Billing Specialist Knowledge Assessment

Please answer all of the following questions to the best of your ability. Your answers to these questions will assist us in determining where your skills could best be utilized in our practice.

1. Explain the difference between a CPT code and an ICD-9-CM code.

2. A CPT code has ______ digits, and an ICD-9-CM code has ______ digits.

3. What are evaluation and management codes?

4. Name all the outpatient consultation codes.

5. Which two types of hospital E/M codes cannot be billed on the same day?

6. What is the difference between a consultation and a referral, according to CPT?

7. How does Medicare define the "global package?"

8. What is "unbundling?"

9. How is the posting of a commercial insurance payment different than the posting of a PPO payment?

10. What is a withhold? Explain exactly how to post it in the computer system.

11. What is the difference between pre-certification and pre-authorization?
12. What's the difference between Regular Medicare, and a Senior HMO?

13. What does it mean to post payments by line item? Why is it so important?

14. A Medicare unpaid claim should be followed up at _____ days if the practice is participating, and files electronically.

15. How would you handle the following EOB rejections or "$0.00 pays?"
   
   "Procedure not a covered benefit"
   
   "Patient not eligible on date of service"
   
   "Contract number does not match information on file"
   
   "Applied to deductible"

16. What is the minimum balance you think appropriate for a patient to pay under a monthly budget plan?

17. How would you set up a budget plan for a working, 35-year old mother, who has not yet met her deductible? The account is 60 days old.

18. If you were discussing the status of a patient's overdue balance with him or her on the telephone, and the patient said, "I can pay you, but not until I get my paycheck next week." What would you say?
1. A CPT code is used to describe a service or procedure (what was done to the patient), and ICD-9-CM is used to describe the diagnoses (why the service or procedure was done).

2. A CPT code has 5 digits, and an ICD-9-CM code has between 3 and 5 digits. (Depending on the level of specificity required.)

3. Also known as "E&M codes," evaluation and management codes describe the cognitive-type services performed - such as an office visit or consultation.

4. 99241, 99242, 99243, 99244, 99245

5. A visit charge (99231-233, 99251-99255, 99261-265) and a discharge (99238).

6. Consultation code: Used when a specialist is asked to give his/her opinion or advice about a patient's condition. Consultation codes reimburse at a higher rate than simply a "new patient" code.

   Referral: Used when a physician thinks the patient needs to see a specialist, and gives the patient an option or two to select from.

7. "Global" codes are used as all-inclusive ways to bill for a procedure that has preliminary or follow up visits "built-in." For example, in obstetrics, there is one code for delivery, but it includes all the anti-partum care. Another example: a lesion removal code such as 11400 includes a "global period" of 10 days - which means if the patient comes in to see the physician within 10 days after the procedure, for a reason that relates to that procedure, there will be no additional reimbursement.

8. "Unbundling" is charging several CPT codes that should actually be reporting using a single CPT code. Unbundling is typically an attempt to obtain additional reimbursement - it is an unethical way to bill. Today's insurance carriers have special software that "scrubs" claims and quickly identifies unbundling.

9. For commercial insurers, the difference between what the plan pays and the practice's fee can be transferred to the patient's responsibility, and a statement sent. For a PPO, you must write off the difference between the PPO's contracted payment and the practice's fee.

10. A withhold is a way managed care plans transfer risk to physicians. A percentage of reimbursement (typically 10-25%) is "withheld" from the contracted payment amount for each service, then returned at the end of the year based on utilization or other performance targets. Since withholds are potential receivables, you want them posted separately from contractual adjustments.

11. Pre-certification means the plan said, "yes, you can do that procedure, for that diagnosis." Pre-authorization means the plan said, "you will be paid for the procedure."
12. Regular Medicare has an allowable charge that's set by CMS annually. Medicare pays 80% of this allowable, and the patient pays the remaining 20%. Senior HMOs have any number of reimbursement schedules, and they are typically less than Regular Medicare. As well, claims are sent to different third party administrators for reimbursement. It's essential to know which plan elderly patients are on; reimbursement depends on it!

13. Posting by line item means you post payments and adjustments to the actual CPT code that was billed; as opposed to the oldest outstanding balance on the account, or the entire "claim." If payments are not posted in this manner, you have no way of retrieving historical payment information by CPT code, by payor.

14. A Medicare unpaid claim should be followed up at 14 days if the practice is participating, and files electronically.

15. A non-Medicare unpaid insurance claim should be followed up at 30-45 days, depending on contractual arrangement.

16. "Procedure not a covered benefit."
   Check the plan guidelines. If this rejection is accurate, transfer the balance to the patient, and send a statement.

   "Patient not eligible on date of service"
   Verify accuracy, then call patient and explain what happened; send statement to patient. (You may have a hard time collecting - should have checked eligibility prior to the patient's visit.)

   "Contract number does not match information on file"
   Call patient to obtain correct information and re-bill. Be sure the front desk is notified that they erred by not updating the patient's account information, or made a typo.

   "Applied to deductible"
   Transfer balance to patient responsibility and send a statement.

17. Typically, $50 should be the minimum, but this may vary by region. Keep in mind that all told, it costs approximately $8.00 - $10.00 to send a statement when you add up labor, postage, supplies, and other overhead expenses.

18. Depending on the amount outstanding, try to get her to agree to $100 per month, and work backward if she cannot afford the $100. Explain that there will be fewer payments if she agrees to a higher amount.

   "That's fine. I'll make a note to myself to watch for that payment from you Mr. Jones, and be sure it is processed immediately. We appreciate you taking care of your account." Make a note to be sure the check really arrives. If it doesn't, place another call.