CRCS Exam Preparation

PATIENT ACCESS/ FRONT OFFICE
FEDERAL AGENCIES & REGULATIONS

American Association of Healthcare Administrative Management
The Premier Organization for Revenue Cycle Professionals
Federal Agencies & Regulations

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Federal Agencies & Regulations Objectives

- List federal agencies playing a major role in healthcare and healthcare change: DHS, its operating divisions, and OIG.
- Describe the role of CMS & OIG
- Name major federal regulations affecting healthcare and describe their impact
- Describe the role of The Joint Commission
Federal Agencies

- Two main governing bodies impacting healthcare:
  - CMS: Center for Medicare and Medicaid Services
  - OIG: Office of Inspector General

- HHS Operating Divisions:
  - National Institutes of Health (NIH)
  - Food and Drug Administration (FDA)
  - Centers for Disease Control and Prevention (CDC)
  - Agency for Toxic Substances & Disease Registry (ATSDR)
  - Indian Health Services (IHS)
  - Health Resources & Services Administration (HRSA)
  - Substance Abuse & Mental Health Services Administration (SAMHSA)
  - Agency for Healthcare Research & Quality (AHRQ)
  - Centers for Medicare & Medicaid Services (CMS)
  - Administration for Children & Families (ACF)
  - Administration for Community Living (ACL)
Federal Agencies

▪ **CMS:**
  ▪ Medicare – Title XVIII
  ▪ Medicaid – Title XIX
  ▪ QIO: Quality Improvement Organization

▪ **OIG: Office of Inspector General**
Federal Regulations

▪ **Areas of regulations:**
  ▪ Patient rights
  ▪ Administrative simplification
  ▪ Anti-fraud & abuse
  ▪ Patient anti-dumping
  ▪ Performance improvement
Patient Rights

Patient Care Partnership:
- High quality hospital care
- Clean and safe environment
- Involvement in your care
- Protection of your privacy
- Help when leaving the hospital
- Help with your billing claims
Right to Privacy and Security of Health Information

- National standards for safe and accurate information exchange:
  - Gives patients more control over their health information
  - Sets boundaries on the use and release of health records
  - Establishes appropriate safeguards that healthcare providers and others must achieve to protect the privacy of health information
  - Holds violators accountable with civil and criminal penalties that can be imposed if they violate patients’ privacy rights
  - Strikes a balance when public responsibility supports disclosure of some forms of data, protect public health
Right to Privacy and Security of Health Information

- Patients can make informed decisions when seeking care and reimbursement for care based on use of their information:
  - How patient information is being used and about disclosures
  - Limits the release of information to a minimum
  - Gives patients the right to examine and obtain a copy of their own records
  - Empowers individuals to control their health information
PHI

- Name
- DOB
- Address
- Phone number
- Email address
- SSN
- Medical record number
- Employer’s name/address
- Relative’s name/address
- Certificate number (pacemaker serial number)
- Photograph
- Fingerprints
Right to Participate in Treatment Decisions

PSDA: Patient Self-Determination Act

- Advance directives
- Living Will
- DNR: Do Not Resuscitate
Fraud & Abuse

- Fraud
- Abuse
- False Claims Act

Administrative Sanctions:
- Denial or revocation of the provider number of application
- Suspension of provider payments
- Application of Civil Monetary Penalties (CMPs)
Patient Anti Dumping

- Emergency Medical Treatment and Active Labor Act (EMTALA):
  - Medical screening examination
  - Necessary stabilizing treatment
  - Restricting transfer until stabilization
Performance Improvement

- Clinical Laboratory Improvement Amendment (CLIA)
  - Requires all clinical lab services furnished to Medicare beneficiaries must be performed by a provider who has a CLIA certificate

- Only states exempt are New York and Washington due to the state requirements being more stringent
The Joint Commission (TJC)

- Private agency that seeks to protect and improve the quality and safety of care
- Hospital audits every 39 months
- Lab audits every 2 years
- Patient Access TJC surveys:
  - Distribution and discussion about advanced directives
  - Patient rights and responsibilities
  - Organizational ethics
  - Continuum of care
  - Management of environment of care
  - Confidentiality
  - Privacy
  - Security
  - Communication
Knowledge Check

Which of the following is a type of advanced directive?

A. Estate Will
B. Durable Power of Guarantor
C. Healthcare Power of Attorney
D. Do Not Recover
Patient Access/ Front Office

CRCS Exam Preparation
Patient Access/ Front Office Objectives

- Describe primary functions and responsibilities
- Describe the purpose, completion, triggering events, and retention of the Advance Beneficiary Notice of Noncoverage ABN
- Describe the use of the Hospital Issued Notice of Noncoverage (HINN)
- Describe the roles and responsibilities of Case Management/ Utilization Review
- Identify the different levels of patient care
- Differentiate between general and special consent form and define types of consent
- Define assignment of benefits
- Define emancipation
Patient Access/ Front Office Objectives (continued)

- Describe the purpose and composition of a medical record and precautions for handling medical records
- List individuals who can accept verbal (telephone) orders from a referring physician and required elements of a verbal order
- Define the different types of coverage determinations
- Describe Medicare Secondary Payer provisions including Initial Enrollment Questionnaire, MSP Questionnaire, and Common Working File
- Describe the purpose and importance of Patient Access/ Front Office following a financial policy and strategies to comply with the policy
- Explain when and how a practice can terminate a patient-physician relationship
- Describe the formulae for the key performance indicators in Patient Access/ Front Office
Primary Functions

- Scheduling
- Preadmission and Preregistration
- Precertification and Preauthorization
- Registration and Admission
- Insurance verification
- Financial Counseling
- Collection
- Compliance
Scheduling

- Maximizing Productivity
- Reduce dissatisfaction of physician, administrative, and clinical staff and patients.
- Requires a balance between patient satisfaction and the collection of demographic, financial, and insurance information, and clinical services.
- Errors in Scheduling can create havoc, down-time, over-booking, and dissatisfied patients.
Preadmission and Preregistration

- Cornerstone of a successful collections process
- Patient Demographic, Financial, and Socioeconomic information collected
- Implementation of a Preregistration program should decrease complaints due to:
  - Financial planning and counseling can be done in advance of DOS
  - Patients are familiarized with the admission process
  - Special needs can be identified and accommodated
  - Admission time is reduced

Goal: 90% of scheduled patients should be pre-registered within 24 hours of DOS.
Precertification and Preauthorization

- Precertification – authorization provided by insurance company review organization approving medical necessity
  - Determine financial risk and develop rapport with Patient/Guarantor
  - Key Success Factor in Preregistration program

![Diagram showing the consequences of not obtaining preauthorization: Billing Delays, Denial of Claims, Increases in Appeals and Rework, Lost Revenue. The central message is "When Preauthorization is not obtained."
Registration and Admission

▪ Patient Access is responsible for timely, courteous and accurate registration or admission of patients.

▪ Registrar responsibilities:
  ▪ Initiating permanent medical record for the stay
  ▪ Creating the patient account for the treatment/condition
  ▪ Ensuring the accuracy of the patient account record
  ▪ Collecting data (demographic, financial, socioeconomic, clinical, etc.)
  ▪ Verifying insurance
  ▪ Collecting valuables
  ▪ “Guest Services”
Insurance Verification

- Purpose – Eliminate delays in reimbursement

- Can be done as part of precertification or registration/admission process.

- Questions to be addressed during insurance verification:
  - Is precertification required? Has it been obtained?
  - What is the deductible amount and has any portion of it been met?
  - Are benefits available for the diagnosis?
  - See AAHAM CRCS Study Manual for additional examples
Financial Counseling

- Important tasks include:
  - Obtain and verify patient demographic detail.
  - Obtain responsible party financial information.
  - Establish the ability to pay and initiate applications for eligibility in financial assistance programs if applicable.
  - Obtain all information regarding third-party resources.
  - Verify the benefits available through insurance sources.
  - Notify the responsible party of his/her financial obligation.
  - Request payment in full of the patient’s estimated responsibility.
  - Establish payment arrangements, if needed.
  - Complete all preadmission paperwork so that the patient’s experience is positive and not stressful.

- In the institutional setting these tasks include explaining the collection policy to the responsible party and calculating the estimate responsibility.
A good preadmission/preregistration process will include determining the estimated patient portion for services and informing patients so they can bring their payment at the time of service. It is the only cost-effective way to collect small dollar co-payments.

- Determine if patient deductibles have been met
  - Online Verification tools
  - Call Insurance for verification
  - Ask patient
  - If not available permissible to ask for total due for services provided that day
Deposit Collection Program Collection

Advantages
- Reduced financial risk and bad debt
- Reduced AR
- Increased hospital cash collections
- Reduced amount due at discharge

Disadvantages
- Public relations issues
Compliance

The compliance plan serves to prevent, identify, and remedy instances of fraud or abuse or other unacceptable conduct. Patient Access is responsible for information entered during the registration process, which will impact other areas and how data can appear on a claim.

Incorrect Data ➔ Fraudulent or Abusive Claims

Documents Issued by Patient Access

- Important Message from Medicare
- Medicare Outpatient Observation Notice (MOON)
- Guarantor forms
- Advance Beneficiary Notice of Noncoverage (ABN)
- Hospital Issued Notice of Noncoverage (HINN)
Knowledge Check

Which of the following is not a potential result of not obtaining a preauthorization?

A. Decrease in Appeals
B. Billing Delays
C. Claim Denial
D. Increased Rework
Advance Beneficiary Notice of Noncoverage

- ABN contains a brief description of the service, the estimated cost and the reason the services is not expected to be covered.
- Providers use the ABN to avoid writing off claims deemed not “reasonable and necessary.”
- Patients sign and date the ABN after indicating their decision to proceed with the service or to forego the service. (knowing they will have to personally pay if Medicare denies payment)
- The ABN MUST be signed before services are provided and the signature MUST be witnessed.
- If ABN is not obtained before service, the provider cannot bill the beneficiary and will be held financially liable.
- Certain Modifiers are required on claim forms when billing with an ABN. (GA, GX, GY, GZ)
- ABN must be retained five years from discharge or completion of care.

Tip! Be familiar with services that do not require an ABN.
ABN Triggering Events

Initiation: Beginning of treatment

Reduction: Frequency or duration of treatment decreases

Termination: Discontinuation in the services provided
Hospital Issued Notice of Noncoverage (HINN)

Hospitals give HINNs to fee-for-service inpatient hospital beneficiaries receiving specific diagnostic or therapeutic procedures separate from treatment covered / paid / bundled into inpatient stay.
Case Management/Utilization Review

- Patient Access and Case Management/UR work together in a collaborative approach including assessing, providing, coordinating and monitoring.
- Patient Access MUST obtain correct insurance information so Case Management can properly perform its functions.

Case Management plays a critical role

| Prevent unnecessary services or treatment | Evaluates an individual’s safety and ability to live independently at home | Ensure appropriate level of care & obtains appropriate medical care | Secure necessary supplies and medical equipment | Assist in obtaining home care nursing services/home health | Coordinates medical follow-up, transportation to and from appointments | Obtain approvals when clinically necessary | Discharge planning | Assist with appeals for denials | Complete the MOON form |

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Levels of Patient Care

- Acute Inpatient
- Observation
- Outpatient (ED, ambulatory, clinic, same-day surgery)
- Recurring or Series
- Long Term Care
- Respite Care
- Skilled Nursing Facility (SNF)
- Hospice Care
- Home Health Care
- Office
Consents

**General**

- Routine labs
- Diagnostic imaging (radiology, CT scan, MRI, etc.)
- Medical treatment

**Special**

- HIV Positive testing
- Major/Minor surgery
- Anesthesia
- Nonsurgical procedures with more than slight risk
- Cobalt or radiation therapy
- Electroshock procedures
- Experimental procedures
- Treatment for drug/alcohol disorders
- Blood transfusions

Consent: Patient’s permission to render services.
Types of Consent

- **Actual or Expressed**
  - Written or Oral, the patient agrees to the treatment outlined.

- **Informed Consent**
  - Risks and benefits are understood, patient decides whether to receive that treatment. (Special Consents)

- **Implied Consent - in fact**
  - Consent by **silence**; the patient implies consent by not objecting.

- **Implied Consent - by law**
  - Occurs when the patient is unconscious and is taken to ED; **law** allows for treating the patient.

- **Parental Consent**
  - Refers to the fact that a parent may give consent on behalf of a child for most services.

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**A person is prevented from consenting to services if they are:**

- Intoxicated
- Unconscious
- Declared Mentally Incompetent by the courts
Assignment of Benefits

A written authorization, signed by the policy holder to an insurance company, to pay benefits directly to the provider.*

If assignment is not accepted the payment will be sent to the patient and the provider will have to recover payment from the patient.

*If the policyholder is unavailable the patient can sign the assignment of benefits.
Emancipation

- The process by which a minor is freed from parental control.

- Emancipate minor – any minor where a court of law has declared the child emancipated based on the following criteria:
  - No longer requires parental guidance or financial support
  - Has fathered or given birth to a child
  - Has reached the age of majority (varies between states, usually 18-21)
Knowledge Check

Which type of consent is written or oral, and permission has been given to perform the treatment outlined?

A. Informed Consent
B. Implied Consent-in-Fact
C. Actual or Expressed
D. Implied Consent by Fact
Medical Records

- Serve as a legal document and must be complete, accurate and detailed
- Often initiated in Patient Access department
- Supports charges and coding
- Information cannot be released without the patient’s written consent
- Serves as the communication and continuity of care tool among physicians and other healthcare professionals involved in the patients care and can be faxed from one facility to another
- Electronic Health Record (EHR) and Electronic Medical Record (EMR)
- Review what is included in the Medical Record in the Exam Study Manual

Tip! Know who is authorized to make entries in a patient’s medical record.
Verbal Orders

- Who can accept verbal telephone orders from a referring physician:
  - Physician extender
  - Registered nurse

- All telephone orders must contain:
  - Date and time the order was received
  - Name of the ordering physician
  - Name of the patient and their status
  - Exact order transcribed verbatim
  - Full name and designation of staff member documenting the order
Coverage Determinations

Policies that CMS and fiscal intermediaries use to pay or deny claims based on medical necessity.

National Coverage Determinations (NCDs)
- Policies issued by CMS that identify the extent to which Medicare will cover specific services, procedures, or technologies. This is done on a National basis.

Local Coverage Determinations (LCDs)
- Policies developed by MACs defining how to cover a particular service and what qualifies as reasonable, necessary and appropriate. This is done on an intermediary-wide or carrier-wide basis.
Coverage Determinations

Definitive vs. Non-Definitive

- Definitive – LCD or NCD lists specific diagnosis codes, ICD procedure codes, and potentially symptoms to support need for the service.

- Non-definitive – Provides potential coverage circumstances. Does not list specific codes.
  - Ex. “This Policy is not exclusive. Claims not supported by these diagnoses may be reimbursable with supporting documentation.”
Medicare Secondary Payer

MSP data is gathered to determine coordination of benefits.

Circumstances where Medicare is the secondary payer:

- Working aged
  - Individuals 65 and older with coverage through a Group Health Plan (GHP)
  - Coverage through employed spouse of any age
  - Employer must have at least 20 employees to meet working aged provision
- Individuals under 65, disabled, and covered under a GHP with 100 or more employees
- ESRD
  - During 30-month coordination period (Medicare remains secondary even if beneficiary becomes entitled based on age or disability)
  - Medicare ESRD coverage ends 12 months after no longer requiring maintenance dialysis, 36 months after kidney transplant, or if patient becomes deceased
- Worker’s Compensation
- Black Lung Benefits Act
- Automobile, No-fault or Liability coverage
Initial Enrollment Questionnaire

- Mailed to patients about three months before Medicare entitlement
- Asks about other healthcare coverage that may be primary to Medicare
- IEQ responses are processed and entered into the Common Working File (CWF)
MSP Questionnaire

- MSP Questionnaire (MSPQ) is completed on an ongoing basis
  - MSPQ can be completed once every 90 days for recurring outpatient accounts if receiving exact same services as previous month
- Asks employment, accidents etc.
- Providers are required by Medicare to obtain MSPQ information
- MSP data collected must be retained for 10 years

Provider should review contracts with individual Medicare Advantage plans to see if MSPQ is required.
Common Working File

A CMS file containing patient eligibility and utilization data such as:

- Entitlement to Medicare Part A and B
- Date of Birth
- Date of Death
- Deductible information
- MSP Information
Patient Access/ Front Office Financial Policies

Financial policies should:

- Define acceptable methods of payment
- Outline charity guideline and application procedures
- Explain how accounts are sent to a collection agency

Patient Access sets the tone! Their interactions with the patient will set expectation of payment.
Patient Access/ Front Office Financial Policies

To support these polices Patient Access/ Front Office staff should:

▪ Identify uninsured patient prior to admission
▪ Gather demographic and billing information
▪ Verify insurance benefits
▪ Screen for repeat bad debt patients
▪ Request deposits for deductibles and coinsurances
▪ Identify potential charity cases

▪ Review other examples in Section 3 in the Exam Study Manual
Terminating a Patient-Physician Relationship

Why would a physician terminate a relationship with a patient?

Answer: Patient’s continued failure to pay, repeated no-show, failure to comply with medical treatment

A physician is required by law to provide patient care until the relationship is properly ended. Specific guidelines for ending responsibility for a patient must be in place and followed consistently.

The process should include providing notification in writing, requesting return receipt, and 30-day notice to terminate care.
Performance Metrics

**Average Length of Stay (ALOS)**

Calculated by dividing the total number of patient days by the number of discharges.

Total # Patient Days/Number of Discharges=ALOS

**Midnight Census**

Determined from the census count for the previous midnight, minus and discharges, plus any admissions, plus/minus any status changes.

Previous Midnight Census-Discharges+ Admissions +/-Status Changes= Midnight Census

**Average Daily Census (ADC)**

The average number of inpatients maintained in the hospital for each day for a specific period of time.

Total Number of Patient Days/ Number of Days=ADC
Performance Metrics
(continued)

**Number of Patients Seen per Day**

The total number of patient encounters in a time period divided by the number of days in the period.

Total Number of Patient Encounters/ Number of Days=Number of Patients Seen per Day

**Percentage of Occupancy**

The ratio of actual patient days to the maximum patient days as determined by bed capacity.

Census/Number of Licensed Beds Available=Percentage of Occupancy
Knowledge Check

How is the Average Daily Census calculated?

A. Census/Number of Licensed Beds Available
B. Total Number of Patient Days/Number of Days
C. Total Number Patient Days/Number of Discharges
D. Previous Midnight Census - Discharges + Admissions +/- Status Changes
Q & A

You have Questions
We have Answers

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