CPAR

Training and Reference Manual

2024/2025 AL CPAR Committee

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SECTION 1
PRACTICE MANAGEMENT

Practice Management Introduction & General Overview

Medical practices may be of many types. They can provide very basic medical care, urgent care, emergency care, and/or highly specialized care. Those practices of a more basic type are referred to as primary care. Primary care includes practices such as general medicine, internal medicine, family medicine, obstetrics, and gynecology, etc. Specialty care includes practices such as neurosciences, oncology, cardiology, pulmonary, surgical services, bariatric, etc.

Medical practices can be provided in a solo practitioner setting, group practice setting, single-specialty setting, and/or multi-specialty setting. Medical practices may be owned and operated by hospitals and/or health systems or they may be privately owned organizations. Physicians and other care providers may be employees of an organization, sole proprietors, and/or business partners.

Regardless of the type of care that is provided, patients fall into two basic categories in the context of practice management: new patients and established patients. New patients typically require a more in-depth review of records, body systems, tests, and procedures than established patients with whom the practice is already familiar. New patient visits typically take longer than established patient visits but not necessarily.

The time taken for any patient visit is dependent upon the symptoms and complaints of the patient, whether lab, x-ray or other tests are needed, and considerations for treatment of the diagnosed problem. These basic in-office provider meetings with patients are referred to as evaluation and management (E & M) services. We will learn more about the coding and valuation of E & M services in subsequent chapters.

Medical coding and charging for services provided in medical practice go together. Coding and charging may be performed manually via a “fee ticket” or “superbill” document from which codes and charges are entered. Or coding and charging may occur via documentation in an electronic health record which flows through to the practice management billing system. In both cases, there is typically a reconciliation process in place to be sure that charges for all services are captured and coded correctly in a timely manner. Such operations may include “scrubber” technology which is searching the data for anomalies and producing reports which allow workers to clean up data as soon as possible in the process.

Each service provided is considered a “line item” which will eventually appear on a (Centers for Medicare & Medicaid) CMS-1500 professional billing form to be submitted electronically to the applicable insurance company through which the patient is covered. Each line item has a corresponding medical code recognized by the insurance payer system. Each such item will be processed by the payer and paid according to an agreed upon fee schedule, denied, or possibly applied to the insured party’s deductible or co-insurance. Insurance benefits and coverage determinations will be discussed in more detail in subsequent chapters.

Each medical practice should have an easily understood and very specific financial policy. Such a policy provides information about what is expected from the patient and/or guarantor (person responsible for paying the bill). The patient is often the same as the guarantor. Most medical practice financial policies include, but are not necessarily limited, to the following information:

- Point of service payment for any co-payment due at the current visit
- Point of service payment for any outstanding balance due on from the patient/guarantor for prior services
- Payment for balances due after insurance
- Payment arrangements
- Statement cycles with escalating urgency
- Collection agency referral

It is typical to see a sign prominently displayed in a medical office that reads……

"Payment is due at the time of service unless other prior arrangements have been made".

The Health Insurance Portability & Accountability Act (HIPAA) is a basic part of checking in for a medical appointment. HIPAA forms will be presented for signature along with several other forms to be completed by the patient such as medical history and demographic and insurance information. New patients typically have more forms to complete than established patients but even established patients will need to update all forms at least once a year. HIPAA was passed into law to protect patient's security and privacy. You will learn more about HIPAA throughout your CPAR training.

It is essential that medical practices be able to report a variety of data sets for several reasons. Some reports are required by regulatory agencies, others by hospital and health systems, and others by insurance companies, medical malpractice companies, and professional associations. Some reports related to internal clinical and business operations are required for accountants, business managers, and financial advisors. It is important for providers to monitor their productivity and many other metrics to ensure the medical practice is operated in an efficient, effective, and professional manner.

Preservice Revenue Cycle (Front-End Revenue Cycle)

The preservice revenue cycle includes those aspects of the revenue cycle that occur before the patient arrives for services. This includes, but may not be limited to, the following:

- **Scheduling** – the process of making and confirming with the patient an appointment date, time, provider name, and location and entering applicable data into the scheduling application of the practice management system.
- **Pre-registration** – the process of collecting and entering demographic, insurance, and guarantor information into practice management system.
- **Insurance verification** – the process of collecting current third-party coverage information for the patient to ensure the patient is eligible for benefits and to identify the details of the coverage/benefits and entering this information into the practice management system. This information is requested

from the patient and then verified with the applicable payer source via payer portals, insurance cards, telephonic communication, etc.

- It may be determined during the pre-registration and/or insurance verification processes, that the scheduled service is not covered by the patient's insurance coverage. This may be due to plan specifics or the result of an ABN (Advanced Beneficiary Notice).
  - There are some services that are deemed medically unnecessary and as such an ABN will be generated upon entry of the applicable medical codes to warn the provider that the service/test about to be administered is considered medically unnecessary for the diagnosis provided.
  - This warning gives the provider the opportunity to clarify the diagnosis and more specifically define the medical necessity. Such clarifications may "remove" the ABN.
  - If the ABN is not "cleared", the patient is requested to acknowledge in writing, BEFORE SERVICES ARE PROVIDED that he/she is taking personal responsibility for paying for the medically unnecessary services.

- **Pre-certification/authorization** – the process of contacting the payer to acquire an authorization number for those types of services/procedures which require pre-certification. This number will be required to be on the claim when it is submitted to the payer for processing.
- **Financial counseling** – the process of communicating with patients/guarantors regarding their insurance benefits and any out-of-pocket amounts for which they are held personally responsible to pay. This includes collecting deposits, co-pays, etc. for amounts that will not be paid by the insurance carrier.

Point of Service Revenue Cycle (Middle Revenue Cycle)

The point of service revenue cycle includes those aspects of the revenue cycle that occur at the time the patient arrives for service at the appointed location at the appointed time on the appointed date to be seen by the appointed provider. This includes, but may not be limited to, the following:

- **Check in** – the process where a patient is "arrived" in the practice management system and the medical assistant (MA) or nursing staff is notified that the patient has arrived and is ready to be seen. Most patients will be asked to be seated in the waiting room until their name is called by the MA or nurse.
  - During check in, demographics, insurance benefits, and guarantor information is verified directly with the patient and any updates are recorded in the practice management system. It may be necessary, depending upon updates, to reschedule non-urgent services if suitable financial arrangements cannot be developed.
  - Medical consent, financial responsibility, and HIPAA (Health Insurance Portability & Accountability Act) forms are presented to the patient and signatures obtained.
- **Co-pay collection** – Co-pay amounts identified in the insurance verification process are collected preferably at the time of check-in. In some cases, they are collected at the time of check-out and as a part of making any follow-up appointments and/or scheduling any follow-up procedures/tests.
- **Rooming** – the process where the MA or nurse reaches out to the patient to move to the exam room and/or provider's office. The patient may be asked to wait again once "roomed" and after the MA or

nurse has taken their vital signs, inquired about "today's complaint", and entered the applicable information in the medical record application of the practice management system.

  - There are times when an ABN (see section above) will be generated when the provider orders certain tests/procedures. In such cases, the ABN will need to be "cleared" or the patient will need to sign the ABN and accept responsibility for payment BEFORE the tests/procedures are performed.

- **Patient Care** – This is the time during the appointment when the patient and the caregiver(s) are exchanging information, and the caregiver(s) are examining the patient based on the patient's complaints and/or whatever the caregiver(s) consider necessary to make a differential diagnosis of the patient's ailments/problems. The diagnosis then dictates the course of action that will be taken by the caregiver(s) to help the patient. This may involve prescriptions, additional tests, procedures, and/or referral to one or more specialists. During the patient care process, the caregiver(s) document the patient's medical record, usually electronically.
- **Coding & Revenue Capture** – This is the process through which the care documented in the patient's medical record is reviewed and assigned CTP4, HCPCS, and ICD-10 codes. These codes are documented in practice management/billing systems so that they will be appropriately included on claims sent to insurance companies. Insurance companies evaluate the clinical care provided based on these codes and reimburse caregivers accordingly and in keeping with any contracted fee schedules.
  - CPT = Current Procedural Terminology
  - HCPCS – Healthcare Common Procedural Cody System (HCPCS encompasses CPT)
  - ICD – International Classification of Diseases
- **Check out** – This is the process during which the patient pays any amount due from him/her that was not paid at the point of check in
- **Financial Counseling** – Depending upon the patient's financial circumstances, it may be necessary to engage the patient/guarantor in a discussion about payment options.
  - Schedule of repayments within a specified period.
  - Deposit to "kick-off" repayment plan
  - Financial evaluation for partial or full financial assistance
- **Confirmation of the accuracy and completeness** of applicable demographic, insurance, and guarantor information to insure full collection and resolution of the charges.
- **Follow-up appointments** and/or referrals are scheduled during the check-out process.

Post Service Revenue Cycle (Back End Revenue Cycle)

The post service revenue cycle includes those aspects of the revenue cycle that occur after the patient has received medical services and left the practice. This includes, but may not be limited to, the following:

- **Pre Bill-Review** - Claims scrubber systems are designed to detect issues with claims that are likely to cause the claims to fail the "clean claim" test at the payer. Once claims have been scrubbed and deemed clean claims, they are transmitted to the applicable payers via the 837 EDI transmittal or in some cases on paper.
- **EDI / Billing (837 EDI transmittal file) and/or Paper claim types**
  - **Government Payers**

- Medicare – Medicare is a federal payer system that applies to citizens 65 years and older and some other citizens not yet 65 years of age who qualify for Medicare due to disability, e.g. End stage renal disease (ESRD) and others.
- Medicare Advantage – Commercial payers contracted with CMS to offer Medicare coverage to Medicare-eligible individuals. Benefits may, or may not, be equivalent to traditional Medicare.
- Medicaid – Medicaid is a state program payer that receives matching federal funds but only applies to the citizens of the applicable state. The qualifications for Medicaid include such things as income, family size, medical conditions, etc.
- Managed Medicaid – Medicaid claims/benefit adjudication is most often administered through contracted companies such as Amerigroup, Peach State, etc. These companies' contract with hospitals and medical providers based on state Medicaid fee schedules.
- Tricare – Tricare is the payer for those who served in the armed forces and their dependents. A person who reaches the age of 65 and is a veteran will likely have Medicare and Tricare for Life.

- **Managed Care**
  - This category includes insurance plans offered by various payers that have contracted with hospitals and providers to pay contractually agreed-upon fees for services provided to their members. These plans include Point of Service (POS), Preferred Provider Organizations (PPO), Health Maintenance Organizations (HMO), Exclusive Provider Organizations (EPO), etc.
  - These plans typically require members to obtain services from in-network providers to be fully or partially covered for the applicable services and for claims to be paid to providers.
  - HMO plans require members to use in-network providers or risk being held personally responsible for full payment for services.
- **Commercial**
  - This category includes fee-for-service insurance plans which have been disappearing from the market in the last decade. These plans typically have "rich" benefits and high premiums.
- **Marketplace/Exchange**
  - These plans are offered because of the Affordable Care Law passed into law in 2012.
    - Federally funded exchange plans are those offered on the healthcare.gov marketplace in states that did not choose to take Medicaid expansion. Premium subsidies may be available for low-income families during the 3-to-4-month period the marketplace is open for people to apply for, and gain, coverage. This period is typically between mid-November and mid-March.
    - State-branded exchanges are those offered in states that accepted Medicaid expansion. Premium subsidies may be available for low-income families during the 3-to-4-month period the marketplace is open for people to apply for, and gain, coverage. This period is typically between mid-November and mid-March.

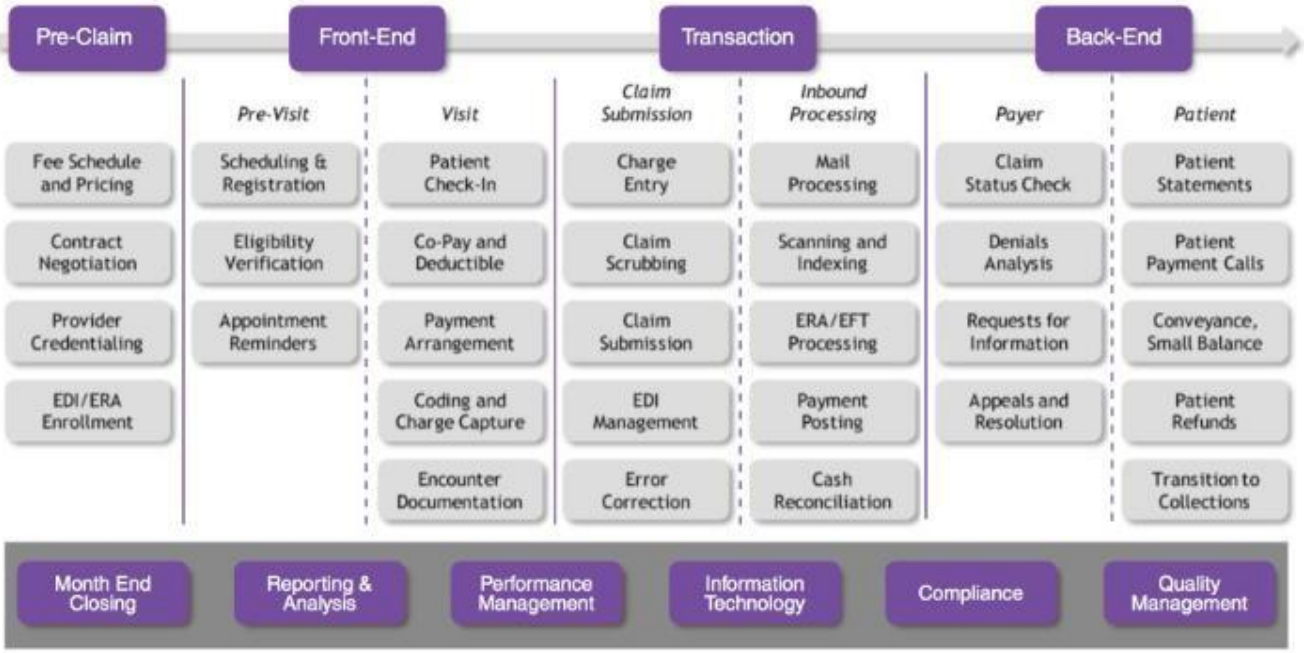
- **Worker's Compensation (WC)**
  - WC is not an insurance plan. WC is a medical/legal system designed to compensate persons experiencing work-related injuries and/or sicknesses. WC coverage is determined by the employer's worker's compensation carrier according to the worker's compensation legal state statues. WC covers only those medical services provided that are directly related to the injuries/sicknesses that have been deemed authorized under the WC case.
  - WC may be awarded for a specified period including for the remainder of a person's life for the applicable injuries/sicknesses. States have established WC fee schedules. These fee schedules are the basis for payment when WC claims are submitted by healthcare providers. There are WC managed care plans in various states which attempt to contract for a percent of the state fee schedule.
- **Veteran's Administration (VA)**
  - The VA serves patients with military service-related injuries/sicknesses. Services provided by non-VA providers must be pre-approved by the VA before services are rendered. VA hospitals are not supposed to authorize services outside the VA system unless the necessary services are not offered by the applicable VA facilities and providers.
- **Liability**
  - Motor Vehicle/Accident (MVA)
    - Automobile insurance typically contains some medical coverage to protect drivers in case of an accident in which someone is hurt. This coverage varies from state to state and is governed by state statute.
  - Other Lability Coverage
    - Persons injured on public property such as a fall in the parking lot at a shopping center may be eligible for medical care covered by the property owner's medical coverage.
    - Persons injured on private property such as a fall on the sidewalk of a property owner's home may be eligible for medical care covered by the property owner's medical coverage.

- **Follow-up**
  - This process is dedicated to monitoring unpaid/unprocessed claims for timely and accurate payment from third-party payers of all types. Follow-up strategies are typically based on account balance amount, age from time of service and/or billing, and expected payer source. For example, a clean Medicare claim typically pays within 21 to 30 days, so any Medicare claims not paying and/or denied/rejected during this time frame warrants investigation and work effort.
  - Denied/rejected claims need to be reviewed for "next steps" in a timely manner to facilitate cash flow, maintain appropriate AR days and appropriate AR aging.
- **Posting Payments & Adjustments**
  - As payments are received via the EDI 835 transmission file, the lockbox and/or actual checks, they are posted to applicable patient invoices and applicable contractual adjustments are processed.

  - This process typically results in any remaining balance due being transferred to the patient liability "bucket" such that applicable patients will begin to receive statements.
  - Patient amounts paid at the point of service are typically posted to patient invoices in a centralized payment posting operation even though receipts are given to the patients at the point of service.
  - Payment Variances occur when a payment is received but it is not an amount that was expected based on the applicable fee schedule. These variances need to be investigated to determine if they are acceptable, require further action and/or need to be reported to those who negotiate contracts. Payment variance trends are monitored and discussed with payers to resolve issues interfering with proper processing and payment of claims.
- **Patient Balances**
  - Once insurance payments and applicable adjustments have been posted and any remaining balance is due from the patient, statement cycles are "kicked off" and patients begin to receive statements at assigned intervals typically with increasingly strong verbiage requesting payment. These statements will result in partial or full payment. Or these statements may be ignored by the debtor and result in no payment.
- **Customer Service & Collections**
  - The customer service and collections staff typically work based on inbound and/or outbound dialer strategies. Regardless of whether there is dialer technology or not, customer service accepts incoming inquiries from patients and collection staff make outgoing contacts with patients to collect past due balances.
  - Financial Assistance may be one of the options offered to patients with outstanding balances and limited resources. The customer service representatives (CSRs) typically negotiate terms for repayment of outstanding balances based on the financial policies/procedures established by the organization.
  - Medicaid and/or SSI Disability qualification may be offered to patients who are determined to be eligible for such programs.
  - Charity Care may be one of the options offered to patients who are not able to establish plans for repayment, qualify for any form of agency assistance and/or otherwise be able to pay their outstanding debt.
  - Patients who do not respond and engage in good faith efforts to resolve their outstanding balances typically find their balances placed with an outside bad debt collection agency.

Healthcare Revenue Cycle Flowchart

An efficient revenue cycle management system is a win-win for patients and providers. The revenue cycle starts when a patient makes an appointment for services, and it continues until full payment has been remitted. While the healthcare revenue cycle flowchart is unique to each organization, some fundamental characteristics remain unchanged. The four main sections of the healthcare revenue cycle flowchart include pre-claim, front-end, transactional and back end.


Pre-Claim
Front-End
Transaction
Back-End
Pre-Visit
Visit
Claim Submission
Inbound Processing
Payer
Patient
Fee Schedule and Pricing
Contract Negotiation
Provider Credentialing
EDI/ERA Enrollment
Scheduling & Registration
Eligibility Verification
Appointment Reminders
Patient Check-In
Co-Pay and Deductible
Payment Arrangement
Coding and Charge Capture
Encounter Documentation
Charge Entry
Claim Scrubbing
Claim Submission
EDI Management
Error Correction
Mail Processing
Scanning and Indexing
ERA/EFT Processing
Payment Posting
Cash Reconciliation
Claim Status Check
Denials Analysis
Requests for Information
Appeals and Resolution
Patient Statements
Patient Payment Calls
Conveyance, Small Balance
Patient Refunds
Transition to Collections
Month End Closing
Reporting & Analysis
Performance Management
Information Technology
Compliance
Quality Management

SECTION 2
PATIENT ACCESS SERVICES

Introduction to Patient Access

Patient Access is the process by which a patient receives access to medical care from a healthcare organization (i.e. outpatient facility, urgent care, physician office or hospital). Patient Access Professionals are usually the patient's first exposure to the facility. Patient Access is a critical function in all healthcare provider organizations. It has a direct impact on:

- Patient Identification
- Patient Safety by Ensuring Correct Patient Identification
- Employee Engagement and Retention
- Accuracy of Registration to Produce Clean Claims
- Reduction in Duplicate Medical Records
- Streamlining Process to Reduce Wait Times and Increase Patient Satisfaction

To yield optimum positive results the following recommendations should be considered for front end processes:

- All access departments should be properly aligned. (i.e. scheduling, pre-registration, insurance verification, pre-certification, point- of-service and financial clearance)
- Systems should safely interface to ensure a seamless flow from one application or process to another.
- There should be on-going compliance and quality assurance.
- Staff should receive continuous education on changes and management should recommend and support outside certification programs (i.e., CPAR, CFC, CHAA, and CHAM).

With the increased complexity of Patient Access responsibilities, strong emphasis is being placed on hiring highly qualified managers and team members. Access processing has become the following:

- Patient Identity and verification of identity-utilizing robust probability systems and biometrics. In addition to confirming two patient identifiers, by conducting a proper search.
- Initiating the medical record (ADT Data Capture)
- Obtain Insurance information and eligibility verification.
- Generate a financial estimate.
- Providing patients with a cost and estimated responsibility
- Armband Verification (Spell back of Full Name and DOB from patient)
- Signing and Scanning of Compliance documents

There are many forces that impact the method patients are processed, requirements of registration and decisions made by management. These forces include:

- Increased federal and state regulations require Access staff to educate patients about their rights, give HIPAA privacy notices ad provide information on Advanced Directives and Billing processes.
- Increased participation in managed care requires Access to be experts in insurance verification, pre-certification, and referrals.
- Shorter lengths of stay demand more up-front processing to efficiently manage the patient's account prior to discharge.
- Upfront collections prior to or at the point of service

- Reduced reimbursement from third party payers requires a more aggressive approach to managing financial reimbursement from patients and insurance companies.
- Increased information requirements to process a complete clean claim, such as Medicare Secondary Payer Questionnaire (MSPQ) information to determine coordination of benefits with Medicare.
- Accuracy of information provided at the time of registration.
- Medical terminology and coding
- Insurance guidelines and requirements
- Duplicate MRN's and overwrites.

To preparing to become a Certified Patient Account Representative, the Patient Access portion of this manual will include the following processes:

- Scheduling
- Pre-Registration
- Insurance Verification
- Pre-Authorization
- Registration/Admission
- Financial Counseling and Financial Clearance
- Customer Service
- Point-of Service Collections

Better performing hospitals ensure that most scheduled patients are pre-registered, insurance is verified, pre-authorization requirements are met, and patient liability is determined and point of service collections is complete. Each of these processes is addressed in the CPAR preparation. However, the order of occurrence may differ by facility.

There are laws, regulations, and processes that either impact Patient Access or Patient Access is involved in the function. The following topics and/or terms will be addressed separately at the end of the Patient Access Section.

- Emergency Medical Treatment and Active Labor Act (EMTALA)
- Meaningful use
- Medicare Secondary Payer
- The Importance of Patient Identification
- Wayfinding
- Telephone Consumer Protection Act (TCPA)
- HIPAA Notice of Privacy Practices
- Advanced Beneficiary Notice
- Important Message from Medicare
- Call Centers
- Affordable Care Impact on Patient Access
- Patient Access Impact to Billing forms CMS-1500 and UB04
- Special Payer Requirements
- No Surprises Act

Scheduling

Scheduling is defined as the process by which a patient is allotted time for elective or urgent services ordered by a physician. In addition to a patient's allotted time, other resources (i.e. equipment) may also be determined in this process. Scheduling may be totally decentralized, partially centralized, or totally centralized. The reporting structure may vary from hospital to hospital with some scheduling departments reporting to the clinical department and some reporting up through patient financial services.

The physician or physician office staff should provide enough information to identify the patient in the master patient index, schedule the patient for the ordered test or procedure, verify insurance, validate, or obtain the pre-certification and/or referral and ensure that medical necessity has been met. Required information may vary from hospital to hospital.

The physician and/or physician office staff should provide schedulers with the following information:

- Patient demographic information (name, date of birth, address, phone, etc.)
- Service/procedure requested (CPT code preferable to ensure the correct test is scheduled)
- ICD-10 diagnosis code with description (ensuring medical necessity is met before the appointment is placed on the schedule)
- Ordering physician information
- Insurance information (ID# and Group# preferable to run real time eligibility and benefit information)
- Patient status (or expected status after procedure takes place)
- Any known additional resources to be utilized (examples include room, physician, equipment, or outside representative)
- Any additional data as it relates to a specific procedure or patient safety (example: allergies to contrast)
- Pre-certification authorization or clinical information needed to obtain pre-certification (preferred)

In addition to the above information, a physician order or referral must be obtained for a requested appointment to be considered complete. The test scheduled, the test performed, and the test billed should all matches. A valid physician order as defined by CMS regulations must include:

- Patient Name
- Patient Date of Birth
- Procedure/Services
- ICD-10 diagnosis code and description
- Physician Signature with Date/Time

Some scheduling departments combine the pre-registration, insurance verification, pre-certification, and collections functions. If these access functions are not completed during the scheduling call, systems must be in place to pass the information to downstream areas who handle these functions (i.e. pre-registration or pre-authorization team).

Call Centers

Call Centers allow an opportunity to centralize and complete registration during the scheduling process. This ensures patients are seen quickly and can be fast tracked when they arrive for their appointment. One call will allow the Patient Access staff to gather all the information needed to register the patient, verify the patient's

insurance, calculate the patient's liability, collect the patient's liability, and refer to the appropriate resources to financially clear the patient for services. In some call centers the patient access staff also make presumptive charity decisions. When the patient presents on the day of service, wait times are reduced as the process is changed from registration to a check-in process.

Some hospitals have expanded the Call Center where they cater to new patients and have a welcome line. The welcome line may assist patients with locating new doctors in the area.

Pre-Access/Pre-Registration

All hospitals should create a Pre-Access/Pre-Registration process designed to capture all data necessary to expedite the patient's ability to pay or meet hospital financial requirements. Several effective methods to pre-register a patient is:

- Web-site-on-line registration
- Face to Face
- Telephone
- Fax
- Mailed pre-registration forms.

Pre-Access/Pre-Registration should include the following information to meet requirements for registration, insurance verification, and pre-certification:

- Name, address, telephone number and e-mail address.
- Date of birth
- Social security number
- Next of kin
- If the patient is the guarantor, next of kin information is needed (name, address, telephone number and date of birth)
- Employment status
- Employer information (name, address, and telephone number
- Guarantor information (if not the patient)
- Advanced Directive information
- Organ donor information
- Language preference
- Race
- Primary Care Physician name
- Privacy status

Guarantor Information

If the guarantor is different from the patient, the following information is needed:

- Name, address, telephone number and e-mail address.
- Date of birth

- Social security number
- Employer information (name, address, and telephone number)

Insurance information

- Name, address, and telephone number of insurance company.
- Name of insured/subscriber/sponsor
- Birth date of insured/subscriber/sponsor for the insurance plan
- Relationship of insured/subscriber/sponsor to the patient
- Policy or contract number (suffix or prefix, if applicable)
- Group number and group name.
- Payer ID
- Retirement date (if applicable)
- Claim mailing address.
- Pre-cert agency and telephone number
- Pre-certification/authorization number
- Accident type, date, state, and location
- Medicare Secondary Payer questions (for all Medicare beneficiaries)
- Coordination of Benefits information

Other Essential Information

- Name of ordering/admitting physician and other physician information required by the facility.
- Diagnosis code/chief complaint
- Admission date or date of scheduled service
- Special needs
- Occurrence code

Once the required information has been obtained the information is used to:

- Verify the patient's insurance.
- Determine pre-certification and authorization requirements.
- Provide pre-registration and pre-certification information to the appropriate departments.
- Notify the patient of any services that do not meet Medical Necessity/Authorization requirements and complete any Advance Beneficiary Notice of Non-Coverage (ABN)/waivers, if applicable
- Provide patients with information on the time and location of the scheduled procedure.
- Provide patients with pre-operative or preparatory information.
- Provide financial estimate to the patient for services and determine if financial counseling is needed.

Patient Identification

Validating patient identity is crucial to the continuity of patient care, patient safety through the reduction of patient record errors and minimizing fraud in the healthcare facility.

Patient identity is typically initially validated via government-issued identification card (driver's license, passport, military ID). Subsequent validations depend on the organization's choice of identification mechanism.

Subsequent identification validation mechanisms:

- Manual inspection of government-issued identification card
- Manual inspection of healthcare system-issued identification card
- Patient Identity Management Solution (technology that uses unique identifiers to subsequently identify patients. These solutions require an initial enrollment, usually at patient's initial visit to the healthcare facility.)
    - Smart Cards
        - A card with an embedded chip that can store information and be used for identification.
    - Magnetic Stripe Cards
        - Magnetic stripe cards store information on magnetic material that can be read and written when swiped.
    - Phone Apps
        - Smart phone apps can be associated to a unique identifier. A downloadable patient application can scan a unique QR code generated by a patient identity management solution.
    - Biometric technology
        - Fingerprint
        - Palm Vein Imaging
        - Iris Mapping

Why is Poor Patient Identification an Issue?

Poor patient identification may result in identification errors. Identification errors result in:

- HIPAA violations
- Compromised patient safety.
- Successful intentional fraud

HIPAA Violations:

- Selecting the wrong patient from the Master Patient Index (MPI)
    - The current patient now has the wrong person's Personal Health Information (PHI).
    - The wrong patient, if error not caught, receives bill for visit they didn't have, and they now have PHI for the other patient in their possession.

Patient Safety:

- Selecting the wrong patient from the MPI
    - The wrong health information will be used in treatment, missing any allergies and prior health concerns, which could be deadly.
    - The wrong health information now populates the wrong patient's record so that when they present it in the future, the wrong information will be used to treat them.
    - If the patient is a bedded patient and the patient whose MPI was erroneously used presents for care, their record will not be readily available.

Incomplete or Incorrect Medical Record Terminology

- **Duplicate** – more than one entry or file for the same person in a single facility. The patient has more than one facility-level identifier, usually referred to as a medical record number.
- **Overlap** – more than one MPI entry or file for the same person in two or more facilities within an enterprise. The patient has more than one enterprise-level identifier, sometimes referred to as a Corporate Identification Number (CIN), Corporate Patient Identifier (CPI), Enterprise Identification Number (EIN), etc.
- **Overlay** – One MPI entry or file for more than one person, i.e. two people are erroneously sharing the same identifier).

With today's healthcare environment moving toward Health Information Exchanges (HIE), the importance of positive patient identity increases, as the impact is beyond the healthcare organization, it crosses to pharmacies, other healthcare organizations, etc.

Selecting incorrect insurance plan codes is the main source of delayed reimbursement. Incorrect or missing patient and/or insurance information can lead to incorrectly selecting the correct insurance plan code. Reimbursement can be improved by obtaining basic information from patients to provide accurate data to the insurance company when verifying coverage of services. The following should be gathered directly from the patient or a knowledgeable family member and furnished to the insurance company:

- Insurance card (scan front and back or copy front and back)
- Correct spelling of patient's and insured's first, middle and last name. It is important to compare this with the spelling indicated on the insurance card, as it could be different.
- Patient/insured social security number.
- Patient/insured birth date
- Relationship of insured/subscriber/sponsor to the patient
- Insurance plan policy and group name and number, gathered directly from the insurance card suffix or prefix, if applicable
- Correct claim-mailing address, often this can be different from what is on the insurance card. The best practice is to select from the insurance table within the ADT system.

Registration and Admissions

There is often confusion over the term's "registration" and "admissions." Generally, registration refers to the process of gathering all the information to process an outpatient and "admission" refers to gathering all the information to process an inpatient. Many patients are being scheduled on an outpatient basis. Therefore, the term registration is used instead of admission. Registration prior to services (Pre-Registration) is the optimal way to expedite the Access process. However, if pre-registration has not occurred, the Access team should obtain the information outlined in the pre-registration section above from the patient as they present for services. When a patient presents for services, the Access team should:
Request a government issued photo ID and insurance card(s), obtain demographic and financial information - For existing patients, the demographic information would be validated and updated as needed.

- Assign/verify eligibility of appropriate insurance plan codes.
- Scan the government issued photo ID and front and back of the insurance card(s)
- Complete the appropriate Access documents, which include but are not limited to the Advance Directive, HIPAA Privacy Notice, Medicare Secondary Payer Questionnaire (MSPQ), Medicare and Champus/Tricare beneficiary notice.

- Obtain signature manually or electronically for Assignment of Insurance benefits and release of medical information to the appropriate third parties, this form is also known as the Annual Acknowledgment
- Obtain signature manually or electronically for any additional waivers or Advanced Beneficiary Notices (ABN's)
- Provide patient with appropriate literature which include but are not limited to HIPAA Privacy, Medicare Beneficiary Notice, About Your Billing and Patient Rights and Responsibility
- Collect any Financial Estimated Amount- co-pays, deductibles, co-insurance, outstanding balance and/or self-pay amount. This amount is determined during the pre-registration process or calculated at the time of service.
- Offer any applicable prompt pay amount for non-insured or under-insured patients.
- Refer the patient to the Financial Counseling team if the patient expresses an inability or difficulty in paying the estimated amount due. Financial counseling will conduct a financial assessment and provide options not limited to but to include financial and charity assistance programs for qualified applicants.

Name Importance, Date of Birth, and Insurance Plan Selection

The most important responsibilities of Patient Access are ensuring proper identification of the patient by accurately spelling the patient's full name (first, middle and last), ensuring the date of birth is correct and the appropriate insurance plan has been selected. The patient's legal name should always be used when registering patients.

Name Importance

- When a patient is registered into the Admission, Discharge, and Transfer (ADT) system for the first time, a medical record number is automatically created, and the patient is saved into the Master Patient Index (MPI). All subsequent registration, by selecting the correct patient will link the patient to the existing medical record number.
- To avoid creating duplicate medical records, conduct a proper medical record search of the MPI to ensure the patient doesn't already have an existing medical record number. It is highly recommended that the search be conducted using probability software to increase the accuracy of the search.
- If the patient cannot be in the MPI, conduct a second search, double check for misspelling of the information entered. In addition, for women, inquire if the name has changed due to a marriage or divorce. For children, inquire if the child was born at the facility for which the current services are being done. If the answer is yes, a new search should be conducted with the previous name used and updated accordingly.
- Selecting the correct patient ensures the correct person is treated, the correct insurance is billed, and the patient's personal health information (PHI) is kept confidential and protected.
- Ensuring the correct person is selected practices patient safety:
    - Reduces misidentified patients.
    - Improves quality of care by ensuring the correct person receives the correct care timely.
    - Ensures the organization is compliant from a HIPAA standpoint.
    - Ensures timely reimbursement for services rendered from insurance payer.
    - Increases productivity and patient flow.

Insurance Plan Selection

One of the most important functions for Patient Access is ensuring the revenue cycle flows seamlessly. By selecting the correct insurance plan code and filing primary and secondary plan(s) appropriately to each registration, ensures the following:

- Timely filing and reimbursement
- Reduction in re-billing due to denials
- Timely pre-authorization/pre-certification

Insurance is a complex area of registration due to constant changes being mandated from insurance payers and the increased amount of insurance plans to choose from. The following are suggestions to assist registrars with the insurance selection process as follows:

- Maintain an insurance plan code directory for team referral.
- Utilize accuracy software to provide real-time feedback of the errors to ensure prompt correction.
- Offer ongoing training and education around insurance and plan codes.
- Providing actual copies of the cards and updated information to accompany the card.
- Conduct Insurance Audits: include front line registrar to serve on audit committee.
- Offer specialty training and education based on the audit finding.

Insurance Verification

Insurance verification is a necessary process in the Revenue Cycle. The purpose of insurance verification is to avoid any surprises, both for the medical provider and the patient. It is a simple fact of the healthcare revenue cycle: Insurance eligibility drives payment. In the absence of proper eligibility determination, countless downstream problems are created which include delayed payment, rework, decreased patient satisfaction, increased errors, and potentially, non-payment.

If the patient has expired coverage, or limited coverage that will not cover the services being performed, the facility must be aware of this if possible. Payment arrangements will need to be made with the patient prior to treatment. Insurance verification is the foundation of pre-certification, pre-registration, and pre-notification.

For efficiency purposes, providers are installing automated insurance verification systems. There are many third-party vendors who offer these products. When an account is registered, the insurance verification request can be sent out to the payer and most times returned while the patient is still available. However, the return information is dependent on the payer's response time and varies by payer. Even if the verification information returns and the patient has moved through the registration process and into another area of the facility, the information is still valuable to ensure the first bill goes out to the right payer with accurate information. Affecting overall collection efforts is also putting in place a collection of co-payment and deductible during the initial patient access experience.

The critical validation points of insurance verification, pre-certification and prior authorization are determining factors if a hospital will be paid for its services. Effectively identifying primary, secondary, or tertiary insurance coverage upfront can help prevent denied claims and the rework involved to recover lost revenue. Insurance verification impacts the patient's experience. If coverage is accurately verified and billed, the guarantor is not

unnecessarily billed for services that their insurance may not cover. Insurance verification requires a thorough understanding to ensure these functions are completed with efficiency and accuracy.

It has become challenging to determine the various types of insurance products. Some organizations rely on integrated eligibility systems to validate active coverage and plan types on the date of service, which allows employees to accurately identify insurance coverage. Insurance plans consist of HMO, PPO, indemnity plans, and other managed care products. Also, it is important to understand the requirements of government healthcare programs such as Medicaid, Medicare, Tricare, and the healthcare insurance exchange.

It is crucial that healthcare providers understand the importance of insurance verification and authorized services in the healthcare industry to maximize reimbursement. Patient Access has the front-end responsibility of confirming eligibility and securing authorization before the claim is billed to avoid denials.

The information gathered during the pre-registration or registration process is used to verify insurance benefits and pre-authorization requirements. Verification of insurance benefits is recommended for all patients prior to services being rendered, except when EMTALA (Emergency Department), laws apply. This process helps to expedite the entry process and eliminate any unnecessary waits or unexpected problems with insurance benefits or pre-authorization. Best practices complete insurance verification prior to service for a large portion of scheduled patients. Each facility should determine which patient types are most beneficial to pre-register and verify benefits prior to service. This process should be supported by sound policies and procedures and supported by Revenue Cycle leadership.

There are several methods used to verify insurance coverage:

- Review the insurance card.
- Contact the payer directly.
- Utilize payer websites or portals.
- Automated systems.

To identify the correct insurance payer, Patient Access staff must review critical data elements from the insurance card, payer website or interview the guarantor or subscriber if an insurance card is not present. When registering patients with insurance cards, employees obtain pertinent information from the card. The following information may be found on most insurance cards:

- Insurance plan information (i.e. Cigna PPO)
- In-network or out of network information
- Group name and/or number that correlates to an employer.
- Name of primary care physician
- Co-pay, coinsurance, and deductible amounts
- Address to submit the claims.
- Authorization requirements
- Customer services and pre-certification/authorization phone numbers

Insurance verification should obtain the following information:

- Benefit levels – Verify coverage exists and the amount of coverage for the services being provided. Example: Patient is covered by insurance but has no maternity benefits and the patient is being admitted for a delivery.
- In-network/out-of-network – Determine in-network and out-of-network benefits for the facility. If the facility is out-of-network, determine if any out-of-network benefits are available and if so, amount of the benefits.
- Dependent coverage if a dependent is the patient.
- Deductible, co-insurance and co-payments.
- Out-of-pocket maximums
- Effective dates of coverage, from and through
- Pre-certification/authorization and referral requirements
- Age limits for dependents – The Affordable Care Act increased the age to 26.

Coordination of benefits (COB) is a necessary determination in the verification process. This is the process by which a health insurance company determines if it should be the primary or the secondary payer of medical claims for a patient who has coverage from more than one health insurance policy. The following are rules used to determine the order of insurance as primary or secondary.

- Under the Birthday Rule, the parent with the first birthday in the calendar year (year of birth is not considered) is used to determine primary payer where a dependent is covered under both parents. (i.e. Mother's birthday is May 1st and Father's birthday is July 31st. Mother's insurance is primary).
- The Insured Dependent Rule applies when the patient (over 18 years) is the subscriber to a policy and is covered under another policy such as a spouse. The subscriber on a policy is primary.
- The Medicare Secondary Payer Questionnaire (MSPQ), a requirement of Medicare is used to determine the order of payment for patients with multiple sources of payment.
- Worker's compensation is primary for services provided because of an employment related injury or illness.
- Medicaid is always the payer of last resort.

Pre-Certification/Pre-Authorization

The terms pre-certification and pre-authorization are used interchangeably. It is a determination by the health plan that the recommended medical services, supply, or drug meets the definition of medical necessity. Medical necessity is used to describe care that is reasonable, necessary and/or appropriate. Certain services such as diagnostic studies, hospital admissions, and pharmacy require pre-authorization/pre-certification prior to services being rendered.

Pre-determination is like pre-authorization as it allows services or treatment to be reviewed for medical necessity. In this process, benefit coverage is determined before services are rendered and any limitation under a plan can be addressed before services are provided. A predetermination is a courtesy, where a pre-authorization is a requirement under the health plan. However, when a payer recommends a predetermination for services, it is recommended to do so.

Most hospitals are contracted with managed care insurance plans to provide medical care to their subscribers. Large payers such as Blue Cross, United Healthcare, Aetna, Humana, Viva, and Cigna sell managed care plans to employers.

Each managed care plan has its own unique requirements for services that must be pre-certified (prior to service). This non-standardization of requirements is problematic for providers of medical care. Staff in hospitals must have tools to assist them in complying with each plan's requirements. It is difficult for hospitals to keep up with each plan's requirements. Hospitals throughout Alabama and the nation are moving toward more technological solutions.

If authorization or certification is required, the insurance company or review agency requires information pertaining to the clinical reason for the visit or admission. The insurance company or agency may also have different days they allow to make the determination. Payer requirements may change with minimal notification to providers. Care should be taken to ensure the most current information is used. Best practice is to validate authorization requirements for outpatient and inpatient settings prior to performing the service.

For outpatient services, a CPT code is assigned to the test, drug, or procedure. The diagnosis and clinical information must support the medical necessity for the requested service. The test/procedure scheduled, the test/procedure performed, test/procedure billed, and the test/procedure authorized should always match. If the diagnosis and clinical information does not support the test/procedure ordered, the insurance may request additional clinical information or require a peer-to-peer with another physician. If this is not completed prior to service, most often the patient cannot be held accountable for the charges and the hospital will write off the cost of the test/procedure if the test/procedure is denied.

It is critical to associate the correct ICD-10 code to the correct CPT code. This is called "linking". If not done properly, the insurance carrier will deny payment with a "not medically necessary" reason code. The linked ICD-10 is compared to codes indicating medical necessity. If the code is not "linked" the insurance may deny the claim, request additional information, or request a peer-to-peer discussion with the ordering physician.

Care should be taken that the authorization is received, not only does the authorization cover the scheduled CPT but the authorization has been issued for the correct facility and the effective dates cover the date of service.

Inpatient and observation most often use pre-established criteria to decide. The most common sets of criteria used in the industry are Milliman and InterQual. Inpatient and observation admissions require pre-certification and/or notifications. Typically, notifications must be made within 24-48 hours of the hospital admission. Many insurance plans will require additional clinical information throughout a patient's hospital stay as well as discharge needs such as home health, durable medical equipment, or long-term rehabilitation. A standard Medicare hospital admission does not require pre-certification. However, Medicare Advantage policies do have pre-certification requirements. Medicaid also requires pre-certification on most inpatient procedures, select outpatient procedures and hospital inpatient admissions.

Another area of caution is the hospital settings. Many payers have requirements of whether the service should be performed in an inpatient setting. For this reason, it is important to understand the requirement and ensure the service is performed in the appropriate setting.

It is important to understand the impact of pre-authorization. Pre-authorization does not guarantee reimbursement of services. However, the lack of pre-authorization could result in non-payment from the insurance company. When pre-authorization is obtained from a payer, a pre-authorization number is issued. The pre-authorization number is required on the claim upon submission to avoid unnecessary denials.

Emergency Medical Treatment and Active Labor Act (EMTALA)

EMTALA is an act pertaining to emergency medical situations. EMTALA requires hospitals to provide emergency treatment to individuals, regardless of insurance status and ability to pay. This act has a direct impact on the registration department, creating multiple steps to complete a registration. Patients presenting to the hospital for an emergent reason or when in active labor, are not to be questioned about the financial aspects of their care prior to receiving stabilizing care. However, the patient must be asked for the basic demographic data to ensure positive patient identification. For this reason, many organizations employ the use of a "quick reg" in their Emergency Department and in the Labor and Delivery registration/check-in areas. A quick reg typically only asks for the most basic information to accomplish positive patient identification (name, date of birth, zip code, gender, complaint).

Understanding Health Insurance Networks

Before the days of managed-care health insurance plans, most people had fee-for-service plans otherwise known as indemnity insurance. This type of plan offered patients the freedom to go to almost any doctor. However, today's health insurance plans are dominated by the managed-care style plans (HMO, PPO, and POS/Point of Service). In such plans, the insurance companies create lists of doctors and facilities which patients utilize to select "in network" providers for their needed services. This list is known as the provider network, or preferred provider network. It is composed of physicians, hospitals and other providers that offer health care services to members of that health insurance plan.

To stay competitive, health insurance plans must have a diverse list of providers and hospitals within their networks. The same is true for doctors and hospitals, which often rely on inclusion in these networks to help direct patients to their organizations, thereby adding business/volume. To become part of a network, a provider must usually contract with that health insurance company. This agreement usually helps to provide these doctors and other providers with a steady stream of patients and offers the health insurance companies the ability to purchase such services at generally reduced rates. Because of this, managed care plans are usually more affordable than fee-for-service plans, but they do impose limitations on the freedom to choose providers.

Providers that are specifically contracted with payers are generally considered "in network". Some types of insurance coverages (usually PPO and POS plans) allow patients to utilize providers that are not directly contracted with that insurer. Such providers would be considered "out of network". Usually the coverage/benefits for such providers are less than if they had been "in network" thereby leaving the patients with a greater portion of the balance to pay. However, such plans do provide a greater degree of options and choice for their patient population although that choice comes at an increased price to the patient!

Understanding the type of plan and the restrictions of the plan that a patient has in place is needed to correctly calculate and communicate patient responsibility. To further complicate the calculation of patient responsibility, contracts are different from provider to provider and within the payer contracts with various hospitals. There also may be differences driven by "employer sponsored" plans that have special coverage and

payment rules that may apply even though they are utilizing a national insurance type product (such as Blue Cross, Cigna, Aetna, UHC, etc.).

Accounts Receivable & Revenue Cycle

The billing process within healthcare facilities is very complex and is achieved through various processes that gather evidence for the services provided to the patient (charges) alongside the process of gathering and documenting information. This documentation creates the medical record and serves as evidence of medical needs and eligibility to receive such services. This process requires total integration of the entire revenue cycle: customer service, clinical staff, medical records and coding staff, admissions and scheduling, billing, and collection's management. The by-product of all these processes is reflected in the amounts captured as accounts receivable. In fact, accounts receivable reflects the entire revenue cycle process.

There are many factors that directly affect the revenue cycle process and determine its success or failure, thereby affecting revenue integrity for the entire organization. Some of these factors are payer driven or more directly related to the provider's operations, but many are internal to the organization and create significant and ongoing challenges for any provider. Here are some common problems that may have a direct effect on accounts receivable:

- Understaffed or untrained billing and collection departments.
- Lack of company policies and procedures for the business office function.
- Lack of accountability in the admissions, billing, coding, and collections functions.
- Lack of system utilization or inappropriate system utilization.
- Incomplete medical records.

Basically, accurate and thorough reimbursement is everybody's job; from the clinical staff, physicians, to the customer service and business office staff, including any external agencies hired to collect on the back end of the process. It is only when these processes are "clean" that organizations can achieve streamlined payment from insurers and can create understandable and "patient friendly" bills for their patients.

Payers' impact on the Revenue Cycle

Numerous factors that originate from the payer's side of the house may impact cash flow and revenue integrity for the provider. Several key issues are noted below:

- **Slow-Paying Claims** – While many states have prompt-pay statutes that impose financial penalties on insurers that do not pay claims on a timely basis, a large majority of insurance products are exempt from such laws because they are not specifically licensed within that state. Larger insurers are generally covered under ERISA (Employee Retirement Income Security Act of 1974) and exempt from state prompt pay law.
- **"Usual & Customary" Denials and Repricing** – If reimbursement terms are not specifically contained within a contractual agreement, the insurer may pay using "usual and customary" pricing criteria. While this is supposed to represent the "norm" paid for services in your area, the data is often outdated and may unfairly value the amounts due to your facility for services rendered. The key to obtaining additional reimbursement when an insurer contends that the hospital's charges are too high is to shift the burden of proof to the insurer.

- **Silent PPOs** – A Silent PPO is an organization that accesses a discounted rate for services from a physician, hospital, or other health care provider without direct authorization from the provider (insurance company). Such organizations are generally not actually contracted with the payer's network and therefore not entitled to the payment rates they are claiming. Cross-checking of a patient's insurance card against the EOB can help to identify this unauthorized pricing practice between PPO brokers and non-contracted payers. Relying on the data mining skills of external agencies that specialize in this form of "underpayment/denial" may be warranted, depending on the size of your organization and the impact realized from these type practices in your area of the country.
- **Pre-existing Conditions** – the passage of the **Health Insurance Portability & Accountability Act (HIPAA)** set federal guidelines for the application of pre-existing condition exclusion however some providers may still encounter this reason for non-payment. The provider should investigate all such denials and seek to overturn using current law as their basis for appeal.
- **Mis-verification of Benefits** – Courts have used the legal theory of **promissory estoppel** to hold insurers liable for benefits quoted in error. When providers have rendered services in good faith with an expectation of payment, they are often successful in recovering payment if the insurer later denies stating that benefits were less than represented or no coverage exists for the actual services originally certified.
- **COBRA Issues** – Confusion about the law regarding termination of coverage often leads to lost reimbursement. Providers need to understand the timelines associated with COBRA eligibility and aggressively manage accounts denied because coverage has been recently terminated.
- **Lack of Medical Necessity** – Successful appealing medical necessity denials requires a thorough review of the patient's medical record, as well as the application of the correct medical criteria and legal standards. Even claims denied by Medicare and other governmental payers for medical necessity can be successfully appealed and overturned if support can be found that underscores the medical need for the patient. This is especially true when dealing with Local Coverage Determination policies (LCD's)….if other jurisdictions provide coverage for similar services a provider can often successfully present a case for appeal and receive payment.
- **Pre-authorization Denials** – Documentation is the basis of a strong appeal for a denial based on the lack of pre-authorization of a submitted claim. Keeping records of conversations and any correspondence, paper or electronic is essential.
- **Fighting Refund Demands** – Hospitals are usually justified in not refunding payments erroneously paid by an insurer due to the legal theory of **unjust enrichment**. Providers should know and understand this clause.
- **Auto Accident and other Third-party liability** - Many hospitals lose substantial reimbursement because required **liens and /or letters of protection** are not properly obtained or not obtained within a timely manner that meet any state or legal guidelines that may apply. Navigating the rules associated with auto and other legal type collections is tricky and may be best handled by external experts, depending on the individual needs of the organization.

Payer Types

There are several payers that healthcare providers may interact with:

- Medicare - A government payer that started operation in 1966 and provides coverage for various types of medical benefits. Medicare is generally one of the largest payer groups represented within a

hospitals' accounts receivable. Medicare has several key coverage areas that may impact healthcare facilities:

- Part A, or hospital insurance, pays for inpatient hospital care, critical access hospitals, skilled nursing facilities, home health and hospice care.
- Part B, or medical insurance, pays for outpatient hospital services, medically necessary physician services and other supplies not covered under Part A benefits.
- Part C, Managed Medicare plans; may follow Medicare rules but payment structure may differ as it may depend on the contracts in place.
- Part D, prescription drug coverage, pays for prescription drugs as outlined by the selected plan.

- Medicaid was established under Title XIX of the 1965 Federal Social Security Act.
  - It is a state-administered program jointly funded by the State of Alabama and the Federal Government.
  - The Alabama Medicaid Agency, which began operations on January 1, 1970, is a state/federal program that pays for medical and long-term care services for low-income pregnant women, children, certain people on Medicare, disabled individuals, and nursing home residents. The individuals must meet certain income and other requirements.
  - The AMA (Alabama Medicaid Agency) is the State agency in Alabama that administers the Medicaid program.
  - Gainwell Technologies, Inc. is the fiscal agent responsible for the processing and payment of Traditional Medicaid claims in the State of Alabama.
- Private/Commercial payers offer diverse coverage and payment methodologies.
  - Coverage is determined by each Plan through review of all provisions outlined within the individual policy in question as well as plan specific policy and practice.
  - Payments are often linked to "reasonable charges" which are generally set based on historical data and geographic areas (often referred to as Usual and Customary payment schedules)
  - There are two basic types of commercial insurance coverage: group health care plans or individual care plans.
- Managed Care plans are systems that manage the delivery of health care to control its costs. The common goal of all the various forms of managed care is achieving reasonable and appropriate utilization of health care products and services with maximum cost savings to the plan. Managed care systems can include:
  - Health Maintenance Organizations (HMOs),
  - Preferred Provider Organizations (PPOs),
  - Point of Service (POS)
  - Exclusive Provider Organization (EPOs)
- Third Party Administrators (TPAs) are organizations that are hired by employers to process claims, administer benefits per the employer's policies and pay claims at rates the TPA determines as reasonable (generally using the "usual and customary" logic)
- Workers Compensation is a state program funded by the employers in that state. This coverage provides funds to pay for illness or injury that resulted from a job-related accident.
- No fault insurance, also known as Personal Injury Protection (PIP) or Med-Pay, is an automobile accident medical coverage that can be purchased from various private automobile insurance providers.

Reimbursement (Payment) Methodologies

Today there are several types of reimbursement methodologies used by payers. Listed below are some of the most common reimbursement methodologies used.

- **Ambulatory Payment Classifications (APC)** - *is* a method of outpatient reimbursement where all the services associated with a given procedure or visit is bundled into the APC. Medicare uses this method to reimburse outpatient claims. The APC methodology is subject to change each year and healthcare facilities should be aware that commercial payers may group certain procedures differently from Medicare and often change which procedures group to which levels of reimbursement/care. It is critical for reviewing payment accuracy to know the exact list of procedures and how those are grouped to payment levels.
- **EAPG**- The 3M™ Enhanced Ambulatory Patient Grouping (EAPG) System is a methodology that captures the current changes in clinical practice and resource use to provide a broader, more inclusive classification of outpatient care.
    - Using the 3M EAPG methodology, providers can more easily manage the complexity of outpatient claims, identify cost recovery opportunities, and improve both outpatient coding compliance and reimbursement.
    - As of March 2023, 12 state Medicaid programs and eight major commercial payers use 3M EAPGs to reimburse providers. More than 1,000 provider organizations have licensed 3M EAPGs to predict and verify payment as well as analyze and improve internal operations.
    - EAPG Payment Methodology- Detail *Line Payment = Provider Base Rate X EAPG Relative Weight X Bundling/Discounting/Adjusting*
- **Capitation** - is a specified amount paid periodically (usually monthly) to a health provider for a group of specified health services, regardless of quantity rendered:
    - Amounts are determined by assessing a payment "per covered life" or per member.
    - The method of payment for the provider is paid based on a fixed amount for each person served, no matter what the actual number or nature of services delivered may be.
    - The cost of providing an individual with a specific set of services over a set period is usually a month or a year.
    - Providers are not reimbursed for services that exceed the allotted amount.
    - The rate may be fixed for all members, or it can be adjusted for the age and gender of the member, based on actuarial projections of medical utilization.
    - Can be used by hospitals or physicians.
- **Diagnosis related groups (DRGs)** - are inpatient or hospital classification systems used to pay a hospital or other provider for their services and to categorize illness by diagnosis and treatment.
    - A classification scheme used by Medicare& other commercial payers that clusters inpatients into categories based on patients' illnesses, diseases and medical problems and assigns a payment amount that covers the entire inpatient episode (exception may be excessively costly “outlier” cases)
    - Groupings of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.
    - Used under Medicare's prospective payment system to reimburse inpatient hospitals, regardless of the cost to the hospital to provide services.

- **Discounted Fee-For-Service** - is a financial reimbursement system whereby a provider agrees to supply services on a fee-for-service basis, but with the fees discounted by a certain percentage from the physician or hospital's usual and customary charges.
    - An agreed upon rate for service between the provider and payer that is usually less than the provider's full fee.
    - This may be a fixed amount per service, or a percentage discount.
    - Providers generally accept such contracts because the contract offers the provider a means to increase their volume or reduce their chances of losing volume.
- **Fee-For-Service** - is a traditional method of payment for health care services where specific payment is made for specific services rendered. People usually speak of this in contrast to capitation, DRG or per diem discounted rates, none of which is like the traditional fee for service method of reimbursement.
    - Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones.
    - Payment may be made by an insurance company, the patient, or a government program such as Medicare or Medicaid.
    - With respect to the physicians or other supplier of service, this refers to payment in specific amounts for specific services rendered.
    - In relation to the patient, it refers to payment in specific amounts for specific services received, in contrast to the advance payment of an insurance premium or membership fee for coverage.
- **Flat Fee-Per-Case** - a flat fee paid for a client's treatment based on their diagnosis and/or presenting medical problem.
    - For this fee the provider covers all the services the client requires for a specific period of time.
    - Often characterizes "second generation" managed care systems.
    - After the MCOs squeeze out costs by discounting fees, they often come to this method.
    - This approach can be good for the provider and clients, since it permits a lot of flexibility for provider in meeting client needs.
- **PCP Capitation** - is a reimbursement system for healthcare providers of primary care services who receive a prepayment per member every month. The payment amount is based on age, sex and plan of every member assigned to that physician for that month.
- **Per Diem Rates** - is a form of payment for services in which the provider is paid a daily fee for specific services or outcomes, regardless of the cost of provision.
    - Per Diem rates are paid without regard to actual charges and may vary by level of care, such as medical, surgical, intensive care, skilled care, psychiatric, etc.
    - Per Diem rates are usually flat all-inclusive rates.
- **Prospective Payment System (PPS)** - is a payment method that establishes rates, prices or budgets before services are rendered and costs are incurred. Providers retain or absorb at least a portion of the difference between established revenues and actual costs. (Another term for DRG and ASC/APC methodologies)
    - Prospective per-case payment rates are set at a level intended to cover operating costs in an efficient hospital for treating a typical inpatient in each diagnosis-related group.
    - Payments for each hospital are adjusted for differences in area wages, teaching activity, and care to the poor, and other factors.

  - Hospitals may also receive additional payments to cover extra costs associated with atypical patients (outliers) in each DRG.
- **Periodic Interim Payments and Cash Advances (PIPs)** - are periodic interim payments and cash advances where the plan advances a hospital cash to cover expected claims. (generally tied to Medicare participation but can be used by commercial type plans)
- **Penalties and Withholds** - may be negotiated so that if goals are met, the healthcare provider receives its' withholds or bonus. These goals are usually tied to utilization or quality outcomes.

Importance of Point of Service Collections

Self-Pay is the fastest growing payer class. Some mistakenly thought the Affordable Care Act (OBAMA CARE) was the answer to eliminating or greatly reducing self-pay patients. While the ACA imposed penalties for not obtaining insurance, increasing patient responsibilities continue to challenge hospitals because insurers costs keep escalating and those costs are being passed on to the employers and patients that purchase those coverages. The individual mandate still exists but there is no longer a federal penalty for non-compliance. The penalty was removed in 2018. A Healthcare Bulletin from July 2014 identified the following issues that impact this rising patient responsibility.

- Nearly one-third of employers have increased employee's out-of-pocket limits by more than 20 percent or has increased co-payments.
- More than 40 percent of employers expect to see the greatest cost increase due to ACA in 2015.
- Nearly one in six businesses with 50 or fewer employees has reduced their workforce.
- 10 percent of small businesses have reduced hours, frozen pay, or limited hours.

The best time to collect healthcare self-pay portions from the patient is prior to the patient receiving service, except where EMTALA (Emergency Treatment and Active Labor) laws apply. The worst time is after medical services have already been provided. The provider has a psychological advantage when collections are attempted closer to the time of service. The hospital should have methods in place to calculate patient portions of an estimated hospital bill prior to the time of service. While completely accurate calculations are often impossible in complex surgical and inpatient cases, guidelines should be established for requesting advance payments from patients; especially known amounts such as deductibles, copayments, and co-insurance when specific services are known.

For example: An estimate may be derived by verifying coverage limits and co-pay requirements, then applying that to the average charges. Self-pay estimates and deposits can be based on historical averages. There should always be a disclaimer to state "this is only an estimate." Staff should offer detailed explanations of the charges and estimate when talking to the patient, always stressing "this is an estimate."

Implementing a Point-of-Service Collection Program

The key to a successful point-of-service collection program is to have a solid point-of-service collection policy that is supported by the executive level and the board of directors. The policy should address or have separate policies that address.

- Financial assistance
- Prompt pay discounts.
- Payment options

- Payment arrangements and guidelines
- Prior balances

Processes should be built around the point-of-service collection policy. Although hospitals vary in the tools and technology, their processes should include the following:

- Insurance verification
- Method of calculating patient responsibility
- Training
- Scripting
- Metrics for measurement – potential vs. actual cash
- Patient education
- Methods for processing payments
- Support from all departments.
- Financial counseling
- Medicaid eligibility program (internal or external)
- Physician communication
- Patients can be classified as:
- Employed with historical insurance (often means Lower out-of-pocket amounts)
- Employed with high deductibles and high co-insurance -These patients could have chosen the higher out-of-pocket amounts because they believed their risks were small or their employer raised patient responsibility to reduce costs. Or they purchased coverage through the Exchange and selected a plan with the high out of pocket cost options.
- Employed with no insurance -The employer does not offer insurance, or the patient failed to enroll in insurance or OBAMA Care.
- Unemployed - Not enrolled in insurance.

Challenges to Point-of-Service Collections

- Limited information obtained at scheduling.
- Limited time from date of booking to date of service
- Insurance files not always current – Some insurance eligibility files are not updated frequently enough and may be 90 days out of sync.
- Lack of support from clinical departments
- Lack of support from physicians
- Executive support can assist with all the above except keeping insurance eligibility files current.

Benefits to Point-of-Service Collections

- Better informed patients
- Increased cash flow
- Decreased cost to collect.
- Reduced AR days
- Reduced bad debt.
- Identification of patients needing financial assistance at the point of service or prior to the service
- Reduced phone calls

- Decreased patient complaints.
- Reduced statement expense
- Reduced rework

Point-of-Service Collections Recommendation

- Prepare cost estimates for self-pay and all high out of pocket accounts.
- Verbally tell the patient and provide written document for estimates.
- Verbally review insurance coverage, benefits and patient liability and provide written document.
- Always document system as an audit trail
- Check prior open balances.
- Check prior bad debt.
- Incorporate financial counseling into the process.
- Use scripting.
- Train staff to ensure they can answer questions.
- Offer point-of-service discounts.
- Offer alternative payment options (with or without interest payment options)

Eight Steps to a Successful Collection Interview

- Ask for a balance by stating the facility policy.
- Listen to the guarantor. (psychological pause)
- Determine the problem. (use sympathy and empathy)
- Find a solution. (check, cash, or credit) If the patient is truly unable to pay, determine whether a charity care program is right for them.
- Ask for the balance due.
- Listen to the guarantor. (psychological pause)
- Agree on payment.
- If the patient is not able to pay in full now, have the guarantor summarize and repeat the agreement; update the account.

Coping with an Angry Guarantor

- Let the guarantor speak their mind.
- Listen to the reasons the guarantor has provided to support them not paying. Try to determine what is upsetting them.
- Try to agree with some part of what the guarantor is upset about. Absorb the guarantor's anger and try to understand their position. Avoid getting emotionally involved.
- Help the guarantor find the answers to their problems.
- Often, if you receive rude treatment by a guarantor, it is due to circumstances beyond your control – that has nothing to do with you, i.e., family, illness, marital problems, death in the family and obviously money problems.
- If communication is established, attempt to get the guarantor to commit to when payment will be made and have them confirm the agreement.

Financial Counseling and Financial Clearance

Financial Counseling and Financial Clearance are sometimes confusing. Financial Clearance refers to satisfying all requirements to ensure the hospital's financial interest is protected. Financial Clearance includes the following:

- Gathering and/or validating patient demographic and personal information. Many hospitals have pre-determined criteria where it is allowed to pull information from history. Once the patient arrives, they are asked to validate the information.
- Verifying insurance benefits and coverage.
- Obtaining all necessary referrals or pre-authorizations.
- Resolving patient liability. The objective should always be to collect the estimated patent liability. However, there are times the patient cannot meet the financial requirements in full. A collection policy should be in place that identifies allowable payment plans, deposits, and actions if the requirements cannot be met. For a collection policy to be successful, it must be supported by the Administration.

The Financial Counseling process is initiated when the patient cannot be financially cleared. It is highly recommended that Financial Counselors be included in the insurance verification process so they can be involved immediately when problems with benefits or network issues arise. The insurance verification partnership with Financial Counseling is essential to the Patient Access workflow.

Although point of service collection is a large part of the Financial Counselor's role, point-of-service should be a part of any control point. When a patient cannot be financially cleared at any control point, the Financial Counselor should become involved in assisting the patient with financial clearance. There are five collection control points in the healthcare process. At any time, there is a breakdown in the functions within the five collection control points, financial counselors should be involved. The collection points and the tasks during each phase are outlined below:

1. Before Admissions/Registration and before service is provided, except when EMTALA laws apply.
    - Obtain all critical information by telephone.
    - Verify insurance and obtain any pre-authorization.
    - Estimate patient's portion of bill and insurance coverage.
    - State policy and financial counseling process.
    - Have a Financial Counselor assist, as needed.
2. At Admission/Registration
    - Review information obtained with patient/guarantor.
    - Obtain necessary signatures on legal documents.
    - Triage consistent with EMTALA for Emergency Department admits.
    - Obtain insurance and demographic information and estimate patient portion for all direct admissions.
    - Collect amounts due from patient/guarantor.
    - Refer patients to a Financial Counselor for financial assessment, if needed
3. In-House
    - Monitor charges or any changes in benefit levels.

- For in-house admissions, hospitals should set a dollar amount of charges and length of stay thresholds for Financial Counselor review. (i.e. 7 days length of stay and/or $10,000 in charges)
- Financial Counselors should work closely with in-house Case Managers/Utilization Management to ensure insurance coverage and funding for medical services.

4. At Discharge
    - Collect patient's portion or make financial arrangements.
    - Review insurance benefits as documented and explain the statement cycle that the patient/guarantor should expect.
    - Refer patients to a Financial Counselor for financial assessment, if needed
5. Post Discharge-Collection Follow-Up
    - Follow-up overdue accounts from patient or insurance
    - Follow-up by telephone, on payer web sites, by fax, or other payer specified access avenues.
    - Take problematic accounts to periodic payer Provider Representative meetings.
    - Don't just obtain a status-get a payment release date. Set tickler file for follow-up call on that date.

If a patient cannot pay the calculated patient liability, a Financial Counselor should become involved to assist the patient in becoming financially cleared. The following are resources used to assist patients in becoming financially cleared.

- Prompt Payment Discounts – Prompt pay discounts may be offered to patients who pay up front prior to service.
- Payment arrangement – Payment arrangements guidelines should be included in the collection policy. Payment guidelines may include any or all the following.
    - Deposit requirements.
    - Length of time the medical facility will carry the balance.
    - Minimum payment amount
    - Next steps if the patient defaults
- Loan Programs – Many hospitals offer loan programs through a business partner. This allows patients who cannot meet the payment arrangements to finance the balance for a longer period. These programs may be offered to a patient interest free, interest charged after a specified period or interest charged from the beginning.
- Medicaid eligibility – Many patients may qualify for Medicaid benefits. Often, the Medicaid eligibility will cover previous balances. Most medical care providers outsource this process to companies with expertise in Medicaid eligibility. Medicaid eligibility requirements will be addressed in the Medicaid eligibility section.
- Cancer State Aid- Patients who have cancer and meet certain medical and financial conditions may qualify for Cancer State Aid.
- Crime Victims – Patients who are victims of a crime may qualify for state reimbursement if conditions are met.
- Financial Assistance/Charity Care – Patients may qualify for a 100% write-off or a percentage reduction in their balance. The 2010 Patient Protection and Affordable Care Act (commonly referred to as Obama Care) require charitable hospitals to establish a written financial assistance policy (FAP). The

requirements of the financial assistance policy are addressed in multiple sections of this manual. The impact and requirements of the 501r section is addressed in the Patient Access section of this manual under "The Impact of the 501r on Patient Access.

Medicaid

Medicaid is a state managed program funded jointly by individual state and federal government funds to provide health insurance to individuals and families with low incomes and resources and meeting a specific set of eligibility criteria (e.g. pregnant, aged, blind, or disabled). Medicaid is the largest source of funding for medical and health-related services for people with limited income. Among the groups of people served by Medicaid are eligible low-income parents, children, seniors, and people with disabilities.

Many providers utilize various methods to assist in screening uninsured patients for Medicaid eligibility. Regardless of the method, HFMA encourages hospitals to assess the uninsured patient population for Medicaid using one or more of the following avenues:

- Contract with a vendor partner.
- Use automated or web-based software.
- Interact with the local DFACS (Department of Family and Children's Services)
- Create an internal program with Financial Counselors

Sterilizations- Medicaid is prohibited from making payment for sterilizations performed on any person under the age of 21, or who is not mentally competent, is institutionalized in a correctional facility, mental hospital, or other rehabilitation facility. A sterilization consent form must be properly completed and signed for all sterilization procedures. The signed consent expires 180 days from the recipient's signature. There is a mandatory waiting period of 30 days from the date the patient signs the sterilization consent form until the procedure is performed. The physician must sign the consent form after the sterilization. Processes should be in place to ensure that the requirements are met.

Certified Application Counselor (CAC)

The certified application counselor (CAC) program provides an opportunity for people and organizations to get trained and certified to help the uninsured understand their new health coverage options, apply for financial help with coverage, and enroll in private health plans through the health insurance marketplaces. Using community-based organizations, including community health centers, and hospitals, to assist with Medicaid and CHIP enrollment has been a core element of successful state strategies in maximizing children's health coverage over the years.

The Medicaid rule mentions "trusted community-based organizations, providers, or other organizations with expertise in social service programs" as potential CACs. The Exchange certifies "employees and volunteers of organizations, which may include health care providers and entities, as well as community-based organizations.

There are differences in how a CAC in Medicaid/CHIP and the Exchange CACs. The similarities and differences are outlined below:

- CAC programs in Medicaid/CHIP agencies are a state option. In the Exchange, they are required.
- The Exchange must accept any CAC that Medicaid/CHIP certifies but the reverse is not required.

- CACs are authorized and registered by Medicaid, while CACs register with the exchange, suggesting that Medicaid agencies can be selective in choosing CACs while Exchanges must accept anyone who registers, gets trained and signs an agreement.
- If Medicaid opts to have a CAC program, it must provide a web portal for CACs to use. There is no corresponding requirement in the Exchange.
- While state laws may apply conflict of interest standards to CACs, the federal regulations do not disqualify an entity with conflict of interest from being certified.

501r Impact to Patient Access

There are two major impacts of the 501r section that affect Patient Access.

- Communication – The 501r requires that individuals who receive care from a hospital facility be informed about the Financial Assistance Program. Patient Access Staff must be educated to inform patients of the FAP and to direct them to the appropriate party to apply for assistance. The communication section of 501r requires the following:
    - Offer a paper copy of the plain language summary of the FAP to patients as part of the intake or discharge process.
    - Include a conspicuous written notice on billing statements that notifies and informs recipients about the availability of financial assistance under the hospital facility's FAP and includes the telephone number of the hospital facility office or department that can provide information about the FAP and FAP application process and the direct website address where copies of the FAP, FAP application form, and plain language summary of the FAP may be obtained.
    - Setting up conspicuous public displays that notify and inform patients about the FAP in public locations in the hospital, including, at a minimum, the emergency room and admission areas.
- Written Financial Policy
    - The eligibility criteria for financial assistance and whether such assistance includes free or discounted care.
    - The basis for calculating amounts charged to individuals.
    - The method for applying for financial assistance.
    - The actions that may be taken in the event of non-payment. This requirement may be included in a separate billing and collection policy.
    - If applicable, any information the hospital facility obtained from sources other than the individual seeking financial assistance and whether and under what circumstances the hospital uses this eligibility determination.
    - A list of providers, other than the hospital itself, delivering emergency or other medically necessary care in the hospital and specify which providers are covered by the hospital financial assistance policy.
    - Eligibility criteria for financial assistance.
    - Action the hospital may take in the event of non-payment.
    - Measures to widely publicize the FAP.
        - Make the FAP, FAP application form, and plan language summary of the FAP available on a website.
        - Make paper copies of the FAP and FAP application form, and plain language summary of the FAP available on request and without charge, both by mail and in public

locations in the hospital, including, at a minimum in the emergency room and waiting areas.
    - Notify and information members of the community served by the hospital about the FAP in a manner reasonably calculated to reach those members who are most likely to require financial assistance from the hospital.
- There are also requirements for processing the Financial Assistance Application. This is covered in the Financial Assistance Program section.

Financial Assistance Programs

The basis for determining qualifications for indigent and/or charity care is the Federal Poverty Guidelines (FPG), which are established annually by the U.S. Department of Health and Human Services. Hospital indigent and charity care financial assistance policies should incorporate the most recent guidelines and income levels in force at the time the determination for financial assistance was made. Federal requirements for Financial Assistance Programs are covered in 501r in the previous section.

Definitions:

- Indigent – Generally considered to be a 100% write-off if the income level of the patient/guarantor is 200% or less of the FPG.
- Charity – Usually the write off is tiered based on the guarantor/patient's income level and other factors and is generally a write-off of less than 100%. The balance would be owed by the patient. Approval for partial write-off may max out at somewhere between 200% and 400% of FPG.

2024 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household	Poverty Guideline
1	$15,060
2	$20,440
3	$25,820
4	$31,200
5	$36,580
6	$41,960
7	$47,340
8	$52,720

For families/households with more than 8 persons, add $5,380 for each additional person.

The State of Alabama currently requires a not-for-profit provider to be charitable to maintain tax exemption. The purpose of an indigent and/or charity care program is to provide financial relief or assistance to those who are unable to meet their financial obligation to the healthcare facility. Although programs and policies will vary between hospitals, there are some overriding guidelines that are generally accepted by all healthcare providers.

Eligibility – Patient Eligibility must be based on the following:

- All inpatient and outpatient accounts exceeding a pre-determined level, say $500 or $1,000, are eligible for applying for financial assistance – indigent/charity care. An application must be completed by the patient/guarantor.

- The application should include:
    - Income from all resources, listing at a minimum, gross income for the most recent three-month period. Some providers may require additional documentation such as W2 for the prior year.
    - Resources from savings and checking accounts, certificates of deposit, stocks, bonds, real estate, etc.
    - Assets including homes, cars, boats, and other vehicles, or other assets.
    - Monthly expenses
    - Number of dependents
    - A copy of the most recent federal income tax forms
- All third-party resources and non-profit hospital financial aid programs, including public assistance available through Medicaid, must be exhausted before financial assistance can be approved.
- Deductible and co-insurance amounts may be eligible for assistance if financial circumstances warrant.
- Some hospitals do not allow financial assistance applications after an account has been sent to legal counsel for collections.

Program Administration – The financial assistance (indigent/charity) program should be administered according to the following guidelines:

- The application information, along with the federal income tax forms, should be reviewed and verified by a Financial Counselor or authorized person.
- After reviewing income and expenses, the Financial Counselor or authorized person should determine if the patient/guarantor qualifies for financial assistance based on and Income and Assets Guideline Worksheet. A specific worksheet for use by financial counselors will ensure that all patients are assessed using the same criteria and represents a best practice:
    - If the patient/guarantor qualifies for 100 percent write-off, he or she should be notified, and the balance of the account should be written off per the facility's procedures.
    - If the patient/guarantor qualifies for a reduction in liability, he or she should be notified, and payment arrangements made for the non-write off amount. Best practice dictates that the out-of-pocket payment should be received prior to the charity write-off on the account.
- Falsification of any information on the financial assistance application or refusal to cooperate should result in denial of financial assistance approval. For example, refusal to provide income documents or lack of cooperation to apply for Medicaid should disqualify a patient from receiving financial assistance.
- The healthcare facility's policy should reserve the right to change benefit determination if financial circumstances change.

Procedure – the financial assistance program should follow certain procedures:

- Applicants for financial assistance should complete a financial information form. The healthcare facility should reserve the right to check the validity of the information at their discretion, including accessing credit bureau reports.
- A determination of eligibility should be made within a reasonable, pre-determined period, usually within seven to ten business days, and the patient should be informed in writing of that determination by a copy of the application, or a formal approval letter sent within the stated period.

- Family size should be determined primarily by the information supplied on the federal income tax return. Income will include all income of the family unit.
- Best practice dictates that the patient/guarantor completes the financial assistance application prior to or at the time the service is given. Required documentation for validating the information may be delayed since most people do not routinely carry these documents with them. A time limit for receipt of the documents should be communicated to the patient.
- Each facility's policy should determine who has final approval of determination of eligibility, based on dollar amount of write-off, type of service, documents provided, etc. Some facilities allow the Financial Counselor full approval rights if all documentation is provided. Others require management approval.
- While the application for financial assistance consideration should be made by the time of service, payment from all other sources must be received and the patient must have been denied Medicaid, or otherwise be known not to qualify for Medicaid before the financial assistance is approved and the indigent/charity allowance is applied to an account.
- Some organizations include all outstanding accounts when financial assistance has been approved. Others require that the patient/guarantor specify the accounts that he or she would like included for consideration. Whichever, the facility's policy should clearly indicate the specifics for the Financial Counselor.
- Each application should be considered effective for the calendar month in which it was made. Should a patient have services later in the month for which he or she wants consideration, best practice does not require an additional application, but the patient must notify a Financial Counselor that he or she desires the additional services be included in the original consideration. Some providers may allow an extension of eligibility beyond one month, to even three or six months depending on the hospital's approved policy.
- Medicare allows indigent and charity allowances for Medicare patients' deductibles and co-insurance amounts following the same policy as other patients. Clear documentation must be kept for Medicare auditing purposes.
- Documents should be retained for the required seven years.

Screening for Financial Assistance Needs

Uninsured Patient – The Financial Counselor should be responsible for determining a self-pay inpatient or outpatient's eligibility for financial assistance or his or her ability to pay based on the hospital's indigent and charity care policy. In most cases, eligibility is readily apparent, and a determination can be made before, on, or soon after the date of service. In other cases, it can take investigation to determine eligibility, particularly when the patient has limited ability or an unwillingness to provide necessary information.

The Financial Counselor should execute the following steps to determine a patient's eligibility for financial assistance.

- Receive a daily report or review an automated work list that lists the admissions, pre-admissions, and outpatient surgeries registered or scheduled the previous day.
- Upon review of the daily report, initiate counseling – which should include pre-screening for financial assistance (indigent or charity care), or payment arrangements.

- If it is determined through the financial assistance pre-screening process that the patient is eligible for assistance, the specific procedures for that facility should be allowed.
- If a patient does not qualify for financial assistance (uncompensated care), the same financial application should be used to determine a payment plan that is agreeable to the patient and the Financial Counselor.
- If there is insufficient information to fully evaluate all the criteria and the ability to pay cannot be reliably determined, the case should be reviewed by a designated management person in the organization.

Medicare Patients and Financial Assistance – Medicare patients who have no supplemental insurance should be pre-screened for payment arrangements, or possible financial assistance. The same procedures outlined for self-pay patients should be used for Medicare patients. Because most Medicare patients have a static income level, many hospitals only require Medicare patients to complete financial assistance applications annually.

Patients with Self Pay Balances after Insurance – Through the insurance verification process, patients will be identified who have large patient co-pays or terminated benefits. The Insurance Verification Specialist normally will determine which accounts should be forwarded to the Financial Counselor for follow-up. Determining factors include, but are not limited to, service not covered, medical necessity denial, termination of benefits, size of co-pay/deductible (typically greater than $500 or $750), and pre-existing condition. All inpatient accounts should be forwarded immediately to the Financial Counselor and the same procedures outlined for self-pay patients should be utilized. It is important that Financial Counselors document all conversations and decisions made during the process.

As indicated in the 501r section, not-for-profit hospitals are required to communicate their Financial Assistance Program. Methods of communication include, but are not limited to the following:

- Patient request
- Billing statements
- Provided by Financial Counselors
- Included in the information provided at registration.
- Posted on the hospital's web site.
- Included on Financial Counselor's voice mail message.
- Posted on signage in the registration areas.
- Newspaper advertisements

Internal Revenue Code Section 501r requires the hospital to not engage in extraordinary collection actions (ECA) against an individual to obtain payment for care before the hospital has made reasonable efforts to notify patients of the Financial Assistance Program and determine whether the individual is eligible for assistance under the Financial Assistance Policy.

- The final regulations require hospitals to wait 120 days before initiating ECA's against patients. This is the notification period. This is the notification period. The regulation also provides a 240-day period during which a hospital facility is required to process any application submitted by the individual. The applicable 120-day and 240-day periods start on the date the first "post-discharge" billing statement.

- The hospital will only have satisfied the requirement to make reasonable efforts to notify the individual about the FAP, if it does the following at least 30 days before initiating more or more ECAs:
    - Provide the individual with a written notice that indicates financial assistance is available to eligible individuals, identifies the ECA(s) that the hospital (or other authorized party) intends to initiate to obtain payment for the care, and states a deadline after which ECA(s) may be initiated that is no earlier than 30 days after the date that the written notice is provided: and provides the individual with a plain language summary of the FAP and makes a reasonable effort to orally notify the individual about the hospital facility's FAP and how the individual may obtain assistance with the FAP process.
    - A hospital may satisfy the notification requirements simultaneously for multiple episodes of care and notify the individual about the ECAs the hospital intends to initiate to obtain payment for multiple outstanding bills for care. However, if a hospital aggregates an individual's outstanding bills for multiple episodes of care before initiating one or more ECAs to obtain payment for those bills, it will not have made reasonable efforts to determine whether the individuals is FAP eligible unless it refrains from initiating the ECAs until 120 days after it provided the first post-discharge billing statement for the most recent episode of care included in the aggregation.

Complete or Incomplete FAP Applications – In the case of an individual who submits an incomplete FAP application during the 240-day, the hospital must suspend any ECAs until the hospital notifies the individual about how to complete the FAP application and gives the individual a reasonable opportunity to do so. In the case of an individual who submits a complete FAP application during the 240-day period, the hospital must suspend any ECAs taken against the individual to obtain payment for the care, make a timely determination of whether the individual is FAP eligible for the care, and notify the individual in writing of the determination and basis of the determination and the basis of the determination.

If the hospital determines the individual is FAP eligible for care, the hospital must:

- Provide the individual with a billing statement that indicates the amount the individual owes for the care as a FAP eligible individual and how that amount was determined and states, or describes how the individual can get information regarding the AGB for the care, and
- Refund the individual any amount he or she has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP eligible individual, and
- Take all reasonably available measures to reverse any ECA taken against the individual to obtain payment for the care.

Determination Based on a Complete FAP Application – A hospital will have made reasonable efforts to determine whether an individual is FAP eligible if, before initiating any ECAs, it determines whether the individual is FAP eligible for the care based on a complete FAP application and otherwise meets the requirements described above for complete FAP applications. If these conditions are satisfied, the hospital will have made reasonable efforts to determine whether the individual is FAP eligible for the care, regardless of whether it has notified the individual of the existence of the FAP.

Customer Service and Guest Relations

Providing excellent customer service must be the goal at every interaction with the patients and guests of medical care providers. Patient Access, whether during the scheduling process, pre-registration or registration point is most often the first contact with the patient or guest and sets the tone for the rest of the visit.

As stated above, Patient Access is most often the first point of contact with the patient. The patient's experience plays a big part in whether they return for their next service. And not only does it impact whether they will return for future services; patients and guests communicate their experience and influence others on their decisions. Unfortunately, more bad experiences are communicated than good experiences.

Many healthcare providers have emphasized evaluating revenue cycle process not only with the goal of improving net revenue, but also with the objective of enhancing the patient's experience. Front end functions such as insurance verification, pre-certification and accurate data collection play a significant role in shaping the patients/guardian's impression of the organization. Taking a proactive approach to screen patients, validate insurance coverage and adhering to the payer requirements prior to the service date provides the patient with a seamless experience.

Revenue cycle leaders continue to assess operations to identify areas of improvement. Health systems are focusing efforts on redesigning Patient Access operations in a way that promotes positive patient perception.

Patient Access – Other Areas of Interest, Rules, and Processes

The following topics are rules and/or regulations that impact Patient Access requirements and the processes they follow.

Wayfinding

The term, "wayfinding," is simply a formal name for mechanisms that help people find their way. In healthcare facilities, wayfinding is the mechanism(s) that help patients and visitors find their way to various services, cafeteria, parking, etc. Wayfinding may refer to a signage system, color-coded lines on the walls, floors, ceilings, location tickets (as seen in some parking garages), hand-held maps, electronic maps via smart devices, etc. With the growth of medical complexes and the onset of consolidation, the physical environment may be very complicated. Directions that seem self-evident to employees and people who are familiar with the facility may be confusing to others, especially when they are under stress. Wayfinding also encompasses such items as: directions and alternate means of transportation to the facility, location of parking and patient drop off points in relation to points of service, campus maps, visual cues (such as color-coding and repetitive designs,) etc.

Advance Beneficiary Notice of Non-Coverage (ABN)

There are services that Medicare may not pay for. An Advance Beneficiary Notice of Non-Coverage is a form that lets patients know they may be financially responsible for a test, procedure, or other service if Medicare refuses to pay. The ABN allows patients to make an informed decision whether to receive the service and pay for it or refuse the service. If a patient refuses the service, the provider or patient should notify the ordering physician and inform them of the patient's decision.

Requirements for Providing an ABN to Patients

The Advance Beneficiary Notice must be given to the patient:

- As written notice from his/her physician or provider of services when services might not be covered by Medicare.
- In advance of the services being provided. Providing the ABN in advance gives the patient time to consider the options and make an informed choice. If not provided prior to service, the patient cannot be held responsible for payment of the service.

ABN is **not** required in emergency or urgent care situations.

Medical Necessity

Services to be rendered must be medically necessary for Medicare to pay for the services. Services must meet specific medical necessity requirements contained in the regulations, manuals and medical necessity criteria defined by National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). National Coverage Determinations are developed by the CMS and determine the extent to which Medicare will cover specific services on a national basis. Local Coverage Determinations may be developed to further define an NCD and are a coverage determination made to provide guidance within a specific geographic area.

Common reasons Medicare may deny an item/service as not medically necessary can include care that is:

- Experimental, investigational, or considered research only.
- Not indicated for diagnosis or treatment in the specific case.
- Not considered safe and effective; or
- Exceeds the allowable Medicare number of services in a specific period for the diagnosis.

Key Sections and Blanks to Be Completed on the ABN

- **Notifier** (or service provider): This information may be in the form of the provider's logo and should include their name, address, and telephone number.
- **Patient Name**: The patient's first and last name, as well as a middle initial if shown on the Medicare card, should be entered here.
- **Service to be rendered:** The service provider must list the specific service or items believed to be non-covered.
- **Reason Medicare May Not Pay:** The service provider must explain why Medicare may not pay for the listed service/item. Examples of appropriately stated reasons are "Medicare does not pay for this test for your condition" or "Medicare does not pay for this test as often as this."
- **Estimated Cost**: The estimated cost should be entered to ensure the patient has all the information needed to make an informed decision.
- **Options:**
    - **OPTION 1**. I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays, or deductibles.
    - **OPTION 2**. I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

  - **OPTION 3**. I don't want the _____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay**.
- **Signature**: The beneficiary or representative must sign the notice to indicate he/she has received and understands the notice.
- **Date**: The beneficiary must write the date he/she signed the notice.

Process for Completing the Form

- ABN must be verbally reviewed with the patient or his/her representative, and any questions must be answered before the ABN is signed.
- Employees of the provider of service may deliver the ABN, review the information on the ABN and explain the three options listed.
- Under no circumstances may the provider of service decide for the beneficiary which option to choose. Pre-selection of an option by the provider of service invalidates the notice.
- At the beneficiary's request, the provider of service may enter the patient's selection if the patient is physically unable to do so. The provider of service must annotate the notice accordingly.
- If a patient is having multiple services (listed in Blank D) and chooses to have some but not all of the services, more than one ABN may be issued.
- If the patient cannot or will not make a choice, the ABN should be noted. An appropriate example would be "the patient refused to choose an option".
- The ABN must be signed by the patient or patient's representative.
- A copy of the signed form should be given to the patient. The provider of services must keep the original notice.

HIPAA Notice of Privacy Practices

Purpose of the HIPAA Notice of Privacy Practices (NPP)

The HIPAA Notice of Privacy Practices informs patients of the privacy practices of their health care providers, as well as their own privacy rights with respect to personal health information (PHI). The NPP must be made available to anyone who asks for it. Health care providers who maintain a physical site must post their entire notice at the facility in a clear and prominent location.

The notice must be in plain language, include an effective date and describe:

- How the provider may use and disclose the patient's protected health information.
- The patient's rights and how he/she may exercise these rights, including how the patient may present complaints to the provider.
- How the patient may access his/her medical information.
- The provider's legal obligations are in maintaining the privacy of protected health information.
- A contact for further information about the provider's privacy policies, such as a hospital's Privacy Officer.

Delivery Methods

Because not all initial patient encounters are face-to-face, the HIPAA Privacy Rule allows enough flexibility to address the various types of relationships health care providers may have with their patients.

The notice may be delivered to patients in the following ways:

- **Face-to-Face**: The notice and acknowledgement requirements may be taken care of at the time the patient arrives for his/her appointment.
- **Through the Mail**: A provider who first treats a patient over the phone can satisfy the notice requirement by mailing the notice to the patient the same day. To satisfy the acknowledgement provision, the provider can make a good faith effort to obtain written acknowledgement by including a document to be signed and returned by the patient.
- **Electronically**: For service provided electronically, the notice should be sent automatically in response to the patient's first request for service. An electronic return receipt from the patient is considered a valid written acknowledgement of the notice.

The Notice of Privacy Practices: An Overall View of What Is Included in the Notice

The NPP is meant to focus patients on privacy issues and concerns, encouraging patients to have discussions with their health care providers and exercise their rights.

The following is a synopsis of the sections and information included in the Notice of Privacy Practices:

A. Opening Disclosure Statement:
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This section advises patients of the health care facility's legal obligations to:

- Keep medical information confidential.
- Provide the Notice of Privacy Practices to patients.
- Follow the terms of the current Notice of Privacy Practice.

B. Your Privacy Rights
This section informs patients they have certain rights and explains what those rights and responsibilities are when it comes to their health information.

Examples of rights included in the NPP are patients' rights to:

- Get an electronic or paper copy of their medical record.
- Ask to have any incorrect or incomplete medical record information corrected.
- Ask the provider to limit what they use or share.
- File a complaint if they feel their rights have been violated.

C. Your Choices
In certain situations, patients can tell the provider their preferences for how their medical information is shared. Patients are encouraged to talk to the health care provider about such choices.

In these cases, patients have the right and choice to tell the provider to:

- Share information with family, friends or others involved in care.
- Share information in a disaster relief situation.
- Include the patient's name in a hospital directory.
- Contact the patient for fundraising purposes. The provider may contact a patient for fundraising purposes, but the patient can ask not to be contacted again.

In these cases, the health care provider will never share patient information without permission:

- Marketing purposes.
- Sales of patient information.
- Most sharing of psychotherapy notes.

D. Uses and Disclosures of Your Medical Record

This section informs patients of ways in which their health information is normally used or shared. While health information may be used for purposes of treatment, business, and billing, it may also be shared for reasons relating to public health, research, or law.

The following are examples of use and disclosure information included on the NPP. The health care provider may use and share health information to:

- Treat the patient.
- Run the organization.
- Bill for the patient's services.
- Comply with the law and regulations.
- Address workers' compensation and government requests.
- Assist with public health and safety issues.

E. Our Responsibilities:

This section informs patients of the responsibilities of the health care provider who is rendering services to the patient.

Health care provider responsibilities listed on the NPP state the provider is required:

- To maintain the security and privacy of patients' PHI.
- To let patients know promptly if their information is compromised.
- To follow the duties and privacy practices described in the notice.
- To provide a copy of the notice to patients.

F. Changes to the Terms of This Notice

The patient is advised of the provider's right to change the terms of the Notice of Privacy Practices and that changes will apply to all the patient's information. The new notice should be available upon request, at the provider's location and on the provider's website.

The required effective date of the notice will also be listed in this section of the NPP.

HIPAA Requirements for a Notice of Privacy Practices Acknowledgement

HIPAA requires health care providers to obtain a patient's written acknowledgement that the patient received the provider's Notice of Privacy Practices, or to make a good faith effort to obtain such acknowledgement. HIPAA also requires providers to document that the patient's written acknowledgement was obtained or that a good faith effort was made to do so. HIPAA does not require subsequent revisions of the notice to have another written acknowledgement, but the revised notice should be made available upon request on or after the effective date of the revision.

While the verbiage of the actual acknowledgement of the receipt of the Notice of Privacy Practices may vary among providers, the form should contain:

- Acknowledgement statement asking patients to verify they have received the provider's NPP and has been encouraged to read the notice in full.
- A signature line for the patient or their representative's signature and date.

An Important Message from Medicare (IMM)

Purpose

The Centers for Medicare and Medicaid (CMS) require that all Medicare inpatients receive written information about their rights. An Important Message from Medicare (IMM) is the hospital inpatient notice given to all beneficiaries with Medicare or a Medicare Managed Care plan. The IMM explains the Medicare patient's rights while in the hospital and how they may file an appeal if they feel they are being discharged too soon. It is important that Medicare beneficiaries receive the IMM notice so they will understand their rights and be able to

exercise them if necessary. For the hospital, delivering the IMM is necessary in maintaining compliance with CMS requirements regarding the notice.

Components of the Important Message from Medicare Notice

Hospital Inpatient Rights

As a hospital inpatient, beneficiaries have the right to:

- Receive Medicare covered services.
- Be involved in any decisions about their hospital stay and who will pay for it.
- Report any concerns they have about the quality of care received.

Medicare Discharge Rights

If beneficiaries think they are being discharged too soon, they may:

- Talk to the hospital staff, their physician and managed care plan.
- Appeal their discharge and have it reviewed by a Quality Improvement Organization (QIO).

While a patient's review is in progress, the patient will not have to pay for the services received during the appeal (except for charges such as copays and deductibles). If the beneficiary does not appeal and decides to stay in the hospital past the planned date of discharge, the patient may have to pay for any services he/she receives after that date.

Steps to Appeal the Discharge: Beneficiaries are given precise details on how to appeal their discharge and what will happen during the appeal process. Information is also included on what to do should the appeal deadline be missed.

Signature and Date: The IMM notice must be signed and dated by the beneficiary or his/her representative to acknowledge receipt and understanding of the notice.

Delivery Timeframe and Policy

The Important Message from Medicare Form: The Important Message from Medicare form is an Office of Management and Budget (OMB) approved form and **cannot** be altered from its original form. The form is available from the CMS.

Initial Delivery and Signature: Responsibility for delivery of the form is determined by the hospital and is usually performed by Registration, Case Management, Nursing or Social Work. Hospitals must deliver the original copy of the IMM at or near admission, no later than two calendar days following the admission date. The IMM must be delivered to the beneficiary in person and signed by the beneficiary. If the beneficiary is unable to understand the notice, the IMM must be delivered to and signed by the beneficiary's representative.

The initial copy may also be delivered during a preadmission visit, but not more than seven calendar days before the admission. If a beneficiary receives and signs the initial notice during a preadmission visit which is more than two days prior to the admission, a follow-up copy must be given to the patient.

The IMM must be signed and dated by the beneficiary (or beneficiary's representative) to indicate that he/she has received the notice and understands its contents. If a beneficiary refuses to sign the notice, the hospital must note the IMM to indicate the refusal to sign. The notation may be entered on the signature line, in the "Additional Information" section (page 2) of the notice or a separate piece of paper may be attached to the form if necessary.

Follow Up Delivery

The follow-up copy of the IMM must be delivered as far in advance of discharge as possible, but no more than two calendar days before the planned discharge date. When discharge seems likely within one or two calendar days, arrangements should be made to deliver the follow-up copy of the IMM. When discharge cannot be predicted in advance, the follow-up copy may be delivered as late as the day of discharge, but beneficiaries who need it must be given at least four hours to consider their right to appeal.

If the follow-up notice has been delivered, and the beneficiary's status changes causing the discharge to be beyond the two-day timeframe, another copy of the IMM must be delivered within two days of the new discharge date.

Retention of the IMM

The beneficiary keeps the original copy of the notice. Hospitals are required to retain a copy of the signed IMM and may do so electronically.

Part A Medicare Outpatient Observation Notice (MOON)

Purpose

The MOON informs all Medicare beneficiaries when they are an outpatient receiving observation services and are not an inpatient of the hospital or critical access hospital (CAH).

The MOON must be delivered to beneficiaries in Original Medicare (fee-for-service) and Medicare Advantage enrollees who receive observation services as outpatients for more than 24 hours. The hospital or CAH must provide the MOON no later than 36 hours after observation services as an outpatient begin. This also includes beneficiaries in the following circumstances:

• Beneficiaries who do not have Part B coverage (as noted on the MOON, observation stays are covered under Medicare Part B).

• Beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON. • Beneficiaries for whom Medicare is either the primary or secondary payer.

Initial Delivery and Signature: Hospitals and CAHs must provide both the standardized written MOON, as well as oral notification. Oral notification must consist of an explanation of the standardized written MOON. The format of such oral notification is at the discretion of the hospital or CAH, and may include, but is not limited to, a video format. However, a staff person must always be available to answer questions related to the MOON, both in its written and oral delivery formats. The hospital or CAH must ensure that the beneficiary or

representative signs and dates the MOON to demonstrate that the beneficiary or representative received the notice and understands its contents. Use of assistive devices may be used to obtain a signature. Electronic issuance of the MOON is permitted. If a hospital or CAH elects to issue a MOON viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic issuance if that is what the beneficiary prefers. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the MOON and the required beneficiary specific information inserted, at the time of notice.

The MOON must be delivered to a beneficiary who receives observation services as an outpatient for more than 24 hours and must be delivered not later than 36 hours after observation services begin. The MOON must be delivered 36 hours following initiation of observation services if the beneficiary is transferred, discharged, or admitted. The MOON may be delivered before a beneficiary receives 24 hours of observation services as an outpatient.

If the beneficiary refuses to sign the MOON, and there is no representative to sign on behalf of the beneficiary, the notice must be signed by the staff member of the hospital or CAH who presented the written notification. The staff member's signature must include the name and title of the staff member, a certification that the notification was presented, and the date and time the notification was presented. The staff member annotates the "Additional Information" section of the MOON to include the staff member's signature and certification of delivery. The date and time of refusal is the date of notice receipt.

Retention of the MOON

The hospital or CAH must retain the original signed MOON in the beneficiary's medical record. The beneficiary receives a paper copy of the MOON that includes all the required information. Electronic notice retention is permitted.

Meaningful Use

Meaningful use is using certified electronic health record (EHR) technology to:

- Improve quality, safety, efficiency, and reduce health disparities.
- Engage patients and family.
- Improve care coordination, and population and public health.
- Maintain privacy and security of patient health information.

CMS Definition: Meaningful Use is a CMS Medicare and Medicaid program that awards incentives for using certified electronic health records (EHRs) to improve patient care. To achieve Meaningful Use and avoid penalties, providers must follow a set of criteria that serve as a roadmap for effectively using an EHR.

- Stage 1 - Promotes basic EHR adoption and data gathering.
- Stage 2 - Emphasizes care coordination and exchange of patient information.
- Stage 3 - Improves healthcare outcomes.

Patient Access Impact: Must correctly record all the following demographics:

- Preferred language
- Gender

- Race
- Ethnicity
- Date of birth

No Surprises Act

The No Surprises Act prohibits providers and facilities from billing patients an amount above what they would typically pay for their in-network cost-sharing—an amount outlined in patients' insurance plans. These protections apply to health care delivered in emergency settings (including air ambulances but excluding ground ambulances) and in non-emergency settings when a patient receives care from an out-of-network provider (without advance notice).

The No Surprises Act also outlines processes for resolving payment disputes between an out-of-network provider or facility and the health plan. Providers and plans will have a 30-day negotiation period to settle disputes. If they cannot reach an agreement, the parties can use a binding arbitration process, also known as an independent dispute resolution (IDR), where one offer prevails. Processes will be administered by third party, unbiased entities with no affiliation to the providers or payers. The administrators must consider the market-based, median in-network rate, along with other relevant information provided by the parties. Following the IDR, the party who initiated the process may not request another arbitration process with the same party for the same item or service within 90 days of a decision.

- Holds patients liable only for their in-network cost-sharing amount, while giving providers and insurers an opportunity to negotiate reimbursement.
- Allows providers and insurers to access an independent dispute resolution process in the event disputes arise around reimbursement. The legislation does not set a benchmark reimbursement amount.
- Requires both providers and health plans to assist patients in accessing health care cost information.
- Bans surprise billing for emergency services. Emergency services, regardless of where they are provided, *must be treated on an in-network basis without requirements for prior authorization.*
- Bans high out-of-network cost-sharing for emergency and non-emergency services. Patient cost-sharing, such as co-insurance or a deductible, cannot be higher than if such services were provided by an in-network doctor, and any coinsurance or deductible must be based on in-network provider rates.
- Bans out-of-network charges for ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances.
- Bans other out-of-network charges without advance notice. Health care providers and facilities must provide patients with a plain-language consumer notice explaining that

patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

SECTION 3
PATIENT FINANCIAL SERVICES

The World of Patient Financial Services

The role of Patient Financial Services (PFS) is continuing to change to keep up with the increasing demands of the healthcare industry. During the last 15 years, the healthcare industry has experienced many changes affecting the revenue cycle.

The most recent major changes impacting PFS are the implementation of the ICD-10 CM and PCS coding methodology change in October 2015, and the implementation of the regulations impacting financial assistance policies. Both changes are covered in detail in other chapters of this manual or in the Advanced CPAR reference materials.

In addition, the ongoing confusion around pricing transparency and the increase in high deductible insurance plans have put extra stressors on the PFS department to step up their game related to these topics. To improve the cash flow, PFS departments have had to increase resources, including patient loan or financing programs, addition of staff and outsourcing partners, and the implementation of new technologies to aid them in collecting more from the patient than in the past. The ongoing challenge around accurate price estimates and access to understandable information for the consumer continues to be a struggle for healthcare providers.

Managing Denials

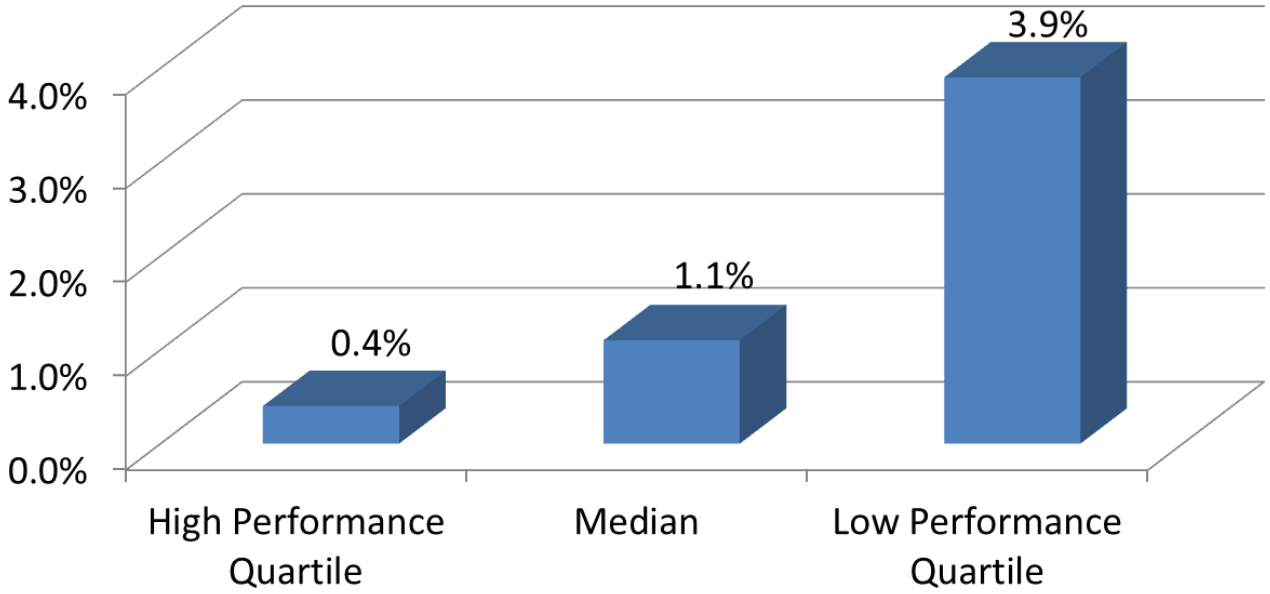
Denials Management Role in an Effective Revenue Integrity Program

Effective and aggressive management of denials is essential to a robust revenue integrity program. Similar to current trends in the management of patients from a sickness to a wellness model, recent trends in denials management are recasting denial initiatives from an "after-the-fact" appeals effort toward an effective prevention program.

Successful organizations aggressively manage front end processes to limit the impact of denials, expedite cash flow and provide a solid level of assurance that monies collected today are protected from post review audit and takeback efforts.

Impact on Results Operation

- Industry data indicates that initial denials as a percentage of outstanding accounts receivable for half of hospitals exceed 5%; with 30+% of hospitals reporting initial denials above 10% (Source: *Financial Leadership Council 2011, Revenue Cycle Survey; The Advisory Board Company*).
- Denial write-offs, based on a 2011 Advisory Board Company study indicated that the Percentage of Net Patient Revenue lost to total denials range from .4% to 3.9%, annually.



- More recent studies show that average denial write-offs, as a percentage of Net Patient Service Revenue, have increased slightly to 1.2%. (Source: *Healthcare Business Insights' Solution Provider Academy Survey)*

Making Sense of Denial Numbers

- Making sense of your own denial numbers is vital to understanding the impact denials can have on operational results.
  - EXAMPLE: HOSPITAL "A"
  - Annual Gross Revenue = $1Billion ($83M per month)
  - Net revenue is approximately 30% of Gross (30% of $1 Billion = $300Million)
  - Facility's net operating margin = 3% (3% of $300M) = $9 Million
  - 1.2% lost to denials annually = $3.6M left on the table
  - Losing 40% of potential net operating margin!
  - EVERY YEAR!!!!!
- In addition to the total denied dollars, it is estimated to cost an organization between $2-$10 ***per claim*** to re-bill or re-process a claim, with difficult issues costing up to $25 per claim.
- ***75% of initial denials*** are traced back to the front end:

Source: Financial Leadership Council 2011 Revenue Cycle Survey. The Advisory Board Company. 2011.

Types of Denials

Understanding the type and source of denials received by an organization is critical to designing a program focused on prevention and/or effective appeal and overturn**.**

Denials are generally analyzed and reported using the following breakdowns:

Clinical vs. Technical Denial

- **Clinical denial** = A claim that fails to meet established coverage guidelines or the care fails to meet certain medical necessity criteria as established by the payer. Examples of clinical denials include:
    - No pre-authorization/no pre-certification was obtained (either before or after service was provided)
    - Post-billing medical necessity review failed to deem care as medically necessary. May include downgrade of inpatient status (level of care or length of stay)
    - Pre-existing conditions may be excluded.
    - Procedure deemed experimental and not approved.
    - Emergency care is deemed to be non-emergent in nature.
- **Technical denial** = A claim that fails to contain the necessary information required for the payer to process the claim. Also known as "administrative" denials, such denials are generally linked to claims that were incorrectly filed. Examples of technical denials include:
    - Claim not submitted per payer's timely filing guidelines (Note: There is no one set guideline for commercial and managed care payers; these are contract specific and may be product (HMO vs. PPO) specific)
    - Service was out-of-network and insured's plan does not pay when out-of-network.
    - Improper bill type used to file claim.
    - Wrong demographic information (name, birth date, relationship to insured, policy number missing or invalid)
    - Non-covered procedure or invalid/incorrect revenue code
    - Wrong or missing pre-certification number.

Hard Denials, Soft Denials & Partial Denials

- **Hard denial** = Claim will require an appeal for the payer to reconsider payment for the claim. Examples of "Hard" denials include:
    - Medical necessity
    - Untimely claim
    - Coding incorrect/incomplete
- Soft denial = Claim requires further submissions or work on behalf of the provider to provide the payer with the required information to process and pay the claim. Soft denials may have limited timelines within which the provider must respond to prevent a denial for untimely filing. Examples of "Soft" denials include:
    - Additional information requested from patient (potential third-party situation)
    - Medical records requested to substantiate medical necessity.
    - Ungrouped code on claim requiring further input from provider.

- **Partial denial** = Line items within the claim are denied or require additional input from the provider. Examples of "Partial" denials include:
    - Certain dates of service denied for lack of authorization (for claims spanning multiple date ranges)
    - Line-item denial for certain procedures performed in Emergency room settings (i.e. medical necessity for CTs or MRIs performed in the ER)
    - Dates of service on span claims denied because insured was not covered for a portion of the claim period (may apply when insured changed employer plans or crossed over into another period of coverage under a different plan/same employer)

Tracking/Reporting and Automation of Denials
Tracking/Reporting of denials should include:

- Initial denial rate
- Final denial rate
- Underpaid claims (potential silent PPO activity; contract interpretation issues with payer)
- Zero paid claims (Patients enrolled in Hospice, potential other Third-Party liability claims; incorrect claim for VA coverage)
- Payer specific/Payer report cards to be used for contracting/negotiations.
- CAS/ANSI reason code
- Inpatient vs. Outpatient
- Dollars by Department/Clinical area (Outpatient vs Inpatient)
- Dollars by Performing/Ordering MD

Automating denial workflow

- Best practice=robust workflow tool & design
- Route denials to area(s) of responsibility
    - Billing need (Itemized bill, claim form change)
    - Coding/Documentation issues
    - Clinical/Charge review audits
    - Additional information requests
    - Medical necessity denial experts (clinical and MD expertise)

Proactive Processes to Decrease/Manage Denials

Denials management and protecting payment dollars from retroactive takeback are not isolated to just the front-end processes. Providers can instill best practices that positively impact denials or take-backs throughout the revenue cycle process as outlined below:

"BEST-PRACTICE"- Pre-Service processes:

- Standardized communication & workflow
- Centralized/spontaneous eligibility and insurance verification tools/systems.
- Centralized pre-certification/authorization.

- Pre-procedural coding reviews (Screen for Inpatient only procedures to assure that patient's status is correctly assigned)
- Use of Payer Pre-determination reviews (closer to a guarantee of payment)
- Effective Peer to Peer communication (MD to MD re: Authorizations/Medical Necessity)
- Accurate/complete clinical documentation; including:
    - Justification & Medical reasoning to support all procedures performed and services provided.
    - Documentation for use of Specific Drugs
    - Documentation for use of Implants
    - Documentation and support for use of high-cost biologics
- Robust estimates and pre-service collection discussion with patient
- Engagement of patient in pre-authorization process
    - Understanding & communicating re: eligibility, authorization & plan benefits
    - Advance notification
    - Use of scripting & coaching to assist patient access with front-end collection processes.
    - Payment/Payment Plan discussion
- Creation of permanent record for all authorization related documents & conversations; preferably an "Electronic Revenue Record" system
- Effective rescheduling process (authorization updates)
- Review of Medical Necessity vs. Covered Services

"BEST-PRACTICE "- Time of Service processes:

- Medical necessity/ABN flags within clinical systems (Ordered vs. Authorized)
- Effective management of Add-on Procedures
- Post-Procedural coding reviews (Ordered vs. Performed, Inpatient only)
- Post-Procedure change notifications to payer
- Care Coordination/Utilization Review: Concurrent Notification of initial status & subsequent changes to payer and patient.
- Aggressive late charge management
- Timely procurement of invoices related to implants/drugs/biologics (where required for claim filing)
- Payment/Payment Plan discussions with patient

"BEST-PRACTICE "- Post Service processes:

- Timely & Effective claim follow-up processes
- Comprehensive denial reporting
- Aggressive appeals process – Root cause analysis
- Effective use of external resources for denial overturns
- "State of Art" claim filing tools (Claim scrubbers/electronic attachments)
- Timely & Proactive analysis and management of retroactive adjustments/takebacks
- Rebill analysis – Root cause.
- Contract performance by payer.
- Routine Provider: Payer Round Reviews (Underpayments/Average time to pay/Denial Trending)

- Effective use of State Hospital Association & Insurance Commissioner Office related to negative payment trends.
- Bad Debt and Charity analysis – Use of Propensity to pay systems.
- HCAPHS/Customer Service results – Why are patients not happy?
- Understanding impact of reimbursement "penalties" for Medicare – Proactive management of Readmission and Quality data)

Follow-Up (Collections)

In recent years, the explosive growth in the cost of healthcare services and the introduction of the Affordable Care Act has dramatically increased the portion of the bill paid by the patient. Increasing deductibles, copayments and cost-sharing limits has caused the percentage of payments being owed by patients to escalate. Patient portions now make up a much greater percentage of hospitals accounts receivable. The type of insurance products seen today are like "major medical" plans often found 40 - 50 years ago; providing limited coverage for routine and day to day medical costs but providing a "fail-safe" for higher dollar/catastrophic situations. Because the collection of the patient responsibility portion can make or break the financial health of any organization, it is vital to the organization to have a robust follow-up department supported by sound policies and procedures.

Best Practices

Because of rising self- pay portions, the following best practices have been identified and should be implemented as part of the Access (Pre-Service) Department. These initiatives can help dramatically reduce the amount of time spent on follow-up.

- Utilize a comprehensive and financially focused pre-registration program/policy that includes:
    - Financial counseling
    - Insurance eligibility checks
    - Verification of benefits
    - Pre-authorization / certification
    - Accurate patient estimates and proration of patient portion
- Establish payment options for patients to be easily able to pay their portion of the bill. Actively promote alternative payment options such as credit or debit cards, ACH bank drafts, long-term payment plan options, etc.
- Implement a financially focused discharge area for inpatients, emergency room and high dollar outpatients to collect deposits and/or make payment arrangements for estimated dollars due.
- Make visits to bedded patients' rooms to investigate all potential third-party coverages that may be available (including options such as crime victim funds) and make financial arrangements for self-pay portions.
- Collect dollars due or finalize payment arrangements before services are rendered.
- Identify previous bad debt accounts and provide patients with financial counseling prior to rendering services at all entry points, except where EMTALA laws apply.
- Establish a tracking mechanism to monitor cash collections and implement goals to achieve better collections in all areas and to differentiate between all collection points.

Follow-up Process

Follow-up should be performed both before and after claim and/or appeal submission. It is critical to contact the insurer, patient, or any other relevant party before spinning your wheels in attempts to correct claims or prepare appeals, without first ensuring that all necessary information has been obtained. The explanation of benefits or letter, which denied the claim, in whole or in part, may contain erroneous or incomplete information. Many times, an insurer will deny a claim for only one reason and will stop once that error or omission is identified. Other problems may, in fact, also exist with the claim but may not have been fully addressed at that time. This type of claim processing approach is used by many insurers and effectively legitimately lengthens the time of payment of the claim. If you make initial contact prior to acting, you may prevent further denials and additional delays.

Once correct claims or appeals have been submitted, you must follow up accordingly with the appropriate insurance company representative. Merely contacting customer service representatives monthly is many times insufficient to ensure proper handling of your issues. Simply asking for a "status" of the claim is woefully insufficient. Blanketed acceptance as the gospel of what is told to you is also grossly unacceptable. You must do more than merely ask questions and acknowledge answers. Instead of viewing claims as a follow-up as an attempt to understand the status of the insurer, this should be an aggressive attempt to ***collect*** on the claim. Therefore, the goal of claims follow-up should be to understand all barriers to payment with an attempt to resolve each and allow for speedy resolution and payment.

Proper "follow-up" is the gathering of information, prying for additional details, forcing proper handling, and documenting all actions and information. Anything less than this is insufficient and will result in further delay of payment – and may cause additional complications with your claims. This process is often much like a game – insurers count on you dropping the ball! This stage is the prime opportunity for that to happen. Don't lose out simply by failing to finish the game! Follow-up is as important as any other stage of the process. If you can forget about a claim, the insurance company surely can!

Exhaust All Available Options

You must know your contracts. If they or their relevant information is not available to you, aside from addressing this problem with management, you must ask pertinent questions of the insurer to determine what exactly you may do to rectify certain situations. Granted, asking the insurer for this sets up quite a biased situation, since you cannot expect them to know your contracts when you do not, let alone finding out what THEY are required to do and not do, but if it is all you have available to you, then it is better than nothing at all.

Once you have determined (to the best of your knowledge) the processes you must adhere to proceed with preparation of your plan of action. Again, this is a game – you MUST know the rules to properly formulate your game plan! First, determine whose rules you must follow; if no contract exists and you are an out-of-network provider, Alabama laws strictly dictate all handling by both parties. If you are in-network, your contract dictates accordingly.

Before proceeding, you must decide how many levels of review and what methods are available to you. For instance, if you are in-network with Blue Cross Blue Shield of Alabama and it is determined that only one appeal level is accepted, do you allow your new, inexperienced employee to attempt resolution? You only have one bite at the apple – know that going in and make it a good one.

And once that level is gone, are there other avenues of recourse left? Is the situation at-hand worthy of going to all available lengths? This is a critical question to ask before beginning any process, no matter how many levels are available, but especially if only a very small window of opportunity exists to resolve the claim. If you are willing and the account denial is worthy based on quality, quantity, dollar amount, principle or otherwise, you are best suited for action by being aware of that upfront, and more importantly, by informing the insurer of that up front. Regardless of the situation, it is always prudent to exhaust all available levels of appeal. You just never know what that next set of eyes will see whether from your staff or the insurers. Mistakes are made and opportunities missed simply by failing to run the course!

The Follow-up Department

A successful follow-up department should be comprised of knowledgeable employees who can demonstrate good customer service techniques to collect dollars due. These best practices should be implemented by the Follow-up Department:

- Self-pay balances should be segregated based on dollar amounts. Utilize actual phone calls for high dollar inpatient and outpatient claims vs. written notices for smaller dollar outpatient claims.
- Utilize multiple tools such as credit reports & propensity to pay analytics to prioritize which self-pay accounts are likely to be more collectable and which may need to be sent directly to external collection and bad debt agencies to accelerate cash flow.
- Outsourcing the Medicaid application process, applications for other status funded programs, out of state Medicaid, specialty lines of business such as Workers Compensation, VA claims and Patients holding international insurance may be recommended due to the unique nature and complexity in navigating the barriers to approval and ultimate payment.

Follow-up Categories

Follow-up should be separated into two different categories, one dealing with patient dollars owed and the other dealing with insurance dollars owed. Document all follow-up actions taken as this is critical to eliminating re-work and helps to ensure the effectiveness of each action being taken. Robust system workflow, if available, can streamline this process and use pre-selected criteria to assure that follow-up efforts are more efficient. Such systems allow only claims that meet your criteria appear for follow-up, provide timely reminder notices to assure claims do not go untimely and allow for maximum effectiveness of staff assigned to the follow-up/collections role.

Insurance Dollar Follow-up

Resolving Outstanding Issues

A well-educated employee can be the key to good follow up when insurance companies are involved. The employee should be able to communicate with the insurance company knowing the terminology used to be an effective collector.

The following tips can be used when dealing with Insurance payers to resolve outstanding claims issues:

- Claim Not on File – Before accepting this statement, review your documentation for previous notes or discussions with the insurance carrier representative.
- Verify the claim submission address.

- Cannot identify the Patient/Subscriber – Have the insurance representative check by name, date of birth, and SSN for both as well as the employer.
- Terminated Coverage – verify if the individual or group terminated. If it was the group, ask which insurer took over.
- Medical Records Requested – Why? Make sure it is not a general excuse. What specific records do they need? Verify if already submitted.
- Claim in Review –
    - Why? What are you reviewing for?
    - When did it go into review and when will it be out of review?
    - Who should I talk to when the claim is out of review?
    - Claim Denied – When was explanation of benefits sent and what were denial reasons?

Benefit Terminology

Some of the following benefit terminology will be helpful in reading and understanding the Explanation of Benefit Forms (EOBs) used by the insurer. It is critical that you understand how to read the EOBs to determine whether proper payment has been made by the insurer.

- Out-of-Pocket – A set amount (usually per year) that the patient must pay prior to the insurance company paying 100% of the allowed amount.
- Cost Share (Co-Insurance) – Patient responsibility usually with Tricare or Medicaid.
- Spend Down – Patient responsibility on Medicaid accounts.
- Copayment – A set amount the patient must pay each time certain type services are provided (such as Emergency Room).

EOB Information

EOBs are not standardized but most will provide some of the following information:

- Patients Name
- Member / Policy Number
- Dates of Service
- Amount Charged / Amount Allowed
- Provider Responsibility – amount cannot be billed to the patient (sometimes considered contractual adjustments)
- Patients Responsibility - equals co-pays, deductibles, co-insurance, or non-covered charges. These amounts can be billed to the patient.
- Other Insurance Payments
- Amount Paid by Insurance Company
- Contract Type – HMO, PPO, POS
- Remarks – codes whose definition is usually found elsewhere on EOB.

Determining Correct Payment / Contractual Adjustments

Many times, the EOB will give you two pieces of information and from that, you must calculate the missing piece. The following are examples of calculations used to determine correct payments / contractual adjustments:

- Total Charges minus Allowed Amount equals Contractual Adjustment
- Total Charges minus Contractual Adjustment equals Allowed Amount
- Allowed Amount plus Contractual Adjustment equals Total Charges
- Payment plus Contractual Adjustment plus patient responsibility equals Total Charges
- Patient responsibility plus insurance payment equals Allowed Amount
- How to figure percentages paid / owed on non-managed care or contracted services
- The percentage an insurance company paid equals payment amount divided by allowed amount.

The percentage a patient owes equals total patient responsibility divided by allowed amount.

Tips for collecting insurance dollars due.

- Prior to calling the insurance company, be knowledgeable of any contractual obligations your facility has with the company and/or employer. Be up to date on the patient's insurance benefits so that deductibles and co-insurance amounts can be determined. The more prepared and organized you are the better you can present your "case" to the payer.
- Use of imaging software for document retrieval of explanation of benefits and integrated posting of electronic remittance advices can save vast amounts of time for collectors. If you don't have to search file cabinets for documents, you can be much more effective.
- Work your A/R by payer type. When calling a carrier, it is more efficient if you can address more than one account at a time. This can easily be orchestrated if the accounts are being worked by insurance classification. Also, by consistently assigning a payer type to the same staff member, that individual can become familiar with the payer's system, reimbursement schedule and personnel.
- Work on your bigger dollar accounts first. Your major collection efforts should be directed to the dollars that have the most impact on your organization. Organize your A/R follow-up to monitor the biggest accounts first.
- Get the patient involved. Contact the patient at the first sign of payment delay, thereby reducing lag time. By working more closely with the patient, a team effort can be created to help reduce insurance denials or to help find payment options after a denial has been given.
- Have a sense of humor. You are more likely to get a positive reaction from the insurance company if you maintain a positive attitude.
- Have the persistence of a bulldog. Insurance companies always follow up to make sure they pay when they are supposed to. If promises are made during your call, document them in the account and hold the company responsible for following through.
- Appeal to a higher authority. If you feel you are being treated unfairly by the insurance company, remember your ability to get the patient or insurance commissioner involved. Sometimes just mentioning this to an insurance company will help.
- Be creative. If any insurance company says they never received a claim, get the company's fax number, and fax the claim over, then call to be sure the fax was received. Or request a secure portal address and ask that you be allowed to upload the requested information directly; TODAY!

Patient Dollar Follow-Up

Be familiar with the patient's account. Analyze the data in the file to give yourself a mental picture of the patient's demographic and socioeconomic background. By being familiar with this mental picture, you may be able to find payment solutions more easily.

Call your patients to follow up on their accounts. Identify yourself, state the reason for your call, and pause. Do not enter into a discussion of patients' financial or personal problems but give them a chance to make their own provisions for meeting their financial obligation.

If a commitment is not forthcoming, offer options:

- Listen to what the patient has to say. Work with patients and make sure they know you understand their problems, but it is still important they pay their bill.
- When speaking to patients, speak calmly and never, ever become sarcastic. Do not leave the call open ended. This is your chance to work with the patient and get the account paid.
- With uncooperative patients, mention the possibility of using a commercial collection agency and how that may affect the patient's credit rating. If the patient seems unimpressed, follow through with the necessary next steps for collection.
- Document all correspondence and telephone work. Do follow up and track all conversations, correspondence, and commitments and document everything in the patient's account.
- Offer discounts for prompt payments if this process is an approved method within your facility. This is probably the most effective way to get payments early. However, should you go this route, do some quick calculations to make sure that you haven't given away the store with your strategy.
- For those patients who have been identified as truly having financial issues, it may be necessary to refer those accounts to a Financial Counselor so that determination can be made regarding Hill Burton or Indigent Care Trust Fund eligibility. You do not want to leave unpayable dollars on the A/R however you must make sure your facility follows all 501R collection requirements and that you are appropriately representing the mission and values of your organization. It is often difficult to deal with patients that have financial issues so utilize trained Financial Counselors within your organization whenever appropriate.

Refunds and Credit Balances

Credit balances on patient accounts are a continuous occurrence in healthcare accounting. The management of credit balances should be done on a regular basis to conform to State and Federal guidelines and to maintain the integrity of the facility's outstanding Accounts Receivable. The return of an overpayment or refund should not be considered until the appropriate source is researched and identified. Sources/reason for overpayments or credits may include:

- Third party payers such as Commercial Carrier, Medicare, Medicaid, and Worker's Compensation
- Patient Payment
- Error in posting payments.
- Adjustment(s) or contractual improperly applied or absent

Third party payer credit balances should be returned to the appropriate carrier in accordance with guidelines established by the State Insurance Commissioner's Office. Overpayments are not returned to the

guarantor/patient in cases of a credit balance created by the co-ordination of benefits (multiple third-party payers). Monies are returned to the appropriate carrier.

If an insurance provider requests a refund for a payment mistakenly made, before any action is taken, consult your provider contract. If that contract covers erroneous payments, then the medical provider is obliged to comply with the provisions of the contract. If it is silent on this issue, then no refund should be processed unless an overpayment has occurred because of duplicate payments on the same account, or the amount paid is larger than the agreed upon contractual amount. Courts have consistently held that unless there is fraud or advance knowledge by the medical provider of the mistake, the provider is under no obligation to refund the erroneous payment. The reasoning relied upon is that the hospital/medical provider rendered services equal to the amount received, so they have not been unjustly enriched. When an erroneous payment occurs, one party is going to lose and the court's reason that the one who should take the loss is the one who was in a better position to have prevented the loss and that would have been the insurance provider that paid the claim.

The following information is broken down by payer category outlining the normal expectation for that line of business and should only be used only as a guideline. Each facility should have their own Policy and Procedure for handling refunds and should be aware of any specific obligations contained in their payer specific contracts.

Individual plans

Cancer plans and street plans (AARP, Principal Mutual, etc.) that pay as secondary/tertiary generally do not want overpayments coming back to them, provided they were billed with correct charges. Often the overpayment will be refunded to the guarantor. Initially, you will have to call and get clarification on the individual plan policies.

Commercial, HMO and PPO

Insurance plans follow certain criteria that establish them as primary, secondary, and tertiary carriers. Oftentimes, two carriers pay as primary, and it can be difficult to determine who the required primary payer is. Reviewing the EOBs, calling the payers, verifying with the place of employment, or calling the patient and/or guarantor can usually assist in clarifying the primary responsible payer. Once the proper payer order has been confirmed, you can then follow the payer's policy regarding processing a refund.

Workers Compensation (Work Comp)

Work Comp payers are normally the only payer liable on a Work Comp account. So, if there is an overpayment (and multiple payers) it will usually be refunded to the other payer, provided Work Comp considered all correctly billed charges. There will, however, be times where the Work Comp carrier is not responsible for total charges but for only a portion of the charges on the account. This is usually the case where the patient had "non-work injury related services" performed at the same time as the confinement for the work-related injuries. It is not uncommon to see where a provider has maintained all charges on a single account but then manually split the charges and billed the Work Comp carrier and another payer. Accounts where this has occurred "should" have notes within the system explaining the actions taken.

Governmental Payers

Medicare, Medicaid, and Tricare are very rarely refunded. These payers require a corrected bill (TOB xx7), or a voided/cancel bill (TOB xx8) be sent to them, and they will reprocess, and reverse payments made and pay correctly on the next remittance advice. When submitting xx7 or xx8 claims you must include the original claim's DCN/ICN number on the UB04 in FL 37.

When there is a liability payment and a payment from a governmental payer and the dollar amount for billed services is equal, the liability carrier is liable only up to the amount of the Governmental payer allowed amount. A corrected/voided (TOB xx7 & xx8 respectively), must be submitted to the governmental payer to reprocess and take back the original payment, the liability carrier must be refunded up to the governmental payer's allowed amount (inclusive of deductibles and co- ins) and a contractual adjustment must be posted for the difference between allowed amount and total charges.

Medicare

There are several situations where Medicare may need to be refunded money. At times, only a portion of the Medicare payment needs to be refunded, while at other times it may require that the total payment be returned. Whether the claim needs to be adjusted or fully recouped, it can usually be accomplished using the on-line FISS (Federal Intermediary Shared System).

If only a portion of the payment needs to be refunded, the payment will need to be adjusted on-line. The claim is retrieved on-line, appropriately adjusted/corrected, and condition/reason codes noted. In instances where Medicare should have been the secondary payer, the appropriate changes should be made on-line. If a claim needs to be cancelled because it was billed in error, etc., this can also be accomplished online using the appropriate and applicable codes.

Best practices should include continual monitoring of Medicare credit balances and timely corrections, where required. This will diminish the volume of data that must be reported to Medicare each quarter.

Providers participating in the Medicare program are required to complete a quarterly Medicare Credit Balance Report (CMS-838) and submit it to their Fiscal Intermediary (FI) within 30 days after the close of each fiscal year quarter to help ensure that monies owed to Medicare are repaid in a timely manner.

CMS-838 is specifically used to monitor identification and recovery of "credit balances" owed to Medicare. A credit balance is an improper or excess payment made to a provider as the result of patient billing or claims processing errors. Examples of Medicare credit balances include instances where a provider is:

- Paid twice for the same service either by Medicare or by Medicare and another insurer.
- Paid for services planned but not performed or for non-covered services.
- Overpaid because of errors made in calculating beneficiary deductible and/or co-insurance amounts; or
- A hospital that bills and is paid for outpatient services included in a beneficiary's inpatient claim.

For purposes of completing the CMS-838, a Medicare credit balance is an amount determined to be refundable to Medicare. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records as a "credit." However, Medicare credit balances include monies due to the program regardless of its classification in a provider's accounting records. For example, if a provider maintains credit

balance accounts for a stipulated period, e.g., 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider must identify and repay all monies due to the Medicare program.

Only Medicare credit balances are reported on the CMS-838. You should report all Medicare credits regardless of when they occurred (you are liable for any overpayments you have received back to when you began to participate in the Medicare program). If you have reported a credit once, do not report again.

Providers should refer to detailed CMS guidelines regarding the appropriate attestation requirements, specific data required about each credit being reported, approved methods for submitting your report and answers to any questions you may have about this required reporting.

NOTE: Failure to submit the quarterly credit report on a timely basis will result in suspension of future payments from the Medicare program. Only after the delinquent submission is accepted may payments be re-instated. Therefore, this quarterly reporting requirement is vitally important to prevent any cash flow delays.

Medicaid

Medicaid is always the payer of last resort. If an account has a credit balance and there are payments from multiple payers, Medicaid will usually be the first to be refunded. This is, of course, providing that all payments are applied correctly, and all charges are considered.

Processing Medicaid Refunds

At the beginning of each month a Medicaid Credit Balance report should be generated. Medicaid Billing staff should review all credit balance accounts and process overpayments for Medicaid. At the end of each reporting quarter the Medicaid billing staff will finalize the “Medicaid Credit Balance Report Form” and submit following the guidelines provided by the State Medicaid program.

Patient Overpayments

These may be transferred to another account. It is common practice and legal for US hospitals to transfer a patient payment originally posted to one account (that has resulted in a credit balance) to other accounts, provided the patient has an outstanding balance on the accounts where the money is being transferred. This practice can result in a single payment “floating” around the A/R on various accounts if the patient has multiple visits to a facility. Excess patient money is applied first to open A/R accounts where there is an outstanding patient balance shown, if there are no accounts fitting that criteria, the money is applied to open A/R accounts where there is an insurance balance due, if there are no accounts on the open A/R then money is applied to outstanding Bad Debt accounts. Only after these three categories have been exhausted should the overpayment be refunded to the patient.

Patient overpayments do not always go to the patient. You must know exactly who the Guarantor is on the account. If other than the patient, the refund goes to the guarantor. Additionally, if the patient information screens identify the patient as deceased or expired and the patient is also listed as the guarantor, refunds need to be addressed to “To the Estate of (Patient Name)”. This helps reduce returned mail and reduces the number of checks requiring new payee information. Be sure to review your facilities policy for specific refund policies.

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services

Contractual Allowances and Adjustments

Contractual Allowances

A "contractual" is a portion of charges that a provider agrees to forego (ultimately writing those charges off its books) and does not pass that amount on to the patient. It is based on a predetermined contract arrangement between an insurer (the payer of the claim) and the provider. The contractual amount is usually reflected on the Explanation of Benefits generated by the insurer.

The contractual amount can also be calculated by subtracting the allowed amount from the gross charges.

Allowed Amount

The allowed amount is the maximum dollar value assigned for a procedure by the payer and is based on various pricing mechanisms.

Tip - How to figure the allowed amount:

- Add together your insurance payment plus any patient liability (including patient co-pay, co-insurance, deductible etc.) this equals the allowed amount.

Allowances

Allowances are the amount of money that is written off and not collected due to a contractual obligation with a payer.

Adjustments

Adjustments are the amounts written off or written onto patient accounts, by a provider, due to policies and procedures of either the payer or the provider. Examples of adjustments include:

- Small balances as determined by the facility e.g. under $10.00.
- Late charges or credits as determined by the facility e.g. under $20.00.
- Charity Care approvals
- Late charges or credits on Inpatient Medicare accounts which are paid on DRG.

Contractual Allowance and Adjustment Tracking Codes

Contractual and adjustments are usually tracked by a code used when adjusting the patient's account. This supplies vital information to the provider for necessary items such as negotiating managed care contracts, reviewing departmental charge accountability, and indigent care levels.

Coordination of Benefits

Coordination of Benefits is a provision that establishes an order in which insurance plans pay their claims. It provides the authority for the orderly transfer of information needed to pay claims promptly and eliminates duplicate coverage when a patient is covered by multiple group plans. A coordination of benefits, or "non-duplication," clause in either policy prevents double payment by making one insurer the primary payer and assuring the insured's benefits from all sources do not exceed 100% of his allowable medical expenses.

- The procedures set forth in a Subscription Agreement to determine which coverage is primary for payment of benefits to Members with duplicate coverage.
- Used by insurers to avoid duplicate payment when more than one policy exists.
- Standard rules determine which of the plans, each having COB provisions, pays its benefits in full and which one becomes the supplementary payer on the claim in question.

Order of Benefits Determination is a sequence of regulations developed by the National Association of Insurance Commissioners (NAIC). The COB model determines which group plan pays benefits first.

For the Plan that Covers:	The Primary Plan is:	NAIC COB Model:
Subscriber and Spouse	The plan that covers the person as an employee or subscriber	Dependent/Nondependent Rule
Dependent Children	The plan of the parent whose birthday falls earlier in the calendar year. The actual year is ignored.	Birthday Rule, if the parents: • are married • are not separated • have a court decree awarding joint custody without assigned health care coverage responsibility
Dependent Children of divorced or separated parents *with* divorce decree	The plan of the parent that the court deems is responsible for the child's health care coverage.	Divorce Decree
Dependent Children of divorced or separated parents *without* a divorce decree	In this order; the plan of the: • parent with custody • spouse of custodial parent • non-custodial parent • spouse of non-custodial parent	Custody Rule
Subscriber of two plans - active and non-active	The plan that is active	Active/Inactive
Subscriber of two plans - active and Cobra or State Continuance	The plan that is active	Subscriber Rule
Subscriber and a Spouse - active and Cobra or State Continuance	The subscriber's plan	Subscriber Rule
Subscriber - two active plans	The plan that has been in effect the longest period of time	Longer/Shorter Length of Coverage

Birthday Rule

The benefits of the insurance plan of the parent whose birthday falls earlier in a year are determined before those of the insurance plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the insurance plan which covered one parent longer are determined before those of the insurer which covered the other parent for a shorter period.

Example:

- Mom has insurance through Aetna (effective date is 1/01/2000) DOB: 1/5/1952.
- Dad has insurance through BCBS of AL (effective date 1/01/1999) DOB 2/1/1952.

In the above example, the mother's insurance is the primary payer due to her date of birth. If the date of birth were to be changed so that both mom and Dad have the same birthday, it would change to primary payer to the father since his coverage has been in effect longer than his wife's policy.

Gender Rule

This rule is still in use by some payers. If this rule is used, the male's insurance is the primary payer.

Dependent Child / Separated or Divorced

Insurance payers have different rules regarding primary benefits in child custody situations. The most common rule is the Custody Rule which dictates that the primary insurer will be determined by whichever parent has full custody. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are most likely determined in this order:

- First, the plan of the parent with custody of the child.
- Then, the plan of the spouse of the parent with the custody of the child.
- The plan of the parent not having custody of the child.
- Finally, the plan of the non-custodial parent's *spouse*.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan.

Medicare Secondary Payer

Patients who are covered by Medicare are required to complete the MSP Questionnaire during the registration process to determine which payer is primary. Medicare is Secondary to most other insurers.

Allowable Expense

The 2013 Coordination of Benefits Model Regulation developed by the National Association of Insurance Commissioners (NAIC) defines an "allowable expense" as any healthcare expense that is covered partially or in full by any of the insurance plans covering the individual. Allowable expenses include co-insurance and co-payments.

Many states adopt the NAIC model regulation in part or in full. However, states can adopt or reject portions of the NAIC model regulation. It is important to review applicable state regulations, as coordination of benefits requires a comprehensive understanding. For example, the New Jersey Department of Banking and Insurance (Bulletin 03-17; Appendix A of N.J.A.C. 11:4-28) limits the secondary plan's allowable expense to the lesser of (a) the amount of any deductible, co-insurance, or copayment assigned by the primary plan or (b) the amount the secondary plan would have paid had it been the primary plan. Therefore, under New Jersey state law, a provider cannot receive an amount more than what the primary plan would have paid.

Secondary Plans: Process to Determine Benefits and Pay Claims

The model regulation developed by the NAIC provides guidance as to how a secondary plan should process claims. While most states adopt the NAIC regulations in part or in full, some states have chosen to enact legislation that differs from the NAIC model regulation. Additionally, please note that contractual agreements may counter the NAIC model regulation. For the purposes of this example, assume that the state regulations mirror the NAIC model.

Should a secondary payer wish to coordinate benefits and make payment on a claim, the secondary plan should calculate benefits as though there was no other health care coverage present. In other words, the secondary plan should calculate the benefits it would have paid when the plan is primary. The secondary plan should then apply the calculated amount to any allowable expense that the primary plan did not pay. The secondary plan

may adjust its payment such that the sum of the amounts paid by the primary and secondary plans does not exceed 100 percent of the total allowable medical expense for that claim.

Coordination between Differing Insurance Types

Depending on state law, coordination between varying insurance types may or may not be permitted. State law plays a role in determining whether two plan types (e.g. auto insurance med pay and commercial group health plan) can coordinate benefits as described above. Please review the applicable state regulations as they may determine whether two plans can coordinate with one another. The examples below examine some of the insurance types and the impact it may have on coordination of benefits.

Primary Plan	**Secondary Plan**	**Coordination of Benefits**
Group Health Plan	Group Health Plan	Primary plan processes the claim at their allowable; secondary plan determines their allowable, deducts the primary payment from their payment
Auto Med Pay/ Personal Injury Protection (PIP)	Group Health Plan	Auto med-pay/Personal Injury Protection (PIP) typically remits payment until benefits are exhausted ($1-5k flat payment); group health plan determines their allowable, deducts the med pay (primary) payment from their payment. However, plans may not be permitted to coordinate based upon state law. See below for more detail.
Group Health Plan	Individual Health Plan	Depending upon state law, group health plans and individual plans may not be permitted to coordinate with one another. If they are restricted from coordinating with one another, each plan will pay as though they are the primary payer.

In some states, auto insurance plans and individual plans are excluded from the definition of a plan. As such, these types of plans are not permitted to coordinate with other plan types (typically group health plans) under state law. For example, California's Code of Regulations (28 CCR § 1300.67.13(b) (2) (A)) does not include medical payments made by an auto insurer in the definition of a plan. As such, both the auto insurance (assuming a patient has med pay/PIP through their auto insurer) and the group health plan would be required to pay as though they were the primary plan. The secondary plan may not reduce benefits by the amount paid by the primary plan. Similarly, some states do not allow for coordination between group health plans and individual health plans. California's Department of Insurance COB Regulation (10 CCR §2232.55) explicitly states that the definition of a "Plan" within a COB provision may not include individual policies.

Medicare Bad Debt and Charity

Definitions

Bad Debts

Bad debts are amounts considered to be uncollectible (generally due from patients)

Allowable Medicare Bad Debts

Allowable bad debts are amounts the provider has been unable to collect. Uncollected deductible and co-insurance amounts due from Medicare patients must meet criteria set forth in Section 308 of the CMS Provider Reimbursement Manual Part I. Allowable bad debts must be related to specific deductibles and co-insurance amounts.

Charity Allowances

Charity allowances are reductions in charges made by the provider of service because of the patients' indigence or medical indigence.

Courtesy Allowances

Courtesy Allowances are reductions in charges by the provider in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Reductions in charges made as employee fringe benefits, such as hospitalization and personnel health programs are not considered courtesy allowances.

Deductible and Co-insurance Amounts

Deductible and co-insurance amounts are amounts payable by beneficiaries for covered services received from providers of services, excluding medical and surgical services rendered by physicians and surgeons. These deductibles and co-insurance amounts, including the blood deductible, must relate to inpatient hospital services, post-hospital extended care services, home health services, outpatient services, and medical and other health services furnished by a provider of services.

Bad Debts under Medicare

Bad debts resulting from deductible and co-insurance amounts which are uncollectible from beneficiaries are not included in the provider's allowable costs; however, un-recovered costs attributed to bad debts are considered in the Program's calculation of reimbursement to the provider.

The allowance of un-recovered costs attributed to bad debts in the calculation of reimbursement by the Program results from the expressed intent of Congress that:

The costs of services covered by the Program will not be borne by individuals not covered,

The costs of services not covered by the Program will not be borne by the Program (deductibles and co-insurance amounts). These are the responsibility of the beneficiaries.

The inability of the provider to collect these deductibles and co-insurance amounts from beneficiaries could result in part of the costs of covered services being borne by others who are not beneficiaries of the program.

Therefore, to ensure that costs of covered services are not borne by others, the Medicare Program will reimburse the provider for allowable bad debts, not to exceed the total amount of un-recovered costs of covered services furnished to the beneficiary.

Bad Debts Relating to Non-covered Services or to Non-beneficiaries.

If a beneficiary does not pay for services which are not covered by Medicare the bad debts attributable to these services are not reimbursable under the Medicare Program. Likewise, bad debts arising from services to non-Medicare patients are not reimbursable.

Services which are not covered are defined generally in the following Health Information Manuals:

- HCFA-PUB-10 Hospital Manual – SECTION 230
- HCFA-PUB-11 HOME HEALTH AGENCY MANUAL – SECTION 230 AND 232
- HCFA-PUB-12 SKILLED NURSING FACILITY MANUAL – SECTION 240

Criteria for Allowable Bad Debt

A debt must meet the following 4 criteria to be considered an allowable Medicare bad debt:

- The debt must be related to covered services and derived from deductible and co-insurance amounts.
- The provider must be able to establish that reasonable collection efforts were made.
- The debt was uncollectible when claimed as worthless.
- Sound business judgment established that there was no likelihood of recovery at any time in the future.

Reasonable Collection Effort

To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and co-insurance amounts must be like the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. Additional collection attempts, such as subsequent billings, collection letters and telephone calls or personal contacts with this party should constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment.

Collection Agencies

A provider's collection effort may include the use of a collection agency in addition or in lieu of the provider's collection actions. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of the like amount to the agency without regard to class of patient (i.e. non-Medicare and Medicare patients treated in the same manner).

Documentation Required

The provider's collection effort should be documented in the patient's file by copies of the bills, follow-up letters, reports of telephone and personal contact, etc. (or in electronic file if paper files are not maintained).

Collection Fees

Where a provider utilizes the services of a collection agency and a reasonable collection effort is applied, the fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider.

When the collection agency obtains payment of an account the full amount collected must be credited to the patient's account and the collection fee charged to administrative costs. The fee charged by the agency is merely a charge for providing the collection service and therefore is not treated as a bad debt.

Presumption of non-collectability

If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectable.

Indigent or Medically Indigent Patients

In some cases, the provider may have established before discharge or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. Providers can deem Medicare beneficiary's indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:

- The patient's indigence must be determined by the provider, not the patient. A patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence.
- The provider should consider a patient's total resources which include, but are not limited to, an analysis of assets (only that convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses.
- The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill.
- The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information.

Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible.

Accounting Period for Bad Debts

Uncollectible deductibles and co-insurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless. Since bad debts are uncollectible accounts receivable, the provider should have the usual accounts receivable records-ledger cards and source documents to support its claim for a bad debt for each account included.

Examples of the types of information to be retained may include but are not limited to, the beneficiary's name and health insurance number; admission/discharge dates for Part A bills and dates of service for Part B bills; dates of write off; and a breakdown of the uncollectible amount by deductible and co-insurance amounts.

Medicare Bad Debts under State Welfare Programs

Where the State is obligated by either statute or under the terms of its plan to pay all or part of the Medicare deductible or co-insurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible or co-insurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided that the requirements are met.

In some instances, the State has as obligation to pay, but either does not pay anything or pays only a part of the deductible or co-insurance because of a state's payment ceiling. In these situations, any portion of the deductible or co-insurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare, and provided all requirements are met.

PROVIDER-BASED PHYSICIANS' PROFESSIONAL COMPONENT IS NOT CONSIDERED AN ALLOWABLE BAD DEBT.

Applying Collections from Beneficiaries

When a partial payment is paid to the provider and it is not specifically identified as to which debt it is intended to satisfy, the payment is to be applied proportionately to Part A deductibles and co-insurance, Part B deductibles and co-insurance and non-covered services.

Charity, Courtesy and Third-Party Payer Allowances Cost Treatment

Charity, courtesy, and third-party payer allowances are not reimbursable Medicare costs.

Credit Card Costs

Reasonable charges made by credit card organizations to a provider are recognized as allowable administrative costs.

Allowances to Employees

Allowances, or reduction in charges, granted to employees for medical services, as fringe benefits related to their employment are not considered courtesy allowances. Any costs of the services not recovered by the provider from the charge assessed the employee are allowable costs.

Note: Collection efforts need to comply with all requirements under IRS Code Section 501(r) (6) including the following:

Making reasonable efforts to notify the beneficiary of the hospitals' Financial Assistance Policy (FAP)

Not engaging in extraordinary collection efforts prior to making those reasonable efforts to determine if the beneficiary is eligible for financial assistance per the FAP.

Billing

Introduction

Billing a patient for services rendered begins at the first point of contact with the patient. Billing an accurate claim and getting the appropriate reimbursement that is due to the provider depends on how complete and accurate the data gathering process is at the point of access.

Many of the billing software products offer detailed reports that measure the accuracy of claims that are pending submission to the payers. The minimum standard for claim accuracy varies by provider and based on software used but the target accuracy rate should be more than 90%. Daily reports should be reviewed to monitor accuracy rates and failed claim rates.

The billing and claims submission process is vital to the integrity of the revenue being reported by any hospital or medical facility. A key component of a strong revenue integrity program is to ensure that billed and collected dollars are also safeguarded against post-service takebacks due to negative audit results.

Comprehensive processes within each organization should be in place to assure the following:

- All services provided are appropriately and accurately charged on the patient's bill.
- Clinical documentation supports the items billed and the need for the services provided.
- Bills are submitted in a timely manner to the payer and patient.
- Records are maintained post service for the legally required periods of time and available for post payment audit review.
- Unpaid and underpaid claims are pursued on a timely basis.
- Inaccurately paid claims are investigated and resolved on a timely basis.

There are many groups within the facility that are critical to assuring revenue integrity:

- Admissions/Pre-Access/Scheduling
- Physicians and other clinical staff
- Care Coordination/Case Management
- Medical Records/coding
- Billing/Post claim follow-up

The above areas are generally defined as the key players in a facility's "Revenue Cycle". Robust Revenue Cycle operations are key to an institution's cash flow and overall financial health.

Preparing the Claim

There are so many ways to improve or maintain the financial goals of the medical provider. One of the most important ways is by the effective preparation, submission, and collection of claims for maximum reimbursement. The first step of this process is the preparation of a clean claim.

Each successfully prepared claim directly impacts the financial health of the medical provider. An efficient claims management process needs to be understood by all members of the team because every member of the practice or hospital contributes to the preparation of a clean claim.

Front Office Staff

The front office staff is responsible for obtaining accurate patient demographic and insurance information. This is also the point that eligibility should be confirmed and verified. When the correct information is entered into the hospital billing or practice management system, the patient's claim has a greater chance of being paid by the insurer. When this information is incorrect, the claim can be denied for many reasons. Verifying insurance information is the best way to avoid inaccuracies that can potentially cause claims to be denied. The physician's office often supplies insurance information to hospitals when scheduling services which often leads to incorrect information for hospitals. Hospital providers should independently verify all billing information.

Physicians and Clinical Staff

The physician and clinical staff are responsible for the appropriate documentation of services provided and assignment of ICD and CPT codes at the physician's office. These codes should be provided for scheduling when scheduling services. Physicians and clinical staff are responsible for treating the patient and documenting the patient's history, treatment plan, procedures, diagnosis, symptoms, and other parts of the medical record. This information is necessary for the appropriate coding of the medical claim as well as providing documentation if requested by the insurer. Coding can only code what is documented. **If it's not documented, it didn't happen, as far as billing and coding is concerned.** Appropriate coding is also essential to the correct billing and processing of the claim. The most current and up-to-date ICD and CPT codes are used to accurately reflect the medical care the patient received during the visit.

Charge Capture: Each encounter points with the patient; contributes to billing accuracy and leads to a more effective and accurate revenue cycle. Charges are usually placed on the bill by an order entry system or, in some cases, manually. It is very important to capture all charges accurately and timely. Many facilities bill claims as early as three or four days after inpatient discharge or treatment date for outpatient services. Charges that are posted late to the patient's account can require a re-bill from the business office, lost charges, and lost revenue.

Case-Management/Care Coordination staff now play a vital role in the hospital's billing practices. Appropriately trained case managers are involved in assisting the physicians in determining the accurate status of the patient (inpatient vs. outpatient) and the setting in which that care is delivered (intensive care, routine skilled care, etc.). In recent years, much focus has been placed upon the accuracy of patient status and how these flow into the billing equation. Both CMS, as well as major national insurers, exert tremendous effort to review patient status and how services are billed for each patient. This area is often one of the top concerns due to the magnitude of dollars involved and may be where some facilities are the most vulnerable for post service payment adjustment and takeback.

Coding Staff

Coding professionals verify, compare, and review the documentation recorded in the medical record by the physicians and clinical staff against the ICD and CPT codes provided. When services and procedures don't match the diagnosis and symptoms on the claims, the claim will most likely be denied to medical necessity. In other cases, the claim may be denied for no authorization, or the authorization was obtained for a different procedure. Therefore, it is important for the coding staff to be an integral part of the billing and revenue cycle process.

In some medical practices and hospitals, staff members with coding training are responsible for contacting the insurer for the pre-authorization, pre-certification, and redetermination of services, as needed. Prior authorization is best obtained by someone with clinical or coding expertise because they can provide the

supporting information and documentation to the insurer that is critical to gain approval for the medical procedure/treatment and authorization for payment.

Accurate procedural and diagnostic coding are essential for the provider to receive correct and thorough reimbursement. Current Procedural Terminology (CPT) codes are assigned by the Coder or hard coded in the Charge Description Master (CDM). The Coder assigns the proper ICD-10 diagnostic and/or procedural codes according to documentation recorded in the patient's medical record.

Discharged Not Final Billed (DNFB)

Discharged Not Final Billed is another important aspect related to the effective management of accounts receivable and billing. DNFB measures how many discharged- not-final- billed/unbilled accounts are pending. Most health information systems provide reports that can be used to determine the volume and billed charges associated with accounts receivable the have not been billed to the payers. If the provider has a separate billing system, the rejected and not yet billed accounts in the billing system should also be monitored. Best practice facilities monitor DNFB daily and set specific targets for the total dollar amount carried in DNFB; generally, at or below 4 days from discharge/treatment.

Most facilities code records after patients have been discharged. However, exceptions may occur when an organization has a concurrent-coding program or for long-stay patients, during which interim billing and, therefore, interim coding may occur. Those accounts that are not yet billed at the time of discharge are listed on the DNFB list. This listing will include patient accounts categorized as suspended or discharged but unbilled. Accounts may be unbilled for a variety of reasons, such as the following:

- Coding has not been completed.
- Coding has been completed but there is no corresponding charge – often identified during the initial claim-editing process.
- Coding has been completed but there are no charges entered which will be entered within the "suspense period."
- Coded but rejected during the claim-editing process because of an unrelated HIM element, such as invalid revenue code, missing data element, or an inaccurate payer designator.

Billing Staff

The billing staff is generally responsible for generating the claim. Most practice management and hospital billing software systems are designed to generate a claim for billing. A biller's expertise is needed to resolve edits, review for accuracy, and validate the claim. Billers give the claim the final overview and rely on the other staff to provide information they need to submit a "clean claim". The billers' most important job is to know what information each payer requires on the claim for it to be processed quickly and accurately. Billers need to know the 4W's and 1H for billing claims – **Who, Where, What, When and How.**

- **Who** is the correct payer?
- **Where** is the correct address to send the claim?
- **What** is the information each payer requires?
- **When** is the time requirement for filing claims to the payer?
- **How** the claim to be is billed…What billing method is required by the payer? (Electronic, paper, etc.)

Patient Friendly Billing

Clear and understandable billing benefits both patients and healthcare providers, but it is the responsibility of providers to establish clarity from the beginning. Too much detail can be confusing, but too little can result in "no action" and no payment from patients. Finding this balance is tricky, and patients can become frustrated with the many providers whose quality ranges from superb to confusing.

Is Patient Friendly Billing the answer? It is certainly intended to be. In recent years, this initiative, spearheaded by Healthcare Financial Management Association (HFMA) with the partnership of the American Hospital Association (AMA) and the Medical Group Management Association, has emerged to defend patients' rights for clear and understandable billing. It is a seemingly simple term with a noble goal, but making it work in the real world can be a challenge. When care is given, communication is clear, and payment is received more promptly, the time and effort is justified.

How is Patient Friendly billing put into practice? Many providers have different ideas of what Patient Friendly billing means to them, but the essence should be common sense and clarity which help patients feel well-informed. Patients need to clearly understand what is expected of them or if more information is needed from them, especially if they owe a balance. The right amount of information at the right time, presented in a clean, professional format can set the tone for good, lasting communications.

There are three methods most providers use, in one form or another, to communicate with patients:

- Send and receive all correspondence themselves.
- Use services provided by their information systems vendor.
- Rely on a third-party vendor partner.

Any provider that has handled correspondence internally knows the considerable resources required to do so promptly, stay compliant and remain profitable. That is why so many providers rely on outside services that efficiently handle large volumes every day. As with most services, available technology, knowledge of healthcare billing and a desire to work closely with providers all play a big part in the quality of external solutions. Not all companies that print and mail patient statements are created equal.

If a decision is made to outsource billing for your facility, there are many factors to consider. When deciding on outside sources to implement Patient Friendly billing, a healthcare provider must carefully evaluate the following:

- How familiar is the vendor with the unique challenges associated with compliant healthcare billing?
- Will the vendor's services help collect additional payments more easily?
- Does the vendor provide flexible statement designs?
- Are bills and statements delivered promptly and efficiently?
- Is the vendor prepared for the future of patient billing?
- Will the vendor work closely with you to implement a successful solution?
- How much will your facility spend on vendor outsourcing? Is the effort cost effective?

When choosing a vendor for outsourcing, you should determine how familiar the vendor is with the unique challenges associated with compliant healthcare billing. Healthcare billing is different than credit card, utility, or other types of billing. Just because a vendor processes statements for one industry does not mean that the

vendor is adequately prepared to do the same for healthcare. Compliance with governmental security requirements, such as HIPAA is critical, but there is also a strong emotional component to healthcare issues, because they involve the well-being of loved ones. If patients feel well-informed and they understand their responsibilities, they are more at ease and are motivated to act more promptly on requests. It is critically important that patient communications be clear and that you find a partner that understands this need.

Regardless of the decision to outsource or to keep the billing process internally, collecting payments from patients should be easier. It has been said that a bill that is understood is a bill that is paid. It is imperative that healthcare organizations use design services that optimize the look of statements to this end. Flexible designs, multiple methods of delivery for the billing information and multiple payment methods (i.e., credit cards and online bill payment options) are preferred. Additional support tools that help your personnel answer patients' questions more quickly should also be offered and explored.

Flexible statement designs are critical to any Patient Friendly Billing initiative. Bills should be the result of your facility's personal input and not directed by technology or system limitations. Depending on your monthly volume, customization options may vary, since hospital information systems sometimes limit both design and messaging choices. Look for systems with flexibility in both areas, since they provide such valuable opportunities to improve patient understanding.

Bills and statements should be delivered promptly and efficiently. Compiling information from multiple sources to create patient statements is only half the battle. Equally important is prompt delivery. In the mail business, volume generates speed, but reprocessing creates delays. The United States Postal Service makes available many tools intended to minimize the amount of work needed to deliver bulk mail to its destination. It is up to each facility to use the tools available to them. The advent of efficient electronic data interchange (EDI) solutions has reduced rework and distance as obstacles for prompt delivery. Providers accustomed to processing statements locally or internally may find that remote vendors are now just as fast or faster. Clear, easy-to-understand statements delivered accurately and in a timely manner are the key business drivers to outsourcing patient statements.

Progressive healthcare facilities use the latest technologies to generate and deliver statements in a multitude of ways. Keeping up with price-level tracking options and file-based processing are just two such sophistications. In addition, the number of people who use the internet to pay bills continues to grow, making Online Bill Presentment and Payment now a viable alternative to paper statements. Patients can receive and review bills at their convenience through hospital websites and then pay by credit card or eCheck. This saves patients time and uses fewer provider resources as well. As more patients demand payment and presentment alternatives, the ability to integrate new and traditional methods will become essential to selecting a vendor that can get the job done.

Implementation of patient-friendly billing systems and processes can take anywhere from two weeks to several months, depending upon your needs and how dedicated you are to an acceptable and timely solution. It is imperative to develop a good implementation plan and know what to expect during implementation. This plan should help keep you on track without being burdensome on your IT staff,

Adding finishing touches to your process can be beneficial to your patients. For example, you may choose to send letters to thank patients for choosing your healthcare facility for their services. Many providers send

appreciation letters to new patients. This letter can also help verify insurance at the commencement of the relationship, instead of when a claim is denied, and can provide an organized summary of care. Patients can clearly see a progression of events and respond if insurance or treatment information is incorrect. This initial correspondence is intended to be a snapshot of care, from which future bills will follow.

Subsequent statements should communicate balances due or request that patients contact business offices with additional information. All these communications should be pleasing to the eye and easy to understand.

Billing Forms

Manual claims filing

The CMS-1450 or UB04 claim form is the instrument used to bill hospital inpatient, outpatient, hospice, home health, swing bed, and skilled nursing services. The National Uniform Billing Committee (NUBC) is responsible for developing and maintaining the form and approved codes. They make their UB-04 manual available on their website.

The UB-04 form currently defines use for 81 of an available 99 fields of information that can be contained within the UB-04 form. These data elements are referred to as form locators (FL) and the use of these fields is pre-determined by the NUBC, however certain payers may or may not require data in all fields. There are unique and specific codes used within each field of the form. Form locators (FL) guides are provided by most insurers to assist medical institutions in filing accurate and complete claims. The UB-04 manual provides the current specifications for each data element and codes that are required to be submitted when submitting manual claim forms.

In depth understanding of the data elements and the complexities required to accurately complete each data field is critical to expediting clean claims and payment turnaround time. More extensive information related to the UB fields can be found in the Advanced Certified Patient Accounts Representative (ACPAR) training manual.

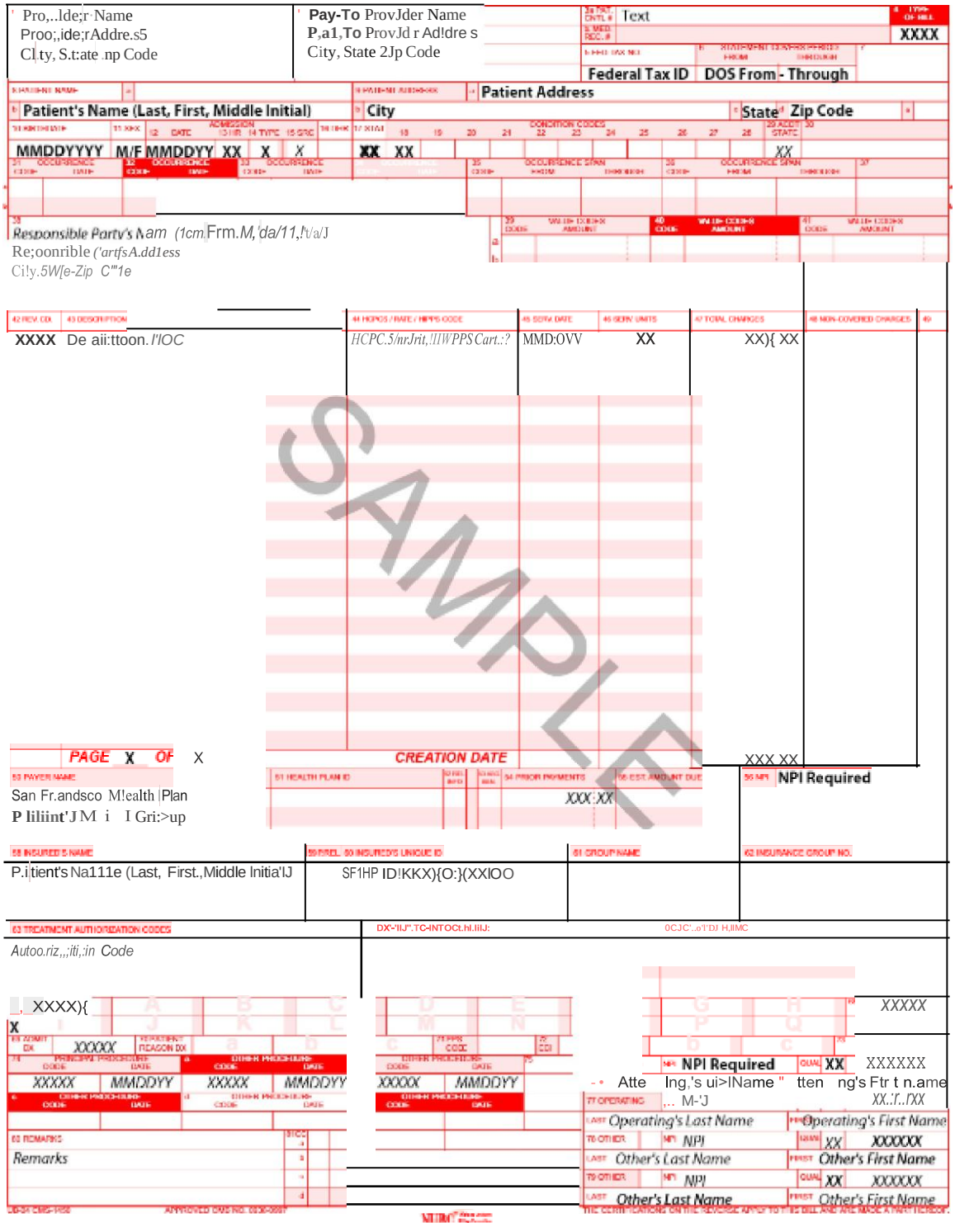
Special Note: Manual claim form submitters should be aware that the colored version of the UB-04 form is unique and designed to allow the form to be automatically “read” by certain types of claims processing systems. Use of forms that do not contain the correct coloring (i.e. copies of forms) will generally be deemed unacceptable for processing by most payers.

Electronic filing

The 837I Institutional electronic “form” is a standard format used to submit electronic claims by Hospitals, Skilled Nursing Facilities, Home Health agencies, Hospices, and other designated entities. The data requirements and specifications are consistent with the UB-04 data requirements and guidelines. The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) provides information via their *ASC X12 Website* to assist organizations in submitting accurate and complete electronic claims.

When originally developed, there were numerous additional data elements required under HIPAA ANSI 837 guidelines. Clearinghouses played a vital role in translating the UB04 data to the ANSI 837 electronic formats that are now used by most payers. ANSI billing formats and these additional required data elements have often required new information to be gathered during patient registration such as the Insured’s date of birth because such data was not required when the new 837 formats were adopted many years ago.

CMS-1450 or UB04 claim form -



Legal Aspects of Collecting

This section addresses the legal aspects of patient accounts as it pertains to collections and the hospitals and the patient's rights from the standpoint of federal and state laws.

Consent for Treatment

It is important in any type of patient care that a patient gives consent for treatment. There are four types of consent that occur:

- Actual or expressed consent – can be written or oral. The treatment is outlined, and the patient agrees either orally or in writing.
- Implied consent – in fact – consent by silence. By not objecting to Treatment, the patient implies consent to treatment.
- Implied consent – by law – This occurs in a situation where the patient is unconscious and is taken to the emergency room and the law states that you can treat the patient.
- Informed consent- this is what hospitals aim for. Under this consent the patient understands what he is being treated for and what procedures he is having performed.

Who can give consent?

- Competent adult
- Guardian of a child or of an incompetent adult.
- Emancipated minor.
- Parents of minors.
- Person with Durable Power of Attorney for Healthcare
- DFCS Case Manager for children in foster care

Liability for Payment

There are two legal theories under which a medical provider may collect for services rendered. The first is the Contract. A Contract is created when the patient or guarantor signs the financial responsibility statement. The five elements of an enforceable contract are:

- Requirement for competent parties. Individuals declared incompetent by a court of law, minors, and anyone intoxicated with drugs or alcohol cannot enter an enforceable contract.
- Need for an offer and acceptance by mutual consent. There must be an understanding by both parties as to what is being accepted. Both need to understand the terms (subject matter, money, time) of the contract. This is referred to as a "meeting of the minds".
- Consideration. Consideration must be provided by both parties. Both must give and get something. (I.E. Treatment by the hospital to the patient is consideration and payment by the patient to the hospital is consideration). Failure of consideration by either party allows a lawsuit for enforcement.
- Proper legal form. Not all contracts have to be in writing. However, it is important that there is written documentation that a verbal discussion took place.
- Legal subject matter. If the treatment given violates the law, a legal contract does not exist.

Once the proper consent has been obtained, a legal contract has been entered, and service has been performed, it should be established who is responsible for the bill. Often this is very clear, but sometimes it is not.

According to the laws of Alabama, the age of contractual capacity is 19 years old. Therefore, anyone 19 or over can be contractually bound to pay for their own medical expenses. Emancipated minors are also responsible for their own treatment. However, it is the joint duty of each parent to provide for the necessaries of his or her child until the child reaches 19, dies, marries, or becomes emancipated, whichever occurs first. Common law has interpreted "necessaries" to include hospital and medical services.

A spouse is not responsible for the debts of their mate unless they sign the financial guarantee. The second legal theory under which a medical provider may collect for services rendered is the theory of the open account. Under this theory, by receiving services without paying up front an open account is created and owed. Contract is the preferable method for bringing a collection action.

Garnishments

A garnishment is the most used remedy for satisfying a judgment. The balance owed on the judgment plus court costs determines the amount of the garnishment. The Court specifies what funds are subject to a garnishment and the debtor no longer controls the payment process.

A continuing garnishment withholds for 6 months either 25% of debtor's wages after taxes per week or amount by which wages after taxes for that week exceed $217.00, whichever is lower. A bank garnishment withholds all non-exempt funds for 24 hours from date of service. The debtor can contest the garnishment within 20 days of service and will be granted a hearing within 10 days to determine if funds were exempt from garnishment, if there was no valid judgment, or if the amount of the garnishment is incorrect. Garnishment pleadings must now provide a list of funds that are exempt from garnishments.

Estates

When the patient is deceased there are procedures that should be followed to collect the debt. When filing a claim on the estate you must know the county in which the patient last resided. To locate an estate, you can search the legal newspaper of that county or contact the Probate Court of that county. A statement of claim should be filed with the court once an estate is opened. The first publication of the Notice of Administration will specify the time frame in which a claim can be made. Make sure that all insurance has been pursued as well as any other guarantors that are liable on the account.

The order of preference in payment of creditors in an estate is as follows:

- Year's support for family
- Funeral expenses
- Other necessary expenses of administration, administrative fees of Estate
- Reasonable expenses of last illness
- Taxes, unpaid or other debts
- Judgments, secured interest, and other liens
- All other claims

A person who dies without a valid will is considered "intestate". Special laws apply in intestate situations to control the disposition of property.

Real property owned in another state by a person dying intestate is subject to the laws of the intestacy in the state in which the property resides. When a person dies intestate, the judge will appoint an executor to the estate from the following list, in the following order: surviving spouse, children, and other heirs, any of the creditors.

An example of a statement of claim to be used to file an estate claim follows:

Estate Claim

State of: _____

County of: _____

Personally appeared before me _____a Notary Public, in and for the said State and County _____

who, upon oath deposes and says that Exhibit A, hereto attached, and now referred to, is a correct statement of the

claim which asserts and files against the estate of _____, deceased for $_____, that the affiant has a

personal knowledge of the correctness of said claim; that the amount claimed is justly due from the estate of

_____deceased to after allowing all proper credits, and now constitutes a subsisting demand for

$_____, and that affiant is duly authorized to make this affidavit.

_____
Office Manager

Subscribed and sworn to before me, this _____day of _____, 20_____.

_____
Notary Public

_____County, _____

Bankruptcy

Alabama Bankruptcy Process: In most respects, filing for bankruptcy in Alabama isn't different from filing in another state. The bankruptcy process falls under federal law, not Alabama state law, and works by unwinding the contracts between you and your creditors. That's what gives you a fresh start. But Alabama's laws come into play in a significant way because they determine the property you can keep in your bankruptcy case.

The 2005 Bankruptcy Act Credit Counseling: The 2005 Bankruptcy Act requires all individual debtors who file bankruptcy on or after October 17, 2005, to undergo credit counseling within six months before filing for bankruptcy relief and to complete a financial management instructional course after filing bankruptcy.

What is Bankruptcy?

2005 Bankruptcy Act Means Test: Under the 2005 Bankruptcy Act your income and expenses will be analyzed to determine if you qualify for Chapter 7 or if you must file Chapter 13. To apply the means test, the courts will look at the average income for the 6 months prior to filing and compare it to the median income for the state. If the income is below the median, then you may choose Chapter 7. If your income exceeds the median, the remaining parts of the means test will be applied to determine if you can file Chapter 7 or if you must file Chapter 13.

Types of Bankruptcies

There are several types of bankruptcies:

- **Chapter 7:** Complete discharge of all debts.
- **Chapter 11:** Business reorganization (may sometimes be used by consumers).
- **Chapter 12:** Bankruptcies for farmers
- **Chapter 13:** Wage earners proceedings where the debtor can reorganize debt and restructure a payment plan with the Bankruptcy Court.

Dealing with a Bankrupt Debtor

There are several steps to follow in dealing with a bankrupt debtor.

- You should pull the account and flag it as a bankrupt account.
- You should stop all routine collection efforts.
- File proof of claim if cost justified based on amount of bills owed by debtor.
- Attend the first meeting of creditors if cost justified based on amount of bills.
- If a partial payment comes in, find out the patient's intentions before depositing the check. By accepting the payment, you may be giving up your rights to further payment under bankruptcy law.
- Document your conversations with the patient. If a lawyer represents the patient, it is illegal for the hospital to contact the patient. The patient's attorney should be contacted.

Facts on Chapter 13 Bankruptcy Claims

Below are listed facts that are important in handling Chapter 13 Bankruptcy claims.

- If the medical facilities account with the patient is not listed by the patient who is filing bankruptcy, the medical facility may proceed with normal collection efforts.

- If a motion for dismissal is issued, the hospital may resume collection efforts.
- Most debt adjustment plans are for a period not exceeding three years, but with special judicial approval, can be extended to as much as five years.
- After the debtor is discharged, any remaining balance cannot be pursued for collection. The unpaid balance must be written off and the account closed.
- The creditor does not have to attend the meeting of creditors to be eligible to receive payment on claims.
- Any new charges incurred by the patient after the petition has been filed are eligible for collection.
- Before a patient can qualify for Chapter 13, he must reside in the United States or own property or a business and have a regular source of income.

Hospital Liens (related to 3rd Party Liability)

What is a lien?

A lien is a claim that is usually recorded, against a piece of property or against an owner, to satisfy a debt or other obligation. The purpose of the lien is to enable the lienholder or creditor to institute an action to foreclose his lien. This means that the property can be sold by the creditor. The proceeds of the sale will be used to satisfy the debt. The proceeds of the sale, after the debt is satisfied, are paid to the former owner. In the case of a tax lien, the lien is recorded in the county in which the property is located.

When does a lien apply?

When a person has been injured by another party, at no fault of their own, (auto accident, negligent condition on a property, gunshot wound, slip, and fall in a store, etc.) presents to a medical facility for treatment of those injuries (see below for specifics regarding which providers may file medical liens). The admissions personnel will be the primary point of contact to determine whether a lien may be applicable to the service provided.

What it means to the Medical Provider

When a patient arrives in the emergency room after a motor vehicle accident, the hospital may not know whether the accident victim has insurance, but they must treat them. To ensure the bills are paid, the Alabama law (Alabama Code §35-11-370, et seq.) allows hospitals to file a lien granting them funds from any personal injury settlement or jury award.

Generally, a hospital lien involves situations in which someone is brought to the emergency room by ambulance or medevac. Only hospitals, not physicians or other healthcare providers, may file this lien. There is an exception if the accident victim completes a document allowing these other healthcare providers the right to settlement or judgment proceeds to pay outstanding bills.

Keep in mind that hospital charges for the uninsured are far higher than for those with insurance. The insurance premiums paid by the insured help them qualify for discounts negotiated between the hospital and the insurance company. Before a recent change in the law, when a hospital filed a lien, the amount was not for what Medicare or private insurance would pay, but for the full charges. That meant the hospital could collect an amount far greater from a settlement or judgment than the amount for which an insurer was billed.

However, a hospital lien cannot go after the patient's home or personal property. It also does not affect workers' compensation benefits. While that is a relief for many people, it still means that the hospital can receive the bulk of any settlement or judgment amounts.

The Alabama hospital lien statute allows hospitals to place an automatic lien on a patient's judgment or settlement if the hospital treated the patient for those injuries within one week of the injury.

Such a lien requires perfection. To perfect a lien, the hospital's administration must file a verified statement with the probate court of the county in which the hospital is located stating the patient's name and address, the dates of the patient's admission and discharge, the hospital's name and address, and the amount the hospital claims is due for care. The lien attaches to all "reasonable charges" for the patient's "hospital care, treatment, and maintenance" if they entered the hospital within one week of suffering the injuries.

Within one day of the lien filing, the hospital is required to send a copy of the filing to every person, firm, or corporation named via certified mail it claims are liable for damages. It is also sent to the patient or their guardian or personal representative. A filing of the lien notice constitutes notice to all parties, parties, known or unknown, at the time of the filing of the lien, as per Alabama Property Code §§ 35-11-370 – 375.

A perfected hospital lien has top priority over any other claims to these funds, except for an attorney's lien.

Here is how it works: When a person enters a settlement or the court awards them a judgment, the first entities receiving the funds are the attorneys or hospitals with perfected liens. After those liens are paid, the plaintiff then receives the remaining funds.

Under an amended law that went into effect in 2019, if the patient is covered by Medicare or Medicaid or the hospital is unaware that the patient has health insurance, the lien is perfectible within 20 days of the patient's discharge.

However, if the hospital discovers that the patient is covered by insurance after the lien is perfected, it is required to bill the patient's insurance company. The lien stays in place until the insurer pays the bill. Once the bill is paid, the hospital must release the lien within ten days.

Besides the one-week limit on injuries, a hospital may only file a lien under the amended law if the patient does not have health insurance coverage or the insurer denied the claim. If the insurance company does not pay the bill within six months of its submission, the hospital may file a lien. No longer can the hospital file a lien in lieu of billing the insurer, and no longer can it charge the full price rather than the rate offered to the insurance company.

The Alabama hospital lien is valid until the insurer pays the bill. As noted, once the bill is paid, the lien requires release within ten days. Alabama's statute of limitations for filing personal injury lawsuits is two years from the date of the accident.

Medical (Hospital) Liens are not:

- Liens against the injured party
- Liens against the patient's legal representative
- Liens against property

- Liens against other assets
- Evidence of the person's failure to pay a debt.

Securing the Lien

Hospitals must do the following to secure the lien:

- At least 15 days prior to the actual filing of this lien, a letter of intent to file a lien must be sent to the patient and all known possible responsible parties. This letter must contain language that states the lien is not against the patient, his property or assets and is not evidence of his failure to pay a debt. This letter of intent must be sent both certified and regular mail and the sender must retain the postal receipt acknowledgements. Although there is no legal requirement as to the amount of permissible elapsed time after discharge before the intent notice is sent, it must be done such that the actual lien document is filed in the required counties within 75 days of discharge. Note: If it is a lien for a physician, the time requirements are slightly different. The physician's time begins at the time of the first treatment. They, like the hospitals, must sent a letter of intent including the same information at least.
- 15 days prior to filing their lien in the respective counties, but the doctors have 90 days from first treatment to have the lien filed.
- File a lien with the Clerk of the Superior Court in the county where the patient resides as well as the county where the hospital is located.
- Send a copy of the lien to the patient and to any other liable party, such as the person, firm, or corporation liable for the injury or the insurance company of the third party.
- Once a settlement occurs and payment is received, satisfy the lien.

No settlement or release of third-party monies shall be effective against a lien properly perfected unless the Hospital is a party to the release or settlement unless an affidavit is obtained from the injured party stating that all bills incurred for treatment for the injuries for which a settlement is made have been fully paid and that the residence of the affiant is Alabama. If the affidavit is provided but the bills have not been paid, the patient has given a false affidavit and commits the offense of false swearing and can be pursued for this. If not, an affidavit is obtained but a settlement is reached with the inclusion of the hospital's lien, the hospital may enforce the lien by an action against the person, firm, or corporation liable for the damages or such person's insurer. The action must be originated within one year of the date of the settlement.

A Medical (Hospital) Lien must contain the following:

- Name and address of patient as it appears on the hospital record.
- Name and address of hospital.
- Name and address of the operator of the hospital.
- Dates of admission and discharge of patient
- Amount of the hospital bill
- Names and addresses of all known persons or corporations allegedly liable for the injuries to the patient
- The lien must be notarized and signed by the person preparing the lien.

Alabama, _____COUNTY

To the Superior Court and Clerk of Superior Court of said County:

Notice is hereby given to all persons, firms, and corporations, including.

Name: _____
Address: _____

that General Hospital of Montgomery, Alabama, which operates and does business as General Hospital, Montgomery, Alabama has treated as a patient: _____whose residence is located at:
_____and who was admitted for treatment at General Hospital, Atlanta Highway, Montgomery, AL 36109, on ___and discharged on _____and said patient incurred charges in the amount of $_____for hospital care and treatment, and General Hospital now claims a lien on all sums and amounts, whether in property or money, paid to the above named patient or his legal representative, by any person, firm or corporation, including those specifically named above, if any, as a settlement, as a release or as a consideration to a covenant not to sue, when said sum or amounts represent damages or compensations for the patient's injuries for which General Hospital has rendered its services to such injuries.

The above-named persons, firms or corporations, if any, are claimed by the patient or his legal representative to be liable for said injuries and such persons, firms or corporations are so listed to the best of claimant's knowledge.

Said lien is for the above amount incurred by the patient for hospital care and treatment the said amount being claimed to be fair and reasonable charges for services rendered.

A copy of this lien will be mailed to the above-named persons, firms or corporations claimed to be liable for said injuries within one day after filing of this lien.

ALABAMA, _____COUNTY BY:_____

Personally appeared before the undersigned-attesting officer, duly authorized by law to administer oaths, the undersigned, who on oath, deposes and says that he is authorized to make this affidavit on behalf of the General Hospital and the statements contained in the above and foregoing lien are true to the best of his knowledge and belief.

Sworn to and subscribed before me this _____day of _____, 20____.

Notary Public: _____

Health Information Management (HIM)

Medical Records

Health Information Management (HIM) is the practice of acquiring, analyzing, and protecting digital and traditional medical information vital to providing quality patient care. With the widespread computerization of health records, traditional (paper based) records are being replaced with Electronic Health Records (EHRs). The tools of health informatics and health information technology are increasingly being utilized to introduce efficiency in information management practices in the health care sector. Health Information Management (HIM) is responsible for the maintenance and protection of all medical records created in the process of providing healthcare services. A medical record is the strongest element in supporting patient billing and hospital reimbursement. A complete medical record contains all documentation related to the patient's care and is defined by different regulatory agencies, such as:

- The Joint Commission (JC) – https://www.jointcommission.org/
- Medicare – https://www.medicare.gov/
- Medicaid – https://medicaid.alabama.gov/
- Department of Human Resources (Alabama DHR) – https://dhr.alabama.gov/

Record Requirements

Any organization that accesses patient health information is considered a covered entity and is required by law to comply with HIPAA provisions or face civil and/or criminal penalties. It is imperative that medical records remain confidential and cannot be accessed by people that do not have proper authorization. Disclosures made regarding a patient's protected health information (PHI) without their authorization are considered a violation of the Privacy Rule.

Each record must contain information that will:

- Justify the admission (validated by the Utilization Review process)
- Support the diagnosis and treatment.
- Describe the outcome.
- Plan the patient's aftercare.

Information from a medical record is used to record the history of a patient's health care, to facilitate reimbursement from third party payers, assist attorneys seeking settlement in injury cases, other legal issues, and research.

Process

The creation of the medical record starts at registration. Attaining a complete medical record begins with collection and assembly of all the components during the stay. This can be tricky as the patient travels through many departments during a visit. Any documentation needed to complete the record is identified and the responsible caregiver is held accountable to provide the appropriate reports.

A record should accurately reflect what was wrong with the patient and what was done to help the patient. The well-documented record provides the best opportunity to adequately make coding decisions that optimize the level of reimbursement. Records that have incomplete or conflicting documentation or fail to meet content requirements present an obstacle to appropriate coding and therefore reimbursement.

Diagnosis Related Group (DRG)

Optimizing Diagnosis Related Group (DRG) assignment during the coding process can only be done through good documentation. DRG is a patient classification system that relates demographic, diagnostic, and therapeutic characteristics of the patient to the length of inpatient stay and amount of resources consumed. Complete records substantiate the diagnosis, treatment and charges, outcome of the treatment and plans for continued care. All this information enables communication to the coders for coding specificity and optimizing of DRGs.

Requests for Records

Requests for copies of records are received in both the PFS and HIM departments. The request may be for a copy of portions or all the records. Insurance companies may receive a copy of the patient's record if there is a waiver signed by the patient on the record. The insurance company should only receive records that would be billed to them.

> Example: a patient was seen a month ago for surgery and that was charged to the insurance company. Yesterday, the same patient was seen in the emergency department for an injury on the job and will be charged with worker's compensation. The waiver would only cover the surgery visit for records to the insurance company. A separate authorization would be needed for the release of the second visit to the insurance company.

There are many rules and regulations related to releasing records. Always review the company's policies and procedures and be familiar with the rules. When in doubt - stop, do not release, ask clarifying questions, and seek direction. There are large fines and penalties to a facility for an inappropriate release as well as corrective action and termination for the associate.

Benefits

The medical record is the foundation for obtaining the best reimbursement on each patient's account. However, registering the patient with correct billing information, gathering all the information in the medical record in a timely manner, having all the charges entered the financial system correctly and generating the bills in a timely manner requires the teamwork of the entire facility.

Coding

Coding Definition and Classifications

Coding is the process of converting a narrative description of diseases, injuries, and procedures into a classification system. Classification systems are used to standardize the documentation into a language that all can understand. A medical record may be 500-5000 pages long with documentation. Translating those pages into the classification system simplifies the narration and review of the stay. There are several classification systems that are used:

ICD-10-CM (International Classification of Diseases 10th Edition Clinical Modification) codes identify diagnosis, signs, and symptoms, which are gathered at the time of registration or documented in the patient's medical record.

ICD-10-PCS (International Classification of Diseases, 10th Edition, and Procedural Coding System) represents the procedures done during the visit. The system was built to allow for expansion as technology and techniques continue to change and grow. This system was defined to be used for hospital inpatient stays.

CPT (Current Procedure Terminology) coding manual provides descriptions of healthcare services. CPT is technically part of the Healthcare Common Procedure Coding System and is otherwise known as HCPCS Level 1. This entire system is copyrighted and maintained by the American Medical Association (AMA). There are three levels of codes within this classification.

- **Level I** is the (AMA) American Medical Association's CPT (Current Procedural Terminology). It is a listing of descriptive terms and identifying codes for reporting medical services and procedures. The purpose of a CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services serving as an effective means for reliable nationwide communication among physicians, patients and third parties. These codes are five-digit numeric codes that were developed by the American Medical Association to identify procedures performed by physicians in a clinical setting. These codes are updated annually by the AMA.

  The CPT codes are organized into six major sections:

  - Evaluation and Management (E & M codes)
  - Anesthesiology
  - Surgery
  - Radiology
  - Pathology and Laboratory
  - Medicine

- **Level II** are assigned, updated, and maintained by CMS. The Level II codes are often referred to as the HCPCS codes. Level II codes are primarily used to identify products, supplies and services not included in the CPT codes, for example, ambulance services and durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office. Level II codes are also referred to as alphanumeric codes because they consist of a single alphabetical letter followed by 4 numeric digits.

Purpose of diagnosis coding:

Diagnosis codes serve **several purposes**:

- **Establishes medical necessity** – this is the first step in the reimbursement process. Each service or procedure must be reported with a diagnosis that will justify the care provided.
- **Reflects the acuity of the patient's illness** –shows how sick the patient is during the visit. For example, someone with the flu can be treated at home. But someone with the flu, heart failure and respiratory failure will need more aggressive monitoring and treatment.
- **Provides data for statistical analysis** –used for data reporting and allows researchers to calculate health related statistics including the leading causes of death, to the number of cases of certain infectious diseases, to the number and percent distribution of physician office visits by principal diagnosis. This same data can be used to study health care costs associated with a diagnosis or group of diagnoses, to research the quality of health care, and to predict and plan for health care trends and needs.

There are **different types** of diagnosis codes:

- **Reason for visit:** The complaint or symptom which is the primary reason for an outpatient visit.
- **Provisional diagnosis:** The working diagnosis at the time of admission or reason for surgical procedure.
- **Principal diagnosis:** The condition established after study to be the chief reason for admission. This would be listed as the first diagnosis on a hospital claim.
- **Secondary diagnosis:** This can be used for both inpatient and outpatient visits. It refers to all conditions that are present at the time of service or those that develop during an inpatient stay that affect treatment or length of stay. This can also be referred to as an additional diagnosis.

Code structure:

ICD-10 can contain up to seven characters. Each character has a purpose, the first three are considered the category, the next three will reflect etiology, anatomic site or manifestation and the last digit is an extension.

There are many guidelines that affect accurate diagnosis code assignment:

- Identify each service, procedure, or supply with a diagnosis code to describe the diagnosis, symptom, complaint, or problem.
- Identify services or visits for circumstances other than disease or injury, such as follow-up care after chemotherapy, with status codes provided for this purpose.
- Sequencing of the codes (principal, secondary and so on)
- Code any co-existing condition that affects the treatment of the patient for that visit or procedure or supplementary care
- Do not code a diagnosis that is no longer applicable.
- Code to the highest degree of specificity.
- Code a chronic diagnosis if it is applicable to the patient's treatment.

All claims, whether CMS 1500 or UB04, must have at least one diagnosis code on it. On UB04, the first diagnosis code must describe the principle reason for the care provided. If additional facts are required to substantiate the care provided, providers should list the codes in the order of their importance. Providers should code only the current condition that prompted the patient's visit. Chronic complaints should be coded only when the patient has received treatment for the condition. When the diagnostic statement identifies an acute condition, providers should use the code that specifies "acute" whenever it is available.

Procedure Coding:

Procedures are coded on both inpatient and outpatient visits to reflect the services and products provided during the stay. ICD-10-PCS was designed to reflect inpatient services. However, some facilities choose to code these on outpatients as well for data comparison. CPT and HCPCs are coded for outpatient visits only.

CPT and HCPCS may be charge master driven, which means they are applied to the bill as charges are entered for the service. For example, lab tests, radiology exams and medications are often charge master driven.

Procedure Code structure:

ICD-10-PCS will be seven characters. There is no list; rather the coder constructs the codes from tables. The tables are defined into body systems and then root operations to guide the coder to an accurate assignment.

CPT will be five characters. The code consists of numbers. 10000-69999 is known as the surgical section and is often assigned by the coders in the HIM department. Other common areas are the 70000 series for the radiology exams and 80000 for the lab tests. HCPCs will be four to five and may be alpha and numeric.

Procedure Code Edits:

Assigning correct procedure codes can be tricky as there are many rules in play. For example, some tests done together cannot be billed separately. The following is a breakdown of some of the code editing programs.

Correct Coding Initiative

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (CCI) in 1996 to reduce Medicare program expenditures by detecting inappropriate codes submitted on claims and denying payment for them; promote national correct coding methodologies; and eliminate improper coding practices.

Medicare National CCI Terms and Definitions

CCI edits (Correct Coding Initiative) - Pairs of CPT and/or HCPCS Level II codes which are not separately payable except under certain circumstances (e.g. reporting appropriate modifier). The edits are applied to services billed by the same provider for the same beneficiary on the same date of service.

ABNs – Advanced Beneficiary Notice of Non-Coverage

Definition

An ABN is a form that lets Medicare patients know they may have to pay for a test or procedure their doctor has ordered if Medicare refuses to pay. An ABN helps the patient make an informed decision whether to receive the service and pay for it or refuse the service. If the service is refused, the provider/patient should notify their physician and inform them they did not receive the test.

Requirements

Medicare beneficiaries must be supplied an ABN as a written notice by their physician or provider of services when services might not be covered by Medicare and before the service is performed. If the ABN has not been signed before service is rendered and Medicare does not pay, the patient cannot be held responsible for payment of their service. The service is screened using the diagnosis provided by the physician against the coverage determinations policies provided by the fiscal intermediary.

> Example: CT of head ordered; diagnosis provided is neck pain. This may not cover the CT and therefore an ABN should be issued prior to the CT being complete.

General Payer Information

Managed Care

What is Managed Care? The answer to that question will vary greatly, depending on who answers:

- To **health care providers** delivering health care services, managed care is simply a health insurance company who contracts with health care providers to give discounts on health care services.
- For the **Managed Care Organization** (MCO), managed care is the provision of a network of health care providers who agree to a pre-established reimbursement schedule, programs which insure appropriate use of health care services, or programs which promote quality of care.
- To the **patient**, also known as a member or subscriber by the MCO, it is a health benefit plan that typically costs them less money when they choose a health care provider that is in the network.
- To a **State or other regulatory agency**, managed care may mean only those health benefit plans, which provide for health benefits on a prepaid basis.

In current times, managed care can simply be defined as an established program or network used or administered by an employer's or an individual's health benefit plan to address the appropriateness and cost of health care services delivered. Managed care may include one or several of the following interventions:

- Financial incentives to use health care providers that are in a network.
- A utilization management program that requires upfront and ongoing communication with the MCO regarding a patient's treatment needs and treatment plan.
- A quality management program that examines the quality of health care services delivered.
- A disease management or case management program which assists patients, families, and health care providers during treatment of a chronic or catastrophic condition.
- Programs geared to prevent illness and injury and promote wellness.

Background of Health Insurance, Managed Care and HMO

Until the 1970s, indemnity health insurance was the dominant type of insurance coverage available to employees individually or through their employer. Also known as traditional or major medical insurance, hospitals are paid a percentage of the hospital's billed charges. Unlike managed care, a patient was allowed to choose any health care provider and was not restricted to a select physician and hospital network.

The Health Maintenance Organization Assistance Act of 1973 was passed, but Health Maintenance Organizations (HMOs) remained in the background. During the 1980s, the cost of healthcare began to escalate at a tremendous rate. Employers, the main source for provision of group health insurance, worried that providing health insurance for employees and their families would soon become unaffordable. "Cost containment" became the buzzword in the insurance industry, and the private insurance market began to think more like the government health care programs, Medicare, and Medicaid.

Major insurance companies began to require the use of utilization review programs. The goals of utilization review are to ensure health care services are:

- Medically necessary
- Appropriate for the patient's condition and treatment
- Each hospital day is necessary.

Utilization Review starts with pre-certification for elective admissions and continues with concurrent review of the care and treatment while the patient is hospitalized. For emergency admissions, certification must be requested after the patient's admission. If the clinical reviewers find any part of the treatment plan does not meet one of the goals, the insurance company can deny part or all the reimbursement for those services. With

indemnity insurance, health care providers may seek payment from the patients for amounts not covered by the insurance carrier.

Another cost-effective organization emerged throughout the country during this period, Third Party Administrators (TPAs).

- TPAs are companies that specialize in administering health benefit plans for employers who use their own funds to pay for health care benefits for their employees.
- TPAs may also pay claims on behalf of insurance companies.
- TPAs found they could provide this service directly to employers at much less cost than insurance companies could do so.
- TPAs or the employer's insurance broker also would arrange for reinsurance for self-funded employers.
- Reinsurance may also provide reimbursement to an employer for an individual claim that is extremely high cost or if all the health benefit claims summed together exceed a certain dollar threshold.
- TPAs also participate in managed care programs, with some even building their own health care provider networks or providing utilization review services.

Second surgical opinions for certain surgical or invasive procedures were also made mandatory during this era to make sure the procedures were "medically necessary." Lengths of hospital stays were monitored, and discharge planning and case management programs were developed to assist patients and families to move a patient from a hospital setting to their home or other alternative setting in a timely fashion. Insurance companies began to mandate that certain procedures be performed in outpatient settings and as a reward for doing so, paid those procedures at 100 percent of the charges.

By the 1990s HMOs became a nationally accepted alternative to indemnity insurance. They did so with a new concept. Instead of paying for the delivery of health care services for illness and injury after the fact, HMOs felt they could eliminate a great deal of the health cost by preventing illness and injury and "maintaining" a better state of health for individuals.

While indemnity insurance had focused on:

- Payment for unforeseen illnesses and injuries
- After the insured individual paid a deductible
- And perhaps a co-insurance

HMOs moved toward:

- Minimal out-of-pocket expenses for the individual
- Encouraged preventive screenings.
- Annual checkups.

These benefits were readily available, as were visits to a primary care physician (PCP), at a nominal expense to the patient known as co-pay. PCPs are trained to assess, evaluate, and treat patients for more common medical problems.

HMOs also made it less expensive for insured individuals and patients to get necessary prescriptions with less out-of-pocket expense. Responding to patients who went without medications because of the cost for prescriptions, HMOs choose to ensure that patients with chronic conditions have the medications necessary to better manage their disease and prevent complications.

HMOs, recognizing they would increase the cost of health care on the upside to prevent catastrophic illnesses and injuries on the downside, decided it was appropriate to recruit selected physicians, hospitals, and ancillary care providers to be in a network. In exchange for rates that were less than their normal charges, HMOs would develop benefit plans that encouraged members to use the providers in the network.

Early HMOs came in five basic models.

1. **Staff Model:** All physicians and support staff are employees of the staff model HMO and are available to the HMO members (patients) in a clinic-type setting, frequently owned by the HMO. The clinic is usually complete with lab and radiology services. Most staff models attempt to include all physician specialties but may have to refer out for some specialties. Staff model HMOs contract with hospitals at preferred rates for hospital services. Staff model HMOs are also known as closed panel HMOs. Staff models limit the choice of providers from which members may choose.
2. **Group Model:** All physicians and support staff are employees of a multi-specialty, physician group practice, which is under contract to the HMO to provide all physician services to its' members. The practice may be a captive group model, meaning they can see only HMO members, or an independent group model, meaning they can see HMO members and non-HMO members. Group models are also known as closed panels since a physician must be a member of the group practice to participate in the HMO. Group models also limit the choice of providers from which members may choose.
3. **Network Model:** In this model, the HMO contracts with several different groups of physicians to care for HMO members. The network typically has a larger number of private practice groups of primary care physicians, including family practice, internal medicine, pediatrics, and obstetrics and gynecology. They also have a limited number of specialist physician practices including general surgery, orthopedics, neurosurgery, etc. Physicians see HMO members and non-HMO members in their own practice setting.
4. **Individual Practice Association (IPA) Model:** Physicians oftentimes develop their own entity called an association, and in the IPA model, the HMO contracts with that association. Typically, an IPA will have large numbers of physician practices representing a variety of primary and specialty care physicians. The physicians provide services to HMO and non-HMO members.
5. **Direct Contract Models:** In this situation, the HMO contracts directly with individual physicians to provide physician services to their members, including an array of primary care and specialty care physicians.

Despite the increased benefits for earlier health care intervention through PCP office visits, a better array of preventative health benefits, and less out-of-pocket expense, HMOs were found not to be the answer for those who wanted to retain their non-HMO physicians or who wanted a choice in the health care providers caring for them. As HMOs slowly grew, the concept of Preferred Provider Organizations (PPOs) became more popular. While HMO networks did not allow for benefits for individuals choosing health care providers who were not in the network, PPOs did.

Traditional insurance carriers and TPAs found they could compete easily with HMOs when they used a PPO by providing financial incentives in the benefit plan tied to the use of in-network providers. But if the member wanted to use a health care provider not in the network, a lower level of benefit coverage was available. Like the HMOs, PPOs contracted with physicians, hospitals, and other ancillary care providers to deliver health care services at a rate less than their normal charge.

The Progression of Managed Care

Employers responded to the idea of promoting improved health through early detection, health screenings, and check-ups for those on their benefit plans. Even Medicare, who had always paid for health care services on a fee-for-service basis, decided to offer HMOs to its population. HMOs were gaining market share and by the mid-1990s had a strong foothold.

HMOs take the financial risk for the cost of health care claims for its' members, and as such are very involved through clinical staff, procedures, and protocols as health care services are delivered to their members. Most HMOs are profit-oriented, and members and physicians oftentimes were suspicious that HMOs might withhold authorization for services in exchange for their own profitability. Though growing in market share, both the medical community and patient population had some level of suspicion.

As HMOs grew, so did PPOs. As a response to this growing market, HMOs developed a new approach, calling it a Point of Service (POS) plan. Like PPOs, a POS plan allows choice for the member, allowing them to seek health care services from health care providers who are not in the network, but at their own higher out-of-pocket expense. This flexibility provided some comfort that care outside the network could be obtained with some level of benefits being paid, and it allowed HMOs to be competitive with PPOs.

HMOs and PPOs soon created networks that included "gatekeepers". The theory behind a gatekeeper is simple. A member chooses or is assigned one PCP who coordinates all health care services on the member's behalf. MCOs and some employers feel this coordination of care reduces unnecessary or inappropriate care and duplication of health care services.

Gatekeeper programs require the patient to obtain a "referral", a type of permission slip, from their PCP prior to seeking other health care services. A patient's failure to obtain a referral prior to seeking other health care services could result in the MCO denying payment for unauthorized services. Gatekeeper models are generally seen as the most restrictive models and are operationally and administratively intensive for the medical community and the patient.

Understanding that Americans like choice and control and consider their patient-physician relationship sacred, HMOs next developed a network plan commonly called Open Access. This approach, which remains popular today, allows patients to choose any provider that is in the network. The networks in these plans are large and expansive and include most health care providers in the medical community. Co-pays, which used to be nominal for PCP visits, have increased and co-pays for specialist visits are even higher than those of PCPs. While other HMO plans restrict access to health care services through gatekeepers and by limiting the number of health care providers in their network, the open access HMO has not done this.

The Next Generation of Managed Care

While the impact of managed care of the 80s and 90s had great success, health care costs once again are escalating at a rapid pace. Medical technology and the availability of new drugs and therapies have contributed greatly to this cost, as has the state of health for those experiencing serious disease or injury. Replacements of joints, placement of stints and defibrillators in patients with heart disease, and other such procedures that save or improve the quality of lives are commonplace. The cost of new technology provided by hospitals and physicians is passed on to the recipients. Utilization of health care services by insured and uninsured alike continues to grow. For many, especially individuals and small employers, the result of rising cost and utilization is health insurance premiums that are not affordable. The uninsured market grows daily.

MCOs now focus on new programs such as Pay for Performance (P4P), Provider Profiling, Quality Indicators, and Report Cards. All these initiatives tie a particular health care provider's payment for services to the quality of care delivered. MCOs provide websites where their members can look at Report Cards on providers in the network. If the health care consumer chooses a provider who is deemed by the MCO to provide quality, cost-effective care, the benefit plan will pay more of the cost of the service. If the consumer chooses a provider with a lesser rating, the benefit plan pays less of the cost of the service and the consumer pays more.

Health care providers have responded to this trend of pay for performance by becoming more organized in their practice of medicine, using Evidence-Based Medicine (EBM). With Evidence-Based Medicine, medical experts study treatments and care given to patients with the same condition and determine which has the best patient outcomes. These guidelines become the treatment plan of choice as the scientific evidence has demonstrated it to be so.

Though slowly emerging, the insurance industry also sees an opportunity for a new type of benefit plan to become commonplace. T h e Consumer Driven Health Plans (CDHP) is a model that allows consumers to make their own health care decisions, linking a health care spending account that is the individuals to use, with high-deductible insurance policies. If the individual exhausts all the money in their spending account, and they have met the benefit plan's high deductible, they are eligible for health benefit coverage under the insurance policy. It is widely acknowledged that this product will work only for specific populations, as the health consumer must be able to appropriately manage their own spending account effectively.

Consumer-Driven Healthcare

Consumer-driven health care plans had their origin in the U.S. in the late 1990s. It was developed as a business model for health ventures. They were designed to engage consumers more directly in their health care purchases. The initial conceptual model made cost and quality information available to the consumer, usually through the Internet.

HSAs are seen by proponents to make health care more affordable and accessible in the U.S. The Medicare Prescription Drug, Improvement, and Modernization Act, which included provisions designed to stimulate the popularity of these plans, was passed by Congress in November 2003, and signed into law by President Bush in December 2003. The law expanded medical savings accounts, renaming them Health Savings Accounts, and created tax incentives to encourage adoption of high- deductible health plans. Banks were empowered to create HSAs, which deliver tax-free interest to the holders, who can then withdraw money tax free to pay for qualified health care expenditures. To qualify for an HSA, the purchaser must also have a qualifying **high-deductible** health insurance plan. Over time, participants are allowed to contribute more (cumulatively) to the savings account than

would be required to fulfill their annual deductible for a given year (although annual limits on pre-tax contributions [other than a

1-time IRA rollover option] are well below the annual deductible), and any unused portions of the account accrue without tax penalty so long as the funds are used only for qualified medical expenses.

Further enhancements to HSAs went into effect in 2007. The combination of tax breaks for premiums and the health savings account as well as a tax subsidy to pay for the catastrophic insurance premium of lower income individuals has boosted the popularity of these plans. By April 2007, some 4.5 million Americans were enrolled in HSAs; more than a fourth of those were previously uninsured.

Another model of consumer driven health care is Health Reimbursement Arrangements (**HRAs**), which are employer-funded, and in which employers receive the tax benefits.

In 2014, when major portions of the Patient Protection and Affordable Care Act are implemented in the United States, high deductible plans and the concept of consumer-driven healthcare may become more popular. Although new federal tax subsidies will help reduce health insurance rates for many consumers, individuals and families that do not qualify are expected to consider Health Savings Accounts (HSAs) if they do not have employer-sponsored overage.

Commercial Insurance

Overview

Commercial insurance provides health care benefits to beneficiaries through a for-profit insurance company. Commercial carriers are charge-based carriers as opposed to cost-based payers, and as such, deserve close attention and follow-up.

Most insurance carriers pay for covered medical expenses using either a fee schedule or by a Usual and Customary payment schedule. Fee schedule commercial policies identify payment for covered services using a payment schedule that sets a maximum dollar amount payable for specific services. Usual and Customary (or Reasonable and Customary) use a regional average fee profile to determine the allowable reimbursement for specific procedures. This allowable reimbursement rate is also referred to as “covered charges.”

Two Basic Commercial Insurance Coverage’s:

- Individual or Direct Pay Health Care Plans
- Group Health Plans

Individual Plans

Normally cover the subscriber and possibly the subscriber’s family with the premiums being paid solely by the subscriber.

Group Plans

Are normally employer-provided and the employer generally pays the premiums in full or in part. Group coverage may also be a part of membership in various organizations, business groups, or fraternal groups. In

either case, carrier selection is done by the organization, not the subscriber. Group plans may cover only the employee or the employee and the employee's family.

Coverage Verification

Subscribers of commercial insurance plans are issued policies and/or identification cards. Insurance identification cards should usually give the following information:

- Name of the Insurance Carrier
- Central Office address
- Address for claims processing.
- Telephone number for benefit verification.
- Policy and/or contract number and/or group name and/or number
- Limited benefit/coverage information
- Pre-Certification, prior authorization and second opinion requirements
- Waiver/rider indicators

Covered Services

It is critical that hospital personnel determine what benefits are provided to the insured by the plan so that patient responsibility may be determined at the earliest possible time.

Once the insurance carrier processes a claim, an Explanation of Benefits (EOB) is sent to the patient and to the provider. The EOB will list:

- All the charges submitted on the claim.
- Amount allowed by the carrier.
- Contractual allowances if contracted.
- Any amount applied toward the patient's co-pay and/or deductible.

If the facility is not contracted with the commercial payer, then there is no obligation to honor fee schedule or the usual and customary payment schedule.

Pre-Certification

Most Commercial Insurance Companies offer group policies requiring justification of medical necessity prior to admission. This pre-authorization process may be handled by the company internally or contracted to an outside agency. Although it is generally the patient's or the doctor's responsibility to secure "pre-certification" most carriers have substantial penalties reducing hospital benefits or denying payment if authorization has not been obtained. The hospital needs to ensure all inpatient services are pre-certified to be paid.

Submission of Claims

In submitting claims to commercial insurance carriers, it is essential to have on file an assignment of benefits obtained from the patient and/or insured. The Assignment of Benefits Form and/or Employee Statement must contain:

- Authorization to release medical information.
- Authorization for payment to be made directly to the hospital of all hospital insurance benefits.
- Date and signature of policyholder.

The standard billing form for commercial insurance claims is the UB-04.

Individual Claims

Individual or direct pay plans require much the same information as required under group plans. Although policies and/or identification cards will usually be provided by the subscriber, verification of coverage and/or benefits is often more difficult for individual coverage.

The most apparent difference between group plans and an individual plan is the source of payment of the premiums. The fact becomes significant when overpayments occur, and a determination of the refunded party must be made. The following steps are suggested to verify individual coverage:

- Name of Insurance Company
- Confirm coverage and benefits with the insurance company directly. Determine contact, address, and telephone number where coverage and benefits can be verified.
- Verify correct address (and contact person) for claims processing and follow-up.
- Determine if company honors an assignment of benefits.

When individual plans are involved and benefits are given, but the company does not confirm coverage, consideration should be given to requiring a patient deposit until such time as coverage is confirmed.

Group Claims

The information to obtain for Group Claims is:

- Patient's name and home address
- Marital status, sex, date of birth, employment status
- Was the condition(s) employment related? Accident? If accident, date of accident?
- Patient's Insurance Company name and address
- Name and address of policy holding employer.
- Group number and/or name.
- Policy Number
- Patient's relationship to subscriber
- Insured employee's social security number and employee number (if different)
- Pre-Certification, prior authorization numbers, contracts, etc.
- Date of Employment

In verifying group coverage, the following steps are suggested:

- Contact Insurance Company to verify coverage/benefits.
- Obtain or verify complete mail address, contact person, and telephone number. Verify claim submission address.

- Confirm effective date of policy for possible waiting period status.
- Obtaining limitations on benefits when admission diagnosis provokes doubt concerning routine coverage.
- Secure any medical necessity approvals from insurance carrier or medical review agency prior to admission when appropriate.
- Verify coverage through union should be with the appropriate local union office unless directed otherwise.

Payment Delays

Payment for claims may be delayed if the insurance company is not sent a "clean" claim. To minimize delay in payment, verify that the following information is on the claim:

- Correct spelling of the patient's and guarantor's name
- Correct date of birth, sex, and social security number
- Correct policy and group number
- Correct provider number
- Correct diagnosis, procedure, and revenue codes

Payment for claims may also be delayed if the claim is audited. There are two types of audits:

- Insurance Company Audit whereby the carrier informs the provider that the claim is being reviewed in-house for charges and/or medical necessity.
- Hospital/Defense Audit whereby the carrier informs the provider that the claim is being audited to ensure that all charges on the claim were provided to the patient. The hospital has the right to audit the claim along with the carrier and add any late charges.

Government Payers

Medicare

Brief History of the Medicare Program

The first movement toward a national health program began in 1945 when President Harry Truman called for a national health insurance program for everyone. His initiatives died in legislation in 1945 and again in 1947 and 1949. In 1961, President John F. Kennedy created a task force which recommended creating a national health program specifically for those over 65. In 1962, Kennedy gave a televised speech about the need for Medicare. After Kennedy's death, President Lyndon Johnson called on congress to create Medicare. In 1965, legislation creating Medicare as well as Medicaid passed the Senate by a vote of 70 – 24 and the House of Representatives by a vote of 307-116. President Johnson signed the Medicare bill into law with former President Harry Truman

at his side on July 30, 1965.

After the ceremony, President Johnson signed up President Truman for Medicare and presented him with the first Medicare card. Truman was the first of 19 million Americans over 65 who enrolled in Medicare in 1966.

Original Medicare consisted of Medicare Part A and Part B (Inpatient and Outpatient coverage). Like today, Medicare Part A was financed by payroll deductions from employees and matching contributions from employers. Part B was an optional program with monthly premiums required. Originally, there was an annual Part A deductible of $40. The initial Part B monthly premium was $4.

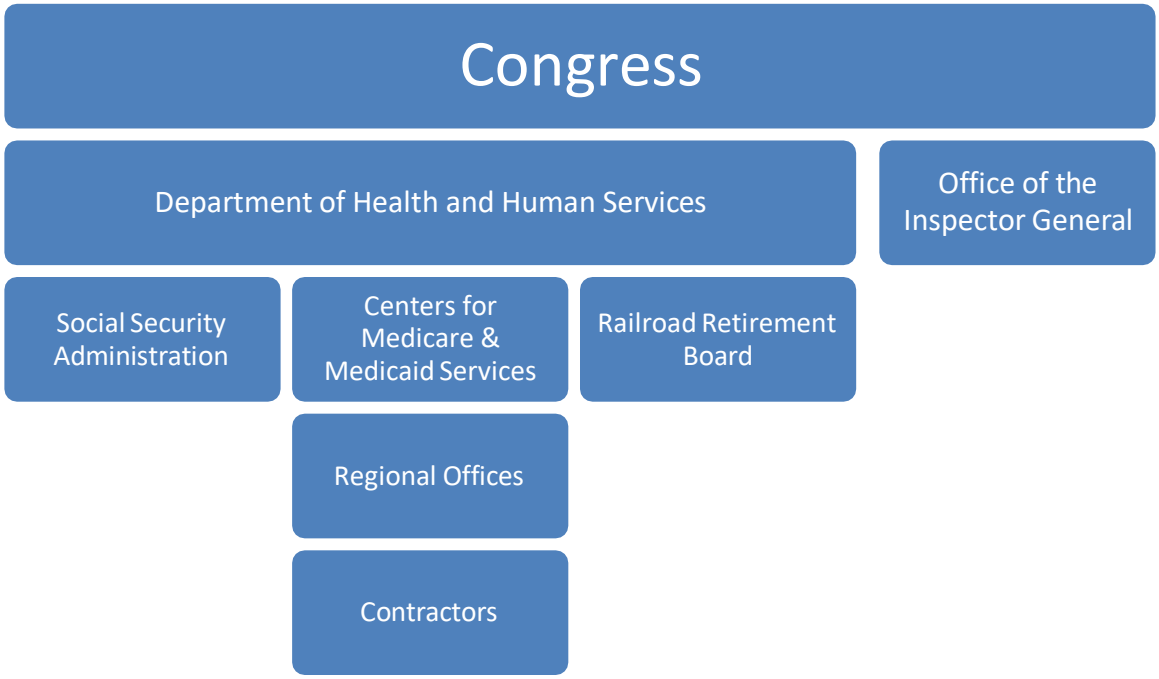
In 1972, President Richard Nixon signed legislation to expand Medicare to individuals under 65 who had long-term disabilities or end-stage renal/kidney disease. There were minimal changes in the plan offerings under the Medicare program until 1997 when private health plans, originally called Medicare Choice or Part C, began giving beneficiaries the option of choosing an HMO-style Medicare plan instead of the traditional fee-for-service Medicare program.

The Medicare program was again expanded on December 8, 2003, when President George W. Bush signed the Medicare Modernization Act which established an optional prescription drug benefit (Part D). On January 1, 2006, Part D went into effect and enrolled beneficiaries began receiving subsidized prescription drug coverage.

On March 23, 2010, as part of the Patient Protection and Affordable Care Act, preventative care services and health screenings such as mammograms were added and were to be provided free of charge under the program as the focus on prevention and wellness was enhanced. Out-of-pocket expenses under Part D were also reduced.

Today, over 55 million Americans – 17 percent of the nation's population -- are enrolled in Medicare for their health insurance coverage. With increasing life expectancies and more baby boomers turning 65 each day, the number of people enrolled in Medicare is expected to double by 2030.

Medicare Organizational Chart



Congress – Regulates Medicare through legislation.

Department of Health and Human Services - Oversees administration of the Medicare program.

Office of Inspector General – Audits and investigates Medicare fraud, waste, abuse, and mismanagement.

Social Security Administration – Administers Social Security and Medicare through regional and local offices. Handle Enrollment of beneficiaries and processes premium payments.

Centers for Medicare and Medicaid Services – Responsible for the coordination of Medicare.

Railroad Retirement Board – Administers retirement, survivor, unemployment, and sickness benefits for railroad workers.

Contractors – Companies contract with the Centers for Medicare and Medicaid to provide administrative services to the Medicare program. Intermediaries and carriers both process claims and are common examples of the type of services provided by Medicare Program contractors.

Basic features of the Medicare Program

Medicare has four parts:

- Part A – Covers inpatient hospital stays, hospice care, home health care and skilled nursing facilities (SNFs)
- Part B – Covers doctor services, outpatient care, some preventive services.
- Part C – Medicare Advantage allows individuals with Medicare Part A or B to choose to receive care through a private insurance company that is contracted with the Medicare program.

- Part D – Optional prescription drug coverage available to all that are eligible for Medicare.

Medicare Eligibility

There are three covered groups for Medicare. Originally only people who were 65 years or older qualified for Medicare. Coverage has expanded to include people who are disabled and people who have end-stage renal disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

The first covered group is related to coverage that begins at age 65, if the following conditions are met:

- You receive or are eligible to receive social security benefits; or
- You receive or are eligible to receive railroad retirement benefits; or
- Your spouse receives or is eligible to receive social security or railroad retirement benefits; or
- You or your spouse (living or deceased, including divorced spouses) worked long enough in a government job where Medicare taxes were paid; or
- You are the dependent parent of a fully insured deceased child.

The second coverage group is for individuals who do not meet the above conditions but may be able to get Medicare hospital insurance by paying a monthly premium. The Medicare application should be completed three months before the 65th birthday. Medicare coverage can begin before age 65 if the person has a disability and has received social security disability or a disability pension from the railroad for 24 months. There is a five-month waiting period after a person is determined to be disabled before a beneficiary begins to collect social security benefits.

The third group of coverage is for people who have ESRD or ALS. The 24-month waiting period is waived if the individual meets the following criteria.

- ESRD – Generally three months after a course of regular dialysis or after a kidney transplant.
- ALS – Immediately upon collecting social security benefits.

There is no difference in the Medicare coverage after the individual meets eligibility requirements.

Upon meeting Medicare requirements, the beneficiary is sent a Medicare card. Regardless of how the individual became eligible for Medicare, the coverage for Medicare is the same.

Medicare Card

The new Medicare cards have a Medicare number that is unique to the beneficiary. Social Security numbers are no longer used. This helps to protect identity. The card is paper, which is easier for many providers to use and copy. The MBI is 11 characters long, comprised of numbers and uppercase letters. CMS began utilizing the new MBI starting in April 2018.

Eligibility can be determined online by researching the Common Working File (CWF) information accessible in the Health Insurance Query Access (HIQA) of the Federal Intermediary Shared Systems (FISS). Information on all enrolled beneficiaries can be found in the CWF.

Medicare HMO Insurance Card

If a beneficiary is enrolled in a Medicare HMO, he or she should use a separate membership card from the HMO. Original Medicare and Medicare HMO's do not coordinate benefits and it will be necessary to call the HMO to verify benefits, obtain prior authorization if necessary, and confirm the address of where to bill the claim. Some Medicare Managed Care contracts will also require the provider to file an information-only claim (known as a "shadow claim" to the intermediary in addition to the claim they file to the Medicare Managed Care plan for reimbursement).

> ***Special alert – Many members enrolled in HMOs still carry their standard Medicare cards and often present them to healthcare providers as they are confused regarding "managed care" Medicare coverage and Medigap/Supplement programs. It is always advisable to check the Common Working File/Eligibility information for status for each patient for each visit and admission.***

Funding for Medicare

Medicare is a federally funded health insurance program, created by Title XVIII of the Social Security Act. In 2014, Medicare benefit payments totaled $597 billion, roughly 14 percent of the federal budget and 22% of national health spending. (Note that this amount is the "net" outlay, i.e. Medicare spending minus the total dollars collected from premiums and other offsetting funds).

Part A Medicare is financed primarily through a tax on earnings. Employers and employees each pay 1.45 percent of their earnings. Higher income taxpayers (more than $200,000 per individual) pay a higher payroll tax on earnings – 2.35 percent. The additional .9% Medicare withholding begins with the pay period in which the wages exceed the $200,000 threshold.

Part B Medicare is financed through general revenues, beneficiary premiums, interest, and other sources. Beneficiary premiums for 2024 range from $174.70 per month for individuals with annual income less than $103,000 or couples with annual incomes less than $206,000 to as high as $594.00 for singles with annual incomes greater than $500,000 or couples with annual incomes greater than $750,000.

Part D prescription coverage is financed through general revenues, beneficiary premiums, and state payments for dual eligible beneficiaries*. Individuals with higher incomes pay a larger share of the cost.

*Dual eligible beneficiaries include individuals who receive full Medicaid benefits as well as those who only receive assistance with Medicare premiums or cost sharing. They must meet certain income and resource requirements and be entitled to Medicare Part A and/or Part B and one of the following Medicaid programs:

Qualified Medicare Beneficiary (QMB) Program – Helps pay Part A and/or Part B premiums, deductibles, co-insurance and co-payments.

- Specific Low-income Medicare Beneficiary (SLMB) Program – Helps pay for Part B premiums.
- Qualified Individual (QI) Program – Helps pay for Part B premiums.
- Qualified Disabled Working Individual (QDWI) Program – Pays Part A premium for certain people for certain people who have disabilities but are still able to work.

Dual eligible beneficiaries may choose coverage under fee for service Medicaid or a Medicaid managed care plan (State laws vary on this issue). Medicare-covered services are paid first by Medicare because Medicaid is always the payer of last resource. Medicaid may cover the cost of prescription drugs and other care that Medicare does not cover.

The Medicare Advantage program (Part C) is not separately financed. Medicare Advantage plans such as HMO's and PPO's cover all Medicare Part A, Part B and typically Part D benefits. Beneficiaries enrolled in Medicare Advantage typically pay monthly premiums for additional benefits covered by their plan in addition to the part B premium.

Beneficiaries also contribute to the cost of services through deductibles and co-insurances. These will be discussed further under reimbursement.

How Does Medicare Work?

Payments are handled/adjudicated by private organizations under contract (contractors) with the federal government. Part A claims are billed to Intermediaries on a Universal Billing (UB) form. The following Part A services are billed on the UB form.

- Hospital

- Skilled Nursing Facilities (SNF)
- Home Health Agencies
- Hospices
- Community Outreach Rehab Facilities
- Community Mental Health Facilities
- Dialysis Facilities

Part B claims are billed to the MAC on the CMS 1500 claim. The following Part B services are billed on the 1500 form.

- Physician Services
- Free-standing labs and radiology
- Vendors/Supplies
- Durable medical equipment

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Section 911 mandated that the Secretary of the Department of Health and Human Services replace the contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. During the initial implementation phase (2005 – 2011) CMS awarded contracts for 15 Medicare contractors servicing most of all types of providers (both Part A and Part B). As of October 2017, there are 12 MAC regions administered by 7 different contractors.

As a result of this contracting reform, the MAC serves as the single point of contact for providers and suppliers for all claim-related business. In addition to processing claims, the MAC can assist providers and suppliers with obtaining information on behalf of patients about items or services received from another provider or supplier that could affect claim payment. This also allowed for a single point of contact for beneficiaries thus improving customer service to beneficiaries.

How Does Medicare Work?

- Just because it has a code, does not mean it's covered.
- Just because it is covered, does not mean you can bill for it.
- Just because you can bill for it, does not mean that you'll get paid for it.
- Just because you've been paid for it, doesn't mean you can keep the money.
- Just because you've been paid once, doesn't mean you'll get paid again.
- Just because you got paid in one state, doesn't mean you'll get paid in another state.
- You will never know all the rules.
- Not knowing all the rules can land you in the slammer.
- There is always someone who does not get the message.
- There is always someone else who gets the message but ignores it.

What Services Does Medicare Cover?

Medicare will pay for care that is “reasonable and necessary” for the treatment of all illnesses or injury. Medicare does not pay for services that are “routine/custodial” or “inpatient care that could be provided by persons without professional skills/training.”

Medicare uses specific policies to evaluate whether the services are deemed reasonable and necessary. National Policies are statutes or regulations written by Congress. Examples include the Mammography policy and National Laboratory policies.

In the absence of statutes, regulations or national coverage policies, MACs write Local Coverage Determinations (LCDs). LCDs were previously known as Local Medical Review Policies (LMRPs). Examples include medical necessity policies published in bulletins, e.g. coverage policies on EKGs, chest x-rays, etc.

Part A patient cost sharing for 2024 includes:

- Part A Deductible - $1632 per benefit period
- Part A Co-insurance Day for 61st- 90th day- $408 per co-insurance day
- Part A Lifetime Co-insurance Day 91 and beyond - $816 per lifetime reserve day
- Part A Skilled Nursing Facility Co-insurance Day 21-100 - $204

Covered Part A inpatient services (not limited to)

- Semi-private room
- All meals, including special diets.
- Routine nursing services
- Intensive care/coronary care units
- Drugs and medications
- Operating and recovery room costs
- Lab tests, radiology services
- Blood transfusions
- Rehabilitation services
- Speech, physical, occupational therapy

Non-covered hospital services (not limited to)

- Private duty nurses
- Personal convenience items
- Cosmetic surgery
- Private room – unless requested as medically necessary by physician.
- Self-Administered Drugs (see separate explanation, below, on this issue)

Self-Administered Drug

A self-administered drug is a drug a patient can physically give to himself or herself. People with Medicare coverage may receive drugs as a part of their inpatient treatment during a covered stay in a hospital or skilled nursing facility (SNF). Usually, Part A payments made to a hospital or other inpatient setting cover all drugs provided during the stay.

The following are general guidelines regarding self-administered drugs.

- Drugs administered intravenously (IV) are presumed to be not self-administered.
- Drugs administered intramuscular (IM) are presumed to be not self-administered.
- Subcutaneous (SQ) injections are presumed to be self-administered.
- Non-injectable drugs, such as oral, suppository and topical drugs are self-administered drugs.

Part B does not cover self-administered drugs. Part B coverage is generally limited to drugs that are given by infusion or injection when furnished in a hospital outpatient department.

Although some hospitals provide an ABN notice as a courtesy reminder to inform the patient that these costs are non-covered and therefore are patient responsibility, this is not a Medicare requirement.

Hospital Spell of Illness – Benefit Periods

A benefit period is a method Medicare uses to measure inpatient utilization for each Medicare beneficiary/patient. A benefit period begins when the beneficiary is admitted as an inpatient for the first time after receiving Medicare Part A. The benefit period ends when the beneficiary has not been an inpatient (acute or sub-acute/skilled nursing) for 60 days. There is no limit on the number of benefit periods.

A benefit period provides:

For Plan Year 2022		
Days 1 – 60	60 days full coverage	$1,556 deductible per day
Days 61 – 90	30 days co-insurance	$389 co-insurance per day
Days 91 – 150	60 lifetime days	$778 per day

Note: The daily co-insurance amount is ¼ the deductible amount. The daily lifetime patient responsibility amount is ½ the deductible amount.

Lifetime reserve days (LTRD) are not renewable. A beneficiary has 60 additional days over their entire life. Once full coverage and co-insurance days have been exhausted, permission to use LTR days must be obtained from the patient or the patient's representative. Permission may be obtained by letter or phone. If the patient is deceased, permission does not need to be obtained.

Once the lifetime days have exhausted, all charges following the last covered day become the full responsibility of the patient and must be shown in the non-covered column on the claim. This includes all revenue codes, not just room charges.

Benefit Period Examples and Practice

Example:
Mary Jones became eligible for Medicare on January 1, 2021. Since becoming Medicare eligible, she has received the following medical services.

- January 26, 2021- Outpatient X-ray/Outpatient Lab
- July 14, 2021- Outpatient Services

- December 21, 2021- Surgery Inpatient
- January 3-31, 2022- Inpatient Services
- February 5-27, 2022- Inpatient Services
- March 2-26, 2022- Inpatient Services
- June 9-30, 20202- Inpatient Services

1. How many benefit periods did Mary Jones have?
2. How many days were used each benefit period?
3. What was Mrs. Jones liability each benefit period?

Answers to Benefit Period Example

There are two (2) Benefit Periods

- Benefit Period 1 (continuous stay)
  January 3 – 31, 2022 - 28 days
  February 5 – 27, 2022 - 24 days
  March 2 – 26, 2022 - 25 days
  Total Days - 77 days
  Patient out of hospital from March 27 – June 8 = 74 days

  Benefit Period 2
  June 9-30, 2022 - 21 days
- Benefit Period 1 = 77 days (60 full + 17 co-insurance)
  Benefit Period 2 = 21 days
- Benefit Period 1 Patient Responsibility =
  Deductible (2022) $1,556
  Co-insurance ($371 x 17).....$6,613
  Total Patient Responsibility $8,169
- Benefit Period 2 Patient Responsibility =
  Deductible.....$1,556

Medicare Advantage Plans – Part C

There are five general types of plans under Medicare Advantage:

1. Health Maintenance Organizations (HMO) Plans (Some offer Point of Service options at a higher cost.)
2. Preferred Provider Organizations (PPO) Plans
3. Private Fee-for-Service (PFFS) Plans
4. Special Needs Plans (LTC)
5. Medicare Medical Savings Account (MSA) Plans

Beneficiaries must elect a plan within their service area. The beneficiary must have Medicare Part A and Part B to purchase a Medicare Advantage plan. Benefits are not always the same as under traditional Medicare Part A and B. Each plan has its own benefit package.

Beneficiaries continue to pay their Part B premiums. Some plans also require a monthly premium.

Generally, under Medicare Advantage, beneficiaries must use providers in the plan's network. Many of the Medicare Advantage plans also provide additional levels of coverage, such as vision, hearing, dental and prescription drug services.

NOTE: Special Care should be taken when communicating with beneficiaries covered under Part C. Many beneficiaries mistakenly think they have traditional Medicare Part A as primary and Part C as secondary.

Medigap Coverage

Many Medicare patients are confused about their Medicare coverage. They must be carefully questioned, have cards reviewed and insurance verified to ensure services are not denied for missing authorizations.

- Some Medicare patients think they have supplementary coverage to traditional Medicare when they are enrolled in a Medicare Advantage (managed care plan). These patients often don't understand why they have any financial responsibility.
- Some Medicare Advantage patients think that Medicare Advantage pays for all costs.

Private insurance companies may offer supplement insurance to fill the "gap" between what Medicare pays and the total due for all services rendered (i.e. amounts due under traditional Medicare for deductibles, co-insurance, and co-pays). These policies are "Medigap" policies. The insurance card must say "Medicare Supplement Insurance." There are up to 12 standardized plans as set forth under Medicare guidelines. Standardizing such plans allows for easy comparisons. Beneficiaries with Medicare Advantage plans under Part C are not eligible to purchase Medigap coverage.

A beneficiary may purchase a Medigap policy:

- Within six months of enrolling in Medicare Part B (Must be 65 or older)
- If they lose certain kinds of healthcare through no fault of their own
- If they leave Medicare Advantage/Part C under certain conditions
- From any insurance company that's licensed to sell such policies in the state where the beneficiary lives

Note: Medigap policies sold after 1/1/2006 are not allowed to include prescription drug coverage. Beneficiaries must join a Medicare Prescription Drug Plan (Part D) if they want prescription coverage. Medigap policies also don't cover items such as long-term care, vision or dental, hearing aids, glasses, or private care nursing services.

Hospital Inpatient Reimbursement

Hospital inpatient stays are paid at a pre-determined rate per discharge, otherwise known as the "Prospective Payment System (PPS)". Prospective reimbursement is intended to help control Medicare expenses. Each inpatient, when discharged is classified into a Diagnosis Related Group (DRG) which is used by Medicare to

determine reimbursement. The payment is considered payment in full by Medicare. The beneficiary is responsible for deductible, co-insurance, and non-covered charges.

Medicare may make additional payments to a facility (above the DRG amount) if one of the following applies:

- The hospital is a Disproportionate Share Hospital (DSH) (treats a high %age of low-income patients
- The hospital provides Indirect Medical Education (IME) (for approved teaching hospitals)
- The bill meets Outlier criteria*

* Cases that are particularly costly are known as outlier cases, and additional payment can be made. The additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payments are added to the adjusted base payment rate, plus any Disproportionate Share (DSH) or Indirect Medical Education (IME) adjustments.

The following facilities are currently not paid under Prospective Payment System reimbursement:

- Psychiatric Hospitals
- Children's Hospitals
- Cancer Hospitals
- Critical Access Hospitals
- Some excluded units

Medicare is billed on a UB04 or electronic 8371. Specific National Provider ID numbers and Hospital Acute Provider numbers are required.

Medicare Exhausted Benefits

When the patient has Part A Medicare, an inpatient claim must still be submitted, even if all benefits have been exhausted. All charges should be included on an original "no pay claim". The non-covered charges are patient responsibility. An ABN is not needed to bill the secondary insurance.

If the beneficiary also has Medicare Part B coverage, an ancillary claim must be filed with Medicare after the original bill is processed. Room and board charges are not included on the bill.

Part B only ancillary claims should be filed for the following conditions:

- The patient has no Part A coverage.
- The patient exhausts Part A benefits during a hospital stay.
- Benefits were exhausted before the patient came to your facility.
- The total stay is exhausted, or the patient has no Part A coverage, then total days are considered Part B only (i.e. covered Part B charges incurred for each day in the facility are billable under Part B)
- When the patient exhausts their benefits in the middle of the stay then on the days starting after the last covered day allowable Part B charges can be billed as Part B only

If a beneficiary has Part B only or Part A benefits are exhausted leaving the patient with Part B only, not all charges are billable under Part B. Any outpatient charges prior to the patient's Part B only stay should be billed separately. The three-day window does not apply when the total claim is Part B only. Only revenue codes with either CPT4 or HCPCS codes are billable under Part B only and even then, not all revenue codes are billable.

There are other covered services under Part B that are paid for under other payment methods instead of under the Outpatient Prospective Payment System methods (prosthetic devices, screening mammography, outpatient physical, occupational or speech therapy).

Influenza and PPV vaccines, when given during an inpatient stay, need to be billed separately and not included with the inpatient claim. These charges are not subject to a deductible or co-insurance.

More robust hospital billing systems allow the provider to create "split claims" so that inpatient bills contain only those items needed to file for the DRG payment while other charges fall to an outpatient type bill. Following this protocol allows providers to seek reimbursement for all items for which they are rightfully entitled.

Certain types of outpatient services require billing modifiers to be added to claims to better describe the type of services rendered. Modifiers are required for accurate and appropriate payment to occur.

The Medicare timely filing limit is one calendar year after the discharge date or date of service.

Part B - Medical Insurance

Part B helps cover the following when they are deemed medically necessary:

- Doctors' services, excluding routine physical exams, apart from the Initial Preventative Physical Exam (IPPE) which is provided and covered within the first 12 months of enrollment in Medicare Part B,
- Outpatient hospital care for medical and surgical services and supplies,
- Ambulatory surgery center facility fees for approved procedures,
- Some medical services that Part A does not cover,
- Outpatient physical and occupational therapists, including speech and language therapy,
- Some home health care,
- Outpatient mental health care,
- Second surgical opinions,
- DME (Durable Medical Equipment) including wheelchairs, hospital beds, oxygen, walkers, etc.; and
- Diagnostic tests.

Medicare should be billed only for actual outpatient type services provided. Medications prepared by the pharmacy for an inpatient cannot be sent home with the patient and billed to Medicare. Blood or IV fluids prepared for a patient but not administered cannot be charged. Most people DO pay a premium for Part B Coverage.

Medicare Advantage Plans (Part C)

The Medicare Advantage (MA) Plans are offered by private companies approved by Medicare to provide care under a contract with Medicare. These plans will provide all your Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. Medicare Advantage Plans may also offer extra coverage, such as vision, dental, and/or health and wellness programs. Most MA plans include Medicare prescription drug coverage (Part D).

You can often receive extra benefits such as:

- Prescription drugs and routine or screening services
- You may have additional rules that you must follow. For example, you must use specific providers and services may need to be pre-authorized.
- You may also have to pay a monthly premium for the extra benefits.
- Medicare requires notification through a nonpayment/zero claim (Bill Type 110) of inpatient services provided to a beneficiary with a Medicare Advantage Plan. This allows Medicare to accurately track inpatient stay accumulation.

Medicare Prescription Drug Plan (PDP)

As of January 1, 2006, this new benefit was made available to the millions of Americans that receive health insurance coverage through the Medicare Program. The Medicare Prescription Drug Plan (PDP) sometimes referred to as Medicare Part D was established by the Medicare Modernization Act (MMA), which was enacted in 2003.

Deductibles and Co-insurance

There are certain financial responsibilities that a beneficiary will be responsible for, before Medicare begins to pay on any inpatient or outpatient services:

Inpatient Part A Deductible – This is the amount the beneficiary is responsible for during a single benefit period.

For the year 2022 the Part A deductible is $1,556.00. This usually increases each year in January.

Outpatient Part B Deductible and Premium – This is the amount a beneficiary must pay for health care each calendar year before Medicare begins to pay. Once the deductible is satisfied, Medicare pays its share, and the beneficiary is responsible for any additional co-insurance.

The Part B deductible for 2022 is $233.00 per calendar year. Medicare members also pay a co-insurance amount of 20% of the Medicare approved amounts.

Clinical Laboratory Services Coverage

Medicare Part B covers lab services if they meet medical necessity. The beneficiary pays nothing for Medicare-approved clinical laboratory services. There is no deductible or co- insurance for these approved clinical lab services, however, other lab services are subject to deductible and co- insurance, for example pathology.

Preventive Services

Medicare helps cover certain health care services to keep beneficiaries healthy. These services are provided based on age, gender, and medical history. If any of the screening exams indicate that further tests are needed, this test would then be considered diagnostic.

Medicare helps cover the following preventive services, but specific coverage criteria and frequency requirements must be met for Medicare to cover and pay. Medicare also has specific billing and coding requirements for many of these services.

- Glaucoma screening

- Flu (Influenza) shot.
- Hepatitis B shot.
- Diabetes services
- Pneumococcal pneumonia vaccination
- Mammogram screening
- Pap test and pelvic exam with clinical breast exam
- Colorectal cancer screening
- Prostate cancer screening
- Bone mass measurement
- Depression screening

Ambulance

Medicare Part B will pay for ambulance transportation that has been determined to be medically necessary. The UB04 should contain only those charges pertaining to the ambulance trip. Ambulance billing requires specific information that may include:

- Ambulance report (maintain within your facility),
- Physician's certification for medical necessity (maintain within your facility),
- Supporting documentation (maintain within your facility),
- Revenue code 54x,
- HCPCS codes for mode of transfer,
- Pick up and destination modifiers.

Blood Coverage and Payments

Medicare Part A covers blood during an inpatient stay. Medicare Part B helps cover pints of blood a beneficiary receives as an outpatient or as part of a service covered by Part B. The beneficiary pays for the first three pints of blood; this is the blood deductible. The beneficiary or someone else may donate blood to replace what is used rather than be financially responsible for it.

3-Day Rule or Sometimes Called the 72-Hour Rule

Medicare requires that all diagnostic services (regardless of the diagnosis) and any related therapeutic (same diagnosis) outpatient services provided to a beneficiary three days prior to an inpatient admission to the same hospital or a hospital, owned, operated, or managed by the same hospital be included on the inpatient claim and not billed separately on an outpatient claim.

Guidelines for Registering the Medicare Patient

Facilities should perform the following steps, at a minimum when registering Medicare patients for treatment and other medical services:

- Obtain Medicare identification and eligibility information.
- Enter Patient's name exactly as shown on their Medicare card.
- Enter their MBI (Medicare Beneficiary Identifier), which is not the social security number of the patient.

- Keep a copy of the Medicare card and a picture ID to confirm the individual's identity per your facilities policies and procedures.
- Obtain other required information from either the beneficiary or their legal representative.
- Verify information by researching the common working file/eligibility screen in the Fiscal Intermediary Shared System (FISS).

Registration Requirements

Medicare has specific registration requirements for facilities that treat Medicare patients:

An Important Message from Medicare

If the patient is being admitted as an inpatient, you must give the beneficiary "AN IMPORTANT MESSAGE FROM MEDICARE" notice. This information explains the Medicare Patient's rights while in the hospital and explains how they may file an appeal if they are informed their inpatient care is no longer medically necessary. (NOTE: This applies to original Medicare beneficiaries and Medicare Advantage Plan enrollees.)

*An example of the Notice of Privacy Practices is included in Billing and Other Forms under the HIPAA section.

Inpatient Admissions and Medicare Benefit Period

If this is an inpatient admission, you must ask the patient if they have been an inpatient in the past 60 days. This will allow you to determine if this is a new benefit period or if this stay will be extending a benefit period already in progress, and:

- Calculate the available benefits.
- Inform the beneficiary of their responsibility for deductible and/or co-insurance amounts due.
- Ask if they want to use their Lifetime Reserve Days, if applicable
- Ask the beneficiary if they have received any outpatient services from the hospital where they are being admitted (or wholly owned or managed hospital) in the three days prior to this admission. (If the answer is yes, charges for the outpatient visit must be combined with the inpatient admission)

Medicare Secondary Payer Questionnaire

The hospital participation agreement requires the hospital to attempt to identify any other coverage the patient may have that could be primary to Medicare.

All questions on the Medicare Secondary Payer (MSP) questionnaire must be asked and answered by the patient and either recorded on-line or hardcopy by the registration clerk. The information must be retained in the patient's record for audit purposes.

Specific questions must be asked to determine if any of the following payers could be primary over Medicare:

- Working Aged (covered by Employee Group Health Plan)
- Disabled (but still on Employee Group Health Plan)
- ESRD (but under Employee Group Plan during waiting period)
- Worker's Compensation

- Federal Black Lung Program
- VA
- Auto, No Fault, Medical and Liability
- Law Enforcement and other Government Programs such as Research Grants

Working Aged

If the beneficiary is 65 years or older and is covered under an Employee Group Health Plan (EGHP) coverage based on his/her own employment status or the Beneficiary has Employee Group Health coverage based on employment of his/her spouse of any age—and the Employee Group Health plan has 20 or more employees, the EGHP will be primary to Medicare.

Disability

If the beneficiary is entitled to Medicare based on disability and is under 65 years of age and the beneficiary has Large Group Health Plan (LGHP) coverage due to his/her current employment status or the current employment status of a spouse or guardian and the Large Group Health Plan has 100 or more employees, the LGHP is primary to Medicare.

ESRD (End Stage Renal Disease)

The Beneficiary has Medicare based on the diagnosis of end stage renal disease (ESRD). If a beneficiary has an EGHP and is entitled to Medicare strictly based on ESRD and has waived the self-dialysis training or has not received a transplant:

If the beneficiary is covered by an Employee Group Health Plan (EGHP), that EGHP is primary to Medicare for a period of 30 months, which is the coordination period,

The coordination period begins after a 3-month waiting period, which is waived if the patient takes the self-dialysis training or receives a transplant,

The 30-month coordination period begins the first day the patient is entitled to Medicare,

If the Beneficiary has a three-month waiting period before their Medicare is effective, it will be 33 months before Medicare will be primary to the EGHP.

Worker's Compensation

If the illness or injury the Beneficiary is receiving services for is due to a work-related accident or condition, worker's compensation benefits would be primary to Medicare.

Black Lung

If the beneficiary has coverage under the Federal Black Lung Program and the services, the Beneficiary is to receive is a covered Black Lung diagnosis---then Black Lung benefits would be primary to Medicare.

Veterans Administration VA

If the Department of Veterans Affairs (Administration) has authorized and agreed to pay for care in your facility, then VA should be billed for the Beneficiary's services.

If the Beneficiary does not have VA authorization the hospital should bill Medicare for services. You will never bill Medicare and VA; you will always bill one or the other. This is the only MSP situation where the beneficiary can select which coverage they would prefer the hospital to bill. But if VA has not authorized the services, they may not pay so it would be better to bill Medicare in the absence of an authorization.

Auto, Medical, No-Fault and Liability

If the Beneficiary is at fault and medical coverage under an auto policy exists, the medical coverage should be billed primary to Medicare. If the patient is not at fault and Medical Coverage exists, but no liability coverage, then medical coverage should be billed as primary to Medicare.

If the Beneficiary is not at fault and intends to seek a liability settlement from a third party determined to be at fault, the hospital must file a lien or a letter of intent to file a lien within 30 days of discharge to be a party to this type of settlement—in this case the hospital would not bill Medicare until after the settlement. If Medicare is billed the provider must adjust the lien and the settlement would be used to refund Medicare.

Law Enforcement and Other Government Programs

If Law Enforcement admitted the patient, Law Enforcement would be responsible and should be billed primary to Medicare.

Other Government Programs, such as research grants may also be primary to Medicare. Complete MSP information can be researched on the Common Working File (CWF)/Eligibility screens. The MSP information is found on the last screen if Medicare has the information. If your claim is the first claim to be filed with the MSP information, you will not find any information in CWF.

Other important questions to ask the Medicare beneficiary:

ASK THE BENEFICIARY IF THEY HAVE ELECTED HOSPICE BENEFITS

- If the answer is **yes**, the Hospice should be immediately contacted to allow them to manage the patient's care. If the patient is admitted the hospital cannot bill Medicare but must bill the Hospice and if the Hospice has not coordinated the admission or services received by the patient, then the Hospice will not be responsible.
- If the Beneficiary is admitted or receives treatment for a diagnosis not related to the terminal diagnosis for Hospice the Hospital may register as usual and bill Medicare—note-condition code 07 must be on the claim to inform Medicare this is not related to Hospice diagnosis.
- Hospice effective and termination dates and the Hospice Provider number may be found on the common working file/eligibility screen.

ASK THE BENEFICIARY IF THEY ARE A MEMBER OF A MANAGED CARE PLAN SUCH AS AN HMO

- If the answer is **yes**, then get the patient's card and call the plan to determine other information that may be required to bill and receive payment from the managed care plan.
- Verify what types of authorizations and notifications are required by the payer.
- Additional information may also be found on common working file/eligibility screens.

Advanced Beneficiary Notice

The ABN is a notification that the patient may be expected to pay for certain laboratory or diagnostic testing that Medicare has determined to be non-covered services. By signing the ABN, the patient understands they will be financially responsible for the test(s) in the event Medicare denies payment to the hospital. This applies to all patients who are covered by Medicare, regardless of whether Medicare is their primary or secondary insurance. This notice must be signed and maintained within your facility according to policies and procedures. If the ABN is not signed and services are denied or determined to be non-covered by Medicare the beneficiary cannot be held financially responsible.

Medical Necessity Requirement upon Registration

Medical necessity is an analysis of the medical treatment ordered to determine if it is reasonable and necessary, and provided in the most appropriate setting to meet the needs of the patient's illness or injury.

Medicare has developed policies to determine if tests and procedures ordered are medically necessary. There are National Policies and Local Policies.

LCD (Local Coverage Determination) (formerly called Local Medical Review Policies of LMRPs) is developed by the Intermediaries/Carriers. These policies provide the specific diagnosis that supports medical necessity for certain outpatient services. NCDs are National Coverage Determination developed by CMS.

Hospitals utilize these policies to screen orders to determine if medical necessity exists. The Hospital's Patient Access Department must determine if medical necessity is supported ***prior*** to the test/procedure being performed.

If the diagnosis provided by the physician's order does not support medical necessity

- The physician should be contacted to determine if another diagnosis exists, (according to facility policies and procedures).
- If a physician cannot provide a diagnosis that supports medical necessity, then an ABN would be issued for the patient's signature prior to services being rendered. If the patient chooses to have the procedure and signs the ABN, they accept responsibility for payment of charges related to the services.
- Many times, the patient may choose to not have the services and discuss other options with their physician.

The Key Element to the Medical Necessity screening process is the Physician's order! The order should be clear and contain what tests/procedures the physician is requesting and the corresponding HCPCS codes, it should also include the reason for the tests/procedures ordered and the corresponding ICD- 10 diagnosis codes.

Billing Medicare

Medicare requires many elements of information to be reported on the claim; this information can be provided through the utilization of codes.

Codes used to provide information to Medicare and other payers, when applicable, are as follows:

- HCPCS - HCFA Common Procedural Coding System, (Usually for OP services only, Alpha- numeric codes),
- CPT – Current Procedural Terminology (Usually for OP services only, numeric codes),
- ICD-10-CM - International Classification of Diseases, version 10, Clinical Modifications, are alphanumeric codes.
- Condition Codes
- Occurrence Codes,
- Occurrence Span Codes
- Value Codes.

Condition, occurrence and value codes will be defined as we discuss some of the most frequently used when billing a claim to the Medicare Intermediary on the UB-04.

During the billing process, there are several key Form Locators on the UB-04 or within the EDI billing system that can cause payment delays or denials if they are not completed properly. The following list addresses several of these fields.

Type of Bill

FL 4 denotes the type of claim that is being submitted to Medicare. The most typical bill types are:

11X	Inpatient Stay
13X	Outpatient visit
14X	Lab Only
85X	Critical Access
121X	Part B Only

Patient Discharge Status

FL17 denotes the patient discharge status. The most typical codes are:

01	Home (routine)
02	Another Short-term General Hospital for Inpatient Care
03	SNF
04	Facility that Provides Custodial or Supportive Care
05	Designated Cancer Center or Children’s Hospital
06	Home Health

07 Against Medical Advice or Discontinued Care

20 Expired

Condition Code

FL 18-28 defines certain conditions relating to the claim that may affect how the payer processes and pays the claim. Some examples of these codes include:

02 Condition employment related.

05 Lien has been filed.

06 ESRD patient in first 30 months of entitlement

07 Treatment of nonterminal condition for Hospice patient

08 Beneficiary would not provide information concerning other insurance coverage.

09 Neither patient nor spouse employed.

10 Patient and/or spouse is employed but no EHGP coverage.

11 Disabled beneficiary, but no EHGP coverage

20 Beneficiary requested billing.

21 Billing for Denial Notice

28 Patient and/or spouse's EGHP is secondary to Medicare.

38 Semi-private room not available

39 Private room medically necessary

40 Same day transfer

55 SNF bed not available

Occurrence Code

FL 31 - 34 defines a significant event relating to the claims that may affect payer processing and payment. Examples of these codes include:

01 Accident/Medical Coverage

03 Accident/Tort Liability

04 Accident – Employment Related

05 Accident/No Medical or Liability coverage

11 Onset of Symptoms/Illness

18 Date of retirement of Beneficiary/Patient

19 Date of Retirement of Spouse

24 Date Insurance Denied

Occurrence Span Codes and Dates

FL 35-36 codes and dates that relate to a span of time that may affect the processing and payment of the claim:

71 Prior stay dates

74 Non covered level of care/Leave of absence dates

76 Patient Liability

77 Provider Liability Period

Value Code

FL 39 - 41 identifies data of a monetary nature that is necessary for processing the claims by the payer. Examples of these codes include:

02 Hospital has no semi-private rooms.

06 Medicare blood deductible

12 Working aged beneficiary with EGHP.

15 Workers Compensation

50 Physical therapy visits

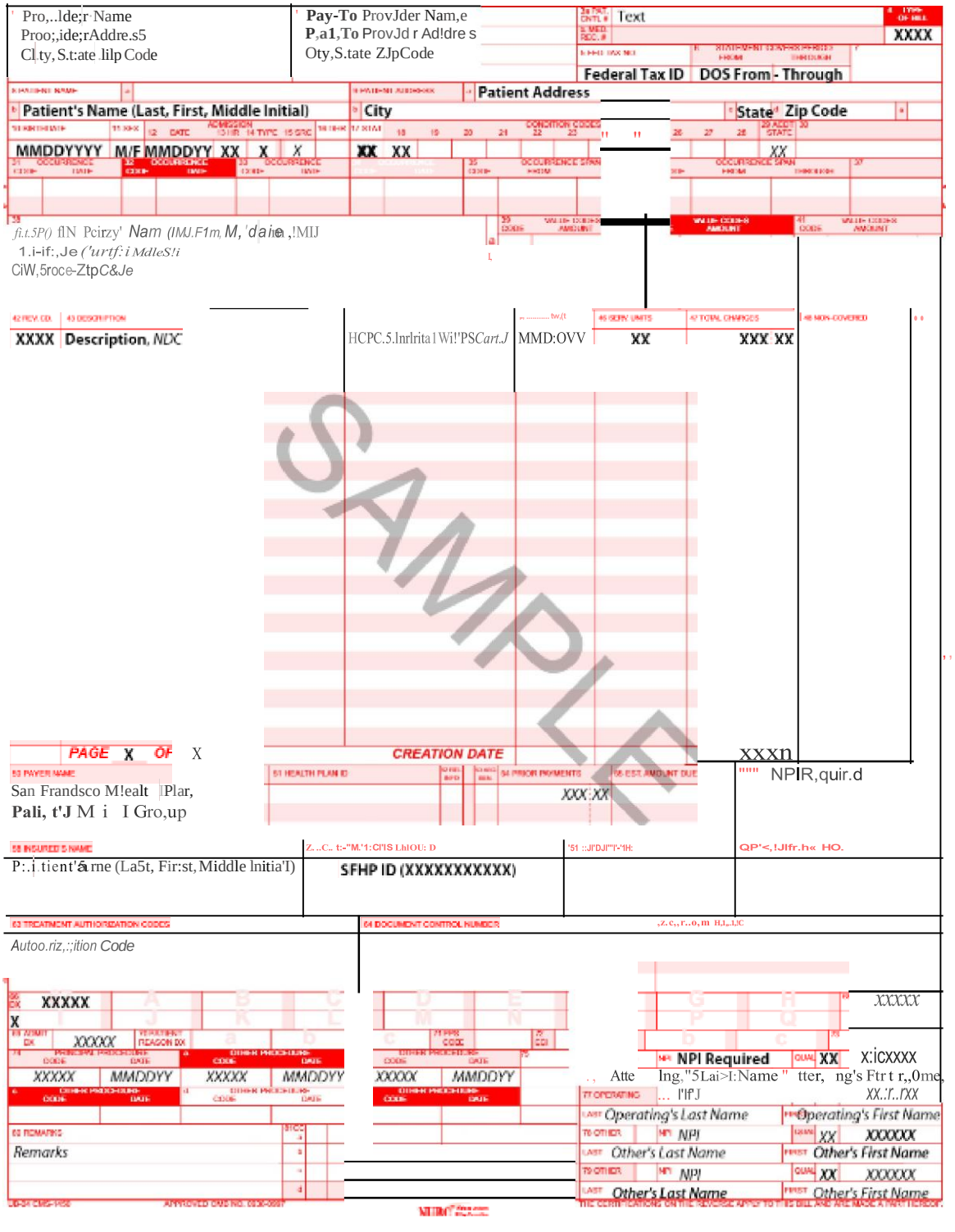
Federal Intermediary Shared System Adjustment

There are several situations where claim adjustments or cancellations may be required, or where a refund is due to the Medicare program. Sometimes only a portion of the Medicare payment will need to be refunded, other times total payments will need to be returned. Whether the claim needs to be adjusted or recouped, it can usually is accomplished on-line using the Federal Intermediary Shared System (FISS).

- Examples of items that can be handled using the online system:
- A portion of the payment needs to be refunded or adjusted (may be related to late charges, credits)
- The entire claim needs to be cancelled because it was billed in error.
- The refund is due to Medicare due to another payer that is primary.

For DDE providers that adjust claims online, there are specific conditions and adjustment codes. Common examples are noted below. (For a full listing of codes, refer to CMS manuals/website)

Condition Code	Definition	Adjustment Reason Code	
D0	Dates of service change	DT	
D1	Changes to charges	CC	
D2	Change in revenue code	CE	
	Change in HCPCS code	OE	
D3	PPS Interim Bill	IB	
D4	Change in grouper input	AG	
	Change in surgical procedure code	SP	
D5	Cancel only to correct a health insurance claim number	IH	
	Cancel only to correct the Provider number	IP	
D6	Cancel only to repay a duplicate payment or OIG overpayment	BE	
D7	Change to make Medicare the secondary payer and other primary	WA	Working Aged
		ES	ESRD
		AU	Automobile
		LI	Liability
		WC	Work Comp
		FA	Federal Agency
		DB	Disability
		BL	Black Lung
		VA	Veterans Admin.
D8	Change to make Medicare primary over other insurance	WB	Working Aged
		ER	ESRD
		AT	Automobile
		LJ	Liability
		WD	Work Comp
		FC	Federal Agency
		DE	Disability
		BM	Black Lung
		VA	Veterans Admin.
D9	Any other changes	OT	
E0	Change in inpatient status	DS	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Medicare Administrative Contractor (MAC)

The MAC for Alabama is:

Palmetto GBA, LLC

The following are the addresses to mail claims and correspondence to Palmetto GBA:

Palmetto GBA
Attn: JJ Medicare Part A
P.O. Box 100305
Columbia, SC 29203

Palmetto GBS, LLC (Palmetto GBA) handles the combined administration of Part A/Part B Medicare claims payment for Jurisdiction 10 (Alabama, Georgia, and Tennessee)

Timely Filing

The time for filing Medicare claims is one calendar year after the date of service. For Inpatient claims filing must occur within 1 year of the admission date.

Where administrative error (that is, misrepresentation, delay, mistake, or other action of the SSA or its intermediaries or carriers) causes the failure of the claim to be filed within the time limit specified, the time limit may be extended through the close of the sixth (6th) calendar month following the month in which the error is rectified.

If a provider was a participating provider within the time limit, but failed to submit a timely claim, or failed to do timely follow-up on the claim, the provider is liable and cannot bill the patient or other person for the services or for deductible or co-insurance amounts.

Recovery Audit Contractors (RACs)

Safeguarding the Medicare program and its continued financial viability are at the heart of the Recovery Audit Contractor (RAC) Program. The RAC demonstration program was implemented by CMS in March of 2005. The current RAC's for Alabama are: Cotiviti (for Medicare).

The RAC program is designed to identify and recover improper payments made by CMS.

Some examples of improper payments that occur in the Medicare FFS program is:

- Payments are made for services that were not medically necessary.
- Payments are made for services that are incorrectly coded.
- The provider fails to submit documentation when requested to support a claim.

Two Midnight Rule (Hospital Inpatient/Outpatient/Observation Status)

Hospital inpatients are patients who are admitted to the hospital to receive services and are expected to occupy a hospital bed. Outpatients are not admitted to the hospital but are registered as outpatients and receive services. Outpatient services can include planned procedures or care provided in the emergency department. In many cases, the same service could be provided on an inpatient or an outpatient basis. Medicare pays for

inpatient services and outpatient services under separate and very different payment systems, which can produce substantially different payment amounts for similar patients receiving similar services. The patient responsibility can also differ substantially due to co-insurance amounts and deductibles.

Until 2013, CMS provided little guidance to hospitals on how to determine whether a patient should be treated on an inpatient or outpatient basis. In 2013, CMS announced the "two-midnight rule" to clarify when it expected a patient to be designated to inpatient status. Under this rule, only patients that the doctor expects will need to spend two nights in the hospital would be considered as hospital inpatients.

The two-midnight presumption directs medical reviewers to select Part A claims for review under a presumption that the occurrence of two midnights after formal inpatient hospital admission pursuant to a physician order indicates an appropriate inpatient status for a reasonable and necessary Part A claim. CMS will instruct the Medicare Administrative Contractors (MACs) and Recovery Auditors, absent evidence of systematic gaming or abuse, they are not to review claims spanning two or more midnights after admission for a determination of whether the inpatient hospital admission and the patient status are appropriate.

Reviewing agencies will once again begin to review patient status and classifications to assure program integrity and adherence to established rules/guidelines.

MEDICAID

What is Medicaid?

Medicaid, established under the provisions of Title XIX of the 1965 Federal Social Security Act, is a medical assistance program that helps many people who can't afford medical care pay for some or all their medical bills. Some covered services are mandated by federal law. States may expand on other covered services but must include the mandated services.

- It is a state-administered program jointly funded by the State of Alabama and the Federal Government.
- The Alabama Medicaid Agency, which began operations on January 1, 1970, is a state/federal program that pays for medical and long-term care services for low-income pregnant women, children, certain people on Medicare, disabled individuals, and nursing home residents. The individuals must meet certain income and other requirements.
- The AMA (Alabama Medicaid Agency) is the State agency in Alabama that administers the Medicaid program.
- Gainwell Technologies, Inc. is the fiscal agent responsible for the processing and payment of Traditional Medicaid claims in the State of Alabama.

Eligibility Certification

The provider may not deny services to any eligible Medicaid member because of the member's ability/inability to pay the co-payment. Medicaid certification is a plastic identification card that is issued upon determination of eligibility. Recipients no longer receive a monthly card, and each recipient has his/her own card. The web portal is the best resource for eligibility information.

Retroactive Eligibility

When an individual is not a Medicaid recipient on the date of service, but later is determined eligible and further determined to be eligible at the time service was rendered, a claim may be submitted. HPES must receive retroactive eligibility claims within one (1) year of the month in which the determination of retroactive eligibility is made. After an individual is determined eligible, he/she will receive a Medicaid card for ongoing eligibility.

Pre-Certification/Prior Approval

Pre-certification pertains to medical necessity and appropriateness of setting only. The patient must be eligible at the time the service is rendered. The purpose of the program is to ensure that medically necessary quality health services are provided in the most cost-effective setting. Pre-certification does not guarantee reimbursement.

All services, regardless of certification, are subject to review for medical necessity.

Blue Cross and Blue Shield of AL

Background- Blue Cross is the largest provider of healthcare benefits in Alabama and have served Alabamians for over 87 years. They provide coverage to over 2.8 million people. Their corporate headquarters is in Birmingham, AL.

Provider Portal- https://providers.bcbsal.org/portal/

Enhanced Ambulatory Patient Grouping (EAPG)

EAPG is a patient classification system designed to reflect the amount and type of resources used in an outpatient visit using one set of payment weights that reflect the relativity of costs for all services in the payment system. Additionally, provider-specific base rates are used to reflect the cost of similar providers, services, and service settings. EAPG payments will alleviate the requirement for a specific Blue Cross cost report and retroactive settlements.

Which providers and services are impacted by EAPG?

All claims for outpatient hospital services submitted by Alabama hospitals, including critical access and acute care hospitals, will be reimbursed using the EAPG system. Specialty hospitals (psychiatric and rehabilitation), long-term acute care (LTAC) facilities, freestanding ambulatory surgical center (ASC) facilities, and freestanding dialysis center (FDC) facilities will not be reimbursed using the EAPG system.

EAPG classifies Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS) procedure codes, and International Classification of Diseases diagnosis codes reported on a claim as one of the following primary EAPG types:

- Significant procedure – A procedure or service which constitutes the reason for the visit and dominates the time and resources required for the visit. Examples include treating a fractured arm, stress test, carpal tunnel release, or insertion of a central venous catheter.

- Medical visit – A visit where medical treatment is received but no significant procedures are performed. The medical visit EAPG assigned is based on the principal diagnosis code. Examples include a follow-up visit for chronic obstructive pulmonary disease (COPD) and evaluation and management (E&M) of headache symptoms.
- Ancillary test and procedure – A test or procedure ordered by the treating physician to assist in the patient's diagnosis or treatment. Examples include immunizations, plain film x-rays or laboratory tests.
- Incidental procedure – This is an integral part of a medical visit and is usually associated with professional services being given to the patient. An example may include range of motion measurements.

Classification Process

- EAPG first attempts to assign a significant procedure or therapy EAPG.
- If no significant procedures are billed, EAPG attempts to assign a medical visit EAPG, if:
    - A medical visit indicator (MVI) is present on the claim, and
    - major signs, symptoms, or findings (diagnosis) are present on the claim, then.
    - the medical visit EAPG associated with the principal diagnosis is assigned.
- If no significant procedure or medical visit criteria are met, EAPG attempts to assign an ancillary EAPG, if:
    - Ancillary tests or procedures are present, then.
    - the ancillary EAPG related to the type of test or procedure is assigned.
- For each EAPG classification, the following applies:
    - Multiple EAPGs may be assigned per visit.
    - Each revenue line is assigned an EAPG, but each revenue line may not be eligible for separate reimbursement.
    - If significant procedure, medical visit, or ancillary service criteria are not met, the claim will not be a payable outpatient visit. EAPG 999 identifies services that cannot be assigned to a valid EAPG.

Are HCPCS/CPT procedure codes required to be billed on all lines of an outpatient claim?

All revenue lines (with limited exceptions) must be billed with a valid HCPCS/CPT procedure code, or the claim will be returned to the provider with notification to file the procedure codes. There is a list of specific revenue codes that are exempt from this requirement.

Which revenue codes are exempt from the HCPCS/CPT procedure code requirement?

The revenue codes listed below may be submitted without a corresponding procedure code. These revenue lines submitted without corresponding procedure codes will not receive separate payment:

- 250-259 Pharmacy
- 270-273 Medical Supplies
- 278 Other Implants

- 370, 371, 372, 374, 376 Anesthesia
- 637 Self-Administered Drugs
- 681-684, 689 Trauma Response
- 710 Recovery Room
- 990-999 Patient Convenience Items

Medical Policies-

Blue Cross's draft medical policies and final medical policies are displayed on this site. Medical policies are based on the most current medical research available at the time of the policy development.

Policies are written to cover a given condition for most people. Everyone's unique clinical circumstances may be considered considering current scientific literature. Medical policies are based on constantly changing medical science and the Plan reserves the right to review and update our policies as necessary.

Blue Cross encourages practicing physicians to provide input related to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner is welcome to provide comments, suggestions, or concerns. Our internal policy committee will review and take your comments into consideration.

Subrogation Information for Hospitals and Providers

Claims should be immediately filed with Blue Cross and Blue Shield of Alabama when treating a patient that has been involved in an accident of any nature. In accordance with our PMD, Participating Hospital, Preferred Home Health, or Preferred DME agreements, it is our policy to consider each claim under normal contract benefits and make payment accordingly to the provider.

When Blue Cross is involved in subrogation activity, the full amount of the Blue Cross payment should be refunded to Blue Cross not to exceed the amount received. Any remaining amount over the Blue Cross allowable should be refunded to the patient or returned to the issuing carrier.

Payment made under the terms of the provider's contract agreement is to be considered as payment in full. Liens should not be filed against a patient with valid Blue Cross coverage, except to cover any deductibles, copayments or other out-of-pocket expenses related to treatment. Any such liens should be filed only after reasonable efforts have been made to collect amounts deemed patient responsibility.

Alabama House Bill 11, which became effective August 1, 2019, clarifies the hospital lien provisions, and places a requirement upon hospitals to seek payment for claims from a patient's health insurance provider first. The hospitals can no longer hold back the bills to extract a higher payment from a third party.

Alabama Code 35-11-371 will now include the following critical language:

(b) Unless specifically contrary to any contractual agreement between the hospital and the injured person's health care payor or unless contrary to any statute or governmental rule or regulation of the United States or this state, no hospital shall perfect a lien as to any injured person who was covered by a health care payer's policy, until the hospital submits to the health care payor an accurate and properly coded claim, or if a contract

exists between the hospital and the health care payor, in the form required pursuant to the contract, and there is a failure to satisfy the claim.

For more information about subrogation for hospitals and providers, email Subrogation-Referral@bcbsal.org.

Blue Card Program

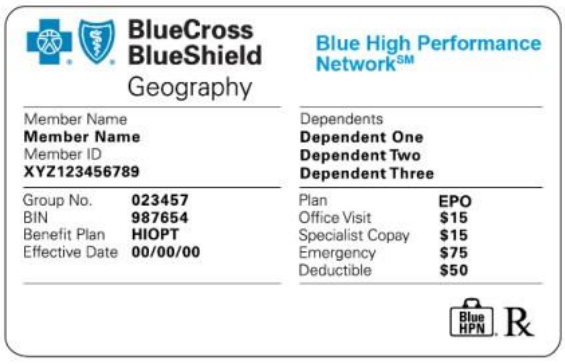
BlueCard® is a national program that enables members of one BCBS Plan to obtain healthcare service benefits while traveling or living in another BCBS Plan's service area. The program links participating healthcare providers with the independent BCBS Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

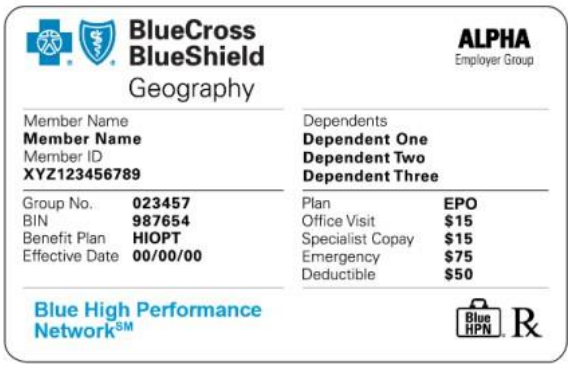
The BlueCard Program lets you conveniently submit claims for members from other BCBS Plans, including international BCBS Plans, directly to Blue Cross and Blue Shield of Alabama. As such, Blue Cross and Blue Shield of Alabama will be your only point of contact for all your claims-related questions.

BlueCard ID cards have a suitcase logo, it may be an empty suitcase, a PPO in a suitcase or a BlueHPN in a suitcase. The PPO in a suitcase logo indicates that the member is enrolled in either a PPO product or an EPO product. In either case, you will be reimbursed according to Blue Cross and Blue Shield of Alabama's PPO provider contract. Please note that EPO products may have limited benefits out-of-area. The potential for such benefit limitations is indicated on the reverse side of an EPO ID card.

The PPOB in a suitcase logo indicates that the member has selected a PPO or EPO product, from a BCBS Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic. Providers will be reimbursed for covered services in accordance with your BlueCard® PPO or BlueCard® Traditional contract with Blue Cross and Blue Shield of Alabama. The BlueHPN EPO product includes a BlueHPN in a suitcase logo on the ID card. Members must obtain services from BlueHPN providers to receive full benefits. If you are a BlueHPN provider, you will be reimbursed for covered services in accordance with your BlueHPN contract with Blue Cross and Blue Shield of Alabama.

Sample ID Cards





TRICARE

What Is TRICARE?

TRICARE (formerly called CHAMPUS) is the Department of Defense's worldwide health care program available to eligible beneficiaries in any of the seven uniformed services---the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, Commissioned Corps of the U.S. Public Health Service and the Commissioned Corps of the National Oceanic and Atmospheric Administration. TRICARE is managed in three stateside regions---TRICARE North, TRICARE East, and TRICARE West. TRICARE Management Activity (TMA) and TRICARE Regional Offices jointly manage TRICARE in these regions.

The East Region is administered by Humana Military Healthcare Services, Inc. for more than 2.8 million individuals including Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, and Texas with the exclusion of the Ft. Campbell area in Tennessee and the El Paso area in Texas.

TRICARE provides eligible beneficiaries the freedom to choose how their healthcare will be delivered by offering the following program options (http://www.humana-military.com/south/provider/tools-resources/handbook/program-options.asp):

TRICARE Program Options

TRICARE Prime

Enrollment plan like a Health Maintenance Organization (HMO). TRICARE Prime is available in the North, South and West Regions in areas known as Prime Service Areas to all beneficiaries who are not entitled to Medicare due to age (65). Enrollment is required to participate in TRICARE Prime.

In most cases, the TRICARE Prime enrollment fees are not refundable. There are no enrollment fees for active-duty service members and active-duty family members (or for survivors during the transitional survivor period following the active-duty service member's death) enrolled in TRICARE Prime. Retired service members, their families, survivors, eligible former spouses, and others enrolled in TRICARE Prime are required to pay an annual enrollment fee ($230 per individual or $460 per family). There is no copayment for outpatient services for Active-Duty members and their families. Enrollees select a primary care manager who coordinates their healthcare; to include referral and/or prior authorization to receive nonemergency care from another provider. Active-duty service member coverage begins on the date the enrollment application is received. Otherwise, if a completed enrollment application is received by a regional contractor by the 20th of the month, coverage will begin on the first day of the next month. The application must be received by the 20th of the month, not postmarked by the 20th of the month. If the form is received after the 20th of the month, then coverage begins on the first day of the second month following receipt of your application.

TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active-Duty Family Members (TPRADFM)

These two program options provide coverage to active-duty service members and their families who live in remote locations through a network of civilian TRICARE authorized providers. Eligibility to these programs requires that active members and families who live and work more than 50 miles or a one-hour drive time from the nearest military treatment facility designated as adequate to provide primary care.

There are no enrollment fees for active-duty service members and active-duty family members (or for survivors during the transitional survivor period following the active-duty service member's death) enrolled in TRICARE Prime Remote or TRICARE Prime Remote for Active-Duty Family Members. There is no copayment for outpatient

services for Active-Duty members and their families. Each enrollee is assigned or may select a PCM. Whenever possible, A TRICARE network primary care manager is assigned, but a non-network may be assigned if a network provider is not available. In most cases, an enrollee must obtain a referral and/or prior authorization to receive nonemergency care from another provider.

TRICARE Point of Service (POS)

The point-of-service (POS) option allows non-active-duty service members enrolled in TRICARE Prime, Prime Remote and Prime Remote for Active-Duty Family Members to receive nonemergency care from any TRICARE-authorized provider without requesting a referral from your primary care manager, resulting in higher out-of-pocket costs. The POS deductible applies only to outpatient services, and the cost-share applies to both inpatient and outpatient care.

Out-of-pocket expenses you pay under the POS option are not applied to your annual catastrophic cap. The POS option is not available to active-duty service members and does not apply to newborns or newly adopted children in the first 60 days after birth or adoption, emergency care, or if you have other health insurance. When using the POS option, beneficiaries must pay a deductible and 50% of the TRICARE allowable charge.

TRICARE Standard and TRICARE Extra

TRICARE Standard and Extra is a fee-for-service plan available to all non-active-duty beneficiaries throughout the United States. Enrollment is not required. Coverage is automatic if your information is current in the Defense Enrollment Eligibility Reporting System.

Any TRICARE-authorized provider, network or non-network may be accessed with either of these options. Care at a military treatment facility is on a space-available basis only. No referral is required for any type of care, but some services may require prior authorization.

The type of provider seen determines which option is utilized and how pay out-of-pocket expense is expected. If a non-network provider is selected, the Standard option is used. If a network provider is selected, the Extra option is used. By using the Extra option, less out of pocket is paid and the provider will file the claims.

TRICARE for Life

TRICARE for Life (TFL) is TRICARE's Medicare-wraparound coverage available to *all* Medicare- eligible TRICARE beneficiaries, regardless of age or place of residence, provided they have Medicare Parts A and B. While Medicare is the primary insurance, TRICARE acts as the secondary payer minimizing out-of-pocket expenses. TRICARE benefits include covering Medicare's co-insurance and deductible. Basically, if a Medicare participating or non- participating provider is used, the provider will file the claims with Medicare. Medicare pays its portion and electronically forwards the claim to the Tricare for Life claims processor who pays the provider directly for TRICARE-covered services.

- For services covered by both Medicare and TRICARE, Medicare pays first and TFL pays your remaining co-insurance for TRICARE-covered services.
- For services covered by TRICARE but not by Medicare, TFL pays first, and Medicare pays nothing. You must pay the TRICARE fiscal year deductible and cost shares.

- For services covered by Medicare but not by TRICARE, Medicare pays first and TFL pays nothing. You must pay the Medicare deductible and co-insurance.
- For services not covered by Medicare or TRICARE, Medicare and TRICARE pay nothing, and you must pay the entire bill.

When using Tricare for Life, the beneficiary doesn't pay any enrollment fees, but must pay Medicare Part B monthly premiums which are based on income. For more information about Part B premiums visit www.medicare.gov or call Social Security at 1-800-772-1213 (TTY: 1-800-325-0778).

DEERS, ID Cards, and Eligibility

http://www.tricare.mil/mybenefit/home/overview/Eligibility/DEERS/Updating?

Active duty and retired military sponsors, eligible family members and all other eligible beneficiaries must be entered into the Defense Enrollment Eligibility Reporting System (DEERS) to show eligibility for TRICARE benefits. It is the sponsor's responsibility to make sure that his or her eligible family members are enrolled in DEERS, which can be done through the personnel office or at the nearest Uniformed Services ID Card issuing facility. All sponsors should ensure that their family member's status (marriage, divorce, new child, etc.), residential address, telephone numbers and email are current in the DEERS files so TRICARE can send out information and claims processed quickly and accurately. Family members can update personal information such as addresses and phone numbers once they are registered in DEERS.

Note: Addresses must be a physical address; P.O. boxes cannot be used. Additionally, if both parents are service members, then either parent (must choose one) may be listed as the Child(ren)'s sponsor in DEERS.

Providers must verify TRICARE eligibility at the time of service and must ensure beneficiaries have valid Common Access Cards (CACs), uniformed services ID cards or eligibility authorization letters. The sponsor's Social Security number is used to verify eligibility.

Note: In response to a growing need to protect the identification information of beneficiaries, Social Security numbers are being removed from the Department of Defense ID cards. Although SSNs are being removed, TRICARE continues to base all operations on the sponsor's SSN. This removal process has three phases and changes are made when beneficiaries renew their ID cards.

- Phase 1 (2008) affects family member ID cards.
- Phase 2 (2009) removes all printed SSNs.
- Phase 3 (2012) removes SSN information embedded in barcodes.

Providers may not verify TRICARE enrollment directly in DEERS because of the Privacy Act (*Title 5, United States Code, Section 552a*), but can log on to "MyHMHS for Providers" portal at www.humana- military.com or by contacting Humana Military Healthcare Services at 1-800-444-5445 to confirm eligibility.

Beneficiaries can verify eligibility in DEERS by calling 1-800-538-9552.

SPECIAL NOTE FOR NEWBORN CHILDREN

Newborns should be enrolled in DEERS as soon as possible to establish eligibility for TRICARE benefits and to ensure claims are not denied because of non-enrollment.

The following must be submitted to an ID card office:

- An original or certified-copy of the birth certificate or certificate of live birth (signed by the attending physician or other responsible person from a U.S. hospital or military treatment facility), or consular report of birth (FS-240) for children overseas.
- A record of adoption or a letter of placement of the child into the home by a recognized placement/adoption agency or the court before the final adoption; and
- An *Application for Uniformed Services Identification Card and DEERS Enrollment (DD Form 1172)* signed by the sponsor and verifying official from a uniformed services identification (ID) card-issuing facility. *If the sponsor can't sign the DD Form 1172 in person at an ID card facility, then a notarized copy of the form is required. The spouse must submit presentation of a power of attorney if the sponsor didn't sign the DD Form 1172.*

Parents can apply for a child's Social Security number (SSN) on the Social Security Administration Website, or by calling 1-800-772-1213. Once the child's SSN is received, their DEERS information must be updated.

If any family member is enrolled in Prime, TRICARE Prime covers the following:

- Newborns for 60 days beginning from the date of birth.
- Adopted children for 60 days beginning from the effective date of the actual adoption.
- and
- Pre-adoptive children for 60 days beginning on the date of placement of the court or approved adoption agency.

To continue Prime coverage past the first 60 days, the newborn or adoptee must be enrolled in either TRICARE Prime or TRICARE Prime Remote within the 60-day window. On the 61st day and after, if the child isn't enrolled, TRICARE processes all future claims under TRICARE Standard and Extra (higher costs) until the child is enrolled.

Note: To give parents overseas sufficient time to meet all TRICARE overseas eligibility requirements for newborns, the enrollment period for TRICARE Prime and TRICARE Prime Remote Overseas is 120 days. The child loses TRICARE eligibility after 365 days unless they are enrolled in DEERS.

ELIGIBILITY VERIFICATION

To verify eligibility, log into Humana Military's secure "MyHMHS for Providers" portal at www.humana-military.comor by calling 1-800-444-5445. The sponsor's Social Security number is used to verify eligibility.

A valid Common Access Card (CAC), Uniformed Services Identification Card (ID), valid ID photo with a copy of the sponsor's activation orders (activated for more than 30 consecutive days) or eligible authorization letter is required to establish eligibility. However, children under age 10 are not normally issued ID cards. Their eligibility is established based on either parent's ID card.

The Uniformed Services ID card incorporates a digital phone of the bearer, barcodes and printed.

ID and entitlement information. The ID card's color determines the beneficiary's category.

- Active-duty family members (ADFMs): DD Form 1173 – tan
- National Guard and Reserve family members: DD Form 1173-1 – red
- Retirees: DD Form 2 [RET] – blue
- Retiree dependents: DD Form 1173 – tan
- Transitional Assistance Management Program (TAMP) beneficiaries: DD Form 2765 – tan.

ID Cards include:

- Last 4 digits of SSN or sponsor SSN
- Expiration Date: Should read "INDEF" (indefinite) for retirees. If expired, the beneficiary must update in DEERS and obtain a new card.
- Civilian: The center section should read "YES" under the box titled "CIVILIAN".

The categories of individuals eligible for TRICARE benefits are:

- Members of the Uniformed Services receiving or entitled to receive retired, retainer, or equivalent pay based on duty in the service.
- Spouses of active-duty members
- Children of active-duty members (see note below)
- Spouses of retirees of the Uniformed Services
- Children of retirees (see note below)
- Un-remarried widowers and widows of deceased active-duty members and deceased retirees
- Children of deceased active-duty members and deceased retirees (see note below)
- Ex-spouses who have valid ID cards.

Note: To be eligible, children must be un-remarried and under the age of 21 (age 18 for CHAMPVA). Financial dependence is not required, except for students and disabled children who have passed their 18th or 21st birthday.

The following persons are not eligible for TRICARE:

- Persons not enrolled in the Defense Enrollment Eligibility Reporting System (DEERS).
- Persons entitled to Medicare Part A, who do not have Medicare Part B coverage, except for the following individuals:
- Family members of active-duty service members: *Medicare Part B not required until the sponsor retires.*
- Beneficiaries enrolled in the US Family Health Plan: *Medicare Part B not required for US Family Health Plan enrollment. But, if you dis enroll from the US Family Health Plan, you must have Medicare Part B to be eligible for any other TRICARE benefits.*

Loss of Eligibility

Each member of beneficiary's family will automatically receive a certificate of creditable coverage upon loss of TRICARE which serves as evidence of prior coverage under TRICARE, so that beneficiary and dependents cannot be excluded from a new health plan for pre-existing conditions.

All individuals permanently losing TRICARE eligibility have the option to purchase temporary health care coverage through the Continued Health Care Benefit Program (CHCBP).

The following are some of the reasons eligibilities for TRICARE may end for an individual:

1. Sponsor Separates from Active Duty - Separation from active duty means the individual "gets out" of the military before retiring. The member and family may qualify for transitional health benefits under the Transitional Assistance Management Program (TAMP) in some cases.
2. Beneficiary Becomes Entitled to Medicare Part A but does not Purchase Medicare Part B -If beneficiary is receiving Social Security disability benefits, beneficiary becomes entitled to Medicare Part A beginning the 25th month of receiving Social Security disability payments. The beneficiary is notified by the Social Security Administration of the entitlement start date. If a beneficiary does not purchase Medicare Part B at time of being entitled to Medicare Part A, regardless of age, eligibility for TRICARE is lost.
3. Dependent Child Reaches Age Limit - If a sponsor continues to provide 50% of a child's financial support, the child remains eligible for TRICARE coverage up to age 21 or age 23 if enrolled in college as a full-time student. After "aging out" at 21 or 23 as described above, Unmarried children ages 23-26 and not eligible for their own employer sponsored health insurance may qualify for TRICARE Young Adult.
4. Divorce - The former spouse loses eligibility for TRICARE unless he or she meets specific requirements to maintain eligibility as a former spouse.
5. Surviving Spouse, Widow, or Former Spouse Remarries - If a widow, surviving spouse or eligible former spouse remarries, TRICARE eligibility is lost only if the marriage is to another TRICARE-eligible sponsor.
6. DEERS Information Not Kept Updated - Lapsed/inaccurate DEERS information is another way to temporarily lose coverage. Coverage is restored when the information is updated in DEERS.

NOTE: If the sponsor does not properly disenroll a family member and the ineligible family member improperly continues to receive care under TRICARE, the Government is required, by law, to recoup the amount it paid for care from the party that received the care. What this means is the family is responsible for paying for the care received once the individual became ineligible. When ineligible beneficiaries improperly receive care, this may be considered fraud.

Continues Healthcare Benefit Program (CHCBP)

If an individual has lost or will soon lose military health care coverage, the Continued Health Care Benefit Program (CHCBP) can protect during the interim between military health benefits and civilian health care. Individuals may apply for temporary, transitional medical coverage under the CHCBP Program which is a premium-based health care program providing medical coverage for former military beneficiaries and is not part of TRICARE. The CHCBP program began on October 1, 1994, and extends health care coverage to the following individuals:

- The Service Member (who can also enroll his or her family members)
- Certain un-remarried former spouses
- Children who lose military coverage due to age or marriage

CHCBP Basics

- **Continuous coverage:** CHCBP acts as a "bridge" between military health benefits and the new job's medical benefits, continuous medical coverage can be received. It is a health care program intended to provide you with continuous health care coverage on a temporary basis following your loss of military benefits.
- **Pre-existing condition coverage***:* CHCBP may entitle individuals to coverage for preexisting conditions often not covered by a new employer's benefit plan.
- **Benefits***:* The CHCBP benefits are comparable to the TRICARE Standard benefit, which covers most medical conditions, uses existing TRICARE providers, and follows most of the rules and procedures of TRICARE Standard. However, for some types of treatment, coverage can be limited. Prior to enrolling in CHCBP, interested beneficiaries are encouraged to contact a TRICARE Service Center to ask specific questions regarding TRICARE Standard coverage.

Enrollment and Coverage

Eligible beneficiaries must enroll in CHCBP within 60 days following the loss of entitlement to the Military Health System. To enroll, beneficiary submits:

- A completed CHCBP Enrollment Application form (DD Form 2837).
- Documentation as requested on the enrollment form, e.g., DD-214-Certificate of Release or Discharge from Active Duty; final divorce decree; DD1173-Uniformed Services ID Card. Additional information and documentation may be required to confirm an applicant's eligibility for CHCBP.
- A premium payment for the first 90 days of health coverage.
- **For enrollments with an effective date of September 30, 2010 or before**, and quarterly payments to pay for periods beginning September 30, 2010 or before, the rate is $933 per quarter for individuals and $1,996 per quarter for families.
- **For enrollments with an effective date of October 1, 2010, or after**, and quarterly payments to pay for periods beginning October 1, 2010, and after, the rate is $988 per quarter for individuals and $2,213 per quarter for families. Humana Military Healthcare Services, Inc. will bill you for subsequent quarterly premiums through your period of eligibility once you are enrolled.

The program uses existing TRICARE providers and follows most of the rules and procedures of the TRICARE Standard program.

Depending on the beneficiary category, CHCBP coverage is limited to either 18 or 36 months. Eligibility periods are:

- 18 months for separating Service Members and their families.
- 36 months for others who are eligible (in some cases, un-remarried former spouses may continue coverage beyond 36 months if they meet certain criteria).

You may not elect the effective date of coverage under CHCBP. For all enrollees, CHCBP coverage must be effective on the day after military benefits are lost.

Non-Availability Statement (NAS)

Any beneficiary who lives within the zip code catchments area of a Uniformed Services Hospital must obtain a NAS before TRICARE will cover the cost of non-emergency inpatient care received from a civilian hospital except as noted below. It is the beneficiary's responsibility to obtain the NAS from their local Uniformed Services Hospital. A NAS is not required if the patient has other health insurance that is primary to TRICARE. CHAMPVA beneficiaries are never required to obtain an NAS. Emergency admissions never require an NAS nor do TRICARE PRIME beneficiaries receiving in-patient care.

Prior Authorizations and Referrals

An authorization is different from a referral. TRICARE must authorize certain medical treatments before you can receive them. The doctor who is going to provide the treatment must seek authorization from TRICARE.

When a Primary Care Manager (PCM) cannot provide the treatment needed, he or she refers to a specialist. The PCM must then file the referral with TRICARE.

Under all TRICARE programs, no referrals or authorizations are required for beneficiaries receiving emergency care inside or outside of their TRICARE regions. However, TRICARE Prime beneficiaries must contact their primary care manager or regional contractors within 24 hours of an inpatient admission, or the next business day, to coordinate ongoing care.

Referral and Authorization Submission may be requested in one of the following ways:

- For quickest response, submit online requests via the "MyHMHS for Providers" portal at www.humana-military.com
- Fax a completed *PRAF (Patient Referral Authorization Form* to 1-877-548-1547.
- By phone at 1-800-444-5445
- Contact ValueOptions for behavioral health care referrals and authorizations at 1-800-700-8646 or submit requests online via the "MyHMHS for Providers" portal at www.humana-military.comor fax a TRICARE Outpatient Treatment Report form to Value Options @ 1-866-811-4422. This form can be downloaded from www.humana-military.com
    - Click "Provider"
    - Click "Tools & Resources"
    - Click "Forms"
    - Click "Behavioral Health Related Forms"

Prior Authorization List for the East Region

Procedures and Services

- Adjunctive dental
- Advanced life support air ambulance in conjunction with stem cell transplantation
- Bariatric surgery
- Department of Defense In-Utero Fetal Surgical Repair of Myelomeningocele Clinical Trial
- Educational interventions under the Enhanced Access to Autism Services Demonstration
- Extend Care Heath Option (ECHO) services.
- Home health services, including home infusion.

- Hospice
- Phase II and II cancer clinical trials
- All home health services require prior authorization from Humana Military and must be renewed every 60 days.

Inpatient Hospital Stays

- Admissions or transfers to skilled nursing facility, rehabilitation, long-term acute care
- Concurrent reviews upon request by Humana Military
- Discharge notification.
- Notification of acute care admission by the next working day
- SNF admissions require authorizations when TRICARE is the primary payer.

Behavioral Health

- All nonemergency inpatient admissions for substance abuse disorder or behavioral health care and a non-enrolled beneficiary may also have to obtain a NAS (Non- availability statement). Inpatient lengths of stay limits are 30 days per FY or one any single admission for patients aged 19 and older and 45 days per FY or any single admission for patients 18 and under. Waivers can be granted for medical or psychological necessity.
- Emergency care ***doesn't*** require prior authorization, however, if the patient is admitted, the facility must report to ValueOptions within 24 hours of the admission or the next business day (but within 72 hours) to obtain authorization.
- Psychoanalysis
- Residential treatment center programs
- Outpatient therapy for Mental Health exceeding eight (8) visits per fiscal year (October 1 – September 30) must be authorized by ValueOptions at 1-866-811-4422.
- TRICARE only covers one outpatient initial evaluation (either psychiatric diagnostic exam [CPT 90801] or interactive diagnostic exam [CPT 90802]. This initial evaluation counts toward the first eight outpatient visits.

Maternity Care

Maternity care includes medical services related to prenatal care, labor and delivery and postpartum care. Care for TRICARE-eligible women begins from the first obstetric visit through six weeks after the child's birth.

The Primary Care Manager for a pregnant beneficiary will need to refer to an obstetrician or manage the pregnancy responsible for obtaining the required prior authorizations as obstetric services require prior authorization from Humana Military. Both inpatient and outpatient services require authorization beginning with the first prenatal visit and remain valid until 42 days after birth. If the patient delivers to a civilian facility or birthing center, a separate prior authorization is required. Maternity inpatient stays require additional prior authorization. The length of stay for a normal vaginal delivery cannot be restricted to less than 48 hours and 96 hours for a cesarean section.

TRICARE's well-child benefit (birth to age 6) covers routine newborn care, comprehensive health promotion exams, disease prevention exams, height, weight and head circumference measurement, routine immunizations,

hearing and vision screenings and behavioral and developmental appraisals. Well-child preventive care visits for an eligible child include no more than nine visits in two years.

NOTE: Postpartum inpatient stays for a mother to stay with newborn primarily for breastfeeding when the infant requires extended stay or continued inpatient stay for the newborn primarily to remain with mother when the mother requires extended postpartum inpatient stay are specific excluded services by TRICARE.

Emergency Care

No referrals or authorizations are required for any TRICARE programs for beneficiaries receiving emergency care inside or outside their TRICARE regions. TRICARE Prime beneficiaries must contact their Primary Care Manager or regional contractor within 24 hours of an inpatient admission or the next business day to coordinate continued care.

Inpatient and Outpatient Reimbursement Methodology

DRG reimbursement is a reimbursement system for inpatient charges from facilities in which a payment level to each DRG is assigned based on the average cost of treating all TRICARE beneficiaries in each DRG. This payment system is modeled on the Medicare inpatient PPS (Prospective Payment System). As of October 2008, TRICARE uses the TRICARE Severity DRG payment system which is modeled on the Medical Severity DRG payment system (MS- DRG). Short and/or long stay cost outliers may be reimbursed for atypical inpatient stays.

Effective for admissions on or after October 1, 2009, inpatient acute care hospitals paid under the TRICARE DRG-based payment system are required to report a POA (Present on Admission) indicator for both primary and secondary diagnoses on inpatient acute care hospital claims.

The DRG calculator and a listing of hospital-acquired conditions are available at www.tricare.mil/drgrates.

There are some institutions which may be exempted from the DRG reimbursement methodology. Sole Community Hospitals are reimbursed at 100% of billed charges. Psychiatric Hospitals and exempt Psychiatric units within a DRG facility are reimbursed on a per diem basis that is determined by the location of the facility and the number of TRICARE admissions per year.

Outpatient Reimbursement Methodologies

Hospital outpatient services are paid for by the OPPS (Outpatient Prospective Payment System) implemented on May 1, 2009. The following organizations are some of those exempt from the Tricare OPPS:

- Indian Health Service hospitals that provide outpatient services
- Cancer and children's hospitals
- Community mental health centers
- Department of Veterans Affairs hospitals
- Freestanding birthing centers
- Freestanding end-stage renal disease facilities
- Hospice programs
- SNFs
- Residential treatment centers

For more information on the TRICARE OPPS implementation:

- Chapter 13 of the TRICARE Reimbursement Manual at http://manuals.tricare.osd.mil
- www.tricare.mil/opps
- Contact Humana Military at 1-800-444-5445

Ambulatory surgery facility payments fall into one of 11 TRICARE grouper rates. All procedures reimbursed under this methodology can be found at http://manuals.tricare.osd.mil. Reimbursements, surgery rates and grouper assignments are available at www.tricare.mil/ambulatory.

When outpatient multiple surgical procedures are performed, the primary surgical procedure will be paid at 100% of the contracted rate and any additional covered procedures performed during the same surgical session will be allowed at 50% of the contracted rate. Any incidental surgical procedure is performed at the same time as a more complex primary surgical procedure requiring little additional physician resources and/or is clinically integral to the performance of the primary procedure, therefore, payment is inclusive in the primary procedure payment.

Covered Services

Semi-private Room***	Radiation Therapy
Physical Therapy	Intensive Care Unit
Oxygen	Operating Room
Intravenous Injection	Recovery Room
Chemotherapy	Treatment Room
Blood and Blood Derivatives	Drugs and Medicines
Renal Dialysis	Medical Supplies
Shock Therapy	Medical Equipment
Hospice Care	Diagnostic Tests
X- rays	Vision
Behavioral Health	Urgent Care
Anesthesia	Skilled Nursing
Home Health	Mammograms
Meals, Special Diets	Other as Specified

*** Semiprivate rooms and special care units may be covered if medically necessary.

NOTE: Surgical procedures designated as "inpatient only" will only be covered by TRICARE when performed in an inpatient setting.

TRICARE covers most inpatient and outpatient care that is medically necessary.

For additional information concerning covered and non-covered services, call 1-800-444-5445 or review the TRICARE Policy Manual at http://manuals.tricare.osd.mil

Covered Services or Procedures with Significant Limitations (*not all inclusive)*

- Abortions

- Botulinum toxin type A injections
- Breast pumps
- Cardiac and pulmonary rehabilitation
- Chiropractic care
- Cosmetic, plastic, or reconstructive surgery
- Cranial orthotic device or molding helmet
- Dental care and dental x-rays
- Education and training
- Eyeglasses and contact lenses.
- Facility charges for non-adjunctive dental services
- Food, food substitutes and supplements, and other nutritional supplements
- Gastric bypass
- Genetic testing Hearing aids Intelligence testing Laser/LASIK/refractive corneal surgery Private hospital rooms
- Shoes, shoe inserts, shoe modifications, and arch supports
- Vitamins

NON-COVERED SERVICES

Humana Military Healthcare Services (HMHS) is required to deny all claims for non-covered services including complications occurring because of non-covered services being performed. The charges then become matters between the patient and the provider. Providers should note that beneficiaries must agree in advance of each non-covered service procedure, in writing, to accepting responsibility for any specified non-covered services. This ensures there is no misunderstanding and that the beneficiary is assuming responsibility for 100% of the costs of the non-covered services (TRICARE Non-Covered Services Waiver TP-1568.5). The patient is "held harmless" in cases of non-covered services provided by a network provider without specific, advanced written agreement by patient for each non-covered service. A general waiver does not meet this requirement. The provider is responsible for billing and collection for non-covered services. Examples of non-covered services include, but are not limited to, the following:

- Acupuncture
- Artificial insemination, or any forms of artificial conception
- Autopsy Services or postmortem examinations.
- Birth control/contraceptives (non-prescription)
- Bone marrow transplants for treatment of ovarian cancer
- Camps (diabetics/obesity)
- Care or supplies furnished or prescribed by a person in the immediate family.
- Counseling services such as that are not medically necessary for the treatment of a diagnosed medical condition (i.e. vocational, stress management, educational, lifestyle modification)
- Custodial care
- Diagnostic admission
- Domiciliary care
- Dyslexia treatment

- Electrolysis
- Elevators or chairlifts
- Exercise equipment, spas, hot tubs, whirlpools, swimming pools, health club memberships or other such charges or items.
- Experimental or unproven procedures
- Foot care (routine), except when there is a medical problem.
- General exercise programs, even if recommended by a physician regardless of whether rendered by an authorized provider.
- Inpatient stays:
    - For rest or cures
    - To control or detain a runaway child, whether admitted to an authorized institution.
    - To perform diagnostic exams, tests and procedures that are performed routinely as outpatient.
    - In hospitals above the appropriate level required to provide necessary medical care
- Learning disability services
- Medications:
    - Prescriptions for cosmetic purposes
    - Herbal or homeopathic preparations
    - Fluoride preparations
    - Multivitamins
    - Over-the-counter products excluding diabetic and insulin supplies.
- Mind expansion or elective psychotherapy.
- Naturopaths
- Non-surgical treatment of obesity
- Preventive care to include annual employment-requested physical examinations, routine screening procedures or immunizations except as provided under clinical preventive services benefits.
- Psychiatric treatment for sexual dysfunction
- Sex changes
- Sexual inadequacy treatment
- Smoking cessation supplies
- Sterilization reversal surgery
- Transportation, except by ambulance
- X-ray, laboratory and pathological services and machine diagnostic tests not related to a specific illness or injury or defined set of symptoms, except for cancer-screening mammography, cancer screening, Pap smears, and other test allowed under clinical preventive services benefits.

NOTE: Remember coverage is dependent on whether the facility is network or non-network.

Always verify benefits prior to treatment. **

Active-Duty Family Members:

Coordination of Benefits (Double Coverage)

TRICARE never has primary liability in a double coverage situation EXCEPT with Medicaid. Section 779 of Public Law 97-377 of the FY 83 Department of Defense Appropriations Act changed the procedure of determining the primary payer in a double coverage situation. According to this law, no TRICARE funds "shall be available for the payment for any service or supply for persons enrolled in any other insurance, medical service, or health plan to the extent that the service or supply is a benefit under the other plan". In other words, TRICARE is now a secondary payer to all other insurance, medical service, or health plans in all cases. The law was effective December 21st, 1982. Active-duty families no longer have the option to file with TRICARE first. The exclusionary clause for policies in effect prior 1966 is no longer in existence and private plans are now also included as double coverage situations.

TRICARE'S Relationship to Other Payers

Medicare

TRICARE eligible dependents of active-duty sponsors with Medicare Part A maintain TRICARE as secondary payer. Non-active-duty dependents under age 65 with a disability maintain TRICARE as secondary payer if they have Medicare Part A and B.

NOTE: Effective October 1st, 2001, the new TRICARE for Life program went into effect and Medicare – eligible retirees (including retired guardsmen and reservists); Medicare - eligible family members and survivors; and certain former spouses (if they were eligible for TRICARE before age 65) will retain TRICARE as a secondary payer to Medicare once their Medicare entitlement begins IF they are eligible for Medicare Part A and enrolled in Medicare Part B.

Medicaid

If a person is eligible for Medicaid as well as TRICARE benefits, TRICARE always pays first.

Worker's Compensation

Expenses for medical care related to job connected illness or injury that are paid by the Worker's Compensation Program, or can be paid by such a program, are not covered by TRICARE. Only if benefits were exhausted under the Worker's Compensation Program would TRICARE, then assume responsibility of the balance.

Private Automobile Insurance

Any amounts paid by TRICARE arising out of an automobile accident when these same amounts are also payable, in whole or in part, under a policy of automobile insurance, may be subject to recovery under the Federal Claims Collections Act.

Special Notes

Waiver of Other Benefit Not Permitted

When double coverage exists as outlined above, a TRICARE beneficiary does not have the option of waiving benefits under the other plan or program to be paid in full TRICARE benefits. The beneficiary must apply for benefits under the plan or program that has been determined to have primary responsibility/coverage first.

Claims Processing and Billing Information *(East Region)*

The contractor for claims processing for the TRICARE East Region is PGBA, LLC.

TRICARE requires claims to be filed electronically. A network provider much file claims within 90 days of the date care was provided. If TRICARE is secondary, the 90-day filing begins once the primary has paid or denied the claim.

All covered entities must use their National Provider Identifiers (NPIs). Billing NPIs are always required and when applicable, rendering provider NPIs are also required.

When filing paper claims, a CMS-1500 claim form must be used for professional fees and a UB-04 claim form is to be used for institutional charges.

Submit paper claims to: TRICARE East Region

Claims Department
P.O. Box 7981
Madison, WI 53707

To check the status of a claim, call Humana Military at 1-800-444-5445 (24/7) or visit www.humana-military.com and select "MyHMHS for Providers."

To check on the status of a claim in writing or to resubmit a claim:

TRICARE East Region
Customer Service Department
P.O. Box 7981
Madison, WI 53707

The NAS is not required to be sent in with the UB-04, but you must indicate by use of the appropriate condition code that the statement is on file at the hospital.

To avoid delays in payment, be sure the following form locators (FL) are filed correctly. If you have problems, refer to the current UB-04 manual.

FL 1	Provider name, physical address and telephone number ***required***
FL 2	Pay-to name and address ***required***
FL 3a	Patient control number
FL 3b	Medical/health record number
FL 4	Type of bill (three-character alphanumeric identifier)
FL 5	Federal Tax Identification (ID) number
FL 6	Statement covers period (from– through). The beginning and ending dates of the period included on the bill are shown in numeric fields (MM-DD-YY).
FL 7	Not required
FL 8a-b	Patient's name (surname first, first name, and middle initial, if any). Enter the patient's Social
	Security number (SSN) in field "a." Enter the patient's name in field "b."
FL 9a-e	Patient's address including ZIP code. This must be a physical address. Post office boxes are not acceptable.

FL 10	Patient's birth date (MM-DD-YYYY). If the date of birth was not obtained after reasonable efforts by the provider, the field will be zero filled.
FL 11	Patient's sex. This item is used in conjunction with FLs 66–69 (diagnoses) and FL 74 a–e (surgical procedures) to identify inconsistencies.
FL 12	Admission date
FL 13	Admission hour
FL 14	Type of admission. This code indicates priority of the admission.
FL 15	Source of Admission. This code indicates the source of admission or outpatient registration.
FL 16	Discharge hour
FL 17	Patient status. This code indicates the patient's status as of the "Through" date of the billing period (FL 6).
FLs 18–28	Condition codes
FL 29	Accident state
FL 30	Not required
FLs 31–34	Occurrence codes and dates
FLs 35–36	Occurrence span code and dates
FL 37	Not required
FL 38	Responsible party name and address
FLs 39–41	Value codes and amounts
FL 42	Revenue code
FL 43	Revenue description—A narrative description or standard abbreviation for each revenue code in FL42. Descriptions or abbreviations correspond to the revenue codes.
FL 44	HCPCS/rates. When coding HCPCS, enter the HCPCS code describing the procedure. May be required for correct reimbursement.
FL 45	Service date. If submitting claims for outpatient services, report a separate date for each day of service
FL 46	Service units. The entries in this column quantify services by revenue category (e.g., number of days, a particular type of accommodation, and pints of blood). Up to seven digits may be entered.
FL 47	Total charges
FL 48	Non-covered charges. The total non-covered charges pertaining to the related revenue code in FL 42 is entered here.
FL 49	Not required
FLs 50A–C	Payer identification. Enter the primary payer online A.
FLs 51A–C	Health plan ID number
FLs 52A–C	Release of information. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.
FLs 53A–C	Assignment of benefits certification indicator
FLs 54A–C	Prior payments. For all services other than inpatient hospital and skilled nursing facility (SNF) services, the sum of any amount(s) collected by the provider from the patient toward deductibles and/or co-insurance are entered on the patient (last) line of this column.
FLs 55A–C	Not required
FL 56	National Provider Identifier (NPI). Beginning May 23, 2008, NPI number is required.
FLs 57A–C	Other provider identifier number
FLs 58A–C	Insured's name
FLs 59A–C	Patient's relationship to insured
FLs 60A–C	Insured unique ID/SSN/health insurance claim/ID number
FLs 61A–C	Group name. Indicate the name of the insurance group or plan.
FLs 62A–C	Insurance group number
FLs 63A–C	Treatment authorization code. Contractor-specific or Home Health Agency Prospective Payment System (PPS) OASIS code. Whenever Peer Review Organization (PRO) review is performed for outpatient/inpatient preadmission or pre procedure, the authorization number is required for all approved admissions or services.
FLs 64A–C	Document Control Number (DCN). Original DCN number of the claim to be adjusted.
FLs 65A–C	Employer name. Name of the employer that provides health care coverage for the individual identified on FL 58.

FLs 66	Diagnosis and procedure code qualifier (ICD Version Indicator) FLs 67 Principal diagnosis code. HCFA only accepts ICD-9-CM diagnostic and procedural codes that use definitions contained in Department of Health and Human Services (DHHS) Publication Number (PHS) 89-1260 or HCFA-approved errata supplements to this publication. Diagnosis codes must be full ICD-9-CM diagnosis codes, including all five digits where applicable.
FLs 67A–Q	Other diagnosis codes
FL 68	Not required
FL 69	Admitting diagnosis. For inpatient hospital claims subject to PRO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's hospital admission.
FLs 70a–c	Patient's reason for visit
FL 71	Prospective payment system (PPS) code
FLs 72a–c	External cause of injury (ECI) code
FL 73	Not required
FL 74	Principal procedure code and date. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis.
FLs 74a–e	Other procedure codes and dates. The full ICD-9-CM, Volume 3, Procedure Codes, including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure (which is shown in FL 74). The date of each procedure is shown in the date portion of Item 74, as applicable (MM-DD-YY).
FL 75	Not required
FL 76	Attending/referring physician ID
FL 77	Operating physician name and identifiers
FLs 78–79	Other physician ID
FL 80	Remarks. Notations relating to specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Authorized signature of non-network providers.
FLs 81a–d	Code field

Worker's Compensation

If you regularly employ less than five (5) employees, full-time or part-time and including officers of a corporation in any one business, other than the business of constructing or assisting on-site in the construction of new single-family, detached residential dwellings, the Alabama Workers' Compensation Law does not require you to have workers' compensation insurance coverage. Employers of domestic employees, farm laborers, or casual employees and municipalities having a population of less than 2,000 (according to the most recent federal census) are not required to provide coverage but can elect to be covered by the provisions of the Alabama Workers' Compensation Law.

Why should you have workers' compensation coverage?

- It is required by law.
- It is the exclusive remedy for on-the-job injury and occupational disease.
- Having coverage enables you to have limited civil liability, avoid double compensation, and avoid penalties and fines.

Alabama's Workers' Compensation Law provides significant and valuable benefits to both employer and employee. The employee is guaranteed a "benefit certain" in the event of an on-the-job injury or occupational disease. The employer pays for this insurance. The employer is protected by the "exclusive remedy" provisions of the Law. This means that an injured worker is entitled only to the benefits required by law, thus the employer's liability is limited.

Authorization of Coverage

Employers choose an insurance company to handle worker's compensation cases. Before admission, the insurance company should be notified, and verification of coverage obtained. The patient should have a written authorization form (possibly in the form of an incident report) signed by a representative of the employer. If not, this documentation should be requested of the employer. It should be established with the employer whether they recognize responsibility for the injury. If so, a letter stating this obligation should be requested. If verification of coverage cannot be obtained from the employer, the hospital should make the account self-pay until verification is received.

Denial of Coverage

If the workers' compensation carrier denies a worker's compensation case, the patient has the right to appeal the denial to the State Board, requesting a hearing. If the patient has an appeal pending, even though the claim may have been previously denied, the hospital cannot pursue payment from the patient. Inquiry regarding case status can be made either through the carrier or through the State Board of Worker's Compensation.

Claims Processing

When processing workers' compensation claims, providers must file hard copy claims to include the UB04 or 1500 form (if applicable), itemized statement and complete medical records.

COBRA

The COBRA law was included in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to provide employees (or former employees), their spouses and their dependents with a temporary extension of group health insurance when coverage is lost due to certain events. Under federal COBRA laws, employees who voluntarily resign, or were terminated for any reason other than "gross misconduct", may receive group health continuation coverage to help bridge the gap while in-between jobs. Since 1986, the law requires most employers to provide a temporary continuation of group health coverage that might otherwise be terminated.

Eligibility

Both full-time and part-time employees are eligible to receive continuing COBRA insurance coverage, subject to other eligibility requirements involving plan coverage, qualified beneficiaries, and qualifying events. Under COBRA, a group health plan is any arrangement that an employer establishes or maintains to provide employees or their families with medical care, whether it is provided through insurance by a health maintenance organization, out of the employer's assets on a pay-as-you-go basis, or otherwise. Coverage under COBRA must be identical to the benefits offered under the employer plan. Medical care typically covered by a group health plan for this purpose includes:

- Inpatient and outpatient hospital care
- Physician care
- Surgery and other major medical benefits
- Prescription drugs
- Dental and vision care

Group health plans covered by COBRA that are sponsored by private-sector employers generally are governed by ERISA – the Employee Retirement Income Security Act of 1974. ERISA does not require employers to establish plans or to provide any type or level of benefits, but it does require plans to comply with ERISA's rules. ERISA gives participants and beneficiaries rights that are enforceable in court.

There are three basic requirements for COBRA eligibility:

1. The group health plan must be covered by COBRA.
2. A qualifying event must occur.
3. There must be a qualified beneficiary for the qualifying event.

Plan Coverage

COBRA covers group health plans sponsored by an employer (private-sector or state/local government) that employed at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Both full and part-time employees are counted on to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time. There are exceptions with the federal government and church plans that have separate rules for continuation of coverage.

Qualifying Events

"Qualifying events" are events that cause an individual to lose his or her group health coverage. The type of qualifying event determines who the qualified beneficiaries are for that event and the period that a plan must offer continuation of coverage. COBRA establishes only the minimum requirements for continuation of coverage. A plan may always choose to provide longer periods of continued coverage.

The following are qualifying events for a **covered employee** if they cause the covered employee to lose coverage:

- Termination of the employee's employment for any reason other than "gross misconduct"
- Reduction in the number of hours of employment.

The following are qualifying events for the **spouse and dependent child** of a covered employee fi they cause the spouse or dependent child to lose coverage.

- Termination of the covered employee's employment for any reason other than "gross misconduct"
- Reduction in the hours worked by the covered employee.
- Covered employees become entitled to Medicare.
- Divorce or legal separation of the spouse from the covered employee.
- Death of the covered employee

In addition to the above, the following is a qualifying event for a **dependent child** of a covered employee if it causes the child to lose coverage.

- Loss of "dependent child" status under the plan rules. Under the Patient Protection and Affordable Care Act, plans that offer coverage to children on their parents' plan must make the coverage available until the adult child reaches the age of 26.

Qualified Beneficiaries

A qualified beneficiary is an individual who was covered by a group health plan on the day before a qualifying event occurred that caused him or her to lose coverage. Only certain individuals can become qualified beneficiaries due to a qualifying event. The type of qualifying event determines who can become a qualified beneficiary when it happens. A qualified beneficiary must be a covered employee, the employee's spouse or former spouse, or the employee's dependent child. In certain cases, involving the bankruptcy of the employer sponsoring the plan, a retired employee, the retired employee's spouse (or former spouse), and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during a period of continuation of coverage is automatically considered a qualified beneficiary. Employers' agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

COBRA Rights and Responsibilities – Notice and Election Procedures

Under COBRA, group health plans must provide covered employees and their families with certain notices explaining their COBRA rights. Plans must also have rules for how COBRA continuation of coverage is offered, how qualified beneficiaries may elect continuation of coverage, and when it can be terminated.

Notice Procedures

Summary Plan Description – The COBRA rights provided under the plan must be described in the plan's Summary Plan Description (SPD). The SPD is a written document that gives important information about the plan, including what benefits are available under the plan, the rights of participants and beneficiaries under the plan, and how the plan works. ERISA requires group health plans to give an SPD within 90 days after the beneficiary becomes a participant in a plan (or within 120 days after the plan is first subject to the reporting and disclosure provisions of ERISA). In addition, there are material changes to the plan, the plan must give a summary of Material Modifications (SMM) not later than 210 days after the end of the plan year in which the changes become effective; if the change is a material reduction in covered services or benefits, the SMM must be furnished not later than 60 days after the reduction is adopted. A participant or beneficiary covered under the plan may request a copy of the SPD and any SMM (as well as plan documents), which must be provided within 30 days of a written request.

COBRA General Notice – Group health plans must give each employee and each spouse who becomes covered under the plan a general notice describing COBRA rights. General notice must be provided within the first 90 days of coverage. Group health plans can satisfy this requirement by giving the plan's SPD within this time, if it contains the general notice information. The general notice should contain the information needed to know to protect the beneficiary's COBRA rights when they first became covered under the plan, including the name of the plan and the name of the contact person to obtain additional information, a general description of the continuation coverage provided under the plan, and an explanation of any notices to protect COBRA rights.

COBRA Qualifying Event Notices – Before a group health plan must offer continuation of coverage, a qualifying event must occur, and the group health plan must be notified of the qualifying event. The employer must notify the group health plan within 30 days when the following qualifying events occur.

- Termination or reduction in hours of employment of the covered employee
- Death of the covered employee
- A covered employee becoming entitled to Medicare.
- Bankruptcy of a private-sector employer

The employee must notify the plan within 60 days if the following occurs of the following.

- Divorce
- Legal separation
- A child's loss of dependent status under the plan

COBRA Election Notice – When the plan receives notice of a qualifying event, the plan must give the qualified beneficiaries an election notice which describes their rights to continuation of coverage and how to make an election. The notice must be provided to the qualified beneficiary within 14 days after the plan administrator receives the notice of the qualifying event. The election notice should contain all the information needed to understand continuation of coverage and make an informed decision whether to elect continuation of coverage. If should also give the name of the plan's COBRA administrator and how to get the information.

COBRA Notice of Unavailability of Continuation of Coverage – Group health plans may sometimes deny a request for continuation of coverage or for an extension of continuation of coverage. If the plan determines that

the beneficiary or family member is not entitled to the requested coverage for any reason, the plan must give the person who requested it a notice of unavailability of continuation of coverage. The notice must be provided within 14 days after the request is received and the notice must explain the reason for denying the request.

Election Procedures – The beneficiary is given an election period of at least 60 days, starting on the later of the dates the election notice was furnished or the date the beneficiary loses coverage, to choose whether to elect continuation of coverage.

Each qualified beneficiary for a qualifying event may independently elect continuation of coverage. This means that if both the beneficiary and the spouse are entitled to elect continuation of coverage, each may decide separately whether to continue coverage. The covered employee or the spouse must be allowed to elect on the behalf of any dependent children or on behalf of all the qualified beneficiaries. A parent or legal guardian may elect on behalf of a minor child.

If the beneficiary waives continuation of coverage during the election period, they must be permitted later to revoke the waiver of coverage and to elect continuation of coverage if they do so during the election period. Under those circumstances, the plan may provide continuation of coverage beginning on the date the beneficiary revoked the waiver.

Benefits under Continuation of Coverage – The coverage under COBRA must be identical to the coverage that is currently available under the plan to similar active employees and their families. The benefits, choices and services must be like the active employee and their family, including the right to choose among available coverage options during an open enrollment season. The same rules and limits apply to similar active employees, such as co-payment requirements, deductibles, and coverage limits. The plan's rules for filing benefit claims and appealing any claim denials also apply.

Any changes made to the plan's terms that apply to similarly active employees and their families will also apply to qualified beneficiaries receiving COBRA continuation coverage. If a child is born to or adopted by a covered employee during a period of continuation of coverage, the child is automatically considered to be a qualified beneficiary receiving continuation of coverage.

Duration of Continuation of Coverage

Maximum Periods – COBRA requires that continuation of coverage extend from the date of the qualifying event for a limited period of 18 or 36 months. The length of time for the continuation of coverage must be made available depends on the type of qualifying event. A plan may provide longer periods of coverage beyond the maximum period required by law.

When the qualifying event is the end of employment or reduction of the employee's hours, and the employee became entitled to Medicare less than 18 months before the qualifying event, COBRA coverage for the employee's spouse and dependents can last until 36 months after the date the employee becomes entitled to Medicare. For example, if a covered employee becomes entitled to Medicare 8 months before the date his/her employment ends (termination of employment is the COBRA qualifying event), COBRA coverage for his/her spouse and children would last for 28 months (36 months minus 8 months).

The chart below identifies the length of time by qualifying event.

Qualifying Event	Qualified Beneficiaries	Maximum Period of Continuation Coverage
Termination or reduction in hours	Employee Spouse Dependent Child	18 months
Employee enrollment in Medicare	Spouse Dependent Child	36 months
Divorce or legal separation	Spouse Dependent Child	36 months
Death of employee	Spouse Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

Early Termination

A group health plan may terminate continuation of coverage earlier than the end of the maximum period for any of the following reasons.

- Premiums are not paid in full on a timely basis.
- The employer ceases to maintain any group health plan.
- A qualified beneficiary begins coverage under another group health plan after electing continuation of coverage.
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation of coverage.
- A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation of coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice.

Extension of an 18-Month Period of Continuation of Coverage

There are two circumstances in which a beneficiary may be eligible for an extension of coverage. The first is when a qualified beneficiary becomes disabled. The second is when a second qualifying event occurs.

Disability

If a qualified beneficiary becomes disabled and meets certain requirements, all the qualified beneficiaries receiving continuation of coverage due to a single qualifying event are entitled to an 11-month extension of the maximum period of continuation of coverage (a total of 29 months). The plan can charge qualified beneficiaries an increased premium, up to 150% of the cost of coverage, during the 11- month disability extension. The Social Security Administration (SSA) must determine that the disabled qualified beneficiary is disabled before the 60th day of continuation of coverage and the disability must continue during the rest of the 18-month period of continuous coverage.

The disabled qualified beneficiary or another person on his or her behalf must notify the plan of the SSA determination. The plan can set a time limit for providing this notice of disability, but the time limit cannot be shorter than 60 day, starting from the latest of: (1) the date on which SSA issues the disability determination; (2) the date on which the qualifying event occurs; (3) the date on which the qualified beneficiary loses coverage under the plan as a result of the qualifying event; or (4) the date on which the qualified beneficiary is informed, through the furnishing of the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedure for doing so.

Second Qualifying Event

An 18-month extension may be given if one of the following second qualifying events occurs.

- Death of a covered employee
- Divorce or legal separation of a covered employee and spouse.
- Employees become entitled to Medicare.
- Loss of a dependent child status under the plan

The COBRA law was included in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to provide employees (or former employees), their spouses and their dependents with a temporary extension of group health insurance when coverage is lost due to certain events. Under federal COBRA laws, employees who voluntarily resign, or were terminated for any reason other than “gross misconduct”, may receive group health continuation coverage to help bridge the gap while in-between jobs. Since 1986, the law requires most employers to provide a temporary continuation of group health coverage that might otherwise be terminated.

Eligibility

Both full-time and part-time employees are eligible to receive continuing COBRA insurance coverage, subject to other eligibility requirements involving plan coverage, qualified beneficiaries, and qualifying events. Under COBRA, a group health plan is any arrangement that an employer establishes or maintains to provide employees or their families with medical care, whether it is provided through insurance by a health maintenance organization, out of the employer’s assets on a pay-as-you-go basis, or otherwise. Coverage under COBRA must be identical to the benefits offered under the employer plan. Medical care typically covered by a group health plan for this purpose includes:

- Inpatient and outpatient hospital care
- Physician care
- Surgery and other major medical benefits
- Prescription drugs
- Dental and vision care

Payment of Continued Coverage

The group health plan requires payment for continuation of coverage. The amount charged to qualified beneficiaries cannot exceed 102 percent of the cost to the plan for similar individuals covered under the plan who have not had a qualifying event. In determining COBRA premiums, the plan can include the costs paid by employees and the employer, plus an additional 2 percent for administrative costs. For qualified beneficiaries receiving the 11-month disability extension, the COBRA premium for those additional months may be increased to 150 percent of the plan's total cost of coverage for similarly individuals.

When the beneficiary elects a continuation of coverage, payment is not required with the election form. Payment is required within 45 days after the date of COBRA election. Failure to make any payment within that period would cause a loss of all COBRA rights. The plan can set premium due dates for successive periods of coverage (after the initial payment), but it must give the option to make monthly payments, and it must give a 30-day grace period for payment of any premium.

Coordination with Other Federal Benefit Laws

The Family and Medical Leave Act (FMLA) requires an employer to maintain coverage under any "group health plan" for an employee under FMLA leave under the same condition's coverage would have been provided if the employee had continued working. Group health coverage that is provided under FMLA during family or medical leave is not COBRA continuation of coverage, and taking FMLA leave is not a qualifying event under COBRA. However, a COBRA qualifying event may occur when an employer's obligation to maintain health benefits under FMLA ceases, such as when an employee taking FMLA leave decides not to return to work and notifies an employer of his or her intent not to return to work.

The Patient Protection and Affordable Care Act (ACA) provides additional protections for coverage under employment-based group health plans, including continuation of coverage. These include:

- Extending dependent child coverage to age 26
- Prohibiting limits or exclusions from coverage for pre-existing conditions
- Banning lifetime or annual dollar limits on coverage for essential health benefits
- Requiring group health plans and insurers to provide an easy-to-understand summary of a health plan's benefits and coverage.
- Certain preventive services without cost sharing
- Emergency services in an emergency department of a hospital outside the plan's network without prior approval from the health plan

COBRA Enforcement and Penalties

The COBRA law is enforced by different governmental entities. For failing to comply with COBRA, the IRS can levy excise taxes. The Department of Labor can file a lawsuit against the employer.

Affordable Care Act

History of National Health Coverage

The movement for National Health Coverage or socialized medicine began in 1912 when Theodore Roosevelt ran on a platform calling for health insurance for industry. Over the years the American public, as measured in opinion polls as far back as the 1930's, has generally been supportive of the goals of guaranteed access to health care and health insurance for all, as well as a government role in health financing. However, support typically tapered off when reforms were conditioned on individuals needing to contribute more to the costs.

Prior to the passage of the Affordable Care Act on March 23, 2010, and short of National Health Insurance, major health reforms have been enacted in the last fifty years that have proved to be broadly popular and effective in improving access to healthcare for millions through Medicare, Medicaid, and the Children's Health Insurance Program. Other attempts had failed.

Attempts at National Insurance Coverage include:

1934-1939 –National Health Coverage and the New Deal

1945-1950 – National Health Coverage and the Fair Deal

1960-1965 – The Great Society: Medicare and Medicaid

1970-1974 - Competing National Health Insurance Proposals

1976-1979 – Cost-Containment Trumps National Health Insurance

1992-1994 – The Health Security Act

The passage of the Affordable Care Act was unpopular to many people. The question was whether the government could mandate an insurance requirement and force states to expand the Medicaid program. The Supreme Court ruled on June 29, 2012. The Supreme Court upheld most of the law stating that the requirement to purchase insurance was like a tax and people could be required to purchase insurance or face a penalty.

A second portion of the law required for the expansion of the Medicaid program to include all individuals under the age of 65 with incomes below 133% of the federal poverty level. The ACA required that States comply with the expansion of the Medicaid program or risk losing Medicaid federal funding. The Court determined that incentivizing States to comply with the Medicaid expansion by threatening to terminate their existing Medicaid funding was unconstitutional. The Court ruled that Congress may offer funds under the ACA to expand the availability of health care and require that States accepting such funds comply with the conditions of their use. However, Congress is not free to penalize States that choose not to participate in the expansion of Medicaid by taking away their existing Medicaid funding.

Affordable Care Act Implementation

Since ACA became law on March 23, 2010, some portions of the law have already been implemented.

- Preventative Care for certain items or services – Insurances must provide preventative care for items listed as A or B in the current recommendations of the US Preventative Services Task Force. Typically, these include well checks for children, mammograms, PAP smears and others listed in the guidelines with no out of pocket to the insured. This means no co-pay, deductible or co-insurance.
- Medicare Donut Hole- This most likely won't affect any of us but it probably will affect your parents. Medicare recipients are usually covered for drugs under Medicare Part D. There are numerous Medicare Part D plans to choose from but the most common require the recipient to pay 25% of the cost of the drugs until $2800 is met. The recipient then enters the "donut hole" where they pay the total cost of drugs until $4550 out of pocket is met. Under the ACA, beginning in 2011, Medicare recipients receive a 50% discount on brand name drugs and a reduction in generic drugs. The out of pocket will gradually be reduced until the "donut hole" is completely closed by 2020 and the recipient is responsible for only 25% of the reduced amounts.
- Insurance Coverage of Children to Age 26 – Parents may continue to insure their children up to age 26 even if they don't live with the parents, are out of school, are not financially dependent on their parents or are married. If married, the spouse and any children are not covered.
- Tax Credits for Small Business Help Pay for Health Insurance – Employers qualify if they provide health care to their workers, have fewer than 25 full-time employees or the equivalent of
- 25 full-time employees and provide average annual wages below $50,000. In 2011, the tax credit will cover 35% of health insurance expenses for small businesses and 25% for non-profit businesses. The tax credit will increase to 50% for small businesses and 35% for non-profit organizations starting in 2014.
- Pre-Existing Condition Insurance Plan (PCIP) – Young adults who were previously denied coverage because of pre-existing conditions and who have been uninsured for at least three months may obtain insurance coverage. There are currently three options, the Standard Plan, the Extended Plan, and the Health Savings Account. Families can also enroll eligible children at child-only rates. In 2014, individuals will have access to health coverage regardless of their health status.
- Elimination of Lifetime Benefits – This rule applies to employer health coverage and individual insurance policies bought after March 23, 2010. The ban on lifetime limits takes effect with the plan year or policy year that begins on or after September 23, 2010. Health plans can still limit non-essential health care services.

Other provisions of ACA will be phased in with most of them to become effective in 2014. These include the following:

- Pre-existing Rule Expanded – Starting January 1, 2014, health insurance companies will no longer be able to refuse coverage or charge a higher premium because of a pre-existing condition or disability.
- State Marketplace Insurance Exchanges – Beginning in 2014, health insurance policies will have to offer a set of essential benefits on a state-based marketplace called exchanges. The idea behind exchanges is to increase competition among insurers. Those who cannot afford insurance may receive tax credits to help them purchase insurance if they buy through the exchange. The exchange will list health plans offered in the state and allow individuals to compare and shop for plans. All Medicaid state plans must cover the same key benefits. Small employers will also be able to shop for and buy health coverage through exchanges. State insurance exchanges are not mandatory but if the state elects not to establish

an exchange, the Federal government will do it for them. There must be at least two multi-state plans in each.

- Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by Federal Law. States may receive grants and loans to assist them in setting up exchanges through 2015.
- Mandatory Purchase of Insurance – In 2014, most Americans will be required to purchase health coverage that covers essential health benefits. Those who have trouble paying for insurance may receive financial help to offset the cost. Income and citizenship will be documented to validate eligibility and the amount of assistance. Those who choose not to purchase health insurance will be required to pay a penalty. The fee is based on income and will range from $695 to $2,095.
- Elimination of Annual Limitations on Coverage - By 2014, there will be no annual limit on the amount that an insurance company will cover.
- Expanded Medicaid Coverage in Some States – Beginning in 2014, states will have the option to expand Medicaid to cover individuals making up to 133% of the FPL. The guidelines may change by 2014. Based on the Supreme Court ruling, States cannot be penalized by withholding funding they already receive because they elect not to expand Medicaid programs.
- Employer Requirement to Offer Insurance – Employers with 50+ employees will have to offer insurance by 2014 or pay fines. Employers with 200+ employees will be required to enroll employees in health plans. Employees may opt out but then they would have to purchase insurance through the exchange or be subject to a penalty. There are many rules and others to be decided on this requirement. Some believe that it will be cheaper for employers to pay the fines than offer insurance and will drop insurance coverage as a benefit.
- Medical Loss Ratio – Insurance must spend a certain amount collected on premiums on either medical services or quality improvement. Every year the insurance company spends less than 80% for small group plans and 85% for large group plans, the difference must be refunded to the policy holder as rebates.
- Reductions to Flexible Spending Accounts – Effective 2022, flexible spending contributions will be limited to $2,850.
- Increase Itemized Medical Deductions – Effective 2013. The threshold for the itemized deduction for unreimbursed medical expenses will be increased from 7.5% to 10% of adjusted gross income for regular tax purposes. The increase will be waived for individuals 65 and older for tax years 2013 through 2016.
- Increased Medicare Part A Tax on earnings greater than $200,000 – Effective 2013, the Medicare Part A tax rate will increase by .9% for individuals making greater than $200,000 and couples making more than $250,000. A 3.8% tax will be imposed on unearned income for higher- income taxpayers.
- Financial Disclosure – Financial relationships between health entities, including physicians, hospitals, pharmacists, other providers and manufactures and distributors of covered drugs, devices, and biological and medical supplies must be reported by April 2013.
- Requirements for Non-Profit Hospitals - Additional requirements for non-profit hospitals will be imposed. A community needs assessment will be required every three years and a strategy to meet those needs must be identified. A widely publicized financial assistance policy must indicate whether free or discounted care is available and how to apply for assistance. Charges to patients who qualify for financial assistance must be limited to the amount generally billed to insured patients and a reasonable attempt must be made to determine eligibility for financial assistance before undertaking extraordinary

collection efforts. There will be a $50,000 fine per year for failure to meet the requirements. As part of the enforcement of this provision, the U.S. Department of Treasury has released proposed guidelines.

- Financial Assistance Policy and a Policy Relating to Emergency Medical Care - Each tax-exempt hospital must establish a financial assistance policy that clearly describes the eligibility criteria for receiving financial assistance and how to apply for it. The financial assistance policy must include:
  - Eligibility criteria for financial assistance and whether such assistance includes free or discounted care.
  - The basis for calculating amounts charged to patients.
  - The method for applying for financial assistance.
  - In the case of an organization which does not have a separate billing and collections policy, the actions of the organization may take in the event of nonpayment, including collections action and reporting to credit agencies.
  - Measures to widely publicize the policy within the community to be served by the organization.
  - The Emergency Care Policy must require the organization to provide, without discrimination, care for emergency medical conditions regardless of their eligibility under the financial assistance policy.
- Limitation on Charges – A tax exempt hospital organization must limit amounts charged for emergency or other medically necessary care that is provided to individuals eligible for assistance under the organization's financial assistance policy to not more than the amounts generally billed to individuals who have insurance. Other points of consideration include:
  - Gross charges may not be used.
  - The amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated rates or Medicare rates.
- Billing and Collection - Collection actions are to be limited to allow for the investigation of financial assistance.
  - Patients must be provided with a plain language summary of the financial assistance policy before discharge and with the first three bills.
  - Patients must be given at least 120 days following the first bill to apply before commencing certain collection activities.
  - An additional 120 days (total 240 days) must be given to allow the patient to complete the application.
  - If the patient is determined eligible for financial assistance during these 240 days, the patient must be refunded any excess payments made before applying for financial assistance and any collection activities already commenced will have to be reversed.
  - A tax-exempt hospital organization must forego extraordinary collection efforts against an individual before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the hospital organization's financial assistance policy.
  - Extraordinary Collection Actions as provided in the Joint Committee's explanation provides examples as "lawsuits, liens on residences, arrests, body attachments, or similar collection processes" each of which requires a court proceeding.

- 13. Other
    - Standard summary of benefits and coverage - The form must be less than four pages, font greater than twelve, be uniform in insurance terms and definitions, and written in terms the average person will understand.
    - Quality Reporting Requirements – By 2014 reporting will be required from all insurers on effective case management, care coordination, chronic disease management, medication and compliance issues and hospital readmissions.
    - Linking Payment to Quality Outcomes in Medicare – A value-based purchasing program for hospitals launched in 2013 and linked Medicare payments to quality performance on common high-cost conditions such as cardiac, surgical and pneumonia care.
    - Encouraging Development of New Patient Care Models – Accountable Care Organizations that take responsibility for cost and quality received by patients will receive a share of savings they achieve for Medicare.

Provider Issues

Although insurance is mandated for most individuals and the individual may have signed up, that doesn't necessarily mean the patient will have active coverage, even if they have an insurance card. The individual market is made up of people with tentative work histories. They may be self-employed or seasonal workers with surges of income, or they may work several part-time jobs, or they may even be fully employed in good paying positions, but their employers don't provide insurance.

In any case, they are required to pay their own premiums. Insurance companies are attempting to get them on some type of automated payment plan, but many don't have bank accounts or credit cards. As of May 1, 2014, about 20% had not paid premiums on the plans they signed up for. It is expected that the default rate will rise when premiums compete with daily living expenses. There is a grace period of 90 days to allow the insured to catch up their premiums. If the patient defaults on their premiums, the provider will be paid for the first month of the default. The insurance company must also meet the following requirements.

- Notify HHS of non-payment of the premium.
- Notify the provider of the possibility of denied claims for the second and third month.
- Notify the insured that they are in default.
- Continue to collect the advanced credit on behalf of the policy holder.
- Return the tax credit for the second and third month to the Treasury if the insured fails to pay the premiums.
- Issue a termination notice to the insured at the end of the grace period.

Hospitals must verify eligibility at each service to ensure patients have current insurance coverage.

SECTION 4
CORPORATE COMPLIANCE

HIPPA

What is HIPAA?

Health Insurance Portability and Accountability Act (HIPAA) is a federal law enacted in 1996 as an attempt at incremental health care reform. HIPAAs intent is to reform the health care industry by reducing costs, simplifying administrative processes and burdens, and improving the privacy and security of patients' information and to help patients maintain their medical history seeking care at multiple providers and to have control over how that information is used and shared. Many experts considered it to be one of the most significant health care legislations since the introduction of Medicare in 1965. HIPAA regulations are structured as five major provisions or titles.

There are five major provisions of HIPAA that fall into two major categories, **Administrative Simplification and Insurance Reform**. The Administrative Simplification sections are most relevant to health care providers while the Insurance Reform sections are most relevant to payers.

The five major provisions of HIPAA are:

- Title 1 - Health Insurance Access, Portability and Renewability
- Title 2 - Preventing Healthcare Fraud and Abuse, Administrative Simplification and Medical Liability Reform.
- Title 3 - Tax-related Health Provisions
- Title 4 - Application and Enforcement of Group Health Insurance Requirements
- Title 5 - Revenue Offsets

Health Insurance Portability Reform

Health Insurance Portability Reform has been in effect since 1997 and has changed the practices of health plans and insurers regarding **portability** and **continuity** of health coverage in the following ways:

- Provides limitations on pre-existing condition exclusions,
- Prohibits discrimination against individuals based on health status,
- Helps individuals to keep health insurance when they change jobs,
- Prevents insurers from imposing pre-existing condition exclusions on new members when they have prior creditable coverage, and
- Guarantees that once employers or individuals purchase health insurance, those policies will be renewed.

Protected Health Information

Covered entities as defined by HIPAA maintain and transmit Protected Health Information (PHI). These include:

- Health care providers (Hospital, physicians, clinical laboratories, dentists, pharmacies, etc.)
- Health plans
- Health care clearing houses.

Protected Health Information (PHI) is defined as any individually identifiable information about the patient i.e. name, address, date of birth, sex, age, genders, financial information, social security number, medical/mental health information, etc. that is maintained in any form (i.e. oral, paper, electronic) and stored.

Workforce members (staff and contracted staff), volunteers or students of health care facilities are responsible for making sure PHI is not released to anyone who does not need to know to perform their job or without the patient's authorization. Generally, individuals requesting to access their PHI are referred to the Health Information Management Department and/or MyChart (personalized internet access). A request to release authorization form is generally required. In all appropriate release of patients' information, only the minimum necessary information (the least reasonable amount possible) must be released. PHI may be shared without the patient's authorization for treatment, payment, and healthcare operations purposes.

Organizations' HIPAA policies and procedures must always be adhered to. Any HIPAA violations or suspected violations must be reported to the Privacy and/or Security Officers.

Notice of Privacy Practices

Under HIPAA, organizations' Notice of Privacy Practices must inform the patient of their rights to access their health information was well as how their healthcare information (PHI) may be used.

Patients are given the following rights under HIPAA:

- To access their medical records
- To request to amend incorrect / incomplete information in their records.
- To authorize release of their information
- To complain to the organization and/or the Office for Civil Rights if they feel any of their privacy rights were violated.

Healthcare providers and insurance plans are required to notify patients/plan participants that a privacy notice is available and to tell them how to obtain the notice. Health plans must send reminder notices at least once every three years. The reminder notice can be sent electronically only if the participant has agreed to receive the notice by email. Organizations must their privacy notices periodically to determine whether it needs to be revised reflect current practices and any material changes to the HIPAA law that impacts the NPP.

Organizations (covered entities) subject to the privacy rules, must also meet the following requirements:

- Ensure the confidentiality, integrity, and availability of all electronic protected health information that it creates, receives, maintains, or transmits.
- Protect against any reasonably anticipated threats or hazards to the security or integrity of electronic protected health information.
- Protect against any reasonably anticipated uses or disclosures of electronic protected health information that are not permitted or required under HIPAA; and
- Ensure compliance with the security standards by its workforce.

HIPAA Security Rule

The security rules standards are more limited in scope than the privacy standards. The security standards apply to protect only electronic protected health information. Therefore, the security standards cover individually identifiable health information that is transmitted by electronic media or maintained in electronic media.

To comply with the HIPAA security requirements, covered entities must undertake the following actions:

- Appoint a Security Officer (this individual may be, but is not required to be, the same person as the plan's Privacy Officer).
- Amend plan documents to incorporate the required electronic security provisions:
- Train members of the workforce with access to electronic protected health information to follow security policies and procedures.
- Amend business associate agreements (business partners that create, maintain, transmit PHI on behalf of the covered entity) to incorporate security provisions.
- Adopt written policies and procedures implementing the security standards (including, but not limited to (i) conducting a security risk analysis of the plan's operation and identifying risks; (ii) reviewing each of the security standards and implementation features and modifying or creating policies and procedures to comply with the requirements; and (iii) documenting the results of risk analysis and the policies and procedures).

Transactions and Code Sets

Transactions are activities involving the transfer of health care information for specific purposes. Under the HIPAA Administration Simplification rule if a health care provider engages in one of the identified transactions, they must comply with the standard for that transaction. HIPAA requires every provider who does business electronically to use the same health care transactions, code sets and identifiers. HIPAA has identified ten standard transactions for Electronic Data Interchange (EDI) for the transmission of health care data. Claims and encounter information, payment and remittance advice and claims status and inquiry are several of the standard transactions.

Code sets are the codes used to identify specific diagnosis and clinical procedures on claims and encounter forms. The CPT-4 and ICD codes are examples of code sets for procedure and diagnosis coding. Other code sets adopted under the Administrative Simplification provisions of HIPAA include codes sets used for claims involving medical supplies, dental services, and drugs.

HIPAA Business Associates

HIPAA defines business associates a person who:

- On behalf of the covered entity or of an organized health care arrangement in which the covered entity participates, creates, receives, maintains, or transmits protected health information for a function or activity regulated by HIPAA, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities, billing, benefit management, practice management, and repricing; or
- Provides legal, actuarial, accounting, consulting, data aggregation management, administrative, accreditation, or financial services the service involves the disclosure of protected health information from the covered entity or arrangement, or from another business associate of the covered entity or arrangement to the person.

Enforcement

Since the compliance date of the Privacy Rule in April 2003, OCR has received over 130,748 HIPAA complaints and has initiated over 885 compliance reviews. The OCH has resolved ninety-six percent of these cases (125,472).

OCR has investigated and resolved over 24,477 cases by requiring changes in privacy practices and corrective actions by, or providing technical assistance to, HIPAA covered entities and their business associates. Corrective actions obtained by OCR from these entities have resulted in change that is systemic and that affects all the individuals they serve. OCR has successfully enforced the HIPAA Rules by applying corrective measures in all cases where an investigation indicates noncompliance by the covered entity or their business associate, which may include settling with the entity in lieu of imposing a civil money penalty. To date, OCR has settled 33 such cases resulting in a total dollar amount of $33,689,200.00. OCR has investigated complaints against many different types of entities including national pharmacy chains, major medical centers, group health plans, hospital chains, and small provider offices.

As implicated above a covered entity can be held liable for violations committed by an agent if the agent acted within the scope of its authority. However, if a covered entity complies with the business associate provisions of the Privacy and Security Rules, the covered entity will not be liable for the actions of the business associate. Effective March 2013, the OCR held business associates liable for HIPAA violations. Business associates' contracts should be reviewed to ensure compliance with current regulatory provisions.

The Secretary of Health and Human Services delegated to the Administrator, Centers for Medicare and Medicaid Services (CMS), the authority to investigate complaints of noncompliance with, and to make decisions regarding the interpretation, implementation, and enforcement of certain regulations adopting administrative simplification standards. This delegation does not include authority with respect to the Privacy Rule. The Secretary has delegated to the Office for Civil Rights (OCR) the authority to receive and investigate complaints as they may relate to the Privacy Rule.

Reasonable cause means an act or omission in which a covered entity or business associate knew, or by exercising reasonable diligence would have known, that the act or omission violated HIPAA, but the act was not willful neglect.

Reasonable diligence means the business care and prudence expected from a person seeking to satisfy a legal requirement under similar circumstances.

Willful neglect means conscious, intentional failure or reckless indifference to the obligation to comply with the administrative simplification provision violated.

A business associate is liable for a civil money penalty for a violation based on the act or omission of any agent of the business associate.

For violations occurring prior to February 18, 2009, the Secretary may not impose a civil money penalty—

- In the amount of more than $100 for each violation; or
- More than $25,000 for identical violations during a calendar year (January 1 through the following December 31).

For violations occurring on or after February 18, 2009, the Secretary may not impose a civil money penalty—

- For a violation in which it is established that the covered entity or business associate ***did not know*** and, by exercising reasonable diligence, would not have known that the covered entity or business associate violated such provision,
    - In the amount of less than $100 or more than $50,000 for each violation; or
    - In excess of $1,500,000 for identical violations during a calendar year (January 1 through the following December 31);
- For a violation in which it is established that the violation was due to ***reasonable cause and not to willful neglect,***
    - In the amount of less than $1,000 or more than $50,000 for each violation; or
    - In excess of $1,500,000 for identical violations during a calendar year (January 1 through the following December 31);
- For a violation in which it is established that the violation was due ***to willful neglect and was corrected during the 30-day period*** beginning on the first date the covered entity or business associate liable for the penalty knew, or, by exercising reasonable diligence, would have known that the violation occurred,
    - In the amount of less than $10,000 or more than $50,000 for each violation; or
    - In excess of $1,500,000 for identical violations during a calendar year (January 1 through the following December 31).
- For a violation in which it is established that the violation was ***due to willful neglect and was not corrected during the 30-day period*** beginning on the first date the covered entity or business associate liable for the penalty knew, or, by exercising reasonable diligence, would have known that the violation occurred,
    - In the amount of less than $50,000 for each violation; or
    - More than $1,500,000 for identical violations during a calendar year (January 1 through the following December 31).

Other HIPAA Regulations

A covered entity that is a covered health care provider must:

- Obtain a National Provider Identification number from the National Provider System (NPS) for itself or for any subpart of the covered entity that would be a covered health care provider if it were a separate legal entity.
- Use the NPI to identify itself on all standard transactions that it conducts where its health care provider identifier is required.
- Disclose its NPI, when requested, to any entity that needs the NPI to identify that covered health care provider in a standard transaction.
- Communicate to the NPS any changes in its required data elements in the NPS within 30 days of the change.
- If it uses one or more business associates to conduct standard transactions on its behalf, require its business associate(s) to use its NPI and other NPIs appropriately as required by the transactions that the business associate(s) conducts on its behalf.

Health plans

- A health plan must use the NPI of any health care provider to identify that health care provider on all standard transactions where that health care provider's identifier is required.
- A health plan may not require a health care provider that has been assigned an NPI to obtain an additional NPI.

Health care clearinghouses

A health care clearinghouse must use the NPI of any health care provider to identify that health care provider on all standard transactions where that health care provider's identifier is required.

The NPI is a 10-digit, intelligence free numeric identifier (10-digit number). This number will replace health care provider identifiers in use today in HIPAA standard transactions. Those numbers include Medicare legacy IDs (UPIN, OSCAR, PIN and National Supplier Clearinghouse or NSC). It does not replace DEA, NCPDP, TIN, EIN numbers. The purpose of this change is to make simpler electronic transmission of HIPAA standard transactions. The NPI number will provide standard unique health identifiers for health care providers, health plans, employers, and more efficient coordination of benefits transactions.

All health care providers are eligible for NPIs. Health care providers are individuals or Health care providers can apply for their NPI on the National Plan and Provider Enumeration System (NPPES) web site at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Affordable Care Act – Compliance Programs are Mandatory.

Section 6401 of the Affordable Care Act provides that a "provider of medical or other items or services or supplier within a particular industry sector or category" shall establish a compliance program as a condition of enrollment in Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

The Affordable Care Act further required the Secretary of Health and Human Services (HHS), in consultation with the HHS Office of Inspector General (OIG), to establish "core elements" for provider and supplier compliance programs within a particular industry or sector. In doing so, HHS has the discretion to determine both the timeline for implementation of the core elements and the requirement to have a compliance program.

The enforcement date for provider compliance plans as mandated in the Affordable Care Act is yet to be issued. However, in the late 1990s, the Office of Inspector General (OIG) began a major initiative to support Health care Professions in establishing a compliance program for their offices, organizations, and practices. Through that initiative, the OIG has been advising providers to voluntarily adopt compliance plans and has issued several extremely helpful compliance program guidance for provider types, including hospitals, nursing homes, pharmaceutical manufacturers, and physician group practices.

The guidance is published in the Federal Register as well as the OIG website at oig.hhs.gov.

There is no "one-size fits all" approach to compliance. Organizations must customize their compliance program based on their organization needs.

The OIG Guidelines provided the following seven steps for implementing an effective compliance program:

- Written and distributed standards of conduct and policies and procedures promoting commitment to compliance.

- The designation of a chief compliance officer (preferably someone that is high in the corporate structure) with a supporting compliance committee.
- The development and implementation of regular, effective education and training programs addressing compliance issues.
- The establishment of a reporting system (hotline, etc.) to promote the reporting of real or potential compliance problems. This should include a procedure for providing anonymity to the reporter.
- The development of a system for responding to reported compliance problems and enforcing appropriate disciplinary action for those violating policy, regulatory statutes, or Federal healthcare program requirements.
- A regular system of auditing and monitoring compliance issues.
- A system to investigate and remediate identified problems and to ensure that the organization does not employ or retain individuals that have been sanctioned by the federal government.

In 2004 the United States Sentencing Commission amendment the sentencing guidelines to include what is now known as Chapter 8 of the 2011 Federal Sentencing Guidelines Manual. Chapter 8, Part B of the sentencing guidelines states an organization's "Effective Compliance and Ethics Program" will mitigate its culpability score. The organization must show it:

- exercise due diligence to prevent and detect criminal conduct; and
- otherwise promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law.

The sentencing commission says "Such compliance and ethics program shall be reasonably designed, implemented, and enforced so that the program is generally effective in preventing and detecting criminal conduct. The failure to prevent or detect an instant offense does not necessarily mean that the program is not generally effective in preventing and detecting criminal conduct. Implementing the compliance elements is the first step to demonstrating an effective compliance program.

Fraud and Abuse Risk Areas

Compliance guidance issued by the OIG is intended to help hospitals identify areas of their operations that present a potential risk of liability under several key Federal fraud and abuse statutes and regulations such as:

- Submission of accurate claims and information.
- the referral statutes.
- payments to reduce or limit services.
- the Emergency Medical Treatment and Labor Act (EMTALA).
- Substandard care.
- Relationships with Federal health care beneficiaries.
- HIPAA Privacy and Security Rules; and
- Billing Medicare or Medicaid substantially more than usual charges.

The OIG guidance is specific to state "submission of accurate claims and information" is perhaps the single biggest risk area for hospitals, that is, the preparation and submission of claims or other requests for payment from the Federal health care programs. It is goes without saying that all claims and requests for reimbursement from the Federal health care programs—and all documentation supporting such claims or requests—must be

complete and accurate and must reflect reasonable and necessary services ordered by an appropriately licensed medical professional who is a participating provider in the health care program from which the individual or entity is seeking reimbursement. Hospitals must disclose and return any overpayments that result from mistaken or erroneous claims.

Providers should take extra care to ensure that:

- The information necessary to bill all payers, including federal payers, is accurate and complete.
- Coding should be appropriate for the services rendered and should accurately reflect the information in the medical record.
- The medical record must contain complete documentation that fully justifies the medical necessity of all procedures and treatments and supports the codes used to bill the payers.
- Patient Financial Services' high priority should be to obtain accurate billing information and valid insurance information.
- Ensure that co-pay\co-insurance and deductible amounts are accurately calculated and collected.

Reporting

If information provided in the medical record and/or on the claim is known or suspected to be false or inaccurate please report this information immediately to your supervisor or the compliance officer for validation and implementation of appropriate corrective action, if warranted.

Generally, each staff or workforce members should know:

- The name and extension of the Compliance Officer,
- The number of their organization's compliance hotline,
- How to get a copy of their organization's Code of Conduct (or similar publication),
- How to get more information concerning a specific question.

By having this information each staff and/or workforce member can play an active role in helping to ensure compliance with the rules and regulations governing the healthcare industry and in protecting their organization from making costly errors.

Finding Information

Information regarding compliance programs and the Medicare program can be found on many websites. The provider's Medicare Administrative Contractor (Medicare Part A) and Carrier (Medicare Part B) should have websites.

In addition to the OIG website, the CMS website contains very valuable information. Additionally, the state government maintains many websites.

Corporate Integrity Agreement/False Claims Act

Hospitals that are determined by the Department of Justice for violating the False Claims Act (submissions of false claims for reimbursement) may be subject to entering a Corporate Integrity Agreement with the Office for

the Inspector General and may be fined three time the amount of the violation (civil monetary penalties) as well as could face exclusion from participating in Federal healthcare programs like Medicare and Medicaid.

A CIA is an agreement between the organization and the OIG where the organization agrees to ensure an effective compliance program is implemented with government oversight. CIAs generally last from three to five years. During this period the organization reports routinely to the OIG of its compliance efforts and the agreed upon requirements via an Independent Review Organization.

SECTION 5
GLOSSARY

Glossary

1 - 9

72-Hour Rule
A Medicare regulation in which all outpatient diagnostic services or other services related to admission performed within the three days prior to a hospital admission must be bundled together on the same bill to Medicare. This general rule applies only to subsection (d) hospitals.

A

ABN
The abbreviation for the term Advance Beneficiary Notice. It is a notification that the patient may be expected to pay for laboratory testing that Medicare has determined as non-covered services. By signing the ABN, the patient understands they will be financially responsible for the test(s) in the event Medicare denies payment to the hospital. This applies to all patients who are covered by Medicare, regardless of whether Medicare is their primary or secondary insurance.

Abuse
When used as a legal term in the business of healthcare, it normally refers to actions that do not involve intentional misrepresentations in billing but which, nevertheless, result in improper conduct. The consequences can result in civil liability and administrative sanctions. An example of abuse is the excessive use of medical supplies.

Access
The patient's ability to obtain medical care. Ease of access is determined by such components as the availability of medical services and their acceptability to the patient, the location of health care facilities, transportation, and hours of operation and cost of care. An individual's ability to obtain appropriate health care services. Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers) and sociological (e.g., discrimination, language barriers). Efforts to improve access often focus on providing/improving health coverage.

Accreditation
The process by which an organization recognizes a provider, a program of study or an institution as meeting predetermined standards. Two organizations that accredit managed care plans are the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO). JCAHO also accredits hospitals and clinics. CARF accredits rehabilitation providers.

Accrual
The amount of money that is set aside to cover expenses. The accrual is the plan's best estimate of what those expenses are, and (for medical expenses) is based on a combination of data from the authorization system, the claims system, lag studies, and the plan's prior history.

Actuarial
Refers to the statistical calculations used to determine the managed care company's rates and premiums charged their customers based on projections of utilization and cost for a defined population.

Actuary

In insurance, a person trained in statistics, accounting and mathematics who determines policy rates, reserves, and dividends by deciding what assumptions should be made with respect to each of the risk factors involved (such as the frequency of occurrence of the peril, the average benefit that will be payable, the rate of investment earnings, if any, expenses, and persistency rates), and who endeavors to secure as valid statistics as possible on which to base his assumptions. Professionally trained individual, usually with experience or education in insurance, who conducts statistical studies such as determining insurance policy rates, dividend reserves and dividends, as well as conducts various other statistical studies. A capitated health provider would not accept or contract for capitated rates or agree to a capitated contract without an actuarial determining the reasonableness of the rates.

Acute Care

A pattern of health care in which a patient is treated for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Specialized personnel using complex and sophisticated technical equipment and materials usually give acute care in a hospital. Unlike chronic care, acute care is often necessary for only a short time.

Adjudication

Adjudication is a phrase used in the insurance industry to refer to the process of paying claims submitted or denying them after comparing claims to the benefit or coverage requirements.

Adjusted Community Rate (ACR)

Health plans and insurance companies estimate their ACRs annually and adjust subsequent year supplemental benefits or premiums to return any excess Medicare revenue above the ACR to enrollees. These are the estimated payment rates that health plans with Medicare risk contracts would have received for their Medicare enrollees if paid their private market premiums, adjusted for differences in benefit packages and service use.

Administrative Costs

Costs related to utilization review, insurance marketing, medical underwriting, agents' commissions, premium collection, claims processing, insurer profit, quality assurance programs, and risk management. Administrative costs also refer to certain allowable costs on hospital CMS cost reports, usually considered overhead. Rules exist which disallow certain expenses, such as marketing. Costs not linked directly to the provision of medical care. Includes marketing, claims processing, billing and medical record keeping, among others.

Administrative Service Organization (ASO)

A contract between an insurance company and a self-funded plan where the insurance company performs administrative services only and the self-funded entity assumes all risk.

Admission

The formal acceptance of inpatients into a hospital or other inpatient health facility. Such inpatients are typically provided with room, board, continuous nursing service and stay at least overnight.

Admission Certification

Methods of assuring that only those patients who need hospital care are admitted. Certification can be granted before admission (preadmission) or shortly after (concurrent). Length-of-stay for the patient's diagnosed problem is usually assigned upon admission under a certification program.

Admit-through-discharge claim
An indicator that a bill is expected to be the only one to be received for a course of treatment or inpatient confinement. This will include bills representing a total confinement or course of treatment, and bills that represent an entire benefit period of the third-party payer

Admitting Department
The hospital department that secures patient demographic and financial information on inpatients or registration purposes; schedules preadmission testing; coordinates patient room assignments; records all patient movement including transfers and discharges for the purpose of maintaining accurate census data; and disseminates patient information to other hospital departments.

Advanced Directives
Authorizes a hospital to use methods of treatment requested by patient in advance.

Adverse Event
An injury to a patient resulting from a medical intervention.

Affiliated Provider
A health care provider or facility that is part of the HMO's network usually having formal arrangements to provide services to the HMO member.

Affiliation
An agreement between two or more otherwise independent entities or individuals that defines how they will relate to one another. Agreements between hospitals may specify procedures for referring or transferring patients. Agreements between providers may include joint managed care contracting.

Aged Trial Balance
Report generally listing account numbers, patient and insurance balances, financial class, patient type, last payment date and other pertinent data.

Agency for Health Care Policy and Research (AHCPR)
The agency of the Public Health Service responsible for enhancing the quality, appropriateness, and effectiveness of health care services.

Aggregate Margin
This is computed by subtracting the sum of expenses for all hospitals in the group from the sum of revenues and dividing by the sum of revenues. The aggregate margin compares revenues to expenses for a group of hospitals, rather than one single hospital.

Aid to Families with Dependent Children (AFDC)
The federal AFDC program provides cash welfare to: (1) needy children who have been deprived of parental support and (2) certain others in the household of such child. States administer the AFDC program with funding from both the federal government and state. The Personal Responsibility and Work Responsibility Act of 1996, enacted in August 1996, replaced AFDC with a new program called Temporary Assistance for Needy Families (TANF).

All Patient Diagnosis Related Groups (APDRG)
An enhancement of the original DRG's designed to apply to a population broader than that of Medicare beneficiaries, who are predominately older individuals. The APDRG set includes groupings for pediatric and maternity cases as well as of services for HIV-related conditions and other special cases.

Allowable Charge
The maximum charge for which a third party will reimburse a provider for a given service. An allowable charge is not necessarily the same as either a reasonable, customary, maximum, actual, or prevailing charge.

Allowance
(1) The amount of money that is written off and not collected due to a contractual obligation with a payer, (2) The fee maximum or amount of money that a particular insurance company "allows" or agrees to pay for a procedure.

Allowed Amount
Maximum dollar amount assigned for a procedure based on various pricing mechanisms. Also known as a maximum allowable.

Allowed Charge
The is the amount Medicare approves for payment to a physician but may not match the amount the physician gets paid by Medicare (due to co-pay or deductibles) and usually does not match what the physician charges patients. Medicare normally pays 80 percent of the approved charge, and the beneficiary pays the remaining 20 percent. The allowed charge for a nonparticipating physician is 95 percent of that for a participating physician. Non- participating physicians may bill beneficiaries for an additional amount above the allowed charge. The CMS intermediary in each state publishes these rates.

All-Payer System
A system in which prices for health services and payment methods are the same, regardless of who is paying. For instance, in an all-payer system, federal or state government, a private insurer, a self- insured employer plan, an individual, or any other payer could pay the same rates. The uniform fee bars health care providers from shifting costs from one payer to another.

Alternate Delivery Systems
Health services provided in other than an inpatient, acute-care hospital, or private practice. A phrase used to describe all forms of health care delivery except traditional fee-for-service, private practice. The term includes HMOs, PPOs, IPAs, and other systems of providing health care. Examples within general health services include skilled and intermediary nursing facilities, hospice programs, and home health care. Alternate delivery systems are designed to provide needed services in a more cost-effective manner. Most of the services provided by community mental health centers fall into this category.

Ambulatory Care
Health services provided without the patient being admitted. Also called outpatient care. The services of ambulatory care centers, hospital outpatient departments, physicians' offices and home health care services fall under this heading provided that the patient remains at the facility less than 24 hours. No overnight stay in a hospital is required.

Ambulatory Patient Classification (APC's)
System like DRGs to be used for outpatients. The current scheme includes 346 APC's broken into categories of Medical, Diagnostic, Surgical and Radiology and includes Emergency Department and partial hospitalization services.

Ancillary Services (Ancillary Charges)
Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy that are provided in conjunction with medical or hospital care.

ANSI
American National Standards Institute. A national organization founded to develop voluntary business standards in the United States.

Antitrust
A legal term encompassing a variety of efforts on the part of government to assure that sellers do not conspire to restrain trade or fix prices for their goods or services in the market.

Appropriateness
Appropriate health care is care for which the expected health benefit exceeds the expected negative consequences by a wide enough margin to justify treatment. This term is not to be confused with "usual and customary" or "approved" service. The extent to which a particular procedure, treatment, test, or service is clearly indicated, not excessive, adequate in quantity, and provided in the setting best suited to a patient's or member's needs. See also Medically Necessary.

Approval Days
Authorized for payment after Retrospective Medical and Technical Review. As the term indicates, retrospective authorization takes place after the fact. For example, a patient is admitted, has surgery, and is discharged, and then the plan finds out. It appears that any service rendered without authorization would have payment denied or reduced, but there will be circumstances when the plan will genuinely agree to authorize services after the fact. Except for emergency cases, there are few retrospective authorizations.

Assignment of Benefits
Method used when a claimant directs that payment be made directly to the health care provider by the health plan.

Assisted Living
Broad range of residential care services but does not include nursing services. Normally lower in cost than nursing homes.

Attending Physician
The name and/or number of licensed physician who would normally be expected to certify and re- certify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.

Attestation
The requirement that the attending physician certify, in writing, the accuracy and completion of the clinical information used for DRG assignment.

Authorization
Consent, permit, approve, give the right to and/or authorize a person medical care. Can be either written or oral and usually involves a number to be used when billing. The real issue is determining what non-primary care services will require authorization. In a tightly controlled system, such as most HMOs, all services not rendered by the PCP require authorization. In other words, any service from a referral specialist, any hospitalization, any procedure, and so forth requires specific authorization, although there may be certain exceptions such as an optometry visit or a routine check-up from a gynecologist. In less tightly controlled systems, such as many PPOs and most indemnity plans, the requirements are less stringent. In those cases, it is common for authorization only to be required for elective hospitalizations and procedures, both inpatient and outpatient. In any plan there will be times when a member is unable to obtain prior authorization. This is usually due to an emergency or to an urgent problem that occurs outside of area. In those cases, the plan must make provisions for the retrospective review of the case to determine whether authorization may be granted after the fact. Certain rules may also be defined regarding the member's obligation in those circumstances (e.g., notification within 24 hours of the emergency). Be careful that such requirements do not allow for automatic authorization if the plan is notified within 24 hours but only for automatic review of the case to determine medical necessity. Required by a patient for disclosure of clinical data relative to hospital reimbursement claims. An authorization form allows the provider to release to the third party: 1) the admitting diagnosis for determining eligibility and 2) the diagnosis of any procedures performed as needed in claims reimbursement processing. Categories of Authorization

Authorization may be classified into six types:

1. Prospective - Sometimes referred to as pre-certification. This type of authorization is issued before any service is rendered. This is commonly used in plans that require prior authorization for elective services.
2. Concurrent - A concurrent authorization is generated at the time the service is rendered. For example, the utilization review nurse discovers that a patient is being admitted to the hospital that day.
3. Retrospective - As the term indicates, retrospective authorization takes place after the fact. For example, a patient is admitted, has surgery, and is discharged, and then the plan finds out. It appears that any service rendered without authorization would have payment denied or deduced, but there will be circumstances when the plan will genuinely agree to authorize services after the fact. Except for emergency cases, there are few retrospective authorizations.
4. Pended (For Review) - Pended is a claim term that refers to a state of authorization purgatory. In this situation, it is not known whether an authorization will be issued, and the case has been pended for review. This refers to medical review (for medical necessity, such as an emergency department claim) or to administrative review.
5. Denial - Denial refers to the certainty that there will be no authorization forthcoming. You cannot assume that every claim coming into the plan without an authorization will be denied because there are reasons that an unauthorized claim may be paid.
6. Sub-authorization - This is a special category that allows one authorization to hitchhike on another. This is most common for hospital-based professional services. For example, a single authorization may be

issued for a hospitalization, and that authorization is used to cover anesthesia, pathology, radiology, or even a surgeon's or consultant's fees.

Auto-assignment
A term used with Medicaid mandatory managed care enrollment plans. Medicaid recipients who do not specify their choice for a contracted plan within a specified time frame are assigned to a plan by the state.

Auto-Enrollment
The automatic assignment of a person to a health insurance plan, typically done under Medicaid plans.

B

Bad debt
An account which is uncollectible from a patient, although the patient has had or may have the ability to pay. This results in a credit loss for the hospital, clinic, or other health care facility. These losses may be reflected as an allowance from revenue or as an expense of doing business of the entity.

Balance Billing
The practices of billing a patient for the fee amount remaining after insurer payment and co- payment have been made. Under Medicare, the excess amount cannot be more than 15 percent above the approved charge.

Base Capitation
Specified amount per person per month to cover healthcare cost, usually excluding pharmacy and administrative costs as well as optional coverage such as mental health/substance abuse services.

Bed
A bed located in a hospital or nursing home used for inpatient. Beds are used as one important measure of an institution's capacity and size.

Bed size
The number of hospital beds, vacant or occupied; maintained regularly for use by inpatients during a reporting period. (The typical reporting period is 12 months.) To determine this amount, first add the total number of beds that are available every day during the hospital's reporting period. Then, divide this amount by the total number of days in the reporting period.

Behavioral Health, Behavioral Healthcare
An umbrella term that includes mental health, psychiatric, marriage and family counseling, addictions treatment and substance abuse. Services are provided by a myriad of providers, including social workers, counselors, psychiatrists, psychologists, neurologists and even family practice physicians. Many states have "parity" laws that attempt to require that behavioral health insurance coverage be provided "on par" to physical health coverage.

Benchmark
A goal to be attained. These goals are chosen by comparisons with other providers, by consulting statistical reports available or are drawn from the best practices within the organization or industry. Benchmarks are used in quality improvement programs to encourage improvement of care, efficiencies, or services. Benchmarks are

also used for length of stay comparisons, costs, utilization review, risk management and financial analysis. The benchmarking process identifies the best performance in the industry (health care or non-health care) for a particular process or outcome, determines how that performance is achieved, and applies the lessons learned to improve performance.

Beneficiary (also eligible; enrollee; member)
Individual who is either using or eligible to use insurance benefits, including health insurance benefits, under an insurance contract. Any person eligible as either a subscriber or a dependent of a managed care service in accordance with a contract. An individual who receives benefits from or is covered by an insurance policy or other health care financing program.

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)
A type of QIO (a group of doctors and other health care experts under contract with Medicare) that reviews complaints and quality of care for people with Medicare. The BFCC-QIO makes sure there is consistency in the case review process while taking into consideration local factors and local needs, including general quality of care and medical necessity.

Beneficiary Liability
The amount beneficiaries must pay providers for Medicare-covered services. Liabilities include co- payments, deductibles, and balance billing amounts. CMS has very strict rules about health providers billing patients for their liabilities. Cost based facilities are not allowed to charge non-payment by beneficiaries to bad debt unless a clear history of collection activity is recorded.

Benefit Package
Aggregate services specifically defined by an insurance policy or HMO that can be provided to patients. The services a payer offers to a group or individual. The package will specify included cost, limitation on the amounts of services, and annual or lifetime spending limits.

Benefits
Benefits are specific areas of Plan coverage's, i.e., outpatient visits, hospitalization and so forth, that makes up the range of medical services that a payer markets to its subscribers. Also, a contractual agreement, specified in Evidence of Coverage, determines covered services provided by insurers to members.

Billed Claims
Fees submitted by a health care provider for services rendered to a covered person. Fees billed and fees paid are rarely synonymous.

Billing Number
Number used as patient's account number for billing purposes, created for each registration (case).

Birthday Rule
This rule relates to coordination of benefits and determination of the primary payer when the patient is a child covered by both parents' health insurance plans. The Rule is: The birthday of the parent born first in the calendar year will be determined as the primary payer.

Blue Cross
A non-profit organization covering hospital, medical, surgical, and major medical. Most Blue Cross subscribers sign up for coverage at work under a group plan.

Board certified
A physician who has passed a written and oral examination given by a medical specialty board and who has been certified as a specialist in that area.

Boarder Baby
A baby that remains in the hospital after the mother has been discharged.

Bonus Payment
An additional amount paid by Medicare for services provided by physicians in Health Professional Shortage Areas. Currently, the bonus payment is 10 percent of Medicare's share of allowed charges. This is not to be confused with other payments to hospitals, such as the disproportionate share payment or the settlement made to facilities at the end of a cost report year.

Broker
One who represents an insured in solicitation, negotiation, or procurement of contracts of insurance, and who may render services incidental to those functions. By law, the broker may also be an agent of the insurer for certain purposes such as delivery of the policy or collection of the premium.

Bundled Payment
A single comprehensive payment for a group of related services. Bundled payments have become the norm in recent years and CMS and other payers investigate unbundled services closely. Unbundling service charges has been a common form of fraud as defined by CMS.

Bundling
The practice of billing certain outpatient procedures with their corresponding inpatient admissions on the same bill. When a service is bundled with another service, the hospital is paid for only one of the services, not both. Therefore, when a hospital is required to bundle a bill, it receives a smaller amount of reimbursement than it would if it were allowed to bill each service separately.

Business Associate
Under HIPAA rules, this term refers to an outside person/entity that performs a service on behalf of the health care provider (including a researcher) or the health care institution during which individually identifiable health information is created, used, or disclosed. For example, web hosting or data storage companies will be business associates if they receive protected health information. In addition, third parties that handle billing for a research study, or recruitment and screening will also be business associates. Certain exceptions apply.

Business Office Manager
The person responsible for managing accounts receivable.

C

Cafeteria Plan
Arrangements under which employees may choose their own benefit structure. Sometimes these are varying

benefit plans or add-ons provided through the same insurer or 3rd party administrator, other times this refers to the offering of different plans or HMOs provided by different managed care or insurance companies.

Capitation (Cap, Capped, Capitate)
Specified amount paid periodically to health provider for a group of specified health services, regardless of quantity rendered. Amounts are determined by assessing a payment "per covered life" or per member. The method of payment in which the provider is paid is a fixed amount for each person served no matter what the actual number or nature of services delivered. The cost of providing an individual with a specific set of services over a set period, usually a month or a year. A payment system whereby managed care plans pay health care providers a fixed amount to care for a patient over a given period. Providers are not reimbursed for services that exceed the allotted amount. The rate may be fixed for all members, or it can be adjusted for the age and gender of the member, based on actuarial projections of medical utilization.

Carrier
An insurer; an underwriter of risk that finances health care. Also refers to any organization, which underwrites or administers life, health, or other insurance programs. When an employer has a "self- insured" plan, the carrier (such as Aetna or Blue Cross) may not serve as carrier in this case but may serve only as a "third party administrator".

Carve Out
Practice of excluding specific services from a managed care organization's capitated rate. In some instances, the same provider will provide the service, but they will be reimbursed on a fee-for-service basis. In other instances, carved out services will be provided by an entirely different provider. A payer strategy in which a payer separates ("carves – out") a portion of the benefit and hires an MCO to provide these benefits. A health care delivery and financing arrangement in which certain specific health care services that are covered benefits (e.g., behavioral health care) are administered and funded separately from general health care services. The carve-out is typically done through separate contracting or sub- contracting for services to the special population. Common carve outs include such services as psychiatric, rehab, chemical dependency, and ambulatory services. Increasingly, oncology and cardiac services are being carved out. This permits the payer to create a separate health benefits package and assume greater control of their costs. Many HMOs and insurance companies adopt this strategy because they do not have in-house expertise related to the service "carved-out". A "carve-out" is typically a service provided within a standard benefit package but delivered exclusively by a designated provider or group. This process may or may not seem transparent to the subscriber, but it often means that separate UR and pre-certification entities are involved as well as different payers and providers. Carve-outs are also called sub-contractors, sub-captivators, or junior capitation contracts.

Carve out Days
The period of days in the middle of an otherwise certified patient stays that are denied.

Carve-in
A generic term that refers to any of a continuum of joint efforts between clinicians and service providers; also used specifically to refer to health care delivery and financing arrangements in which all covered benefits (e.g., behavioral, and general health care) are administered and funded by an integrated system.

Case
When a patient comes to the Hospital with a new illness or injury (new registration).

Case Management
Method designed to accommodate the specific health services needed by an individual through a coordinated effort to achieve the desired health outcome in a cost-effective manner. The monitoring and coordination of treatment rendered to patients with specific diagnosis or requiring high-cost or extensive services. The process by which all health-related matters of a case are managed by a physician or nurse or designated health professional. Physician case managers coordinate designated components of health care, such as appropriate referral to consultants, specialists, hospitals, ancillary providers, and services. Case management is intended to ensure continuity of services and accessibility to overcome rigidity, fragmented services, and the incorrect utilization of facilities and resources. It also attempts to match the appropriate intensity of services with the patient's needs over time.

Case Manager
A nurse, doctor, or social worker who works with patients, providers, and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

Case Mix
The mix of patients treated within a particular institutional setting, such as the hospital. Patient classification systems like DRGs can be used to measure hospital case mix. (See also DRGs and Case-Mix Index). Measurement reflecting servicing needs uses of hospital capabilities, and the general rate of hospital admissions. The types of inpatients a hospital or post-acute facility treats. The more complex the patients' needs, the greater the amount spent to patient care. Case mix is generally established by estimating the relative frequency of various types of patients seen by the provider in question during a given time and may be measured by factors such as diagnosis, severity of illness, utilization of services, and provider characteristics.

Case Rate
Flat fee paid for a client's treatment based on their diagnosis and/or presenting problem. For this fee the provider covers all the services the client requires for a specific period of time. Also bundled rate, or Flat Fee-Per-Case. Very often used as an intervening step prior to capitation. In this model, the provider is accepting some significant risk, but does have considerable flexibility in how it meets the client's needs. Keys to success in this mode: (1) properly pricing case rate, if provider has control over it, and (2) securing a large volume of eligible clients.

Case-Mix Index (CMI)
The average DRG weight for all cases paid under PPS. The CMI is a measure of the relative costliness of the patients treated in each hospital or group of hospitals. (See also DRG.) A measure of the relative costliness of treating in an inpatient setting. An index of 1.05 means that the facility's patients are 5 percent more costly than average.

Catastrophic Charges
A term used by Medicaid to describe a serious illness that is expected to consume the major share of the recipient's income and resources.

Centers for Medicare and Medicaid Services (CMS)
The Centers for Medicare and Medicaid Services (CMS) is a Federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), HIPAA and CLIA. Formerly was HCFA.

Certificate of Need (CON)
In some states, a state agency must review and approve certain proposed capital expenditures, changes in health services provided, and purchases of expensive medical equipment. Before the request goes to the state, a local review panel (the health systems agency or HSA) must evaluate the proposal and make a recommendation. CON is intended to control expansion of facilities and services by preventing excessive or duplicative development of facilities and services. Many states have eliminated their CON processes and requirements.

Certification
The process by which a government or private agency or a health-related association evaluates and recognizes individual, institutional, or educational programs in meeting predetermined standards.

Charges
These are the published prices of services provided by a facility. CMS requires hospitals to apply the same schedule of charges to all patients, regardless of the expected sources or amount of payment. Controversy exists today because of the often-wide disparity between published prices and contract prices. Many payers, including Medicare and Medicaid, are becoming managed by health plans that negotiate rates lower than published prices. Often these negotiated rates average 40% to 60% of the published rates and may be all-inclusive bundled rates.

Chronic Care
Long term care of individuals with long standing, persistent diseases, or conditions. It includes care specific to the problem as well as other measures to encourage self-care, to promote health, and to prevent loss of function.

Civilian Health and Medical Program of the Uniformed Services (Tricare)
A program administered by the Department of Defense that provides benefits for health care services furnished by civilian providers, physicians, and suppliers and to spouses and children of active duty, retired, and deceased members. Now known as TRICARE

Civilian Health and medical Program of the Veterans Administration (CHAMPVA)
A program administered by both the Department of Defense and the Veterans Administration that provides benefits for health care services furnished by civilian providers, physicians, and suppliers for spouses and children of veterans who are entitled to VA permanent and total disability benefits and to widows and children of veterans who die of service-connected disabilities.

Claim
A request by an individual (or his or her provider) to that individual's insurance company to pay for services obtained from a heath care professional.

Claims Review
The method by which an enrollee's health care service claims are reviewed prior to reimbursement. The purpose is to validate the medical necessity of the provided services and to be sure the cost of the service is not excessive.

CLIA
See Clinical Laboratory Improvement Amendments.

Clinic
An independent organization of physicians and allied health personnel or a hospital-operated facility designed to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services on an outpatient basis.

Clinic Charges
Clinic (non-emergency/scheduled outpatient visit) charges for providing diagnostic, curative, rehabilitative and education services on a scheduled basis to ambulatory patients.

Clinic Referral
The patient was admitted to this facility upon recommendation of this facility's clinic physician.

Clinical Data Repository
That component of a computer-based patient record (CPR) which accepts, files, and stores clinical data over time from a variety of supplemental treatment and intervention systems for such purposes as practice guidelines, outcomes management, and clinical research. May also be called a data warehouse.

Clinical Laboratory Improvement Amendments (CLIA)
CMS regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). In total CLIA covers approximately 175,000 laboratory entities. The Division of Laboratory Services, within the Survey and Certification Group, under the Center for Medicaid and State Operations has the responsibility for implementing the CLIA Program. The objective of the CLIA program is to ensure quality laboratory testing. Although all clinical laboratories must be properly certified to receive Medicare or Medicaid payments, CLIA has no direct Medicare or Medicaid program responsibilities.

Clinical or Critical Pathways
A "map" of preferred treatment / intervention activities. Outlines the types of information needed to make decisions, the timeliness for applying that information, and what action needs to be taken by whom. Provides a way to monitor care "in real time". These pathways are developed by clinicians for specific diseases or events. Proactive providers are working now to develop these pathways for most of their interventions and developing the software capacity to distribute and store this information.

Clocking
The system is searching for the information requested.

Closed Access
Gatekeeper model health plan that requires covered persons to receive care from providers within the plan's coverage. Except for emergencies, the patient may only be referred to and treated by providers within the plan. A managed health care arrangement in which covered persons are required to select providers only from the plan's participating providers.

Closed Panel
Medical services are delivered in the HMO-owned health center or satellite clinic by physicians who belong to a

specially formed, but legally separate, medical group that only serves the HMO. This term usually refers to a group or staff HMO models.

CMS (formerly HCFA)
See Centers for Medicare and Medicaid Services.

COB
See Coordination of Benefits.

COBRA
See Consolidated Omnibus Budget Reconciliation Act.

Coding
A mechanism for identifying and defining physicians' and hospitals' services. Coding provides universal definition and recognition of diagnoses, procedures, and level of care. Coders usually work in medical records departments and coding is a function of billing. Medicare fraud investigators look closely at the medical record documentation, which supports codes and looks for consistency. Lack of consistency of documentation can earmark a record as "up coded" which is considered fraud. A national certification exists for coding professional, and many compliance programs are raising standards of quality for their coding procedures.

Co-Insurance
A cost-sharing requirement under a health insurance policy that provides that the insured will assume a portion or percentage of the costs of covered services. Health care cost which the covered person is responsible for paying, according to a fixed percentage for amount. A policy provision frequently found in major medical insurance policies under which the insured individual and the insurer share hospital and medical expenses according to a specified ratio after payment of the deductible. Under Medicare Part B, the beneficiary pays co-insurance of 20 percent of allowed charges. Many HMOs provide 100 percent insurance (no co-insurance) for preventive care or routing care provided "in network".

Compliance
Accurately following the government's rules on Medicare billing system requirements and other federal or state regulations. A compliance program is a self-monitoring system of checks and balances to ensure that an organization consistently complies with applicable laws relating to its business activities. (See also Fraud, OIG and DOJ)

Concurrent Review
Review of a procedure or hospital admission done by a health care professional (usually a nurse) other than the one providing care, during the same time frame that the care is provided. Usually conducted during a hospital confinement to determine the appropriateness of hospital confinement and the medical necessity for continued stay.

Consent Forms
The documents that patients are asked to sign giving permission to the hospital or its physicians to perform procedures during the patient's hospital stay whether as an outpatient or inpatient.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
Federal law that continues health care benefits for employees whose employment has been terminated. Employers are required to notify employees of these benefit continuation options, and failure to do so can result in penalties and fines for the employer. An act that allows workers and their families to continue their employer-sponsored health insurance for a certain amount of time after terminating employment. COBRA imposes different restrictions on individuals who leave their jobs voluntarily versus involuntarily.

Continued Stay Review
A review conducted by an internal or external auditor to determine if the current place of service is still the most appropriate to provide the level of care required by the client.

Contract
A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is limited to a 12-month period and is subject to renewal thereafter. Contracts are not required by statute or regulation, and less formal agreements may be made.

Contract Provider
Any hospital, physician, skilled nursing facility, extended care facility, individual, organization, or licensed health care provider that has a contractual arrangement with an insurer for the provision of services under an insurance contract.

Conversion
In group health insurance, the opportunity given the insured and any covered dependents to change his or her group insurance to some form of individual insurance, without medical evaluation upon termination of his group insurance.

Coordination of Benefits (COB)
Provision regulating payments to eliminate duplicate coverage when a claimant is covered by multiple group plans. The procedures set forth in a Subscription Agreement to determine which coverage is primary for payment of benefits to Members with duplicate coverage. Used by insurers to avoid duplicate payment for losses insured under more than one insurance policy. A coordination of benefits, or "non- duplication", clause in either policy prevents double payment by making one insurer the primary payer and assuring that not more than 100 percent of the cost is covered.

Co-Payment
A cost-sharing arrangement in which the HMO enrollee pays a specified flat amount for a specific service (such as $10 for an office visit or $5 for each prescription drug). The amount paid must be nominal to avoid becoming a barrier to care. It does not vary with the cost of the service, unlike co- insurance that is based on some percentage of cost.

Cost Containment
Control of inefficiencies in the consumption, allocation, or production of health care services that contribute to higher than necessary costs. Inefficiencies are thought to exist in consumption when health services are inappropriately utilized; inefficiencies in allocation exist when health services could be delivered in less costly settings without loss of quality; and inefficiencies in production exist when the costs of producing health services

could be reduced by using a different combination of resources. Cost containment is a word used freely in healthcare to describe most cost reduction activities by providers.

Cost Reimbursement
Payment to hospitals and other providers by a third-party carrier for costs actually incurred by the providers. Cost rates are calculated after the service is rendered.

Cost Sharing
Payment method where a person is required to pay some health costs to receive medical care. The general set of financing arrangements whereby the consumer must pay out-of-pocket to receive care, either at the time of initiating care, or during the provision of health care services, or both. Cost sharing can also occur when an insured pays a portion of the monthly premium for health care insurance.

Cost-Benefit Analysis (Evaluation)
An analytic method in which a program's cost is compared to the program's benefits for a period, expressed in dollars, as an aid in determining the best investment of resources. For example, the cost of establishing an immunization service might be compared with the total cost of medical care and lost productivity that will be eliminated because of more people being immunized. Cost-benefit analysis can also be applied to specific medical tests and treatments.

Coverage Code
Identifies the patient's insurance coverage and its policy limits.

Covered Days
The number of days covered by the primary payer, as qualified by the payer organization.

Credentialing
Review procedure where a potential or existing provider must meet certain standards to begin or continue participation in each health care plan, on a panel, in a group, or in a hospital medical staff organization. The process of reviewing a practitioner's credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining if criteria for clinical privileges are met. The recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, professional association membership, or the award of a degree in the field. Certification and licensure affect the supply of health personnel by controlling entry into practice and influence the stability of the labor force by affecting geographic distribution, mobility, and retention of workers. Credentialing also determines the quality of personnel by providing standards for evaluating competence and by defining the scope of functions and how personnel may be used. In managed care arenas, one hears of a new basis for credentialing, referred to as financial credentialing. This refers to an organization's evaluation of a provider based on that provider's ability to provide value, or high-quality care at a reasonable cost.

Current Procedural Terminology (CPT)
A standardized mechanism of reporting services using numeric codes as established and updated annually by the AMA. A manual that assigns five-digit codes to medical services and procedures to standardize claims processing and data analysis. The coding system for physicians' services developed by the CPT Editorial Panel of the American Medical Association, basis of the Medicare coding system for physicians services.

Customary Charge
One of the factors determining a physician's payment for a service under Medicare. Calculated as the physician's median charge for that service over a prior 12-month period.

D

Data
Information gathered and entered the computer system.

Date of Birth (DOB)
Refers to the patient's date of birth. Obtained during the registration of a patient and necessary for the billing department.

Deductible
The amount of money, or value of certain services (such as one physician visit), a patient or family must pay before costs (or percentages of costs) are covered by the health plan or insurance company, usually per year.

Default
The system automatically enters the information into a blank field after pressing the enter key.

Demographic Information
The patient's address, employer, and insurance information.

Dependent
An insured's spouse (wife or husband), not legally separated from the insured, and unmarried children who meet certain eligibility requirement, and who are not otherwise insured under the same group policy. The precise definition of a dependent varies by insurer.

Diagnosis
The reason the patient requires services. Identified on claim by ICD-9 codes.

Diagnosis
Related Group (DRG Rate)
A dollar amount used by Medicare to pay hospitals for services rendered. It is based on the average of all patients belonging to a specific DRG adjusted for economic factors, inflation, and bad debts.

Diagnosis related groups (DRGs)
A system for classifying hospital stays according to the diagnosis of the medical problem being treated, for the purposes of payment.

Diagnostic Services
For purposes of the 72-hour rule, "diagnostic services are defined by the presence of certain billing codes on the hospital's bill to Medicare. Any service that qualifies as a diagnostic service must be bundled if it is performed within the 72-hour window.

Diagnostic Testing Area
Area where routine tests are performed (i.e. Lab, Blood Bank).

Direct access
The ability to see a doctor or receive a medical service without a referral from your primary care physician.

Discharge
The process whereby the patient leaves the hospital provided certain criteria are met.

Disease Management
Programs for people who have chronic illnesses, such as asthma or diabetes that try to encourage them to have a healthy lifestyle, to take medications as prescribed, and that coordinate care.

Disposable Personal Income
The amount of a person's income that is left over after money has been spent on necessities such as rent, food, and clothing.

DMERC
An acronym for Durable Medical Equipment Regional Contractor.

DOJ - United States Department of Justice
One of several federal government offices that is actively pursuing alleged the violators of the 72- hour rule.

DRG
See Diagnosis-Related Group.

Durable Medical Equipment (DME)
Equipment that typically withstands repeated use, improves function, or retards further deterioration of a physical condition, and primarily provides a medical function.

E

Effective Date
The date on which a policy's coverage of a risk goes into effect.

Elective
A healthcare procedure that is not an emergency and that the patient and doctor plan.

Elective Admission
The admission of a patient to a hospital prior to the actual scheduled date of admission. This admission can be delayed without potential risk to the health of the individual.

Electronic Claim
A digital representation of a medical bill generated by a provider or by the provider's billing agent for submission using telecommunications to a health insurance payer. Most claims are electronically submitted.

Electronic Data Interchange (EDI)
The automated exchange of data and documents in a standardized format. In health care, some common uses of this technology include claims submission and payment, eligibility, and referral authorization.

Electronic Medical Record (EMR)
A computer-based record containing health care information. This technology, when fully developed, meets provider needs for real-time data access and evaluation in medical care. Together with clinical workstations and clinical data repository technologies, the EMR provides the mechanism for longitudinal data storage and access.

Eligible Dependent
Person entitled to receive health benefits from someone else's plan.

Eligible Employee
Employee who qualifies to receive benefits.

Emergency
A medical condition that starts suddenly and requires immediate care.

Emergency Admission
The admission of a patient to a hospital immediately or within a very short period to save the patient's life or to protect the patient's health and well-being.

Emergency Department (ED)
The department or unit of a hospital organized to provide medical services necessary to sustain life or to prevent critical consequences. This department sometimes provides non-urgent, walk-in care.

Emergency Department Charges
Charges for emergency treatment to those ill and injured persons who require immediate, unscheduled, medical, or surgical care.

Emergency Medical Treatment and Labor Act (EMTALA)
An act pertaining to emergency medical situations. EMTALA requires hospitals to provide emergency treatment to individuals, regardless of insurance status and ability to pay.

Emergency Patient
An outpatient, usually acutely ill, who uses a hospital or freestanding emergency department for treatment.

Employee Retirement Income Security Act (ERISA)
A Federal act, passed in 1974, which regulates the majority of private pension and welfare group benefit plans in the U.S. It sets forth requirements governing, among many areas, participation, crediting of service, vesting, communication and disclosure, funding, and fiduciary conduct. Key legislative battleground now, because ERISA exempts most large self-funded plans from State regulation and, hence, from any reform activities undertaken at state level – which is now the arena for much healthcare reform.

Employer Mandate
Under the Federal HMO Act, describes conditions when federally qualified HMOs can mandate or require an employer to offer at least one federally qualified HMO plan of each type (IPA/network or group/staff). The option

is that federally qualified HMOs have to exercise over employees, requiring them to have available one or more types of HMOs per plan. This requirement was sun settled in 1995.

EMTALA
An acronym for Emergency Medical Treatment and Active Labor Act.

Enrollee (Also beneficiary, individual, member)
Any person eligible as either a subscriber or a dependent for service in accordance with a contract.

Enrollment
Initial process whereby new individuals apply and are accepted as members of a prepayment plan. The total number of covered persons in a health plan. Also refers to the process by which a health plan enrolls groups and individuals for membership or the number of enrollees who sign up in any one group.

EOF (End of Field) Key
Erases information in each field.

Episode of Care
A term used to describe and measure the various health care services and encounters rendered in connection with identified injury or period of illness.

Exclusions
Conditions or situations not considered covered under contract or plan. Clauses in an insurance contract deny coverage for select individuals, groups, locations, properties, or risks. Providers will negotiate for exclusions for outliers and carve-out of certain high-cost procedures, while payers will negotiate for exclusions to avoid payment of higher cost care.

Exclusive Provider Arrangement (EPA)
An indemnity or service plan that provides benefits only if care is rendered by the institutional and professional providers with which it contracts.

Exclusive Provider Organization (EPO)
A plan that limits coverage of non-emergency care to contracted health care providers. Operates like an HMO plan but is usually offered as an insured or self-funded product. Sometimes looks like a managed care organization that is organized similarly to a PPO in that physicians do not receive capitated payments, but the plan only allows patients to choose medical care from network providers. If a patient elects to seek care outside of the network, then he or she will usually not be reimbursed for the cost of the treatment. Uses a small network of providers and has primary care physicians serving as care coordinators (or gatekeepers). Typically, an EPO has financial incentives for physicians to practice cost- effective medicine by using a prepaid per-capita rate or a discounted fee schedule, plus a bonus if cost targets are met. Most EPOs are forms of POS plans because they pay for some out-of-network care.

Exclusivity Clause
A part of a contract which prohibits physicians, providers, or other care entities from contracting with more than one managed care organization. Exclusive contracts are common in staff model HMOs and IPAs but becoming less common in other health plan contracting.

Explanation of Benefits (EOB)
A statement sent to covered individuals explaining services provided, amount to be billed, and payments made. A summary of benefits provided subscribers by the carrier.

Extramural Birth
A birth in a non-sterile environment.

F

Facesheet
Registration form containing patient's registration information. Also known as the patient record.

Fee Schedule
A listing of accepted fees or established allowances for specified medical procedures. As used in medical care plans, it usually represents the maximum amounts the program will pay for the specified procedures.

Fee-For-Service
Traditional method of payment for health care services where specific payment is made for specific services rendered. Usually, people speak of this in contrast to capitation. DRG or per diem discounted rates, none of which are like the traditional fee for service method of reimbursement. Under a fee- for-service payment system, expenditures increase if the fees themselves increase, if more units of services are provided, or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or other prepayment systems, where the payment to the physician is not changed with the number of services used. Payment may be made by an insurance company, the patient, or a government program such as Medicare or Medicaid. With respect to the physicians or other supplier of service, this refers to payment in specific amounts for specific services rendered – as opposed to retainer, salary, or other contract arrangements. In relation to the patient, it refers to payment of an insurance premium or membership fee for coverage, through which the services or payment to the supplier are provided.

Fiduciary
Relating to, or founded upon, a trust or confidence. A legal term. A fiduciary relationship exists where an individual or organization has an explicit or implicit obligation to act on behalf of another person's or organization's interests in matters which affect the other person or organization. This fiduciary is also obligated to act in the other person's best interest with total disregard for any interests of the fiduciary. Traditionally, it was generally believed that a physician had a fiduciary relationship with patients. This is being questioned in the era of managed care as the public becomes aware of the other influences that are affecting physician decisions. Doctors are provided incentives by managed care companies to provide less care, by pharmaceutical companies to order certain drugs and by hospitals to refer to their hospitals. With the pervasive monetary incentives influencing doctor decisions, consumer advocates are concerned because the patient no longer has an unencumbered fiduciary.

Financial Class
Code used in billing to identify the insurance type. Example: All the Commercial insurance plan codes would have a financial class of C.

Financial Counselor
Those responsible for interviewing patients and assisting them in making suitable arrangements to meet their financial obligations to the provider.

Fiscal Intermediary
The agent (e.g. Blue Cross) that has contracted with providers of service to process claims for reimbursement under health care coverage. In addition to handling financial matters, it may perform other functions such as providing consultative services or serving as a center for communication with providers and making audits of providers' needs. This entity may also be referred to as TPA or third-party administrator. A private organization, usually an insurance company, that serves as an agent for the Center of Medicare and Medicaid Services (CMS), which is part of HHS, that determines the amount of payment due to hospitals and other providers and paying them for the Medicare services they have provided. Intermediaries make initial coverage determinations and handle the early stages of beneficiary appeals.

Flat Fee-Per-Case
Flat fee paid for a client's treatment based on their diagnosis and/or presenting problem. For this fee the provider covers all the services the client requires for a specific period of time. Often characterizes "second generation" managed care systems. After the MCOs squeeze out costs by discounting fees, they often come to this method. If provider is still standing after discount blitz, this approach can be good for provider and clients, since it permits a lot of flexibility for provider in meeting client needs. DRGs are an example of flat fees paid by diagnosis.

Flexible Benefit Plan
Program offered by some employers in which employees may choose among a few health care benefit options. See also the Cafeteria Plan.

Flow
Your pathway into the system. A sequence of screen displays.

Formulary
An approved list of prescription drugs; a list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care. Organizations often develop a formulary under the aegis of a pharmacy and therapeutics committee. In HMOs, physicians are often required to prescribe from the formulary.

Fraud
Intentional misrepresentations that can result in criminal prosecution, civil liability, and administrative sanctions.

Full-time Equivalent (FTE)
The term used in hospital budgeting and human resources that represents the number of hours that a full-time employee would be expected to work each year. In other words, 40 hours a week or 2,080 annual hours. This term is used in hospital budgeting, position control and productivity.

G

Garnishment
Proceeding whereby property, money, or credits of a debtor in the possession of another are applied to the debts of the debtor.

Gatekeeper
A primary care physician, utilization review, case management, local agency, or managed care entity responsible for determining when and what services a patient can access and receive reimbursement. An arrangement, in which a primary care provider serves as the patient's agent, arranges for, and coordinates appropriate medical care and other necessary and appropriate referrals. A PCP is involved in overseeing and coordinating all aspects of a patient's medical care. For a patient to receive a specialty care referral or hospital admission, the PCP must preauthorize the visit, unless there is an emergency. The term gatekeeper is also used in health care business to describe anyone (EAP, employer-based case manager, UR entity, etc.) that makes the decision of where a patient will receive services.

Grace Period
Period past the due date of a premium during which coverage many are not cancelled.

Group Insurance
Any insurance policy of health services contract by which groups of employees (and often their dependents) are covered under a single policy or contract, issued by their employer or other group entity.

Group Model HMO, Group Network HMO
An HMO that contracts with one or more independent group practices to provide services to its members in one or more locations. Health care plan involving contracts with physicians organized as a partnership, professional corporation, or other legal association. It can also refer to an HMO model in which the HMO contracts with one or more medical groups to provide services to members. In either case, the payer or health plan pays the medical group, which is, in turn, responsible for compensating physicians. The medical group may also be responsible for paying or contracting with hospitals and other providers.

Group Name/Number
The name or numerical identification assigned to a specific group of insured parties.

Group Practice
A group of persons licensed to practice medicine in the State, who, as their principal professional activity, and as a group responsibility, engage or undertake to engage in the coordinated practice of their profession primarily in one or more group practice facilities, and who in their connection share common overhead expenses if and to the extent such expenses are paid by members of the group, medical and other records, and substantial portions of the equipment and the professional, technical, and administrative staffs. Group practices use the acronyms PA, IPA, MSO, and others. Group practices are far more common now than a decade ago because physicians seek to lower costs, increase contracting power, and share payer contracts.

Guarantor
The person or organization taking financial responsibilities for payment of a patient's bill.

Hardware
The machinery used to enter data (i.e. Computer, Keyboard, and Printer).

HCFA 1500
The Health Care Finance Administration's standard form for submitting provider service claims to third party companies or insurance carriers. HCFA is now called CMS.

HCPCS
HCFA Common Procedure Coding System-a medical code set using CPT4, alphanumeric and local codes to identify health care procedures, equipment and supplies for claims submission. It is maintained by CMS and has been selected for use in HIPAA transactions.

Health
The state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. It is recognized, however, that health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined. The relative importance of various disabilities will differ depending upon the cultural milieu and the role of the affected individual in that culture. Most attempts at measurement have been assessed in terms or morbidity and mortality.

Health and Human Services (HHS)
The Department of Health and Human Services that is responsible for health-related programs and issues. Formerly HEW, the Department of Health, Education, and Welfare. The Office of Health Maintenance Organizations is part of HHS and detailed information on most companies is available here through the Freedom of Information Act

Health Benefits Package
The services and products a health plan offers.

Health Care Clearinghouse
An entity that standardizes health information (e.g. a billing service that processes or facilitates the processing of data from one format into a standardized billing format).

Health Care Financing Administration (HCFA)
The federal government agency within the Department of Health and Human Services which directs and oversees the Medicare and Medicaid programs and conducts research to support those programs. It is now called CMS and generally it oversees the state's administrations of Medicaid, while directly administering Medicare.

Health Care Provider
Providers of medical or health care or researchers who provide health care are health care providers. Normally health care providers are clinics, hospitals, doctors, dentists, psychologists, and similar professionals.

Health Insurance
Financial protection against the health care costs of the insured person. May be obtained in a group or individual policy.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Sometimes referred to as the Kennedy-Kassebaum bill, this legislation sets a precedent for Federal involvement

in insurance regulation. It sets minimum standards for regulation of the small group insurance market and for a set group in the individual insurance market around portability and availability of health insurance. As a result of this law, hospitals, doctors, and insurance companies are now required to share patient medical records and personal information on a wider basis. This wide- based sharing of medical records has led to privacy rules, greater computerization of records and consumer concerns about confidentiality. HIPAA is a federal law that was designed to allow portability of health insurance between jobs. In addition, it required the creation of a federal law to protect personally identifiable health information; if that did not occur by a specific date (which it did not), HIPAA directed the Department of Health and Human Services to issue federal regulations with the same purpose. The Department of Health and Human Services has issued HIPAA privacy regulations as well as other regulations under HIPAA.

Health Maintenance Organization (HMO)

HMOs offer prepaid, comprehensive health coverage for both hospital and physician services. The HMO is paid monthly premiums or capitated rates by the payers, which include employers, insurance companies, government agencies, and other groups representing covered lives. The HMO must meet the specifications of the federal HMO act as well as meeting many rules and regulations required at the state level. There are 4 basic models: group model, individual practice association, network model and staff model. An HMO contracts with health care providers, e.g. physicians, hospitals, and other health professionals. The members of an HMO are required to use participating or approved providers for all health services and generally all services will need to meet further approval by the HMO through its utilization program. Members are enrolled for a specified period. HMOs may turn around and sub-capitate to other groups. For example, it may carve- out certain benefit categories, such as mental health, and sub capitate these to a mental health HMO. Or the HMO may sub capitate to a provider, provider group or provider network. HMOs are the most restrictive form of managed care benefit plans because they restrict the procedures, providers, and benefits.

HHS-OIG

Office of the Inspector General of the United States Department of Health and Human Service. One of several federal government offices which is actively pursuing alleged violators of the 72-hour rule.

Hold Harmless Clause

A clause frequently found in managed care contracts whereby the HMO and the physician hold each other not liable for malpractice or corporate malfeasance if either of the parties is found to be liable. Many insurance carriers exclude this type of liability from coverage. It may also refer to language that prohibits the provider from billing patients if their managed care company becomes insolvent.

Home Health Care

Full range of medical and other health related services such as physical therapy, nursing, counseling, and social services that are delivered in the home of a patient by a provider.

Hospice

Facility or program providing care for the terminally ill.

Hospital

Any institution duly licensed, certified, and operated as a hospital. In no event shall the term “hospital” include a

convalescent facility, nursing home, or any institution or part thereof which is used principally as a convalescence facility, rest facility, nursing facility, or facility for the aged.

Hospital Information System (HIS)
A system which collects data from many areas of hospital to provide all levels of hospital management with timely, meaningful information on hospital operation.

Human Resources
The department responsible for, in conjunction with other departments, recruitment, selection, orientation, and employee training programs. The department is also responsible for maintaining personnel records and statistics, initiating, and maintaining salary and wage administration, and recommending personnel policy and procedure to the administrator.

I

Indemnity
Health insurance benefits provided in the form of cash payments rather than services. Insurance program in which the covered person is reimbursed for covered expenses. An indemnity insurance contract usually defines the maximum amounts that will be paid for covered services. Indemnity insurance plans may have a PPO option, UR, and case management features, or include a network or other preferred provider restrictions, but will not have an HMO plan. Indemnity is the traditional form of insurance. Normally when one thinks of indemnity health coverage, one is thinking of the type of plan that does not require "pre-certification" and does not restrict the physicians, drugs or hospitals that will be paid for. Indemnity coverage usually has higher premiums. Indemnity insurance plans are the classic plans – where few restrictions are in place. With these plans, members are normally able to use the providers of their choice and can make independent decisions about the type of care they wish to receive. Usually these plans include co-payments, deductibles and maximums but rarely require case management certification or approvals. Managed care, particularly HMO and capitation, has evolved away from the indemnity method. Yet, many people are still covered under indemnity plans.

Indemnity Carrier
Usually an insurance company or insurance group that provides marketing, management, claims payment and review, and agrees to assume risk for its subscribers at some pre-determined rate.

Indemnity Plan
A plan that reimburses physicians for services performed, or beneficiaries for medical expenses incurred. Such plans are contrasted with group health plans, which provide service benefits through group medical practice.

Independent Practice Association (IPA) or Organization (IPO)
A delivery model in which the HMO contracts with a physician organization, which in turn contracts with individual physicians. The IPA physicians practice in their own offices and continue to also see their FFS patients. The HMO reimburses the IPA on a capitated basis; however, the IPA may reimburse the physicians on a FFS or capitated basis.

Individual Plans
A type of insurance plan for individuals and their dependents that is not eligible for coverage through employer group coverage.

Informed Consent
Refers to requirements that healthcare providers and researchers explain the purposes, risks, benefits, confidentiality protections, and other relevant aspects of the provision of medical care, a specific procedure or participation in medical research. Informed consent is also required for the authorization of release or disclosure of individually identifiable health care information.

Inpatient
A patient who has been admitted for at least one night to a hospital or other health facility for the purpose of receiving diagnostic treatment or other medical service.

Inpatient Care
Care given a registered bed patient in a hospital, nursing home or other medical or post-acute institution.

Insurance Claim
The statement of total charges on patient accounts that are examined by insurance companies for reimbursement purposes. (The standard form is UB-04).

Insurance Plan Code
Code used to tell the system how and where to send the patients bill.

Interface
A means of communication between two computer systems, two software applications or two modules. Real time interface is a key element in healthcare information systems due to the need to access patient care information and financial information instantaneously and comprehensively. Such real time communication is the key to managing health care in a cost-effective manner because it provides the necessary decision-making information for clinicians, providers, and payers.

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9- CM)
This is the universal coding method used to document the incidence of disease, injury, mortality, and illness. A diagnosis and procedure classification system designed to facilitate collection of uniform and comparable health information. The ICD-9-CM was issued in 1979. This system is used to group patients into DRGs, prepare hospital and physician billings and prepare cost reports. Classifications of disease by diagnosis codified into six-digit numbers.

Intestate
One who dies without leaving a will.

J

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
Formerly called JCAHO, or Joint Commission on Accreditation of Hospitals, this is the peer review organization which provides the primary review of hospitals and healthcare providers. Many insurance companies require providers to have this accreditation to see 3rd party payment, although, many small hospitals cannot afford the cost of accreditation. JCAHO usually surveys organizations once every 3 years, sending a medical and administrative team to review policies, patient records, professional credentialing procedures, governance, and quality improvement programs. JCAHO revises it “standards” annually.

K

L

Laboratory Charges
Charges for the performance of diagnostic and routine clinical laboratory tests.

Late Charge
Charges, which are received by the provider after an insurance claim has been submitted.

Length of Stay (LOS)
The duration of an episode of care for a covered person. The number of days an individual stays in a hospital or inpatient facility.

Length of Stay, average
The average number of days of service rendered to each patient who is discharged during a given time period. To compute this figure, divide the total number of days spent in the hospital by patients discharged in a given time period by the total number of inpatients discharged during the time period. Example: 120 total patient days for 20 patients discharged. The average length of stay is 120/20 = 6 days.

Licensing
A process most states employ, which involves the review and approval of applications from HMOs prior to beginning operation in certain areas of the state. Areas examined by the licensing authority include: fiscal soundness, network capacity, MIS, and quality assurance. The applicant must demonstrate it can meet all existing statutory and regulatory requirements prior to beginning operations.

Lifetime Limit
A cap on the benefits paid under a policy. Many policies have a lifetime limit of $1 million, which means that the insurer agrees to cover up to $1 million in covered services over the life of the policy.

Lifetime Reserve Days
Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.

Long-Term Care
Health and medical care and social services provided on a continual basis to patients suffering from chronic medical and mental conditions.

Long-Term Care (LTC)
A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long- term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals. Ambulatory services such as home health care, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.

M

Managed Behavioral Health Program
A program of managed care specific to psychiatric or behavioral health care. This usually is a result of a "carve-out" by an insurance company or managed care organization (MCO). Reimbursement may be in the form of sub-capitation, fee for service or capitation.

Managed Care
Systems and techniques used to control the use of health care services. Includes a review of medical necessity, incentives to use certain providers, and case management. The body of clinical, financial, and organizational activities is designed to ensure the provision of appropriate health care services in a cost-efficient manner. Managed care techniques are most often practiced by organizations and professionals that assume risk for a defined population, but this is not always the case. Managed care is a broad term and encompasses many different types of organizations, payment mechanisms, review mechanisms and collaborations. Managed care is sometimes used as a general term for the activity of organizing doctors, hospitals, and other providers into groups to enhance the quality and cost- effectiveness of health care. Managed Care Organizations (MCO) includes HMO, PPO, POS, EPO, PHO, IDS, AHP, IPA, etc. Usually when one speaks of a managed care organization, one is speaking of the entity that manages risk, contracts with providers, is paid by employers or patient groups, or handles claims processing. Managed care has effectively formed a "go-between", brokerage, or 3rd party arrangement by existing as the gatekeeper between payers and providers and patients. The term managed care is often misunderstood, as it refers to numerous aspects of healthcare management, payment, and organization. It is best to ask the speaker to clarify what he or she means when using the term "managed care". In the purest sense, all people working in healthcare and medical insurance can be thought of as "managing care". Any system of health payment or delivery arrangements where the plan attempts to control or coordinate use of health expenditures, improve quality, or both. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan.

Managed Care Organization (MCO)
A health plan that seeks to manage care. Generally, this involves contracting with health care providers to deliver health care services on a capitated (per-member per-month) basis.

Managed Care Plan
A health plan that uses managed care arrangements and has a defined system of selected providers that contract with the plan. Enrollees have a financial incentive to use participating providers that agree to furnish a broad range of services to them. Providers may be paid on a pre-negotiated basis.

Management Services Organization (MSO)
Usually an entity owned by a hospital, physician group, PHO or IDS that provides management services and administrative systems to one or more medical practices. The management services organization provides administrative and practice management services to physicians. A hospital, hospitals, or investors may typically own an MSO. Large group practices may also establish MSOs to sell management services to other physician groups.

Maximum Out-of-Pocket Expenses
Limit on total number of co-payments or limit on total cost of deductibles and co-insurance under a benefit plan.

Medicaid
Government entitlement program for the poor, blind, aged, disabled or member of families with dependent children (AFDC). Each state has its own standards for qualification. A Federally aided, state-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all the poor, however, but only persons who meet specified eligibility criteria. Subject to broad Federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

Medicaid Integrity Review Contracts (MIC)
Contractors used to audit Medicaid providers using statistical claims data. Claim level audits are also conducted to identify potential overpayments, as well as to provide education.

Medical Necessity
A determination that a covered service meets all the necessary conditions for allowing treatment.

Medical Record
Patients file containing sufficient information to clearly identify the patient, to justify the patient's diagnosis and treatment, and to accurately document the results. The record serves as a basis for planning and continuity of patient care and provides a means of communication among physicians and any other professionals involved in the patient's care. The record also serves as a basis for review, study, and evaluations on serving and protecting the legal interests of the patient, provider, and responsible practitioner.

Medical Record Department
The facility's department responsible for the cataloging, maintenance, processing, and control of patient hospital medical records.

Medical Services Organization (MSO)
An organized group of physicians, usually from one hospital, into an entity able to contract with others for the provision of services.

Medically Necessary – Medical Necessity
Services or supplies which meet the following tests: They are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; They are provided for the diagnosis or direct care and treatment of the medical condition; They meet the standards of good medical practice within the medical community in the service area; They are not primarily for the convenience of the plan member or a plan provider; and They are the most appropriate level or supply of service which can safely be provided.

Medically Needy
Person who are categorically eligible for Medicaid and whose income, less accumulated medical bills, are below state income limits for the Medicaid program. Often seen as a problem among the "working poor" or among the senior population.

Medicare
A federal program for the elderly and disabled, regardless of financial status. It is not necessary, as with Medicaid, for Medicare recipients to be poor. A U.S. health insurance program for people aged 65 and over, for

persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents that need kidney transplantation or dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).

Medicare Traditional or Original
Traditional or Original Medicare is a fee-for-service coverage under which the government pays health care providers directly for Part A and Part B benefits.

Medicare Advantage Plan (Part C)
A type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans and Medicare Medical Savings Plans. If enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Co-Insurance Amount
Under Part A, the amount the patient is responsible for paying is equal to one-fourth of the Part A Medicare Cash Deductible for each inpatient day from the 61st to the 90th day. Under Part B, the amount the patient is responsible for paying is equal to 20% of the charges after the annual Part B Medicare Cash Deductible is met.

Medicare Cost Report (MCR)
An annual report required of all institutions participating in the Medicare program. The MCR records each institution's total costs and charges associated with providing services to all patients, the portion of those costs and charges allocated to Medicare patients, and the Medicare payments received.

Medicare Health Plan
Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part Be benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans and Demonstration/Pilot Programs. Programs of all-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans that can be offered by public or private entities and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare Part A Hospital Insurance
A basic part of the health insurance program that provides benefits for inpatient hospital care and post hospital extended care furnished by skilled nursing facilities, and home health agencies.

Medicare Part B or Supplementary Medical Insurance
A basic part of the health insurance program designed to supplement the basic hospital insurance coverage to include coverage for outpatient procedures such as ambulatory surgery.

Medicare Prescription Drug Coverage (Part D)
Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

Medicare Recovery Audit Contractors (RAC)
CMS contracted organizations that identify improper payments of Medicare Part A and Part B claims by conducting post payment reviews to identify overpayments and underpayments and recoup any overpayments they identify. The contractors receive payment based on the number of improper payments identified.

Medicare Secondary Payer
A system which requires providers to identify payers that is primary to Medicare as part of the registration process.

Medicare Supplemental Policy
A policy that pays for the cost of services not covered by Medicare, such as co-insurance and deductibles.

Medicare, Title XVIII of the Social Security Act, Public Law 89-97
A federal program that pays providers for certain medical and other health services for individuals 65 years of age or older or the disabled, regardless of their income. The program has two parts: hospital insurance (Part A) and medical insurance (Part B). Part B is also known as supplementary medical insurance.

Medigap
Private health insurance plans that supplement Medicare benefits by covering some costs not paid for by Medicare. MediGap plans are supplements to Medicare insurance. MediGap plans vary from State to State; standardized MediGap plans also may be known as Medicare Select plans.

Member
Used synonymously with the terms enrollee and insured. A member is any individual or dependent who is enrolled in and covered by a managed health care plan.

Morbidity
The extent of illness, injury, or disability in a defined population. It is usually expressed in general or specific rates of incidence or prevalence.

MSA
Medical Savings Account.

N

Network
An affiliation of providers through formal and informal contracts and agreements. Networks may contract externally to obtain administrative and financial services. A list of physicians, hospitals and other providers who provide health care services to the beneficiaries of a specific managed care organization.

Network Model HMO
This type of HMO contracts with more than one physician group and may contract with single or multi- specialty groups as well as hospitals and other health care providers. A health plan that contracts with multiple physician

groups to deliver health care to members. Generally limited to large single or multi- specialty groups. Distinguished from group model plans that contract with a single medical group, IPA's that contract through an intermediary, and direct contract model plans that contract with individual physicians in the community.

Newborn Admission
The status of a baby born within a facility.

No Balance Billing Provision
A provider contract clause which states the provider agrees to accept the amount the plan pays for medical services as payment in full and not to bill plan members additional amounts (except for co- payments, co-insurance, and deductibles)

Non-Aggregate Deductible
This term refers to the type of deductible that is based on a certain number of people, rather than on a specific dollar amount.

Non-Covered Days
Days of care not covered by the primary payer.

Non-Participating Physician (or Provider)
A provider, doctor or hospital that does not sign a contract to participate in a health plan, usually which requires reduced rates from the provider. In the Medicare program, this refers to providers who are therefore not obligated to accept assignment on all Medicare claims. In commercial plans, non- participating providers are also called out of network providers or out of plan providers. If a beneficiary receives service from an out of network provider, the health plan (other than Medicare) will pay for the service at a reduced rate or will not pay at all.

Non-PPS Hospital
A hospital that is excluded from the Prospective Payment System and is therefore reimbursed by Medicare based on the Reasonable Cost Reimbursement System. Any hospital that is a psychiatric hospital, rehabilitation hospital, children's hospital, long term hospital, psychiatric or rehabilitation distinct part unit of a general acute care hospital, cancer hospital, or hospital outside of the fifty states, the District of Columbia, or Puerto Rico is a non-PPS hospital.

Notification Number
A number given to the provider of service indicating that the provider has been made aware that a third-party client is present at the provider's site.

Nurse Practitioner (NP)
A registered nurse qualified and specially trained to provide primary care, including primary health care in homes and in ambulatory care facilities, long-term care facilities, and other health care institutions. Normally, NPs are licensed and possess a master's degree. Nurse practitioners generally function under the supervision of a physician but not necessarily in his or her presence. In some states, NPs can provide basic medical services without requiring MD or DO supervision. They are either salaried or reimbursed on a fee-for-service basis.

O

Occupancy Rate
A measure of inpatient hospital use. The ratio of inpatient beds occupied to inpatient beds available for occupancy.

Office of Inspector General (OIG)
The office responsible for auditing, evaluating and criminal and civil investigating for HHS, as well as imposing sanctions, when necessary, against health care providers.

One Day Rule
An exception to the general 72-hour rule. This is a Medicare regulation in which all outpatient diagnostic services or other services related to admission must be bundled together on the same bill to Medicare. This exception applies only to hospitals that do not qualify as subsection (d) hospitals.

Open Access
A term describing a member's ability to self-refer for specialty care. Open access arrangements allow a member to see a participating provider without a referral from another doctor. Health plan member's abilities, rights or invitation to self-refer for specialty care. Also called Open Panel.

Open Enrollment Period
A period during which subscribers in a health benefit program have an opportunity to select among health plans being offered to them, usually without evidence of insurability or waiting periods. A period of time which eligible subscribers may elect to enroll in, or transfer between, available programs providing health care coverage. Under an open enrollment requirement, a plan must accept all who apply during a specific period each year.

Open Panel
A term describing a member's ability to self-refer for specialty care. Open access arrangements allow a member to see a participating provider without a referral from another doctor. Health plan members' abilities, rights, or invitation to self-refer for specialty care.

Other Services Related to the Admission
Non-diagnostic services that are furnished in connection with the principal diagnosis that required the beneficiary to be admitted as an inpatient. These services must be bundled if they are performed within the 72-hour window.

Out of Network Benefits
With most HMOs, a patient cannot have any services reimbursed if provided by a hospital or doctor who is not in the network. With PPOs and other managed care organizations, there may exist a provision for reimbursement of "out of network" providers. Usually this will involve higher co-pay or a lower reimbursement.

Out of Pocket Expense
The maximum amount of money that a patient must pay before his/her insurance will consider benefits at 100%.

Out of Pocket Expenses, Out of Pocket Costs
Costs borne by the member that are not covered by health care plans. Portion of health services or health costs that must be paid for by the plan member, including deductibles, co-payments, and co- insurance. In the age of

managed care, out of pocket expenses can also refer to the payment of services not covered by or approved for reimbursement by the health plan.

Out of Pocket Limit
A cap placed on out-of-pocket costs, after which benefits increase to provide full coverage for the rest of the year. It is a stated dollar amount set by the insurance company, in addition to regular premiums.

Outlier
A patient whose length of stay or treatment cost differs substantially from the stays or costs of most other patients in a diagnosis related group. Under DRG reimbursement, outliers are given exceptional treatment subject to peer review and organization review.

Out-of-Network Provider
A health care provider with whom a managed care organization does not have a contract to provide health care services. Because the beneficiary must pay either all the costs of care from an out-of- network provider or their cost-sharing requirements are greatly increased, depending on the particular plan a beneficiary is in, out-of-network providers are generally not financially accessible to Medicaid beneficiaries.

Outpatient
A patient receiving ambulatory care at a hospital or other health facility without being admitted as an inpatient.

Outpatient Care
Care given a person who is not bedridden. Also called ambulatory care. Many surgeries and treatments are now provided on an outpatient basis, while previously they had been considered the reason for inpatient hospitalization.

P

Part A Medicare
Refers to the inpatient portion of benefits under the Medicare Program, covering beneficiaries for inpatient hospital, home health, hospice, and limited skilled nursing facility services. Beneficiaries are responsible for deductibles and co-payments. Part A services are financed by the Medicare HI Trust fund, which consists of Medicare tax payments. Part B, on the other hand, refers to outpatient coverage.

Part B Medicare
Refers to the outpatient benefits of Medicare. Medicare Supplementary Medical Insurance under Part B of the Title XVII of the Social Security Act covers Medicare beneficiaries for physician services, medical supplies, and other outpatient treatment. Beneficiaries are responsible for monthly premiums, co-payments, deductibles, and balance billing. Part B services are financed by a combination of enrollee premiums and general tax revenues.

Partial Hospitalization Program (PHP)
Acute level of psychiatric treatment normally provided for 4 or more hours per day. Normally includes group therapies and activities with homogeneous patient populations. Is used as a referral step-down from inpatient care or as an alternative to inpatient care. Unlike intensive outpatient or simple outpatient services, PHP provides an attending psychiatrist, onsite nursing, and social work. Reimbursed by payers at a rate that is roughly one half of inpatient psychiatric hospitalization day rate. Patients do not spend the night at the partial hospital.

Participating Physician or Participating Provider

Simply refers to a provider under a contract with a health plan. A physician or hospital that has agreed to provide services for a set payment provided by a payer, or who agrees to other arrangements, or who agrees to provide services to a set of covered lives or defined patients. Also refers to a provider or physician who signs an agreement to accept assignment on all Medicare claims for one year.

Password
Assigned code to give you entry into the system.

Patient Accounts and Billing Department
The department (traditionally referred to as the business office) responsible for managing patient accounts, hospital receivables, and patient bills.

Patient Liability
The dollar amount that an insured is legally obligated to pay for services rendered by a provider. These may include co-payments, deductibles, and payments for uncovered services.

Patient Management System (PMS)
The system used to register, update insurance, add a diagnosis, enter charges, and revise patient data.

Patient Responsibility
That portion of the bill that the patient is responsible to pay for services, deductible, co- payment, and non-covered services.

Patient Status
Identifies the patient's current registration disposition in the computer system.

Payer
The public or private organization that is responsible for payment for health care expenses. Payers may be insurance companies or self-insured employers.

PCP
Primary care physician who often acts as the primary gatekeeper in health plans. That is, often the PCP must approve all referrals to specialists. Particularly in HMOs and some PPOs, all members must choose or are assigned a PCP.

PCP Capitation
A reimbursement system for healthcare providers of primary care services who receive a pre-payment every month. The payment amount is based on age, sex and plan of every member assigned to that physician for that month.

Peer Review
The mechanism used by the medical staff to evaluate the quality of total health care provided by the Managed Care Organization. The evaluation covers how well all health personnel perform services and how appropriate the services are to meet the patient's needs. Evaluation of health care services by medical personnel with similar

training. Generally, the evaluation by practicing physicians or other professionals of the effectiveness and efficiency of services ordered or performed by other members of the profession. Frequently, peer review refers to the activities of the Professional Review Organizations, and also the review of research by other researchers. This is the most common method utilized in managed care for monitoring the utilization by physicians. In other words, other physicians will review the decisions made by a physician. Much controversy has surfaced in this area in recent years. Some physicians are reluctant to be reviewed by physicians over the phone or by having their written records read. Some consumers suspect that peer review is not true peer review since both the providers and the reviewers often have financial incentives to reduce or increase medical care. Nonetheless, peer review is utilized in all managed care settings.

Peer Review Organization (PRO)
An organization established by the Tax Equity and Fiscal Responsibility Act of 1982 to ensure quality of care and appropriateness of admission, readmissions, and discharges for Medicare and Medicaid. These organizations are held responsible for maintaining and lowering admission rates, reducing lengths of stay, while insuring against inadequate treatment. PROs can conduct review of medical records and claims to evaluate the appropriateness of care provided. PROs also exist within private carriers and providers. Peer Review itself is a process whose confidentiality in private organizations is protected by law. This allows hospitals and groups to conduct internal investigation and monitoring of care decisions and outcomes without the production of related documents in court proceedings. Providers have fought for these protections.

Per Diem
A pre-established price per day paid for services.

Per Diem Rates
A form of payment for services in which the provider is paid a daily fee for specific services or outcomes, regardless of the cost of provision. Per Diem rates are paid without regard to actual charges and may vary by level of care, such as medical, surgical, intensive care, skilled care, psychiatric, etc. Per Diem rates are usually flat all-inclusive rates.

Physician Organization
This term describes physician linkages and alliances that allow physicians to manage risk and capitation. Information systems, physician's relationships, and financial integration allow these organizations to be more integrated than the traditional solo practice or IPA relationship between healthcare providers and / or managed care organizations that are working to develop a "seamless" continuum of healthcare services. Sometimes physician organizations are simply group practices or professional organizations without intention of acting as a contracting entity.

Physician-Hospital Organization (PHO)
An organization representing hospitals and physicians as an agent. A legal entity formed by a hospital and a group of physicians to further mutual interests and to achieve market objectives. A PHO generally combines physicians and a hospital into a single organization for the purpose of obtaining payer contracts. A contracted arrangement among physicians and hospitals wherein a single entity, the PHO, agrees to provide services to insurer's subscribers. The PHO serves as a collective negotiating and contracting unit. A PHO may be structured to share the risk of contracting between hospital and doctors. PHOs may also own, operate, or subcontract

MSOs, health plans or providers. A PHO can manage risk. It is typically owned and governed jointly by a hospital and shareholder physicians.

Plan Administration
A term often used to describe the management unit with responsibility to run and control a managed care plan – includes accounting, billing, personnel, marketing, legal, purchasing, possibly underwriting, management information, facility maintenance, servicing of accounts. This group normally contracts medical services and hospital care. If an insurance company is the underwriter, it may serve as its own administrator or may contract a 3rd party administrator. Self-insured plans do the same.

PMS (Patient Management System)
The system used to register, update insurance, add a diagnosis, enter charges, and revise patient data.

Point of Service (POS)
A POS plan is a combination of an HMO and a commercial insurance policy. It is named this because at the point that a patient needs service, he/she determines the benefit level by the way in which he/she accesses healthcare.

Point-of-Service Plan (POS)
A health services delivery organization that offers the option to its members to choose to receive a service from participating or a nonparticipating provider. Generally, the level of coverage is reduced for services associated with the use of non-participating providers. A managed care plan that specifies that those patients who go outside of the plan for services may pay more out of pocket expenses. A health insurance benefits program in which subscribers can select between different delivery systems when in need of health care services and at the time of accessing the services, rather than making the selection between delivery systems at time of open enrollment at place of employment. Typically, the costs associated with receiving care from the "in network" or approved providers are less than when care is rendered by non-contracting providers. Or the costs are less if provided by approved providers in either the HMO or PPO rather than "out of network" or "out of plan" providers. This is a method of influencing patients to use certain providers without restricting their freedom of choice too severely.

Portability
Requirement that health plans guarantee continuous coverage without waiting periods for persons moving between plans. The ability for an individual to transfer from one health insurer to another health insurer about pre-existing conditions or other risk factors. This is a new protection for beneficiaries involving the issuance of a certificate of coverage from previous health plan to be given to new health plan. Under this requirement, a beneficiary who changes jobs is guaranteed coverage with the new plan, without a waiting period or having to meet additional deductible requirements. Primarily, this refers to the requirement that insurers waive any pre-existing condition exclusion for beneficiaries previously covered through other insurance.

PPS
See Prospective Payment System.

PPS Hospital
A hospital which is reimbursed by Medicare using the Prospective Payment System. Any hospital that is not a psychiatric hospital, rehabilitation hospital, children's hospital, long term hospital psychiatric or rehabilitation distinct part unit of a general acute care hospital, cancer hospital, or hospital outside of the fifty states, the

District of Columbia, or Puerto Rico is a PPS hospital. Therefore, general acute care hospitals are PPS hospitals and must use the Prospective Payment System to be reimbursed by Medicare.

Preadmission
The process of obtaining and confirming patient demographic and financial information at least twenty-four hours in advance of arrival.

Preadmission Certification
Review and approval of the necessity and appropriateness for proposed inpatient service. The term also refers to actual admission to an institution prior to the proposed admission time.

Preadmission Review, Pre-Admission Certification, Pre-Certification, or Pre-authorization
Review of "need" for inpatient care of other care before admission. This refers to a decision made by the payer, MCO or insurance company prior to admission. The payer determines whether the payer will pay for the service. Most managed care plans require pre-cert. This is a method of controlling and monitoring utilization by evaluating the need for service prior to the service being rendered. The practice of reviewing claims for inpatient admission prior to the patient entering the hospital to assure that the admission is medically necessary. A method of monitoring and controlling utilization by evaluating the need for medical service prior to it being performed. The process of notification and approval of elective inpatient admission and identified outpatient services before the service is rendered. An administrative procedure whereby a health provider submits a treatment plan to a third party before treatment is initiated. The third party usually reviews the treatment plan, monitoring one or more of the following: Patient's eligibility, covered service, amounts payable, application of appropriate deductibles, co-payment factors and maximums.

Pre-Authorization
A cost containment feature of many groups medical policies whereby the insured must contact the insurer prior to a hospitalization or surgery and receive authorization for the service.

Pre-certification
Also known as preadmission certification, preadmission review and pre-cert. The process of obtaining certification or authorization from the health plan for routine hospital admissions (inpatient or outpatient), often involves appropriateness review against criteria and assignment of length of stay. Failure to obtain pre-certification often results in a financial penalty to either the provider or the subscriber.

Pre-existing Condition
A medical condition developed prior to issuance of a health insurance policy that may result in the limitation in the contract on coverage or benefits. Some policies that exclude coverage of such conditions often exclude them for a period or indefinitely. Federally qualified HMOs cannot limit coverage for pre-existing conditions. New statutes in 1997 and 1998 altered the freedom other health plans have enjoyed in setting pre-existing time limits. Certification of prior coverage may mean new insurers would need to waive pre-existing clauses for some subscribers.

Preferred Provider Network (PPN)
A network of physicians and healthcare organizations that provide services to a health plan's members.

Preferred Provider Organization (PPO)
Some combination of hospitals and physicians that agrees to render services to a group of people, perhaps under contract with a private insurer. A health care delivery system that contracts with providers of medical care to provide services at discounted fees to members. Members may see care from non-participating providers but generally are financially penalized for doing so by the loss of the discount and subjection to co-payments and deductibles. The services may be furnished at discounted rates and the insured population may incur out-of-pocket expenses for covered services received outside the PPO if the outside charge exceeds the PPO payment rate. A PPO can also be a legal entity, or it may be a function of an already formed health plan, HMO or PHO. The entity may have a health benefit plan that is also referred to as a PPO. PPOs are a common method of managing care while still paying for services through an indemnity plan. Most PPO plans are point of service plans; in that they will pay a higher percentage for care provided by providers in the network. Many insurers will offer PPOs as well as HMOs. Generally, PPOs will offer more choice for the patient and will provide higher reimbursement to the providers.

Premium
The periodic payment to an insurance company, Medicare or a health care plan for health or prescription drug coverage.

Preventive Care
Health care that emphasizes prevention, early detection, and early treatment, thereby reducing the costs of healthcare in the long run. Health care that seeks to prevent or foster early detection of disease and morbidity and focuses on keeping patients well.

Primary
The principal insurance payer.

Primary Care
Basic or general health care usually rendered by general practitioners, family practitioners, internists, obstetricians, and pediatricians – who are often referred to as primary care practitioners or PCPs.

Primary Care Network (PCN)
A group of primary care physicians who share the risk of providing care to members of a given health plan.

Primary Care Physician (PCP)
A “generalist” such as a family practitioner, pediatrician, internist, or obstetrician. In a managed care organization, a primary care physician is accountable for the total health services of enrollees including referrals, procedures, and hospitalization.

Primary Care Provider (PCP)
The provider that serves as the initial interface between the member and the medical care system. The PCP is usually a physician, selected by the member upon enrollment, who is trained in one of the primary care specialties who treats and is responsible for coordinating the treatment of members assigned to his/her plan.

Primary Payer
The insurance carrier or program that takes precedence in the payment of a health care bill when two or more third-party payers have potential responsibility for the reimbursement.

Principal Diagnosis
The medical condition that is ultimately determined to have caused a patient's admission to the hospital. The principal diagnosis is used to assign every patient to a diagnosis related group. This diagnosis may differ from the admitting and major diagnoses.

Prior Authorization
A formal process requiring a provider to obtain approval prior to providing services or procedures before they are done. This is usually required for non-emergency services that are expensive or likely to be abused or overused. A managed care organization will identify those services and procedures that require prior authorization, without which the provider may not be compensated.

Prior Authorization (PA)
A process whereby a provider must justify the need for delivering a particular service to a patient prior to providing it.

Probe
Use the light pen to select desired function or to change screens.

Procedure Code
CPT4 code entered for professional charges.

Professional Review Organization
An organization that reviews the services provided to patients in terms of medical necessity professional standards, and appropriateness of setting.

Proration
Process of determining the patient's portion of charges as separate from the insurance portion. Proration enables a hospital to determine what a patient owes at or prior to discharge.

Prospective Payment System (PPS)
A payment method that establishes rates, prices or budgets before services are rendered and costs are incurred. Providers retain or absorb at least a portion of the difference between established revenues and actual costs. (1) The Medicare system used to pay hospitals for inpatient hospital services; based on the DRG classification system. (2) Medicare's acute care hospital payment method for inpatient care. Prospective per-case payment rates are set at a level intended to cover operating costs in an efficient hospital for treating a typical inpatient in each diagnosis-related group. Payments for each hospital are adjusted for differences in area wages, teaching activity, and care to the poor, and other factors. Hospitals may also receive additional payments to cover extra costs associated with atypical patients (outliers) in each DRG. Capital costs, originally excluded from PPS, are being phased into the system.

Protected Health Information (PHI)
Under HIPAA, this refers to individually identifiable health information transmitted or maintained in any form.

Provider
Usually refers to a hospital or doctor who "provides" care. A health plan, managed care company or insurance carrier is not a healthcare provider. Those entities are called payers. The lines are blurred sometimes, however,

when providers create or manage health plans. At that point, a provider is also a payer. A payer can be a provider if the payer owns or manages providers, as with some staff model HMOs.

Provider Relations
The department within a managed care organization that is responsible for responding to requests from medical providers in relation to rendering care as a participating provider in their network.

Provider Services Organization (PSO)
Defined by CMS as a public or private entity that is established or organized by a health care provider or group of affiliated providers; that provides a substantial proportion of the services under its Medicare contract directly through the provider or group of affiliated providers; and in which the provider or affiliated providers directly or indirectly share substantial financial risk and have at least a majority financial interest. Similar to the concept of MSO.

Q

Quality Improvement (QI)
Also called performance improvement (PI). This is the more commonly used term in healthcare, replacing QA. QI implies that concurrent systems are used to continuously improve quality, rather than reacting when certain baseline statistical thresholds are crossed. Quality improvement programs usually use tools such as cross-functional teams, task forces, statistical studies, flow charts, process charts, Pareto charts, etc.

R

Reasonable and Customary
The most common fee charged for like professional services in a particular geographical area where the services are rendered.

Reasonable Cost Reimbursement System
One of the two systems used by Medicare to reimburse hospitals for services they perform for Medicare beneficiaries. Under this system, Medicare reimburses based on the reasonable costs incurred by the hospital in performing the services, subject to a ceiling that is imposed by Congress.

Receivable
Refers to either the total or a portion of patient's account, which represents uncollected revenue for the facility.

Recipient ID
The personal identification number patients receive when they enroll for health care coverage.

Recurring/Series Patient
A patient for whom a definite and repeated treatment program is established or an extended period of time (e.g. physical therapy, radiation oncology, prenatal care, etc.)

Referral
The process of sending a patient from one practitioner to another for health care services. Health Plans may require that designated primary care providers authorize a referral for coverage of specialty services.

Referral System
The process through which a primary care provider authorizes a patient to see a specialist to receive additional care.

Registration
Open a case for a patient, assigns a new billing number.

Reimbursement
The amount paid to providers for services they provide to patients.

Reinsurance
An insurance arrangement whereby the MCO or provider is reimbursed by a third party for costs exceeding a pre-set limit, usually an annual maximum. A method of limiting the risk that a provider of managed care organization assumes by purchasing insurance that becomes effective after set amount of health care services have been provided. This insurance is intended to protect a provider from the extraordinary health care costs that just a few beneficiaries with extremely extensive health care needs may incur. Insurance purchased by an insurance company or health plan from another insurance company to protect itself against losses. A contract by which an insurer procures a third party to insure it against loss or liability by reason of such original insurance. The practice of an HMO or insurance company of purchasing insurance from another company to protect itself against part or all the losses incurred in the process of honoring the claims of policyholders.

Reserves
Monies earmarked by health plans to cover anticipated claims and operating expenses. A fiscal method of withholding a certain percentage of premiums to provide a fund for committed but undelivered health care and such uncertainties as: longer hospital utilization levels than expected, over-utilization of referrals, accidental catastrophes and the like. The fiscal method of providing a fund for committed but undelivered health services or other financial liabilities. A percentage of the premiums support this fund. Businesses other than health plans also managed reserves. For example, hospitals document reserves as that portion of the accounts receivables that they hope to collect but have some doubt about its collectability. Rather than book these amounts as income, hospitals will “reserve” these amounts until paid.

Respite Care
Temporary care provided in a nursing home, hospice inpatient facility or hospital so that a family member or friend who is the patient’s caregiver can rest or take some time off.

Revenue Code
A code on the UB-04 used to identify a specific accommodation charge, ancillary service charge, or a type of billing calculation.

Rural Health Clinic
A public or private hospital, clinic or physician practice designated by the federal government as in compliance with the Rural Health Clinics Act. The practice must be in a Medically Underserved area or a Health Professions

Shortage Area and use a physician assistant and/or nurse practitioner to deliver services. A rural health clinic must be licensed by the state and provide preventive services. These providers are usually qualified for special compensations, reimbursements, and exemptions.

S

Same-day Surgery
Surgical services received as a diagnostic outpatient.

Secondary Coverage
Health plan that pays costs not covered by primary coverage under coordination of benefits rules. Any insurance that supplements Medicare coverage. The three main sources for secondary insurance are employers, privately purchased Medigap plans and Medicaid.

Secondary Payer
The secondary insurance payer, carrier or program that is secondary to the primary insurance carrier or program (usually billed after the first carrier).

Self-Funding
Employer or organization assumes complete responsibility for health care losses of its covered employees. This usually includes setting up a fund against which claim payments are drawn and claims processing is often handled through an administrative services contract with an independent organization. In this case, the employer does not pay premiums to an insurance carrier, but rather pay administrative costs to the insurance company or health plan, and in essence, treats them as a third-party administrator only. However, the employee may not be able to detect any difference because the plan description and membership card may carry the name of the insurance company not the employer.

Self-insured
A type of insurance arrangement where employers, usually large employers, pay for medical claims out of their own funds rather than contracting with an insurance company for coverage. This puts the employer at risk for its employees' medical expenses rather than an insurance company. Many employers choose to self-insure because they are then exempted from certain insurance laws and think that they will spend less money in the short run. Employers assume the risks involved and have full rights to all insurance claim information. The employees or patients will not be able to discern if their employer is self- insured easily since all paperwork or benefits cards usually contain the name of the insurance company overseeing the plan.

Self-Pay
Individuals, institutions, or corporations assuming the entire responsibility for payment of hospital and medical bills which otherwise might be covered by an insurance policy.

Sentinel Event
Adverse health events that may have been avoided through appropriate care or alternate interventions. Providers are required to alert JCAHO and often state licensing authorities of all sentinel events, including a review or risk factors, preventative measures, and case analysis.

Sick Baby
A baby delivered with medical complications, other than those related to premature status.

Sign Off/Log Off
When you clear out of the system.

Sign On/Log On
When you enter your ID and your personal password.

Skilled Nursing Facility (SNF)
A licensed institution, as defined by Medicare, which is primarily engaged in the provision of skilled nursing care. SNFs are usually DRG or PPS exempt and are located within hospitals, but sometimes are located in rehab facilities or nursing homes.

Skip
When a debtor cannot be located by a creditor.

Skip Tracing
The act of locating the debtor using information from the initial registration, telephone directories, credit bureau report, etc. so that the hospital can receive payment.

Social Security Administration (SSA)
Founded in 1946. This is the bureau of the federal government that is responsible for the administration of Medicare, whose financing is under the direction of the Health Care Financing Administration (HCFA). The SSA is also responsible for administering several other programs including the Old Age Survivors and Disability Insurance Program.

Social Service Department
The unit responsible for working with patients, their families, and the institution's professional staff to assist patients with personal, socioeconomic, and environmental problems related to their medical conditions.

Source of Admission
Refers to the source from which a patient was admitted to a facility. For example, emergency or transfer from another hospital.

Specific Stop Loss
The form of excess risk coverage that provides protection for the employer against high claim on any one individual. This is protection against abnormal severity of a single claim rather than abnormal frequency of claims in total.

Spend Down
A term used in Medicaid for persons whose income and assets are above the threshold for the state's designated medically needy criteria, but are below this threshold for the state's designated medically needy criteria, but are below this threshold when medical expenses are factored in. The amount of expenditures for health care services, relative to income, that qualifies an individual for Medicaid in States that cover categorically eligible, medically indigent individuals. Eligibility is determined on a case-by-case basis.

Staff Model HMO
A model in which the HMO hires its own physicians. All premiums and other revenues accrue to the HMO, which, in turn, compensates physicians. Very much like the group model, except the doctors are employees of the HMO. Generally, all ambulatory health services are provided under one roof in the staff model.

State Children's Health Insurance Program
A program for uninsured children in the United States that is administered by CMS in conjunction with the Health Resources and Services Administration

State Health Insurance Assistance Program (SHIP)
A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare and Medicaid.

Stop Loss
Maximum out-of-pocket expenses an insured must pay due to deductibles and co-payments.

Stop Loss Insurance
Insurance purchased by an insurance company or health plan from another insurance company to protect itself against losses. Reinsurance purchased to protect against the single overly large claim or the excessively high aggregated claim during a set period. Stop loss may also be used by providers when purchasing Malpractice, Workers Comp and Liability coverage.

Subrogation
Procedure where insurance company recovers from a third party when action resulting in medical expense was the fault of another person (e.g. auto accident). The recovery of the cost of services and benefits provided to the insured of one health plan when other parties are liable.

Subscriber
Person responsible for payment of premiums, or person whose employment is the basis for membership in a health plan. Employment group or individual that contracts with an insurer for medical services. Usually synonymous with enrollee, covered individual or member.

Subsection (d) Hospital
A hospital that must abide by the general 72-hour rule. A subsection (d) hospital is any hospital in the fifty states, the District of Columbia, or Puerto Rico other than a psychiatric hospital, a rehabilitation hospital, a children's hospital, a long-term hospital, or a cancer hospital. Therefore, general acute care hospitals are subsection (d) hospitals.

Supplemental Security Income (SSI)
A federal cash assistance program for low-income, aged, blind, and disabled individuals established by Title XVI of the Social Security Act. States may use SSI income limits to establish Medicaid eligibility.

T

Teaching Hospital
A hospital providing undergraduate or graduate medical education, usually with one or more medical or dental internships and/or residency programs in affiliation with a medical school.

Tertiary Medicare Care
Highly sophisticated diagnostic and therapeutic services given to patients with complex and serious medical conditions. This type of care is usually rendered at teaching hospitals or at university affiliated hospitals.

Third – Party Payer
Any organization, public or private that pays or insures health or medical expenses on behalf or beneficiaries or recipients. An individual pays a premium for such coverage in all private and in some public programs; the payer organization then pays bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service, the individual or institution providing it and the organization paying for it.

Third - Party Payment
Payment by a financial agent such as an HMO, insurance company or government rather than direct payment by the patient for medical care services. The payment for health care when the beneficiary is not making payment, in whole or in part, on his own behalf.

Third Party Administrator (TPA)
An independent organization that provides administrative services including claims processing and underwriting for other entities, such as insurance companies or employers. Often insurance companies will contract as TPAs with other insurance companies or health plans. TPAs are not always insurance companies. TPAs are organizations with expertise and capability to administer all or a portion of the claims process. Self-insured employers will often contract with TPAs to handle their insurance functions. Insurance companies will sometimes outsource the claims, UR, or membership functions to a TPA. Sometimes TPAs will only manage provider networks, only claims or only UR. Hospitals or provider organizations desiring to set up their own health plans will often outsource certain responsibilities to TPAs.

Title XIX (Medicaid)
The title of the Social Security Act that contains the principal legislative authority for the Medicaid program and therefore a common name for the program.

Title XVIII (Medicare)
The title of the Social Security Act that contains the principal legislative authority for the Medicare program and therefore a common name for the program.

Tort Reform
Legislative limits or changes or judicial reform of the rules governing medical malpractice lawsuits and other lawsuits. Tort simply refers to lawsuit. Reform implies that limits can be placed on individual rights to sue or on the amounts or situations for which they can seek relief. Tort is one of the primary causes of the rising costs of health care. Reform, then, would lower health care costs. On the other hand, patient advocates are against tort reform, claiming that the health care industry and managed care industries require monitoring and that lawsuits keep health care providers and payers in check. Congress debates tort reform each session, but, to date, few restrictions have been placed on tort cases.

Transfer
Refers to a patient who was admitted to a facility as a transfer from a previous facility where he or she was an inpatient.

Triage
Triage is the act of categorizing patients according to acuity and by doing so, determining who needs services first. Most commonly occurs in emergency rooms, but can occur in any healthcare setting. Classification of ill or injured persons by severity of condition. Designed to maximize and create the most efficient use of scarce resources of medical personnel and facilities. Managed care organizations, health plans and provider systems are setting up programs or clinics called "triage centers". These centers serve as an extension of the utilization review process, as diversions from emergency room care or as case management resources. These triage centers also serve to steer patients away from more costly care. Triage can also be handled on the telephone and be called a pre-authorization center, crisis center, call center or information line.

Triage Providers
Medical personnel who classify ill or injured persons by severity of condition. When providers or insurance companies manage triage on the telephone, this service may be referred to as pre-authorization center, crisis center, and call center or information line. Providers may also manage triage in emergency rooms, walk-in centers, disaster scenes or outreach centers.

Triple Option Plan
A triple option plan, which is usually offered either by a single insurance plan or as a joint venture among two or more insurance carriers, provides subscribers or employees with a choice of HMO, PPO, or traditional health insurance plans. It is also called a cafeteria plan (or flexible benefit plan) because of the different benefit plans and extra coverage options provided through the insurer or third-party administrator. Triple option plans are intended to prevent the problem of covering members who are sicker than the general population. A risk pool is created when several people are grouped for insurance purposes. The cost of health care coverage is determined by employees' health status, age, sex, and occupation.

TTY
A TTY (teletypewriter) is a communication device used by people who are deaf, hard-of-hearing or have severe speech impairment. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.

U

UB-04
Uniform Billing Code of 2004 – Bill form used to submit hospital insurance claims for payment by third parties. Similar to HCFA 1500 but reserved for the inpatient component of health services.

Unbundling
the practice of providers billing for a package of health care procedures on an individual basis when a single procedure could be used to describe the combined service.

Uncompensated Care
Service provided by physicians and hospitals for which no payment is received from the patient or from third

party payers. Some costs for these services may be covered through cost-shifting. Not all uncompensated care results from charity care. It also includes bad debts from persons who are not classified as charity cases but who are unable or unwilling to pay their bill.

Underinsured
People with public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay.

Underwriting
Process of selecting, classifying, analyzing and assuming risk according to insurability. The insurance function bearing the risk of adverse price fluctuations during a particular period. Analysis of a group that is done to determine rates or to determine whether the group should be offered coverage at all.

Uninsured
People who lack public or private health insurance.

Update
all information entered in the system is accepted.

Urgent Admission
That patient requiring admission to the hospital for a clinical condition that would require admission for diagnosis and treatment within 48 hours, otherwise the patient's life or well-being could be threatened. (The other two categories for admission are emergency or elective.)

Usual, Customary and Reasonable (UCR) Charges
The amount a health plan will recognize for payment for a particular medical procedure. It is typically based on what is considered "reasonable" for that procedure in your service area. Commonly charged fees for health services in a certain area. The use of fee screens to determine the lowest value of provider reimbursement based on: (1) the provider's usual charge for a given procedure, (2) the amount customarily charged for the service by other providers in the area (often defined as a specific percentile of all charges in the community), and (3) the reasonable cost of services for a given patient after medical review of the case. Most health plans provide reimbursement for usual and customary charges, although no universal formula has been established for these rates.

Utilization
Use of services and supplies. Utilization is commonly examined in terms of patterns or rates of use of a single service or type of service such as hospital care, physician visits, and prescription drugs. Measurement of utilization of all medical services in combination is usually done in terms of dollar expenditures. Use is expressed in rates per unit of population at risk for a given period such as the number of admissions to the hospital per 1,000 people over age 65 per year, or the number of visits to a physician per person per year for an annual physical.

Utilization Management (UM)
The process of evaluating the necessity, appropriateness, and efficiency of health care services against

established guidelines and criteria. Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM usually includes new actions or decisions based on the overall analysis of the utilization.

Utilization Review (UR)
A formal review of utilization for appropriateness of health care services delivered to a member on a prospective, concurrent, or retrospective basis. In a hospital, this includes review of the appropriateness of admissions, services ordered and provided, length of a stay, and discharge practices, both on a concurrent and retrospective basis. A peer review group, or a public agency can do utilization review. UR is a method of tracking, reviewing, and rendering opinions regarding care provided to patients. Usually, UR involves the use of protocols, benchmarks, or data with which to compare specific cases to an aggregate set of cases. Those cases falling outside the protocols or range of data are reviewed individually. Managed care organizations will sometimes refuse to reimburse or pay for services that do not meet their own sets of UR standards. UR involves the review of patient records and patient bills primarily but may also include telephone conversations with providers. The practices of pre-certification, re-certification, retrospective review, and concurrent review all describe UR methods.

V

Verification
The process performed by registrars to verify and interpret the patient's insurance coverage prior to or at the time of registration.

Visit
When a patient returns to the hospital to be seen by a physician for the same illness or injury they had been previously registered for.

Vital Statistics
Statistics relating to births, deaths, marriages, health, and disease. Vital statistics for the United States are published by the National Center for Health Statistics. Vital statistics can be obtained from CDC, state health departments, county health departments and other agencies. An individual patient's vital statistics in a health care setting may also refer simply to blood pressure, temperature, height, and weight.

W

Waiting Periods
The length of time an individual must wait to become eligible for benefits for a specific condition after overall coverage has begun.

Waiver
Approval that the Center for Medicare and Medicaid Services, the federal agency that administers the Medicaid program, may grant to state Medicaid programs to exempt them from specific aspects of Title XIX, the federal Medicaid law. Most federal waivers involve loss of freedom of choice regarding which providers beneficiaries may use, exemption from requirements that all Medicaid programs be operated throughout an entire state, or exemption from requirements that any benefit must be available to all classes of beneficiaries.

Wholly Owned or Operated

Within the 72-hour rule, an entity is "wholly owned or operated" if the hospital is the sole owner or operator of the entity. A hospital does not have to exercise administrative control over the facility to operate it. A hospital is the sole operator of a facility if it is exclusively responsible for implementing the policies of the facility, including oversight of routine operation, even if the hospital does not have the power to make the policies. An entity that is "wholly owned or operated" by a hospital that is subject to the 72-hour rule must also comply with the 72-hour rule.

Withhold

Portion of a claim deducted and held by a health plan before payment is made to a capitated physician. A form of compensation whereby a health plan withholds payment to a provider until the end of a period at which time the plan distributes any surplus based on some measure of provider efficiency or performance.

Workers' Compensation

A state-mandated program providing insurance coverage for work related injuries and disabilities. Several states have either enacted or are considering changes to the Workers Compensation Laws to allow employers to cover occupational injuries and illnesses within their own existing group medical plans. Some employers pay premiums to the state or to insurance companies for this coverage. Others are self-funded and use third party case management or administrative services to manage these processes.

X, Y, Z

SECTION 6
RESOURCES

Resources

https://medicaid.alabama.gov/content/Gated/7.6.1G_Provider_Manuals.aspx
http://health.state.ga.us/programs/cms
https://providers.bcbsal.org/portal/home
http://www.cms.gov/
http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf
http://www.cms.hhs.gov/MLNEdWebGuide/05_AppealsFFS.asp
http://www.cms.hhs.gov/MLNProducts/downloads/MediareAppealsProcess.PDF
http://www.dch.georgia.gov/shbp
http://www.dfcs.dhr.georgia.gov/portal/site/DHS-DFCS/
http://www.dhr.georgia.gov/
http://www.djj.state.ga.us/FacilitiesPrograms/DistrictsMain.html
http://www.hhs.gov/dab/DAB101.pdf
http://www.humana-military.com
http://www.mmis.georgia.gov
http://www.tricare.mil/providers/
https://www.cms.gov/transmittals/downloads/R1104CP.pdf
http://www.slideshare.net/karna.indian/cms-1450-ub04- instructions-presentation
https://www.oxhp.com/secure/materials/COB_FAQ_Brochure.pdf
http://www.staysmartstayhealthy.com/health_insurance_deductibles
http://health.howstuffworks.com/medicine/healthcare/insurance/deductible-copay.htm
http://questions.medicare.gov/app/answers/detail/a_id/2305/session/L3NpZC9zMTJaVFh1aw%3D%3D
http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-c.aspx
http://www.dcor.state.ga.us/pdf/ReportCorrectionalHealthCareSystem.pdf
http://law.justia.com/codes/georgia/2010/title-42/chapter-4/article-3/42-4-50/
http://law.justia.com/codes/georgia/2010/title-42/chapter-5/article-1/42-5-2/
http://www1.legis.ga.gov/legis/2011_12/versions/hb197_LC_35_2065_a_2.htm
http://law.justia.com/codes/georgia/2010/title-42/chapter-4/article-1/42-4-4/
http://www.files.georgia.gov/SBWC/Files/employee_handbook.pdf
http://sbwc.georgia.gov/portal/site/SBWC/
https://medicalbillingmaster.home.blog/category/revenue-cycle-flowchart/
https://www.nolo.com/legal-encyclopedia/filing-bankruptcy-in-alabama-yourself.html#1
https://warrenandsimpson.com/news/alabama-hospital-lien-statute/
https://providers.bcbsal.org/portal/home