Psychiatry Coding & Reimbursement Alert

Human Resources: Test Candidate's Billing and Coding Know-How With These Sample Questions

Start with these questions and alter the assessment to fit your practice.

When trying to hire new people for your coding team, you will want to pick up the best of the best to match your needs. To find the best person for your team, you will need to know the questions that you need to ask during the interview.

Take a look at these sample questions and tailor a test for candidates looking for a job with your practice.

Billing & Coding Knowledge Assessment Questions

Please answer all of the following questions to the best of your ability. Your answers will assist us in determining where we can best use your skills in our practice.

1. Explain the difference between a CPT® code and an ICD-9-CM code.
2. What are evaluation and management (E/M) codes?
3. What is the difference between a consultation and a transfer of care?
4. What is "unbundling"?
5. What is a "withhold"? Explain exactly how to post it in the computer system.
6. What is the difference between pre-certification and pre-authorization?
7. What does it mean to post payments by line item? Why is it so important to do so?
8. You should follow up on an unpaid Medicare claim at ____ days if the practice is participating and files electronically.
9. You should follow up on an unpaid non-Medicare claim at ____ days.
10. How would you handle the following EOB rejections or "$0.00 pays"?

    a. "Procedure not a covered benefit"
    b. "Patient not eligible on date of service"
    c. "Contract number does not match information on file"
    d. "Applied to deductible"

11. When do you write off balances, and what parameters do you use when adjusting off the balance due?
12. If a patient is a 100 percent cash pay patient and you have agreed to a discount, such as allowing 50 percent to multiple surgeries and other possible reductions, and the payment of the large balance is being put on a payment plan, how do you handle the agreed upon discounts?

Billing Specialist Knowledge Assessment Answers

Important: There is some room for individual interpretation with the answers to these questions. A potential hire may provide a correct answer that is not stated exactly as in this answer key.

1. A CPT® code describes a service or procedure (what the provider did for the patient), and an ICD-9-CM code in physician billing describes the diagnosis (why the provider performed the service or procedure).

2. E/M codes describe office visits, hospital and outpatient services, and consultation services rendered by providers. The "evaluation" is the history and physical exam. The "management" is the medical decision-making process.

3. A consultation is when a patient's physician or other appropriate source asks another physician (usually a specialist) to give his opinion about the patient's medical problem. A consultation visit must include a documented request for opinion

from the requesting physician, rendering the service, documentation of the consulting physician's E/M service and opinion, and documentation of a report from the consulting physician explaining his opinion and findings to the requesting physician.

A transfer of care is when a physician thinks the patient needs another physician (sometimes a specialist) to assume responsibility for all or a portion of the patient's care because he can better manage the patient's medical problem. Therefore, the treating physician "transfers" the care of his patient to another physician.

4. "Unbundling" is when you bill several CPT® procedure codes that are more accurately billable under a single CPT® code. The National Correct Coding Initiative (CCI) outlines bundling edits for codes. Billers often use modifiers, such as modifier 59 (Distinct procedural service), to override CCI bundling edits and get paid for services that deserve payment under the circumstances.

5. A "withhold" is a percentage of reimbursement (typically 10 to 25 percent) that is withheld from the contracted payment amount for each service, then returned to the practice at the end of the year based on utilization or other performance targets of the managed-care company. Because withholds are potential receivables, you should post them separately from contractual adjustments.

6. Pre-certification means the plan said, "Yes, you can do that procedure for that diagnosis." Pre-authorization means the plan said, "You will be paid for the procedure." Pre-authorization is like a guarantee for payment, whereas pre-certification may not be.

7. Posting by line item means you post payments and adjustments to the actual CPT® code that your practice billed, as opposed to the oldest outstanding balance on the account, or the entire claim. If payments are not posted in this manner, you have no way of retrieving historical payment information by CPT® code or by payer. You are also unable to run reports on allowances per CPT® to compare to your fee schedule, less able to capture monies that were unpaid inappropriately, and have overall less money to manage your practice. Your billing system is a management information system, but its effectiveness is only as good as the quality of the data put into it.

8. You should follow up on an unpaid Medicare claim at 14 days if the practice is participating and files electronically.

9. This depends on your state's prompt pay laws. States that have prompt pay laws requiring payers to pay clean claims in a shorter time frame would indicate that practices follow up on unpaid claims sooner than indicated above. With states that have longer prompt payment laws (or no prompt payment laws), you may find you actually need to wait a bit longer to follow up. This also assumes that you are caught up with your payment posting. If you are behind on your payment posting, you need to offset your follow-up period by the amount of time you are behind posting your payments.

10. a) Check the plan guidelines. You may be able to get this electronically from your eligibility module, or you may have to request the patient bring in their policy guidelines and/or summary plan description for ERISA. If this rejection is accurate, transfer the balance to the patient and send a statement.

b) Verify the patient's effective insurance coverage dates with the payer using your eligibility verification module (if you have one) and/or calling the insurance. If the patient was not covered at the time of service, then call the patient and explain what happened. If the patient has proof that she was covered on the dates of service, ask her to provide that to you so that you can appeal the denial. You can also ask that the patient, as the customer with the insurance company, contact the insurance company to get her records corrected. If the patient is unable to prove that the insurance records are inaccurate, explain to the patient that the bill is now her responsibility.

c) Call the patient to obtain correct information and re-bill. Be sure the front desk is notified that they erred by not updating the patient's account information, or made a typo.

d) Transfer balance to patient's account, try to collect the balance, and if unsuccessful, send the first statement to the patient.

11. The payment poster can make adjustments found on the remittance advices as contractual adjustments for items such as negotiated fee schedule, bundling, non-covered services, etc, (or they can be taken automatically during auto

posting processes). However, billers should not automatically make other adjustments such as "too costly to bill" for small balances, negotiated adjustments for self-pay and other non-participating situations, failed appeals, and inappropriate bundles. A supervisor should sign off on these types of adjustments, since these write offs reduce the accounts receivable balances of the practice. By controlling write off adjustments, the billing department makes sure that reductions to A/R only happen when there are adjustments for which the practice has no control, such as negotiated fee schedules, and agreed upon bundling as per the contract.

12. You should not take reductions (write offs) until the patient pays in full the amount he has agreed to pay. Once he has completed and fulfilled his payment plan as the practice and the patient agreed on, the agreed discounts can be taken and you can write off the balances that remain for that service. Never write off services before the patient has paid his responsibility.