Video Mentor Self-Reflection

Instructions for using this document.

1. Download the document to your desktop.
2. Open document from your desktop.
3. Complete exercise by filling in your responses.
4. Save all changes as you use the document. Please note there are multiple assignments in the document.
5. Follow your facilitators instructions to submit the assignment.

MODULE 1

Indicators of Potential Billing Fraud and Abuse

BILLEE: The new provider who will be working in our after-hours clinic just asked me about coding encounters and suggested that we report 99205 or 99215 for all encounters. The provider feels this is okay since the patients will likely have urgent or acute problems. This isn't a good idea, but I'm just not sure how to respond.

CODEE: I agree this is a challenging situation, but it's important to address the issue. Coding every patient at the highest level - just because it's after hours - is incorrect coding, and would be an indicator of potential fraud. This would be a red flag to Medicare or any other payer, and it goes against our policies. The best way to address it is to remind the provider of our documentation policy and to state that code assignment is based on the documentation for each encounter.

BILLEE: I agree! Thanks for talking about this with me. I knew the answer all along, but it's great to have support when communicating with others.

As a medical biller and coder, you will be responsible for verifying accuracy of codes and claims. What will you look for as an indicator of fraud and abuse while coding or preparing claims? What actions would you take if you discovered an instance of fraud or abuse? In the field below, take on Billee's task and provide a response to the provider. Your message should include the following.

- Your purpose and responsibility related to the accuracy of codes and claims.
- Your concerns about the proposed coding for all afterhours encounters.
- Steps you will take if you identify an instance of fraud or abuse.

RESPONSE	

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Billee is covering the front desk phones during lunch and answers a patient call.

BILLEE: ABC clinic, this is Billee - how may I help you?

PATIENT: I'm having a scheduled surgical procedure next week, and I wanted to know if you must release my private health history to the hospital. It's very personal and I don't want it shared.

BILLEE: Sure, I can help you. May I ask what your specific concern is?

PATIENT: I am HIV positive. I don't want to be treated differently because of it.

BILLEE: I understand your concern. To make sure that you get the best possible care, we need to provide the hospital with your health history, including your HIV status.

In this case, disclosing the patient's HIV status is necessary to coordinate care and manage the condition.

In this situation, Billee had to prioritize care management and the confidentiality of patient records. What are some examples of precautions Billee could take to protect confidentiality?

RESPONSE	

MODULE 2

Claim Processing Denial

Billee finds an error with data entry on both the patient demographic information and the insurance policy number. The patient's DOB is 12/10/53; however, it was entered as 12/10/35. And the policy number is 48569275, but it was entered as 45869275. The cause of the error was due to numbers in the DOB and insurance plan being transposed. The claim was corrected and resubmitted.

Billee plans a billing department training meeting to review the critical elements of patient registration, insurance screen details, and the impact to the revenue cycle that occurs when claims are submitted with errors.

There can be many reasons a claim may be denied. If Billee came to you to help create a questionnaire to help target why this issue keeps happening, what are two reasons that you'd recommend she include and why?

RESPONSE	

Preauthorization and Patient Responsibility

Billee calls BCBS UM department and provides the insurance agent with the patient's name, DOB, policy number, and plan. She explains the reason for the call is to obtain an urgent preauthorization for carpal tunnel surgery on Mr. James's right hand and determine the insurance benefits and patient responsibility for the procedure.

Billee provides the agent with the patient's medical history. Over the past three months, Mr. James has tried conservative treatment with OTC Tylenol, NSAIDS medication, a hand brace that is used at work night, steroid injections, and physical therapy with no results. The patient reports constant pain in the palm of the hand and numbness with tingling in the little finger and a recent exacerbation is causing acute pain rated 8 out of 10.

The agent provided Billee with an authorization number and expiration date, with the understanding that a written copy would be provided later in the day. Billee documents this information in the patient account notes and notifies the patient scheduler to prioritize this patient's case.

Billee would normally have used the practice management system to request the preauthorization for this elective service. However, in this case, an urgent request was appropriate. Payers have different protocols for preauthorizations, and Billee knew that calling in this case was the best solution.

Why is obtaining a preauthorization important before medical services are provided?

If Billee does not obtain the required preauthorization, what are the implications to the provider, practice, and patient?

Identify three ways Billee effectively communicated the necessity of this preauthorization.

RESPONSE	

CPT® vs HCPCS

Codee is correcting claims and notes that several Medicare claims were denied because of incorrect code assignment.

Codee realizes that the new coder may have forgotten to check the insurance type when reviewing the code assignments, since CPT codes were assigned instead of HCPCS codes for screening services and annual wellness visits.

Codee makes note of the most common error—using preventive medicine service CPT codes (99381–99397) instead of the Medicare specific HCPCS codes G0438–G0439 for annual wellness visits—and plans a brief meeting with the biller to review this important payer-specific requirement.

Sometimes knowing which code set to use can be confusing. Using the wrong code set or leaving off certain codes from the claim can negatively affect the revenue cycle. What have you learned in your studies to know when and how to differentiate whether to use CPT or HCPCS codes? Provide two examples.

RESPONSE	

MODULE 3

Abstracting Health Information

Codee is searching through the new electronic health record (EHR) system and cannot find the operative report needed to code the providers surgical services. Billee notices their frustration and asks if Codee is doing okay.

BILLEE: You seem frustrated. Is there something I can do to help you?

CODEE: The billing software shows a pacemaker that was placed last week. The only patient encounter under the NOTES tab in the EHR is the hospital admission. And that does not help me to verify the coding for the pacemaker insertion.

BILLEE: The NOTES tab includes admissions and progress notes for subsequent provider encounters. The SURGERY tab in the EHR will include both inpatient and outpatient surgery reports by the date of the procedure. Let's look in the SURGERY tab to see if we can find the correct documentation.

CODEE: Yes, I found it under the SURGERY tab. Thank you. It is going to take some time to learn this new EHR system because I am used to the old one.

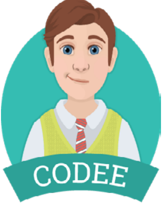
BILLEE: You are welcome. It is going to take time to for everyone to become familiar with the new system, but the results are worth it.

Electronic health record systems are used throughout the health care industry. Navigation will vary based on the vendor and organization; however, the organization of the data (progress notes, lab and diagnostic reports, etc.) will be relatively the same. It is important to locate the necessary information to review the medical records and assign the correct codes for claim submission.

When working as a biller and coder, you will likely be working in an EHR, both in abstracting and reviewing progress notes and in verifying accuracy of codes and transmitting claims. There are many EHRs on the market, and each is different yet contains many similarities. What kind of EHR training do you think is necessary to do your job efficiently and accurately? How would you convey what your proficiency is using an EHR and electronic code look-up?

RESPONSE	

Choosing the Correct E/M Code Level



Billee approaches Codee to discuss an upcoming staff in-service for Evaluation and Management coding.

BILLEE: I am excited about our upcoming in-service for E/M coding. What do you think is the best way to open a conversation about choosing the correct code level?

CODEE: I think we should focus on the requirements for the services that we report most often—office visits and preventive medicine services. By focusing on explaining the requirements for each level, we can improve our reporting and billing accuracy.

BILLEE: Great idea, I will create some examples based on our typical billing scenarios.

It is important to understand the guidelines for Evaluation and Management code selection. Sometimes E/M codes are intentionally downcoded, due to uncertainty. A billing and coding specialist can help prevent a reduction in revenue by performing routine in-service training for E/M and other coding topics as a way to support correct coding and the revenue cycle.

Working in the outpatient/ambulatory field, you will be using E/M codes for most claims. The rules for applying E/M codes are very specific. What are those rules, and how are they different for new and established patients?	
RESPONSE	

Coding for Specialty Areas

Codee approaches Billee to explain a code change made to the patient's encounter form.

CODEE: Hi, I wanted to make sure you knew why there was a code change on this encounter form. The original code was for a mid-level telehealth E/M service. But in this case, the code for a psychiatric diagnostic evaluation services applies and is an acceptable telehealth service. Because the documentation supports the use of the psychiatric evaluation code, I spoke with the provider, who approved the change and then updated the encounter form with the new code.

BILLEE: Thank you for taking a few minutes to explain this change to me. I will verify with the payer that this code is a covered benefit for the patient. I also think we should mention this at this week's staff meeting to make sure we are correctly capturing telehealth encounters.

There have been a number of codes added to the acceptable telehealth services list since these services began over a decade ago. There have also been many new and revised regulations regarding billing for telehealth services. Billing and coding specialists should periodically review individual payer policies and state regulations regarding telehealth services to help prevent claim rejections and reduced reimbursement.

Think about all the types of specialty services in health care and how recently there has been a big adoption of telehealth services due to the COVID-19 pandemic. Where would you look for new and updated codes? How is telehealth used in specialty practices? What would you need to be aware of when coding and billing telehealth services?	
RESPONSE	

MODULE 4

Submitting Clean Claims

Codee approaches Billee with an idea for improving the submission rate of clean claims.

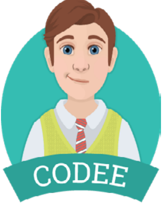
CODEE: I have been reviewing the rejection analysis report, and I was wondering if we could talk about my observations? I think if we work together, we can come up with a way to improve our clean claim submission rate.

BILLEE: That sounds great! Let's plan a time to talk about it and schedule a billing department in-service meeting.

Reflection: The success of the revenue cycle is largely dependent on rapid and accurate reimbursement, which is influenced by the rate of clean claims submitted. An organization's success can be linked to its ability to discover and adapt to areas of challenge or improvement.

Reflecting on the video, what contributes to the success of the revenue cycle? How would you, as a biller and coder, ensure that claims are clean at first submission?	
RESPONSE	

Analyze Aging Reports



Billee is reviewing patient accounts in the billing system and discovers a 60-day-old claim that has no payment posted. Billee checks the insurance portal and discovers payment was issued 20 days ago.

BILLEE: Codee, I noticed a payment was issued for a claim, but the amount did not get posted to the patient account. Now the claim is in the 60-day column of the AR. How can I resolve this?

CODEE: Let me show you how to manually post the payment to the claim in the patient account. Good catch, by the way. It's great that you investigated the claim instead of rebilling it.

The financial health of the practice depends upon collecting all receivables in a timely manner. Where are there opportunities to collect patient balances? Explain how you would communicate with a patient regarding an amount due.

RESPONSE	

Collecting Patient Responsible Amounts

The medical billing specialist is checking in a patient at the front desk.

BILLEE: OK, Mrs. Miller, your insurance requires a $20 copay. Will you be paying that with cash or debit today?

PATIENT: I'd like to use my debit card. I don't usually carry cash.

It is important to collect the patient copay at the time of service. The copay is the contractual amount the patient has agreed to pay for professional medical services they receive from the provider.

Thinking about how and when copays are collected, why is it important to collect copays at the time of service? What tools are available to view copay amounts and amounts due? In your studies, if you learned about real-time adjudication (RTA), how is that used and to what benefit of the practice?

RESPONSE	

Resolve Claim Denials and Rejections

The medical billing specialist is working on claim denials and rejections.

Brief tip or pointer

Denied claims are claims that were received and processed by the payer and determined to be unpayable. A rejected claim contains one or more errors found before the claim was processed. Medical claims that are rejected were never entered into the payer's computer system because the data requirements were not met.

Reflection: It is important that medical billing specialists understand the difference between denied claims and rejected claims.

Think about the effect on the revenue cycle when there are claim denials and rejections. Many times, you will note that the contracted amount of the service may in fact be a very low fee—for example, the administration of a vaccine to a Medicare patient. Reflect on the amount of administrative time that will be required to investigate why the claim was denied or rejected and the administrative time that will be required to correct and resubmit the claim. What actions will you incorporate as a biller and coder to ensure clean and accurate claims and ethical coding?

RESPONSE	