

Chapter 7-Visit Charges and Compliant Billing

Key Words

Advisory Opinion-OIG helps providers act legally

Allowed Charges-Amount is the most the payer will pay any provider for a particular code. Also known as maximum allowable fee, maximum charge, allowed amount, allowed fee, allowable charge

Assumption Coding-Reporting items or services that are not actually documented, but coder assumes were provided

Audit-Formal examination or review

Balance Billing-Bill patient difference between higher physician fee and lower allowed charge

Cap Rate-Capitation-Fixed prepayment for each enrolled plan member in a capitation contract. Could also assign a different rate for each category of plan members

CCI Code Edits-Screen for improperly or incorrectly reported procedure codes

CCI-Correct Coding Initiative-Controls improper coding that would lead to an inappropriate payment for Medicare claims

CCI Column 1, Column 2 Code Pair-Column 1 includes all services described in Column 2. So 2 cannot be billed together (unbundling)

CCI Mutually Exclusive Code Edits-Codes cannot be billed for a patient on the same day of service

Charged Base Fee Schedule-Amount that provider typically charge for services, procedures, similarity, and experience

CMS/AMA Documentation Guidelines-Rules for the criteria selection of E/M codes

Code Linkage-Diagnosis must support the billed services as necessary to treat or investigate the patient's condition

Conversion Factor-Dollar amount assigned to a base unit. Assigned once each year

Credit Balance-Overpayment

Documentation Template-Assists PHYSICIAN as they document the exam

Downcoding-Reporting codes at a lower level to avoid government investigation. Some payers automatically downcode a claim

Excluded Party-May not work for or under the Medicare Program

External Audit-Private payer's or government investigators review selected records of a practice for compliance. Audit that is OUTSIDE the practice

GPCI Geographical Practice Cost Index-Used to multiply each relative value element. Used in Medicare purpose. Regional differences in costs

Internal Audit-Conducted to verify that a medical practice is in compliance with reporting regulations. Audit that is within the practice

Job Reference Aids-"Cheat Sheets"-Could be frequently reported procedures and diagnosis. Must list ALL the E/M codes. Do not show properly linked diagnosis and procedure codes

MPFS Medicare Physician Fee Schedule-Based on RBRVS fees

Midpoint-50% are paid higher and 50% are paid lower

OIG Work Plan-Annual list of planned projects under Medicare Fraud and Abuse Initiative. List the types of billing and reporting practices that OIG intends to investigate in the upcoming year

Overpayment-CREDIT balance-Improper or excessive payment to a provider as a result of billing or claims processing error for which a refund is owed by the provider

Physician-Ultimate responsibility for proper documentation

Postpayment Audit-Done after payment has been made. Make sure claims are compliant

Practice Expense-LARGEST cost element in Medicare RBRVS

Prepayment Audit-External audit performed by payers before claims are processed

Professional Courtesy-Discounted charges for other providers and their families

Prospective Audit-Concurrent-Done before claims are sent

Provider Withhold-Fund set aside to cover unanticipated medical expenses. Maybe repaid of the physician

RBRVS Resource Based Relative Value Scale-Federally mandated relative values scale for establishing Medicare charges. Skill and time required for similar services. Uniform value, GPCI, Conversion factor. Usually lower than UCR fees. NEWEST PLAN

Relative Value Unit-Factor assigned to a medical service based on the relative skill and time to perform it

Retrospective Audits-Internal conducted after the claims have been sent and the R/A has been received. Permits auditor to see which codes have been rejected or downcoded by the payer and set up ways to avoid making the same errors in the future

RVS Relative Value Scale-Time and skill required to perform a medical service setting its payment level

Truncated Coding-Using diagnosis that are not as specific as possible. Ex-mismatched gender codes

UCR Usual Customary Reasonable-Setting fees by comparing the usual fee the provider charges for services

Upcoding-Procedure code that provides a higher reimbursement rate than the correct code. DO NOT DO THIS

Write Off-The difference between subtracted from patient bill-NOT COLLECTABLE

*To calculate RBRVS fees, multiply each RVU by its respective GPCI X CF=RBRVS

**Main method payers use to pay providers: Allowed charges, contracted fee schedule and capitation