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HEALTHCARE IT

Exa® PACS/RIS

Feature Summary

Studies in Billing

500-000691A

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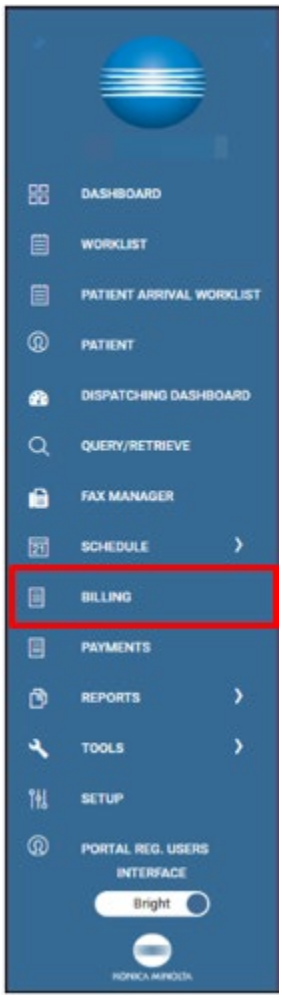
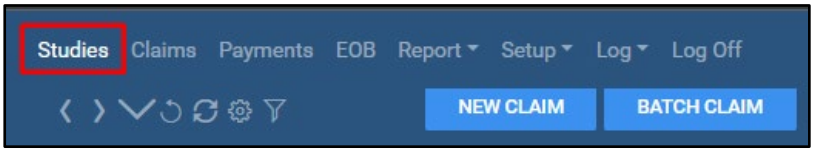
Open the Studies screen

Burger > **Billing...**



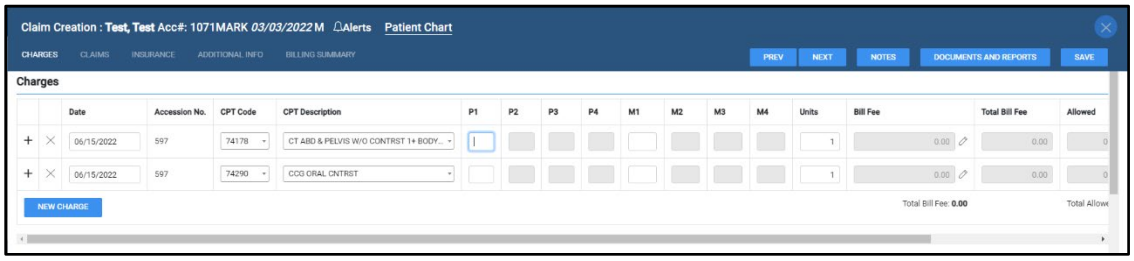
...**Studies**



Study basics

How the patient is registered impacts how the claim information is gathered. Registration is done at the time of the study, and when the study is ready to bill, it goes to claim status for review. This is where the claim is created. The billing status will be Unbilled. You can navigate to different sections of the studies screen by selecting the titles below the patient's name.

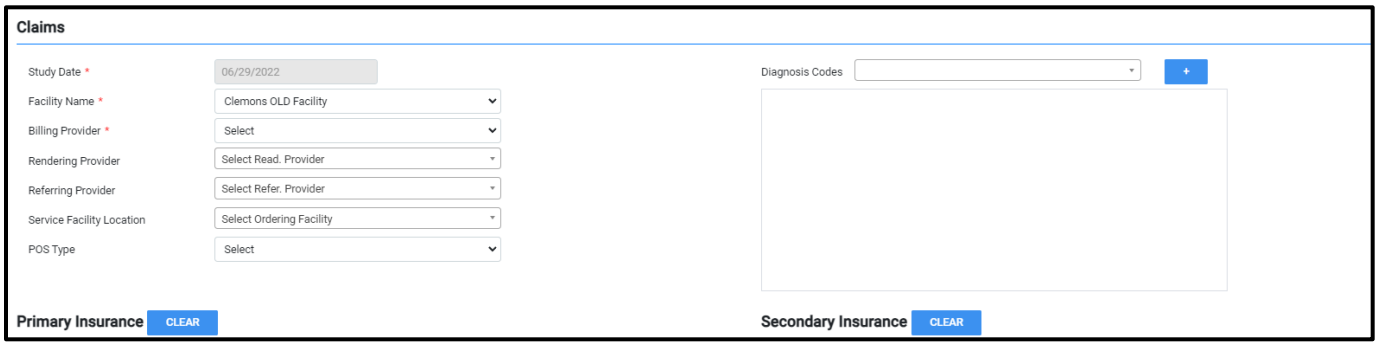
Charges



To create or confirm a charge, the following are available:

- Date: The date of study
- Accession No.: Assigned from the appointment.
- CPT Code: From the appointment type, including modifiers if applicable. Additional codes can be added by selecting New Charge.
- P1–P4: Diagnoses pointers
- M1–M4: Modifiers
- Units: Quantity
- Bill Fee: Per the CPT code with the fee schedule. The total bill fee auto-populates based on the quantity, which appears on the claim.
- Allowed Amount: The total allowed fee auto-populates based on the quantity.
- Auth No.: The authorization number, based on information entered in RIS.
- Exclude: Select to hide the charge on claims. This can be used for unbillable charges such as a surgical tray or miscellaneous item that is not payable or billed with the service. These items can be excluded from the claim but will still show in the patient charges screen.

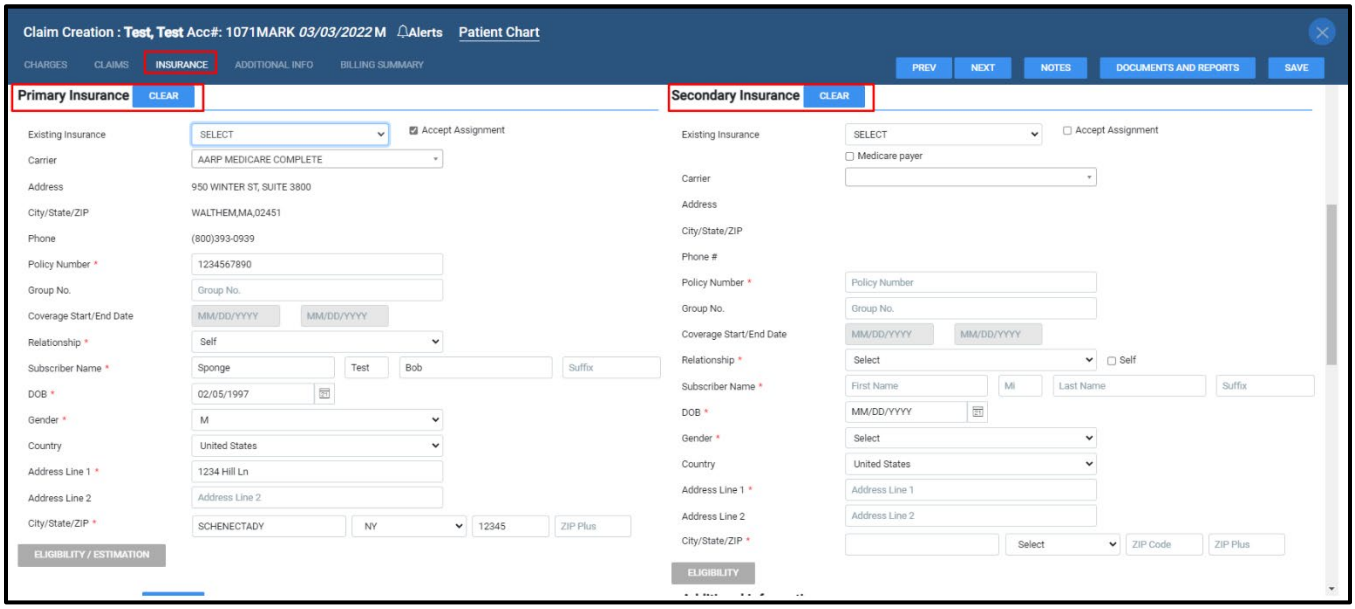
Claims



Most of the claim data populates based on the patient's registration.
Study Date: Should match the charge date.
Facility Name
Billing Provider: Displayed in Item 33 on the CMS 1500.
Rendering Provider: Displayed in Item 31 on CMS1500.
Referring Provider: Displayed in Items 17 and 17b on the CMS1500.
Service Facility Location: Displayed in Item 32 on the CMS1500.
POS Type: Based on how the service facility location is mapped. Displayed in Item 24B on the CMS 1500 form.

The studies area does not monitor participation with carriers (such as PECOS, commercial enrollment, certified with Canadian province).

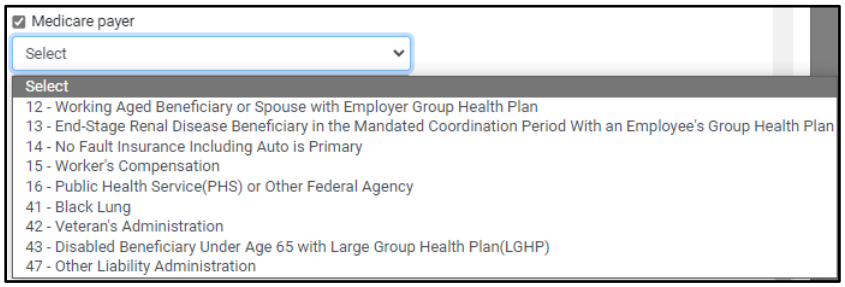
Insurance



The primary, secondary, and tertiary insurance information populates from the registration. The billing user can add or edit this information. Adding a payer makes the payer available to save in the insurance profile. You cannot edit the effective to and from dates in the studies/claims area, but you can do so by opening the patient chart.

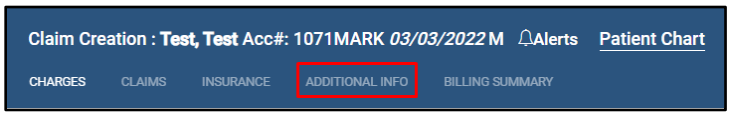
Secondary Insurance

If the patient has Medicare Part B secondary to another type of coverage, select the **Medicare payer** checkbox. In the dropdown list, select the MSP rule that needs to be reported on the claim.



It is important to educate front desk staff on how to identify the reasons why Medicare is considered secondary.

Additional information



If the patient's claim is associated with a particular condition or accident, such as an employment or automobile accident, enter the relevant information in this section.

Employment: Cconditions relay to CMS1500 Item 10a. If you select Employment, then you also need to select the following.

Date of Illness onset, injury/accident/pregnancy – CMS1500 Item 14.

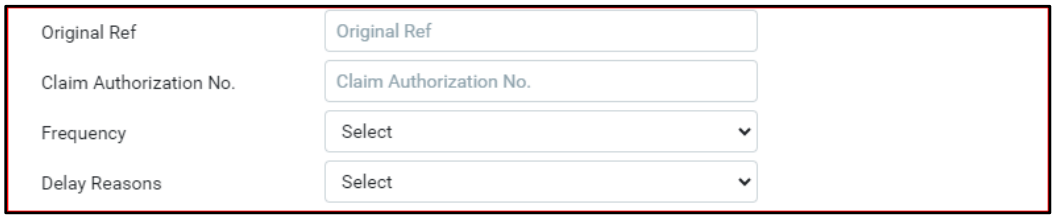
Dates Patient unable to work at current occupation - CMS1500 Item 16.

Auto Accident: Also, we need to note the 'accident state' CMS1500 Item 10b.
Other Accident: Usually these are other liability cases, such as falls. CMS1500 Item 10c.
Hospitalization Patient Related to Current Services. This is required when submitting claims for inpatient services. CMS1500 Item 18.

Claim Notes. Add any notes you want to appear on the claim in Item 19.

Outside Lab: Select if there needs to be any communication about purchased services. This populates in Item 20 on the CMS 1500 form.

(...continued from Additional Information)



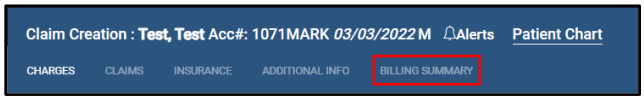
Original Ref: Item 22 on CMS1500 form.
Used to note resubmissions and original reference numbers needed for corrected claims. When using the ERA process (Uploading/downloading 835 files), this will populate from the ERA file for any payments or denials.

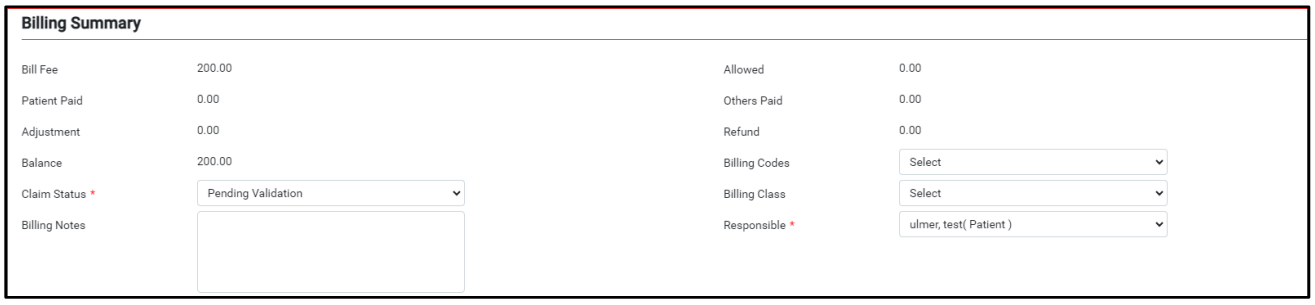
Claim Authorization No.

Frequency: Used for claim resubmissions.
If resubmitting a claim with a Frequency 1, you must remove the original ref number.
If resubmitting a claim with a Frequency 7, you must include the original ref number.

Delay Reasons: EMG - Exceptions to the billing limit can be made if the reason for late billing is allowed by regulations. Delay reasons also have time limits. Please check with the insurance carrier before using delay reason codes.

Billing summary





Bill Fee: Mapped to the total claim amount. Note that if multiple accessions are billed on one claim, the claim inquiry shows the bill amount of the first accession.

Claim Status: Claims ready to be billed have a claim status of Pending Validation. As the claim moves through the payment cycles, the status changes to Pending Submission, Pending Payment, and Paid in Full/Denied.

Billing Codes and classes
Responsible: Changes as the claim goes through the payment cycle.