BILLING/ CLAIMS REPORTS

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DEFINITIONS

Reference these definitions to guide you in pulling Billing/Claims report fields.

Provider Name/Identifier
A unique identifier for each provider. Be sure to use the same Provider Name/Identifier as utilized on your other uploaded files.

Provider NPI
The provider's National Provider Identifier (NPI) is a unique, 10-digit identifier. Provider NPIs can be found here:
https://npiregistry.cms.hhs.gov/

CPT Code
All CPT codes performed by each provider.

CPT Description
A description of what service/procedure the CPT code is referring to.

Modifier 1, 2 and 3
Any modifiers that were used with each CPT code.

Place of Service
The two-digit CMS place of service code that corresponds with where each CPT procedure was performed.

Service Date
The date each CPT service/procedure was completed.

Total Charges
The total charges billed for each CPT code.

Net Payment
The net amount paid for each CPT code by the payer.

Payer
The payer for each CPT code (ex: Medicare, Medicaid, Private, or self-pay).

Frequency
The number of times each CPT code was billed by each provider.

Does the physician's productivity include any that was not their own? *(Physicians)*
If the physician's productivity measures (collections, charges, encounters, CPTs, ASA units) include any productivity attributed to an advanced practice provider working under the physician's supervision, indicate "Yes". Otherwise indicate "No".

Can advanced practice provider bill under themself? *(APPs)*
If the advanced practice provider (APP) can bill the procedures they perform under themselves, as opposed to under a physician within the practice, indicate "Yes". Otherwise indicate "No".

Percent of provider productivity that was telehealth
The percentage of total services completed via telehealth appointments.

% of TC Included in Productivity

Collections for professional charges and gross charges for laboratory, radiology, medical diagnostic and surgical procedures may have two components: the physician's professional charge such as interpretation and the technical charge for the operation and use of the equipment. If collections for professional charges and gross charges did not include the technical component (TC), referred to as professional services only billing, indicate "0%". If collections for professional charges and gross charges did include the technical component, referred to as global fee billing, indicate the approximate percentage of charges represented by the technical component by indicating either "1-10%" or "greater than 10%."

ASA Units *(Anesthesiology Providers)*

The American Society of Anesthesiologists (ASA) units for a given procedure consist of three components:

- Base unit;
- Time in 15-minute increments; and
- Risk factors.

Please note:

- Adjustments should be made if a provider supervises a CRNA that is not employed by the reporting practice to avoid double reporting of ASA Units under the physician and advanced practice provider. This can be done by utilizing one of the following methods:

  — Report the total sum of ASA Units for the entire team under the supervising physician and indicate "Yes" to "Did the physician's productivity include any that was not their own?". DO NOT report the same sum across all physicians and advanced practice providers.
  — Report the individual productivity for each provider and indicate "No" to the question "Did the physician's productivity include any that was not their own?".

- Do not duplicate units for split bills. Instead, report units on a per case basis.

Number of individual patients

The total number of individual patients who received services from the practice during the reporting period. This includes fee-for-service and capitation patients. A patient is simply a person who received at least one service from the practice, regardless of the number of encounters or procedures received by that person. A patient is not the same as a covered life. The number of capitated patients, for example, could be less than the number of capitated covered lives if a subset of the covered lives did not utilize any services during the reporting period.

Panel size for past 18 months

The panel size or 'set of patients cared for by a provider' is the number of individual unique patients that have been seen by any provider within the practice over the past 18 months. To determine the panel size, use the following methodologies:

- If a patient has only seen one provider in the practice, assign the patient to that provider.
- If a patient has seen more than one provider in the practice, assign the patient to the provider seen most frequently.
- If a patient has seen more than one provider in the practice the same number of times, assign the patient to the provider who did the patient's last physical.
- If a patient has not had a physical, assign him/her to the provider seen most recently.

Collections for Professional Charges

The amount of collections attributed to a provider for all professional services.
Include:

- Fee-for-service collections;
- Allocated capitation payments;
- Administration of chemotherapy drugs; and
- Administration of immunizations.

Do not include:

- Administration of drugs, including vaccinations, allergy injections, biologics, and immunizations, as well as chemotherapy and antinauseant drugs administered by someone other than the provider (i.e. nurses, techs, etc.);
- The technical component associated with any laboratory, radiology, medical diagnostic or surgical procedure collections. If you cannot break this out, report collections and indicate the appropriate response to the question regarding technical component. If you can report collections without technical component, indicate 0% for the technical component question;
- Collections attributed to physicians separate from advanced practice providers. If you cannot break this out, report collections and indicate "Yes" to "Did the physician's productivity include any that was not their own?". If you can report physician collections without advanced practice providers, indicate "No" to "Did the physician's productivity include any that was not their own?";
- Infusion-related collections;
- Facility fees;
- Supplies; or
- Revenue associated with the sale of hearing aids, eyeglasses, contact lenses, etc.

Professional Gross Charges

The total gross patient charges attributed to a provider for all professional services. Gross patient charges are the full dollar value, at the practice's established undiscounted rates, of services provided to all patients, before reduction by charitable adjustments, professional courtesy adjustments, contractual adjustments, employee discounts, bad debts, etc. For both Medicare participating and nonparticipating providers, gross charges should include the practice's full, undiscounted charge and not the Medicare limiting charge.

Include:

- Fee-for-service charges;
- In-house equivalent gross fee-for-service charges for capitated patients;
- Administration of chemotherapy drugs; and
- Administration of immunizations.

Do not include:

- Administration of drugs, including vaccinations, allergy injections, biologics, and immunizations, as well as chemotherapy and antinauseant drugs administered by someone other than the provider (i.e. nurses, techs, etc.);
- The technical component associated with any laboratory, radiology, medical diagnostic or surgical procedure. If you cannot break this out, report gross charges and indicate the appropriate response to the question regarding technical component. If you can report charges without technical component, indicate 0% for the technical component question;
- Charges attributed to physicians separate from advanced practice providers. If you cannot break this out, report gross charges and indicate "Yes" to "Did the physician's productivity include any that was not their own?". If you can report physician gross charges without advanced practice providers, indicate "No" to "Did the physician's productivity include any that was not their own?";
- Infusion-related charges;
- Facility fees;
- Supplies; or
- Charges associated with the sale of hearing aids, eyeglasses, contact lenses, etc.

Total Patient Encounters

An instance of direct provider to patient interaction, regardless of setting (including tele-visits and e-visits), between a patient and a provider who is vested with the primary responsibility of diagnosing, evaluating, and/or treating the patient's condition, where the provider exercises clinical judgment that may or may not be billable.

Current to 30 days in A/R

Amounts owed to the practice by patients, third-party payers, employer groups, and unions for fee-for-service activities before adjustments for anticipated payment reductions, allowances for adjustments, or bad debts. Amounts assigned to "Accounts receivable" are due to "Gross fee-for-service charges." Assigning a charge into "Accounts receivable" initiates at the time a practice submits an invoice to the payer or patient for payment. For example, if an obstetrics practice establishes an open account for accumulation of charges when a patient is accepted into a prenatal program and the account will not be invoiced until after delivery, then "Accounts receivable" will not reflect these charges until the creation of an invoice. Deletion of charges from "Accounts receivable" is done when the practice receives payment, turns over debt to a collection agency, or writes off the account as bad debt. This is the net amount owed after patient refunds.

Not included:
- Capitation payments owed to the practice by HMOs.

31 - 60 days in A/R

Percent of Accounts receivable that are still outstanding after 31-60 days.

61 - 90 days in A/R

Percent of Accounts receivable that are still outstanding after 61-90 days.

91 - 120 days in A/R

Percent of Accounts receivable that are still outstanding after 91-120 days.

120+ days in A/R

Percent of Accounts receivable that are still outstanding after 120+ days.

Medicare percent of charges

The sum of all fee-for-service, managed care fee-for-service and capitated charges for all services provided to Medicare patients.

Medicaid percent of charges

The sum of all fee-for-service, managed care fee-for-service and capitated charges for all services provided to Medicaid or similar state healthcare program patients.

Commercial percent of charges

The sum of all fee-for-service, managed care fee-for-service and capitated charges for all services provided patients under a commercial capitated contact.

Workers' compensation percent of charges

Fee-for-service gross charges, at the practice's undiscounted rates, for all services provided to patients covered by workers' compensation insurance.

Not included:
- Charges for Medicare patients;
- Charges for Medicaid patients;
- Charges for charity or professional courtesy patients; or
- Charges for self-pay patients.

Charity care and professional courtesy percent of charges

Fee-for-service gross charges, at the practice's undiscounted rates, for all services provided to charity patients. Charity patients are patients not covered by either commercial insurance or federal, state, or local governmental healthcare programs and who do not have the resources to pay for services. Charity patients must be identified at the time that service is provided so that a bill for service is not prepared.

Self-pay percent of charges

Fee-for-service gross charges, at the practice's undiscounted rates, for all services provided to patients who pay the medical practice directly. Note that these patients may or may not have insurance.

Included:

- Charges for patients who have no insurance but do have the resources to pay for their own care and do so; and
- Charges for patients who have insurance but choose to pay for their own care and submit claims to their insurance company directly. Since the practice may or may not be aware of this situation, all charges paid directly by the patient should be considered as self-pay.

Other federal government payers percent of charges

Fee-for-service gross charges, at the practice's undiscounted rates, for all services provided to patients who are covered by other federal government payers other than Medicare.

Included:

- Charges for TRICARE patients.

Not included:

- Charges for Medicare and Medicaid patients.
- Charges for Medicare and Medicaid patients.