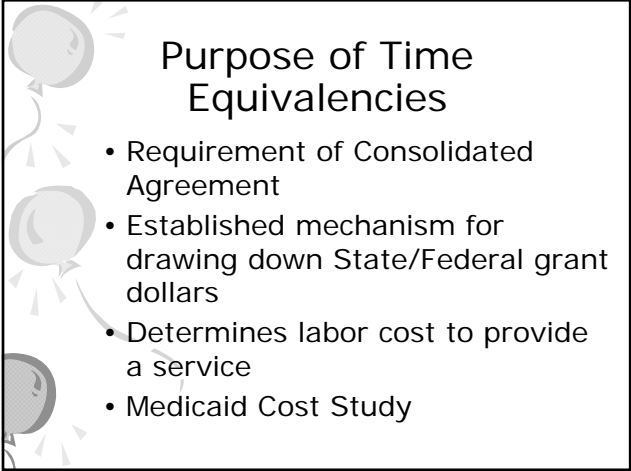




Financial Integrity thru Time Study and Billing

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Purpose of Time Equivalencies

- Requirement of Consolidated Agreement
- Established mechanism for drawing down State/Federal grant dollars
- Determines labor cost to provide a service
- Medicaid Cost Study



RECORDING TIME

- Time reported by employees on Time Study should always follow the service that was entered in the HSIS/HIS System
- Example: If a Maternal Health visit was provided, the employee should be reporting their time to Maternal Health



WCH PROGRAMS

- WCH Program charges should always be based on a "sliding fee scale"
- "Flat rate fee" cannot be charged in WCH Programs
- Charges to Family Planning must be "method related"

OTHER SERVICES & PRIMARY CARE

- Use of OS & PC program types are restricted
- Requires completion of application & approval by: Joy Reed, Head LTAT Branch
- Upon approval "OS" & "PC" should be reflected on TS to capture time, as appropriate in those programs

CHILD HEALTH VS HEALTH CHECK

- Time study should reflect a column for Child Health to include three sub types
- (1) Child Health, clinic/physicals
- (2) Child Service Coordination
- (3) Health Check Coordination
- Time & Services should be reported according to the appropriate program type

SERVICES BASED ON "FLAT RATE FEE"

- "Walk in Pregnancy test" can be charged at a flat rate fee, provided they are NOT associated with WCH Programs
- TB skin test, specifically for work or school, based on flat rate fee should not be charged to TB Clinic or Immunizations
 - TB Skin test, for this purpose are not State supplied

TB SKIN TEST cont.

- This particular service is not a Medicaid billable service, therefore the Medicaid patient can be charged. You should always inform a patient before providing a service if they will be responsible for the charges.
- If the patient is "at risk" for TB, Medicaid can be billed then the time & service should be reported to the TB Program

IMMUNIZATIONS

- Local Health Departments shall administer State supplied immunizations at no cost to the patient
- The administration fee for State supplied immunizations can be billed to third parties such as: insurance, Medicaid or Medicare.
- Report or bill administration fees for all vaccines

Other

- All WCH programs are based on a sliding fee scale
- Flat rate fees cannot be charged to ANY WCH Program
- Local Use (LU) codes can be used to bill or report a service that is not otherwise defined by a CPT code.

Other

- Primary Care, Adult Health and OS programs can all support flat rate fees because these programs are not supported by any State or Federal dollars.

Common Errors: Documentation Issues

- Chief Complaint not clearly documented to include reason for visit
- Patient information not on each page of record
- Documentation of visit needs to be completed at time of visit-avoid late entries
- Problem List not used or up-dated

Common Errors: CPT CODES

- CPT Codes – tell the “what” is done
- ICD-9 Codes – provide the “why”
 - Only need one but needs to be the “right” one, some programs require an ICD-9 Code for their services (FP = 25.XXX)

Common Errors: Encounter Form

- New vs Est patient to agency or program
- Mark all services provided to the patient
- Should be marked by person providing the service
- If service is report only need to indicate on encounter form

Common Errors: Encounter Form

- Program type is determined by the primary reason the patient came for the visit. Patient may have more than one problem but the main reason for the visit will determine the **Program type**. The provider is ultimately responsible for determining correct Program type.

Common Errors: Immunization

- Immunization Administration fee can be billed with E/M visit but is included with the preventive visit
- Vaccines provided in Prenatal or Family Planning Clinics must be on a SFS BUT you can provide them in another clinic and not apply the sliding fee
- Remember your charge is your charge

Billing Tips:

- If a patient presents for a visit usually done by an RN and billed as a 99211 visit then a Mid-level or MD providing the same service should also bill as a 99211
 - However when an additional problem is noted the Mid-level or MD should bill at the E&M level appropriate to the care provided

Billing Tips:

- For abnormal pap follow-up refer patient as indicated for treatment to appropriate program:
 - Pap follow-up is not a FP Program activity
 - BCCCP Medicaid may be an option for patients based on income and clinical criteria
 - PC program may also be used

Billing Tips:

- FP Waiver will pay E&M visit code when administering Depo-provera
 - Subject to the 6 visit/year limit
 - Only bill visit if all visit components are completed
 - When only administering Depo charge a J1055 and the **96372** admin. fee
 - Do not charge the admin. fee when charging E&M code

Billing Tips:

- S4993 OCP's can bill a total of 14 packs of pills per 365 days
- You can Bill a Medicaid patient for services NOT COVERED by Medicaid. You must inform the patient prior of offering the service
- Services provided outside the program requirements and not related to providing the program service are considered non-covered charges. Patient must be informed prior to receiving the service about their financial responsibility

Billing Tips Lab:

- Venipuncture Blood Collection
 - Use CPT Code 36415 to bill
 - May only be billed once per visit despite number of tests ordered
 - Will only pay provider who performed blood collection (i.e.: billed the 36415 Code)
 - Must be sending sample to outside lab for processing

Billing Tips Lab:

- Venipuncture Blood Collection
 - If lab work is done in agency do not charge the 36415 for drawing the blood since the fee charged for processing in-house should already include: drawing, the sample, supplies used, processing sample, and interpretation of results

Billing Tips Lab:

- Handling Fee - CPT Code 99000
 - Handling/Conveyance of specimen for transfer between physician's office (Health Department) and outside lab
 - Medicaid does not reimburse this code
 - May charge a handling fee but must charge it to everyone if so
 - ***Once Medicaid has denied a code as a non-covered service, it is not necessary to continue billing Medicaid***

Modifiers

- Modifiers are suffixes to the CPT Code
 - FP Modifier - Used in Family Planning program type for services related to contraception
 - 90 Modifier – Used when lab procedures are performed by a party other than the treating or reporting physician. Labs collected by the HD but sent to outside labs for actual procedure performance (e.g. state or reference labs)

Modifiers

- Modifier -25: Used if a separately identifiable E&M service is done by same provider on same day as another procedure or other service
 - The modifier is attached to the E&M Code not the procedure code

Tips:

- Standing Orders must be in place to provide medical acts such as ultrasounds, lab work or medications to patients prior to being seen by the provider.
- When codes are provided, such as N=no Y=yes staff need to use those codes.
- If a code is not provided, symbols need to be clearly documented, easily understood and included in agency policies.
- Make sure that all marks fall within the blank you are marking

Tips

- Use only Approved Abbreviations, check for duplicate or Do Not Use Abbreviations
- Make sure you have access to the current year's CPT and ICD-9 books
- Review and Update CPT codes on your Encounter Forms yearly
- Self and peer auditing are good practices to assure internal consistency and provide education for staff on better documentation and coding practices, it also helps to identify needed policy or practice changes

QUALITY IMPROVMENT

- To assure agency is reimbursed for all services it provides
- To assure accurate billing practices
- Lost revenue due to under-billing is not recoverable from Medicaid nor the cost-settlement