**ACTIVITY #9: Scheduling and Registration**

Study subjects have to be flagged in both Invision (Scheduling and Registration System) and EMR. Such flagging achieves the following purposes:

- Separates billing streams to Study Accounts and Insurance Accounts
- Tracks study procedures and services for Health Information Management Disclosures
- Creates flags for billers to issue correct claims

Please note that substantial revisions are in works due to the upcoming release of Epic EMR Research functionality. Please follow CTSC Clinical Trials updates for current information.

### 9.1 Review Scheduling and Registration Training Materials

- Policy 2382 “Research Subjects Patient Registration, Healthcare Information Collection, Sharing and Maintenance”
- Policy 2317 “Documentation of Research Patient Status in the Electronic Medical Record (EMR)”
- CTSC SOP 10B “Outpatient Scheduling and Registration”
- CTSC SOP 10A “Inpatient, Emergency and Short Stay Research process for registration and Billing”

### 9.2 Outpatient Studies: Follow CTSC SOP #10B

Refer to the *Coverage Analysis* to determine if there are hospital/clinical charges payable by the study bulk account.
OUTPATIENT Scheduling and Registration: Overview

In order to efficiently separate charges to bulk account vs. insurance account, the UCDHS created a new financial class for outpatient study patients. These research accounts (47-accounts) are used to place study charges that go to the bulk accounts. In cases where the entire study is billed to Medicare or to private insurance, procedures are billed via the patient’s regular insurance accounts (38- or 40- accounts). In this case, no billing to the bulk account occurs, and therefore 47-accounts are not required. 47-type accounts will remain open for 999 days, unless explicitly closed by the research team.
Study charges placed on 47-accounts are never billed to the patient. A 47-account type is opened in the Invision Scheduling and Registration System. This account type is intrinsically linked with the bulk account number. Where an insurance account has a payer plan code, a 47-account has a bulk account number. In addition, 47-accounts carry embedded hospital code RSH (Research) and plan code 121. All together, these components enable the seamless routing of the charges placed on this account type to the bulk account for the study. A coordinator or a MOSC (front desk registration staff) can open the 47-accounts.

Three important things to remember about 47-accounts:

1. DO NOT NEED 47-ACCOUNTS for 100% INSURANCE-BILLED STUDIES.
2. 47-ACCOUNT ROUTES CHARGES TO YOUR BULK ACCOUNT
3. NO BULK ACCOUNT = NO 47-ACCOUNT

47-accounts must be created before scheduling an appointment. These accounts are used for outpatient charges only. This path:

- Enables correct routing of charges to bulk accounts
- Enables placing Lab and Rad orders from EMR
- Enables return of Lab and Rad results into EMR
- Used for those procedures in the Coverage Analysis that are labeled “Paid by the Study”

Outpatient Scheduling and Registration: Step-by-Step

1. Create a 47-account for each study subject. Only studies that bill procedures/services to bulk accounts use 47-accounts.

2. Schedule patient visit on a 47-account. If the visit is billed to the bulk account in its entirety, this visit should be scheduled on that patient’s 47-account. However, in many cases the visit would combine procedures billable to insurance and procedures billable to the study. In this case, two scheduling entries must be created, one for routine care (38- or 40- account) and one for research (47-account). This also applies if the PI is treating the patient for routine care issues (unrelated to the trial) during the same visit.

If patient is double-scheduled, the two appointments could be scheduled only 1 minute apart in Invision. Scheduling the same patient on two types of accounts results in two separate encounters in EMR (“Office visit” and “Research”).
The physician must choose the appropriate encounter to place the orders and make notations. Services billed to patient insurance are documented on the “office visit” encounter and services billed to the bulk account are placed on the “Research” encounter.

3. Add V70.7 diagnosis code to the problem list. V70.7 plays an important role in tracking research study subjects and the protocol-related orders. The V70.7 diagnosis code is especially important when billing Medicare for research procedures. V70.7 placed in different positions on a claim identifies a patient’s participation in a clinical trial and fulfills the requirements for diagnosis reporting per Medicare rules. This code also helps our own Health Information Management to separate research-related procedures and visits from routine care visits for legal purposes.

Even if the research participant is undergoing standard of care (routine) procedures, the diagnosis code V70.7 must be documented and reported along with the patient’s primary diagnosis. ALL protocol-related services and procedures must be associated with V70.7.

**REMEMBER:** V70.7 diagnosis code does not route the *charges* to insurance/bulk accounts. It routes *information.*

Moreover, all orders associated with V70.7 will be excluded from MyChart. This is critically important for double blinded studies and placebo studies.

Additional information with regard to V70.7 codes can be found in the Clinical Trials Newsletters from January 2013, October 2011, and August 2011 ([http://intranet.ucdmc.ucdavis.edu/ctsc/area/ctnewsletters/](http://intranet.ucdmc.ucdavis.edu/ctsc/area/ctnewsletters/)).

9.3 **Inpatient, Short Stays, and Emergency: Follow CTSC SOP #10A**

Refer to the *Coverage Analysis* to determine if there are hospital/clinical charges payable by the study bulk account.

These types of patients do not have alternative accounts. They are admitted using the usual admission process (10-accounts for inpatient, 50-accounts for short stay, 20-accounts for emergency). In order to correctly separate the charges, the UCDHS utilizes the “Bill Hold” process. This means that the bills for those patients that have study-related charges that are payable by study accounts and by insurance are stopped. Next, an itemized listing of services has to be reviewed by a CRC or PI, and the charges manually classified as “insurance” or “bulk.”
1. Once the patient is identified as a study patient, you need to modify a Plan Code for each person in the following manner:

<table>
<thead>
<tr>
<th>Inpatient, Emergency and Short Stay</th>
<th>All charges billed to the Sponsor</th>
<th>All charges billed to the Payer</th>
<th>Some charge billed to the Sponsor and some charges billed to the Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Code (PC)</td>
<td>PC 121 (Research Grants) in primary position</td>
<td>Plan codes as appropriate for the patient’s financial class in the primary and subsequent positions</td>
<td>Plan Code 136 (Research-Needs Review) in the primary position and then other plan codes as appropriate for the patient’s financial class in the subsequent positions.</td>
</tr>
<tr>
<td>Notify MSA unit (CRC/PI Responsibility)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

2. Create the Folder notes, containing contact information of the Principal Investigator (PI), Clinical Research Coordinator (CRC), including name and phone number, the study name and bulk account number (if applicable). To gain access to Folder Notes, submit an on-line Access Request Form. Select “Grant by System” and search for FMS00-C-M (Folder Notes).

In addition, you need to send an e-mail to Medical Services Abstracting (MSA) unit (msaanalystteam@ucdmc.ucdavis.edu) to move the professional charges to bulk accounts as appropriate. The MSA staff will collaborate with the PI/CRC to identify which professional charges should be billed to the patient’s account and which charges should be billed to the bulk account. The charges will be directly posted to the correct account based on this analysis.

9.4 Placing Laboratory Orders and Radiology Orders for Research Patients


When placing lab or rad orders, decide whether to place an order on the Office Encounter or Research Encounter. This placement will determine how charges will be routed.
The orders for Lab or Radiology services ordered in EMR using a regular OFFICE visit and scheduled on either 38- or 40- account, should be associated with a PRIMARY diagnosis and a SECONDARY diagnosis of V70.7. The bills for these research participants will be reported to Medicare (with the V70.7 in the secondary position) in accordance with the Medicare requirements.

Lab or Radiology services ordered in EMR using a RESEARCH visit (and scheduled on a 47- account) should be associated with the V70.7 diagnosis code only. Simply placing the order on a 47-case is not sufficient to complete the lab visit. Phlebotomists at the draw station are not always able to link the order with the account number. Therefore, to ensure that the order is billed to the bulk account correctly, this order must be printed. The printed order should accompany the patient or the sample to the Lab. For detailed process map for lab orders see: http://intranet.ucdmc.ucdavis.edu/ctsc/area/clinicaltrials/processmaps.shtml.

Microbiology and blinded laboratory orders follow a different path. These orders are placed using specially printed Requisition Forms from Department of Pathology. The paper requisition will need to accompany the specimen to be processed. Please make sure that you have completed the intake process with the Pathology Client Services (916-734-7373) prior to starting the study.

Additional information with regard to placing radiology and laboratory orders is available in the Clinical Trials Newsletter, August 2011 (http://intranet.ucdmc.ucdavis.edu/ctsc/area/ctnewsletters/).