AAPC

Medical Billing Training

CPB

Certified Professional Biller (CPB)®

Certification Preparation

2023

2023

Official Study Guide

Medical Billing Training:

Certified Professional Biller (CPB)® Certification

AAPC

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Clinical Examples Used in this Book

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides and exams are *actual, redacted* office visit and procedure notes donated by AAPC members.

To preserve the *real world* quality of these notes for educational purposes, we have not rewritten or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially, they are as one would find them in a coding setting.

Reviewers:

Contents

Chapter 13
Commercial Insurance Carriers

Chapter 14
Workers' Compensation

Appendix A
Sources

Introduction to Healthcare

Introduction

AAPC would like to introduce the Study Guide for the Certified Professional Biller Examination. This material was developed to help billers and other medical professionals prepare for the Certified Professional Biller Exam necessary to obtain the Certified Professional Biller (CPB)® credential.

AAPC has prepared a study guide aimed at providing the most up-to-date information related to billing, including HIPAA, consumer driven health plans, ICD-10-CM, CPT®, accounts receivable (A/R), and health plans (governmental and commercial) to assist in the preparation for the Certified Professional Biller (CPB)® examination.

The objectives for this chapter include:

- Understand a background in healthcare
- Provide an overview of HIPAA including privacy standards and transaction and code set standards
- Recognize standards for Conditions of Participation (CoP)
- Recognize the difference between fraud and abuse
- Identify how the False Claims Act (FCA) affects billing practices
- Review Federal regulations including Stark Law, Anti-Kickback, Healthcare Fraud Statute, and Federal Civil Penalties Inflation Adjustment Act Improvements Act
- Understand how the Truth in Lending Act affects collection efforts

Background of Healthcare

The business of medicine is highly complex, ever changing, and tightly regulated. Healthcare providers are subject to many guidelines and requirements, as implemented by insurers and government agencies. These rules cover a wide range of issues, from how providers must handle medical records, to the documented diagnoses or clinical indications a patient must demonstrate if an insurer is to pay for a procedure and regulations for payment timelines and refunds.

Until the 1940s, healthcare insurance was not commonplace for Americans. During World War II, wage and price controls were placed on employers by the 1942 Stabilization Act. Congress limited the wages that could be offered but allowed the adoption of employee insurance plans. The 1954 Internal Revenue Code stated employer contributions to employee health plans were exempt from employee taxable income, making the demand for health insurance even more appealing.

Medicare was signed into law on July 30, 1965 by President Lyndon B. Johnson under title XVIII of the Social Security Act. Beneficiaries could sign up for the program on July 1, 1966. U.S. citizens were automatically enrolled in Part A Medicare at age 65, which covered hospital stays, and they had an option to choose to enroll in Part B Medicare, which covered physician services.

The Health Maintenance Organization Act of 1973 (P. L. 93-222) was proposed under the Nixon Administration to try to help control healthcare costs. It authorized $375 million to assist in establishing and expanding HMOs. The act also overrode state laws that prohibited the establishment of prepaid health plans and required employers with 25 or more employees to offer an HMO option if they furnished healthcare coverage to their employees. According to the Rand Corporation, HMO enrollment went from 3 million in 1970 to over 80 million in 1999, representing a 12 percent increase every year.

Preferred Provider Organizations (PPO) then emerged. A PPO is within the framework of managed care health insurance. PPOs set up a group of doctors, hospitals, and other healthcare providers to create a network and negotiate predetermined fees with a given carrier. PPOs offer members more options in that they do not have to maintain a primary care physician, nor do they require referrals.

The addition of these - and more - types of health plans led to a high level of complexity in the business of medicine. Hospitals, clinics, and private physician practices all contend with many issues to stay in business. This has led to the expansion in the healthcare field of medical professionals with the skillsets necessary to keep the business side running smoothly.

Healthcare Regulations

Healthcare regulations are not always definitive and may vary by payer, geographic area, and the setting in which patient care is provided. To be effective, the biller must distinguish and comprehend the precise regulatory requirements that apply in a particular circumstance. The healthcare regulations that affect medical billing will be reviewed in this chapter.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted on August 21, 1996. HIPAA was originally enacted to provide rights and protections for participants and beneficiaries of group health plans. Under this law, exclusions for pre-existing conditions were limited, and discrimination against employees and dependents based on their health status were prohibited. HIPAA also established the Healthcare Fraud and Abuse Control Program, a far-reaching program to combat fraud and abuse in healthcare, including both public and private health plans.

HIPAA Administrative Simplification provisions required that sections of the law be publicized to explain the standards for the electronic exchange, privacy, and security of health information. Congress did not enact privacy legislation within the specified time governed by HIPAA. The U.S. Department of Health and Human Services (HHS) then developed a proposed rule, which was published and released in final form on August 14, 2002.

Privacy Rule

The Privacy Rule standards address how an individual's protected health information (PHI) may be used. Its purpose is to protect individual privacy, while promoting high quality healthcare and public health and well-being. All "covered entities" are required to follow the Privacy Rule. Covered entities are defined as health plans, healthcare clearinghouses, and any healthcare provider who transmits health information in an electronic format.

- **Health Plan** covered entities are organizations that pay providers on behalf of an individual receiving medical care. These plans include health, dental, vision, and prescription drug insurers (for example, Health Maintenance Organizations [HMOs], Medicare, Medicaid, and employer, government, and church-sponsored group health plans). There are exceptions: An employer who solely establishes and maintains the plan with fewer than 50 participants, is exempt. Two types of government-funded programs are not health plans: food stamps and community health centers. Insurers providing only worker's compensation, automobile insurance, and property and casualty insurance are not considered to be health plans.
- **All healthcare providers** who electronically transmit health information through certain transactions are covered entities. Some examples of transactions that may be submitted electronically are claim forms, inquiries about eligibility of benefits, and requests for authorization of referrals. Simply using electronic technology, such as sending emails, does not mean a

healthcare provider is a covered entity; the transmission must be in connection with a standard transaction. The rule applies to all healthcare providers, regardless of whether they transmit the transactions directly, or use a billing service or other third party to transmit on their behalf.

- **Healthcare clearinghouses** include billing services, re-pricing companies, and community health management information systems that process nonstandard information, received from another entity, into a standard (or vice versa).

Business associates perform certain functions or activities, which involve the use or disclosure of individually identifiable health information, on behalf of another person or organization. These services include claims processing or administration, data analysis, utilization review, billing, benefit management, and re-pricing. Business associate services to a covered entity are limited to legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services. To be considered a business associate, the persons or organizations would involve the use or disclosure of PHI between the two parties. The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, also specifies that an organization that provides data transmission of PHI to a covered entity and that requires access to PHI routinely, such as a Health Information Exchange Organization (HIEO), will be treated as a business associate. A contract is required between business associates to impose specified written safeguards on the individually identifiable health information used or disclosed by the business associate.

If a covered entity identifies a material breach or violation of the contract or agreement, reasonable steps must be taken to cure the breach or end the violation. If that is not possible, the contract must be terminated and the problem reported to the HHS Office for Civil Rights (OCR).

The Privacy Rule includes exceptions to the business associate standard, which do not require a covered entity to have a written agreement in place prior to disclosing PHI. Examples include:

- Disclosures by a covered entity to a healthcare provider for treatment of the individual, such as:
  - A hospital referring a patient to a specialist and transmitting the patient's medical chart for treatment purposes.
  - A physician sending specimens to a lab for analysis.
  - A hospital lab sending specimens to a reference lab for analysis.

HCPCS Level II Concepts

Introduction

CMS created a three-level coding system in 1983 known today as the Healthcare Common Procedural Coding System (HCPCS). This system was developed to meet the operational needs of Medicare and Medicaid and to coordinate a uniform application of CMS policies for all government healthcare programs. As Medicare and other insurers cover a variety of services, supplies, and equipment not identified by CPT® codes, the HCPCS Level II codes were established for submitting claims for these items. Representatives from CMS, the Health Insurance Association of America (HIAA), and the Blue Cross/Blue Shield Association help maintain (additions, revisions, and deletions) the national permanent HCPCS Level II codes.

HCPCS Level II codes are in the public domain and free to use. They are available from the CMS website (public use files), the *Federal Register*, Medicare Administrative Contractor websites, and commercial publishers.

The objectives for this chapter include:

- Understand an overview of HCPCS Level II
- List commonly used HCPCS Level II modifiers
- Explain how to report discarded drugs/medication

BILLING TIP

When a CPT® code and HCPCS Level II code exist for the same service, check with the payer to determine which code to report. For example, Medicare requires the HCPCS Level II code be reported rather than the CPT® code when a code exists in both code sets for the same service.

HCPCS Level II Codes

HCPCS Level II codes are grouped according to type of service or supply within a section of the book. They are alphanumeric consisting of a single letter, A-V, followed by four digits versus CPT® codes identified using five digits. Understanding which letter precedes specific types of services, supplies, equipment, devices, and medications is helpful for accurate coding. In the HCPCS Level II code book, instructions, and information applicable to a specific category of codes are found at the beginning of each major category.

A Codes: Transport Services including Ambulance; Medical & Surgical Supplies; Administrative, Miscellaneous & Investigational

A codes are used to describe both emergency and non-emergency transportation services; supplies commonly used by the physicians and facilities to complete the necessary treatment of each patient; and a miscellaneous category that includes non-prescription drugs and radiopharmaceutical diagnostic imaging agents. The transportation and medical supplies sections are further sub-categorized to lend the greatest level of specificity for more precise coding.

EXAMPLE

Transportation:

    A0427 Ambulance service, advanced life support, emergency transport, Level 1 (ALS 1-Emergency)

Supplies:

    A6504 Compression burn garment, glove to wrist, custom fabricated

Miscellaneous:

    A9583 Injection, gadofosveset trisodium, 1 ml

BILLING TIP

The biller must read the code description completely, as many of these codes have specific quantities in each description. Be extremely mindful of terms such as "each," "per pair," "per ounce," and "per square inch." Units used are very important to observe in reviewing claims to ensure correct reimbursement.

B Codes: Enteral and Parenteral Therapy

B codes are used to describe "Enteral and Parenteral" therapy. This section of codes includes both the formula used and the supplies necessary to administer these types of services.

EXAMPLE

Kit:

   B4035 Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressing, tape

Solution:

   B4150 Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit

BILLING TIP

Take care to note the units of measure when using these codes. The unit value may be 100 calories per unit, 500 mL per unit, or in some instances the units are dependent on the grams of protein.

C Codes: Outpatient Prospective Payment System (OPPS)

C codes describe services, drugs, and supplies reported solely in the outpatient hospital setting. These codes include supplies, drugs, biologicals, radiopharmaceuticals, and radiology.

EXAMPLE

Device: C1722 Cardioverter-defibrillator; single chamber (implantable)

Radiology: C8919 Magnetic resonance angiography without contrast, pelvis

BILLING TIP

C codes are always billed on a UB-04 as they are exclusively used in the outpatient hospital setting.

D Codes: Dental Procedures

D codes are used to describe all dental services and are a separate category of national codes developed and copyrighted by the American Dental Association (ADA). The Current Dental Terminology code set is commonly referred to as CDT® codes. Types of dental services characterized by these codes include diagnostic, preventative, endodontic, periodontal, and surgical

services. These categories are subdivided for added specificity. D codes are no longer listed in the HCPCS Level II code book because royalties to publish them would raise book prices prohibitively. They are available through the ADA but are not included on the Certified Professional Biller (CPB)® certification exam.

BILLING TIP

D codes are always submitted on an ADA form. Each service is listed separately. There are no applicable modifiers for dental codes.

E Codes: Durable Medical Equipment

E codes are used to describe durable medical equipment (DME) that include canes, crutches, commodes, decubitus care equipment, bath and toilet aids, hospital beds and accessories, monitoring equipment, and wheelchairs.

DME may be defined as sturdy, long lasting items and appliances that can withstand repeated use, are designed to serve a medical purpose, and are not generally useful to a person in the absence of a medical condition, illness, or injury. These codes are used by the physician office or entity other than a DME Medicare Administrative Contractor (MAC).

EXAMPLE

Equipment:

   E0163 Commode chair, mobile or stationary, with fixed arms

   E0105 Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips

BILLING TIP

The biller must ensure that the code chosen best describes the equipment to its greatest level of specificity.

G Codes: Procedures/Professional Services (Temporary)

CMS assigns G codes are assigned by CMS to identify professional healthcare procedures and services that would otherwise be coded in the CPT® book but for which no CPT® codes exist or are not reimbursed by Medicare. G codes are under Medicare's jurisdiction. Many codes needed for value-based payment-related documentation are also included in this chapter.

Chapter 12 Questions

1. What is a timely filing requirement?

    A. The time frame which an insurance payer must pay a claim

    B. The time frame a provider has to apply for participation in the insurance plan

    C. The time frame a provider has to submit a claim

    D. The time frame which an insurance payer must process a claim

2. A _____ is correspondence sent from the insurance payer to the patient after they receive healthcare services to explain the status of a claim.

    A. Explanation of Benefits

    B. Remittance Advice

    C. Coordination of Benefits Form

    D. CMS-1500 claim form

3. Based off of the Explanation of Benefits example below, what is the amount that is adjusted off by the provider?

Service Information

Service Description	Service Date	Amount Billed	Member Discount (Not Covered)	Covered
ABC Physician Group				
Office Visit, Level III	07-09-20XX	$75.00	$6.00	$69.00
Totals		**$75.00**	**$6.00**	**$69.00**

Coverage Information

Totals	$75.00	$6.00	$69.00
PARTICIPATING PROVIDER (REDUCTION)		$6.00	
Deductions			
Your PCP Copayment Amount		$15.00	
Total Deductions			**-$15.00**
Total Benefits Approved			**$54.00**
Amount You Owe Provider			**$15.00**
Total covered benefits approved for this claim $54.00 to ABC Physician Group on 07-21-20XX.			

    A. $6.00

    B. $15.00

    C. $75.00

    D. $54.00

4. Which of the following is **NOT** a data entry denial?

   A. Incorrect provider number

   B. Incorrect member number

   C. Missing quantity billed

   D. Coverage terminated

5. Review this insurance card:

   Blue Cross
   Blue Shield

   Subscriber Name:
   JOHN DOE
   Identification Number:
   XOF123456789

Group Number: 123456	Office Copay: $20
Coverage Date: 09/01/08	Emergency Copay: $100
	RX Generic Copay: $25
	RX Brand Copay: $50/$100
SINGLE	RxBIN: 011550
	RxPCN: ILDR

   What is the group number from the example insurance card above?

   A. X0F123456789

   B. 123456

   C. 011550

   D. None of the above

6. What is the copayment amount the patient will pay to go to the emergency department in the example above?

   A. $20.00

   B. $25.00

   C. $50.00

   D. $100.00

7. What does a participating provider agree to when signing a contract with an insurance payer?

   A. The provider will only see the patients with that specific insurance

   B. The provider will not charge for services provided to patients with that specific insurance

   C. The provider wishes to participate with and agree to accept the fee schedules set by that specific insurance

   D. All of the above

1.   **Answer:** A. Veterans with service-connected disabilities and their families

     Rationale: The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) covers veterans who are permanently and totally disabled due to a service-related disability and their spouse and children.

2.   **Answer:** B. The employer's group health plan

     Rationale: The health insurance plan is billed first and then through the process of subrogation it will be determined if a liability payer should be considered primary.

3.   **Answer:** D. Medicare Part A, B & C

     Rationale: Medicare Part A, B & C are all administered by private companies that contract with CMS as Medicare Administrative Contractors or MACs.

4.   **Answer:** C. A flat amount paid to the healthcare provider when the policyholder is seen for an office visit.

     Rationale: Co-payments are paid at the time the policyholder is seen for an office visit. Co-insurance is the percentage the policyholder pays for covered services after deductible has been reached and copayment has been paid. The premium is paid every month by the policyholder to maintain insurance coverage.

5.   **Answer:** B. The non-PAR limiting charge is 115% of the non-PAR Medicare Physician Fee Schedule.

     Rationale: Per CMS, the non-PAR limiting charge is 115% of the non-PAR Medicare Physician Fee Schedule.

6.   **Answer:** A. A policy that covers healthcare services that Medicare does not cover.

     Rationale: Medigap was designed by the federal government but marketed by private commercial insurance companies to supplement coverage to fill in the "gaps" of Medicare's deductibles, copayments, and coinsurance costs.

7.   **Answer:** C. ESRD and meet certain requirements

     Rationale: Medicare Part A coverage is available to individuals below the age of 65 who have: 1) received Social Security or RRB disability benefits for 24 months, 2) End-Stage Renal Disease and meet certain requirements.

8.   **Answer:** C. Medicaid programs receive matching federal funding only if certain healthcare services are provided to eligible individuals.

     Rationale: Medicaid programs must provide certain healthcare services to eligible individuals in order to receive matching federal funds known as Federal Medical Assistance Percentage (FMAP). The percentage is determined on a year-to-year basis using a formula that compares the state's per capita average income with the national average. States with lower average income per capita receive a higher FMAP.

9.   **Answer:** C. MGAP 123456789

     Rationale: In item 9a enter MEDIGAP followed by the policy number and group number if applicable. These should be separated by spaces i.e., MEDIGAP 123456 222. MG or MGAP is also acceptable.

10. **Answer:** D. Early and Periodic Screening, Diagnostic, and Treatment

     Rationale: The acronym EPSDT stands for Early and Periodic Screening, Diagnostic, and Treatment and refers to routine pediatric checkups that include dental, hearing, vision, and other screening services to detect potential problems in all children enrolled in Medicaid.

11. **Answer:** A. One

     Rationale: Medicare requires that only one diagnosis be reported for each service provided. Commercial payers may or may not have this same requirement.

12. **Answer:** C. Medically unlikely edits

     Rationale: Medically Unlikely Edits (MUE) determine CPT® and HCPCS Level II codes that have a maximum number of units of service (UOS) that can reasonably be performed by the same provider on the same patient on the same date of service.

13. **Answer:** B. Established patient seen by a mid-level provider for follow-up for blood pressure check, physician is in the office suite.

     Rationale: Medicare's incident-to billing for mid-level providers allows for services to be billed under the physician's provider number when Medicare patients are seen in collaboration with a physician. New patients must be seen by the physician to establish care. Physician must be readily available onsite in order to bill incident-to services.

14. **Answer:** C. Diagnoses to procedures or services that are determined to be reasonable and medically necessary for Medicare patients

     Rationale: National and Local Coverage Determinations (NCD & LCD) are continually being developed to link diagnoses and procedures based on medical necessity and reasonability. When an NCD/LCD review determines that a procedure or service is not reasonable or medically necessary, the provider is allowed to bill the patient only if an ABN has been signed prior to providing the procedure or service.

15. **Answer:** D. Write-off the charge for 64418 because it is a bundled procedure

     Rationale: Services or procedures that are determined to be bundled as part of the payer's contract must be written off. Costs for the bundled procedure cannot be shifted to patient responsibility.

16. **Answer:** B. Directing the insurance company to send the reimbursement to the provider.

     Rationale: As stated on the CMS-1500 claim form item 13. "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

17. **Answer:** C. UB-04 claim form

     Rationale: UB-04 claim form is used to bill facility services. Revenue codes are four-digit codes that indicate location or type of services provided to a patient in a healthcare facility.

18. **Answer:** A. Digit 1 identifies the type of facility.

     Rationale: The TOB (Type of Bill) is alphanumeric and describes three specific types of information after the leading "0". Digit 1 is the leading zero and CMS does not recognize this digit. Digit 2 identifies the type of facility, digit 3 classifies the type of care provided, digit 4 is the frequency code which identifies the sequence of the bill for each particular episode of care.

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