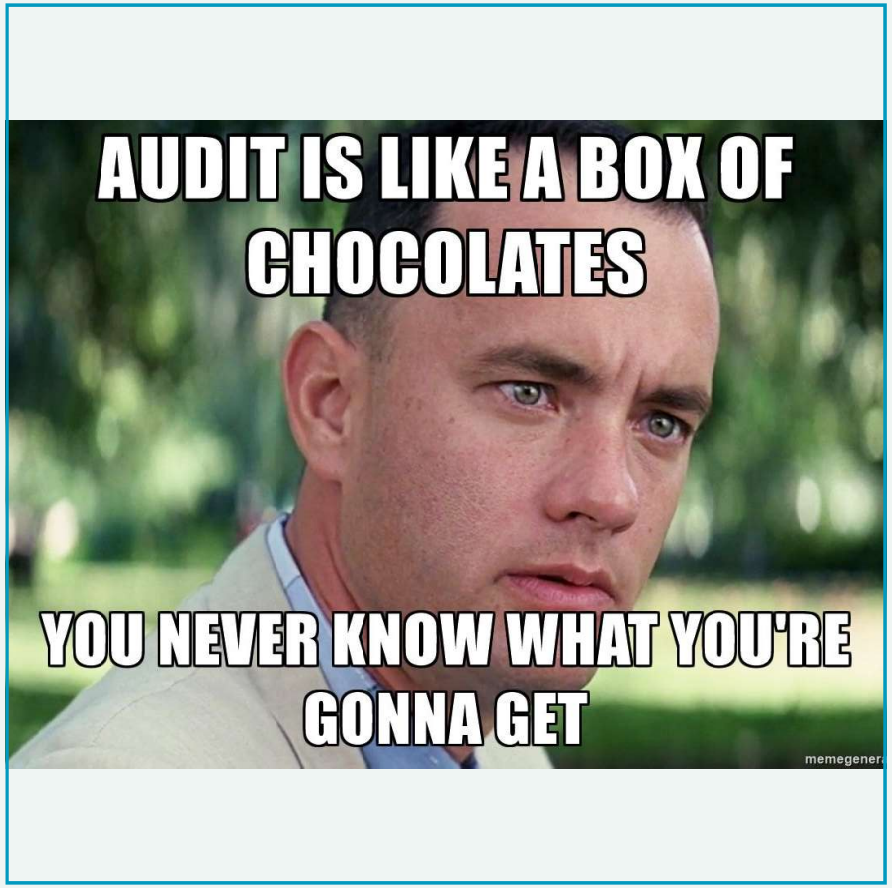

PedsOne
Pediatric Business Specialists

UC 2023

A Practical Guide on Auditing Your Billing Department

Presented by Heidi Chamberlin

PedsOne Billing Team Lead & Culture and Connections Lead

THE FOCUS AREAS

Charge Posting/Coding

Reporting

Payment Posting

Personal Billing

A/R Follow-Up

Time for Questions

CHARGE POSTING AND CODING

Holiday/After Hour Codes

Modifiers

Screenings

HOW AND WHEN TO USE THE 99051 VS 99050

99051 should be used for when you have scheduled office hours but are open later than a standard M-F business. "Services provided in the office during regularly scheduled evening, weekend or holiday hours"

99050 should be used for when your office is NOT scheduled to be open and you go in to see a patient. "Services provided in the office at times other than regularly scheduled hours or days when the office is normally closed (holidays or Sundays, etc.)"

MODIFIER USE

- **Modifier -25:** this Modifier is used to report an Evaluation and Management (E/M) service on a day when another service was provided to the patient by the same physician or other qualified health care professional
- **Modifier -59:** used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.
- **Modifier -76:** It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service.
- **Modifier -95 (also FQ, GQ, GT):** Real-time interaction between physician/other qualified health care professional and patient who is located at a distant site from the physician/other qualified health care professional.
- **Modifier -24:** The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure.
- **Modifier -52:** Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion.
- **Modifier -50:** Bilateral procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session and should be identified by adding the modifier 50 to the appropriate five-digit code.
- **Modifier -33:** Modifier 33 is a CPT® modifier used to identify medical care whose primary purpose is delivery of an evidence based service, based on recommendations from the US Preventive Services Task Force. Using modifier 33 indicates to the payer that the service is in accordance with the USPSTF recommendation The payer should process the claim without a patient due balance Be sure to use a screening diagnosis if your payer doesn't recognize the Z00 code for those services.

Screenings under 96160/96161

1. Acute Concussion Evaluation (96160)
2. CRAFFT Screening Interview (96160)
3. Edinburgh Postnatal Depression Scale (EPDS) (96161/96127)- this code varies from payer to payer

Screenings under 96127

1. Ages and Stages Emotional Questionnaire
2. Patient Health Questionnaire (PHQ-2 or PHQ-9)
3. Pediatric Symptom Checklist (PSC)
4. Screen for Child Anxiety Related Disorders (SCARED)
5. Vanderbilt Rating Scale
6. Edinburgh Postnatal Depression Scale (EPDS)- however, this code varies from payer to payer

Screenings under 96110

1. Ages and Stages-Third edition
2. Modified Checklist for Autism in Toddlers (MCHAT)
3. Parents' Evaluation of Developmental Status (PEDS)

SAMPLES FROM UHC PREVENTATIVE GUIDELINES

- **Maternal Depression Screening:**
  Routine screening for postpartum depression should be integrated into well-child visits at 1, 2, 4, and 6 months of age. Required for 96127 Only:
  Encounter for Screening for Depression:
  Z13.31, Z13.32

- **Depression in Children and Adolescents (Screening)**
  USPSTF Rating (October 2022): B
  The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12-18 years.
  Bright Futures (February 2017):
  Maternal Depression Screening:
  Routine screening for postpartum depression should be integrated into well-child visits at 1, 2, 4, and 6 months of age.
  Note: The Bright Futures Periodicity Schedule recommends depression screening begin at age 12-21 years.
  Procedure Code(s):
  96127, 96161, G0444
  Diagnosis Code(s):
  Required for 96127 Only:
  Encounter for Screening for Depression:
  Z13.31, Z13.32

- **Formal Developmental/ Autism Screening**
  Bright Futures:
  A formal, standardized developmental screen is recommended during the 9 month visit.
  A formal, standardized developmental screen is recommended during the 18 month visit, including a formal autism screen.
  A formal, standardized autism screen is recommended during the 24 month visit.
  A formal, standardized developmental screen is recommended during the 30 month visit. Procedure Code(s):
  96110
  Diagnosis Code(s):
  Z00.121, Z00.129, Z13.40, Z13.41, Z13.42, Z13.49

Hearing Screenings:

1. **92551- Screening test, pure tone, air only**
2. **92552- Pure tone audiometry (threshold), air only**
3. **92567- Tympanometry (impedance testing)**
4. **92558- Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis**
5. **92650- Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis**
6. **92587- Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report**
7. **92588- see above WITH comprehensive diagnostic evaluation, with interpretation and report**

Vision Screenings:

1. **99173- Screening test of visual acuity quantitative, bilateral**
2. **99174- Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral, with remote-analysis and report**
3. **99177- Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral, with on-site analysis**

SCREENING FOR VISUAL IMPAIRMENT IN CHILDREN
USPSTF RATING (SEPT. 2017): B
THE USPSTF RECOMMENDS VISION SCREENING AT LEAST ONCE IN ALL CHILDREN AGE 3 TO 5 YEARS TO DETECT AMBLYOPIA OR ITS RISK FACTORS.
PROCEDURE CODE(S):
VISUAL ACUITY SCREENING (E.G., SNELLEN CHART):
99173
INSTRUMENT-BASED SCREENING:
99174, 99177
DIAGNOSIS CODE(S):
SEE THE PREVENTIVE BENEFIT INSTRUCTIONS.
VISUAL ACUITY SCREENING (99173):
UP TO AGE 21 YEARS (ENDS ON 22 ND BIRTHDAY). DOES NOT HAVE DIAGNOSIS CODE REQUIREMENTS FOR PREVENTIVE BENEFITS TO APPLY.
INSTRUMENT-BASED SCREENING (99174 AND 99177):
AGE 1 TO 5 (ENDS ON 6TH BIRTHDAY):
DOES NOT HAVE DIAGNOSIS CODE REQUIREMENTS FOR PREVENTIVE BENEFITS TO APPLY

HEARING TESTS
BRIGHT FUTURES (APRIL 2017):HEARING TESTS: RECOMMENDED AT AGES: NEWBORN; BETWEEN 3-5 DAYS TO 2 MONTHS; 4 YEARS; 5 YEARS, 6 YEARS; 8 YEARS; 10 YEARS; ONCE BETWEEN AGE 11-14 YEARS; ONCE BETWEEN AGE 15-17 YEARS; ONCE BETWEEN AGE 18-21 YEARS; ALSO RECOMMENDED FOR THOSE THAT HAVE A POSITIVE RISK ASSESSMENT.
RISK ASSESSMENT: RECOMMENDED AT AGES: 4 MO, 6 MO, 9 MO, 12 MO, 15 MO, 18 MO, 24 MO, 30 MO, 3 YEARS, 7 YEARS, AND 9 YEARS.
PROCEDURE CODE(S):
HEARING TESTS:
92551, 92552, 92553, 92558, 92587, 92588, 92650, 92651, V5008
DIAGNOSIS CODE(S):
EXAMINATION OF HEARING: Z01.10
ROUTINE CHILD: Z00.121, Z00.12 GENERAL EXAM (FOR 18-21YEARS): Z00.00, Z00.01
NOTE: A RISK ASSESSMENT IS INCLUDED IN THE CODE FOR A WELLNESS EXAMINATION VISIT; SEE THE CODES IN THE WELLNESS EXAM.

Ages 0-90 days: Does not have diagnosis code requirements for the preventive benefit to apply.
Ages 91 days to 21 years (ends on 22nd birthday). Requires one of the diagnosis codes listed in this row.
Limit of once per year

united healthcare policy otoacoustic

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UHCprovider.com
https://www.uhcprovider.com › public › policies PDF

Otoacoustic Emissions Testing Policy, Professional

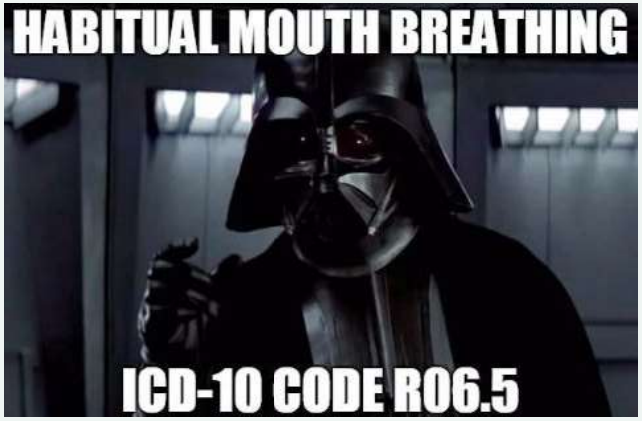
Oct 1, 2007 — **Auditory screening or diagnostic testing using OAEs is not medically necessary for all other patient populations and conditions** including ...

https://www.uhcprovider.com › public › policies PDF

Otoacoustic Emissions Testing – Oxford Clinical Policy

Jan 1, 2023 — **Neonatal hearing screening as** a preventive service using otoacoustic emissions (OAE) is proven and medically necessary for infants who are 90 ...

PAYMENT POSTING



Denials & Write-Offs

ERAS/EFTS

Interest & Overpayments

Proving Out

Denials and Write-Offs

1. How quickly are denied claims getting reviewed, corrected and sent back out?
2. Is someone reviewing a list of codes that are written off?
3. How quickly are payments being posted?
4. When a charge drops to manual posting is staff looking for the reason to correct it going forward?

ERA/EFTS

1. Has your billing staff added any and all payers available for ERA?
2. Things change frequently- if a payer did not offer ERA or EFT in the past, they may now. Have a schedule to recheck any payers that are not set up.
3. How many paper checks are you receiving? How many virtual credit cards are you having to run?

Interest and Overpayments

1. Are interest payments being posted and how?
2. Where are overpayments posted and how are they documented?
3. Is staff reaching out to correct overpayments?

Proving Out

1. Do you have a deposit sheet that you can access?
2. Is someone double checking prove outs?
3. Proving out should be done for front desk collections, after every check is posted, any payments made through websites or portals

CARC code set-up for Autoposting

In your system double check your CED configurations under ECS. There is a line that asks "which provider/insurance CARC values are exceptions". This is where you want to have your billers enter the CARCS that SHOULD be autoposted such as 45. Anything that your billers would want to see such as 96, 97, etc would not be listed in there for review. The same for the line that asks for patient responsibility CARCs - you would want the 1, 2, 3, etc CARCS in there. Make sure you review these to ensure no claim lines that have been denied have been autoposting full adjustments.

042723 99212	105.00	0.00	-25.00	3PR
	105.00	0.00	-25.00	

Payer Claim Control Number: 2023125DI7865

* Payment was less than the allowed amount amount (CPT 99212)

050423 99214	236.00	0.00	-25.00	3PR
	236.00	0.00	-25.00	

Payer Claim Control Number: 2023128DB7708

* Copay listed did not match charge history (CPT 99214)

042523 99393EP	200.00	0.00	0.00	0.00
042523 9616059	25.00	0.00	0.00	0.00
042523 99173	6.00	0.00	0.00	0.00
Claim Level Adjustment		0.00	0.00	0.00
	231.00	0.00	0.00	0.00

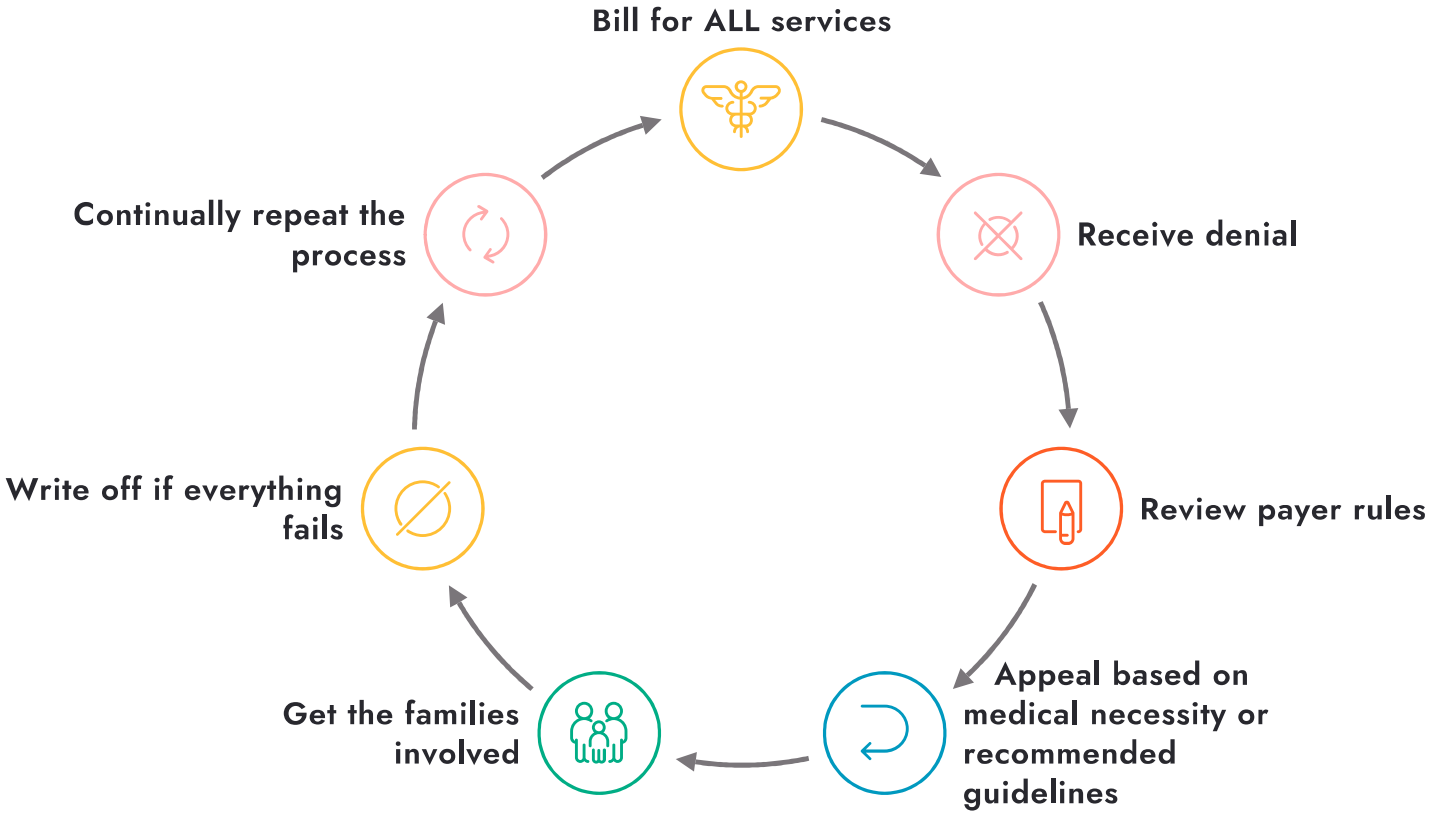
Billed Service Not Covered by Health Plan (9616059)

Payer Claim Control Number: 23G257800200

* Adjustment reason not configured for autoposting (Adjustment Reason: 96)

Proving Out/Balancing

Date	Insurance Company	Payment Amount	Check #	Amount Autoposted	Percent Autoposted	Partner Balance	Difference	Notes	Posted by	☐
	Merchant Bank	$656.24		$0.00	0.00%	$656.24	$0.00		HC	☑
	UHC	$2,326.73	1TZ45371851	$1,624.07	69.80%	$2,326.73	$0.00		HC	☑
					#VALUE!		#VALUE!			☐
3/14/2023	Healthy Blue	$97.29	3204689929	$94.01	96.63%	$97.29	$0.00		HC	☑
	UHC MW	$230.90	20230311a2000623	$0.00	0.00%	$230.90	$0.00		HC	☑
	UHC MW	$271.15	20230311A2000624	$0.00	0.00%	$416.31	$145.16	Recoup $145.16	HC	☑
	Merchant Bank	$1,741.47		$0.00	0.00%	$1,741.47	$0.00		HC	☑
	Cash $45								HC	☑
	Deposit $2146.08				#DIV/0!		$0.00		HC	☑
	PCK $371.33				#DIV/0!		$0.00		HC	☑
	CBA	$130.20	0061476170	$130.20	100.00%	$130.20	$0.00		HC	☑
	UMR	$443.17	0000001111	$138.59	31.27%	$443.17	$0.00		HC	☑
	UMR	$105.19	0000560487	$75.43	71.71%	$105.19	$0.00		HC	☑
	Home State	$1,051.19	000309647	$0.00	0.00%	$1,051.19	$0.00		HC	☑
	Deposit $6146.00				#DIV/0!		$0.00		HC	☑
	PCKs $540.86				#DIV/0!		$0.00		HC	☑
	Plumbers	$105.64	15325508	$0.00	0.00%	$105.64	$0.00		HC	☑
	Plumbers	$42.21	15325509	$0.00	0.00%	$42.21	$0.00		HC	☑
	Plumbers	$42.21	15325510	$0.00	0.00%	$42.21	$0.00		HC	☑
	Plumbers	$151.61	15325511	$0.00	0.00%	$151.61	$0.00		HC	☑
	ABS	$115.31	2000345	$0.00	0.00%	$115.31	$0.00		HC	☑
	Maries	$71.83	1493	$0.00	0.00%	$71.83	$0.00		HC	☑
	Osage	$216.23	2566	$0.00	0.00%	$216.23	$0.00		HC	☑
	ABS	$53.03	1999665	$0.00	0.00%	$53.03	$0.00		HC	☑
	ABS	$53.03	1999666	$0.00	0.00%	$53.03	$0.00		HC	☑
	ABS	$92.00	1999667	$0.00	0.00%	$92.00	$0.00		HC	☑
	Home State	$1,704.19	308621	$0.00	0.00%	$1,704.19	$0.00		HC	☑
	Marketplace	$94.46	5018574	$0.00	0.00%	$94.46	$0.00		HC	☑



Remember Things Change!
Do not accept a denial as the standard- persistence is the key

FAMILY APPEAL LETTER

To Whom It May Concern:

The code 96160 (Health Risk Assessment) for our child, (INSERT PATIENT NAME), was denied stating that it is not a covered benefit. Under the Affordable Care Act payers are required to cover, without cost sharing, preventative services recommended by the United States Preventative Task Force (USPSTF) and Bright Future Guidelines. CPT code 96160 was approved for the administration of patient-focused health risk assessment instrument with score and documentation, per standardized instrument. Payers are required to provide coverage benefits and are urged to pay appropriately for this service per the Bright Futures/AAP Recommendations for Preventative Pediatric Health Care Periodicity Schedule. Please review the enclosed documents regarding the use of this code and the medical documents from the visit and please reconsider payment of this code.

Sincerely,

A/R WORK

Timely A/R Follow Up

Ask Questions

Set Goals

ENSURE A/R IS BEING WORKED!

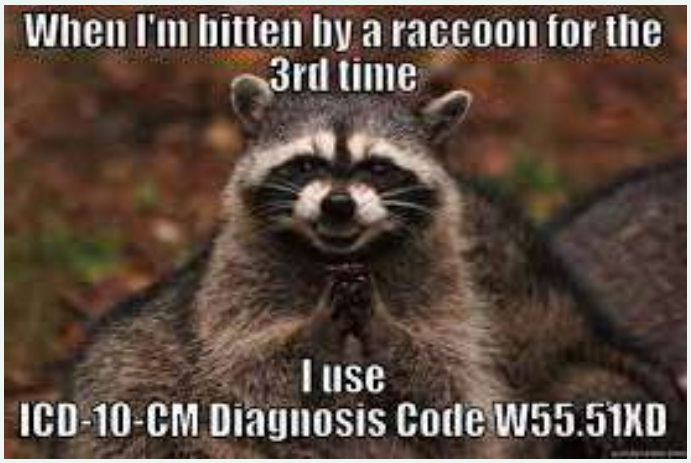
1. Find a system that works for your staff
2. Require approval on all large write-offs
3. Be strategic! Know your timely filing guidelines and have staff work payers with the shortest limits first.
4. Have staff utilize websites as much as possible
5. Use calendar reminders to ensure proper follow-up
6. Review A/R with staff members regularly to ensure all accounts are being touched and nothing gets missed. This also helps avoid chronic resubmission of claims that have not been corrected.
7. Set benchmarks and goals for the team

INSURANCE INFO AND TIMELY LIMITS

Sample only! This is info is to be used as an example on how to set up your own sheet

Insurance	Website	UN/PW		Provider Rep	Timely
Aetna	Availity		888-632-3862	N/A	Original claims 90 days from DOS/corrected claims 90 days from date of denial/appeals 6 months from date of last denial
BCBS	Navinet		866-688-2242 IVR	Faye H. (insert email or phone)	180 days for original and corrected from DOS/60 days for appeals from date of denial
Cigna	www.cignaforhcp.com		800-244-6224	Matthew F.	90 from DOS for original/180 days for corrected/appeals
UHC	www.unitedhealthcareonline.com		877-842-3210	Elaine R.	90 days from DOS for original/180 days for corrected or appealed claims from last date of denial
Tricare	www.mytricare.com		844-866-9378	N/A	210 days from DOS/210 days for corrections from DOS/90 day disputes from date of denial

REPORTING



Insurance Aging

Error/Rejections

Zero Pay/Full Pay

REPORTING

Aging

Staff should be running an insaging report on a weekly basis and review with management. This allows you to see the buckets with the highest percentage in them and create priorities.

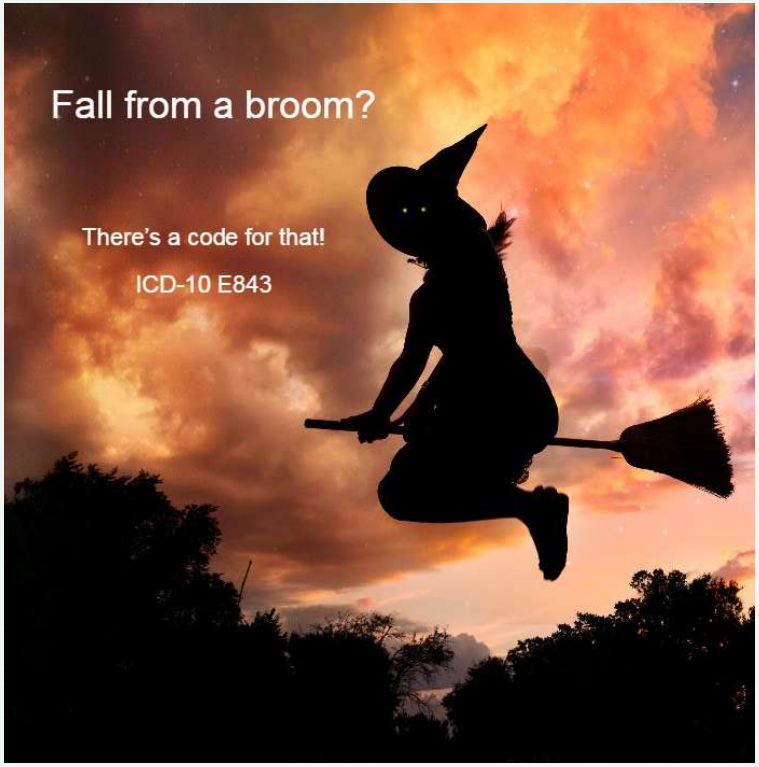
Rejections

Does your staff know where to find claim rejections? Do they know how to fix different rejection types? Let's talk about the CER and CES reports!

Zero Pay/Full Pay

Did you know you have the option of getting a report that shows any codes that are fully written off or paid in full?

PERSONAL BILLING



Policies and Protocols

CCOF & Budget Plans

Past Due Accounts

POLICIES AND PROCEDURES

1. **Financial Policy**
   Are staff members adhering to what is listed in your financial policy? For example, are late fees mentioned in the policy being added accordingly to accounts?

2. **Self Pay Policy**
   Do you have a well documented self pay policy that your billers can use to apply appropriate discounts? Are your billers following state guidelines?

3. **COB Policy**
   Does your staff know how to properly handle a COB denial?

4. **Newborns**
   Do you have a protocol documented of how to handle newborns and the first charges of a child's life?

5. **Take-backs and Refunds**
   Does your staff know the state law on recoupments and patient refunds?

SELF PAY POLICY

Charge everyone the same price- self pay and insured patients. The reason is compliance, especially when it comes to state medicaid. You can adjust and discount after the fact but it's better to have all the charges the same across the board instead of charging self pay patients a different amount up front. Always check your state guidelines to be sure you are in compliance. Typically you cannot discount a self pay patient for less than what the state medicaid allows. The biggest area to watch out for is the vaccine administration charge.

Have a formal written payment policy which clearly reflects payment is due at time of service unless you make other arrangements in advance.

COB PROTOCOL

If a claim denies for COB our "best practice" recommendation is put the entire balance out to patient responsibility and immediately reach out to the family. Try to reach them by phone or email and if you are unable to you can send them a letter informing them of the denial and how to fix it. At PedsOne we have used brightly colored paper in the past to help alert the familes that there is something worth paying attention to upon opening the notice. The key part of the COB is to make sure you request a reference number during the call so that your staff can follow up after the parent has done their part.

Sample of a COB letter:

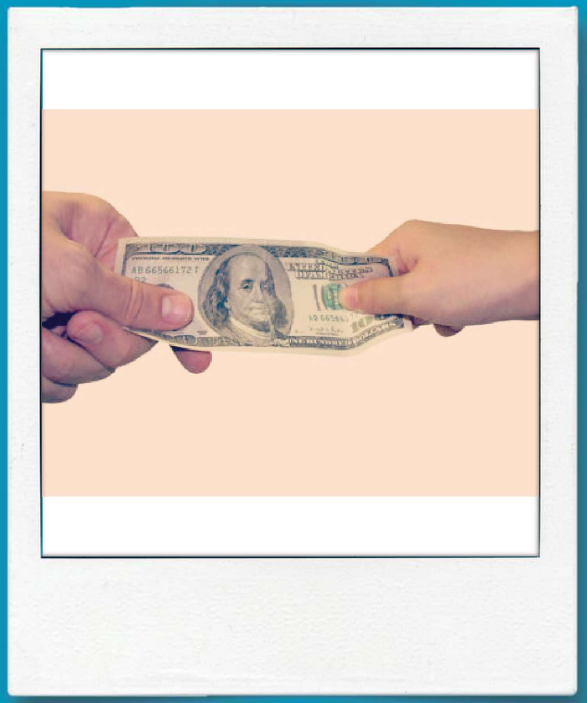
"We have received notification that your insurance company has requested a Coordination of Benefits update (COB) from you. Please call your insurance company right away and let them know if you have any other insurance coverage for your child(ren). They will ask you a short questionnaire to verify and rule out other insurance coverage. During your call, please request that any outstanding claims for your child/children be reprocessed.

Please obtain a confirmation number from your call and the name of the representative that you spoke with. Your insurance company will NOT pay for these claims until you provide this information to them. We will follow up with your insurance company on your behalf, but only if we have this confirmation number"

NEWBORN PROTOCOL

There are several ways to manage newborns but typically the "best practice" we recommend is to try to get insurance information from the family (even if the baby hasn't been added yet) and enter the policy into the system. The reason for this is to avoid letting the balance age or on the flip side, billing your parents before they have the time to contact their insurance. If the parents are unsure, you can use a dummy policy named "newborn" to place hold until you have the active policy. Flag the account "newborn" and utilize the "hold bill till" option and allow the parents 30 days to get the insurance information for you to bill. Remind the parents that while most insurances have automatic coverage for the baby for the first 30 days after birth, they still need to inform them about the baby in order for coverage to start. Also remember that not every plan has this benefit. There are always outliers- have the parents call as soon as possible to avoid newborn denials. Once the 30 day time period has passed and the parents still do not have active coverage, this is when we would recommend moving the balance to patient responsibility and send them a letter letting them know why they are receiving a bill.

TAKE-BACKS AND REFUND REQUESTS



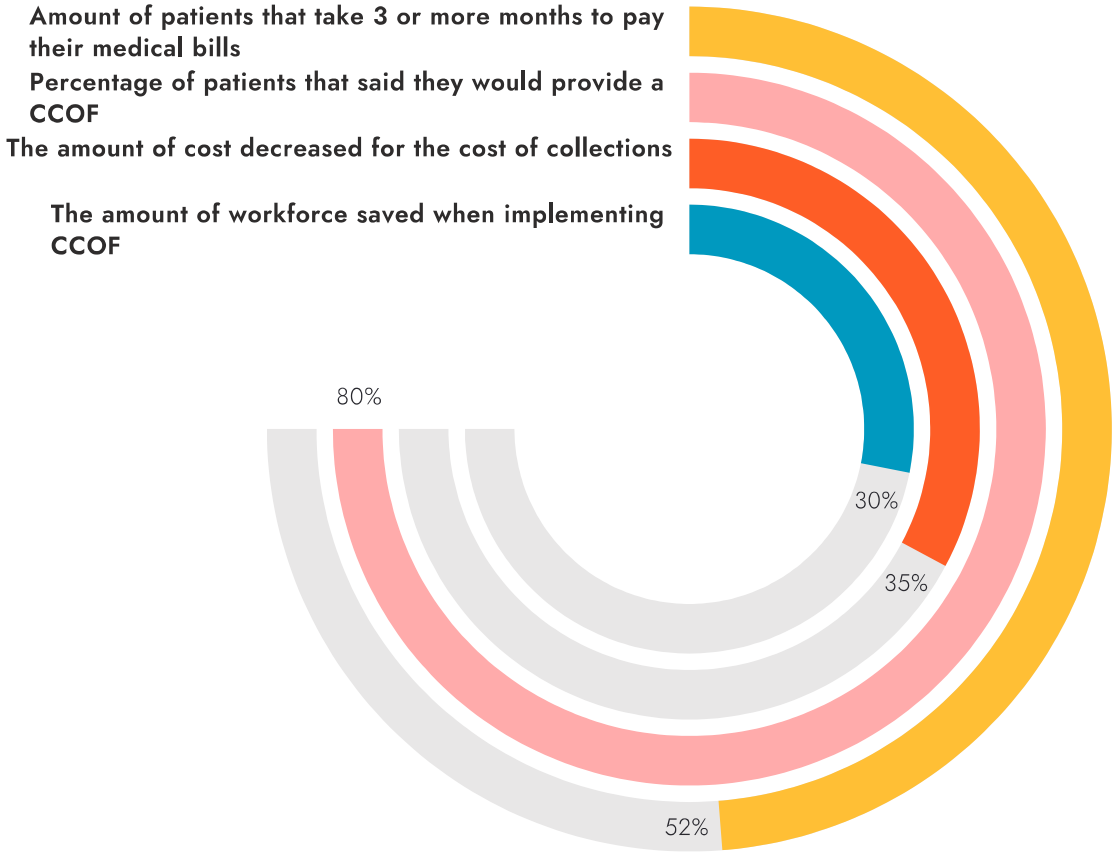
When an insurance requests a refund the first thing you should do is keep in mind your state's recoupment law. Not all states have a limitation, but knowing if you do can help prevent refunding money you are not liable to do! For example, in California a private payer only has 365 days to request a refund from the date of payment .

Research EVERY refund request before just sending a check or letting it be recouped. There are many times we have found that a refund request is not actually warranted.

If you have the option to let a valid refund request be recouped from a future payment take that option. We have seen checks sent out but with the delay in receiving the request, review, check approval and mailing it's past the deadline and they have already recouped the payment creating an overpayment on your end. Then you have to try to get the payment refunded back to you.

Research your state guidelines on patient credits and refunds. Most states have a requirement of how long you have once an overpayment has been identified to refund your patient's family. If the patient would like to keep the credit on the account have them sign a form that acknowledges that for security purposes.

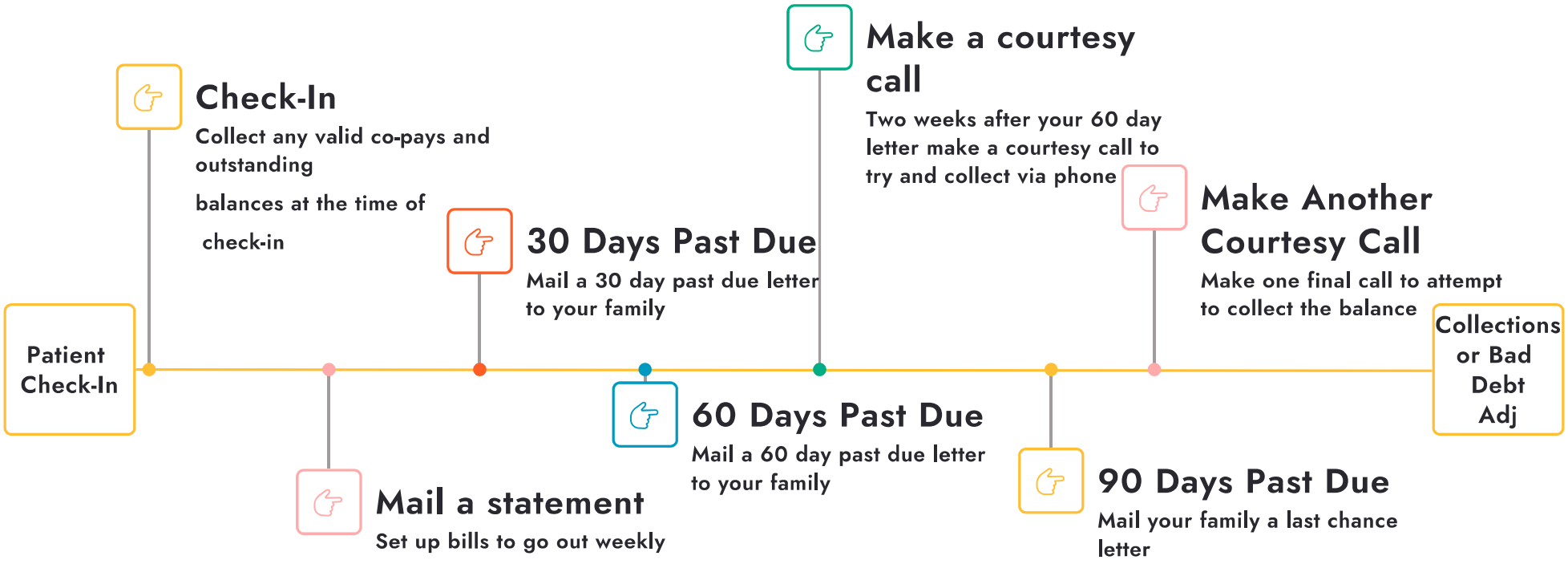
CCOF AND BUDGET PLANS



BUDGET PLANS

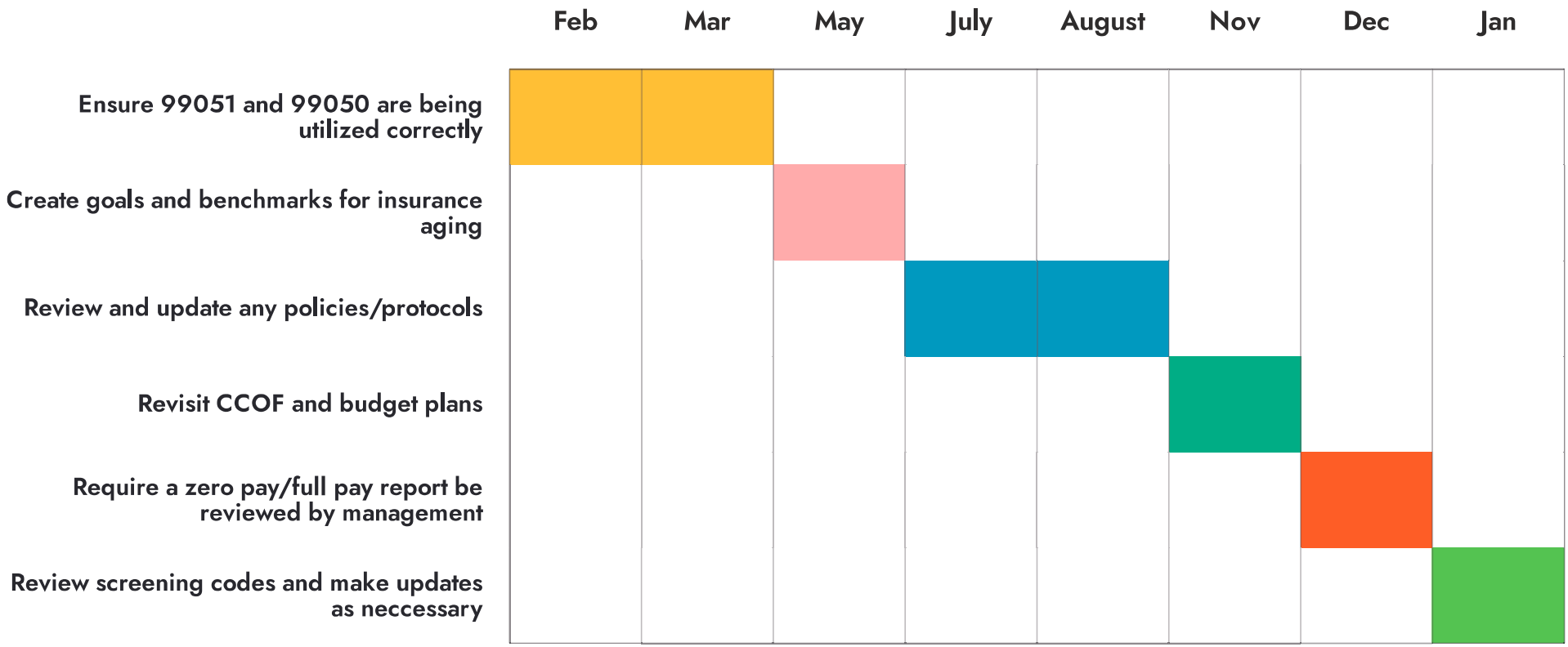
Is your staff offering budget plans and how are they being monitored? Do you have a set allowed amount or will you accept anything? Is this clearly documented?

COLLECTING PATIENT BALANCES



CREATE A MONTHLY PLAN

Don't try to get it all done at once- sample implementation plan



HAVE MORE QUESTIONS?

Please feel free to contact me at heidi@pedsone.com

Heidi Chamberlin

Senior Billing Specialist, Team Lead
and Culture & Connections Lead,
PedsOne