

#### Orange County Health Care Agency

#### Auditor-Controller, HCA Accounting





# 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





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

Best Practices in Billing Topics (Continued)





## **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



#### **Core Functions:**

## MBU Core Functions & Responsibilities

- 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



#### **Responsibilities:**

## MBU Core Functions & 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 3<sup>rd</sup> 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 <u>only</u> payer, is six months from the <u>date</u> 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

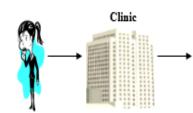
The following is a list of possible scenarios that could result in a claim being submitted beyond one year:

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



## TB DOT BILLER REVIEW





WORKFLOW

Clinical staff completes the order / progress note through a Power Form in EHR

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.

Clinic creates a new

includes all health plan

Encounter/FIN in

PM Registration;

information.

- 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.



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).

#### **Initial TB Screening Exam**

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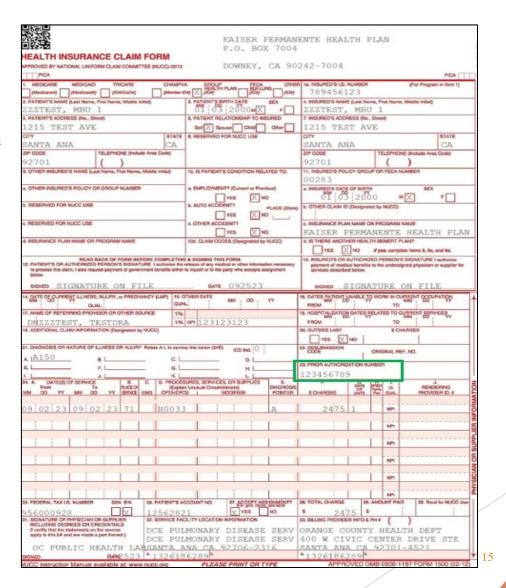


#### Enter the Prior Authorization Number in Box 23, as applicable.

(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.

## TB Direct Observed Therapy (Prior Authorization Required)







#### **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.

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## 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					
ALTH INSURANCE CLAIM FORM		EDIARY-XEROX STATE HEAL	THCARE			
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OC PUBLIC HEALTH LABSANTA	SANTA ANA LA 927111-4321					







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.

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92701 ( s. OTHER INSURED'S NAME (Last Name,	Fort Name I	Middle Indian	50.0	DATIENTS	CONDITION RELA	TEO TO	92701 11. NSURED'S POL	CY OBO	E-00 F	(CAN	)		_
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a. OTHER INSURED'S POLICY OR GROU	PNUMBER		a. Eli	PLOYMENT	T (Current or Previo	(inst)	a. INSURED'S DATE	OF SIRT	H			EK.	
					YES X NO	1	01 03	200	00		X	F	
b. RESERVED FOR NUCC USE			b. At	JTO ACCIDE	YES X NO	PLACE (State)	b. OTHER CLAIM ID	(Designat	ed by N	UCC)			
c. RESERVED FOR NUCC USE			6.01	THER ACCID			c. INSURANCE PLAI	N NAME O	R PRO	GRAM P	VAIVE		
			515%		YES X NO		KAISER P	ERMA	MEN	TE	HEAL	TH PL	AN
d. INSURANCE PLAN NAME OR PROGRA	M NAME		100.0	CLAIM COOR	ES (Designated by N	NUGC)	d. IS THERE ANOTH	-	TH BEN	ERIT PI	LANT		
						2 1 2 2	ves X	NO	If yes,	comple	ote items 9,	9s, and 9d.	
HA DATE OF CUPPENT ILLNESS, BLURS	or PRECIO	NEY (LMP)	15. OTHER GUAL	DATE	MM   00	YY	16. DATES PATIENT	BHARTE	To wo			CCCUPATION	
GUAL. 17. NAME OF REPERPRING PYROVIDER OR	OTHER SOL	ISCE	179.				18. HOSPITALIZATIO	to Date 6	RE AT	TC TED TO		REBUICER	-
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21. DIAGNOSIS OR NATURE OF ILLNESS	OR INJURY	Raista A-L to	service line	below (SEE)	ICO Inc.		22. RESUBMISSION CODE	-	ORIO	DINAL P	EF.NO.		
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IUCC Instruction Manual available					E PRINT OR T	YPE						PM 1500 (0	02-129



## 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 2<sup>nd</sup> 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.

TO SERVICE STATES OF THE SERVICE STATES OF THE SERVICE	P O BOX 1	5700	DIARY-XEROX	STA	TE HEA	ALTHCARE
PICA	VA GROUP FECA	OTHER	1a. INSURED'S LD. NUMBE 789456123	R	(For	Program in item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH CATE SE	DX .	4. INSURED'S NAME (Last II	tame, First	Name, Middle	pettern
ZZZTEST, MBU 1	01 03 2000mX	F	ZZZTEST, MB			- 20
S. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSUR	ED	7. INSURED'S ADDRESS (N			
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ZIP CODE TELEPHICNE (Include Area Code)			ZP CODE	TELE		de Area Gode)
2701 ( )			92701	(	)	
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATE	ID TO:	11. INSURED'S POLICY GR	OUP OR FE	CANUMBER	
			00283			
LOTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous	0	01 03 20	OY.		SEX
RESERVED FOR NUCC USE	b. AUTO ACCIDENT?				m X	F
PESENYED FOR ROOG USE		ACE (State)	b. OTHER CLAIM ID (Design	seled by NU	CC)	
RESERVED FOR NUCC USE	YES X NO		c. INSURANCE PLAN NAME			
RESERVED FOR NUCC USE	c. OTHER ACCIDENT?					
INSURANCE PLAN NAME OR PROGRAM NAME		-	KAISER PERM			ALTH PLAN
INSURANCE PLAN NAME OF PROGRAM NAME	10d. GLAIM GODES (Designated by NU	60)				
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## Best Practices in Billing TB Services 2024

# Questions?