CPAR Coaching Manual

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CHAPTER 1

PATIENT ACCOUNTS RECEIVABLE OVERVIEW

(REVENUE CYCLE)

INTRODUCTION TO PATIENT ACCOUNTS RECEIVABLE MANAGEMENT

Today, more than ever before in the history of health care delivery and financing, there is the need for appropriately qualified personnel to staff the hospitals' Patient Financial Services offices. Complex, ever-changing third party overages have brought new challenges to personnel responsible for understanding the coverage, and, even more importantly, interpreting those benefits to the patients serviced in our hospitals.

A period of unparalleled cost increases in health care delivery, the onset of severe economic pressure, a significant increase in regulatory constraints and a much more competitive environment for both patients and patients' dollars have created much greater demands for managing the patients' financial relationship to the hospital. Also increasing is the obvious requirement that our hospital Patient Financial Services be staffed with professionally trained personnel, prepared to cope innovatively and enthusiastically with today's challenges.

Changes in Terminology have evolved. For example:

- Patient Financial Services (Business Office)
- Patient Access (Admitting)
- Health Information (Medical Records)
- Information Technology (Data Processing)

For purposes of this training manual, the description, "Patient Financial Services", will be consistently used to refer to all functional areas serving the patient's pre-admission, admission, and financial affairs related to the hospital.

A well-planned organizational structure designed around key functional areas of the hospitals' Patient Financial Services and supported by sound, well-defined policies and procedures, forms the foundation for effective Patient Accounts Receivable management which is the primary role of the Patient Financial Services personnel.

Regardless of how a particular hospital has organized the Patient Financial Services areas, or who is specifically responsible for the various activities that occur in these areas, specific functional control areas that potentially exist (or should exist in all hospitals) have been clearly defined. The functional control areas are:

Pre-Access (Pre-admission) (May include Scheduling Department or Scheduling may be Separate Department)
Admission (Patient Access)
In Hospital
Discharge
Post-discharge or Follow-up Collection

The proposal is that these functional control areas exist for both inpatient and outpatient activities. There may be some difficulty to achieve this in some areas especially with the limitations on time with outpatients and special problems created by 'non-scheduled' and emergency-type admissions. Therefore, the following outline will focus around the five functional control areas above and relate to inpatients and outpatients. Appropriate exceptions or special suggestions relative to outpatients or emergency situations will be made.

The five functional areas also include other responsibilities, such as ***Insurance Verification, Pre-certification/Pre-authorization, and Financial Counseling***

Patient Access/Admissions: An Overview

Traditionally, admission processing has included: identifying the patient, initiating the medical and financial record for the visit, and orienting the patient to the hospital setting. Although these basic duties have not changed, the details involved have dramatically increased due to several recent changes in the health care environment:
Increased Federal and State regulations in regard to the information required to be gathered from and given to the patient upon admission, such as patients' rights and advanced directives.
Development of managed care requiring more processes to be initiated prior to or upon admission, such as pre-admission approvals and discharge planning.
Increased number of pre-certification requirements.
Decreasing lengths of stay requiring more up-front processing to efficiently manage the patient account prior to discharge.
Decreasing benefit levels; therefore, increasing self pay portions necessitating up-front collections.
Increasing amount of information required to process a complete claim, such as Medicare Secondary Payor information to determine coordination of benefits with Medicare, and varied requirements across insurance payers.

In the area of patient accounts, these changes have necessitated emphasis on "front -end" over the traditional “back-end" patient accounting. Therefore, admissions and registration areas have grown to encompass many of the functions previously completed "post-admission".
This "front-end” emphasis does not eliminate the need for other specialized areas of patient accounting but allows these areas to concentrate on exceptions and those accounts where resolution would be most beneficial, such as large balances, extended stays, audits, or bankruptcies. Although hospitals are organized differently from one institution to another, for the purpose of this manual, **Patient Access/Admissions will include the following first four of the five functional control areas of patient accounting: Pre-admission, Admission, In-House, and Discharge.**

PRE-ADMISSION/PRE-REGISTRATION

Definition of Pre-Admission (Pre-Access)

Pre-admission, the first functional control area, can be .defined as the process of accumulating socio-economical and essential medical information from the patient **prior to their actual admission or outpatient visit**. Pre-authorization/Pre-certification guidelines/requirements must be reviewed to determine that services meet the guidelines and/or additional activity will be needed to ensure coverage by third party carrier and/or patient liability.
Although the duties included in the Pre-admission Program may vary depending on the patient type or service to be rendered, **the objective of the Pre-admission Program should be to complete all possible processes prior to the admission or date of service.** A well-planned and coordinated Pre-admission Program **provides numerous benefits to the patient, physician and hospital.**

Establishing a Pre-Admission System

A matter of Policy:

To be effective, the Pre-admission Program must be supported by sound policy that has been approved by the Board of Trustees. The policy must clearly define:

- Which patient types will be pre-admitted (Maternity, scheduled, etc.),
- How the pre-admission information will be collected and distributed,
- Acceptance of assignments on third party coverage,
- Prepayment deposit criteria, and
- The hospital's willingness to finance accounts

***NOTE: Often, these items are included as part of the collection or financial policy of the hospital. If not included, the pre-admission policy should be coordinated with the collection policy to avoid conflicts.**

Procedures

The pre-admission process is usually initiated by the patient's physician who schedules the patient for admission, surgery, clinic visit or other treatment. In the case of maternity patients, the expected date of confinement (EDC) or "due date" is considered to be the anticipated date of service**. Because so many patients are being handled on an outpatient basis, the term "Pre-Registration" is often used instead of Pre-Admission.**

Advantages to the Patient

Pre-admission establishes a relationship between patient and hospital personnel before the actual admission. Consequently, there is increased communication between the patient and hospital about various aspects of the hospitalization experience such as:

The admission process, including directions, appointment times, pre-op studies, etc.

Pre-certification, second opinion or HMO/PPO/employer requirements.

Payment expectations, including deposits, term arrangements, and third party billing.

Allows the patient to voice any special concerns, have specific questions answered and provides for early referral to social services.

Eliminates unnecessary waits at the time of admission.

Advantages to the Physician

Pre-admission facilitates the flow of information between physician and hospital. This timely data exchange can prevent unnecessary work duplication, improve the quality of patient information, and foster a more cooperative relationship between hospital and physician. Examples include:

Identification and appropriate follow-up on pre-admission authorization requirements, including the identification of services not meeting medical necessity guidelines.

Arrangements for patients with special needs (physical or mental restrictions, language barriers, etc…

Early initiation of discharge planning, including potential discharge problems, and

Collaborative resolution of potentially controversial financial situations such as workers' compensation, accident-related or charity/indigent care.

Advantages to the Hospital

Finally, pre-admission allows the hospital to proactively plan for a patient's admission. The benefits of an effective Pre-admission Program are numerous, including:
Speedy resolution of accounts, prompt identification of incomplete or incorrect data,
Resolution of outstanding billing issues,
Initiation of the collection process before the patient walks in the door.
Improved public relations: the patient knows what to expect in regards to the overall admitting process as well as payment expectations.
Timely referrals to social service and government agencies, as well as quick identification of uncompensated care candidates.
Improved work-flow: the admitting process can be streamlined. The discharge process can also be expedited since many pre-admitted patients receive a courtesy discharge at the time of their admission.
Maximization of payment through the fulfillment of pre-certification requirements,
Early intervention to resolve issues such as exhausted benefits, recognition of poor payment histories,
A patient-doctor-hospital team approach to account resolution
Improved patient care and satisfaction.

Generally, the information gathered during scheduling will include patient name, address and phone number(s); diagnosis or reason for visit; surgery/procedures to be performed; special needs of the patient, and sources of payment. From this basic information, the admission can be categorized as to the pre-admission procedures required, and financial assessment can begin. Properly trained scheduling staff can inform the' physician office of any known pre-admission approval or deposit requirements, and cooperative resolution of accounts between the physician and hospital can be initiated.
The scheduling area is often located in the Admission Department. If scheduling is located elsewhere, pre-admission staff should have access to the scheduling information which should at least include the necessary data to contact the patient and physician.
Pre-admission staff should screen scheduling information for high-risk procedures or procedures requiring extensive pre-admission approvals, such as plastic or dental surgery, sterilization, or accident-related injuries and review special needs for referral to social services.
Once scheduling is complete, the patient should be contacted by phone or by mailing a pre-admission form to the patient's address.

The Pre-admission Form

Although there is no standard for all hospitals, the form should capture all data necessary to assess the patient's ability to pay (or otherwise meet hospital financial requirements), to alert the hospital to any special problem situations (such as poor payment history, exhausted benefits, discharge planning, etc.), and to prepare admission documents in advance. An effective pre-admission form will, therefore, include the following essential information:

<u>Patient</u>

Name, address and home telephone number
Date of Birth
Marital Status
Religious affiliation (medical reason)
Race (medical reason)
Type of accommodation preferred
Name, address and telephone number of next of kin or spouse
Social Security Number
Occupation/Employer - Name and address
Employee I.D. Number (if different than Social Security Number)

Guarantor or Responsible Party-
Name, address and telephone number of person responsible for bill (if other than patient)
Occupation/Employer - Name and address
Social Security Number or Employee Number, (if different than Social Security Number)

Insurance/Third-Party Coverage
Name of Hospitalization Insurance/coverage (i.e., Medicare, Medicaid, Commercial, etc.)
Name, address (where claims are filed) and telephone number of the insurance company
Policy or Contract Numbers and Group Numbers of plans
Obtain any required pre-admission authorization/certification numbers
Accident type, date and place (if applicable)
Medicare Secondary Payor questions

Other Essential Data
Name attending physician, referring or primary physician (if applicable) and admitting physician (if different from attending)
Admitting diagnosis or reason for service
Admission and pre-operative appointment dates or, for maternity patients, EDC (Estimated Date of Confinement)
Special requests and needs (translator, special equipment, etc.)
Place for comments and release of information to complete pre-admission approvals

The Pre-Admission Procedure

101.5a Pre-Admission by Mail
In many cases, the most effective way to pre-admit patients is to mail a pre-admission form to the patient's home. The form should include instructions on how to complete the form, when and where to return the form, and who to call for questions or additional information. A patient handbook or other literature may also be sent with the pre-admission form to better acquaint the patient with the hospital. For example, information on visiting policies, parking maps, admission appointment times, social services, patient valuables, and patient rights, including advance directives, often accompanies pre-admission forms.
Patients who cannot practically be pre-admitted by mail (usually due to time constraints) can be pre-admitted by phone. This is a more time consuming process for the pre-admission registrar; however, it is an effective way to obtain the patient's data.
When the pre-admission form has been returned, or the information otherwise collected, the pre-admission person should:
Verify coverage and benefits with any insurance carrier,
Initiate any required pre-admission authorization,
Determine if prepayment deposit is necessary after computing benefit coverage,
Investigate potential payment sources indicated on the form (auto insurance, worker's comp, etc.), and
Determine past payment record, open balances, bad debts, etc.

After the pre-admission data has been collected and processed, the Admission Office should have an agreed-upon time frame for following up with the patient. By a certain date, the pre-admission person should call the patient, review the pre-admission information (insurance coverage, address, etc.) and discuss the findings with the patient. This is the time to request pre-admission deposits, to instruct the patient to bring necessary claim forms or current Medicaid cards and, if appropriate, make financial arrangements for any balance that the patient cannot pay by the time of admission.
An effective Pre-admission Program is appropriate for all elective and maternity admissions, which are two of the most obvious classes of patients that fit into a pre-admission system. However, any patient

who is scheduled at least 24 hours in advance is a likely candidate for pre-admission processing. **Due to the advantages of pre-admission for patient and hospital, maintaining the highest possible percentage of pre-admitted patients should be an ongoing goal of the Admission Office.**

101.5b Pre-Admission by Phone

When time does not permit pre-admission by mail or if the form is not returned within a set time length, or is returned incomplete, contacting the patient by phone is an effective way to obtain the patient's data and allows the patient to ask any questions they may have. However, the call must be coordinated with the patient's schedule and does not alleviate the need to call the patient again to discuss verified, information and self-pay balances.

Once the pre-admission information is gathered, a financial evaluation is completed. As early as possible and prior to admission, the pre-admission staff should:

Review account history - past payment record, open balances, bad debts, etc.

Investigate potential sources of payment (such as auto insurance, worker's comp, COBRA, etc.)

Verify coverage and benefits with all identified insurance carriers -noting special requirements (such as claim form submission) and any special situations (such as pre-existing conditions, exhausted benefits, etc.).

Compute the benefit coverage and the expected self-pay portion, and determine if pre-admission deposit is necessary.

As soon as the financial evaluation is complete, the pre-admission staff should notify the patient or guarantor of the findings, instruct them to bring additional documentation (such as claim forms or current Medicaid cards), and notify them of the expected self-pay portion and the hospital's payment policy. If appropriate, financial arrangements can be made for any balance the patient cannot pay at the time of admission. Financial counseling and determination of eligibility for uncompensated care can be initiated for patients unable to meet the financial obligations to the hospital. If the financial requirements are met, a courtesy discharge may be extended to the patient.

To complete pre-admission processing, the admission documents should be prepared in advance. Patients having elective surgery are usually scheduled for a pre-operative visit to the hospital that may include testing, anesthetic evaluation, etc. At this time, all documents, authorizations and deposits can be collected. On the day of surgery, the patient has completed all admission requirements and treatment can begin immediately.

101.5c Pre-Admit on Line

Some facilities have initiated an on-line process enabling patients to complete an on-line registration form.

ADMISSION/REGISTRATION

Definition of Admission/Patient Registration

Admission, the second functional control area, can be defined as the process of obtaining certain socio-economical and essential medical information from the patient at the time of their hospitalization.

Procedures

The admission process must be preceded by a physician's order to admit. Admission can take place at any time of day and through multiple entry points (Admission Office, Emergency Department, Outpatient Surgery Center, etc.). Because so many patients are being handled on an outpatient basis, the term "Patient Registration" is often used instead of Admission.

Obviously, there are patients who cannot be pre-admitted, such as emergency patients and patients requiring urgent care. Others, such as unscheduled outpatients or those coming for minimal services (chest x-ray, etc.), may also not be appropriate pre-admission candidates.

For patients not pre-admitted, the same basic information outlined in the pre-admission section should be gathered at the time of admission. The following activities should be completed upon admission, whether the patient is pre-admitted or not:

1. Obtain positive identification of patient and Guarantor. (Photo ID, driver's license, insurance cards).

Confirm Essential Data. Is the address correct? Is the insurance information correct and complete to meet UB92 requirements? Since pre-admission streamlines the admitting process, review only the basic data with the pre-admitted patient. For patients who have not been pre-admitted, all data should be carefully verified.

Complete appropriate admission records – usually includes admission face sheets (similar to the pre-admission form), advance directives, claim forms, Medicare Secondary Payor Questionnaire, and the Medicare or CHAMPUS message, Medicaid XIX form and HIPAA Notice of Private Practices.

Obtain signatures of insurance assignments and releases of medical information for appropriate third parties.

Review and confirm that all necessary pre-certification/pre-authorization requirements have been met.

a) Notification to applicable pre-cert agency
b) Must meet medical necessity requirements
c) Notification prior to elective procedures
d) Notification within 24-48 hours of emergency procedures/admissions
e) Increase in number of Outpatient Procedures requiring Precertification

Documentation of Third-Party Contact Name and authorization number.

Collect deposits, either determined during the pre-admission process or calculated at the time of admission.

If there is inadequate third party coverage, and the patient expresses an inability to pay, obtain financial information to determine eligibility for Financial Assistance program of the hospital.

PRE-ADMISSION/ADMISSION CONTROL STANDARDS

When evaluating the performance in the functional control areas of pre-admission and admission, there are several areas believed to be very measurable and which may serve as "yardsticks" to compare planned performance against what actually has occurred in the hospital. The following suggestions are offered:

All scheduled elective admissions have been pre-admitted either through completion of mailed forms or by personal telephone interview, or a combination of both.

Coverage and benefits have been verified on all pre-admitted patients prior to admission.

All required prior approvals and admission authorization numbers have been obtained.

Computation of any anticipated self-pay portion of the planned confinement has been completed and communicated with the patient (responsible guarantor) prior to admission, or at admission (if not pre-admitted), and will be collected at time of admission. (This will probably be calculated on estimated length of stay.)

All Deductibles and Co-Insurance estimated will be collected at time of admission.

All pre-admission/admission information data will be verified for accuracy before processing into billing/collection control areas for follow-up.

Emergency Department

a. EMTALA (Emergency Treatment and Active Labor Act) is applicable to all emergency patients.
b. Patients must be stabilized prior to financial screening.

IN-HOUSE CONTROL AREA

After the patient has already been admitted to either an inpatient bed or rendered outpatient services, **the period of time the patient remains on the hospital premises is the next most important functional control area.**

Most financial information should have been obtained either in the pre-admission or admission control areas. Determination of the patient's third party coverage and estimated self-pay portion, based on the anticipated length of stay, should have been made no later than at the time of admission. Of course, there are exceptions to this practice being enforced, especially with emergency and/or unscheduled (non-pre-admitted) patients.

The in-house functional control area must concentrate on the EXCEPTIONS where financial requirements and/or arrangements have been fully satisfied. In the suggestions that follow, we emphasize handling the patient accounts on an exceptional basis where COLLECTION PROBLEMS are suspected, either due to circumstances surrounding the current admission or financial history from previous admissions - inpatient or outpatient.

ADMISSIONS/SPECIAL CONSIDERATIONS

Transfers from One Facility to Another -

Although the majority of the transfers from one facility to another are medically or otherwise justified, there have been instances where a facility has a long-term and/or high-cost patient who is underinsured or uninsured, and transfers the financial loss to the "unknowing" other facility**. When there is no other reason for the transfer, this is called "patient dumping" and is illegal.**

For this reason, all transfers should be properly screened except the true emergency where the services necessary cannot be provided at the facility in which the patient is currently located. Financial information can be obtained from the transferring facility and confirmed prior to any requested transfer.

Transfers within the Same Facility

Facilities providing acute care and services such as rehabilitation, mental health, or intervention often transfer patients from one type of service to another.

Insurance carriers and Medicare, Medicaid, and CHAMPUS often have different benefits or payment schedules for these type services. These benefits are prone to inpatient day, outpatient visit, and maximum dollar limits. Usually, only specific types of treatment are covered. Therefore, financial screening, including a complete verification of benefits and requirements for payment is necessary prior to this type of transfer.

Cobra Duties of a Hospital

Under COBRA, a transfer is defined as any time the patient leaves the campus of the hospital including discharge, unless AMA or deceased.

Hospitals which receive Medicare benefits are required to:

- ***Provide a medical screening examination to all patients that present upon its premises.*** This provision, as interpreted and applied, requires hospitals to accept and evaluate any patient on its premise who presents for a non-scheduled visit and seeks care, regardless of ability to pay. The scope of the medical screening exam will be discussed later, but is extensive and triage does not meet the screening requirements. Hospital premises includes hospital-owned and operated ambulances and off-campus locations billing under the same Medicare provider number and areas, facilities or services contained in the hospital's operating certificate--i.e. Hospital-owned clinics or physician practices owned by the hospital.

- ***Provide stabilizing care.*** Stability under COBRA requires a much higher level of patient condition than that typically connoted by the word "stable" in usual medical usage. It requires that a pregnant female experiencing contractions is not legally stable until the baby and placenta are delivered. It also requires that in non-maternity cases the hospital must assure that patient is not reasonable at risk to deteriorate from, during, or following transfer or discharge. If the patient is reasonably at risk to deteriorate from the natural process of the condition, they are legally unstable under this standard, just as if the transfer or discharge itself caused the deterioration. Courts have determined that COBRA applies to in-house patients as well as emergency department patients, while HCFA enforces COBRA primarily in cases of ED admissions that are not yet stabilized when they are transferred or discharged.

- ***Not transfer patients who are potentially unstable if the hospital has the capabilities and the physical capacity to treat the patient.*** Patient may only be transferred under COBRA for medical necessity. Physician convenience or preferences are not permissible reasons for transfer.

- ***Maintain an on-call system to provide coverage to be available to assist stabilizing patients.*** The on-call list must include every specialty privileged in the hospital; unless too few physicians exist in a specialty to provide coverage on-call (special rules apply). A named individual must be responsible for call at a given time in a given specialty, and the call list must be conspicuously posted in the ED at all times. An accurate record of each on-call list must be maintained for 5 years. On-call physicians must respond to the hospital and render evaluation and care in the hospital - it is not permissible to send patients to a specialist's office for definitive care.

  If it is necessary to transfer a patient because an on-call physician failed or refused to come in, the Emergency Physician must list the name and addresses of the on-call physician in the transfer documentation. This results in the receiving hospital reporting the incident for COBRA investigation, with the resulting likelihood that the hospital and on-call physician will be cited for COBRA violation. Failure to list the name is a specific violation which may result in hospital, ED physician, and on-call physician being cited.

- ***Provide medically appropriate transfers where the patient is transferred for medically necessity.*** This process requires:

  A. Physician certification that at the time of transfer, the risks of transfer are outweighed by the reasonably anticipated benefits. Specific individual risks and benefits must be listed and the record must support them; OR
  B. Written request for transfer by the patient, without suggestion or pressure of the hospital or physician to induce the request.
  C. Advanced acceptance by the destination hospital, which is documented in the record.
  D. Written consent to transfer from the patient.

E. Transfers by appropriate medical transfer vehicle - i.e., private passenger vehicles are not permitted unless ambulance transport has been refused in writing.
F. Medical orders for appropriate attendant personnel - i.e. must have the licensure and skill level to maintain and/or initiate/re-.initiate ordered treatment or drugs and deal with the known potential adverse affects of the procedures or drugs.
G. Medical orders for appropriate life support equipment - i.e. field ambulance equipment may not be sufficient for a specific transfer.
H. Copies of medical records, tests, and x-rays must be sent with the patient unless delay for records might jeopardize the patient in which case records must be transported to the receiving hospital as soon as completed and on a STAT basis.

- ***Accept requests for in-coming transfer if the hospital has the specialized capabilities needed by the patient, and the transferring hospital is relatively less able to care for the patient.*** The hospital may decline a patient who does not need the services of the facility, who can be adequately and completely cared for at the originating facility, or when the hospital lacks the physician capacity to handle the patient. Hospitals are at great risk, if they decline a transfer. Where the hospital has the ability to utilize on-call personnel, it must do so to accommodate the patient. Where the hospital has handled patients in excess of its stated capacity on prior occasions, it is required to accept the patient. Where the hospital could use step-down beds or early discharge to accommodate a patient, it must do so. Patients must be accepted without regard to means or ability to pay, or the third party payer involved.

Scope of Medical Screening Examinations

The scope of medical screening exams (MSE) under COBRA is to provide all necessary testing and on-call services within the capability of the hospital to reach a diagnosis that excludes the presence of legally defined EMC's. The term EMC will be defined below. Exams that are "*complaint based"* and fail to address affected and potentially affected system and known chronic conditions have been held inadequate by HCFA.

Federal law basically requires all necessary definitive treatment to be rendered and that only true follow-up care (maintenance care) may be referred to physician offices and clinics.

Triage of patients without provision of medical screening exams is not acceptable under COBRA.

Screening of psychiatric patients must be sufficient to rule out underlying trauma, disease or organic condition that might have caused or contributed to the presenting symptoms.

Screening of intoxicated individuals must be sufficient to rule out medical, toxic, psychiatric, and trauma causes for the apparent state. Use of non-physician medical screening personnel is discouraged but not prohibited. Screeners must have the capability to order tests and diagnose to meet the screening criteria. Specific actions are required to authorize non-physician screening, and HCFA does not have to accept screening plans set up under the criteria for non-physician screening in individual cases - i.e. the system will be judged retrospectively in case.

Based upon past citations by HCFA, advisory letters from HCFA, and past litigation, it is our considered opinion that a medical screening examination should contain the following elements:

Log entry with disposition
Triage record
On-going vitals recorded
Oral history
Physician exam of affected systems
Physician exam of potentially affected systems and known chronic conditions
Any testing necessary to rule out the presence of legally defined emergency medical conditions
Use of on-call personnel PRN to complete above
Use of on-call physicians PRN to diagnose and stabilize patient
Discharge/transfer vitals

Adequate documentation of all above

We recommend against the use of non-physicians for emergency department medical screening examination. We urge the use of objective clinical criteria and scoring systems for OB screening in the Labor and Delivery department.

Emergency Medical Conditions (EMC)

The term EMC is much broader under COBRA than under typical medical usage. This is a significant underlying cause for many COBRA violations. The term includes any conditions that are a danger to the health and safety of the patient or unborn fetus: or may result in a risk of impairment or dysfunction to the smallest bodily organ or part if not treated in the foreseeable future; and includes a specific range of itemized conditions:

A. Undiagnosed, acute pain sufficient to impair normal functioning is an EMC;
B. Pregnancy with contractions present is an EMC - i.e. legally defined as unstable;
C. Symptoms of substance abuse - i.e. alcohol ingestion;
D. Psychiatric disturbances - i.e. severe depression, insomnia, suicide attempt or ideation, dis-associative state, inability to comprehend danger or to care for one's self.

Managed Care Conflict with COBRA

Federal law permits the obtaining of information in the routine registration process, but the information may not be acted on - i.e. no advance approval may be obtained from a third-party payer or employer. Calls to insurance companies or employers have repeatedly resulted in citations for COBRA violation. Handing a phone to the patient and having then call their insurance has likewise resulted in citations. HCFA specifically states that third-party payers do not have the authority to authorize treatment and those hospitals that follow HMO and insurance company procedures and directions do so at their own risk and will be held to COBRA compliance.

Patient transfers decisions may not be based on HMO/PPO direction or policy. Standing systems, such as trauma center programs, do not exempt participating hospitals from COBRA compliance, although certain Regional Offices are more flexible with community-based plans for services than others. Transfer documentation is required in every region, however.

State waivers for Medicaid do not waive COBRA. Many waiver states have adopted managed care and gate-keeper models to discourage emergency department use. Compliance with these systems has resulted in significant enforcement action against hospitals in the past year under COBRA.

A COLLECTION POLICY

It is most important that the hospital have a clearly defined collection policy. The policy should be approved by the Board of Trustees, supported by the administration, implemented and enforced by the financial services management team, including the full support of the Patient Financial Services Management. The policy must be distributed (and effectively communicated) to all Patient Financial Services personnel that have responsibility for:

1. Gathering or collecting financial and social data that is necessary for financial evaluation (e.g., pre-admission/admission staff, financial counselors, patient service representatives, etc.),

2. Evaluating or assessing the financial data (i.e., third party coverage/benefits, patient's ability to pay, etc.) to determine adequacy of financial coverage for hospital stay,
3. Determination of special third party requirements and/or limitations such as assignments, special eligibility stipulations, etc.),
4. Calculation of amounts that will be due from patient or responsible party,
5. Billing and/or collecting of amounts due from patients, third party payers or other guarantors, and
6. Management of the functional areas outlined above in items 1-5.

The approved collection policy should be in writing and cover at least the following areas:

1. The third party - coverage/benefits that will be acceptable (when assigned by the patient or guarantor) to the hospital, and the terms under which this coverage will be accepted (i.e., verifiable benefits, identification card, etc.),
2. The payment portion that is expected from the patient or guarantor (self- pay portion),
3. When the self-pay portion will be due and collected (i.e., at admission, in-house, discharge, etc.),
4. When third party coverage is expected to pay and when account will transfer to self-pay due to delay in third party payment,
5. The required billing schedule for third parties and self-pay amounts,
6. Follow-up billing requirements; and
7. Determination of uncollectible accounts and guidelines for disposition of same, including how Hill Burton eligibility is determined, and procedure to identify these accounts and/or Charity Care.

Reviewing the Pre-Admission/Admission

In-house collection personnel must assume responsibility for reviewing all admissions (records) for completeness, accuracy, and potential collection problems (EXCEPTIONS, REFERRED TO EARLIER). For patients pre-admitted, there is opportunity to perform the review in advance of the patient's admission, check for possible open accounts, anticipate collection problems, and establish appropriate requirements for admission.
Whether the in-house personnel complete their review prior to admission time or immediately following admission, this review can be more objective and serve as an additional control when conducted outside the admission process. In no way is the procedure intended to diminish the responsibility of pre-admissions or admission personnel to obtain complete and accurate financial data and enforce hospital collection policy.
Listed below are activities that should occur when the patient has been admitted or pre-admitted:
The pre-admission records should be reviewed for completeness and accuracy.

Determine immediately who will be financially responsible for the account

a. Patient
b. third party
c. guarantor, other than patient
d. relationship of guarantor to patient (i.e., employer, spouse, parent)
e. work-related injury (liability verified)
f. other liability (accident)

Determine that appropriate guarantor assignments and authorizations are on file for timely collection of third party payment.
Verify third party coverage/benefits and billing addresses.

Compute (or verify) that all estimated amounts due from patient or guarantor directly have been collected at time of admission or arrangements have been made for collection during hospital confinement or at discharge.
Review open account listing to determine if there are open inpatient or outpatient accounts that have not been paid or appropriate arrangements made (for patient or guarantor).
If patient or guarantor has been inpatient or outpatient previously, verify past payment history to assist in evaluating potential risks.
Notify appropriate financial counselor and/or management where collection problems are anticipated; determine disposition and/or alternatives, (i.e., other sources of financing accounts, transfer to other facilities if resources available for such cases).

In-house Billing

1. Compute and deliver weekly bills to patients (guarantors) for self-pay amounts due.
2. When the patient's stay, amount of charges and third party coverage warrant, send an interim bill to the third party. As a matter of policy interim third party billing should always be done except when third party regulations prohibit:
    a) if the length of stay is 30 days or more;
    b) if dollar amounts exceed limits determined by the hospital;
    c) if benefits are exhausted during the stay and final bill can be created for third party; and
    d) if third party regulations require such billing.

Adherence to the foregoing guidelines and procedures will support an assertive program of cash flow management that is critical to your hospital.

DISCHARGE CONTROL AREA

The discharge process offers the final "on site" opportunity for hospital personnel to collect information, assignments and/or authorizations and monies due the hospital. It is most important to complete information and collect monies or secure the debt (if unable to collect the balances due) prior to the patient and/or guarantor leaving the hospital. There are definite activities that should occur at discharge, but, the specific limitations should also be recognized at this control area.

Limitations at the Discharge Control Area

- The patient is convalescing and not usually in the best physical and emotional state to be handling financial affairs;
- Not time for verification of data at discharge point - must take everything at face value;
- No tangible property that can be held;
- Patients sometimes displeased with services or treatment;
- Hospital's strong desire to preserve the humanitarian image limits aggressiveness in collection, especially at discharge time;

- Some hospitals are unable to give an accurate final accounting of charges (bill) at discharge time;
- Occasionally, when benefits have not been accurately determined, amount due from patient cannot be exactly computed.

Discharge Activities

Even with the limitations listed above, the following activities should occur at the Discharge Control Area:

1. Verify Third Party Coverage, Benefits, Billing Addresses and any changes in coverage.
2. Compute self-pay portions of the account and request full payment from the patient (unless prior extended payment arrangements have been made).
3. Review the hospital's collection policies with the patient (guarantor), especially those portions that directly relate.
4. Clearly express to the patient (guarantor) their liability for charges -including that which third party fails to pay.
5. If payment is not made on self-pay balances, secure "promissory note" with appropriate repayment terms negotiated with the patient and/or guarantor.
6. Encourage use of alternative payment financing such as bank charge cards or bank loan/credit, (of course, these plans should be made in advance).
7. Alert follow-up collection control area and/or management when potential collection problems become evident at the discharge control area.

CHAPTER 2

PATIENT FINANCIAL SERVICES AND COLLECTION ACTIVITIES

Follow-Collection

Special Situations in outpatient area

Legal aspects of collecting

Federal regulations

Summary

CHAPTER 2

PATIENT FINANCIAL SERVICES AND COLLECTION ACTIVITIES

THE FOLLOW-UP COLLECTION CONTROL AREA

The greatest volume, in number and dollars, of the hospital's Patient Accounts Receivable are collected through the Follow-up Collection Control Area, typically located in the hospital's Business Office. If each of the various functional control areas previously described in Chapter 1 have been successful in accomplishing their objectives, then accounts being transferred for follow-up collection are:
to be collected from a third party payor.
to be billed to the patient (guarantor) under an established agreement or note, or
a combination of third party and patient (guarantor) billing,

The hospital's objective in the follow-up collection area is to obtain the balance of monies due the hospital as quickly as possible.

The Follow-up Collection Policy

To encourage a consistent, assertive procedure that is adhered to in follow-up collection activity, a clearly defined written policy should be adopted by the hospital that addresses the following:

1. The breakdown (for analytical purposes) of patient accounts between the appropriate, major financial classes (i.e. major third parties and due from patients)·
2. The required billing schedule (both routine and special) for
3. initial billing (guarantor),
4. third party billing,
5. Joint billing (guarantor and patient).
6. Time permitted for third parties to pay before transferring back to patient responsibility
7. Criteria for judging account uncollectible (as bad debt) and transferring to an outside collection agency or executing legal action against the debtor to protect the hospital.
8. Establishment of criteria for evaluating other types of uncollectible balances that should be deducted timely from the accounts receivable, such as charity care (the medically indigent patients not covered under other programs), courtesy allowances and contractual allowances.
9. Establish an effective analytical reporting system that keeps management informed relative to the disposition of all patient accounts receivable.

Collection Follow-up Activities

Listed below are activities that should occur in the collection follow-up control area of hospitals:

1. Where possible, determination should be made as early as possible as to the collectibility of the patient account.
2. When the collectability is determined, the account should immediately be written off hospital accounts receivable and reassigned appropriately (i.e. to collection agencies if "skip" of bad debt is indicated or to other appropriate write-off category).
3. Third party billing should be mailed to intermediaries or carriers as promptly as possible and no later than 4 days after discharge (except in most unusual circumstances - which should be documented and justified).
4. Balances due from patients or guarantors should be billed immediately upon discharge within 24 hours (or as soon as hospital audit period is complete).
5. Follow-up (tracers) should be sent on a routine schedule for both third parties and self-pay account balances; please refer to specific tracer procedures for third parties as outlined in subsequent sections of this manual.
6. Follow-up statements should be sent on approximately 21-day cycles with no more than three (3) cyclical bills after the itemization of initial billing is sent until a final bill (before transfer to legal department or outside collections). This type of billing interval provides:
7. only about 60-65 days until disposition should be made of the account,
8. supports more assertive collection techniques and thus improves cash flow,
9. better competes with other creditors for the debtor's dollars; and
10. staggers the billing time each month to avoid billing routine becoming too familiar to debtor.
11. Telephone follow-up should be planned on an exception basis, such as:
12. all self pay account balances of established amounts (Example: Balances $500 or greater) with no payments or other response in 30 days;
13. all third party account balances over established limit (Example: $1000) not paid in 21 days.
14. Larger third party and self-pay balances must be followed more closely, using telephone contact and, if appropriate, "certified" mail; the hospital should set the guidelines in these cases to assure appropriate follow-up is carried out in these cases; (NOTE: original billings on the accounts may be handled in a similar manner to assure more special handling).
15. Special collection letters should be used on a regular basis, where collection problems exist, but should not be routine or suggest actions that will not be carried through (i.e. do not indicate the account is to be transferred to an attorney unless you plan to do so).

SPECIAL SITUATIONS IN OUTPATIENT AREAS

Although almost everything presented in the previous sections have applied to both inpatient and outpatient control areas, there are special characteristics, circumstances, and activities that are unique to outpatient collection control that bear special mention.

Characteristics of Outpatient Accounts

1. Three types (sources)
2. Emergency Service Department
3. Diagnostic and treatment Clinics
4. Physician referrals for Diagnostic Treatment Services
5. Limited control of patient flow
6. Emergency patients generally serviced without regard to ability to pay (should not prevent assertive collection policy from being enforced)
7. Clinic patients are often part of certified teaching program; limited ability to pay usually; can control some elective services based on ability to pay in coordination with medical staff;
8. Physician referred outpatients can generally be scheduled and are often of an elective nature.
9. High volume of outpatients served (relative to inpatients).
10. Lower dollar charges (less revenue generated)
11. Generally, less third party coverage for outpatient services because of high deductibles and co-insurance amounts generating more self-pay balances.
12. Historically, outpatient accounts are less collectible and generate a higher percentage of bad debt.
13. With such brief encounters with the patient, there is very limited opportunity to assess and verify financial situations.

Suggested Special Procedures for Outpatients

To accommodate the special characteristics of outpatients described above, listed below are suggested collection control activities:

- All self-pay amounts for services rendered at each outpatient control area should be collected at time of service (with caution not to interfere with emergency care); cash, check or bank card should be the acceptable modes of payment.
- Where outpatient services can be scheduled, (i.e. clinic services and elective referral outpatients, short-stay surgery, etc.) pre-admission procedures should be encouraged
- Physician office scheduling/information sharing,
- mail out pre-admission forms (time permitting),
- telephone interview.
- Hospital financial requirements should be clearly communicated to outpatients at all service areas, registration points, and during pre-admission if applicable.
- Positive identification should be required at all registration control points.
- Where third party coverage/benefits are accepted (when verified), accuracy, completeness of information, assignments and authorizations must be present.
- Where possible, records of third party outpatient coverage in the hospital's service area should be obtained and recorded in outpatient registration areas to assist in determination of coverage; where confirmation cannot be obtained it is best to require cash payment for services; (hospital personnel can offer assistance in completion of the patient's claim form to file with their carrier to maintain good public relations) where courtesy billing is offered.
- Billing schedules and follow-up procedures should be similar to those described for inpatients with emphasis on efficiency and timeliness; automated processing should be used where possible with only exceptional cases (larger dollar amounts) receiving additional personal follow-up.
- If collection problems are obvious, refer to a legal department or outside collection agency as quickly as uncollectible determination is made.

LEGAL ASPECTS TO COLLECTING

This section addresses the legal aspects of patient accounts. It considers the legal aspects of collecting and the hospital's and the patient's rights from the standpoint of federal and state laws.

Consent for Treatment

It is important that in any type of patient care 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 - 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.

Liability for Payment

Generally the legal ability for a hospital to collect a bill depends upon a valid contract. If the treatment being provided violates the law, then there is no binding and enforceable contract. From a legal point, five elements must exist for a receivable to be valid and collectible. The five elements of an enforceable contract are:

1. Requirement for competent parties - Individuals declared incompetent by a court of law, minors, and anyone intoxicated with drugs or alcohol cannot enter into an enforceable contract.
2. Need for an offer and acceptance by mutual consent.
3. Consideration - Consideration is the actual treatment of the patient. Once the treatment has been provided, the patient is legally bound to pay the hospital. This means that there must be a meeting of the minds in terms of what is being offered to the patient.
4. Proper legal form - Not all contracts have to be in writing. However, it is important that there is written documentation that verbal discussion took place.

5. 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.

In Alabama a minor becomes an adult at the age of 19 and is responsible for his or her own bills. Parents are no longer liable for bills incurred by children who are over the age of 19 unless the parent has signed an agreement to pay the bill. However, each parent is jointly and severally liable for the medical expenses of their children despite separation, custody or divorce agreements. If possible, written agreement to pay should be signed by each parent.

An emancipated minor is a child who has left home and is totally independent of his parents. The parents cannot provide any type of support to the child for the child to qualify as an emancipated minor. If the child is truly emancipated, the parents' duty to support the minor has been terminated,
If the patient is married, it is preferable to have both husband and wife sign an agreement to pay.
When there is a third party guarantor, the promise to pay must be in writing. The debtor is primarily liable for the debt, and the guarantor is secondary liable.

Hospital Liens

Lien cases should be recognized at the time of admission. The admission's office must determine that a third party may be liable for the injuries to the patient. Some of the most common cases where liens are involved are automobile accidents, gun shot wounds, slip and fall cases, and work-related injuries not covered by Worker's Compensation. The patient's file should indicate that a lien should be filed at the time of discharge.
When the patient is discharged, the patient's file should be sent to the Patient Financial Services for the lien to be prepared.
The lien must be filed with the Clerk of the Probate Court in the county where the accident occurred. A copy of the lien as recorded must be sent within one day of the filing to the person or corporation claimed to be liable for the injuries in the lien.

Hospital Lien Law

The Alabama Hospital Lien Law, Sections 35-11-370 through 35-11-373, Code of' Alabama, 1975, consists of four basic principles:

1. Lien is for hospital care and treatment of person injured by a third party who enters the hospital within one week after receiving such injuries,
2. Lien is against any settlement accruing to the patient as a result of the injuries
3. A copy of the lien must be sent by registered or certified mail within one day after filing the lien to any person or corporation liable for the damages, and
4. The date the lien is filed or "perfected" determines priority in claiming settlement proceeds. (Guin v. Carraway Methodist Medical Center, Supreme Court of Alabama 89-1838, June 21, 1991)

Lien Content

A Hospital Lien must contain the following:

1. Name and address of patient as it appears on the hospital record,
2. Name and address of hospital,
3. Name and address of the operator of the hospital,
4. Date of injury,
5. Dates of admission and discharge of patient,
6. Amount of the hospital bill,
7. Names and addresses of all persons or corporations allegedly liable for the injuries to the patient, and
8. The lien must be notarized and signed by the person preparing the lien (Patient Financial Manager or other authorized person/representative).

If settlement is reached between the patient and the third party, the lien must be paid or a direct cause of action accrues to the hospital against the third party.
The hospital may proceed directly against the patient for the amount of the hospital bill.
The hospital is not precluded from taking action against the patient directly or from accepting payment from a third party source while the lien is pending. However, if the hospital bill is paid, the lien must be marked "paid and satisfied" and the satisfaction should be filed with the Clerk of the Probate Court where the lien is filed.
Patient Financial Services should keep in touch with the patient and/or liability carrier to determine when a settlement is reached between the patient and the third party. An example of a hospital lien is shown on the next page.

NOTICE OF HOSPITAL LIEN
GENERAL HOSPITAL

STATE OF ALABAMA
JEFFERSON COUNTY

Notice is hereby given, as provided by the laws of the State of Alabama that General Hospital of Birmingham, Alabama, which operates a hospital of the same name at the same address, claims a lien for the reasonable charges of hospital care, treatment and maintenance received by _____ of _____against all causes of action, suits, claims, counter claims, and demands accruing to the said _____or his legal representative, and against all judgments, settlements and settlement agreements entered into by virtue thereof and or account of such injuries giving rise to such causes of action, suits, claims, counter claims, demands judgments, settlements or settlement agreements and which necessitated such hospital care.

Amount claimed: _____ Date of admission: _____
Date of injury: _____ Date of discharge: _____

The names and addresses of all persons, firms or corporations claimed by such injured person, or the legal representative of such person, to be liable for damages arising from such injuries are, to the best of the claimant's knowledge, as follows:

Name: _____- Name:_____
Address: _____ Address: _____

Name: _____- Name:_____
Address: _____ Address: _____

General Hospital of Birmingham, Alabama

By:_____

Before me, _____, a Notary Public in and for the County of Jefferson, State of Alabama, personally appeared _____, who being by me first duly sworn, doth depose and say that he is the authorized representative for the claimant, and as such has personal knowledge of the facts set forth in the foregoing statement of lien, and that the same are true and correct.

Subscribed and sworn to before me this _____ day of _____20____

_____
Notary Public

Bankruptcies

Bankruptcy refers to a situation in which a person is adjudged insolvent by a court of law. The person's property is administered for and divided among his creditors. The fact that a debtor has filed bankruptcy proceedings indicates that he doesn't want to deal with his creditors or be obligated to pay his creditors. There are several types of bankruptcies. The types of bankruptcies are:
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 earner's proceedings where the debtor is allowed to reorganize debt and restructure a payment plan with the Bankruptcy Court.
There are several steps to follow in dealing with a bankrupt debtor.

1. You should pull the account and flag it as a bankrupt account. You should stop all routine collection efforts.
2. File a proof of claim
3. Attend the first meeting of creditors.
4. 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.
5. Document your conversations with the patient. If the patient represented by a lawyer, it is illegal for the hospital to contact patient. The patient's attorney should be contacted.

Facts on Chapter 13 Bankruptcy Claims

Below are facts that are important in handling Chapter 13 bankruptcy claims:

1. If the medical facility's account with the patient is not listed by patient who is filing bankruptcy, the medical facility may proceed with normal collection efforts.
2. A co-signer or co-debtor cannot be required to pay if the responsible party has filed a petition for bankruptcy listing the hospital as a creditor.
3. If a motion for discharge is issued, the hospital may resume collection efforts.
4. 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.
5. After the debtor is discharged, any remaining balance cannot be pursued for collection. The unpaid balance must be written off and the account closed.
6. The creditor does not have to attend the meeting of creditors to be eligible to receive payment on claim.
7. Any new charges incurred by the patient after the petition has been filed are eligible for collection.
8. 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.

Estates

When the patient is deceased, there are procedures that should be followed to collect the debt. Legal notices regarding obituaries that are listed in the newspaper are a source to determine if an estate has been opened. If an estate has not been opened, a caveat can be filed to insure notification should filing be made later. Newspapers will publish public notice to creditors announcing acceptance of clams against the estate.

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. Wait for dispersal of funds. If not paid within a few months, look for a public notice of hearing to probate and disperse remaining properties, any creditor who filed a claim in the allowed time but was not paid may attend the meeting to voice a complaint to the judge and executor of the estate. 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:

1. Fees for executor and attorney of executor.
2. Reasonable funeral expenses.
3. Family allowances.
4. Homestead allowances.
5. Exempt property.
6. Taxes.
7. Medical and hospital expenses of the last illness.
8. Other Claims.

A person who dies without a valid will is considered "intestate." Special state 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' 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, other heirs, any of the creditors.

An example of a statement of claim to be used to file an estate claim follows on the next page.

ESTATE CLAIM

STATE OF

COUNTY OF

Personally appeared before me _____, a Notary Public, in and for 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 _____ Dollars, 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 _____ allowing all proper credits, and now constitutes a subsisting demand for _____ Dollars, and that affiant is duly authorized to make this affidavit.

_____
Betsy Green, Office Manager

Subscribed and sworn to before me, this _____ day of _____, 20___

_____
NOTARY PUBLIC

Garnishments

A garnishment is the most commonly used remedy for satisfying a judgment. Cash earnings of the debtor are seized and the debtor no longer controls the debt payment process.
When a garnishment is used, the employer of the debtor or the bank of the debtor will collect all the money until the debt is paid. Failure of an employer or bank to comply with garnishments may cause them to become liable for the debt. Wages and salaries can have 25 percent of pay after taxes withheld. Bank accounts can have I00 percent of available funds withheld. Ail money seized is sent to the county clerk or court and paid to the creditor's attorney.

FEDERAL REGULATIONS

Truth In Lending Act

The Truth in Lending Consumer Credit Cost Disclosure Act became effective on July 1, 1969. It is also called the Consumer Credit Protection Act or Federal Regulation Z, It usually applies when interest is involved or more than four installment payments are made. The basic purpose of the regulation is to require disclosure of all direct and indirect costs, terms and conditions relating to the granting of credit. It is a consumer protection law that informs borrowers and customers as to the real cost of commercial credit.
This is a regulation not just for health care, but hospitals are affected if interest or finance charges are involved or payments exceed four installments. The Act requires the hospital to disclose all the terms of credit to include finance charges, annual percentage interest rates, and the number of installment payments expected.

Fair Credit Reporting Act

The Fair Credit Reporting Act became effective April 25, 1971. It is another law enacted for consumer protection. This act affects all institutions who issue or use reports on consumer related to the credit worthiness of that consumer. The Act provides the maximum protection of a consumer's right to privacy and confidentiality of credit reports.
The Act specifically states:

1. Who can legally use a credit report.
2. What types of information a consumer reporting agency may not report.
3. What disclosures the users and issuers of consumer reports are obligated to make to consumers and when these disclosures must be made.
4. What procedures must be followed when a consumer disputes the accuracy of information in a report agency's file.
5. What the penalties are for noncompliance.
6. Which Federal agencies are responsible for enforcement of the act.

From a hospital standpoint, it is important to understand how a credit report is to be used, what information can be released, and how to interact with consumers on what is on the credit report. If a hospital refuses to grant credit based on a credit report, the consumer (patient) must be told why credit was refused. The name and address of the agency providing the credit report must be given to the person seeking credit. The credit applicant has 30 days from the date of denial of credit to demand in writing from the credit reporting agency any information relating to the credit report
The applicant may contact the credit reporting agency to have any errors corrected and a corrected credit report issued.

Fair Credit Billing Act

The Fair Credit Billing Act became effective on October 28, 1975. This is another act for the protection of consumers, This act applies to all creditors who regularly extend open-ended credit payable in more than four payments. If a bill is sent to the patient after service is rendered, an extension of credit is not implied. The Act provided the following:

1. A patient must notify the hospital within 60 days alter a statement is mailed of any error.
2. The hospital must respond to the complaint within 30 days of receiving it.
3. The error must be corrected or the accuracy of the statement explained to the customer within two billing cycles or a maximum of 90 days.

If any of the above time frames are not met, a patient's rights are violated and forfeiture of collection of the account may occur.

Fair Debt Collection Practices Act

This Act was enacted in 1978 after Congress found that there was evidence of the use of abusive, deceptive, and unfair debt collection practices by many debt collectors, This Act generally does not apply to hospitals. However, hospitals should be aware if their collection agencies are complying with the act. This Act provides that legal action against the customer should not be threatened unless legal action is planned or the collector normally brings suit on claims for similar accounts. This act bars unscrupulous conduct of collectors.

Another practice under the Fair Debt Collection Practices Act is that a collector cannot and should not hold a check postdated for five days or more unless the patient is notified in writing before the check is deposited.

SUMMARY

In summary, *REMEMBER*, the patient is responsible for charges incurred when services are rendered. Billing third parties and/or follow-up billing to the patient is a courtesy the hospital has extended to the patient and third party. The cost of carrying patient's accounts receivable for third parties and patients is contributing very significantly to the already rising cost of healthcare delivery.

Hospitals have a fiscal responsibility and accountability to all patients served to minimize the working capital needed to carry accounts receivable due from patients and third parties. Therefore· hospitals must make every effort to demonstrate their responsible role in establishing an assertive collection program using the talents of well-trained, responsible personnel in the Patient Financial Services

This Training Manual, when used as a reference resource should be useful in accomplishing hospital objectives in the collection/patient accounting control areas.

REVIEW QUESTIONS – CHAPTER 2

Follow-up Collection Control Area:

What functional control area collects the greatest volume of the hospital's Patient Accounts Receivable?
Answer: Collection Control Area

The hospital's objective in the follow-up collection area is to obtain the balance of monies due quickly.
Answer: True

Follow-up Collection Policy:

Should a hospital adopt a clearly defined written collection policy?
Answer: Yes

The required billing schedule should be addressed in the policy.
Answer: True

Collection Follow-up Activities:

Gross income should be calculated in the collection follow-up control area of the hospital.
Answer: False

Characteristics of Outpatient Accounts:

The following sources are outpatient areas: Emergency Department, Diagnostic Clinics, and Physician referrals for Diagnostic Services.
Answer: True

Historically, outpatient accounts are less collectible and generate a lower percentage of bad debts.
Answer: False

Suggested Special Procedures for Outpatients:

Cash, checks or bankcards should be the acceptable method of payment.
Answer: True

Positive identification should be required at the pre-admission control area only.
Answer: False

Legal Aspects to Collecting:

Must a patient give consent for treatment?
Answer: Yes

What are the four types of consents that occur?
Answer: Actual or Expressed Consent, Implied Consent (in fact), Implied Consent (by law), and Informed Consent.

Of the four types of consent, which is the most desirable?

a) Actual or expressed consent
b) Implied consent (in fact)
c) Informed consent
d) Implied consent (by laws)

Answer: C

Name one person who can give consent.

Answer: Competent Adult, Guardian, Emancipated Minor, Parents of minors and Person(s) with durable Power of Attorney

Generally, the legal ability for a hospital to collect a bill does not depend upon a valid contract.

Answer: False

Name one of the elements of an enforceable contract.

Answer: Requirement for competent parties, Need for an offer and acceptance by mutual consent, Consideration, Proper legal form, Legal subject matter

In Alabama, a minor becomes an adult at the age of 21 and is responsible for his or her own bill.

Answer: False

An emancipated minor is a child who has left home and is totally independent of his or her parents.

Answer: True

What are some of the most common cases where liens are involved?

Answer: Automobile accidents, gun shot wounds, slip and fall cases and work related injuries not covered by Workers' Compensation

Should a copy of the lien be sent by certified mail within one day after filing the lien to any person or corporation liable for the damages?

Answer: Yes

If settlement is reached between the patient and the third party, should the lien be paid?

Answer: Yes

The lien must be filed with the clerk of the Probate Court in the county where the accident occurred.

Answer: True

Bankruptcy refers to a situation in which a person is adjudged insolvent by a court of law.

Answer: True

What are the types of bankruptcies?

Answer: Chapter 7; Chapter 11; Chapter 12 and Chapter 13

Should you flag bankrupt accounts and stop all routine collection?

Answer: Yes

Should you deposit a partial payment from a bankrupt debtor?

Answer: No

When the patient is deceased, a statement of claim should be filed with the court in the county in which the patient resided once an estate is opened.

Answer: True

What is the most commonly used remedy for satisfying a judgment?
Answer: Garnishment

What act requires hospitals to disclose all the terms of credit to include finance charges, annual percentage interest rates and the number of installment payments expected?
Answer: The Truth in Lending Act.

The Fair Credit Reporting Act provides the maximum protection of a consumer's right to privacy and confidentiality of credit reports.
Answer: True

How long does a patient have to notify the hospital of errors on a statement?
Answer: 60 days

How many days must the hospital respond after receiving the complaint?
Answer: 30 days

Error must be corrected of accuracy of the statement explained to the customer within how many days or billing cycles?
Answer: 90 days or 2 billing cycles

When the above time frames are not met what happens?
Answer: Patients rights are violated and forfeiture of collection may occur.

What act bars unscrupulous conduct of collectors?
Answer: Fair Debt Collection Practices Act

CHAPTER 3

BLUE CROSS-BLUE SHIELD OF ALABAMA

Provider Manual

(NOTE: Information obtained from Blue Cross-Blue Shield of Alabama Manuals and Website)

REVIEW QUESTIONS – CHAPTER 3

Provider Customer Service:

How may providers participating with BCBS of AL's Preferred Medical Doctor (PMD) program access patient eligibility, benefit and claim status information?
Answer: Voice Response Unit (VRU)

What two ways may general patient account information be obtained/retrieved?
Answer: (1) Dedicated customer Service Representatives and (2) Electronic Software Connection

Provider News and Updates

What is the website from which all of the communications from BCBS of AL may be obtained?
Answer: www.bcbsal.com

Name three publications that are available from BCBS of AL.
Answer: (1) Provider Facts (2) Special Bulletins and (3) EDI Times.

Network Services Representatives

With what items are Network Services Representatives able to assist?
Answer: (1) Education and training on BC programs (2) Information concerning plan procedures and policies through town meetings and workshops (3)Physician claim filing updates and changes (4) Requirements for compliance with rules and regulations of the plan (5) Efficiencies of utilizing other services of the plan (6) Problem identification and resolution and (7) General information and implementation of changes.

EDI Services

EDI services assist with questions related to electronic connections to BCBS of Alabama. These include?
Answer:
Claim Filing
Audit Trail and Remittance Retrieval
Patient Eligibility
Benefits Information
Claim Status
Fee Schedule
Payment History Data
General Information

What are reasons why a claim rejects as a non-covered service?
Answer:
Benefit Restrictions
Type of Service
Diagnosis

Why would a claim be rejected stating service rendered after coverage terminated but the system shows the patient active?
Answer: Probably due to a retroactive update on the contract

If a claim from a remittance is not showing in the Blue Cross system, what could be the reason?
Answer: It could be due to a prefix change. Eligibility should be checked for contract updates.

Professional, Supplier and dental Claim Submitters

What are the benefits of filing electronically?
Answer:
Payments are processed at a faster rate
Receiving audit trails electronically can save time and money
Electronic audit trails provide documentation re the status of claims transmission without delay of mail.
Electronic claims submission qualifies you to receive electronic access to patient account information including benefits and eligibility claims status, fee schedule and payment history information.
Eligibility for direct deposit of the Blue Cross check.

What is InfoSolutions®?
Answer: InfoSolutions® is a Medical Information network developed to provide more complete patient health information to healthcare providers and to provide a more stable environment for electronic information exchange.

Coordination of Benefits (COB)

Why was the COB rules developed?
Answer:
To help prevent the overpayment of health and dental benefits that would occur if coverage under two plans both provided coverage independent of the other.
To establish which insurance plan will pay first (primary) and consideration of any remaining amounts not paid by the primary plan (secondary)
To reduce the possibility of members profiting from duplicate insurance coverage as well as preventing health care providers from receiving duplicate payments from two insurance plans.
To help control the rising costs of health and dental insurance.

What are the three basic COB Benefit Methods?
Answer:
Model COB
Non-Duplication COB
Secondary Limit COB

What is the difference between Group Plan and Non-Group Plan?
Answer:
Group Plan normally applies to employer-sponsored health and dental insurance. However, it may apply to any group plan by which dental, medical or other health care benefits are provided by an employer, fraternal organization or franchise insurance coverage. Group Plans generally include COB provisions and should coordinate benefits.
Non-Group Plan normally applies to individually purchased insurance. Generally, non-group plans do not coordinate benefits with other plans.

How is the Order of Benefit Determination made?
Answer:
Payment order is determined by a set of rules that were developed by the National Association of Insurance Commissioners (NAIC)
And Adopted by most state Insurance Departments (Alabama State Regulation 56a)
And Plan Administrators.

What Order of Benefits does Regulation 56 specify?
Answer: The Birthday Rule. Generally, the Birthday Rule is an accepted guide for most plans in determining the order of benefits. The Plan of the parent that has the earliest birthday in the year is primary. If the parents have the same birthday, the Plan that has provided coverage for one of the parents the longest is the primary plan

Name the types of insurance plans that are not coordinated by BCBS of Alabama.
Answer:
Non-group plans
Individual or family supplemental insurance policies
Subscriber purchased contracts
School accident-type coverage
Individual or family prepayment, group payment or individual practice claims
Federally funded insurance

How does Blue Cross coordinate with TRICARE (formerly CHAMPUS)?
Answer: Blue Cross coverage is always primary as if no other coverage exists.

Subrogation/Work-Related Injuries

What is Subrogation?
Subrogation is the substitution of one party for another when the injured party has a legal claim against another party. It allows BCBS of Alabama to recover from any other 'payer' the cost of BC's healthcare benefits.

Worker's Compensation is an exclusion in the BCBS of AL group health care contracts with the exception of a few groups that are covered under the Work Related Injury Plan. What is the prefix for these groups?
Answer: WRI (Work Related Injury Plan)

How many employees must an employer have to be required to carry Worker's Compensation insurance for their employees?
Answer: Five or more.

What does the Work Related Injury (WRI) Plan cover?
Answer: Work-related injuries and illnesses. This benefit is not subject to deductibles, copayments or maximums.

What are some of the Pre-certification Guidelines?
Answer:
Written pre-certification for inpatient hospital admission is required.
Telephone notification of emergency inpatient hospital admissions is required within 48 hours of admission.
Telephone pre-certification for elective outpatient surgeries is required.

Name some reasons why Provider Inquiry should be contacted.
If a member requests a copy of his or her claim and the reason for the request.
If a patient asks for a check that has been issued by another payer to be endorsed.
If duplicate payments from two payers are received for the same injury.

Preferred Care and Participating Programs

Describe the Preferred Medical Doctor (PMD) program.
Statewide preferred Provider Organization (PPO)
Contract has been signed by PMD physicians with BCBS of Alabama.
PMD benefits are payable only when a patient sees a PMD physician.
When a PMD patient receives services from a non-PMD physician, out-of-network contract benefits are paid.

The PMD fee schedule indicates a maximum allowance for each procedure code.
PMD doctors agree to accept as payment in full, the lower of the submitted charge or the PMD allowance on covered services.
The patient is responsible for any co-payment.
The PMD physician agrees to file all PMD claims.
Payment is made to the physician.

What are the advantages of Participation in the PMD Network to the Provider?
Answer:
Increase or maintain number of patients
Know what payment to expect
Payment for services made directly to the physician
Efficiency and timeliness in claim processing and payment
Increased communication and participation
Physicians manage their patients.

What are the advantages of Participation in the PMD Network to the Subscriber?
Answer:
No Claims to file
Less out-of-pocket expense
No restrictions in physician selection.

Why is consistent and complete documentation in the medical record essential in quality patient care?
Answer:
To determine appropriate benefits
To verify the services were rendered
To justify the medical necessity, appropriateness and quality of care provided.

What is the standard contract exclusion relative to a PMD physician treating Same Family/Household member?
Answer:
Services or expenses rendered to a member who is related to the provider by blood or marriage or who regularly resides in the provider's household should not be filed to Blue Cross.
The practice of a physician who prescribes a medication for a non-covered family member but writes the prescription for a covered family member in order for the claim to be paid is considered fraudulent.

Is it an acceptable practice for the PMD to allow a Non-preferred physicians or other allied health professionals to bill for services using his/her number?
Answer:
No, it is a violation of the PMD Agreement. Inappropriate use should be reported to the Network Integrity Unit at Blue Cross.

How long may the services of a locum tenens or covering physician for the PMD physician be billed using the PMD physician's provider number?
Answer:
If the locum tenens or covering physician replaces the physician for more than two weeks, or on a regular ongoing basis (for example every weekend), the covering physician should obtain a provider number through BC and bill under his/her own provider number.

Preferred Medical Laboratories

What are the billing procedures for referring Laboratory Work by a PMD physician?
Answer:
PMD physicians are required to refer laboratory work to a Preferred Medical Lab (PML).
When a test is referred to a PML, the PML will bill BCBS of AL directly for the test.
Benefits will be paid according to the fee schedule for PMLs.
When a test is referred to a non-PML, the non-PML will bell BC directly for the test.
Benefits will be paid under Major Medical when available and subject to the deductible and co-payment amounts.

Preferred Physical Therapy
For how long will a new physical therapist that joins the Preferred Physical Therapy Network be on provisional status?
Answer:
For two years in order to determine continued participation.

How are benefits determined for physical therapy services?
Determination is based on the member's contract benefit.
Answer:

Preferred Occupational Therapy
What are the covered services provided by the Preferred Occupational Therapy Network?
Answer:
Hand Therapy
Treatment of Lymphedema
Medical Necessity must be established.
Member contracts that do not have coverage for additional occupational therapy services will have no coverage other than hand therapy.

Primary Care Network

Whose responsibility is it to make sure the proper steps have been taken to ensure a referral to a specialist?
Answer:
The patient's responsibility

Diagnosis Codes

What is the code that is used to identify each patient's diagnosis or nature of illness or injury?
International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).

What is the Procedure Code system utilized by BCBS of Alabama?
Answer:
Healthcare Common Procedure coding System (HCPCS)

What are Modifiers?
Answer:
The CPT/HCPCS modifier is a two-character (alpha and/or numeric) code reported in addition to the CPT/HCPCS procedure code that indicates that the service or procedure performed has been altered by some specific circumstance but not changed in its definition or code.

Time Limits for Filing Claims

What are some of the current time limits for filing claims by specific groups?
Answer:
State of Alabama (group #13000) claims must be received within one year from the date of service.
Federal Employee Program (group #53533) claims must be received by December 31 of the following calendar year of the date of service.
BellSouth claims must be received within one year from the date of service.

Preadmission Certification/Pre-certification

What is Preadmission Certification?
Answer:
A process that requires a member with coverage through BCBS of Alabama to receive authorization for inpatient hospital admissions.
When applicable on group coverage, requires that scheduled/planned admissions be certified prior to the admission.
Urgent/emergency admissions require certification within 48 to 72 hours of the admission.
Not all pre-certifications for groups with BCBS of AL coverage are handled by BCBS of AL.
If another company handles the pre-certification, instructions given by that company must be followed.

If the facility is a concurrent utilization review participating (CURP) facility and the customer has PMD benefits, who is responsible for the pre-certification?
Answer:
The facility is responsible for the pre-certification.

Medical Policy

How are BCBS of Alabama Medical Policies communicated and finalized?
Answer:
Draft policies are posted on the BCBS of AL web page under the Provider Section for a 45-day comment period.
Comments may be received by e-mail, fax, or postal mail.
Claims are processed based on the draft policy recommended during the 45-day comment period.
Policies will be posted as final when all reviews have been completed.

The Alabama Caring Program for Children

What is the Alabama Caring Program for Children?
Answer:
A health benefits program for children who are ineligible for health care coverage through a public health program (such as Medicaid), who have no private health insurance, and who meet income criteria.
The goal of the program is to keep children healthy rather than responding to health problems that have already developed.

The Concurrent Utilization Review Program

CURP What is the CURP program?
Answer:
A partnership between BCBS of Alabama and participating hospitals.
The goal is to ensure appropriate and efficient use of hospital services while maintaining high quality patient care.
In participating hospitals, the delegated Utilization Reviewer is designated to carry out the medical utilization review process.
A Registered Nurse (RN) or Licensed Practical Nurse (LPN) is the delegated Utilization Reviewer for medical cases and an RN, LPN or Licensed Clinical Social Worker (LCSW@) is the delegated Utilization Reviewer for psychiatric cases.
All pertinent information in the medical record is reviewed.

Utilization review activities include identification of post-hospitalization requirements, along with appropriate referrals to personnel within the hospital and the Blue cross Individual Case Management and care Management Programs.

The BlueCard Program

What is the BlueCard Program?
Answer:
The BlueCard Program was designed for members living outside of their BCBS Plan's service area, vacationing away from home, or traveling away from home on business.
The BlueCard Program links participating health care providers and the independent BCBS Plans across the country through a single electronic network for professional, outpatient and inpatient claims processing and reimbursement.
The program allows participating BCBS providers in every state to submit claims for indemnity and Preferred Provider Organizations (PPO) claims for BCBS subscribers to their local BCBS Plan.

Where should you submit claims for any BCBS member?
Answer:
All claims should be submitted directly to BCBS of Alabama. BCBS of AL should be the sole contact for all claim submissions, payments, adjustments, services and inquiries.

What is the BlueCard Traditional Program?
Answer:
A national program that offers members traveling or living outside of their Blue Plan's area traditional or indemnity level of benefits (non PPO) when they obtain services outside their Blue Plan's Service area.

What is the BlueCard PPO Program?
Answer:
A national program that offers members traveling or living outside of their Blue Plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO Provider.

What products and accounts are excluded from the BlueCard Program?
Answer:
Stand alone dental and prescription drugs are excluded from the BlueCard Program.
Claims for the Federal Employees Program (FEP) are exempt from the BlueCard Program.

How are traditional Medicare related claims handled?
Answer:
When Medicare is primary, claims are submitted to the local Medicare carrier or intermediary.
After receipt of the Remittance Advice from Medicare, claims with BC as secondary are submitted to the local Plan if the claim has not been automatically forwarded by Medicare.

What are BCBS Medicare Advantage claims?
Answer:
Several Blue Plans have been authorized by the Centers for Medicare and Medicaid Services (CMS) to offer products that provide choices to Medicare beneficiaries along with traditional Medicare.
The Blue Plan becomes the primary payer and replaces traditional Medicare.

Where are out of state Medicare Advantage claims submitted?
Answer:
Claims are submitted to BCBS of Alabama
Medicare is not billed directly for any service rendered to a Medicare Advantage member. Payment is made directly by a Blue Plan.
CMS regulations state that a provider who accepts Medicare assignment and renders services to Medicare Advantage members from other Blue Plans will be reimbursed the equivalent of the current Medicare allowable amount for all covered services.

The Medicare allowable amount is considered

CHAPTER 4
MEDICARE

GENERAL INFORMATION
Inpatient Hospital Admission
Hospital Stay
Medicare Card
United Mine Workers (UMWA
Railroad Retirees (United HealthCare Insurance Company
Covered and Non-Covered Services
Claims Filing & Reimbursement
Prospective Payment for Hospital
Services Furnished to Inpatient of Participating Hospitals
Non-Physician Services
Billing Claims for Same Day Transfer
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Time Limit On Claims Filing
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Medicare Part A Remittance Advice
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Secondary Payer
Outpatient Surgery
Billing for Outpatient Therapy Service
Outpatient Clinical Diagnostic Lab
Screening Pap Smears
Outpatient Radiology and Other Diagnostics Services
Outpatient Observation Services
Outpatient Diabetes Education Program
Cardiac Rehab Program
Pulmonary Rehab Program
Hospital Based CRNA
Reimbursement
Medicare APC's
National Coverage Determination

Medicare, Medicaid and BCBS of Alabama

The ABN must be issued for each encounter
The ABN must be in writing and must indicate
The Issuer of the ABN must:

(NOTE: Information obtained from CMS and Cahaba GBA Manuals and Website)

GENERAL INFORMATION

Instituted in 1966; Federal Government health insurance program for people age 65+ and some people under 65 who are disabled and/or have End Stage Renal Disease. Two parts include:

- Part A – (Hospital) Pays for inpatient hospital care, inpatient skilled nursing care, and home health visits which are defined as covered by the program regulations.
- Part B – (Medical) Pays for physician services, outpatient hospital services, physical therapy/speech pathology, durable medical equipment, and voluntary home health visits.

BC/BS of Alabama is the Intermediary for Medicare Part A and the Carrier for the Medicare Part B claims in Alabama.

Medicare only covers services that are reasonable and medically necessary; no extra doctors visits, extended hospital stay, or custodial care.

Inpatient Hospital Admissions:

Spell of Illness Limitation – Beginning January 1, 1990; Beneficiary is entitled to 60 days of full coverage, followed by 30 days with coinsurance, followed by any available lifetime reserve days. (Lifetime Reserve Days are 60 days but are not reinstated once used).

Hospital Stay:

Begins on the first day the individual receives inpatient hospital services and ends the day before the day of discharge from the hospital, or death. A transfer between hospitals is not considered a discharge.

Medicare Card:

Shows name, Medicare Claim Number, sex, type of coverage and effective date. When a husband and wife are both covered, each will have a separate card and claim number.

United Mine Workers (UMWA):

When a United Mine Worker Retiree has Medicare Part B coverage, the Part B claim should be filed with UMW.

Railroad Retirees (United HealthCare Insurance Company):

The Part B claim (HCFA-1505) of a Railroad Retiree should be filed with United Health Care Insurance Company. The contract number for Medicare Railroad Retirees can be identified by an alpha prefix followed by 6 or 9 digits. All Part A claims should be filed with the Intermediary, BC/BS of Alabama.

Covered and Non-covered Services:

A service must be defined as covered before it becomes reimbursable by Medicare Part A.

Some examples of covered services are:

- Semi –private room (2-4 beds)
- All meals, including special diets
- Regular nursing visits
- Drugs furnished by the facility
- Medical supplies
- Use of appliances

Some examples of non-covered services are:

- Doctors' services (reimbursed by Medicare Part B medical insurance)
- Personal convenience items
- Private duty nurses
- Extra charge for private room (unless medically necessary or only type of bed in a facility)
- First three pints of blood in a benefit period

CLAIMS FILING AND REIMBURSEMENT

Prospective Payment for Hospitals:

The Social Security Amendments Act of 1983 required activation of the Prospective Payment System (PPS), proposed by the Health Care Financing Administration* (HCFA). PPS categorizes discharges by a method known as Diagnosis Related Group (DRG) classifications based on diagnosis, age, sex, treatment procedure, and discharge status.

Yale University, under contract with HCFA, developed 467 DRGs over a 10-year period. There are regional, rural and urban wage adjustments for the DRG rates. The rates are updated annually. Hospitals are paid the preset rate, even if they can provide the service at a lower cost.

*HFCA is now Centers for Medicare and Medicaid Services (CMS).

Services Furnished to Inpatients of Participating Hospitals:

In PPS hospitals, Part B payment could be made for services if:

No Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days before admission.
The admission was disapproved as not reasonable and necessary and waiver of liability payment was not made.
The patient was not eligible for or entitled to coverage under Part A.
No Part A day outlier payment is made for one or more outlier days due to patient exhaustion of benefit days after admission but before the cases' arrival at outlier status or because outlier days are not covered and waiver of liability payment is not made.

All hospitals are covered by this system of reimbursement except psychiatric hospitals, long-term care hospitals, children's hospitals, hospitals in Puerto Rico and/or the Federal Territories, rehabilitation hospitals and other special cases.

Non-Physician Services:

The following items are covered as hospital services under Medicare Part A.

- Lab tests
- Prosthetic devices
- Radiology services
- Total parenteral nutrition and maternal therapy
- Ambulance/Transportation for diagnostic or therapeutic services
- Primary surgical dressings
- Outpatient physical/occupational therapy and speech pathology
- Any other non-physician service

Billing Claims For Same Day Transfer:

In order for the account to pass the edits in the system the *admit*, *from* and *through* dates must be the same, the covered days are 0 and the non-covered days are 1.

Outpatient Services Treated As Inpatient Services:

Diagnostic services provided within 3 days prior to the admission date are considered inpatient services, unless there is no Part A coverage. This provision applies to all inpatient payment, not just PPS. Non-diagnostic outpatient services that are related to a patient's hospital admission and that are provided by the hospital to the patient during the 3 days immediately preceding the date of the patient's admission are also considered inpatient services. This applies only when the patient has Part A coverage. Whenever Part A covers an admission, you may bill Non-diagnostic preadmission services to Part B as outpatient services only if they are not related to the admission.

Outpatient Registration Procedures:

The Health Insurance Claim Number (HICN) is needed from the insurance card. If the patient is unable to provide it, contact the Social Security Office (SSO) for assistance. Determine the appropriate source of admission (referred by registering hospital, another hospital, another source) and the proper source of admission (referred by a physician, clinic, HMO, hospital, transfer, ER, Court/Law Enforcement).

Types of bills:

- 14X - Diagnostic tests ordered by a source other than your facility
- 13X - Consultation or therapy as a result of an encounter in your hospital

Diagnostic Services – Examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition.

Encounter – Direct personal contact in the hospital between a patient and physician to order or furnish services for diagnosis or treatment. This does not include telephone contact.

If an outpatient is referred to another provider, you are responsible for arranging for services with the other entity. You are not required to follow up on the verification of these services, only that the initial contact was made. When a patient has follow up visits, each will be treated as a separate encounter. The HCFA-1450 (UB-04) claim form is used for filing Medicare

Part A and inpatient services covered under Part B where no payment is possible under Part A.

Medicare Claims Filing For Physician Services:
HCFA-1505 – Used when submitting Medicare Part B claims.

All claims for Medicare covered services that are a result of a referral require the physicians name and Unique Physician Identification Number (UPIN). All physicians must obtain a UPIN even though they may never bill Medicare directly. When a claim involves multiple referring/ordering physicians, a separate HCFA-1505 claim form must be used for each one. If a physician has not been assigned a UPIN, a surrogate UPIN should be used temporarily (except for retired physicians). The diagnosis must be identified using ICD-9-CM codes. Up to 4 codes may be listed in priority order. A 2-digit Place of Service (POS) code, as well as a HCFA Common Procedure Coding System (HCPCS), should be used to identify location and services rendered. For anesthesia, hours should be converted into minutes.

Time Limit On Claims Filing:
The fiscal year runs October 1 thru September 30. The filing limit is always the end of the next calendar year following the fiscal year. For example, for services that are rendered between October 1, 2002 and September 30, 2003, the claim must be submitted by December 31, 2004.

MEDICARE PART A DEDUCTIBLE & COPAYS

YEAR	INPATIENT DEDUCTIBLE	CO-INS DAY 61-90	LIFETIME RESERVE 60 DAYS	SNU CO-INS DAY 21-100
2011	1132.00	283.00	566.00	141.50

PART B MEDICAL INSURANCE

DEDUCTIBLE	CO-INSURANCE
$162.00 Each Calendar Year Beginning January 1, 2011	20% of Allowed Charges ***After Deductible***

(Note: Ambulatory Payment Classification –APC's have variable co-pays)

Special Signature Requirements For Patient Authorization:
Medicare allows the servicing facility to secure the patients signature on a onetime statement to permit payment of benefits and to authorize the release of medical information. Either party may revoke this agreement or a patient's death will revoke it. The intermediary and Carrier will make periodic audits of signature files selected on a random basis.

Outstanding Claims Report:
Report received each week, which lists all outstanding claims and their status. If a claim was submitted 2-3 weeks before the generated date of the report but is not listed on the report; check audit trails for errors, review Medicare remittances to see if it was rejected/paid, and/or review mail for returned hard copy.

If a claim is listed on the report, do not rebill an account for this claim. This report should be reviewed weekly to follow the status of the account. Any account in Status 35 or Status 65 should be noted.

Status 35 – Billed with Medicare as primary insurance, but Medicare shows the beneficiary as having another primary insurance; account stays in this status until additional information is received by Medicare, which will resolve this matter.

Status 65 – Medicare is requesting additional/corrected information. Another UB92 claim form should not be sent unless specified in the request letter.

The remaining codes are for informational purposes and require no additional input from the provider.

Credit Balance Reporting Requirement (Form HCFA-838):
All health care providers participating in the Medicare program are required to submit a Medicare Credit Balance Report (HCFA-838) to the Intermediary on a quarterly basis within 30 days after the close of each calendar quarter. This is used to monitor credit balances that are due to Medicare. A credit balance is an improper or excess payment made to a provider in error.

The HCFA-838 consists of a certification page and a detail page. The certification page must be signed and dated by an Officer or the Administrator, whether or not there is a credit balance reflected. The detail page provides space for 17 claims, but it may be reproduced as many times as necessary. Credit balances attributable to Part A should be grouped separately from those attributable to Part B by reporting them on separate detail pages. No credit balances due to HCFA-1505 billing should be included. The detail pages should be submitted on computer diskette, and the certification page must be submitted in hard copy. If there are separate provider numbers for different units within the same facility, a report should be completed for each provider number.

The amount owed to Medicare is so large that immediate repayment would cause financial hardship; therefore extended repayment is the usual procedure. Providers must develop and maintain documentation, which shows that each patient record with a credit balance was reviewed to determine credit balances attributable to Medicare and the amount owed. Penalties may be imposed for failure in doing this or for not submitting the HCFA-838. Intermediaries will review this during audits.

Medicare Secondary Payer (MSP) requires providers to reimburse Medicare within 60 days from the date they receive payment from another payer for the same service.

Medicare Part A Remittance Advice:
After Medicare Part A claims have been processed, information is sent on Remittance Advice (RA) forms, each having a different sequence number to identify if all RAs have been received.
Medicare Part B (Physicians) Remittance:
Physicians are paid daily using the remittance, which is in a free-form format.

A weekly letter has been developed in an effort to advise providers of Accounts Receivable information, hopefully providing an audit trail of overpaid claims in which Medicare is requesting reimbursement.

SECONDARY PAYER):
If a patient has other primary insurance coverage, a claim must be filed with the primary insurer before filing any claim with Part A or Part B. All Part B claims must include a copy of the Explanation of Benefits from the primary insurance, and Part A claims should be filed electronically. The Admission Development Form must be completed for each Medicare beneficiary for whom you submit a Medicare claim, eliminating denials and delays in processing your claims.

Providers have access to current MSP information through their remote terminals by using the HIQA command function, which shows the Common Working File. Contacting an Electronic Claims Representative can also retrieve this information.

Medicare is secondary payer for services related to injuries/illnesses for which payment will be made by an automobile or liability insurance policy or plan, or under no-fault insurance. To ensure that supporting documentation is available on all accident related claims

Medicare will not pay for services rendered as a result of an injury/disease in connection with employment for employees who are covered under Workers Compensation.

Medicare will not cover services, which are in connection with Black Lung. The claim should be filed to the Department of Labor and then filed as secondary to Medicare.

When an Employer Group Health Plan (EGHP) pays benefits as primary payer but does not pay in full, secondary Medicare benefits may be paid to supplement the amount paid by the EGHP.

Medicare is secondary payer for services rendered to End Stage Renal Disease (ESRD) patients who are covered by EGHPs . (Section 4631(b)Balanced Budget Act (BBA) of 1997 permanently extended the coordination period to 30 months for any individual whose coordination period began on or after March 1, 1996. Therefore, individuals who have not completed a 18 month coordination period by July 31, 1997, will have a 30 month coordination period under the new law. This provision does not apply to individuals who would reach the 18 month point on or before July 31, 1997. they would continue to have an 18 month coordination period.

Medicare is secondary payer for individuals under age 65 who have Medicare because of disability (other than permanent kidney failure) and who are covered under a Large Group Health Plan (LGHP) based on their "current employment status".

Providers need to ensure they are using correct occurrence codes, value codes and condition codes on the UB-04
claims. Deductibles/co-payments should never be collected when Medicare is secondary.

When giving notice of a Medicare Secondary Payer credit balance, a corrected billing should be included. If a refund is included, a Health Insurance Claim (HIC) number must be with the check.

OUTPATIENT SURGERY

The Omnibus Budget Reconciliation Act (OBRA) of 1986 requires hospitals to use the HCFA Common Procedure Coding System (HCPCS) to bill for all outpatient services and significant surgical procedures. The bill must include the hospital charges for the surgery and other charges for services provided on the day the procedure is performed. If more than one procedure is performed, they should all be listed on the bill. The first procedure will pull the charges. All other codes will pull zero.

BILLING FOR OUTPATIENT THERAPY SERVICES

Outpatient therapy services may be reimbursed only if they meet all requirements established by Medicare, and they must be supported with adequate documentation (submitted on a specific form or copies of the original record).

OUTPATIENT CLINICAL DIAGNOSTIC LAB

Clinical diagnostic lab tests are paid on the basis of fee schedules. Neither deductible nor coinsurance applies to outpatient or non-patient lab tests paid under the fee schedule. A hospital outpatient is a person who has not been admitted as an inpatient, but is registered as an outpatient receiving services from the hospital.

SCREENING PAP SMEARS:

OBRA (1989) provides for coverage of screening Pap smears, but must be prescribed by the physician. Coverage is limited to one every three years unless the physician has evidence that the patient is at high risk of developing cervical cancer and the test should be performed more frequently.

OUTPATIENT RADIOLOGY AND OTHER DIAGNOSTIC SERVICES

Coverage of Outpatient Mammography Screening:
COBRA (1990) provides for Part B coverage of mammography screening. No symptoms need to be present for the examination to be covered, and it is not necessary for the exam to be prescribed by a physician. The person who is performing the mammography screening must be certified by the State. Part B deductible and coinsurance do apply.

OUTPATIENT OBSERVATION SERVICES

Observation services usually do not exceed 24 hours. These must be furnished on hospitals premises, be reasonable and necessary to evaluate an outpatient's condition, and be ordered by a physician.

OUTPATIENT DIABETES EDUCATION PROGRAMS

The education program must be hospital-based or affiliated with a Medicare approved rural health clinic, and a written description must be provided to the Intermediary. The patient must be referred by his/her treating physician, and must not have previously completed a formal diabetic education program. Formal education is allowed only once in a lifetime unless there is a compelling reason to repeat the program. This includes a maximum of 5 education sessions. These claims should be billed electronically.

CARDIAC REHABILITATION PROGRAMS

The outpatient department of a hospital may provide these programs. A written description of the program must be provided to and approved by the Intermediary. Services may be provided for up to 36 sessions, usually 3 sessions/week in a single 12-week period. Extended participation would be allowed only on a case-by-case basis, and should not exceed a maximum of 24 weeks.

PULMONARY REHABILITATION PROGRAMS This program should be hospital-based and referred by a physician. Therapy should be accomplished in group fashion. A written description is required and the Intermediary must approve it beforehand. Medical screening should be conducted to determine whether or not the patient would benefit from the program.

HOSPITAL-BASED CRNAs AND AAs

All Certified Nurse Anesthetists (CRN) and Anesthesiologist Assistants (AA) should bill Medicare Part B for any anesthesia services.

REIMBURSEMENT:

If the anesthesiologist is only directing one anesthetist, only the anesthesiologist will be reimbursed for the service. The claims may be filed electronically.

MEDICARE APC's

The Balanced Budget Act of 1997 (BBA) gave the authority for CMS (Centers for Medicare and Medicaid Services) to implement an outpatient prospective payment system (OPPS) under Medicare for hospital outpatient services, certain Part B services furnished to hospital inpatients who have no Part A coverage, and partial hospitalization services furnished by community mental health centers. The OPPS applies to facility payments only and does not include physician payments.

All services paid under the OPPS are classified into groups called Ambulatory Payment Classifications or APCs. There are currently close to 500 different APC groupings. Services

in each APC are similar clinically and in terms of the resources that are required to provide the service/procedure to the patient. Each APC has an established relative weight which, when combined with a conversion factor, determines the payment rate for the procedure. This conversion factor is used to adjust payment of the APCs based on geographic wage differences.

The assignment of the APC is determined by the CPT-4 or HCPCS code included on the bill. Some services included on the outpatient bill may not be reimbursed separately. The APC is a "packaged" or "bundled" payment that includes incidental services that CMS has determined are not separately reimbursable. Charges associated with items such as operating room, recovery room, anesthesia and pharmaceuticals (with some exceptions) are some of the services that are not eligible for separate reimbursement.

Depending on the services provided, hospitals may be paid for more than one APC for an encounter but will not be paid for those services deemed incidental. Multiple surgical APCs performed during the same operative session will be discounted, with the full APC payment being made for the procedure with the highest weight and 50% being paid for any other surgical procedure(s).

Some high-cost items and services are eligible for additional payment in addition to the APC. These "transitional payment pass-throughs" are temporary payments for certain new medical devices, drugs, and biologicals whose cost, because of newer technology, development, and research, have not been included in the APC payment rate. "Pass-through" payments were not originally a part of the OPPS system, but were created by the Balanced Budget Refinement Act of 1999 (BBRA-99) in order to prevent losses associated with emerging technology. The "pass-through" items that are eligible for additional reimbursement are reviewed and change frequently as CMS recalculates the APC payment to include the cost of the new technology. In order for a pass through item to be paid, it must appear on the bill with its appropriate HCPCS or CPT code.

Some services are excluded from OPPS. CMS has determined that these services will continue to be paid based on their respective fee schedules:

- Diagnostic Laboratory Services
- Orthotics and Prosthetics
- Chronic Dialysis (acute dialysis is covered under OPPS)
- Screening Mammograms
- Outpatient rehabilitation services (Physical Therapy, Occupational Therapy)
- Corneal Tissue

Under the provisions of the BBA, Medicare beneficiaries are responsible for coinsurance related to services paid under PPS. The coinsurance amount is initially calculated for each APC based on 20 percent of the national median charge for services in the APC. The coinsurance amount for an APC will not change until such time as the amount becomes 20 percent of the total APC payment. No coinsurance amount can be greater than the hospital inpatient deductible in a given year.

National Coverage Determination

Medicare, Blue Cross-Blue Shield of Alabama and Medicaid

National Coverage Determination – "(NCD's) explains under what clinical circumstances a service or item, is covered and correctly coded. Local contractors publish LCD's to provide guidance to the public and medical community within a specific state or group of states." (Medicare Coverage Glossary - Centers for Medicare & Medicaid Services) Cahaba GBA is the local contractor that publishes LCD'S for the state of Alabama. Each test/procedure has a CPT code which requires a supporting ICD-9 code and description.

Section 1862(a)(1) of the Social Security Act requires that Medicare patients be notified prior to service, if the test they are scheduled to receive may not be covered by Medicare.

To determine if a test or procedure meets medical necessity, the LCD'S should be reviewed via the Medicare website www.almedicare.com or from various software programs containing the LCD'S data that validates the CPT code against the ICD-9 code. Medical necessity for patient services may be validated at the physician=s office, at point of scheduling, registration and/or servicing area.

Regarding services furnished in an emergency room, an OIG/CMS (formerly HCFA) Special Advisory Bulletin published on 11/10/99 advises that "the best practice would be for a hospital **not** to give financial responsibility forms or notices to an individual, or otherwise attempt to obtain the individual's agreement to pay for services before the individual is stabilized." This is because the circumstances surrounding the need for such services, and the individual's limited information about his/her medical condition, may not permit an individual to make a rational, informed consumer decision. ABNs given to any individual who is in a medical emergency or otherwise under great duress cannot be considered to be proper notice.

Consideration should also be given to EMTALA (Emergency Medical Treatment and Active Labor Act) (Section 1867(a)(h) states that all patients must be provided an appropriate medical screening by a qualified medical person designed in the hospital bylaws or rules and regulations and prohibits a delay in providing required screening or stabilization services in order to inquire about the individual's payment method or insurance status).

If the test or procedure does not meet medical necessity per the National Coverage Determination, the patient must be notified in the form of the Advance Beneficiary Notice (ABN). An ABN is a written notice given to a Medicare beneficiary before Part B services are furnished when you believe that Medicare will not pay for some or all of the services on the basis that they are not reasonable and necessary.

The ABN must be issued for each encounter when one or more of the following circumstances exist:

- The diagnosis provided does not meet medical necessity requirements
- The test is for non approved investigative or research purposes
- The test is only paid for a limited number of times within a specified time period and this visit may exceed that limit, i.e. pap smear
- The test has not been approved by the Food and Drug Administration (FDA)

The ABN must be in writing and must indicate:

- The specific service or services that is likely to be denied, including the procedure name and CPT/HCPCS code
- The reasons why the service may be denied
- The patient's name
- The patient's Medicare number (HIC#)
- The patient/guarantor signature and date
- That you (the provider of service) are issuing the ABN and not the Medicare Program

The Issuer of the ABN must:

- Hand deliver the ABN to the patient or authorized representative
- Instruct the patient on the purpose of the form
- Determine if the patient is able to comprehend the notice. Examples include patients with Alzheimer's disease, comatosed or in a medical emergency (this list is not all inclusive)
- Ensure one of two options have been selected:
  - Option 1. Yes, I want to receive these items or services. With this option the patient agrees to receive the service and agrees to accept responsibility for cost of the service if denied by Medicare
  - Option 2. No, I have decided not to receive these items or services. With this option the patient does not receive the service and refuses to accept responsibility for cost of services.
  - Provide the patient/guarantor with a copy of the ABN and retain a copy in the patient record.

After the services are received and results coded by Medical records and the claim fails the billing edits, the physician may be contacted for additional information. If no additional diagnosis information is available to support the test/procedure and the patient signed the ABN, the claim is submitted to Medicare. If no ABN was obtained the charges may not be billed to the patient they must be written off. **Remember, the patient cannot be billed if they were not notified (via the ABN) prior to services, that Medicare may not cover the test/procedure.**

Blue Cross and Blue Shield of Alabama has Medical Policies that are based on the most current medical research available at the time of policy development. Medical Policies are listed on the Blue Cross and Blue Shield website www.bcbsal.org. They include:

- Draft medical Policies
- Alphabetical Final medical Policies
- Categorical Final Medical Policies

Per the medical Policies section on the website, 'Policies are written to cover a given condition for the majority of people. Each individual's unique clinical circumstances may be considered in light of current scientific literature. Medical policies are based on constantly changing medical science and Blue Cross reserves the right to review and update our policies as necessary.; The Medical Policies Disclaimer states that 'benefits are payable under Blue Cross and Blue Shield of Alabama health plans only in cases of medical necessity and only if services or supplies are not investigational. The following Association Technology Evaluation Criteria must be met for a service/supply to be considered for coverage:

1. The technology or treatment must have final approval from the appropriate government regulatory bodies:
2. The scientific evidence must permit conclusions concerning the effects of the technology on health outcomes;
3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives;
5. The improvement must be attainable outside the investigational setting.

Blue Cross and Blue Shield medical policies are intended to be used for some or all of the following purposes in Blue Cross and Blue Shield's administration of plans:

- Adjudication of claims (including pre-admissions certification, predeterminations and pre-procedure review
- Retrospective review of provider claims
- Provider audits
- Fraud and abuse investigations
- Other programs instituted from time to time to determine the appropriateness of payments under plans.

The **Alabama Medicaid Agency** adopted Medicare's LCD'S process August 1, 2003. LCD's are posted on the Agency's website www.medicaid.state.al.us under 'What's New'. To eliminate errors, Medicaid will not re-publish the LCD'S in its entirety but will reference the Medicare LCD'S. If there are any discrepancies they will be detailed.

Review Questions

1. The authority to establish an Outpatient Prospective Payment System was given to CMS by:

   a. the Consolidated Omnibus Budget Reconciliation Act

   b. The Balanced Budget Act of 1997

   c. The Emergency Medical Treatment and Active Labor Act

   d. The Balance Budget Refinement Act of 1999

   (Answer: b)

2. The creation of transitional pass through payments was a part of :

   a. The Consolidated Omnibus Budget Reconciliation Act

   b. The Balanced Budget Act of 1997

   c. The Emergency Medical Treatment and Active Labor Act

   d. The Balance Budget Refinement Act of 1999

   (Answer: d)

3. APCs are paid using a conversion factor to adjust payments based on geographic wage differences for the area in which the facility is located. True of False (Answer: True)

4. Which service is an example of a charge that would be considered "packaged" in the APC and would not be eligible for additional reimbursement?

   a. Operating Room

   b. Recovery Room

   c. Anesthesia

   d. All of the above

   (Answer: d)

5. Multiple surgical APCs performed during the same operative session are eligible for 100% reimbursement of the associated APC. True or False (Answer: False)

6. Transitional pass-through payments are established for any new medical device, drug, or biological technology that has not had time for its cost to be built into the APC. True or False

   (Answer: False, only high-cost items have pass through payments established)

7. Some services are excluded from OPPS and are paid using their established fee schedule. Which item is not paid using this method?

   a. Orthotics and Prosthetics

   b. Diagnostic Lab Services

   c. Radiology

   d. Outpatient rehabilitative services

   (Answer: C)

8. The coinsurance amount established under OPPS is currently set at what level?

   a. 15%

   b. 20%

   c. 25%

   d. 30%

   (Answer: b)

9. The amount of coinsurance that a beneficiary must pay is limited and cannot be greater than the hospital inpatient deductible. True or False

   (Answer: True)

10. Which entities are covered under the Balanced Budget Act of 1997 and receive their payments using the Outpatient Prospective Payment System (OPPS)?

    a. Facilities

    b. Physicians

    c. Both A and B

    d. None of the above

    (Answer: a)

Review Questions
Medicare, Blue Cross-Blue Shield of Alabama and Medicaid
National Coverage Determination

1. Describe NCD'S
   Answer: National Coverage Determination

2. LCD'S explains under what economic circumstances a service or item is covered and correctly coded. (**True or False)**
   Answer: False (clinical not economic)

3. The local contractor that publishes LCD's for the State of Alabama is:
   a. United Healthcare
   b. Cahaba GBA
   c. CMS
   d. Social Security Office
   Answer: b. Cahaba GBA

4. What federal act requires that Medicare patients are notified prior to services being rendered that their test may not be covered by Medicare?
   Answer: Social Security Act

5. Where may valid LCD'S data be found?
   Answer: Alabama Medicare Website, www.almedicare.com or any software program that contains the same.

6. Which pair best defines the LCD'S validation comparison?
   a. OIG and CMS
   b. FDA and JCAHO
   c. CPT and ICD-9
   d. ABN and HIN
   Answer: c. CPT and ICD-9

7. Define ABN
   Answer: The ABN is a written notice given to a Medicare beneficiary before Part B services are furnished when you believe that Medicare will not pay for some or all of the services on the basis that they are not reasonable and necessary.

8. Name at least one location where Medical Necessity may be validated?
   Answer: Physician's office, point of scheduling, point of registration or servicing area/department.

9. Name at least four items that must be included in the ABN?
   Answer:
   1. The specific service or services that is likely to be denied, including the procedure name and CPT/HCPCS code.
   2. The reasons why the service may be denied.
   3. The patient's name
   4. The patient's Medicare number (HIC#)
   5. The patient/guarantor signature and date
   6. That you (the provider of service) are issuing the ABN and not the Medicare Program.

10. Under what circumstance can the patient be billed?
    Answer: The patient can be billed if they were notified with the ABN prior to service that Medicare may not cover the test/procedure.

11. Medicare adopted Medicaid's LCD'S process.
    Answer: False

12. Medicaid LCD's will be posted on the Medicare website.
    Answer: False

13. Which of the following policies are found on the Blue Cross-Blue Shield of Alabama website, www.bcbsal.org?
    a. Categorical Final Medical Policies
    b. Draft Medical Policies
    c. Alphabetical Final Medical Policies
    d. A and C
    e. All of the above
    Answer: e. All of the above

14. Benefits are payable under Blue Cross and Blue Shield of Alabama health plans for investigational services or supplies based on the individual's unique clinical circumstances.
    Answer: False

15. Name at least one purpose the Blue Cross-Blue Shield medical policies are used in administration of plans?
    Answer: Any of the following
    a. Adjudication of claims (including pre-admission certification, pre-determinations and pre-procedure review
    b. Retrospective review of provider claims
    c. Provider audits
    d. Fraud and abuse investigations
    e. Other programs instituted from time to time to determine the appropriateness of payments under plans.

Review Questions OPPS

1. The authority to establish an Outpatient Prospective Payment System was given to CMS by:

    e. the Consolidated Omnibus Budget Reconciliation Act

    f. The Balanced Budget Act of 1997

    g. The Emergency Medical Treatment and Active Labor Act

    h. The Balance Budget Refinement Act of 1999

    (**Answer: b**)

2. The creation of transitional pass through payments was a part of :

    i. The Consolidated Omnibus Budget Reconciliation Act

    j. The Balanced Budget Act of 1997

    k. The Emergency Medical Treatment and Active Labor Act

    l. The Balance Budget Refinement Act of 1999

    (**Answer: d**)

3. APCs are paid using a conversion factor to adjust payments based on geographic

4. wage differences for the area in which the facility is located. True or False ? (**Answer: True**)

5. Which service is an example of a charge that would be considered "packaged" in the APC and would not be eligible for additional reimbursement?

    a. Operating Room

    b. Recovery Room

    c. Anesthesia

    d. All of the above

    (**Answer: d**)

6. Multiple surgical APCs performed during the same operative session are eligible for 100% reimbursement of the associated APC. True or False (**Answer: False**) (Full APC payment will be made for procedure with highest weight and 50% paid for any other surgical procedure(s)).

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   (**Answer: False, only high-cost items have pass through payments established**)

8. Some services are excluded from OPPS and are paid using their established fee schedule. Which item is **not paid** using this method?

   a. Orthotics and Prosthetics

   b. Diagnostic Lab Services

   c. Radiology

   d. Outpatient rehabilitative services

   (**Answer: C**)

9. The coinsurance amount established under OPPS is currently set at what level?

   a. 15%

   b. 20%

   c. 25%

   d. 30%

   (**Answer: b**)

10. The amount of coinsurance that a beneficiary must pay is limited and cannot be greater than the hospital inpatient deductible. True or False?

    (**Answer: True**)

11. Which entities are covered under the Balanced Budget Act of 1997 and receive their payments using the Outpatient Prospective Payment System (OPPS)?

    a. Facilities

    b. Physicians

    c. Both A and B

    d. None of the above

    (**Answer: a**)

REVIEW QUESTIONS – CHAPTER 4

General Information:

When was Medicare instituted?
Answer: 1966

What is the age minimum for receiving Medicare, unless disabled or End-Stage Renal Disease?
Answer: 65 years of age

What are the two different portions of Medicare?
Answer: Part A and Part B

What part deals mainly with the hospital?
Answer: Part A

Who is the Intermediary for Part A and the Carrier for Part B?
Answer: BC/BS of Alabama

Is a transfer between hospitals considered a discharge?
Answer: No

When a husband and wife are both covered by Medicare do they use the same claim number?
Answer: No, each has a separate card and a separate claim number.

When a United Mine Worker Retiree has Part B coverage, should the claim be filed with BC/BS of Alabama?
Answer: No, it should be filed with UMW.

When a Railroad Retiree has Part B coverage, should the claim be filed with BC/BS?
Answer: No, it should be filed with United Health Care.

Is a semi-private room a covered service?
Answer: Yes, and a private room is only covered when it is medically necessary.

Claims Filing and Reimbursement:

What is PPS?
Answer: Prospective Payment System

Who proposed the PPS?
Answer: CMS (formally known as Health Care Financing Administration - HCFA)

What is DRG?
Answer: Diagnosis Related Group

How often are the DRG rates updated?
Answer: Annually

If the hospitals can provide a service at a lower cost than the DRG rate, are they able to make a profit?

Answer: Yes, the hospitals are paid the preset rate. This is a way of rewarding the hospital for keeping costs down.

In PPS hospitals, if no Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days before admission, could Part B payment be made for services?

Answer: Yes

Are prosthetic devices covered under Part A or Part B?

Answer: Part A, although they are non-physician services.

When billing claims for same day transfers, should the *admit*, *from* and *through* dates be different?

Answer: No, they should be the same.

Are diagnostic services that are provided within 3 days before the admission date considered inpatient or outpatient?

Answer: Inpatient, unless there is no Part A coverage. This applies to all inpatient payment, not only PPS.

When registering a patient, what is the most crucial information needed from the Medicare card?

Answer: The Health Insurance Claim Number (HICN)

If the patient is unable to provide the HICN for registration purposes, who should be contacted to retrieve this information?

Answer: The Social Security office (SSO)

Can a telephone conversation between a patient and physician be considered an encounter?

Answer: No, an encounter is only direct personal contact.

What is a UPIN?

Answer: Unique Physician Identification Number

Which number assigned to each physician does not change regardless of the location in which he/she practices?

a) Medicare Provider number
b) Blue Cross provider number
c) UPIN
d) A & C

Answer: C

If a claim is for Medicare covered services that are a result of a referral, is the physician's name adequate identification for the claim?

Answer: No, the UPIN must also be on the claim.

If a physician will not ever bill Medicare directly, is obtaining a UPIN necessary?

Answer: Yes, it is a requirement that all physicians obtain a UPIN.

When a claim involves multiple referring or ordering physicians, can all of them be reported on the same HCFA-1505 claim form?
Answer: No, each physician must use a separate claim form.

When billing for anesthesia, how should the time be reported?
Answer: The hours should be converted to minutes.

Is a patient's "original" signature required each time to permit payment of benefits and to authorize the release of medical information?
Answer: No, a patient's signature can be secured by the servicing facility on a one-time statement.

In what ways can the secured signature statement be revoked?
Answer: Either party can revoke it, or upon patient's death.

If a claim is listed on the Outstanding Claims Report, should the account be rebilled for this claim?
Answer: No, the report should be monitored weekly to follow the status of the account.

Which 2 status codes should be noted on the Outstanding Claims Report?
Answer: Status 35 and Status 65. These both require additional information.

How often are the Medicare Credit Balance Reports due?
Answer: Quarterly, within 30 days after the close of each calendar quarter.

Who receives the Medicare Credit Balance Report?
Answer: The Intermediary

The Medicare Credit Balance Report consists of what 2 parts?
Answer: The Certification page and the Detail page.

Who must sign and date the certification page of a Credit Balance Report?
Answer: An Officer or the Administrator

How many days are covered under the Medicare Inpatient Benefit?
Answer: 60 full, 30 coinsurance, 60 lifetime

If there is no credit balance reflected on the credit Balance Report, is a signature still required?
Answer: Yes

Since the detail page of the Credit Balance Report only provides space for 17 claims, what is done with the rest of the claims?
Answer: The detail page may be reproduced as many times as necessary.

How are the credit balances arranged on the detail page of the Credit Balance Report?
Answer: Credit balances attributable to Part A should be grouped together on a separate page from those attributable to Part B.

How should the Medicare Credit Balance Report be submitted?
Answer: The detail pages should be submitted on computer diskette, and the certification page should be submitted in hard copy.

If there are separate provider numbers for different units within the same facility, can one report be used?
Answer: No, a separate report should be completed for each provider number.

Is immediate repayment of the credit balance to Medicare required?
Answer: No, the amount owed is so large that this would cause financial hardship. Extended payment is the usual procedure.

Medicare Secondary Payer (MSP) requires providers to reimburse Medicare within how many days from the date they receive payment from another payer for the same service?
Answer: 60 days

How can it be determined if all Remittance Advice (RA) forms have been received?
Answer: Each RA form has a different sequence number.

On what basis are physicians paid using the Part B remittance?
Answer: On a daily basis.

The Medicare Inpatient deductible is due every 60 days they are out of the hospital.
Answer: True

Secondary Payer:

How can a provider gain access to current MSP information?
Answer: Through their remote terminals by using the HIQA function which shows the Common Working File.

Is Medicare the primary payer for services related to injuries or illnesses for which payment will be made by an automobile insurance policy?
Answer: No, Medicare is the secondary payer.

Is Medicare the primary payer for services rendered as the result of an injury or disease in connection with employment for employees who are covered under Workers Compensation?
Answer: No, Medicare will not pay for services in this situation.

Is Medicare the primary payer for services rendered in connection with Black Lung?
Answer: No, Medicare is secondary. The claim should be filed with the Department of Labor.

Should deductibles and co-payments be collected when Medicare is secondary?
Answer: No

Outpatient Surgery:

What is the name of the coding system that all hospitals are required to use to bill for all outpatient services and significant surgical procedures?
Answer: HCFA Common Procedure Coding System (HCPCS)

CPT4, HCPCS and local level codes are methods used to describe services rendered? Answer: True

If more than one procedure is performed, should each one be listed on a separate bill?
Answer: No, they may be listed together on the same bill.

Outpatient Therapy:

In order for Medicare to pay for outpatient therapy, what 2 types of documentation are accepted to adequately support the necessity of the service?
Answer: Information can be submitted on a specific form used for this purpose or copies of the original record will be accepted.

Outpatient Clinical Diagnostic Lab:

On what basis are clinical diagnostic lab tests paid?
Answer: Fee schedules

Do the deductible or coinsurance apply to outpatient or non-patient lab tests paid under the fee schedule?
Answer: No

Is a person that is receiving services from the hospital, but is not admitted as an inpatient, considered an inpatient or an outpatient?
Answer: Outpatient

Does OBRA (1989) provide for coverage of screening Pap smears?
Answer: Yes, but a physician must prescribe this.

How often are Pap smear screenings covered?
Answer: Once every 3 years unless the physician has evidence that the patient is at high risk of developing cervical cancer.

Cardiac Rehabilitation Programs:

May the outpatient department of a hospital provide Cardiac Rehab Programs?
Answer: Yes

How many sessions of a Cardiac Rehab Program can be covered by Medicare?
Answer: Up to 36 sessions. These usually consist of 3 sessions per week in a single 12-week period.

Is participation in a Cardiac Rehab Program beyond the initial coverage allowed?
Answer: Yes, but only on a case-by-case basis. It cannot exceed a maximum of 24 weeks.

Pulmonary Rehabilitation Programs:

Why is medical screening of the patient conducted before determining coverage of the Pulmonary Rehab Program?
Answer: To see whether the patient is healthy enough not to cause additional harm.

Does the Pulmonary Rehab Program require referral by a physician in order for services to be covered?
Answer: Yes, and a written description of the program must be provided.

Outpatient Radiology:

Which part of Medicare is required by OBRA (1990) to cover mammography screening?
Answer: Part B

Do symptoms need to be present in order for Medicare to cover a mammography screening?
Answer: No

Is it necessary for the mammography screening to be prescribed by a physician?
Answer: No

Outpatient Observation:

What is the usual length of time of observational services?
Answer: 24 hours

If an observation service is to be covered by Medicare, is it required to be on hospital premises?
Answer: Yes

Outpatient Diabetes Education:

How many times may a person complete a Diabetes Education Program with Medicare coverage during their lifetime?
Answer: Once, unless there is a compelling reason to repeat the program.

What is the maximum number of sessions that are included in a Diabetes Education Program?
Answer: 5

In order for Medicare to cover services rendered, does the Diabetes Education Program have to be referred by a physician?
Answer: Yes, the treating physician must refer, along with a written description of the program.

Hospital Based CRNAs and AAs:

Which part of Medicare should CRNAs and AAS bill for any anesthesia services?
Answer: Part B

If the anesthesiologist is only directing one anesthetist, do both get reimbursed for the service?
Answer: No, only the anesthesiologist will be reimbursed for the service.

CHAPTER 5

MANAGED CARE

GENERAL INTRODUCTION

HEALTH MAINTENANCE ORGANIZATION

STAFF MODEL

GROUP MODEL

NETWORK MODEL

INDIVIDUAL PRACTICE ASSOCIATION MODEL

DIRECT CONTRACT MODEL

PREFERRED PROVIDER ORGANIZATION

POINT OF SERVICE PLAN

MANAGED CARE OVERLAYS TO INDEMNITY INSURANCE

TYPES OF REIMBURSEMENT

GENERAL INTRODUCTION

Traditional healthcare in the United States was based on a charge at time of service that a patient generally paid and then remitted to their insurance carrier for reimbursement. This 'fee-for-service', world made it extremely easy for the Hospital and Physician to bill and collect for services. It also, unfortunately, helped to contribute to increases in healthcare costs. Providers of care were encouraged by the payment system to acquire new technologies and methodologies for delivering care and passing the costs for those on to the patient. That type of system offers its recipients the highest quality of care available. It is also very expensive.

In an effort to stem the cost of healthcare, several 'Alternate,, means of delivery' have emerged. These new "Alternate Delivery Systems' attempt to take advantage of competition in the healthcare market combined with utilization disincentives to offer the quality of care that Americans have come to expect at reasonable prices.

The various types of managed health care organizations were fairly distinct until 1988. Since that time the differences between traditional forms of health insurance and managed care organizations have narrowed. Originally the two major managed care systems were **health maintenance organizations (HMOs)** and **preferred provider organizations. (PPOs).** There were also traditional forms of **indemnity health insurance**. Today, many HMOs, which traditionally limited their members to a designated set of participating providers, now allow their members to use non-participating providers at a reduced coverage level. These point-of-service plans combine HMO and indemnity system characteristics, allowing members to choose which system they want to access at the time medical services are needed.

Some PPOs that in the past allowed unrestricted access to physicians, have implemented **primary care gatekeepers**. They have also added some financial risk to their reimbursement systems. Finally, indemnity insurance plans now include utilization management features in their plans. These features were once only found in PPOs and HMOs.

Although the term ***managed care*** may not perfectly describe the current health care delivery and financing systems, it provides a convenient shorthand description for the range of alternatives to traditional indemnity health insurance. This section briefly describes some of the different types of managed health care organizations and the common acronyms used to represent them.

HEATH MAINTENANCE ORGANIZATIONS

Public Law 93-222, the Health Maintenance Act of 1973, created the framework for this delivery option.

The Federal mandate for HMOs was accompanied with a requirement that employers who meet certain size and benefit requirements, must offer an HMO to their employees.

HMOs generally attempt to reduce costs of healthcare delivery through utilization review, ambulatory surgery versus inpatient surgery, second opinions and preventive medicine.

Participants are required to use HMO facilities, physicians and hospitals for all non-emergency care. The HMO system is funded through monthly premiums paid by recipients. Since it is a "full care" service, HMOs also save administrative costs in claims handling. There are some questions that should be asked of the HMO regarding the delivery of care before participating in that type of system. How emergency care is handled, what happens if you are out-of-state and where services are geographically placed might be issues.

HMOs are a viable option to traditional indemnity care but, as in any business decision, should be fully examined before selection.

STAFF MODEL

In a staff model HMO, the physicians who serve the HMOs covered beneficiaries are employed by the HMO. These physicians are normally paid on a salary basis and may receive bonus or incentive payments based on their performance and productivity. Staff Models must employ physicians for common specialties to provide for the health care needs of their members.

Staff Models are also referred to as closed panel HMOs because most participating physicians are employees of the HMO. Physicians in Staff Model HMOs usually practice in one or more centralized ambulatory care facilities. These facilities contain physician offices and ancillary services such as laboratory and radiology. Staff Model HMOs usually contract with hospitals for inpatient services. One **advantage** of Staff Model HMOs is that they have a greater degree of control over the practice patterns of their physicians. Thus, it can be easier for Staff Model HMOs to manage and control utilization There are several **disadvantages** of the Staff Model

HMOs. They are usually more costly to develop because of the large fixed salary expense for staff physicians and support staff. Second, the choice of participating physicians from which potential HMO members may select is limited. Third, some Staff Model HMOs have experienced productivity problems with their staff physicians.

GROUP MODEL

In a **pure Group Model** HMO, the HMO contracts with a multi-specialty physician group practice to provide all physician services to the HMOs' members. The physicians are employed by the group practice and not by the HMO. Physicians may be allowed to see HMO patients and other patients.

Physicians in a group practice share facilities, equipment, medical records, and support staff. The group may contract on a cost basis to provide services. It may contract on an all-inclusive capitation basis to provide physician services to HMO members. **Capitation** means a provider is given a maximum amount of money per person no matter how many or how few services *are* used. In the **captive Group Model**, the physician group practice exists solely to provide

services to the HMO's beneficiaries. Usually, the HMO formed the group practice to serve its members. The HMO provides administrative services to the group.

In the **independent Group Model** HMO, the HMO contracts with an existing, independent, multi-specialty physician group to provide physician services to its members. In many cases, the independent physician group is the sponsor or owner of the HMO. Typically, the physician group in an independent Group Model HMO continues to provide non-HMO services while it participates in the HMO.

Both types of Group Model HMOs are *referred* to as **closed panel HMOs** because physicians must be members of the group practice to participate in the HMO. The HMO is considered closed to physicians who are not part of the group. Both types of group model HMOs make it easier to conduct utilization management. Also, group practice HMOs may have lower capital needs because the HMO does not have to support the large fixed salary cost of staff physicians associated with staff model HMOs.

Group Model HMOs have several **disadvantages**. They provide a limited choice of participating physicians. This limited physician panel makes the HMO harder to market. The limited number of office locations can make it difficult for the HMO to market its coverage to a wide geographic area.

NETWORK MODEL

In Network Model HMO the HMO contracts with more than one group practice to provide physician services to the HMO's members. The HMO may contract with several small groups of primary care physicians, which may be called a **primary care Network Model**. In the primary care Network Model, the HMO contracts with family practice and/or internal medicine, pediatrics, and obstetrics/gynecology to provide physician services to its members.

The HMO usually reimburses the physician group on an all-inclusive physician capitation basis. The group is responsible for providing all physician services to the HMO members assigned to the group and may refer to other physicians as necessary. The group is financially responsible for reimbursing other physicians for any referrals it makes.

Network Models may be either closed or open panel models. Network Model HMOs usually have more limited physician participation than IPA models or direct contract model plans.

INDIVIDUAL PRACTICE ASSOCIATION MODEL

IPA Model HMOs contract with an association of physicians to provide physician services to their members. The physicians are members of the IPA, which is a separate legal entity. However, the individual physicians retain their separate offices and identities. They continue to see non-HMO patients. IPA model HMOs are **open panel plans**.

Generally, IPAs attempt to recruit physicians from all specialties to participate in their plans, IPAs may be formed as large community - wide entities where physicians can participate without regard to the hospital with which they are affiliated. Some IPAs may be hospital - based and formed so that only physicians from one or two hospitals are eligible to participate in the

IPA.

Most HMO's compensate their IPAs on an all-inclusive physician capitation basis to provide services to the HMO members. The IPA then compensates its participating physicians on either a fee-for-service basis or a combination of fee-for-service and primary care capitation.

IPA model HMOs require less capital to establish. They also provide a broad choice of participating physicians who participate in their private offices. IPA model HMOs may devote more administrative resources to managing utilization than other HMO models because physicians remain individual practitioners with little sense of being a part of the HMO.

DIRECT CONTRACT MODEL

Direct Contract model HMOs contract directly with individual physicians to provide physician services to their members. Direct Contract model HMOs try to recruit broad panels of community primary care and specialist physicians to provide physician services. This model typically uses a primary care physician as a gatekeeper.

Direct Contract model HMO's compensate their physicians on either a fee-for-service basis or a primary care capitation basis. This contracting model eliminates the potential of a physician bargaining unit. It also reduces the possibility of mass termination of physician participation agreements.

It can be more difficult and time consuming for a Direct Contract model HMO to recruit physicians because it lacks the physician leadership in an IPA model plan. Utilization management may be more difficult in Direct Contract model HMOs because all contact with physicians is on an individual basis.

PREFERRED PROVIDER ORGANIZATIONS

PPOs have been offered by Insurance Carriers, groups of Physicians, or groups of Hospitals. There are generally financial incentives offered to plan holders to use the "Preferred" group of providers for care. PPOs will contract with the carrier forming the organization on a discounted fee or flat fee basis. *Participants* using the preferred provider will *benefit* from *lower deductibles or other incentives*. The *providers*, in turn, *benefit* from increased utilization and *prompt payment* from the carrier.

Preferred Provider Organizations derive many of the cost saving benefits from discounting by providers. They also use some of the same techniques as HMOs to minimize utilization of services. Utilization review, second opinions and ambulatory surgery options may also be required.

Patients utilizing PPOs generally have a broader choice of providers to select from than in an HMO environment. To receive the full benefits of the program, however, the preferred group must be used. Again, there are questions that need to be asked regarding geographic locations,

types of physician services available, sponsorship, etc.

The *key common characteristics* of PPOs typically include the following:

Select provider panel. Most PPOs contract directly with hospitals, physicians, and other diagnostic facilities. Providers are selected based upon their cost efficiency, community reputation, and scope of services.

Negotiated Payment rate, PPOs attempt to negotiate payment rates that provide them with a competitive cost advantage relative to charge-based payment systems. These negotiated payment rates can be a discount from charges, all-inclusive per diem rates, or DRG payment.

Rapid payment terms. PPOs will include prompt contracts in return for some payment features in their favorable payment rates.

Utilization Management. Many PPOs implement utilization management programs to control the utilization and cost of health services provided to their covered beneficiaries.

Consumer choice. PPOs generally allow covered beneficiaries to use non-PPO providers instead of PPO providers when they need health services. Higher beneficiary cost shares are imposed when non-PPO providers are used.

POINT-OF SERVICE PLAN

These are hybrids of more traditional HMO and PPO models. Capitated and primary care PPOs have the following *characteristics*:

Primary care physicians are reimbursed through capitation payments (a fixed payment each month) or other performance - based reimbursement methods

There is often an amount withheld from the physician compensation that is contingent upon achievement of utilization or cost targets.

The primary care physician acts as a gatekeeper for referral and institutional medical services.

The member retains some coverage for services rendered that either are not authorized by the primary care physician or are delivered by nonparticipating providers.

Also, there are open-access or point-of-service health maintenance organizations These plans provide some level of indemnity - type coverage for their members. The member is allowed to make a coverage choice at the point of service when medical care is needed. If the indemnity coverage is used, usually high deductibles and coinsurance are incurred by the patient to encourage members to use HMO services instead of out-of-plan services. Coverage under HMO point-of-service plans recently has been the fastest growing segment of health insurance.

MANAGED CARE OVERLAYS TO INDEMNITY INSURANCE

Entrepreneurs have developed managed care overlays that can be combined with traditional indemnity insurance, service plan insurance, or self insurance. These managed care overlays were designed to control costs for insured plans while allowing individuals freedom to choose providers and coverage for out-of-plan services. The following are *current types* of Managed Care Overlays:

General utilization management. These companies offer a complete utilization management menu from which individual employees or insurers can select.

Specialty utilization management. Common among these are firms that focus on utilization for specialty services. *Mental health* and *dental care* are two common types of specialty utilization overlays.

Catastrophic or large case management. This service involves the management of catastrophic cases regardless of the specialty involved.

Workers' Compensation utilization management. These firms handle Workers' Compensation claims.

TYPES OF REIMBURSEMENT

There are a number of reimbursement methodologies available in contracting with hospitals. A brief discussion of these methodologies follows:

Straight Charges

The easiest payment method in health care is straight charges. It is the most expensive and the least desirable for managed care companies.

Straight Discount on Charge

Under this agreement the hospital submits a claim for total charges and the plan discounts it by the agreed upon percentages.

Sliding Scale Discount on Charge

With a sliding scale, the percentage discount is reflective of total volume of admissions and outpatient procedures. An interim percentage discount could be negotiated as well as a greater discount if volumes reach certain levels.

Straight Per Diem Charges

A negotiated per diem is a single charge for a day in the hospital regardless of any actual charges or costs incurred. Multiple per diems based on service type may be negotiated.

Differential by Day in Hospital

This simply refers to the fact that most hospitalizations are more expensive on the first day. Under this method, usually the first day is paid at a higher per diem than each subsequent day.

Diagnosis-Related Groups

Diagnosis-related groups (DRGs) are used to pay for inpatient care.

Service-Related Case Rates
Service-related case rates are flat per-admission reimbursement methods for whatever type of service to which the patient is admitted.

Case Rate
Certain categories may need to have special rates negotiated. For example - a normal delivery may be at one rate and a cesarean section may be at another rate.

Bed Leasing
This is a relatively uncommon reimbursement mechanism where beds are actually leased from an institution. Under this plan an amount is paid per bed per day regardless of whether the beds are used or not.

Capitation or Percentage of Revenue
Capitation is a payment system where fees are paid per person per month to cover all institutional costs for a defined population of members. *Percentage of revenue* refers to a fixed percentage of premium revenue being paid to the hospital.

Periodic Interim Payment and Cash Advance
Periodic Interim payments (PIPs) and cash advances are methods where the plan advances a hospital cash to cover expected claims.

Penalties and Withhold
These may be negotiated so that if goals are met, the hospital receives it's withhold or bonus.

Ambulatory Patient Groups
Ambulatory Patient Groups (APGs) is a method of outpatient reimbursement where all the services associated with a given procedure or visits are bundled into the APG reimbursement.

Reimbursement methods are tools for the hospital and managed care plan to use to develop win-win situations for both parties. The methods chosen can be a pivotal issue in the ultimate success of the hospital.

REVIEW QUESTIONS – CHAPTER 5

Health Maintenance Organization (HMO):

Employers who meet a certain size and benefit requirement must offer an HMO to their employees.
Answer: True

HMOs attempt to reduce the costs of healthcare delivery through utilization review, ambulatory surgery versus inpatient surgery, second opinions and preventive medicine.
Answer: True

Who funds the HMO system?
Answer: The recipients

There are 5 common HMO models.
Answer: True

Staff Model:

How are physicians who are employed by HMOs in a Staff Model paid?
Answer: Salary basis; may receive bonus or incentive payments based on performance or productivity.

A physician in the Staff Model would practice in his office.
Answer: False

Staff Model HMOs contract with hospitals for outpatient services.
Answer: True

One advantage of Staff Model HMOs is the convenience of one-stop service.
Answer: True

Do the Staff Model HMOs experience productivity problems with their staff physicians?
Answer: Yes

One disadvantage of Staff Model HMOs is they are usually more costly to develop.
Answer: True

Group Model:

In a pure Group Model, the physicians are not employed by the HMO.
Answer: True

Pure Group Model HMOs contract with a multi-specialty physician group practice to provide physician services to HMO members.
Answer: True

Capitation is when a provider is given a maximum amount of money per person no matter how many or how few services are rendered.
Answer: True

Do physicians in a group practice share facilities, equipment, medical records and support staff?
Answer: Yes

The captive Group Model exists solely to provide services to the HMOs beneficiaries.
Answer: True

Who does the independent group model contract with to provide services to its members?
Answer: Existing, independent, multi-specialty physician groups.

An HMO panel that does not allow physicians who are not a member of a group to participate is considered what?
Answer: A closed panel HMO

A disadvantage of the Group Model HMOs is they have lower capital needs.
Answer: False

A disadvantage of the Group Model HMO is the limited physician panel making it harder to market.
Answer: True

Network Model:

The Network Model HMOs contract with more than one group practice to provide physician services to the HMOs members.
Answer: True

In the Primary Care Network, name a type of physician affiliated with the HMO.
Answer: Family Practice, Internal Medicine, Pediatrics and Obstetrics/Gynecology.

How is this group reimbursed?
Answer: All-inclusive physician capitation basis.

Individual Practice Association Model:

Do the individual physicians retain separate offices and identities?
Answer: Yes

IPAs recruit physicians from their group only.
Answer: False

HMOs compensate their IPAs on an all-inclusive physician capitation basis.
Answer: True

Does the IPA compensate its participating physician?
Answer: Yes

Direct Contract Model:

Who is the gatekeeper for the Direct Contract Model HMOs?
Answer: Primary Care Physician

What 2 ways does the Direct Contract Model HMOs compensate their physicians?
Answer: Fee-for-Service basis or a primary care capitation basis.

Is the utilization management more difficult in the Direct Contract Model?
Answer: Yes

Preferred Provider Organizations: (PPO)

PPOs contract with the carrier forming the organization on a discounted fee or flat fee basis.
Answer: True

CHAPTER 6
ALABAMA MEDICAID AGENCY

Alabama Medicaid Agency Mission Statement

Alabama Medicaid Agency – 'A Statement of our Values'

A Medicaid Primer

Application (Medicaid, SOBRA, ALL Kids & Child Caring

Co-Payments for Medicaid Services

Medicaid Non-Covered Services

Out of State Services

Medicaid Manual – Chapter One-General Services

Medicaid Manual – Chapter Seven-Hospitals

Glossary

Review Questions

(Note: Information Obtained from Alabama Medicaid Agency Manuals and Website)

CHAPTER 6
ALABAMA MEDICAID AGENCY

REVIEW QUESTIONS

MEDICAID PRIMER

What is the program that provides medical assistance for certain individuals and families with low income and resources?

Answer: Title XIX of the Social Security Act (SSA) known as Medicaid.

When did the program become law?

Answer: 1965

What are the three agencies in Alabama that certify individuals for Medicaid?

Answer: The Social Security Administration, The Department of Human Resources, and the Alabama Medicaid Agency

What are the programs for which Alabama Medicaid Agency certifies individuals?

Answer:

- **Pregnant women and children under age 19**
- **Plan First Program**
- **Breast and Cervical Cancer Program**
- **Nursing home and institutional level of care**
- **SSI related groups**
- **Medicare related groups**
- **Emergency services for Aliens**
- **Medicaid for Low Income Families Program (MLIF)**

What are the Medicare related groups?

Answer: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiaries (SLIMB), Qualifying Income Groups and Qualified Disabled Working Individuals.

What is the Medicare program that provides Hospital Insurance (HI) also known as Part A coverage and supplementary medical insurance (SMI), also known as Part B coverage?

Answer: The Medicare Program (Title XVIII of the Social Security Act).

Who are 'dual eligible'?

Answer: Medicare beneficiaries who have low income and limited resources may receive help paying for their out-of-pocket medical expenses from their State Medicaid program. These 'dual eligible' are entitled to Medicare and are eligible for some type of Medicaid benefit.

Who are Alabama's Medicaid Providers?

Answer: Any physician or dentist who is licensed by their State License Boards may become a Medicaid provider.

Who is the Fiscal Agent for Alabama Medicaid?

Answer: EDS (P.O. Box 7600, Montgomery, AL. 1-800-688-7989)

What is SOBRA?

Answer: Sixth Omnibus Budget Reconciliation Act. This legislation allowed states to expand eligibility for Medicaid without expanding eligibility for Aid to Families with Dependent Children (AFDC). These laws together with other federal laws have been enacted mandating coverage to even more children and pregnant women and mandating the out stationing of social workers in disproportionate share hospitals and health centers for easy access to the program by potential clients.

What is CHIP?

Answer: Title XXI Child Health Insurance Program.

What does Plan First cover?

Answer: Family Planning Services to all women of childbearing age (ages 19 through 44) with incomes at or below 133% of the federal poverty level that would not otherwise qualify for Medicaid coverage.

How is Medicaid Funded?

Answer: Federal and State Governments jointly fund Medicaid.

<u>Co-Payments for Medicaid Services</u>

Name some of the services for which Medicaid charges co-payments.

Answer:

- **Doctor Visits**
- **Visits to Rural Health Clinics**
- **Outpatient Hospital Visits**
- **Medical Equipment**
- **Ambulatory Surgical Centers**
- **Visits for Health Care Centers**
- **Inpatient Hospital**
- **Prescription drugs**
- **Supplies and Appliances**

What are some of the services that do not require a co-payment?

Answer: Family Planning Services, Chemotherapy, Emergencies, Physical Therapy in a Hospital Outpatient setting.

<u>Medicaid Non-Covered Services</u>

What are some of the services for which Medicaid will make no payment?

Answer: Cosmetic Surgery or procedures; Dental Services for adults (age 21 or older); Hospital meal trays or cots for guests; Infertility services or treatment; Services to persons who are in jail or prison; Sitter Services.

Out-of-State Services

What are the reasons why services that Medicaid covers in Alabama that may be covered out of state?

Answer:

- **If there is a certified emergency.**
- **If it would be hazardous to travel back to Alabama for treatment**
- **If the medical services needed are more readily available in the other state**
- **If an out-of-state medical provider has a contract with Medicaid in Alabama.**

Medicaid Manual – Chapter 1 – GENERAL

Providers with unsolved problems or provider dissatisfaction with the response from the fiscal agent should direct their questions to whom?

Answer: Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, AL 36104, Telephone # 334-242-5010.

Do Providers who agree to accept Medicaid payment have to agree to do so for all medically necessary services rendered during a particular visit?

Answer: Yes

If a recipient fails to advise a provider of his/her Medicaid eligibility and furnish other information necessary to file the claim within the time allowed by Medicaid, is the provider under obligation to file with Medicaid?

Answer: No, the Provider is under no obligation to file and may elect to file with Medicaid or bill the patient.

How many digits does the identification number of Medicaid eligible recipients contain?

Answer: 13

What information is contained on the Identification number of Medicaid eligible recipients?

Answer: The first 3 digits will be '000' followed by the recipient's nine (9) digit Social Security number and a number verification check digit.

Where should patients who are 65 or older but do not have a Medicare Claim Number assigned be referred?

Answer: To the local SSA Office to make application for Medicare.

Describe the procedure for claims for services covered by Medicare for persons 65 years or older.

Answer: The claim should be filed first with Medicare with the Medicaid number listed on the Medicare claim as 'other insurance'.

What does a Medicare claim number with a suffix 'M" indicate?

Answer: There is no Medicare Part A (hospital insurance) entitlement. Hospital claims for this type number may be filed with Medicaid as regular Medicaid claims.

How many digits does the Identification Number for an Alabama Medicaid Provider have?

Answer: 9 except for pharmacies.

How many months prior to the month of application for an SSI recipient may Medicaid claims be submitted for unpaid charges?

Answer: 3 Months

Name three reasons why a Medicaid recipient may lose eligibility.

- **Medicaid recipients residing in an institution if they are discharged from the institution to home or if their monthly income rises about the ceiling for Medicaid eligibility.**
- **If a Medicaid eligible person, other than a foster child, moves permanently outside the State of Alabama**
- **Foster children will lose eligibility when they cease to be foster children.**
- **Minors eligible for EPSDT when they reach age 18.**
- **When income exceeds the ceiling level established for eligibility.**

What are crossover payments?

Answer: crossover payments are partial payments to providers by Medicaid for covered Medicaid services, supplies and equipment furnished to recipients eligible for both Medicare and Medicaid.

What does Medicaid cover for Medicare/Medicaid and/or Qualified Beneficiaries (QMB) Eligible Recipients?

Answer: The monthly premiums for Medicare insurance to the SSA and the applicable Medicare Part A and Part B deductibles and/or coinsurance for an eligible Medicare/Medicaid and/or QMB recipient.

When a Medicaid recipient has third party health insurance of any kind, including Medicare, when does Medicaid pay?

Answer: Medicaid is the payer of last resort.

What is the time limit for claim submission to Medicaid?

Answer: Medicaid will pay only clean claims submitted to its fiscal agent. A timely claim is a clean claim which is received by the fiscal agent within 1 year of the date of service unless a different limitation is specifically provided elsewhere in the Medicaid Code.

What are some of the Exceptions to Time Limits for Claims Submission?

Answer:

- **A clean claim that is received by the fiscal agent within 120 days of the notice date of disposition by a Third Party Payor with such date indicated on the face of the claim.**
- **A clean claim received by the fiscal agent within 1 year of the date of the award notice for a recipient who receives retroactive eligibility.**
- **A claim that has been paid by Medicaid but is subsequently recouped, a resubmitted clean claim may be processed if received within 120 days of the recoupment date with such date indicated on the face of the claim. A copy of the EOP showing the recoupment must be attached.**

What is the Time Limit for Claims Payments?

Answer:

- **Except for Exceptions, the Medicaid fiscal agent must process and pay all clean claims within twelve (12) months of receipt of the claim.**
- **A provider who submits a clean claim to the fiscal agent should normally receive payment or denial within 90 days.**

15MMG If a Provider does not receive payment within the established Medicaid Time Limit for Claims payments, who should the Provider contact?

Answer: The Fiscal Agent for a status report of the claim.

If a Provider's efforts to receive payment, with the help of the fiscal agent are fruitless, who should be contacted?

Answer:

- **The Associate Director for its program at Medicaid before the time limitation expires.**
- **For Problems with TPL-related claims, Providers should contact the Third Party Section at Medicaid.**

If all administrative remedies have been exhausted and the claim is denied, from whom can the Provider collect?

Answer: The Provider cannot collect from either the recipient (Patient) or his/her sponsor or family.

When may Medicaid payments not be made?

Answer: When there is no availability of appropriated funds for the Alabama Medicaid Program.

Are Providers who have been convicted of fraud being considered for contract with the Medicaid Agency?

Answer: No

If a medical benefit is a non-covered service under the Alabama Medicaid Program, are ancillary charges related to the delivery of that benefit covered?

Answer: No

Must organ transplants receive prior approval by Medicaid?

Answer: Yes with the exception of Cornea Transplants

What transplants are covered for recipients of any age?

Answer:

- **Bone Marrow**
- **Cornea**
- **Kidney**
- **Heart**
- **Lung**
- **Heart/Lung**
- **Liver**
- **Pancreas**
- **Pancreas/Kidney**

- **Liver/Small Bowel**
- **Small Bowel**

How is reimbursement for Transplants made?

Answer: Global Payment established by Medicaid with the exception of Cornea Transplants which are reimbursed at the normal Medicaid pricing methodology. Services provided after discharge will be reimbursed on a fee for service basis.

What are the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program?

Answer: This coverage is provided for medically necessary health care, diagnosis, treatment and/or other measures to correct or ameliorate a defect, physical or mental illness, or other conditions discovered during or as a result of an EPSDT screen for Medicaid-eligible recipients under the age of 21 years.

What is Managed Care?

Answer: The Managed Care Plan will be available for Medicaid recipients residing in areas of the State targeted for managed care implementation. The Plan must cover all services as specified in the contract between the Agency and the Plan and shall not be less in amount, duration and scope, than those available to other Alabama Medicaid recipients.

CHAPTER 7 – HOSPITALS

Hospital Program - General

How many inpatient days per calendar year for adults and children for preventive, diagnostic, therapeutic, rehabilitative, or palliative outpatient services are provided by the Medicaid Plan of Alabama?

Answer: 16

For what service may additional inpatient days be authorized upon request for recipients who have exhausted their initial 16 covered days?

Answer: Deliveries only (onset of active labor to discharge up to a maximum of 8 days effective July 1, 1991).

After July 1, 1991, medically necessary inpatient days are unlimited for services by a hospital which has been designated by Medicaid as a disproportionate share hospital for children under what age?

Answer: Children under the age of 6.

After July 1, 1991 medically necessary inpatient days are unlimited in all hospitals for recipients under what age?

Answer: Children under the age of 1.

Who is responsible for enrolling any Title XVIII (Medicare) certified hospital that wishes to enroll as a Qualified Medicare Beneficiary (QMB-only) provider?

Answer: The Fiscal Agent

Inpatient Benefits

What is the Medicaid definition of an inpatient?

Answer: An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services with the expectation that he/she will remain at least overnight and occupy a bed.

When does a day begin and end?

Answer: A day begins at midnight and ends 24 hours later.

How does Medicaid cover the day of admission and day of discharge?

Answer: Medicaid covers the day of admission but not the day of discharge. If admission and discharge occur on the same day, the day is considered a day of admission and counts as one inpatient day.

How many days nursery care will be covered by an eligible mother's claim for newborns delivered in the hospital and the mother is in the hospital and is otherwise entitled to such coverage?

Answer: Up to 10 Days.

What is the billing procedure for newborns delivered outside the hospital for those remaining in the hospital after the mother is discharged and those admitted to accommodations other than the well baby nursery?

Answer: These newborns must be eligible for Medicaid benefits in their own right and claim must be billed under the baby's own name and Medicaid number. The only exception is when twins are billed; the nursery days can be twice the number of the mother's days.

Bed and Board in Semi-Private Accommodations

For what type room accommodations will Medicaid pay?

Answer:

- **Semi-Private (2,3, or 4 bed accommodations)**
- **Private rooms medically necessary. Must be certified by physician at the time of admission or within 48 hours of the onset of the need and the specific medical condition requiring a private room. Certification must appear in the hospital records as a written order by the physician. Order must be recertified as medically necessary if physician determines need for continued hospitalization. *Medicaid will not cover a private room on the basis of a retroactive statement of medical necessity by the physician.***
- **Private rooms not medically necessary. When accommodations more expensive than semi-private are furnished the patient because at the time of admission less expensive accommodations were not available or because the hospital ha only private accommodations, Medicaid may pay for the semi-private accommodations. *The patient is not to be billed or required to pay the difference.***

Drugs and Biologicals

Does Medicaid cover Take-Home Drugs and medical Supplies?

Answer: Take-home drugs and medical supplies are not covered in the Medicaid Program. However, a patient may, on discharge from the hospital, take home remaining amounts of drugs which have been supplied for him either on prescription or doctor's order, if

continued administration is necessary, since they already would have been charged to his account.

Will Medicaid cover Hemodialysis?

Answer: Hemodialysis for chronic renal cases is provided under the Medicaid Program when the patient is not authorized this care under Medicare.

Are whole blood or equivalent quantities of packed red cells covered by Medicaid?

Answer: No, since these are provided by Red Cross. However, blood processing and administration is a covered service.

Does Medicaid cover Sterilization, Hysterectomy and Abortions?

Answer: Yes, subject to the criteria and regulations for these procedures.

Physical Therapy

When does Medicaid cover Physical Therapy?

Answer:

- **Medically Necessary (requires the professional skills of a qualified physical therapist to perform or supervise).**
- **In a Hospital Outpatient Setting**
- **For Acute Conditions**

Will Physical Therapy performed in an outpatient hospital setting count against the recipient's three non-emergency outpatient visit limits?

Answer: No

Dental Services

Under which Medicaid Program are the items and services in connection with the care, treatment, filling, removal or replacement of teeth, or structures directly supporting the teeth covered?

Answer: For recipients eligible for treatment under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

Outpatient Services

What is the limitation for outpatient hospital visits (excluding the exceptions) per calendar year?

Answer: 3. Outpatient Observation is considered an outpatient visit and will be counted in the yearly outpatient visit benefit limit, unless documented as a certified emergency by the attending physician at the time of service.

Name some of the services that do not count against the 3 outpatient hospital visits.

Answer:

- **Specimens and Blood Samples sent to the hospital for tests**
- **Outpatient visits solely for chemotherapy, therapeutic radiation, radiology and/or laboratory services are unlimited and do not count against benefit limitations.**
- **Outpatient surgery reimbursement is a fee-for-service rate established for each covered surgical procedure indicated on the Medicaid outpatient surgical list.**

- **Multiple surgical procedures on the claim will be reimbursed the lesser or charges or 100% of the fee on the pricing file for the initial procedure and the less of charges or 50% of the fee on the pricing file for subsequent procedures.**
- **Emergency Services that are a 'certified emergency'.**
- **Outpatient dialysis services cannot be reimbursed as an outpatient hospital service but are covered under the End-Stage Renal Disease Program.**
- **Inpatient Admission after Outpatient hospital Services. If patient is admitted as an inpatient before midnight of the day outpatient services were rendered at the same hospital, all services are considered inpatient services for billing purposes.**

What is the limitation for recipients to be in the observation unit?

Answer: A minimum of 3 hours but no more than 23 hours.

Name some guidelines that must be met for Outpatient Observation to be billed to Medicaid.

Answer:

- **Defined as the medically necessary extended outpatient care provided to a patient whose condition warrants additional observation before a decision is made about admission to the hospital or prolonged patient care.**
- **Limited to no more than 23 hours.**
- **Unless certified as an emergency will be counted in the yearly outpatient visit benefit limit.**
- **Observation Unit may be located in various part of the hospital but is an area designated by hospital in which patient beds are set aside to provide any medically necessary extended outpatient care to a patient whose condition requires either additional observation before decision is made about admission to the hospital or prolonged patient care is rendered.**
- **Outpatient observation charges must be billed in conjunction with the appropriate emergency room facility fee.**
- **A recipient must receive observation services a minimum of 30 minutes before the observation charge can be billed.**
- **The first three hours of observation are included in the emergency room facility fee.**
- **Ancillary charges may be billed with the emergency room facility fee and observation fee.**
- **Outpatient observation charges cannot be billed in conjunction with outpatient surgery or critical care.**

How many obstetrical ultrasounds will Medicare cover per year without documentation of a medical condition that meets the criteria established by Medicaid?

Answer: 2

When may a recipient be billed by the Provider?

Answer:

- **For allowable co-payment amounts**
- **When benefits have been exhausted**
- **For services not covered by Medicaid**

CHAPTER 7

TRICARE

BACKGROUND INFORMATION

TRICARE PRIME

TRICARE EXTRA

TRICARE STANDARD

TRICARE PRIME REMOTE

TRICARE FOR LIFE

DEERS

INDENTIFICATION CARDS

ELIGIBILITY

ELIGIBILITY VERIFICATION

NON-AVAILABILITY STATEMENT

PRE-AUTHORIZATION

WRITTEN PRIOR-AUTHORIZATION

MENTAL HEALTH

SERVICES

COVERED SERVICES

NON-COVERED SERVICES

OTHER HEALTH INSURANCE

WAIVER/OTHER BENEFITS NOT PERMITTED

THIRD PARTY LIABILITY

CLAIMS SUBMISSION

BACKGROUND INFORMATION

TRICARE is the Department of Defense's managed health care program that became effective 1 July 1996. This is a healthcare program for active duty family members and military retirees, their family members and survivors. It includes care available from Military Treatment Facilities (MTFs) and from civilian sources.

The program in TRICARE Regions 3 and 4 (Florida, Georgia, South Carolina, Alabama, Tennessee, Mississippi and parts of southeastern Louisiana) is administered by Humana Military Healthcare Services, Inc. (HMHS), a subsidiary of Humana. The plans offered to TRICARE-eligible beneficiaries are:

TRICARE Prime

This is an HMO-like benefit plan in which beneficiaries enroll and select a Primary Care Manager (PCM). The enrollment period is for one year and does have an enrollment fee of $230 per individual or $460 per family. There are also some per visit fees (see chart comparison for breakdowns). This plan also includes a point of service option.

TRICARE Extra

With this option, you don't have to enroll or pay an annual fee. You do have to satisfy an annual deductible for outpatient care. There are also per visit fees (see chart comparison for breakdowns).

TRICARE Standard

This plan was once known as Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This plan shares most of the costs of care from civilian hospitals and doctors when care is not received through a uniformed services hospital or clinic. Active duty service members, dependent parents, and parents-in-law are not eligible for TRICARE Standard. They are, however, eligible for care in military medical facilities on a space-available basis. There is an annual deductible and some per visit fees (see chart comparison for breakdowns).

TRICARE Prime Remote

The TRICARE Prime Remote (TPR) program serves active duty service members who live and work more than 50 miles away from a Military Treatment Facility.

TRICARE for Life

On October 1, 2001, Medicare-eligible uniformed services retirees and their eligible family members and survivors gained access to expanded medical coverage known as TRICARE for Life (TFL). Under the law health care for Medicare-eligible military beneficiaries became a permanent entitlement program. Therefore it will require annual renewals by the Congress. TFL pays secondary to Medicare. The only monthly premiums incurred are for Medicare Part B. The address for TRICARE for Life is P.O. Box 7890, Madison, WI 53707.

DEERS

Patients must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS) to receive care in MTFs or to have claims for civilian health care processed by TRICARE. Both active and retired military sponsors and all family members must be entered in the DEERS computer data banks and shown as eligible for TRICARE benefits. Newborns should be enrolled in DEERS as soon as possible after birth, in order not to risk denial of a claim. ***It is the sponsor's responsibility to make sure that his or her family members are enrolled in DEERS through the nearest military personnel office.***

Identification Cards

To use TRICARE benefits, the patient must have a valid identification (ID) card issued by the uniformed services and be in the DEERS database. The back of the ID card, in the "Medical" block, indicates whether the patient is eligible for medical care from the military or civilian sources. Children under 10, as a rule, can use either parent's or guardian's ID card, but must be enrolled in DEERS. After the age of 10, the child's sponsor should obtain an ID card for the child. Children under 10 should also have an ID card of their own when in the custody of a parent who is not eligible for benefits.

Eligibility

TRICARE is a health benefit program for all seven uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration. To use TRICARE, the patient must be listed in DEERS as being eligible for military health care benefits.

TRICARE-eligible persons include the following:

- Active duty service members
- Spouses and unmarried children of active duty service members
- Uniformed service retirees, their spouses, and unmarried children
- Un-remarried former spouse and unmarried children of active duty or retired service members who have died
- Ex-spouses who have valid ID cards
- Children of deceased active duty members and deceased retirees (to be eligible, children must be unmarried and under the age of 21)
- Spouses and unmarried children of reservists and National Guard who are ordered to active duty for more than 30 consecutive days or of reservists and National Guard who die on active duty
- Persons who have received the Congressional Medal of Honor, and their family members, who are not otherwise TRICARE-eligible.
- Children placed in the custody of a service member or former member by a court of law or by a recognized adoption agency in anticipation of legal adoption by the member.
- Spouses and children of North Atlantic Treaty Organization (NATO) and "Partners for Peace" (PFP) Nation representatives who are officially accompanying the NATO or PFP nation representatives while stationed in or passing through the United States on official business. **These family members are eligible for outpatient benefits only* *

Persons that are not TRICARE-eligible include the following:

- Individuals not enrolled in DEERS
- Individuals 65 years of age or over who qualify for Medicare Part A, but who are **not** enrolled in Medicare Part B.
- Individuals under age 65 who are Medicare-eligible because of disability or end-stage renal disease, but not enrolled in Medicare Part B.
- Individuals who are eligible for benefits under Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMP VA and CHAMP VA for Life)

Eligibility Verification

A currently valid Uniformed Services Identification Card is required to establish eligibility. Children under age 10 are not normally issued ID cards except under unusual circumstances. Their eligibility is established on the basis of either parent's ID card. A "Yes" in block 15b on the back of the card indicates eligibility.

NON-Availability Statement

Certification from the uniformed service hospital that states it can not provide the care needed. If a patient lives in certain ZIP codes around a military hospital, a NAS must be obtained prior to receiving non-emergency inpatient care at a civilian hospital. The statement must be entered electronically in the Department of Defense's DEERS system by the closest MTF. Outpatient services no longer require NAS certification (the exception to this is child birth).

Pre-Authorization

Certain types of care under TRICARE require Pre-certification prior to the care being rendered (see charts). To avoid waiting on the phone for prior authorization a request may be submitted online at the HMHS website www.humana-military.com. The request including clinical information may be faxed on the HMHS Fax Form to 1-800-762-9920. To call for authorization the following information must be available:

- Sponsor ID, Social Security number and address
- Patient name, date of birth, relationship to sponsor
- Admitting hospital, date, time, physician tax ID, name and mailing address
- Clinical conditions for surgery for InterQual review, including CPT codes.

Most authorizations can be completed by phone or within 24 hours of receipt of all information. Authorizations are valid only for care that begins within 30 days of the authorization. Prior authorization for maternity is completed upon diagnosis of pregnancy. The hospital must notify the Health Care Finder at the time of admission for delivery.

Written Prior- Authorization

While most procedures requiring Prior-Authorization can be done either by phone, fax or online, there is a list of procedures (see charts) that require written prior authorization. Failure to obtain written authorization in advance of the procedure may result in denial of the claim.

To ensure authorization in a timely manner, the request should be submitted six weeks prior to the treatment date. Written requests may be faxed to 1-800-762-9220 ATTN: WPA.

A request submitted by mail should to be sent to:

Written Prior Authorizations Dept.
TRICARE Regional Review Center
931 South Semoran Blvd
Suite 218
Winter Park, FL 32792

Mental Health

After the first eight visits per year, all outpatient mental health treatment services provided to TRICARE-eligible beneficiaries must be prior authorized by contacting CHOICE via the Mental Health Care Finder Line at 1-800-700-8646. An Outpatient Treatment Report must be submitted

The following services are not included in the first eight visits and must always have prior authorization by CHOICE:

- All substance use treatment (inpatient or outpatient)
- All inpatient levels of care including care rendered by residential treatment centers
- All partial hospital levels of care
- All psychological testing (both psychological and neuropsychological)
- All psychoanalysis
- Electro convulsive Therapy

Services

Generally, TRICARE covers most health care that is medically necessary and not considered unproven. However, there are special rules or limits on certain types of care. There are some types of care and services that are not covered at all.

Covered Services

Following is a partial list of covered services:

- Ambulances
- Cardiac Rehabilitation
- CT Scans & MRI
- Dental Care
- Durable Medical Equipment (wheelchairs, hospital beds, respirators)
- Eye Exams
- Family Planning (Infertility diagnosis and treatment, Birth control, sterilization)
- Maternity Care
- Hospice Care
- Mammograms and Pap Smears
- Medical Equipment and Supplies (needles, syringes, crutches)
- Implants (type approved by FDA)
- Medication (FDA approved)
- Obesity Treatment
- Organ Transplants
- Same Day Surgery
- School Physical Exams (child must be between 5 and 12 years of age)

Non-Covered Services

This is only a partial list of what TRICARE does not cover:

- Abortion (except when mother's life is in danger)
- Anabolic Steroids
- Artificial Insemination (includes In Vitro fertilization and gamete intafalopian transfer)
- Bone Marrow Transplants for Treatment of Ovarian Cancer
- Chronic Fatigue Syndrome (no generally accepted standards for CFS)
- Counseling Services (nutritional, marriage, self-help, diabetic, stress management)
- Experimental Procedures (except under NCI)
- Eye Glasses and Contact Lenses
- Hearing Aids
- Hearing Exams
- Immune Globulin
- Investigational Drugs
- Learning Disabilities (dyslexia)
- Over-the-counter Drugs (those not requiring prescription by physician)
- Private Hospital Rooms (unless doctor orders for medical reasons)
- Sex Changes
- Speech Therapy Services (unless authorized by physician for physical defect)
- Sexual Dysfunction or Inadequacy Treatment (Viagra is covered within certain limits)
- Workers Compensation

Other Health Insurance

TRICARE always pays secondary to private insurance policies or coverage provided through the beneficiary's place of employment, except in the following cases:

- When the patient has Medicaid
- When there are benefits payable under a State Victims of Crime Compensation Program
- Certain insurance policies that are specifically designated as TRICARE supplements.

When the beneficiary has other health coverage, the appropriate authorizations for care must be obtained if TRICARE will be billed for the services. Primary insurance must be submitted and adjudicated first. This also includes the medical portion of an auto insurance policy or any coverage that students in the family may have through their schools.

Workers' Compensation - Expenses for medical care related to job - connected illness or injury that are paid by the Workers' Compensation Program, or can be paid by such a program, are not covered by TRICARE. Only if benefits were exhausted under the Workers' Compensation Program would TRICARE then assume responsibility for the balance.

Waiver of Other Benefits 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 in order to be paid in full with TRICARE benefits. The beneficiary must apply for benefits under the plan or program that has been determined to have primary responsibility.

Third Party Liability

Third Party Liability refers to situations where the financial responsibility for care of a TRICARE beneficiary falls to a third party other than the normal health insurance. This can include auto insurance or personal injury protection.

Government policy requires that all TRICARE inpatient claims and any outpatient claims over $500.00 submitted with a diagnosis of 800-909 (with the following exceptions) be reviewed for potential third party liability.

The following codes in the specified range are excluded from this requirement:

910.2 - 910.7	911.2 - 911.7	912.2 - 912.7	913.2 - 913.7
914.2 - 914.7	915.2 - 915.7	916.2 - 916.7	917.2 - 917.7
918.0 - 918.2	919.2 - 919.7		

Claims Submission

Electronic claims can process faster and more accurately than paper claims. If a claim requires supporting information, it may still be submitted electronically; however the documentation must be faxed to 803-713-0354 with a specific cover sheet. Contact the EMC help desk at 803-325-5920, Option #2, to get a copy of the fax cover sheet. Institutional claims (UB92) should have the following bill type 111, 112, 113, 114, and 131 in order to be submitted electronically. If the claim cannot be submitted electronically, it should be mailed to the appropriate address for your region. For TRICARE regions 3 and 4 mail the claim to the following address:

TRICARE Regions 3 &4
PO Box 7031
Camden, South Carolina 29020.

If there is a need to resubmit a corrected claim, “Corrected Claim” should be written across the top. This applies to claims that have previously been accepted by PGBA for processing.

Review Questions
Chapter 7 – TRICARE

What is TRICARE?

Answer: Health Care Program for Active Duty and Retired Members of the Uniformed Services, their families and survivors.

What are the six TRICARE regions?

Answer: TRICARE North, TRICARE South, TRICARE West, TRICARE Europe, TRICARE Pacific and TRICARE Latin America/Canada.

Who is the Managed Care Support Contractor for the TRICARE South Region?

Answer: Humana Military Healthcare Services, Inc. (Humana Military).

What is the TRICARE website?

Answer: www.tricare.osd.mil/provider

What is the Humana Military website?

Answer: www.humana-military.com

What is the Humana Military's TRICARE Service Linea?

Answer: 1-800-444-5445 and is available 24 hours a day, seven days a week.

What are the TRICARE Provider Types?

Answer:

- Authorized Providers
- Certified Providers
- Network Providers
- Non-network Providers
- Participating Providers
- Nonparticipating Providers

For what may TRICARE beneficiaries be billed?

Answer:

- Network Providers may only bill for applicable deductible, co-payment, or cost-sharing amounts, but may not bill for charges that exceed contractually allowed payment rates. The beneficiary's responsibility is reflected on the explanation of benefits (EOB) or the provider's remittance advice.
- Non-Network Providers who accept assignment are limited to collecting the TRICARE allowable charge. If the billed charge is less than the allowable charge, the billed charge becomes the billable amount to the beneficiary. Balance billing applies only to services covered by TRICARE.
- Providers who do not accept assignment on a claim, non-network, and nonparticipating providers can collect applicable deductibles and/or cost-shares and any outstanding amounts up to 15% above the allowable charge (shown on the remittance advice) from a TRICARE Standard beneficiary. If the billed charge is less than the TRICARE-allowed amount, the billed charge becomes the billable amount to the beneficiary.

- Balance billing applies only to services covered by TRICARE. TRICARE's balance-billing limit also applies when other health insurance (OHI) is involved. Providers are limited to collecting the amount described above, regardless of the beneficiary's OHI financial responsibility.
- When OHI is involved, the provider of care may receive no more than the TRICARE allowable charge or if a non-network, nonparticipating provider, 115 percent of the allowable charge through payment by the other health insurer and TRICARE. Providers may not collect any amount from a beneficiary after payment of the claim unless TRICARE and the OHI combined have failed to pay the allowable charge. In the case of a network provider, the contractually negotiated amount is the allowable charge.

Release of Information

When an inquiry is made by a beneficiary, including an eligible dependent child, regardless of age, for release of information, to whom should the reply be addressed?

Answer: Reply should be addressed to beneficiary, not the beneficiary's parent or guardian. The only exceptions are:

- When a parent writes on behalf of a minor child (under 18 years old)
- When a guardian writes on behalf of a physically or mentally incompetent beneficiary.
- In responding to a parent or guardian in the above circumstances, the Privacy Act of 1974 precludes disclosure of sensitive information which, if released, could have an adverse effect on the beneficiary.
- Providers must not furnish information to the parents or guardians of minors or incompetents when services are related to the following diagnostic codes: AIDS (ICDM-9-CM 079.53;042); ALCOHOLISM (ICDM-9-CM 291.9;303-303.9;305); ABORTION (ICDM-9-CM 634-639.9;779.6)DRUG ABUSE (ICDM-9-CM 292-292.2;304-304.9;305.2-305.9) AND VENERAL DISEASE (ICDM-9-CM 090-099.9; 294.1)

What is the 'signature on file' requirement for TRICARE beneficiaries?

Answer: The physician's office must maintain a 'signature on file' to protect the patient's privacy, for the release of important information and to prevent fraud. A new signature is required every year for professional claims submitted on a CMS-1500 and every admission for claims submitted on a UB-04. Claims submitted for diagnostic tests, test interpretations, or other similar services do not require the beneficiary's signature. Providers submitting these claims must indicate 'patient not present' on the claim form.

- If the beneficiary is without legal representation, the provider must submit a written report with the claims describing the patient's illness or degree of mental competence and should annotate in Box 12, 'Patient's or Authorized Representative's Signature – Unable to Sign'.
- If the beneficiary's illness is temporary, the signature waiver must specify the dates the illness began and ended.
- When the beneficiary is mentally competent but physically incapable of signature, the representative may be issued a general or limited power of attorney by signing an 'X' in the presence of a notary public.

Release of Medical Records

When should TRICARE beneficiaries sign a release of medical information?

Answer: All providers are required to request that the TRICARE beneficiary sign a release of medical information at each office visit (unless a signed release is on file), to include ancillary services associated with each visit whereby the primary care manager (PCM) and/or the MTF commanders are designated as the recipients of the medical records. For an urgent care visit, the records should be given to the beneficiary at the time of the visit. Providers are required to submit beneficiary records for review upon request.

Hold Harmless Policy

What is the 'Hold Harmless Policy' for TRICARE beneficiaries?

Answer: TRICARE beneficiaries must be properly informed in advance and in writing of specific services or procedures that are not covered under TRICARE before they are provided. If they choose, beneficiaries may sign a waiver agreeing to pay for non-covered services. If the provider does not obtain a legal signed waiver, and the care is not authorized, the provider is expected to accept full financial liability for the cost of the care. A waiver signed by a beneficiary after the care is rendered is not valid under TRICARE regulations.

For the beneficiary to be considered fully informed, TRICARE regulations require that:

- The agreement is documented prior to the specific non-covered services being rendered
- The agreement is in writing
- The specific treatment and date(s) of service and billed amounts are documented.

Veterans Affairs and CHAMPVA

Do the provider rates that apply to the TRICARE contract apply to the Department of Veterans Affairs (DVA) and to Civilian Health and Medical program (CHAMPVA) when the provider is a TRICARE network provider?

Answer: No.

Non-availability Statements (NAS)

What is a non-availability statement?

Answer: A certification from an MTF stating that it cannot provide a specific required service at a particular time to a non-enrolled beneficiary. Effective for admissions on or after December 28, 2003, the NAS requirement was eliminated for all inpatient admissions except for mental health admissions.

TRICARE Eligibility

Who are eligible beneficiaries for TRICARE?

Answer:

- All eligible beneficiaries from any of the 7 uniformed services (Army, Navy, Air Force, Marine Corps, Coast Guard, the U.S. Public Health Service and the National Oceanic and Atmospheric Administration.
- All eligible beneficiaries must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS).

What forms of verification should be made by providers when beneficiaries request service?

Answer:

- Ensure that patients have a valid uniformed services (military) identification (ID) card or authorization letter of eligibility.
- Be sure to check the expiration date
- Make a copy of both sides of the ID card for the files
- Beneficiaries can verify their enrollment in DEERS by calling 1-800-538-9552. A provider may not verify DEERS enrollment directly because of the Privacy Act (5 U.S.c.552a)
- Children under the age of 10 will probably not have an ID card. Providers should check the parent's ID care in these cases.

What are some of the special circumstances affecting Eligibility?

Answer:

- Family members of active duty service members lose their eligibility at midnight on the day the active duty sponsor is discharged from service unless they have extended benefits through the Transitional Assistance Management Program.
- Active duty service members *cannot* use TRICARE Standard or TRICARE Extra. They must enroll in TRICARE Prime.
- The active service member's branch of service provides for the care of active duty service members and is responsible for paying for any civilian emergency care requi4red by active duty members.

If a patient under the TRICARE Standard DRG payment system loses or gains eligibility during a hospitalization, how will the DRG hospital be paid?

Answer: As if the patient were eligible during the entire admission.

If a patient becomes eligible for Medicare because of age and is not an active duty family member during a hospitalization, how will TRICARE pay?

Answer: TRICARE's secondary pay status is for that claim only. The patient's cost-share will be based on the status of the sponsor (active duty or retired) at the time of admission.

What is 'Dual-Eligible'?

Answer: TRICARE beneficiaries under age 65 who are also entitled to Medicare Part A due to a disability or end-state renal disease (ESRD) are considered dual-eligible.

- TRICARE coverage may continue as a secondary payer to Medicare
- Must be enrolled in Part B to retain TRICARE benefits (does not apply to ADFMs regardless of age).
- May maintain their regular TRICARE eligibility (Prime, Extra or Standard).
- TRICARE will pay secondary to Medicare (similar to TRICARE for Life (TLF).
- TRICARE beneficiaries become titled to Medicare Part A upon attaining age of 65 and purchase Medicare Part B, they become eligible for TFL and TRICARE will pay secondary to Medicare.

What is the choice of a beneficiary who is eligible for benefits under both the TRICARE and VA program?

Answer:

- May choose to use TRICARE benefit at a VA medical facility as long as the service is covered under TRICARE and not a service-connected condition.
- If TRICARE is chosen, Veterans must comply with the TRICARE program rules.
- Care received in a VA facility for service-connected conditions must be received under veterans' benefits.
- If a TRICARE/VA dual-eligible beneficiary is seeking care in a facility other than a VA facility, he/she may choose to use TRICARE benefits regardless of whether it is for a service-connected condition. Once that choice is made, the TRICARE benefit must be used to complete the entire 'episode of care'. (An episode of care generally includes all covered services provided for a particular medical incident.)

What are the TRICARE Program Options?

Answer:

- TRICARE Prime
- TRICARE Extra
- TRICARE Standard
- TRICARE Prime Remote and TRICARE Prime Remote for Active Duty Family Members
- TRICARE for Life
- TRICARE Plus
- TRICARE Pharmacy Program
- TRICARE Dental Program
- TRICARE Retiree Dental Program
- TRICARE for the Reserve Component
- Temporary Reserve Health Care Benefits for 2004
- Department of Defense/National Cancer Institute Demonstration Program
- Program for Persons with Disabilities
- Supplemental Health Care Program

What is TRICARE Prime?

Answer: A managed Care Option with fewer out-of-pocket costs

- Beneficiaries who are enrolled to a civilian Primary Care Manager (PCM) receive most of their care from the civilian PCM who provides and coordinates for care, maintains patient health records and refers patients to specialists, if necessary.
- Beneficiaries who are enrolled to a military treatment facility (MTF) PCM receive most of their care from an MTF, augmented by the Humana Military Healthcare Services, Inc. (Humana Military) provider network. Specialty care must be arranged and approved by Humana Military to be covered under TRICARE Prime.

What are TRICARE Extra and TRICARE Standard and the differences in the two Programs?

Answer:

- These programs are available for all TRICARE –eligible beneficiaries who choose not to enroll in TRICARE Prime. Active Duty Service Military are not eligible for TRICARE Extra or TRICARE Standard.
- Beneficiaries are responsible for fiscal year deductibles and cost-shares.
- Beneficiaries may see any TRICARE-certified provider they choose
- TRICARE will share the cost with the beneficiaries after deductibles are met.

- *TRICARE Extra* is a preferred provider option in which beneficiaries choose a doctor, hospital or other medical provider within the Humana Military provider network.
- *TRICARE Standard* is a fee-for-service option. Beneficiaries may seek care from any TRICARE-certified provider. The out-of-pocket cost-share deductible is larger than for TRICARE Extra.

What is a Catastrophic Cap?

Answer: A Catastrophic Cap limits the out-of-pocket liability for TRICARE beneficiaries on copayments, cost-shares and deductibles.

What is TRICARE Prime Remote and TRICARE Prime remote for Active Duty Family Members?

Answer: These programs provide health care coverage through civilian network or TRICARE-certified providers for Active Duty Service Military and their families on remote assignment, typically 50 miles or a one hour drive time from a Military Treatment Facility.

What is TRICARE for Life?

Answer: A program option available for uniformed services retirees, their spouses and survivors age 65 and over who are titled to Medicare Part A and enrolled in Medicare Part B. TFL is available as secondary coverage to Medicare in addition to offering access to TRICARE services that may not be covered under Medicare. TRICARE pays secondary to Medicare beginning on the first day of the month that the beneficiary turns 65.

Who administers TRICARE for Life?

Answer: Wisconsin Physicians Service (WPS).

What is TRICARE Plus?

Answer: A primary care enrollment program that is offered at selected MTFs.

Explain TRICARE for the Reserve component.

Answer: Members of the reserve Component (RC) who are called to active duty for more than 30 consecutive days are eligible for TRICARE, the same as any ADSM. Families of these individuals also become eligible for TRICARE if the sponsor is called to active duty for more than 30 consecutive days.

What proactive step should sponsors take to ensure their family members are eligible for TRICARE upon activation?

Answer: Register their family members in DEERS.

What is the TRICARE Reserve Family Demonstration Project?

Answer: It is a nationwide project for health care services received on or after September 14, 2001 and is limited to families of Reserve and National Guard members called to active duty for periods of more than 30 days in support of operations that result from the terrorist attacks of September 11, 2001.

Name some Operations that would be included in the TRICARE Reserve Family demonstration Project?

Answer: 'Operations Enduring Freedom', 'Noble Eagle' and 'Iraqi Freedom'.

Name three components included in the TRICARE Reserve Family Demonstration Project.

Answer:

- Waiver of TRICARE Standard annual deductible
- Waiver of the TRICARE allowable charge under TRICARE Standard
- Waiver of Non-availability Statement (NAS) requirement for non-emergency inpatient care.

What is the Supplemental Health Care Program?

Answer: Coverage provided for Active Duty Service Members (except those enrolled in TPR) and non-active individuals under certain conditions when referred to civilian providers for certain services or treatments.

When Supplemental Health Care Program individuals need services that are not available at MTF, what is needed to be treated at a Civilian Provider?

Answer: A referral by the MTF physician and individuals are not responsible for deductibles, cost-shares, or copayments.

What is Emergency Care?

Answer: Emergency care is covered for medical, maternity or psychiatric emergencies that would lead a 'prudent layperson' (someone with average knowledge of health and medicine) to believe that a serious medical condition existed or that the absence of medical attention would result in a threat to life, limb, or sight, or that the person may be a danger to self or others and requires immediate medical treatment or manifests painful symptoms requiring immediate palliative effort to relieve suffering. This includes situations where a beneficiary arrives at the emergency room with severe pain. In the case of a pregnant woman, the danger to the health of the woman or her unborn child should be considered.

Who should be contacted for services for behavioral health or substance use?

Answer: ValueOptions (1-800-700-8646). The Primary Care Manager (PCM) is responsible for the coordination of all care.

Who is the Humana Military Healthcare Service, Inc. partner for claims processing in the TRICARE South Region?

Answer: PGBA, LLC (PGBA). The website is: www.mytricare.com.

How should claims be filed?

Answer: Claims should be filed electronically with the appropriate HIPAA-compliant standard electronic claims format. If there is a need for a paper claim, (CMS-1500 or UB92) should be completed accurately and fully and submitted to:

- TRICARE South Region
- Claims Department
- P. O. Box 7031
- Camden, SC 29020-7031.

What is the timely filing limit for TRICARE provider claims to be submitted to PGBA?

Answer: Within one year of the date the service was rendered or according to the provider contract.

Will TRICARE cost-share work-related illnesses or injuries that are covered under workers' compensation programs?

Answer: No

Describe the Uniformed Services Identification Card.

Answer:

- Credit Card Sized
- Incorporates a digital photograph image of the bearer
- Bar Codes containing pertinent machine-readable data
- Printed Identification and Entitlement Information
- Beneficiary category determines the ID Card's Color

What are the colors of the Uniformed Services Identification Cards?

Answer:

- Active Duty Service Members – Green
- Active Duty Family Members – Tan
- Members of the Reserve Component and their Eligible Family Members – Red
- Retirees - Blue

CHAPTER 8
COMMERCIAL

REVIEW QUESTIONS – CHAPTER 8

Children's Rehabilitation Services:

The Children's Rehabilitation Services is part of the Alabama State Department of Rehabilitation Services.
Answer: True

This service is for children with special health care needs and adults with what type of condition?
Answer: Hemophilia

Is every county in Alabama eligible for these services through community based offices?
Answer: Yes

What is the major source of funding for the 18 million dollar annual budget for this program?
Answer: The Alabama State Legislature

Do third party insurance reimbursements make up the remaining program funds?
Answer: Yes

What is the maximum age for a resident of the State of Alabama to be eligible for Children's Rehabilitation Services?
Answer: 21 and Beyond 21 with Hemophilia

The primary mode of treatment providing services is done in an outpatient clinic setting.
Answer: True

The CSR Authorization for services number serves as both an authorization to perform services, and when services are completed, the authorization number identifies an authorized invoice.
Answer: True

Vendor billing is requested to be submitted to the local CRS office on a bi-weekly or monthly basis. Billing is required no later than 60 days after services are performed.
Answer: True

Billing may be submitted on the vendor's own standard form or the Universal HCFA 1500 form.
Answer: True

Vendors are expected to process for any and all insurance carried on the patient prior to billing CRS for reimbursement of service.
Answer: True

There are some situations that may occur regarding insurance reimbursement to the vendor:

a) If reimbursement is equal to or greater than CRS fee, that is full payment.
b) If reimbursement is rejected or less than CRS fee, the vendor may bill CRS for the monetary difference up to the fee. A copy of the insurance explanation of benefits (EOB) indicating payment or rejection must be attached.
c) Both A and B

Answer: C

What is the fiscal year for Children's Rehabilitation Services?

Answer: October 1 through September 30 of each year.

Are all services and medications provided to the CRS clients required to be preauthorized?

Answer: Yes

Vocational Rehabilitation Services:

What is the largest division in the Alabama Department of Rehabilitation Services?

Answer: Vocational Rehabilitation Services (VRS)

Is eligibility for rehabilitation assistance determined by the local field counselor?

Answer: Yes

To be eligible for VRS, individuals must have a physical or mental impairment that is a substantial impediment to employment and must be able to benefit from services.

Answer: True

What are some of the covered services under the VRS?

Answer: Medical Services

May the hospital ever bill the patient for any hospital charges covered by VRS reimbursement?

Answer: No

May physicians or group of physicians under contract with the hospital, but who use separate billing, bill VRS for services provided to eligible patients?

Answer: Yes

Commercial Insurance:

Do commercial insurance companies have contractual obligations with commercial insurance carriers?

Answer: No

Commercial carriers are:

a) Charge-based payors
b) Cost-based payors
c) None of the above

Answer: A

The two basic types of commercial insurance coverage are:

a) Group Health Care Plans
b) Individual or Direct Pay Heath Care Plans
c) HMOs
d) Both A and B

Answer: D

The most apparent difference between group plans and individual plans is the source of payment of the premiums.

Answer: True

Are credit balances on any account, which only have an individual policy, usually, refunded to the provider?

Answer: No, they are usually always refunded to the patient.

When submitting claims to commercial insurance carriers, it is essential to have a file:

a) An assignment of benefits form
b) Your religion
c) Authorization to release medical information
d) Both A and C

Answer: D

What is the standard billing for commercial hospital insurance claims?

Answer: A UB04 form

Workers' Compensation:

What is effective when hospital services are required to treat an illness or injury that is the result of employment?

Answer: Workers' Compensation

In Workers' Compensation cases, a written authorization form (incident report) should be presented.

Answer: True

If a Workers' Compensation case is denied by the carrier, the patient does not have the right to appeal the denial to the State Department of Industrial Relations.

Answer: False

As long as the patient has an appeal pending, even though the claim may have been previously denied, the hospital can pursue payment from the patient.

Answer: False (can not)

Emergency Room records should accompany Workers' Compensation Emergency Room billings to avoid delay in processing.

Answer: True

COBRA:

What does COBRA stand for?

Answer: Consolidated Omnibus Budget Reconciliation Act

Under the COBRA plan, the employer must notify the Group Health Plan of an employee's termination or other changes within how many days of the qualifying event?

Answer: 30 days

CHAPTER 9

UB04 CLAIM FORM

GENERAL INTRODUCTION

IDENTIFICATION BY FORM LOCATOR NUMBERS

INTRODUCTION

The UB-04, is a paper billing form that can be translated into an electronic format. In its electronic form, it is referred to as a "flat file". On screen, it resembles the paper form. The UB04 was developed by the National Uniform Billing Committee (NUBC), a consortium of providers and payers chaired by the American Hospital Association (AHA). The NUBC, formally organized in 1975, functions as a collective body whose primary goal is to bring some standardization to healthcare data collection. Prior to its inception, uniform bills were developed and implemented with varying degrees of success in a number of states. In 1978, the Health Care Financing Administration (HCFA) agreed to participate in a five state pilot test of the then latest version of a uniform hospital bill, the UB-16-78. As a result of an evaluation of this project, together with deliberations of the NUBC, the UB-82, often referred to as Medicare's master bill for inpatient services, emerged as the uniform hospital bill and endorsed by both the provider and third party representatives which served on the NUBC.

The uniform bill for institutional providers today is known as the UB-04. It was approved y the Nation al Uniform Billing Committee (NUBC) at its February 2005 meeting. The UB-04 is the replacement for the UB-04 form, which replaced the UB-92 form in 2007, and represents the culmination of a four-year study. The members of the NUBC mutually agreed to the data elements for inclusion into the UB-04 Manual and the layout of the UB-04 form. Many of the data elements referenced in the UB-04 Manual are also used in the electronic claim standard as called upon by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Consequently, there was additional emphasis placed on aligning the reporting instructions to closely mirror the HIPAA claim standard for institutional providers. Other HIPAA changes included adding forthcoming national identifiers for providers and health plans.

In additional to aligning the UB-04 to the electronic standard, the NUBC recognized the changing need for information and its importance with respect to health services research and health policy development. As a result, the NUBC introduced several new data elements to the UB-04 to further improve the understanding of health care services. Most of the UB-04, however, is conceptually similar to earlier versions—the UB-04 and UB-92.
The NUBC has learned that a few Medicaid programs will not be ready for the UB-04 by the May 23, 2007date As an alternative to maintaining two concurrent paper systems (one for UB-04 and one for the UB-92), the NUBC has encouraged providers to submit claims electronically using the HIPAA 837 transaction standard.

UB-04 Implementation and NPI

TRANSITION:
Receivers (health plans and clearinghouses) were to have been ready to receive the new UB-04 by March 1, 2007. Submitters (health care providers such as hospitals, skilled nursing facilities, hospice, and other institutional claim (filers) could use the UB-04 beginning March 1, 2007; however, there was a transition period between March 1, 2007 and May 22, 2007 where either the UB-04 or the UB-92 could be used. Starting May 23, 2007 all institutional paper claims must use the UB-04; the UB-92 will no longer be acceptable after that date.

NPI Contingency: MPI and Legacy Id Reporting on UB-04

The reporting of the NPI on the UB-04 follows the NPI final Rule and subsequence Guidance on Compliance with the HIPAA National Provider issued by CMS ("contingency notice"). The recent NPI contingency notice has no effect on the implementation of the UB-04.

The UB-04 allows the reporting of the NPI, the legacy ID number, or both. The NUBC is recommending reporting both numbers on the UB-04 if they are readily available during the CMS contingency period (the 12 month period after the compliance date (i.e., through May 23, 2008). This contingency period provides additional time for conducting testing that can eventually lead to exclusive NPI only claims. The NPI contingency notice

Recommends increasing communication with health plans and others about NPI readiness. The purpose of the communication is to determine whether a health plan has adopted a contingency plan and the specifics surrounding their plan (duration, testing, etc.) The approach providers should follow will be based on readiness on their part, that of the trading partners, and whether testing and vendor system support is available.

Guide to the UB-04 Manual

The UB-04 Manual is the Official source for the UB-04 information adopted by the NUBC. It is organized by the corresponding boxes or "form Locators" on the paper UB-04. The Manual also includes a crosswalk to help users understand the changes from the UB-04 to the UB-92.

The first page of each Form Locator contains the data element name, a brief description, and the reporting requirements for the data elements for submission in either paper or electronic format. Also included are the field attributes for each data element, i.e., alphanumeric/numeric characteristics, left/right justification and the numbers of lines, subfields and positions available on the paper form. Finally, on some pages you will find usage notes that further explain or elaborate on the reporting of information. There are some form locators that have specific codes along with a narrative description of the code. Codes are listed in numeric order followed by alpha order. "Reserved" (unassigned) codes are not to be used; only the NUBC members will determine when they should be approved for a particular purpose.

The UB-04 also contains a section established for State Guidelines. This section is intended to elaborate on the special reporting requirements established by the state billing committee for the purpose of reporting to state data gathering agencies or the reporting to worker's compensation programs. This section should not be used for establishing different or unique billing requirements at the state level; it is intended solely for reporting not covered under the HIPAA legislative provisions.

UPDATES

A major change for 2008 relates to the revamping of Source of Admission Codes. The new code list (now called "Point of Origin for Admission or Visit") becomes effective October 1, 2007 and should eliminate much of the ambiguity associated with the original code sent.

All coding changes are detailed in the NUBC meeting minutes available to subscribers. Routine NUBC code maintenance is published annually each July 1 in a new version of the manual. Errata, information on new codes, clarifications, emergency (off-cycle) changes, together with their respective effective dates, and other guidance will also be posted periodically to the subscribers section of the NUBC website (http://www.nubc/org/).

The NUBC typically meets several times a year at the AHA's offices in Chicago to discuss and approve/deny changes requested from the State Uniform Billing Committees (SUBCs), HCFA, and other payers. Obviously, issues discussed at the NUBC are not limited to the paper format; they also encompass discussions regarding the electronic format. These meetings are usually open to the public and, any change requests are required to be submitted in writing to the Chairman of the NUBC. It is important to note that while everyone is allowed to express their opinions, the NUBC distributes votes based on a balanced number of votes given to payer and provider representatives. Committee votes are allocated as follows:

Provider Organizations: (8 votes)			Payer Organizations: (8 Votes)	
AHA	-	4	HCFA-BPO	1.142857
HFMA	-	1	HCFA – Medicaid Bureau	1.142857
FAHS	-	1	Medicaid (State)	1.142857
Homecare	-	1	CHAMPUS	1.142857
AHCA	-	1	BCBSA	1.142857
			HIAA	1.142857
			GHAA	1.142857

State Hospital Assn. NO VOTE
OH, MA, CA

UB – 04

IDENTIFICATION BY LOCATOR NUMBER

1 – BILLING PROVIDER NAME, ADDRESS, PHONE NUMBER
2 – PAY-to NAME AND ADDRESS
3a – PATIENT CONTROL NUMBER
3b – MEDICAL /HEALTH RECORD
4 – TYPE OF BILL – INPATIENT, OUTPATIENT, OR ADJUSTMENTS
- 111 – ADMIT THRU DISCHARGE
- 112 – INTERIM BILL
- 113 – CONTINUING BILL
- 114 – LAST INTERIM BILL
- 117 – INPATIENT – REPLACEMENT OF PRIOR CLAIM
- 131 – OUTPATIENT
- 137 – OUTPATIENT – REPLACEMENT OF PRIOR CLAIM
- 211 – SKILLED NURSING

5 – FEDERAL TAX NUMBER
6 – DATES COVERED ON THIS PARTICULAR CLAIM (FROM – TO)
7 – RESERVED for ASSIGNMENT by the NUBC
8 – PATIENT NAME/IDENTIFIER
9 – PATIENT ADDRESS
10 – PATIENT BIRTH DATE
11 – PATIENT SEX
12 – ADMISSION/START of CARE DATE
13 – ADMISSION HOUR
14 – PRIORITY (TYPE) of VISIT
15 – SOURCE OF REFERRAL for ADMISSION or VISIT (discontinued 10-1-07)
15 – SOURCE of ORIGIN for ADMISSION or VISIT (effective 10-1-07)
16 – DISCHARGE HOUR
17 – PATIENT DISCHARGE STATUS
18 – 28 CONDITION CODES
29 – ACCIDENT STATE
30 – RESERVED for ASSIGNMENT by the NUBC
31 – 34 OCCURRENCE CODES and DATES
35 – 36 OCCURRENCE SPAN CODES and DATES

37 – RESERVED for ASSIGNMENT by the NUBC
38 – RESPONSIBLE PARTY NAME and ADDRESS
39 – 41 VALUE CODES and AMOUNTS
42 – REVENUE CODES
43 – REVENUE DESCRIPTION
44 – HCPCS/ACCOMODATION RATES/HIPPS RATE CODES
45 – SERVICE DATES
46 – SERVICE UNITS
47 – TOTAL CHARGES
48 – NON-COVERED CHARGES
49 – RESERVED for ASSIGNMENT by the NUBC
50 – PAYER NAME
51 – HEALTH PLAN IDENTIFICATION NUMBER
52 - RELEASE of INFORMATION CERIFICATION INDICATOR
53 – ASSIGNEMNT of BENEIFTS CERTIFICATION INDICATOR
54 – PRIOR PAYMENTS – PAYER
55 – ESTIMATED AMOUNT DUE – PAYER
56 – NATIONAL PROVIDER IDENTIFIER – BILLING PROVIDER
57 – OTHER (BILLING) PROVIDER IDENTIFIER
58 – INSURED'S NAME
59 – PATIENT'S RELATIONSHIP to INSURED
60 – INSURED'S UNIQUE IDENTIFIER
61 – INSURED'S GROUP NAME
62 – INSURED'S GROUP NUMBER
63 – TREATMENT AUTHORIZATION CODE
64 – DOCUMENT CONTROL NUMBER (DCN)
65 – EMPLOYER NAME (of the INSURED)
66 – DIAGNOSIS and PROCEDURE CODE QUALIFIER (ICD version indicator)
67 – PRINCIPAL DIAGNOSIS CODE and PRESENT ON ADMISSION INDICATOR
67a- Q- OTHER DIAGNOSIS CODES
68 – RESERVED for ASSIGNMENT by the NUBC
69 – ADMITTING DIAGNOSIS CODE
70a-c – PATIENT'S REASON for VISIT
71 – PROSPECTIVE PAYMENT SYSTEM (PPS) CODE
72 a-c – EXTERNAL CAUSE of INJURY (ECI) CODE
73 – RESERVED for ASSIGNMENT by the NUBC
74a_e – PRINCIPAL PROCEDURE CODE and DATE
75 – RESERVED for ASSIGNMENT by the NUBC
76 – ATTENDING PROVIDER NAME and INDENTIFIERS
77 – OPERATING PHYSICIAN NAME and INDENTIFIERS
78/79 – OTHER PROVIDER NAME and IDENTIFIERS
80 – REMARKS FIELD
81 – CODE-CODE FIELD

REVIEW QUESTIONS – CHAPTER 9

The UB-04 is a paper billing form that can be translated into electronic format. It can also be referred to as a flat file.

Answer: True

NUBC is the acronym for:

Answer: National Uniform Billing Committee

The function of the NUBC was to bring some standardization to healthcare data collected.

Answer: True

CMS (formally known as HCFA) is the acronym for:

Answer: Center for Medicaid/Medicare Services

The UB-04 is often referred to as Medicare's master bill for inpatient services.

Answer: True

The UB-04 has how many fields or form locators?

a) 80
b) 81
c) 86

Answer: 81

The NPI is the acronym for National Provider Identifier and is required data on May 23, 2008?

Answer: True

CHAPTER 10

CUSTOMER SERVICE

GENERAL INFORMATION

WHAT IS CUSTOMER SERVICE ?

WHO ARE OUR CUSTOMERS ?

What are their needs?

TELEPHONE ETIQUETTE

HANDLING THE IRATE CUSTOMER

Abusive Callers

KEYS TO GOOD CUSTOMER SERVICE

GENERAL INFORMATION

Successful companies know that the **first impression** is a lasting one.

Good Customer Service is all about customers coming back and sending customers away happy. Customers are the lifeblood of any business.

Customers form an opinion based on their interaction with the employees. **You** are the company, no matter what your job! During each encounter, you have the opportunity to create a positive memory of your organization or a negative one. *The success or failure of your organization depends on the customer's perception of their interaction or service.*

Present a positive attitude to customers. The attitude you project to others depends on the way you look at your job. You should have a confident attitude and welcome the challenges you will face each day. You should strive to provide quality service every day to everyone.

WHAT IS CUSTOMER SERVICE ?

According to the ACA Group, customer service is the ability of an organization to constantly and consistently give the customer what they want and need. This definition goes beyond the traditional way we think about customer service. It covers areas that do not come in direct contact with the customer at all.

Accepting this definition means expanding our thinking about customer service. In order to consistently exceed customers' expectations, we must recognize that every aspect of our business has an impact on customer service, not just those aspects of our business that involve face-to-face customer contact. To demonstrate excellent service involves making a commitment to learning what our customers' needs and wants are, and developing action plans that implement customer friendly processes.

WHO ARE OUR CUSTOMERS ?

Always identify and know just who your customers are. Often we want to exclude the person sitting beside us or other departments within our organizations. However, our customers are internal and external. We are to treat every customer (internal or external) with thoughtfulness, courtesy, warmth and respect. The following are some examples of who are customers might be:

Patient,
Patient's family,
Visitors,
Co-workers
Insurance Companies

What are their needs?

Identify the needs of your customer. *Listening* to the customer is the key to identifying their needs. You need to be able to look at situations through "your customer's eyes". Following is a list of some human needs that customers have:

need to feel welcome
need for timely service
need to feel comfortable
need to be understood
need to receive help or assistance
need to feel important
need to be appreciated
need for respect

TELEPHONE ETIQUETTE

When you are on the telephone with a customer, you represent your company.

Following are some tips to keep in mind:

1. Answer the phone promptly. A general rule is to answer on the second ring.

2. Greet the caller. Take a breath and smile before you pick up the phone. A friendly greeting such as "Good Morning" or "Thank you for calling" is a pleasant way to begin a conversation. Introduce the hospital or department and your name.

3. Offer assistance. Indicates that you are ready and eager to help. Ask the caller "How may I help you?" or "What may I help you with today?"

4. Listen empathetically. Listen carefully to the caller's introduction and situation. You want to listen with the intent to really understand how the customer feels.

5. Use the caller's name. A person's name should be used at least once throughout the conversation. Make a special effort to use names correctly.

6. Placing the caller on hold. Always ask the caller if they will hold. For example, "Would you mind holding?" Check with the caller throughout a long hold. A minute seems forever when you are on hold and thank the caller for holding.

7. Offer additional service. By offering additional service, you can confirm satisfaction. Always ask the caller "Is there anything else I can help you with?"

HANDLING THE IRATE CUSTOMER

There are times when service situations are frustrating. Not all customers will be satisfied with the service or product they receive. Nancy Friedman, the telephone doctor, offers the following suggestions when handling the irate customer:

Don't take it personal. The customer isn't unhappy with you, but the situation.

Acknowledge the person's feelings and apologize for the inconvenience the customer has encountered.

Sympathize and empathize with the caller. "I can understand why you are upset," helps soothe ruffled feathers. Pretend it is you calling. Then get busy solving the problem.

Accept 100 percent responsibility for the call. Chances are you had nothing to do with the problem. However, it is your job to accept responsibility and initiate work on a solution.

Prepare to help. Begin by reintroducing yourself. State that you will be able to help. Use the caller's name, if possible, which helps diffuse the anger.

Abusive Callers

Unfortunately, there are callers who use abusive language and as a service representative you are not required to listen to abusive language. Try the Telephone Doctor® "swear stopper" technique. Say to the caller in a firm, but pleasant voice, "Excuse me, I can handle your problem; that's no problem, but I'm not able to handle your abusive language." By using this wording, you are taking control of the conversation. Then immediately begin asking questions that will help solve the problem. This helps you stay in control of the conversation.

KEYS TO GOOD CUSTOMER SERVICE

Value the customer. Treat every customer with respect and courtesy. Always make customers feel important and valued. Keeping customers is crucial to staying in business.

Attitude is Key. It is important to always keep a positive attitude. You are the company to your customers. Use phrases like "we" and "our" instead of "they" and "their".

Listening is crucial. It is annoying to tell someone your problem and realize that the person has not been paying attention.

Keep your promises. This shows integrity and honesty. Do not make promises to customers that you cannot keep. Think before you make promises since broken promises annoy customers.

Exceptional service. In addition to meeting the needs of customers, Go above and Beyond the call of duty. Go the extra mile to make customers happy.

Feedback from customers is **essential to provide quality service.**

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- It creates an **awareness of what is being done** well and **where improvement is needed.**
- **Each encounter is the moment of truth**. Customers will be either satisfied or dissatisfied. Often "dissatisfied" customers will not come back and will tell 1 out of 5 people they know.
- **"The Customer is always Right."** Even if it is obvious that the customer is wrong, it is better to take the loss and compensate the customer.

REVIEW QUESTIONS – CHAPTER 10

Attitude is the Key:

The success or failure of your company depends on your attitude.
Answer: True

Always dress for success. Be neat, well groomed and professionally dressed. Keep your hair and nails clean.
Answer: True

You should keep your work area cluttered and dirty. Your building equipment should be filled with pencil marks.
Answer: False

Try to frown and do not have eye contact with your customer.
Answer: False

Speak in a pleasant tone. Speak clearly and naturally. Be sure to project your voice from your diaphragm rather than your throat.
Answer: True

Dissatisfied customers will not come back and will tell 1 out of 5 people the way they were treated.
Answer: True

Telephone Etiquette:

A general rule is to answer the phone by which ring?
Answer: The second ring

Always answer the phone with your name, social security number and rank.
Answer: False

Should you ask the caller ”How may I help you?” or “What can I help you with?”
Answer: Yes

Should you listen and respond to customers with sympathy or empathy?
Answer: Listen empathetically to really understand how the customer feels.

Never use the callers’ name when referring to the caller.
Answer: False

How many times should the callers’ name be used during the conversation?
Answer: A callers’ name should be used at least once throughout the conversation.

When placing a customer on hold, always ask the customer if they mind holding.
Answer: True

Which of the following phrases best describes offering additional services; “What’s next?” “Bye now” or “Is there anything else I can help you with?”

Answer: Offer additional service by asking, “Is there anything else I can help you with?”

By offering additional services, you can confirm the customers’ satisfaction with your services and how they were treated.

Answer: True

Quality Service:

Which of the following should be used to treat every customer; care and prayer, respect and courtesy, or loyalty and favoritism?

Answer: The customer should be valued and treated with respect and courtesy.

Listening to the customer is the key to identifying their needs. All customers’ need to;

a) Feel welcome
b) Feel comfortable
c) Feel important
d) Feel understood
e) All of the above

Answer: E

Should the needs of every customer be met?

Answer: Yes

You can handle irate customers by;

a) Listening to the complaint
b) Acknowledging the customers feelings
c) Apologizing on behalf of your company
d) Explain what action you will take to correct the problem
e) All of the above

Answer: E

How is feedback from customers essential to providing quality service?

Answer: It provides an awareness of what is being done well and where improvements are needed.

CHAPTER 11
NURSING HOME FACILITIES

Nursing Facility

Enrollment

Benefits and Limitations

Reimbursement and Payment Limitations

Nursing Facility

Medicaid reimburses medically necessary nursing facility services other than services provided in an institution for tuberculosis. Nursing facilities must meet the licensure requirements of the Alabama Department of Public Health and the certification requirements of Title XIX and XVIII of the Social Security Act, and must comply with all applicable state and federal laws and regulations.
A nursing facility is an institution that primarily provides one of the following:
· Nursing care and related services for residents who require medical or nursing care
· Rehabilitation services for the rehabilitation of injured, disabled, or sick persons

· Health care and services to individuals who require a level of care available only through institutional facilities

A facility may not include any institution for the care and treatment of mental disease except for services furnished to individuals age 65 and over, nor any institutions for the mentally retarded or persons with related conditions.
The policy provisions for nursing facility providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 10, and Part 483 of the Code of Federal Regulations.

Enrollment

EDS enrolls nursing facility providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code,* and the *Alabama Medicaid Provider Manual.*
Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a nursing facility is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for nursing facility-related claims.

Nursing facility providers are assigned a provider type of 11 (Nursing Facility). The valid specialty for nursing facility providers is Nursing Facility (S5).

Enrollment Policy for Nursing Facility Providers

To participate in the Alabama Medicaid Program, nursing facility providers must meet the following requirements:

· Possess certification for Medicare Title XVIII

· Submit a budget to the Provider Reimbursement Section at Medicaid for the purpose of establishing a per diem rate

· Execute a Provider Agreement and a Nursing Facility/Patient Agreement with Medicaid

The Provider Agreement presents in detail the requirements imposed on each party to the agreement. It is also the document that requires the execution of the Nursing Facility/Patient Agreement.

The Nursing Facility/Patient Agreement must be executed promptly for each patient on admission. One

copy of the agreement is given to the patient/sponsor and a copy is retained by the nursing facility. The completed Nursing Facility/Patient Agreement becomes an audit item by Medicaid.

EDS is responsible for enrolling all nursing facility providers including any Medicare certified nursing facilities who wish to enroll as a QMB Medicare only provider.

Renewal Process for Nursing Facilities

The Alabama Department of Public Health conducts annual re-certification of all nursing facility providers and provides the re-certification information to Medicaid.

Benefits and Limitations

This section describes program-specific benefits and limitations. Providers should refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Nursing facilities must be administered in a manner that enables them to use their resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident.

Nursing facilities must comply with Title VI of the Civil Rights Act of 1964, the Federal Age Discrimination Act, Section 504 of the Rehabilitation Act of 1973, and the Disabilities Act of 1990.
Nursing facilities must maintain identical policies and practices regarding transfer, discharge, and covered services for all residents regardless of source of payment.

Nursing facilities must have all beds in operation certified for Medicaid participation.
Nursing facilities must not require a third party guarantee of payment to the facility as a condition of admission, expedited admission, or continued stay in the facility.

Nursing facilities may require an individual who has legal access to a resident's income or available resources to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

Covered Services
The following services are included in basic nursing facility charges:

- All nursing services to meet the total needs of the resident, including treatment and administration of medications ordered by the physician
- Personal services and supplies for the comfort and cleanliness of the resident (see below)
- Room (semiprivate or ward accommodations) and board, including special diets and tube feeding necessary to provide proper nutrition. This service includes feeding residents unable to feed themselves.
- All services and supplies for incontinent residents, including diapers
- Bed and bath linens, including linen savers
- Nursing and treatment supplies as ordered by the resident's physician or required, including needles, syringes, (catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W)
- Safety and treatment equipment such as bed rails, standard walkers, standard

wheelchairs, intravenous administration stands, suction apparatus, oxygen concentrators and other items generally provided by nursing facilities for the general use of all residents

- Materials for prevention and treatment of bed sores

- Medically necessary over-the-counter (non-legend) drug products when ordered by a physician. Generic brands are required unless the brand name is specified in writing by the physician.

- Personal apparel laundry services

Personal services include assistance with eating, dressing, toilet functions, bathing, brushing teeth, combing hair, and shaving; hair and nail hygiene services; basic personal laundry; and incontinence care.

Personal supplies include items necessary to permit the resident to maintain a clean, well-kept personal appearance, including hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents (when indicated to treat special skin problems or to fight infection), razors, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleanser, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, and over-the-counter drugs.

Non-covered Services

The following special services are not ordinarily included in basic nursing facility charges: · Prosthetic devices, splints, crutches, and traction apparatus for individual residents

- Personal services, when requested by the resident/sponsor, when provided by the facility, and when charges are itemized for the sponsor by services rendered (dry cleaning of personal apparel; beauty and barber services provided by professional barbers and beauticians; radio, television, and telephone services)
  Services of licensed professional physical therapist
  Dental services and supplies
  Special duty nurse and/or sitter
  Additional charge for private room
  Special inhalation equipment such as positive pressure treatment and oxygen

These services, drugs, or supplies may be provided by the nursing facility or by arrangement with other vendors by mutual agreement between resident, sponsor, and the nursing facility.

Other services are provided by Medicaid under separate programs, including prescription drugs as listed in the Alabama Drug Code Index, hospitalization, laboratory and x-ray services, and physician services.

Payment for Reservation of Beds

Medicaid does not pay for beds for residents who are temporarily absent on admission to a hospital.

Therapeutic Visits

Payments to nursing facilities will only be made for therapeutic visits not to exceed three days per visit and eight such visits per patient during any calendar year; limited to two visits per calendar quarter to home, relatives and friends.

The nursing facility must ensure that each therapeutically indicated visit by a patient to home, relatives, or friends is authorized and certified by a physician.
Medicaid is not responsible for the record-keeping process involving therapeutic leave for the nursing facility. Medicaid will track the use of therapeutic leave through the claims processing system.

The nursing facility must provide written notice to the resident and a family member or legal representative of the resident, specifying the Medicaid policy when a resident takes therapeutic leave and when a resident transfers to a hospital.

The nursing facility must establish and follow a written policy under which a resident who has been hospitalized or who exceeds therapeutic leave policy is readmitted to the facility. Patients are readmitted immediately upon the first available bed in a semi-private room if the resident requires the services provided by the facility.

Residents with Medicare Part A
Medicaid may pay the Part A coinsurance for the 21st through the 100th day for Medicare/Medicaid eligible recipients who qualify under Medicare rules for skilled level of care.
An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the facility's Medicaid rate will be paid for the 21st through the 100th day. No payment will be made by Medicaid for nursing care in a nursing facility for the first 20 days of care for recipients qualified under Medicare rules.
Nursing facilities must ensure that Medicaid recipients eligible for Medicare Part A benefits first use Medicare benefits before accepting a Medicare/Medicaid recipient as a Medicaid resident.
Residents who do not agree with adverse decisions regarding level of care determinations should contact the Medicare fiscal intermediary.

Application of Medicare Covered
Patients 65 years or older may be eligible for Medicare coverage up to 100 days.
Nursing facilities must apply for eligible Medicare coverage prior to Medicaid coverage.
Nursing facilities cannot apply for Medicaid eligibility while a patient is receiving Medicare until Medicare coverage is discontinued.

Periods of Entitlement
The earliest date of entitlement for Medicaid is the first day of the month of application for assistance when the applicant meets all requirements for medical and financial eligibility.
Individuals with income in excess of the Federal Benefit Rate (FBR) can become eligible for Medicaid after they have been in an approved medical institution for 30 continuous days. After completing 30 continuous days the individual is entitled to retroactive coverage to the first day of the month of entry provided the recipient meets all other points of eligibility.
Individuals entering the nursing facility who are Medicaid eligible through SSI will be eligible for the month in which they enter the nursing facility. Eligibility after the first month must be established through the Medicaid District Office unless the individual's income is less than $50. An individual with income less than $50 must be certified for SSI by the Social Security Administration.
An applicant must be medically approved by Medicaid or Medicare prior to financial approval.
Financial eligibility will be established in accordance with the *Alabama Medicaid Agency Administrative Code,* Chapter 25.
Retroactive Medicaid coverage is an exception to the above. An individual who has been living in the nursing facility prior to application and has unpaid medical expenses during that time can seek retroactive Medicaid coverage for up to three months prior to financial application if the individual meets all financial and medical eligibility requirements during each of the three prior months.
For a determination of medical eligibility for retroactive Medicaid coverage, the nursing facility should furnish Medicaid with Form MED-54, attaching all physician's orders, physician's progress notes, and nurse's notes for the period of time in question.

Resident Records
Medicaid monitors the admission and discharge system and maintains a record for each active patient in the nursing facility.
An inactive file is kept for three years on each resident who has been discharged or has died.

Nursing Aide Training

A nursing facility must not use (on a full-time, temporary, per diem, or other basis) any individual as a nurse aide in the facility for more than four months unless the individual has completed training and a competency evaluation program approved by the state.
The Alabama Department of Public Health is responsible for the certification of the Competency Evaluation programs and maintains a nurse aide registry.

Pre-admission Screening and Resident Review
All individuals seeking admission to a nursing facility must be evaluated to determine if there is an indication of mental illness, mental retardation, or a related condition and whether the individual's care and treatment needs would most appropriately be met in the nursing facility or in another setting.
An accurate Level I screening document (LTC-14) must be completed for each person applying for admission to a nursing facility. This document is completed by the referral source, such as the attending physician or the referring agency/hospital.
The Alabama Department of Mental Health and Mental Retardation provides pre-admission screening and resident reviews on all present nursing facility residents with a diagnosis of mental illness and/or mental retardation.

The Alabama Department of Mental Health and Mental Retardation conducts the Level II Screenings on each resident with a primary or secondary diagnosis of MI/MR and determines the resident's need for active treatment.
For all residents with a primary or secondary diagnosis of MI/MR, the Alabama Department of Mental Health determines appropriate placement in a nursing facility based on the results of the Level II Screening and Medicaid medical criteria.

Admission Criteria
The principal aspect of covered care relates to the care rendered. The controlling factor in determining whether a person receives covered care is the medical supervision that the resident requires. Nursing facility care provides physician and nursing services on a continuing basis. The nursing services are provided under the general supervision of a licensed registered nurse. An individual may be eligible for nursing facility care under the following circumstances:

- The physician must certify the need for continuing stay.

- The recipient requires nursing care on a daily basis.

- The recipient requires nursing services that as a practical matter can only be provided in a nursing facility on an inpatient basis.

- Nursing services must be furnished by or under the supervision of an RN and under the general direction of a physician.

A nursing care resident must require two **or more** of the following specific services:
- Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment

- Restorative nursing procedures (such as gait training and bowel and. bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis

- Nasopharyngeal aspiration required for the maintenance of a clear airway

- Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created

- Administration of tube feedings by nasogastric tube

- Care of extensive decubitus ulcers or other widespread Skin disorders

- Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse
- Use of oxygen on a regular or continuing basis
- Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, post operative, or chronic conditions
- Comatose patient receiving routine medical treatment

The above criteria apply to all admissions to a nursing facility with the exception of Medicaid residents who have had no break in institutional care since discharge from a nursing facility. These residents need to meet only one of the above criteria.

Medical Director
The nursing facility shall retain a physician licensed under state law to practice medicine or osteopathy, to serve as medical director on a part-time or full time basis as is appropriate for the needs of the residents and the facility.

- If the facility has an organized medical staff, the medical director shall be designated by the medical staff with approval of the governing body.

- A medical director may be designated for a single facility or multiple facilities through arrangements with a group of physicians, a local medical society, or a hospital medical staff, or through another similar arrangement.

The medical director is responsible for the overall coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to residents.
The medical director is responsible for the development of written bylaws, rules, and regulations that are approved by the governing body and include delineation of the responsibilities of attending physicians.
The medical director coordinates medical care by meeting with attending physicians to ensure that they write orders promptly upon admission of a patient, and periodically evaluating the professional and supportive staff and services.

The medical director is also responsible for surveillance of the health status of the facility's employees, and reviews incidents and accidents that occur on the premises to identify hazards to health and safety.
The medical director gives the administrator appropriate information to help ensure a safe and sanitary environment for residents and personnel.

The medical director is responsible for the execution of resident care policies.

Conditions Under Which Nursing Facility Is **Classified as Mental Disease** Facility

If the facility under examination meets one of the following criteria, Medicaid considers the facility to be maintained primarily for the care and treatment of individuals with mental disease:

- It is licensed as a mental institution.
- It is advertised as a mental institution.
- More than fifty percent (50%) of the patients receive care because of disability in functioning resulting from a mental disease.

Mental diseases are those listed under the heading of Mental Disease in the Diagnostic and *Statistical Manual of Mental Disorders, Third Edition, International Classification of Diseases,* adopted for use in the United States, except mental retardation.

Conditions Under Which Nursing Facility Is Not **Classified as Mental Disease Facility**

Nursing facilities located on grounds of state mental hospitals or in the community must meet specific conditions in order to qualify for federal matching funds for care provided to all individuals eligible under the state plan.

Medicaid is responsible for coordinating with the proper agencies concerning the mental disease classification of nursing facilities. Facilities are NOT considered institutions for mental disease if they meet any of the following criteria:

- The facility is established under state law as a separate institution organized to provide general medical care, and provides such care.
- The facility is licensed separately under state law governing licensing of medical institutions other than mental institutions.
- The facility is operated under standards that meet those for nursing facilities established by the responsible State authority.
- The facility is dually certified under Title XVIII and XIX.
- The facility is not maintained primarily for the care and treatment of individuals with mental disease.
- The facility is operated under policies that are clearly distinct and different from those of the mental institutions, and the policies require admission of patients from the community who need the care it provides.

Nursing facilities in the community must meet all but the last of the preceding policy conditions in order to provide care to eligible individuals under the state plan.

Nursing facilities on the grounds of mental hospitals must meet all of the preceding policy conditions in order to provide care to eligible individuals under the state plan.

The facilities that do not meet the conditions listed above are classified as institutions for mental diseases for Medicaid payment purposes. In such facilities, unless the facility is JCAHO-accredited as an inpatient psychiatric facility, payments are limited to Medicaid patients who are 65 years of age and older. If the facility is JCAHO-accredited as an inpatient psychiatric facility, payments may be made on behalf of the individuals who are under age 21 or are 65 years of age and older.

Medicaid Per Diem Rate Computation

The Medicaid per diem rate is determined under reimbursement methodology contained in the *Alabama Medicaid Agency Administrative Code,* Chapter 22. The rates are based on the cost data contained in cost reports (normally covering the period July I through June 30).

Reimbursement and Payment Limitations
Reimbursement is made in accordance with the *Alabama Medicaid Agency Administrative Code,* Chapter 22.

Each nursing facility has a payment rate assigned by Medicaid. The patient's available monthly income minus an amount designated for personal maintenance (and in some cases, amounts for needy dependents and health insurance premiums) is first applied against this payment rate, and then Medicaid pays the balance.

- The nursing facility may bill the resident for services not included in the per diem rate (non-covered charges) as explained in this section.

- Actual payment to the facility for services rendered is made by the fiscal agent for Medicaid in accordance with the fiscal agent billing manual.

Medicaid defines a ceiling for operating costs for nursing facilities. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 22, or contact the Provider Audit Division at the Agency for more details.

Nursing Facility Records

Nursing facilities are required to keep the following minimum records:

- Midnight census by patient name at least one time per calendar month (more frequent census taking is recommended)

- Ledger of all admissions, discharges, and deaths

- Complete therapeutic leave records

- A monthly analysis sheet that summarizes all admissions and discharges, paid hold bed days, and therapeutic leave days

Refer to Appendix E, Medicaid Forms, for the Nursing Facility Statistical Report. This is the recommended analysis sheet; however, providers may use any form of their own design if it provides the same information.

Cost Reports

Each provider is required to file a complete uniform cost report for each fiscal year ending June 30. The complete uniform cost report must be received by Medicaid on or before September 15. Should September 15 fall on a state holiday or weekend, the complete uniform cost report is due the next working day. Please prepare cost reports carefully and accurately to prevent later corrections or the need for additional information.

Review of Medicaid Residents
Medicaid or its designated agent performs the following reviews of services provided to Medicaid residents in nursing facilities.

- Pre-admission review on all Medicaid residents to assure the necessity and appropriateness of their admission and that a physician has certified the need for nursing facility services. Medicaid certifies the resident at the time of admission using the following forms: MDS assessment, Level 1 Screening and Level II Screening where appropriate. Medicaid certifies the resident at the time of readmission. A control number is provided for each new Medicaid resident admitted.

- Review of the effectiveness of discharge planning

- Review for quality assessment and assurance

Prior Authorization and Referral Requirements

The application to establish medical need for Medicaid benefits is a two-step process consisting of the following:

- For applications that are prior authorized, performing the prior authorization procedure through Medicaid's Long Term Care Admissions Records Unit

- For applications that are not prior authorized, approval or denial of medical eligibility made by Medicaid in-house physician

Providers use the following procedures to obtain prior authorization:

- All Medicaid certified nursing facilities are required to furnish the LTC Admissions Records Unit with an admission application packet within 60 days from the date Medicaid coverage is requested. The 60 days are calculated from the date the application is received and date stamped in the LTC Admissions Records Unit. All applications with a date greater than 60 days old are assigned an effective date that is 60 days prior to the LTC Admissions Records Unit stamp date. No payment will be made for the days between the requested date and the assigned LTC effective date. The facility will be informed in writing of the assigned effective date.

- A MED 54 (Request for Retroactive Eligibility) may not be used to cover the time lost due to an application over 60 days old. Retroactive Eligibility may be granted for periods prior to the time lost due to the 60-day late period. The family or sponsor may not be charged for the non-covered period.

The admission application packet consists of the following:

- A fully completed written application form XIX-LTC-9 and an LTC-4. The facility and the applicant's attending physician must provide as much information as exists on each question on the LTC-9 and LTC-4, attaching documentation where such is available. All required medical information must be submitted.

- A fully completed Level 1 Screening for Mental Illness/Retardation/Related Condition (LTC-14)

- For a person with a diagnosis of mental retardation and/or mental illness, a fully completed DMH PSO 1 (Medical and Drug History), DMH PSO 2 (Psychosocial Assessment), DMH PSO 3 (Psychiatric History), and DMH PSO 4 (Pre-admission Screening Report)

A total evaluation of the resident must be made before admission to the nursing facility or authorization for payment.
An interdisciplinary team of health professionals, which must include the resident's attending physician, must make a comprehensive medical, social, and psychological evaluation of the resident's need for care. The evaluation must include each of the following medical findings:

- Diagnosis
- Summary of present medical, social, and developmental findings
- Medical and social family history
- Mental and physical functional capacity
- Prognosis
- Kinds of services needed
- Evaluation of the resources available in the home, family, and community
- The physician's recommendation concerning admission to the nursing facility or

continued care in the facility for residents who apply for Medicaid while in the facility and a plan of rehabilitation where applicable

When the Medicaid staff approves an application for medical need through prior authorization, the date the application is processed is documented on the LTC-4.

- In the event the resident does not have a Medicaid number, the facility must contact the appropriate Medicaid Certification District Office and/or SSI office.

- A facility will not be paid for services for a resident until a Medicaid number is on record with Medicaid.

An LTC-2 and/or LTC-2A are generated by Medicaid.
The LTC-2 specifies the dates the Medicaid recipient is eligible for nursing facility care.
When a patient is discharged, dies, or transfers, the facility must complete the information on the bottom of the LTC-2 and return it to Medicaid within 48 hours.
Failure to forward the above information prevents Medicaid from issuing another LTC-2 for readmission to the facility or admission to another facility.

Application Denials
On each denied admission application, Medicaid advises the recipient and/or sponsor, the attending physician, and the facility of the recipient's opportunity to request a reconsideration of the decision and that they may present further information to establish medical eligibility.
If the reconsideration results in an adverse decision, the patient and/or sponsor are advised of the patient's right to a fair hearing. If the reconsideration results in a favorable decision, normal admitting procedures are followed.

Cost Sharing (Co-payment)
Co-payment does not apply to services provided by nursing facility providers.

Completing the Claim Form
To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.
Nursing facility providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround

- Immediate claim correction

- Enhanced online adjustment functions

- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.
This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

Providers are required to send a statistical page with the each month's claim submissions for recording purposes. Appendix E, Medicaid Forms, contains a sample statistical reporting form. This form may be faxed to (334) 834-5301 Attn: LTC Division.

Time Limit *for Filing* ***Claims***
Medicaid requires all claims for nursing facilities to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

CD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Medicaid does not cover diagnosis codes preceded by an "E," "M," or "Y." Do not use decimal points in the diagnosis code field.

Covered Revenue Codes

The type of bill for nursing facilities is 21X.
Nursing facilities are limited to the following revenue codes:

Code	***Description***
101	All inclusive room & board
183	Therapeutic leave

Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

REVIEW QUESTIONS – CHAPTER 11

General Information:

The purpose for the Medicaid program is to assure the availability of quality medical care to low-income individuals and families through payments for a specified range of services.

Answer: True

Under Title XIX of the Social Security Act, Federal and State governments share funding and control.

Answer: True

Does a nursing facility provide nursing care and related rehabilitative services on a regular basis to individuals who because of their mental or physical condition require care and services, which may be available to them only through institutional facilities?

Answer: Yes

What does ICF/MR stand for?

Answer: Intermediate Care Facility for the Mentally Retarded

What does the acronym IMD stand for?

Answer: Institution for Mental Disease

The primary function of the IMD is for the care and treatment of persons with mental disease.

Answer: True

What administers the administrative procedures such as enrollment, sanctions, unresolved billing problems, and policy interpretations?

Answer: Nursing Home Program

What is the function of the Utilization Control (UC) Admissions Program?

Answer: They determine the recipient's medical eligibility for services and processes updates such as discharges, readmissions and death information.

Who is responsible for receiving and investigating complaints on nursing facilities?

Answer: The Department of Public Health, Bureau of Health Provider Standards.

What is the function of the fiscal agent of the Alabama Medicaid Agency?

Answer: Distribute forms and billing manuals, receive and process claims, reimburse providers

Alabama Medicaid eligibility is determined by policies established by and through the following agencies:

a) Dept of Human Resources
b) Social Security Administration
c) Alabama Medicaid Agency Outstation Eligibility Workers and Medicaid Eligibility District Offices
d) All of the above

Answer: D

Nursing facilities must comply with all requirements relating to maintaining written policies and

procedures regarding advance directives.
Answer: True

Provider Participation:

All nursing facilities must execute a Nursing Facility/Resident Agreement that details the requirements imposed on each party.
Answer: True

What does the acronym QMB stand for?
Answer: Qualified Medicare Beneficiary

How often does the Bureau of Health Provider Standards recertify each facility and notifies Alabama Medicaid of certification including deficiencies, plans of correction and automatic contract termination dates?
Answer: Annually

Change of ownership is defined as:
a) The removal, addition or substitution of one or more parties in a partnership.
b) Consolidation with another corporation resulting in the creation of a new corporate entity.
c) All of the above
Answer: C

You must notify the Bureau of Health Provider Standards by filing an application for change of ownership.
Answer: True

Recipient Eligibility:

To become eligible for Medicaid services in a nursing facility, residents must meet only medical eligibility.
Answer: False (and Financial)

A physician should certify placement in a nursing care facility as necessary and appropriate.
Answer: True

ICF/MR facility care is for individuals who are at least 65 years of age.
Answer: False (IMD)

To receive treatment in an IMD care facility, an individual must already be hospitalized in a mental disease facility and be at least 65 years of age.
Answer: False (and require active treatment)

Who determines approvals or denials to establish medical necessity for Medicaid benefits?
Answer: Medicaid's UC Admissions Program's RN staff

The RN refers questionable applications to whom for a determination of medical need?
Answer: The Staff physician

All facilities must submit an application for admission within 30 days from the date Medicaid coverage is requested.

Answer: False (60)

Within how many hours must Medicaid be notified if a recipient is discharged, transferred or dies?

Answer: 48 hours (per Medicaid)

The resource limit for an individual in a nursing facility is $2,000.

Answer: True

Medicaid individuals entering the nursing facility are not eligible through Social Security.

Answer: False (are)

A resident of an approved nursing facility for at least 30 continuous days is a factor for financial eligibility.

Answer: True

Loans are counted as a resource.

Answer: True

Facilities receive a monthly eligibility list of residents who are Medicaid eligible.

Answer: True

How can eligibility be confirmed?

Answer: Through the fiscal agent via AVRS.

Medicaid eligible nursing facility residents receive identification cards.

Answer: False (do not)

What is the medical gate keeping program that operates under a freedom of choice waiver?

Answer: Patient First (PCCM)

In a PCCM program, a physician contractually agrees to deliver and coordinate healthcare for patients who select or are assigned to the physicians as their primary medical provider.

Answer: True (PMP)

Is Nursing Home Care a service included in PCCM?

Answer: No

The PCCM will dis-enroll residents of a nursing facility when it is determined that they reside in a nursing facility.

Answer: True

Standards:

On the administrative staff of a facility, the administrator must be licensed by the State and is responsible for the management of the facility.

Answer: True

A nursing facility cannot charge a Medicaid applicant or family private pay rates during the Medicaid eligibility determination period.

Answer: False (can)

Once eligibility has been established, the nursing facility must bill Medicaid for the prior months for which the resident was determined as eligible.

Answer: True

Residents can be charged the difference between the billed and paid amounts.

Answer: False (must accept as payment in full)

The facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received that are not covered by Medicaid as long as the facility gives proper notice of the availability and cost of the services to the resident.

Answer: True

Does Medicaid pay for holding a bed for therapeutic leave when authorized by an attending physician?

Answer: Yes

A therapeutic visit is defined as an overnight stay outside the facility visiting home, family or friends.

Answer: True

A resident has the right to manage his/her financial affairs, and the facility may not require the resident to deposit their funds with the facility.

Answer: True

A Medicaid recipient is allowed to keep how much a month out of his/her income as personal needs allowance?

a) $50
b) $100
c) $300
d) None of the above

Answer: D ($30.00)

The facility must deposit any resident's personal funds in excess of:

a) $50
b) $100
c) $300

Answer: A

Upon the death of a resident with a personal fund at the facility, they must convey those funds within how many days to the resident's estate?

Answer: 30 days

The utilization review of a resident is done at the facility to determine the necessity of the continued stay.

Answer: True

Does Medicaid cover payment for reserving a bed in long-term care facilities for residents who are temporarily absent on admission to a hospital?

Answer: No

Within 14 days of a resident's admission to a nursing facility and every 12 months thereafter, the facility must conduct a complete comprehensive assessment of the resident's functional capacity.

Answer: True

What does the acronym MDS stand for?

Answer: Minimum Data Set

When a patient is admitted to a nursing facility, a plan of care must be completed within how many days after the completion of the initial MDS?

a) 10
b) 7
c) 5

Answer: B

During a disaster or in the event of a temporary relocation, Medicaid will continue to pay the responsible facility.

Answer: True

Can Medicaid deny payment for all new admissions when the facility is not substantially compliant three months after the last survey date of the nursing facilities compliance?

Answer: Yes

Can new or readmits be processed during the termination period beginning with the termination date?

Answer: No

Enforcement Compliance:

When a facility is to be terminated from the Medicaid program, the facility is notified how many days prior to the termination date?

a) 7
b) 15
c) 30

Answer: B

Reimbursement and Billing:

Does Medicaid pay a daily rate for care in a nursing facility?

Answer: Yes, this daily rate is called per diem.

11.27 What is the Federal insurance program for the Aged and Disabled?

Answer: Medicare

Describe a Qualified Medicare Beneficiary Only (QMB) recipient.

Answer: Not qualified for Medicaid and income may not exceed 100% of the federal poverty level. Medicaid will consider for payment the deductible and/or co-insurance if Medicare covers the service. QMB Only recipients are eligible for crossover services and are not eligible for Medicaid only services.

What is a QMB+ recipient?
Answer: Medicare eligible recipient who also qualifies for Medicaid.

What is the difference between Medicaid/Medicare recipients and QMB+ recipients?
Answer: Medicaid/Medicare recipients have an income level above the QMB level.

Can Medicaid recipients be covered by insurance in addition to Medicaid and Medicare?
Answer: Yes

Who funds the Medicaid program?
Answer: Both the Federal and State governments share the funding.

Can Medicaid payment be made directly to patients?
Answer: No

When can a patient be billed?
Answer: The patient can only be billed for services that are not covered by Medicaid.

An administrative review must be received by the Medicaid Agency within how many days of the time the claim becomes outdated?
Answer: 60 days

11.30 After receiving the information, a reply is sent to the provider in what form?
Answer: Written response

Can the Nursing Home Statistical Report be submitted via fax?
Answer: Yes, but only if the claims are filed electronically. Otherwise it should be mailed.

How often is the Nursing Home Statistical Report due?
Answer: Once a month.

What do providers to simplify billing procedures use?
Answer: Turn Around Document (TAD)

When is the TAD submitted?
Answer: The close of every month.

Once new admission information is initially added to the TAD, will it remain there?
Answer: Yes, until the nursing facility deletes the information.

CHAPTER 12

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

What is HIPAA

The HIPAA Privacy Regulation

HIPAA Privacy Standards

What is HIPAA?

HIPAA is the Health Insurance Portability and Accountability Act (Public Law 104-191) that includes provisions on health insurance reform, administrative simplification, and privacy. Our primary emphasis will be on privacy. HIPAA protects medical records and other personal health information by:

- Limiting the use and release of protected health information (PHI)
- Giving patients the right to access their medical records and
- Restricting most disclosures of health information to the minimum needed for the intended purpose.

Organizations directly affected by HIPAA, also known as **covered entities**, include organizations that bill and are paid for health care services. These are the three main groups:

1.) All health care providers that use electronic transactions for which the Secretary of Human Health Service (HHS) has adopted standards – includes, but is not limited to:

- Hospitals,
- Hospice programs,
- Rural health clinics,
- Psychological services,
- Home health agencies, Physicians, and
- Ambulance services.

2.) **All health plans** – includes, but is not limited to:

- Group health plans (with some exception for plans covering small groups),
- Health insurance carriers,
- Health maintenance organizations, and
- Most federal health care agencies, including CMS

3.) **All health care clearinghouses** – any organization that converts or translates transactions from non-standard formats to standard formats, and vice-versa includes, but is not limited to:

- Billing service companies,
- Repricing companies,
- "Value-added" networks that process nonstandard elements into standard data elements (usually for the purpose of transmitting claims between health care providers and health plans).

The HIPAA Privacy Regulation

Under HIPAA, the **privacy regulation** empowers patients by

- guaranteeing them access to their medical records,
- giving them more control over how their protected health information (PHI) is used and disclosed,
- and providing a clear avenue of recourse if their medical privacy is compromised.

The rule will protect medical records and other personal health information maintained by certain health care providers, health plans and health care clearinghouses.

Under the privacy regulation:

- Patients must give specific authorization before entities covered by this regulation could use or disclose protected information in most non-routine circumstances -such as releasing information to an employer or for use in marketing activities. Health care providers, health plans and other covered entities would be required to follow the regulation's standards for the use and disclosure of personal health information.

- Covered entities generally will need to provide patients with written notice of their privacy practices and patient's privacy rights. The notice will contain information that could be useful to patients choosing a health plan or health care provider. Patient would generally be asked to sign or otherwise acknowledge receipt of the privacy notice from direct treatment providers.

- Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before sending them to marketing.

- Pharmacies or other covered entities will be prohibited from selling personal medical information to a business that wants to market its products or services under a business associate agreement.

- Patients generally will be able to access their personal medical records and request changes to correct any errors. In addition, patients generally could request an accounting of non-routine uses and disclosures of their health information.

HIPAA Privacy Standards

Incidental Use and Disclosure – The final Rule acknowledges that uses or disclosures that are incidental to an otherwise permitted use or disclosure may occur. Such incidental uses or disclosures are not considered a violation of the Rule provided that the covered entity has met the reasonable safeguards and minimum necessary requirements. For example, if these requirements are met, doctors' offices may use waiting room sign-in-sheets, hospitals may keep patient charts at bedside, doctors can talk to patients in semi-private rooms, and doctors can confer at nurse's stations without fear of violating the rule if overheard by a passerby.

Minimum Necessary – The final Rule exempts from the minimum necessary standards any uses or disclosures for which the covered entity has received an authorization. The Rule previously exempted only certain types of authorizations from the minimum necessary requirement, but since the rule will only have one type authorization, the exemption is now applied to all authorizations. Minimum necessary requirements are still in effect to ensure an individual's privacy for most other uses and disclosures.

The Department clarifies in the preamble that *the minimum necessary standard is not intended to impede disclosures necessary for workers' compensation programs*. The Department will actively monitor to ensure that worker's compensation programs are not unduly affected by the Rule.

Protected Health Information – any information that is transmitted or maintained in any medium (electronically, on paper, or via the spoken word) that is created or received by a health care provider, health plan, or health care clearinghouse that relates to or describes the past, present or future mental health or condition of an individual or future payment for the provision of healthcare to the individual, and that can be used to identify the individual.

Treatment, Payment and Healthcare Operations (TPO) - The final rule clarifies that covered entities can disclose protected health information for the treatment and payment activities of another covered entity or a health care provider, and for certain health care operations of another covered entity.

Review Questions - CHAPTER 12

Questions and Answers - HIPAA

1. **Physicians' conversations with patients in semi-private rooms are considered a Violation of the rule.**
   Answer: FALSE

2. **Incidental uses or disclosure are not considered a violation if the covered entity has met the reasonable safeguards and minimum necessary requirements.**
   Answer: TRUE

3. **Can Protected Health Information (PHI) be used for Treatment, Payment and Healthcare Operations?**
   Answer: YES

4. **Providers should disclose or use only the minimum necessary amount of PHI in order to do their jobs.**
   Answer: TRUE

5. **Providers should use Professional discretion and Professional judgment when disclosing PHI.**
   Answer: TRUE

6. **If another covered entity calls and request D.O.B which of the following can we disclose:**
   a. Social Security
   b. Diagnosis
   c Address
   d. None of the above
   Answer: D

7. **Which of the following is a covered entity?**
   a. Baptist Medical
   b. CVS Pharmacy
   c. UAB Hospital
   d. All of the above
   Answer: D

8. **PHI covers not just a patient's health-related information, such as his/her diagnosis, but also other identifying information such as social security number and telephone numbers.**
   Answer: TRUE

CHAPTER 13

COMPLIANCE

WHY A COMPLIANCE PROGRAM
FRAUD AND ABUSE
STATUTES THAT GOVERN
- **False Claims Act (FCA)**
- **Jurisdiction of ORT**
- **Social Security Act**
- **Safe Harbor/Anti-Kickback Regulations**
- **Anti-Kickback Statute**
- **Safe Harbors**
- **Hospital Compliance with EMTALA**
- **Antitrust Issues**

MANAGEMENT RESPONSIBILITY FOR COMPLIANCE
SARBANES-OXLEY ACT

Why a Compliance Program?

In 1995, the federal government launched its "Operation Restore Trust" (ORT) program to investigate and enforce fraud and abuse in the federally funded healthcare programs. The financial risks to healthcare organizations, resulting from noncompliance or poor compliance with health laws, are so great that they must be proactively planned for by all of the financial management personnel. The Compliance Officer is the individual responsible for ensuring that the organization complies with governmental regulations surrounding Medicare and Medicaid.

Fraud and Abuse

Fraud is an intentional act of deception.

Abuse is an improper act that is unintentional but is inconsistent with standard practice.

Examples of fraud and abuse include false claims, double billing and kickbacks for referrals or medical procedures.

Statutes that Govern Compliance

False Claims Act (FCA)

- Federal Government's primary CIVIL remedy for improper or fraudulent claims
- When a health care provider knowingly makes a false or fraudulent claim, they are fined $5,500 to $11,000 per claim filed plus up to three times the amount of the damages caused to the Federal Government
- This Act originated in 1863, but was amended in 1986. Under these changes, the government no longer has to prove specific intent to defraud, only that the claim submitted was false and that it was submitted knowingly.
- FCA policy is coordinated between the Health Care Fraud Coordinator of the US Attorney's office, the Department of Justice (DOJ), Health and Human Services (HHS) Office of Inspector General (OIG), the Federal Bureau of Investigation (FBI), state Medicaid fraud units and other federal agencies.
- The U.S. Supreme Court ruled that state-owned providers could not be subject to damages under FCA.

Jurisdiction of ORT
The activities of the ORT include:

- Financial audits by the OIG and Center for Medicare and Medicaid Services (CMS)

- Criminal investigations and referrals by the OIG to appropriate law enforcement officials
- Civil and administrative sanctions and recovery actions by the OIG and other appropriate law enforcement officials
- Surveys and inspections of long-term care facilities by CMS and state officials in search of fraudulent activities
- Studies and recommendations by the OIG and CMS for program adjustments to prevent fraud and reduce waste and abuse
- Issuance of special fraud alerts to notify the public and the health care community about schemes by fraudulent providers of home health services, nursing care, and medical equipment and supplies

Social Security Act

Criminal Disclosure Provision

- It is a felony, punishable by up to five years in prison and/or a fine of up to $25,000 for a health care provider or beneficiary who possesses "knowledge of the occurrence of any event affecting the initial or continued right to any such benefit or payment; the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, to conceal or fail to disclose such event with a fraudulent intent to secure such benefits or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized."

- Must disclose overpayments to the government regardless of the provider's good faith at the time of submission of claim

- Compels disclosure of overpayments so that collection efforts may begin

Safe Harbor/Anti-Kickback Regulations

Stark II Law

- Prohibits physicians or immediate family members from referring patients to providers with which the physician has a financial relationship.
- Prohibited relationships include payments for referrals, hospital renting office space to a physician at below market value levels, and even, providing free parking for physicians while charging others.
- Penalties for violating this statute is a civil monetary penalty of up to $15,000 per service, treble damages, and exclusion from the Medicare/Medicaid programs

Anti-Kickback Statute

- Prevents the offer or payment of bribes or other remuneration (kickback, bribe, or rebate, direct or indirect, overt or covert, in cash or in kind, and any ownership, interest, or compensation interest) as an inducement to refer Medicare patients for treatment or services

- Makes it a crime to knowingly and willfully offer, pay, solicit or receive any remuneration to induce a person to refer an individual to a person for the furnishing of any item or service covered under a federal health care program
- Or to purchase, lease, order, arrange for, or recommend any good, facility, service or item covered under the federal health care program
- Penalties include up to 5 years in prison and $50,000.00 fine for each violation

Safe Harbors

- Established by Congress to protect the provider from vague statutes.

- Emergency Medical Treatment and Active Labor Act (EMTALA)

- Requires all Medicare- and Medicaid- participating hospitals with an emergency department (ED) to provide appropriate medical screening to each patient requesting emergency care to determine if patient needs such care.
- Also known as the "antidumping" law because it prohibits a hospital from transferring an emergency patient to another hospital simply because of the patient's inability to pay
- If emergency care is needed, hospital must medically stabilize the patient, irrespective of ability to pay (Triage is not adequate under this statute)
- The statute prohibits the emergency department staff from discussing financial or insurance information with the patient before the medical screening exam (MSE) and medical stabilization has occurred

Hospital Compliance with EMTALA

- Requires all clinical, administrative, and contract staff to review and understand EMTALA requirements, as well as, review and understand all statutory requirements regarding transfers of a patient to another facility
- Ensure that all patients who decide to leave the hospital without receiving treatment or who withdraw their request for emergency treatment are offered a MSE and treatment before they leave the hospital.
- Must have adequate staffing in the emergency room
- Make reasonable effort to obtain the patient's written informed consent to refuse any examination or treatment and that the patient's medical record contains explanation of examination and /or treatment and the patient's refusal for emergency care
- Prohibited from posting payment information in the ED

Antitrust Issues

- Purpose is to promote a competitive, free marketplace and protect the public from monopolies
- **Sherman Act** prohibits all conspiracies or agreements that restrain trade

- **Clayton Act** prohibits all mergers and acquisitions of stock or assets that may substantially lessen competition or that tend to create a monopoly
- The **Federal Trade Commission (FTC)** Act prohibits unfair methods of competition
- The **DOJ and FTC** jointly enforce antitrust laws

Management Responsibility For Compliance

Internal Control

- Process effected by an entity's board of directors, management, and others to provide: reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations

Sarbanes-Oxley Act

In 2002 Congress passed the Sarbanes-Oxley Act. It was passed to deal with what officials perceived as abuses of the system, and put in place mechanisms to enforce director and auditor independence. This act has two regulatory functions:

- For –Profit Companies-Protect shareholders and integrity of the public trading of stock
- Non-profit companies- Protect the assets held in charitable trust against private inurement and private benefits
- Only applicable to publicly-traded companies but, corporate governance initiatives are already being adopted as "best practices" for non-profits

The Enforcement of this regulation includes:

- For-Profit: Securities Exchange Commission (SEC)
  Shareholder derivative suits against the board of directors for breach of fiduciary duty
  Share holder suits against the corporation for fraud, misleading financial statements, etc.
  DOJ

- Non-Profit: State Attorney General (AG) under the "cy-pres" doctrine hold that the assets of a nonprofit corporation are held in a "charitable trust" for the benefit of the public, and breaches of that trust can be remedied by the State AG
  Breach of fiduciary duty can lead to suits by members or by State AG
  Internal Revenue Service (IRS) may revoke tax exempt status or place Intermediate Sanctions for "excess benefit transactions" with a person who is in a position of control

Review questions Chapter 13

1. What are the duties of the Compliance Officer?

a. To oversee HIPAA compliance
b. To oversee JACHO compliance
c. ensure the organization complies with governmental regulations surrounding Medicare and Medicaid
d. all of the above

Answer: c

2. True or False?

FRAUD is the improper act that is unintentional but is inconsistent with standard practices.

Answer: False

3. Which of the following is true?

a. Abuse is the improper act that is unintentional but is inconsistent with standard practices
b. Abuse is the intentional act of deception
c. False claim is an example of fraud, but not abuse.
d. None of the above

Answer: a

4. Statutes that govern compliance include:

a. False Claims Act
b. Social Security Act
c. Stark II Laws
d. All of the Above

Answer: d

5.What does EMTALA stand for?

a. Even money takes away lacerations and aches.
b. Eating more tomatoes alleviates lactic acid
c. Emergency Medical Treatment and Active Labor Act
d. None of the Above

Answer: c

6.Under Anti-Kickback Statutes:

a. Payment of bribes is prohibited
b. Accepting of a bribe is prohibited
c. Penalties include up to 5 years in prison and $50,000 fine for each violation
d. All of the above

Answer: d

7. True or False

Under EMTALA, Providing Triage is sufficient for transferring an emergent patient to another facility.

Answer: False

8. EMTALA rules allow for:

a. All Medicare and Medicaid-participating hospitals with an Emergency Department to provide appropriate medical screening to each patient requesting emergency care to determine if patient needs such care
b. Dumping patients who are unable to pay to other hospitals
c. Emergency Department staff to discuss financial and insurance information before the patient is screened
d. None of the above

Answer: a

9. In order for a hospital to remain compliant to EMTALA:

a. Review of EMTALA rules for ED staff
b. Document that every patient who enters is offered a medical screening exam before they leave the facility
c. Is prohibited from posting payment information in the ED
d. All of the above

Answer: d

10.True or False

Under the Sarbanes-Oxley Act, Non-Profit hospitals are held in charitable trusts and breaches of the trust can be remedied by the State Attorney General.

Answer: True

Chapter 14

NPI – National Provider Identifier

NPI Overview

Overview

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses will use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions. Covered entities may invoke contingency plans after May 23, 2007, and guidance about contingency plans may be found in the Downloads section below.

All healthcare providers submitting claims for services are required to apply for an NPI number. Obtaining an NPI is easy and it is **FREE.** A delay in obtaining the NPI number places you at risk for a reduction in cash flow.

As outlined in the Federal Regulation, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI numbers with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Review questions Chapter 14

1. What is NPI?
   Answer: National Provider Identifier
2. What standard covers NPI?
   Answer: HIPAA
3. Who needs to obtain an NPI number?
   Answer: All healthcare providers who provide services and submit healthcare claims to a health plan or through a clearinghouse.
4. The NPI number contains how many digits?
   Answer: 10
5. May the health care providers share an NPI number for billing purposes?
   Answer: Yes
6. When did NPI go into effect?
   May 23, 2007
7. What is the cost for obtaining an NPI number?
   Answer: Free