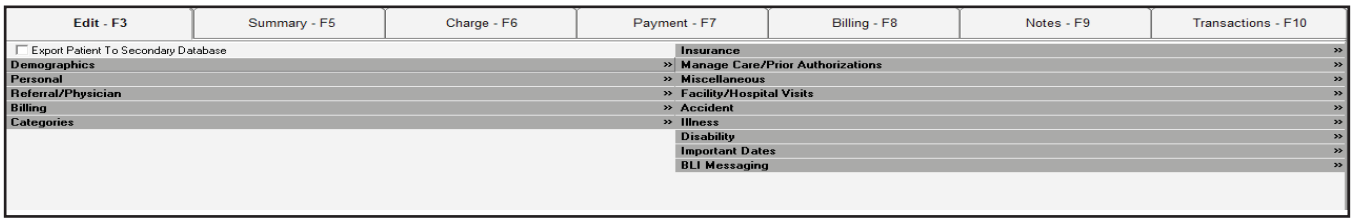
Click *Folders*, *Patients*, and then *Go To Patients* to open the list of all patients. You can change the order of patients, listing them alphabetically by last name, by clicking on the gray *Last Name* bar. It may be easier to locate patients this way. Now, double click on Steven Gibbs to review the contents of the *Patient Account*. You will notice tabs across the top of the page as shown.

Edit—F3	Edit patient information
Summary—F5	A glimpse of the patient's account status
Charge—F6	Enter diagnosis and procedures codes
Payment—F7	Post payments to services
Billing—F8	View and submit claims
Notes—F9	Documentation pertaining to the patient
Transactions—F10	Quick list of all debits and credits

Next, you'll have the chance to explore the *Edit*, *Summary*, *Charge* and *Billing* tabs.

Patient Account—Edit

The *Edit* tab has sections that will collapse by clicking the arrows to the right. These sections include demographics, personal, referral/physician, billing, categories, insurance, managed care/prior authorizations, miscellaneous, facility/hospital visits, accident, illness, disability, important dates and messaging. The following shows the entire *Patient Account* database, with the sections collapsed.



Now, you will learn about sections, and the necessary fields to complete, as you add a new patient to the database. Click *Folders, Patients* and then *New Patient* to open the window for the new patient information.

Each section includes various fields. You will not complete all fields within each section for every claim. It is not necessary to complete all sections. In fact, the demographic, referral/physician, insurance sections and managed care/prior authorization are the primary focus of the *Edit* tab for this course. You will learn how the sections and fields relate to the CMS-1500 form, and when it is necessary to complete the fields and sections.

Demographics

As previously mentioned, the *Demographics* section is one of the primary sections that you will complete in this tab. Let's briefly review the fields you'll find here.

MedLook assigns the *Account Number* and *Chart Number*, which are dependent on the number of patients entered. You'll see in the examples and keys that field 26 shows XXXX for the account number. This indicates that the number will vary and that this variance is acceptable.

When entering a new patient, you'll enter the *Last Name*, *First Name* and middle initial (*MI*), when these are provided. To select the *Title*, you'll click the arrow to expand the field, and then click on the appropriate title. Alternatively, you can skip this area to leave the title blank. You'll complete the mailing address, along with the *City*, *State* (abbreviation) and *Zip Code*.

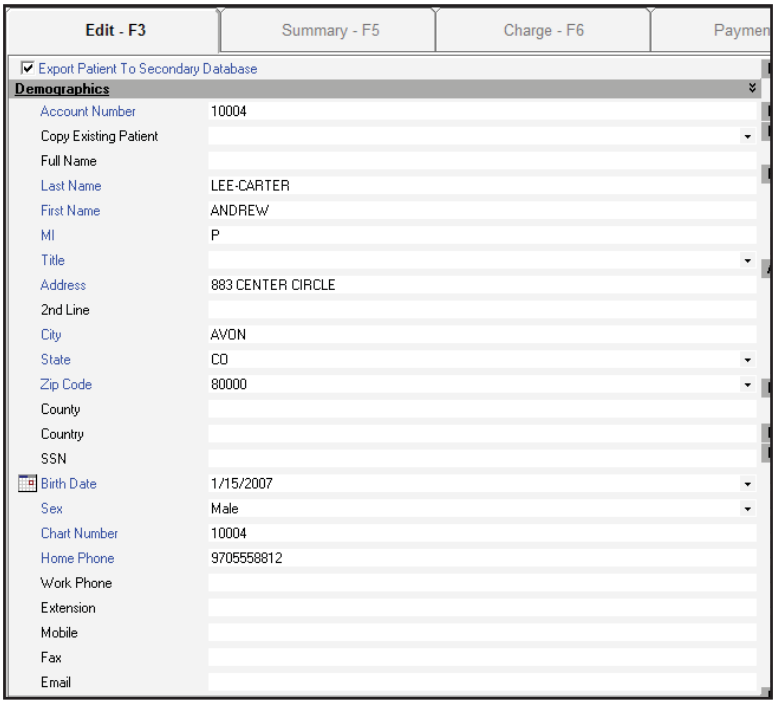
The *County*, *Country* and *SSN* fields are optional, and you will not complete them in this course. Next, you'll enter the patient's birth date, using the XX/XX/XXXX format, and edit the sex of the patient. You can either use the drop-down box to select the patient's sex, or simply type "*m*" or "*f*" for the field to populate. The NUCC does not require a phone number, but if one is provided, you'll enter the home phone number next. You can type all 10 digits without hyphens or parentheses, and the software will format the phone number after you click *Save*. The other fields in the *Demographics* section are not required.

Hands-on Activity

Enter the following information:

Patient: Andrew Paul Lee-Carter
Address: 883 Center Circle, Avon CO 80000
Phone: 970-555-8812
DOB: January 15, 2007
Sex: Male

The information should appear the same as follows on your screen:



Does your demographic look like the one above? If so, you're ready to move on to the next step. First, go ahead and click *Save* so you don't lose what you have entered so far. You'll continue to edit this patient record as you learn more about the different sections.

The *Personal* section is for additional information relating to the patient that the office may obtain and record. It is not necessary for the claims or reimbursement process, so you can skip this section.

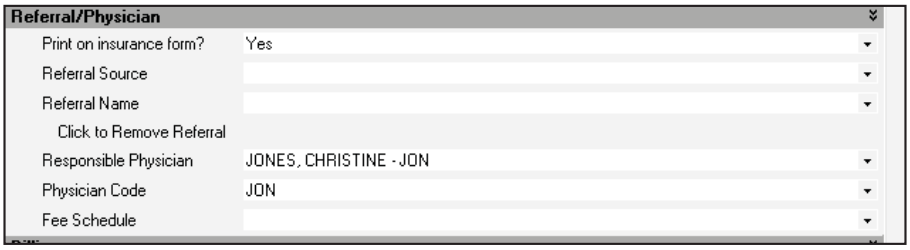
Referral/Physician

This section identifies the referring provider, if any, as well as the responsible physician. The referral source and referral name areas will list the same provider. The difference is in the format of the information. If you click *Referral Source*, the *Referral Sources Table* appears. Meanwhile, if you click *Referral Name*, you'll simply get a drop-down box with the names that appear in your table. You see that it is the same information, just with different ways to access it. If a name is listed and there shouldn't be a referral for the patient, you'll just *Click to Remove Referral* and the area will then appear blank.

With MedLook, each time you set up a new patient, you must assign a responsible physician. To assign the responsible physician, you can either click the arrow to open the entire physician list, or simply type in the *Physician Code*. You can speed the pace of data entry by typing the physician code, rather than moving your hand over to the mouse to point and click to the provider. Either method provides the same results.

When entering the charge, you'll have the opportunity to change the responsible physician. However, the default will always be the provider listed in this section. You'll learn more about this when you learn about the *Charge* tab.

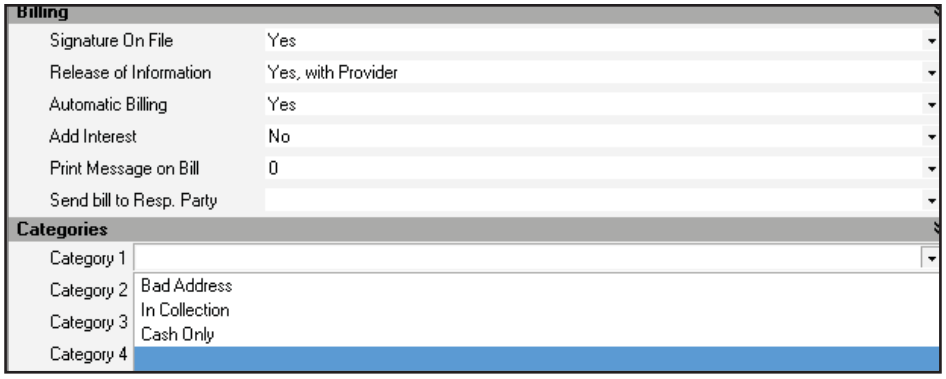
Now, let's go back to Andrew Lee-Carter and edit this section. There is no referral source, so select *Click to Remove Referral*, and then select Christine Jones, MD as the responsible physician. Your screen should look like the following:



If your screen looks like the one shown above, be sure to click *Save*, and then you'll be ready to move on to the next sections. Please note that when you select the responsible physician, the *Physician Code* appears after the physician's name. However, the *Physician Code* will disappear if you close and reopen the *Edit* tab.

Billing and Categories

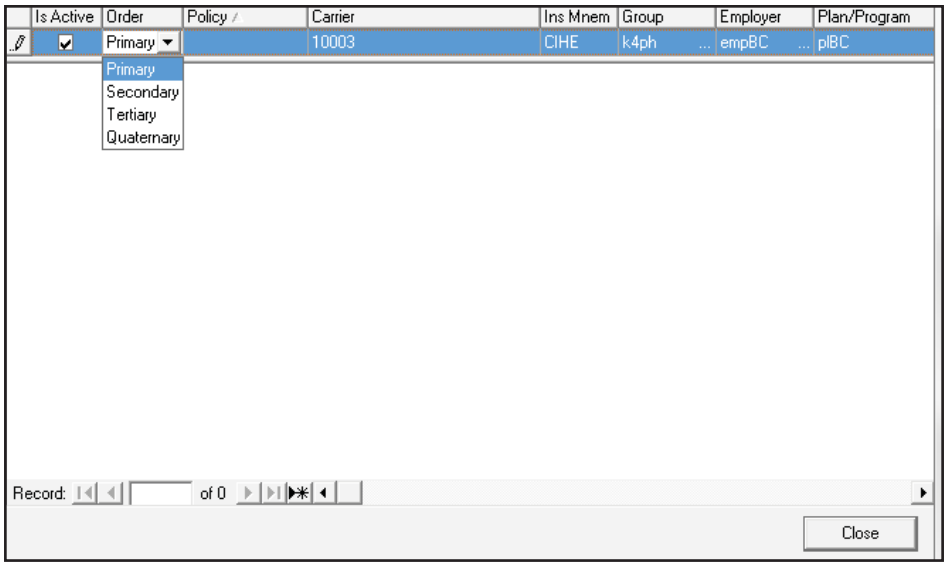
The *Billing* section tracks whether you have the signature and release of information on file, which relates to field 12 on the CMS-1500 form. You can also select *Automatic Billing* and *Add Interest*. You can edit or create messages to add to the bill, and then send the bill to the responsible party. In most cases, and in this course, you'll just leave this section as the default settings.



The *Categories* section is a feature that you might use in the billing field to flag an account with a bad address or one that is in collections. However, you won't use this function in your course.

Insurance

Besides the *Demographics* section, the *Insurance* section is the most frequent area that you will complete in this tab. Under the *Insurance* section, you'll find *Click to Manage Policies*; click that now to open the insurance window.

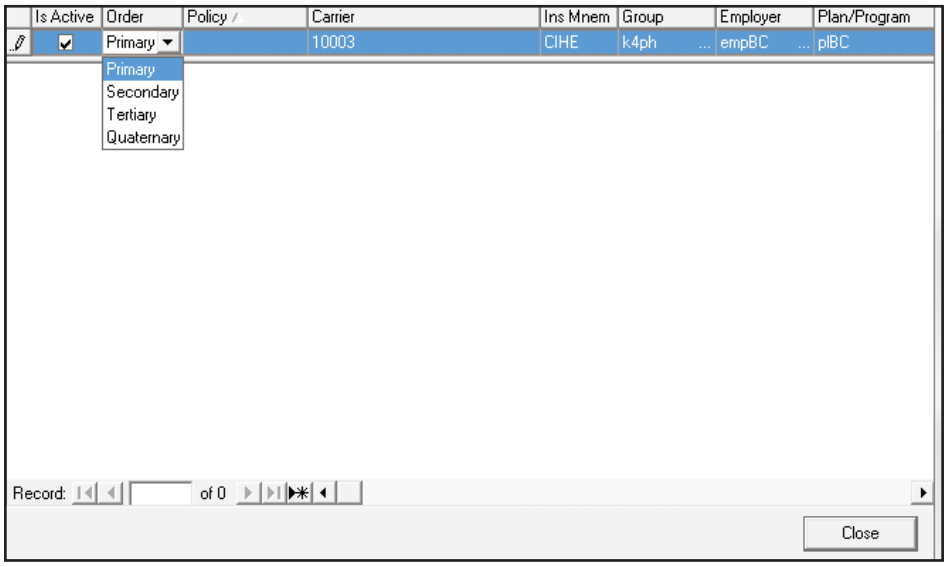


This window may appear small, but you will find quite a lot of information within it! You'll need to keep scrolling to the right to review all of the fields. The blue area is the data entry area. Click in the blue to review the following fields.

Order	Click arrow to expand box to select the carrier: *Primary*, *Secondary*, *Tertiary* or *Quaternary*
Policy	Tab to area to enter in policy number for the carrier
Carrier	Click arrow to expand box to select the carrier
Ins Mnem	Automatically filled by MedLook when carrier is selected
Group	Tab to area to enter in group number for the carrier
Employer	Leave blank—not necessary to complete
Plan/Program	Relates to field 11c; enter program name
Accept	Click arrow to expand box: *Accept Assignment; Yes for Labs only; Not Assigned; Refuses Assignment*
Pay	Relates to field 13; indicate if payment should be sent to the provider by selecting *Yes* or *No*
Copay	Enter in the copayment amount, if known
Percent	Enter in the percentage of payment, if known
Deductible	Enter the deductible amount, if known
Start Date	Enter the date insurance coverage starts, if known
Ending Date	Enter the date insurance coverage ends, if known
Box 10d	Leave blank
Box 19	Leave blank
Medicare Plus2	Identifies the secondary carrier when Medicare is primary: select *None, Medigap, Employer retiree coverage* or *Medicaid*. Leave this field at the default of *None* unless Medicare is primary.
Insured Relation	Relates to field 6; either click arrow to expand the box to select the correct relation, or simply type the first letter of the choices: *Self, Spouse, Child, Other*
Sex	Indicate sex of the insured for this carrier; either click the arrow to expand the box to select the correct sex, or simply type the first letter of the choice: *Male, Female*
DOB	Defaults to the patient's DOB; change the date of the insured for this carrier, if necessary, in the XX/XX/XXXX format
Phone	Defaults to the patient's phone number; change if necessary
Ins First	Defaults to the patient's first name; change if necessary
Ins MI	Defaults to the patient's middle initial; change if necessary
Ins Last	Defaults to the patient's last name; change if necessary
Address 1/2	Defaults to the patient's address; change if necessary
Zip/City/State	Defaults to the patient's address; change if necessary

Hands-on Activity

Now, let's build on your patient account by adding insurance for Andrew. Under *Order*, you'll find *Primary*, *Secondary*, *Tertiary* and *Quaternary*. Click on *Primary*.



You'll use the blue data entry area to edit or add information. Simply click the blue area and it will turn white. At that time you can enter the necessary information or use the drop down box to select information.

You'll need the following information for the primary carrier:

Carrier: Blue Cross of Wyoming
Policy: 630A
Group: BM
Accept: Accept Assignment
Pay: Yes
Copay: 20.00
Insured: Mark K. Carter
Insured Relation: Child
Sex: Male
DOB: 07/06/1978
Address: Same as patient
Phone: Same as patient

Once you have entered all of this information, press "*enter*" to save the insurance. You'll see that the first line is blue and the second is white. If you need to change the primary information, click down to the white area to edit, and then press "*enter*" to save the information. To add another insurance carrier, use the data entry area which is at the top in the dark blue. Enter the following in the data entry area to add Andrew's secondary carrier:

Carrier: CIGNA
Policy: 1191031
Group: 488C
Accept: Accept Assignment
Pay: Yes
Copay: 10.00
Insured: Cecelia Lee
Insured Relation: Child
Sex: Female
DOB: 10/09/1980
Address: Same as patient
Phone: Same as patient

Once you have entered all of this, press "*enter*" to save the insurance information. As you scroll to the right, does your screen have the same information as the following? The top data entry area may vary and that's okay as long as the next two lines match.

	Is Active	Order	Policy	Carrier	Ins Mnem	Group	Employer	Plan/Program
	☑	Primary	52960	BLUE CROSS OF WYOMING ...	BLUE C...	BM ...	...	BLUE CROSS O...
	☑	Primary	630a ...	BLUE CROSS OF WYOMING ...	BLUE C...	BM ...	...	BLUE CROSS O...
	☑	Secondary	1191031 ...	CIGNA	CIGNA	488C ...	...	CIGNA

	Accept	Pay	Copay	Percent	Deductible	Start Date	Ending Date	Box 10	Box 19	Medicare Plus2	Insured Relation
	Accept Assignment	Yes	$20.00	0	$0.00			...	...	None	Child
	Accept Assignment	Yes	$20.00	0	$0.00			...	...	None	Child
	Accept Assignment	Yes	$10.00	0	$0.00			...	...	None	Child

Sex	DOB	Phone	Ins First	Ins MI	Ins Last	Address1	Address2	Zip	City	State
Male	1/15/2007	9705558812	ANDREW	P	LEE-CARTER	883 CENTER CIR...		80000	AVON	CO
Male	7/6/1978	9705558812	MARK	K	CARTER	883 CENTER CIR...		80000	AVON	CO
Female	10/9/1980	9705558812	CECELIA		LEE	883 CENTER CIR...		80000	AVON	CO

If you need to edit any of the information you entered, you'll change it on this screen, and then press "*enter*" again. Be sure the *Active* box is checked. When you are done, click *Close* in the lower, right-hand corner to close the screen to manage policies. And then click *Save*.

If you happen to add insurance incorrectly, you aren't able to delete the line. However, if you click *Is Active* so there isn't a check in the box, the information won't appear on the *Patient Account*.

Manage Care/Prior Authorization

To open this section, select *Click to Manage Authorizations.* You know that the process of notifying an insurance company before hospitalization, surgery or tests is called preauthorization. To receive payment on a claim, you'll include the prior authorization number you obtained during preauthorization in field 23 of the CMS-1500 form. For claims sent to Medicare, Medicaid and TRICARE, field 23 must be completed with the CLIA number assigned to the office if a lab procedure was performed by that physician's office. Private insurance normally does not require a CLIA number.

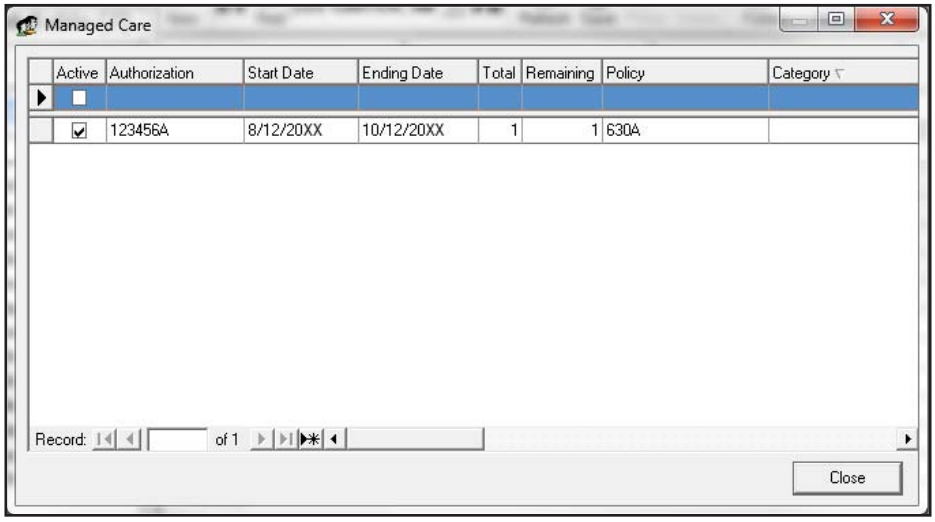
You can either enter the preauthorization or CLIA number here, or do it while you are entering charges. Let's review the process of adding it now; you will take a look at this again later in the lesson, as well.

Hands-on Activity

Let's say that Andrew has preauthorization for a procedure through the primary carrier. First, select *Click to Manage Authorization*, and a *Managed Care* window opens. Enter the following information:

Authorization: 123456A
Start Date: 8/12/20XX
Ending Date: 10/12/20XX
Total: 1
Remaining: 1
Policy: 630A (correlates to primary carrier policy number)
Category: Blank
CPT Codes: Blank

You will enter the current or previous year, rather than 20XX, as that is an invalid year. Be sure to click on the box under *Active*; otherwise, you won't be able to access this information later. Once you have entered all of the necessary information, press "*enter*" to accept. Does your screen look similar to the following?



If your screen does not match what appears here, edit the necessary information and press "*enter*" to save it again. If your screen does match, go ahead and press "*enter*" to save, and then click *Close* at the lower right. Click *Save* to continue. You'll see how this applies to the CMS-1500 form when you enter charges.

Other Sections

You do not need to complete the other sections found within the *Edit* tab. When you enter the charge, you'll have the option to enter admission and discharge dates, accident and illness information and disability dates for each specific charge. Therefore, you'll learn more about these options when you study the process of adding charges to the patient account.

Patient Account—Summary

The Summary tab provides a glimpse of the patient's account status, including insurance, balance and aging. **Aging** is an insurance term that shows how long a payer has taken to respond to an insurance claim; it usually indicates an unpaid claim. Now, if you go to the Summary tab of Andrew's patient account, you'll see that Blue Cross is listed as the primary insurance, and CIGNA is listed as secondary.

New | Find | LEE-CARTER, AN | Refresh | Save | Printer | Delete | Folders | Recent | Options | Alerts | Templates

Edit - F3 | Summary - F5 | Charge - F6

Find | B | I | U | Format | Times New Roman | 10

LEE-CARTER, ANDREW P	**Acct:** 10004, **Sex:** Male	**Primary Insurance** (t: Unknown)
883 CENTER CIRCLE	**DOB:** 1/15/2007 **Age:** X	BLUE CROSS, Assigned, 630a
AVON, CO 80000	**H:** (970)555-8812	PO BOX 465,
SSN:	**W:** Unknown	CASPER, WY 82002-0456
DOL Bill: Charge: Payment:		**Copay:** $20.00 (or **%Copay:** $0.00)
Phys: JON	**Status:** True	**Note:**
Marital Status:		**Referral:**
Auto Billing: On	**Recall Date:**	**ICD9s:**

Balance Summary

Primary Insurance:	0.00	**Patient:**	0.00	**Charges/Debits:**	0.00
Secondary Insurance:	0.00	**Other:**	0.00	**Payments/Credits:**	0.00

Aging	**0-30**	**31-60**	**61-90**	**91-120**	**120+**	**Unassigned**	**Total**
PatAging	0.00	0.00	0.00	0.00	0.00		0.00
InsAging	0.00	0.00	0.00	0.00	0.00		0.00
Balance	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Unposted	**Charges**	**Payments**	**Credits**	**Debits**	
Totals:	0.00	0.00	0.00		

Responsible Party	**Scheduled Appointments**	**Secondary Insurance** (t: Unknown)
		CIGNA, Assigned, 1191031
		1212 DRAKE,
		CLEVELAND, OH 44102-1912
		Managed Care
		From to 8/12/20XX to 10/12/20XX
		Visits of 1 of 1
		Code 123456A

You can print the summary, or use it for cut-and-paste operations. Its purpose is to provide some basic information about the patient that you can quickly review without having to actually edit the account, produce a bill or generate an aging report of the account balance.

Now, it's time to pause and add to your sample database. Again, accuracy and completeness are essential! You will use the information you add here to complete Practice Exercises and Quizzes later in the course.

Step 11: Practice Exercise 21-3

Using MedLook, add the following information to the *Patient Account*.

1. **Kristen Arnold**

FAMILY CARE
1800 Circle Court
Brown, CO 80001-9898
(970) 555-3344

___ Kenneth Miles, MD **NPI:** 02-67679942
_X_ David Mills, MD **NPI:** 08-10998051
___ Roger Small, MD **NPI:** 01-44878804
Group NPI: 08-81099885

☑ 11 Physician Office
☐ 12 Private Residence
☐ 22 Outpatient Hospital
☐ 23 Hospital Emergency Room
Participating Provider ☑Y ☐N

Physician signature: David Mills, MD
EIN 66-6870600

Patient Information

Name Kristen Ann Arnold
Address 3519 Habit Road
City Yampa **State** CO
ZIP 80004
Home Phone 970-555-8838
Date of Birth April 7, 2011
Sex F

Insurance Information

Primary Insurance
Name Blue Cross of Ohio
ID# 811924
Group# J620
Address 3737 Sylvania Avenue
City Toledo
State OH **ZIP** 43623-4422
Primary Insured Name Barbara Jane Arnold
Relation to Patient Mother
DOB/Sex 01-10-1989 Female
Address/phone Same as patient

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Barbara J. Arnold
Signature of patient (or parent of minor child)

Secondary Insurance
Name Country Group Life
ID# 73055
Group# 210B
Address PO Box 37
City Toledo
State CO **ZIP** 43623-0037
Secondary Insured Name Peter James Arnold
Relation to Patient Father
DOB/Sex 12-23-1990 Male
Address/phone Same as patient

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Peter J. Arnold
Signature of patient (or parent of minor child)

Date of Service	10/11/20XX	
Diagnosis	**Procedure**	**Charge**
J06.9 Upper Respiratory Infection	99202 New Patient Office Visit	$71.00

2. **Rebecca Bloom**

Greg North, MD
800 Medical Court
Brown, CO 80001-9898
(970) 555-2222

☑ 11 Physician Office
☐ 12 Private Residence
☐ 22 Outpatient Hospital
☐ 23 Hospital Emergency Room

Physician signature: *Greg North, MD*

Participating Provider ☑Y ☐N

EIN: 47-9823559
NPI: 04-05674390

Patient Information

Name Rebecca Kay Bloom
Address 409 Yorkshire Court
City Brown **State** CO
ZIP 80001
Home Phone 970-555-5875

Date of Birth June 25, 2007
Sex F

Insurance Information

Primary Insurance
Name MedLink
ID# 52960
Group# WB02
Address PO Box 560
City Brown
State CO **ZIP** 80001-0560
Primary Insured Name Richard Michael Bloom
Relation to Patient Father
DOB/Sex March 10, 1977 Male
Address/Phone Same as patient

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Richard M. Bloom
Signature of patient (or parent of minor child)

Secondary Insurance none
Name
ID#
Group#
Address
City
State **ZIP**
Secondary Insured Name
Relation to Patient
DOB/Sex
Address/Phone

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Signature of patient (or parent of minor child)

Date of Service	11/27/XX	
Diagnosis	**Procedure**	**Charge**
J42 Chronic Bronchitis	99213 Est. Patient Office Visit	$69.00

Today's Charge	$69.00
Cash/Check	$ 0.00
Balance	$69.00

Step 12: Review Practice Exercise 21-3

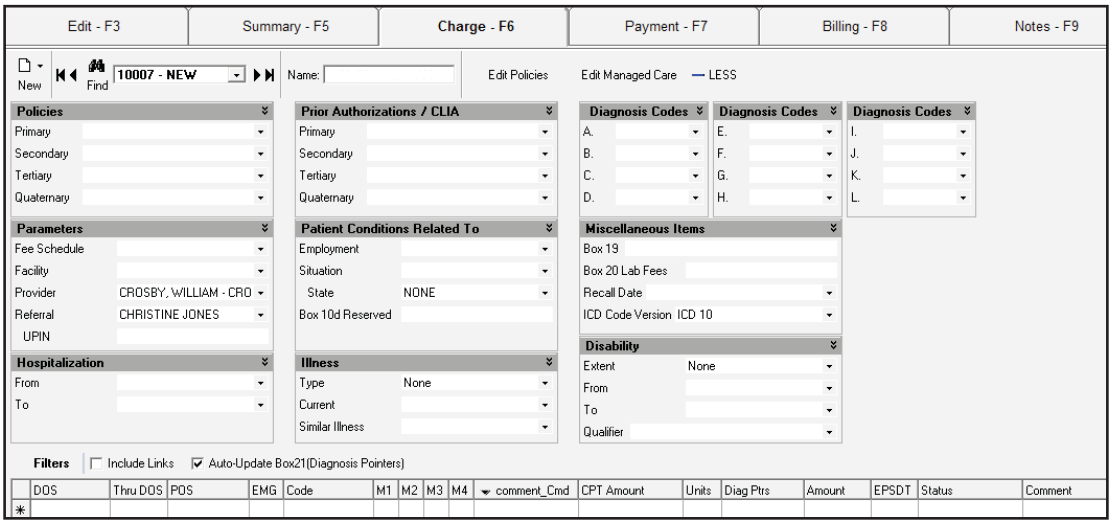
Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 13: Patient Account—Charge

What do you think of MedLook so far? It may require some additional data entry in the beginning, but once you have the database complete, the process of creating claims will be a breeze! You're probably ready to create claims, right? Once you learn how to add charges, you'll be ready to view the claims. You're almost there!

As you know, no one provides services for free—including physicians. The *Charge* tab allows you to input all charges associated with the claim form you are completing. You will enter and save each charge separately.

You'll start at the patient's account to enter a charge. Click *Folders,* then *Patients* and then *Go To Patients.* You'll double click on a patient's name to open the patient account, and then click the *Charge* tab.



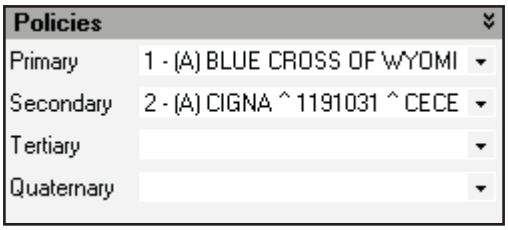
As you can see, this tab is divided into the following sections:

- Policies
- Prior Authorization/CLIA
- Diagnosis Codes
- Parameters
- Patient Condition Related To
- Miscellaneous Items
- Hospitalization
- Illness
- Disability

Now, you will explore the details of the *Charge* tab. Open Andrew Lee-Carter's account, and work through the examples that apply as you read the materials.

Policies

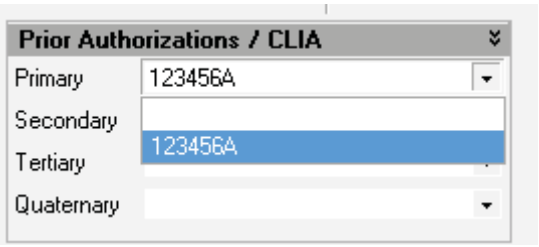
The *Policies* section simply lists the insurance carriers that you entered in the *Edit* tab. You'll click the arrow and select the primary and other insurance, if applicable.



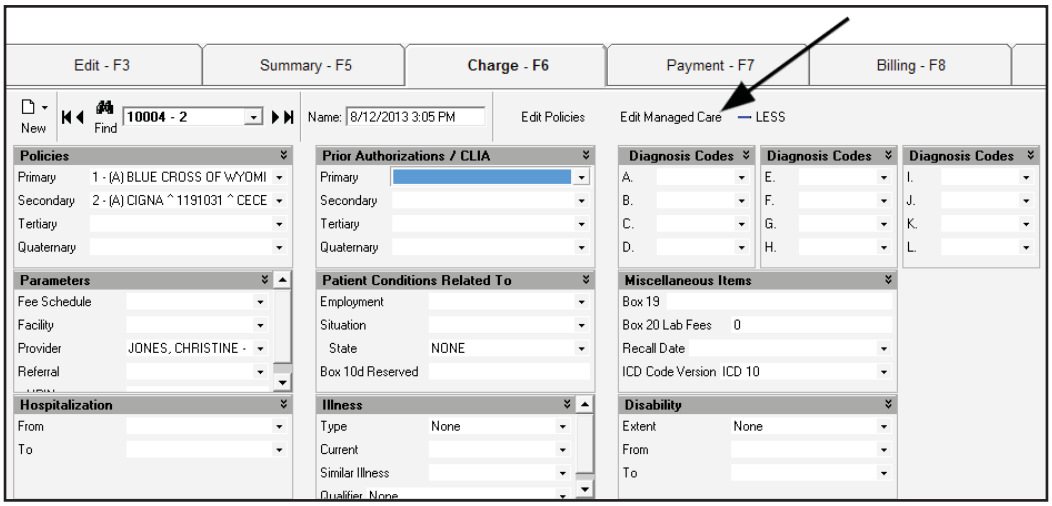
Prior Authorizations/CLIA

The *Prior Authorizations/CLIA* field relates back to each specific policy. Keep in mind that a preauthorization for the primary carrier does not apply to the secondary carrier. Do you recall entering the authorization for Andrew's primary carrier? You learned that you can enter the preauthorization either when you're editing the account, or when you apply the charges. Let's take a look at both options now.

If you have already entered prior authorizations/CLIA into the *Patient Account—Manage Care/ Preauthorization* section, you'll click the drop down arrow next to *Primary* and select the authorization number.

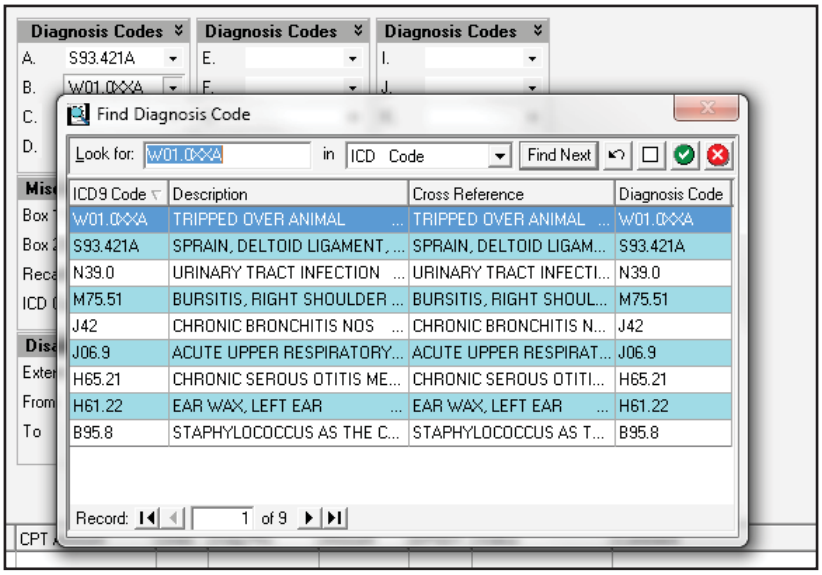


If you haven't yet entered this information, click *Edit Managed Care*. Then, the same window that you used with *Patient Account—Managed Care* will open. You'll enter the preauthorization number.Keep in mind, if you leave this screen to edit the managed care, you will need to add the policies when you return to this screen.



Diagnosis Codes

Just as with the CMS-1500 version 0212, there are 12 spaces here for the diagnostic codes. To select the code, click the down arrow on the right to open the window containing all codes you've added to the database. Then, double click on the code, and it will appear in the box.



Parameters

In this section, you can change the information you selected with the *Edit* function. For instance, imagine that a patient's regular physician is Dr. Johnson, but the patient sees Dr. Knott. You can indicate that here, rather than editing the *Patient Account*. You can also assign a referring physician or facility here.

So, let's say that Andrew was seen at the emergency department by his regular physician. You'll add the facility as Weston Hospital and leave the provider as Christine Jones, with no referral.

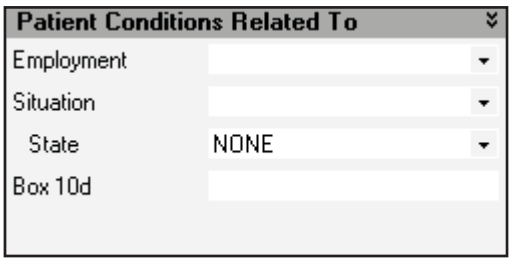
Patient Condition Related To

This section relates to fields 10a, 10b and 10c, as well as field 10d, on the CMS-1500 claim form. For Andrew's service, you will leave these fields blank, but for a better understanding, take a look at the sections below:

Employment—The first box identifies whether the condition is employment related, with the drop-down box selection of *No* or *Yes*.

Situation—The second box provides choices for *Auto Accident*, *Other Accident* or *Neither*. If you want both 10b and 10c to indicate no, select *Neither*. If it was an auto accident, indicate that and then change the State from *NONE* to the correct state abbreviation. You'll select *Other Accident* if the patient's condition is the result of an accident other than an employment-related or auto accident, such as a third-party liability.

Remember, you will mark the *NO* box if the patient's primary or secondary insurance is providing coverage for the injury or accident. In addition, you'll mark the *NO* box if the patient's condition is not the result of an injury or accident.



Recall that, for the CMS-1500 version 02/12 claim form, field 10d applies for claims codes. These codes provide additional information about the circumstances of the encounter to assist in processing the claim. For workers' compensation, these codes identify a duplicate or appeal as shown below:

W2 Duplicate of original bill

W3 Level 1 appeal

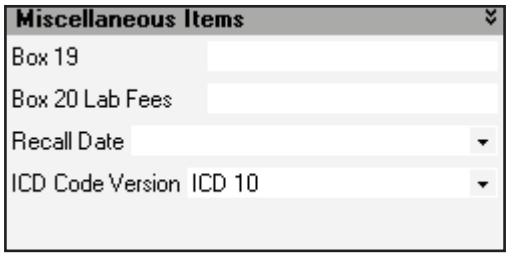
W4 Level 2 appeal

W5 Level 3 appeal

You'll enter the claims code here in MedLook to apply to the CMS-1500 form.

Miscellaneous Items

This section contains several miscellaneous items for the claim form.



Box 19—This box identifies additional information about the patient's condition or about the claim. It may be payer-specific, which means that individual payers' requests for the field may vary. Once you're working as a healthcare professional, you'll want to refer to the most current instructions from each payer regarding the use of this field.

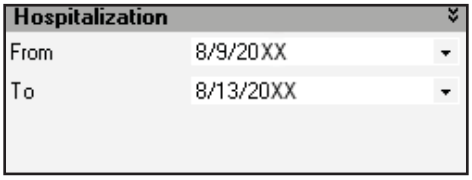
Box 20 Lab Fees—This box provides the fees for the outside lab. However, this field is rarely used, because most outside labs do their own billing and don't rely on reimbursement from the provider. You'll just leave this area blank.

Recall Date—This is used internally to alert the office to send the patient a reminder.

ICD Code Version—This identifies whether you are using the *ICD-9-CM* or *ICD-10-CM* manual for diagnosis codes. For this course, you'll use the *ICD-10-CM* manual, so be sure the setting is correct now.

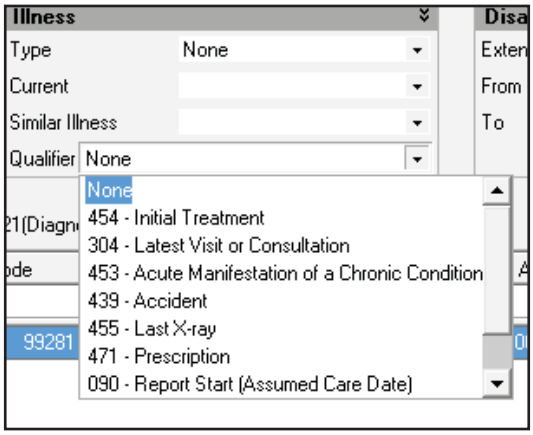
Hospitalization

This section relates back to field 18 on the CMS-1500 claim form. Again, field 18 refers to an inpatient stay and indicates the admission and discharge dates. For Andrew's service, you will leave this field blank.



Illness

This section provides information for fields 14 and 15 of the CMS-1500 claim form.



Type and *Current* relate to field 14. For *Type*, you'll select *Pregnancy* for qualifier 484, and either *Illness* or *None* for qualifier 431. Then, select the date that applies under *Current*. For Andrew's service, select *None* and enter 3/19/20XX as the date of injury.

IMPORTANT NOTE: For the purpose of this course, you will assume the onset date of the current symptoms or illness is the date of service, unless otherwise specified.

Similar Illness and *Qualifier* relate to field 15. The date for *Similar Illness* will apply to the date in field 15. You'll select the appropriate modifier from the drop-down list under *Qualifier*.

Disability

Disability relates to field 16 for the beginning date and ending date the patient was unable to work at his current position. You will not complete this field for Andrew. However, to complete the field on future claim, you'll select *None*, *Partial* or *Total* to indicate the *Extent*, and then select the "from" and "to" dates to complete the field.

Disability	
Extent	Partial
From	8/13/20XX
To	8/23/20XX

To remove information from these fields, either open the drop-down box and click the white space, or highlight the information and press "delete."

Enter Charge

Once you have all the necessary information, you're ready to enter the charge. You'll do this by completing the box in the middle of the page. This box is quite long, but you only need to focus on the following fields:

	DOS	Thru DOS	POS	EMG	Code	M1	M2	M3	M4	comment_Cmd	CPT Amount	Units	Diag Ptrs	Amount	EPSDT
*															

DOS	Date of Service relates to field 24A "from" date; select the date on the drop-down calendar, or enter the date in XX/XX/20XX format
Thru DOS	Through Date of Service relates to field 24A "to" date; usually the service is one day, so select the same date as in DOS
POS	Place of Service, relates to field 24B; use the drop-down box to select the appropriate place of service
EMG	Emergency; relates to field 24C; the default is no, so only change this field if "yes" applies
Code	CPT/HCPCS code relates to field 24D; use the drop-down box to select the appropriate code
M1	Modifier 1 relates to field 24D; enter the two-digit modifier if it applies
M2	Modifier 2 relates to field 24D; enter the two-digit modifier if it applies
M3	Modifier 3 relates to field 24D; enter the two-digit modifier if it applies
M4	Modifier 4 relates to field 24D; enter the two-digit modifier if it applies
comment_Cmd	Leave this field blank
CPT Amount	Relates to field 24F; MedLook completes it based on your Procedure Code Table, but you can change here if needed
Units	Relates to field 24G; defaults to 1, but can be changed here if needed
Diag Ptrs	Diagnosis Pointers relates to field 24E; it defaults to what is entered above, but can be changed here if needed
Amount	Be sure to change the amount here if you've changed the CPT amount above
EPSDT	Relates to field 24F; defaults to no, but can be changed here if needed

Let's try entering a charge for Andrew, who was seen in the emergency room, using 8/12/20XX as the date of service and 99281 as the CPT code. You may need to change the diagnosis pointer to "A B," but the units will default to "1." Remember, 20XX is not a valid year; you should use the current or previous year when using your MedLook software. Your screen should appear similar to below:

	DOS	Thru DOS	POS	EMG	Code	M1	M2	M3	M4	comment_Cmd	CPT Amount	Units	Diag Ptrs	Amount	EPSDT
	8/12/20XX	8/12/20...	(23) EMERG ...	N	99281						$68.00	1	A B	$68.00	N

Does it look the same? If so, press "*enter*" and the charge will drop down to the white area. You can either enter another charge, or click *Save* if you are done. Once you click *Save*, the transaction will remain in MedLook. To delete a charge, you'll use the *Transactions* tab. Let's take a closer look before moving on.

Step 14: Patient Account—Transactions

The *Transactions* tab contains all payments, charges, credits and debits within the patient's account. You'll learn more about this tab when you take a look at posting payments, but for now, let's review the process of deleting a charge.

For instance, imagine that you are distracted when entering a charge and realize that you've entered the same charge twice. Or, you make a data-entry error and click *Save* before realizing the error. You'll need to know how to delete the second charge in instances like this. So, go ahead and enter the charge for Andrew twice. Now, click *Transactions*, and you'll see something similar to the following:

Edit - F3 | Summary - F5 | Charge - F6 | Payment - F7 | Billing - F8 | Notes - F9 | **Transactions - F10**

Transaction Type: Charges Only From: To:

Type	TR #	DOS	Trx Date	Thru DOS	Amount	Applied	Balance	Bal. Err.	Ptnt	Explanation	M1	M2	M3	M4	Prim Sub	Sec Sub	Ins1	Ins2	Ins3	Ins4	Other	Copay
Doctor: JON, Count: 2																						
C	9	8/12/20XX	8/12/20XX	8/12/20XX	$68.00	$0.00	$68.00	$0.00	$0.00	99281							$48.00	$0.00	$0.00	$0.00	$0.00	
C	10	8/12/20XX	8/12/20XX	8/12/20XX	$68.00	$0.00	$68.00	$0.00	$0.00	99281							$68.00	$0.00	$0.00	$0.00	$0.00	
					$136.00	$0.00	$136.00	$0.00	$0.00								$116.00	$0.00	$0.00	$0.00	$0.00	

First, you'll select the charge you want to delete by highlighting it in blue. Then, right click and select *Delete Record*.

Edit - F3 | Summary - F5 | Charge - F6 | Payment - F7 | Billing - F8 | Notes - F9 | **Transactions - F10**

Transaction Type: Charges Only From: To:

Type	TR #	DOS	Trx Date	Thru DOS	Amount	Applied	Balance	Bal. Err.	Ptnt	Explanation	M1	M2	M3	M4	Prim Sub	Sec Sub	Ins1	Ins2	Ins3	Ins4	Other	Copay
Doctor: JON, Count: 2																						
C	9	8/12/20XX	8/12/20XX	8/			0	$0.00	$0.00	99281							$48.00	$0.00	$0.00	$0.00	$0.00	
C	10	8/12/20XX	8/12/20XX	8/			0	$0.00	$0.00	99281							$68.00	$0.00	$0.00	$0.00	$0.00	
							0	$0.00	$0.00								$116.00	$0.00	$0.00	$0.00	$0.00	

- Show Preview Lines
- Preview Print
- Show Fields...
- Sort...
- Group By...
- Format View...
- Expand/Collapse Groups
- Restore Default Layout
- Delete Record
- Delete Assignments
- Undelete Transaction
- Clear Submission Dates
- Add Note
- View Notes

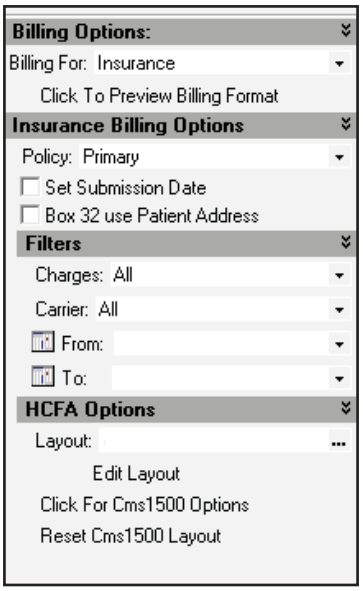
Two windows will appear to verify that you're sure and then to confirm your answer. You'll select *Yes* for both. The record is then deleted.

You're finally ready to put together everything you've learned to create an actual claim form! You won't study the *Payment* tab just yet. You'll skip over that tab for now, and discover the details of the *Billing* tab, where you'll see claims that are submitted for reimbursement. You'll return to the *Payment* tab in a later lesson, and you'll explore more about the *Transactions* tab, as well. Are you ready to wrap up this lesson? Let's get to it!

Step 15: Patient Account—Billing

Are you ready to complete a CMS-1500 claim form? You've made it to the final step in the process. You'll use Andrew's charges to see how the *Billing* tab works, and then you'll enter other charges to gain more practice. In no time, you'll be ready to demonstrate your understanding of the medical billing software!

Open Andrew's patient account by clicking *Folders*, *Patients*, *Go To Patients*. Find Andrew and double click on his name to open his *Patient Account*. You've already entered the charge, so you can go directly to the *Billing* tab. There is a lot of information on this page, so let's go through it step by step. On the far left, you'll find *Billing Options, Insurance Billing Options, Filters* and *HCFA Options*.



Billing Options—You will select this option if you are billing the insurance or the patient. At this time, you are submitting the claim to the insurance carrier, so you'll select *Insurance*. You'll learn about patient billing later in the course.

Insurance Billing Options—You can select primary, secondary, tertiary, quaternary, all secondaries or all policies. At this time, you're submitting to the primary carrier, so select *Primary*. Click *Set Submission Date* to remove the check.

Filters—The default setting shows *Unsubmitted* charges for *All* carriers with no specific dates. Change *Unsubmitted* to *All*. This is the recommended setting.

HCFA Options—You'll recall that HCFA was the term used prior to CMS; this selection changes the form and/or format of the claim. If you change the default setting and need to change it back, click *Reset CMS 1500 Layout*.

TR #	DOS	Thru DOS	Amount	Explanation	Doctor	Posted	Place	Comment	Applied	Ins1	Ins2	Ptnt	Other	Prior Auth	Prim PD	Sec PD	Copay	Deduct
Deduct: 0, Count: 1																		
10	8/12/20XX	8/12/20XX	$68.00	99281	JON	☐	23	...	$0.00	$68.00	$0.00	$0.00	$0.00	123456...			$0.00	$0.00

Since there is only one charge, it is the only one highlighted in blue. To view the claim, click *View/eClaims*. You'll see the top portion of the claim, and you can then use the bar on the right side to slide down and see the entire claim.

From this screen you can save or print the claim, change the font, remove or add the red information or make the image bigger. Take a closer look at these features:

Save—Saves the file as a text to your hard drive

Print—Prints the claim, which we will discuss later

Font—Changes the font, but this is not recommended for claims submission

Image—Shows the claim with and without the red background

Bigger—Click this if the writing is not within the red boxes

Hands-on Activity

Before starting this activity, delete the transaction and start fresh with Andrew using the following encounter form. In addition, in the *Edit* tab, select *Click to Manage Authorizations* and remove the check from *Active* so that the preauthorization number will not appear on the claim. Click *Enter, Close* and then *Save* before continuing with the activity.

Christine Jones, MD
1414 Swallow Street
Brown, CO 80001-9898
(970) 555-1514

☐ 11 Physician Office
☐ 12 Private Residence
☐ 22 Outpatient Hospital
☑ 23 Hospital Emergency Room

Physician signature: *Christine Jones, MD*

Participating Provider ☑Y ☐N

EIN: 33-0457789
NPI: 0203048901

Patient seen at Weston Hospital

Patient Information

Name Andrew Paul Lee-Carter
Address 883 Center Circle
City Avon **State** CO
ZIP 80000
Home Phone 970-555-8812

Date of Birth January 15, 2007
Sex male

Insurance Information

Primary Insurance
Name Blue Cross of Wyoming
ID# 630A
Group# BM
Address PO Box 465
City Casper
State WY **ZIP** 82002-0456
Primary Insured Name Mark K. Carter
Relation to Patient father
DOB July 6, 1978
Address Same as patient

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Mark K. Carter
Signature of patient (or parent of minor child)

Secondary Insurance
Name CIGNA
ID# 1191031
Group# 488C
Address 1212 Drake
City Cleveland
State OH **ZIP** 44102-1912
Secondary Insured Name Cecelia Lee
Relation to Patient mother
DOB Oct 9, 1980
Address Same as patient

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Cecelia Lee
Signature of patient (or parent of minor child)

Date of Service	3-20-20XX	Date of Injury	3-19-20XX

Diagnosis	Procedure	Charge
S93.421A Deltoid ligament sprain, R	99283 Emergency Department	$125.00
W01.0XXA Tripped over dog	73610 X-ray, ankle, complete	$ 54.00

Today's Charge	$179.00
Cash/Check	$ 0.00
Balance	$179.00

Once you have entered the necessary information, view the claim and compare it with the following:

BLUE CROSS OF WYOMING

PO BOX 465
CASPER, WY 820020456

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID# DoD#) CHAMPVA [ ] (Member ID #) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 630A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LEE-CARTER ANDREW P

3. PATIENT'S BIRTH DATE MM DD YY: 01 15 2007 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): CARTER MARK K

5. PATIENT'S ADDRESS (No., Street): 883 CENTER CIRCLE

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): 883 CENTER CIRCLE

CITY: AVON STATE: CO

8. RESERVED FOR NUCC USE

CITY: AVON STATE: CO

ZIP CODE: 80000 TELEPHONE (Include Area Code): (970) 5558812

ZIP CODE: 80000 TELEPHONE (Include Area Code): (970) 5558812

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: BM

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 1191031

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 07 06 1978 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: BLUE CROSS OF WYOMIN

d. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE XX XX XX

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS INJURY or PREGNANCY (LMP) MM DD YY: 03 19 XX QUAL 431

15. OTHER DATE MM DD YY QUAL

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S93421A B. W010XXA C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM DD YY	TO MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
03 20 XX	03 20 XX	23		99283		AB	125 00		1	NPI	
03 20 XX	03 20 XX	23		73610		AB	54 00		1	NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 33 0457789 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: XXXXX

27. ACCEPT ASSIGNMENT? YES [X] NO [ ]

28. TOTAL CHARGE $ 179 00

29. AMOUNT PAID $ 0 00

30. Rsvd for Nuccc Use

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

32. SERVICE FACILITY LOCATION INFORMATION
WESTON HOSPITAL
2002 MEDICAL COURT
BROWN CO 800019898
a. 0755622355 b.

33. BILLING PROVIDER INFO & PH # (970)5551514
CHRISTINE JONES MD
1414 SWALLOW STREET
BROWN CO 800019898
a. 0203048901 b.

The claims process is so much more efficient when all of the information is already entered into the database. You'll note that the date in fields 12 and 31 is the date when you completed the claim. In addition, remember that the account number will also vary. These fields are completed with Xs to indicate that the information may vary; this variance is acceptable. In addition, you know that 20XX is an invalid year, so you'll complete fields 14 and 24A with the current or previous year. You'll also see that MedLook does not include the decimal in the diagnosis code.

Does your claim look similar to the example here? If not, take the time to review the material and correct each of the fields. Please note field 11c will vary based on what you enter. "BC" is acceptable for Blue Cross, and names may be cut off due to character limitations. If it does look the same, you have a solid grasp of the process and you're ready to refine your skills! Take the following Practice Exercise to prepare for completing more claims on your next Quiz.

Step 16: Practice Exercise 21-4

Use the following information to create a claim using MedLook.

1. **Kristen Arnold**

FAMILY CARE
1800 Circle Court
Brown, CO 80001-9898
(970) 555-3344

___ Kenneth Miles, MD **NPI:** 02-67679942
_X_ David Mills, MD **NPI:** 08-10998051
___ Roger Small, MD **NPI:** 01-44878804
Group NPI: 08-81099885

☑ 11 Physician Office
☐ 12 Private Residence
☐ 22 Outpatient Hospital
☐ 23 Hospital Emergency Room
Participating Provider ☑Y ☐N

Physician signature: David Mills, MD
EIN 66-6870600

Patient Information

Name Kristen Ann Arnold
Address 3519 Habit Road
City Yampa **State** CO
ZIP 80004
Home Phone 970-555-8838
Date of Birth April 7, 2011
Sex F

Insurance Information

Primary Insurance
Name Blue Cross of Ohio
ID# 811924
Group# J620
Address 3737 Sylvania Avenue
City Toledo
State OH **ZIP** 43623-4422
Primary Insured Name Barbara Jane Arnold
Relation to Patient Mother
DOB/Sex 01-10-1989 Female
Address/phone Same as patient

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Barbara J. Arnold
Signature of patient (or parent of minor child)

Secondary Insurance
Name Country Group Life
ID# 73055
Group# 210B
Address PO Box 37
City Toledo
State CO **ZIP** 43623-0037
Secondary Insured Name Peter James Arnold
Relation to Patient Father
DOB/Sex 12-23-1990 Male
Address/phone Same as patient

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Peter J. Arnold
Signature of patient (or parent of minor child)

Date of Service	10/11/20XX	
Diagnosis	**Procedure**	**Charge**
J06.9 Upper Respiratory Infection	99202 New Patient Office Visit	$71.00

2. **Rebecca Bloom**

Greg North, MD
800 Medical Court
Brown, CO 80001-9898
(970) 555-2222

☑ 11 Physician Office
☐ 12 Private Residence
☐ 22 Outpatient Hospital
☐ 23 Hospital Emergency Room

Physician signature: *Greg North, MD*

Participating Provider ☑Y ☐N

EIN: 47-9823559
NPI: 04-05674390

Patient Information

Name Rebecca Kay Bloom
Address 409 Yorkshire Court
City Brown **State** CO
ZIP 80001
Home Phone 970-555-5875

Date of Birth June 25, 2007
Sex F

Insurance Information

Primary Insurance
Name MedLink
ID# 52960
Group# WB02
Address PO Box 560
City Brown
State CO **ZIP** 80001-0560
Primary Insured Name Richard Michael Bloom
Relation to Patient Father
DOB/Sex March 10, 1977 Male
Address/Phone Same as patient

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Richard M. Bloom
Signature of patient (or parent of minor child)

Secondary Insurance none
Name
ID#
Group#
Address
City
State **ZIP**
Secondary Insured Name
Relation to Patient
DOB/Sex
Address/Phone

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Signature of patient (or parent of minor child)

Date of Service	11/27/XX	
Diagnosis	**Procedure**	**Charge**
J42 Chronic Bronchitis	99213 Est. Patient Office Visit	$69.00

Today's Charge	$69.00
Cash/Check	$ 0.00
Balance	$69.00

Step 17: Review Practice Exercise 21-4

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 18: Lesson Summary

Electronic claims submission can save time and money—both key incentives for the use of this process. You may also choose a clearinghouse to assist with the process by checking your claims for accuracy, formatting the claims and providing you with the ever-important proof of timely filing.

Now, it's time to demonstrate your understanding of medical billing technology by completing the following Quiz. Good luck!

Step 19: Quiz 19

Once you have mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the Quiz instructions carefully.

Lesson 22
The Future of Health Care

Step 1: Learning Objectives for Lesson 22

When you have completed the instruction in this lesson, you will be trained to:

- Discuss important trends in the electronic health record.
- Differentiate between encoders and autocoding.
- Summarize the pros and cons of electronic coding.
- Explain key concerns with remote coding.

Step 2: Lesson Preview

From experimental drugs and cutting-edge procedures to computers and the Internet, health care is changing. From the operating room to the front office, every level of medicine is undergoing a revolution. Why? What's driving this change? Technology! Technology is rewriting not only the rules of what is necessary, but what is possible.

In this lesson, we're going to look at how technology is shaping the future of health care. We'll focus on trends in electronic health records and examine what they mean for the healthcare professional. You'll learn about new and upcoming coding tools, such as encoders and computer-assisted coding. You'll also learn more about Web-based medical records.

The healthcare profession is changing. Understanding those changes will help prepare you for success in the years to come.

Step 3: Technology and Health Care: Today

The goal of medicine is quality patient care. The backbone of patient care is health information management. Transcriptionists, coders, billers and administrators keep the gears of our health system spinning. Without them, providers wouldn't get paid, medical files couldn't be located, and the system would back up like a traffic jam.

Healthcare professionals, like yourself, are the unsung heroes of health care. They make sure the provider has the medical record when she's examining the patient. They make sure the patient doesn't overpay for services, supplies and advice. They keep an eye out to make sure the diagnosis, the procedure and the bill all match. All in all, they manage the massive amount of information needed by the healthcare industry.

In the past, a medical record was a thick paper file containing notes on all of your visits. Hospitals and physician offices maintained hundreds and thousands of these files which took up a lot of space and time. More importantly, files at one hospital could not easily be shared with another hospital. This was not only a matter of distance. Different providers often used different record formats and filing systems. When the healthcare industry was smaller, this was not a big deal. But now, with health care booming, patients, providers, insurance companies and the government all realize the drawbacks of the old paper system.

The healthcare industry is in the middle of a major shift. On one front they are slowly converting from paper medical files to electronic health records. Top to bottom they are learning to use computers in health information management.

Health information exchange (**HIE**) is the transmission of healthcare-related data among facilities, health information organizations and government agencies according to national standards.[1] The goal of HIE is to provide safe, timely, efficient and effective access to and retrieval of patient information for providers.

The Institute of Medicine (IOM) originally created the term *CPR* (*computer-based patient record*) to describe the computerized version of a medical record. The IOM defined the **CPR** as "an electronic patient record that resides in a system specifically designed to support users by providing accessibility to complete and accurate data," with other uses, as well (IOM, 1997).

In 2003, the IOM report established eight core functions that a computer-based patient record should be capable of performing.[2]

1. **Health Information and Data**. The IOM determined that the electronic health record should contain the same items that are found in the paper chart, including problem lists, medications and test results. In addition, the IOM further stated that it should be a well designed interface to enable the provider to review the information efficiently.
2. **Result Management**. This function refers to accessing information easily when and where it is needed. The focus should be on availability, convenience, reliability and ease of use. The provider should be able to access lab or x-ray results any time and from anywhere.

   For example, Bonnie had severe pain in the bottom side of her heel for the past two days. The pain is localized to a single location. After exam, the provider has an x-ray taken to rule out a fracture or tumor. Bonnie has the x-ray taken onsite and returns to the exam room. Her provider returns and pulls the image up on her computer. The provider determines there is no sign of a fracture or mass, but suspects a bone spur is causing the pain. Bonnie is provided symptomatic care and is advised that a radiologist will review the x-ray as well, so she'll be called the next day to confirm the diagnosis.

   In this case, the electronic health record allowed the provider to import the x-ray. However, the level of access should be considered as well. For instance, the dietitian and pharmacist do not require the same level of access to a patient record.
3. **Order Management**. Computerized entry and storage of data on all medications, tests and other services is an important function of a computer-based patient record. **Computerized provider order entry** (**CPOE**) refers to any system in which clinicians directly enter medication orders (and, increasingly, tests and procedures) into a computer system, which then transmits the order directly to the pharmacy.[3] The advantages of CPOE include standardized, legible and complete orders, which will reduce medical errors.

4. **Decision Support**. This function of the electronic health record will alert providers and patients to vaccines, screenings and or preventative measures. In addition, it provides warnings and reminders to assist providers in making the decision in patient care. Decision support can aid in: drug interactions/prescriptions/prevention, detection of disease outbreaks, evidence-based guidelines, etc.[4]
5. **Electronic Communications and Connectivity**. This function focuses on patient safety and quality of care. It allows multiple providers in multiple setting to communicate and coordinate care.
6. **Patient Support**. Studies have found that home monitoring and educational materials are directly related to improving the control of a chronic illness, such as diabetes.
7. **Administrative Processes**. Providing better, timelier services to patients also helps the efficiency of a healthcare organization. Electronic health records also assist with billing and claims management. The provider can immediately validate insurance eligibility, as well as obtain authorizations. This function results in more timely payments and less paperwork.
8. **Reporting and Population Health Management**. Computer-based patient records provide a standardized system for reporting requirements for safety and quality that are necessary for state, federal and local entities.

Step 4: Electronic Health Records

When the IOM suggested the key functions in 2003, it also established the term electronic health record for this format. Let's look at the alternative terms and requirements of an electronic health record.

Electronic medical record, or **EMR**, is another description that is widely used for this type of record. In hospital or office settings, EMR often refers to entire systems that are based on document imaging, or electronic document management systems as a whole. However, a more accurate term for the actual electronic record is **electronic health record**, or **EHR**. The health information management field generally recognizes the distinction between EMR and EHR as the degree of interoperability that each offers. For our purposes, an EHR is defined as follows, according to the Health Information Technology for Economic and Clinical Health (HITECH) component of the American Recovery and Reinvestment Act (ARRA) of 2009:

A **qualified EHR** "includes patient demographics and clinical health information, and has the capacity to provide clinical decision support; support physician order entry; capture and query information relevant to health care quality; and exchange electronic health information with and integrate such information from other sources."[5]

Certified EHR technology "gives assurance to purchasers and other users that an EHR system or module offers the necessary technological capability, functionality and security to help them meet the *meaningful use* criteria. Certification also helps providers and patients be confident that the electronic health IT products and systems they use are secure, can maintain data confidentially and can work with other systems to share information."[6]

Meaningful use generally describes the ability to demonstrate quality improvement through the use of EHRs. However, HITECH identifies three base requirements for meaningful use:

- Use of certified or qualified EHR technology.
- Electronic exchange of health information.
- Use of EHR in reporting on clinical and other quality measures.[7]

The Certified Commission for Health Information Technology (CCHIT) is recognized by the U.S. Department of Health and Human Services as the entity to certify that EHRs support meaningful use.

To ensure meaningful use, data comparability standards are necessary. Data comparability standards make certain the meaning of a term is consistent across all users. Standard vocabulary helps achieve data comparability. Until recently, the specific vendor that developed the EHR software established most vocabularies. However, HITECH requirements demand the use of *controlled vocabulary* to allow for electronic exchange of health information. **Controlled vocabulary** means that a specific set of terms in the EHR's data dictionary must be used.

Providers may use different terms that mean the same thing. For instance, one provider may document a *heart attack*, while another indicates an *MI*, and still another notes a *myocardial infarction*. While these terms mean the same thing to a cardiologist, they are entirely different to a computer. Without standard terminology, it's difficult to gather and retrieve information for research. Controlled vocabulary allows users to index, store and retrieve information from an EHR.

The National Committee on Vital and Health Statistics (NCVHS) was asked to recommend a national standard for vocabulary use in an EHR. The NCVHS recommended that the federal government use the following "core set" of terminologies:[8]

- SNOMED CT—Systematized Nomenclature of Medicine - Clinical Terms
- LOINC—Logical Observation Identifiers Names and Codes
- RxNorm—federal drug terminologies

SNOMED CT presents data in a completely machine-readable format. While the ICD coding database was designed for billing and reimbursement, SNOMED CT is meant to organize the contents of a medical record to capture, encode and use data for clinical care of patients and research. Due to the controlled vocabulary, SNOMED CT can increase quality of care because it allows more accurate descriptions of a patient's medical issues in words physicians understand and doesn't cross into the administrative interpretations of diagnosis codes that are more familiar to coding staff.[9]

Health Level Seven (**HL7**) develops specifications for electronic healthcare information. HL7's mission is to increase the effectiveness and efficiency of healthcare information.

HL7 standards identify types of errors and corrections in an electronic medical record. HL7 has created computer messages to communicate corrections to different computer systems. Let's take a look at a couple of scenarios:

1. To create an addendum: Author dictates additional information as an addendum to a previously transcribed document. A new document is transcribed. This addendum has its own unique document ID that is linked to the original document via the parent ID. Addendum document notification is transmitted. This creates a composite document.
2. To correct errors that were discovered in the original health document that haven't been made available for patient care: Errors, which need to be corrected are discovered in a document. The original document is edited, and an edit notification is sent.[10]

One variation of the EHR is the **personal health record** (**PHR**), which is medical information that the patient maintains. The PHR puts control in the consumer's hands. Instead of being a tool for the provider, the health record will become a tool for the patient. In the future, people will have more responsibility for their own well-being. Insurance companies are not the only ones pushing for a shift from doctor as repairman to doctor as coach. Many people see the benefits of healthy living and preventative medicine. The fitness and nutrition industry is growing. So is interest in alternative medicines such as acupuncture and chiropractics. Knowledge is power. Taking personal responsibility for your own health is the first step in the fight against death, disease and aging. Personal health records will be valuable weapons in this fight.

Now, you'll learn about different types of Internet connections and networks.

Step 5: Access the Internet and the Web from a Computer

OK, you have a computer and a Web browser; you're viewing Web sites left and right. But how exactly does it happen that these Web pages appear in your browser?

The Internet does not exist in one location. It exists in shared locations between hundreds of millions of computers, servers and networks. For example, Erik in Denmark may publish the photographs he took on his recent trip to Thailand. Xing Mao in China may publish statistics on the ratios of female and male children that families in the United States adopt. And Gabriela in Chile may publish a daily **blog** (short for **Web log**, which is like an online diary) that describes her life in South America, including sales information for the handmade products from her alpaca, sheep and goat farm.

So where is all of this information? Well, remember that each of these Web pages is published on the World Wide Web, which exists on the Internet. You, Erik, Xing Mao and Gabriela can view these Web pages—and all the others that people everywhere write—anytime you want, as long as you have access to the Internet.

Before you learn about the computer network, let's look at the language of the Internet. Many know that **HTML** (**Hypertext Markup Language**) was designed to display data and is the most widely used language for Web-based documents. A document using HTML contains embedded tags that provide guidance to HTML viewers (usually called Web browsers) as to how to display the document and connect it to other documents.[10]

HTML has its advantages and disadvantages:

Advantages	Disadvantages
Linkability—data is hyperlinked, letting you move from one site to another	Intelligibility—limited in how well data knows itself
Simplicity—it's easy to learn and to display	Adaptability—limited in data changes in response to environmental changes
Portability—it's portable over networks, operating systems and languages	Maintainability—limited in ease of data maintenance

Basically, the HTML format is not interoperable, which means that data cannot be shared across organizations. EHRs don't just "contain" or transmit information, they also compute with it—for example, a qualified EHR will not merely contain a record of a patient's medications or allergies, it will also automatically check for problems whenever a new medication is prescribed and alert the clinician to potential conflicts. HTLM is unable to compute. **XML** (**Extensible Markup Language**) was designed to overcome this limitation, which improves the functionality of the Web by letting you identify your information in a more accurate, flexible and adaptable way. XML is the language of EHRs.

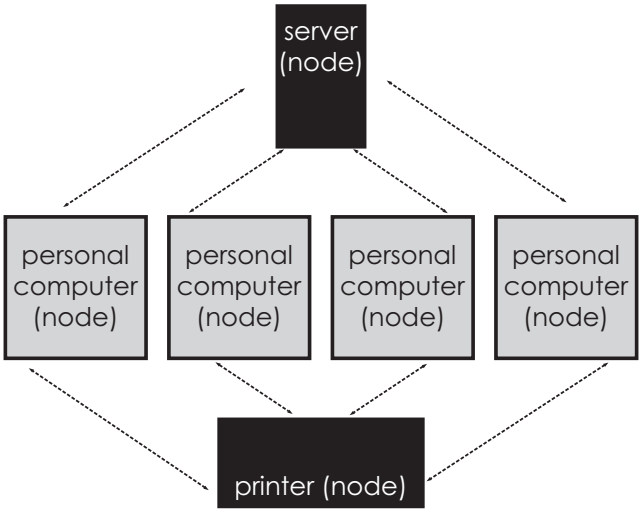
The Computer Network

To access the information on the Internet, your computer must be part of a network. A network is a system of computers and/or servers, printers and databases that communications lines connect. All computers, servers, printers or databases connected to one network are called nodes. All nodes have the means to share information and communicate with one another.

Types of Networks

Networks exist so that different computers can rely on one another to perform functions like storing, sending and retrieving information.

Network Diagram



To access the information on the Internet, your computer must be part of a network.

There are four basic types of computer networks.

1. **Client/Server Network**—One or more computers (called clients) are connected to one another and to a central computer or mainframe (called a server). We'll talk about servers in more detail in a moment, but first, let's look at an example of a client/server network.

   A manufacturing plant in Michigan makes engines for hybrid vehicles. All of the conveyer belts that move the engines throughout the plant are connected to a central computer. Based on signals from other, smaller computers at different workstations, the central computer knows how fast or how slow to run the conveyer belts. It even knows when to turn the conveyer belts off if there is an emergency or a breakdown in one area of the plant. These computers are on a client/server network.

2. **Peer-to-Peer Network**—Two or more computers are connected to one another and share information without the presence of a server.

   Let's say that Cody and Ben are college roommates, and both young men use Mac Book laptops with iTunes and iPods. Cody has a great collection of more than four thousand listening hours of Classic Rock, Pop and Indie Rock music, while Ben has a substantial amount of rare Jazz and Blues recordings. They've decided to set up a peer-to-peer network so they can easily share music files without violating copyright laws.

3. **LAN Network**—LAN stands for **local area network**. Such a network consists of one or more computers in a home or office that are connected to one another and a server. They are a self-contained network with a gateway or link to the Internet. Let's study an example.

   Martin is a freelance graphic designer and avid photographer who runs his own business from the comforts of his home office. Martin uses three printers, a copier, a laptop computer and a large desktop computer with a huge flat screen monitor for his work. Meanwhile, his wife owns a laptop, and his daughters share a desktop computer and printer in their bedroom. Martin and his family's computers all have Internet access, and they are connected to one server (and one back up server) that he keeps in the basement. This arrangement is an example of a LAN.

4. **WAN Network**—WAN stands for **wide area network**. Such a network consists of two or more LANs in several different buildings that are connected to one another.

   An example of a WAN might be an international broadcasting company that has offices in the United States, Canada, Panama, Brazil, Great Britain, Germany, France, Spain, Poland, Saudi Arabia, Sri Lanka, South Korea, the Philippines and New Zealand. Each of these offices contain multiple LANs, but the LANs are connected into a larger WAN to facilitate faster e-mail communication and to share full access to photographic images and video footage database files.

Servers

A **server** is a data resource that other computers access for information. Some people call a server a **host computer**, and that analogy works well when you think about the functions a server performs. For example, when you host a party, you make introductions among your guests. You refill the drinks, make important announcements and manage the music or overall atmosphere at the party. A server operates in much the same way. Since the server is a host to the computers attached to its network, the server relays information, transfers files, delivers programs and awaits and fulfills the requests of its client computers.

Step 6: Electronic Coding

Electronic coding uses computers to speed up the coding process. As technology develops, more and more computers will be used in coding. With more computers helping in the health information department, medical coding specialists will act more as editors to the computer's coding.

There are several different levels of electronic coding: *encoder programs*, *computer-assisted coding* and *NLP autocoding*. Let's take a look at each.

Encoder Programs

An **encoder** is an interactive computer program that helps the medical coder assign codes. With this program, the user inserts a keyword and then selects different sections, subsections, headings, subheadings and code listings related to that keyword. Think of this type of encoder as a computer-version of the *ICD-10-CM*, *CPT* and the *HCPCS* manual, all rolled into one. This encoder assists in navigating to codes quickly and with the click of a button.

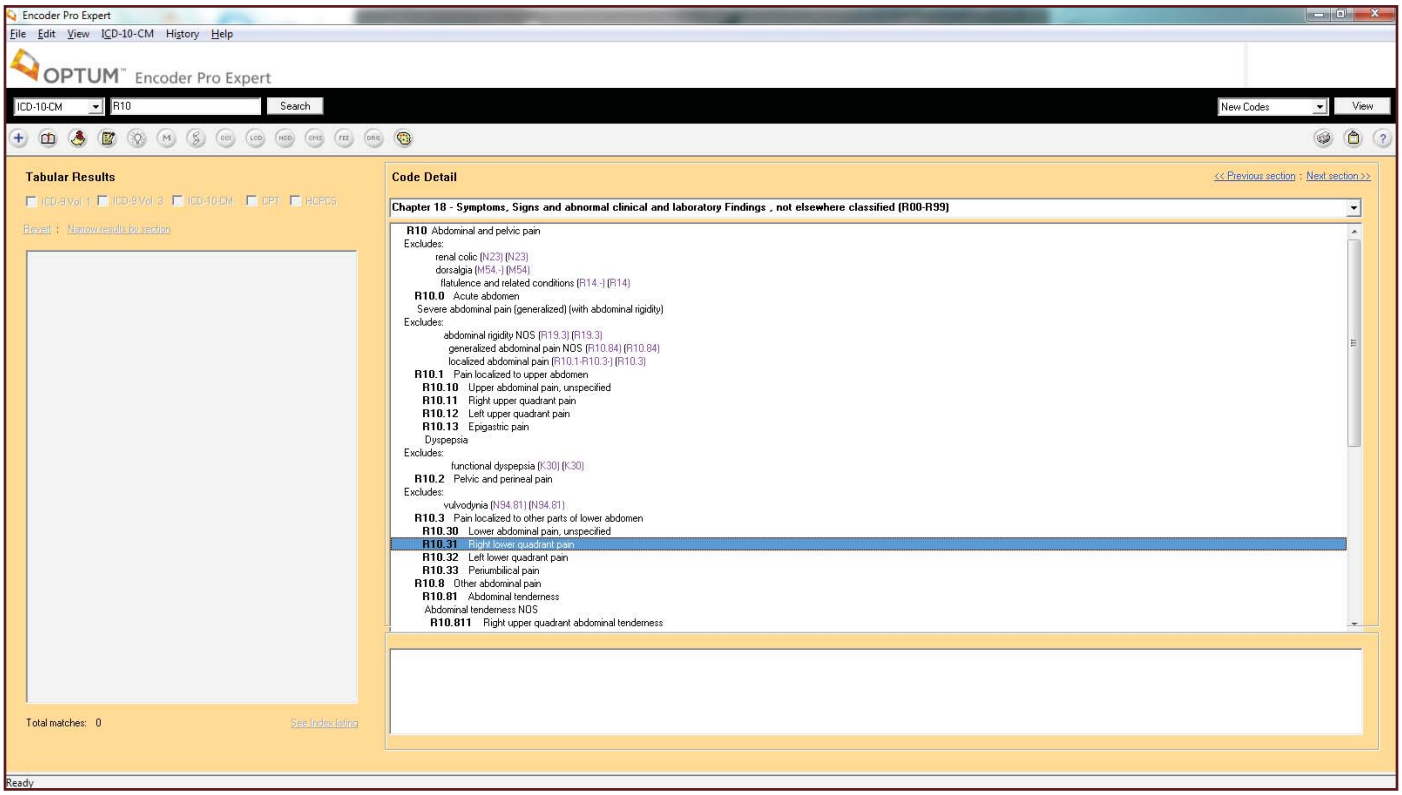
For many coders, the encoder program is more useful as a verification tool. For example, let's say you're looking up the code for abdominal pain. If you use this as the basis for your encoder search, you are likely to get so many potential codes that you'll have a hard time narrowing it down to the right one.

One of the benefits of using encoders is efficiency. And when it comes to coding, efficiency equals money.

Look at the following example. A search in the *ICD-10-CM* for *Abdominal pain* retrieved several code categories.

Let's narrow down our search. If you already know that the code for abdominal pain starts with R10, you can use the encoder to fine-tune your search. Here's an example using the encoder in that way.

If you are unsure of the correct fifth digit to use for RLQ (right lower quadrant), just scroll down the list like the example below. Do you see the code R10.31? Great!



Computer-assisted Coding

After encoders, the next level of technology is computer-assisted coding (CAC). **CAC** uses a computer to assign an actual code. Whereas an encoder determines the best code, a computer-assisted program is programmed to pick codes itself. The computer can do this in one of two ways: by using inputted information or by finding the diagnosis and procedure in the chart itself. Let's examine how each of these methods work.

The most common automated coding systems require a user to input data. The user will read a medical chart and figure out the diagnoses and the procedures. Next she will type this information into the computer-assisted program. The computer uses logic and coding rules programmed into its memory to code the diagnoses and the procedures. Of course, this system isn't perfect. CAC programs are not advanced enough to handle rules which can be interpreted in several different ways. Not all codes are black and white; however, CAC software can draw the user's attention to any codes it has trouble with.

The second type of CAC software is much more advanced than the first. Some medical providers use a software called **natural language processing** (**NLP**), which can read and translate English. Instead of having to input the diagnoses and procedures to be coded, the entire medical chart can be uploaded into the NLP autocoder. This program will read the chart, pick out the diagnoses and procedures, and then assign the appropriate code.

But how accurate is it? Today, NLP technology is not advanced enough to rival the accuracy of an experienced, human coder. However, NLP software is getting better. Instead of using a rigid set of rules to program the computer-assisted coding, NLP uses complex statistical methods to predict how an experienced human would code the information. Using statistics gives NLP autocoders flexibility, as well as the ability to improve. Like a human, the more the NLP software translates and codes, the better it gets. Like standard computer-assisted programs, NLP software can alert the user when it is unsure about a code. In fact, because it uses statistics, it can say exactly how unsure it is.

But NLP technology isn't perfect. There is more to coding than just connecting the dots! While the NLP autocoding software companies are touting their programs as the next wave in health information management, not everyone is so sure. Many providers are skeptical and question just how valid the programs are. It doesn't matter how fast the programs are if they aren't accurate enough.

What does computer-assisted coding mean for the coding healthcare professional? Will they be replaced by computers? The answer is no, although there will be some changes. Computers will eventually take over much of the manual work of assigning simple codes and transcribing basic medical reports. Computer-assisted coders will zip through the easy and routine codes. However, healthcare professionals will still be needed to tackle all of the challenging reports which stump the computer. And with medicine constantly evolving, there will always be plenty of exciting and new charts to code.

In addition, healthcare professionals may be responsible for managing these programs and their coded data. They may be in charge of quality-control, security, and monitoring the regular additions, deletions, and changes to the code sets. While you won't be working directly with these programs, it's good to know they are out there and how they are used in healthcare.

Step 7: Web-based Medical Records

One of the advantages of being a healthcare professional is that you may work from home. With **Web-based medical records**, the medical record is an encrypted file so unauthorized people can't read it and e-mails it to a secure computer server. The chart is given a digital certificate. A digital certificate is like an electronic lock. Only the person with the right electronic key—such as a password—can open it. When a chart is stored on the server and assigned to a medical billing specialist, it is given a digital certificate that only that healthcare professional can open.

You can either work with the medical chart while it is saved on the server, or you may download the file and work with it after disconnecting from the Internet. The latter is more secure because there are less opportunities for hackers to break in and view the information. Once you're done, you e-mail the chart back to the server and delete the information from your computer.

Security is a very important issue for Web-based medical records. This is especially true with all of the security guidelines mandated by HIPAA. In addition to encryption and digital certificates, physical security is important. The computer you use for home coding shouldn't be used for non-work activities (like Internet shopping). The system should be protected by a password, and others should not have access to it. Some remote companies and agreements stipulate that management can inspect the home office at any time to ensure that security is being maintained.

Now, let's review what you've learned with a Practice Exercise.

Step 8: Practice Exercise 22-1

On scratch paper, identify four trends in the technology of health care.

Step 9: Review Practice Exercise 22-1

Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 10: Lesson Summary

Computers are revolutionizing health care. With electronic health records, they're helping ensure consistent, quality care. With personal health records, computers empower people to manage their own health. On the coding front, they improve accuracy with encoders and speed with computer-assisted coding (CAC) programs. Natural language programming (NLP) will free healthcare professionals up to focus more on managing medical information. The Internet allows more and more people to work safely and efficiently from home. All in all, computers are the future. The change to a fully-electronic health information system will be slow. But it will come, and health care will never be the same. And you will be on the front line of this exciting technology!

Now, complete the following Quiz to demonstrate your understanding of the future of health care.

Step 11: Quiz 20

Once you've mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the Quiz instructions carefully.

Endnotes

1 "Health information exchange (HIE)." Search Health IT, May 10, 2012. Web. 4 October 2013.

2 "Core Functions of an EHR." EHR Scope, July 14, 2009. Web. 4 October 2013.

3 "Computerized Provider Order Entry." Agency for Healthcare Research and Quality. Web. 4 October 2013.

4 "Core Functions of an EHR." EHR Scope. July 14, 2009. Web. 4 October 2013.

5 "Frequently Asked Questions on HITECH Provider Incentives Under Medicare." Minnesota e-Health, 18 June, 2009. Web. 4 October 2013.

6 "Overview." Centers for Medicare & Medicaid Services, 9 April, 2012. Web. 4 October 2013.

7 "Frequently Asked Questions on HITECH Provider Incentives Under Medicare." Minnesota e-Health, 18 June, 2009. Web.

8 Lumpkin, John. "Letter to The Honorable Tommy G. Thompson." 5 Nov., 2003. Web. 4 October 2013.

9 Fluckinger, Don. "SNOMED CT will be coming to EHR systems and patient records near you." TechTarget, n.d. 4 October 2013.

10 "XML vs. HTML: A Publishing Comparison." United States Bureau of the Census's Statistical Compendia Branch, July 19, 2002. Web. 4 October 2013.

Answer Key

Lesson 19

Practice Exercise 19-1

1. Bobby lives with his mother and stepfather. Bobby's mother's health plan is with Windy City Benefits. Bobby's father's health plan is with Rocky Road Health. His stepfather's health plan is with Health Benefits of Northern Colorado. What is the order of the payer coverage? **1) Windy City Benefits; 2) Health Benefits of Northern Colorado; 3) Rocky Road Health**

2. Sally's parents are Mark and Grace. Since both Mark and Grace have family insurance benefits, you will have to use the birthday rule to determine Sally's primary and secondary policies. Mark's birthday is July 10, 1968, and Grace's birthday is September 5, 1967. Which is the primary payer and why? **Sally's primary policy is Mark's, because July 10 comes before September 5 in the calendar year.**

3. Mark and Grace have divorced, and Grace has custody of Sally; however, the court decree indicates that Mark is responsible for Sally's healthcare expenses. Which is the primary payer and why? **Sally's primary policy is still Mark's. Although Grace has custody, the court decree indicates Mark is responsible for the healthcare expense.**

Practice Exercise 19-2

1.

BLUE CROSS OF COLORADO
PO BOX 99

YAMPA, CO 80004-2299

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID# DoD#) CHAMPVA [ ] (Member ID #) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 630A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LEE-CARTER, ANDREW, P

3. PATIENT'S BIRTH DATE MM 01 DD 15 YY 2007 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): CARTER, MARK, K

5. PATIENT'S ADDRESS (No., Street): 883 CENTER CIRCLE

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): 4279 MAIN STREET

CITY: AVON STATE: CO

8. RESERVED FOR NUCC USE

CITY: AVON STATE: CO

ZIP CODE: 80000 TELEPHONE (Include Area Code): (970) 5558812

ZIP CODE: 80000 TELEPHONE (Include Area Code): (970) 5552289

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: BM

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 1191031 488C

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM 07 DD 06 YY 1978 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: BLUE CROSS OF COLORADO

d. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE XX XX XX

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS INJURY or PREGNANCY (LMP) MM 03 DD 18 YY XX QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S93.421A B. W21.9XXA C. Y92.321 D. Y99.8
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	03	20	XX	03	20	XX	11		99212		ABCD	50 00	1		NPI	
2	03	20	XX	03	20	XX	11		73610		ABCD	54 00	1		NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER 33 0457789 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES [X] NO [ ]

28. TOTAL CHARGE $ 104 00

29. AMOUNT PAID $ 0 00

30. Rsvd for Nuccc Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (970)5551514
CHRISTINE JONES MD
1414 SWALLOW STREET
BROWN CO 80001-9898

a. 0203048901 b.

2. Why is $19.00 not covered? **The charge exceeds the UCR for the plan.**

   What is the coinsurance amount for the office visit? **$9.00**

   How much did Blue Cross of Colorado pay Christine Jones, MD? **$68.00**

3.

CIGNA
1212 DRAKE ROAD

CLEVELAND, OH 44102-1912

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid#) TRICARE (ID# DoD#) CHAMPVA (Member ID #) GROUP HEALTH PLAN X (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1191031

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LEE-CARTER, ANDREW, P

3. PATIENT'S BIRTH DATE MM 01 DD 15 YY 2007 SEX M X F

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

5. PATIENT'S ADDRESS (No., Street): 883 CENTER CIRCLE

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child X Other

7. INSURED'S ADDRESS (No., Street): 883 CENTER CIRCLE

CITY: AVON STATE: CO

8. RESERVED FOR NUCC USE

CITY: AVON STATE: CO

ZIP CODE: 80000 TELEPHONE (Include Area Code): (970) 5558812

ZIP CODE: 80000 TELEPHONE (Include Area Code): (970) 5558812

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): CARTER, MARK, K

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 488C

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 630A BM

a. EMPLOYMENT? (Current or Previous) YES X NO

a. INSURED'S DATE OF BIRTH MM 10 DD 09 YY 1980 SEX M F X

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES X NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA

d. INSURANCE PLAN NAME OR PROGRAM NAME: BLUE CROSS OF COLORADO

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE XX XX XX

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS INJURY or PREGNANCY (LMP) MM 03 DD 18 YY XX QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S93.421A B. W21.9XXA C. Y92.321 D. Y99.8

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	03	20	XX	03	20	XX	11		99212		ABCD	50 00	1		NPI
2	03	20	XX	03	20	XX	11		73610		ABCD	54 00	1		NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER 33 0457789 SSN EIN X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? X YES NO

28. TOTAL CHARGE $ 104 00

29. AMOUNT PAID $ 68 00

30. Rsvd for Nuccc Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (970)5551415

CHRISTINE JONES MD
1414 SWALLOW STREET
BROWN CO 80001-9898

a. 0203048901 b.

Practice Exercise 19-3

1.

PREFERRED COVERAGE
729 CLAYTON DRIVE

BROWN, CO 80001-9898

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID# DoD#) CHAMPVA [ ] (Member ID #) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 375067

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HARRIS, BRIAN, D

3. PATIENT'S BIRTH DATE MM DD YY: 03 17 2005 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): HARRIS, JESSICA C

5. PATIENT'S ADDRESS (No., Street): 3721 HUCKLE AVENUE

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): 3721 HUCKLE AVENUE

CITY: BROWN STATE: CO

8. RESERVED FOR NUCC USE

CITY: BROWN STATE: CO

ZIP CODE: 80001 TELEPHONE (Include Area Code): (970) 5552456

ZIP CODE: 80001 TELEPHONE (Include Area Code): (970) 5552456

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): HARRIS, JOHNATHAN, R

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 320

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 40201 H480

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 01 30 1971 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: PREFERRED COVERAGE

d. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE XX XX XX

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS INJURY or PREGNANCY (LMP) MM DD YY: 01 07 XX QUAL 431

15. OTHER DATE MM DD YY QUAL

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S00.11XD B. W50.0XXD C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE FROM MM DD YY	TO MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 17 XX	01 17 XX	11		99212		AB	50 00	1		NPI	0144878804
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 66 6870600 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES [X] NO [ ]

28. TOTAL CHARGE $ 50 00

29. AMOUNT PAID $ 0 00

30. Rsvd for Nuccc Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (970)5553344

FAMILY CARE
1800 CIRCLE COURT
BROWN CO 80001-9898

a. 0881099885 b.

2. What is the amount of the annual family deductible? **$350.00**

   What is the coinsurance amount for the office visit? **$0.00**

   How much did Preferred Coverage pay Roger Small, MD? **$25.00**

3.

CIGNA
1212 DRAKE

CLEVELAND, OH 44102-1912

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID# DoD#) CHAMPVA [ ] (Member ID #) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 40201

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HARRIS, BRIAN, D

3. PATIENT'S BIRTH DATE MM 03 DD 17 YY 2005 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): HARRIS, JOHNATHAN, R

5. PATIENT'S ADDRESS (No., Street): 3721 HUCKLE AVENUE

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): 928 S MONROE

CITY: BROWN STATE: CO

8. RESERVED FOR NUCC USE

CITY: BROWN STATE: CO

ZIP CODE: 80001 TELEPHONE (Include Area Code): (970) 5552456

ZIP CODE: 80001 TELEPHONE (Include Area Code): (970) 5552765

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): HARRIS, JESSICA, C

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 375067 320

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME: PREFERRED COVERAGE

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

c. OTHER ACCIDENT? YES [ ] NO [X]

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: H480

a. INSURED'S DATE OF BIRTH MM 07 DD 07 YY 1972 SEX M [X] F [ ]

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME: CIGNA

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE XX XX XX

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS INJURY or PREGNANCY (LMP) MM 01 DD 07 YY XX QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S00.11XD B. W50.0XXD C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM DD YY	TO MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 17 XX	01 17 XX	11		99212		AB	50 00	1		NPI	0144878804
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER 66 6870600 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES [X] NO [ ]

28. TOTAL CHARGE $ 50 00

29. AMOUNT PAID $ 25 00

30. Rsvd for Nuccc Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (970)5553344

FAMILY CARE
1800 CIRCLE COURT
BROWN CO 80001-9898

a. 0881099885 b.

Lesson 20

Practice Exercise 20-1

1. **5** Federal Tax Number
2. **51** Health Plan ID
3. **58** Insured's Name
4. **8b** Patient Name
5. **50** Payer Name
6. **2** Pay-to Name and Address
7. **74** Principal Procedure Code/Date
8. **38** Responsible Party Name and Address
9. **42** Revenue Code
10. **45** Service Dates

Practice Exercise 20-2

1. The patient's control number in FL 3a is **CA4456A**.
2. The one-digit code indicating the reason for the admission is **2**.
3. The one-digit code indicating the source of the referral for this admission or visit. **1**
4. The occurrence span dates are **0512XX-0513XX**.
5. The radiology KUB charge is **$188.00**.
6. FL 52 is completed "Y" indicating the provider has what? **A signed statement permitting the provider to release data for reimbursement**.
7. The principal procedure code is **0TF43ZZ**.
8. The physician who performed the surgical procedure is **Jennifer Rose**.
9. The attending physician is **Donald Allen**.
10. The NPI for Rocky Mountain Hospital is **6565886565**.

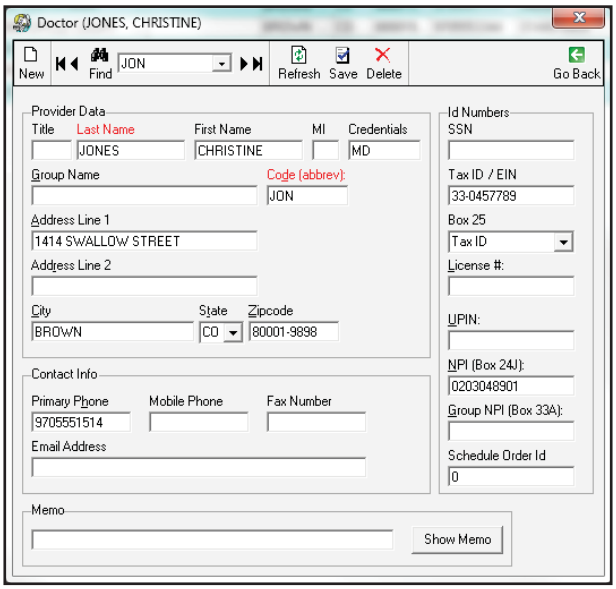
Lesson 21

Practice Exercise 21-1

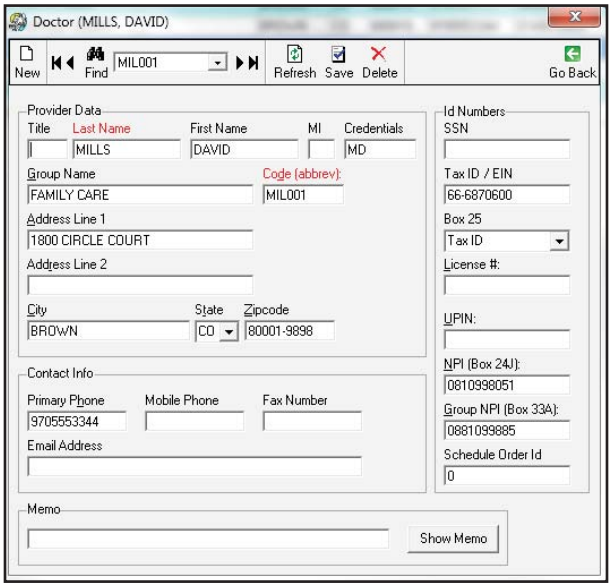
1. Clearinghouse **i. Company that facilitates the processing of claims**
2. Carrier-direct submission **e. When a provider files a claim directly to the insurance company**
3. Digitizing **a. The process of entering data into a computer record**
4. Paper claims **d. Non-electronic claim forms**
5. Direct deposit **g. A method by which a payer can have money placed into a provider's account**
6. Web-based claim submission **c. Claim submitted via a carrier's Web site**
7. Modem **j. Allows you to submit claims electronically via computer**
8. Clean claim form **b. A claim form without errors**
9. Per-claim charge **h. One type of fee that a clearinghouse charges to submit claims**
10. Payers **f. Insurance companies**

Practice Exercise 21-2

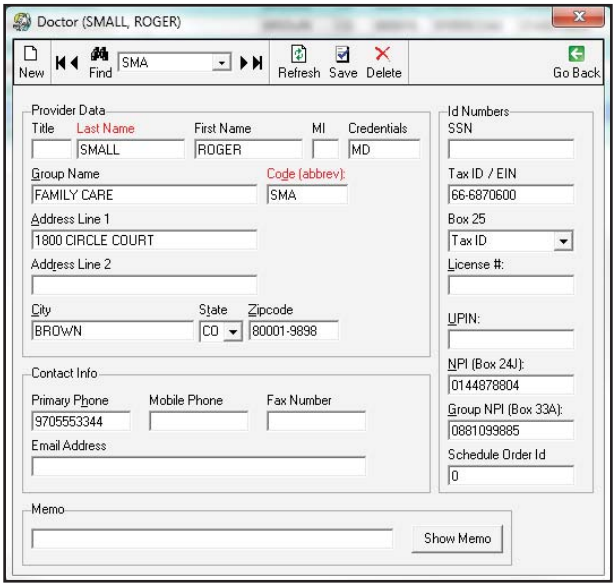
1. **Click *Folders, Providers, New Provider* to enter the provider information.**



2. Click *Folders, Providers, New Provider* to enter the provider information.



3. Click *Folders, Providers, New Provider* to enter the provider information.



4. **Click *Folders, Insurance Carriers, New Insurance Carrier* to enter the insurance information. Note: The *Code Id* may vary.**

Insurance Carrier (BLUE CROSS OF WYOMING)

New | Find | BLUE CROSS | Refresh | Save | Delete | Recent | Go Back

Demographics
Carrier Name: BLUE CROSS OF WYOMING
Code Id (Abbrev): BLUE CROSS
Serial #: 6
Address: PO BOX 465
Address 2:
City: CASPER
State: WY
Zip Code: 82002-0456
Contact Person:

Contact Info
Primary Phone
Mobile Phone
Fax Number
Secondary Phone
Email Address

Box11d
Yes if box 9 contains primary or secondary
Yes if box 9 is primary only
Leave Blank

Type Settings
Claims Submission Mode:
Send To Printer
Send To File (electronic)
None (No batch claims)
Insurance Type: 5 Group Health

Print To File Name
CLAIMS.TXT
CLAIMS2.TXT
CLAIMS3.TXT

Defaults
Accept Assignment: Accept Assignment
Pay Provider

Layout File [Default Layout]
Edit ...
C:\Users\Brenda\Documents\MedLook4\40\Cms1500NPI.xml

PINS for 24J and 32B
Name/Facility | PIN
Record: of 0

ID Numbers
Group # (Box 33B)
Payor ID
EligibilityID

More
Category/Group
Memo
CrossOver
Show Memo

Box 33 (Billing Provider)
Use Group Info if available
Use Provider Info

5. **Click *Folders, Insurance Carriers, New Insurance Carrier* to enter the insurance information. Note: The *Code Id* may vary.**

Insurance Carrier (CIGNA)

New | Find | CIGNA | Refresh | Save | Delete | Recent | Go Back

Demographics
Carrier Name: CIGNA
Code Id (Abbrev): CIGNA
Serial #: 7
Address: 1212 DRAKE
Address 2:
City: CLEVELAND
State: OH
Zip Code: 44102-1912
Contact Person:

Contact Info
Primary Phone
Mobile Phone
Fax Number
Secondary Phone
Email Address

Box11d
Yes if box 9 contains primary or secondary
Yes if box 9 is primary only
Leave Blank

Type Settings
Claims Submission Mode:
Send To Printer
Send To File (electronic)
None (No batch claims)
Insurance Type: 5 Group Health

Print To File Name
CLAIMS.TXT
CLAIMS2.TXT
CLAIMS3.TXT

Defaults
Accept Assignment: Accept Assignment
Pay Provider

Layout File [Default Layout]
Edit ...
C:\Users\Brenda\Documents\MedLook4\40\Cms1500NPI.xml

PINS for 24J and 32B
Name/Facility | PIN
Record: of 0

ID Numbers
Group # (Box 33B)
Payor ID
EligibilityID

More
Category/Group
Memo
CrossOver
Show Memo

Box 33 (Billing Provider)
Use Group Info if available
Use Provider Info

6. Click *Folders, Insurance Carriers, New Insurance Carrier* to enter the insurance information. Note: The *Code Id* may vary.

Insurance Carrier (COUNTRY GROUP LIFE)

New | Find | COUNTRY GR | Refresh | Save | Delete | Recent | Go Back

Demographics
Carrier Name: COUNTRY GROUP LIFE
Code Id (Abbrev): COUNTRY GR
Serial #: 8
Address: PO BOX 37
Address 2:
City: TOLEDO
State: OH
Zip Code: 43623-0037
Contact Person:

Contact Info
Primary Phone
Mobile Phone
Fax Number
Secondary Phone
Email Address

Box11d
Yes if box 9 contains primary or secondary
Yes if box 9 is primary only
Leave Blank

Type Settings
Claims Submission Mode:
Send To Printer
Send To File (electronic)
None (No batch claims)
Insurance Type: 5 Group Health

Print To File Name
CLAIMS.TXT
CLAIMS2.TXT
CLAIMS3.TXT

Defaults
Accept Assignment: Accept Assignment
Pay Provider

Layout File [Default Layout]
Edit ...
C:\Users\Brenda\Documents\MedLook4\40\Cms1500NPI.xml

PINS for 24J and 32B
Name/Facility | PIN
Record: of 0

ID Numbers
Group # (Box 33B)
Payor ID
EligibilityID

More
Category/Group
Memo
CrossOver
Show Memo

Box 33 (Billing Provider)
Use Group Info if available
Use Provider Info

7. Click *Folders, Insurance Carriers, New Insurance Carrier* to enter the insurance information. Note: The *Code Id* may vary.

Insurance Carrier (MEDLINK)

New | Find | MEDLINK | Refresh | Save | Delete | Recent | Go Back

Demographics
Carrier Name: MEDLINK
Code Id (Abbrev): MEDLINK
Serial #: 9
Address: PO BOX 560
Address 2:
City: BROWN
State: CO
Zip Code: 80001-0560
Contact Person:

Contact Info
Primary Phone
Mobile Phone
Fax Number
Secondary Phone
Email Address

Box11d
Yes if box 9 contains primary or secondary
Yes if box 9 is primary only
Leave Blank

Type Settings
Claims Submission Mode:
Send To Printer
Send To File (electronic)
None (No batch claims)
Insurance Type: 5 Group Health

Print To File Name
CLAIMS.TXT
CLAIMS2.TXT
CLAIMS3.TXT

Defaults
Accept Assignment: Accept Assignment
Pay Provider

Layout File [Default Layout]
Edit ...
C:\Users\Brenda\Documents\MedLook4\40\Cms1500NPI.xml

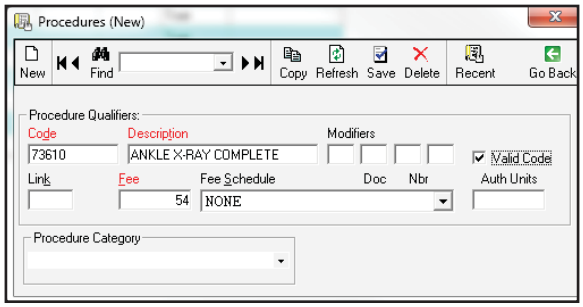
PINS for 24J and 32B
Name/Facility | PIN
Record: of 0

ID Numbers
Group # (Box 33B)
Payor ID
EligibilityID

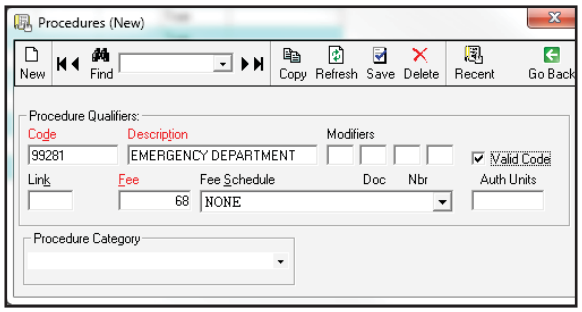
More
Category/Group
Memo
CrossOver
Show Memo

Box 33 (Billing Provider)
Use Group Info if available
Use Provider Info

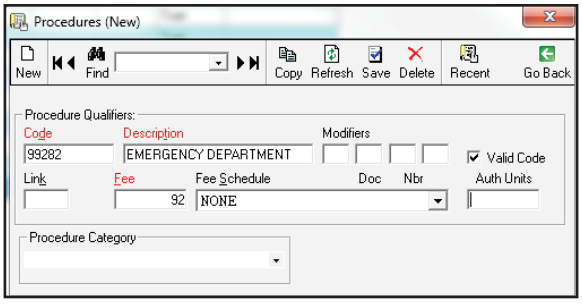
8. **Click *Folders, Procedure Codes, New Procedure code* to enter the procedure code, description and fee.**



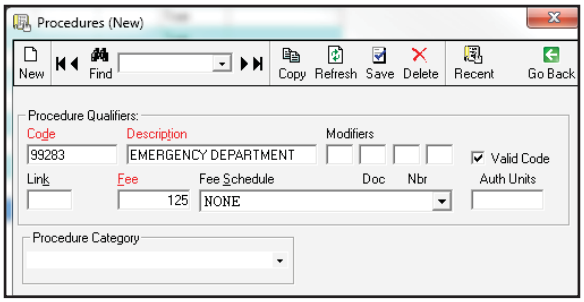
9. **Click *Folders, Procedure Codes, New Procedure code* to enter the procedure code, description and fee.**



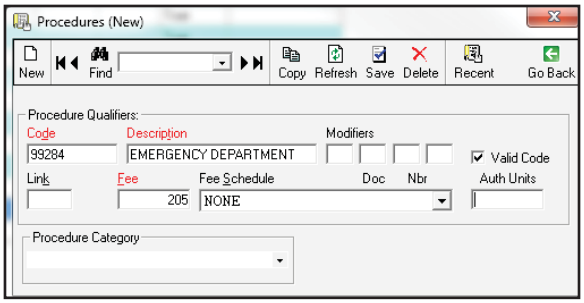
10. **Click *Folders, Procedure Codes, New Procedure code* to enter the procedure code, description and fee.**



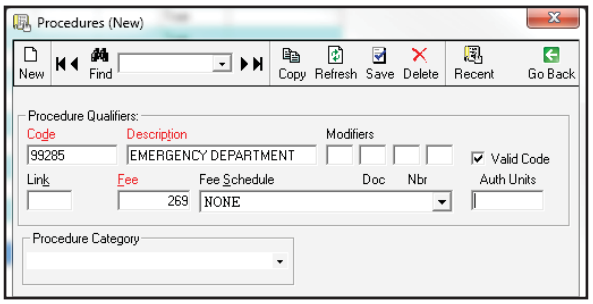
11. **Click *Folders, Procedure Codes, New Procedure code* to enter the procedure code, description and fee.**



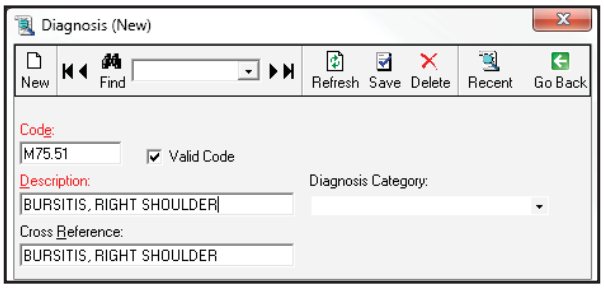
12. Click *Folders, Procedure Codes, New Procedure code* to enter the procedure code, description and fee.



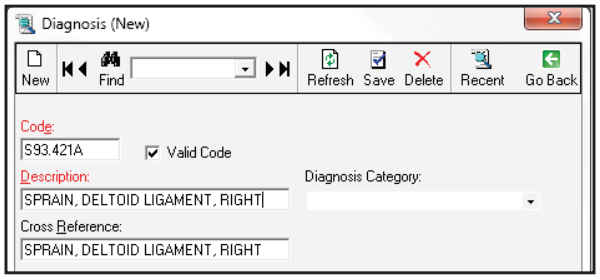
13. Click *Folders, Procedure Codes, New Procedure code* to enter the procedure code, description and fee.



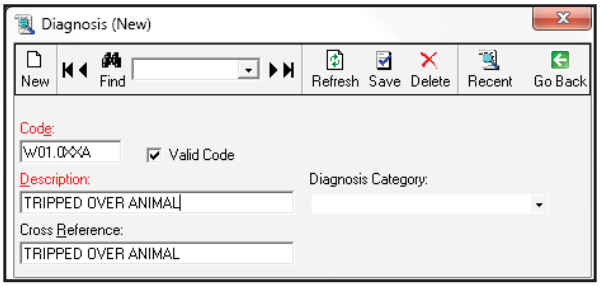
14. Click *Folders, Diagnosis Codes, New Diagnosis code* to enter the diagnosis code and description.



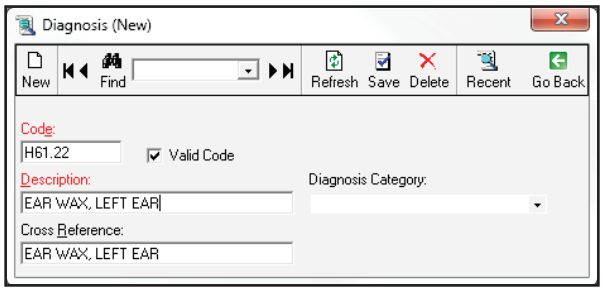
15. Click *Folders, Diagnosis Codes, New Diagnosis code* to enter the diagnosis code and description.



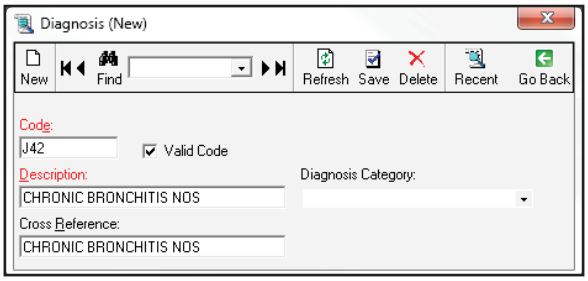
16. Click *Folders, Diagnosis Codes, New Diagnosis code* to enter the diagnosis code and description.



17. Click *Folders, Diagnosis Codes, New Diagnosis code* to enter the diagnosis code and description.



18. Click *Folders, Diagnosis Codes, New Diagnosis code* to enter the diagnosis code and description.



Practice Exercise 21-3

1. Kristen Arnold

Enter the demographics as below:

Demographics

Account Number	10005
Copy Existing Patient	
Full Name	KRISTEN A ARNOLD
Last Name	ARNOLD
First Name	KRISTEN
MI	A
Title	
Address	3519 HABIT ROAD
2nd Line	
City	YAMPA
State	CO
Zip Code	80004
County	
Country	
SSN	
Birth Date	4/7/2011
Sex	Female
Chart Number	10005
Home Phone	(970)555-8838
Work Phone	
Extension	
Mobile	
Fax	
Email	

Enter the Referral/Physician as below. Then, click *Save* to add the insurance.

Referral/Physician

Print on insurance form?	Yes
Referral Source	
Referral Name	
Click to Remove Referral	
Responsible Physician	MILLS, DAVID - MIL001
Physician Code	MIL001
Fee Schedule	

Enter the primary and secondary insurance informatio. Please note, the Plan/Program information may vary. "BC" is acceptable for Blue Cross.

Manage Insurance Policies - #10005 - ARNOLD, KRISTEN

Is Active	Order	Policy	Carrier	Ins Mnem	Group	Employer	Plan/Program	Accept /	Pay	Copay	Percent	Deductible	Start Date	Ending Date	Box 10	Box 19
☐	Secondary	73055	CIGNA	CIGNA	488C		CIGNA	Accept Assignment	Yes	$10.00	0	$0.00				
☑	Primary	811924	BLUE CROSS OF OHIO	BLUE C...	J620		BC OF OHIO	Accept Assignment	Yes	$0.00	0	$0.00				
☐	Secondary	73055	COUNTRY GROUP LIFE	COUNT...	2108		COUNTRY GRO...	Accept Assignment	Yes	$0.00	0	$0.00				

Medicare Plus2	Insured Relation	Sex	DOB	Phone	Ins First	Ins MI	Ins Last	Address1	Address2	Zip	City	State
None	Self	Female	4/7/2011	9705558838	KRISTEN	A	ARNOLD	3519 HABIT ROAD		80004	YAMPA	CO
None	Child	Female	1/10/1989	9705558838	BARBARA	J	ARNOLD	3519 HABIT ROAD		80004	YAMPA	CO
None	Child	Male	12/23/1990	9705558838	PETER	J	ARNOLD	3519 HABIT ROAD		80004	YAMPA	CO

The *Summary* tab for Kristen Arnold should appear as follows:

ARNOLD, KRISTEN A	**Acct:** 10005, **Sex:** Female	**Primary Insurance** (t: Unknown)
3519 HABIT ROAD	**DOB:** 4/7/2011 **Age:** X	BLUE CROSS, Assigned, 811924
YAMPA, CO 80004	**H:** (970)555-8838	3737 SYLVANIA AVENUE,
SSN:	**W:** Unknown	TOLDEO, OH 43623-4422
DOL Bill: Charge: Payment:		**Copay:** $0.00 (or **%Copay:** $0.00)
Phys: MIL001 **Status:** True	**Note:**	
Marital Status:	**Referral:**	
Auto Billing: On **Recall Date:**	**ICD9s:**	

Balance Summary					
Primary Insurance:	0.00	**Patient:**	0.00	**Charges/Debits:**	0.00
Secondary Insurance:	0.00	**Other:**	0.00	**Payments/Credits:**	0.00

Aging	**0-30**	**31-60**	**61-90**	**91-120**	**120+**	**Unassigned**	**Total**
PatAging	0.00	0.00	0.00	0.00	0.00		0.00
InsAging	0.00	0.00	0.00	0.00	0.00		0.00
Balance	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Unposted	**Charges**	**Payments**	**Credits**	**Debits**	
Totals:	0.00	0.00	0.00		

Responsible Party	**Scheduled Appointments**	**Secondary Insurance** (t: Unknown)
		COUNTRY GR, Assigned, 73055
		PO BOX 37,
		TOLEDO, OH 43623-0037
		Managed Care
		From to
		Visits of
		Code

2. Rebecca Bloom

Enter the demographics as below:

Demographics	
Account Number	10006
Copy Existing Patient	
Full Name	REBECCA K BLOOM
Last Name	BLOOM
First Name	REBECCA
MI	K
Title	
Address	409 YORKSHIRE COURT
2nd Line	
City	BROWN
State	CO
Zip Code	80001
County	
Country	
SSN	
Birth Date	6/25/2007
Sex	Female
Chart Number	10006
Home Phone	(970)555-5875
Work Phone	
Extension	
Mobile	
Fax	
Email	

Enter the Referral/Physician as below. Then, click *Save* to add the insurance.

Referral/Physician	
Print on insurance form?	Yes
Referral Source	
Referral Name	
Click to Remove Referral	
Responsible Physician	NORTH, GREG - NOR
Physician Code	NOR
Fee Schedule	

Enter the primary insurance information as below:

Manage Insurance Policies - #10006 - BLOOM, REBECCA

Is Active	Order	Policy	Carrier	Ins Mnem	Group	Employer	Plan/Program	Accept	Pay	Copay	Percent	Deductible	Start Date	Ending Date	Box 10	Box 19
☑	Primary	52960	BLUE CROSS OF WYOMING	BLUE C...	BM		BLUE CROSS O...	Accept Assignment	Yes	$20.00	0	$0.00				
☑	Primary	52960	MEDLINK	MEDLIN...	WB02	"	MEDLINK	Accept Assignment	Yes	$0.00	0	$0.00				

Medicare Plus2	Insured Relation	Sex	DOB	Phone	Ins First	Ins MI	Ins Last	Address1	Address2	Zip	City	State
None	Self	Female	6/25/2007	9705555875	REBECCA	K	BLOOM	409 YORKSHIRE...		80001	BROWN	CO
None	Child	Male	3/10/1977	9705555875	RICHARD	M	BLOOM	409 YORKSHIRE...		80001	BROWN	CO

The *Summary* tab for Rebecca Bloom should appear as follows:

BLOOM, REBECCA K	**Acct:** 10006, **Sex:** Female	**Primary Insurance** (t: Unknown)
409 YORKSHIRE COURT	**DOB:** 6/25/2007 **Age:** X	MEDLINK, Assigned, 52960
BROWN, CO 80001	**H:** (970)555-5875	PO BOX 560,
SSN:	**W:** Unknown	BROWN, CO 80001-0560
DOL Bill: Charge: Payment:		**Copay:** $0.00 (or **%Copay:** $0.00)
Phys: NOR **Status:** True	**Note:**	
Marital Status:	**Referral:**	
Auto Billing: On **Recall Date:**	**ICD9s:**	

Balance Summary					
Primary Insurance:	0.00	**Patient:**	0.00	**Charges/Debits:**	0.00
Secondary Insurance:	0.00	**Other:**	0.00	**Payments/Credits:**	0.00

Aging	**0-30**	**31-60**	**61-90**	**91-120**	**120+**	**Unassigned**	**Total**
PatAging	0.00	0.00	0.00	0.00	0.00		0.00
InsAging	0.00	0.00	0.00	0.00	0.00		0.00
Balance	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Unposted	**Charges**	**Payments**	**Credits**	**Debits**	
Totals:	0.00	0.00	0.00		

Responsible Party	**Scheduled Appointments**	**Secondary Insurance** (t:)
		None, N/A,
		Managed Care
		From to
		Visits of
		Code

Practice Exercise 21-4

1. Kristen Arnold

BLUE CROSS OF OHIO

3737 SYLVANIA AVENUE
TOLEDO, OH 436234422

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID# DoD#) CHAMPVA [ ] (Member ID #) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1): 811924
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ARNOLD KRISTEN A
3. PATIENT'S BIRTH DATE MM 04 DD 07 YY 2011 SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): ARNOLD BARBARA J
5. PATIENT'S ADDRESS (No., Street): 3519 HABIT ROAD
6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]
7. INSURED'S ADDRESS (No., Street): 3519 HABIT ROAD
CITY: YAMPA STATE: CO
8. RESERVED FOR NUCC USE
CITY: YAMPA STATE: CO
ZIP CODE: 80004 TELEPHONE (Include Area Code): (970) 5558838
ZIP CODE: 80004 TELEPHONE (Include Area Code): (970) 5558838
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): ARNOLD PETER J
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: J620
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 73055
a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM 01 DD 10 YY 1989 SEX M [ ] F [X]
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: BLUE CROSS OF OHIO
d. INSURANCE PLAN NAME OR PROGRAM NAME: COUNTRY GROUP LIFE
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

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

14. DATE OF CURRENT ILLNESS INJURY or PREGNANCY (LMP) MM 10 DD 11 YY XX QUAL 431
15. OTHER DATE QUAL MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. J069 B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10	11	XX	10	11	XX	11		99202		A	71 00	1		NPI	0810998051
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER 66 6870600 SSN [ ] EIN [X]
26. PATIENT'S ACCOUNT NO. XXXXX
27. ACCEPT ASSIGNMENT? YES [X] NO [ ]
28. TOTAL CHARGE $ 71 00
29. AMOUNT PAID $ 0 00
30. Rsvd for Nuccc Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
DAVID MILLS MD
SIGNED DATE XX XX XX
32. SERVICE FACILITY LOCATION INFORMATION
a. b.
33. BILLING PROVIDER INFO & PH # (970)5553344
FAMILY CARE
1800 CIRCLE COURT
BROWN CO 800019898
a. 0881099885 b.

2. Rebecca Bloom

MEDLINK

PO BOX 560
BROWN, CO 800010560

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID# DoD#) CHAMPVA [ ] (Member ID #) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 52960

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BLOOM REBECCA K

3. PATIENT'S BIRTH DATE MM DD YY: 06 25 2007 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): BLOOM RICHARD M

5. PATIENT'S ADDRESS (No., Street): 409 YORKSHIRE COURT

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street): 409 YORKSHIRE COURT

CITY: BROWN STATE: CO

8. RESERVED FOR NUCC USE

CITY: BROWN STATE: CO

ZIP CODE: 80001 TELEPHONE (Include Area Code): (970) 5555875

ZIP CODE: 80001 TELEPHONE (Include Area Code): (970) 5555875

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: WB02

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 03 10 1977 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDLINK

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE DATE: XX XX XX

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS INJURY or PREGNANCY (LMP) MM DD YY: 11 27 XX QUAL 431

15. OTHER DATE MM DD YY QUAL

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. J42 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS UNITS	H. EPSDT FAMILY	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11	27	XX	11	27	XX	11		99213		A	69 00	1		NPI	
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER: 47 9823559 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: XXXXX

27. ACCEPT ASSIGNMENT? YES [X] NO [ ]

28. TOTAL CHARGE $ 69 00

29. AMOUNT PAID $ 0 00

30. Rsvd for Nuccc Use

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

GREG NORTH MD

SIGNED DATE XX XX XX

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (970)5552222

GREG NORTH MD
800 MEDICAL COURT
BROWN CO 800019898

a. 0405674390 b.

Lesson 22

Practice Exercise 22-1

1. **Electronic health records will replace paper health records.**
2. **People will use personal health records and take more responsibility for their health and well-being.**
3. **Providers will move toward an electronic document management system based on computers.**
4. **Electronic coding will complete many of the easy, simple coding tasks.**