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Medical Billing Mini Course**

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MEDICAL BILLING MINICOURSE

CHAPTER 1

HEALTH CARE HISTORY

During the first trimester of this century, health care was largely free of interests, which have now firmly attached themselves to the health care delivery system, resulting in exponentially escalating costs while in recent years reducing net income to the traditional health professionals. What began as an intense and knowledge-based relationship between patient and doctor evolved into convoluted maze of corporate and bureaucratic confusion.

The patient receiving the care is not normally involved in determining the relative value (often even the need for) and cost for the service, that relationship having evolved to one between third party payers and "providers" a generic term incorporating not only doctors -- traditional managers of health care - but all skill levels involved in health care delivery. Virtually ignored in the contracting, approval and payment cycle are the employers and cooperative associations who are the financial resources paying for most of the nation's health care costs.

The fragmentation of health care delivery systems, ad hoc grouping of recipients and providers of service, third party differential standards for billing, and benefits allocation have prevented the controls and incentives which otherwise emerge in a free market economy. Effects are across-the-board cost increases, continually changing record-keeping requirements, (often reflecting administrative and regulatory perceived demands rather than provider/patient needs) bureaucratic overhead, and expanding medical malpractice litigation. These costs, approaching more than 300 billion dollars annually, result in only marginal benefits to the consumer in an increasingly competitive health care industry.

How did we arrive at such a wasteful, costly and counter-productive health care social environment?

This century has experienced a complete cycle in the style and mode of providing health care. A vignette from the turn of the century would portray health care as a family doctor in a one-horse shay making his rounds to his patient's home, not only intimately knowing each one (and family members on a personal level), but also every detail of the medical history because he had diagnosed and treated all of their diseases, injuries and illnesses from birth.

A contemporaneous and less idealistic but parallel health care image emerged with the nation's industrialization and urbanization. Those unable to afford to pay a doctor to come to their homes or who had chronic incapacitating illness or who suffered with communicable diseases demanding quarantine received health care through government or charity funded "hospitals" whose social burden was the "care of strangers." Until World War I, hospitals were institutional "poor houses" subsidized as public charities. Most of the patients were indigent, often stigmatized for having to be treated at such institutions. The hospital was recognized as almost a "place to die."

As technology made inroads into what had theretofore been regarded as an art, the need to more specifically categorize diseases, illnesses, injuries and appropriate treatments led to medical specialization which, over time, co-opted hospitals by distributing "staff privileges" according to standards of care defined by the specialties staffing those "departments". The next half-century marked health care as a *technologically based service*. Following the line of least resistance it also became increasingly hospital-oriented to the emerging specialties converging in increasingly complex, scientifically sophisticated and increasingly costly care.

Along with the of insurance, private and public, came a whole new set of billing rules.

Compounding the intrinsic problems of care are patients', providers', and payers' obvious but discreet needs to accumulate and assimilate the vast and increasingly complex information and data from and into a disintegrated delivery system. One demonstrable result is the insidious cost-escalation drivers unrelated to delivery of service. They only burden the system and compromise the care of the patient while emplacing numerous layers of bureaucratic overhead.

Regulatory agencies and third party payers (insurance companies or benefit trusts, public and private) have historically failed to coordinate or standardize reporting, tracking and billing requirements, thus forcing providers and claimants to wade through the compliance, billing and claims adjudicating maze.

When problems of billing and payment allocation are compounded with the obvious need to keep a finger on the pulse of medical advancements, diagnostic and treatment procedure codes and nomenclature evolution, providing for and managing the care insured groups, enrollees, and dependents, and individual members of self-insured groups, massive data management and real time processing are imperative, however daunting.

While the federal government has an obviously vested interest in containing health care costs due to budgetary pressures and political demands, (Medicare being a prime example) the staggering number of interest groups, including the government's own agencies, limits its ability to address the problem in a comprehensive manner.

Health care is the only component of the U.S. economic infrastructure in which third-party payers indemnify patients against the risk of adverse economic conditions resulting from health problems. Purchasing risk of one's own disease through indemnity coverage is perhaps the only illustration in an enterprise-based economy, which is at once the central conduit and controlling unit for the provision and delivery of service.

Medical billing must accommodate all of the complexities identified in an efficient way, and as economically as possible. Therefore, it is a very complex process.

CHAPTER 2 OFFICE STAFF

1. Office Manager

The office manager will often review processes and procedures with the staff. It's important to do this periodically in a review process. All functions should be examined for efficiencies and the strengths and weaknesses appropriately adjusted to improve the process. The staff who are in daily contact with the patients and the processes have the most knowledge on how to improve. Office managers should listen to those ideas.

2. Receptionist:

The receptionist is the staff member who answers the telephone to make the appointment. This person needs to be able to discuss anything to do with the practice, and how the financial relationship works. S/he listens to the patient and arranges an appointment. Once the appointment is made, it is important to convey and to collect any information that will make it easier to participate in the office billing/collection process.

3. Billing Clerk:

The financial part of the process once the visit is completed is handled by the billing clerk.

4. Health Insurance Specialist (HIS):

This individual monitors the insurance process (sometimes billing clerks and health insurance specialists fulfill the same responsibilities). If it is a large practice, a HIS may be assigned to one or two payers.

5. Receivables Specialist (Collections Specialist)

This individual is responsible for collecting amounts due from the patient, copayments, estimated shortfalls in insurance payment, exit balances, and payment plan setups.

6. Coder

Procedural (CPT) and diagnostic (ICD) must be accurate. This individual must have a thorough knowledge of medical terminology in order to use the codebooks required. Though most billing and collections staff may have a cursory knowledge of the process and how the coding impacts the entire business, a trained coder is needed to do the actual coding and convey the information to the biller.

7. Staffing Levels

Assessment of the need for staff is based upon workload, processes, and the type of automation in place.

CHAPTER 3 BASIC PRACTICE ELEMENTS

1. Payment Policies and Fees

The practice obviously has to have a system in place related to expectations on payment. This should be a written policy that every staff member clearly understands and is able to communicate to patients or payers.

The practice may purchase fee data from many vendors who provide the "typical" fee (based on many variables) for a particular code. These fee schedule benchmarks may then be logically compared to the practice fee listings and adjustments made accordingly.

Payment expectations should be published and apparent in the office itself, and staff should orally communicate them with every encounter. If the patient knows what is expected, s/he will try to comply.

The policy should include provisions for patients who have not made current payments on delinquent accounts, managed care patients who arrive for appointments without a necessary primary care referral, and patients who have no means to pay at the current visit (no checkbook, credit card or cash).

2. Assignment

Most insurance companies allow patients to assign benefits paid directly to the provider. This does not require any particular arrangement between the payer and the provider. The patient signs the form adopted by the practice, which may be open-ended date-wise to cover every visit with the exception of Medicare (and each visit needs an assignment and financial responsibility by the patient for charges not covered by Medicare at all).

It should be pointed out to the patient that the assignment does not relieve in any way the patient responsibility to pay.

3. Payments and Adjustments

The key to a successful billing and collections process entails obtaining correct billing information, inputting the data as error-free as possible, collecting co-payments, reviewing Explanation of Benefits (EOB) information, evaluating overdue amounts and establishing a policy to collect them.

4. Copayments

Copayments represent significant revenue to the practice and are a mandatory process in the patient encounter. An average practice generates \$5000 to \$10000 in revenue from copays per physician per year. Failure to collect a copay has serious consequences.

Most patients expect (and are advised by their insurance company too) to make the

copay and the portions of estimated charges that won't be covered by insurance payers. During the encounter process, the patient should also be advised and asked to pay past due balances or to arrange a payment plan.

The copayments should be collected at the time of service, preferably when the patient checks in. At the checkout, any other payments that are due should be discussed. In some large practices, this function is handled by a "collections specialist." Though people prefer to wait until the insurance has paid, it is perfectly reasonable to ask for payment for deductibles or a balance that will likely be due based on the patient's insurance plan at the encounter visit.

If a sizable balance exists (surgery, etc.), the staff may help the patient find a way to pay. Educating the patient on what to expect both medically and financially increases the likelihood of collecting. If financial arrangements are made, it is a good policy to provide a signed financial agreement (a separate document than those generated on the entry level visit). The payment option should be clearly identified, the term, the interest, the amount of payments, any late charges, and a paragraph relating to default assessing the cost of collection (agency or legal firm) to the patient.

5. Intake forms:

The registration process may be the only opportunity to get all of the information needed to pursue for collection in the event any information is incorrect, and the patient never comes back in for further treatment. Hundreds of thousands of dollars are wasted filing claim forms to insurance companies, which are not the correct ones to bill. The same is true for the collection process. It sometimes takes up to two months or more to hear from the insurance company about those errors, so the account is already "old" before the errors are repaired. Obtaining a judgment and not having a social security number sometimes ultimately prevents collection of the judgment.

When completed by the patient, the Patient Information intake form must be reviewed carefully to see that is completely filled in. If there are blanks, the patient or guarantor is asked for the specific information to complete it. The social security number is very important for both the insurance payment processes, and in the event hard-core collection activities (for credit reporting and judgment collection) are necessary.

The patient (or guarantor) must agree in writing to the terms of the patient/provider contract.

6. Privacy Act - HIPAA

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. It is now law governing the management of confidential information. Every practice must have written policies about how they comply with the act.

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The chapters you have just read provided a brief overview of the billing course.

O.K. Now let us test your understanding of what you just read through. This is the same way we do it in the courseware. Go to the next page and read the questions, referring to the information in the 3 chapters presented, answer the questions, check your answers, and arrive at a score. **READY? GO!**

## QUESTIONS

Answer the questions then check your answers (which immediately follow).

1. Health care in this country is well organized, logical and inexpensive T/F
2. Government involvement in health care made it less complicated T/F
3. Purchasing risk of one's own disease through indemnity coverage is essentially what insurance is all about T/F
4. Medical billing has become far less complex than it used to be T/F
5. Name 3 office staff functions  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Policies relating to patients and payments should be \_\_\_\_\_
7. Assignment is where payments are made directly to the \_\_\_\_\_
8. An EOB stands for \_\_\_\_\_
9. Copays due from patients are small and do not affect the practice finances T/F
10. Intake forms are designed to obtain \_\_\_\_\_
11. Patient/provider agreements do not have to be written to be enforceable T/F
12. Data entry errors do not really slow payments down T/F
13. HIPAA stands for \_\_\_\_\_
14. The practice need not have a written policy about HIPAA rules T/F

## ANSWERS

1. F
2. F
3. T
4. F
5. Office manager, receptionist, billing clerk, health insurance specialist, coder, collector - ANY 3
6. Written
7. Provider
8. Explanation of Benefits
9. F
10. all the information possible
11. F
12. F
13. Health Insurance Portability and Accountability Act
14. F

### SCORING

Determine how you did by dividing total correct answers by 14 (number of questions). If you score 80% or better, you did pretty well, with 85% even better, and 90% or better is outstanding.

### SUMMARY:

If you enjoyed your brief entrée into the world of learning the mechanics of billing for a medical provider, seriously consider enrolling in the course. As the wise old owl says:



**"He who hesitates is lost!"**