

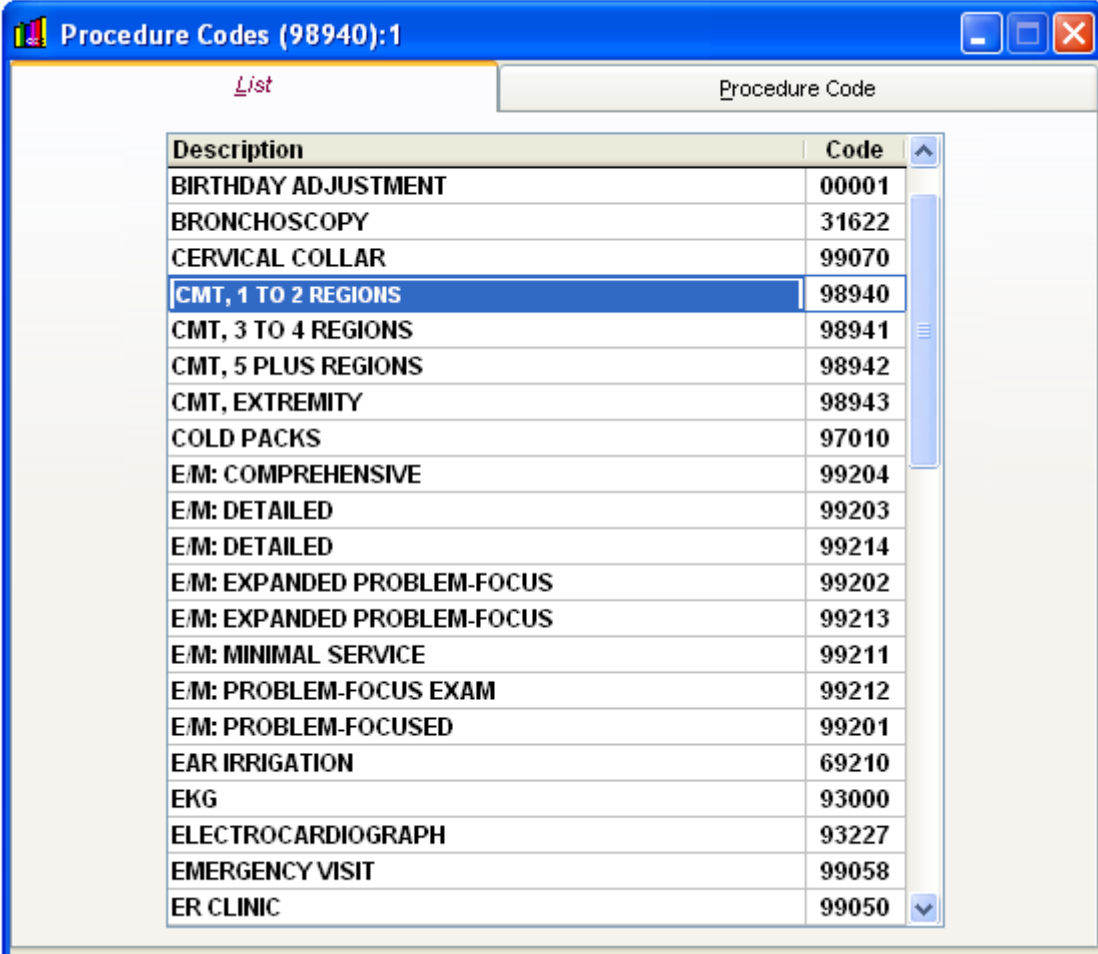
## PROCEDURES & FEES

This list of Procedures is set up in your system to bill services at specific prices. The Procedures can be set to bill the insurance carriers as well as services that stay “in house.” (Examples: supplements, services, purchased items, and payment plans.)

### Add a New Procedure

To add a new Procedure, open up the Procedure screen under Lists

Press the New  icon:



The screenshot shows a window titled "Procedure Codes (98940):1" with a "List" tab selected. The window contains a table with two columns: "Description" and "Code". The table lists various medical procedures and their corresponding codes. The row "CMT, 1 TO 2 REGIONS" with code "98940" is highlighted in blue.

Description	Code
BIRTHDAY ADJUSTMENT	00001
BRONCHOSCOPY	31622
CERVICAL COLLAR	99070
<b>CMT, 1 TO 2 REGIONS</b>	<b>98940</b>
CMT, 3 TO 4 REGIONS	98941
CMT, 5 PLUS REGIONS	98942
CMT, EXTREMITY	98943
COLD PACKS	97010
E/M: COMPREHENSIVE	99204
E/M: DETAILED	99203
E/M: DETAILED	99214
E/M: EXPANDED PROBLEM-FOCUS	99202
E/M: EXPANDED PROBLEM-FOCUS	99213
E/M: MINIMAL SERVICE	99211
E/M: PROBLEM-FOCUS EXAM	99212
E/M: PROBLEM-FOCUSED	99201
EAR IRRIGATION	69210
EKG	93000
ELECTROCARDIOGRAPH	93227
EMERGENCY VISIT	99058
ER CLINIC	99050

The Procedure window allows you to customize many different services you render and allow the functionality of adding these customized procedures on to the patient transaction cards.

**Procedure Codes (98941):1**

List *Procedure Code*

Code  Description

Carrier	Charge	Approved
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Default Charge Amount  Base Units

Min. Appt. Duration  minutes Inactive Date

Place of Service

Type of Service

BS Place of Service

Mods

Inventory Item Number

Taxable Item  Bill Patient Only  Anesthesia Units

Last Update  By

### CPT Code & Description

The Common Procedural Terminology (CPT) code and short description for the service being rendered. Every year the American Medical Association updates the CPT codes. At that time, Clinic Pro users may choose to add procedure codes that have been added to the CPT manual.


For in-house codes not being billed to insurance companies you can specify any 5-character code you wish (Remember to use Bill Patient Only for in-house codes!)

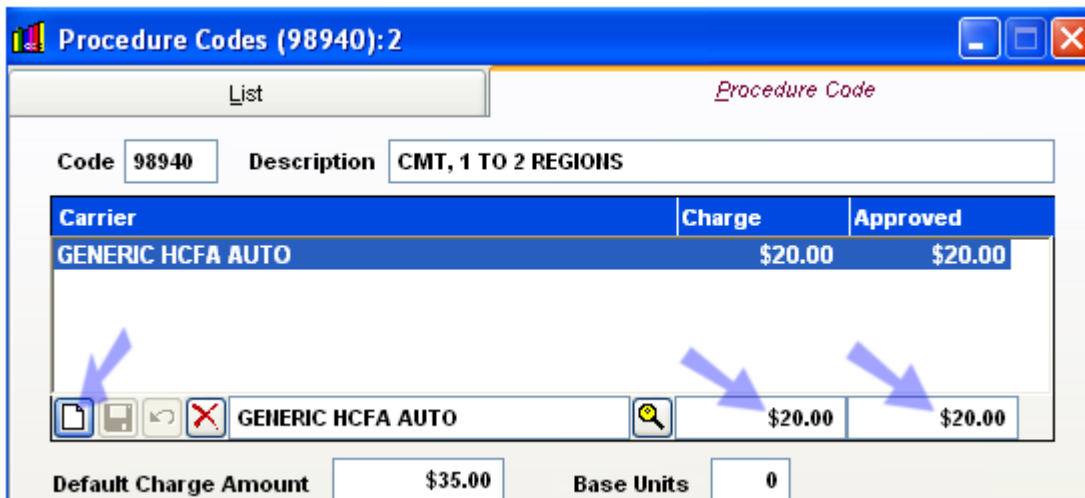
Duplicate CPT codes are allowed; make sure the Description is different.

## Multiple Fee Schedules

The Procedure screen allows you to create multiple fee schedules for individual insurance companies using the same CPT.

**This screen should only be used if you are comfortable with your state's laws in Medical Billing.** By creating multiple fee schedules for different insurance companies, it can be viewed during an audit as charging one patient more than another patient for the exact same medical procedure. In some states this can be a very serious offense. Some exclusions are made for insurance companies that are non-participating and require a different amount be billed in the industry, **Please use this only if you are sure of your state's laws and that it is standard to specify these exclusions.**

To set up a new fee schedule for a procedure, click the New  button, then double-click on an insurance company.



Carrier	Charge	Approved
GENERIC HCFA AUTO	\$20.00	\$20.00

Default Charge Amount: \$35.00      Base Units: 0

Put in the charge and approved amount that the fee schedule shows the insurance company will pay. Save. When entering this procedure code, used as an example, on a patient with this “Generic HCFA Auto” insurance, it will generate a \$20 charge rather than a \$35 charge.

### Default Charge

This is the amount you want to charge for one unit of this service code.

### Base Units

This applies specifically to Anesthesia codes. When entering this procedure onto a patient's transaction card, it will automatically bill this amount of anesthesia units. Leave this field at 0 if the code is not anesthesia.

**Min. Appt. Duration**

Not used currently.

**Inactive Date**

If you would like to add a specific procedural code to your inactive list, place a date in this field. This alleviates having to maintain a list of codes that no longer are utilized in your practice.

**Place of Service**

The place of service codes are determined by the Health Care Financing Administration (HCFA). Code 11 is for a Physicians' Office and a very common place of service to use.

**Type of Service**

This reflects the type of medical care being given. Enter "1" for most medical procedures. The value "4" for Diagnostic X-rays is also used frequently. Click the magnifying glass for more options.

**BS Place of Service**

This is a 1 digit version of the Place of Service code used in some states' electronic billing for Blue Cross / Blue Shield. The equivalent for 11, Physicians' Office, is 3.

**Modifiers**

You may select up to 3 modifier codes to be automatically included every time this Procedure is added to a transaction card. This is helpful for some states' Medicare billing that requires certain modifier codes.

ClinicPro allows you to set up multiple different transactions for the same CPT code, but contain different information. This can be especially useful when billing Medicare and some other Insurance companies that require modifiers be sent.

It can be beneficial to setup a "Medicare" version of a commonly billed CPT code to save time when entering transactions. This "Medicare" version of the transaction can have the modifier codes included, and the "Regular" version does not have them. If you do this, be sure to name these codes distinctly so you don't accidentally add a modifier-filled code to a wrong patient! As seen below, the codes are named to express that the Medicare one contains the Modifier codes attached to it and the regular CMT 98940 does not contain the modifier codes.

Description	Code
CMT, 1 TO 2 REGIONS	98940
CMT: MEDICARE ADJUSTMENT 1-2 REGION	98940
CMT 3 TO 4 REGIONS	98941

**Inventory Item Number**

ClinicPro can keep track of the number sold of a certain inventory item by specifying an inventory ID under the Procedures and Fees screen. By assigning a unique ID in this blank, ClinicPro will keep a counter for each time a procedure with this ID is put on a transaction card. This is helpful for knowing when and how much to order to fully restock items.

**Taxable Item**

By checking this box, you can add the default tax amount to the procedure. The amount of tax you charge will be applied in the SYSTEMS PARAMETER MAINTENACNE screen.

**Bill Patient Only**

By checking this box, this will force the balance of this procedure to be added under patient responsibility, and will never bill to an insurance carrier. This is very helpful for in-house codes, used for things like NSF Check fees, Late Fees, or Supplements.

**Anesthesia Units**

Check this box if the CPT code used is an Anesthesia code.