Orange County Health Care Agency

Auditor-Controller, HCA Accounting

Medical Billing Unit

CTCA 2023 EDUCATIONAL CONFERENCE

Best Practices in Billing TB Services

Information Presented By: Claudette Serrano

Best Practices in Billing Topics

- County of Orange Auditor Controller
- County of Orange Healthcare Agency
- Purpose and Objectives
- Medical Billing Unit Core Functions & Responsibilities
- Orange County Healthcare Pulmonary Disease Services

Reimbursement Training Topics *(continued)*

- Billing Guidelines & Program Requirements
- PDS & Direct Observed Therapy (DOT) Billing Workflow
- Examples of Billing TB Screening & TB DOT Services
- Accurate Applications of CPT/ICD-10/HCPCS Codes

Auditor-Controller

VISION

To be the County's trusted source of financial information to account for the past, direct the present, and shape the future.

MISSION

To promote public oversight, provide accountability, and support financial decision-making for the County.

Health Care Agency

Vision

Quality health for all.

Mission

In partnership with the community, deliver sustainable and responsive services that promote population health and equity.

Goals

Promote quality, equity and value. Ensure the HCA's sustainability. Offer relevant services to the community.

HEALTHCARE AGENCY &
HCA ACCOUNTING, MEDICAL BILLING UNIT

Purpose and Objectives:

- Each and every individual involved in delivering a service, documentation, and billing of a service provided by the Health Care Agency has an obligation to ensure proper protocol, integrity and compliance is maintained at all times.
- All coding, documentation and billing requirements must be met by the clinical provider or individual involved in the administrative process, including coding, reviewing services and billing.
- Medical Billing Unit (MBU) and HCA programs, collaborate as needed to complete billing in a timely manner with the highest level of accuracy.

MBU Core Functions & Responsibilities

Responsibilities:

- MBU staff will conduct all billing and coding activities as agreed upon by contract between the Health Care Agency and Auditor-Controller
- To act as the primary resource for billing and coding and assist the Health Care Agency in implementing accurate billing, coding and HIPAA compliance practices
- Collaborate with various payers to coordinate billing requirements.
- Conduct all required activities necessary for billing and coding
- Implement compliant billing and coding procedures.
- Conduct Medicare, Medi-Cal and other payer billing and follow-up, as necessary.
- Conduct internal monitoring and auditing.
- Create proper checks and balances for all functions.
- Processing of refunds as appropriate.

Pulmonary Disease Services

- Tuberculosis Control is housed within the Health Care Agency Pulmonary Disease Services (PDS) Program
- PDS services include TB screening, TB treatment, laboratory tests, chest x-rays, injections and physician evaluation
- TB-DOT – Directly Observed Therapy is provided to Tuberculosis (TB) infected individuals
- TB-DOT services can be provided at the clinic, field, via video or via telehealth
- TB-DOT services are provided by community workers and/or public health nurses
- Services are billed to Fee-For-Service Medi-Cal, CalOptima and Third Party Payers
- CalOptima Health Care Plans are billed directly to CalOptima

Billing and Program Requirements

Review of Pulmonary Disease (PDS) Services

Coder reviews medical record to ensure the following are present:

- Signed Consent Form
- Documentation the client received a Notice of Privacy Practices (NPP)
- Demographic information/record identifier is present on each page
- Progress note documentation to include:
  - Vital Signs, Chief Complaint(CC), Review of Systems(ROS), History of Present Illness (HPI), Exam, Medical Decision Making(MDM)
- ICD-10 code/Diagnosis is documented
- Documentation is legible
- Proper error correction form is used
- Provider signature is present including credentials

Billing and Program Requirements

Review of TB-DOT Services

Biller reviews medical record to ensure the following are present:

- M.D. orders documented in chart to include DOT regimen
- Month of Service is listed
- Primary Diagnosis must be tuberculosis. Tuberculosis related manifestations must be code as secondary diagnosis
- AM and PM TB-DOT justification must be documented
- TB-DOT worker's name, initials, and signature are present
- TB-DOT is documented in the medical record
- Patient's demographic information is present
- HCPCS code H0033 is documented and the POS is present
- Documentation is legible
- Supervising physician name is present
- Group NPI is present

Billing PDS & TB DOT Services

Coordination of Health Plan Benefits

- Coordination of Benefits is required when a client has more than one health plan. Health plans must be billed in sequential order primary, secondary and/or tertiary.
- Providers are responsible for determining which health plan is the primary, secondary, or tertiary, **prior** to billing, to ensure the health plans are billed in the correct order.
- Once determination has been made by the client's primary or secondary health plan, the Remittance information must be included with the claim(s) billed to the subsequent health plan(s).

Timely Filing Limits :

The billing time limitation for **3rd Party Health Plans** plans will vary as it is **determined by the health plan**.

The billing time limitation for **Medi-Cal fee-for service** is six months from the **date** of service for 100% reimbursement of approved services; reimbursement rates are reduced for claims received after the six-month filing limit.

PHS PDS – TB DOT WORKFLOW

Clinic

Clinic creates a new Encounter/FIN in PM Registration; includes all health plan information.

Clinical staff completes the order / progress note through a Power Form in E.H.R.

Charge posts into Revenue Cycle, Biller Review Hold is applied and enqueued to Biller Review Work Queue for 100% pre-audit of PDS & TB DOT services.

MBU Biller Review Steps:

- Verify patient eligibility, ensure the correct health plan(s) is/are registered.
- Verifies TB DOT service is recorded in patient's E.M.R.
- CPT/HCPCS and ICD-10 coded correctly.
- Assignment of correct modifier(s).
- Apply Action Code to release Biller Review Hold to allow claim generation.

Accepted / Passed Biller Review

Claims Generation:

Prior to claims submission, the billing system runs claim edits to ensure claim data is complete:

- Claim that fail system edits enqueue for Biller Review.
- Review Edit Failed claims for errors.
- Submit/request corrections as appropriate.
- Cancel / correct Edit Failed claims and/or generate a new claim as appropriate.

Pended / Failed Biller Review

- Send Clinical Staff electronic request for missing information / corrections.
- Clinical staff responds electronically back to MBU Biller when missing information updated / corrected.
- MBU Biller verifies information / correction and follows steps above.

'Clean' claims are electronically transmitted to various payers for reimbursement.

CLAIM STATUS

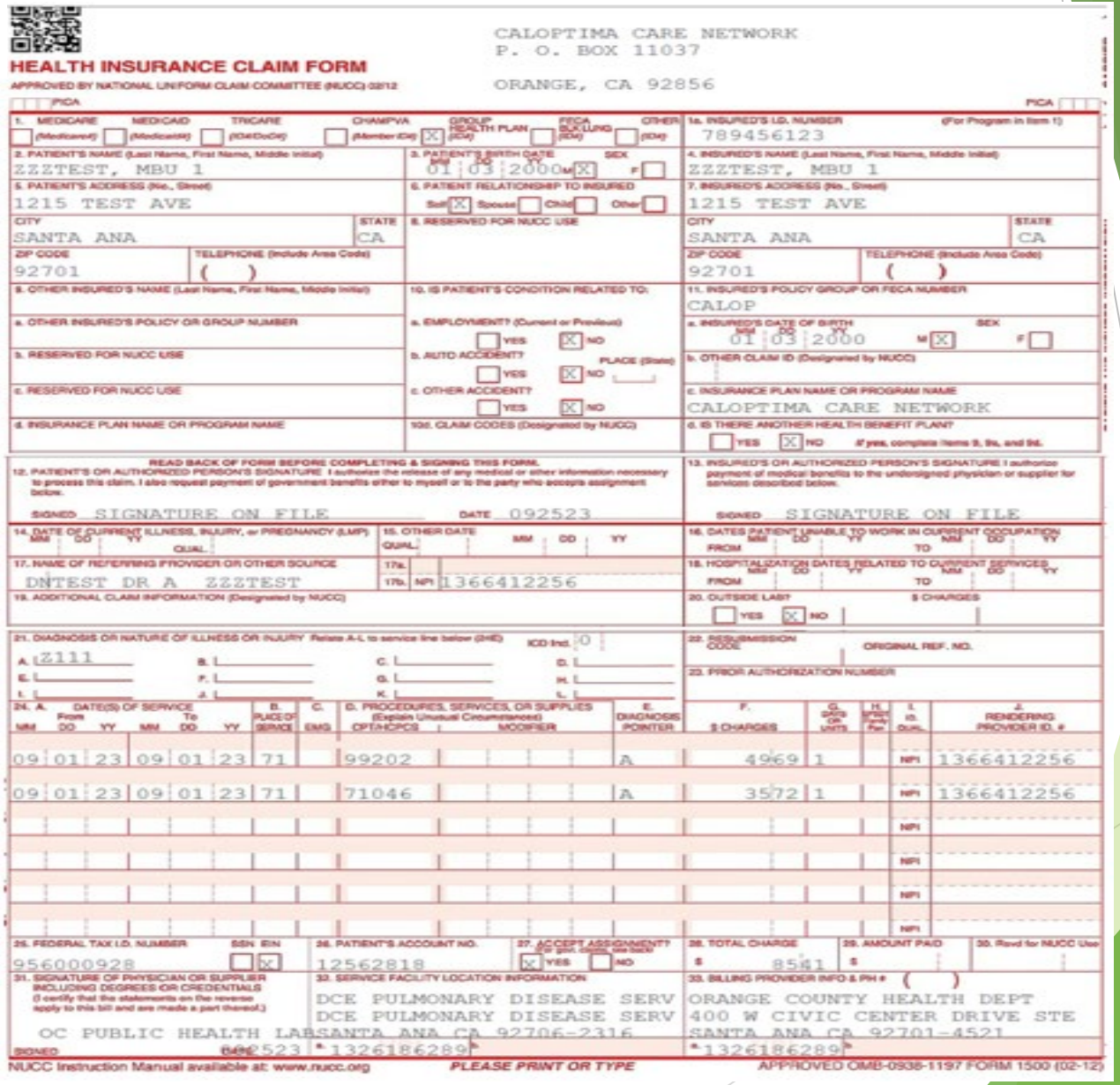
Claim Paid:

- Payment is posted; claim is resolved.

Claim Denied:

- Denied claims enqueue for Biller Review.
- Biller follows Pended/Failed Biller Review steps and processes corrected claim when appropriate.

Initial TB Screening Exam



CALOPTIMA CARE NETWORK
P. O. BOX 11037
ORANGE, CA 92856

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 789456123
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ZZZTEST, MBU 1	3. PATIENT'S BIRTH DATE: 01 03 2000 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): ZZZTEST, MBU 1	
5. PATIENT'S ADDRESS (No., Street): 1215 TEST AVE	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 1215 TEST AVE	
CITY: SANTA ANA STATE: CA	8. RESERVED FOR NUCC USE
CITY: SANTA ANA STATE: CA	
ZIP CODE: 92701 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 92701 TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: CALOP	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH: 01 03 2000 SEX: M [X] F [ ]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: CALOPTIMA CARE NETWORK	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 092523

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNTEST DR A ZZZTEST	17a. 17b. NPI 1366412256
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0
A. Z111 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
09 01 23	09 01 23	71		99202		A	4969	1		NPI	1366412256
09 01 23	09 01 23	71		71046		A	3572	1		NPI	1366412256
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 956000928 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.: 12562818	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 8541	29. AMOUNT PAID: $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) OC PUBLIC HEALTH LAB SIGNED 092523	32. SERVICE FACILITY LOCATION INFORMATION: DCE PULMONARY DISEASE SERV DCE PULMONARY DISEASE SERV SANTA ANA CA 92706-2316 *1326186289		33. BILLING PROVIDER INFO & PH #: ( ) ORANGE COUNTY HEALTH DEPT 400 W CIVIC CENTER DRIVE STE SANTA ANA CA 92701-4521 *1326186289		

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

TB Direct Observed Therapy (Prior Authorization Required)

KAISER PERMANENTE HEALTH PLAN
P.O. BOX 7004
DOWNEY, CA 90242-7004

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN [X] / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER: 789456123
2. PATIENT'S NAME: ZZZTEST, MBU 1	3. PATIENT'S BIRTH DATE: 01 03 2000 M [X] F [ ]
4. INSURED'S NAME: ZZZTEST, MBU 1	
5. PATIENT'S ADDRESS: 1215 TEST AVE	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS: 1215 TEST AVE	
CITY: SANTA ANA — STATE: CA	8. RESERVED FOR NUCC USE
CITY: SANTA ANA — STATE: CA	
ZIP CODE: 92701 — TELEPHONE: ( )	
ZIP CODE: 92701 — TELEPHONE: ( )	
9. OTHER INSURED'S NAME	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: 00283	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH: 01 03 2000 — SEX: M [X] F [ ]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: KAISER PERMANENTE HEALTH PLAN	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE — DATE: 092523

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNCLAUDETTE SERRANO	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. A150 B. C. D. E. F. G. H. I. J. K. L.	23. PRIOR AUTHORIZATION NUMBER: 123456789

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	J. RENDERING PROVIDER ID. #
09 02 23	09 02 23	71		H0033		A	2475	1		NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 956000928 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.: 12562821	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 2475	29. AMOUNT PAID: $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) OC PUBLIC HEALTH LAB SIGNED DATE 092523	32. SERVICE FACILITY LOCATION INFORMATION: DCE PULMONARY DISEASE SERV DCE PULMONARY DISEASE SERV SANTA ANA CA 92706-2316 *1326186289		33. BILLING PROVIDER INFO & PH #: ( ) ORANGE COUNTY HEALTH DEPT 400 W CIVIC CENTER DRIVE STE SANTA ANA CA 92701-4521 *1326186289		

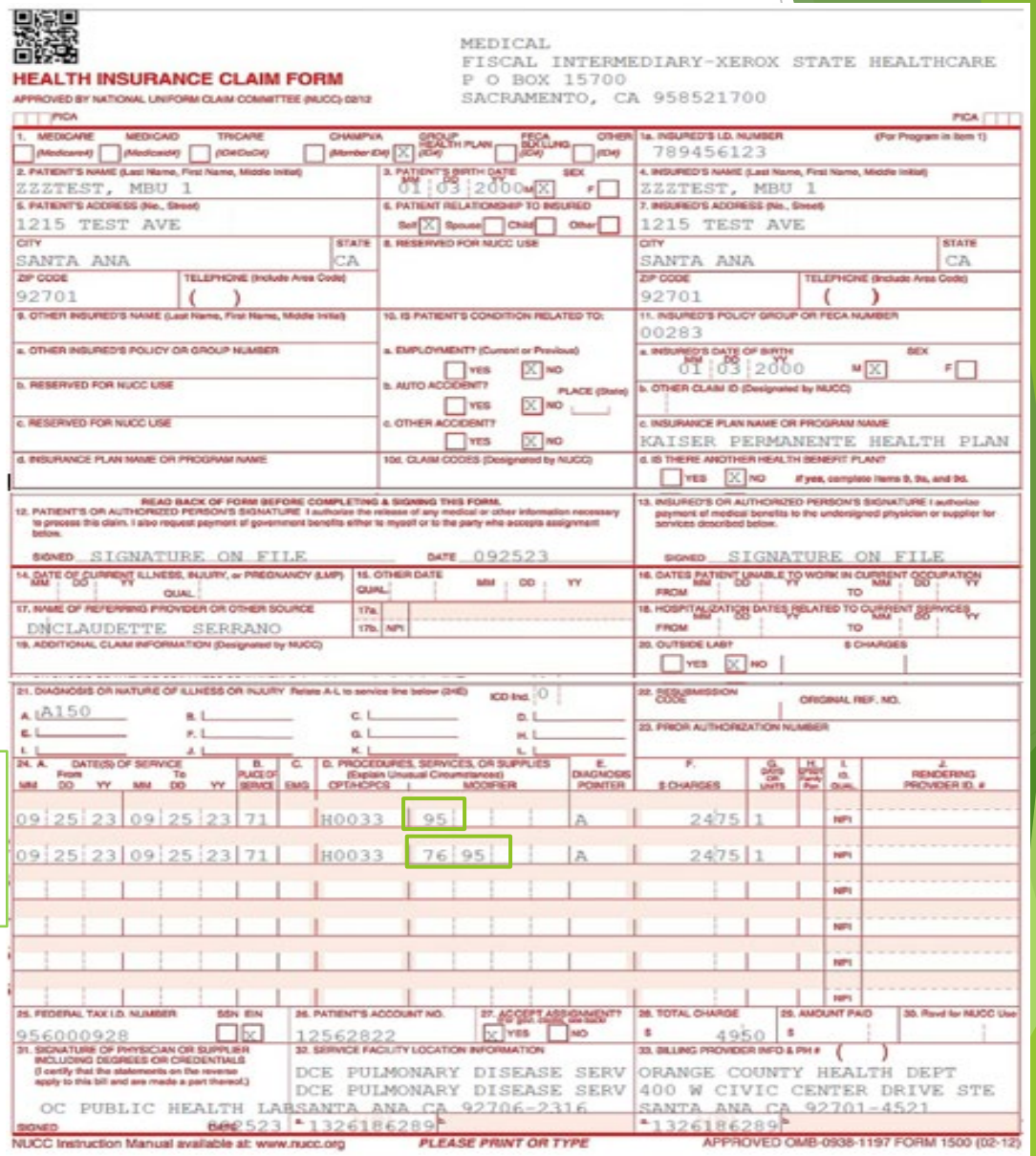
NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-1197 FORM 1500 (02-12)

TB Direct Observed Therapy

Synchronous Video
Requires Modifier -95

AM & PM Dose
Requires Modifier-76
***Medical record must include justification for PM dose:**

PDS DOT
DOT Place of service : Synchronous VOT (02) dose provided
DOT Schedule : Twice a day
DOT AM/PM Justification : Unable to swallow single dose



MEDICAL
FISCAL INTERMEDIARY-XEROX STATE HEALTHCARE
P O BOX 15700
SACRAMENTO, CA 958521700

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER: 789456123
2. PATIENT'S NAME: ZZZTEST, MBU 1	3. PATIENT'S BIRTH DATE: 01 03 2000 SEX: M
4. INSURED'S NAME: ZZZTEST, MBU 1	
5. PATIENT'S ADDRESS: 1215 TEST AVE	6. PATIENT RELATIONSHIP TO INSURED: Self
7. INSURED'S ADDRESS: 1215 TEST AVE	
CITY: SANTA ANA STATE: CA	8. RESERVED FOR NUCC USE
CITY: SANTA ANA STATE: CA	
ZIP CODE: 92701 TELEPHONE: ( )	
ZIP CODE: 92701 TELEPHONE: ( )	
9. OTHER INSURED'S NAME	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: 00283	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) NO
a. INSURED'S DATE OF BIRTH: 01 03 2000 SEX: M	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: KAISER PERMANENTE HEALTH PLAN	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 092523

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL.	15. OTHER DATE QUAL.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNCLAUDETTE SERRANO	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: A. A150 ICD Ind. 0

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
09 25 23	09 25 23	71		H0033	95	A	2475	1		NPI	
09 25 23	09 25 23	71		H0033	76 95	A	2475	1		NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 956000928 SSN EIN	26. PATIENT'S ACCOUNT NO.: 12562822	27. ACCEPT ASSIGNMENT? YES	28. TOTAL CHARGE: $ 4950	29. AMOUNT PAID: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED: 092523	32. SERVICE FACILITY LOCATION INFORMATION: DCE PULMONARY DISEASE SERV / DCE PULMONARY DISEASE SERV / OC PUBLIC HEALTH LABSANTA ANA CA 92706-2316 a. 1326186289		33. BILLING PROVIDER INFO & PH #: ( ) ORANGE COUNTY HEALTH DEPT / 400 W CIVIC CENTER DRIVE STE / SANTA ANA CA 92701-4521 a. 1326186289	30. Rsvd for NUCC Use

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CTCA 2023 EDUCATIONAL CONFERENCE

Best Practices in Billing TB Services