AAPC

OFFICIAL STUDY GUIDE

MEDICAL BILLING TRAINING

CPB™

CERTIFIED PROFESSIONAL BILLER

2021

Benefiting

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See back for details

2021

Official Study Guide

Medical Billing Training: CPB™ Certification

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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.

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Print ISBN: 978-1-646310-609
e-Book ISBN: 978-1-646311-262

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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 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 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

Chapter 2 Questions

1. This type of healthcare organization combines the functions of health insurance, delivery of care, and administration.

   A. HMO
   B. MCO
   C. IPA
   D. EPO

2. A patient presents to be seen by his primary care physician. The physician belongs to a multispecialty group that provides care to the members of the patient's insurance. The group is paid quarterly on a per member basis with a flat fee. The group also contracts with other health plans. What type of insurance plan does this patient have?

   A. IPA
   B. EPO
   C. MSO
   D. HMO

3. A Medicare patient is seen in an office that accepts Medicare assignment. Code 99213 for $100 is billed to Medicare and the patient has no secondary insurance. The EOMB is received and Medicare approved $73.08 and pays $58.46. What amount does the patient owe?

   A. $41.54
   B. $14.62
   C. $73.08
   D. $100

4. An employee has money deducted from her paycheck every week and put into an account. She uses this to pay for her deductibles, copayments, glasses, and dental care. Her employer allows no options, so if she does not use all the money she puts in, she loses it. What type of account does she have?

   A. Flexible spending account (FSA)
   B. Health savings account (HSA)
   C. Health insurance account (HIA)
   D. Healthcare reimbursement account (HRA)

5. A new provider wants to bill insurance for his services. He has his biller apply for a number to be HIPAA compliant with his claims submission. The number is unique to him. What type of number is this?

   A. UPIN number
   B. Claim number
   C. NPI number
   D. Claims provider number

Chapter 6

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.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-1197 FORM 1500 (02-12)

Image 4.A

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13. Which of the following scenarios would support billing incident-to services?

    A. New patient seen by a mid-level provider who is an employee of the physician.
    B. Established patient seen by a mid-level provider for follow-up for blood pressure check, physician is in the office suite.
    C. Established patient seen by a mid-level provider for an established problem, the physician is performing hospital rounds.
    D. New patient to the practice, physician in exam room next door, mid-level provider is an employee of the physician.

14. What is linked by NCDs and LCDs?

    A. Diagnoses to procedures or services that are determined to be payable for Medicare patients
    B. Diagnoses to procedures or services that are determined to be reasonable for Medicare patients
    C. Diagnoses to procedures or services that are determined to be reasonable and medically necessary for Medicare patients
    D. Diagnoses to procedures or services that need to have a signed ABN

15. CPT® codes 64418 and 19380 were reported together for the injection of the supra capsular nerve with anesthetic agent (64418) with revision of a reconstructed breast (19380). The injection was denied as a bundled service.

Colum1/Column2 Edits					
Column 1	Column 2	Effective Date	Deletion Date	Modifier	PTP Edit Rationale
19380	64418	20090401	*	0	Standards of medical / surgical practice

    What is the next step for the biller?

    A. Resubmit corrected claim adding modifier -59 to 64418.
    B. Resubmit corrected claim adding modifier -51 to 64418.
    C. Move the charge for the bundled procedure to patient responsibility
    D. Write-off the charge for 64418 because it is a bundled procedure

16. By signing the Assignment of Benefits in item 13 of the CMS-1500 claim form, the patient is:

    A. Directing the insurance company to send the reimbursement to the patient.
    B. Directing the insurance company to send the reimbursement to the provider.
    C. Agreeing that services were provided.
    D. Preventing the claim from being paid.

17. A revenue code indicating the type or location of service would be reported on the:

    A. CMS-1500 claim form
    B. UB-02 claim form
    C. UB-04 claim form
    D. ABN form

Chapter 1

1. **Answer:** D. False Claims Act

   Rationale: This act would violate the "reverse false claims" section of the Act, which provides for liability if a person acts improperly to avoid paying money owed to the government.

2. **Answer:** C. Covered entity

   Rationale: A covered entity under HIPAA is defined as health plans, healthcare clearinghouses, and any healthcare provider who transmits health information in an electronic format.

3. **Answer:** C. Minimum necessary standard

   Rationale: The minimum necessary standard in HIPAA requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for, protected healthcare information to the minimum necessary to accomplish the intended purpose. To copy all the notes is unnecessary when only three dates of service were requested.

4. **Answer:** A. ICD-10-CM, ICD-10-PCS, HCPCS, and CPT®

   Rationale: The standardized code sets adopted under HIPAA for all transactions are: HCPCS, CPT®, ICD-10-CM, ICD-10-PCS, NDC, and CDT.

5. **Answer:** D. Fraud

   Rationale: CMS defines fraud as making false statements or misrepresenting facts to obtain an undeserved benefit or payment from a federal healthcare program. As the drugs were given for free, they cannot be billed to Medicare.

6. **Answer:** B. *Qui Tam* action

   Rationale: A Qui Tam action is a civil action on behalf of a person and the U.S. government. If there is a recovery, the relator may be awarded 15-25 percent of the dollar amount recovered through the Qui Tam action.

7. **Answer:** D. Truth in Lending Act

   Rationale: The Truth in Lending Act is a federal law that was enacted to protect consumers in their dealings with lenders or creditors. If the office is going to charge finance charges on outstanding balances, they are considered a creditor and subject to the law.

8. **Answer:** C. Business associate

   Rationale: 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.

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2021 Official Study Guide: CPB™

9 781646 310609

Print ISBN: 978-1-646310-609
e-Book ISBN: 978-1-646311-262