Certified Revenue Cycle Representative
Coaching Course Unit 2: Pre-service - Financial Care

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Unit 2: Pre-Service – Financial Care

2.1: Patient Types

- Identify the differences between scheduled and unscheduled patients.
- Identify the different patient types and when to use each patient type.

Types of patients

- Scheduled
- Unscheduled
- Non-Acute Types

Scheduled Patients

- Scheduled Inpatient
- Scheduled Outpatients
- Scheduled Recurring/Series Patients

Unscheduled Patients

- Inpatient or Urgent Patients
- Outpatients or Walk in Patients
- Emergency Patients
- Observation Patients
- Newborns

Non-Acute Types

- Skilled Nursing
- Hospice Care
- Home Health Services
- Durable Medical Equipment
- Clinic

Key Points

- The broad categories of patients depending on the type of care needed are Scheduled, Unscheduled and Non-Acute types.
- Patient scheduling ensures appropriate reimbursement and/or significant resource coordination, such as reserving rooms and/or equipment, ordering devices or supplies, and ensuring that professional staff, such as physicians, nurses, and/or technicians are available.

2.2: Scheduling

- Identify the typical patient demographic information obtained during scheduling.
- Identify each component of the patient scheduling process.

Scheduling: Key Concepts

- Scheduling patients for service allows the facility to prepare for the patient's service.
- Understanding and executing the process correctly is a key to patient satisfaction and to payment for services.

Core Concept Steps

- Patient Identification
- Requested Service
- Scheduling Instructions
- Review and Validation
- Patient Reminders and Arrival Instructions
- Order Requirements

The Scheduling Process

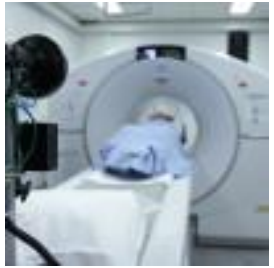
- Patient identification:
  - When there is a request for service, scheduling staff must confirm the patient's key identification information to ensure they access the correct patient account

The Scheduling Process

- Requested Service
  - A physician order is generated and becomes the basis for the request for service.

The Scheduling Process

- Scheduler Instructions
  - The type of requested service will determine the scheduling instructions.
  - Many healthcare organizations use automated scheduling systems and build the scheduling questions in the system.



The Scheduling Process

- Patient Instructions
  - Scheduled procedures routinely include patient preparation instructions that must be completed prior to the test/procedure

The Scheduling Process

- Patient Reminders and Arrival Instructions
  - The patient reminder is a written listing of the patient's responsibilities and usually includes the same items summarized at the end of the scheduling call along with any additional instructions provided as part of additional access processing activities.

Review and Validation

Information to review:

- The service to be provided
- Date and location of the scheduled service
- Arrival time and procedure time
- Required pre-service testing, including completion time frame.
- Patient preparation instructions
- Patient arrival instructions, such as where to park, where to report, how to get to service area

Patient Reminders and Arrival Instructions

- Reminder letters can also include maps that show the patient where to park, where to report when he/she arrives, and where the service department is located.
- Many facilities call the patient a day or two prior to the scheduled visit to remind him/her of the appointment.

Order Requirements

- Tests and services can only be provided with a valid physician order.
  - Verbal Orders
  - Exceptions
- Medicare has certain data requirements to consider a physician order

- Full Legal Name	- Date order written
- Test or service	- Diagnosis
- Name of ordering doc	- Signature

Medical Necessity Screening and ABN Processing

- Medicare will only pay for tests and services that it determines are “reasonable and necessary.”
- If a test or service is not medically necessary, a signed Advanced Beneficiary Notice (ABN) must be obtained from the patient

Advance Beneficiary Notice of Noncoverage (ABN)

Hospital Issued Notice of Non- Coverage

- Medically unnecessary
- Not delivered in the most appropriate care setting
- Custodial in nature

Key Points

- Key patient information including the patient's full legal name, date of birth, and Social Security Number are collected and used as patient identifiers.
- Medicare has established guidelines called Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) that are used to determine which diagnoses, signs or symptoms are payable. Test and services can only be provided with a valid physician order.

2.3: Pre-Registration

- Identify the data that must be obtained and confirmed during pre-registration.
- Identify the purpose and importance of Insurance Verification and the Medicare Secondary Payer (MSP) screening process.
- Identify the consequences of failing to obtain or confirm patient information during pre-registration.

Reason for Pre-Registration

- Successful pre-registration program should gather the following:
  - Demographic data
  - Insurance data
  - Financial Information
  - Insurance information
  - Potential need for financial assistance
  - Give patients preparation instructions
  - Collect patient liability

Benefits of Pre-Registration

- Patient arrival process is completed efficiently
- Paperwork, both clinical and financial, can be assembled ahead of time
- Patients can expedite the registration process
- Patients can report directly to the service unit
- Patients can focus on clinical care/treatment

Data Collection

MPI and Data Collection

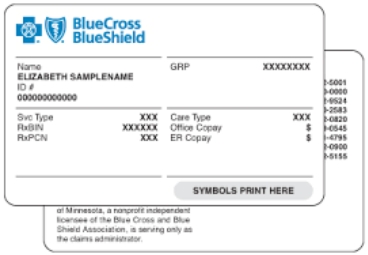
- Comprehensive access processing:
- Identifying the patient in the MPI
- Creating a registration record
- Completing Medical Necessity Screening
- Determining Insurance Eligibility
- Obtaining Insurance befits
- Resolving Managed Care Requirements
- Completing financial education/resolution

Consequences of Improper Data Collection

- Wrong Medical History
- Billing information is not correct
- Incorrect Medical Record

Insurance Verification

- Insurance verification is conducted to ensure the accuracy of the insurance information. Coverage issues are identified and communicated to the patient.
- Can be completed through electronic inquiry or telephone contact.



Medicare Secondary Payer Screening

- The MSP Screening questions help to clarify the patients situation, including:
  - Working Aged
  - Disability
  - End Stage Renal Disease (ESRD)
  - Accident/ Auto or Workers Compensation

Incomplete Pre-Registration

- Return mail affecting the ability to contact the patient and collect self pay amounts.
- Insurance Denials
- Unnecessary health plan follow up and rebilling resulting in higher rework costs.

Cost of a Denied Claim

Key Points

- Properly completed pre-registration ensures that patient access staff will avoid the following issues:
  - Return mail, impacting the ability to contact the patient to collect self-pay amounts
  - Insurance denials
    - Missing/invalid subscriber information
    - Ineligible on date of services
    - Authorization requirements
    - Out-of-network status
    - Medical necessity failures
    - Coverage limitations
    - Unnecessary health plan follow-up and rebilling

Questions?

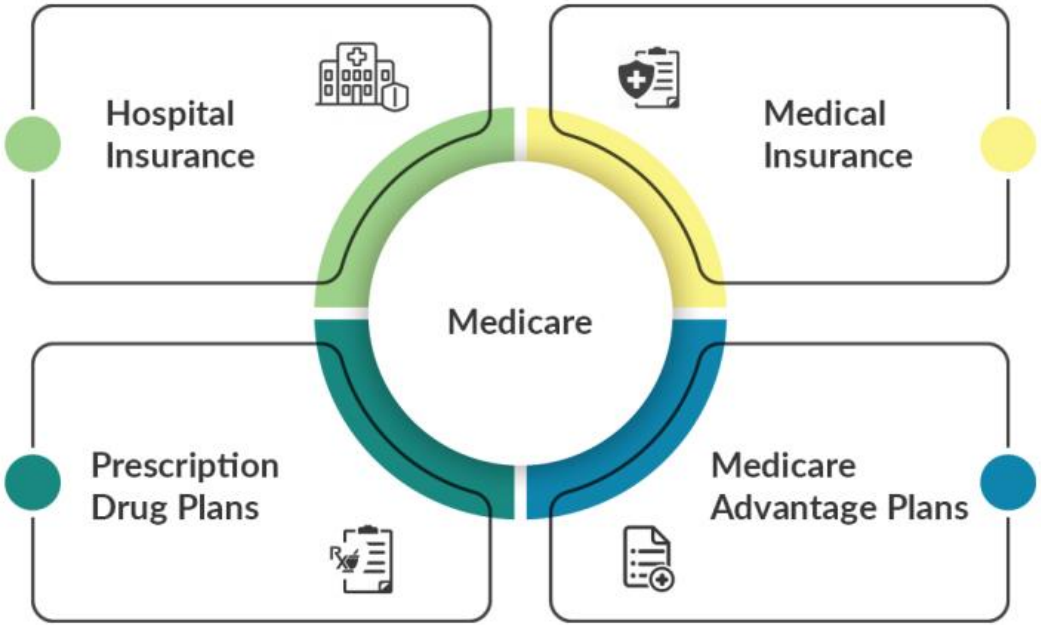
2.4: Health Plans

- Identify the basic features and benefits of major government-funded health plans.
- Identify the basic features and benefits of other health plans including commercial plans and smaller government-funded plans.

Health Plans

- Medicare
- Medicaid
- TRICARE
- Other Health Plans
  - Indian Health Services
  - Blue Cross Blue Shield
  - Commercial
  - Self Insured
  - Liability
  - Managed Care

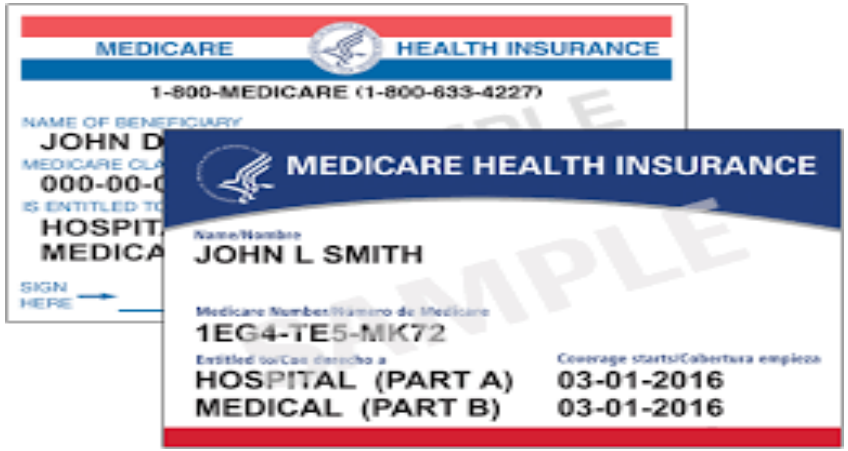
Medicare


Hospital Insurance
Medical Insurance
Medicare
Prescription Drug Plans
Medicare Advantage Plans

Medicare Part A Benefits

Medicare Part A benefits consist of “benefit periods.”

Medicare Part B



Medicare Claims

To be eligible for Medicare reimbursement, claims must be filed within one calendar year of the date of service. Medicare systems will reject or deny claims that are not received within the specified time requirements. Medicare Advantage plan claims must be filed within the specific health plan's qualifying time limit per the provider contract.

Medicaid

Tricare

- Tricare Prime
- Tricare Standard
- Tricare for Life

Key Points

- Major health plans include Medicare, Medicaid and TRICARE.
- Medicare is a government-funded program which is finances through taxes and general revenue funds.
- Medicaid is a federally-aided, state-operated and administered program to provide health and long-term care coverage for low-income individuals or families.
- TRICARE (formerly known as CHAMPUS) is the uniformed services' healthcare program.

2.5: Health Plans – Managed Care

- Identify the different types of managed care health plans and their requirements.

Managed Care

Types of Managed Care plans:

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Point of Service (POS) plans
- Medicare Advantage plans

Managed Care Plans

(cont'd.)

- Medicaid HMO
- Capitation
- Consumer-Directed Health Plans (CDHP)

Specific Managed Care Requirements

- Pre-certification/pre-authorization
- Referrals
- Notification
- Days approval, continued stay review, and additional days approval
- Site of service limitations

Key Points

Managed care plans have agreements with physicians, hospitals and other healthcare providers to offer a range of services to the plan members at a reduced cost. Managed care plans include:

-Health Maintenance Organization (HMO)

-Preferred Provider Organization (PPO)

-Exclusive Provider Organization (EPO)

-Point-of-Service Plan (POS)

-Consumer Directed Health Plans (CDHP)

-Medicare Advantage Plans

-Medicaid HMO Plans

2.6: Price Transparency

- Identify the purpose, principles and importance of price transparency.
- Identify the necessary elements of price determination.

What is Price Transparency?

Elements of Determining Price

- Verification
- Identify Service Involved
- Health Plan Response

Providing Price Estimates

Key Points

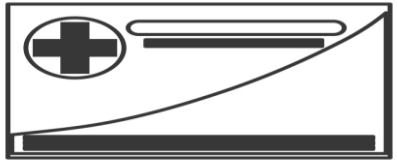
- It is important to apply price transparency principals to the development of information necessary to successfully complete a financial responsibility with the patient.
- While health care is different from commodity purchases, consumers do expect that providers will inform them of their responsibility for the service.
- Coupling the price estimate with patient financial communication best practices allows providers to provide a high quality level of financial care to patients.

2.7: Patient Financial Communication

- Identify the components and goals of patient financial education and financial resolution.
- Recognize payment arrangement alternatives including Medicare eligibility, payment discounts, payment plans, and financial assistance (charity care).
- Identify the concepts and components of time-of-service collections.

Financial Counseling

Self Pay and BAI



HFMA Best Practices

Patient Financial Communications

- Payment Options:
  - Full
  - Short Term
  - Bank Loan Program

- Medicaid Eligibility

Financial Assistance Program (FAP)

TOS Collections Program

- Greeting
- Name
- Dignity and Establish Rapport
- Validate time is convenient
- Be prepared to explain and show calculations
- Ask for Payment in Full
- Process according to receipting rules and provide a detailed receipt

Questions?

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Insurance Terminology

- Access: An individual's ability to obtain medical services on a timely and financially acceptable level.
- Administrative Services Only (ASO): Usually contracted administrative services to a self-insured health plan.
- Anniversary: The beginning of a subscriber group's benefit year.
- Assignment: The process whereby a patient requests that a third-party payer send the payment for covered health services directly to the provider.

Insurance Terminology

- Benefit Package: The specific services or benefits that the insurance company covers.
- Case Management: The process whereby all health-related components of a case are managed by a designated health professional.
- Claim: A demand by an insured person for the benefits provided by the group contract.

Insurance Terminology

- Coordination of Benefits (COB): A typical insurance provision that determines the responsibility for primary payment when the patient is covered by more than one employer-sponsored health benefit program. The coordination avoids duplicate reimbursement for the same medical services.

Insurance Terminology

- Dependents: Persons designated in writing by the insurance company meeting the dependency tests as stipulated by the insurance policy.
- Discounted Fee-for-Service: A reimbursement methodology whereby a provider agrees to provide service on a fee-for-service basis, but the fees are discounted by a certain percentage.
- Elective: Refers to medical procedures not immediately necessary, usually procedures that can be scheduled in advance.

Insurance Terminology

- Eligibility: Patient status regarding coverage for healthcare insurance benefits.
- First dollar coverage: A healthcare insurance policy that has no deductible and covers the first dollar of an insured's expenses.
- Gatekeeping: A concept wherein the primary care physician provides all primary patient care and coordinates all diagnostic testing and specialty referrals required for a patient's medical care. Diagnostic and specialty care must be "pre-authorized" by the gatekeeper except for emergencies.

Insurance Terminology

- Healthcare Plan: An insurance company that provides for the delivery or payment of healthcare services.
- Indemnity Insurance: Negotiated healthcare coverage within a framework of fee schedules, limitations, and exclusions that is offered by insurance companies. The important point is that indemnity relates a benefit paid by an insurance policy for an insured loss.

Insurance Terminology

- Medically Necessary: Healthcare services that are required to preserve or maintain a person's health status.
- Out-of-Area Benefits: Healthcare plan coverage allowed to covered persons for emergency situations outside of a prescribed geographic area.
- Out-of-Pocket Payments: Cash payments made by the insured for services not covered by the health insurance plan.

Insurance Terminology

- Pre-admission Review: The practice of reviewing requests for inpatient admission before the patient is admitted to ensure that the admission is medically necessary.
- Pre-existing Condition Limitation: A restriction on payments for charges directly resulting from a pre-existing health condition.
- Pre-existing Medical Condition: A physical and/or mental condition that a patient has before applying for insurance coverage.

Insurance Terminology

- Same-Day Admission: Requires that pre-procedure testing and preparation are completed on an outpatient basis and the patient is admitted the same day as the procedure.
- Self-Insured: Large employers who assume direct responsibility or risk for paying employees' healthcare without purchasing health insurance.

Insurance Terminology

- Subrogation: Seeking, by legal or administrative means, reimbursement from another party that is primarily responsible for a patient's medical expenses.
- Subscriber: An employer, a union, or an association that contracts with an insurance company for the healthcare plan it offers to eligible employees.
- Sub-specialist: A healthcare professional who is recognized to have expertise in a specialty of medicine or surgery.

Insurance Terminology

- Third-Party Administrator (TPA): Provides services to employers or insurance companies for utilization review, claims payment, and benefit design.
- Third-Party Reimbursement: A general term used to identify that for benefit plans there are three parties in the transaction: the patient, the provider, and the third party (e.g., insurance company, employer, government) that is responsible to reimburse the provider for the patient's covered services.

Insurance Terminology

- Usual, Customary, and Reasonable (UCR): Health insurance plan reimbursement methodology that limits payment to the lower billed charges, the provider's customary charge, or the prevailing charge for the service in the community.
- Utilization Review: Review conducted by professional healthcare personnel of the appropriateness of, quality of, and need for healthcare services provided to patients.