Orange County Health Care Agency

Auditor-Controller, HCA Accounting

Medical Billing Unit

BEST PRACTICES IN BILLING TB SERVICES 2024

Information Presented By: Claudette Serrano

Best Practices in Billing Topics

- County of Orange Auditor Controller
- County of Orange Healthcare Agency
- Medical Billing Unit Core Functions & Responsibilities
- Orange County Healthcare Pulmonary Disease Services
- Medical Billing Unit Coder and Biller Review Requirements

Best Practices in Billing 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

MBU Core Functions & Responsibilities

Core Functions:

- Auditor-Controller, HCA Accounting and its Medical Billing Unit are 'contracted' by Orange County Healthcare Agency to conduct billing and reporting activities for services provided by the Healthcare Agency.
- 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 staff will conduct all billing and coding activities as agreed upon by contract between the Health Care Agency and Auditor-Controller

HEALTHCARE AGENCY &
HCA ACCOUNTING, MEDICAL BILLING UNIT

MBU Core Functions & Responsibilities

Responsibilities:

- 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
- Perform comprehensive system testing before implementing a new program or new services, working with HCA I.T. and the County's billing vendor to ensure compliant claims submission and accurate reporting.
- Collaborate with various payers to coordinate billing requirements.
- Implement compliant billing and coding procedures.
- Conduct Medicare, Medi-Cal and other payer billing and follow-up, as necessary.
- Conduct internal monitoring and auditing of client electronic health records.
- Create proper checks and balances for all functions.
- Processing of refunds as appropriate.

HEALTHCARE AGENCY PUBLIC HEALTH
Pulmonary Disease Services

- Tuberculosis Control is housed within the Health Care Agency Public Health 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

Review of Pulmonary Disease (PDS) Services - Coder

Coder reviews medical record to ensure the following are present:

- Signed Consent Form is present
- Notice of Privacy Practices (NPP) Form is present
- 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 selected matches documented note
- CPT code selected matches documented note
- Provider signature is present

Review of Directly Observed Therapy (DOT) Services - Biller

Biller reviews patient demographic information and confirms:

- Verifies patient health plan eligibility.
- TB Diagnosis is coded correctly as Primary. Tuberculosis related manifestations must be coded as the secondary diagnosis
- AM and PM TB-DOT justification must be documented
- Patient's demographic information is present
- HCPCS code H0033 is documented, and the POS is present
- Supervising physician name 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).

Billing PDS & TB DOT Services

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 when **Medi-Cal fee-for service** is the **only** payer, 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.

The billing time limitation when **Medi-Cal fee-for service** is the **SECONDARY** payer, is TWELVE months from the **date** of service for 100% reimbursement of approved services. The claim must include the appropriate Delay Reason Code in the EMMG Field of the CMS-1500 Form (DRC 7 = Third party processing delay).

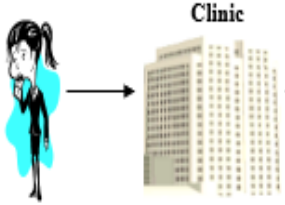
Claims Billed Beyond One Year. Occasionally, a claim may be delayed more than one year past the date of service. These claims must be billed hard copy and with appropriate attachments and mailed to:

Attn: Over One Year Claims Unit
California MMIS Fiscal Intermediary
P.O. Box 13029
Sacramento, CA 95813-4029

The following is a list of possible scenarios that could result in a claim being submitted beyond one year:

- Determination of Medi-Cal eligibility
- Third party decisions or appeals
- Treatment Authorization Request (TAR) approval delay

TB DOT BILLER REVIEW 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 billing module, Coder and/or Biller Review Hold is applied and enqueued to appropriate Work Queues for review of PDS & TB DOT services.

MBU Coder Review:

- Signed Consent Form is present
- Notice of Privacy Practices (NPP) Form is present
- 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 selected matches documented note
- CPT code selected matches documented note
- Provider signature is present

Pended / Failed Coder 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 Biller Review steps.

MBU Biller Review:

- Verifies patient health plan eligibility.
- TB Diagnosis is coded correctly as Primary.
- AM and PM TB-DOT justification must be documented
- Patient's demographic information is present
- HCPCS code H0033 is documented, and the POS is present
- Supervising physician name is present

Accepted / Passed Releases for Billing

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.

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

CLAIM STATUS

Claim Paid:

- Payment is posted; claim is resolved.

Claim Denied:

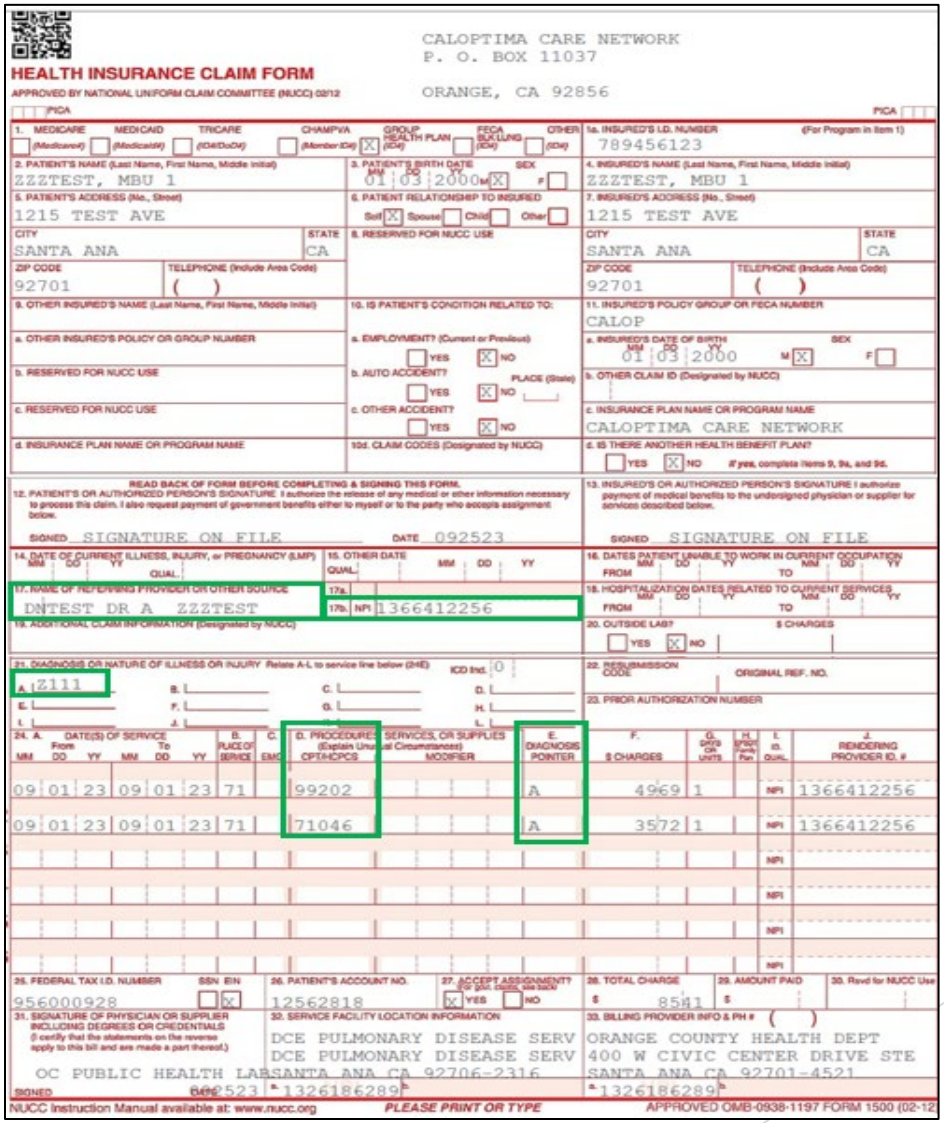
- Denied claims enqueue for Biller Review.
- Biller follows Pended/Failed Biller Review steps and processes corrected claim when appropriate.

Initial TB Screening Exam

Enter the Name of the Referring Provider in Box 17.

Enter the NPI of the Referring Provider in Box 17B.

Bill services using the appropriate ICD-10; CPT procedure code(s) and diagnosis pointer(s).



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

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

1. MEDICARE [X] (Medicare#) — MEDICAID — TRICARE — CHAMPVA — GROUP HEALTH PLAN [X] (ID#) — FECA BLK LUNG — OTHER
1a. INSURED'S I.D. NUMBER: 789456123 (For Program in Item 1)

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.)
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

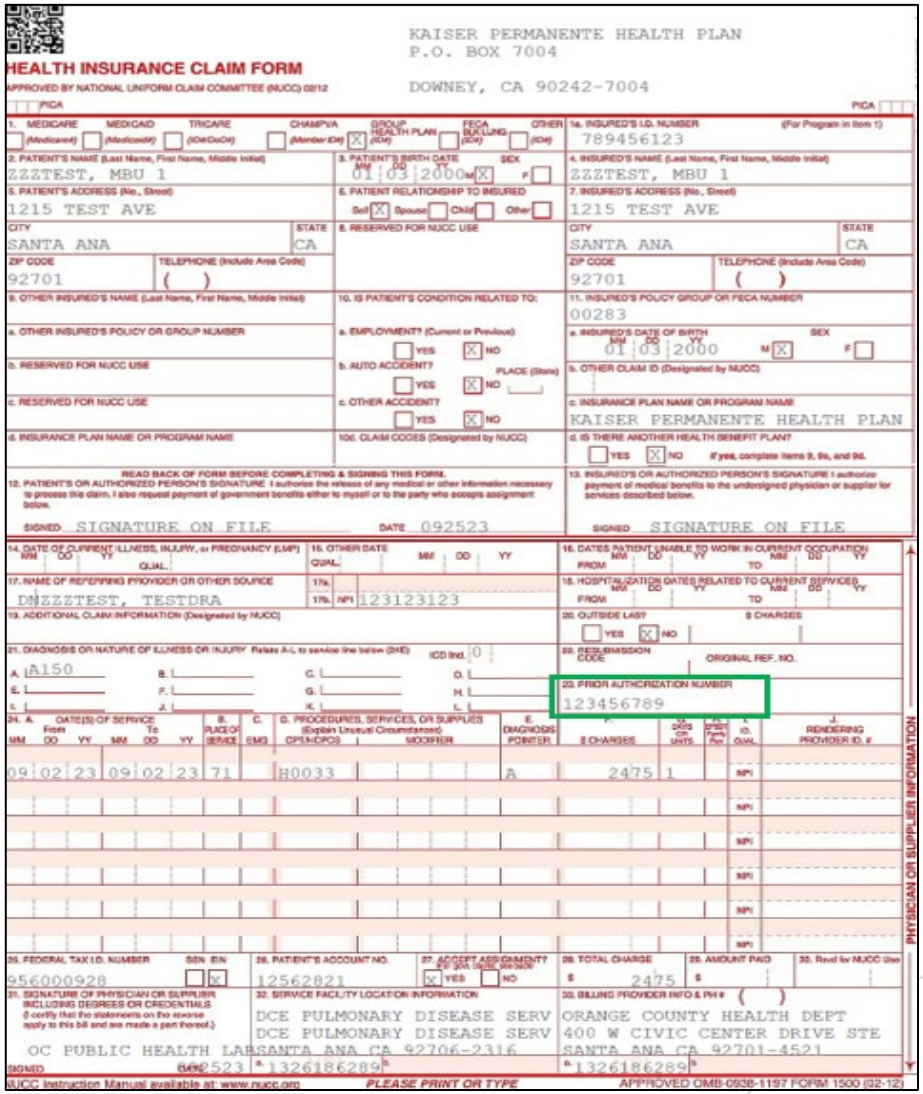
NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-1197 FORM 1500 (02-12)

TB Direct Observed Therapy (Prior Authorization Required)

Enter the Prior Authorization Number in Box 23, as applicable.

(A copy of the TAR/SAR does NOT need to be attached to the claim, but Recipient information on the claim must match the TAR/SAR.)

***Note: TAR and non-TAR procedures should <u>not</u> be combined on the same claim.**



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

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) QUAL.
15. OTHER DATE QUAL.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DWZZTEST, TESTDRA
17a.
17b. NPI 123123123
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 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. A150 B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
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	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. 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. Reserved 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.)
SIGNED 092523
32. SERVICE FACILITY LOCATION INFORMATION: DCE PULMONARY DISEASE SERV / DCE PULMONARY DISEASE SERV / OC PUBLIC HEALTH LAB SANTA 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

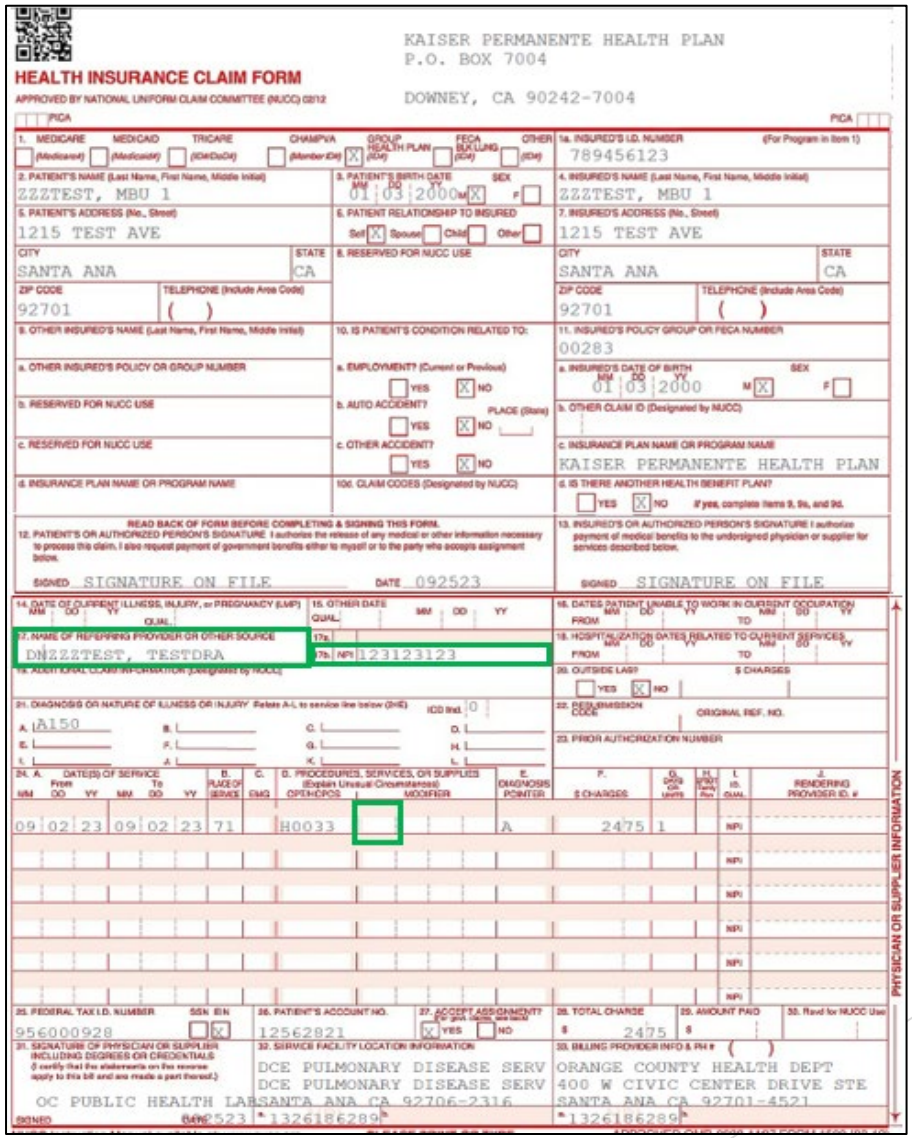
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

PHYSICIAN OR SUPPLIER INFORMATION

TB Direct Observed Therapy (DOT)

Use Procedure/HCPCS code H0033 to bill TB Direct Observed Therapy (DOT) services.

NOTE: DOT therapy provided in the clinic or in the Field does NOT require a modifier in Box 24D.



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 [X] — 1a. INSURED'S I.D. NUMBER: 789456123
2. PATIENT'S NAME: ZZZTEST, MBU 1
3. PATIENT'S BIRTH DATE: 01 03 2000 M [X]
4. INSURED'S NAME: ZZZTEST, MBU 1
5. PATIENT'S ADDRESS: 1215 TEST AVE
6. PATIENT RELATIONSHIP TO INSURED: Self [X]
7. INSURED'S ADDRESS: 1215 TEST AVE
CITY: SANTA ANA — STATE: CA
ZIP CODE: 92701
11. INSURED'S POLICY GROUP OR FECA NUMBER: 00283
11a. INSURED'S DATE OF BIRTH: 01 03 2000 M [X]
11c. INSURANCE PLAN NAME OR PROGRAM NAME: KAISER PERMANENTE HEALTH PLAN
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: SIGNATURE ON FILE — DATE 092523
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: SIGNATURE ON FILE
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNZZZTEST, TESTDRA
17b. NPI: 123123123
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: A: A150

24. A. DATE(S) OF SERVICE From	To	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 02 23	09 02 23	71		H0033		A	2475	1		NPI	

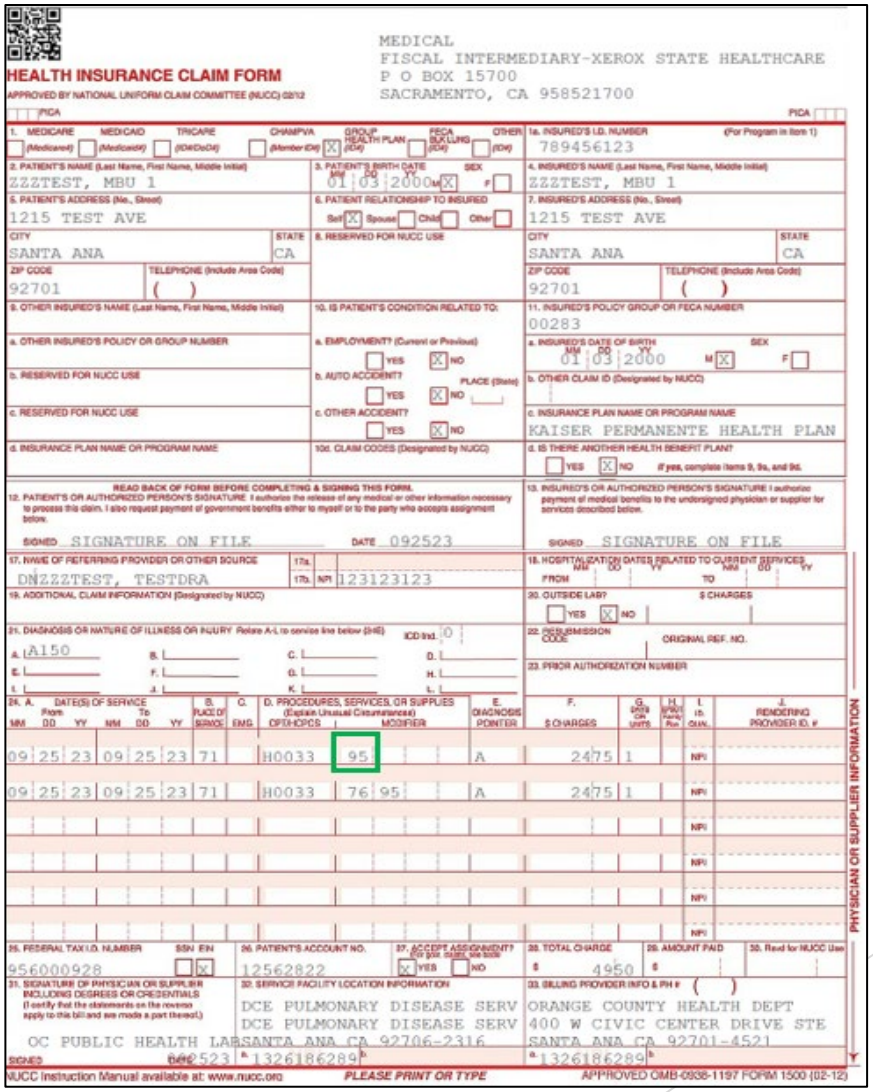
25. FEDERAL TAX I.D. NUMBER: 956000928 SSN [X]
26. PATIENT'S ACCOUNT NO.: 12562821
27. ACCEPT ASSIGNMENT? [X] YES
28. TOTAL CHARGE: $ 2475
29. AMOUNT PAID: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS: OC PUBLIC HEALTH LAB
32. SERVICE FACILITY LOCATION INFORMATION: DCE PULMONARY 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*

PHYSICIAN OR SUPPLIER INFORMATION

TB Direct Observed Therapy (Telehealth)

Direct Observed Therapy Telehealth services provided via 'Synchronous' (Real Time) inter-active audio & visual telecommunications, requires Modifier -95 to be included on the claim.

NOTE: Other applicable modifiers should still be included on the claim.



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 (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (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: 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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNZZZTEST, TESTDRA	17a. 17b. NPI 123123123
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. A150 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 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	
										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 956000928 SSN EIN X	26. PATIENT'S ACCOUNT NO.: 12562822	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO	28. TOTAL CHARGE: $ 4950
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 a. 1326186289 b.		33. BILLING PROVIDER INFO & PH #: ( ) ORANGE COUNTY HEALTH DEPT 400 W CIVIC CENTER DRIVE STE SANTA ANA CA 92701-4521 a. 1326186289 b.

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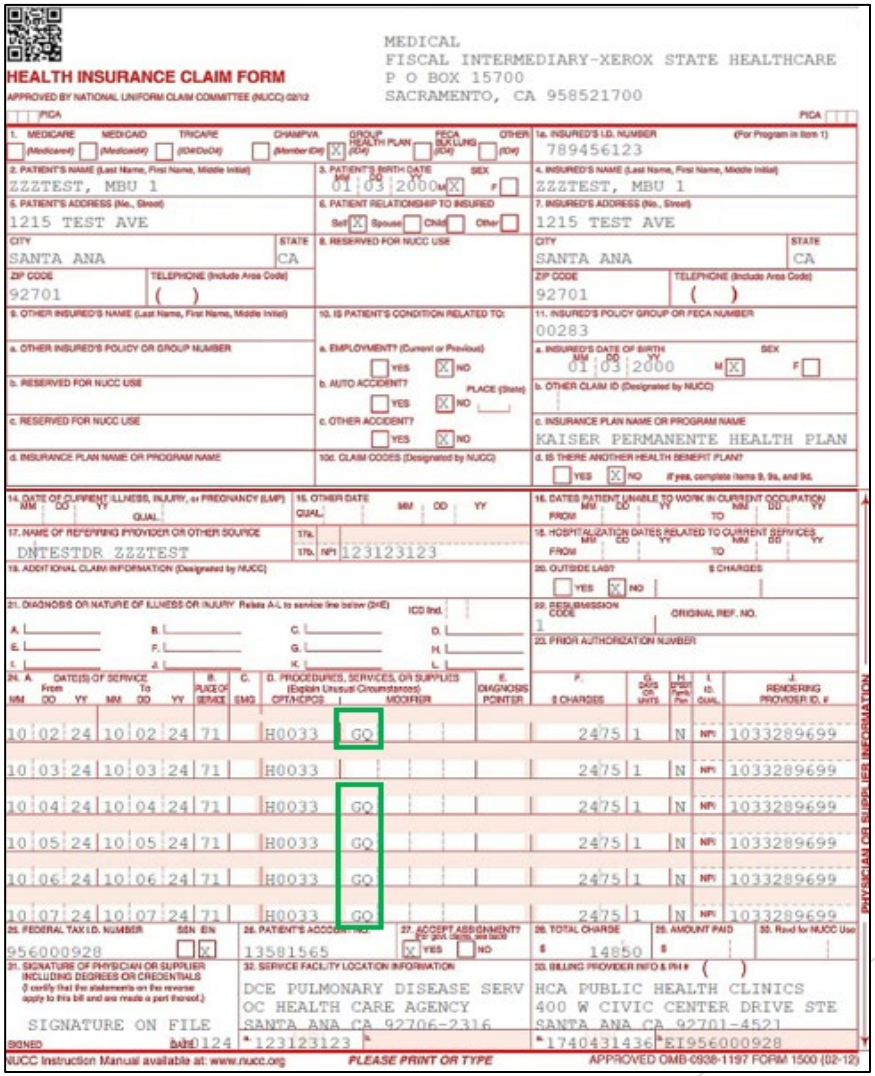
TB Direct Observed Therapy (Telehealth)

Direct Observed Therapy Telehealth services provided via 'Asynchronous' (store and forward) telecommunications systems, requires Modifier -GC to be included on the claim.

***The modifier must be applied to each service as applicable.**



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

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	X GROUP HEALTH PLAN
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 / SEX	01 03 2000 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 / STATE	SANTA ANA / CA
8. RESERVED FOR NUCC USE	
CITY / STATE	SANTA ANA / CA
ZIP CODE / TELEPHONE (Include Area Code)	92701 / ( )
ZIP CODE / TELEPHONE (Include Area Code)	92701 / ( )
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	00283
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. EMPLOYMENT? (Current or Previous)	YES / X NO
a. INSURED'S DATE OF BIRTH / SEX	01 03 2000 M X / F
b. RESERVED FOR NUCC USE	
b. AUTO ACCIDENT? PLACE (State)	YES / X NO
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	
c. OTHER ACCIDENT?	YES / X 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?	YES / X NO (If yes, complete items 9, 9a, and 9d.)
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	DNTESTDR ZZZTEST
17a. / 17b. NPI	123123123
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? / $ CHARGES	YES / X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind.	A. B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE / ORIGINAL REF. NO.	1
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. #
10 02 24	10 02 24	71		H0033	GQ		2475	1	N	NPI	1033289699
10 03 24	10 03 24	71		H0033			2475	1	N	NPI	1033289699
10 04 24	10 04 24	71		H0033	GQ		2475	1	N	NPI	1033289699
10 05 24	10 05 24	71		H0033	GQ		2475	1	N	NPI	1033289699
10 06 24	10 06 24	71		H0033	GQ		2475	1	N	NPI	1033289699
10 07 24	10 07 24	71		H0033	GQ		2475	1	N	NPI	1033289699

25. FEDERAL TAX I.D. NUMBER / SSN / EIN	956000928 / X
26. PATIENT'S ACCOUNT NO.	13581565
27. ACCEPT ASSIGNMENT?	X YES / NO
28. TOTAL CHARGE	$ 14850
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.)	SIGNATURE ON FILE
SIGNED / DATE	124
32. SERVICE FACILITY LOCATION INFORMATION	DCE PULMONARY DISEASE SERV OC HEALTH CARE AGENCY SANTA ANA CA 92706-2316
a. / b.	123123123 /
33. BILLING PROVIDER INFO & PH #	( ) HCA PUBLIC HEALTH CLINICS 400 W CIVIC CENTER DRIVE STE SANTA ANA CA 92701-4521
a. / b.	1740431436 / EI956000928

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PHYSICIAN OR SUPPLIER INFORMATION

TB Direct Observed Therapy (Second AM/PM Dose)

Some patients may require two doses – one in AM & one in PM. AM/PM dosing requires repeat Modifier-76 to be entered on the 2nd dose.

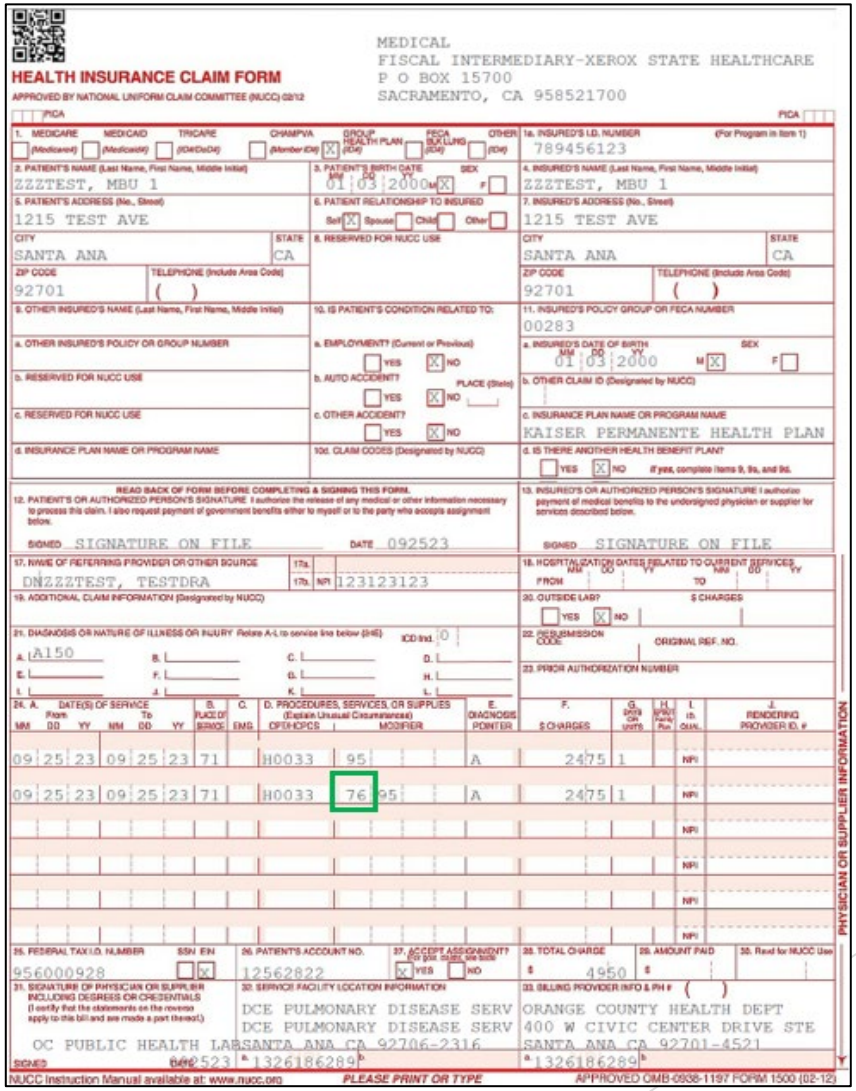
The Patient's Medical Record must include justification for Second / PM dose.

Progress Note Examples:

DOT Schedule: Twice a day.

DOT AM/PM Justification:

- **Negative reaction to more than one dose at a time.**



MEDICAL
FISCAL INTERMEDIARY-XEROX STATE HEALTHCARE
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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	X
1a. INSURED'S I.D. NUMBER	789456123
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	ZZZTEST, MBU 1
3. PATIENT'S BIRTH DATE / SEX	01 03 2000 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 / STATE	SANTA ANA / CA
8. RESERVED FOR NUCC USE	
CITY / STATE	SANTA ANA / CA
ZIP CODE / TELEPHONE (Include Area Code)	92701 / ( )
ZIP CODE / TELEPHONE (Include Area Code)	92701 / ( )
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	00283
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. EMPLOYMENT? (Current or Previous)	YES / X NO
a. INSURED'S DATE OF BIRTH / SEX	01 03 2000 M X F
b. RESERVED FOR NUCC USE	
b. AUTO ACCIDENT? PLACE (State)	YES / X NO
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	
c. OTHER ACCIDENT?	YES / X 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?	YES / X NO 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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	DNZZZTEST, TESTDRA
17a. / 17b. NPI	123123123
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? / $ CHARGES	YES / X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.	0
A.	A150
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 / SSN EIN	956000928 / X
26. PATIENT'S ACCOUNT NO.	12562822
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	X YES / NO
28. TOTAL CHARGE	$ 4950
29. AMOUNT PAID	$
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SIGNED / DATE	092523
32. SERVICE FACILITY LOCATION INFORMATION	DCE PULMONARY DISEASE SERV DCE PULMONARY DISEASE SERV SANTA ANA CA 92706-2316
a. / b.	1326186289
33. BILLING PROVIDER INFO & PH #	( ) ORANGE COUNTY HEALTH DEPT 400 W CIVIC CENTER DRIVE STE SANTA ANA CA 92701-4521
a. / b.	1326186289

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Best Practices in Billing
TB Services 2024