APPENDIX

C

ICD-9-CM Information

ICD-9-CM DIAGNOSTIC CODING

Accurate diagnostic coding gives insurance carriers clearly defined diagnoses to help them process claims efficiently. An error in coding conveys to an insurance carrier the wrong reason a patient received medical services. This causes confusion, a delay in processing, and possibly a reduced payment or denial of a claim. An incorrect code may also raise the question of fraudulent billing if the insurance company decides that, based on the diagnosis, the services provided were not medically necessary. Active diagnostic code databases can also provide statistics for medical researchers, physicians, and third-party payers about costs, trends, and future healthcare needs.

The *ICD-9-CM*

The diagnosis codes are found in the ***ICD-9-CM***, the *International Classification of Diseases*. The *ICD* lists codes according to a system assigned by the World Health Organization of the United Nations. *ICD* codes are used by government healthcare programs, professional standards review organizations, medical researchers, hospitals, physicians, and other healthcare providers. Private and public medical insurance carriers also use the codes.

The *ICD* has been revised a number of times. In the title, *ICD-9-CM*, the initials *CM* indicate that the edition is a clinical modification. For example, the *ICD-9-CM* is the clinical modification of the ninth revision of the *ICD.* Codes in this modification describe various conditions and illnesses with more precision than did earlier codes. Since 1988, *ICD-9-CM* coding has been required on all Medicare claims. HIPAA mandates the use of current *ICD-9-CM* codes on insurance claim forms. Updates of the *ICD-9-CM* are published every year. However, as of October 1, 2014, *ICD-9-CM* codes will no longer be used; instead, *ICD-10-CM* codes are the HIPAA-mandated code set for insurance claim forms from that point forward. Medical offices should have a copy of the most recent publication.

The *ICD-9-CM* uses three-digit codes for broad categories of diseases, injuries, and symptoms. Fourth- and fifth-level codes are created by the addition of a decimal point followed by a one- or two-digit subclassification suffix (for example, *380.01* [2013 edition] represents a fifth-level diagnostic code). Such subclassification permits the specification of a diagnosis as exactly as possible.

In addition to the categories for diseases, there are two sections of *ICD-9-CM* codes that begin with the letters *V* and *E*. These letters are followed by up to four digits. The codes that begin with a *V* are used for visits for reasons other than illness or injury. In these situations, patients often do not have a complaint or an active diagnosis. For example, a routine annual physical examination is a reason for an office visit without a complaint. Visits for treatments for already diagnosed conditions, such as for chemotherapy for cancer, also receive codes beginning with a *V.* Codes beginning with an *E* indicate the external cause of an injury or a

COMPLIANCE TIP

Using fourth- and fifth-level *ICD* codes is not optional. When coding, always use the highest-digit code available. Use a three-digit code only if there are no four-digit codes within the category. Likewise, use a four-digit code only if there is no five-digit code for that subcategory. Use the five-digit subclassification code wherever possible. Most *ICD-9-CM* books use a symbol, such as ⑤, next to a subcategory to indicate that a five-digit code is required.

poisoning. For example, a patient's harmful reaction to the proper dosage of a drug is assigned an E code. V codes and E codes are described in more detail later in this section.

An insurance claim for a patient must show the diagnosis that represents the patient's major health problem for *that encounter's* claim. This condition is known as the "primary diagnosis." The primary diagnosis must provide the reason for medical services listed on that claim. At times, there is more than one diagnosis because many patients are treated by a healthcare provider for more than one illness. The primary diagnosis—the underlying condition—is listed first on the insurance claim. After that, as many as three other coexisting conditions may be listed. Coexisting conditions occur at the same time as the primary diagnosis and affect the treatment or recovery from the primary condition. For example, a patient sustained a severe laceration on the right forearm and also has type 1 diabetes. The laceration is the primary condition, and type 1 diabetes does affect the treatment and recovery of the laceration. Consequently, the patient's type 1 diabetes is a coexisting condition.

The information for identifying a patient's diagnosis and any coexisting conditions is found in the patient's medical record. Notes about the patient's chief complaint may be entered in the patient's medical record by an administrative medical assistant, a nurse, or a physician. However, *only* the physician determines the diagnosis. A good rule of thumb to remember is "if it is not documented, it was not done" and, therefore, may not be coded. Thorough documentation by the provider is a must for accurate coding. If there is a question about the medical documentation, query the physician. All medical office team members who enter encounter data in the patient's chart should make clear and complete medical entries. Ongoing training for all personnel is a key element in keeping the medical office team up to date on documentation guidelines and maintaining accurate medical documentation.

When the diagnosis is reported on the patient encounter form after the patient's visit, the physician or coder converts the physician's written diagnosis statement to the correct code. In many medical offices, the encounter form lists the most frequently used diagnoses together with their codes for that medical practice. The physician can then simply check off the appropriate diagnosis from the list on the form, without having to look up the code in the *ICD-9-CM*.

When a diagnosis code is not provided by the physician, the coder must know how to use the *ICD-9-CM* to look up and correctly code the physician's written statement about the diagnosis. Similarly, an administrative medical assistant may need to use the *ICD-9-CM* to verify a diagnosis code or to ensure that the codes listed on the office's current encounter form are consistent with the annual updates of the *ICD-9-CM*.

Using the *ICD-9-CM*

Whether the *ICD-9-CM* is bound as a single book or a set of two or three books, three sections are available:

Volume 1—Diseases: Tabular List
Volume 2—Diseases: Alphabetic Index
Volume 3—Procedures: Tabular List and Alphabetic Index

Notice that the *ICD-9-CM* covers two major areas—diseases and procedures. The procedures (Volume 3) are used only for hospital tests and treatments. Codes from Volume 3 are used by hospital coders. An administrative medical assistant in a medical office would generally need to refer only to the diagnosis codes (Volumes 1 and 2).

In the *ICD-9-CM* diagnoses are listed two ways, as illustrated in Figures C.1 and C.2. One is the Alphabetic Index, which lists diagnoses in alphabetic order with their corresponding diagnosis codes. The other is the Tabular List, which provides diagnosis codes in numeric order with additional instructions. Since the Alphabetic Index (Volume 2) is referenced first when locating a diagnostic code, many publishers now place Volume 2 in front of Volume 1 in coding references.

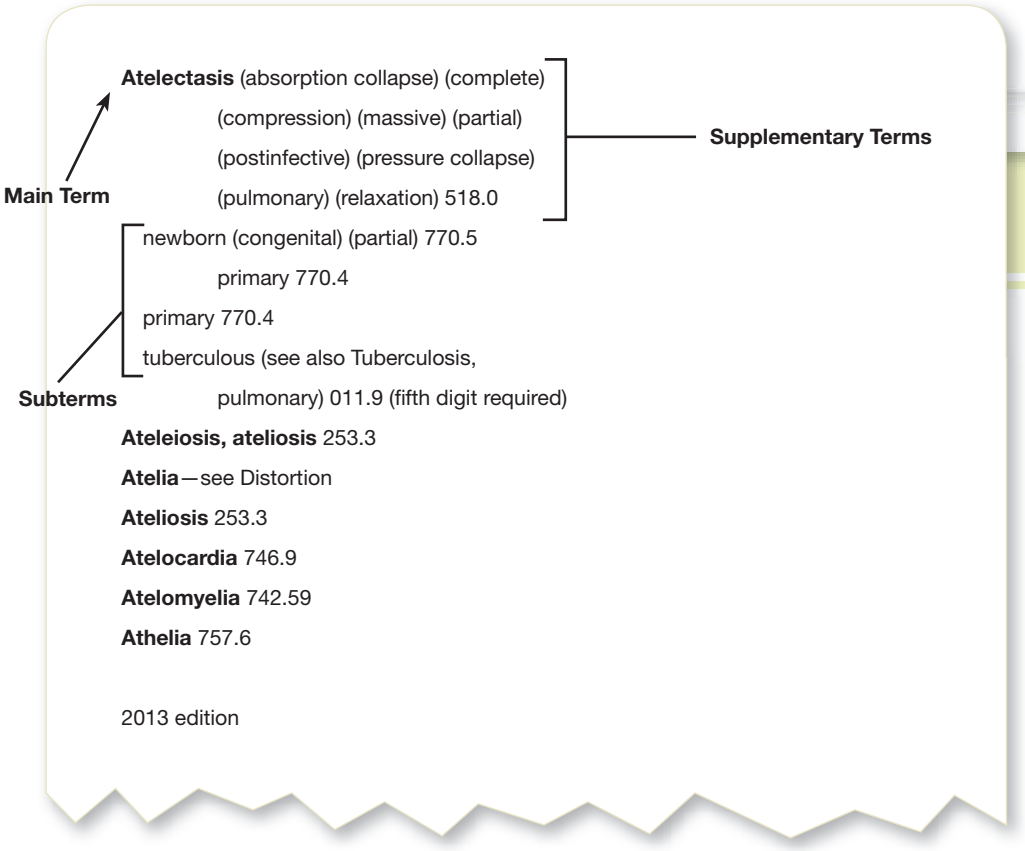


Figure C.1

Example of the *ICD-9-CM* Alphabetic Index

Both the Alphabetic Index and the Tabular List are used to find the right code. The Alphabetic Index is never used alone, because it does not contain all the necessary information. After a code is located in the Alphabetic Index, it is looked up in the Tabular List. Notes in this list may suggest or require the use of additional codes. Alternatively, notes may indicate that conditions should be coded differently because of exclusion from a category.

The Alphabetic Index is organized by main terms in boldface type according to condition, as shown in Figure C.1. A main term may be followed by a series of terms in parentheses, called "supplementary terms." These supplementary terms help define the main term but have no effect on the selection of the code. Because of this fact, they are referred to as "nonessential" supplementary terms. Another type of term, a "subterm," is indented underneath the main term in regular type. Subterms do affect the selection of appropriate diagnosis codes. They describe essential differences in body sites, etiology (the cause of disease), or clinical type.

In contrast to the Alphabetic Index, the Tabular List, as shown in Figure C.2, in the *ICD-9-CM* presents diagnosis codes in numeric order. It also organizes the codes according to body system, site, or type of procedure, rather than according to medical condition, as in the Alphabetic Index.

V codes and E codes are found in numeric order following the Tabular List. V codes classify factors that influence health status or give reasons that a patient may seek medical services when there is no clear diagnosis or disease process. Examples of V codes include routine care during pregnancy and immunizations.

Some insurance companies accept V codes for primary diagnoses. In these cases, the V code is listed first, followed by the code for the condition that requires medication or treatment. Other insurance companies require that the condition being treated be listed first, followed by a V code. Medical insurance specialists verify the requirement of each plan.

Figure C.2

Example of the *ICD-9-CM* Tabular List

④ **362 Other retinal disorders**

Excludes *chorioretinal scars (363.30–363.35)*

chorioretinitis (363.0–363.2)

⑤ ***362.0 Diabetic retinopathy***

Code first diabetes (249.5, 250.5)

+362.01 Background diabetic retinopathy

Diabetic retinal microaneurysms

Diabetic retinopathy NOS

+362.02 Proliferative diabetic retinopathy

+362.03 Nonproliferative diabetic retinopathy, NOS

+362.04 Nonproliferative diabetic retinopathy

+362.05 Moderate nonproliferative diabetic retinopathy

+362.06 Severe nonproliferative diabetic retinopathy

+362.07 Diabetic macular edema

Diabetic retinal edema

Note: Code 362.07 must be used with a code for diabetic retinopathy (362.01-362.06)

⑤ **362.1 Other background retinopathy and retinal vascular changes**

362.10 Background retinopathy, unspecified

362.11 Hypertensive retinopathy

362.12 Exudative retinopathy

Coats' syndrome

362.13 Changes in vascular appearance

Vascular sheathing of retina

Use additional code for any associated atherosclerosis (440.8)

2013 edition

It is appropriate to use V codes

- When a patient is not sick but receives a service for a purpose, such as an ultrasound during pregnancy.
- When a patient with a current or recurring condition receives treatments, such as physical therapy.
- When a patient has a past condition that affects current health status or has a family history of disease.

E codes are diagnosis codes for external causes of poisonings and injuries. E codes are used *in addition to* the main code that describes the injury or poisoning itself; they are never used as primary codes. For example, if a person had a concussion from the impact sustained in a car accident, an E code would be used to indicate the external cause of the diagnosis. E codes are required for workers' compensation and liability insurance, since they are used to define what happened and where it happened.

Basic Steps in Diagnostic Coding

Diagnostic coding follows a five-step process:

Step 1 *Locate the statement of the diagnosis in the patient's medical record.* If necessary, decide which is the main term or condition of the diagnosis. For example, in the diagnosis *peptic ulcer,* the main condition is *ulcer,* and peptic describes what type of ulcer it is.

Step 2 *Find the diagnosis in the* ICD-9-CM*'s Alphabetic Index.* Look for the condition first. Then find descriptive words that make the condition more specific. Read all cross-references to check all the possibilities for a term and its synonyms. Examine all subterms under the main term in the Alphabetic Index to be sure the correct term is found. Do not stop at the first one that "sounds right." When you find the correct term, make a note of the code that follows it.

Step 3 *Locate the code from the Alphabetic Index in the* ICD-9-CM*'s Tabular List.* The Tabular List gives codes in numeric order. Look for the number in boldface type.

Step 4 *Read all information and subclassifications to get the code that corresponds to the patient's specific disease or condition. Note fourth- or fifth-digit code requirements and exclusions.* Observe all notes for help in locating the exact code. For example, the *ICD-9-CM* may indicate "fifth code required." This note means that the correct code for the diagnosis must have five digits. The *ICD-9-CM* may also use the boxed and italicized word *Excludes* under a main term to indicate that a certain entry is not to be included as part of the preceding code. The note may also give the correct location of the excluded condition.

Fourth- and fifth-digit code requirements and exclusions are generally used in the *ICD-9-CM* to accommodate the changes in diagnoses that occur over time. Where, in the past, a single code was used for a condition, now multiple codes might be used to specify the various types and complications of the condition. This requires adding more digits to a code or grouping related codes differently.

Step 5 *Record the diagnosis code on the insurance claim, and proofread the numbers.* As part of the proofreading process, a coder should always ask: Have all the numbers been entered in the right order? Are the codes complete? Has the highest code level been used?

Coding becomes easier with practice, but do not be tempted to take shortcuts. Every case is different, and additional terms or digits may be necessary to make a diagnosis code as specific as possible. If a step is skipped, important information may be missed. If more than one diagnosis is listed in a patient's medical record, work on only one diagnosis at a time to avoid coding errors.

COMPLIANCE TIP

Special attention should be given to the use of some E codes because of their sensitive nature. For example, suicide attempts and assaults are likely to be highly confidential matters.

INSURANCE CLAIMS

Overview of the Process

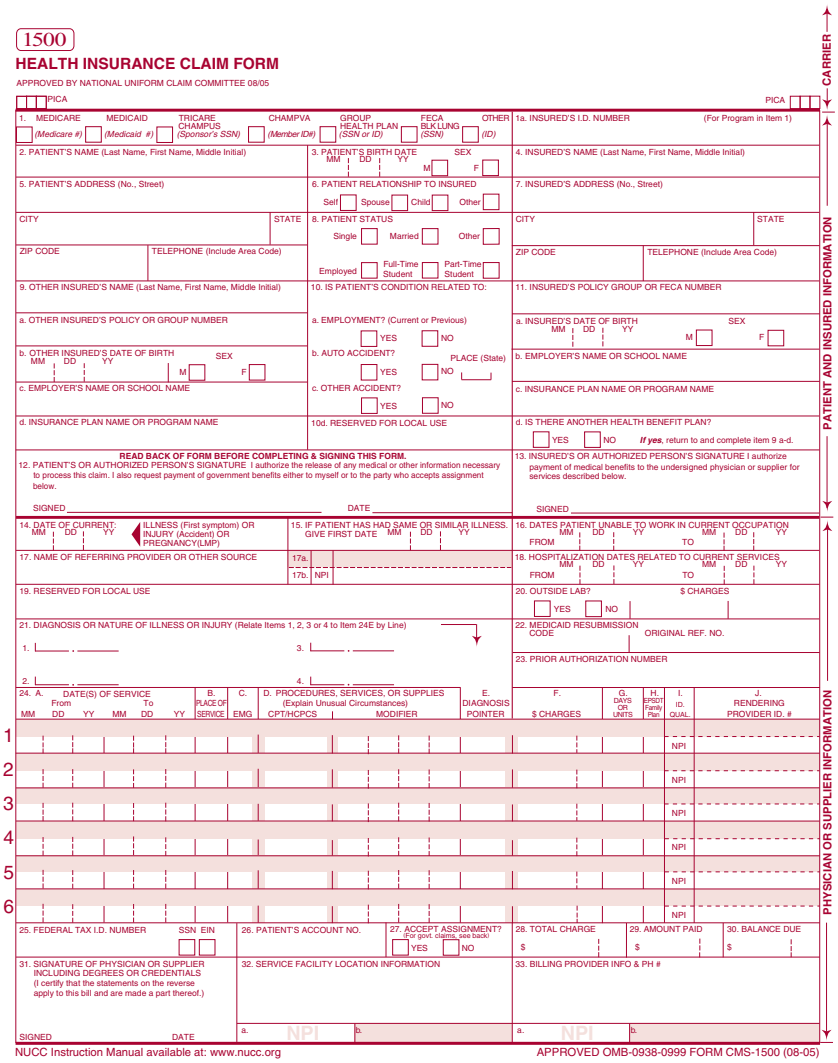
When patients receive services from a medical practice, either they pay for services themselves or the charges are submitted to their insurance company or government agency for payment. Most medical practices complete an insurance claim form on behalf of the patient. The insurance claim form contains both clinical and financial information and is transmitted to the patient's insurance carrier for partial or full reimbursement of the services rendered.

Using the CMS-1500 Paper/Hardcopy Claim Form

The terms "paper" and "hardcopy" are used interchangeably, and both refer to a manually produced CMS claim form. The most commonly used paper or hardcopy claim form is the

Figure C.3

Blank CMS-1500 Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

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 DATE

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

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID 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 OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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. NPI b.

33. BILLING PROVIDER INFO & PH #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS-1500 claim form (formerly known as the HCFA-1500 claim form). See Figure C.3 for an example. Accepted by private as well as government-sponsored programs, it is also called the "universal claim form." Two medical office forms are used to complete the CMS-1500 claim form: the **patient information form**, which is filled out or updated by the patient, and the patient encounter form. The patient information form may also include release-of-information and assignment-of-benefits statements. Prior to HIPAA, if a provider submitted a claim for a patient, a release-of-information statement had to be completed by the patient. Since HIPAA, the payment portion of TPO gives providers the authority to release claim-pertinent PHI to obtain third-party payment. If the patient decides to authorize a nonPAR provider to receive payments for medical services directly from third-party payers, an assignment-of-benefits statement must be signed by the patient and filed in the patient's medical record. For participating physicians, an assigned (direct) payment is one of the incentives for participation, and the patient's signature authorizing assignment of benefits is not needed. For convenience, some medical practices include these statements on the patient information form. Other practices prefer to use separate forms for each of them.

Submitting Paper/Hardcopy or Electronic Claims

Increasingly, medical offices are using computerized insurance claim forms, known as **electronic claims**, in place of paper claims. Electronic claims are prepared on a computer and transmitted electronically (from one computer to another) to an insurance carrier for processing. If necessary, an electronically prepared claim may be printed and a hardcopy claim sent to the carrier by postal service or other non-electronic methods. The HIPAA 837, version 5010, claim is the standard format for electronic claims. Currently, HIPAA 837, version 5010, claim submissions are to be used by offices with 10 or more full-time employees or the equivalent of 10 full-time employees, such as 20 employees whose combined work status equals 10 full-time employees. Advantages of using electronic claims include immediate transmission, faster payment (Medicare claims are paid within 14 days versus 29 days), and easier tracking of claim status.

Processing by a Third-Party Payer

When the claim form arrives at the office of the insurance carrier, either on paper or as a computer file, the insurance carrier processes the claim. This entails a step-by-step review or adjudication process to determine the benefit payment level. Following are the steps used by the insurance payer:

Step 1 *The claim is received in the payer's system.* In step 1, the claim is prescreened for any missing information, such as a date of birth.

Step 2 *The patient's eligibility and benefit level are determined.* In step 2, the patient's benefit level, medical necessity, and covered/noncovered services are determined based on the patient's health plan.

Step 3 *The discount is applied.* In step 3, the payer may reduce the physician's billed amount(s) based on the payer-provider contracted fee schedule or on the maximum allowed payment.

Step 4 *The claim edits and payer payment rules are applied to the claim.* In step 4, further adjustments are made to the claim to allow for modifying factors, such as global payments, modifiers, and multiple procedures, which may either increase or decrease the payment amount. Noncovered services identified in this step are denied for payment.

Step 5 *The final payment is determined.* In step 5, the auto-adjudication process is completed and the final benefit payment is calculated.

Step 6 *The EOB and/or ERA is generated and the payment is sent.* In step 6, the EOB and ERA are sent to both the patient and the billing physician. Each of these is discussed in the next section.

A claim may be removed from the automated review cycle and submitted for a manual review if data for any of the above steps are missing or unclear.

Receiving an EOB or ERA

After the insurance carrier reviews the claim and makes a final reimbursement determination, it sends a remittance advice to the patient and the provider with an explanation of its decision. The remittance advice also takes into account any deductibles or coinsurance the insured may owe. If the insurance company determines that there are benefits to be paid, a check for the appropriate amount is attached to the provider's report or an electronic deposit is made into the provider's financial account. In cases in which the benefits have not been assigned to the provider, the remittance is sent directly to the patient.

Figure C.4

An Example of an EOB

Cross and Shield National Government Program
1290 Cimmons Road
Cincinnati, OH 45555

#FEI12398095643567#
Lena T. Crac
2520 Arizona Lane
Floyd, KY 41199-2520

Check sent to:	Karen Larsen, MD
Provider:	Karen Larsen, MD
Type:	PAR
Patient Name:	LENA CRAC
DOS:	03/23/20— to 03/23/20—
You Owe the Provider:	$20.00

EXPLANATION OF BENEFITS
This Is Not a Bill

ID Number:	R55559990
Claim Number:	R213213892308
Claim Paid On:	03/30/20--
Claim Received On:	03/25/20—
Claim Processed On:	03/30/20—
Claim Processed By:	Annie B.

Service Rendered	Submitted Charge(s)	Allowance	Codes	Deductible Amount	COB	Coinsurance or Copayment	Plan Payment	Patient Owes
OFFICE VISIT	100.00	61.15	160			20.00	41.15	20.00
TOTALS:	100.00	61.15		0.00		20.00	41.15	20.00

160-The charge submitted by the provider exceeds the allowable amount for this service. You are not responsible for the difference between the submitted charge and the plan allowance.

On this claim your out-of-pocket expenses are:

Yearly Deductible:	0.00
Admission Copay:	0.00
Coinsurance Amount:	0.00
Copayment Amount:	20.00
Preauthorization Penalty Charge:	0.00
YOUR TOTAL:	20.00

	Yearly Ded	PAR	NonPAR
What You Have Paid:	34.91	0.00	0.00
Family:	34.91	301.00	301.00
Your Annual Max	400.00	0.00	0.00
Family:	800.00	5,000.00	7,000.00

If you have a question concerning this claim, please call a customer service assistant. Refer to the Claims Section of your Service Booklet for disputed claims.

1-800-555-5555

In the case of paper claims, the remittance advice sent by the insurance company in response to the claim is transmitted through the mail and is referred to as an **EOB** (explanation of benefits). Figure C.4 shows an example of an EOB for an office visit. In the case of electronic claims, the report is transferred from one computer to another and is therefore referred to as an **ERA** (electronic remittance advice). As with an electronic claim, an ERA is never printed. When an ERA is electronically sent to the provider, a hardcopy EOB is sent to the patient. Although the formats used for the EOB and the ERA differ, the information conveyed in both types of reports is the same—both explain the amount of benefits to be paid to, or on behalf of, the insured and how that amount was determined.

Frequently, providers receive bulk payments—a single benefit payment that covers more than one submitted claim. For example, the insurance carrier submits one payment covering benefits for 15 Blue Cross Blue Shield patients instead of processing a single payment for each claim. Administrative medical assistants who process payments must be able to separate the bulk payments into individual claim benefits and post the payment and/or adjustments to the patient's account. The following is an example of three patient payments on one bulk statement. Using an 80/20 payment split, calculate how much should be credited to each patient's account from the insurance carrier and how much is left as patient responsibility. The provider is PAR.

Pt Name & Number	Submitted	Plan Allowance	Ins Pay	Deduct	Coins/Copay
PATIENT A					
0012BA					
09/16/20–	$ 80.00	$ 60.00	_____	$0.00	_____
09/23/20–	160.00	100.00	_____	0.00	_____
PATIENT B					
0106SM					
09/02/20–	80.00	60.00	_____	0.00	_____
PATIENT C					
0219LS					
09/15/20–	120.00	120.00	_____	0.00	_____
TOTALS	$440.00	$340.00	$272.00	$0.00	$68.00

Calculating the insurance payment and balance due from the patient using an 80/20 payment split:

Patient A

09/16/20– Insurance payment of $48.00 and patient balance of $12.00
09/23/20– Insurance payment of $80.00 and patient balance of $20.00

Patient B

09/02/20– Insurance payment of $48.00 and patient balance of $12.00

Patient C

09/15/20– Insurance payment of $96.00 and patient balance of $24.00

Patient A will require two entries into the payment system—one for each date of service. Also, since the provider is PAR, an adjustment will need to be made to each patient's account for the difference between the submitted amount and the plan allowance amount. What is the amount to be adjusted off each patient's date of service?

Patient A

09/16/20– Adjustment amount _____
09/23/20– Adjustment amount _____

Patient B

09/02/20– Adjustment amount _____

Patient C

09/15/20– Adjustment amount _____

Patient A adjustments are $20.00 and $60.00, respectively. Patient B will have an adjustment of $20.00, and Patient C will have no adjustment to the account.

Checking the Reimbursement Details

After the medical office receives the remittance advice (the EOB or ERA), the administrative medical assistant reviews it and checks it against the original claim. If all is in order, the assistant files the report with the patient's financial records. If a check from the insurance company is attached to the EOB, the assistant posts the payment received to the appropriate patient's account and marks the check for deposit in the practice's bank account. Generally, if a claim is processed electronically, the method of payment is also electronic. In such cases, the payment attached to the ERA is deposited into the practice's bank account through an electronic funds transfer (EFT) rather than mailed in the form of a check to the medical practice.

Billing the Patient

If the patient still owes money to the medical practice after the EOB or ERA has been received—usually for charges that were not fully reimbursed by the insurance company, such as deductibles or noncovered services—the assistant bills the patient for the amount due. If the patient is confused or has any questions about payments, the assistant can try to help by going over the terms of the insurance plan with the patient. The assistant may also need to call the insurance carrier and act as a go-between for patients. The assistant can build goodwill for the physician's office by using problem-solving and communication skills to fulfill this role. Patients understandably get upset when they receive unexpectedly large bills or an incorrect payment. The assistant is the patient's advocate with the insurance carrier. Sometimes explaining the solution again to the patient in different terms after speaking with the insurance carrier will help clear up the problem.

Patients may also accuse the medical office of billing incorrectly when they are unhappy with the benefits received. The assistant should remember to use respect and care in solving any miscommunications or misunderstandings in such circumstances. It is important to separate the patient's feelings from the facts. When documented facts, such as EOB or ERA information, are professionally yet empathetically discussed with angry patients, they may be more accepting of the information. Be careful to avoid insurance and medical jargon; this will only add to patients' frustration.

Once the patient understands the terms of the payment due, the assistant follows up with the patient to see that the amount due is collected in a timely manner. When the patient pays the balance due, the account is listed as a zero balance and the insurance claim process is complete.

Appealing Claims

If the physician thinks that the reimbursement decision is incorrect or unfair, the medical office may initiate an appeal. Appeals must be filed within a stated period after the determination of claim benefits or denial. Most insurance carriers have an upward structure for appeals, beginning at the lowest level and progressing upward. For example, the first step may be to submit a formal complaint. If the provider is not satisfied with the outcome, the second step may be to file an appeal. A grievance would be filed if the appeal did not produce the desired results. When making an appeal of an electronic claim, include the electronic claim number. Each insurance company has its own appeal process. A representative from the insurance company can instruct the assistant on the appeal process the insurer uses, if necessary. This information may also be available on the Internet by initiating a search from the insurance carrier's Web site.

Completing and Transmitting the Claim Form

Completing and transmitting the claim form accurately for a patient is one of the most important steps in successful claim reimbursement. Therefore, the administrative medical assistant should be familiar with the details of the process.

Verifying Insurance Information

The first step in processing a claim is to verify the patient's insurance information. With new patients, most practices routinely check insurance coverage before the patient's first appointment. Basic information about the patient and the patient's insurance is obtained over the phone when the first appointment is scheduled. The assistant then contacts the insurer by telephone, fax, Internet, or other electronic methods specified by the insurance carrier to verify that the patient is currently enrolled in the plan as specified and has paid all required premiums or other charges.

Checking the Accuracy of Essential Claim Information

Claim forms must be completed accurately. The following basic information is required on most claim forms:

- Contract numbers—that is, the group number and the insured's identification number from the insured's current insurance card
- The patient's complete name, date of birth, gender, and relationship to the insured
- The insured's complete name, address, date of birth, and employer
- Information on a secondary carrier—subscriber's name, date of birth, and employer
- Information about whether the condition is job-related or accident-related and whether it is an illness or an injury
- The patient's account number (if the facility assigns numbers to patients)
- Complete and current diagnostic codes for the submitted claim
- Information about the provider—name, address, identifying codes, NPI and other required identifiers, and signatures
- A statement of services rendered, which should include dates, procedure codes, charges, and total charges

The following is information presented on the front of an insured's insurance card submitted to the provider through the registration process. Additional information, including important phone numbers, are listed on the back of the card. Always make a copy of both the front and back sides of an insurance card.

CROSS AND SHIELD PPO

INSURED
DAYS CATALINA S
ID NUMBER
R123456789XX
GROUP CODE 555
DOC 04-19-20—

www.crossandshield.org

Customer Service	1-800-555-5555
Precertification	1-800-555-1234
Retail Service Pharmacy	1-800-555-5678
Mail Service Pharmacy	1-800-555-9012
Substance Abuse Precertification	1-800-555-1235

A claim was submitted with the following information, and the claim was denied. What is wrong with the submitted claim information?

Patient Name: Catalina S. Dayes ID Number: R123456798XX Group Code: 555

Before submitting claims, the assistant must carefully check every bit of information for accuracy. Typographical errors and transposition of numbers are two of the most common claim submission errors. This example contains two errors—a misspelled name and transposition of the numbers in the ID number.

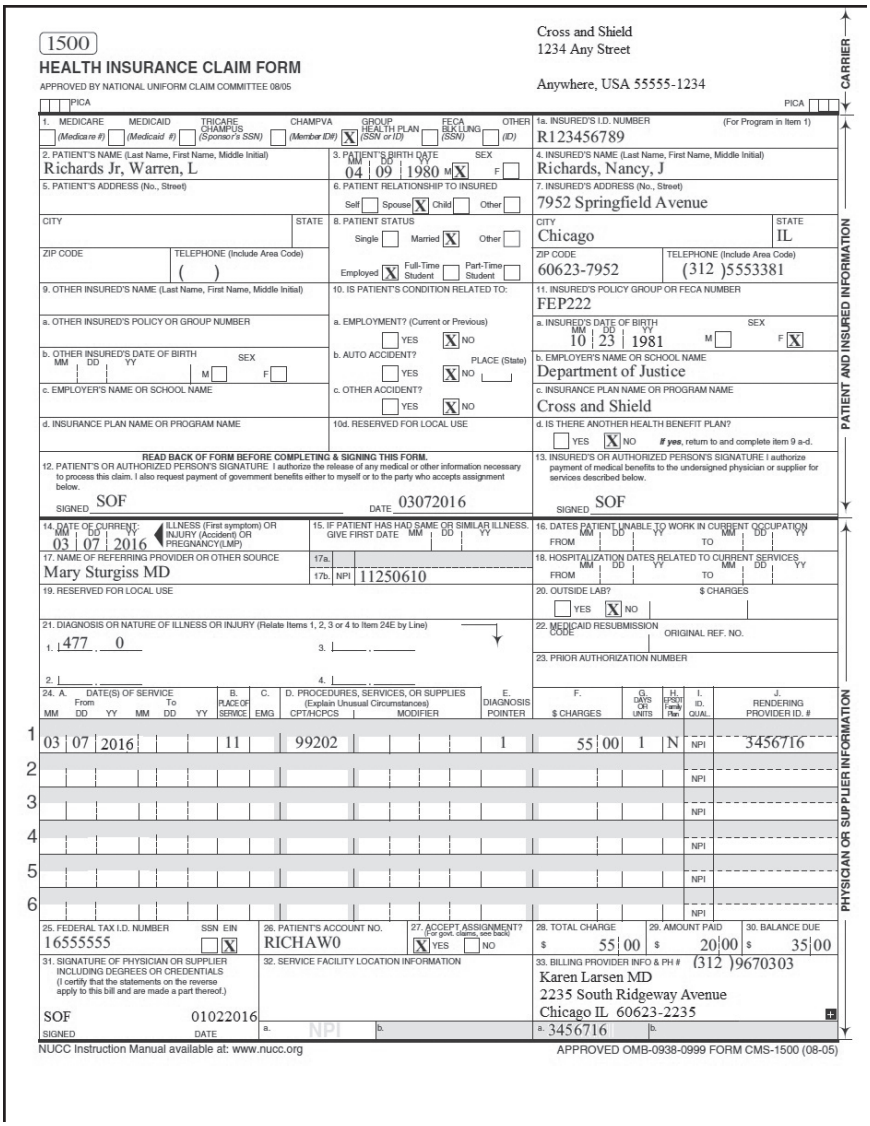
Completing the CMS-1500 Claim Form

Most insurance companies accept the CMS-1500 for processing claims. However, the assistant may need to complete a specifically designed claim form for a carrier. Although the form may be different, the information required on most insurance claim forms is the same. If the assistant is familiar with the various fields on the CMS-1500 form, the same knowledge can be applied to other claim forms for successful completion.

Figure C.5 shows a completed CMS-1500 claim form. Note that the form is divided horizontally into two parts: The top half contains patient and insured information (Items 1–13), while the bottom half contains physician or supplier information (Items 14–33).

Figure C.5

Completed CMS-1500 Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Cross and Shield
1234 Any Street
Anywhere, USA 55555-1234

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): R123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Richards Jr, Warren, L	3. PATIENT'S BIRTH DATE: 04 09 1980 M X F; SEX
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Richards, Nancy, J	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse X Child Other
7. INSURED'S ADDRESS (No., Street): 7952 Springfield Avenue	
CITY	STATE
8. PATIENT STATUS: Single Married X Other; Employed X Full-Time Student Part-Time Student	
CITY: Chicago	STATE: IL
ZIP CODE	TELEPHONE (Include Area Code): ( )
ZIP CODE: 60623-7952	TELEPHONE (Include Area Code): (312)5553381
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: FEP222	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES X NO
a. INSURED'S DATE OF BIRTH: 10 23 1981; SEX: M F X	
b. OTHER INSURED'S DATE OF BIRTH; SEX: M F	b. AUTO ACCIDENT? YES X NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME: Department of Justice	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: Cross and Shield	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes*, return to and complete item 9 a-d.	

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 SOF DATE 03072016

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 SOF

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 03 07 2016	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Mary Sturgiss MD	17a. 17b. NPI 11250610
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 477.0 2. 3. 4.	22. MEDICAID 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 OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 07 2016		11		99202		1	55 00	1	N	NPI	3456716
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 16555555 SSN EIN X	26. PATIENT'S ACCOUNT NO.: RICHAW0	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE: $ 55 00
29. AMOUNT PAID: $ 20 00	30. BALANCE DUE: $ 35 00		
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.): SOF 01022016 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: a. NPI b.	33. BILLING PROVIDER INFO & PH #: (312)9670303 Karen Larsen MD 2235 South Ridgeway Avenue Chicago IL 60623-2235 a. 3456716 b.	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

COMPLIANCE TIP

Updated guidelines for completing claim forms are found at the National Uniform Claim Committee's Web site at http://NUCC.org. Guidelines are updated yearly.

Figure C.6 presents the information that should be entered in each numbered blank (called a "form locator"). Figure C.6 contains generalized information, and individual carriers, such as Medicare, should be contacted prior to completing CMS-1500 forms for specific completion instructions. It is beneficial to keep a log with an example of a properly completed claim form for each insurance carrier. The log can be easily referenced when completing future claims. CMS-1500 forms are purchased from vendors and are printed in red. Black ink should be used to complete the paper form.

After a claim has been completed and sent to the insurance company, make a notation in the patient ledger by entering the date and the phrase "Submitted to insurance" after the last entry. When insurance claims are submitted using an electronic submission program, the program places the submission date in the patient's electronic ledger account. An updated patient statement is then sent to the patient for billing purposes on the next billing date. The patient or another designated person is still responsible for the complete charge, even if insurance is involved.

Figure C.6 CMS-1500 Completion Guideline Chart

ITEM NO.	DESCRIPTION	RESOURCE
Carrier block	Enter the name and address of the insurance payer in the upper right margin of the form. Do not use punctuation except for hyphen in a nine-digit ZIP code.	ID card
1	Type of insurance. Use an "X" to indicate the correct carrier.	Chart, patient's registration information
1a	Insured's ID number. Do not use spaces.	Patient's registration information
2	Patient's name. Enter last, first, middle initial. Use commas to separate the last, first, and middle initial. Use a hyphen in a hyphenated last name. Do not use periods.	Patient's registration information
3	Patient's date of birth and gender. Use an eight-digit format. Use an "X" to indicate gender. If unknown, leave it blank.	Patient's registration information
4	Insured's name. Enter last, first, middle initial. Use commas to separate the last, first, and middle initial. Use a hyphen in a hyphenated last name. Do not use periods. For worker's compensation claims, enter the name of the employer.	Patient's registration information
5	Patient's address and telephone number. If the information is the same as insured, do not reenter the information.	Patient's registration information
6	Patient's relationship to insured. Enter an "X" in the appropriate box. If the patient is not "Self," "Spouse," or "Child," use "Other" for categories such as employee, ward, or an insured-defined dependent.	Patient's registration information
7	Insured's address and telephone number. If Number 4 is completed, complete Number 7. Enter the address without punctuation except for a hyphen in the ZIP+4 code. Use the two-letter state abbreviation. Do not use a space in the telephone number.	Patient's registration information
8	Marital and employment status. If the information is available and required by the payer, enter an "X" in the appropriate box.	Patient's registration information
9, 9a–d	Other insured's name and information. If 11d is marked Yes, complete Number 9a–d. If the policy is held **by someone other than the person listed in Number 4,** complete Numbers 9 and 9a–d using formatting instructions from 5 and 11.	Patient's registration information
10a–c	Patient's condition as related to a work injury, an automobile accident, or other type of accident. Place an "X" in the appropriate box. If Yes is marked for Auto Accident, place the two-letter state abbreviation in the provided space.	Patient's registration information
10d	Reserved for Local Use. Refer to the payer's instruction for 10d.	Insurance manual
11	Insured's policy, group, or FECA number. Do not use spaces or hyphens.	Patient's registration information
11a	Insured's date of birth and gender. Use an eight-digit format. Use an "X" to indicate gender. If unknown, leave it blank.	Patient's registration information
11b	Employer's name or school name. If required by the payer, complete 11b.	Patient's registration information
11c	Insurance plan name or program name.	Patient's registration information
11d	Is there another health plan? Use an "X" to mark the appropriate box. If marked Yes, complete 9 and 9a–d.	Patient's registration information
12	Patient's or authorized person's signature. Enter Signature on File, SOF, or the patient's legal signature. If using a legal signature, enter the date either in six- or eight-digit format.	Patient's and/or insured's legal signature or the referenced signature on file in the patient's record
13	Insured's or authorized person's signature. Enter Signature on File, SOF, or the insured's legal signature. If no signature on file exists, either leave Number 13 blank or enter No Signature on File.	Insured's legal signature or the referenced signature on file in the patient's record

continued

Figure C.6 CMS-1500 Completion Guideline Chart—*continued*

ITEM NO.	DESCRIPTION	RESOURCE
14	Date of the current illness, injury (accident date), or pregnancy (LMP). Use either six- or eight-digit format.	Patient's record
15	If the patient has had similar illness. Enter in six- or eight-digit format of first date of a similar illness. A previous pregnancy is not considered a previous illness.	Patient's record
16	Dates patient is unable to work in current occupation. Use six- or eight-digit format to indicate the "from" and "to" dates the patient is not able to work in the current occupation.	Patient's record
17	Referring doctor or other source. Enter the name of the referring, ordering, or supervising physician. Do not use periods or commas. Use a hyphen in a hyphenated last name. If more than one physician meets the criteria for Number 17, list only one physician using this hierarchy: Referring, ordering, supervising physician.	Patient's record
17a	Referring, ordering, or supervising physician's non-NPI number. Enter the "qualifier" found at http://NUCC.org at the left side of the box of the line and the number at the right side of the line.	Patient's record, insurance manual
17b	Referring, ordering, or supervising physician's NPI number.	Patient's record, insurance manual
18	Hospitalization dates. Enter in six- or eight-digit format the admission and, if discharged, the discharge date for inpatient hospitalization.	Patient's record
19	Reserved for local use. Refer to payer's instructions for Number 19.	Insurance manual
20	Usage of outside lab services. Use an "X" to mark Yes or No. If no outside lab services were used, mark No. If outside lab services were purchased by the provider, such as processing blood or lab work, mark Yes and enter the amount paid for the services. Enter the amount in the left-hand side of the field using dollars and cents format. If the amount is whole dollars, use "00." Do not use a dollar sign, commas, or periods. The right-hand side of the field should be blank.	Patient's record, patient's ledger
21	Diagnostic codes. Enter the diagnostic codes related to the current visit. Leave a space in lieu of a period.	Patient's record, coding manual
22	Medicaid resubmission code. List the original Medicaid code for a claim that is resubmitted to Medicaid.	Medical procedure/manual
23	Prior authorization code. If prior authorization/precertification codes are required by the payer, enter the number with no spaces or hyphens.	Contact payer
24a	Dates of service. Using a six- or eight-digit format, enter the dates of service for the procedure listed on the line. Only one service may be listed per line. For services rendered on one day, enter only the From date. If required by the payer, the same date may be listed in the To column.	Patient's record, patient's ledger
24b	POS codes. Enter the two-digit Place of Service code. Place of Service codes may be found at www.cms.gov	Patient's record, patient's ledger
24c	Emergency. If required by the payer, enter "Y" for Yes or leave blank for No.	Patient's record

Figure C.6 CMS-1500 Completion Guideline Chart—*continued*

ITEM NO.	DESCRIPTION	RESOURCE
24d	Procedures, services, or supplies. Using the *CPT* or HCPCS code set for the services or supplies, enter the appropriate code. Up to four, two-digit modifiers may be entered in the Modifier column.	Patient's record, coding manuals
24e	Diagnostic pointer. Enter the line number from Number 21 that relates to the service stated on the current line in Number 24. Use only the line number, such as 1 or 2, not the diagnostic code. If more than one diagnostic code relates to the rendered service, list the primary diagnostic line number first. Diagnostic line numbers should be left-justified with no commas or spaces, i.e., 13.	Patient's record
24f	Charges. Enter the charge related to the service listed on the line in 24. Enter the amount in dollars and cents format (24 00), right-justified with no commas or periods. If there is no charge for the service, enter 0 00 in 24f.	Patient's record, patient's ledger
24g	Days or units. Enter the number of days/units associated with the service listed on line 24. The number should be right-justified with no leading zeros. Fractions should be shown by using a decimal point. Examples would be .5, 1, and 1.5.	Patient's record, patient's ledger
24h	Early and periodic screening and diagnostic testing. Enter or "Y" or "N" if a reason code is not required. If a reason code is required, refer to NUCC.org for the code.	Patient's record, patient's ledger, http://NUCC.org Web site or payer's manual
24i	ID qualifier. Enter the qualifier, found at http://NUCC.org describing the non-NPI number of the providing physician.	Physician's information
24j	Rendering providing's ID. Enter the non-NPI number in the shaded, upper portion of 24j and the NPI number in the lower portion.	Physician's information
25	Federal tax ID number. Enter the employer identification number (EIN) or the Social Security number of the billing provider listed in Number 33. Enter an "X" to mark the appropriate box for EIN or SS. Numbers should be left-justified without hyphens.	Physician's information
26	Patient's account number. Enter the patient's account number assigned by the provider. The number should be left-justified without hyphens.	Patient's record, patient's ledger
27	Accept assignment? Use an "X" to indicate Yes or No. Accepting assignment means the physician agrees to accept payment based on the payer's fee schedule.	Physician's information
28	Total charge. Enter the total amount for all charges on the current claim form. The amount should be in dollars and cents format and right-justified without periods or commas. Use "00" for whole dollar amounts.	Patient's record, patient's ledger
29	Amount paid. Enter the amount the patient or another payer paid on covered services listed on the current claim form. Enter the total amount paid in dollar and cents format and right-justified without periods or commas. Use "00" for whole dollar amounts.	Patient's record, patient's ledger
30	Balance due. If required by the payer, enter the amount due for services listed on the current claim form. Enter the amount in dollar and cents format and right-justified without periods or commas. Use "00" for whole dollar amounts.	Patient's record, patient's ledger
31	Signature of physician or supplier including degrees or credentials. Enter the legal signature, "Signature on File," or SOF along with the date the form was signed. Enter the date in six- or eight-digit format.	Physician's information

continued

Figure C.6 Cms-1500 Completion Guideline Chart

ITEM NO.	DESCRIPTION	RESOURCE
32, 32a, 32b	Service facility location information. If laboratory or services were purchased by the providing physician, as indicated by a "Y" in Number 20, list the complete address of the provider from whom services were purchased. Enter the address in a three-line format: name, street address, city, state, and ZIP code. Enter the address with no punctuation or symbols except a hyphen in the nine-digit ZIP code, and place a space between the city, state, and ZIP code. Enter the NPI number of the facility in 32a and the qualifier and non-NPI number in 32b. Do not enter a space between the qualifier and non-NPI number in 32b.	Patient's record, patient's ledger
33, 33a, 33b	Billing provider's information and phone number. Enter the name, address, and phone number of the billing provider. Enter the address in a three-line format: name, street address, city, state, and ZIP code. The address should be entered with no punctuation or symbols except a hyphen in the nine-digit ZIP code, and place a space between the city, state, and ZIP code. Place the phone number in the right side of the titled field without hyphens or spaces. Enter the NPI number of the facility in 33a and the qualifier and non-NPI number in 33b. Do not enter a space between the qualifier and non-NPI number in 33b.	Physician's information

Using Computer Billing Programs

Generating claim forms (whether paper or electronic) on the computer is one of the major uses of computer technology in the medical office today. The computer automatically processes the information required to create a completed claim by transferring the patient's and the insured's information, the charges, the procedure and diagnostic codes, and so forth from the various databases set up in the computer onto the insurance claim form.

The computer stores facts about the medical practice in the practice database; information about the carriers that most patients use in the insurance carrier database; information about payments made by patients, as well as benefits received from insurance companies, in the transaction database; and information about each patient—personal as well as clinical data—in the patient database. Careful attention must be given when keying information and updating system data. Errors in keying will be transferred to the claim form.

When all new data and transaction information have been entered and checked regarding a patient's visit to the physician, the administrative medical assistant creates the electronic claim. The format for the claim—either the CMS-1500, HIPAA 837-5010 version, or a specialized claim form—is also designated. The software program then organizes the necessary databases and selects the data from each one as needed to produce a completed claim form. When this is completed, the administrative medical assistant will electronically transmit the claim to the insurance carrier for processing.

Electronic Claims Versus Paper Claims

The main difference between electronic claims and paper claims is the means by which they are transmitted to the insurance carrier. The use of electronic claims not only speeds up transmission and payments but also ensures a greater degree of accuracy and costs less.

Paper claims, whether printed from a computer billing program or typed, are usually transmitted to insurance carriers through the mail. When they reach the insurance carrier, the information on the form must be keyed into the insurance company's computer by data entry personnel. Alternatively, the information may be scanned using an optical character reader (OCR). In either case, a certain percentage of error is introduced.