Resource and Patient Management System (RPMS) Third-Party Billing

Table Maintenance

Who Should Have Access

- Designated users
- Business Office manager
- Site manager
- Programming staff
- Designated Area Office staff

Who Should Not Have Access

- Nonbilling users
- New users
- Everyone!

Basics

- Options should be accessed only when:
  - Setting up or troubleshooting
  - Maintenance
  - Auditing
- Some site parameters are unique to facility logged in to
- Entries should never be deleted unless otherwise specified

What to Expect

- Most changes take effect right away!
  - Form Locator Override edits
  - Insurer file edits such as International Classification of Disease (ICD)/Current Procedural Terminology (CPT) procedure code display in Claim Editor
- Changes that impact claim generator will be effective when claim generator runs.
  - Deleting or adding unbillable clinics
  - Changes in back-billing limits

Site Parameters

- Controls how..
  - Claims are generated
  - Claim editor looks
  - Bills are printed
  - Bills are displayed
- Locked with ABMZ SITE SETUP

Site Parameters

- Facility to Receive Payments
  - Pulls location entry from Location file
  - Mailing address to send checks to
  - Location fields are audited
- Printable Name of Payment Site
  - Prints location of payment receiving facility
  - This field is audited as well

Site Parameters

- Days Inactive Before Purging
  - Indicates when a claim will be ‘canceled’ from the claim editor.
  - Canceled claims can never be retrieved.
  - Canceled claims have an impact on bills that are reprinted.

Site Parameters

- Select Default Unbillable Clinics
  - Add clinics that are unbillable regardless of payer.
  - No claims will be generated if clinic is on Patient Care Component (PCC) visit.
  - Ensure data entry does not use the clinic code for valid visits (make sure coding correctly!).
  - Field should be audited at least once a year.

Site Parameters

- Select Default Invalid Provider Disciplines
  - Add provider classes that are unbillable regardless of payer.
  - No claims will be generated if “primary provider holds unbillable provider class” is on PCC visit.
  - Ensure data entry does not use the primary provider for valid visits (make sure coding correctly!).
  - Field should be audited at least once a year.

Site Parameters

- Orphan Visit Lag Time
  - Lets Claim Generator know when orphan visit can be generated
  - Recommended to be set to number of days that Data Entry is entering forms plus five days
  - Setting number too low results in duplicate claims generation in the Claim Editor
  - Recommended to be monitored every one to two weeks

Site Parameters

- Uncoded DX Lag Time
  - Lets Claim Generator know when visits containing a diagnosis code of .9999 can be generated
  - Usually for Electronic Health Record (EHR) visits
  - Recommended to be set to number of days that Data Entry is completing visits plus five days
  - Setting number too low results claims generations in the Claim Editor that are uncoded
  - Recommended to be monitored every one to two weeks

Site Parameters

- User Accounts/Receivable (A/R) Parent/Satellite Set Up
  - Used only when adding new billing locations
    - Home, school, local hospital locations
  - Location must be set up in A/R Manager option prior to use.
  - Huge impact on where claims are generating
  - Should never be modified unless sure that it should be turned on
  - Claims generated in one location cannot be moved

Site Parameters

- Medicare Part B?
  - Allows system to generate one or two claims for Medicare depending on billing guidelines
  - Only: One Medicare claim generates with Professional Component (999) visit type
    - Intended to bill to Medicare Part B
  - Yes: One Medicare claim generates with an Outpatient (131) visit type
    - Intended to bill to Medicare Part A
  - No (or blank): Two Medicare claims generate
    - Intended to bill to Medicare Part A and Part B

Site Parameters

- Default Dental Code Prefix
  - Used to add either an ‘S’, ‘D,’ or number ‘0’ to an American Dental Association (ADA) code
    - Adds for all payers
  - Doesn’t display in Claim Editor but prints on claim forms
  - May be set up for individual payers in Dental Remap Table Maintenance option

Site Parameters

- RX Dispense Fees
  - Only used if billing for pharmacy in 3P's Claim Editor (not Point of Sale [POS])
  - Check with POS staff to see if needs to be populated
  - Defaults to dispense fee that displays in Claim Editor

Site Parameters

- Insurers without 837 PRV Segment
  - New in version 2.5 Patch 10
  - Removes all PRV segments (taxonomy code) from selected insurers' 837 files
  - Note: National Provider Identifier (NPI) requires taxonomy codes to be submitted on 837

Insurer File

- Controls how claims are generated
- Controls how claims are printed/exported

Insurer File

- Two Insurer files
  - Patient Registration
    - Shared by all visit locations on one database
    - Includes fields such as Insurer Name, Street, City, State Zip Code
    - Data stored in the Insurer file
  - Third-Party Billing
    - Parameters unique to each visit location
    - Options covered in this demonstration
    - Data stored in the 3P Insurer file

Insurer File

- Mailing Address vs. Billing Address
  - Mailing address used by billing, registration, Contract Health Services (CHS) staff to look up insurers
  - Billing address used to print on claims forms
  - If no billing address entered, mailing address is used

Insurer File

- Area Office (AO) Control Number
  - Used as a electronic payer identifier
    - Provided by payor
  - Populates in the EMC File Name generated by RPMS
    - Ex: E0040001.44
  - Populates in ISA08 and GS03 on the 837 export mode
  - Exception is Medicare, which uses combination of AO Control Number and Visit Type

Insurer File

- Insurer Status
  - Billable: Allows claim to generate if the patient has open eligibility.
  - Unbillable: Does not generate a claim even if the patient has this insurer as open eligibility.
  - Unselectable: Allows claim to generate if the patient has open eligibility. Used if insurer has been merged to a Billable insurer. Registration staff will not see this entry.

Insurer File

- Type of Insurer
  - Places insurer into class of insurer
  - Determines allowance categories (federal sites only)
  - Used for:
    - Reporting purposes
    - Claim generation process
    - Printing/exporting bills (display)

Insurer File

- All Inclusive Mode
  - Used for Flat Rate Billing to allow for flat rates to display in Claim Editor or print on paper/electronic formats
  - Visit Type must be set up with Flat Rate
  - Turns on prompts in Visit Type to allow entry of default Revenue Code, Default Bill Type, and Default CPT Code
  - Should never be turned off if flat rates are entered and being used

Insurer File

- Backbilling Limit
  - Prevents claim from generating if Date of Service exceeds limit
  - Prevents old claims from generating if not needed
  - Should be set to insurance filing limit, if known.
  - If blank, defaults to Site Parameter’s Backbilling limit

Insurer File

- Dental Bill Status/RX Billing Status
  - Allows claim to generate if that service is covered by insurance
  - Prevents insurer from displaying on claim if not billable for service
  - If using POS, RX Billing Status must reflect for the POS insurer
    - For now, does not prevent the generation of POS claims

Insurer File

- Select Clinic Unbillable
  - Add clinics that are unbillable a specific insurer
  - No claims will be generated if clinic is on PCC visit for this insurer
  - Ensure data entry does not use the clinic code for valid visits (make sure coding correctly!)
  - Field should be audited at least once a year or when billing guidelines issued

Insurer File

- Electronic Media Claim (EMC) Submitter Identification (ID)/EMC Password/EMC Test Indicator
  - Used when billing electronically
  - Populates on 837:
    - EMC Submitter ID = ISA06 with a ‘ZZ’ indicator
    - EMC Password = ISA04 with an ’01’ indicator
    - EMC Test Indicator = ISA15

Insurer File

- Group Number/Provider PIN#
  - Used for Medicare Part B billing only
  - Allows Part B group and individual provider numbers to print on paper/electronic formats
  - Used only when billing with Professional Component (999) Visit Type
  - NPI will replace entries in these fields

Insurer File – Visit Types

- Visit types allow for different billing scenarios
- Allows for certain entries to default
  - Export mode
  - Facility group numbers
- Impacts Claim Generator – allows Visit Type to be generated on claim
  - If not in insurer file, defaults to Outpatient (131) for all outpatient services, excluding Dental
- Used for reporting purposes

Insurer File – Visit Types

- Billable Status
  - The following status’ can be applied:
    - Yes: Allows claim to generate for this type of service
    - No: Does not generate a claim if it falls under this category.

      *Remember that if you have other insurer types set up (i.e. Dental), the system looks at those properties first.
    - Billable–Billed Elsewhere: Does not generate a claim.

Insurer File – Visit Types

- Do You Want to Replace with Another Insurer?
  - Used to bill for services without adding eligibility to the patient's file
  - Sends claim to another insurer
  - Triggered by visit type
  - Mainly for services such as Durable Medical Equipment (DME), pharmacy, etc., where the patient's policyholder ID remains the same

Insurer File – Visit Types

- Procedure Coding
  - Used to identify procedure coding for claim/visit
    - ICD: Does not allow for itemization of charges
      - Used mainly for Flat Rate billing
    - CPT: Allows for itemization of charges
      - Not used for Flat Rate billing
      - Mainly used for Private Insurance billing
    - ADA: Allows for billing of dental codes
      - Displays Page 6 (Dental) and allows for billing of dental charges

Insurer File – Visit Types

- Fee Schedule
  - May be used to link to specific insurer
  - If linked, remember to update when fee schedule is updated yearly
  - Once has been linked, claim generator will pull charges for future claims

Insurer File – Visit Types

- EMC Submitter ID #/EMC Reference ID
  - Used for billing 837
  - EMC Submitter ID populates the ISA06 segment of the 837.
    - Mainly used for insurers that use different ID numbers based upon type of service

Insurer File – Visit Types

- Auto Approve
  - Automatically generates claim, then approves it into a bill
  - Uses the individual who turned on the claim generator as the approving official
  - Utilizes ‘Beneficiary Patient’ as the active insurer
  - Use with caution!

Insurer File – Visit Types

- Export Mode
  - Allows for entry of default export mode
  - Ideal for site to enter as default
    - Saves time for biller

Insurer File – Visit Types

- Block 24k, Block 29, Block 33 PIN #
  - Used if export mode is HCFA-1500
  - Is populated only if Payor Assigned Provider Number populated for provider
    - Located in New Person file

Insurer File – Visit Types

- Itemized UB92?
  - Displays only when export mode is UB92 or 837I
  - Allows for itemization of the UB92
    - Prints CPT or NDC codes on UB92

Insurer File – Visit Types

- DME Contractor?:
  - DME Group Name/Number
    - If "DME Contractor?" is answered YES, displays and allows entry of default group name/number to print on paper/electronic forms
  - Clinical Laboratory Improvement Amendments (CLIA) # Required:
    - Allows for default CLIA number to print if billing for DME services
      - Required for certain DME carriers

Coverage Type

- Used to provide further clarification of the patient's benefits
- Must be added to Coverage Type file for private insurance
- Affects how claims are generated
  - Unbillable Clinics
  - Unbillable Provider Disciplines

Fee Schedule

- Fee schedules are maintained individually by location
- Ensure that Healthcare Common Procedural Coding System (HCPCS), Dental, and Anesthesia codes are included

Provider File

- Provider file entries are stored in File 200 (New Person file)
- Users can access menu options with the PETM (Provider Number Edit)
  - Medicare Provider Number
  - Medicaid Provider Number
  - Unique Provider Identification Number (UPIN)
  - Licensing State and Number
  - Payor Assigned Provider Number

Provider Taxonomy

- Describes the provider class using an X12 transaction code
- Crosswalk built into Third-Party Billing package
  - Uses provider class to match to taxonomy code
  - Taxonomy code comes from the 3P Provider Taxonomy file

NPI

- NPI updates to be released in Third-Party Billing version 2.5 Patch 11
- Sites already entering NPI into New Person file
  - Changes sent in Kernel Patch 8.0*1013
- Sites testing NPI and entries into the Institution file
  - Changes sent in Kernel Patch 8.0*1014

Form Locator Override

- Allows for overriding of form locators on the HCFA-1500 only
- Can override fields such as
  - Block 10 – Reserved for Local use
  - Block 11 – Box 11C (Insurance Plan/Program Name)
  - Block 24 – Line Items
  - Block 32 – Where services were rendered
  - Block 33 – Billing information

CPT/ICD Updates

- Updates released annually for CPT and ICD updates
- ICD released in September
- CPT released in December
  - Patch 1 released in January or February
  - Contains HCPCS codes

Questions?