Tips for Implementing a Newly Published Medical Billing Code

The HealthySteps National Office Policy & Finance Team

The good news? There is a new billing code open for use by HealthySteps practices! But where to begin? When seeking reimbursement for a newly established billable service at your HealthySteps (HS) practice, it may be overwhelming to know where to begin. When new services and their billing codes are implemented and published, there are a variety of administrative steps to be taken before providing patient services, and billing.

> Keep in Mind: The order in which the below steps are taken may change, and/or additional steps may be needed, depending on your practice's policies and procedures.

This document contains a few steps that can assist in utilizing new billing code(s) and reaching sustainability.

Verify if new billing codes are approved for reimbursement for your clinic type (e.g., Federally Qualified Health Center, Regional Health Center)

The clinic departments/personnel responsible for verifying if a code is open and approved for reimbursement (e.g., billing and/or finance department administrator/revenue cycle team/medical coders) will conduct research of the information that will enable them to answer the below questions:

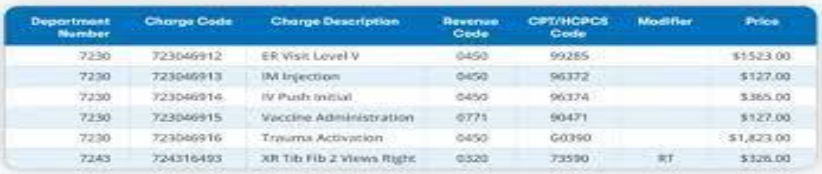
1) Is your specific clinic type able to bill and receive reimbursement for the services?
2) Do the insurance carriers contracted with your clinic know and understand the new codes?
3) Which professionals are eligible to render and/or bill for the services?

Confirm service, documentation, and billing guidelines

The departments/personnel responsible for service documentation and billing (e.g., medical billers/medical coders/finance and billing staff) should also verify the following:

- Required services to be furnished when reporting the billing code,
- Required documentation elements, and
- Billing guidelines such as appending modifiers, and how to report units of service when applicable.

The information gathered should be shared with those departments who hold responsibility for approving the usage of the new codes (e.g., departments of compliance and/or revenue cycle). Additionally, your practices' protocol may include adding new codes to the "charge master."



Department Number	Charge Code	Charge Description	Revenue Code	CPT/HCPCS Code	Modifier	Price
7230	723046912	ER Visit Level V	0450	99285		$1523.00
7230	723046913	IM Injection	0450	96372		$127.00
7230	723046914	IV Push Initial	0450	96374		$365.00
7230	723046915	Vaccine Administration	0771	90471		$127.00
7230	723046916	Trauma Activation	0450	G0390		$1,823.00
7243	724316493	XR Tib Fib 2 Views Right	0320	73590	RT	$326.00

What is a Hospital Charge Master? A hospital charge master is the collection of standard list prices for services. It is essentially a comprehensive list of charges for each inpatient and outpatient service provided by a provider or practice (e.g., tests, exams, procedures, inpatient and outpatient visits) and includes both billing codes and site-specific charge master codes. This list is important because it is used to manage a practice or health system's revenue cycle. The rates reflected on a charge master list serve as baselines when negotiating the rates at which payers will reimburse for services.

Add new billing codes to your Electronic Health Record (EHR)

To report and bill for services, the billing codes must be entered into your practice's EHR database. The department/personnel responsible for providing new and/or additional information to be added to the EHR database will be responsible for providing the new billing codes and their descriptions. Below includes, but is not limited to, some of the information that may be needed by the EHR department:

- The new billing codes and their descriptions.
- The professional departments who can utilize the new billing codes.
- The clinical specialties authorized to bill for the service(s).
- The EHR template build if the decision has been made to do so (e.g., creating a template can help ensure required documentation and service compliance).
    - If the service is time-based, a template can contain a "time in" and a "time out" stamp where a clinician may complete and sign their documentation (a hard stop in this area of the template may be created by the EHR team to ensure this functionality is not bypassed).

- An EHR template can contain documentation requirement fields, to ensure the clinician is adhering to the documentation and service requirements necessary for reporting and billing for the new codes/services.

Education/Training

Educating and training clinicians in understanding the service(s) and billing code(s), along with their guidelines, is essential to the success of receiving reimbursement for services.

The department(s)/personnel accountable for educating administrators and clinicians on the new services and the billing codes should compile all information to prepare training on:

- The service requirements that are needed to report/bill for the new codes.
- The documentation requirements for the services rendered.
- Billing guidelines such as billing modifiers and reporting units of service.
- Location and proper use of the templates and codes in the EHR.

Reporting and Tracking

Medical billing reports are key for understanding billing and reimbursement activity in your medical practice. Without good reporting, it is difficult to determine whether your practice is coding and billing correctly, and if your practice is receiving maximum reimbursement.

Soon after billing for the new service(s) commences, claim submissions, rejections, denials, and reimbursement should be tracked by the personnel assigned at the site level, to assure the above practices were successful.