Appointments, Plans, and Billing

LESSON 2

ASSIGNMENT 4

Read Chapter 9 on pages 262–289. Then read Assignment 4 in this study guide.

Chapter 9 discusses the methods necessary to maintain an efficient scheduling system, with the emphasis on computerized applications. Although the actual software package in use might vary with the medical office, the basic fields will be essentially the same. Study the illustrations in this chapter. They'll give you a good idea of the entry fields that will be at your disposal.

The common features of a computerized scheduling system are listed on page 263. Note Figure 9.2 on page 264, which is a calendar used for scheduling appointments. The calendar employs a point-and-click function that triggers a pop-up booking sheet for the particular date. It can also generate automatic reminders of upcoming appointments and forward these reminders to patients by email or phone.

Pages 263–267 discuss the major features of appointment-booking software. Select a doctor and the respective schedule will appear. From the schedule, the AHP can select a patient and view his contact information and the reason for his medical appointment.

Note the doctor-unavailability criteria listed on page 268. This information can be entered onto the electronic calendar in the appointment software to prevent accidental booking of patients when the doctor is unavailable. The software will warn you that the time slot in question can't be used to book patients.

Your textbook discusses the scheduling considerations on page 269. Note the common medical abbreviations in Table 9.1, and pay particular attention to the warning to never book a woman in pregnancy on the same day as a patient suffering from symptoms of rubella.

On pages 270–274, your textbook discusses the types of scheduling. Before any system can be adopted, it's vital to estimate the average amount of time that the doctor spends per patient. Then, the doctor can select the type of system that he would prefer. It should be noted that wave scheduling would be more applicable to practices in which examinations are quick than in practices where 30 minutes may be needed per patient. For example, wave scheduling wouldn't be the optimum system for a doctor who has many elderly patients. The time required to process each patient would create a backlog if—say, in an hour—the doctor could only see one or two patients.

Take a few minutes to study the illustrations of scheduling displays depicted in Figures 9.7–9.8. Note the flexibility afforded by blended scheduling. Your textbook points out that stream scheduling is the most common method of scheduling appointments. Under this method, patients arrive and leave in a steady stream. If the system breaks down, it may be for any one or combination of the reasons listed on page 274:

- Insufficient time is allotted for each client.
- The doctor is taking too much time per client. (This, of course, is up to the doctor, but he will have to be aware that he is compromising the scheduling system that he selected.)
- Clients book for one complaint but then present with multiple issues.
- Too many walk-ins are delaying the processing of booked patients.
- A client brings an additional family member with a health issue when the appointment was for the client only.

Page 275 discusses approximate times for various health assessments and the criteria used to determine the type of visit being booked. This is important because it allows the AHP to double-book for issues requiring only a few minutes of examination time.

Always remember to keep a few time slots open for "catch-up," as these

- Let the doctor catch up if she's running late
- Provide an office break
- Allow the doctor to return phone calls and review prescription requests
- Squeeze in clients who require immediate attention

Self-Check 4

1. *True or False?* Double-column booking is frequently used as a primary scheduling method in many health care settings.

2. Why should the day sheet be printed if it's available on the computer?

   _____

3. Patients Crosby, Stills, and Nash are all booked for Tuesday at 10:30 A.M. to see Dr. Marrakesh. Of which type of schedule system is this an example?

   _____

4. What are two main methods by which a new client's completed health questionnaire may be added to her record?

   _____

Check your answers with those on page 44.

ASSIGNMENT 5

Read Chapter 10 on pages 292–317. Then read Assignment 5 in this study guide.

Chapter 10 reiterates some of the topics discussed in Chapter 4, but it discusses in more detail the specific health services covered under provincial medical insurance as opposed to those services not reimbursed under the provincial plans. Pages 295–297 list publicly insured services and those that aren't covered under provincial plans.

For some selected topics (discussed on pages 297–300), the extent of coverage under the public plans varies from province to province. Note as well the determinants of an insured service's value:

- The time the physician spends with the client
- The client's age
- Additional interventions rendered at the time of service
- Special circumstances such as where and when the service is rendered

The fee schedule in any given province is subject to change. Therefore, medical office administrators should consistently check their province's website for current information.

To receive health services in Canada, a client must present his or her provincial or territorial health card. If a client presents without a card or with a card that has expired, he or she will be denied the health care service.

Each health card has a personal identification number on it, which will range from 7 to 12 digits, depending on the province or territory. Keep in mind that some provinces issue a personal health number and a family account number for billing purposes. When minors reach the age of maturity, they'll be issued a new family account number but will retain their personal health number. In other provinces, billing numbers don't exist—only the personal health number, which individuals retain for the rest of their lives, is issued.

Though the person's health number won't expire, the health card will. Therefore, a health card must be renewed at periodic intervals. This is the responsibility of the individual cardholder.

However, the AHP should alert any client about a pending expiration date when the client presents a card. This holds true when the client has changed his or her place of residence. If the health card lacks current information, the client may find that he or she will be expected to pay for the health service in question and seek reimbursement from the province. In the case of a lost or stolen card, the client should be advised to contact the appropriate government office without delay.

The following steps outline the procedure for billing out-of-province claims:

1. Insist on seeing the actual card.
2. Check the expiration date.
3. Swipe the card and record the appropriate service code.
4. Bill your province's health insurance board.
5. If the client doesn't have his or her health card, collect payment and issue the client a receipt, which the client can use for reimbursement from his or her particular province.

Self-Check 5

1. List six hospital or medical services that aren't covered under most provincial and territorial medical plans.

   _____

2. List the three categories of documentation a person must present when applying for health care coverage.

   _____

   _____

(Continued)

Self-Check 5

3. *True or False?* An individual's family account number is assigned for the life of the individual.

4. How are newborns covered by the provincial/territorial health plan?

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_____

_____

Check your answers with those on page 44.

ASSIGNMENT 6

Read Chapter 11 on pages 319–364. Then read Assignment 6 in this study guide.

Chapter 11 focuses on the billing procedure—specifically on the methods used to validate health cards and on the identification and application of the correct service codes. This is vitally important to the AHP, since an incorrectly completed claim will be rejected by the provincial/territorial health boards, putting the physician's service payment in jeopardy.

The claims review process is summarized on page 320. For a claim to be processed, it must meet the following criteria:

- The provider has a valid billing number.
- The service claim is authorized by provincial or territorial guidelines.
- The fee claimed is the one determined by the fee schedule.
- The client has a valid health card.
- The claim is submitted in a technically correct manner.

Claims are usually submitted electronically within a stipulated time frame. Not all medical procedures can be claimed for remuneration from the health service boards. This is especially the case when the service involves cosmetic surgery.

As your textbook emphasizes, every health card presented should be validated to ensure prompt payment of claims and reduce health care fraud.

Pages 322–323 discuss the methods of health card validation. Electronic validation, though fast, will be inapplicable in certain settings, such as walk-in clinics.

A *point of service device* (POS) transfers the information from the health card into a computer. Any missing information may be added manually by keyboard. Once the information has been compiled, it's submitted to the provincial ministry for authentication and acceptance or rejection as the case may be. The procedure is depicted in Figures 11.1–11.2. If a card is rejected, the AHP must inform the cardholder that he or she will be charged for the visit before the client accepts the health service.

Page 325 of your textbook discusses the procedure for dealing with a card that appears to be fraudulent. In this event, the AHP should

- Collect the card if the client will allow you to do so
- Try to determine where and when the card was obtained
- Report the incident to his or her ministry's fraud hotline

For a health service to be provided by a physician, the physician must have a billing number authorized by the college of physicians and surgeons in the province/territory in which he or she practices. The billing number consists of two parts: practice number and payment number. A billing number consisting of three segments is displayed on page 326 of your textbook. The three segments are (1) the group identification number, (2) the unique physician billing number, and (3) the specialty identification number.

Note the specialty numbers listed in Table 11.1 on pages 327–329. Become familiar with these codes; the most frequent code is the 00 designation for family practice/general practice.

In addition to the practice codes, you'll encounter the diagnostic codes representing the condition/treatment procedure for the health service in question. These are three-digit, numerical codes, such as 477 (hay fever) or 487 (flu).

Pages 330–331 discuss billing codes, which are of equal importance. These codes alert the health services board to the degree of service performed and who actually performed the service. Pages 330–331 describe the three components of the code:

- *Prefix,* which could represent (1) the type of assessment, (2) where the assessment occurred, and (3) the specialty of the provider
- *Numeric component,* three numbers that represent the degree of assessment, that is, minor, intermediate, and comprehensive
- *Suffix,* an alpha component that records who actually performed the service

Keep in mind that codes for diagnostic tests may allow two providers to bill for the same service. For example, both the doctor ordering an X-ray and the clinic performing the X-ray will bill under the same procedural code. The doctor would bill under the procedure's "Professional" component, while the clinic would bill under the procedure's "Technical" component. If the doctor had performed the examination through which he or she recommended the X-ray and had personally taken the X-ray, he or she could bill under both components.

Your textbook discusses the commonly used services on pages 332–338. Although you should familiarize yourself with the criteria used to determine each type of service, it will be the service provider him- or herself who will decide on the service classification and authorize you to file the claim.

Pay particular attention to pages 339–340, which discuss using fee codes and procedural codes. A doctor may, depending on the services performed, bill by both fee code and procedural code.

Some common diagnostic codes are listed in Table 11.2 on pages 342–343. Be aware, however, that codes change quite frequently, which necessitates constant refamiliarization with these codes. Most codes are entered into a computer database and can be edited easily. They can also be entered on the client's electronic dossier readily by simply scanning the diagnostic procedure alphabetically and selecting it by mouse. Following this step, the code will appear on the client's file and subsequent service-provider claims.

In addition to all of the codes, a health care claim often requires the listing of the applicable *time units.* Time units are a means by which the health services board determines whether the service provider is efficiently providing the service, is padding his or her claims, or is inefficiently providing service. Thus, various procedures have stipulated time constraints. Time units are measured in 15-minute increments. A surgeon performing an operation for which three hours is considered sufficient, therefore, would bill a total of 12 units (three multiplied by four 15-minute increments in one hour). As your textbook points out, the time units aren't inviolate—in an operation in which complications occur, the surgeon wouldn't stop because the three-hour recommended time unit had been exceeded.

Pages 341–345 discuss using premium codes. The premise behind premium codes is that any given procedure might be more demanding depending on the age/condition of the patient. As your textbook points out, taking a blood sample from a baby may be much more demanding than obtaining the sample from a 20-year-old man. Given the difference in the level of difficulty, the service provider would be paid more for performing the blood test on the baby than on the man.

Pages 345–347 discuss the sample scenarios. For these scenarios, your textbook explains how to designate the appropriate codes. Although you don't have billing software included in your program, you should still try Application Exercise 3 on page 353. The next chapter contains a more detailed discussion of the billing screen, so at this point, you should simply list the applicable codes for each scenario. Remember that at this time, you're concentrating on identifying the appropriate codes rather than entering them. When you're finished, check your answer with that given on page 47. The exercise will use Ontario Health Insurance Plan (OHIP) diagnostic codes. Most of the diagnostic codes are included in your textbook. However, you may do a Google search for OHIP diagnostic codes and browse them online.

Self-Check 6

1. Define *premium code.*

   _____

   _____

2. *True or False?* An intermediate assessment is the most frequently used code for a primary care assessment.

3. In the number 0000-832682-07, what does the 07 indicate?

   _____

   _____

4. *True or False?* The last component of the service code A001A indicates that the anaesthetist performed the service.

Check your answers with those on page 45.

ASSIGNMENT 7

Read Chapter 12 on pages 365–393. Then read Assignment 7 in this study guide.

Chapter 12 discusses the claims submission process, which is the same in all provinces. The process consists of the following steps:

1. Collect the information needed for the claim.
2. Store the forms on the information system (computer).
3. Compile the files.
4. Submit them to the ministry.

The ministry reports which claims are accepted and which have been rejected. Any rejected claims can be corrected, if possible, and resubmitted. The ministry processes the corrected claims and sends out a final statement to the provider, along with its payment.

The billing process is described in general terms. Any AHP starting a new job will require some time to become used to the particular billing/records management system used in that particular office. It takes practice to acquire a familiarity with the codes and the billing procedure in general. Strive for accuracy and your errors will be minimal. When submitted claims are rejected, the reasons for their rejection will fall into two general categories: *explanatory codes* or *error codes.* Page 366 discusses these categories. Note that explanatory codes tend to be concerned with regulatory infractions such as filing a late claim, whereas error codes usually relate to incorrect or missing information on the claim.

Keep in mind the emphasis on teamwork. For example, the AHP can't process any claim until he or she can obtain the proper diagnostic codes from the client's chart or the doctor's day sheet.

The standard method of claims submission is through *machine readable input (MRI).* Once the ministry receives the information, it will send its response as *machine readable output (MRO).*

In Canada, the most popular billing method is *electronic transfer (ET).* Though the name varies with the province in question, the system—irrespective of the province in which it operates—requires that the AHP log into a secure site by means of a confidential password, after which the files can be transferred back and forth from the ministry to the medical office. ET allows for the submission of daily claims as opposed to the submission of claims on a weekly or monthly basis using tapes or disks.

The first step in the electronic billing process is to register the client. Pages 370–372 of your textbook discuss this process. Once this has been accomplished and the information verified, the claim can be devised by entering the informational components discussed on pages 372–378. Figure 12.5 is of particular usefulness; it indicates where the various pieces of information are to be entered on a sample billing screen.

Note that the most common entry, usually the default, for the payment program is *HCP,* the entry for health care plan. In addition, the most common code indicating the *payee* (the party to whom the payment is made) is *P.* The letter *P* indicates that the payment is to be made to the service provider. In the event that claim being made varies from the programmed billing criteria, the MR box is ticked and a manual review note added. As this entails that someone at the ministry review the claim individually, make sure to fax supporting documentation to the ministry on the same day that the claim is being submitted for review. An example would be a surgical procedure taking longer than the time unit allotted, in which a premium code would be included. In this case, an explanation for the variance would have to be included to prevent the claim being disputed.

Note the *price per unit* (PPU) that's entered in accordance with the fee schedule set by the ministry. Once you've determined the appropriate service code in consultation with the physician, you can ascertain and enter the appropriate PPU. The PPU is a dollar amount. Keep in mind that the PPU isn't necessarily the fee submitted. The fee submitted could comprise the PPU for multiple services if more than one service code was applied. The fee submitted employs neither dollar

signs nor decimals. A fee of $27.50 would therefore be entered as 2750. Make certain that you don't misread this as $2,750. The amount of $2,750.00 would actually be entered 275000.

If you're submitting claim files on a daily basis, you should send them in a set according to the parameters of your software program. This is called *batching*. The program will notify you that a batch of claim files is ready to be submitted to the ministry.

To obtain feedback from the ministry on the status of your claims, whether they've been accepted or rejected, you'll have to log on regularly to the system to check for the ministry reports. If a claim is rejected, it will be assigned an error code representing the reason for the rejection. The error codes are particular to each province/territory and are provided along with the province's/territory's fee schedule.

The electronic submission process is encapsulated by the steps listed on pages 380–381:

1. Receipt of a claim file or batch of files
2. Notification if the entire file or components of the file were rejected
3. A preliminary check of a file's individual components
4. Return of rejected claims so that they can be corrected and resubmitted in the same billing cycle
5. Acceptance of corrected claims
6. Adjudication—final check on claims
7. Remittance and payment

Study Figure 12.6 on page 381 for a sample transmission of claims to the Ontario Ministry of Health.

The types of uninsured services and billing procedures for these services are discussed on pages 384–386. Remember that any prospective client required to pay out of pocket must be informed that he or she will be charged for the service, and the advisory given before allowing him or her to accept the service.

When clients are covered by private insurance, the HOP will either invoice the insurance company and receive payment directly from the insurer or invoice the client. As your textbook points out, a great many service providers prefer to invoice the insurance company as a means to guarantee payment. Note the common insurance forms with which you may come into contact. These common forms are listed in Table 12.1 on pages 388–389.

Billing Exercise

Enter as much information as possible from your textbook concerning the following scenarios. You may create a matrix similar to that found on page 394. The general assessment costs $54.10, and an intermediate assessment is $28.50.

a. Ivy comes in to have her ears syringed. The procedure is done in the allotted time. The cost is $11.25.

b. Rodney comes in complaining of chest pains. The doctor gives him a general examination and a professional-level electrocardiogram. The cost of the ECG is $9.55.

c. Regina was assessed for diabetes complications. The assessment took twice the amount of the prescribed time, and her insulin regimen was regulated. Home care was ordered to assess and apply a dressing to her foot.

d. Lana comes in to have a wart removed. The doctor removed the wart using a chemical substance. The cost of the chemical therapy is $10.85.

e. Arnold has gone from 210 pounds to 160 pounds. He is concerned and comes in to the doctor's office. The doctor performs an assessment and recommends Arnold to a dietician.

Check your answers with those on page 47.

Self-Check 7

1. Your total PPU has amounted to $326.25. How would you enter this in the computer input field?

   _____

2. *True or False?* A rejected claim indicates that the ministry will never accept the claim for payment.

3. When entering the payment program, what will *most* likely be the default entry?

   _____

4. How should an RA report received by the ministry be reconciled?

   _____

Check your answers with those on page 45.