KONICA MINOLTA

HEALTHCARE IT

Exa® PACS/RIS

Feature Summary

Studies in Billing

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500-000764A

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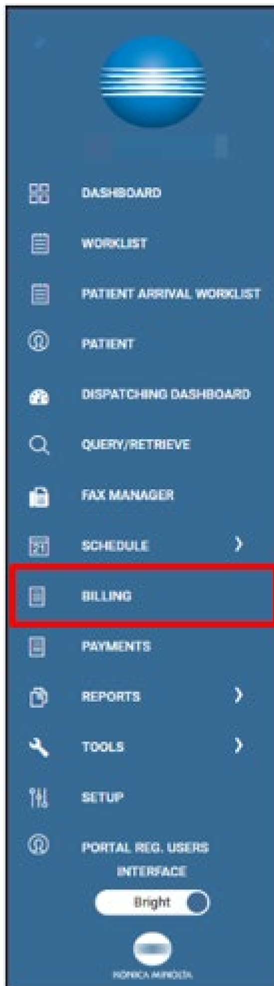
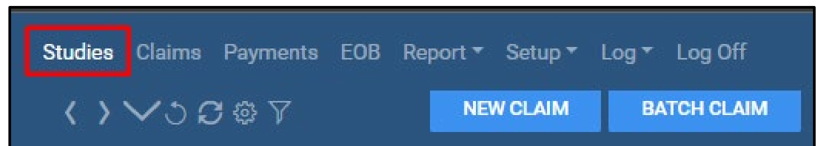
Open the Studies screen

Burger > **Billing** >



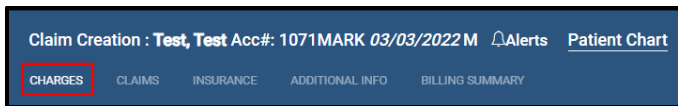
... **Studies**

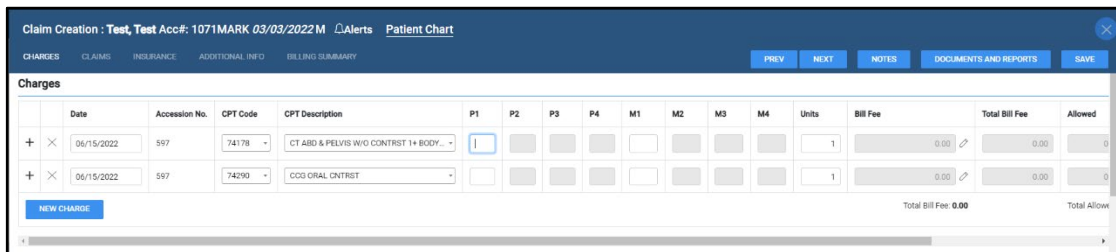


Study basics

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

Charges





To create or confirm a charge, confirm the following:

- Date of study
- Accession No. is assigned from the appointment
- CPT code(s) – Populates based on what is mapped to an appointment type, including modifiers if appropriate. Add codes by selecting NEW CHARGE.
- P1-P4 – Diagnoses pointers
- M1-M4 – Modifiers
- Units – Quantity
- Bill fee – From the CPT code within 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. (authorization number) - Based on what is entered in RIS, and can be modified.
- Exclude - Select to exclude the charge on claims but show in the patient charges screen. This can be used for unbillable charges such as a surgical tray or miscellaneous item that is not payable or billed with the service.

Claims

Most of the claim data populates based on the patient's registration information.

Information includes:

Study date - Matches 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 the service facility location mapping. 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 information. The billing user can add or edit information. Add a new payer to allow the payer to be saved in the insurance profile. You cannot edit the effective to and from dates in the studies/claims area, but you can in the patient chart.

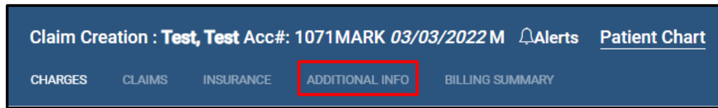
Secondary insurance:
If the patient has Medicare Part B secondary to another type of coverage, select the Medicare payer box.

A dropdown list opens to identify the MSP rule to report on the claim.
The dropdown list includes the following:

Medicare payer
Select
- 12 - Working Aged Beneficiary or Spouse with Employer Group Health Plan
- 13 - End-Stage Renal Disease Beneficiary in the Mandated Coordination Period With an Employee's Group Health Plan
- 14 - No Fault Insurance Including Auto is Primary
- 15 - Worker's Compensation
- 16 - Public Health Service(PHS) or Other Federal Agency
- 41 - Black Lung
- 42 - Veteran's Administration
- 43 - Disabled Beneficiary Under Age 65 with Large Group Health Plan(LGHP)
- 47 - Other Liability Administration

Front desk staff must be educated on how to identify the reasons why Medicare is considered secondary.

Additional information



Additional Information

Patient's Condition is Related to:

Employment

Auto Accident

Other Accident

Accident State

Select

Date of Illness Onset, Injury/Accident, or Pregnancy (LMP):

Date

Other Date

MM/DD/YYYY

Dates Patient Unable to Work at Current Occupation:

From Date

To Date

Hospitalization Patient Related to Current Services

From Date

To Date

Claim Notes

Outside Lab

Additional information:

If the patient's claim is associated with a particular condition or accident, such as employment, automobile accident, or other accidents, this is the section where the relevant information must be provided.

Employment conditions relay to CMS1500 Item 10a.

If you select this checkbox you must also:

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

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

Auto accident. Also note the accident state CMS1500 Item 10b.

Other accidents – 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. Enter notes to add to the claim in Item 19.

Outside Lab. Select to require communication about purchased services. This populates in Item 20 on the CMS 1500 form.

(Addition Information Cont.)

Original Ref	Original Ref
Claim Authorization No.	Claim Authorization No.
Frequency	Select
Delay Reasons	Select

Original Ref - Item 22 on CMS1500 form.
This indicates resubmissions and original reference numbers needed for corrected claims.
When using the ERA process (uploading/downloading 835 files), this populates from the ERA file for any payments or denials.

Claim Authorization No.

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

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

Billing summary

Claim Creation : **Test, Test** Acc#: 1071MARK *03/03/2022* M Alerts Patient Chart
CHARGES CLAIMS INSURANCE ADDITIONAL INFO BILLING SUMMARY

Billing Summary

Bill Fee	200.00	Allowed	0.00
Patient Paid	0.00	Others Paid	0.00
Adjustment	0.00	Refund	0.00
Balance	200.00	Billing Codes	Select
Claim Status *	Pending Validation	Billing Class	Select
Billing Notes		Responsible *	ulmer, test(Patient)

Bill fee - This is 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 – When the claim is ready to be billed, the claim status changes to Pending Validation. When the claim moves through the payment cycles, the status changes to Pending Submission, Pending Payment, Paid in Full/Denied.

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