

HEALTHCARE IT

Exa® PACS/RIS

Feature Summary

Studies in Billing

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Contents

Open the Studies screen	. 3
Study basics	.4
Charges	.4
Claims	. 5
Insurance	. 6
Additional information	. 7
Billing summary	. 8

Open the Studies screen

Burger > Billing...



...Studies

Studies	Claims	Payments	EOB	Report -	Setup 🔻	Log 🕶	Log Off
$\langle \rangle$	~ 32	7 @ 7		NEV	V CLAIM	BA	TCH CLAIM

Study basics

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

Charges

CHAR	GES CLA	ums ins	ISURANCE	ADDITIONAL	al Info	BILLING	i sum	MARY											
im C	reation : Test, T	Test Acc#: 107	71MARK 03/0	/03/2022 M 🕮 Ale	Alerts Patie	ent Chart													
														REV NEX	N	TES DOCI	IMENTS AND	REPORTS	SAVE
RGES															_				
rdes	CLAIMS IN	NSURANCE AD	ODITIONAL INFO																
ges	CLAIMS IN	NSURANCE AD	DUTIONAL INFO																
ges	CLAIMS IN	Accession No.	 CPT Code 	CPT Description			P1	P2	P3	P4	M1	M2	M3 M4	Units	Bill Fee		Total	Bill Fee	Allowe
ges	CLAIMS IN Date 06/15/2022	Accession No.	 CPT Code 74178 - 	CPT Description	IS W/O CONTRST	1+ BODY	P1	P2	P3	P4	M1	M2	M3 M4	Units	Bill Fee	0.00	Total	Bill Fee	Allowe
rges	CLAIMS IN Date 06/15/2022	Accession No.	 CPT Code 74178 • 	CPT Description	IS W/O CONTRST	1+ BODY *	P1	P2	P3	P4	M1	M2	M3 M4	Units	Bill Fee	0.00	Total	Bill Fee 0.00	Allowe
arges	CLAIMS IN Date	Accession No.	a. CPT Code	CPT Description			P1	P2	P3	P4	М1	М2	M3 M4	Units	Bill Fee		Total	Bill Fee	
< 35 <	CLAIMS IM Date 06/15/2022 06/15/2022	ACCESSION No.	 CPT Code 74178 • 74290 • 	CPT Description CT ABD & PELVIS W CCG ORAL CNTRST	IS W/O CONTRST	1+BODY.,	P1	P2	P3	P4	M1	M2	VI3 M4	Units	Bill Fee	0.00	Total	0.00	Allo

To create or confirm a charge, the following are available:

- Date: The date of study
- Accession No.: Assigned from the appointment.
- CPT Code: From the appointment type, including modifiers if applicable. Additional codes can be added by selecting New Charge.
- P1–P4: Diagnoses pointers
- M1-M4: Modifiers
- Units: Quantity
- Bill Fee: Per the CPT code with 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.: The authorization number, based on information entered in RIS.
- Exclude: Select to hide the charge on claims. This can be used for unbillable charges such as a surgical tray or miscellaneous item that is not payable or billed with the service. These items can be excluded from the claim but will still show in the patient charges screen.

Claims

Claim Cre	eation : Te s	st, Test Acc#:	1071MARK <i>03/0</i>	03/2022 M 🗘 Alerts	Patient Chart
CHARGES	CLAIMS	INSURANCE	ADDITIONAL INFO	BILLING SUMMARY	

Study Date * 06/29/2022 Diagnosis Codes Facility Name * Clemons OLD Facility • Billing Provider * Select • Rendering Provider Select Read. Provider • Referring Provider Select Refer. Provider •
Facility Name * Clemons OLD Facility Billing Provider * Select Rendering Provider Select Read. Provider Referring Provider Select Refer. Provider
Billing Provider Select Rendering Provider Select Read. Provider Referring Provider Select Refer. Provider
Rendering Provider Select Read. Provider Referring Provider Select Refer. Provider
Referring Provider Select Refer. Provider •
a di se d
Service Facility Location Select Ordering Facility *
POS Type Select 🗸

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

Study Date: Should match 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 how the service facility location is mapped. 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

Claim Creation : Test, Test	Acc#: 1071MARK <i>03/03</i>	8/2022 M	⊖Alerts <u>P</u>	atient Char	t										\otimes
CHARGES CLAIMS INSURA	ANCE ADDITIONAL INFO							PREV	/ NEX	U.	NOTES	DO	CUMENTS AND REPORT	TS S	AVE
Primary Insurance CLEAR						Secondary Insurance	CLEAR								
Existing Insurance	SELECT	~	Accept Ass	signment		Existing Insurance		SELECT			Acc	ept Assig	gnment		
Carrier	AARP MEDICARE COMPLETE		Ψ.				0	Medicare payer							
Address	950 WINTER ST, SUITE 3800					Carrier									
City/State/ZIP	WALTHEM,MA,02451					Address									
Phone	(800)393-0939					City/State/ZIP									
Policy Number *	1234567890					Phone #									- 1
Group No.	Group No.					Policy Number *	F	Policy Number							
Coverage Start/End Date	MM/DD/YYYY MM/D	D/YYYY				Group No.		3roup No.							- 1
Relationship *	Self		~			Coverage Start/End Date	1	MM/DD/YYYY	MM/D	D/YYYY					
Subscriber Name *	Sponge	Test	Bob		Suffix	Relationship *		Select			~	□ Se	elf		
DOB *	02/05/1997 🕅					Subscriber Name *	I	First Name		Mi	Last Na	me	S	uffix	
Gender *	м		~			DOB *		MM/DD/YYYY	21						
Country	United States		~			Gender *		Select			~				
Address Line 1 *	1234 Hill I n					Country	D	United States			~				
Address Line 2	Addrees Line 2					Address Line 1 *	1	Address Line 1							
City/State/7IP *		10 m				Address Line 2		Address Line 2							
ony, otator En	SUHENECTADY	NY	v	12345	ZIP Plus	City/State/ZIP *				Sele	ect	~	ZIP Code ZIP	Plus	
ELIGIBILITY / ESTIMATION						FUGIBILITY									
															*

The primary, secondary, and tertiary insurance information populates from the registration. The billing user can add or edit this information. Adding a payer makes the payer available to save in the insurance profile. You cannot edit the effective to and from dates in the studies/claims area, but you can do so by opening the patient chart.

Secondary Insurance

If the patient has Medicare Part B secondary to another type of coverage, select the **Medicare payer** checkbox. In the dropdown list, select the MSP rule that needs to be reported on the claim.



It is important to educate front desk staff on how to identify the reasons why Medicare is considered secondary.

Additional information

Claim Cr	eation : Tes	t, Test Acc#	: 1071MARK <i>0</i>	3/03/2022 M	∆ Alerts	Patient Chart
CHARGES	CLAIMS		ADDITIONAL INF		MMARY	
Additional Info	ormation					1
	Patie	nt's Condition is Relat	ed to:			
	🗌 Er	nployment	Auto Accident	🗌 Other A	ccident	
Accident State	Se	lect 🗸				
	Date (LMI	of Illness Onset, Injur P):	/Accident, or Pregnancy			
Date		6	Other Date	MM/DD/YYYY	27	
	Date	s Patient Unable to Wo	rk at Current Occupation:			
From Date		6	To Date		27	
	Hosp	italization Patient Rela	ated to Current Services			
From Date		5	To Date		27	
Claim Notes						
	0	utside Lab				J

If the patient's claim is associated with a particular condition or accident, such as an employment or automobile accident, enter the relevant information in this section.

Employment: Cconditions relay to CMS1500 Item 10a. If you select Employment, then you also need to select the following.

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

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

Auto Accident: Also, we need to note the 'accident state' CMS1500 Item 10b. Other Accident: 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. Add any notes you want to appear on the claim in Item 19.

Outside Lab: Select if there needs to be any communication about purchased services. This populates in Item 20 on the CMS 1500 form.

(...continued from Additional Information)

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

Original Ref: Item 22 on CMS1500 form.

Used to note resubmissions and original reference numbers needed for corrected claims. When using the ERA process (Uploading/downloading 835 files), this will populate from the ERA file for any payments or denials.

Claim Authorization No.

Frequency: Used for claim resubmissions.

If resubmitting a claim with a Frequency 1, you must remove the original ref number.

If resubmitting a claim with a Frequency 7, you must include the original ref number.

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

Billing summary

Claim Cre	ation : Te s	t , Test Acc#:	1071MARK <i>03/(</i>	0 <i>3/2022</i> м Да	Ilerts Patient Chart		
CHARGES							
Billing Su	mmary						
Bill Fee		200.00					Allowed
Patient Paid		0.00					Others Paid
Adjustment		0.00				F	Refund
Balance		200.00				Billing Cod	les
Claim Status	*	Pending	Validation	~		Billing Class	
Billing Notes						Responsible *	

Bill Fee: 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: Claims ready to be billed have a claim status of Pending Validation. As the claim moves through the payment cycles, the status changes to Pending Submission, Pending Payment, and Paid in Full/Denied.

Billing Codes and classes

Responsible: Changes as the claim goes through the payment cycle.