Getting Started with Billing through DrChrono

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Getting Started With Billing

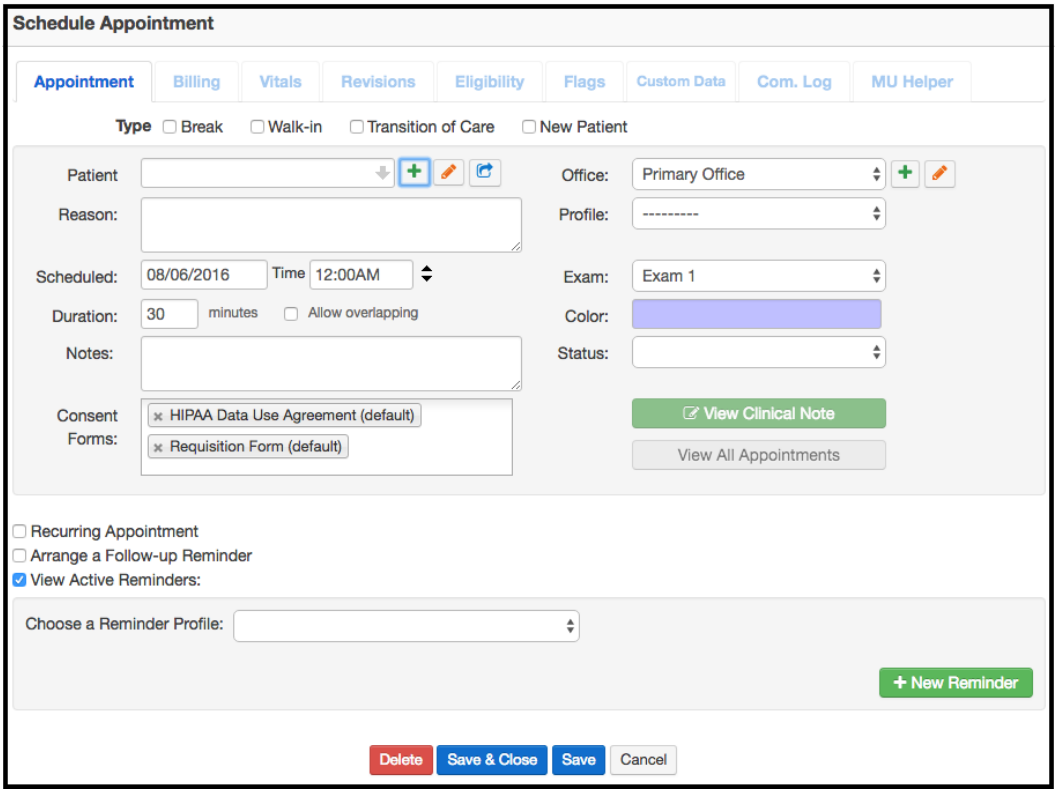
CPT Code Search | Billing Profile

The DrChrono platform centers around patient appointments. It works this way since that is how you interact with patients and bill for the care provided.

First, fill out the schedule appointment prompt created through your scheduling portal.

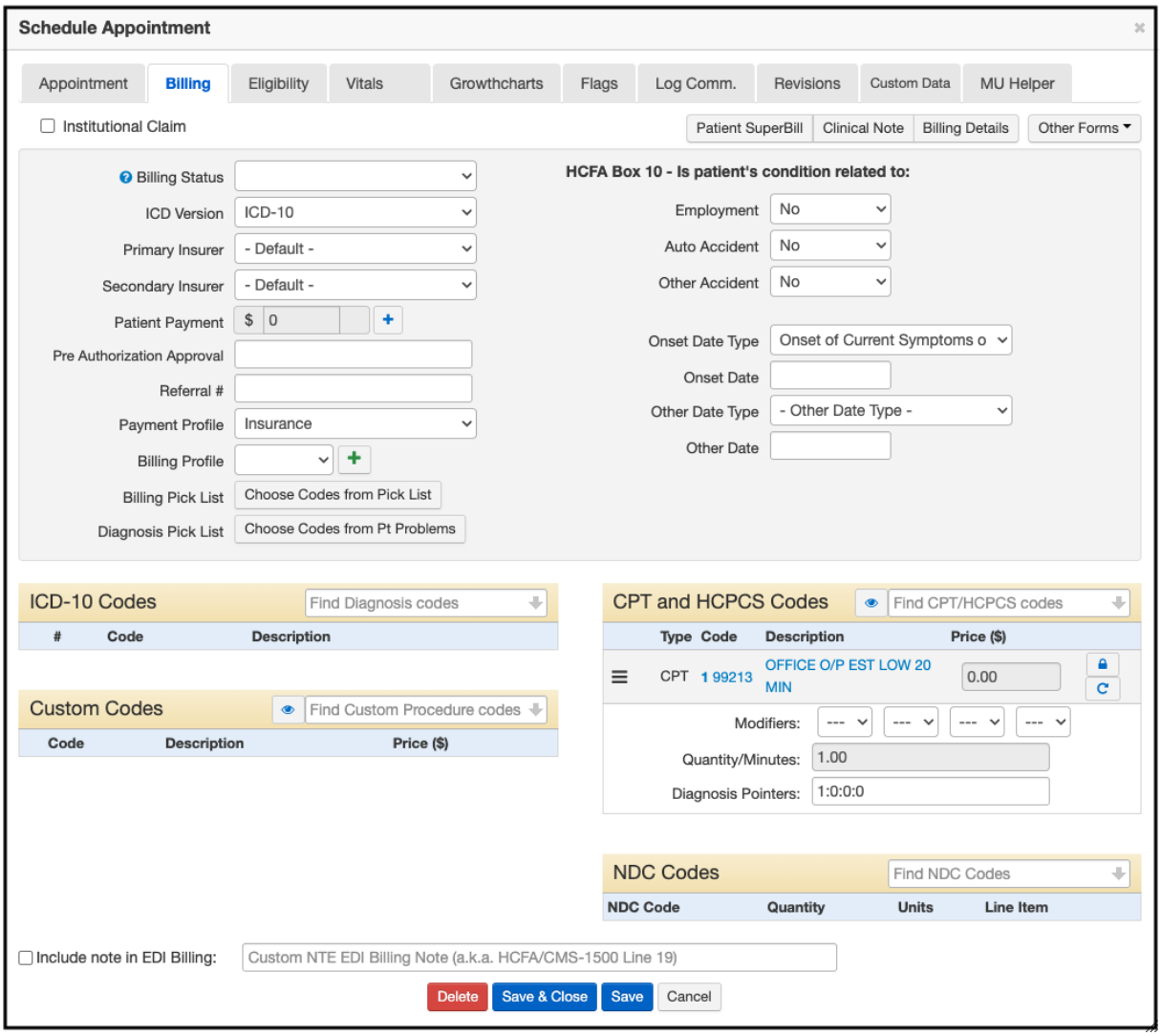
1. Navigate to **Schedule > Calendar > + New Event**
2. Select **Save** after you fill in the appointment details.

> *Note: You cannot navigate to other tabs without first completing and **saving** the basic information in the Appointment tab.*



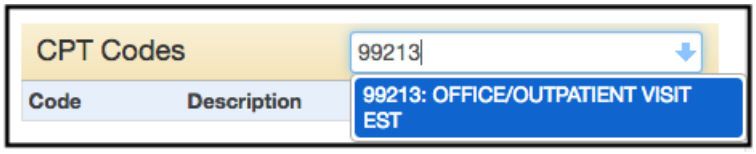
Once the appointment is saved, the "Billing" tab becomes available. Select the **Billing tab** to enter the billing information associated with the appointment.

- **Billing Status:** Refers to how the payment is or has been processed
- **ICD Version**: Refers to the ICD version your practice uses
- **Patient Payment**: Refers to the amount the patient has paid toward the appointment
- **Payment Notes**: A section to add any additional notes regarding the payment
- **Payment Posted Date**: The date the payment was issued
- **Pre-Authorization Approval #:** The number provided by your insurance for pre-authorization. Insurance sometimes requires prior approval for procedures and will require a pre-authorization approval number to consider the claim when it is received
- **Referral Number:** Insurance may require a referral from another physician to treat the patient. The referral number can be entered here.
- **Payment Profile**: The type of payment obtained for the services you provide
- **Billing Profile**: A DrChrono convenience feature that allows you to select from various profiles to pre-populate sections of the billing form that can be customized to your own needs.
- **Billing Pick List**: Commonly used ICD and procedure codes used in your billing
- **Diagnosis Pick List:** Previous diagnoses populated from the patient problems list
- **Employment/Auto/Other Accident**: For insurance and legal purposes, select what accident caused the patient's condition (if applicable).
- **Onset Date Type**: The type of event that caused the onset of the condition
- **Onset Date**: The date of the condition onset.
- **Initial Visit Date**: The first date the patient visited your office for this condition
- **Last Related Visit Date:** The last date the patient visited your office for this condition

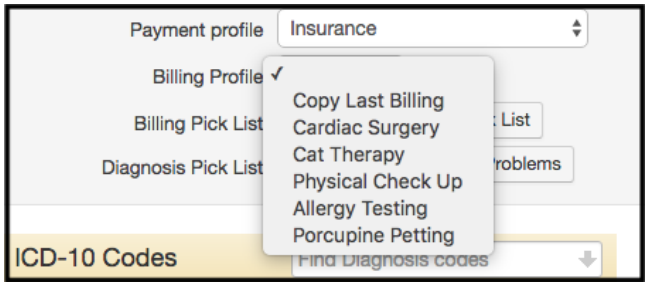


To add an item to charge to your patient, begin by adding the CPT or HCPCS code associated with the service(s) rendered. You can pre-populate the CPT fields by selecting your billing profile through the drop-down menu. If a billing profile is used, additional CPT codes can be added to the appointment through the CPT Code search box.

Using the CPT Code Search:

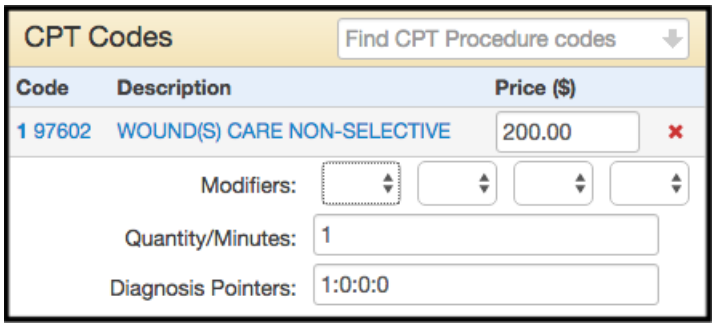


Using a billing profile:

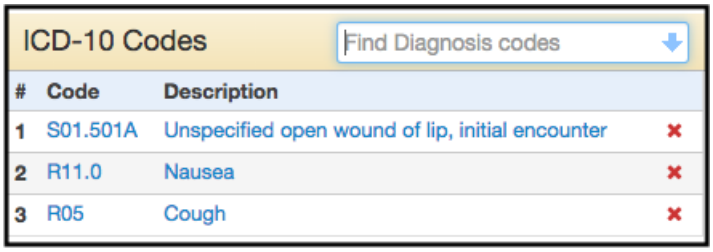


After populating the CPT Code section, you can adjust the procedures.

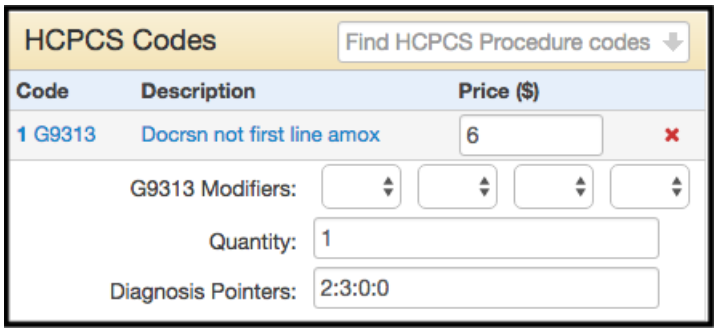
- In the **Price** box, the price per unit is entered, which will be multiplied by the quantity you enter.
- The **Modifiers** option allows you to choose CPT modifiers to attach to the procedure (ie. AF: Specialty Physician"). Modifiers may describe if multiple procedures were performed, where the procedure was performed on the patient, and if there were multiple providers involved in the patient's care.
- The **Quantity/Minutes** box allows you to input a quantity to multiply by the rate determined by your entry in the 'Price' box (ie. Price = $5, Quantity = 60 minutes will result in a $300 bill for a 1-hour procedure).
- The **Diagnosis Pointers** box is important for insurance purposes and refers to the primary ICD-10 code(s) to the CPT/HCPCS procedure billed. The pointer format A:B:C:D points toward the order of the ICD-10 codes you may enter (see below). For example, the format 2:1:0:0 means that the procedure was primarily performed for the second diagnosis listed and secondarily for the first diagnosis listed. By default, the pointer is set to 1:0:0:0, which means the procedure is intended to affect the first item of the ICD-10 code list.



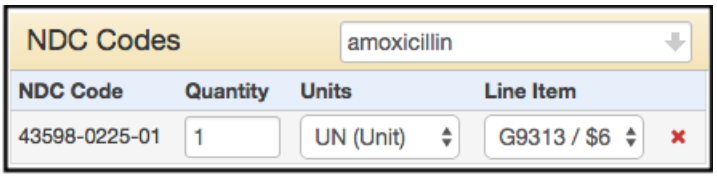
In this example, the Diagnosis Pointer 1:0:0:0 refers that code 97602: WOUND CARE is intended to treat #1 of the ICD-10 code list (below), 'S01.501A: Unspecified open wound of lip ', and indicates that it was performed to treat this particular diagnosis.



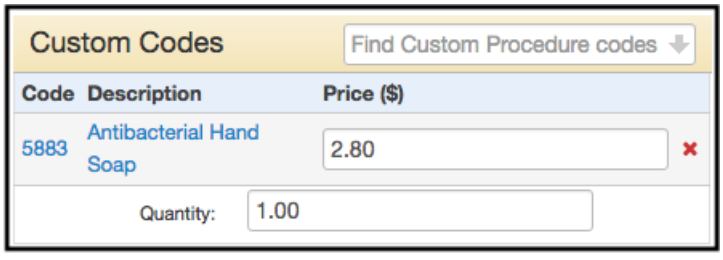
HCPCS codes represent medical procedures to Medicare, Medicaid, and third parties. HCPCS is separated into three levels to represent different services. Level I HCPCS codes are used to bill Medicare or Medicaid and are identical to CPT codes. These CPT codes used for billing Medicare and Medicaid are actually HCPCS codes by definition. Level II and Level III HCPCS modifiers are where CPT and HCPCS really differentiate. You may add your HCPCS codes by searching by keyword or code in the HCPCS Procedure Code search box. Modifiers, Quantity, and Diagnosis pointers work in the same way as CPT codes.



The drugs you use in your procedures can be recorded for insurance billing purposes in the NDC Code box. Search for your drug by keyword or by the 10-digit NDC code. The price entered in the HCPCS section will show up as a line item in the NDC Code section.



If you would like to charge your patients for any other items or services, you can add them by searching by keyword or custom code through the Custom Code search box. If you are unfamiliar with Custom Codes, please feel free to read our guide on inventory and service management.



Conclusion

Once you press Save, if you selected **Bill Insurance** or any of the 5 claim submission statutes (Bill Insurance, Bill Secondary Insurance, Worker's Comp Claim, Auto Accident Claim, Durable Medical Equipment Claim) under Billing Status, your claim will be batched and transmitted to the clearinghouse at their designated time. Claims are submitted 7 days a week, regardless of holidays or weekends. You can view claim progress through the RCM Cycle by watching the claim status in the Live Claims Feed.

