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“ADVANCING THE POSSIBILITIES THROUGH HFMA”

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INTRODUCTION

What is CPAR?
The Georgia Chapter of HFMA instituted the Certified Patient Account Representative (CPAR) certification program in 1982 to provide education and support to Account Representatives in all care settings. As healthcare is ever changing, CPAR certification provides an educational foundation, builds confidence, increases motivation and develops a network of educational and career opportunities in the financial realm of the healthcare industry.

What is the purpose of the CPAR Manual?
The manual is a self-study training and reference guide to prepare Representatives for the annual CPAR exam. Annual updates by a dedicated committee provides the most current forms, terminology, changes in Medicare, Medicaid and Managed Care methodologies and a detailed overview of the intricacies of the revenue cycle from registration to the last dollar collected. Not only does this in-depth educational resource serve as a testing preparation tool, but provides continued value as a reference guide and insight to the complexities of daily productivity.

What are “Wise Cracks”?
The CPAR Committee utilized the concept of “Wise Cracks” noted throughout the manual in recognition of noteworthy points of importance instilling character and creativity to its content as a means of making this an exciting learning experience for all.
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Section 1.1.A - Overview

Introduction
Patient Access is a critical function in all healthcare provider organizations. Poor processes and quality can impact patient satisfaction, reimbursement, cost and even patient care. Areas of concern in most Patient Access department include:

- Improving staff satisfaction and reducing turnover
- Reducing errors that impact billing and reimbursement
- Achievement of efficiencies and better work flow improving patient satisfaction

Some organizations should consider changes in all patient access areas, which would typically include:

- Implementation of more effective organizational structures
- Redesigning of the patient access and scheduling processes
- Development or customization of policies and procedures
- Establishment of formal staff training including a preceptor and competencies testing programs
- Implementation of on-going quality assurance programs

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

- Identifying the patient/obtain verification of identity
- Obtain insurance information and eligibility verification
- Initiating the medical record
- Establishing the financial record of the visit
- Orienting the patient to the hospital setting

Due to new demands placed on Access personnel by the ever-changing health care environment, it has become more beneficial than ever to pre-register patients scheduled for services.

Impacts
Forces that impact the Access process include:

- Increased federal and state regulations require Access staff to educate patients of their rights, give HIPAA privacy notices and provide information on Advanced Directives.
- Increased participation in managed care requires Access staff to be experts in pre-certification, referrals and discharge planning.
- Shorter lengths of stay demand more up-front processing to efficiently manage the patient’s account prior to discharge.
- Reduced reimbursement from third party payers require a more aggressive approach to collection of co-insurance and deductibles at time of service or prior to discharge.
- Increased information requirements to process a complete clean claim, such as Medicare Secondary Payer (MSP) information to determine coordination of benefits with Medicare, (and varied requirements across insurance payers)
Included Services
Access areas have grown to encompass many functions with more emphasis being placed on the “front-end”. However, this “front-end” emphasis does not eliminate the need for other specialized areas of patient accounting to concentrate on exceptions such as large balances, extended stays, audits, etc.

Although hospitals are organized differently from one institution to another, for the purposes of this manual, Access will include:
- Scheduling
- Pre-admission and Registration
- Insurance Verification
- Pre-certification and Preauthorization
- Financial Counseling
- HIPAA
- Medical Necessity
- Advanced Beneficiary Notice
- Coding
- Medical records
- Utilization Management
Section 1.1.B - Scheduling

Definition
Scheduling is defined as the process by which a patient is allotted a time for services ordered by their physician.

Scheduling Process
The physician and/or his office staff will provide schedulers with the following information:

- Demographic information on the patient
- The service being requested
- The diagnosis
- Required codes, e.g. ICD9 and/or CPT codes/HCPCS codes
- The preferred time frame for service
- Pre-certification Authorization or Clinical information needed to obtain pre-certification

Scheduling should be utilized for any elective services and urgent services. The Access staff must obtain a physician order for all services except Emergency Room patients.

Schedulers should also be verifying medical necessity at the time of scheduling with the physician office. Scheduling information is then forwarded to the pre-registration area for patient contact.
Section 1.1.C - Pre-access / Pre-registration

Purpose
All hospitals should create a Pre-Access form designed to capture all data necessary to assess the patient’s ability to pay or meet hospital financial requirements. Several effective ways to pre-register a patient are by the following methods:

- Mail
- Phone
- Via web-site – on-line registration
- Fax
- Face to Face

The following information should be obtained from the patient.

Patient Information
- Name, address, telephone number and email address
- Date of birth
- Social security number
- Next of kin
- If the patient is the guarantor, next of kin information is needed (name, address and telephone number)
- Employer information (name, address and telephone number)
- Still employed (no - last date worked)
- Guarantor information (if not the patient)
- Advanced Directive information
- Organ Donor Information

Guarantor Information
If different than the patient
- Name, address, telephone number and email address
- Date of birth
- Social security number
- Employer information (name, address and telephone number)

Insurance Information
- Name, address and telephone number of insurance company
- Name of insured/subscriber/sponsor
- Birth date of insured/subscriber/sponsor for every insurance plan
- Relationship of insured/subscriber/sponsor to patient
- Policy or contract number
- Group number and group name
- Retirement date (if applicable)
- Claim mailing address
- Pre-cert agency and telephone number
- Pre-certification / authorization / certification number
- Accident type, date, state and place
- Medicare Secondary Payer questions (for all Medicare beneficiaries)

### Other Essential Information
- Name of ordering / admitting physician and other physician information required by the facility
- Diagnosis or reason for service
- Admission date or date of scheduled service
- Special needs.

Once the information above has been obtained, the Access staff will complete the registration and:
- Verify the patient’s insurance by phone/web or electronic and determine the pre-certification and authorization requirements
- Forward pre-registration and pre-certification information to appropriate department either by paper or electronic format
- Notify the patient of any services that do not meet Medical Necessity/Authorization guidelines
- Provide patient with information on time and location of scheduled procedures
- Provide patient pre-operative or preparatory information
- Provide financial counseling and determine special needs of the patient
- Alert the patient of any deposits due, special insurance provisions or network issues

### Result
This process helps to expedite the entry process and eliminate any unnecessary waits or unexpected problems with insurance benefits or preauthorization. Your facility should determine which patient types are most beneficial to pre-register. This process should be supported by sound policies and procedures and supported by your Board of Directors.
Section 1.1.D - Registration

Guidelines
Many patients are being handled on an outpatient basis therefore the term “registration” is often used instead of Admission. Registration prior to services is the optimal way to expedite the Access process. However, if pre-registration has not occurred, the Access staff should obtain the information outlined above from the patient as they present for services. When any patient presents for services, the Access staff should:

- Obtain copy of patient information or verify all existing data to ensure accuracy
- Obtain and scan front and back of insurance card
- Obtain positive identification of the patient (photo ID, Driver’s license, etc.)
- Complete appropriate Access documents, which include Advanced Directives, HIPAA Privacy notice, Medicare Secondary Payer Questionnaire, Medicare or Champus beneficiary notice
- Obtain signatures for Assignment of Insurance benefits and release of medical information to appropriate third parties
- Obtain signatures for any additional waivers or Advanced Beneficiary Notices (ABNs)
- Provide patient with appropriate copies of forms such as HIPAA Privacy Notice, Medicare Beneficiary Notice, ABNs, etc.
- Collect deductibles, co-pays, co-insurance, deposits and other self-pay amounts determined during the pre-access process or calculated at the time of visit
- If the patient is unable to pay and has no insurance, payment options should be explored. If the patient expresses an inability or difficulty in paying the self-pay amounts, financial counseling should occur.
Section 1.1.E - Insurance Verification

Types of Insurance
There are many types of health insurance plans and many variables within each, such as Medicare, Medicaid, Tri-Care, Individual Policies and Group Policies. Most people are covered by group insurance through their employers, who offer a choice of different plans to employees. Plans include indemnity plans, HMO’s, PPOs or other managed care products. Employees should investigate the benefits and provisions of each health plan being offered before selecting one. When employer’s contract with an insurance carrier for their employees, they negotiate or purchase policies that provide specifically requested benefits.

Obtaining Information from the Patient
Incorrect billing information is the source of many unpaid bills. Reimbursement can be improved by obtaining basic information from your patient to provide accurate data to the insurance company when verifying coverage for services. Coverage can be verified through several means, including, automated verification software, telephone, faxing or email. The following should be gathered directly from the patient or a knowledgeable family member and furnished to the insurance company:

- Correct spelling of patient’s and insured’s first, middle and last name. It is important to compare this with the spelling contained on the insurance card, as it could be different
- Patient / insured social security number
- Patient / insured birth date
- Relationship of insured/subscriber/sponsor to the patient
- Insurance plan policy and group name and number, gathered directly from the insurance card
- Correct claim-mailing address. Often this can be different than what is on the insurance card, especially if a third party administrator is involved

Verifying Service with the Insurance Carrier
Verification of insurance benefits is recommended for all patients prior to services being rendered, except when EMTALA (see glossary) laws apply. If verification of insurance benefits is not possible on all patients, high dollar accounts should always be verified prior to services. Emergent admissions may require insurance notification within 24 hours of admission in order to determine any necessary follow up needed. For example: pre-certification, preauthorization, referral, network issues to be resolved, etc.

Scanning of documents will allow for quick and easy, real time, access to insurance cards and positive patient identification. These documents can be reviewed to ensure all information is entered correctly prior to claims submission. Another tool that can be utilized to avoid mail returns is a software program offered by the United States Postal Service via the internet (www.usps.com).
The following information should be obtained from the carrier:

- Benefit levels - verify coverage exist and determine amount of coverage for services being provided
- In-network vs. out of network status
- Dependant coverage
- Deductible and/or co-insurance, co-pay amounts
- Out of pocket maximum
- Pre-existing exclusions
- Lifetime maximum
- Effective date of coverage – from and through dates needed to investigate possible COBRA rights to continue benefits
- Special provisions – maternity and baby coverage, psychiatric, cosmetic / reconstructive surgery
- Pre-certification / preauthorization requirements
- Age limits for dependents.

**Working with Financial Counselors**

It is highly recommended that Financial Counselors be included in the insurance verification process so they can be involved immediately when problems with benefits or network issues arise. Financial Counselors should be the intermediary between the patient, insurance company and the hospital and be capable of identifying any potential resolutions to ensure reimbursement is obtained for the services being provided.
Section 1.1.F - Pre-certification / Pre-authorization

What is Pre-certification?
One of the mechanisms that managed care uses to control healthcare costs is pre-certification or preauthorization of services, e.g. diagnostic studies, procedures, hospital admissions, and pharmaceuticals.

Pre-certification is the process of determining medical necessity with the insurance company for a procedure and/or visit if payment is to be expected. Pre-certification can be a continuing review process during a patient stay, for inpatients.

Requirements
Preauthorization is required for certain procedures, determined by insurance/Medicare and Medicaid Carriers. These procedures must be authorized prior to a patient visit and/or procedure if payment is to be expected. An example of a case where preauthorization must be obtained prior to being performed is sterilization or reconstructive procedures.

Requirements vary between plans; the basic characteristic of pre-certification includes notification to the insurance company or review agency and verification of pre-certification criteria for medical necessity for services.

Typically, notification must be made:
- Prior to the visit on elective preplanned procedures / admissions and
- Within 24-48 hours of urgent/emergent procedures and hospital admissions

Insurance cards
Most insurance cards will list specific notification requirements along with applicable telephone numbers. Upon notification most commercial insurance companies will advise:
- The level of benefits
- Deductible, coinsurance and co-pay amounts specific to the plan
- At that time, their representative will notify the caller of pre-certification and preauthorization requirements

Insurance Requirements
If precert or authorization is required, the insurance company or review agency will require information pertaining to the clinical reason for the visit. This sometimes will include CPT/HCPCS codes as well as DRG information, which is usually dependent on the payer. Review agencies use criteria, which describes acceptable reason for a visit, and in some cases minimal treatment requirements. The two most common sets of criteria used in the industry are Milliman & Robertson and Interqual. Many insurance plans will require additional clinical information throughout a patient's hospital stay, as well as discharge needs such as home health care, equipment, or long-term rehabilitation.
Process
The review agency will typically issue a certification or authorization number. These numbers will tie the service, claim, and authorization together to facilitate timely reimbursement. If a claim is received without the certification/authorization number, the payment will most likely be delayed. The claim is compared to the authorization on file, if there is a discrepancy, reimbursement will be made only for the approved days. This may require that the hospital submit an itemized statement in order for the insurance company to identify the days that are not approved.

Some insurance plans will pay certain procedures on a case rate basis. This means that if a patient is admitted and has a procedure on an approved day that is designated as a case rate, the hospital will be reimbursed a flat rate for the procedure regardless of the number of days or treatment involved in caring for the patient. However, if the procedure is performed on a day that is not approved, the hospital will not be reimbursed for that procedure.

Medicare Pre-certification
A standard Medicare hospital admission does not require pre-certification. However, Medicare HMO policies do have this requirement and will deny payment to all providers involved in a case if pre-certification is not obtained.

Medicaid Pre-certification
Medicaid also requires pre-certification on most inpatient procedures, selected outpatient procedures, and medical inpatient admissions. Medicaid will allow a provider 30 days post discharge to submit precert requests if the admissions were urgent / emergent. The exceptions to the pre-certification requirement are:

1. Delivery admissions and a newborn stay up to 30 days.

Some inpatient procedures require authorization prior to the procedures being performed, e.g. dental, etc. However, not all outpatient procedures will require pre-certification with Medicaid, and in some cases the requirements are dependent upon the age of the patient. The Georgia Department of Community Health, a state agency, issues and periodically updates a listing of all CPT codes that require pre-certification or preauthorization if performed on an outpatient basis. This listing is also available on line at http://www.mmis.georgia.gov. Providers also have the capability of submitting cases for pre-certification on-line at the same web address.

Insurance Pre-certification
Insurance companies may apply a penalty to providers for untimely notification or pre-certification.

Some insurance companies will allow providers an opportunity to make the notification and respond to requests for clinical information after discharge. Some insurance companies will do so only if the provider can provide them with information regarding acceptable extenuating circumstances involved in not meeting the pre-certification requirements, this is called retrospective review. Thorough documentation becomes imperative in cases where the
insurance information is not available at the time of registration. If it is documented in a computer system or location where others involved in the pre-certification and claims process have access, the notations may make the difference in the level of reimbursement available to the provider.

There are times that the hospital, in reviewing these cases, determines that the patient type should be changed. For instance, a patient may have been admitted inadvertently as an inpatient and should have been admitted as an outpatient or observation. The hospital must obtain an order from the physician and place it in the medical record to retrospectively convert the stay to an outpatient. After the insurance company is advised of the change, precert requirements for the new patient type must be fulfilled, the medical records coding must be updated, and all parties must submit revised claims.

**Denial and Appeals**
If a case does not meet the medical necessity or treatment protocol criteria, the agency will deny those days. A hospital admission may be authorized, and part of the stay may meet the criteria, but the days that do not meet their criteria will be denied. In such cases, the next course of action is to submit an “appeal” to the insurance company. Procedures for an appeal vary between insurance companies and also between individual plans or employers. The majority of insurance companies will require either a part of the medical record or the entire medical record. Some will also require a narrative justification written by a clinical representative of the hospital stating why they feel the hospital stay should be approved. There are time limitations for submitting appeals, most insurance companies allow between 90 and 180 days from the date that the denial was issued. When an appeal is received by an insurance company or agency, they will forward the material submitted to a physician reviewer who will make a disposition and advise all parties involved, including the patient. If the denial is not overturned, some companies offer an opportunity to submit another level of appeal, which will be forwarded by the insurance company to an outside physician consultant group.

**Importance of Pre-certification**
Pre-certification and authorization are important parts of the revenue cycle and must be performed to the insurance companies’ specifications in order to ensure that claims are paid in a timely manner. It is imperative that thorough and accurate documentation is made on all correspondence and claims sent to the insurance company regarding a case.
Section 1.1.G - Financial Counseling

Purpose
One of the keys to success of any healthcare facility is a solid Financial Counseling program. Financial Counselors are the gatekeepers to ensure bills for services rendered will be covered by the patient once they walk out the doors of your facility. While some Americans have insurance coverage for their unexpected health care needs, many do not. Some uninsured can pay for the health care needs, but America’s hospitals treat millions of patients each year that can make only minimal payment or no payment at all.

Often, the patient is unaware of payment alternatives such as installment plans, which are typically arranged based on the patients’ ability to pay, on income level and a number of other variables. Patients are often fearful of how they are going to pay their hospital bills.

Financial Counselor Role
The primary duty of the Financial Counselor is to interview, investigate and seek to find and identify all potential sources of payment for the patient’s hospital bill. In many cases, you must be a great investigator and detective.

Financial Counselors must have good communication skills and be empathetic to their patients’ financial situation. Financial counselors are critical as they alleviate financial fears and gain cooperation of the patient. When cooperation has been established, payment is more likely to occur. In a recent survey a staggering 38% of those interviewed sited an inability to pay medical bills as one of their gravest concerns.

Patient Options
Many patients are reluctant to discuss financial matters when they are ill, injured and hospitalized. Therefore, it is important for the financial counselor to deal with the patient in a professional manner. Through the financial interview, the Financial Counselor should be able to identify sources of potential reimbursement.

These include
- Cancer State aide
- Vocational Rehabilitation funds
- COBRA continuation of insurance benefits
- Reimbursement from Veterans Administration
- Hill Burton
- Indigent Care funds
- Others (refer to specific sections for additional information)

Medicaid Eligibility
They should also be able to identify patients, who may, based on disability or income reasons, be eligible for a variety of Medicaid programs. The financial counselor should always be aware of resources, their requirements, regulations and means to access these services as potential for reimbursement of the patients’ account.
Hospital Responsibilities
In order to establish a good Financial Counseling program, hospitals should:

- Make information available to the public on hospital-based charity care policies, Hill Burton, Indigent Care Trust Funds and other known programs of financial assistance. Written policies should outline eligibility criteria so that financial counselors can determine under which programs patients will qualify,
- Communicate information to the patient in a way that is easy to understand and culturally appropriate
- Hospitals should have understandable, written policies to help patients determine if they qualify for public assistance programs or hospital-based assistance programs. All written policies for assisting low-income patients must be applied consistently,
- Hospitals should seek information from appropriate community health and human service agencies and other organizations that assist people in need so that appropriate referrals for assistance can be made
- Hospitals must ensure that financial counseling staff is educated about hospital billing, financial assistance and collection policies and procedures.

Financial Counselors Responsibilities
Financial Counselors should:

- Be well-educated about alternate payment sources such as Cancer State Aide, Vocational Rehabilitation funds, reimbursement from Veterans Administration, Victim of Crime, COBRA continuation of benefits, Medicare and Medicaid programs
- Continue their education on governmental regulations and eligibility requirements because of constant changes with these aspects of potential reimbursements and to adequately assess the needs of their patients
- Obtain sufficient information from their patients, through an all inclusive financial interview, to assess the patients qualifying situations and whether they exist. Documentation of their circumstances should be required such as proof of residency, verification of income or other assets, credit report, bank statements, etc. The financial interview should be comprised of a “credit application”, to identify the patient’s income, assets and resources that help to evaluate their ability to pay. It is important to consider all assets when determining the need for charity. An asset is defined as any item in the possession of the patient that can be sold or exchanged for cash. Examples include stocks, certificates of deposit, savings accounts, bonds, 401K and other accounts that can be liquidated for the principal amount or cash value, and any real property other than the property used for personal residence by the patient. This will also serve as a document to justify indigent care charity write-offs, and to write off deductibles for Medicare patients who are indigent
- Be able to identify those accounts that need to be protected by the filing of a lien when tort liability is involved
Financial Assistance Evaluation
When patients are being evaluated for charity or other financial assistance, the medical facility is entitled to and required to obtain as much information as possible from the patient before the determination can be made.

Hospitals may need to modify the use of these guidelines to comply with internal policies and procedures and state and federal regulations. These guidelines are intended to strengthen relationships between hospitals and patients. Regardless of the patients’ ability to pay, hospitals are committed to caring for the patient.
SECTION 1.2 PATIENT FINANCIAL SERVICES
Section 1.2.A - Overview

PFS Role
The role of Patient Financial Services (PFS) is continuing to change in an attempt to keep up with the increasing demands of the healthcare industry. In 2003 the healthcare industry and Georgia hospital providers experienced several major changes affecting the revenue cycle.

- The Centers for Medicare & Medicaid Services impose new (APC) Ambulatory Payment Classification’s starting January 1, 2003.
- The Georgia Department of Community Health contract with ACS as the new intermediary for processing of Medicaid claims started April 1, 2003.
- New HIPAA regulations implemented in 2003:
  - Privacy Practices went into effect on April 14, 2003
  - Health Insurance Reform standards for electronic transactions started October 16, 2003

Impacts of PFS Changes
The impact of these major changes continues to challenge several areas of the revenue cycle that involve the Patient Financial Services areas.

In addition, the following forces impact PFS:
- Increasing public and media pressure on hospital collection practices has ignited many debates about hospital charging, collections, and charity-care policies. This has resulted in hospitals restructuring self-pay collection practices and charity policies in serving patients with limited ability to pay. However, the situation is far more complex. Ultimately, the problems related to hospital charging and collection practices are symptoms of the vast complexities of administering the U.S. healthcare system.
- Implementation of the new intermediary ACS for processing of Medicaid claims required additional staff training on the new web portal and understanding of their internal processes to receive maximum reimbursement.
- The new HIPAA regulations regarding Privacy Practices created numerous new policies and procedures, and required extensive training for the business office staff to ensure compliance with areas such as customer service, correspondence, medical records and other required documentation needed for billing or collection of the claim.
- The changes in Medicare policies in 2003 required additional training in both the Billing and Collection areas to ensure new claim requirements are met to achieve maximum reimbursement.
The new HIPAA regulations regarding all providers and insurance carriers to begin using “standardized” code sets created enormous cash flow issues during the last quarter of 2003. We will be reviewing the aspects of the Patient Financial Service departments in this Chapter, which includes these areas.

- Appeals
- Bad Debt
- Billing
- Coordination of Benefits
- Deductibles and Co-Insurance
- Contractuals and Adjustments
- Corporate Compliance
- Follow-up
- Legal
- Bankruptcy
- Liens
- Federal Regulations
- Refunds
- Reimbursements
- Self Pay Collections

**National Drug codes**

**National Drug Codes (NDC) Billing requirements for Injectable Drugs**: Effective January 1, 2007 all state Medicaid programs were mandated to begin requiring providers to submit claims for injectable drugs using the NDC number rather than the Health Care Current Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) codes. Except for the use of the NDC number, established billing protocols for injectable drugs shall remain unchanged.

Also, as of January 1, 2007 the only other providers to require NDC numbers at billing is Workers Comp and Tricare.
Definition
The Appeals Process is the methodology used by the provider to ask for reconsideration of
payment on denied claims. Each payer may have their own requirements for filing an appeal.

Medicare Appeals

Who Can File an Appeal?
- A claimant dissatisfied with the initial determination, e.g. denied charges, made on a claim
  by Medical Review is entitled by law to specified appeals.
- Either the provider or the beneficiary, depending on the liability of the denied charge, may
  initiate the appeals.
- The beneficiary has the right to appeal any decision about their Medicare services. This is
  true whether they are in the original Medicare Plan or a Medicare managed care plan. If
  Medicare does not pay for an item or service they have been given, or if they are not given
  an item or service they think they should get, they can appeal.
- If you are enrolled in the original Medicare Plan, you can file an appeal if you think
  Medicare should have paid for, or did not pay enough for, an item or service you received.
  If you file an appeal, ask your doctor or provider for any information related to the bill that
  might help your case. Your appeal rights are on the back of the Explanation of Medicare
  Benefits (EOMB) or Medicare Summary Notice (MSN) that is mailed to you from a
  company that handles bills for Medicare. The notice will also tell you why your bill was not
  paid and what appeal steps you can take.

Part A and Part B Appeals
The same process applies to filing an appeal for both Part A and B Medicare claims. A provider
may initiate an appeal only if:
- The provider is liable for the charges OR
- The beneficiary is liable and he/she will not exercise his/her appeal rights

A determination is made that the beneficiary will not exercise his/her appeal rights if:
- The beneficiary is liable for a portion of the items or services and the beneficiary has stated
  in writing that he/she does not intend to request an appeal, OR
- The beneficiary's liability was entirely waived in the initial determination

Appeal Rights under Medicare Managed Care Plans
If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for,
does not allow, or stops a service that you think should be covered or provided. If you think
your health could be seriously harmed by waiting for a decision about a service, ask the plan
for a fast decision. The plan must answer you within 72 hours.

The Medicare managed care plan must tell you in writing how to appeal. After you file an
appeal, the plan will review its decision. Then, if your plan does not decide in your favor, the
appeal is reviewed by an independent organization that works for Medicare, not for the plan.
See your plan’s membership materials or contact your plan for details about your Medicare
appeal rights.
If you have concerns or problems with your plan which are not about payment or service requests, you have a right to file a grievance. For example, if you believe your plan’s hours of operation should be different, you can file a grievance.

You are protected when you are in the hospital.

This is true whether you are in the Original Medicare Plan or a Medicare managed care plan. If you are admitted to a Medicare participating hospital, you should be given a copy of An Important Message from Medicare. It explains your rights as a hospital patient. If you are not given one, ask for it.

The Message tells you:

You have the right to get all of the hospital care that you need and any follow-up care after you leave the hospital.

What to do if you think the hospital is making you leave too soon.
If you have questions about this call 1-800-MEDICARE. If you ask a Quality Improvement Organization (QIO) to review your case, you may be able to stay in the hospital at no charge during the review. The hospital cannot force you to leave before the QIO makes a decision.

The Appropriateness of an Appeal
A Medicare appeal may be requested when charges are denied as a result of a medical review process, but not when a denial results from a provider billing error.

The Medical Review and Appeals reviews are completely independent of one another, however the same review criteria is utilized at both levels. Common examples of appropriate appeals request include:
- Failure to include all pertinent diagnoses supported by the medical records and
- Missing pieces of information, which are later located.

The medical record is a ‘stand alone’ document and the coverage determination is made on the basis of the information in this record.

Denials
We have all experienced it – it doesn’t matter what we do. We can handle everything perfectly: verify benefits with specific attention to detail; pre-certify in accordance with all relevant rules and regulations, whether required by contract or otherwise; provide the utmost of quality, medically necessary care; continue to re-certify through the course of the admission or other ongoing service; bill a “clean” claim in a timely manner; etc. but denials can still occur:
- Receive notification that patient did not have benefits during dates of service after all
- Informed that pre-certification for 5 days was found to be medically unnecessary per post-treatment medical review – only 4 days were deemed “necessary” and will therefore only be reimbursed at 4 days.
- Informed that facility is out-of-network so emergency treatment will not be covered
- Treatment was deemed “non-emergent” though patient was seen in emergency room
- Health insurer denies as third-party liability. Patient has not returned (TPL) third party liability questionnaire to insurer and patient cannot be located. Questionnaire required in order for health insurer to process claim.
And, even if it makes it through billing without issues…

- No payment/no response whatsoever
- Denied for no coverage, no pre-certification, not medically necessary, etc. long after services complete
- Payment is significantly delayed but eventually arrives – but with no interest
- Payment is the wrong amount – always under – rarely over!
- “Contract discount” taken but you are an out-of-network provider
- Patient’s policy disallowed most services provided; only approximately 15% of total billed charges deemed covered, you are out-of-network, and EOB shows patient responsible for his $500 deductible only, with remaining balance shown in “non-covered” column only
- Proper payment is made – but 2 years later, you receive a refund demand due to retroactive termination of benefits as a result of patient’s employer’s delay in notification of employment termination
- Payment is made via “credit balance” payment from an alleged erroneous payment on another account, so no actual payment is made but account now shows as paid in full according to insurer.
- Payer is an ERISA Plan who says it does not have to pay the claim nor does it have to comply with GA laws

BOTTOM LINE – insurers will always find a way to NOT pay your claims, even when you do everything perfectly! This chapter provides you with the basics necessary to understand prevent and counter the above situations.

An important factor to always remember is that the process of claim submission and insurer denials is best looked at as “a game”. It is your role in the game to ensure that claims are payable; it is the insurer’s role to avoid payment when at all legitimately possible. Do not take the game lightly though; the rules are there for a reason. They may be bendable or avoidable, but they are not expendable. Both sides must ultimately abide by the rules (the law or the contract). Use them to your advantage or lose them.

**Denial Types**

In order to properly handle insurance denials, you must first determine the relevant nature of each denial. Denials generally fall within two main classifications, though problems arise when situations are forced “inside the box” of a particular category. You must always think creatively, with an open mind, when reviewing account denials, though certain templates or standard protocols may be used to avoid re-creating the wheel with each similar situation.

The following information will provide you with general applicable rules to assist in handling insurance denials, though it is up to you to discover the details necessary to determine the precise method to use for most effective and efficient handling.
**Technical vs. Clinical Denials**

"Technical" denials occur when there is alleged coding or informational errors on claims, which prevent them from being considered “clean,” and, therefore, payable by an insurer.

A “clean claim” in one in which all fields of a claim are properly completed with correct codes, all information is accurate, all procedures followed and submitted in a timely manner, all in accordance with an agreed upon contractual provisions or following accepted industry standards when no contract exists.

An insurer may deny a claim for technical reason when it is believed to have been improperly submitted without complete or accurate information, causing the claim to remain unpaid until corrections are made.

Examples of technical denials are as follows:
- Claim untimely upon submission
- No out-of-network coverage
- Improper bill type
- Wrong pre-certification number
- Wrong birth date
- Non-covered procedure or revenue code

“Clinical” denials may occur when certain medical criteria is not met in accordance with standards in the industry or pursuant to insurance contracts and/or utilization review policies and procedures.

This may involve various clinical denials such as:
- No authorization/certification (either before or during service)
- Post-billing medical record review which deemed care not medically necessary for intensity of service or length of stay
- Pre-existing condition exclusions
- Experimental procedures used/not approved
- Emergency medical care deemed non-emergent

**Other Substantive Denials**

There are other substantive denials that are not clearly within the above two categories, such as third-party liability matters, coordination of benefits, or retroactive termination of benefits, though most routine denials generally fit into either the “technical” or “clinical” realm. These other denials are most critical to watch for, since they do not logically or easily fit in either of the two main categories with established protocols for handling and can actually cross into either area based on other specifics of the accounts.

- For instance, a third-party liability matter may be treated and handled as a technical denial when it was denied for this reason simply because of a treatment code used, where the patient’s diagnosis did not actually involve injuries caused by another party, but the code used to describe services provided triggered a TPL review by the insurer, but the patient could not be reached for further explanation.
• A retroactive termination of benefits may actually fall into either the clinical or technical realm of handling, dependent upon whom in your facility handles pre-authorizations, that staff would then be most appropriate to handle the rescission of that pre-authorization – since that is what a retroactive termination of benefits results in. Once a pre-certification is provided by an insurer, it is contrary to Georgia law to rescind that authorization; therefore, it is best to deal with those denials using this method.

It is this “splitting of hairs” that causes these types of denials to slip through the cracks or not be properly addressed or managed by the most relevant staff.

Medical Necessity Denials
Medical necessity denials occur at all stages – before, during and after provision of services. Obviously, if this sort of denial occurs prior to actually performing recommended services, a medical provider still has the choice whether or not to proceed with the services, unless, of course, the services are emergent. In that case, both the medical provider and the insurer are prohibited from denying medical services and prior authorization is not allowed to be mandated.

When an insurer denies pre-authorization of non-emergent (scheduled) care for clinical reason, prior to services actually being performed, it is up to the provider to prove the medical necessity of the requested services. If it is unable to attain that authorization, services provided will not be reimbursed by the insurer; however, if authorization is, in fact, granted, the health insurer is then prohibited from ever denying the submitted claim based on medical necessity, though it may still deny for other reason (i.e. technical or other substantive denial).

Many payers no longer allow retro-authorizations, therefore it is imperative that eligibility is verified and payer is contacted for authorization prior to providing services. If a patient is treated (non-emergent) without prior authorization, the provider must request retro-authorization based on medical necessity. Assuming this is done so in a timely manner, an insurer’s utilization staff will review clinical information supplied by the provider, as well as the patient’s medical chart, to determine whether or not services were medically necessary. Again, once authorization is granted, the insurer is prohibited from later denying the claim for clinical reasons. If retro-authorization is denied, the provider must appeal that decision and continue to try to prove medical necessity of care; otherwise, the services are not reimbursable by the insurer.

Many insurers later deny claims retrospectively (after services already provided for clinical reason). It is important to remember that pre-authorized services may not later be denied for medical necessity, so long as accurate clinical information was provided at time of requested and granted authorization. An insurer may not dictate the precise care a treating medical provider may or may not provide. The treating physician always has the final determination as to which services are medically necessary in any given situation. Insurers who attempt to override that decision are in violation of Georgia law, though particular insurance policies may not “cover” specific services. It is critical to determine whether a claim is being clinically denied for “non-covered” or “not medically necessary” services, since there is a huge difference in methods used to deal with each of these distinctive situations.
**Hard vs. Soft Denials**

You might believe that a denial is a denial – no money is being paid for services, so what is the difference? Well it is important to recognize whether the denial issued is a “hard” or “soft” denial, since the first means your claim is not going to be paid (without a fight) and the later basically means that the claim payment has been delayed based on additional information, documentation or changes necessary in order to process the claim.

A **hard** denial is one in which an “appeal” will be required to rectify the technical, clinical or substantive denial, i.e. medical necessity, improper coding, untimely claims submission, etc. A **soft** denial requires additional work on the part of the medical provider in order to obtain payment, though the claim is not necessarily being said to be permanently un-payable by the insurer. For instance, you may have provided the wrong birth date for the patient or may need to wait for the insured to answer and return a TPL questionnaire for further information. In any case, it would behoove the medical provider to gather all necessary information/documentation or make any required changes to obtain claim payment, whether required of the patient or medical provider. Where information is necessary from the insured, a medical provider must still motivate and encourage the patient to complete and submit that documentation; otherwise, the claim will remain un-payable by the insurer.

Either way – a denial is a denial – left unattended! Soft denials are very rectifiable, so do not miss the opportunity to handle an easy one now and again.

**Partial Denials**

Claims that are only partially payable are referred to as “partial denials”. Where this occurs, there is something missing or additional information necessary or something to prove to obtain payment of the remainder of the claim. Sometimes the balance of a claim is denied as a “hard denial”, i.e. authorization not obtained through a certain date and deemed by the insurer as not medically necessary beyond the authorized dates of service, which requires the appeals process. Sometimes, though, the balance of a claim is only “soft denied”, i.e. requires treatment notes to show certain services included on the claim were, in fact, provided.

It is important to note that an insurer must pay the allowable portion of a claim, even when a certain portion of it remains un-payable. And, the insurer must also supply a detailed explanation or list of items or information necessary to cause the remainder of the claim to become payable. The entire payment may not be held up while rectifying the un-payable portion. If this occurs, or if a detailed explanation of the denial is not provided, look to the Georgia Prompt Payment of Claims Act for remedies.
### Time Limits for Filing Part A Appeals

<table>
<thead>
<tr>
<th>Medicare Part A Appeal Type</th>
<th>Time Limits</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Level I Redetermination</td>
<td>120 days from date of denial letter</td>
<td>Complete the Cahaba GBA Medicare A Redetermination Request Form, Medicare Redetermination Request Form (CMS-20027) or a formal written request for appeal</td>
</tr>
<tr>
<td>Level II Reconsideration</td>
<td>180 days of the date of the notice of the MRN</td>
<td>If dissatisfied with the Redetermination decision, complete &quot;Medicare Reconsideration Request Form&quot;</td>
</tr>
<tr>
<td>Level III Administrative Law Judge Hearing</td>
<td>Requests for ALJ hearing is submitted to the address listed in the QIC decision letter and must be received within 60 days of the date on the QIC’s letter.</td>
<td>Minimum amount in controversy (AIC) to request an ALJ is $120 (for requests made in 2008). Claims from more than one beneficiary can be combined to reach the $120 AIC.</td>
</tr>
<tr>
<td>Level IV Appeals Council Review</td>
<td>. Must be filed in writing within 60 days after the date of the ALJ hearing decision notice.</td>
<td>If dissatisfied with the ALJ decision, you may submit a request for a review from the Appeals Council to the address listed in the ALJ decision letter. Instructions to proceed to the next appeal level are included in the ALJ hearing decision notice.</td>
</tr>
<tr>
<td>Medicare Part B Appeal Type</td>
<td>Time Limits</td>
<td>Comments</td>
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<tr>
<td>Medicare Part B Reopening Request form</td>
<td>Must be requested within one year of the initial determination.</td>
<td>Clerical Error - For providers to submit written reopening requests when the telephone reopening line is not an option for corrections.</td>
</tr>
<tr>
<td>1. Written Recommendations</td>
<td>Redeterminations must be requested within four months of the initial determination.</td>
<td>Written statement (including documentation) from the provider or supplier expressing disagreement with the initial determination or indicating that a redetermination or reexamination should be made. Requests must be made in writing and must be signed</td>
</tr>
<tr>
<td>2. Reconsideration</td>
<td>A written reconsideration request must be filed within 180 days of the redetermination.</td>
<td>The request form is at the end of the redetermination letter.</td>
</tr>
<tr>
<td>3. Administrative Law Judge</td>
<td>Can be sent directly to the Administrative Law Judge within 60 days of the date of the reconsideration decision.</td>
<td>Effective January 1, 2010 the Amount In Controversy (AIC) must be at least $130.00. You may attend this hearing in person, send a representative, or have the ALJ review the record. More than one beneficiary's claim can be used to meet the $130.00 amount in controversy.</td>
</tr>
<tr>
<td>4 Review by the Medicare Appeals Council within the Departmental Appeals Board</td>
<td>Must be submitted in writing within 60 days of receipt of the ALJ's decision.</td>
<td>Must specify the issues and findings that are being contested. The Appeals Council will issue a decision within 90 days of receipt of a request for review (that timeframe may be extended for various reason, including but not limited to, the case being escalated from an ALJ hearing).</td>
</tr>
<tr>
<td>5. Judicial Review</td>
<td>The appeal must be submitted in writing within 60 days from date of receipt of the DAB decision notice.</td>
<td>Effective January 1, 2010, the amount in controversy for requests must be $1,260.00.</td>
</tr>
</tbody>
</table>
Guidelines for Filing Medicare Appeals
The forms for requesting a Medicare appeal can be located at:

https://www.cahabagba.com/part_a/forms/redetermination

When submitting appeals requests, please clarify which type of appeal you are requesting on the envelope. Keep in mind that the timeliness of the request is in jeopardy each time the request is received in your office without the above-mentioned criteria.

Also, all pertinent medical information that should be considered with the review, usually medical records, must be included with the request for appeal.

Appeal requests should be mailed to:

Cahaba GBA
Medicare A Redeterminations
P.O. Box 830867
Birmingham, AL
35283-0867

Priority/Overnight Mail
Cahaba GBA
Medicare A Redeterminations
P.O. Box 830867
Birmingham, AL
35283-0867

Georgia J10
Cahaba GBA
Part B Redeterminations
PO Box 12967
Birmingham, AL 35202

Update on New Guidelines for Medicare Appeals
Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement Protection Act of 2000 (BIPA), Congress required a major restructuring to improve the process that Medicare beneficiaries can use to appeal claims denials. The law includes a series of structural and procedural changes to the appeals process, including:

- Uniform appeal procedures for both Part A and Part B claims
- Reduced decision-making time frames for most administrative appeals levels, as well as the right to escalate a case that is not decided on time to the next appeal level.
The establishment of new entities, Qualified Independent Contractors (QICs) to conduct reconsiderations of claims denials by fiscal intermediaries, carriers, and quality improvement organizations.

Use of QIC review panels, which include medical professionals, to reconsider all cases involving medical necessity issues.

Requirement for appeals-specific data collection by CMS.

Implementation of these new procedures will take place in two stages. First, beginning May 1, 2005, all first level appeals now called “redeterminations” carried out by the fiscal intermediary (generally Part A appeals) will be subject to QIC reconsideration. These appeals generally involve Medicare Part A services, such as services furnished by the hospital. Then beginning January 1, 2006, appeals of redeterminations carried out by Medicare carriers (Part B appeals, involving physician services and DME) will be subject to QIC reconsiderations. The new ALJ rules will be in effect for all appeals that come through the QICs. Thus in 2006, the new Medicare appeals process will take effect for all Part A and B Medicare claims.

**Medicaid Appeals**

**Who Can File an Appeal?**
A provider.

**Medicaid Appeal Type #1 - Administrative Review Request**
All Medicaid initial or Administrative Review requests must include:
- Reasons why filing appeal
- All supporting documentation
- Explanation of what the provider wishes the Medicaid to consider

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<tr>
<th>Medicaid Appeal Type</th>
<th>Time Limits</th>
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<tr>
<td>1. Administrative Review (Initial)</td>
<td>Written notice within 30 days of receipt of Notice of Adverse Action, e.g. denied charges</td>
<td>Failure to comply w/ 30-day requirement, the provider waives all rights to appeals including a hearing. If dissatisfied with the Administrative Review decision, go to the Administrative Law Hearing or Judge (ALH or ALJ).</td>
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<tr>
<td>2. Administrative Law Hearing or Judge (ALH or ALJ)</td>
<td>Written notice within 15 business days after the date of Administrative Review decision.</td>
<td>If dissatisfied with ALJ decision, go to Commissioner’s review.</td>
</tr>
<tr>
<td>3. Commissioner’s Review</td>
<td>Written notice within 10 days of receipt of ALJs decision.</td>
<td>Failure to comply 10-day requirement, the provider waives all rights to any further review or revision of the decision. Written notice should include legal, factual errors on which appeal is based. If dissatisfied with the Commissioner’s decision, go to the Judicial Review.</td>
</tr>
<tr>
<td>4. Judicial Review in the Superior Court of the county of residence of the provider or to the Superior Court of Fulton County</td>
<td>Written notice within 30 days of receipt of final decision of Commission.</td>
<td>This is the final administrative decision!</td>
</tr>
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</table>

**Medicaid Appeal Type #2 – Administrative Law Hearing (ALH)**

A request of the Administrative Law Hearing (ALH) must be sent to:

Georgia Department of Community Health
Legal Services Section
2 Peachtree Street, NW
40th Floor
Atlanta, GA 30303-3159

The Request for an ALH must include the following information:

- A clear explanation from the provider of the appeal and the reason of disagreement
- The Administration Review issues and decisions regarding the appeal
- A specific statement explaining why the provider believes that the Administrative Review decision or other Medicaid action is wrong
- A provider statement of the relief sought (what does the provider want?)
Commercial Appeals / The Appeals Process

Initial Steps
Though all steps have been rigidly followed and vehemently taken to prevent denials, insurers will still find creative ways to deny claims. Once you receive a denial, you must first determine the nature and extent of the denial:

- Has it been **partially** or **fully** denied?
- Is the denial **hard** or **soft**?
- Does the denial relate to **technical**, **clinical** or **other substantive** issues?
- **What** precisely needs to be done to best handle the denial, to counter the contentions of the insurer, to rectify the claim status?
- Has this particular situation been dealt with **before**? If so, were **previous** methods **successful**?
- Is this a **new** situation requiring individual handling of a new methodology and procedure?
- **Who** best to handle the circumstances at-hand?

Once you know specifically what you are dealing with, what needs to be done, and who needs to do it, you then must obtain some other very relevant general information:

- Are you in-network, or out-of-network?
- Were benefits verified? Authorized?
- What types of services are covered?
- What type of policy does the patient have?
- What is the patient’s financial responsibility? Was the proper dollar amount allocated at all responsible parties (contractual write-off, patient, etc.)?
- Were all conditions and provisions of the contract (if relevant) met?
- Was your claim “clean”?
- Did your facility do what it was supposed to do? Did the patient? Did the insurer?
- Who is at-fault – what “caused” this denial?
- Were all relevant insurance laws followed by both parties?

If you can answer most or all of these questions, you are already halfway there in resolving the denial. Gather all of your information and prepare your argument.

*Know Your Contracts*

The most critical piece of information when dealing with any denial is the one most often overlooked and not considered. You must know your contracts (when applicable) to effectively handle insurers’ denials. Many times your solution is very simply contained in black and white in your contract. How can you possibly know if the insurer’s denial is allowable, legitimate and rectifiable, or not?

You must determine what is required of you in order to know whether your medical provider has met those conditions, if the claim submitted was in accordance with applicable provisions, if the insurer has treated the claim appropriately by denying it, etc. and what actions may or can be taken to rectify the situation. You must be aware of the appeals process available to you – do you have but one level of appeal available or are multiple levels afforded?
Imagine driving a car with your eyes closed! Once you get in a wreck, try telling the police officer that you weren’t aware of any traffic laws! Dealing with a claim denial without knowing the applicable contract is practically as treacherous in the medical field.

**Example of One Insurer’s Appeal Requirements:**

Blue Cross and Blue Shield of Georgia, Inc (BCBSGA)
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP)

**Provider Complaint and Appeal Process**

**Introduction**

Effective June 1, 2003, BCBSGA/BCBSHP implemented a new process for handling provider complaints and appeals. This new process will be simpler for providers and all appeals e.g. clinical or administrative will be sent to the same address. In addition, with the implementation of this process it will be easier for providers to inquire on the status of a pending issue. This is a statewide process; which applies to the Indemnity, PPO, HMO and Blue Choice Platinum (BCP) products with the following exceptions:

- State-Indemnity
- NASCO
- Out-of-State Providers
- Non-Contracted Providers

**Initiating Complaints and / Appeals**

Complaints and appeals must be filed in writing with the Provider Complaint and Appeal Form filled out.

Complaint/appeal process must be initiated within 365 days of the date of the explanation of benefits (EOB). Complaint/appeal documentation less than ten (10) pages in length should be faxed with a cover letter outlining the complaint/appeal issues to 1-877-868-7950.

Complaint/appeal documentation more than ten (10) pages in length should be mailed to:

BCBSGA/BCBSHP
P.O Box 9907
Columbus, GA 31908

Once documentation is received providers will be sent an acknowledgement letter within (5) days of BCBSGA/BCBSHPs receipt of the information. Providers will be notified if additional information is required.

A decision will be made within 30 calendar days of receipt of all necessary information. Providers will be notified of complaint/appeal resolution in writing.
Administrative Issue Examples
Timeliness of filing
Reimbursement issues
Pre-authorization not on file.

Providers are entitled to review as a complaint, as well as a first and second level appeal.

First and second level administrative appeals will be subject to committee review.

Clinical Issue Examples
Medical Necessity
Level of Care
Length of Stay (LOS).

Providers are entitled to review at one level of appeal

References
- Blue Cross and Blue Shield of Georgia, Inc (BCBSGA) and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc (BCBSHP) Provider Complaint and Appeal Process, June 1, 2003
- Georgia Department of Community Health website, [www.dch.state.ga.us](http://www.dch.state.ga.us), Part I, Chapter 500, Appeals
- Cabaha Part B, [https://www.cahabagba.com/part_b/claims/appeals_process.htm](https://www.cahabagba.com/part_b/claims/appeals_process.htm)
- [https://www.cahabagba.com/part_b/index.htm](https://www.cahabagba.com/part_b/index.htm)
- [http://www.cahabagba.com/rhhi/contact_mail.htm](http://www.cahabagba.com/rhhi/contact_mail.htm)
Section 1.2.C - Follow-up

Overview
Increasing deductibles and managed care has caused the percentage of payments being owed by patients in recent years to escalate. Patient portions now make up a greater percentage of hospitals accounts receivable. Americans are burying themselves in debt to the point they can’t pay their medical bills. It is vital to the organization to have a follow-up department supported by sound policies and procedures.

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

1. Utilize a comprehensive and financially focused pre-registration program/policy that includes:
   - Financial counseling
   - Insurance eligibility
   - Verification of benefits
   - Pre-authorization / certification
   - Proration of patient portion
2. Establish payment options for patients to pay their portion of the bill and actively promote alternative payment options such as credit or debit cards, bank drafts, etc.
3. Implement a financially focused discharge area for inpatients, emergency room and high dollar outpatients to collect deposits and/or make payment arrangements for estimated dollars due.
4. Make visits to bedded patients rooms to investigate third-party coverage and make financial arrangements for self pay portions.
5. Collect dollars due or finalize payment arrangements before services are rendered.
6. Identify previous bad debt accounts and provide patients with financial counseling prior to rendering services at all entry points, except where EMTALA laws apply.
7. Establish a tracking mechanism to monitor cash collections and implement goals to achieve better collections in all areas and to differentiate between all collection points.

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

Once correct claims or appeals have been submitted, you must follow-up accordingly with the appropriate insurer representative. Merely contacting customer service representatives on a monthly basis is many times insufficient to ensure proper handling of your issues. Simply asking for a “status” of the claim is blatantly insufficient. Blanketed acceptance, as the gospel of what is told to you is also grossly unacceptable. You must do more than merely ask questions and acknowledge answers.

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

**Exhaust All Available Options**

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

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

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

And once that level is gone, are there other avenues of recourse left? Is the situation at-hand worthy of going to all available lengths? This is a critical question to ask before beginning any process, no matter how many levels are available, but especially if only a very small window of opportunity to resolve exists. If you are willing and the account denial is worthy based on quality, quantity, dollar amount, principle or otherwise, you are best suited for action by being aware of that upfront, and more importantly, by informing the insurer of that upfront.

Regardless of the situation, it is always prudent to exhaust all available levels of appeal. You just never know what that next set of eyes will see, whether from your staff or the insurers. Mistakes are made and opportunities missed simply by failing to run the course!
The Follow-up Department
A successful follow-up department should be located in the Patient Business Office and comprised of knowledgeable employees who can demonstrate good customer service techniques in order to collect dollars due. These best practices should be implemented as part of the Follow-up Department:
1. Self-pay balances should be segregated based on dollar amounts. Telephone calls utilized for inpatients and high dollar outpatient vs. written notices for small dollar outpatient claims.
2. Utilize multiple automation tools such as credit reports in order to prioritize which self-pay accounts are collectable and which should be sent directly to bad debt to accelerate cash flow.
3. Outsourcing the Medicaid application process is recommended along with other state funded applications.

Follow-up Categories
Follow-up should be separated into two different categories, one dealing with patient dollars owed and the other dealing with insurance dollars owed. Document all follow-up actions taken; this is paramount to being effective.

Insurance Dollar Follow-up
Resolving Outstanding Issues
A well educated employee can be the key to good follow up when insurance companies are involved. The employee should be able to communicate with the insurance company knowing the terminology used in order to be an effective collector.

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

- Claim Not on File – Before accepting this statement, review your documentation for previous notes or discussions with the insurance carrier representative.
- Verify the claim submission address.
- Cannot identify the Patient/Subscriber – Have the insurance rep check by name, date of birth, and SSN for both as well as the employer.
- Terminated Coverage – verify if the individual or group terminated. If it was the group, who took over?
- Medical Records Requested – Why? Make sure it is not a general excuse. What specific records do they need?
- Claim in Review –
  - Why? What are you reviewing for?
  - When did it go into review and when will it be out of review?
  - Who should I talk to when the claim is out of review?

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

- Out-of-Pocket – A set amount (usually per year) that the patient must pay prior to the insurance company paying 100% of allowed amount.
- Cost Share – Patient responsibility usually with Tricare or Medicaid.
- Spend Down – Patient responsibility on Medicaid accounts.
EOB Information
EOBs are not standardized but most will provide some of the following information:
- Patients Name
- Member / Policy Number
- Dates of Service
- Amount Charged / Amount Allowed
- Provider Responsibility – amount cannot be billed to the patient (sometimes considered contractual adjustments)
- Patients Responsibility - equals co-pays, deductibles, coinsurance, or non-covered charges. These amounts can be billed to the patient
- Other Insurance Payments
- Amount Paid by Insurance Company
- Contract Type – HMO, PPO, POS
- Remarks – codes whose definition is usually found elsewhere on EOB

Determining Correct Payment / Contractual Adjustments
Many times the EOB will give you two pieces of information and from that, you must calculate the missing piece. The following are examples of calculations used to determine correct payments / contractual adjustments:
- Total Charges minus Allowed Amount equals Contractual Adjustment
- Total Charges minus Contractual Adjustment equals Allowed Amount
- Allowed Amount plus Contractual Adjustment equals Total Charges
- Payment plus Contractual Adjustment plus patient responsibility equals Total Charges
- Patient responsibility plus insurance payment equals Allowed Amount
- How to figure percentages paid / owed on non-managed care or contracted services:
  - Percentage insurance company paid equals payment amount divided by allowed amount.
  - Percentage patient owes equals total patient responsibility divided by allowed amount.

Tips for collecting insurance dollars due
Prior to calling the insurance company, be knowledgeable of any contractual obligations your facility has with the company and/or employer. Be up to date on the patients insurance benefits so that deductibles and co-insurance amounts can be determine. The more prepared and organized you are the better you’re able to present your “case” to the payer.

Use of imaging for document retrieval saves vast amounts of time for collectors. If you don’t have to search file cabinets for documents you can be much more effective.

Work your A/R by payer type. When calling a carrier it is more efficient if you can address more than one account at a time. This can easily be orchestrated if the accounts are being worked by insurance classification. Also, by consistently assigning a payer type to the same staff member, that individual can become familiar with the payer’s system, reimbursement schedule and personnel.
Work your bigger dollar accounts first. Your major collection efforts should be directed to the dollars that have the most impact on your organization. Organize your A/R follow-up to monitor the biggest accounts first.

Get the patient involved. Contact the patient at the first sign of payment delay, thereby reducing lag time. By working more closely with the patient, a team effort can be created to help reduce insurance denials or to help find payment options after a denial has been given.

Have a sense of humor. You’re more likely to get a positive reaction from the insurance company if you maintain a positive attitude.

Have the persistence of a bulldog. With insurance companies, always follow up to make sure they pay when they are supposed to. If promises are made during your call, document them in the account and hold the company responsible for following through.

Appeal to a higher authority. If you feel you are being treated unfairly by the insurance company, remember your ability to get the patient or insurance commissioner involved. Sometimes just threatening this to an insurance company will help.

Be creative. If any insurance company says they never received a claim, get the company’s fax number and fax the claim over, then call to be sure the fax was received.

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

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

If a commitment is not forthcoming, offer options.

Listen to what the patient has to say. Work with patients and make sure they know you understand their problems, but it is still important they pay their bill.

When speaking to patients, speak calmly and never, ever become sarcastic. Do not leave the call open ended. This is your chance to work with the patient and get the account paid. With uncooperative patients, mention the possibility of using a commercial collection agency and how that will affect the patient’s credit rating. If the patient seems unimpressed, follow through with the threat.

Document all correspondence and telephone work. Do follow up and track all conversations, correspondence, and commitments and document everything in the patient’s account.

Offer discounts for prompt payments. This is probably the most effective way to get payments early. However, should you go this route, do some quick calculations to make sure that you haven’t given away the store with your strategy.
For those patients who have been identified as truly having financial issues, it may be necessary to refer those accounts to a Financial Counselor so that determination can be made regarding Hill Burton or Indigent Care Trust Fund eligibility. You do not want to leave unpayable dollars on the A/R.
Section 1.2.D - Refunds and Credit Balances

General Information
Credit balances on patient accounts are a continuous occurrence in healthcare accounting. They should be dealt with on a regular basis to conform to State and Federal guidelines and to maintain the integrity of the facility’s outstanding Accounts Receivable. The return of an overpayment or refund should not be considered until the appropriate source is researched and identified. Sources of overpayments or credits may include:
- Third party payers such as Commercial Carrier, Medicare, Medicaid, and Worker’s Compensation
- Patient Payment
- Error in posting payments
- Adjustment(s) or contractual improperly applied or absent

Third party payer credit balances are to be returned to the appropriate carrier in accordance with guidelines established by the State Insurance Commissioner’s Office. Overpayments are not returned to the guarantor/patient in cases of a credit balance created by the co-ordination of benefits (multiple third party payers). Monies are returned to the appropriate carrier.

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

Additionally, Georgia enacted legislation in 2002 that established procedures and time limits for retrospective utilization reviews and retroactive payment denials that result in refund requests or, worse, take backs or set-offs against future payments. The basic provisions are as follows:

1. For claims submitted within 90 days of the last date of service, the final audit or retroactive denial must be completed within 18 months from the last date of service or discharge. Also, written notice by the insurer to audit or deny must be given to the provider within 12 months of the date of service or discharge.
2. For claims submitted more than 90 days of last date of service, the final audit or retroactive denial must be completed within the sooner of 18 months after the submission of the claim or 24 months from the date of service. Notice by the insurer to audit or deny must be given within 12 months of the initial submission of the claim.

That same legislation also limited the time period in which medical providers can request additional payment on previously paid claims. Greater time is allowed for claims submitted within 90 days of service or discharge than for claims submitted after 90 days.
This legislation should certainly provide an incentive to file your claims timely!

The following information is broken down by payer category outlining the normal expectation for that line of business and is to be used as a guideline. Each facility should have their own Policy and Procedure for handling refunds.

**Individual plans**

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

**Commercial, HMO and PPO**

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

**Workers Compensation (Work Comp)**

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

**Governmental Payers**

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

When there is a liability payment and a payment from a governmental payer and billed services are equal, the liability carrier is only liable up to the amount of the Governmental payer allowed amount. A corrected/voided (TOB xx7 & xx8 respectively), must be submitted to the governmental payer to reprocess and take back the original payment, the liability carrier must be refunded up to the governmental payer’s allowed amount (inclusive of deductibles and coins) and a contractual adjustment must be posted for the difference between allowed amount and total charges.
Medicaid
Medicaid is always the payer of last resort. If an account has a credit balance and there are payments from multiple payers Medicaid will usually be the first to be refunded. This is, of course, providing that all payments are applied correctly and all charges are considered.

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

Patient overpayments do not always go to the patient; verify in the account information screens exactly who the Guarantor is. If other than the patient, the refund goes to the guarantor. Additionally, if the patient information screens identify the patient as deceased or expired and the patient is also listed as the guarantor, refunds need to be addressed to “To the Estate of (Patient Name)”. This helps reduce returned mail and reduces the number of checks requiring new payee information.

Be sure to review your facilities policy for specific refund policies.

Processing Blue Cross Blue Shield and State Merit Refunds
These guidelines include action steps that can be taken for appropriate and timely processing of non-government credit balance accounts.

Procedure Hospital Initiated:
- Hospitals may initiate refunds due to health plan by completing a Refund Memorandum, attaching a refund check made payable to Blue Cross and Blue Shield of Georgia, and mailing the check and Refund Memorandum to:
  Blue Cross and Blue Shield of Georgia
  PO Box 4445
  Atlanta, GA 30302
  Attention: Cash Receipts

- Hospital refund inquiries may be sent to:
  Blue Cross and Blue Shield of Georgia
  PO Box 7368
  Columbus, GA 31908-7368
  Attention: Refunds

- Hospitals may initiate SHBP – Indemnity and PPO refunds due to SHBP by completing a Refund Memorandum, attaching a refund check made payable to the State Health Benefit Plan and mailing the check and Refund Memorandum to:
Procedure BCBSGA/ BCBSHP Initiated Refunds
- For refunds owed the health plans that are greater than $10,000, the hospital will be called and notified of the overpayment via fax. Any questions or concerns are handled on this first contact, and arrangements are made for payment.
- A special provider service unit has been established to assist providers with questions concerning overpayment by the health plan. This unit may be reached at 1-800-241-7475 from 7:00 am – 7:00 pm, Monday-Friday. For SHBP call 1-800-626-6402 from 7:00 am – 8:00 pm, Monday-Friday.
- For refunds owed the health plan that are less than $10,000, the hospital’s business office will be mailed a notice of refund recovery requesting payment within 30 days.
- An automated deduction collection process is in place to recover payments issued in error when routine collection efforts have not been successful.

Processing Medicaid Refunds
These guidelines include action steps that can be taken for appropriate and timely processing of Medicaid credit balance accounts.

Georgia Medicaid Policy & Procedure, Part 1, Section 303.6
Effective July 2, 2001, all participating health care providers in the Medicaid program are required to submit a Medicaid Credit Balance Report quarterly. Hospitals and nursing facilities are required to submit these quarterly reports even if a zero ($0.00) credit balance exists. This report must be sent no later than 30 days following the end of each calendar quarter (September 30, December 31, March 31, and June 30). Providers will not receive additional notices or reminders, but are expected to comply within required timeframes.

Procedure
First working day of each month a Medicaid Credit Balance report should be generated. Medicaid Billing staff should review all credit balance accounts and process overpayment for Medicaid. At the end of each reporting quarter the Medicaid billing staff will finalize the “Medicaid Credit Balance Report Form”. The original report with attached documentation will be submitted to:

Credit Balance Reporting Third
Party Liability Unit Division of
Medical Assistance
Department of Community Health
Post Office Box 406867
Atlanta, GA 30384-6867
Processing Insurance and Patient Credit Balances
These guidelines include action steps that can be taken for appropriate and timely processing of non-government credit balance accounts.

Procedure:
1. Each month, generate and review the Credit Balance Report. Verify all information on the report against original documents, for example, insurance remittances, cash receipts and/or adjustment requests. If necessary, pull copies of insurance remittances and patient checks to verify accuracy of account transactions. Verify that all payments were applied to the correct account for the correct date(s) of service.
2. Determine who should receive the refund.
   - If an insurance company should receive the refund, determine which insurance company is the primary payer.
   - If the patient/guarantor should receive the refund, research other accounts for outstanding balances due from him or her. If outstanding balances exist, apply the amount of overpayment to the oldest account with an outstanding balance due from the patient/guarantor.
3. Determine appropriate corrective action.
   - Transfer credit balance to another open account only if the credit is a result of patient payment. Do not transfer the credit balance if the overpayment is the result of insurance payment(s).
   - Refund primary payer.
   - Refund secondary payer.
   - Refund patient/guarantor.
   - Reverse incorrectly posted contractual adjustment.
   - Refund duplicate payment.

Refund Request Forms
1. You may need to complete a Refund Request Form (sample attached). The following documentation may also need to be attached:
   - H.I.S. System documentation of account activity.
   - Photocopy of all payments posted to the account, if available.
   - All documentation initiating account adjustment activity including payments, allowances and write-offs (contractual allowances, courtesy discounts, etc).
2. Complete an analysis of refund requirements, including who should receive the refund, mailing address of refund recipient, and amount of refund to be processed.
3. Make notes of your actions and why, on the patient’s account. Include any payment transfer information; refund information, and the date of the refund request.
4. Submit the Refund request form and attached documentation to Business Office Manager or designee for approval and processing.
REFUND REQUEST FORM

Contact Information

Contact Name ____________________________________________
Contact Phone Number ____________________________________
Date Requested__________________________________________

Patient Information

*Attach EOB

Account Number __________________________________________
Patient Name ____________________________________________
Date of Service __________________________________________
Provider Name ____________________________________________
Insurance Plan ____________________________________________
Date of Payment __________________________________________
Check Number (or other identifying number) __________________

Description of the reason for the refund ______________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
**CREDIT BALANCE WORKSHEET**

Patient Account #_________________________ Patient Name __________________________

From – Thru Dates _________________ Total Charges __________________________

Serv. Period From – Thru Dates_________ Total Serv. Period Chgs.____________________

Current Account Balance ____ _________ Processed by: ____________________________

TOTAL Patient/Guarantor Payments (including transfers) ____________________________

TOTAL **Non-Contractual** Adjustments __________________

Other Payer Information:

<table>
<thead>
<tr>
<th>PAYER:</th>
<th>Considered Charges*</th>
<th>Payment(s)</th>
<th>Contractual Adjustment(s)</th>
<th>Co-Pay / Deductible Due</th>
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</table>

* Considered charges for Primary payer should equal total service period charges.
* Considered charges for Secondary and Tertiary payers should equal to co-pay and deductible due from primary/secondary payers.

✓ **Appropriate categories:**

___ Request Corrected / Void claim to Payer for take back (Incorrect Charges Billed)
___ Request Contractual / Non-contractual Adjustment Correction (Error in Posting)
___ Request Insurance Payment transfer (Applied to Wrong Account)
___ Request Insurance Payment Refund (Over Paid or Not Responsible)
___ Request Patient Payment transfer (Applied to Wrong Account)
___ Request Patient Payment Refund (Over Paid or Not Responsible / Unable to Transfer)
___ Request Insurance Refund payable to Patient (Per Insurance Company – Individual Policy)
Processing Medicare

As per CMS/Medicare regulations, each facility should report all accounts that, at the end of each quarter of the calendar year, reflect a credit balance that is reflective of an overpayment or incorrect payment by Medicare. The Medicare Credit Balance Report should be submitted to the Fiscal Intermediary no later than the end of each month following the end of each calendar year quarter.

Upon receipt of the last report of the quarter, the designated person initiates review of all accounts listed on the Medicare Credit Balance Report to determine if the account was in credit balance status at the end of the calendar year quarter.

The following steps are examples to take to resolve Medicare credit balances:

I. Determines credit balance was created because:
   - Incorrect Contractual Adjustment: Identifies adjustment code in error & requests correction to contractual adjustment utilizing an Adjustment form.
   - Late credit posted after payment received:
     i. Inpatient Accounts: Request adjustment to account via adjustment code
     ii. Outpatient Accounts (Original Bill Type 131 & 141): Demand prints UB04, modify bill type to XX7, attach copy of original EOMB, and attach to Medicare 838 report for submission to FI.
     iii. Ambulatory Surgery (Original Bill Type 831): Demand print copy of correct claim. Log-on to FSSO system, correct the original claim online.
   - Charge posted after time limits for submission to Medicare: Requests adjustment in the amount of the late charge(s) posted.
   - Payment by Third Party Payer: Verify Coordination of Benefits of all payers.
   - Overpayment by Secondary Insurance: Verify coverage is truly a secondary or supplemental plan. Contact plan administrator to determine if refunds should be processed as payable to plan or patient. Process refund request as necessary.
   - Overpayment by patient/guarantor: Review all open accounts in systems, transfer patient money to open accounts. If no other accounts exist for patient, processes refund to patient.
   - Overpayment as a result of primary payer incorrectly listed as secondary payer: Correct payer information in system, demand prints UB04 from system, attach copy of EOMB, list account on Medicare 838 report completing all required fields, requests FI to reprocess claim with Medicare as a secondary payer Via Medicare Claim Adjustment Form.
   - Incorrect Posting of Payment: Research incorrect payment, request payment is moved to correct account.

II. Verify all accounts where money is due Medicare are listed on Quarterly 838 Credit Balance report.

III. Completes Certification Page of Report for each provider number and submit to Hospital Administrator for approval and signatures.

IV. Submits signed reports to FI prior to end of month following end of calendar quarter as defined by CMS.
Strategies
Look for groups of accounts with like ($ value) credit balances. Often times you will see where there are a number of accounts with the same credit balances. Some reasons for this:

- Specific charges (i.e. lab tests, Radiology etc.) were originally charged but later removed in a bulk reversal.
- Room charges were reversed after billing (usually the $250 $700 range)
- Even dollar credit balances ($15.00, $25.00, $50.00) are often created due to the collection of co-pays, estimated co-insurance amounts and estimated deductible amounts at time of service when, in actuality they were not due or paid by a secondary carrier.
- Medicare deductibles – Inpatient Medicare deductibles are also common credit balance occurrences. This is because the patient / guarantor often pay a deductible prior to his/her secondary insurance payment. Identify these accounts by searching for credit balances equal to the deductible amount for the associated year.
Section 1.2.E - Contractuals and Adjustments

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

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

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

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

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

Adjustments
Adjustments are the amounts written off or written onto patient accounts, by a provider, due to policies and procedures of either the payer or the provider. Examples of adjustments include:
- Small balances as determined by the facility e.g. under $10.00
- Late charges or credits as determined by the facility e.g. under $20.00
- Charity Care approvals
- Late charges or credits on Inpatient Medicare accounts which are paid on DRG

Code
Contractuals and Adjustments are usually tracked by a code used when adjusting the patient's account. This supplies vital information to the provider for necessary items such as negotiating managed care contracts, reviewing departmental charge accountability, and indigent care levels.
Coordination of Benefits is a provision that establishes an order in which insurance plans pay their claims. It provides the authority for the orderly transfer of information needed to pay claims promptly and eliminates duplicate coverage when a patient is covered by multiple group plans. A coordination of benefits, or “non-duplication,” clause in either policy prevents double payment by making one insurer the primary payer, and assuring the insured’s benefits from all sources do not exceed 100% of his allowable medical expenses.

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

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

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

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

**Example:**
Mom has insurance through Aetna (effective date is 1/01/2000)
DOB: 1/5/1952

Dad has insurance through BCBS of GA (effective date 1/01/1999)
DOB 2/1/1952

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

**Gender Rule**
This rule is still in use by some payers. If this rule is used, the male’s insurance is considered to be the primary payer.

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

(a) First, the plan of the parent with custody of the child;
(b) Then, the plan of the spouse of the parent with the custody of the child.
(c) Finally, the plan of the parent not having custody of the child.

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

**Medicare Secondary Payer**
Patients who are covered by Medicare are required to complete the MSP Questionnaire during the registration process in order to determine which payer is primary. Medicare is Secondary to most other insurers.
What is a Deductible?
A deductible is the amount of medical costs required to be paid by the insured under a health insurance contract that is deducted from the reimbursable amounts of covered charges. A deductible can be required per calendar year, per condition, per visit deductible, per family, or per inpatient stay.

What is coinsurance?
Co-insurance is a cost-sharing requirement under a health insurance policy. A type of cost sharing where the insured and the insurance payer share payment of the approved charge for covered services in a specified ratio.

Coinsurance indicates how an insurer and an insured will share the costs of a bill that exceeds the insurance policy's deductible up to the policy's stop loss. Once the insured's out-of-pocket expenses equal the stop loss the insurer will assume responsibility for 100% of any additional costs.

Many HMOs provide 100% insurance (no coinsurance) for preventive care or routing care provided "in a network."

What is Co-Payment?
Co-payment is a set fee that a patient has to pay the provider each time he/she receives care or medication.
Understanding the Operations of Reimbursement
Reimbursement is achieved through a process of gathering and documenting information which serves as evidence of medical needs and eligibility. This process requires total integration of the entire revenue cycle: customer service, clinical staff, medical records and coding staff, admissions and scheduling, billing and collection’s management. The by-product of all of these processes is reflected in accounts receivable. In fact, accounts receivable is the mirror image of the entire revenue cycle process.

There are many factors that directly affect the revenue cycle process and determine its success or failure. Some of these factors are payer driven or more directly related to the provider’s operations. Here are some common problems that have direct effect on accounts receivable:

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

Basically, reimbursement is everybody’s job from the clinical staff, physicians, customer service and business office.

Third-Party-Payer Reimbursement Issues
a. Slow-Paying Claims – many states have prompt-pay statutes that impose financial penalties on insurers that do not pay claims on a timely basis.

b. “Usual & Customary” Denials and Repricing – the key to obtaining additional reimbursement when an insurer contends that the hospital’s charges are too high is to shift the burden of proof to the insurer.

c. Silent PPOs – cross-checking of a patient’s insurance card against the EOB can help to identify this unauthorized pricing practice between PPO brokers and non-contracted payers.

d. Pre-existing Conditions – the passage of the Health Insurance Portability & Accountability Act (HIPAA) set federal guidelines for the application of a pre-existing condition exclusion.

e. Misverification of Benefits – courts have used the legal theory of promissory estoppel to hold insurers liable for benefits quoted in error.

f. COBRA Issues – confusion about the law regarding termination of coverage leads to lost reimbursement.

g. Lack of Medical Necessity – successful appealing medical necessity denials requires a thorough review of the patient’s medical record, as well as the application of the correct medical criteria and legal standards.

h. Preauthorization Denials – documentation is the basis of a strong appeal of a denial based on the lack of preauthorization of a submitted claim.

i. Fighting Refund Demands – hospitals are usually justified in not refunding payments to insurers due to legal theory of unjust enrichment.
j. **Auto Accident Problems** – many hospitals lose substantial reimbursement because the liens and/or letters of protection they obtain are not enforceable.

### Types of Reimbursement
There are several types of reimbursement plans in the healthcare industry.

1. **Medicare** is a government payer that started operation in 1966 and provides coverage for all types of medical benefits.
   - Part A, or hospital insurance, pays for inpatient hospital care, critical access hospitals, skilled nursing facilities, home health and hospice care.
   - Part B, or medical insurance, pays for outpatient hospital services, medically necessary physician services and other supplies not covered under Part A benefits.
   - Part D, prescription drug coverage, pays for prescription drugs as outlined by the selected plan.
2. **Medicaid or The Georgia Medical Assistance Program** was established under Title XIX of the 1965 Federal Social Security Act.
   - It is a state-administered program jointly funded by the State of Georgia and the Federal Government.  
   - The Department of Community Health (DCH) is the State agency in Georgia that administers the Medicaid program.
   - Affiliated Computer Services, Inc. (ACS) is the fiscal intermediary in the State of Georgia that handles processing and payment of Traditional Medicaid claims.
3. **Private/Commercial payers** offer diverse coverage and payment methodologies.
   - Coverage is determined by each Plan through review of all provisions outlined within the individual policy in question as well as plan specific policy and practice.
   - Reasonable charges are generally set based on historical data and geographic areas which are referred to Usual and Customary payment schedules.
   - There are two basic types of commercial insurance coverage: group health care plans or individual care plans.
4. **Managed Care plans** are systems that manage the delivery of health care to control its costs. The common goal of all of the various forms of managed care is achieving reasonable and appropriate utilization of health care products and services with maximum cost savings to the plan. Managed care systems can include:
   - Health Maintenance Organizations (HMOs),
   - Preferred Provider Organizations (PPOs),
   - Point of Service (POS)
   - Exclusive Provider Organization (EPOs).
   Third Party Administrators (TPAs) are organizations that are hired by employers to process claims, administer benefits per the employer’s policies and pay claims at rates the TPA determines as reasonable.
5. **Workers Compensation** is a State program funded by the employers in that state. This coverage provides funds to pay for illness or injury that resulted from a job-related accident. Hospital reimbursements for inpatient charges are based on DRG (average) fee schedules. Outpatient charges are also reimbursed on fee schedules.
6. **No-fault Insurance** also known as Personal Injury Protection (PIP) or Med-Pay is an automobile accident medical coverage that can be purchased from various private automobile insurance providers. The State of Georgia does not require all drivers to purchase no-fault insurance coverage.
Reimbursement Methodologies
Today there are several types of reimbursement methodologies used by payers. Listed below are some of the primary reimbursement methodologies used.

1. Ambulatory Payment Classifications (APC) - is a method of outpatient reimbursement where all the services associated with a given procedure or visit is bundled into the APC. Medicare uses this method to reimburse outpatient claims. There are approximately 500 APCs in use.

2. Capitation - is a specified amount paid periodically to a health provider for a group of specified health services, regardless of quantity rendered:
   • Amounts are determined by assessing a payment "per covered life" or per member.
   • The method of payment for the provider is paid based on a fixed amount for each person served, no matter what the actual number or nature of services delivered may be.
   • The cost of providing an individual with a specific set of services over a set period of time is usually a month or a year.
   • Providers are not reimbursed for services that exceed the allotted amount.
   • The rate may be fixed for all members or it can be adjusted for the age and gender of the member, based on actuarial projections of medical utilization.
   • Can be used by hospitals or physicians.

3. Diagnosis related groups (DRGs) - are inpatient or hospital classification systems used to pay a hospital or other provider for their services and to categorize illness by diagnosis and treatment.
   • A classification scheme used by Medicare that clusters inpatients into 468 categories on the basis of patients' illnesses, diseases and medical problems.
   • Groupings of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.
   • Used under Medicare's prospective payment system to reimburse inpatient hospitals, regardless of the cost to the hospital to provide services.

4. Discounted Fee-For-Service - is a financial reimbursement system whereby a provider agrees to supply services on a fee-for-service basis, but with the fees discounted by a certain percentage from the physician's usual and customary charges.
   • An agreed upon rate for service between the provider and payer that is usually less than the provider's full fee.
   • This may be a fixed amount per service, or a percentage discount.
   • Providers generally accept such contracts because they represent a means to increase their volume or reduce their chances of losing volume.

5. Fee-For-Service - is a traditional method of payment for health care services where specific payment is made for specific services rendered. Usually people speak of this in contrast to capitation, DRG or per diem discounted rates, none of which is similar to the traditional fee for service method of reimbursement.
   • Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones.
   • Payment may be made by an insurance company, the patient or a government program such as Medicare or Medicaid.
With respect to the physicians or other supplier of service, this refers to payment in specific amounts for specific services rendered. In relation to the patient, it refers to payment in specific amounts for specific services received, in contrast to the advance payment of an insurance premium or membership fee for coverage.

6. Flat Fee-Per-Case - is a flat fee paid for a client's treatment based on their diagnosis and/or presenting problem? For this fee the provider covers all of the services the client requires for a specific period of time.
   - Often characterizes "second generation" managed care systems.
   - After the MCOs squeeze out costs by discounting fees, they often come to this method.
   - This approach can be good for the provider and clients, since it permits a lot of flexibility for provider in meeting client needs.

7. PCP Capitation - is a reimbursement system for healthcare providers of primary care services who receive a prepayment every month. The payment amount is based on age, sex and plan of every member assigned to that physician for that month.

8. Per Diem Rates - is a form of payment for services in which the provider is paid a daily fee for specific services or outcomes, regardless of the cost of provision.
   - Per Diem rates are paid without regard to actual charges and may vary by level of care, such as medical, surgical, intensive care, skilled care, psychiatric, etc.
   - Per Diem rates are usually flat all inclusive rates.

9. Prospective Payment System (PPS) - is a payment method that establishes rates, prices or budgets before services are rendered and costs are incurred. Providers retain or absorb at least a portion of the difference between established revenues and actual costs.
   - Prospective per-case payment rates are set at a level intended to cover operating costs in an efficient hospital for treating a typical inpatient in a given diagnosis-related group.
   - Payments for each hospital are adjusted for differences in area wages, teaching activity, and care to the poor, and other factors.
   - Hospitals may also receive additional payments to cover extra costs associated with atypical patients (outliers) in each DRG.

10. Periodic Interim Payments and Cash Advances (PIPs) - are periodic interim payments and cash advances where the plan advances a hospital cash to cover expected claims.

11. Penalties and Withholds - may be negotiated so that if goals are met, the healthcare provider receives its' withholds or bonus. These goals are usually tied to utilization.

**Timing**
The best time to collect healthcare self pay portions from the patient is prior to the patient receiving service, except where EMTALA laws apply. The worst time is some time after medical service was provided. The provider has a psychological advantage when collections are attempted closer to time of service. The hospital should have methods in place to calculate patient portions of an estimated hospital bill prior to the time of service. For example, an estimate may be derived by verifying coverage limits and co-pay requirements, then applying that to average charges. There should be disclaimers to state, “this is only an estimate”.
When presenting the estimate to the patient, Patient Access staff should offer detailed explanations. Make sure to:
• **Reveal** the range from which estimates were derived, stressing that you are asking for the lower amount.
• **Clarify** that charges could be more or less than the estimated amount.
• **Explain** how charges are applied.
• Charges are based on actual use.
• **Provide** a written copy of the estimate, including a disclaimer statement.
• **Be prepared** to discuss payment options and means of payment (cash, check, charge cards, debit cards, automated bank drafts)

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**The Five Health Care Collection Control Points**

1. **Before Admissions / Registration and before service is provided, except when EMTALA laws apply**
   - Obtain all critical information by telephone
   - Verify insurance
   - Estimate patients portion of bill and insurance coverage
   - State policy and financial counseling process
2. **At Admission / Registration**
   - Review information obtained
   - Obtain necessary signatures on legal documents
   - Triage consistent with EMTALA for Emergency Department admits
   - Obtain insurance and demographic info and estimate patient portion for all direct admits.
3. **In-house**
   - Monitor charges or any changes in benefit levels
4. **At Discharge**
   - Collect patient’s portion or make financial arrangements
5. **30 Days after Discharge – collection follow up**
   - Follow-up overdue accounts from patient or insurance.
   - Follow-up by telephone on larger accounts; by mail on smaller balances.
Definitions

Bad Debts
Bad debts are amounts considered to be uncollectible.

Allowable Bad Debts
Allowable bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting criteria set forth in Section 308 of the CMS Provider Reimbursement Manual Part I. Allowable bad debts must be related to specific deductibles and coinsurance amounts.

Charity Allowances
Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

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

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

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

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

- The costs of services covered by the Program will not be borne by individuals not covered,
- The costs of services not covered by the Program will not be borne by the Program payment for deductibles and coinsurance amounts. It is the responsibility of the beneficiaries.
• However the inability of the provider to collect these deductibles and coinsurance amounts from beneficiaries could result in part of the costs of covered services being borne by others who are not beneficiaries of the program.

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

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

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

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

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

**Criteria for Allowable Bad Debt**

A debt must meet criteria to be allowable bad debt:
1. The debt must be related to covered services and derived from deductible and coinsurance amounts
2. The provider must be able to establish that reasonable collection efforts were made.
3. The debt was actually uncollectible when claimed as worthless
4. Sound business judgment established that there was no likelihood of recovery at any time in the future

**Reasonable Collection Effort**

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

**Collection Agencies**

A provider’s collection effort may include the use of a collection agency in addition or in lieu of the provider’s collection actions. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of the like amount to the agency without regard to class of patient.

**Documentation Required**

The provider’s collection effort should be documented in the patient’s file by copies of the bills, follow-up letters, reports of telephone and personal contact, etc. (or in electronic file if paper files not maintained)
Collection Fees
Where a provider utilizes the services of a collection agency and the reasonable collection effort is applied, the fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider.

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

Presumption of Non-Collectability
If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectable.

Indigent or Medically Indigent Patients
In some cases the provider may have established before discharge or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:
1. The patient’s indigence must be determined by the provider, not the patient. A patient’s signed declaration of his inability to pay his medical bills cannot be considered proof of indigence
2. The provider should take into account a patient’s total resources which would included, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient’s daily living), liabilities, and income and expenses.
3. The provider must determine that no source other than the patient would be legally responsible for the patient’s medical bill.
4. The patient’s file should contain documentation of the method by which indigence was determined in addition to all backup information.

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

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

Examples of the types of information to be retained may include but are not limited to, the beneficiary’s name and health insurance number; admission/discharge dates for Part A bills and dates of service for Part B bills; dates of write off; and a breakdown of the uncollectible amount by deductible and coinsurance amounts.
**Medicare Bad Debts Under State Welfare Programs**
Where the State is obligated by either statute or under the terms of its plan to pay all or part of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible or coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided that the requirements are met.

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

**PROVIDER-BASED PHYSICIANS’ PROFESSIONAL COMPONENT ARE NOT CONSIDERED AS ALLOWABLE BAD DEBT.**

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

**Charity, Courtesy and Third Party Payer Allowances Cost Treatment**
Charity, courtesy, and third party payer allowances are not reimbursable Medicare costs.

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

**Allowances to Employees**
Allowances, or reduction in charges, granted to employees for medical services, as fringe benefits related to their employment are not considered courtesy allowances. Any costs of the services not recovered by the provider from the charge assessed the employee are allowable costs.
Section 1.2.J - Billing

Introduction
Billing a patient for services rendered begins at the first point of contact with the patient. Billing an accurate claim and getting the reimbursement that is due the provider depends on gathering accurate information at the point of access.

Many of the billing software products offer detailed reports that measure the accuracy of claims that are pending submission to the payers. The minimum standard for claim accuracy should be no less than 96%.

Charge Capture
All patient access points during the revenue cycle contribute to billing accuracy. Charges are usually placed on the bill by an order entry system or in some cases manually. It is very important to capture all charges accurately and timely. Many facilities bill claims as early as three or four days from inpatient discharge or outpatient services. Charges that are late being posted to the patient’s account can require a re-bill from the business office, lost charges, and lost revenue.

Coding
Accurate procedural and diagnostic coding is essential in order for the provider to receive correct reimbursement. Current Procedural Terminology (CPT) codes are assigned by the Coder or hard-coded in the Charge Description Master (CDM). The Coder assigns the proper ICD-9 diagnostic and/or procedural codes according to documentation received.

DNFB
Another important aspect of accounts receivable billing is measuring how many discharged-not-final-billed (DNFB) accounts are pending. This is usually referred to as the unbilled accounts. Most health information systems provide reports that can be used to determine how much of the accounts receivable have still not been billed to the payers.

If the provider has a separate billing system, the rejected and not yet billed accounts in the billing system should also be monitored.

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

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

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

There are three methods most providers use, in one form or another, to communicate with patients:
- Send and receive all correspondence themselves
- Use services provided by their information systems vendor
- Rely on a third party vendor partner

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

If a decision is made to outsource billing for your facility, there are many factors to consider. When deciding on outside sources to implement Patient Friendly billing, a healthcare provider must carefully evaluate the following:
- How familiar is the vendor with the unique challenges associated with compliant healthcare billing?
- Will the vendor’s services help collect additional payments more easily?
- Does the vendor provide flexible statement designs?
- Are bills and statements delivered promptly and efficiently?
- Is the vendor prepared for the future of patient billing?
- Will the vendor work closely with you to implement a successful solution?
- How much will your facility spend on vendor outsourcing?

When choosing a vendor for outsourcing, you should determine how familiar the vendor is with the unique challenges associated with compliant healthcare billing. Healthcare billing is different than credit card, utility or other types of billing. Just because a vendor processes statements for one industry does not mean that the vendor is adequately prepared to do the same for healthcare. Compliance with governmental security requirements, such as HIPAA, is critical, but there is also a strong emotional component to healthcare issues, because they involve the well-being of loved ones. If patients feel well-informed and they understand their responsibilities, they are more at ease and are motivated to act more promptly on requests. It is so important to patients for communications to be clear and for you to find a partner that understands this need.

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

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

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

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

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

Adding finishing touches to your process can be beneficial to your patients. For example, you may choose to send letters to thank patients for choosing your healthcare facility for their services. Many providers send appreciation letters to new patients. This letter can also help verify insurance at the commencement of the relationship, instead of when a claim is denied, and can provide an organized summary of care. Patients can clearly see a progression of events and respond if insurance or treatment information is incorrect. This initial correspondence is intended to be a snapshot of care, from which future bills will follow.

Subsequent statements communicate balances due or request that patients contact business offices with additional information. All of these communications should be pleasing to the eye and easy to understand.
Billing Forms
The CMS-1450 or UB04 claim form is the instrument used to bill hospital inpatient, outpatient, hospice, home health, swing bed, and skilled nursing services. The UB04 claim form contains 81 data elements referred to as form locators (FL). Listed below are these form locators.

- **FL 1**: The name of the provider submitting the bill and the complete mailing address to which the provider wishes payment sent.
- **FL 2**: The name of the pay-to organization that the provider submitting the bill intends payment sent.
- **FL 3a**: Patient Control Number – This is usually the patient account number or patient billing number.
- **FL 3b**: Medical Record Number - The number assigned to the patient’s medical/health record by the provider.
- **FL 4**: Type of Bill: This provides specific information a three-digit code with regards to the type of facility in which the care was rendered, the classification of the services and the frequency of the bill:
  - First digit: Type of provider
    - 1 – Hospital
    - 2 – Skilled Nursing
    - 3 – Home Health
    - 4 – Religious non-medical health care institutions (hospital inpatient)
    - 5 – Religious non-medical health care institutions (post-hospital extended care)
    - 6 – Intermediate Care
    - 7 – Clinic
    - 81 - Hospice Non-hospital based
    - 82 – Hospice Hospital-based
    - 83 – Ambulatory Surgery Center
    - 84 – Free standing Birthing Center
    - 85 – Critical Access Hospital
  - Second digit: Bill classification
    - 1 – Hospital – inpatient
    - 2 – Hospital – inpatient (Medicare Part B only)
    - 3 – Hospital – outpatient
    - 4 – Hospital – referenced diagnostic services
    - 8 – Hospital – swing beds
  - Third digit: Frequency of bill
    - 0 – Non-payment zero claim
    - 1 – Admit-through discharge claim
    - 2 – Interim- first claim
    - 3 – Interim-continuing claim
    - 4 – Interim-last claim
    - 5 – Late charge only claim (not valid for Medicare)
    - 7 – Replacement of prior claim
    - 8 – Void/cancel of prior claim
- **FL 5**: Federal Tax number- The number assigned to the provider by the federal government for tax reporting purposes.
- **FL 6**: Statement Covers Period – Enter the beginning and ending service dates(s) of the billing period for this bill
- **FL 7**: Reserved for Assignment by the NUBC.
- **FL 8**: Patient Name
- **FL 9**: Patient Address
- **FL 10**: Patient Birth date
- **FL 11**: Patient Gender
- **FL 12**: Admission/Start of care date
- **FL 13**: Admission Hour
- **FL 14**: Priority (Type) of visit
- **FL 15**: Source of referral for Admission or visit
- **FL 16**: Discharge Hour (inpatient only)
- **FL 17**: Patient discharge status codes – Listed below are a few examples of discharge status codes Reference the UB04 Editor for a complete listing of all discharge status codes.
  - **Examples**:
    - 01: Discharged to home or self-care (routine discharge)
    - 02: Discharged/transferred to another short-term general hospital
    - 03: Discharged/transferred to skilled nursing provider (SNF)
    - 04: Discharged/transferred to an intermediate care provider (ICF)
    - 05: Discharged/transferred to another type of institution (including distinct parts)
    - 06: Discharged/transferred to home under care of organized home health service organization
- **FL 18-28**: Condition codes – Two-digit alphanumeric codes that indicate conditions or events for the billing period which may affect the claim. Listed below are a few examples of condition codes. Reference the UB04 Editor for a complete listing of all condition codes.
  - **Examples**:
    - 02: Condition is Employment Related
    - 03: Patient Covered by Insurance Not Reflected Here
    - 04: Information Only Bill
    - 05: Lien Has Been Filed
    - 06: ESRD Patient in the First 18 Months
- **FL 29**: Accident State Field
- **FL 30**: Reserved for Assignment by the NUBC
- **FL 31-34**: Occurrence Codes and dates define a significant event relating to this bill that may affect processing. Listed below are a few examples of occurrence codes. Reference the UB04 Editor for a complete listing of all occurrence codes.
  - **Examples**:
    - 01: Accident/Medical Coverage
    - 02: No-Fault Insurance Involved - including Auto Accident/Other
    - 03: Accident/Tort Liability
    - 04: Accident/Employment Related
- **FL 36**: Occurrence span codes and dates identify an event that affects payment of the claim. These codes identify events that happened over a span of time: the beginning and ending dates. Listed below are a few examples of occurrence span codes. Reference the UB04 Editor for a complete listing of all occurrence span codes.
  - **Examples**:
    - 70: Qualifying Stay Dates
    - 71: Hospital Prior Stay Dates
72: First/Last Visit
74: Non-covered Level of Care
75: SNF Level of Care
76: Patient Liability

- **FL 37**: Reserved for Assignment by the NUBC
- **FL 38**: Responsible Party Name and Address
- **FL 39 – 41**: Value Codes – Code(s) and related dollar or unit amount(s) identify data of a monetary nature that are necessary for the processing of this claim. Listed below are a few examples of value codes. Reference the UB04 Editor for a complete listing of all value codes.

**Examples:**
- 01: Most common semiprivate room rate
- 02: Hospital has no semiprivate rooms
- 03: <Reserved for National Assignment>  
- 04: Inpatient professional component charges which are combined billed
- 05: Professional component included in charges and also billed separately to carrier
- 06: Medicare Part A and Part B Blood Deductible

- **FL 42**: Revenue Code – Codes that identify specific accommodation and/or ancillary charges. Enter the appropriate revenue code that is associated with the charge. These codes are assigned in the charge description master. A listing of revenue codes and acceptable CPT and HCPCS codes is available in the UB04 Editor

**Examples:**
- 0290s: Rental/purchase of DME
- 0304: Renal dialysis/laboratory
- 0330s: Radiology therapeutic
- 0367: Kidney transplant
- 0420s: Therapies

- **FL 43**: Revenue Description – A narrative description or standard abbreviation for each revenue code shown in FL 42. The information assists clerical bill review.
- **FL 44**: HCPCS/RATE/HIPPS Rate Codes – When coding HCPCS for outpatient services, the provider enters the HCPCS code describing the procedure here. On inpatient hospital bills the accommodation rate is shown here.
- **FL 45**: Enter the actual date the service was provided.
- **FL 46**: Enter the units of service or number of days.
- **FL 47**: Enter the total charges associated with the revenue code for the current billing period as entered in the statement covers period. The total is reported in this form locator with associated revenue code 001.
- **FL 48**: Enter non-covered charges.

- **FL 49**: Reserved for assignment by the NUBC
- **FL 50**: Payer Identification

- **FL 51**: Health Plan Identification number

- **FL 52**: Indicates that the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

- **FL 53**: Assignment of Benefits Certification Indicator

- **FL 54**: Prior payments by payers or patient

- **FL 55**: Estimated Amount Due

- **FL 56**: National Provider Identifier (NPI number)

- **FL 57**: Other Provider Identifier
• **FL 58:** Insured’s Name
• **FL 59:** Patient’s Relationship to Insured - Caution: This is the patient’s relationship to the insured. For example if the patient is a child and the insured is a mother, then the patient’s relationship to the insured would be: Child not Mother. These codes changed effective 10/01/03

**Examples:**
01: Spouse
04: Grandfather or Grandmother
05: Grandson or Granddaughter
07: Nephew or Niece
10: Foster Child
15: Ward as a result of a court order
17: Stepson or Stepdaughter
18: Self
19: Child
20: Employee
21: Unknown
22: Handicapped dependent
23: Sponsored dependent
24: Dependent of a minor dependent
29: Significant Other
32: Mother
33: Father
36: Emancipated Minor

• **FL 60:** Health Insurance Claim Identification Number – 19 character field. Spaces, hyphens or special characters not valid for electronic transmission.
• **FL 61:** Insured Group Name
• **FL 62:** Insurance Group Number
• **FL 63:** Treatment Authorization Codes
• **FL 64:** Document Control Number (DCN) – assigned to the original bill by the health plan or the health plan’s fiscal agent as part of their internal control.
• **FL 65:** Employer Name
• **FL 66:** Diagnosis and Procedure Code Qualifier Code – ICD Version Indicator
• **FL 67:** Principal Diagnosis Code – The hospital enters the ICD code for the principal diagnosis. The code **must** be the full ICD diagnosis code, including all five digits where applicable. The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the hospital enters the principal diagnosis. Entering any other diagnosis may result in incorrect assignment of a DRG and cause the hospital to be incorrectly paid under PPS.
• **FL 68:** Reserved for assignment by the NUBC
• **FL 69:** Admitting Diagnosis code – The condition identified by the physician at the time of the patient’s admission requiring hospitalization.
• **FL 70a-c:** Patient’s reason for visit
• **FL 71:** Prospective Payment System (PPS) code
• **FL 72:** External Cause of Injury (ECI) Code
• **FL 73:** Reserved for assignment by the NUBC
• **FL 74:** Principal Procedure Code and Date – Required on inpatient claims when a procedure was performed. Not used on outpatient claims.
- **FL 74a-e:** Other Procedure Codes and Dates – Required on inpatient claims when additional procedures must be reported. Not used on outpatient claims.
- **FL75:** Reserved for assignment by the NUBC
- **FL 76:** Attending Physician name and ID – The attending provider is the individual who has overall responsibility for the patient’s medical care and treatment reported in this claim/encounter.
- **FL 77:** Operating Physician name and ID – Required when a surgical procedure code is listed on this claim. If not required, do not send. The name and identification number of the individual with the primary responsibility for performing the surgical procedure(s).
- **FL78-79:** Other provider name and Identifiers
- **FL 80:** Remarks
- **FL 81:** Code Fields – to report additional codes related to a form locator or to report external code.

There are additional data elements now required by the new HIPAA ANSI 837 V4010A1. Clearinghouses have played a vital role in translating the UB04 data to the new ANSI 837 electronic format that is now required by most payers. New information is being gathered during patient registration such as the Insured’s date of birth because it is now one of the data elements required by the new 837 format. The standards for the new form can be found at

http://www.wpc-edi.com/hipaa/hipaa_40.asp
Overview
This section addresses the legal aspects of patient accounts as it pertains to collections and the hospital’s and the patient’s rights from the standpoint of federal and state laws.

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

1. Actual or expressed consent – can be written or oral. The treatment is outlined and the patient agrees either orally or in writing.
2. Implied consent – in fact – consent by silence. By not objecting to Treatment, the patient implies consent to treatment.
3. 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.
4. Informed consent- this is what hospitals aim for. Under this consent the patient understands what he is being treated for and what procedures he is having performed.

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

Liability for Payment
There are two legal theories under which a medical provider may collect for services rendered. The first is the Contract. A Contract is created when the patient or guarantor signs the financial responsibility statement. The five elements of an enforceable contract are:
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. There must be an understanding by both parties as to what is being accepted. Both need to understand the terms (subject matter, money, time) of contract. This is referred to as a “meeting of the minds”.
3. Consideration. Consideration must be provided by both parties. Both must give and get something. (I.E. Treatment by the hospital to the patient is consideration and payment by the patient to the hospital is consideration). Failure of consideration by either party allows a lawsuit for enforcement.
4. Proper legal form. Not all contracts have to be in writing. However, it is important that there is written documentation that a verbal discussion took place.
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.

According to the laws of Georgia, the age of contractual capacity is 18 years old. Therefore, anyone 18 or over can be contractually bound to pay for their own medical expenses. Emancipated minors are also responsible for their own treatment. However, it is the joint duty of each parent to provide for the necessaries of his or her child until the child reaches 18, dies, marries, or becomes emancipated, whichever occurs first. Common law has interpreted “necessaries” to include hospital and medical services.

A spouse is not responsible for the debts of their mate unless they sign the financial guarantee.

The second legal theory under which a medical provider may collect for services rendered is the theory of the open account. Under this theory, by receiving services without paying up front an open account is created and owed. Contract is the preferable method for bringing a collection action

**Garnishments**

A garnishment is the most 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/garnished. Bank accounts can have 100 percent of available funds withheld. All money seized is sent to the county clerk of court and paid to the creditor’s attorney.

**Estates**

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

The order of preference in payment of creditors in an estate is as follows:
1. Year’s support for family
2. Funeral expenses
3. Other necessary expenses of administration, administrative fees of Estate
4. Reasonable expenses of last illness
5. Taxes, unpaid or other debts
6. Judgments, secured interest, and other liens
7. All other claims

A person who dies without a valid will is considered “intestate”. Special laws apply in intestate situations to control the disposition of property.
Real property owned in another state by a person dying intestate is subject to laws of the intestacy in the state in which the property resides. When a person dies intestate, the judge will appoint an executor to the estate from the following list, in the following order: surviving spouse, children, and other heirs, any of the creditors.
An example of a statement of claim to be used to file an estate claim follows:

Estate Claim

State of: ____________________

County of: ____________________

Personally appeared before me ____________________, a Notary Public, in and for said State and County ____________________, who, upon oath deposes and says that Exhibit A, hereto attached, and now referred to, is a correct statement of the claim which ____________________ asserts and files against the estate of ____________________, deceased for $_______, that the affiant has a personal knowledge of the correctness of said claim: that the amount claimed is justly due from the estate of ____________________, deceased to ____________________ after allowing all proper credits, and now constitutes a subsisting demand for $_______, and that affiant is duly authorized to make this affidavit.

______________________________, Office Manager

Subscribed and sworn to before me, this ____________ day of ________________, 20__.

______________________________
Notary Public

________________________ County, ______________________
Section 1.3.B - Bankruptcy

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

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

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

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

1. You should pull the account and flag it as a bankrupt account.
2. You should stop all routine collection efforts.
3. File a proof of claim if cost justified based on amount of bills owed by debtor.
4. Attend the first meeting of creditors if cost justified based on amount of bills.
5. 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.
6. Document your conversations with the patient. If a lawyer represents the patient, it is illegal for the hospital to contact the patient. The patient’s attorney should be contacted.
Facts on Chapter 13 Bankruptcy Claims
Below are listed facts that are important in handling Chapter 13 Bankruptcy claims.

- If the medical facilities account with the patient is not listed by the patient who is filing bankruptcy, the medical facility may proceed with normal collection efforts.
- If a motion for dismissal is issued, the hospital may resume collection efforts.
- Most debt adjustment plans are for a period not exceeding three years, but with special judicial approval, can be extended to as much as five years.
- After the debtor is discharged, any remaining balance cannot be pursued for collection. The unpaid balance must be written off and the account closed.
- The creditor does not have to attend the meeting of creditors to be eligible to receive payment on claims.
- Any new charges incurred by the patient after the petition has been filed are eligible for collection.
- Before a patient can qualify for Chapter 13, he must reside in the United States or own property or a business and have a regular source of income.
Section 1.3.C – Hospital Liens

When Does a Lien Apply?
When a person has been injured by another party, at no fault of their own, (auto accident, negligent condition on a property, gunshot wound, slip and fall in a store, etc.) presents to a medical facility for treatment of those injuries (see below for specifics regarding which providers may file medical liens).

Admissions Staff
The admissions personnel will be the primary point of contact to determine whether a lien may be applicable to the service provided.

What it Means to the Medical Provider
In order to encourage the treatment of accident victims who may have no health insurance as well as better ensure payment to the treating medical provider, the Georgia Legislature enacted statutes located in the Official Code of Georgia Annotated at 44-14-470 et seq. stating that the provider (which now not only includes hospitals and nursing homes, but physician practices and traumatic burn care medical practices with charges in excess of $50k) shall be entitled to a lien for the reasonable charges for cost of treatment on any and all causes of action accruing to the patient or their legal representative arising out of the accident causing the injuries which necessitated the treatment.

The uninsured patient remains ultimately responsible for the medical charges, if not recovered from the third party. It is not advisable to file Hospital Liens on patients with access to a Health Insurance Contract. The contractual language found in most group health plans provides that under no circumstances up to and including the bankruptcy of the insurance provider will the hospital look to the patient/member for payment nor will the hospital seek payment in excess of the agreed upon amounts delineated in the schedules set out in the contract for a group member.

If patients are Medicaid or Medicare eligible and have been injured in an accident in which torts liability is present, both of these payers provide in their regulations that liability insurance is primary and must be pursed before considering billing the government funded source. If liability is determined to be inadequate, you may cancel your lien and then pursue Medicare/Medicaid. Once that determination is made, all related medical charges must be billed to the government source. Refer to Medicaid and Medicare regulations for further details.

Medical (Hospital) Liens are not:
• Liens against the injured party
• Liens against the patients legal representative
• Liens against property
• Liens against other assets
• Evidence of the person’s failure to pay a debt

Securing the Lien
Hospitals must do the following to secure the lien:
• At least 15 days prior to the actual filing of this lien, a letter of intent to file a lien must be sent to the patient and all known possible responsible parties. This letter must contain
language that states the lien is not against the patient, his property or assets and is not evidence of his failure to pay a debt. This letter of intent must be sent both certified and regular mail and the sender must retain the postal receipt acknowledgements. Although there is no legal requirement as to the amount of permissible elapsed time after discharge before the intent notice is sent, it must be done such that the actual lien document is filed in the required counties within 75 days of discharge. Note: If it is a lien for a physician, the time requirements are slightly different. The physician’s time begins at the time of the first treatment. They like the hospitals, must sent a letter of intent including the same information at least 15 days prior to filing their lien in the respective counties, but the doctors have 90 days from first treatment to have the lien filed.

- File a lien with the Clerk of the Superior Court in the county where the patient resides as well as the county where the hospital is located.

- Send a copy of the lien to the patient and to any other liable party, such as the person, firm or corporation liable for the injury or the insurance company of the third party.

- Once a settlement occurs and payment is received, satisfy the lien.

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

A Medical (Hospital) Lien must contain the following:
- Name and address of patient as it appears on the hospital record
- Name and address of hospital
- Name and address of the operator of the hospital
- Dates of admission and discharge of patient
- Amount of the hospital bill
- Names and addresses of all known persons or corporations allegedly liable for the injuries to the patient
- The lien must be notarized and signed by the person preparing the lien.
GEORGIA, ____________________ COUNTY

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

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

Name            Address
__________________________ ________________________________
__________________________ ________________________________

that General Hospital of Atlanta, Georgia, which operates and does business as General Hospital, Atlanta, Georgia has treated as a patient: ________________ whose residence is located at ________________ and who was admitted for treatment at General Hospital, Marietta Street, Atlanta, Georgia 30330, on ___________ and discharged on ___________ and said patient incurred charges in the amount of $____________ for hospital care and treatment, and General Hospital now claims a lien on all sums and amounts, whether in property or money, paid to the above named patient or his legal representative, by any person, firm or corporation, including those specifically named above, if any, as a settlement, as a release or as a consideration to a covenant not to sue, when said sum or amounts represent damages or compensations for the patient’s injuries for which General Hospital has rendered its services to such injuries.

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

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

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

GEORGIA, ____________________ COUNTY    BY: ________________________________

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

______________________________

Sworn to and subscribed before me this ___day of _____, 20__.

Notary Public ________________________________
What is HIPAA?
HIPAA stands for the Health Insurance Portability and Accountability Act. It is a federal law enacted in 1996 as an attempt at incremental health care reform. HIPAA's intent is to reform the health care industry by reducing costs, simplifying administrative processes and burdens, and improving the privacy and security of patients’ information and to help patients maintain their medical history when moving between locations and to have control over how that information is used and shared. Many experts consider it to be the most significant new health care legislation since the introduction of Medicare in 1965. HIPAA regulations are structured as five major provisions or titles.

Purpose
The purpose behind these five Titles logically falls into two major categories: Administrative Simplification and Insurance Reform. The Administrative Simplification sections are most relevant to health care providers while the Insurance Reform sections are most relevant to payers.

The five major provisions of HIPAA are:
- Title 1 - Health Insurance Access, Portability and Renewability
- Title 2 - Preventing Healthcare Fraud and Abuse, Administrative Simplification and Medical Liability Reform.
- Title 3 - Tax-related Health Provisions
- Title 4 - Application and Enforcement of Group Health Insurance Requirements
- Title 5 - Revenue Offsets

Health Insurance Portability Reform
Health Insurance Portability Reform has been in effect since 1997 and has changed the practices of health plans and insurers regarding portability and continuity of health coverage in the following ways:

- Provides limitations on pre-existing condition exclusions,
- Prohibits discrimination against individuals based on health status,
- Helps individuals to keep health insurance when they change jobs,
- Prevents insurers from imposing pre-existing condition exclusions on new members when they have prior creditable coverage, and
- Guarantees that once employers or individuals purchase health insurance, those policies will be renewed.

Protected Health Information
Directly affected by HIPAA are all organizations that maintain and transmit Protected Health Information (PHI).

These include:
- Health care providers
- Hospitals
- Physician practices
- Dental practices
- Health plans
• Laboratories
• All third party payers
• Health care clearing houses
• Pharmacies

Protected Health Information (PHI) is defined as information:
• About the physical or mental health or condition of an individual
• About how health care is delivered and
• Regarding payment for the healthcare of an individual.

As a staff member, volunteer or student of a health care facility, you are responsible for making sure you do not release PHI to anyone who does not need to know it as part of his or her work. You also have a responsibility to only release the minimum necessary information (the least reasonable amount possible) to that person or organization that needs it to do their job.

HIPAA Requirements
Under HIPAA, a patient must be told (in writing) how their healthcare information (PHI) may be used.
• Has a right to see their medical records
• Has a right to request to amend incorrect / incomplete information in their records
• Must give authorization before information is released
• Has a right to complain formally if they feel their privacy was not protected.

Others Affected by HIPAA
Indirectly affected by HIPAA, but still expected to comply with regulations are:
• All third party vendors,
• Business partners that perform services on behalf or exchange data with those organizations that directly maintain or transmit protected health information, and
• Accountants, lawyers, medical answering services, consultants, billing agencies who interact with organizations that are required to protect health information.
• Beginning February 2009, these entities will be directly regulated by the federal HIPAA regulations.

HIPAA Privacy
Under the Privacy Rule, healthcare providers and insurance plans are required to notify plan participants that a privacy notice is available and to tell them how to obtain the notice. The reminder notice must be sent at least once every three years. The reminder notice can be sent electronically only if the participant has agreed to receive the notice by email. Review your privacy notice annually to determine whether it needs to be updated to reflect your current practices.

Organizations (covered entities) subject to the privacy rules, must also meet the following requirements:
1. Ensure the confidentiality, integrity and availability of all electronic protected health information that it creates, receives, maintains or transmits;
2. Protect against any reasonably anticipated threats or hazards to the security or integrity of the electronic protected health information;
3. Protect against any reasonably anticipated uses or disclosures of electronic protected health information that are not permitted or required under HIPAA; and
4. Ensure compliance with the security standards by its workforce.

**HIPAA Security**

If your organization is subject to the HIPAA Privacy Rule, you also need to be familiar with the HIPAA Security Requirements. The security standards are more limited in scope than the privacy standards. The security standards apply to protect only electronic protected health information. Therefore, the security standards cover individually identifiable health information that is transmitted by electronic media or maintained in electronic media.

In order to comply with the HIPAA security requirements, your organization should undertake the following actions:

1. Appoint a Security Official (this individual may be, but is not required to be, the same person as the plan’s Privacy Official);
2. Amend plan documents to incorporate the required electronic security provisions;
3. Train members of the workforce with access to electronic protected health information to follow security policies and procedures;
4. Amend business associate agreements to incorporate security provisions required by the new rules;
5. Adopt written policies and procedures implementing the security standards (including, but not limited to (i) conducting a security risk analysis of the plan’s operation and identifying risks; (ii) reviewing each of the security standards and implementation features and modifying or creating policies and procedures to comply with the requirements; and (iii) documenting the results of risk analysis and the policies and procedures)

**Transactions and Code Sets**

Transactions are activities involving the transfer of health care information for specific purposes. Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) Administration Simplification if a health care provider engages in one of the identified transactions, they must comply with the standard for that transaction. HIPAA requires every provider who does business electronically to use the same health care transactions, code sets and identifiers. HIPAA has identified ten standard transactions for Electronic Data Interchange (EDI) for the transmission of health care data. Claims and encounter information, payment and remittance advice and claims status and inquiry are several of the standard transactions. Code sets are the codes used to identify specific diagnosis and clinical procedures on claims and encounter forms. The CPT-4 and ICD-9 codes that you are familiar with are examples of code sets for procedure and diagnosis coding. Other code sets adopted under the Administrative Simplification provisions of HIPAA include codes sets used for claims involving medical supplies, dental services and drugs.

**Enforcement**

The interim Enforcement Rule defines procedures for Health and Human Services (HHS) investigations, provisions for hearings and the imposition of penalties for covered entities that violate the HIPAA legislation. This interim rules were published on April 17, 2003, became effective on May 19, 2003 and expired on March 16, 2006 when a Final Enforcement rule became effective. The enforcement process for HIPAA continues to be enacted only on complaints which are properly submitted to HHS.
Final rules regarding HIPAA enforcement have been issued. These rules apply to all of the HIPAA administrative simplification standards (which include HIPAA Privacy and Security, and electronic transaction and code sets (which require covered entities to standardize the format and content of certain electronic transactions)).

A covered entity can be held liable for violations committed by an agent if the agent acted within the scope of its authority. However, if a covered entity complies with the business associate provisions of the Privacy and Security Rules, the covered entity will not be liable for the actions of the business associate. All business associate contracts should be reviewed to make sure that the requirements of both the Privacy and security Rules have been included, and all business relationships should be reviewed to ensure that all business associates have been identified.

The Secretary of Health and Human Services delegated to the Administrator, Centers for Medicare and Medicaid Services (CMS), the authority to investigate complaints of noncompliance with, and to make decisions regarding the interpretation, implementation, and enforcement of certain regulations adopting administrative simplification standards. This delegation does not include authority with respect to the Privacy Rule. The Secretary has delegated to the Office for Civil Rights (OCR) the authority to receive and investigate complaints as they may relate to the Privacy Rule.

Penalties
Penalties will be assessed to those not meeting the requirements of HIPAA regulations. They are:

Non-compliance
A civil offense that carries a penalty of $50,000 per person per violation and a maximum of $1.5 million per year per incident.

Unauthorized Disclosure
Misuse of Patient Information under false pretenses or with the intent to sell, transfer, or use for personal gain, or malicious harm is a criminal offense. Penalties for criminal offenses can be up to $250,000 in fines and up to 10 years in prison.

The office of Civil Rights (OCR)
Within the Department of Health and Human Services (HHS) enforces the civil penalties.

The Department of Justice (DOJ)
Is responsible for enforcing the criminal penalties.

Other Pending Regulations
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the National Provider Identifier (NPI) as the identifier.

All HIPAA covered healthcare providers, whether they are individuals or organizations, must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once
enumerated, a provider’s NPI will not change. The NPI remains with the provider regardless of job or location changes.

HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses and large health plans, must use the NPI to identify covered healthcare providers in standard transactions by May 23, 2007. Small health plans must use only the NPI by May 23, 2008.

The Centers for Medicare and Medicaid Services (CMS) announces the following plans for transitioning to the National Provider Identifier (NPI) in the Fee-for Service Medicare Program:

Between May 23, 2005, and January 2, 2006, CMS claims processing systems will accept an existing legacy Medicare number and reject as un-processable any claim that includes only an NPI.
Beginning January 3, 2006, and through October 1, 2006, CMS systems will accept an existing legacy Medicare number or an NPI as long as it is accompanied by an existing legacy Medicare number.
Beginning October 2, 2006, and through May 22, 2007, CMS systems will accept an existing legacy Medicare number and/or an NPI. This will allow for 6-7 months of provider testing before only an NPI will be accepted by the Medicare Program on May 23, 2007.
Beginning May 23, 2007, CMS systems will only accept an NPI.

When applying for your NPI, CMS urges you to include your legacy identifiers, not only for Medicare, but for all payers. If reporting a Medicaid number, include the associated State name. This information is critical for payers in the development of crosswalks to aid in the transition to the NPI.

**HIPAA Administrative Simplification Compliance Deadlines**

**October 15, 2002**
Deadline to submit extension form for Electronic Health Care Transactions & Code Sets.

**October 16, 2002**
Electronic Health Care Transactions and Codes Sets – all covered entities except those who filed for an extension and are not a small health plan.

**April 14, 2003**
Privacy – all covered entities except small health plans.

**April 16, 2003**
Electronic Health Care Transactions and Code Sets – all covered entities must have started software and systems testing.

**October 16, 2003**
Electronic Health Care Transactions and Code Sets – all covered entities who filed for an extension and small health plans.

**October 16, 2003**
Medicare will only accept paper claims under limited circumstances.
April 14, 2004
Privacy – small health plans.

July 30, 2004
Employer Identifier Standard – all covered entities except small health plans.

April 20, 2005
Security Standards – all covered entities except small health plans.

August 1, 2005
Employer Identifier Standard – small health plans

April 20, 2006
Security Standards – small health plans.

May 23, 2007
National Provider Identifier – all covered entities except small health plans

May 23, 2008
National Provider Identifier – small health plans
Federal Sentencing Guidelines
Corporate Compliance is concerned with ensuring that healthcare providers comply with federal and state healthcare rules and regulations. Governmental regulations address every area of healthcare operations, and the programs developed to monitor these operations come in many forms. To bring some order to the picture the Federal Sentencing Guidelines were revised in 1991 to establish a framework for compliance program development.

The Guidelines provided the following seven steps necessary for implementing an effective compliance program:
1. Written and distributed standards of conduct and policies and procedures promoting commitment to compliance.
2. The designation of a chief compliance officer (preferably someone that is high in the corporate structure) with a supporting compliance committee.
3. The development and implementation of regular, effective education and training programs addressing compliance issues.
4. The establishment of a reporting system (hotline, etc.) to promote the reporting of real or potential compliance problems. This should include a procedure for providing anonymity to the reporter.
5. The development of a system for responding to reported compliance problems and enforcing appropriate disciplinary action for those violating policy, regulatory statutes or Federal healthcare program requirements.
6. A regular system of auditing and monitoring compliance issues.
7. A system to investigate and remediate identified problems and to ensure that the organization does not employ or retain individuals that have been sanctioned by the federal government.

In 1997 the Office of Inspector General (OIG) of the Department of Health and Human Services began formulating and distributing compliance guidelines developed for specific areas of healthcare. There are now compliance models for hospitals, clinical labs, hospices, DME (Durable Medical Equipment) providers, home health providers and other healthcare providers. These models all incorporate the seven steps above and address areas of concern that are general to all healthcare providers (e.g. correct coding, billing, anti-kickback, etc.) and areas that are specific to each specialty (e.g. EMTALA ‘Emergency Medical Treatment and Active Labor Act’ for hospitals and DMERC ‘Durable Medical Equipment Regional Contractor’ for DME suppliers). You should become familiar with the compliance model that has been developed for your type of provider. The models can be found at: http://oig.hhs.gov.
Billing Guidelines
Even though the government is concerned with all aspects of healthcare operations there is a particular emphasis on making sure that providers bill federal healthcare payers correctly and are reimbursed appropriately.
• Providers should take extra care to ensure that the information necessary to bill all payers, including federal payers, is accurate and complete.
• Coding should be appropriate for the services rendered and should accurately reflect the information in the medical record.
• The medical record should contain complete documentation that fully justifies the medical necessity of all procedures and treatments and supports the codes used to bill the payers.
• Patient Financial Services’ high priority should be to obtain accurate billing information and valid insurance information.
• Ensure that co-pay\co-insurance and deductible amounts are accurately calculated and collected.

Reporting
If you think that information provided in the medical record is false or inaccurate you should report this to your supervisor or the compliance office so that corrective action can be taken.

Finding Information
Information regarding compliance programs and the Medicare program can be found on many websites. The provider’s Fiscal Intermediary (Medicare Part A) and Carrier (Medicare Part B) should have websites. In Georgia these websites are:
• http://www.cahabaga.com
• http://www.cms.hhs.gov

In addition to the OIG website listed above, the CMS website contains very valuable information. Additionally, the state government maintains many websites. In Georgia, information regarding the Medicaid program and other state healthcare rules and regulations include:
• http://www.communityhealth.state.ga.us
• http://www2.state.ga.us/Departments/DHR/ORS

What you should know
As a general rule each staff member should know:
1. The name and extension of the Compliance Officer,
2. The number of their facility’s compliance hotline,
3. How to get a copy of their facility’s Code of Conduct (or similar publication),
4. How to get more information concerning a specific question.

By having this information each staff member can play an active role in helping to ensure that their facility complies with the rules and regulations governing the healthcare industry and in protecting their facility from making costly errors.
Section 1.4.C - Federal Regulations

Truth in Lending Act
The Truth in Lending Consumer Credit Cost Disclosure Act became effective July 1, 1969. It is also called the Consumer Credit Protection Act or Federal Regulation Z.

Imposition of Interest Charges on Hospital Bills

A. Regulation Z under the Truth-in-Lending Act defines a creditor as:
   1. Someone who regularly extends credit that:
      (a) is subject to a finance charge or
      (b) is payable in more than four installments
   2. And to whom the obligation is initially payable by agreement or on the face of the note.

B. Consumer credit must be granted by virtue of:
   1. A written agreement to pay in more than four installments or a finance charge imposed.
   2. Must be payable to person in the contract.

C. Argument that Hospitals do not regularly extend credit
   1. Hospitals are in the business of health care and not finance.
   2. Hospitals only allow patients to pay their bills after discharge as an accommodation and not in the regular course of business.

D. However, the new regulations provide that:
   1. If a person extends credit more than 25 times in a calendar year, they are a creditor. Therefore, almost all hospitals would be a creditor under the definition of the regulations.

E. Hospital is subject to the act if:
   1. Hospital enters into an agreement with patient to pay their bills in installments and includes a finance charge.
   2. Or if a hospital has a written agreement to pay in more than four installments if there is not a finance charge.
F. Types of Disclosures Required:
   1. English language disclosures
   2. Date on which finance charge begins to accrue
   3. Finance charge expressed an Annual percentage rate
      (a) No disclosure if charges less than $7.50 on amounts less than $75.00
   4. Number, amount and due date of payments plus total of payments
   5. Method of computing default in the event of late charges.
   6. Description of security interest
   7. Description of penalties for pre-payments.

G. How to avoid requirements of Regulation Z
   1. Enter into written agreements for four or less installments
   2. Do not impose a finance charge

H. How to avoid requirements of Regulation Z and receive a finance charge.
   1. The agreement should state that any payments not made when due are subject to a
      “late charge”.
      (a) “Late” charges are not considered a finance charge under Regulation Z.
      (b) Hospital must, as a practice, consider late payments as delinquent.
   2. Oral agreements may also be entered into for more than four installments:
      (a) Late charge may be imposed.
      (b) Regulation Z only applies to written agreements
      (c) Hospital may send a letter confirming such oral agreements without subjecting
          itself to the regulations.
   3. Regulation Z does not apply to hospital bills of over $25,000.00 that are not secured
      by real property.
      (a) Written installment agreements of more than four installments may be entered
          into over $25,000.00

Medical Bills Interest Rate Relief Act (effective January 1, 2006)
To express the sense of the Congress with respect to the price and terms of credit used to pay
large medical bills, to amend the Truth in Lending Act with respect to credit cards issuers
obligations for credit extended to pay medical expenses under certain circumstances, and for
other purposes.

Many families and individuals are forced deep into debt by the combination of large medical
bills and excessively high interest rates. The journal of Health Affairs reports that illness and
medical bills cause half of all bankruptcies. The same report notes that over 2 million
Americans are financially ruined by medical care costs each year. Consumers whose debt
consists largely of credit extended to pay medical expenses are 42 percent more likely than
other debtors to experience lapses in coverage. Many of those forced into bankruptcy by
medical expenses are middle class and have health insurance. Major credit card issuers tied
credit card interest rates to credit records and credit scores. However, previously unforeseen
and burdensome medical expenses may arise whereby the hospital mandated schedule of
payment is more than the individual can immediately afford. Hospitals often report late or
delinquent payers to consumer reporting agencies thereby directly affecting the rates, terms
and availability of credit from other sources that might otherwise be used to pay the medical
expenses. Many individuals and families are forced to place large medical expenses on their
credit cards over time. Credit card issuers are able to raise interest rates on late and delinquent
payers with impunity and without regards to the nature of the delinquency. There currently exists no government enforced ceiling cap on credit card interest rates.

The purpose of this Act is to stem the loss from rising instances of payment delinquencies and bankruptcies so that people who meet their bill payment requirements on time and in full receive the lowest interest rates. It is the sense of the Congress that no American family or individual should be forced to choose between the health and life of a loved one and the financial constraints of medical care. Financial institutions, including credit card issuers, should not take financial advantage of unforeseen, non-preventive, or catastrophic medical situations. Individuals or families saddled with large medical bills should receive a fair and equitable credit rating that disregards off-schedule medical bill payments.

Section 127 of the Truth in Lending Act is amended by adding at the end, the following new subsection: Credit Card Issuers obligations for credit extended to pay medical expenses. In general, if, with respect to a credit card account under an open end consumer credit plan, the consumer notifies the credit card issuer of anticipated, any upcoming medical expenses to be incurred by the consumer, or a member of the consumer’s household, within 30 days of the date of the expense. The annual percentage rate on credit extended under the plan to pay such medical expenses shall not exceed the annual percentage rate in effect for any outstanding balance of the consumer under the plan at the time such notice is given. The annual percentage rate extended under the plan to pay non-medical expenses may not be increased on the basis of, or due to, the extension of credit to pay such medical expenses. Medical expenses include necessary treatments, drugs, tests, hospital stays and expenses, doctor fees and elective surgeries.

**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 issuing or using reports on consumers related to their credit worthiness. 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 an when these disclosures must be made.
4. What procedures must be followed when a consumer disputes the accuracy of information in a reporting 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 can contact the credit-reporting agency to have any errors corrected and a corrected credit report issued.
As part of the Medical Bills Interest Rate Relief Act, Section 623 of the Fair Credit Reporting Act is amended by adding at the end the following new subsection:
Reports furnished by hospitals for credit history reporting purposes in general states that if a consumer, who is unable to make full payments for medical expenses to a hospital or other medical treatment facility in accordance with a schedule of payments imposed by such hospital or facility, continues, in good faith, to make partial payments on the outstanding balance on the prescribed due dates under such schedule, the hospital or facility may not submit negative information relating to the failure of such consumer to maintain the payment schedule in full during the 5 year period beginning when the consumer first fails to make full payment under that payment schedule.

A consumer shall be deemed to be making partial payments in good faith on the prescribed due dates if the consumer is paying at least 20 percent of the amount of the scheduled payment for each due date.

**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 provides the following:
1. A patient must notify the hospital within 60 days after 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, hospital personnel would benefit by being aware of the practices and need to know 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.

This Act applies only to third-party collectors and not to the hospital directly.

Below is a brief outline:
1. Without the consent of the debtor never communicate (in connection with the collect of a debt) with any person other than the debtor, the guarantor, his attorney, a consumer-reporting agency (if permitted by Law), your attorney, the debtor’s parent (if a minor), or the debtor’s guardian, executor or administrator.
2. Never call before 8 am or after 9 p.m. without the debtor’s approval (debtor time).
3. Never misrepresent the character, amount or legal status of any debt.
4. When an attorney represents the debtor (if known), talk only with the attorney, unless the attorney fails to respond.
5. Never threaten suit, garnishment, etc., unless you intend to take that action.
6. Never threaten to communicate to any person credit information known to be false
7. Never threaten to report a debt to a credit-reporting agency unless you can and are doing so.
8. Never deposit or threaten to deposit a post-dated check prior to the date written for deposit. Notice must be sent no more than ten days, or less than three business days prior to depositing the check.
10. Never pursue a debtor who has requested you not to or has stated he will not pay, other than to inform him of what you will do next.
11. Provide verification to a debtor who disputes a debt or any portion of the debt and cease collection until the dispute is resolved.
12. Never apply payments on an undisputed account to a disputed account.

**National Provider Identifier (NPI)**
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 require the adoption of a standard unique identifier for health care providers. The NPI Final Rule issued January 23, 2004 adopted the NPI as this standard. The NPI is a 10-digit, intelligence free numeric identifier (10 digit number). This number will replace health care provider identifiers in use today in HIPAA standard transactions. Those numbers include Medicare legacy IDs (UPIN, OSCAR, PIN and National Supplier Clearinghouse or NSC). Does not replace DEA, NCPDP, TIN, EIN numbers. The purpose of this change is to make simpler electronic transmission of HIPAA standard transactions. The NPI number will provide standard unique health identifiers for health care providers, health plans, employers; and more efficient coordination of benefits transactions.

All health care providers are eligible for NPIs. Health care providers are individuals or organizations that render health care. All health care providers who are HIPAA-covered entities, whether they are individuals (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or organizations (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, HMOs, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI to identify themselves in HIPAA standard transactions.

Health care providers can apply for their NPI on the National Plan and Provider Enumeration System (NPPES) web site [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do)
Introductions
In the 1970’s before the advent of managed care, the term medical necessity came into use in insurance contracts in order to exclude care, such as voluntary hospitalization and surgery that was prescribed primarily for the convenience of the provider or the patient.

Outpatients
In 1985, the Centers for Medicare and Medicaid (CMS) formerly HCFA did away with healthcare providers’ ability to use a general diagnosis such as “rule out”, or “routine”. In 1995, CMS continued to refine this compliance issue and mandated that outpatient tests and procedures must pass criteria developed by CMS to determine if that test or procedure is medically necessary.

To be considered medically necessary, charges on the test or procedure must be:
- Consistent with symptoms or diagnosis of the illness or injury under treatment
- Necessary and consistent with generally accepted professional medical standards, not experimental
- Furnished at the most appropriate level to safely and effectively meet the patient’s medical needs and condition, in the most appropriate care setting

If the test or procedure is not medically necessary in accordance with Local Medical Review Policies / Local Coverage Determination (LCD), or CMS rules / National Coverage Determination (NCD), then the provider must allow the physician to update the diagnosis based on documented condition of the patient, change the test or procedure to one that meets criteria, or cancel the test or procedure per CMS’s rules. The provider must then allow the physician to change the diagnosis, change the test or procedure, or cancel the test or procedure. LCD/NCD’s specify under what clinical circumstances a service is covered and correctly coded. As both an administrative and educational tool, an LCD/NCD assists providers in submitting correct claims for payment and outlines how claims will be reviewed to ensure that they meet Medicare coverage and coding requirements.

If the diagnosis does not meet LCD/NCD requirements, the physician can submit another diagnosis. If the updated diagnosis is determined to be acceptable per CMS’s edits, the test or procedure can be done and Medicare is billed. If the physician does not change the diagnosis or the test or procedure, then we must inform the patient that they now will become financially liable for those charges. At this time the patient may choose not to have the test or procedure. However, if they wish to proceed, a waiver or Advance Beneficiary Notice of Non-coverage (ABN) must be issued and explained to the patient. Failure to provide an ABN when appropriate may be considered a violation of Anti-trust kickback status if the intent is to coerce or induce referrals.
**Inpatients**

The physician must make a determination that a patient is in need of hospitalization. The decision to admit a patient is a complex medical judgment, which can be made only after the physician has considered the following factors:

- The severity of the signs and symptoms exhibited by the patient
- Medical predictability of something adverse happening to the patient
- Need for more information, ex: outpatient diagnostic studies before deciding if the patient should be admitted

The hospital, as a provider, has the responsibility to review each Medicare admission for Medical Necessity, which is based on criteria developed by CMS, the hospital, and by the Peer Review Organization (PRO). The PRO is a medical review organization that contracts with Medicare to review the medical necessity, appropriateness, and quality of the healthcare services or items provided or proposed to be provided to Medicare beneficiaries.
Utilization Management or Review
The Utilization Management (UM) program functions under the guidance of the Medical Staff to facilitate the attending physician in meeting the Medicare, Medicaid, commercial insurance, JCAHO and other regulations related to the appropriate use of resources, in compliance with:
- The Centers of Medicare and Medicaid Services (CMS, formally HCFA Health Care Financing Administration)
- The State Department of Community Services (formally the DMA Department of Medical Assistance) and
- The Hospital's Medical Staff Rules and Regulations.

Criteria
A nationally accepted set of Severity of Illness / Intensity of Service criteria are used as guidelines to determine the most appropriate level of care to meet the patient’s needs. Examples of Severity of Illness / Intensity of Service criteria are McKesson’s InterQual ISD, The Oak Group’s MCAP or Milliman and Robertson. The criteria are not intended to replace a physician’s medical judgment. Therefore any case failing to meet criteria for admission would require further information from the physician to support the level of care requested. Most payers require that the level of care be determined and documented in the medical record at the time of admission or at least within the first 24 hours of the hospital stay. It is the hospital’s responsibility to ensure the appropriate use of services; therefore most facilities perform some type of pre-admission screening or evaluation to determine the appropriate level of care to meet the patient’s clinical needs.

Each patient record is carefully scrutinized to determine the level of care delivered. Some indicators (criteria) require immediate review, while others will be done after discharge. This is commonly referred to as “concurrent review”. The concurrent review process is intended to facilitate the most expedient, cost efficient care in the highest quality available.

Upon completion of the initial review, the concurrent reviews are scheduled based on medical necessity. The period between reviews is based on the anticipation of an “event” during treatment. An event is anything that results in a change in the patient’s level of care or a variance from one of the generic screening criteria initially used. Subsequent reviews should be scheduled within three days of the previous review except in significant extenuating circumstances.

Process
Included in most UM programs are the responsibility for continuing pre-certification of services by the patient’s individual payer. Clinical findings to support the medical necessity of admission and continued stay are relayed to the review agency of the insurance company. This process continues throughout the patient’s hospital stay to ensure appropriate reimbursement for services rendered. The exact process for communicating the clinical findings and obtaining approval for the day or service may vary from payer to payer. The payer will issue a pre-certification number to be included on the claim to indicate that the payer approves the day or service. Pre-certification is not a guarantee of payment. Reimbursement by DRG or Case Rate is becoming more prevalent. With this the onus of the length of stay is on the facility. Frequent
concurrent review and monitoring of medical necessity for continued stay is crucial in managing the length of stay and therefore the cost and profit/loss per case.

**Discharge**

The patient’s clinical stability and the establishment of a safe discharge plan are the factors to determine discharge, not expected reimbursement. Discharge Planning or Transition Planning is a UM function but is not the exclusive responsibility of the UM professional. The clinical staff providing bedside care is responsible for routine discharge instructions and departures. The more complex discharge plans are coordinated by the UM professional. The establishment of a tentative discharge plan is done at the time of admission. The plan is then altered as necessary to meet the needs of the patient.

**Progression of Care**

In general, the UM program and therefore the staff are responsible for coordinating a smooth progression of care from admission, through the hospital stay, to discharge. The UM functions apply to all levels of care, inpatient, outpatient, procedural or medical observation. The UM professional acts as a liaison between the hospital, the patient, the physicians and the payer to ensure the most efficient and highest quality of care is given in the most appropriate setting.

The UM staff will interface with all clinical departments in the hospital as well as community services providing care after the acute hospitalization. Most UM professionals have a Nursing background; however, in small rural facilities these functions may be the responsibility of the Social Worker or the Health Information Management professional. A strong knowledge of clinical practices, standards of care, and federal, state and managed care regulations is required to successfully carry out these functions.
Health Information Management
Health Information Management (HIM) is responsible for the maintenance and protection of all medical records created in the process of providing healthcare services. A medical record is the strongest element in supporting patient billing and hospital reimbursement. A complete medical record contains all documentation related to the patient’s care and is defined by different regulatory agencies, such as:
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Medicare/Medicaid, and
- Department of Human Resources (Georgia DHR).

Record Requirements
Each record must contain information that will:
- Justify the admission (validated by the Utilization Review process)
- Support the diagnosis and treatment
- Describe the outcome
- Plan the patient’s aftercare.

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

Process
Attaining a complete medical record begins with assembly of the discharged record. Any documentation needed to complete the record is identified and the responsible caregiver is held accountable to provide the appropriate reports. As mentioned above, the record content is defined and required by regulatory agency and payer standards. Once the record is assembled and analyzed for completeness, the record is coded e.g. ICD-9-CM, CPT, HCPCS.

Well-documented records provide the best opportunity to adequately make coding decisions that optimize level of reimbursement. Records that have sketchy documentation or fail to meet content requirements present an obstacle to appropriate reimbursement.

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

Requests for Records
Requests for records to review are received in the HIM Department after the account is billed. The request may be for a copy of portions or all of the record. Release of the patient information is made only if the record contains a waiver to release information to insurance companies for payment of the bill or if the requestor presents a signed authorization from the patient to release the information to the requestor.

**Benefits**
The medical record is the foundation for obtaining the best reimbursement on each patient account. However, registering the patient with correct billing information, gathering all of the information in the medical record in a timely manner, having all of the charges entered into the financial system correctly and generating the bills in a timely manner requires the teamwork of the entire facility.
**Section 1.6.B - Coding**

**Definition**
Coding is the process of converting a narrative description of diseases, injuries and operations into a numerical classification system called ICD-9CM codes. ICD-9CM (International Classification of Diseases 9th Edition Clinical Modification) codes are numbers that identify diagnosis, complaint and symptoms, which are gathered at the time of registration or documented in the patient’s medical record.

**Purpose**
ICD9-CM codes serve the following purposes:
- Establishes medical necessity – this is the first step in the reimbursement process. Each service or procedure must be reported with a diagnosis that will justify the care provided.
- Translates written terminology or descriptions into a universal, common language based on numeric codes – Most third party payers, Medicare included, require the use of ICD9-CM codes to report diagnoses on claim forms.
- Provides data for statistical analysis – ICD9-CM is used for data reporting and allows researchers to calculate health related statistics including the leading causes of death, to the number of cases of certain infectious diseases, to the number and percent distribution of physician office visits by principal diagnosis. This same data can be used to study health care costs associated with a diagnosis or group of diagnoses, to research the quality of health care, and to predict and plan for health care trends and needs.

**Diagnosis Definitions**
- Reason for visit: The complaint or symptom which is the primary reason for an outpatient visit.
- Provisional diagnosis: The working diagnosis at the time of admission or reason for surgical procedure.
- Principal diagnosis: The condition established to be the chief reason for an admission. This would be listed as the first diagnosis on a hospital claim.
- Secondary diagnosis: This can be used for both inpatient and outpatient visits. It refers to all conditions that are present at the time of service or those that develop during an inpatient stay that affect treatment or length of stay. This can also be referred to as additional diagnosis.
- Final or discharge diagnosis: The complete list of diagnoses that applies to that visit.
Determining the Code
There are basic steps used by Medical Records Departments to determine the appropriate codes to assign to a visit. All main terms in the diagnostic statement must be identified. Each main term should be identified in the alphabetic index of the ICD-9 code book. Any sub-term listed below the main term in the alphabetic index should be reviewed. The person entering the ICD-9 code should verify the code in the numerical list and look for any additional instructions. The code that should be assigned to the patients account should be the one that is most specific to the main term in the diagnostic statement, and assign a code, which may be three, four or five digits.

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

CPT codes are organized into six major sections:
1. Evaluation and Management (E & M codes)
2. Anesthesiology
3. Surgery
4. Radiology
5. Pathology and Laboratory
6. Medicine

HCPCS is the acronym for the HCFA (Health Care Financing Administration) Current Procedural Coding System. Each year, in the United States, health care insurers process over 5 billion claims for payment. For Medicare and other health insurance programs to ensure that these claims are processed in an orderly and consistent manner, standardized coding systems are essential. The HCPCS was developed for this purpose. The HCPCS is divided into two principal subsystems, referred to as Level I and Level II of the HCPCS. The CPT codes do not include codes needed to report medical items or services that are regularly billed by suppliers other than physician.

Level II are assigned, updated and maintained by CMS. The Level II codes are often referred to as the HCPCS codes. Level II codes are primarily used to identify products, supplies and services not included in the CPT codes, for example, ambulance services and durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician’s office. The development and use of level II of the HCPCS began in the 1980’s. Level II codes are also referred to as alphanumeric codes because they consist of a single alphabetical letter followed by 4 numeric digits.
Correct Coding Initiative
The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (CCI) in 1996 to reduce Medicare program expenditures by detecting inappropriate codes submitted on claims and denying payment for them; promote national correct coding methodologies; and eliminate improper coding practices. There are more than 140,000 CCI code pairs (or edit pairs) that cannot be reported on the same claim, and they are based on coding conventions defined in CPT, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices. CMS contracts with Administar Federal, Inc., an Indiana Medicare carrier, to develop and maintain coding edits, which are published by the National Technical Information Services (NTIS).

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

Comprehensive code
The major procedure or service when reported with another code. The comprehensive code represents greater work, effort and time than to the other code reported. (Also called column 1 codes) Higher payments are associated with comprehensive codes.

Component code
The lesser procedure or service when reported with another code. The component code is part of a major procedure or services and is often represented by a lower work relative value unit (RVU) under the Medicare Physician Fee Schedule as compared to the other code reported. (Also called column 2 codes) Lower payments are associated with component codes.

Column1 / Column 2 edit table
Code combinations (or edit pairs), where one of the codes is a component of the more comprehensive code and only the comprehensive code is paid. (If clinical circumstances justify appending a CCI-associated modifier to either code of a code pair edit, payment of both codes may be allowed).

Mutually exclusive codes
Procedures or services that could not reasonably be performed at the same session by the same provider on the same beneficiary.

Mutually exclusive edit table
Code combinations (or edit pairs), where one of the procedures/services would not reasonably be performed with the other. (If clinical circumstances justify adding a CCI modifier to either code of a code pair edit, payment of both codes may be allowed).
Section 1.6.C - ABNs Advance Beneficiary Notice of Noncoverage

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

Requirements
Medicare beneficiaries must be supplied an ABN as a written notice by their physician or provider of services when services might not be covered by Medicare. If the ABN has not been signed before service is rendered and Medicare does not pay, the patient cannot be held responsible for payment of their service.

Medicare
Medicare pays for tests or procedures considered medically necessary. If the diagnosis provided by the physician does not support the services, Medicare will not pay for them. March 3, 2008 CMS implemented use of the revised Advance Beneficiary Notice of Non-coverage (CMS-R-131). The approved ABNs are placed on the CMS website at http://www.cms.hhs.gov/BNI and can be downloaded for English and Spanish versions; additional ABN information is also available on this website.

Some of the key features of the new form are:
- New official title “Advance Beneficiary Notice of Non-coverage, which more clearly conveys the purpose of the notice
- Replaces ABN-G (CMS-R-131-G) and ABN-L (CMS-R-131-L)
- May be used for voluntary notifications, in place of the Notice of Exclusion from Medicare Benefits (NEMB)
- Mandatory field for cost estimates of the item/services provided the patient at time of issuance of ABN.
- New beneficiary option, in which the patient has choices on how to proceed with services if their diagnosis does not meet Medicare’s definition of medically necessary. Their choices are receiving an item/service and pay for it out of pocket, rather than have a claim submitted to Medicare.

Beginning March 1, 2009, the ABN-G and ABN-L will no longer be valid and the revised Beneficiary Notice of Non-coverage must be used. Previously the ABN was only required for denial reasons but with the revised version of the ABN, this form may also be used to provide voluntary notification of financial liability. This revised ABN should eliminate the widespread need for the Notice of Exclusion from Medicare Benefits (NEMB) in voluntary notification situations.

The ABN must be verbally reviewed with the patient or his/her representative and any questions must be answered before the ABN is signed. The ABN must be presented to the patient in advance that the patient or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent care situations.

Employees of the provider of service may deliver the ABN, reviewing the information on the
ABN and explaining the three options listed in Blank (G). Under no circumstances can the provider of service decide for the beneficiary which of the three checkboxes to select. Pre-selection of the option by the provider of service invalidates the notice. At the Beneficiary’s request, the provider of service may enter the patient’s selection if the patient is physically unable to do so, but the provider of service must annotate the notice accordingly. If a patient is having multiple services listed in Blank (D) and the patient wants to receive some, but not all of the services, the provider of service can issue more than one ABN.

If the patient cannot or will not make a choice, the notice should be noted, for example: “the patient refused to choose an option”.

Options available on the ABN are:

- Option 1- Patient wants the items listed in section (D) listed above. Patient may be asked to pay at time of service, but the patient wants Medicare billed for an official decision on payment, which is sent to the patient on a Medicare Summary Notice (MSN). Patient understands that if Medicare doesn’t pay, the patient is responsible for payment, but the patient can appeal to Medicare by following the directions on the MSN. If Medicare does pay, the provider of services will refund any payments the patient made less co-pays and deductibles. If the patient wants to obtain an official Medicare decision in order to file secondary insurance the patient should choose Option 1.

- Option 2- The patient wants the items listed in section (D) but does not want Medicare billed. The provider of services may ask to be paid now as the patient is responsible for payment. The patient cannot appeal if Medicare is not billed.

- Option 3- The patient does not want the items in section (D) and understands with this choice the patient is not responsible for payment and the patient cannot appeal to see if Medicare would pay.

Once all blanks are completed and the form is signed, a copy is given to the patient or representative. The provider of services must retain the original notice.
CHAPTER 2 – GENERAL PAYER INFORMATION
SECTION 2.1  OVERVIEW
Section 2.1.A - Managed Care

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

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

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

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

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

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

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

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

Utilization Review starts with pre-certification for elective admissions and continues with concurrent review of the care and treatment while the patient is hospitalized. For emergency admissions, certification must be requested after the patient’s admission. If the clinical reviewers find any part of the treatment plan does not meet one of the goals, the insurance company can deny part or all of the reimbursement for those services. With indemnity insurance, health care providers may seek payment from the patients for amounts not covered by the insurance carrier.

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

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

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

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

While indemnity insurance had focused on:

- Payment for unforeseen illnesses and injuries
- After the insured individual paid a deductible
- And perhaps a coinsurance,
HMOs moved toward:
- Minimal out-of-pocket expenses for the individual
- Encouraged preventive screenings
- Annual checkups.

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

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

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

Early HMOs came in five basic models.
1. **Staff Model**: All physicians and support staff are employees of the staff model HMO, and are available to the HMO members (patients) in a clinic-type setting, frequently owned by the HMO. The clinic is usually complete with lab and radiology services. Most staff models attempt to include all physician specialties, but may have to refer out for some specialties. Staff model HMOs contract with hospitals at preferred rates for hospital services. Staff model HMOs are also known as closed panel HMOs. Staff models limit the choice of providers from which members may choose.

2. **Group Model**: All physicians and support staff are employees of a multi-specialty, physician group practice, which is under contract to the HMO to provide all physician services to its' members. The practice may be a captive group model, meaning they can see only HMO members, or an independent group model, meaning they can see HMO members and non-HMO members. Group models are also known as closed panels since a physician must be a member of the group practice in order to participate in the HMO. Group models also limit the choice of providers from which members may choose.

3. **Network Model**: In this model, the HMO contracts with several different groups of physicians to care for HMO members. The network typically has a larger number of private practice groups of primary care physicians, including family practice, internal medicine, pediatrics, and obstetrics and gynecology. They also have a limited number of specialist physician practices including general surgery, orthopedics, neurosurgery, etc. Physicians see HMO members and non-HMO members in their own practice setting.

4. **Individual Practice Association (IPA) Model**: Physicians oftentimes develop their own entity called an association, and in the IPA model, the HMO contracts with that association. Typically, an IPA will have large numbers of physician practices representing
a variety of primary and specialty care physicians. The physicians provide services to HMO and non-HMO members.

5. **Direct Contract Models:** In this situation, the HMO contracts directly with individual physicians to provide physician services to their members, including an array of primary care and specialty care physicians.

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

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

**The Progression of Managed Care**

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

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

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

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

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

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

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

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

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

Though slowly emerging, the insurance industry also sees an opportunity for a new type of benefit plan to become commonplace. Consumer Driven Health Plans (CDHP) has been projected to account for 24 percent of the health insurance marketplace by 2010, replacing a large portion of the PPO and POS market. This model allows consumers to make their own health care decisions, linking a health care spending account that is the individual’s to use, with high-deductible insurance policies. If the individual exhausts all the money in their spending account, and they have met the benefit plan’s high deductible, they are eligible for health benefit coverage under the insurance policy. It is widely acknowledged that this product will work only for specific populations, as the health consumer must be able to appropriately manage their own spending account effectively.
Consumer-Driven Healthcare

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

**HSAs** are seen by proponents as a way to make health care more affordable and accessible in the U.S. The Medicare Prescription Drug, Improvement, and Modernization Act, which included provisions designed to stimulate the popularity of these plans, was passed by Congress in November 2003 and signed into law by President Bush in December 2003. The law expanded medical savings accounts, renaming them Health Savings Accounts and created tax incentives to encourage adoption of high-deductible health plans. Banks were empowered to create HSAs, which deliver tax-free interest to the holders, who can then withdraw money tax free to pay for qualified health care expenditures. To qualify for an HSA, the purchaser must also have a qualifying **high-deductible** health insurance plan. Over time, participants are allowed to contribute more (cumulatively) to the savings account than would be required to fulfill their annual deductible for a given year (although annual limits on pre-tax contributions [other than a 1-time IRA rollover option] are well below the annual deductible), and any unused portions of the account accrue without tax penalty so long as the funds are used only for qualified medical expenses.

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

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

In 2014, when major portions of the **Patient Protection and Affordable Care Act** are implemented in the United States, high deductible plans and the concept of consumer-driven healthcare may become more popular. Although new federal tax subsidies will help reduce health insurance rates for many consumers, individuals and families that do not qualify, are expected to consider Health Savings Accounts (HSAs) if they do not have employer-sponsored coverage.
Section 2.1.B - Commercial

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

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

Two Basic Commercial Insurance Coverage’s:
1. Individual or Direct Pay Health Care Plans
2. Group Health Plans

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

Group Plans
Are normally employer-provided and the employer generally pays the premiums in full or in part. Group coverage may also be a part of membership in various organizations, business groups, or fraternal groups. In either case, carrier selection is done by the organization, not the subscriber. Group plans may cover only the employee or the employee and the employee’s family.

Coverage Verification
Subscribers of commercial insurance plans are issued policies and/or identification cards. Insurance identification cards should usually give the following information:
• Name of the Insurance Carrier
• Central Office address
• Address for claims processing
• Telephone number for benefit verification
• Policy and/or contract number and/or group name and/or number
• Limited benefit/coverage information
• Pre-Certification, prior authorization and second opinion requirements
• Waiver/rider indicators

Covered Services
It is critical that hospital personnel determine what benefits are provided the insured by the plan so that patient responsibility may be determined at the earliest possible time. In addition, most health insurance policies have a pre-existing clause, which states that the insurance carrier will not reimburse, or will only reimburse a limited dollar amount for any condition that the patient had prior to the effective date of the policy.
Once the insurance carrier processes a claim, an Explanation of Benefits (EOB) is sent to the patient and to the provider. The EOB will list:

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

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

**Pre-Certification**

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

**Submission of Claims**

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

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

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

**Individual Claims**

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

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

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

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

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

In verifying group coverage, the following steps are suggested:

- Contact Insurance Company to verify coverage/benefits.
- Obtain or verify complete mail address, contact person and telephone number. Verify claim submission address.
- Confirm effective date of policy for possible waiting period status.
- Obtain limitations on benefits when admission diagnosis provokes doubt concerning routine coverage.
- Secure any medical necessity approvals from insurance carrier or medical review agency prior to admission when appropriate.
- Verify coverage through union should be with the appropriate local union office unless directed otherwise.

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

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

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

1. Insurance Company Audit whereby the carrier informs the provider that the claim is being reviewed in-house for charges and/or medical necessity.
2. Hospital/Defense Audit whereby the carrier informs the provider that the claim is being audited to ensure that all charges on the claim were actually provided to the patient. The hospital has the right to audit the claim along with the carrier and add any late charges.
SECTION 2.2 GOVERNMENT PAYERS
Section 2.2.A - Medicare

Medicare
Congress created the Medicare program in 1965. It is administrated by the Center for Medicare and Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS). The Social Security Administration (SSA) is responsible for enrolling people in Medicare.

Medicare Eligibility
Eligibility can be determined online by researching the Common Working File (CWF) information accessible in the Health Insurance Query Access (HIQA) of the Federal Intermediary Shared Systems (FISS). Information on all enrolled beneficiaries can be found in the CWF. Medicare is a health insurance program for eligible individuals who meet the following entitlement requirements:
- People 65 years of age and older,
- Some people with disabilities who have been receiving Social Security benefits for a set amount of time, 24 months in most cases and
- People with End-Stage Renal Disease (ESRD) or permanent kidney failure requiring dialysis or a kidney transplant.

Once an individual is enrolled in Medicare, he or she has choices that will affect the cost, doctor choice, benefits and convenience of their Medicare benefits. These include:
- Hospital Insurance
- Medical Insurance
- Medicare HMO

Two Parts of the Medicare Program

Medicare Fee-for-Service Benefits Program has Two Parts:

1. Part A - Hospital Insurance

Most people DO NOT pay for Medicare Part A coverage because they paid for it through taxes while working. Part A helps cover the following:
- Inpatient care in hospitals,
- Critical access hospitals,
- Skilled nursing facilities (SNF),
- Hospice care,
- Some home health care,
- Blood and blood products,
- Ambulance services during the inpatient stay.
Hospital Stays
The covered services for inpatient care include:

- A semiprivate room
- Meals
- General nursing and other hospital service and supplies.

This coverage includes care in critical access hospitals, which are small facilities that give limited services to people in rural areas.

Inpatient mental health care in an independent psychiatric facility is also covered under hospital stays. However, this coverage is limited to 190 days in a lifetime.

The coverage for hospital stays does not include:

- Private duty nursing,
- A television in the hospital room,
- A telephone in the hospital room or
- A private room, unless medically necessary.

A terminally ill patient who elects to receive hospice care must assign their Medicare benefits to the hospice.

2. Part B - Medical Insurance
Most people DO pay a premium for Part B Coverage. Part B helps cover the following when they are deemed medically necessary:

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

Medicare should be billed only for services provided. Medications prepared by the pharmacy for an inpatient cannot be sent home with the patient and billed to Medicare. Blood or IV fluids prepared for a patient but not administered cannot be charged.

Medicare Coverage Options
The Medicare Program includes the following coverage options:
1. **Original Medicare Plan**

The Original Medicare Plan is a fee-for-service plan that is available nationwide.

With the Original Medicare Plan:
- You may go to any doctor, specialist, hospital, or other health care provider that accepts Medicare,
- You may be charged a fee (deductible and/or co-insurance) each time you receive a service from a provider,
- You pay a set deductible annually for part B and per benefits period you will pay a deductible for part A,
- Once the deductible is satisfied, Medicare pays its share, and you pay your share (coinsurance or co-payment) and any non-covered charges.
- You may want supplemental insurance to help pay the costs Medicare does not cover.

2. **Medicare Advantage Plans (Part C)**

The Medicare Advantage Plans (formally Medicare + Choice) are offered by private companies approved by Medicare to provide care under a contract with Medicare and currently include managed care plans such as PPO’s, Medicare Private Fee-for-Service plans (PFFS) and Special Needs Plans (SNP). Less common types of MA plans include HMO Point of Service (HMOPOS) and Medical Savings Account Plans (MSA).

If you join a Medicare Advantage Plan, the plan will provide all of your Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. Medicare Advantage Plans may offer extra coverage, such as vision, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D).

You can often receive extra benefits such as:
- Prescription drugs and routine or screening services
- You may have additional rules that you must follow. For example you must use specific providers and services may need to be pre-authorized
- You may also have to pay a monthly premium for the extra benefits.
- Medicare requires notification through a nonpayment/zero claim (Bill Type 110) of inpatient services provided to a beneficiary with a Medicare Advantage Plan. This allows Medicare to accurately track inpatient stay accumulation.
Medicare Prescription Drug Plan (PDP)
January 1, 2006, a new benefit was made available to the 41 million Americans who receive health insurance coverage through the Medicare Program. The Medicare Prescription Drug Plan (PDP) sometimes referred to as Medicare Part D was established by the Medicare Modernization Act (MMA), which was enacted in 2003.

The Basic Plan
Beginning January 1, 2006, new Medicare prescription drug plans were made available to all people with Medicare. Insurance companies and other private companies will be working with Medicare to offer these drug plans and negotiate discounts on drug prices. These plans are different from the Medicare-approved drug discount cards that phased out May 15, 2006. The cards offered discounts, while the plans offer insurance coverage for prescriptions.

Like other plans the beneficiary will be responsible for a monthly premium. A share of the cost of the prescription will also be the beneficiary’s responsibility (co-pay). Certain drugs will be covered. Certain pharmacies may have to be used.

In 2013 there are 32 Medicare PDP options, 14 of which have $0 deductibles for people who qualify for the “low-income subsidy” (LIS) or Extra Help program.

Since your patients will be coming to you for help, the following web sites will provide up-to-date information on the new drug benefit:

http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-d.aspx

The Medicare Card
If a beneficiary is enrolled in the Original Medicare Plan, he or she will have a red, white, and blue Medicare card when obtaining services and supplies from providers. The front of the card will provide the:

• Name of the beneficiary,
• Health insurance claim (HIC) number,
• Patient’s sex,
• Entitlements and
• Effective dates of coverage.

The back of the card will include instructions for using the card.
Front View of Medicare Health Insurance Card:

Please Read the Enclosed Material
Before Making Your Choice

If you DO want Medical Insurance, cut out your Health Insurance Card. Your coverage and your Medical Insurance premium begin on the date shown. Throw away the rest of this form.

If you do NOT want Medical Insurance, carefully follow the instructions on the back of this form.

Back View of Medicare Health Insurance Card:

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical, or health services under Medicare.
3. Your card is good wherever you live in the United States.

WARNING: Issued only for use by the named beneficiary. Intentional misuse of this card is unlawful and will make the offender liable to penalty. If found, destroy in several small pieces.

If you have questions about Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD: 1-877-486-2048 or visit us at www.medicare.gov

If you DO NOT want Medical Insurance
1. Check the box above (top right), sign your name, and return the entire form in the enclosed envelope. Do NOT tear off the Medicare card. It would be improper to use it once you do not want Medical Insurance. You must return the form BEFORE the Medical Insurance effective date shown on the card.
2. Since you are entitled to Hospital Insurance even though you do not want Medical Insurance, we will send you a new card showing that you have Hospital Insurance only.

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

Medicare Benefits

Part A Hospital
Most beneficiaries do not have to pay a monthly premium for Medicare Part A because they (or their spouse) paid Medicare taxes while they were working. The Social Security Administration (SSA) determines if an individual has to pay a premium for Medicare Part A coverage. A beneficiary may not qualify for premium-free Medicare Part A coverage if he or she or his or her spouse did not pay Medicare taxes while working or did not work long enough in Medicare-covered employment (10 years in most cases).
Part B Medical
Since most people do pay for their Part B coverage understanding the enrollment options may prepare you to answer beneficiaries’ questions regarding their Part B coverage:

- The Part B premium may be higher if the beneficiary does not sign up for Part B when he or she first becomes eligible.
- The premiums for Part B may go up 10% for each 12-month period that he or she could have had Part B coverage but did not enroll. Except in special cases, the beneficiary will need to pay the extra amount as long as he or she has Part B coverage.
- The premium is usually taken out of the beneficiary's Social Security, Railroad Retirement, or Civil Service Retirement payment.
- If the beneficiary does not receive one of the above payments, Medicare will send a bill for the premium every 3 months.

Benefit Period
A benefit period is a way in which Medicare measures a beneficiary’s use of hospital and skilled nursing facility (SNF) services.

A benefit period begins the day the beneficiary is admitted to a hospital or SNF (or any inpatient facility) and ends when he or she has not received hospital or SNF (or any inpatient facility) services for at least 60 consecutive days.

For example:

Beginning of a Benefit Period
- If a Medicare beneficiary is admitted (for the first time after the effective date of Part A) as an inpatient to a hospital on January 1, 2014,
- The beginning of the benefit period is January 1, 2014.
- The patient must pay the inpatient hospital deductible for this benefit period.
- This Medicare beneficiary is discharged as an Inpatient on January 5, 2014.

End of a Benefit Period
Using the above patient example – the patient discharged January 5, 2014, and was not readmitted nor did they receive any inpatient care until June 1\text{st} 2014. The end of the benefit period for the example above would be March 6\text{th} 2014 (60 consecutive days elapsed from the date of discharge).

Beginning of a New Benefit Period
In the above example, the patient was readmitted on June 1\text{st}, 2014 and this would begin another benefit period. Therefore, the patient would be responsible for another inpatient deductible.

If the beneficiary is readmitted to the hospital after one benefit period has ended, a new benefit period begins.

The patient must pay the inpatient hospital deductible for EACH benefit period in a calendar year.
There is no limit to the number of benefit periods a beneficiary can have and there could be multiple deductibles due in one calendar year. If the patient does not have the 60-day break between discharges and re-admit dates to start another benefit period then only one inpatient deductible could be due.

**Spell of Illness / Benefit Period**
Medicare will cover a maximum of 150 covered days for inpatient hospital services during any spell of illness/benefit period.
These benefits include:

**Days 1 – 60**
*60 Full Days*
Full or deductible days are renewable during each benefit period. The beneficiary is allotted 60 days and pays the current Medicare deductible for each new benefit period. Medicare covers all Medicare covered services except after the inpatient deductible is paid at the beginning of each benefit period. Full days renew with each benefit period.

**Days 61 – 90**
*30 Coinsurance Days*
Medicare covers all Medicare covered services minus the coinsurance amount for each of these 30 days which is the responsibility of the patient. The coinsurance amount is ¼ of the current inpatient deductible. The 30 coinsurance days are renewable with each new benefit period.

**Days 91 - 150**
*60 Lifetime Reserve Days*
Lifetime Reserve days (LTR) are not renewable. The beneficiary is allotted 60 days in his or her lifetime and once they are used, they are gone. The beneficiary is liable for ½ of the current Medicare inpatient deductible for each day of hospitalization for days 91 - 150. The beneficiary should be notified when they have reached the point in their benefit period where they can elect to utilize Lifetime Reserve Days. The beneficiary has the option to use or not use their Lifetime Reserve days.

All costs beyond the full 150 days of a benefit period are non-covered. This is known as the 60-30-60 rule.

**Benefit Period Payment**
Medicare pays all covered costs during a spell of illness / benefit period except for those charges, which the beneficiary may be responsible for:

**Deductible**
$1216 for a hospital stays of 1 to 60 days for 2014

**Coinsurance Days**
$304 per day for days 61 to 90 of a hospital stay or ¼ of the current Medicare Deductible for each coinsurance day for 2014,

**Lifetime Reserve Days**
$608 per day for days 91 to 150 of a hospital stay or ½ of the current Medicare Deductible for each lifetime reserve day for 2014
Deductibles and Coinsurance
There are certain financial responsibilities that a beneficiary is responsible for, before Medicare begins to pay on any inpatient or outpatient services:

- **Inpatient Part A Deductible** – This is the amount the beneficiary is responsible for during a single benefit period.
  - For the year 2014 the Part A deductible is $1216.00 and it increases each year.

- **Outpatient Part B Deductible and Premium** – This is the amount a beneficiary must pay for health care each calendar year before Medicare begins to pay. Once the deductible is satisfied, Medicare pays its share and the beneficiary is responsible for any additional coinsurance.
  - For 2014, the Part B monthly Premium is **based on yearly income of member**.
  - (as follows)

<table>
<thead>
<tr>
<th>Individual Tax Return</th>
<th>Joint Tax Return</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>$85,000 or less</td>
<td>$170,000 or less</td>
<td>$104.90</td>
</tr>
<tr>
<td>$85,001 - $107,000</td>
<td>$170,001- $214,000</td>
<td>$146.90</td>
</tr>
<tr>
<td>$107,001 - $160,000</td>
<td>$214,001- $320,000</td>
<td>$209.80</td>
</tr>
<tr>
<td>$160,001 - $213,000</td>
<td>$320,001- $426,000</td>
<td>$272.90</td>
</tr>
<tr>
<td>Above $213,001</td>
<td>Above $426,001</td>
<td>$335.70</td>
</tr>
</tbody>
</table>
  - The Part B deductible for 2014 is $147.00 per calendar year.

- **Part B Payments Coinsurance or Copay** – This is the set amount a beneficiary pays for certain services.
  - Coinsurance is the percentage of the Medicare-approved/allowed amount that a beneficiary pays after satisfying the Part B deductible.
  - The percentage depends upon the service but is 20% of the allowed amount in most cases.
  - If a beneficiary can't afford to pay these costs, there are programs available to assist the beneficiary with deductibles and coinsurance amounts if the beneficiary qualifies, for example Medicaid.
  - The beneficiary may also purchase coverage to pay deductibles and coinsurance amounts and this type of coverage is called Medigap Coverage.
  - The Medicare beneficiary is also responsible for the following:
    - 20% for all outpatient physical, occupational, and speech/language therapy and
    - 50% for outpatient mental health care.

Skilled Nursing Facility (SNF)
A benefit period or spell of illness is a way in which Medicare measures a beneficiary’s use of skilled nursing facility (SNF) services. There is also a 3-day qualifying acute/hospital stay and 30-day transfer requirements for SNF benefits to be covered.

SNF reimbursement is paid under a Prospective Payment System (PPS) which are per diem rates based on patient condition as determined by classification into a specific Resource Utilization Group (RUG)
Medicare pays all covered costs during a Spell of Illness / Benefit Period except for those charges which the beneficiary may be responsible for:

**Days 1 – 20**
20 Full Days

**Days 21 – 100**
80 Co-Insurance Days
$141.50 per day for days 21 – 100 of a SNF stay or 1/8 of the current Medicare Inpatient Deductible

**Days 101 +**
Patient Responsibility

**Clinical Laboratory Services Coverage**
Medicare Part B covers lab services as long as they meet medical necessity. The beneficiary pays nothing for Medicare-approved clinical laboratory services. There is no deductible or co-insurance for clinical lab services; other lab services are subject to deductible and co-insurance, for example pathology.

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

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

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

**FOR EXAMPLE--Mammography** – Screening services require specific billing procedures as outlined in the Medicare Guidelines for frequency of occurrence, CPT codes, diagnosis codes, etc.
• Screening – Part B will pay for X-ray screenings for the detection of breast cancer. Normally, screening is allowed annually. The diagnosis code used for a screening mammography is V76.12, with revenue code 403, and HCPCS 76092.
• Diagnostic – Part B will pay for diagnostic X-rays when symptoms are present. These mammograms are allowed as needed. The diagnosis code used for a diagnostic mammography must be appropriate and cannot be V76.12. The revenue code is 401, with HCPCS 76090-76091.

Ambulance
Medicare Part B will pay for ambulance transportation that has been determined to be medically necessary. The UB04 should contain only those charges pertaining to the ambulance trip. Ambulance billing requires specific information that may include:
• Ambulance report (maintain within your facility),
• Physician’s certification for medical necessity (maintain within your facility),
• Supporting documentation (maintain within your facility),
• Revenue code 54x,
• HCPCS codes and modifiers appropriate for mode of transfer and
• Pick up and destination.

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

3-Day Rule or Sometimes Called the 72-Hour Rule
Medicare requires that all diagnostic services (regardless of the diagnosis) and any related therapeutic (same diagnosis) outpatient services provided to a beneficiary three days prior to an inpatient admission to the same hospital or a hospital, owned, operated or managed by the same hospital be included on the inpatient claim and not billed separately on an outpatient claim.

Medicare Registration Requirements
• Hospice
• Medicare Secondary Payer (MSP)
• Medical Necessity

The basic requirements are as follows:
1. Obtain Medicare identification and eligibility information,
2. Name must be entered exactly as Medicare has in their records,
3. HICN (Health Insurance Claim Number) is not always the social security number of the patient, will depend on how that individual is entitled,
4. Usually a 9 digit number followed by a suffix (the suffix is determined by type of eligibility), but may be a 6 digit number with a prefix (railroad retiree)
   The following are common suffixes seen with the HICN number:
   A for Wage Earner (Aged or Disability),
B for Aged Wife and  
D for Aged Widow  
5. Always get a copy of the Medicare card and a picture ID to confirm the individual's identity  
per your facilities policies and procedures,  
6. Information may be obtained from the Beneficiary or their legal representative and  
7. Verification of information can be accomplished by researching the common working  
file/eligibility screen in the Fiscal Intermediary Shared System (FISS).

Registration Requirements  
Medicare has specific registration requirements for the following:  

An Important Message from Medicare  
If the patient is being admitted as an inpatient, you must give the beneficiary “AN IMPORTANT  
MESSAGE FROM MEDICARE”. This information explains the Medicare Patient’s rights while  
in the hospital and also explains how they may file an appeal if they are informed their inpatient  
care is no longer medically necessary.  

*An example of the Notice of Privacy Practices is included in ‘Chapter 3 Billing and Other  
Forms’ under the HIPAA section.

Inpatient Admissions and Medicare Benefit Period  
If this is an inpatient admission you must ask the patient if they have been an inpatient in the  
past 60 days. This will allow you to determine if this is a new benefit period or if this stay will  
be extending a benefit period already in progress, and:  
• Calculate the available benefits  
• Inform the beneficiary of their responsibility of deductible and/or coinsurance due  
• Ask if they want to use their Lifetime Reserve Days, if applicable  
• Ask the beneficiary if they have received any outpatient services from the hospital where  
they are being admitted (or wholly owned or managed hospital) in the three days prior to  
their admission.  
   If the answer is yes, the outpatient must be combined with the inpatient admission.

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

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

The following payers could be primary over Medicare:  
• Working Aged  
• Disabled  
• ESRD  
• Worker’s Compensation  
• Federal Black Lung Program  
• VA  
• Auto, No Fault, Medical and Liability
• Law Enforcement and Other Government Programs such as Research Grants

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

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

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

• If the beneficiary is covered by an Employee Group Health Plan (EGHP), that EGHP is primary to Medicare for a period of 30 months, which is the coordination period,
• The coordination period begins after a 3-month waiting period, which is waived if the patient takes the self-dialysis training or receives a transplant,
• The 30-month coordination period begins the first day the patient is entitled to Medicare,
• If the Beneficiary has a three-month waiting period before their Medicare is effective, it will be 33 months before Medicare will be primary to the EGHP.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/1/08</td>
<td>1st day of dialysis and 3-month waiting period</td>
</tr>
<tr>
<td>9/1/08 – 2/28/11</td>
<td>Entitled to Medicare based solely on ESRD</td>
</tr>
<tr>
<td></td>
<td>Beneficiary begins 30-Month coordination period in which Medicare is secondary!</td>
</tr>
<tr>
<td></td>
<td>EGHP is Primary!</td>
</tr>
<tr>
<td></td>
<td>Medicare becomes Primary on 3/1/11</td>
</tr>
</tbody>
</table>

Worker’s Compensation
If the illness or injury the Beneficiary is receiving services for is due to a work related accident or condition, worker’s compensation benefits would be primary to Medicare.
Black Lung
If the beneficiary has coverage under the Federal Black Lung Program and the services the Beneficiary is to receive is a covered Black Lung diagnosis—then Black Lung benefits would be primary to Medicare.

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

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

Auto, Medical, No-Fault and Liability
If the Beneficiary is at fault and Medical coverage exists, the Medical coverage should be billed primary to Medicare. If the patient is not at fault and Medical Coverage exists, but no liability coverage then medical coverage should be billed as primary to Medicare.

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

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

Other Government Programs, such as research grants may also be primary to Medicare.

Complete MSP information can be researched on the Common Working File (CWF)/Eligibility screens. The MSP information is found on the last screens, if Medicare has the information. If your claim is the first claim to be filed with the MSP information, you will not find any information in CWF.

Other important questions required by Medicare
ASK THE BENEFICIARY IF THEY HAVE ELECTED HOSPICE BENEFITS
- If the answer is yes the Hospice should be immediately contact to allow them to manage the patient’s care. If the patient is admitted the hospital cannot bill Medicare but must bill the Hospice and if the Hospice has not coordinated the admission or services received by the patient they will not be responsible.
- If the Beneficiary is admitted or receives treatment for a diagnosis not related to the terminal diagnosis for Hospice the Hospital may register as usual and bill Medicare—note-condition code 07 must be on the claim to inform Medicare this is not related to Hospice diagnosis.
• Hospice effective and termination dates and the Hospice Provider number may be found on the common working file/eligibility screen

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

• If the answer is yes get the patients card and call the plan to determine other information that may be required to bill and receive payment from the managed care plan and
• Additional information may also be found on common working file/eligibility screens

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

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

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

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

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

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

The Key Element to the Medical Necessity screening process is the Physician’s order! The order should be clear and contain what tests/procedures the physician is requesting and the
corresponding HCPCS codes, it should also include the reason for the tests/procedures ordered and the corresponding ICD-9-CM Diagnosis codes.

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

Codes used to provide information to Medicare and other payers when applicable are as follows:
- HCPCS - HCFA Common Procedural Coding System, (Usually for OP services only, Alphanumeric codes),
- CPT – Current Procedural Terminology (Usually for OP services only, numeric codes),
- Condition Codes,
- Occurrence Codes,
- Occurrence Span Codes and
- Value Codes.

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

During the billing process, there are several key Form Locators on the UB04 or EDI billing system that can cause payment delays or denials if they are not completed properly. The following list addresses several of these fields.

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

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

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

01 Home (routine)
02 Another inpatient facility
03 SNF
04 ICF-non-skilled care
05 Another type of institution-distinct parts
06 Home health
07 Against medical advise
20 Expired (deceased)
30 Still a Patient
61 Swing bed
62 Inpatient rehab facility
**Condition Code**
FL 18-28 defines certain conditions relating to the claim that may affect how the payer processes and pays the claim. Example of these codes include:

- 02 Condition employment related
- 05 Lien has been filed
- 06 ESRD patient in first 30 months of entitlement
- 07 Treatment of non-Terminal condition not related to Hospice diagnosis
- 08 Patient would not provide information concerning other insurance
- 09 Neither patient nor spouse employed
- 10 Employed but no EHGP
- 11 Disabled but no LGHP
- 20 Demand bill
- 21 Billing for Denial Notice
- 28 Patient and/or spouse’s EGHP is secondary to Medicare
- 38 Semi-private room not available
- 39 Private room medically necessary
- 40 Same day transfer
- 55 SNF bed not available

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

- 01 Auto Accident
- 03 Liability Accident
- 04 Employment Related Accident
- 05 Other Accident no liability coverage
- 11 Onset of symptoms/illness
- 18 Date of retirement of beneficiary/patient
- 19 Date of retirement of spouse
- 24 Date insurance denied

**Occurrence Span Codes**
And corresponding Dates – FL 35; codes and dates that relate to a span of time that may affect the processing and payment of the claim:

- 71 Prior stay dates
- 74 Non covered level of care
- 76 Patient Liability
- 77 Provider Liability

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

- 02 Hospital has no semi-private rooms
- 06 Medicare blood deductible
- 12 Working aged beneficiary with EGHP payment
- 15 Workers Compensation payments
- 50 Physical therapy visits, the number of days=visits

**Federal Intermediary Shared System Adjustment**
There are several situations where Medicare may need to be refunded money. Sometimes only a portion of the Medicare payment will need to be refunded, other times total payments will need to be returned. Either way, whether the claim needs to be adjusted or recouped, it can usually be accomplished on-line using the Federal Intermediary Shared System (FISS).

In situations where only a portion of the payment needs to be refunded, the payment is said to be adjusted. This may occur when late credits/charges are posted to an account. When this situation occurs, the charges must be removed from the claim on-line. The claim is retrieved by the patient’s HICN under the Claim Adjustment screen in FISS. Choose Menu selection 30 or 31 depending on whether the claim is inpatient or outpatient. Changes are made using the appropriate condition code and adjustment reason codes to perform the correction. Charge changes are to be reflected on screen page 2. The claim is updated by hitting the F9 key.

For a claim where it is found after payment that Medicare should have been the secondary payer, again choose Menu selection 30 or 31 and retrieve the correct claim. Use appropriate codes to make the group the primary payer. Make appropriate changes on the claim in the FISS showing group payments, adjustments, and changing group to the primary line on page 03 on-line.

Claims that need to be cancelled because they were billed in error should be recouped by choosing the cancel menu selection in FISS. Use appropriate codes for these claims.

For DDE providers that adjust their claims online, the condition codes and adjustment reason codes are as follows:

(Remember, if you are requesting a cancel, you must use the condition code D5 or D6)

<table>
<thead>
<tr>
<th>Condition Code</th>
<th>Definition</th>
<th>Adjustment Reason Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0</td>
<td>Dates of service change</td>
<td>DT</td>
</tr>
<tr>
<td>D1</td>
<td>Changes to charges</td>
<td>CC</td>
</tr>
<tr>
<td>D2</td>
<td>Change in revenue code</td>
<td>CE</td>
</tr>
<tr>
<td></td>
<td>Change in HCPCS code</td>
<td>OE</td>
</tr>
<tr>
<td>D3</td>
<td>PPS Interim Bill</td>
<td>IB</td>
</tr>
<tr>
<td>D4</td>
<td>Change in grouper input</td>
<td>AG</td>
</tr>
<tr>
<td></td>
<td>Change in surgical procedure code</td>
<td>SP</td>
</tr>
<tr>
<td>D5</td>
<td>Cancel only to correct a health insurance claim number</td>
<td>IH</td>
</tr>
<tr>
<td></td>
<td>Cancel only to correct the Provider number</td>
<td>IP</td>
</tr>
<tr>
<td>D6</td>
<td>Cancel only to repay a duplicate payment or OIG overpayment</td>
<td>BE</td>
</tr>
</tbody>
</table>

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Medicare Administrative Contractor (MAC)

THE MAC FOR GEORGIA IS:
Cahaba Government Benefit Administrators (Cahaba GBA)

The following are the addresses to mail claims and correspondence to Cahaba:
- Georgia Part A Claims/Correspondence
  P. O. Box 830867
  Columbus, GA 35283-0867

- Georgia Medicare Part B Claims/Correspondence
  PO Box 12847
  Birmingham, AL 35202-2847

On January 7, 2009, CMS announced it had awarded the MAC contract to: Cahaba Government Benefit Administrators, LLC (Cahaba GBA) was awarded a contract for the combined administration of Part A/Part B Medicare claims payment in Jurisdiction 10 comprised of Alabama, Georgia and Tennessee.

Timely Filing
The time period for filing Medicare claims is one calendar year after the date of service. For Inpatient claims, filing must occur within 1 year from the Admission date.

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Where administrative error (that is, misrepresentation, delay, mistake, or other action of the SSA or its intermediaries or carriers) causes the failure of the claim to be filed within the time limit specified, the time limit may be extended through the close of the sixth (6th) calendar month following the month in which the error is rectified.

If a provider was a participating provider within the time limit, but failed to submit a timely claim, or failed to do timely follow-up on the claim, the provider is liable and cannot bill the patient or other person for the services or for deductible or coinsurance amounts.

**Recovery Audit Contractors  RAC**
Safeguarding the Medicare program and its continued financial viability are at the heart of the Recovery Audit Contractor (RAC) Program. The RAC demonstration program was implemented by CMS in March of 2005. Section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC Program permanent and requires expansion to all 50 states by no later than 2010.

The RAC program is designed to identify and recover improper payments made by CMS. Some examples of improper payments that occur in the Medicare FFS program are: when payments are made for services that were not medically necessary, payments are made for services that are incorrectly coded, or provider fails to submit documentation when requested to support a claim. The provider will work closely with the assigned RAC to ensure compliance with this program. RACS use the same types of review staff as the Medicare claims processing contractors and are guided by Medicare policies, regulations, national and local coverage determination and manual instructions when conducting claim reviews.

The RACs are paid a contingency fee based on the amount of improper payments they correct for both overpayments and underpayments. During the demonstration period of RAC (2005 – 2008), the goal of CMS is to address all concerns raised by a RAC or any other interested party. With that being completed, the RAC
Section 2.2.B - Traditional Medicaid

General Information Traditional Medicaid for the Aged, Blind and Disabled  The information provided here is not designed as an all-inclusive tool for every potential Medicaid situation that may arise. Please refer to your Medicaid Policy and Procedure Manual or the website http://www.mmis.georgia.gov for an in-depth discussion.

The Georgia Medical Assistance Program or Medicaid was established with the objective of providing quality medical care to eligible persons on a cost effective basis under the provisions of Title XIX of the 1965 Federal Social Security Act. Both Medicaid and Peachcare are state administered program jointly funded by the Federal Government and the State of Georgia.

Service delivery is accomplished through a variety of relationships and agreements with private medical providers, state and private agencies. Effective November 1, 2010, Medicaid underwent a huge change in contract from ACS to EDS (an HP company, now known as HP Enterprise Services). An HP Enterprise service manages Medicaid contracts in over 20 states and was awarded the Georgia Medicaid Management Information System (MMIS) and Fiscal Agent Services contract with the Department of Community Health (DCH) in 2008. GAMMIS Partners include the Department of Community Health (DCH), HPES (HP Enterprise Services-fiscal agent for the GA Medicaid program, Georgia Medical Care Foundation (GMCF-professional medical review and administrative services to the GA Medicaid program, and MAXIMUS-enrollment broker services to Medicaid CMO members.

July 2005, DCH selected three managed care organizations to provide a more efficient delivery of health care services to Medicaid and Peach Care for Kids members to ensure the financial viability of these two programs, Georgia Families, Amerigroup Community Care, Wellcare of Georgia and Peach State Health Plan are the three CMO’s that make up Georgia Families.

By contracting with the Department of Family and Children Services (DFCS) and the Social Security Administration (SSA), the Department of Community Health (DCH) is the state agency that administers the Medicaid program and determines eligibility as a part of the services they offer to the clients they serve. DCH is a nine (9) member Board appointed by the Governor and Division of Medical Assistance (the Division) within the DCH that administers Medicaid and Peachcare for Kids. DCH provides the policy guidelines to DFCS for these determinations and ACS is the fiscal intermediary that handles the processing and payment of Medicaid claims.

Agencies and Functions

DCH – Department of Community Health

- Administration
- Budget and fiscal control
- Contract Monitoring
- Policies and Procedures
- Liaison with Federal agencies
ACS/GHP – Affiliated Computer Services/Georgia Health Partnership
- Provider Enrollment
- Provider Services
- Provider written, telephone and electronic inquiry
- Claims Processing
- Member Services
- Telephone and Electronic Inquiry
- Member Outreach

GMCF – Georgia Medical Care Foundation
- Sub contractor to ACS
- Pre-certification / Prior Authorization
- Medical Review Unit
- Outlier Review
- Out of State Services
- Prepayment review
- Nurse Aid Training Program
- Find a Healthcare Resource

DFCS/DHR/SSA – Department of Family and Children Services/Department of Human Resources/Social Security Administration
- Eligibility determination
- Facility licensing
- Compliance

Eligibility Certification
Medicaid certification is a plastic identification card that is issued upon determination of eligibility. Recipients no longer receive a monthly card and each recipient has his/her own card. The web portal is the best resource for eligibility information, other methods of eligibility verification include:
- SSI Notification Letter
- Temporary Medicaid Certification (Form 962)
- Certification of Retroactive Medicaid Eligibility (Form 964)
- Temporary Authorization of SSI
- Newborn Eligibility (DMA 375)
- Telephone (CIC- customer interaction center/ IVR- interactive voice response)
- Point of Sale Terminal Inquiry

Retroactive Eligibility
When an individual is not a Medicaid recipient on the date of service, but later is determined eligible and further determined to be eligible at the time service was rendered, a claim may be submitted. **HPES must receive retroactive eligibility claims within six (6) months of the month in which the determination of retroactive eligibility is made.** After an individual is
determined eligible he/she will receive a Medicaid card for ongoing eligibility, a Medicaid card will not be received for the retroactive month(s).

Emergency Medical Assistance for Immigrants
January 1, 2006, undocumented immigrants who, except for their immigration status, would be eligible for Medicaid, are potentially eligible for Emergency Medical Assistance. Services rendered to EMA eligible recipients are limited to emergency care only as defined by Emergency services are those that are:
1. Medically necessary, and
2. Result from the sudden onset of a health condition with acute symptoms, and
3. In the absence of immediate medical attention, are reasonably likely to result in at least one of the following:
   a. placing the individuals health in serious jeopardy, or
   b. serious impairment to bodily functions, or
   c. serious dysfunction of any bodily organ or part.

A physician verifies the emergency medical services have been rendered by completing the DMA Form 526 “Physician’s Statement for Emergency Medical Assistance”. This document must be submitted to the local county Department of Family and Children Services as a part of the Medicaid eligibility determination.

Except for emergency labor and delivery services, all claims for services provided to members eligible by this program will be reviewed by GMCF on a case-by-case basis to determine if the criteria for the necessity of service were met. The provider claims must be submitted with documentation that supports the emergent nature of the services provided.

Third Party Liability
Providers can make a significant contribution to Medicaid in the area of third party liability. Since providers have direct contact with recipients, they are the best source of timely third party liability information. Providers have an obligation to investigate and report the existence of other insurance or liability since Medicaid is the payer of last resort. Cooperation is essential to the proper functioning of the third party liability subsystem. Those claims that are denied lack of cooperation from the member may be denied by Medicaid. Also, Medicaid will deny those claims that are denied out of network, as the member should be utilizing their insurance to the fullest extent. Pharmacy providers may bill the Department first and the Department will seek reimbursement from third party carriers.

Medically Needy Spend-Down
This program covers children under the age of eighteen (18), pregnant women, and aged blind and/or disabled persons who otherwise would not be Medicaid eligible because their monthly income exceeds the AFDC eligibility payment standards.

Individuals determined to be eligible for this program are issued a DMA 962/964 for the first partial month of eligibility and a DMA 400 form. The DMA 400 form indicates the amount of liability the Medicaid recipient will owe the provider. The Medicaid payment will be reduced by the amount of spend-down indicated on the DMA-400 form. The DMA 962/964 shows the beginning date of eligibility and a statement in the remarks section is given to alert the
providers that a DMA 400 may be necessary for payment of the medically needy claim. If the statement on the forms read, “DMA Form 400 required” and the beginning date of eligibility is the same, as the date of service or within the span of date of service, the DMA 400 does not have to be attached before the claim can be filed for processing. The information must be confirmed that the spend-down information has been loaded by the social worker.

**NOTE: Do not deduct the spend-down amount from total charges of the claim.**

**Georgia Better Healthcare / Peachcare**
Georgia Better Health Care (GBHC) is the primary care case management (PCCM) program for the state of Georgia. This program matches Medicaid recipients to a primary care physician (PCP) or provider. Recipients are given an opportunity to select a primary care physician, for those who do not make a PCP selection, one is assigned for them. Through an ongoing provider/patient relationship, the PCP will provide all healthcare services, including referrals for necessary specialty services and maintain 24-hour availability to these members. Enrollment with a PCP is mandatory for all Medicaid recipients with the exception of those listed in chapter 700 of the Medicaid Manual. The objectives of the program are to improve access to medical care through creation of a “medical home” and decrease cost through the reduction of unnecessary medical expenses.

A distinction is made on the Medicaid card indicating that the member is enrolled in the Georgia Better Healthcare program. The card lists the name, address, and telephone number of the member’s PCP. Medicaid providers, other than the member’s PCP, must obtain a referral number from the PCP in order to be reimbursed for some services provided to the GBHC member.

A referral number can be obtained by contacting the PCP listed on the GBHC member’s Medicaid card or through the web portal. The billing provider must indicate the PCP’s referral number on the claim form in field 17A of the 1500; hospital Services do not require a referral from the PCP.

**NOTE:** The referral number obtained from the PCP is a GBHC referral number, **NOT** a pre-certification number.

**Medicare/ Medicaid**
Many Medicaid recipients are also eligible for Medicare. Hospital Inpatient claims submitted to the Division for Medicaid recipients with only Medicare “Part B” will be reimbursed at the Medicaid’s per-case rate under the DRG payment system. Inpatient hospital admissions for Medicare “Part B” only recipients must be pre-certified.

Medicaid is the primary payer for Medicare “Part B” Hospital Inpatient claims. Do not use bill type classification 121 for these claims; bill type classification 111 should be used.

These claims should be submitted to:

Third party Liability Unit  
Department of Community Health  
2 Peachtree Street, NW 39th Floor  
Atlanta, Georgia 30303-3159

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Medicare Crossover Claims
The Division will limit payment on Inpatient Medicare crossover claims as follows:

The maximum allowable payment to enrolled Georgia hospitals for Medicare inpatient deductible and co-insurance (crossover claims) will be the applicable per case rate under the DRG payment system.

The maximum allowable payment to non-Georgia hospitals not enrolled in the Georgia Medicaid program for Medicare inpatient crossover claims will be the weighted average inpatient per case rate of enrolled non-Georgia hospitals.

The Division will limit payment on outpatient Medicare crossover claims as follows:

a) Multiply the allowable deductible and co-insurance amount by the hospital specific percent of charges rate in effect on the date of payment;

b) Compare the product from (a) to the applicable per case rate under the DRG payment system; and

c) Reimburse the lower of the two amounts

Inpatient Hospital Services
a) The Medicaid maximum allowable payment is the hospital specific DRG rate.

b) The Medicare coinsurance and deductible amounts for a claim are compared to the Medicaid allowable payment minus the Medicare payment.

The actual Medicaid payment will be the lower of the amounts in item (b) less applicable third party liabilities and patient co-payments.

Outpatient Hospital Services
a) The Medicaid maximum allowable payment is the hospital specific DRG base rate including capital and graduate medical education add-ons.

b) The Medicare co-insurance and deductible amounts are multiplied by the hospital specific percent of charges rate for outpatient services.

c) The actual Medicaid payment will be the lower of the amounts in items (a) and (b) less applicable third party liabilities and patient co-payments.

This applies to all patients dually eligible for both Medicaid and Medicare including Qualified Medicare Beneficiaries (QMB).

Exhausted Lifetime Reserve Days
When the total Medicare Lifetime Reserve Days are exhausted, the Division may be billed for charges incurred by the Medicaid recipients. The claims for these charges must be filed on the UB-04 claim form with the Report of Eligibility or Explanation of Medicare Benefits attached. The attachment must state that the patient’s total Lifetime Reserve Days are exhausted, and include the last date of Medicare entitlement. When filing the UB-04, Medicaid liability begins with charges incurred after Medicare benefits were exhausted.

Pre-Certification / Prior Approval
Pre-certification pertains to medical necessity and appropriateness of setting only. The patient must be eligible at the time the service is rendered. The Georgia Health Partnership (GHP) handles all pre-certification requests. The purpose of the program is to ensure that medically necessary quality health services are provided in the most cost effective setting. Pre-certification does not guarantee reimbursement. The medical record must substantiate the

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medical necessity including the appropriateness of the setting for the services provided and billed to the Division.

**All services, regardless of certification are subject to review for medical necessity.**

As a condition of reimbursement, Medicaid requires that most inpatient and some outpatient claims be pre-certified. Elective admissions or scheduled outpatient procedures should be pre-certified/approved prior to the admission or the procedure being performed. Urgent outpatient procedures and Hospital admissions must be certified within thirty (30) calendar days of the procedure/admission and supported by emergency conditions. Inpatient hospital admissions for post delivery services must be pre-certified when a delivery cannot be coded on the hospital claim form (e.g., delivery at home, delivery in route to the hospital, etc.). Deliveries, patients under twenty (21) and recipients with both Medicare Part A and Part B are not subject to pre-certification. Once a newborn has been discharged from the initial birth hospital stay, pre-certification is required for all subsequent admissions.

Newborns remaining hospitalized more than 30 days continuously from the date of birth require pre-certification beginning the 31st day of that hospital stay.

The Outpatient Hospital and Ambulatory Surgical Center Procedures Requiring Prior Approval, Appendix E and O are located in Policy and Procedure Part II for Physician Services.

Cesarean section deliveries at certain hospitals may be exempt from pre-certification, to qualify for exemption; the hospital must perform at least one hundred (100) Medicaid paid deliveries in the calendar year. Additionally, the number of deliveries must have been no more than twenty (20) percent of the hospital’s total Medicaid paid deliveries for the previous calendar year.

An Appendix of the Medicaid Hospital Manual provides detailed information regarding specific outpatient procedures, which must be certified prior to the time they are performed.

**Failure to obtain the required certification will result in denial of reimbursement.**

The attending physician is responsible for obtaining pre-certification for services and providing the pre-certification number to each Medicaid provider associated with the case (i.e., assistant physician, hospital, etc.). The physician’s failure to obtain the correct pre-certification number will impact the hospital and result in denial of payment. If the attending physician is not currently enrolled as a provider or the patient has Medicare Part B only, the hospital is then responsible for obtaining the pre-certification number and making it available to each provider associated with the case.

Request should be initiated at least one (1) week prior to the planned admission or procedure. Approval is valid for ninety (90) days from date of issuance. Hospital admissions exceeding ninety (90) days require re-certification within three (3) calendar days prior to the ninetieth (90th) day following admission to approve the medical necessity of the continued stay.

Telephone: 1-800-766-4456  
Mailing Address: GMCF  
Medicaid Pre-Certification Department
When an individual is made eligible retroactively, requests for certification must be received within six months from the month of determination of retroactive eligibility. Additionally, when recipients are eligible for both Medicare and Medicaid, and Medicare benefits are exhausted, requests for certification must be received within three (3) months of the month of notification of exhaustion of benefits.

When there is a case in which it is unknown if Medicaid is the primary payer, it is recommended that a call be made to GHP to obtain a reference number.

Medicaid patients with Part A and Part B Medicare coverage do not require pre-certification from Medicaid except when the patient has Medicare Part B “only” coverage and is admitted.

**Limited Services**
In order to receive reimbursement for the following services, the hospital must be separately enrolled as a provider of these services. A Policy and Procedure Manual is provided for each specific program.

**These services will not be reimbursed using the UB-04 claim form.**
- Emergency Ambulance Ground Transportation – Prior approval is required for ground transportation over one hundred-fifty (150) miles (institution to institution)
- Air Ambulance Transportation – Prior approval is required for all air ambulance transportation
- Non-Emergency Ambulance Transportation (NET)
- Durable Medical Equipment (DME)
- Orthotics and Prosthetics (O&P)
- Pharmacy
- Early Periodic Screening Diagnosis and Treatment
- Pregnancy Related Services
- Perinatal Case Management
- Children’s Intervention Services
- Rural Health Clinic
- End Stage Renal Disease Dialysis

**Abortion**
In accordance with federal regulations and a recent congressionally enacted revision to the Hyde Amendment, the Division will reimburse for abortions performed on Medicaid eligible patients if the life of the mother would be endangered if the fetus were carried to term or if the mother was a victim of rape or incest. A “Certificate of Necessity for Abortion” form (DMA – 311), certifying the above situation must be properly executed and attached to the claim at the time of submission to the Division, this form may be filled out before or after the abortion is performed.
To ensure that abortions are not being billed through the use of other procedure codes, the Division requires the submission of the History, Physical, Operative Report and Pathology Report with all claims that have the following ICD9-CM Procedure codes:

- 69.0  Dilatation and Curettage of uterus
- 69.02 Dilatation and Curettage following delivery or abortion
- 69.5  Aspiration curettage of uterus
- 69.52 Aspiration curettage following delivery or abortion
- 69.59 Other aspiration curettage of uterus
- 69.6  Menstrual extraction or regulation
- 69.93 Insertion of Laminaria
- 70.0  Culdocentesis
- 70.0  Vacuum extraction
- 72.7  Vacuum extraction with episiotomy
- 72.79 Other vacuum extraction
- 74.99 Other cesarean section of unspecified type Dilatation and Curettage of uterus
- 96.49 Other genitourinary installations
These procedure codes require abortion certification:
- 69.01 Dilatation and Curettage for termination of pregnancy
- 69.51 Aspiration curettage of uterus for termination of pregnancy
- 74.91 Hysterectomy to terminate pregnancy
- 75.0 Intra-amniotic injection for abortion

Sterilizations
The Division is prohibited from making payment for sterilizations performed on any person who is under twenty-one (21) years of age at the time he/she signs the consent; or is not mentally competent; or is institutionalized in a correctional facility, mental hospital, or other rehabilitation facility. A sterilization consent form (DMA 69) must be properly filled out and signed for all sterilization procedures and attached to the claim at the time of submission to the Division. The signed consent expires 180 days from the date of the recipient's signature. The physician must sign the consent form after the sterilization has been performed.

The mandatory waiting period between signed consent and sterilization is 30 days.

All claims with the following ICD9-CM procedure codes will be reviewed prior to payment to ensure proper coding and to ensure that the sterilization consent form is attached:

These codes always require Sterilization Consent Form:
- 63.70 Male sterilization procedure, not otherwise specified
- 66.39 Other bilateral destruction or occlusion of fallopian tubes

These codes require sterilization consent form when done for sterilization purposes:
- 63.73 Vasectomy
- 65.61 Removal of both ovaries and tubes at the same episode
- 65.62 Removal of remaining ovary and tube
- 66.21 Bilateral endoscopic ligation and crushing of fallopian tubes
- 66.22 Bilateral endoscopic and division of fallopian tubes
- 66.29 Other bilateral endoscopic destruction or occlusion of Fallopian tubes
- 66.31 Other bilateral destruction or occlusion of fallopian
- 66.32 Other bilateral ligation and division of fallopian tubes
- 66.4 Total unilateral salpingectomy
- 66.51 Removal of both fallopian tubes at same episode
- 66.52 Removal of remaining fallopian tube
- 66.63 Bilateral partial salpingectomy

With the exception of the limitations described in section 904.6 of the Policy and Procedure Manual for Hospitals, there is no limit on the number of medically necessary inpatient hospital days a Medicaid recipient is allowed. Readmission for the same or related problem within 3 days of discharge is considered the same admission. Medical justification is the only criterion for hospitalization for eligible recipients. Documentation to substantiate medical necessity and appropriateness of setting may be requested in a pre-payment or post-payment review by the Division. Lack of appropriate medical justification may be cause for denial, reduction or recoupment of reimbursement.

Mammography
Screening and diagnostic mammography services are covered. Reimbursement for these services is limited to one per recipient, per year (July1-June30) unless medical documentation
is provided which justifies additional services. Mammography services are reimbursed only when provided by a facility that has been certified by the FDA for mammography services. A facility, which has not been certified, has been denied certification or whose accreditation has been revoked will not be reimbursed for these services.

Reimbursement
Distinct methods of reimbursement have been established for inpatient and outpatient services provided by Georgia and non-Georgia hospitals.

Inpatient services are reimbursed based on a hybrid–DRG prospective payment system. The majority of cases are reimbursed using a DRG per case rate based on the Champus DRG Grouper; remaining cases are paid based on a hospital specific cost- to- charge (CCR) system.

Outpatient services by Georgia hospitals are reimbursed based on a determination of allowable and reimbursable costs as determined from paid claims data. The determination is retrospective based on a cost report submitted by the hospital in accordance with Section 1002 and data included in the non-allowable Cost Questionnaire. Only costs incurred in providing patient care are eligible for reimbursement. Generally, the Provider Reimbursement Manual (HCFA 15-2-1), “Principles of Reimbursement for Provider Costs” and the pertinent policies contained in this manual serve as the basis for classifying a cost as allowable.

The Division will reimburse for cost based outpatient services at 90% of allowable operating costs plus 90 percent of allowable capital costs. The final determination of reimbursable costs will be made at the time outpatient settlements are made using audited cost reports.

Hospitals not included in the prospective hybrid–DRG system that meets the criteria for new hospitals will be grand fathered into the hybrid –DRG system by continuing to be reimbursed on a cost basis for the time period allowed under the policy in existence. A new hospital is defined as a hospital established by the initial issuance of a Certificate of Need, Medicare certification, state license and for which historical base year paid claims data did not exist.
Out of state hospital providers not enrolled in the Georgia Medicaid program as participating providers will be reimbursed for covered services provided to eligible Georgia recipients while out of state if the claim is received within 12 months from the month of service and at least one of the following conditions is met:

- The service was prior authorized
- The service was provided as a result of an emergency or life-endangering situation occurring out of state.

Out of state providers located within 50 miles of the boundary of the state of Georgia will be permitted to enroll for Medicaid and/or Medicare on a participating basis provided all enrollment criteria are met. The Medicaid program will not reimburse providers located outside of the continental United States.

The Medicaid program will not reimburse non-enrolled out of state hospitals for “term” obstetrical deliveries or related services for recipients who travel to other states to bear their children for reasons other than medical.

Routine health care or elective surgery provided by out of state providers is not covered unless prior authorization is obtained. The referring in state provider is required to request prior approval by documenting in writing the medical necessity of obtaining services out of state and providing the name and address of the out of state medical provider.

Reimbursement and coverage of out-of-state services are determined in accordance with current policies and procedures of the Georgia Division of Medical Assistance, and are contingent upon the patient’s eligibility at the time services are provided. Requests for prior approval or questions regarding out-of-state services must be directed to:

HP Enterprise Services / GMCF
Out-of-State
P.O. Box 105329
Atlanta, Ga. 30348
1-800-766-4456
678-527-3003 (fax)

**Emergency Room**

Emergency room visits that cannot be documented as true medical emergencies or potential medical emergencies will be reimbursed at an all-inclusive flat rate of $50. The $50 flat rate covers all ancillary services rendered as well as the fee for the use of the emergency room. The flat rate will not be subject to the hospital’s reimbursement rate and includes any applicable recipient co-payment.

The $50 rate is for medical screening and stabilization services provided in the emergency room without regard to prior authorization. Hospitals are required to notify the patient’s Georgia Better Health Care primary provider of the visit.

There is no limit imposed on the number of visits allowed per day per recipient in true medical emergencies. More than one non-emergency visit by the same recipient in one day is subject to review for medical necessity and possible denial depending on the individual situation.
Services provide within three (3) days of an inpatient admission or discharge for the same or related diagnosis is considered a part of the admission. The three-day window policy applies to services furnished by the hospital and includes laboratory and radiology services.

In non-emergency situations where the provider may be able to identify a chronic abuser of the ER, the provider may exercise its right to advise the recipient that they will not be accepted as a Medicaid recipient and that if they still choose to receive services, they (the recipient) will be responsible for all charges incurred.

**Outlier Cases**
All outlier cases under the hybrid-DRG system are determined based on cost. There is no length of stay thresholds. The determination of outliers is described further in Appendices C and M.

**High Cost DRG Cases**
High cost DRGs will be reimbursed a supplemental amount based on 90% of cost between the DRG base rate and the actual cost of the case. The specialty hospital peer group will be reimbursed a supplemental amount based on 95%.

**High Cost CCR Cases**
High cost CCR DRGs will be reimbursed cost up to a threshold and then 80% of cost above the threshold amount.

**Inpatient/ Outpatient Co-payment**
A co-payment of $12.50 will be imposed on hospital inpatient services and a $3.00 co-payment on non-emergency outpatient services. Recipients affected by the co-payment are limited to adult recipients of Supplemental Security Income (SSI) benefits, certain other adult disabled and aged recipients and parents of children receiving Aid to Temporary Assistance to Needy Families (TANF) benefits. Children under age 21, pregnant women, nursing facility residents, home and community based waivered recipients, dialysis recipients of hospice care participants and recipients receiving family planning services are not required to pay this co-payment. Persons who have both Medicare and Medicaid coverage the Medicaid recipients are not required to pay the co-payment. Services cannot be denied based on the inability to pay these co-payments.

Co-payments will apply to the groups of members who were previously exempt as follows:
- Dialysis (maintenance dialysis for ESRD excluded)
- Medicare/Medicaid
- Members in waivered services programs

The member’s certification card will have “y” indicator when co-payment is required.

**Utilization Control**
The Utilization Review Program of the Georgia Division of Medical Assistance includes but is not limited to:
- Certification of need for acute care
- Plan of treatment
- Review of need for continued stay
• Discharge planning and coordination
• Oversight of hospital utilization review committee monitoring activities
• Data gathering
• Post payment review and assessment including length of stay and ancillary service review
• Referral for educational services

The program is designed to promote both quality and utilization control. The requirements of the program apply to all hospitals that have executed a Statement of Participation, thereby contracting to participate in the Georgia Medicaid Program (Title XIX of the Social Security Act). The requirements further apply to all hospital services provided to individuals who are Georgia Medicaid recipients.

**New Hospitals**
A new hospital is defined as a hospital established by the initial issuance of Certificate of Need, Medicare certification, state license and for which historical base year paid claims data did exist. A hospital formed as a result of a merger, acquisition, other change of ownership, business combination, etc., is not a new hospital. Hospitals of this type will maintain the DRG-hybrid system reimbursement components it would otherwise be assigned. When rates are adjusted after the transaction, the appropriate base period information will be used in determining the hospital’s re-based reimbursement components. Hospitals that meet criteria for new hospitals will be grand fathered into the hybrid-DRG system by continuing to be reimbursed on a cost basis for the time period allowed under the policy in existence. On an interim basis these hospitals will be reimbursed for inpatient services using average peer group rate components (base rate, capital per diem, direct medical education.

**Billing Tips**
Inpatient stays that will exceed the 90 day pre-certification will have to be re-certified prior to the 90th day. Section 802 Policy and Procedures Part II Hospital Services (second paragraph)

Emergency admissions or specific outpatient emergent/urgent procedures must be certified within 30 days calendar days after date of admission/service. Section 802 paragraphs 7 and 8

Dental services in a hospital setting requires pre-certification. Section 803 Policies and Procedures Part II Hospital Services

Documentation and Coding Requirements are identified in Section 902 of Policy and Procedures Part II Hospital Services.

**Medicaid Newborn**
Code structure for Newborn as of October 1, 2007
Admission Source-Field Locator 15 on the UB-04

<table>
<thead>
<tr>
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<th>Description</th>
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<tbody>
<tr>
<td>1-4</td>
<td>Reserved for assignment by the NUBC</td>
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<tr>
<td></td>
<td><em>(Discontinued effective 10/1/07)</em></td>
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<tr>
<td>5</td>
<td>A baby born inside this Hospital</td>
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<tr>
<td>6</td>
<td>Born outside of this Hospital</td>
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<tr>
<td>7-9</td>
<td>Reserved for assignment by the NUBC</td>
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Overview Programs
As part of the Balanced Budget Act of 1997, congress created title XXI, the State Children’s Health Insurance Program (SCHIP), to address the growing problem of children without health insurance. SCHIP was designed as a Federal State partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but not enough money to purchase private insurance. SCHIP is the single largest expansion of health insurance coverage for children since the initiation of Medicaid in the mid 1960’s.

SCHIP is designed to provide coverage to “targeted low-income children.” A “targeted low-income child” is one who resides in a family with income below 200% of the Federal Poverty Level (FPL) or whose family has an income 50% higher than the state’s Medicaid eligibility threshold. Some states have expanded SCHIP eligibility beyond the 200% FPL. (http://www.cms.hhs.gov/schimp/about-schimp.asp)

The Georgia General Assembly voted in its 1998 session to create a program within Georgia called “Peachcare for Kids” which would provide Georgia children eligible for SCHIP with benefits similar to those offered by Medicaid. The Peachcare for Kids program provides health care for uninsured children from birth through age 18 in families with income at or below 235% of the federal poverty level. (https://www.peachcare.org)

The Georgia Department of Community Health (DCH), Division of Medical Assistance (DMA) is the single state agency responsible for administering Georgia’s Medicaid and PeachCare for Kids (S-CHIP) programs. Service delivery is accomplished through a variety of relationships and agreements with private medical providers, state agencies and private agencies.

The Division of Family and Children Services (DFCS) within the Department of Human Resources, at the county level, determine eligibility for most categories. In addition, the Division of Medical Assistance contracts with Dental Health Administration and Consulting Services (DHACS), based in Lisle, IL as third-party administrator for the PeachCare program. Under this contract, DHACS reviews and processes mail-in applications, screens applicants for Medicaid eligibility, enrolls children eligible for PeachCare for Kids, calculates and collects premiums, and provides telephone customer service.

There is also an outreach project called “Right from the Start Medicaid (RSM)” – The Right from the Start Medicaid (RSM) Project began in July 1993 as a response to Georgia’s high infant mortality rate and to provide a medical safety net for Georgia’s working families. The Division of Medical Assistance (DMA) and the Department of Human Resources (DHR) entered into an agreement to place eligibility workers in community settings. RSM staff currently has offices in health departments, hospitals, clinics, schools, community action agencies and other locations. A major feature of the program is the availability of staff during non-traditional work hours each week so that work, school and childcare arrangements are not
a barrier for families. There is currently 195 RSM staff stationed throughout the state. For more information, including contact information by county, go to http://dfcs.dhr.georiga.gov/portal/site/DHS-DFCS/

PeachCare for Kids is the State’s S-CHIP program. It is a separate program; however, eligibility determination and service delivery mechanisms are the same as Medicaid.
Categories for Adults

Right from the Start Medicaid for Pregnant Women (RSM Adults)

Qualifications
- Income cannot exceed 200% of FPL (see chart below for current dollar amounts).
- No resource limit.

Special Considerations
- Pregnant women are presumptively eligible.
- Women are covered for 60 days following the end of the pregnancy.

Breast and Cervical Cancer

Qualifications
- Must have been screened for and found to have breast or cervical cancer, including precancerous conditions.
- Must be under age 65.
- Must be uninsured and otherwise ineligible for Medicaid.

Process
- Women must be screened through the Centers for Disease Control and Prevention’s National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Categories for Families / Children

Right from the Start Medicaid (RSM Children)
- Children under age 1:
  - Income cannot exceed 185% of FPL.
- Children age 1 to 5 (though age 5):
  - Income cannot exceed 133% of FPL.
- Children age 6 to 19 (through age 19)
  - Income cannot exceed 100% of FPL.
- No resource limits for any of these categories.

Katie Beckett Deeming Waiver

Qualifications
Children under 18 who are chronically ill and whose parents have income or resources that make them ineligible for SSI benefits.

Process
Children must be in need of nursing home care but have good home care that costs less than nursing home care.
Low Income Medicaid

**Qualifications**
Adults and children who meet the standards of old Aid to Families with Dependent Children (AFDC) program.

**Income Limits**
- Family Size 1: $235/month
- Family Size 2: $356/month
- Family Size 3: $424/month
- Family Size 4: $500/month

Transitional Medicaid

**Qualifications**
Former Medicaid recipients who have gone to work and are no longer eligible because their income exceeds the income limits.

**Process**
Families are eligible for up to two years after they begin work.

Medicaid - Temporary Assistance for Needy Families (TANF)
See Low Income Medicaid and Transitional Medicaid categories above.

Medically Needy
Covers aged, blind, disabled, children under 18 and pregnant women

**Qualifications**
Family income exceeds the established income limits for their eligibility categories.

**Process**
The Medically Needy program allows a person to use incurred medical bills to “spend down” the difference between their income and the income limit to become eligible.

**Income limits for medically needy pregnant women and children:**
- Family size 1: $208 per month
- Family size 2: $317 per month
- Family size 3: $375 per month
- Family size 4: $442 per month

**Resource limits for medically needy pregnant women and children:**
- Individual: $2,000
- Couple: $4,000
  (Add $100 per additional person)

**Income Limits for Aged, Blind, Disabled:**
- Individual: $317 per month
- Couple: $375 per month

**Resource limits for Aged, Blind, Disabled:**
- Individual: $2,000
- Couple: $4,000
**Elderly / Disabled**
Supplemental Security Income (SSI) Recipients
Aged, blind or disabled individuals who receive SSI

**Resource Limits**
- Individual - $2,000
- Couple - $3,000

**Income Limits**
- Individual: $674 per month / $8088 per year
- Couple: $1011 per month / $12,132 per year

**SSI-Related Public Law Recipients**

**Qualifications**
Includes former SSI recipients who have become ineligible because of an increase in Social Security benefits.

**Process**
Certain increases in Social Security benefits can be excluded to meet the income requirements for SSI.

**Resource Limits**
- Individual - $2,000
- Couple - $3,000

**Income Limits**
- Individual: $674 per month / $8088 per year
- Couple: $1011 per month / $12,132 per year

**Hospice**

**Qualifications**
Terminally ill individuals who are not expected to live more than six months may be eligible for coverage.

**Process**
Recipients must agree to receive hospice services through a Medicaid participating hospice care provider.

**Income Limits**
$2,022 per month / $24,264 per year

**Resource Limit**
$2,000

**Nursing Home**

**Qualifications**
Aged, blind or disabled individuals who live in nursing homes and have low income and limited resources.

**Income Limits**
$2,022 per month / $24,264 per year

**Resource Limit**
$2,000

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Waiver Programs

- Community Care
- Independent Care Waiver Program (ICWP)
- Mental Retardation Waiver Program (MRWP)
- Model Waiver
- Community Habilitation and Support (CHSS)

Qualifications

- Aged, blind or disabled individuals who need regular nursing care and personal services but can live at home with special community care services.
- For Medicaid recipients between 20 and 64 years who are severely physically disabled and meet other specific criteria.
- For developmentally disabled individuals requiring ICF/MR-level care.
- For children under age 21 who meet the income and resource limits for any Medicaid coverage group and meet a nursing home level of care.
- For mentally retarded and developmentally disabled.

Income Limits

$2,022 per month / $24,264 per year

Resource Limit

$2,000

Qualified Medicare Beneficiary

Qualifications

Aged, blind or disabled individuals who have Medicare Part A (hospital) insurance.

Process

Medicaid pays Medicare premiums, coinsurance and deductibles.

Income Limits

Income cannot exceed 100% = $20 of FPL:
 Individual: $928 per month
  Couple: $1,246

Resource Limits

Individual - $6,680
  Couple - $10,020

Specified Low Income Medicare Beneficiaries

Qualifications

Aged or disabled people who are entitled to Medicare Part A. Income must be greater than 100% of FPL but cannot exceed 120% of FPL.

Process

Medicaid pays Medicare Part B premium.

Income Limits

Individual cannot exceed 120% = $20 of FPL
 Individual: $1,109 per month
  Couple - $1,491 per month

Resource Limits

Individual - $6,680
  Couple - $10,020
Qualified Individual

**Qualifications**
Aged or disabled people who are entitled to Medicare Part A.
Income must be greater than 120% of FPL but cannot exceed 135% of FPL.

**Process**
Medicaid pays Medicare Part B premium.

**Income Limits**
Income cannot exceed 135% + $20 of FPL
Individual: $1,246 per month
Couple: $1,675 per month

**Resource Limits**
Individual - $6,680
Couple - $10,020

SCHIP
State Children’s Health Insurance Program

PeachCare for Kids

**Qualifications**
Children under age 19 who do not have health insurance.
Income cannot exceed 235% of FPL.

**Process**
- PeachCare for Kids pays for preventive services and acute medical care, as well as vision and dental care.
- Children are enrolled in Georgia Better Health (GBHC), the State’s Primary Care Case Management (PCCM) program.

**Special Considerations**
- Children must be uninsured for the three months before applying for PeachCare for Kids. There are exceptions for children who have involuntarily lost coverage (e.g., children were covered through their parent’s employer and the parent lost the job, or the employer dropped coverage for dependent children).
- Children cannot be Medicaid eligible and cannot have access to health insurance through parent’s employment with the State of Georgia.
- There is no cost for children under age 5. Starting at age 6, premiums are $10.00 - $35.00 per child/max $70.00 per household. Households below 150% of FPL pay $15.00 and households between 151% - 235% of FPL pay $20.00. There are no copayments or deductibles.

**No resource limits.**
### MONTHLY INCOME LIMITS
RSM AND PEACHCARE FOR KIDS CATEGORIES

<table>
<thead>
<tr>
<th>Family Size</th>
<th>RSM for Pregnant Women</th>
<th>RSM for Children &lt; 1 185% of FPL</th>
<th>RSM for Children 1 to 6 133% of FPL</th>
<th>RSM for Children 6 to 19 100% of FPL</th>
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<td>$982</td>
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<td>3</td>
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<td>$3,545</td>
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<tr>
<td>Additional Member</td>
<td>$604</td>
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<td>$342</td>
<td>$257</td>
</tr>
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Introduction
Georgia’s Medicaid Growth is unsustainable. States across the country are facing falling tax revenues – rising budget shortfalls will total nearly $50 billion this fiscal year and grow even higher by 2010. Georgia’s Medicaid program alone will require 43% of all new state revenue in FY 2005. Like many other states, Georgia is planning immediate action to control spending growth in its Medicaid program.

Redesigning Georgia’s Medicaid Program
The Georgia Department of Community Health (GDCH) recently redesigned its Medicaid program to rely more heavily upon managed care. Its goal is to “achieve the greatest value for the most efficient use of resources.” GCDH intends to create a statewide, full-risk organized system of care for Medicaid and PeachCare members that incorporate Georgia-specific initiatives as well as “best practices” for healthcare.

This new Georgia Medicaid system will be required for low-income Medicaid adults and children, PeachCare for Kids, Right from the Start Medicaid and refugees. Its regionalized approach divides the state into six geographic regions with up to two care management organizations (CMOs) per region. CMOs will:
   a. Be licensed by Georgia Department of Insurance as risk-bearing entities.
   b. Be subject to net worth and solvency standards.
   c. Have demonstrated that ability to provide all covered healthcare services and an adequate provider network.

How will these changes impact physicians?
The transition to managed care will impact Georgia healthcare providers in several important ways, including:
   a. Reimbursement timetable
   b. Co-pays
   c. Volume
   d. Access to information

Georgia Healthy Families – Program Overview
July 2005, DCH selected three managed care organizations to provide a more efficient delivery of health care services to Medicaid and Peach Care for Kids members to ensure the financial viability of these two programs, Georgia Families. Amerigroup Community Care, Wellcare of Georgia and Peach State Health Plan are the three CMO’s that make up Georgia Families.

Georgia Healthy Families (GHF) delivers health care services to members of Medicaid and Peach Care for Kids. The program is a partnership between the Georgia Department of Community Health (DCH) and private Care Management Organizations (CMOs) to ensure accessible and quality health care services for all of the Medicaid managed care members. DCH Managed Care Division also monitors the CMOs to ensure compliance with contract requirement standards for contract management; member services provider services and quality services.
Program Description
GHF provides health care services to children enrolled in Peach Care for Kids and certain children, pregnant women and women with breast or cervical cancer covered by Medicaid. Children in foster care are not enrolled in Georgia Families.

Benefits
Members continue to receive the same benefits that were offered with Medicaid/Peach Care for Kids. The health plans also offer additional benefits such as:

- Expanded access to plans and providers
- Added member education on accessing care, referrals to specialists, member benefits and wellness education
- More efficient health care service delivery and better member care

Cost
Members do not pay more than they are currently paying for Medicaid co-payments or Peach Care for Kids premiums.

Member Ways to Enroll in a Health Plan
1. Mail via Member Packet
2. Call 1-888-GA-ENROLL (1-888-423-6765)

GHF representatives are available to answer any questions about the program and to help members select a plan and primary care physician by calling 1-888GA-ENROLL (423-6765) toll-free or visiting the Web site at http://www.georgia-families.com.

Care Management Organizations (CMOs)
The Georgia Department of Community Health contracts with three CMOs:

- Amerigroup Community Care 1-800-600-4441 www.realsolutions.com
- Peach State Health Plan 1-800-704-1484 www.pshpgeorgia.com
- WellCare of Georgia 1-866-231-1821 www.georgia.wellcare.com

A provider of Georgia Medicaid has the right to decide which; if any of the CMOs he or she participates. Providers must sign a contract and be credentialed according to the CMO requirements. The CMO will assign their own provider numbers, which maybe different than those assigned by DCH. The claims and payments will be processed by the CMO with which the member is enrolled.

It is important that the provider verify Medicaid/Peach Care for Kids, www.mmis.georgia.gov, 800-766-4456 (statewide) or 404-298-1228 (metro Atlanta), to determine if the member is enrolled in a GHF plan. Members will receive a GHP and CMO identification card. The CMO

INCLUDED POPULATIONS
- Peach Care for Kids
- Low Income Medicaid
- Right from the Start Medicaid
- Breast and Cervical

EXCLUDED POPULATIONS
- Foster Care
- Aged, Blind and Disabled
- Nursing Home
- Long-Term Care
card provides the plan and PCP contact information. For verification of benefits the CMO plan should be contacted directly.

<table>
<thead>
<tr>
<th>Region</th>
<th>Counties</th>
<th>Health Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlanta</td>
<td>Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Henry, Jasper, Newton, Paulding, Pickens, Rockdale, Spalding, Walton</td>
<td>Amerigroup Community Care Peach State Health Plan WellCare</td>
</tr>
<tr>
<td>Central</td>
<td>Baldwin, Bibb, Bleckley, Chattahoochee, Crawford, Crisp, Dodge, Dooly, Harris, Heard, Houston, Johnson, Jones, Lamar, Laurens, Macon, Marion, Meriwether, Monroe, Muscogee, Peach, Pike, Pulaski, Talbot, Taylor, Telfair, Treutlen, Troup, Twiggs, Upson, Wheeler, Wilcox, Wilkinson</td>
<td>Peach State Health Plan WellCare</td>
</tr>
<tr>
<td>East</td>
<td>Burke, Columbia, Emanuel, Glascock, Greene, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Putnam, Richmond, Taliaferro, Warren, Washington, Wilkes</td>
<td>Amerigroup Community Care WellCare</td>
</tr>
<tr>
<td>North</td>
<td>Banks, Catoosa, Chattooga, Clarke, Dade, Dawson, Elbert, Fannin, Floyd, Franklin, Gilmer, Gordon, Habersham, Hall, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Oconee, Oglethorpe, Polk, Rabun, Stephens, Towns, Union, Walker, White, Whitfield</td>
<td>Amerigroup Community Care WellCare</td>
</tr>
<tr>
<td>Southeast</td>
<td>Appling, Bacon, Brantley, Bryan, Bulloch, Camden, Candler, Charlton, Chatham, Effingham, Evans, Glynn, Jeff Davis, Liberty, Long, McIntosh, Montgomery, Pierce, Screven, Tattnall, Toombs, Ware, Wayne</td>
<td>Amerigroup Community Care WellCare</td>
</tr>
<tr>
<td>Southwest</td>
<td>Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Clay, Clinch, Coffee, Colquitt, Cook, Decatur, Dougherty, Early, Echols, Grady, Irwin, Lanier, Lee, Lowndes, Miller, Mitchell, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Terrell, Thomas, Tift, Turner, Webster, Worth</td>
<td>Peach State Health Plan WellCare</td>
</tr>
</tbody>
</table>

Eligibility and Enrollment
Children enrolled in PeachCare and children, pregnant women and women with breast or cervical cancer on Medicaid are eligible to participate in Georgia Healthy Families. Members will continue to maintain eligibility and enrollment through Medicaid or PeachCare and should look for information about the CMOs to arrive in the mail.
Implementation for Georgia Healthy Families will occur in phases. Members living in the Atlanta and Central regions will begin receiving services as of June 1, 2006. Members living in the East, North, Southeast and Southwest regions will be able to obtain services as of September 1, 2006. Health plans and primary care providers can be selected by calling a Georgia Healthy Families representative at 1-888-GA-ENROLL (423-6765) or by visiting the website at http://www.georgia-families.com.

Benefits
Medicaid and PeachCare members will continue to be eligible for the same services they receive today as well as new services. Members will not have to pay more than they are currently paying for Medicaid co-payments or PeachCare premiums. With a focus on health and wellness, many CMOs will provide members with health education and prevention programs as well as expanded access to plans and providers, giving them the tools needed to live healthier lives. Providers participating in Georgia’s Healthy Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits and health and wellness education.

Collaboration and partnerships between CMOs and the Department of Community Health provides a more efficient delivery of health care services, better care for members and accountability to taxpayers while at the same time maintaining predictable and sustainable growth for the Department.

Contacting Georgia Healthy Families
Members can visit the Georgia Healthy Families Website at http://www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The three CMOs have toll-free numbers available for health care providers to find out more about enrolling with Georgia Healthy Families:

Amerigroup Community Care:
800-454-3730

Peach State Health Plan:
866-874-0633

WellCare:
866-231-1821

GHF Health Plans
Amerigroup Community Care
Amerigroup Community Care is a wholly owned subsidiary of Amerigroup Corporation, the nation's largest company solely focused on low-income families and people with disabilities. We are dedicated to offering Georgia Medicaid families and PeachCare for Kids members the standard Medicaid benefits plus extra value-added services. Amerigroup will provide effective programs and services to your patients, coordinate quality healthcare and assist you with important case management and preventive care services.
You can learn more about Amerigroup Community Care at www.realsolutions.com. You can also download a provider contract at this website. To request a package by mail or visit by one of our Georgia provider representatives, call us at 1-800-454-3730.

**WellCare**
WellCare is a leading provider of government-sponsored health plans such as Medicare, Medicaid, State Children’s Health Insurance Programs and others. It is the largest Medicaid and Medicare only contractor in the nation and serves more of these members in the Southeast than any other health plan. The company’s headquarters are in Tampa, Florida.

WellCare prides itself on providing industry-leading service to its network of providers and members. Found in 1985, WellCare has partnered with more than 20,000 physicians to serve members in six states. Its members are supported with access to strong community networks and quality healthcare benefits and services. While maintaining access and enhancing quality of care, the company works hard to ensure that providers receive comprehensive and updated information. Local provider relation’s representatives are assigned to each provider.


**Peach State Health Plan**
Peach State Health Plan (Peach State) is a physician-driven, Georgia-based Medicaid managed care plan. Backed by our parent company, Centene Corporation®, we are able to draw on their financial stability and national expertise to deliver local services and programs. Peach State’s mission is to help our members grow healthy and stay healthy by providing access to quality healthcare. In partnership with Georgia Healthy Families, Peach State will help educate both the Georgia Medicaid members and healthcare providers about the enhancements being made to the Medicaid and PeachCare for Kids program.

For more information about Peach State or how to join our growing network of providers, call us at 1-866-874-0633 or visit our website at www.pshegeorgia.com.
Background
The Blue Cross Organization can be traced to a plan for prepayment of hospital expenses for schoolteachers’ set up by Justin Ford Kimball for the Baylor University Hospital in Dallas in 1929. The program provided 21 days of hospital care in a semi private room for prepayment of fifty cents per month.

Today there are many Blue Cross Blue Shield (BCBS) plans across the United States with millions of subscribers. Blue Cross Blue Shield of Georgia (BCBSGa) is the state’s largest and oldest health insurance company. In business for over 55 years, BCBSGa is recognized as a leader in the health insurance industry.

The original entity, the Atlanta Blue Cross Plan, was founded in 1937. Shortly thereafter, in 1939, the Savannah Plan was formed, followed by the Columbus Plan in 1946. Through a merger in 1966 of the Columbus and Savannah plans, Blue Cross Blue Shield of Georgia/Columbus was realized. The Columbus and Atlanta organizations merged in 1985 to form Blue Cross Blue Shield of Georgia and have consistently served the health care needs of Georgians since the 1930’s.

The company offers a complete line of health benefit products including underwritten and administrative service only group health insurance, managed care programs and offers electronic claims processing network systems. Blue Cross and Blue Shield of Georgia, Inc. and its affiliates, Blue Cross and Blue Shield Healthcare Plan of Georgia, Inc., Group Benefits of Georgia, Inc. and Greater Georgia Life Insurance Company offer a variety of innovative health insurance products, enhancements and benefits including preferred provider organization (PPO), health maintenance organization (HMO), point-of-service (POS) products, traditional indemnity insurance, senior plans, dental, pharmacy, life and administrative services products and behavioral health products.

The word plan means a separately incorporated, locally administered corporation authorized to use the Blue Cross name and symbol.

Product Summary
Blue Choice Healthcare Plan (HMO)
This plan is built on the primary care physician (PCP) model, emphasizing the PCP as the coordinator of a Covered Individual’s health care. Physicians in the following specialties are eligible PCPs:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

Blue Choice Healthcare Plan is designed to keep covered Individuals healthy. When illness occurs, the plan provides for quality care in the most appropriate setting at an affordable cost to employers and Covered Individuals. Covered individuals have the freedom to select their PCP from a panel of participating physicians. The PCP provides and arranges all
necessary medical services, including preventive care and treatment for illnesses and injuries. The PCP also coordinates referral specialist services and hospitalizations among participating providers.

**Blue Choice Option (Point of Service)**
A POS plan is a hybrid of an HMO and traditional indemnity coverage. What distinguishes a POS plan from an HMO plan is the inclusion of out-of-network benefits. Blue Choice Option Covered Individuals are considered in-network when they access all healthcare services through their designated PCP and use the services of participating providers. If a Covered Individual uses out-of-network services that are not coordinated by the PCP, his or her benefits are paid at a lower rate, which results in higher out-of-pocket expenses.

**Blue Direct (original Open Access product)**
Blue Direct Covered Individuals are required to select a PCP and are encouraged to maintain that relationship. However, Blue Direct Covered Individuals have the option of accessing specialty care directly through a Blue Choice HMO Specialty Care Physician without obtaining a prior referral from their PCP. Blue Direct Covered Individuals have a specifically labeled Covered Individual identification card. The card will include co-payment amounts along with the standard benefit information included on all Covered Individual ID cards.

**Blue Open Access** is the name of the next generation Open Access product. Blue Open Access Covered Individuals are not required to select a Primary Care Physician (PCP) and are able to access specialty care through a Blue Choice HMO Specialty Care Physician without a referral from a PCP. Covered Individuals will be encouraged to establish or maintain a relationship with a PCP, since that physician would be most knowledgeable of the Covered Individual’s medical history.
Blue Open Access Covered Individuals will have a specifically branded Covered Individual identification card designating them as an Open Access participant. The card will include copayment amounts along with the standard benefit information included on all Covered Individual ID cards.

**Blue Choice PPO**
Blue Choice PPO provides in-network benefits and out-of-network benefits; the Covered Individual has the option to choose either a preferred network provider and have benefits paid at the higher in-network benefit rate, or a non-preferred provider and have benefits paid at the lower out-of-network benefit rate.

**Federal Employee Program (FEP)**
The Blue Cross Blue Shield Association, on behalf of all Blue Cross Blue Shield plans, contracts with the United States Office of Personnel Management (OPM) to provide Government-Wide Service Benefit Plan coverage to federal employees and dependents. Blue Cross and Blue Shield of Georgia currently offers FEP Covered Individuals a choice of either FEP PPO or FEP exclusive provider organization (EPO) plans to choose for their coverage. An EPO is an exclusive arrangement where the Covered Individual must only use preferred providers (similar to an HMO) in order to avoid out-of-network denials. An EPO does not require a referral for services. If you are currently a Blue Choice PPO network provider, you are considered an in-network provider for FEP Covered Individuals.
UniCare
Covered Individuals have access to BCBSGa’s Blue Choice PPO network. There are many different claims processing sites throughout the country. Claims should be submitted to the mailing address that is indicated on the back of the Covered Individual’s identification card. For assistance, please call 877-864-2273.

Tonik
This product includes three flexible PPO plans offering health insurance options designed for Georgia’s “young invincibles” (adults between the ages of 19 and 34). These products include medical, pharmacy, dental and vision coverage. Be sure to submit claims to the mailing address that is indicated on the back of the Covered Individual’s identification card.

Blue Card Program (National Accounts)
The Blue Cross and Blue Shield Association’s Blue Card program allows physicians to file inpatient, outpatient, and professional claims with BCBSGa for Covered Individuals who are covered by other Blue Cross and/or Blue Shield plans. Through a single electronic network for claims processing and reimbursement, this program links physicians with other Blue Cross and Blue Shield plans across the country. BCBSGa remains the sole contact for claims submissions, payments, adjustments, services, and inquiries about the Blue Card program.

• A Covered Individual visits the physician’s office and presents an ID card with a blank suitcase logo. (Not all PPO Covered Individuals are Blue Card Covered Individuals – only those whose Covered Individual cards display the suitcase logo.)

• Look for the three-character alpha prefix that precedes the ID number on the card. The alpha prefix shows the Covered Individual is a Covered Individual of the Blue Card program and identifies his or her plan or national account. This information is important to routing out-of-area claims.

• Once the alpha prefix is identified, Covered Individual eligibility may be verified via www.bcbsga.com, on the Provider Access page, under Eligibility. The alpha prefix, Covered Individual ID number, and date of birth are required. See the Provider Access section of this manual for more details.

• Eligibility can also be verified by calling 1-800-676-BLUE (2583) from 8 AM to 10 PM. The alpha prefix and Covered Individual ID number are required, and alpha characters must be converted to numbers for entry. If there is no alpha prefix, the Covered Individual’s claims are handled outside the Blue Card program.

• Blue Card out-of-area Covered Individuals are responsible for obtaining pre-authorization from their own Blue Cross and/or Blue Shield plan.

• Once the Covered Individual receives care, his or her claim should be submitted to BCBSGa. Again, the alpha prefix and complete ID number are required. Incorrect or missing alpha prefixes and Covered Individual ID numbers delay claims processing.

• When BCBSGa receives the claim, it is electronically routed to the Covered Individual’s Blue Cross and/or Blue Shield plan. The Covered Individual’s plan
processes the claim and approves payment. BCBSGa then pays the physician according to his or her contract.

**Hospital Based Physicians**
Hospital based physicians (Hospitalists) include emergency room physicians, radiologists, pathologists and anesthesiologists. The physicians have a contractual relationship with the hospital.

Facility based physicians do not include Primary Care Physicians or Specialty Care Physicians who are employed by the Facility and have a separate contractual agreement with BCBSGa.

The hospital shall take any action necessary to ensure that its contracted hospital-based physicians cooperate with, participate in and are bound by the BCBSGA/BCBSHP utilization and quality management programs and coordinate as appropriate with admitting physician and PCP.

Likewise, the hospital shall use its best efforts to ensure that only hospital-based physicians who are contracted with Blue Cross Blue Shield of Georgia / Blue Cross Blue Shield Healthcare Plans of Georgia (BCBSGA/BCBSHP) are utilized for the treatment of members.

**QUICK REFERENCE GUIDE**

<table>
<thead>
<tr>
<th>Plan/Service Guide</th>
<th>Phone Number</th>
<th>Hours of Operation (EST)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Access Help Desk/Customer Support (<a href="http://www.bcbsga.com">www.bcbsga.com</a>)</td>
<td>866-292-6253</td>
<td>(8:00 AM – 6:00 PM) 24 hour a day/7 days a week</td>
</tr>
<tr>
<td>BCBSGA/BCBSGa VRU</td>
<td>800-241-7475</td>
<td>8:00 AM – 7:00 PM</td>
</tr>
</tbody>
</table>
| Blue Card/ITS*  
• Eligibility  
• Claim Status | 800-676-2583  
800-628-3988 Option #4 | 7:00 AM – 10:00 PM  
7:00 AM – 9:00 PM |
| Federal Employee Program (FEP) | 800-282-2473 | 7:30 AM – 5:30 PM |
| State Health Benefit Plan Indemnity & PPO  
• Eligibility, Benefits and Claim Status Inquiry | 800-626-6402  
404-262-7191 | 8:00 AM – 6:00 PM (Mon-Fri)  
8:00 AM – 6:00 PM (Mon-Fri) |
| State Health Benefit Plan (HMO) | 800-464-1367 | 7:30 AM – 7:00 PM |
| AT&T | 800-874-8616 | 7:30 AM – 5:30 PM |
| West Pointe Stevens | 800-645-9770 | 8:00 AM – 4:30 PM |
| Mental health and substance abuse services | 800-292-2879 Fax: 1-877-868-7950 | 24 hours a day/7 days a week |
| Georgia Bankers Association** | 706-321-0209 | 8:00 AM – 4:00 PM |
| Wal-Mart VRU** | 800-421-1362 | 7:00 AM – 7:00 PM |
| University System of Georgia Health Benefit Plan (USG Health Benefit Plan) | 800-424-8950 | 7:00 AM – 7:00 PM |
| Utilization Management Pre-Certification Fax | 800-722-6614  
404-842-8390 or 1-888-246-0226 | 8:30 AM – 4:30 PM |

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EDI Services
- For Vendor Supported Sites 888-883-2720
- For EDI Product Customers (Blue Connect, Online DDE and Real-time Transactions – 800-638-9677

Eligibility and Benefits Verification
Providers may call the Provider Service line toll free at 800-241-7475 from 8 a.m. to 7 p.m. and follow the prompts to obtain eligibility information.

Capture the information listed on the member’s ID card for billing purposes. Also, copy the front and back of the member’s ID card and file in the member’s chart for future reference.

The following is a list of steps to take to verify eligibility and benefits of BCBSGA/BCBSHP members.
- Provider Access allows providers to perform transactions 24 hours a day, seven days a week and is available for eligibility and benefit verification.
  - Step one: Log on to www.bcbsga.com
  - Step two: Logging In. Provider Access requires a password to use the service. You may request a password online, which will be mailed to you via US mail within seven to ten business days.
  - Once you receive the password it can be used to access the secure areas for member eligibility, claims status and ordering remittance copies.
- When possible, verify eligibility and benefits before rendering services by either calling the appropriate telephone number based on the member’s benefit plan or utilizing the services of Provider Access. The telephone number can be found on the front of the member’s ID card.
- For certain BCBSGA/BCBSHP plans, verification of a member’s eligibility and benefits can be conducted via a telephonic Voice Response Unit (VRU). A fax confirmation is also available through VRU. Please follow the VRU instructions to obtain the faxed confirmation.
- For all other plans, verification of a member’s eligibility and benefits can be made directly to a customer service associate by telephone. Please refer to the front of the member’s ID card for the appropriate customer service telephone number. CRT customers may verify certain eligibility on-line.

Identification Cards
A member ID card is issued to each member for use when receiving health care services. The ID card is for identification purposes only and may not be considered a verification of eligibility.

Utilization Management
Participating hospitals are responsible for complying with BCBSGA/BCBSHP Utilization Management (UM) programs. Their Utilization Management program represents and reflects an ongoing, comprehensive, integrated and dynamic system of activities and associates which exists to manage and coordinate access to and the delivery of health care services; these processes also look for opportunities to improve the quality and delivery of care and services. The criteria used by BCBSHP and BCBSGA for Utilization Management decisions are based on Milliman Care Guidelines and are used for the management of inpatient care and
ambulatory management. Clinical criteria are available to all members and providers upon request. All criteria and guidelines are reviewed at least annually and approved by the Medical Management Committee.

The following is a list of some claims categories where BCBSGa may routinely require submission of Clinical Information:

- Claims pending for lack of precertification or prior authorization
- Claims involving Medical Necessity or Experimental/Investigative determinations
- Claims for pharmaceuticals requiring prior authorization
- Claims involving certain modifiers
- Claims involving unlisted codes
- Claims for which BCBSGa cannot determine from the face of the claim whether it involves a Covered Service thus the benefit determination can't be made without reviewing medical records (including but not limited to pre-existing condition issues, emergency service reviews, and specific benefit exclusions).
- Claims that BCBSGa has reason to believe involve inappropriate (including fraudulent) billing
- Claims that are the subjects of an internal or external audit to include high dollar claims
- Claims for individuals involved in case management or disease management
- Claims that have been appealed
- Other situations in which clinical information might routinely be requested:
  - Requests relating to underwriting (including but not limited to Covered Individual or physician misrepresentation/fraud reviews and stop loss coverage issues)
  - Accreditation activities
  - Quality improvement/assurance activities
  - Credentialing
  - Coordination of benefits
  - Recovery/subrogation

The Provider's UM program staff is responsible for monitoring the Covered Member’s stay and treatment, ensuring efficient use of services and resources, and evaluating the availability of alternative outpatient treatment options. The Provider agrees to cooperate with BCBSGa in providing access to member’s medical records and performance of on-site concurrent review and discharge planning including, but not limited to the following:

- Emergency and maternity admissions
- Ambulatory surgery
- Case management
- Preadmission testing (“PAT”)
- Inpatient services, including NICU
- Focused procedure review

**Program Components**

- Preauthorization Review to determine benefits available under the member’s Membership Agreement for outpatient surgical and diagnostic procedures.
- Preadmission Review to review an inpatient hospital stay to determine coverage under the member’s Memberships Agreement.
• Concurrent Review to evaluate a member’s coverage under the terms of the Membership Agreement for continued inpatient hospital stay.
• Discharge planning to evaluate a member’s coverage under the terms of the Membership Agreement for health care services for a member after discharge from an inpatient setting.
• Case Management to coordinate and facilitate services and benefits members receive to ensure they seek and receive appropriate and necessary care to minimize duplication of services, tests and costs and to maximize benefits available under their Membership Agreement.

Authorization Requirements
The following are tips to ensure the proper preauthorization of services for BCBSGA/BCBSHP members.

Benefit plans vary widely. The provider is responsible for verification of member eligibility and covered benefits. Except when an emergency, failure to obtain authorization prior to rendering designated services will result in a denial of reimbursement. A minimum time frame of three business days is required to complete a thorough clinical analysis prior to the member’s proposed elective procedure date. An authorization number will be returned to the office of the physician requesting the service within three days of receipt of complete clinical information. The format of the number can be alpha numeric or numeric. Contracted facilities must notify BCBSGA/BCBSHP within twenty-four hours of the next business day from the time of all inpatient admissions.

Preauthorization for professional and facility services related to routine maternity delivery admissions is not required.
• Any non-routine maternity delivery admissions require preauthorization.
• Lengths of stay which are extended beyond forty-eight hours post vaginal and ninety-six hours post cesarean delivery as a result of complications are not considered routine and authorization must be obtained.

This is effective for all lines of business including HMO/POS, PPO and Indemnity products. All inpatient routine maternity delivery claims must be submitted with the following ICD9 procedure codes and diagnosis codes:

<table>
<thead>
<tr>
<th>ICD9 Procedure Codes</th>
<th>72.0 - 73.99 (Vaginal)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>74.0 - 74.99 (Cesarean)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V22.2</td>
</tr>
<tr>
<td>V27.0</td>
</tr>
<tr>
<td>650-653.9</td>
</tr>
</tbody>
</table>

Please note: The above referenced diagnosis codes must be submitted in the primary position for correct claim processing.

Member coverage for all services will continue to be dependent upon eligibility and plan benefit terms at the time the service is rendered. Authorizations are not a guarantee of payment.

Concurrent Review
Concurrent review is the process of reviewing coverage for the member’s inpatient confinement based on the terms of the membership agreement, condition of member, appropriateness of
venue, the discharge treatment plans and potential alternatives to inpatient (acute) confinement and case management.

Concurrent review is a collaborative effort between the UM department at BCBSGA, the admitting physician and the utilization review department of the facility. Concurrent review is performed by BCBSGA UM and on-site nursing staff in hospitals where BCBCGA members are admitted. Continued stays are reviewed by Registered Nurses against Milliman Care Guidelines adopted by BCBSGA and are either authorized for coverage or, referred to BCBSGA medical director or physician reviewer for review which may include discussion with the attending physician.

Claim Submission
BCBSGA/BCBSHP participating facilities are required to accept the member’s ID card in lieu of payment up-front and to file claims for members.

All services provided for Covered Members must be filed using the standard HIPAA compliant claim format and code sets on the appropriate claim form or the equivalent, within the filing standards timeframe, and with applicable charges noted.

Hospitals are encouraged to file members’ claims electronically. Hospitals who file hardcopy claims for reimbursement for services rendered to members should use standard UB 04 claim forms.

For further information about electronic filing, contact EDI Services at 888-883-2720. Procedures for electronic claims filing are also available at www.bcbsga.com, and the Electronic Transaction Manual is available under EDI Services.

BCBSGA has partnered with two vendors offering web based claims submission services:

- MD-Online, Inc.
  4 Campus Drive
  Parsippany, NJ 07054
  888-499-5465

- Payerpath, Inc.
  9030 Stony Point Parkway, Ste 440
  Richmond, VA 23235
  www.Payerpath.com

The following data is required for submitting electronic and/or hardcopy claims to BCBSGA/BCBSHP:

- Current ICD-9 diagnosis and procedure codes, HCPCS and CPT procedure codes. (There should be only one procedure code per line and codes should be listed to the fifth digit. HCPCS and CPT procedure codes should include modifiers where applicable.)
- Valid revenue codes.
- Correct and valid bill types, per the UB-04 Billing Manual.
- Complete coded bills, per the UB-04 Billing Manual. The following are examples of significant data elements:
  - Place of service and type of service
o Procedure and diagnostic codes
o Provider name and tax ID
o Dates of service
• Complete and accurate patient and insurance information including:
  ➢ Alpha prefix and numeric suffix with member number
  ➢ Correct spelling of the patient’s name
  ➢ Date of birth and sex of patient
• Require pre-authorizations and include the pre-authorization number on the claim.
• To identify the claim as an adjustment, corrected bill or tracer, rubber stamp the type of claim on the face of hard-copy bills. Red ink is not suggested as scanning equipment may not be able to read this information.

Rejected Claims
Common reasons for rejected claims
• Outdated, incomplete or non-specific ICD-9, HCPCS and/or CPT codes on the claim.
• Incomplete data elements.
• Invalid or incorrect contract information (i.e. member number)
• Ineligible member for BCBSGA/BCBSHP coverage.
• Illegible hard-copy claims.

Types of claims that should not be submitted electronically
• Claims for reimbursement contracts that require itemized bills or invoices to be submitted with the claims.
• Claims with late charges.
• Claims with adjustments or corrections.

Tips for resubmitting claims to BCBSGA/BCBSHP
• Please do not resubmit claims until at least 30 days have passed from the original date of submission and it has been determined through inquires that BCBSGA/BCBSHP did not receive the claim.
• Resubmitted claims will be denied as duplicates when BCBSGA/BCBSHP has already received the original claim, unless changes have been made and the new claims is identified as an adjusted / corrected type bill.

CLAIMS STATUS
A claim status may be verified via the Internet at www.bcbsga.com through ProviderAccess.

To allow sufficient time for BCBSGa to completed processing a claim, please wait at least thirty (30) calendar days after submitting a claim before checking the claim status via web site or by calling BCBSGa.

If the claim is submitted electronically, verify that the claim is not rejected electronically. If the claim is rejected, and the claim status is not available through the BCBSGa web site, verify that the claim has been corrected and resubmitted.

The status of the claim may also be obtained by calling the appropriate BCBSGa telephone number based on the Covered Member’s benefit plan.
The following information is required to verify a Covered Member’s eligibility and benefits and/or to inquire on the status of a submitted claim:

- Type of plan (i.e.: BlueChoice, Healthcare Plan, FEP, etc.)
- Covered Member’s name,
- Covered Member’s ID number including the alpha prefix and numeric suffix,
- Covered Member’s date of birth (MM/DD/YYYY),
- Date of service (requirement for claim status inquiries only) (MM/DD/YYYY),
- Charges submitted (requirement for claims status inquiries only)

**NOTE:** Corrected bills are those claims for which a remittance advice has already been received by the provider.

**CLAIMS SUBMISSION FOR FEDERAL EMPLOYEE HEALTH BENEFIT PROGRAM**

All claims under the Federal Employee Health Benefit Program must be submitted for payment within one hundred eighty (180) days from the date the services are rendered. The Facility or Professional Provider agrees to provide all information necessary to determine the Plan’s liability, including accurate and complete claims for Covered Services and utilize forms consistent with industry standards or, if available, electronically through an approved medium.

If Plan is the secondary payer, the one hundred eighty (180) day period will not begin until notification of the primary payor’s responsibility has been received. Plan is not obligated to pay claims received after this one hundred eighty (180) day period except where the Covered Member did not provide identification.

The Facility or Professional Provider shall not bill, collect or attempt to collect from Covered Member for claims received after the applicable period regardless of whether Plan pays such claims.

**Mailing Addresses for Hardcopy Claims**

| Claims for Covered Individuals of all products may be mailed to or check the back of the insurance card for the correct mailing address for hard copy claim submissions. | Blue Cross Blue Shield of Georgia  
P. O. Box 9907  
Columbus, GA 31908-6007 |
|---|---|
| University System of Georgia | Blue Cross and Blue Shield of Georgia  
PO Box 9907  
Columbus, Ga. 31908 |
| State Health Benefit Plan | Health Benefit Plan  
(USG Health Benefit Plan)  
University System of Georgia  
PO Box 7728  
Columbus, GA 31908 |
| | Indemnity/PPO  
(for all non-Rx claims, medical and behavioral) |
SPECIAL BILLING SITUATIONS (INPATIENT)

Maternity Claims

- **Blue Cross and FEP** – File both mother and baby charges on the same claim if the baby is a well baby. If the baby is sick then two claims should be submitted. One for the mother’s charges and a separate one for the baby from the date of birth.

- **State Health Benefits** – Always file two separate claims for mother and baby.

Blue Cross, FEP and Medicare

Blue Cross and FEP are primary in those cases when a patient has Medicare if the patient covered is enrolled on an active group policy. There are situations when Blue Cross would be secondary to Medicare. One would be if the patient is covered on a retired Blue Cross group policy. When secondary, Blue Cross will pay Part A and Part B deductibles, coinsurance, and lifetime reserve days.

It must be indicated on the claim that the patient has Medicare. (Note: if a claim is received for a patient over 65 and there is no indication whether or not the patient has Medicare, the hospital/subscriber will be contacted for verification.)

It must be indicated what charges are due. This may be accomplished by attaching a copy of the remittance where Medicare has made payment. If the hospital submits claims electronically, the amount due must be indicated.

Split Billing for Federal Employees Program

The FEP program requires that all inpatient stays exceeding 30 days be split billed every 30 days. (Note: if the inpatient stay is 31 days, it will not be necessary to split bill.) The initial claim must be billed within 45 days of the admission and each subsequent bill every 30 days. If the stay carries over from one year into the next, all charges incurred in the first year should be on the claim.

Example: Date of service 12/1/05 – 1/15/06
1\textsuperscript{st} bill date of service should equal 12/1/05 – 12/31/05
2\textsuperscript{nd} bill date of service should equal 1/1/06 – 1/15/06

Split Billing – Year End Claims
The following lines of Blue Cross and Blue Shield of Georgia business require services that span two years to be split into separate claims for each year of service:
1. State Health Benefit Plan
2. Federal Employees Program (FEP)
3. All Out-of-State Blue Cross Blue Shield Plans

Collecting Payment from Members
Under their membership agreements, BCBSGA/BCBSHP members and guest members may be responsible for paying some portion of the bill for health care services rendered by network facilities. Members may be responsible for any of the following: emergency room copays, deductibles, coinsurance, and non-covered services.
- Emergency Room Copayment – a fixed payment made by member at the time a service is rendered.
- Deductibles – a fixed dollar amount that members must pay out of pocket for covered services before the Plan will pay benefits.
- Coinsurance – coinsurance is usually a fixed percentage of the allowed charges for covered services.
- Non-covered Services – a service not covered under the terms of the Membership Agreement. BCBSGA/BCBSHP members are responsible for payment for services that are not covered under their Membership Agreement.

If possible, BCBSGA/BCBSHP members should pay their emergency room copayments at the time services are rendered, keeping in line with EMTALA regulations. The member ID card will indicate if the member’s coverage includes an emergency room copayment. BCBSGA/BCBSHP facilities should bill members for deductibles, coinsurance amounts and non-covered services after BCBSGA/BCBSHP has adjudicated a claim for services and determined true member liabilities based on the member’s benefit agreement and the terms of the provider’s agreement with BCBSGA/BCBSHP. Providers will receive a remittance advice reporting Plan payment for services and amounts billable to the member. Members should not be billed for charges associated with those services that do not appear as member liability on the remittance advice. Providers should call the Dedicated Facility help line or customer care department with any questions regarding Plan payment or member liabilities.

Reimbursement
The Hospital Agreements for each network the Hospital belongs to establish a network to service BCBSGA/BCBSHP members. The Participating Hospital Agreement (Prudent buyer Program) covers services rendered to indemnity members. The Hospital Agreement for Preferred Provider Organization covers services rendered to Blue Choice PPO members including FEP members. Blue Choice HMO and Blue Choice POS services are covered by the Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. Hospital Agreement.

In the event that a hospital which is not participating in the HMO/POS network renders services to an HMO/POS member, the hospital will be reimbursed at their current Participating Hospital Agreement (Prudent Buyer Program) rates.

Payment methods include but are not limited to but include:
- Per Diem rates
- Global Case rates
- Per visit rates
- Diagnosis related Groupers (DRGs)
• Surgical Categories (SCs)
• Negotiated fee schedules

NOTE: Covered Individuals may not be billed for the difference between the provider's charges and contracted amount.

Coordination of Benefits
If the member's BCBSGA/BCBSHP coverage is secondary to some other primary insurance, BCBSGA/BCBSHP will coordinate the payment of benefits with the primary carrier's payment according to the following guidelines:

1. Coordinating Benefits with Other Health Plans – If a member or his/her eligible dependents have duplicate coverage under another BCBSGA group program, any other group medical expense coverage, or any local, state or governmental program (except school accident insurance coverage and Medicaid), then BCBSGA/BCBSHP benefits will be coordinated with the benefits payable under the other program. The total benefits paid by both programs will not exceed 100% of the provider’s eligible (contracted) reimbursement amount.

2. Automobile Insurance – Benefits available through automobile insurance coverage will be determined before that of any other program.

3. Non-dependent/Dependent – The benefits of the program which cover the person as an employee are determined before those of the program which covers the person as a dependent.

4. Dependent Child/Parents not separated or divorced – Except as stated below, when the BCBSGA/BCBSHP program and another program cover the same child as a dependent of different persons, called “parents”:
   • The Birthday Rule - the benefits of the program of the parent whose birthday falls earlier in a year are determined before those of the program of the parent whose birthday is later in the year.
   • If both parents have the same birthday, the benefits of the program that covered the parent longer are determined before those of the program, which covered the other parent for a shorter period of time.

   However, if the other program does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the programs do not agree on the order of benefits, the rule in the other program will determine the order of benefits.

5. Dependent Child/Parents Separated or Divorced – If two or more programs cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   • First, the program of the parent with custody of the child,
   • Second, the program of the spouse of the parent with custody of the child; and
   • Finally, the program of the parent not having custody of the child. However, if the specific terms of the court decree state that one of the parents is responsible for the child’s health care expenses and the company obligated to pay or provide the benefits of the program is determined first. This paragraph does not apply with respect to any Claim Determination Period or program year during which benefits are actually paid or provided before the company has that actual knowledge.

6. Joint Custody – If the specific terms of a court decree state that the parents shall have joint custody, without stating that one of the parents is responsible for the health care expenses
of the child, the programs covering the child shall follow the order of benefit determination rules outlined above for “Dependent Child/Parents not Separated or Divorced”.

7. Active/Inactive Employee – The benefits of a program that covers a person as an employee who is neither laid off nor retired (or as that employee’s dependent) are determined before those of a program that covers that person as a laid-off or retired employee (or as that employee’s dependent). If the other program does not have this rule, and if, as a result, the programs do not agree on the order of benefits, this rule is ignored.

- Longer/Shorter Length of Coverage – If none of the above rules determines the order of benefits, the benefits of the program which covered an employee or member for a longer time are determined before those of the program that covered that person for the shorter time.

PROVIDER COMPLAINT AND APPEALS PROCESS

Appeals are formal requests, either written or oral, expressing dissatisfaction with a decision not to certify an admission, requesting an extension of a Covered member’s stay, or other health care procedures or services.

Appeals can be initiated by the facility, Covered Member, or the physician. Decisions are generally made within thirty (30) business days after receipt of required/supporting documentation.

The Practitioner/Provider complaint and appeal process establishes the processes and structure by which BCBSGa participating providers can pursue resolution for issues related to administrative and contractual determinations and defines how these issues will be investigated and resolved. The Practitioner/Provider shall be deemed to have waived all rights to disputed payment if not addressed within 365 days of receipt of payment.

For all network practitioners and providers, BCBSGa provides a formal process of handling complaints concerning:

- Administrative procedures and processes, such as claims payments, reimbursements, lack of pre-authorization, etc.
- Contractual disputes, such as timeliness of filing or contract language interpretation.
- These issues are unrelated to utilization management complaints and appeals.

Inquiry

A practitioner or provider may voice concern or dissatisfaction with an issue by calling Customer Service at 1-800-241-7475 from 7 AM to 7 PM weekdays. A customer service representative will either verbally or in writing communicate a response to the provider.

Complaint

If the provider remains dissatisfied after receiving the initial decision, a complaint may by sending a cover letter outlining the issue with supporting documentation. If the complaint is 10 pages or fewer, the complaint can be faxed to 1-877-868-7950. Longer documents can be mailed to:

BCBSGa
Attn: Provider Appeals
P.O. Box 9907
Columbus, GA 31908
A complaint decision will be sent to the provider in writing within 30 calendar days of receipt.

**First Level Appeal**
For an appeal request to be considered, the provider must include documentation about extenuating circumstances or new information. To file an appeal, the practitioner will:
- Submit a formal written request for an appeal
- Include any substantiating documentation that was not previously reviewed
- Send the document either by fax or mail as outlined above
- When all information is received from the provider, the Practitioner and Provider Rights Committee will complete its review and notify the provider of the decision within 30 calendar days. In the event the provider remains dissatisfied, the resolution letter will include instructions to initiate a second level appeal.

**Second Level Appeal**
The practitioner or provider will:
- Submit a formal written request for a second level appeal
- Include any substantiating documentation not previously reviewed
- Submit the document either by fax or mail as outlined above

Within 30 calendar days of receiving the provider's written account, the Second Level Appeals Committee will complete its review and notify the provider in writing of its decision in which this decision of the Second Level Appeals Committee is final and binding for all parties.

**NOTE**: Complaints and appeals submitted by a provider on behalf of a Covered Individual (with the Covered Individual's consent when there is Covered Individual liability) will be considered a Covered Individual complaint.
INTRODUCTION
In 1999, the Georgia Department of Community Health (DCH) became the lead agency for health care planning and purchasing issues in the state of Georgia. The General Assembly created DCH by consolidating four agencies involved in purchasing, planning and regulating health care. DCH administers the State Health Benefit Plan (SHBP). As of April 2013, SHBP provides health coverage for approximately 826,490 members and dependents.

DCH is governed by the Board of Community Health. The Board is comprised of nine people who have policy-making authority for the Department. Board members are appointed by the Governor and confirmed by the State Senate.

Mission Statement
ACCESS to affordable, quality health care in our communities
RESPONSIBLE health planning and use of health care resources
HEALTHY behaviors and improved health outcomes

The State Health Benefit Plan (SHBP) provides health insurance coverage to state employees, teachers, retirees and dependents. Teachers and school personnel represent 72 percent and retirees comprise about 18 percent of the covered lives. The Department of Community Health’s Public Employee Health Benefit Division is responsible for the day-to-day operation.

SHBP is a self-insured plan, with the exception of fully insured HMO options. The plan is funded by employer and employee contributions. There is no insurance company or service plan that collects premiums and assumes risk. Instead, the State assumes the risk and funds the Plan using the tax dollars collected by the State.

Blue Cross Blue Shield GA is the claim administrator and pays most claims for SHBP PPO and HMO. BCBSGA also offers their HMO product to state employees.

BCBSGA continues to administer benefits for BC University Systems, PPO and Indemnity.

Coverage options available under the SHBP include HRA, HDHP, and HMO with United Healthcare and Cigna.

ELIGIBILITY
Eligibility includes full-time employees of the State of Georgia, the General Assembly, or an agency, board, commission, department, county administration or contracting employer that participates in the SHBP. Also eligible are:
- Certified public school teachers or library employees
- Non-certified service employees of a local school
- Employees who are eligible to participate in the Public School Employees’ Retirement System
- State University Employees and dependents
- A retired employee of one of these listed groups.

Eligible Dependents
- Spouse - Your legally married spouse, as defined by Georgia Law.
- Dependent Child –
  - Natural child – A natural child for which the natural guardian has not relinquished all guardianship rights through a judicial decree. Eligibility begins at birth and ends at the end of the month in which the child reaches age twenty-six (26).
• **Adopted child** – Eligibility begins on the date of legal placement for adoption and ends at the end of the month in which the child reaches age twenty-six (26).

• **Stepchild** – Eligibility begins on the date of marriage to the natural parent. Eligibility ends at the end of the month in which the child reaches age twenty-six (26), or at the end of the month in which the stepchild loses his or her status as stepchild of the Enrolled Member, whichever is earlier.

• **Guardianship** – A child for whom the Enrolled Member is the legal guardian. Eligibility begins on the date the legal guardianship is established. Eligibility ends at the end of the month in which the child reaches age twenty-six (26), or at the end of the month in which the legal guardianship terminates, whichever is earlier. Certification documentation requirements are at the discretion of the Administrator. However, a judicial decree from a court of competent jurisdiction is required unless the Administrator concludes that documentation is satisfactory to establish legal guardianship and that other legal paper present undue hardship on the Member or living natural parent(s).

• **Totally Disabled Child** – A natural child, legally adopted child or stepchild age twenty-six (26) or older, if the child was physically or mentally disabled before age twenty-six (26), continues to be physically or mentally disabled, lives with the Enrolled Member or is institutionalized, and depends primarily on the Enrolled Member for support and maintenance.

**INELIGIBLE DEPENDENTS**

SHBP dependent coverage DOES NOT include:

- Former spouse
- Fiancé
- Parents
- Married or formerly married children
- Children age 19 or older who do not qualify as full-time students or disabled dependents
- Children 26 or older who are not already covered as a disabled dependent
- Children in military service
- Grandchildren who cannot be considered eligible dependents
- Stepchildren who do not live in employees home at least 180 days per year
- Anyone living in employee’s home that is not related by marriage or birth, unless otherwise noted.

**Qualifying Events**

Qualifying events include, but not limited to:

- Birth or adoption of a child
- Change in residence by you, your spouse or dependents resulting in ineligibility in the selected option due to location
- Death of a spouse or child, if the only dependent enrolled
- Your spouse’s or dependent’s loss of eligibility for other group health coverage
- Marriage or divorce
- Medicare eligibility

Request is to be made to SHBP within 31 days of the qualifying event.

For a complete description of qualifying events, contact the Eligibility Unit at 1-800-610-1863 or in Atlanta at 404-656-6322.
PLAN OPTIONS
Health Reimbursement Arrangement (HRA)
Choice Fund HRA (Cigna)

A Consumer Driven Health Plan option (CDHP) designed to offer a different approach for managing health care needs. This plan is similar to the OPA with both in-network and out-of-network benefits, except SHBP funds dollar credits to your HRA each year providing first dollar coverage for eligible health care and pharmacy expenses. Any unused HRA dollars roll over to the next Plan year if you are still participating in this option. Unused HRA dollars will be forfeited if you change options during Open Enrollment or due to a qualifying event. Unused HRA dollars can be taken into retirement. Plan features include:

- Unlimited wellness benefits based on age and gender when using in-network providers only
- Available HRA dollar credits used only with the HRA option
- The amount in your HRA reduces your deductible and maximum out-of-pocket
- No separate deductible and out-of-pocket maximum for out-of-network expenses
- After deductible is satisfied, you will pay your coinsurance amount until you reach your out-of-pocket maximum
- Certain drug costs are waived if SHBP is primary and you participate in one of the Disease State Management Programs (DSM) for Asthma, Coronary Artery Disease and/or Asthma

Health Maintenance Organization (HMO)

An HMO allows you to obtain benefits from participating providers only and does not require selection of a Primary Care Physician (PCP). HMOs provide 100 percent benefit coverage for preventive health care needs after applicable co-payments are paid. Certain services are subject to a deductible and co-insurance. Plan features include:

- Both Cigna and BCBSGA provide a national network and services are paid at the same benefit levels when using network providers outside of Georgia.
- No referral is required to see a specialist; however, you are encouraged to select a PCP for the coordination of your health care.
- Coverage is available only when using in-network providers except in cases of emergency
- Co-payments do not apply toward your deductible or out-of-pocket maximum

High Deductible Health Plan (HDHP)

The HDHP Plan is a consumer driven health option with in-network and out-of-network benefits. In return for a low monthly premium, a high deductible must be satisfied that applies to all health care expenses except preventive care. You must meet the entire family deductible before benefits are payable for any family member. You pay co-insurance after satisfying the deductible rather than set dollar co-payments for medical expenses and prescription drugs. You may also qualify to start a Health Savings Account (HSA) to set aside tax-free dollars to pay for current or future eligible health care expense. HSAs typically earn interest and may offer investment options. Plan features include:

- 100% unlimited wellness benefits based on national age and gender guidelines
• A separate in-network and out-of-network deductible and out-of-pocket maximum must be satisfied
• Co-insurance is paid after meeting the entire family deductible for all medical expenses and prescriptions
• This plan is not creditable so if you don’t sign up for Medicare upon eligibility, you may be charged a late enrollment penalty

**Tobacco and Spousal Surcharges**
The $50 monthly Spousal Surcharge applies to members whose spouses are eligible for coverage through their employer but elect not to take the coverage. The $80 Tobacco Surcharge applies to any member and/or any covered dependents that use or have used tobacco products within the last 12 months. This surcharge is designed to encourage tobacco users to encourage tobacco users to adopt a healthier lifestyle. Smoking cessation classes are offered to members and dependents who want to stop using tobacco products.

Members must go online each year and answer surcharge questions during Open Enrollment. Those who fail to answer these questions will be automatically assessed the applicable surcharges excluding retirees.

**Medicare Advantage**
Medicare Advantage PPO – Retirees and their spouses age 65 and older enrolled in Medicare Part B.

Retirees may elect to change options only during the annual retiree option change period or when they become eligible for Medicare. Retirees under age 65 have the same options as active members. Retirees and/or their spouses that are at least age 65 may select from any SHBP option, however they will only receive the state contribution toward the cost of their premiums if they enroll in one of the Medicare Advantage PPO options. Retirees who drop the coverage may not pick up the coverage at a later date. Retirees can only add dependents if they experience a qualifying event. [dch.georgia.gov](http://dch.georgia.gov)

Retirees may choose from one of two Medicare Advantage (MA) PPO options:
- Humana Group Medicare Advantage PPO Standard
- Humana Group Medicare Advantage PPO Premium

**REQUESTING CLAIM CORRECTIONS**
You may request claim corrections for routine or clerical errors by mailing or faxing a corrected claim form and supporting documentation, if needed, to Member Services. The deadline to request claim corrections is one year from the date of your EOB or re-filing online at [www.bcbsga.com](http://www.bcbsga.com).

**CLAIM INQUIRIES**
When inquiring about claims that have been filed, please give the following information:
- Employee’s Name
- Member Number
- Provider of Service name and TIN Number
- Provider of Service telephone number
- Date of Service
LIMITATIONS
Facility claims must be filed within 90 days from the date of discharge if SHBP is primary

PRIOR NOTIFICATION UNITED HEALTHCARE
Prior Notification is required before you receive certain Covered Health Services. In general, Network providers are responsible for notifying United Healthcare before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying United Healthcare.

Call Care Coordination at 1-800-955-7976 for Prior Notification on the following services:

• Dental Services/ Oral Care Surgery
• Durable Medical Equipment over $1,000
• Home Health Care
• Hospice
• Hospital – Inpatient Stay
• Maternity Care more than time frame allowed
• Mental Health Substance Use Disorder treatment
• Non-Network Services **
• Prosthetic Devices
• Reconstructive Procedures
• Transplantation Services

**Any Covered Non-Network Services on the above list requires Prior Notification by the Member

A Non-Notification penalty of 50% of Eligible Expenses will apply to Covered Non-Network Services listed above and is the Member’s Responsibility.

For example, if billed charges are $150 and eligible expenses are $130, the 50% penalty will apply to the $130. The amount reimbursed at the 60% will be $65. The balance billed amount of $20, penalty of $65, and 40% ($26) which is member’s co-insurance amount will be the Member’s Responsibility.

A Non-Notification penalty does not apply to the Out-of-Pocket maximum.

SPLIT BILLING FOR OVERLAPPING YEAR-END CLAIMS
Claims spanning calendar years are required to be split billed. Claims received with year-end overlapping dates will be returned to the hospitals. For example, a hospital stay with December through January charges requires that the claim be separated by year of service and filed separately.

PSYCHIATRIC PROFESSIONAL FEES
All professional fees for psychiatric admission must be filed on a CMS (formerly HCFA) 1500 form and be authorized through the United Behavior Health Services (BHS) Programs. Inpatient and outpatient visits are limited and can only be processed for correct benefits by filing claims submissions utilizing the HCFA 1500 form.
MATERNITY CLAIMS
Mother and baby charges must always be submitted on two separate claims. The State Health individual deductibles, coinsurance amounts and maximums are applied on the baby’s charges, as well as the mother’s charges.

SHBP complies with the Newborns’ and Mothers’ Health Protection Act of 1996 that created minimum lengths of inpatient Hospital care that must be covered for mothers and newborn children under group or individual health plans. The minimum length of stay is 48 hours of inpatient care following normal delivery and 96 hours for cesarean section.

COB (COORDINATION OF BENEFIT) INFORMATION
When SHBP benefits are coordinated, the Plan does not pay more than 100% of the Plan’s Allowed Amount. Non-Covered Services or items, penalties and amounts Balanced Billed are not part of the Allowed Amount and are the Subscriber’s responsibility.

COB does not apply to an individual policy – one for which the member pays the total premium directly to the insurer.

If the 90-day timely filing limit is approaching and you have not received an EOB from the primary plan, submit your claim(s) to the Plan without the EOB prior to the deadline. When you receive the EOB, send it to the Plan for processing, even if the deadline has passed.

ELIGIBILITY APPEALS
If a request for Plan benefits is denied, either totally or partially, you will receive a notice of denial either electronically or in writing – or, in the case of Urgent Care, notice is verbal and then followed by an electronic or written notification. This “adverse benefit determination” includes Precertification decisions, denials based on a person’s ineligibility or benefits, and findings that a service or supply is experimental or is not Medically Necessary or appropriate. The appeal process has three steps, which must be taken in this order:

- Telephone Review (within 90 days of denial)
- Administrative Review (within 180 days of original denial)
- Formal Appeal (within 60 days of Administrative Review denial)

Please forward all written requests for Eligibility Administrative Review - Appeals along with completed appeal forms to:

State Health Benefit Plan
Membership Correspondence Unit
P.O. Box 1990
Atlanta, GA 30303-1990

All member correspondence sent to the Plan should include the enrolled member’s Social Security Number (SSN) to prevent a delay in processing the request.

These are specific items that may not be appealed to the Plan:
- A Medical Necessity determination made by the MCP (Medical Certification Program), BHS (Behavior Health Services) or Prescription Drug Program clinicians,
• The Plan’s method of establishing Allowed Amounts,
• A cutback in Allowed Amounts of $150 or less,
• Any excluded service or expense,
• Administrative reviews and formal appeals received after their respective deadlines and
• At the formal appeal level, a denied claim of $150 or less.

OUTPATIENT BEHAVIORAL HEALTH
Claims exceeding $15,000.00 are subject to either charge or DRG audit. Any DRG paid claim is also subject to audits regardless of the total charge.

Contact: Bettye Reed
State Health Benefit Plan
PO Box 38151
Atlanta, GA 30334

LEGAL NOTICES

Women’s Health and Cancer Rights Act
The Plan complies with the Women’s Health and Cancer Rights Act of 1998. Mastectomy, including Reconstructive Surgery, is covered the same as other surgery under your plan option.

Following cancer surgery, the SHBP covers:
• All stages of reconstruction of the breast on which the mastectomy has been performed
• Reconstruction of the other breast to achieve a symmetrical appearance
• Prostheses and mastectomy bras
• Treatment of physical complications of mastectomy, including lymph edema

Note: Reconstructive surgery requires prior approval, and all inpatient admissions require prior notification

Newborns’ and Mothers’ Health Protection Act
The Plan complies with the Newborns’ and Mothers’ Health Protection Act of 1996. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Experimental and Investigative Care
The Plan does not cover procedures or supplies that are experimental, investigative or intended primarily for research. Generally, experimental/investigative care is any procedure, treatment, supply, device, equipment, facility or drug (all services) determined to not:
• Have final approval from the appropriate government regulatory body;
• Have the scientific evidence, which permits conclusions concerning the effect of the technology on health outcomes;
• Improve the net health outcome;
• Be as beneficial as any established alternative; or
• Show improvement outside the investigational setting.

Effective June 2002, the Plan began covering procedures and supplies associated with cancer clinical trials that meet guidelines established by the Georgia Cancer Coalition Agreement.
Section 2.3.C - TRICARE

What Is Tricare?
TRICARE (formerly called CHAMPUS) is the Department of Defense’s worldwide health care program available to eligible beneficiaries in any of the seven uniformed services—-the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, Commissioned Corps of the U.S. Public Health Service and the Commissioned Corps of the National Oceanic and Atmospheric Administration. TRICARE is managed in three stateside regions—-TRICARE North, TRICARE South, and TRICARE West. TRICARE Management Activity (TMA) and TRICARE Regional Offices jointly manage TRICARE in these regions.

The South Region is administered by Humana Military Healthcare Services, Inc. for more than 2.8 million individuals including Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee and Texas with the exclusion of the Ft. Campbell area in Tennessee and the El Paso area in Texas.

TRICARE provides eligible beneficiaries the freedom to choose how their healthcare will be delivered by offering the following program options:


TRICARE Program Options

TRICARE PRIME
Enrollment plan similar to a Health Maintenance Organization (HMO). TRICARE Prime is available in the North, South and West Regions in areas known as Prime Service Areas to all beneficiaries who are not entitled to Medicare due to age (65). Enrollment is required to participate in TRICARE Prime.

In most cases, the TRICARE Prime enrollment fees are not refundable. There are no enrollment fees for active duty service members and active duty family members (or for survivors during the transitional survivor period following the active duty service member’s death) enrolled in TRICARE Prime. Retired service members, their families, survivors, eligible former spouses, and others enrolled in TRICARE Prime are required to pay an annual enrollment fee ($230 per individual or $460 per family). There is no copayment for outpatient services for Active Duty members and their families. Enrollees select a primary care manager who coordinates their healthcare; to include referral and/or prior authorization to receive nonemergency care from another provider. Active duty service member coverage begins on the date the enrollment application is received. Otherwise, as long as a completed enrollment application is received by a regional contractor by the 20th of the month, coverage will begin on the first day of the next month. The application must be received by the 20th of the month, not postmarked by the 20th of the month. If the form is received after the 20th of the month, then coverage begins on the first day of the second month following receipt of your application.
TRICARE PRIME REMOTE (TPR) and
TRICARE PRIME REMOTE FOR ACTIVE DUTY FAMILY MEMBERS (TPRADFM)
These two program options provide coverage to active duty service members and their families who live in remote locations through a network of civilian TRICARE authorized providers. Eligibility to these programs require that active members and families who live and work more than 50 miles or a one-hour drive time from the nearest military treatment facility designated as adequate to provide primary care.

There are no enrollment fees for active duty service members and active duty family members (or for survivors during the transitional survivor period following the active duty service member’s death) enrolled in TRICARE Prime Remote or TRICARE Prime Remote for Active Duty Family Members. There is no copayment for outpatient services for Active Duty members and their families. Each enrollee is assigned or may select a PCM. Whenever possible, A TRICARE network primary care manager is assigned, but a non-network may be assigned if a network provider is not available. In most cases, an enrollee must obtain a referral and/or prior authorization to receive nonemergency care from another provider.

TRICARE POINT OF SERVICE (POS)
The point-of-service (POS) option allows non-active duty service members enrolled in TRICARE Prime, Prime Remote and Prime Remote for Active Duty Family Members to receive nonemergency care from any TRICARE-authorized provider without requesting a referral from your primary care manager, resulting in higher out-of-pocket costs. The POS deductible applies only to outpatient services, and the cost-share applies to both inpatient and outpatient care. Out-of-pocket expenses you pay under the POS option are not applied to your annual catastrophic cap. The POS option is not available to active duty service members and does not apply to newborns or newly adopted children in the first 60 days after birth or adoption, emergency care, or if you have other health insurance. When using the POS option, beneficiaries must pay a deductible and 50% of the TRICARE allowable charge.

TRICARE STANDARD AND TRICARE EXTRA
TRICARE Standard and Extra is a fee-for-service plan available to all non-active duty beneficiaries throughout the United States. Enrollment is not required. Coverage is automatic as long as your information is current in the Defense Enrollment Eligibility Reporting System.

Any TRICARE-authorized provider, network or non-network may be accessed with either of these options. Care at a military treatment facility is on a space-available basis only. No referral is required for any type of care, but some services may require prior authorization. The type of provider seen determines which option is utilized and how pay out-of-pocket expense is expected. If a non-network provider is selected, the Standard option is used. If a network provider is selected, the Extra option is used. By using the Extra option, less out of pocket is paid and the provider will file the claims.
TRICARE FOR LIFE
TRICARE for Life (TFL) is TRICARE’s Medicare-wraparound coverage available to all Medicare-eligible TRICARE beneficiaries, regardless of age or place of residence, provided they have Medicare Parts A and B. While Medicare is the primary insurance, TRICARE acts as the secondary payer minimizing out-of-pocket expenses. TRICARE benefits include covering Medicare’s coinsurance and deductible. Basically, if a Medicare participating or non-participating provider is used, the provider will file the claims with Medicare. Medicare pays its portion and electronically forwards the claim to the Tricare for Life claims processor who pays the provider directly for TRICARE-covered services.

- For services covered by both Medicare and TRICARE, Medicare pays first and TFL pays your remaining coinsurance for TRICARE-covered services.
- For services covered by TRICARE but not by Medicare, TFL pays first and Medicare pays nothing. You must pay the TRICARE fiscal year deductible and cost shares.
- For services covered by Medicare but not by TRICARE, Medicare pays first and TFL pays nothing. You must pay the Medicare deductible and coinsurance.
- For services not covered by Medicare or TRICARE, Medicare and TRICARE pay nothing and you must pay the entire bill.

When using Tricare for Life, the beneficiary doesn’t pay any enrollment fees, but must pay Medicare Part B monthly premiums which are based on income. For more information about Part B premiums visit www.medicare.gov or call Social Security at 1-800-772-1213 (TTY: 1-800-325-0778).

DEERS, ID Cards and Eligibility
http://www.tricare.mil/mybenefit/home/overview/Eligibility/DEERS/Updating?

Active duty and retired military sponsors, eligible family members and all other eligible beneficiaries must be entered into the Defense Enrollment Eligibility Reporting System (DEERS) to show eligibility for TRICARE benefits. It is the sponsor’s responsibility to make sure that his or her eligible family members are enrolled in DEERS, which can be done through the personnel office or at the nearest Uniformed Services ID Card issuing facility. All sponsors should ensure that their family member’s status (marriage, divorce, new child, etc.), residential address, telephone numbers and email are current in the DEERS files so TRICARE can send out information and claims processed quickly and accurately. Family members can update personal information such as addresses and phone numbers once they are registered in DEERS.

Note: Addresses must be a physical address; P.O. boxes cannot be used. Additionally, if both parents are service members, then either parent (must choose one) may be listed as the Child (ren)’s sponsor in DEERS

Providers must verify TRICARE eligibility at the time of service and must ensure beneficiaries have valid Common Access Cards (CACs), uniformed services ID cards or eligibility authorization letters. The sponsor’s Social Security number is used to verify eligibility.
Note: In response to a growing need to protect the identification information of beneficiaries, Social Security numbers are being removed from the Department of Defense ID cards. Although SSNs are being removed, TRICARE continues to base all operations on the sponsor’s SSN. This removal process has three phases and changes are made when beneficiaries renew their ID cards.

- Phase 1 (2008) affects family member ID cards
- Phase 2 (2009) removes all printed SSNs
- Phase 3 (2012) removes SSN information embedded in barcodes

Providers may not verify TRICARE enrollment directly in DEERS because of the Privacy Act (Title 5, United States Code, Section 552a), but can log on to “MyHMHS for Providers” portal at www.humana-military.com or by contacting Humana Military Healthcare Services at 1-800-444-5445 to confirm eligibility.

Beneficiaries can verify eligibility in DEERS by calling 1-800-538-9552.

**SPECIAL NOTE FOR NEWBORN CHILDREN**

Newborns should be enrolled in DEERS as soon as possible to establish eligibility for TRICARE benefits and to ensure claims are not denied because of non-enrollment.

The following must be submitted to an ID card office:

- An original or certified-copy of the birth certificate or certificate of live birth (signed by the attending physician or other responsible person from a U.S. hospital or military treatment facility), or consular report of birth (FS-240) for children overseas;
- A record of adoption or a letter of placement of the child into the home by a recognized placement/adoption agency or the court before the final adoption; and
- An Application for Uniformed Services Identification Card and DEERS Enrollment (DD Form 1172) signed by the sponsor and verifying official from a uniformed services identification (ID) card-issuing facility. If the sponsor can’t sign the DD Form 1172 in person at an ID card facility, then a notarized copy of the form is required. The spouse must submit presentation of a power of attorney if the sponsor didn’t sign the DD Form 1172.

Parents can apply for a child’s Social Security number (SSN) on the Social Security Administration Website, or by calling 1-800-772-1213. Once the child's SSN is received, their DEERS information must be updated.

If any family member is enrolled in Prime, TRICARE Prime covers the following:

- Newborns for 60 days beginning from the date of birth;
- Adopted children for 60 days beginning from the effective date of the actual adoption; and
- Pre-adoptive children for 60 days beginning on the date of placement of the court or approved adoption agency.

To continue Prime coverage past the first 60 days, the newborn or adoptee must be enrolled in either TRICARE Prime or TRICARE Prime Remote within the 60-day window. On the 61st day
and after, if the child isn't enrolled, TRICARE processes all future claims under TRICARE Standard and Extra (higher costs) until the child is enrolled.

**Note:** To give parents overseas sufficient time to meet all TRICARE overseas eligibility requirements for newborns, the enrollment period for TRICARE Prime and TRICARE Prime Remote Overseas is 120 days. The child loses TRICARE eligibility after 365 days unless they are enrolled in DEERS

### ELIGIBILITY VERIFICATION
To verify eligibility, log into Humana Military’s secure “MyHMHS for Providers” portal at [www.humana-military.com](http://www.humana-military.com) or by calling 1-800-444-5445. The sponsor’s Social Security number is used to verify eligibility.

A valid Common Access card (CAC), Uniformed Services Identification Card (ID), valid ID photo with a copy of the sponsor’s activation orders (activated for more than 30 consecutive days) or eligible authorization letter is required to establish eligibility. However, children under age 10 are not normally issued ID cards. Their eligibility is established on the basis of either parent’s ID card.

The Uniformed Services ID card incorporates a digital phone of the bearer, barcodes and printed ID and entitlement information. The ID card’s color determines the beneficiary’s category.

- Active duty family members (ADFMs): DD Form 1173 – tan
- National Guard and Reserve family members: DD Form 1173-1 – red
- Retirees: DD Form 2 [RET] – blue
- Retiree dependents: DD Form 1173 – tan
- Transitional Assistance Management Program (TAMP) beneficiaries: DD Form 2765 – tan

**ID Cards include:**
- Last 4 digits of SSN or sponsor SSN
- Expiration Date: Should read “INDEF” (indefinite) for retirees. If expired, beneficiary must update in DEERS and obtain a new card.
- Civilian: The center section should read “YES” under the box titled “CIVILIAN”.

The categories of individuals eligible for TRICARE benefits are:

- Members of the Uniformed Services receiving or entitled to receive retired, retainer, or equivalent pay based on duty in the service
- Spouses of active duty members
- Children of active duty members (see note below)
- Spouses of retirees of the Uniformed Services
- Children of retirees (see note below)
- Un-remarried widowers and widows of deceased active duty members and deceased retirees
- Children of deceased active duty members and deceased retirees (see note below)
- Ex-spouses who have valid ID cards.
Note: To be eligible, children must be un-remarried and under the age of 21 (age 18 for CHAMPVA). Financial dependence is not required except for students and disabled children who have passed their 18th or 21st birthday.

The following persons are not eligible for TRICARE:
- Persons not enrolled in the Defense Enrollment Eligibility Reporting System (DEERS).
- Persons entitled to Medicare Part A, who do not have Medicare Part B coverage, except for the following individuals:
  - Family members of active duty service members: *Medicare Part B not required until the sponsor retires*
  - Beneficiaries enrolled in the US Family Health Plan: *Medicare Part B not required for US Family Health Plan enrollment. But, if you disenroll from the US Family Health Plan, you must have Medicare Part B to be eligible for any other TRICARE benefits.*

Persons who are eligible for benefits under Civilian Health and Medical Program of the Department

**Loss of Eligibility**
Each member of beneficiary’s family will automatically receive a certificate of creditable coverage upon loss of TRICARE which serves as evidence of prior coverage under TRICARE, so that beneficiary and dependents cannot be excluded from a new health plan for pre-existing conditions.

All individuals permanently losing TRICARE eligibility has the option to purchase temporary health care coverage through the Continued Health Care Benefit Program (CHCBP).

The following are some of the reasons eligibility for TRICARE may end for an individual:

1. **Sponsor Separates from Active Duty**
   Separation from active duty means the individual "gets out" of the military before retiring. The member and family may qualify for transitional health benefits under the Transitional Assistance Management Program (TAMP) in some cases.

2. **Beneficiary Becomes Entitled to Medicare Part A, but does not Purchase Medicare Part B**
   If beneficiary is receiving Social Security disability benefits, beneficiary becomes entitled to Medicare Part A beginning the 25th month of receiving Social Security disability payments. Beneficiary is notified by the Social Security Administration of the entitlement start date. If beneficiary does not purchase Medicare Part B at time of being entitled to Medicare Part A, regardless of age, eligibility for TRICARE is lost.

3. **Dependent Child Reaches Age Limit**
   If a sponsor continues to provide 50% of a child's financial support, the child remains eligible for TRICARE coverage up to age 21 or age 23 if enrolled in college as a full-time student. After "aging out" at 21 or 23 as described above, Unmarried children ages 23-26 and not eligible for their own employer sponsored health insurance may qualify for TRICARE Young Adult.

4. **Divorce**
   The former spouse loses eligibility for TRICARE unless he or she meets specific requirements to maintain eligibility as a former spouse.
5. Surviving Spouse, Widow, or Former Spouse Remarries
   If a widow, surviving spouse or eligible former spouse remarries, TRICARE eligibility is lost only if the marriage is to another TRICARE-eligible sponsor.

6. DEERS Information Not Kept Updated
   Lapsed/inaccurate DEERS information is another way to temporarily lose coverage. Coverage is restored when the information is updated in DEERS.

NOTE: If the sponsor does not properly disenroll a family member and the ineligible family member improperly continues to receive care under TRICARE, the Government is required, by law, to recoup the amount it paid for care from the party that received the care. What this means is the family is responsible for paying for the care received once the individual became ineligible. When ineligible beneficiaries improperly receive care, this may be considered fraud.

CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP)
If an individual has lost or will soon lose military health care coverage, the Continued Health Care Benefit Program (CHCBP) can protect during the interim between military health benefits and civilian health care. Individuals may apply for temporary, transitional medical coverage under the CHCBP Program which is a premium-based health care program providing medical coverage for former military beneficiaries and is not part of TRICARE. The CHCBP program began on October 1, 1994, and extends health care coverage to the following individuals:

- The Service Member (who can also enroll his or her family members)
- Certain un-remarried former spouses
- Children who lose military coverage due to age or marriage

CHCBP Basics
- **Continuous coverage:** CHCBP acts as a “bridge” between military health benefits and the new job’s medical benefits, continuous medical coverage can be received. It is a health care program intended to provide you with continuous health care coverage on a temporary basis following your loss of military benefits.

- **Pre-existing condition coverage:** CHCBP may entitle individual to coverage for preexisting conditions often not covered by a new employer's benefit plan.

- **Benefits:** The CHCBP benefits are comparable to the TRICARE Standard benefit, which covers a majority of medical conditions, uses existing TRICARE providers and follows most of the rules and procedures of TRICARE Standard. However, for some types of treatment, coverage can be limited. Prior to enrolling in CHCBP, interested beneficiaries are encouraged to contact a TRICARE Service Center to ask specific questions regarding TRICARE Standard coverage.

Enrollment and Coverage
Eligible beneficiaries must enroll in CHCBP within 60 days following the loss of entitlement to the Military Health System. To enroll, beneficiary submits:
- A completed CHCBP Enrollment Application form (DD Form 2837).
• Documentation as requested on the enrollment form, e.g., DD-214-Certificate of Release or Discharge from Active Duty; final divorce decree; DD1173-Uniformed Services ID Card. Additional information and documentation may be required to confirm an applicant’s eligibility for CHCBP.

• A premium payment for the first 90-days of health coverage.

• For enrollments with an effective date of September 30, 2010 or before, and quarterly payments to pay for periods beginning September 30, 2010 or before, the rate is $933 per quarter for individuals and $1,996 per quarter for families.

• For enrollments with an effective date of October 1, 2010 or after, and quarterly payments to pay for periods beginning October 1, 2010 and after, the rate is $988 per quarter for individuals and $2,213 per quarter for families. Humana Military Healthcare Services, Inc. will bill you for subsequent quarterly premiums through your period of eligibility once you are enrolled.

The program uses existing TRICARE providers and follows most of the rules and procedures of the TRICARE Standard program.

Depending on the beneficiary category, CHCBP coverage is limited to either 18 or 36 months. Eligibility periods are:

• 18 months for separating Service Members and their families.

• 36 months for others who are eligible (in some cases, un-remarried former spouses may continue coverage beyond 36 months if they meet certain criteria).

You may not elect the effective date of coverage under CHCBP. For all enrollees, CHCBP coverage must be effective on the day after military benefits are lost.

NON-AVAILABILITY STATEMENT (NAS)
Any beneficiary who lives within the zip code catchments area of a Uniformed Services Hospital must obtain a NAS before TRICARE will cover the cost of non-emergency inpatient care received from a civilian hospital except as noted below. It is the beneficiary’s responsibility to obtain the NAS from their local Uniformed Services Hospital. A NAS is not required if the patient has other health insurance that is primary to TRICARE. CHAMPVA beneficiaries are never required to obtain an NAS. Emergency admissions never require an NAS nor do TRICARE PRIME beneficiaries receiving in-patient care.

PRIOR AUTHORIZATION AND REFERRALS
An authorization is different from a referral. TRICARE must authorize certain medical treatments before you can receive them. The doctor who is going to provide the treatment must seek the authorization from TRICARE.
When a Primary Care Manager (PCM) cannot provide the treatment needed, he or she refers to a specialist. The PCM must then file the referral with TRICARE.

Under all TRICARE programs, no referrals or authorizations are required for beneficiaries receiving emergency care inside or outside of their TRICARE regions. However, TRICARE Prime beneficiaries must contact their primary care manager or regional contractors within 24 hours of an inpatient admission, or the next business day, to coordinate ongoing care.

Referral and Authorization Submission may be requested in one of the following ways:
1. For quickest response, submit online requests via the “MyHMHS for Providers” portal at www.humana-military.com
2. Fax a completed PRAF (Patient Referral Authorization Form) to 1-877-548-1547.
3. By phone at 1-800-444-5445
4. Contact ValueOptions for behavioral health care referrals and authorizations at 1-800-700-8646 or submit requests online via the “MyHMHS for Providers” portal at www.humana-military.com or fax a TRICARE Outpatient Treatment Report form to Value Options @ 1-866-811-4422. This form can be downloaded from www.humana-military.com
   a. Click “Provider”
   b. Click “Tools & Resources”
   c. Click “Forms”
   d. Click “Behavioral Health Related Forms”

PRIOR AUTHORIZATION LIST FOR THE SOUTH REGION

Procedures and Services
- Adjunctive dental
- Advanced life support air ambulance in conjunction with stem cell transplantation
- Bariatric surgery
- Department of Defense In-Utero Fetal Surgical Repair of Myelomeningocele Clinical Trial
- Educational interventions under the Enhanced Access to Autism Services Demonstration
- Extend Care Heath Option (ECHO) services
- Home health services, including home infusion
- Hospice
- Phase II and II cancer clinical trials
- All home health services require prior authorization from Humana Military and must be renewed every 60 days.

Inpatient Hospital Stays
- Admissions or transfers to skilled nursing facility, rehabilitation, long-term acute care
- Concurrent reviews upon request by Humana Military
- Discharge notification
- Notification of acute care admission by the next working day
• SNF admissions require authorizations when TRICARE is the primary payer.

Behavioral Health
• All nonemergency inpatient admissions for substance abuse disorder or behavioral health care and a non-enrolled beneficiary may also have to obtain a NAS (Non-availability statement). Inpatient lengths of stay limits are 30 days per FY or one any single admission for patients age 19 and older and 45 days per FY or any single admission for patients 18 and under. Waivers can be granted for medical or psychological necessity.
• Emergency care doesn’t require prior authorization, however, if the patient is admitted, the facility must report to ValueOptions within 24 hours of the admission or the next business day (but within 72 hours) to obtain authorization.
• Psychoanalysis
• Residential treatment center programs
• Outpatient therapy for Mental Health exceeding eight (8) visits per fiscal year (October 1 – September 30) must be authorized by ValueOptions at 1-866-811-4422.
• TRICARE only covers one outpatient initial evaluation (either psychiatric diagnostic exam [CPT 90801] or interactive diagnostic exam [CPT 90802]. This initial evaluation counts toward the first eight outpatient visits.

Maternity Care
Maternity care includes medical services related to prenatal care, labor and delivery and postpartum care. Care for TRICARE-eligible women begins from the first obstetric visit through six weeks after the child’s birth.

The Primary Care Manager for a pregnant beneficiary will need to refer to an obstetrician or manage the pregnancy responsible for obtaining the required prior authorizations as obstetric services require prior authorization from Humana Military. Both inpatient and outpatient services require authorization beginning with the first prenatal visit and remain valid until 42 days after birth. If the patient delivers in a civilian facility or birthing center, a separate prior authorization is required. Maternity inpatient stays require additional prior authorization. The length of stay for a normal vaginal delivery cannot be restricted to less than 48 hours and 96 hours for a cesarean section.

TRICARE’s well-child benefit (birth to age 6) covers routine newborn care, comprehensive health promotion exams, disease prevention exams, height, weight and head circumference measurement; routine immunizations, hearing and vision screenings and behavioral and developmental appraisals. Well-child preventive care visits for an eligible child include no more than nine visits in two years.

NOTE: Postpartum inpatient stay for a mother to stay with newborn primarily for breastfeeding when the infant requires extended stay or continued inpatient stay for the newborn primarily to remain with mother when the mother requires extended postpartum inpatient stay are specific excluded services by TRICARE.

Emergency Care
No referrals or authorizations are required for any TRICARE programs for beneficiaries receiving emergency care inside or outside their TRICARE regions. TRICARE Prime beneficiaries must contact their Primary Care Manager or regional contractor within 24 hours of an inpatient admission or the next business day to coordinate continued care.

INPATIENT AND OUTPATIENT REIMBURSEMENT METHODOLOGY

DRG reimbursement is a reimbursement system for inpatient charges from facilities in which a payment level to each DRG is assigned based on the average cost of treating all TRICARE beneficiaries in a given DRG. This payment system is modeled on the Medicare inpatient PPS (Prospective Payment System). As of October, 2008, TRICARE uses the TRICARE Severity DRG payment system which is modeled on the Medical Severity DRG payment system (MS-DRG). Short and/or long stay cost outliers may be reimbursed for atypical inpatient stays.

Effective for admissions on or after October 1, 2009, inpatient acute care hospitals paid under the TRICARE DRG-based payment system are required to report a POA (Present on Admission) indicator for both primary and secondary diagnoses on inpatient acute care hospital claims.

The DRG calculator and a listing of hospital-acquired conditions are available at www.tricare.mil/drgrates.

There are some institutions, which may be exempted from the DRG reimbursement methodology. Sole Community Hospitals are reimbursed at 100% of billed charges. Psychiatric Hospitals and exempt Psychiatric units within a DRG facility are reimbursed on a per diem basis that is determined by the location of the facility and the number of TRICARE admissions per year.

OUTPATIENT REIMBURSEMENT METHODOLOGY

Hospital outpatient services are paid by the OPPS (Outpatient Prospective Payment System) implemented on May 1, 2009. The following organizations are some of those exempt from the Tricare OPPS:

- Indian Health Service hospitals that provide outpatient services
- Cancer and children’s hospitals
- Community mental health centers
- Department of Veterans Affairs hospitals
- Freestanding birthing centers
- Freestanding end-stage renal disease facilities
- Hospice programs
- SNFs
- Residential treatment centers

For more information on the TRICARE OPPS implementation:

- Chapter 13 of the TRICARE Reimbursement Manual at http://manuals.tricare.osd.mil
- www.tricare.mil/opps
- Contact Humana Military at 1-800-444-5445
Ambulatory surgery facility payments fall into one of 11 TRICARE grouper rates. All procedures reimbursed under this methodology can be found at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil). Reimbursements, surgery rates and grouper assignments are available at [www.tricare.mil/ambulatory](http://www.tricare.mil/ambulatory).

When outpatient multiple surgical procedures are performed, the primary surgical procedure will be paid at 100% of the contracted rate and any additional covered procedures performed during the same surgical session will be allowed at 50% of the contracted rate. Any incidental surgical procedure is performed at the same time as a more complex primary surgical procedure requiring little additional physician resources and/or is clinically integral to the performance of the primary procedure, therefore, payment is considered to be inclusive in the primary procedure payment.

**COVERED SERVICES**

<table>
<thead>
<tr>
<th>Service</th>
<th>Payment Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-private Room***</td>
<td>Radiation Therapy</td>
</tr>
<tr>
<td>Meals, Special Diets</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>Oxygen</td>
</tr>
<tr>
<td>Operating Room</td>
<td>Intravenous Injection</td>
</tr>
<tr>
<td>Recovery Room</td>
<td>Chemotherapy</td>
</tr>
<tr>
<td>Treatment Room</td>
<td>Blood and Blood Derivatives</td>
</tr>
<tr>
<td>Drugs and Medicines</td>
<td>Renal Dialysis</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Shock Therapy</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>Hospice Care</td>
</tr>
<tr>
<td>Diagnostic Tests</td>
<td>Xrays</td>
</tr>
<tr>
<td>Vision</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>Home Health</td>
</tr>
<tr>
<td>Mammograms</td>
<td>Other as Specified</td>
</tr>
<tr>
<td>DME</td>
<td>(TRICARE HANDBOOK)</td>
</tr>
</tbody>
</table>

*** Semiprivate rooms and special care units may be covered if medically necessary.

**NOTE:** Surgical procedures designated as “inpatient only” will only be covered by TRICARE when performed in an inpatient setting.

TRICARE covers most inpatient and outpatient care that is medically necessary.

For additional information concerning covered and non-covered services, call 1-800-444-5445 or review the TRICARE Policy Manual at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil)

**COVERED SERVICES OR PROCEDURES WITH SIGNIFICANT LIMITATIONS (not all inclusive)**

- Abortions
- Botulinum toxin type A injections
- Breast pumps
- Cardiac and pulmonary rehabilitation
- Chiropractic care
- Cosmetic, plastic or reconstructive surgery

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Cranial orthotic device or molding helmet
Dental care and dental x-rays
Education and training
Eyeglasses and contact lenses
Facility charges for non-adjunctive dental services
Food, food substitutes and supplements, and other nutritional supplements
Gastric bypass
Genetic testing
Hearing aids
Intelligence testing
Laser/LASIK/refractive corneal surgery
Private hospital rooms
Shoes, shoe inserts, shoe modifications, and arch supports
Vitamins

NON-COVERED SERVICES
Humana Military Healthcare Services (HMHS) is required to deny all claims for non-covered services including complications occurring as a result of non-covered services being performed. The charges then become matters between the patient and the provider. Providers should note that beneficiaries must agree in advance of each non-covered service procedure, in writing, to accepting responsibility for any specified non-covered services. This ensures there is no misunderstanding and that the beneficiary is assuming responsibility for 100% of the costs of the non-covered services (TRICARE Non-Covered Services Waiver TP-1568.5). The patient is “held harmless” in cases of non-covered services provided by a network provider without specific, advanced written agreement by patient for each non-covered service. A general waiver does not meet this requirement. The provider is responsible for billing and collection for non-covered services. Examples of non-covered services include, but are not limited to, the following:

- Acupuncture
- Artificial insemination, or any forms of artificial conception
- Autopsy Services or post mortem examinations
- Birth control/contraceptives (non-prescription)
- Bone marrow transplants for treatment of ovarian cancer
- Camps (diabetics/obesity)
- Care or supplies furnished or prescribed by a person in the immediate family
- Counseling services such as that are not medically necessary for the treatment of a diagnosed medical condition (i.e. vocational, stress management, educational, lifestyle modification)
- Custodial care
- Diagnostic admission
- Domiciliary care
- Dyslexia treatment
- Electrolysis
- Elevators or chairlifts
- Exercise equipment, spas, hot tubs, whirlpools, swimming pools, health club memberships or other such charges or items
- Experimental or unproven procedures
• Foot care (routine), except when there is a medical problem
• General exercise programs, even if recommended by a physician regardless if whether rendered by an authorized provider
• Inpatient stays:
  o For rest or rest cures
  o To control or detain a runaway child, whether or not admitted to an authorized institution
  o To perform diagnostic exams, tests and procedures that are performed routinely as outpatient
  o In hospitals above the appropriate level required to provide necessary medical care
• Learning disability services
• Medications:
  o Prescriptions for cosmetic purposes
  o Herbal or homeopathic preparations
  o Fluoride preparations
  o Multivitamins
  o Over-the-counter products excluding diabetic and insulin supplies
• Mind expansion or elective psychotherapy
• Naturopaths
• Non-surgical treatment of obesity
• Preventive care to include annual employment-requested physical examinations, routine screening procedures or immunizations except as provided under clinical preventive services benefits
• Psychiatric treatment for sexual dysfunction
• Sex changes
• Sexual inadequacy treatment
• Smoking cessation supplies
• Sterilization reversal surgery
• Transportation, except by ambulance
• X-ray, laboratory and pathological services and machine diagnostic tests not related to a specific illness or injury or defined set of symptoms, except for cancer-screening mammography, cancer screening, Pap smears, and other test allowed under clinical preventive services benefits

NOTE: Remember coverage is dependent on whether the facility is network or non-network. Always verify benefits prior to treatment. **

TRICARE RATES UPDATES SCHEDULE
TRICARE rates are subject to change on at least an annual basis. Rate changes are usually effective on the dates listed below:
### TRICARE Rates Updates Schedule

<table>
<thead>
<tr>
<th>Update Frequency</th>
<th>Rates Scheduled to Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable at TMA's discretion</td>
<td>• CHAMPUS maximum allowable charge (CMAC) (may be adjusted quarterly)</td>
</tr>
<tr>
<td></td>
<td>• Anesthesia</td>
</tr>
<tr>
<td></td>
<td>• Injectables and immunizations</td>
</tr>
<tr>
<td>April 1</td>
<td>• Birthing Centers</td>
</tr>
<tr>
<td>October 1</td>
<td>• Diagnosis-related group</td>
</tr>
<tr>
<td></td>
<td>• Residential treatment center</td>
</tr>
<tr>
<td></td>
<td>• Mental health per diem</td>
</tr>
<tr>
<td></td>
<td>• Skilled nursing facility prospective payment system (may be adjusted quarterly)</td>
</tr>
<tr>
<td></td>
<td>• Inpatient hospital copayments and cost-shares</td>
</tr>
<tr>
<td></td>
<td>• Hospice</td>
</tr>
<tr>
<td>November 1</td>
<td>• Ambulatory surgery grouper</td>
</tr>
<tr>
<td>December 1</td>
<td>• Critical access hospital</td>
</tr>
<tr>
<td>Quarterly (January, April, July, October)</td>
<td>• Durable medical equipment, prosthetics, orthotics, and supplies</td>
</tr>
<tr>
<td></td>
<td>• Home health prospective payment system</td>
</tr>
<tr>
<td></td>
<td>• Outpatient prospective payment system</td>
</tr>
</tbody>
</table>
Active Duty Family Members:

<table>
<thead>
<tr>
<th></th>
<th>TRICARE Prime</th>
<th>TRICARE Extra</th>
<th>TRICARE Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>None</td>
<td>$150/individual or $300/family for E-5 &amp; above; $50/$100 for E-4 &amp; below</td>
<td>$150/individual or $300/family for E-5 &amp; above; $50/$100 E-4 &amp; below</td>
</tr>
<tr>
<td><strong>Annual Enrollment Fee</strong></td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Civilian Outpatient Visit</strong></td>
<td>No cost</td>
<td>15% of negotiated fee</td>
<td>20% of allowed charges for covered service</td>
</tr>
<tr>
<td><strong>Civilian Inpatient Admission</strong></td>
<td>No cost</td>
<td>Greater of $25 or $13.90/day</td>
<td>Greater of $25 or $13.90/day</td>
</tr>
<tr>
<td><strong>Civilian Inpatient Mental Health</strong></td>
<td>No cost</td>
<td>$20/day</td>
<td>$20/day</td>
</tr>
<tr>
<td><strong>Civilian Inpatient Skilled Nursing Facility Care</strong></td>
<td>$0 per diem charge per admission</td>
<td>$11/day ($25 minimum) Charge per admission</td>
<td>$11/day ($25 minimum) Charge per admission</td>
</tr>
</tbody>
</table>

No separate co-payment/cost-share for separately billed professional charges
### Retirees (under 65), Their Family Members, and Others:

<table>
<thead>
<tr>
<th></th>
<th>TRICARE Prime</th>
<th>TRICARE Extra</th>
<th>TRICARE Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>None</td>
<td>$150/individual or $300/family</td>
<td>$150/individual or $300/family</td>
</tr>
<tr>
<td><strong>Annual Enrollment Fee</strong></td>
<td>$230/individual $460/family</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Civilian Copays</strong></td>
<td></td>
<td>20% of negotiated fee</td>
<td>25% of allowed charges for covered service</td>
</tr>
<tr>
<td><strong>Outpatient Emergency Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Visit</td>
<td>$12 $30 $25 $17 (group visit)</td>
<td>$12 (group visit)</td>
<td></td>
</tr>
<tr>
<td><strong>Civilian Inpatient Cost Share</strong></td>
<td>$11/day ($25 minimum) Charge per admission</td>
<td>Lesser of $250/day or 25% of negotiated charges plus 20% of negotiated professional fees</td>
<td>Lesser of $512/day or 25% of billed charges plus 25% of allowed professional fees</td>
</tr>
<tr>
<td><strong>Civilian Inpatient Skilled Nursing Facility Care</strong></td>
<td>$11/day ($25 minimum) charge per admission</td>
<td>$250 per diem co-payment or 20% cost-share of total charges, whichever is less, institutional services, plus 20% cost-share of separately billed professional charges</td>
<td>25% cost-share of allowed charges for institutional services, plus 25% cost-share of allowable for separately billed professional charges</td>
</tr>
<tr>
<td><strong>Civilian Inpatient Mental Health</strong></td>
<td>$40 per day</td>
<td>20% of institutional &amp; negotiated professional fees</td>
<td>Lesser of $169/day or 25% of allowable fees</td>
</tr>
<tr>
<td>Reserve Component Category</td>
<td>Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Reserve Component members on active duty for more than 30 days | Includes any of the Reserve Component services:  
  - Air Force  
  - Army  
  - Coast Guard  
  - Marine Corps  
  - National Oceanic and Atmospheric Administration  
  - Navy  
  - Public Health Service |
| Spouses and unmarried children of Reserve Component Service Members | Covered while Reserve Component sponsor is on active duty for more than 30 consecutive days.  
Covered if Reserve Component sponsor was injured or died during, or on the way to or from active-duty training for a period of 30 days or less. |
| Retired Reserve Component Service Members and their families | When retired Reserve Component service member is eligible for retirement pay (usually at age 60), member and his or her eligible family members become eligible for TRICARE. |
| Widows or widowers and unmarried children of deceased active-duty or retired service members | Are eligible as family members of deceased member if sponsor was serving or was ordered to active duty for more than 30 days at time of death.  
Claims will be cost-shared at the active-duty family member rate for three years after death of active-duty sponsor, and thereafter at the retiree rate.  
Widow or widowers remain eligible until they remarry (loss of benefit remains applicable even if remarriage ends in death or divorce).  
Children remain eligible until age 21, unless they meet the exceptions listed earlier. |
| Medal of Honor recipients and their family members | Any service member who was awarded the Medal of Honor  
Awardees’ eligible family members and widow or widower are eligible for medical and dental benefits under TRICARE. |
| Certain eligible former spouses or active-duty or retired service members | Must not have remarried (if remarried, loss of benefits remains applicable even if remarriage ends in death or divorce.  
Starting October 1, 2003, eligibility and medical records are listed under former spouses own social security number, not that of the sponsor.  
Must not be covered by an employer-sponsored health plan.  
Must not be former spouse of a North Atlantic Treaty Organization (NATO) or Partners for Peace (PFP) national |
member.

- Must meet the requirements of one of the following three situations:
  - Situation 1: Must have been married to the same member or former member for at least 20 years, and at least 20 of those years must have been creditable in determining the member’s eligibility for retirement pay. If the date of the final decree of divorce or annulment was on or after February 1, 1983, the former spouse is eligible for TRICARE coverage of health care that is received after that date. If the date of the final decree is before February 1, 1983, the former spouse is eligible for TRICARE coverage of health care received on or after January 1, 1985.
  - Situation 2: Must have been married to the same military member of former member for at least 20 years and at least 15 – but less than 20 – of those married years must have been creditable in determining the member’s eligibility for retirement pay. If the date of the final decree of divorce or annulment is before April 1, 1985, the former spouse is eligible only for care received on or after January 1, 1985, or the date of the decree, whichever is later.
  - Situation 3: Must have been married to the same military member or former member for at least 20 years, and at least 15 – but less than 20 – of those married years must have been creditable in determining the member’s eligibility for retirement pay. If the date of the final decree of divorce or annulment is on or after September 29, 1988, the former spouse is eligible for care received for only one year from the date of the decree. Upon completion of the period of eligibility for TRICARE, explained in Situation 3, a former spouse is eligible for the Continued Health Care Benefit Program (CHCBP).

COORDINATION OF BENEFITS (DOUBLE COVERAGE)

TRICARE never has primary liability in a double coverage situation EXCEPT with Medicaid. Section 779 of Public Law 97-377 of the FY 83 Department of Defense Appropriations Act, changed the procedure of determining the primary payer in a double coverage situation. According to this law, no TRICARE funds “shall be available for the payment for any service or supply for persons enrolled in any other insurance, medical service, or health plan to the extent that the service or supply is a benefit under the other plan”. In other words, TRICARE is now secondary payer to all other insurance, medical service, or health plans in all cases. The law was effective December 21st, 1982. Active duty families no longer have the option to file with TRICARE first. The exclusionary clause for policies in effect prior 1966 is no longer in existence and private plans are now also included as double coverage situations.
TRICARE’S Relationship to Other Payers

Medicare
TRICARE eligible dependents of active duty sponsors with Medicare Part A maintain TRICARE as secondary payer. Non-active duty dependents under age 65 with a disability maintain TRICARE as secondary payer if they have Medicare Part A and B.

NOTE: Effective October 1st, 2001, the new TRICARE for Life program went into effect and Medicare – eligible retirees (including retired guardsmen and reservists); Medicare - eligible family members and survivors; and certain former spouses (if they were eligible for TRICARE before age 65) will retain TRICARE as a secondary payer to Medicare once their Medicare entitlement begins IF they are eligible for Medicare Part A and enrolled in Medicare Part B.

Medicaid
If a person is eligible for Medicaid as well as TRICARE benefits, TRICARE always pays first.

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

Private Automobile Insurance
Any amounts paid by TRICARE arising out of an automobile accident when these same amounts are also payable, in whole or in part, under a policy of automobile insurance, may be subject to recover under the Federal Claims Collections Act.

Special Notes
Waiver of Other Benefit Not Permitted

When double coverage exists as outlined above, a TRICARE beneficiary does not have the option of waiving benefits under the other plan or program in order to be paid in full TRICARE benefits. The beneficiary must apply for benefits under the plan or program that has been determined to have primary responsibility/coverage first.

CLAIMS PROCESSING AND BILLING INFORMATION (SOUTH REGION)
The contractor for claims processing for the TRICARE South Region is PGBA, LLC.

TRICARE requires claims to be filed electronically. A network provider must file claims within 90 days of the date care was provided. If TRICARE is secondary, the 90-day filing begins once the primary has paid or denied the claim.

All covered entities must use their National Provider Identifiers (NPIs). Billing NPIs are always required and when applicable, rendering provider NPIs are also required.

When filing paper claims, a CMS-1500 claim form be must used for professional fees and a UB-04 claim form is to be used for institutional charges.

Submit paper claims to:
To check the status of a claim, call PGBA at 1-800-403-3950 (24/7) or visit [www.humana-military.com](http://www.humana-military.com) and select “MyHMHS for Providers.”

To check on the status of a claim in writing or to resubmit a claim:

TRICARE South Region
Customer Service Department
P.O. Box 732
Camden, SC  29020-7032

The NAS is not required to be sent in with the UB-04, but you must indicate by use of the appropriate condition code that the statement is on file at the hospital.

To avoid delays in payment, be sure the following form locators (FL) are filed correctly. If you have problems, refer to the current UB-04 manual.

<table>
<thead>
<tr>
<th>FL</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FL 1</td>
<td>Provider name, physical address and telephone number <strong>required</strong></td>
</tr>
<tr>
<td>FL 2</td>
<td>Pay-to name and address <strong>required</strong></td>
</tr>
<tr>
<td>FL 3a</td>
<td>Patient control number</td>
</tr>
<tr>
<td>FL 3b</td>
<td>Medical/health record number</td>
</tr>
<tr>
<td>FL 4</td>
<td>Type of bill (three-character alphanumeric identifier)</td>
</tr>
<tr>
<td>FL 5</td>
<td>Federal Tax Identification (ID) number</td>
</tr>
<tr>
<td>FL 6</td>
<td>Statement covers period (from– through). The beginning and ending dates of the period included on the bill are shown in numeric fields (MM-DD-YY).</td>
</tr>
<tr>
<td>FL 7</td>
<td>Not required</td>
</tr>
<tr>
<td>FL 8a-b</td>
<td>Patient’s name (surname first, first name, and middle initial, if any). Enter the patient’s Social Security number (SSN) in field “a.” Enter the patient’s name in field “b.”</td>
</tr>
<tr>
<td>FL 9a-e</td>
<td>Patient’s address including ZIP code. This must be a physical address. Post office boxes are not acceptable.</td>
</tr>
<tr>
<td>FL 10</td>
<td>Patient’s birth date (MM-DD-YYYY). If the date of birth was not obtained after reasonable efforts by the provider, the field will be zero filled.</td>
</tr>
<tr>
<td>FL 11</td>
<td>Patient’s sex. This item is used in conjunction with FLs 66–69 (diagnoses) and FL 74 a–e (surgical procedures) to identify inconsistencies.</td>
</tr>
<tr>
<td>FL 12</td>
<td>Admission date</td>
</tr>
<tr>
<td>FL 13</td>
<td>Admission hour</td>
</tr>
<tr>
<td>FL 14</td>
<td>Type of admission. This code indicates priority of the admission.</td>
</tr>
<tr>
<td>FL 15</td>
<td>Source of Admission. This code indicates the source of admission or outpatient registration.</td>
</tr>
<tr>
<td>FL 16</td>
<td>Discharge hour</td>
</tr>
<tr>
<td>FL 17</td>
<td>Patient status. This code indicates the patient’s status as of the “Through” date of the billing period (FL 6).</td>
</tr>
<tr>
<td>FLs 18–28</td>
<td>Condition codes</td>
</tr>
<tr>
<td>FL 29</td>
<td>Accident state</td>
</tr>
<tr>
<td>FL 30</td>
<td>Not required</td>
</tr>
<tr>
<td>FLs 31–34</td>
<td>Occurrence codes and dates</td>
</tr>
<tr>
<td>FLs 35–36</td>
<td>Occurrence span code and dates</td>
</tr>
<tr>
<td>FL 37</td>
<td>Not required</td>
</tr>
<tr>
<td>FL 38</td>
<td>Responsible party name and address</td>
</tr>
<tr>
<td>FLs 39–41</td>
<td>Value codes and amounts</td>
</tr>
<tr>
<td>FL 42</td>
<td>Revenue code</td>
</tr>
<tr>
<td>FL 43</td>
<td>Revenue description—A narrative description or standard abbreviation for each revenue code in FL 42. Descriptions or abbreviations correspond to the revenue codes.</td>
</tr>
<tr>
<td>FL 44</td>
<td>HCPCS/rates. When coding HCPCS, enter the HCPCS code describing the procedure. May be required for correct reimbursement.</td>
</tr>
<tr>
<td>FL 45</td>
<td>Service date. If submitting claims for outpatient services, report a separate date for each day of service</td>
</tr>
<tr>
<td>FL 46</td>
<td>Service units. The entries in this column quantify services by revenue category (e.g., number of days, a particular type of accommodation, pints of blood). Up to seven digits may be entered.</td>
</tr>
<tr>
<td>FL 47</td>
<td>Total charges</td>
</tr>
<tr>
<td>FL 48</td>
<td>Non-covered charges. The total non-covered charges pertaining to the related revenue code in FL 42 is entered here.</td>
</tr>
<tr>
<td>FL 49</td>
<td>Not required</td>
</tr>
<tr>
<td>FLs 50A–C</td>
<td>Payer identification. Enter the primary payer on line A.</td>
</tr>
<tr>
<td>FLs 51A–C</td>
<td>Health plan ID number</td>
</tr>
<tr>
<td>FLs 52A–C</td>
<td>Release of information. A “Y” code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An “R” code indicates the release is limited or restricted. An “N” code indicates no release on file.</td>
</tr>
<tr>
<td>FLs 53A–C</td>
<td>Assignment of benefits certification indicator</td>
</tr>
<tr>
<td>FLs 54A–C</td>
<td>Prior payments. For all services other than inpatient hospital and skilled nursing facility (SNF) services, the sum of any amount(s) collected by the provider from the patient toward deductibles and/or co-insurance are entered on the patient (last) line of this column.</td>
</tr>
<tr>
<td>FLs 55A–C</td>
<td>Not required</td>
</tr>
<tr>
<td>FL 56</td>
<td>National Provider Identifier (NPI). Beginning May 23, 2008, NPI number is required.</td>
</tr>
<tr>
<td>FLs 57A–C</td>
<td>Other provider identifier number</td>
</tr>
<tr>
<td>FLs 58A–C</td>
<td>Insured’s name</td>
</tr>
<tr>
<td>FLs 59A–C</td>
<td>Patient’s relationship to insured</td>
</tr>
<tr>
<td>FLs 60A–C</td>
<td>Insured unique ID/SSN/health insurance claim/ID number</td>
</tr>
<tr>
<td>FLs 61A–C</td>
<td>Group name. Indicate the name of the insurance group or plan.</td>
</tr>
<tr>
<td>FLs 62A–C</td>
<td>Insurance group number</td>
</tr>
<tr>
<td>FLs 63A–C</td>
<td>Treatment authorization code. Contractor-specific or Home Health Agency Prospective Payment System (PPS) OASIS code. Whenever Peer Review Organization (PRO) review is performed for outpatient/inpatient preadmission or preprocedure, the authorization number is required for all approved admissions or services.</td>
</tr>
<tr>
<td>FLs 64A–C</td>
<td>Document Control Number (DCN). Original DCN number of the claim to be adjusted.</td>
</tr>
<tr>
<td>FLs 65A–C</td>
<td>Employer name. Name of the employer that provides health care coverage for the individual identified on FL 58.</td>
</tr>
<tr>
<td>FL 66</td>
<td>Diagnosis and procedure code qualifier (ICD Version Indicator) FLs 67 Principal diagnosis code. HCFA only accepts ICD-9-CM diagnostic and procedural codes that use definitions contained in Department of Health and Human Services (DHHS) Publication Number (PHS) 89-1260 or HCFA-approved errata supplements to this publication. Diagnosis codes must be full ICD-9-CM diagnosis codes, including all five digits where applicable.</td>
</tr>
<tr>
<td>FLs 67A–Q</td>
<td>Other diagnosis codes</td>
</tr>
<tr>
<td>FL 68</td>
<td>Not required</td>
</tr>
<tr>
<td>FL 69</td>
<td>Admitting diagnosis. For inpatient hospital claims subject to PRO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient’s hospital admission.</td>
</tr>
<tr>
<td>FLs 70A–C</td>
<td>Patient’s reason for visit</td>
</tr>
<tr>
<td>FL 71</td>
<td>Prospective payment system (PPS) code</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>FLs 72–c</td>
<td>External cause of injury (ECI) code</td>
</tr>
<tr>
<td>FL 73</td>
<td>Not required</td>
</tr>
<tr>
<td>FL 74</td>
<td>Principal procedure code and date. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis.</td>
</tr>
<tr>
<td>FLs 74a–e</td>
<td>Other procedure codes and dates. The full ICD-9-CM, Volume 3, Procedure Codes, including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure (which is shown in FL 74). The date of each procedure is shown in the date portion of Item 74, as applicable (MM-DD-YY).</td>
</tr>
<tr>
<td>FL 75</td>
<td>Not required</td>
</tr>
<tr>
<td>FL 76</td>
<td>Attending/referring physician ID</td>
</tr>
<tr>
<td>FL 77</td>
<td>Operating physician name and identifiers</td>
</tr>
<tr>
<td>FLs 78–79</td>
<td>Other physician ID</td>
</tr>
<tr>
<td>FL 80</td>
<td>Remarks. Notations relating to specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Authorized signature of non-network providers.</td>
</tr>
<tr>
<td>FLs 81a–d</td>
<td>Code field</td>
</tr>
</tbody>
</table>
Introduction
Workers’ compensation is a benefits program created by state law that provides medical, rehabilitation, income, death and other benefits to employees and dependents due to injury, illness and death resulting from a compensable work-related claim covered by the law. Workers’ compensation coverage begins the first day of employment. Employers with three or more employees are required by law to provide coverage. Any injury, illness or death arising out of and in the course of employment is by definition a compensable work-related claim. This means if employees are injured while performing assigned job duties during assigned work hours; they are covered under the worker’s compensation program. Injuries sustained while engaging in unassigned duties, during lunch and breaks are not covered. In addition, injuries that occur during an employee’s normal commute to and from work are not covered.

Reporting Injuries
If employees are injured on the job, they should immediately report the injury to their employer. Paperwork required by the company must be completed and forwarded to the appropriate organization for processing. Specific information regarding the injury must be provided. If an injury is serious in nature, immediate medical attention should be provided and a report filed as soon as possible. Employers and/or the company responsible for handling the workers’ compensation claims generally investigate on-the-job accidents and injuries. Investigations are necessary to determine why and how the injury occurred, and to implement policies and procedures to make the workplace safer.

Workers’ Compensation does not provide benefits for an injury or accident resulting from an employee’s willful misconduct (i.e. fighting, horseplay, willful act of third party for personal reasons, injuries related to alcohol or drug abuse). Injuries resulting from “haste” or “inattentiveness” would be covered under the workers’ compensation program. However, employees are encouraged to follow company policies and safety rules and may subject themselves to company discipline if these rules are not adhered to.

Reimbursement
All medical charges are paid according to the Georgia Workers’ Compensation Medical Fee Schedule. If the medical provider charges above the fee schedule, the charges will be reduced to the fee schedule, and that amount will be paid. **THE PATIENT IS NOT RESPONSIBLE FOR CHARGES ABOVE THE FEE SCHEDULE.**

Reimbursement of services is done according to the Fee Schedule for Physicians, Surgeons, Pharmaceutical, Home Health Care, and Hospitals and Ambulatory Surgery Centers for services rendered under the Georgia Workers’ Compensation Law. Reimbursement to the provider must be made within 30 days from the date the bill was received by the payer, according to state law. If not paid within 30 days, O.C.G.A. §34-9-203 imposes penalties accordingly. Any appeals must be made within 120 days from receipt of payment and/or explanation of benefits (EOB) (see O.C.G.A. §34-9-203). All bills must be submitted by the medical provider within one year of the date of service (see O.C.G.A. §34-9-203)

Authorization of Coverage
Employers choose an insurance company to handle worker’s compensation cases. Before admission, the insurance company should be notified and verification of coverage obtained. The patient should have a written authorization form (possibly in the form of an incident report) signed by a representative of the employer. If not, this documentation should be requested of the employer. It should be established with the employer whether or not they recognize responsibility for the injury. If so, a letter stating this obligation should be requested. If verification of coverage cannot be obtained from the employer, the hospital should make the account self-pay until verification is received.

Denial of Coverage
If the workers’ compensation carrier denies a worker’s compensation case, the patient has the right to appeal the denial to the State Board, requesting a hearing. As long as the patient has an appeal pending, even though the claim may have been previously denied, the hospital cannot pursue payment from the patient. Inquiry regarding case status can be done either through the carrier or through the State Board of Worker’s Compensation.

Claims Processing
When processing workers’ compensation claims, providers must file hard-copy claims to include the UB04 or 1500 form (if applicable), itemized statement and complete medical records.

Helpful Links
State Board of Workers Compensation:
http://sbwc.georgia.gov/portal/site/SBWC/

State Board of Workers compensation Model Return to Work Program:

Workers Compensation Procedures Manual

Section 2.3.E - COBRA

Introduction
What is COBRA?
The COBRA law was passed to provide employees (or former employees) their spouses and their dependents with a temporary extension of group health insurance when coverage is lost due to certain events.

Requirements of COBRA
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1. Employers must offer continuation of coverage to qualified beneficiaries who lose coverage as the result of a qualifying event.
2. The COBRA coverage must be identical to the coverage provided to similarly situated employees.

Definitions
Employers
1. The COBRA requirements apply only to those employers who had 20 or more employees "on a typical business day" during the preceding calendar year.
   a. A typical business day is defined as 50 percent or more of the business days.
   b. Employees includes all full-time and part-time employees, owners and officers, regardless of their eligibility for the group health plan.
2. Exceptions: the federal government and church plans have separate rules for continuation of coverage.

Qualified Beneficiaries
Individuals who are covered under the employer’s group health plan the day before a COBRA qualifying event takes place.
- Includes the covered employee, covered spouse of employee, covered dependent child of the employee or any child born to or placed for adoption with, the covered employee during the period of continuation coverage.

Qualifying Event
1. 18 month Qualifying Event: The following events provide for 18 months of coverage for all qualified beneficiaries from the date of the qualifying event.
   a. Voluntary termination
   b. Involuntary termination – except for gross misconduct.
   c. Reduction of hours – strike, lay-off, leave of absence, full-time to part-time
2. Thirty-six Month Qualifying Events – the following events provide for 36 months of coverage for all qualified beneficiaries from the date of the qualifying event
   a. Death of employee
   b. Employees Medicare entitlement
   c. Divorce or legal separation
   d. Dependent child ceasing to be a dependent

How COBRA Works

Occurrence of the Qualifying Event:
1. Responsibilities of the Employer
   a. The employer is responsible for knowing when any of the following qualifying events have occurred.
      i. Voluntary Termination
      ii. Involuntary Termination
      iii. Reduction of Hours
      iv. Death of Employee
      v. Medicare Entitlement
2. Responsibilities of the Employee or Qualified Beneficiary
a. The employee or other qualified beneficiary must inform the employer or plan administrator of the following qualifying events:
   i. Divorce or Legal Separation
   ii. Dependent Child Ceasing to be a Dependent
b. The employee or other qualified beneficiary must inform the employer or the plan administrator of occurrence of qualifying event within 60 days from the date of the event.

Notification of COBRA Rights
1. Report of Event
   a. Employers have 30 days from the date of the event to notify the plan administrator that a qualifying even has taken place.
   b. In most cases, the plan administrator is the employer – in that case, the employer does not have 30 days to notify themselves.

2. Qualifying Event Notification
   a. Plan administrators are required to notify all qualified beneficiaries of their COBRA rights within 14 days of the date they learned of the event.
      i. If the employer and the plan administrator are one in the same, then the plan administrator only has 14 days from the date of occurrence of the qualifying event.
   b. The notice should inform each qualified beneficiary that they have rights to continue their group health insurance coverage under COBRA.
   c. Notice must be sent first class mail to all qualified beneficiaries at the last known address
      i. Handing a notice to an employee during an exit interview is not sufficient
      ii. Notice is deemed given on the date it is sent.

Election Period
Each qualified beneficiary has at least 60 days to elect COBRA coverage from the later of:
- Date of Notice
- Loss of Coverage Date

Premiums
1. Once a qualified beneficiary has elected COBRA coverage, he/she has 45 days from the date of election to pay the retroactive premium.
   a. The retroactive premium is the amount of the premium due from the loss of coverage date to the date of election.
2. For monthly (prospective) premiums, COBRA enrollees are allowed a minimum 30-day grace period for each and every month.
3. Employers are allowed to charge COBRA enrollees up to 102 percent of the “applicable premium” for continuation coverage.
4. As a part of the Pentagon spending Bill and the Economic Stimulus Package, workers who were laid off between September 2008 and May 31st, 2010 are provided a subsidy in the form of a tax credit. This tax credit subsidizes 65% of COBRA premiums.
5. Interested third parties can pay the COBRA premium to ensure that the qualified beneficiary has COBRA coverage.

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a. Hospitals can pay premium to ensure their bills will be paid.
b. States can pay premium instead of having Medicaid pay the medical bills
c. A new employer can pay premium to keep a new employee’s claims off their group health plan.

**Terminating Events**
There are only specific times when an employer can cancel COBRA coverage and still be in compliance with the law, including but not limited to:

a. The first day for which timely payment is not made to the plan.
b. The first date on which the qualified beneficiary first becomes, after the date of the election, covered under another group health plan that does not contain any exclusion of limitation with respect to any pre-existing condition of the beneficiary other than an exclusion or limitation which does not apply to, or has been satisfied under, HIPAA.
c. The date on which the qualified beneficiary first becomes, after the date of election, entitled to Medicare.
d. The date the employer ceases to maintain any group health plan.

**COBRA Enforcement and Penalties**

**Enforcement**
1. The COBRA law is enforced by different governmental entities.
2. For failing to comply with COBRA, the IRS can levy excise taxes, the Department of Labor can file a lawsuit against the employer and the Qualified Beneficiaries can sue the employer.

**Penalties**
1. IRS Penalty
   - A nondeductible excise tax of $100 per day, per violation.
2. ERISA Penalty
   - Since COBRAs requirements are part of ERISA, failing to comply with COBRA can subject an employer to an ERISA penalty of up to $100 per day, per violation.
3. Payment of Claims
   - An employer who fails to comply with COBRA may be required to pay the Qualified Beneficiary’s claims.
4. Damages and Attorney Fees
   - Courts have held employers, who are found not to be in compliance with COBRA, responsible for payment of damages and attorney fees.
Section 2.3.F - Uninsured Patients

Background Information
The number of uninsured Americans has risen dramatically since 1998 and is expected to continue to grow due to the declining economy. Most uninsured are working men and women who are employed by small companies or are self-employed. In a recent study, the uninsured population ranked the top two reasons as to why they do not have health insurance:

- Insurance premiums are too expensive
- Job doesn't offer medical insurance coverage
Many of uninsured parents are not taking advantage of existing governmental programs such as PeachCare for Kids. The largest group of newly uninsured had an annual income in excess of $75,000 with nearly 85% of uninsured being in working families. Forty percent of uninsured population is from ages 18 to 34 – a group that is typically in good health and presumably considers their money better spent elsewhere.

Double-digit premium increases have employers looking to reduce, and in some cases eliminate, coverage plans. One bad sign – only 60% of firms with less than 200 employees offered health benefits in 2002, compared with 67% in 2000. National uncompensated care has also risen. As an industry, we lose more than we make. Hospitals spent $22 billion on uncompensated care in 2000. On an average 70% of all hospitals patient pay portion is written off to bad debt.

Considering these trends many insurance companies recognize the statistics and as a result are starting to offer customized programs.

**Identify the Nature of the Uninsured**

Uninsured does not necessarily mean indigent and uncollectible. A financial interview should be conducted with the patient to determine whether needs actually exist for assistance with their hospital account. Our perspective of the uninsured must change; in the past we have looked at this particular population of patients as being indigent and were quick to give assistance when assistance might not have been needed. This is one reason why pre-screening of uninsured patients is so important.

Uninsured patients should be identified through the pre-access process, if possible, and referred to a Financial Counselor. The Pre-Access process should be designed to capture at least 85% of uninsured patients. The Financial Counselor should conduct a financial interview with the patient and inform the patient of their estimated balance based on the procedure to be performed. Before deciding to “give your facilities money away”, wait for the patients’ response as they may give no indication of needing charity assistance.

**Reimbursement Options**

Payment options should be offered to the patients. These include:

- Bank Notes
- Credit or Debit Cards
- Bank Financing
- Prompt Pay Discounts
- Installment Notes
- Payroll Deduction
- Automatic Bank Drafts via Internet

Alternate sources for reimbursement should be kept in mind while conducting the financial interview. A good interview can lead to potential sources of reimbursement that the patient is not familiar with. Some sources to be considered:

- COBRA continuation of benefits
- Cancer State Aid
- Veterans Assistance

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• Medicaid
• SSI
• Liability
• Crime Victims
• Children’s Medical Services
• Vocational Rehabilitation
• Workers Compensation from previous injuries

If the patient expresses an inability to pay, use the financial information gathered during the interview to determine the patients’ eligibility for Indigent Care services. The patient should provide verification of any information given during the interview process in order to comply with State regulations. Sources to be considered as a last resort:
• Indigent Care Trust Fund
• Hill Burton (if facility Hill Burton eligible)

Your facility should have policies and procedures in place to support your indigent and/or charity programs.
What is Cancer State Aid (CSA)?
The Cancer State Aid Treatment Program was established in 1937 by the Georgia legislature at the request of Georgia physicians to provide cancer treatment to uninsured and underinsured low-income cancer patients. This treatment program is available to eligible Georgians who would benefit most from treatment.

In order for hospitals to be reimbursed through Cancer State Aid funds, they must be approved by the Joint Commission on Accreditation of Hospitals and have a Cancer Program approved by the American College of Surgeons.

The program reimburses a portion of costs incurred by participating facilities for treatment and diagnostic services. The Georgia legislature determines funding for this program each year. The cost of treatment is paid through state funding and physicians donate their services.

Contact Information
2 Peachtree Street
16th Floor
Atlanta, GA 30303
(404) 463-5111
(404) 463-5111
Email: CSA@dhr.state.ga.us

http://health.state.ga.us/program/cancer/stateaid/asp

Covered Services
The following services are available to qualified participants:
- Inpatient and outpatient cancer treatment at participating hospitals
- Outpatient chemotherapy and radiation therapy at approved freestanding chemotherapy and radiation centers
- Outpatient chemotherapy and other cancer related drugs provided by private pharmacies in which prior approval is required from the Cancer State Aid Program
- Outpatient cancer related services provided by home health agencies (prior approval is required from the Cancer State Aid Program)

Eligibility Requirements
The following requirements must be met in order to qualify for services:
- Must have cancer that will benefit from treatment
- Must have a family income at or below 200% of the Federal Poverty Level (about $18,000 for an individual and $36,800 for a family of 4)
- Must have either no or limited health insurance coverage. (will cover Medicare participants for medications; will not cover patients with full coverage Medicaid)
- Must be a Georgia resident who is a U.S. citizen or resident alien.
- Must be accepted for treatment by a physician affiliated with a participating facility.
- Patient must also receive treatment at a participating facility.
New patients are prioritized and accepted based on cancer site, stage and expected treatment effectiveness as described in the latest scientific literature and cancer survival rates. Applications are accepted on the availability of state funds. Due to funding restrictions, a limited number of applicants are accepted each quarter. Priority is given to those patients applying for recertification. Applications will be considered based on the date they are received and the availability of funding, but CSA doesn't provide payments for services received prior to program enrollment. If funds are not available to cover new patients, applications can still be taken but will not be processed until funds are once again available. Patients approved for Cancer State Aid will be included in the program for one year after which time they must reapply.

Final eligibility decisions are made by the Georgia Cancer State Aid Program.

Payments
The Cancer State Aid Program (CSA) pays a cost percentage of charges less any third party payment for the following services on approved cancer patients at approved CSA facilities. The cost percentage is determined as of July 1st each year and is based on the hospital’s last audit.

NOTE:
According to CSA’s longstanding agreement with participating hospitals, approved patients should not be billed by the facility for any cancer related services. CSA payment for approved services should be considered payment in full for all approved patients and no co-payments should be billed.

Physicians volunteer their time and effort as a public service and CSA patients should not be billed for any professional fees at all. This includes the anesthesiologist, radiologist and pathologist. However, if the CSA patient has Medicare and/or insurance, physicians may bill these resources for services rendered. The physician must accept whatever is paid as payment in full.

To be approved for CSA, the patient’s physician must agree to participate with the program. Should the patient elect to see a non-participating physician, the patient is responsible for all related bills.

Cancer State Aid benefits will terminate when patients become eligible for Medicaid.

CSA will consider for payment the following services.

I. In-Patient Services
   a. Standard Daily Hospital Care

      **EXCEPT FOR THESE LIMITATIONS**
      i. Payment for semi-private room Rate only, except;
         1. When attending physician recommends or orders a private room
            (These orders must accompany billing).
         2. Facility has only private rooms
      ii. All in-patient admissions for diagnostic evaluation must be medically necessary. The **MAXIMUM** payment for diagnostic evaluation is **two (2)** days. If the patient has cancer and treatment has begun, payment will be
made for the entire admission. If the patient does not have cancer, no additional days will be paid.

iii. The **MAXIMUM** payment for Medicare patients is the in-patient deductible. A Medicare Remittance Notice is required when billing CSA.

iv. Physician’s services and/or visits are not covered.

v. The **MAXIMUM** payment for IN-PATIENT services is $10,000 per patient per fiscal year (July 1st – June 30th). Hospitals may request an exception for a patient who has reached the limit (See Appeals process section below).

vi. Convenience items, such as: cots, extra meals, TVs, etc. are not covered. Exceptions: Cots for parents of small children.

vii. **Charges submitted more than ninety (90) days after date of service or discharge are payable at the end of the fiscal year if funds are available.**

viii. Late discharge fees are not covered.

ix. All charges must be itemized and specific grouped charges will not be reimbursed.

x. Pre-admission work-ups such as lab, x-rays, etc. are not covered as part of the in-patient stay and must be billed as outpatient procedures.

II. OUT-PATIENT SERVICES

CSA will pay for the following standard outpatient services with the noted limitations.

a. Clinic visits and emergency room visits, when necessary (Emergency Room Notes must be attached to bill when submitting).

b. Supplies for treatment and follow-up

c. Laboratory, x-rays and other studies necessary to monitor patient condition.

d. Radiation Therapy

   **Limitations**

   i. Facilities should bill only the technical costs. Physics fees are considered necessities, not a professional component. It is a covered item. Limit **one port film per day**.

e. Chemotherapy (Out-Patient Only)

   In order for payment to be rendered, each facility must use the CSA Chemotherapeutic and Adjunctive Agents Formularies, which shows the price that CSA will pay for these drugs. CSA reserves the right to deny payment for any drug that is not shown on these formularies. The formularies will be updated as needed by the Pharmacy Advisory Committee.

   The hospital is reimbursed at 100% of the drug cost plus an established handling fee per drug, per day. The handling fee is established as of July 1st each year.

   NOTE: The Providers itemized statement should reflect the cost for each chemotherapy drug as shown on the CSA Chemotherapeutic and Adjunctive Agents Formularies.

   **Limitations**

   i. If a drug is dispensed more than one time per day (same drug, same strength, multiple doses), the **handling fee will only be paid one (1) time per day**.
ii. Payment by the CSA Program for Chemotherapy drugs will not exceed the cost found in the CSA Formularies.

iii. Chemotherapy room charges are payable only when chemotherapy drugs are being administered (If chemotherapy drugs are donated, a statement to that effect must be included).

f. Charges for operating room and treatment room:
   **Note:** Facility must specify type of treatment and/or surgery rendered in order for payment to be made.
   
   i. Operating Notes/Short Stay Notes must be attached to CSA Statement of Charges Form when submitting for payment.

   g. Medications for symptomatic relief of cancer and cancer treatment (those drugs that are not considered by CSA as chemotherapy drugs) will be reimbursed at the cost percentage rate. CSA will pay only those drugs that require a prescription and ordered by the physician treating the patient for cancer at our facility.

   h. The **MAXIMUM** payment for Medicare patients for services covered is the outpatient deductible. (This is payable only (1) one time per calendar year and a Medicare Remittance Notice is required when billing CSA).

   i. The **MAXIMUM** payment for **OUTPATIENT** services is $20,000 per patient per fiscal year (July 1st – June 30th). Hospitals may request an exception for a patient who has reached the limit (Appeals Process section).

III. SPECIAL VENDORS

Special Vendors consist of entities such as pharmacies, medical supply houses; home care agencies (both private and hospital connected). All products and services in this group **MUST HAVE PRIOR APPROVAL** from the CSA Director **BEFORE SERVICES ARE RENDERED**. Contact our offices as soon as it is determined that these services are needed:

   a. Medications: A special Medication Request Form supplied by the CSA program is required for every patient, new or re-certified.

   b. Home Care Services: A Special Vendor Criteria Form supplied by CSA program is required.

   **NOTE:** It is the Hospital's responsibility to identify vendors and make preliminary arrangements for these services.

   **CANCER STATE AID DOES NOT PAY FOR THE FOLLOWING:**

   1. Treatment for conditions other than cancer.
   2. Treatment provided by non-participating CSA Facilities.
   3. Treatment rendered by Special/Other Vendors without prior approval of the CSA Administrator.
   4. Prostheses.
   5. Routine dental services and/or treatment.

**Billing Procedures**

In order for reimbursement to be made for services on approved cancer patients, facilities **must** submit the **Statement of Charges Form** provided by CSA for each individual patient. This is to be inclusive of all cancer related services rendered for the month.
I. IN-PATIENT AND OUT-PATIENT HOSPITAL SERVICES

a. The Statement of Charges #3624A must list the name of the hospital (as you want your checks to be issued) and city; the patient’s first name, middle initial and last name; CSA number and approval period. The month of services being submitted needs to be included.

b. For IN-PATIENT: The Statement of Charges must list the dates of admission and discharge, the patient’s hospital control number, the total hospital in-patient expenditures, the total in-patient covered charges at cost percentage. A typed or legible discharge summary with final diagnosis and an itemized statement needs to be included for each date(s) of service being submitted.

c. For OUT-PATIENT: The statement of Charges must list the beginning date and ending date for services in that month, the patient’s hospital control number for these dates of service, the total hospital out-patient expenditures, the total out-patient covered charges at cost percentage. A UB-04 and Itemized Statement needs to be included for each date(s) of service being submitted. If there are any submissions for outpatient surgery or ER services, Short Stay Notes and ER Notes must be included.

NOTE:
Chemotherapy drug charges need to be subtracted from the total of the claim and calculated using the formularies. Once this is figured, the total should be added to the total of the claim after percentage to give you the actual total of outpatient charged covered at cost percentage.

d. If insurance has been or is expected to be collected, it should be deducted from the total in-patient covered charges at cost percentage before the amount is entered into the Statement of Charges. It should not be deducted from the amount of the allowable charges prior to taking the cost percentage.

e. The hospital’s authorized representative must sign each Statement of Charges and submit within 90 days of service or discharge.

NOTE:
A MEDICARE EXPLANATION OF BENEFITS (EOB) IS REQUIRED ON ALL MEDICARE PATIENTS.

NOTE:
ALL BILLS WILL BE CONSIDERED INCOMPLETE AND BE RETURNED if the following items are not attached:

- Discharge Summary if applicable.
- Short Stay or ER Notes, as needed.
- Hospital Itemized Statement

The requested information must be received within thirty (30) days from the date of the request letter or the claim(s) will be held pending status of funds.

NOTE:
MEDICAID NON-ELIGIBILITY SHOULD BE VERIFIED ON EVERY PATIENT BEFORE SUBMITTING CLAIMS TO CSA FOR PAYMENT.
Ordering Cancer State Aid Billing Forms
If you are in need of CSA Billing Forms, contact the CSA Program at 404-657-6523 and request forms #3624A. It will be sent to you as soon as possible.

Appeals Process
Reconsideration:
Providers may request reconsideration of reimbursement decisions.
Reconsideration requests must be submitted in writing to:

Chronic Disease Prevention and Health Promotion Branch
Director, Payables Unit
Administrative Services Section
2 Peachtree Street, N.W.
16th Floor
Atlanta, GA 30303

Reconsideration requests must be submitted within 30 days of receipt of decision and must include rationale and evidence to support the reconsideration request.

Guide for Completing Statement of Charges
1. Facility Name
   Should be the name you want your checks to be paid under (Facility needs to ensure that our program has updated W-2 (to set up a vendor number).
2. Patient Name
   The approved patient that these charges pertain to.
3. Approval Period:
   The year that this patient is covered under the Cancer State Aid Program (CSA). (Show date coverage began).
4. CSA Program #
   The number assigned to this patient at the time of approval.
5. Month of Service
   The month for which you are submitting charges.
6. Actual Date(s) of Service
   The actual days that the patient was seen at your facility. This is usually reflected on the itemized statement not the UB04.
7. Patient Control #
   The number your facility uses for claim tracking purposes.
8. Total Hospital Inpatient Expenditures
   Your total inpatient charges for cancer related services
9. Total Inpatient Covered Charges at Cost Percentage
   The amount that CSA will pay of the total charges.
   NOTE: There is a maximum limit of $10,000 on inpatient charges per patient approval year.
10. Total Hospital Outpatient Expenditures
    Your total outpatient hospital charges for cancer related services.
11. Total Outpatient Covered Charges at Cost Percentage
    Chemotherapy requires special processing using the formulary price plus $4.63 handling fee per drug per day. Other covered charges are paid at the hospital percentage rate. The total charges CSA will pay reflect the adjusted chemotherapy drug charges, total handling fees added to the other covered charges.
NOTE: There is a maximum limit of $20,000 on outpatient charges per patient approval year.

12. For CSA use only
This area is for Cancer State Aid Program use in processing statement to accounting.

13. Facility Agent Signature
For the person preparing the statement of charges at your facility to sign.

14. Date
Date the preparation is complete.
CANCER STATE AID PROGRAM HOSPITAL CLAIM FORM

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>CITY</th>
</tr>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>CSA #</th>
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### Section A

**STATEMENT OF INPATIENT CHARGES**

<table>
<thead>
<tr>
<th>Actual Dates of Service</th>
<th>1. Total Inpatient Charges (from the itemized statement)</th>
<th>2. Total Inpatient Covered Charges at cost percentage</th>
<th>FOR CSA USE ONLY (Corrected Covered Charges/Notes)</th>
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<tr>
<td>FROM TO PT CONTROL #</td>
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<table>
<thead>
<tr>
<th>TOTAL INPATIENT CHARGES</th>
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### Section B

**STATEMENT OF OUTPATIENT CHARGES**

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<th>Actual Dates of Service</th>
<th>1. Total Outpatient Charges (from the itemized statement)</th>
<th>2. Total Outpatient Covered Charges at cost percentage</th>
<th>FOR CSA USE ONLY (Corrected Covered Charges/Notes)</th>
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<table>
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<tr>
<th>TOTAL OUTPATIENT CHARGES</th>
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**REQUIRED HOSPITAL AUTHORIZED SIGNATURE**

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<th>FACILITY AGENT SIGNATURE</th>
<th>DATE</th>
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</table>

### FOR CSA USE ONLY

**PAYMENT INFORMATION**

<table>
<thead>
<tr>
<th>INVOICE NUMBER</th>
<th>PAYMENT TOTAL FOR THIS CLAIM</th>
<th>GRAND TOTAL FOR MULTIPLE CLAIMS</th>
<th>PAGE #</th>
<th>DATE APPROVED FOR PAYMENT</th>
<th>CSA APPROVER</th>
</tr>
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<tbody>
<tr>
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### REFUND INFORMATION

<table>
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<tr>
<th>DATE RECEIVED</th>
<th>REFUND CHECK#</th>
<th>REFUNDED PTC#</th>
<th>ORIGINAL AMOUNT</th>
<th>REFUND AMOUNT</th>
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Form 3624-H (Rev 06/10)
Section 2.4.B - Rehabilitation Services

Background
Background of the Vocational Rehabilitation Program as it pertains to medical coverage for VR clients

Vocational Rehabilitation Services may authorize the provision of a physical or a mental restoration service(s) for a qualified individual to correct or substantially improve a physical or a mental condition, which affects his/her work outcome. The medical provider must be willing to accept the VR established fee(s) and not bill the patient for any remaining balance. The following criteria shall be met for the provision of services:

- The clinical status of the impairment, as indicated by the prognosis of the specialist’s examination, must be stable or slowly progressive to the point that the individual has a work expectancy of at least one year beyond the plan completion
- The anticipated outcome of the proposed treatment must benefit the individual in terms of work outcome, and
- The restoration service(s) is included on an approved work plan

All available comparable and/or similar benefits must be considered first.

Eligibility
Eligibility for Vocational Rehabilitation Services and/or Disability Adjudication Services

Basic Eligibility criteria for Vocational Rehabilitation Services (VRS) are:

- The applicant meets the definition of an individual with a disability, and
- The individual with a disability requires Vocational Rehabilitation Services to prepare for, secure, retain or regain employment
- Supplemental Security Income (SSI), Social Security Disability Income (SSDI), or Temporary Assistance to Needy Families (TANF) beneficiary
- Resident of Georgia
- Meet Financial Needs Assessment (for paid services)

Disability Adjudication Services (DAS), a specialized program of Rehabilitation Services, works with the Social Security Administration (SSA) to make disability determinations for Georgia citizens who apply for entitlement programs administrated by the Social Security Administration (SSI/SSDI).

Examples
Examples of some of the Services provided by these programs

- The Vocational Rehabilitation Program may provide those services necessary to assist an individual with a disability in meeting the entry-level requirements of the qualified individual’s work goal. Services shall be deemed both appropriate and reasonable. Only approved providers may provide services.
Examples of Services:
- Work Adjustment Training - Job Coaching
- Work Readiness Training - Job Placement/Follow-Up
- Counseling and Guidance - College/University Instruction
- Supported Employment - Vocational/Technical Training
- Information and Referral Services - On the Job Training

- The Disability Adjudication Services program include:
  - Initial and First appeal decisions on Federal Entitlement programs
  - Personal Disability hearings for beneficiaries whose claims are being appealed after benefits have ceased
  - Face-to-Face interviews with claimants whose impairment(s) severity can better be realized by observation than through written reports
  - Referral to other Vocational Rehabilitation services for those with rehabilitation potential
  - Eligibility determinations for health care benefits under Medicare (SSDI) and Medicaid (SSI)
  - Assistance to the Department of Family and Children Services (DFCS) Medicaid Unit to determine the earliest date that State Medicaid may assist with payment of a qualified individual’s past medical expenses

Submitting a Claim
Information on how and where to submit a claim:
Eligible applicants work directly with qualified professional Certified Rehabilitation Counselors who authorize payments for services provided by approved providers.

Patients with Insurance
Medicare, Medicaid or Private Insurance is always deemed the “Primary” payer.

Reimbursement
Reimbursement is made to approve providers based on the rates paid by Medicare/Medicaid.

Verification
Verification of a Vocational Rehabilitation or Disability Adjudication Services client: The professional Certified Rehabilitation Counselor can provide this verification.

Website: www.vocrehabga.org

Additional Information
Information given above taken from the Georgia Department of Labor Vocational Rehabilitation Program “Client Services Policy Manual” July 2003
Mission
The mission of Children's Medical Services (CMS) is to provide a community-based, family-focused, care coordinated, culturally appropriate, comprehensive system of medical/health care for eligible children, birth to 21, with chronic medical conditions.

Overview
CMS is the state and federally funded Title V Maternal and Child Health Services program. The CMS program receives an annual appropriation from the Georgia Legislature and grant funds available to the program. Eligibility for the program includes medical and financial requirements. The financial requirements are updated yearly. Families with greater than 150% of the Federal Poverty Level (FPL) through 236% of the FPL will be required to cost participate in the care of their child. Also, children who are Medicaid/PeachCare enrolled, receive SSI, or are in foster care are eligible for CMS services.

In CMS, children from birth to age 21 with eligible conditions receive comprehensive, coordinated specialty care. The medical eligibility includes, but is not limited to the following conditions:
- Burns
- Cardiac conditions
- Chronic lung disease (including cystic fibrosis)
- Craniofacial anomalies (including cleft lip/palate)
- Diabetes mellitus
- Gastrointestinal disorders
- Hearing disorders
- Spina bifida
- Neurological and neurosurgical conditions (including epilepsy and hydrocephalus)
- Orthopedic and/or neuromuscular disorders (including scoliosis)
- Congenital or traumatic amputation of limbs
- Cerebral palsy
- Vision disorders (including cataracts, glaucoma, amblyopia and strabismus)

Programs & Services
CMS offers community-based services through a network of 19 districts (21 offices). The Division of Public Health administers these sites through grant-in-aid contracts to the districts. At each site, care coordinators provide outreach, referral, care coordination, education and follow-up for clients and their families.

The CMS Program provides care to over 10,500 children per year. This network includes physician specialists, therapists (OT and PT), audiologists, nutritionists, equipment providers, prosthetics, pharmacists, and others. CMS may provide or assist in paying for an array of services that include:
- Comprehensive physical assessment
- Diagnostic testing
- In-patient/out-patient hospital services
- Medications
- Medical treatments
• Therapy
• Durable and disposable medical equipment
• Hearing aids
• Dental care (if related to the CMS eligible condition)
• Health education
• Care coordination for client and family (may include referrals to other providers such as schools, day care, social service programs, etc)
• Genetic consultations

Authorization
The Georgia Children’s Medical Services Program requires prior authorization for all services funded by the CMS Program. This includes instances where CMS may be the primary payer as well as situations where CMS has a fiscal liability as part of the coordination of benefits with any other public (Medicaid, PeachCare) or private payer.

CMS is the payer of last resort and all other resources must be completely pursued and documented prior to CMS approval for funding. If a child appears to qualify for Medicaid or PeachCare, you must bill the Medicaid program prior to billing CMS for services. CMS will not cover admissions that have been denied by Medicaid because of failure to meet timely filing limits or because the hospital failed to obtained a pre-certification.

CMS coverage for all non-emergency services including but not limited to inpatient hospitalization, outpatient surgery and office visits will be denied if prior authorization has not been obtained.

Notification of and approval for payment of emergency room visits must be requested at the time of the ER visit (if during normal business hours) or no later than the next business day. Notification of an emergency hospital admission must be made to CMS at the time of admission, or no later than the next business day. Failure to meet these requirements could result in a cap for reimbursement of $2,000.

Receipt of a Prior Authorization form for medical services is the only mechanism to assure that the patient is active on the CMS program and that CMS will cover services. The family should have this document and be able to present it at the time of service.

Reimbursement
Inpatient or outpatient day surgery and 23 hour admissions are reimbursed at 70% or the hospital Medicaid rate, whichever is lower.

Anesthesia is paid by Medicaid rates.

All bills must be submitted to CMS within 180 days of last date of service.

Diagnostic services such as lab, EKG, EEG, CT etc will be paid at Medicaid rates.
What is Crime Victims Compensation?
Crime Victims Compensation assists eligible victims of violent crime with expenses (listed below) that are incurred due to the victimization. Crime Victims Compensation is a payer of last resort and does not cover expenses that have been covered by a third party payer (insurance, sick leave, worker's compensation, etc.). The total award amount cannot exceed $25,000 and the categorical caps are as follows:

- Medical Expenses - $5,000 (Crimes occurring prior to 05/13/02)
- Medical Expenses - $10,000 (Crimes occurring 05/13/02 to 06/30/02)
- Medical Expenses - $15,000 (Crimes occurring on or after 07/01/02)
- Counseling Bills - $2,500 (Crimes occurring prior to 05/13/02)
- Counseling Bills - $3,000 (Crimes occurring on or after 05/13/02)
- Funeral Expenses - $3,000
- Lost Wages/Support - $5,000 (Crimes occurring prior to 05/13/02)
- Lost Wages/Support - $10,000 (Crimes occurring on or after 05/13/02)
- Crime Scene Clean-up - $1,500 (Crimes occurring on or after 05/13/02)

Who is eligible for Victims Compensation?
Innocent victims who have been physically injured in a violent crime are eligible. Including but not limited to victims of:
- Assault/Battery
- Homicide
- Child Abuse
- Sexual Assault
- Domestic/Family Violence
- DUI Crash Victims
- Vehicular Homicide
- Hit and Run
- Serious Injury by Vehicle

Eligibility requirements include
- The crime being reported to proper government authorities (i.e. law enforcement, child protective services, the courts, etc.) within 72 hours. The 72 hours may be waived for good cause shown.
- The claim must be filed within 1 year of the crime.
- Applications received 2 years after the crime cannot be considered for compensation.
• Victims of domestic violence may be eligible for loss of support. A parent of a child victim may be eligible for lost wages, to compensate for medical time spent off of work with the child.
• A Criminal History will be provided and analyzed on all victims 18 years and older.

Who is not eligible?
• Victims of property crime
• Victims who consent, provoke, or incite the crime committed against them
• Victims who were participating in a criminal act
• Victims who do not report the crime to law enforcement officials within 72 hours
• Victims/claimants are required to exhaust funds from other sources such as health insurance, car insurance, social security, annual/sick leave pay, disability insurance, worker’s compensation, unemployment compensation or funds from other government agencies

Financial Counselors in most facilities complete the Crime Victims Application as part of their interview process. The application must be accompanied by an itemized bill and a copy of the police report filed by the patient. If the patient does not intend to press charges against their perpetrator, reimbursement for services will not be approved.

Completed Applications must be submitted to:
Georgia Crime Victims Compensation Program
503 Oak Place, Suite 540
Atlanta, Ga. 30349
Juvenile Patients
Providers often have minor patients present for services that are in the custody of the
Department of Juvenile Justice. These patients typically are presenting to the emergency room
for injuries or for medical clearance to be accepted into a state facility. Although they are
minors and the parent is responsible for their healthcare, recovering payment from these
guarantors is difficult. Many times parents:

- Do not know their child has had medical services
- Did not accompany the child
- There is no signed document stating they are responsible for payment.

Usually, these are not huge dollar claims and legal action is tedious to recover payment.
Therefore, many facilities forgo the excessive efforts required for payment and simply suffer the
loss. By law the state is mandated to provide and pay for these services. A reference list of
Georgia General Assembly Unannotated Code is provided, however CPAR students will not be
tested on these codes.

- If the minor/patient has not yet entered a Detention Facility, the claim typically is filed to the
  county where the minor/patient resides.
- If the patient resides in a Regional Youth Detention Center or Youth Development Campus,
  the claim is submitted to the specific facility of residence.
- If payment is denied or is untimely, the provider can appeal to the specific facility.

State Facilities
A listing of the state facilities and contacts follows, and the website for Juvenile Justice can be

Division of Community Corrections
3408 Covington Highway
Decatur, Georgia 30032

Rob Rosenbloom
Deputy Commissioner
Phone: 404-508-6550
Fax: 404-508-7333
## Regional Youth Detention Centers (RYDCs)

<table>
<thead>
<tr>
<th>Facility</th>
<th>Facility Director</th>
<th>Phone and Fax</th>
</tr>
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<tbody>
<tr>
<td><strong>Albany RYDC</strong></td>
<td><strong>Diane Douglas-Harris</strong></td>
<td><strong>Phone:</strong> 229-430-4167 <strong>Fax:</strong> 229-430-3013</td>
</tr>
<tr>
<td>(Located in Dougherty County)</td>
<td>(Acting Director)</td>
<td></td>
</tr>
<tr>
<td>2030 Newton Road</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albany, GA 31701-3599</td>
<td></td>
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<tr>
<td><strong>Augusta RYDC</strong></td>
<td><strong>Elliott Norman</strong></td>
<td><strong>Phone:</strong> 706-771-4881 <strong>Fax:</strong> 706-771-4917</td>
</tr>
<tr>
<td>(Located in Richmond County)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3485 Mike Padgett Highway</td>
<td></td>
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</tr>
<tr>
<td>Augusta, GA 30906-3815</td>
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<tr>
<td><strong>Blakely RYDC</strong></td>
<td><strong>Sandra Cawthon</strong></td>
<td><strong>Phone:</strong> 229-724-2175 <strong>Fax:</strong> 229-724-2531</td>
</tr>
<tr>
<td>(Located in Early County)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>763 Jesse Johnson Street</td>
<td></td>
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</tr>
<tr>
<td>Blakely, GA 39823-3224</td>
<td></td>
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<tr>
<td><strong>Bob Richards RYDC</strong></td>
<td><strong>Gail Wise</strong></td>
<td><strong>Phone:</strong> 706-295-6035 <strong>Fax:</strong> 706-802-5222</td>
</tr>
<tr>
<td>(Located in Floyd County)</td>
<td></td>
<td></td>
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<tr>
<td>200 Marable Way NW</td>
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<tr>
<td>Rome, GA 30165</td>
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<tr>
<td><strong>Claxton RYDC</strong></td>
<td><strong>Shelia Dease</strong></td>
<td><strong>Phone:</strong> 912-739-4807 <strong>Fax:</strong> 912-739-7932</td>
</tr>
<tr>
<td>(Located in Evans County)</td>
<td></td>
<td></td>
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<tr>
<td>3609 Bill Hodges Road</td>
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<td></td>
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<tr>
<td>Claxton, GA 30417</td>
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<tr>
<td><strong>Martha K. Glaze RYDC</strong></td>
<td><strong>Antonius Robinson</strong></td>
<td><strong>Phone:</strong> 770-473-2100 <strong>Fax:</strong> 770-473-2101</td>
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<tr>
<td>(formerly Clayton RYDC)</td>
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<tr>
<td>(Located in Clayton County)</td>
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<tr>
<td>11850 Hastings Bridge Road</td>
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<tr>
<td>Hampton, GA 30228</td>
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<tr>
<td><strong>Crisp RYDC</strong></td>
<td><strong>Mable Wheeler</strong></td>
<td><strong>Phone:</strong> 229-271-4900 <strong>Fax:</strong> 229-271-4792</td>
</tr>
<tr>
<td>(Located in Crisp County)</td>
<td></td>
<td></td>
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<tr>
<td>130 Rehab Road</td>
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<tr>
<td>Cordele, GA 31015</td>
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<tr>
<td><strong>Aaron Cohn RYDC</strong></td>
<td><strong>Jamie Lee Hooks</strong></td>
<td><strong>Phone:</strong> 706-565-4374 <strong>Fax:</strong> 706-565-3595</td>
</tr>
<tr>
<td>(Located in Muscogee County)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7700 Chattsworth Road</td>
<td></td>
<td></td>
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<tr>
<td>Midland, GA 31820</td>
<td></td>
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</tr>
<tr>
<td><strong>Elbert Shaw RYDC</strong></td>
<td><strong>James R.&quot;Bobby&quot;</strong></td>
<td><strong>Phone:</strong> 706-272-2309</td>
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<tr>
<td>Location</td>
<td>Contact Name</td>
<td>Phone</td>
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</tr>
<tr>
<td>(formerly Dalton RYDC)</td>
<td>Hughes</td>
<td>Fax: 706-272-2367</td>
</tr>
<tr>
<td>(Located in Whitfield County)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2735 Underwood Road, NE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dalton, GA 30721-7499</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DeKalb RYDC</td>
<td>Gary Pattman</td>
<td>Phone: 404-244-2183</td>
</tr>
<tr>
<td>(Located in DeKalb County)</td>
<td></td>
<td>Fax: 404-244-5779</td>
</tr>
<tr>
<td>2946 Clifton Springs Road</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decatur, GA 30034-3820</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eastman RYDC</td>
<td>Debbie Morris</td>
<td>Phone: 478-374-6766</td>
</tr>
<tr>
<td>(Located in Dodge County)</td>
<td></td>
<td>Fax: 478-374-6979</td>
</tr>
<tr>
<td>181 Industrial Blvd.</td>
<td></td>
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<tr>
<td>Eastman, GA 31023-7113</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gainesville RYDC</td>
<td>Gary Payne</td>
<td>Phone: 770-535-5465</td>
</tr>
<tr>
<td>(Located in Hall County)</td>
<td></td>
<td>Fax: 770-535-6968</td>
</tr>
<tr>
<td>450 Crescent Drive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gainesville, GA 30501-5079</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Griffin RYDC</td>
<td>Pamela Mitchell</td>
<td>Phone: 770-228-7350</td>
</tr>
<tr>
<td>(Located in Spalding County)</td>
<td></td>
<td>Fax: 770-412-4783</td>
</tr>
<tr>
<td>105 Justice Blvd.</td>
<td></td>
<td></td>
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<tr>
<td>Griffin, GA 30224-8817</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gwinnett RYDC</td>
<td>Edward Boyd</td>
<td>Phone: 770-995-6921</td>
</tr>
<tr>
<td>(Located in Gwinnett County)</td>
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<td>Fax: 770-339-2341</td>
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<td>650 Hi Hope Lane</td>
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<td>Lawrenceville, GA 30043-4581</td>
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<tr>
<td>Judge Thomas Jefferson Loftiss II RYDC</td>
<td>Stephen Westberry</td>
<td>Phone: 229-227-2764</td>
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<tr>
<td>(Located in Thomas County)</td>
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<td>Fax: 229-227-2659</td>
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<tr>
<td>400 South Pinetree Boulevard</td>
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<td>Thomasville, GA 31792-7128</td>
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<tr>
<td>Macon RYDC</td>
<td>Ronnie Richardson</td>
<td>Phone: 478-751-3400</td>
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<tr>
<td>(Located in Bibb County)</td>
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<td>Fax: 478-751-4417</td>
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<tr>
<td>4164 Riggins Mill Road</td>
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<td>Macon, GA 31217-5999</td>
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<tr>
<td>Marietta RYDC</td>
<td>Gary Morris</td>
<td>Phone: 770-528-4247</td>
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<tr>
<td>(Located in Cobb County)</td>
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<td>Fax: 770-528-4261</td>
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<td>1575 County Services Pkwy, SW</td>
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<td>Marietta, GA 30008-4007</td>
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<tr>
<td>Metro RYDC</td>
<td>Debbie Alexander</td>
<td>Phone: 404-635-4400</td>
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<tr>
<td>(Located in DeKalb County)</td>
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<td>Fax: 404-635-4410</td>
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<td>1300 Constitution Road, SE</td>
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<td><strong>Paulding RYDC</strong></td>
<td><strong>Beverly Westbrooks</strong></td>
<td>770-443-1166</td>
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<td>(Located in Paulding County)</td>
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<td><strong>Sandersville RYDC</strong></td>
<td><strong>Harold Thompkins</strong></td>
<td>478-553-2400</td>
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<tr>
<td>(Located in Washington County)</td>
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<td>423 Industrial Drive</td>
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<td><strong>Savannah RYDC</strong></td>
<td><strong>Rodney Dinkins</strong></td>
<td>912-652-3879</td>
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<td>(Located in Chatham County)</td>
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<td>191 Carl Griffin Drive</td>
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<td>Savannah, GA 31405-1362</td>
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<tr>
<td><strong>Waycross RYDC</strong></td>
<td><strong>Renee Mumford</strong></td>
<td>912-287-6680</td>
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<td>(Located in Ware County)</td>
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<td>3275 Harris Road</td>
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<td>Waycross, GA 31503-8956</td>
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49-5-8. (a) The Department of Human Resources is authorized and empowered, through its own programs and the programs of county or district departments of family and children services, to establish, maintain, extend, and improve throughout the state, within the limits of funds appropriated therefore, programs that will provide:

1. Preventive services as follows:

   (A) Collecting and disseminating information about the problems of children and youths and providing consultative assistance to groups, public and private, interested in developing programs and services for the prevention, control, and treatment of dependency, deprivation, and delinquency among the children of this state; and

   (B) Research and demonstration projects designed to add to the store of information about the social and emotional problems of children and youths and improve the methods for dealing with these problems;

2. Child welfare services as follows:

   (A) Casework services for children and youths and for mothers bearing children out of wedlock, whether living in their own homes or elsewhere, to help overcome problems that result in dependency, deprivation, or delinquency;

   (B) Protective services that will investigate complaints of deprivation, abuse, or abandonment of children and youths by parents, guardians, custodians, or persons serving in loco parentis and, on the basis of the findings of such investigation, offer social services to such parents, guardians, custodians, or persons serving in loco parentis in relation to the problem or bring the situation to the attention of a law enforcement agency, an appropriate court, or another community agency;

   (C) Supervising and providing required services and care involved in the interstate placement of children;

   (D) Homemaker service, or payment of the cost of such service, when needed due to the absence or incapacity of the mother;

   (E) Boarding care, or payment of maintenance costs, in foster family homes or in group-care facilities for children and youths who cannot be adequately cared for in their own homes;

   (F) Boarding care or payment of maintenance costs for mothers bearing children out of wedlock prior to, during, and for a reasonable period after childbirth; and

   (G) Day-care services for the care and protection of children whose parents are absent from the home or unable for other reasons to provide parental supervision;
(3) Services to courts, upon their request, as follows:

(A) Accepting for casework services and care all children and youths whose legal custody is vested in the department by the court;

(B) Providing shelter or custodial care for children prior to examination and study or pending court hearing;

(C) Making social studies and reports to the court with respect to children and youths as to whom petitions have been filed; and

(D) Providing casework services and care or payment of maintenance costs for children and youths who have run away from their home communities within this state, or from their home communities in this state to another state, or from their home communities in another state to this state; paying the costs of returning such runaway children and youths to their home communities; and providing such services, care, or costs for runaway children and youths as may be required under Chapter 3 of Title 39;

(4) Regional group-care facilities for the purpose of:

(A) Providing local authorities an alternative to placing any child in a common jail;

(B) Shelter care prior to examination and study or pending a hearing before juvenile court;

(C) Detention prior to examination and study or pending a hearing before juvenile court; and

(D) Study and diagnosis pending determination of treatment or a hearing before juvenile court;

(5) Facilities designed to afford specialized and diversified programs, such as forestry camps, ranches, and group residences, for the care, treatment, and training of children and youths of different ages and different emotional, mental, and physical conditions;

(6) Regulation of child-placing and child-caring agencies by:

(A) Setting standards for and providing consultation and making recommendations concerning establishment and incorporation of all such agencies; and

(B) Licensing and inspecting regularly all such agencies to ensure their adherence to established standards as prescribed by the department;

(7) Adoption services, as follows:

(A) Supervising the work of all child-placing agencies;

(B) Providing services to parents desiring to surrender children for adoption as provided for in adoption statutes;
(C) Providing care or payment of maintenance costs for mothers bearing children out of wedlock and children being considered for adoption;

(D) Inquiring into the character and reputation of persons making application for the adoption of children;

(E) Placing children for adoption;

(F) Providing financial assistance after the consummation of a legal adoption to families adopting children who would otherwise remain in foster care at state expense. Financial assistance may only be granted for hard-to-place children with physical, mental, or emotional disabilities or with other problems for whom it is difficult to find a permanent home. Financial assistance may not exceed 100 percent of the amount paid for boarding such child and for special services such as medical care not available through insurance or public facilities. Such supplements shall only be available to families who could not provide for the child adequately without continued financial assistance. The department may review the supplements paid at any time but shall review them at least annually to determine the need for continued assistance;

(G) Providing payment to a licensed child-placing agency, which places a child with special needs who is under the jurisdiction of the department for adoption. Payment may not exceed $5,000.00 for each such adoption arranged by an agency. The board shall define the special needs child. One-half of such payment shall be made at the time of placement and the remaining amount shall be paid when the adoption is finalized. If the adoption disrupts prior to finalization, the state shall be reimbursed by the child-placing agency in an amount calculated on a prorated basis based on length of time the child was in the home and the services provided; and

(H) Providing payment to an agency, which recruits, educates, or trains potential adoptive or foster parents for preparation in anticipation of adopting or fostering a special needs child. The board shall define the special needs child and set the payment amount by rule and regulation. Upon appropriate documentation of these preplacement services in a timely manner, payments as set by the board shall be made upon enrollment of each potential adoptive or foster parent for such services;

(8) Staff development and recruitment programs through in-service training and educational scholarships for personnel as may be necessary to assure efficient and effective administration of the services and care for children and youths authorized in this article. The department is authorized to disburse state funds to match federal funds in order to provide qualified employees with graduate or postgraduate educational scholarships in accordance with rules and regulations adopted by the board pursuant to Article VIII, Section VII, Paragraph I of the Constitution of Georgia; and

(9) Miscellaneous services, such as providing all medical, hospital, psychiatric, surgical, or dental services or payment of the costs of such services as may be considered appropriate and necessary by competent medical authority to those children subject to the supervision and control of the department without securing prior consent of parents or legal guardians.
(b) The department is authorized to perform such other duties as may be required under related statutes.

(c)(1) As used in paragraph (2) of this subsection, the term 'state' means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, or any territory or possession of or territory or possession administered by the United States.

(2) The Department of Human Resources is authorized to enter into interstate compacts, on behalf of this state, with other states to provide for the reciprocal provision of adoption assistance services.

(3) The purpose of paragraphs (1) and (2) of this subsection is to comply with the requirements of the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) and Part E of Title IV of the Social Security Act and to assure that recipients of adoption assistance in Georgia who change their residences to other states receive adoption assistance services, other than adoption assistance payments, from their new states of residence.
GA State Prisoners
The U.S. Supreme Court has recognized that government has a constitutional obligation to provide adequate medical care to inmates. This obligation arises from an inmate’s Eighth Amendment right to be protected against cruel and unusual punishment. In short, the Supreme Court determined that the absence or gross inadequacy of medical care to inmates can amount to the infliction of cruel and unusual punishment against a confined individual who has no other access to medical care other than that provided by the correctional facility.

The State of Georgia provides, by law, for the reimbursement of healthcare services for inmates and prisoners.

Inmates of the state serve their sentences in Georgia state prisons, under the authority of the Department of Corrections (DOC). The state is responsible to provide healthcare, hence, they are responsible to make payment for services rendered. The DOC contracts with Georgia Correctional Healthcare (GCHC) to facilitate healthcare for this patient population. The responsibility to insure proper payment is that of the particular institution where the prisoner resides as each prison authorizes claims for payment, and they are then forwarded to their TPA (third party administrator) for payment processing. Any appeals should be directed to GCHC at the following address:

Georgia Correctional Healthcare
1499 Walton Way
HS 3513
Augusta, GA 30912
Phone: 706-721-4481

County Prisoners
County prisoners are held within each county’s law enforcement center. Typically, each county contracts with a TPA to administer healthcare benefits. The law requires that each county provide medically necessary healthcare to anyone in custody. The state does provide, however, that if the inmate has medical healthcare coverage, that it is appropriate for the provider to file directly to the inmate’s healthcare plan. Ultimately, however, each county is responsible for payment. Many TPAs will attempt to pay at the state’s Medicaid Fee Schedule; however, there is nothing in the law that requires a provider to accept this reimbursement.

The law also requires that “the department shall also bear the costs of any reasonable and necessary follow-up medical or hospital care rendered to any such inmate as a result of the initial emergency care and treatment of the inmate.”
Georgia Code
The following is the GA Code that dictates the county’s responsibility for payment. This is reference material and CPAR students will not be tested on the contents of the Code.

Georgia General Assembly
Unannotated Code

42-4-50
Terminology of code::

1.  'Detention facility' means a municipal or county jail used for the detention of persons charged with or convicted of a felony, a misdemeanor, or a municipal offense.
2.  'Governing authority' means the governing authority of the county or municipality in which the detention facility is located.
3.  'Inmate' means a person who is detained in a detention facility by reason of being charged with or convicted of a felony, a misdemeanor, or a municipal offense. Such term does not include any sentenced inmate who is the responsibility of the State Department of Corrections.
4.  'Medical care' means medical attention, dental care, mental health care, optometry care, physical or mental health therapy, and prescribed medicine and prosthesis necessary and associated medical, dental, mental health treatment or optometry costs such as transportation, hospitalization, guards, room, and board.
5.  'Officer in charge' means the sheriff, if the detention facility is under his or her supervision, or the warden, captain, or superintendent having the supervision of any other detention facility.

42-4-4
1.  It shall be the duty of the sheriff:
   • To take from the outgoing sheriff custody of the jail and the bodies of such persons as are confined therein, along with the warrant or cause of commitment;
   • To furnish persons confined in the jail with medical aid, heat, and blankets, to be reimbursed if necessary from the county treasury, for neglect of which he shall be liable to suffer the penalty prescribed in this Code section; provided, however, that, with respect to an inmate covered under Article 3 of this chapter, the officer in charge will provide such person access to medical aid and may arrange for the person’s health insurance carrier to pay the health care provider for the aid rendered; and
   • To take all persons arrested or in execution under any criminal or civil process to the jail of an adjoining county, or to the jail of some other county if the latter is more accessible, if the jail of his county is in an unsafe condition, under such rules as are prescribed in this chapter.

2.  Subject to the provisions of this subsection and except as provided by law or as directed by a court of competent jurisdiction, a sheriff shall not release a prisoner from his custody prior to the lawful completion of his sentence including any lawful credits under a trusty system. The provision shall not, however, preclude a sheriff from designating an inmate as a trusty and utilizing him in a lawful manner and, furthermore, this provision shall not preclude a sheriff from transferring a prisoner to another jail in another county if the sheriff concludes that such transfer is in the best interest of the prisoner or that such transfer is necessary for

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the orderly administration of the jail.

3. Any sheriff or deputy who fails to comply with this Code section shall be fined for contempt, as is the clerk of the superior court in similar cases. The sheriff or deputy shall also be subject to removal from office as prescribed in Code Section 15-6-82.

42-5-2
Responsibilities of governmental unit with custody of inmate generally; costs of emergency and follow-up care; access to medical services or hospital care for inmates; requirements for hospitals that provide emergency health care services to state inmates

Georgia General Assembly
Unannotated Code

42-4-50
Terminology of code:

6. 'Detention facility' means a municipal or county jail used for the detention of persons charged with or convicted of a felony, a misdemeanor, or a municipal offense.
7. 'Governing authority' means the governing authority of the county or municipality in which the detention facility is located.
8. 'Inmate' means a person who is detained in a detention facility by reason of being charged with or convicted of a felony, a misdemeanor, or a municipal offense. Such term does not include any sentenced inmate who is the responsibility of the State Department of Corrections.
9. 'Medical care' means medical attention, dental care, mental health care, optometry care, physical or mental health therapy, and prescribed medicine and prosthesis necessary and associated medical, dental, mental health treatment or optometry costs such as transportation, hospitalization, guards, room, and board.
10. 'Officer in charge' means the sheriff, if the detention facility is under his or her supervision, or the warden, captain, or superintendent having the supervision of any other detention facility.

42-4-4
4. It shall be the duty of the sheriff:

- To take from the outgoing sheriff custody of the jail and the bodies of such persons as are confined therein, along with the warrant or cause of commitment;
- To furnish persons confined in the jail with medical aid, heat, and blankets, to be reimbursed if necessary from the county treasury, for neglect of which he shall be liable to suffer the penalty prescribed in this Code section; provided, however, that, with respect to an inmate covered under Article 3 of this chapter, the officer in charge will provide such person access to medical aid and may arrange for the person’s health insurance carrier to pay the health care provider for the aid rendered; and
- To take all persons arrested or in execution under any criminal or civil process to the jail of an adjoining county, or to the jail of some other county if the latter is more accessible, if the jail of his county is in an unsafe condition, under such rules as are prescribed in this chapter.
5. Subject to the provisions of this subsection and except as provided by law or as directed by a court of competent jurisdiction, a sheriff shall not release a prisoner from his custody prior to the lawful completion of his sentence including any lawful credits under a trusty system. The provision shall not, however, preclude a sheriff from designating an inmate as a trusty and utilizing him in a lawful manner and, furthermore, this provision shall not preclude a sheriff from transferring a prisoner to another jail in another county if the sheriff concludes that such transfer is in the best interest of the prisoner or that such transfer is necessary for the orderly administration of the jail.

6. Any sheriff or deputy who fails to comply with this Code section shall be fined for contempt, as is the clerk of the superior court in similar cases. The sheriff or deputy shall also be subject to removal from office as prescribed in Code Section 15-6-82.

42-5-2
Responsibilities of governmental unit with custody of inmate generally; costs of emergency and follow-up care; access to medical services or hospital care for inmates; requirements for hospitals that provide emergency health care services to state inmates

a) Except as provided in subsection (b) of this Code section, it shall be the responsibility of the governmental unit, subdivision, or agency having the physical custody of an inmate to maintain the inmate, furnishing him food, clothing, and any needed medical and hospital attention; to defend any habeas corpus or other proceedings instituted by or on behalf of the inmate; and to bear all expenses relative to any escape and recapture, including the expenses of extradition. Except as provided in subsection (b) of this Code section, it shall be the responsibility of the department to bear the costs of any reasonable and necessary emergency medical and hospital care which is provided to any inmate after the receipt by the department of the notice provided by subsection (a) of Code Section 42-5-50 who is in the physical custody of any other political subdivision or governmental agency of this state, except a county correctional institution, if the inmate is available and eligible for the transfer of his custody to the department pursuant to Code Section 42-5-50. Except as provided in subsection (b) of this Code section, the department shall also bear the costs of any reasonable and necessary follow-up medical or hospital care rendered to any such inmate as a result of the initial emergency care and treatment of the inmate. With respect to state inmates housed in county correctional institutions, the department shall bear the costs of direct medical services required for emergency medical conditions posing an immediate threat to life or limb if the inmate cannot be placed in a state institution for the receipt of this care. The responsibility for payment will commence when the costs for direct medical services exceed an amount specified by rules and regulations of the Board of Corrections. The department will pay only the balance in excess of the specified amount. Except as provided in subsection (b) of this Code section, it shall remain the responsibility of the governmental unit having the physical custody of an inmate to bear the costs of such medical and hospital care, if the custody of the inmate has been transferred from the department pursuant to any order of any court within this state. The department shall have the authority to promulgate rules and regulations relative to payment of such medical and hospital costs by the department.

(b)(1) The officer in charge will provide an inmate access to medical services or hospital care and may arrange for the inmate's health insurance carrier to pay the health care provider for the services or care rendered as provided in Article 3 of Chapter 4 of this title.
(2) With respect to an inmate covered under Article 3 of Chapter 4 of this title, the costs of any medical services, emergency medical and hospital care, or follow-up medical or hospital care as provided in subsection (a) of this Code section for which a local governmental unit is responsible shall mean the costs of such medical services and hospital care which have not been paid by the inmate's health insurance carrier or the Department of Community Health.

(c) A hospital authority or hospital which is not a party to a contract with the Georgia Department of Corrections or its agents on July 1, 2009, shall be reimbursed no more than the applicable Georgia Medicaid rate for emergency services provided to such state inmate. For purposes of this subsection, the term "state inmate" means any inmate for whom the Georgia Department of Corrections shall be responsible for the payment of medical care thereof. Nothing in this Code section shall prohibit the Georgia Department of Corrections from negotiating higher fees or rates with health care providers. It is the intent of the General Assembly that the Georgia Department of Corrections or its agents enter into negotiations with health care providers to contract for the provision of services as provided in this Code section.

42-4-15

(a) As used in this Code section, the term:

(1) 'Detention facility' means any municipal or county jail or other facility used for the detention of persons charged with or convicted of a criminal offense.

(2) 'Emergency health care' means bona fide emergency services provided after the onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The term includes any form of medical, dental, optical, psychological, or other emergency treatment and the medication administered in conjunction with such treatment.

(3) 'Governing authority' means the governing authority of the county or municipality in which the detention facility is located.

(4) 'Inmate' means a person who is detained in a detention facility.

(b) A hospital or other health care facility licensed or established pursuant to Chapter 7 of Title 31 that provides emergent health care services to a state inmate, and which is not a party to a contract with the department, shall:

(1) Charge an amount not to exceed the applicable Georgia Medicaid rate for such services;

(2) Treat the emergent condition wholly and completely such that any reasonably apparent injuries associated with the condition are also treated; and

(3) Not discharge a state inmate with an emergent condition so as to require an immediate transfer to another provider for the same condition unless the standard of care would require a transfer. For purposes of this subsection, the term 'state inmate' means any inmate for whom the department shall be responsible for the payment of medical care thereof. Nothing in this Code section shall prohibit the department from negotiating fees or rates with health care providers.
SECTION 2.5 OTHER
Section 2.5.A - Liability Insurance

Introduction
All patients should be questioned as to the nature of their illness and/or injury to determine whether an accident was involved. Most insurance companies will not reimburse a claim until all accident / incident information has been provided so that primary payer responsibility can be established. In the event a patient sustained an injury as the result of someone else’s negligence, liability insurance information should be obtained. These situations include but are not limited to, a fall at a store, a dog bite from someone other than the patients’ dog, an injury at someone’s home, etc. Some liability insurance can be filed directly and some must be awarded through the court systems. In these situations, a lien is necessary. Liability insurance should be filed and is primary over health insurance.

Homeowners Insurance
Homeowners insurance exists to provide medical benefits or financial protection in the event of liability or legal responsibility for any injuries caused to other people while visiting or working at your home. This includes damage caused by household pets. Patients cannot file a claim against their own homeowners insurance when the patient sustains an injury at their residence. Homeowners insurance should be billed at the time the patient reaches their maximum benefits on a UB04 form.

Tort Liability
A “tort” is not a crime but a civil wrongdoing, other than a breach of contract done to another person. An injured person may sue anyone who commits a tort against him and collect damages – money to help compensate him for the wrong. The person who is injured and sues for damages as a result of the wrongful conduct is the plaintiff in the lawsuit. The person who has acted wrongfully and becomes liable to the plaintiff is the tortfeasor, or defendant. The primary aim of tort law is to provide relief of injuries incurred and to deter others from committing the same civil wrongs. The injured party may recover the following damages: loss of earnings capacity, pain and suffering and reasonable medical expenses.

The law of torts deals with the allocation of responsibility for loss or harm arising out of human activities. Virtually any type of activity – driving a car, engaging in business, speaking, writing, owning or using property – may be a source of harm and, therefore, of tort liability.

Examples of tort include:
- If you buy a new hunting gun and the first time you shoot it the gun explodes, both the manufacturer and the dealer can be made to pay damages.
- If a neighbor’s dog enters your yard and bites your child, the owner of the dog can be made to pay damages.
Coverage
Georgia’s mandatory auto insurance law requires that drivers have at least the following minimum liability coverage:

- **Bodily injury** (BI) - $25,000 per person, $50,000 per accident payable for bodily injury to others.
- **Property damage liability** (PD) - $25,000 per occurrence payable for damage to the property of others.

Coverage can be purchased in almost any amount above the minimum.

Uninsured / Underinsured motorist (UM) Insurance
Uninsured / Underinsured motorist (UM) Insurance is a category of coverage that protects the policyholder in the event a motorist who causes the accident does not have insurance, or does not have an adequate amount of liability insurance coverage. UM coverage covers the gap between the liability insurance coverage of the person who causes the accident and the amount of your UM coverage. UM coverage is automatically equal to the policyholder’s auto liability coverage unless it is rejected in writing.

If you have multiple cars in your household covered under separate insurance policies, you may be able to “stack” the UM coverage’s of each of the separate policies. In stacking UM coverage’s, priority is determined according to the relationship of the injured person-to-person paying the premiums.

Although bodily injury, property damage, and uninsured motorist coverage are not payable to a medical facility, a lien can be filed so that the hospital bill can be considered at the time a settlement is reached.

Medical payments coverage
Medical payments coverage (Med-Pay) is no longer a requirement but is still available for those who wish to purchase this coverage. Georgia repealed its “no fault” law in 1991; therefore auto insurance policies no longer mandate coverage for medical expenses or wage loss of occupants of the insured vehicle who are injured.

Billing and Collection
It is important to be aware of the availability of Med Pay coverage. Med Pay coverage benefits are paid/distributed at the patient’s/policy holder’s discretion. Some insurance carriers require the member to exhaust his/her Med Pay benefits or provide proof of non-coverage before processing any accident related claim.

Medical Providers do have the option to file a lien. This lien does not attach to the person or their property. The lien is attached to the third party insurance company who may become liable for the bill. Liens may NOT be filed if the patient has coverage through a contracted payer whose contractual language contains a hold harmless clause.
Chapter 3 – Billing and other forms
Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient’s legal representative.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Religious Non-Medical facilities, verifications and necessary re-certifications are on file.

5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR, 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.

6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient’s signature on the provider’s request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal aid, State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.

9. For TRICARE Purposes:

   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter’s knowledge and belief, and services were medically necessary and appropriate for the health of the patient;

   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DO Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

   (c) The patient or the patient's parent or guardian has responded directly to the provider’s request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;

   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;

   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and

   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept any amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care a participating provider.
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PATIENT'S NAME</td>
<td>Last Name, First Name, Middle Initial</td>
</tr>
<tr>
<td>2. PATIENT'S ADDRESS</td>
<td>Street Address, City, State, ZIP Code</td>
</tr>
<tr>
<td>3. PATIENT'S RELATIONSHIP TO INSURED</td>
<td></td>
</tr>
<tr>
<td>4. INSURED'S NAME</td>
<td>Last Name, First Name, Middle Initial</td>
</tr>
<tr>
<td>5. INSURED'S ADDRESS</td>
<td>Street Address, City, State, ZIP Code</td>
</tr>
<tr>
<td>6. DATE OF SERVICE</td>
<td></td>
</tr>
<tr>
<td>7. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</td>
<td></td>
</tr>
<tr>
<td>8. EMPLOYER'S NAME</td>
<td></td>
</tr>
<tr>
<td>9. EMPLOYMENT</td>
<td>Current or Previous</td>
</tr>
<tr>
<td>10. INSURED'S POLICY OR GROUP NUMBER</td>
<td></td>
</tr>
<tr>
<td>11. INSURED'S DATE OF BIRTH</td>
<td></td>
</tr>
<tr>
<td>12. MEDICAL BENEFIT PLAN</td>
<td>Medicare, Medicaid, TriCare, CHAMPVA, Group FECA, Order, Other, None</td>
</tr>
<tr>
<td>13. AUTOCOUNT</td>
<td></td>
</tr>
<tr>
<td>14. DATES PATIENT WAS WORKING CURRENTLY</td>
<td></td>
</tr>
<tr>
<td>15. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td></td>
</tr>
<tr>
<td>16. OUTSIDE LAB CHARGES</td>
<td></td>
</tr>
<tr>
<td>17. PROCEDURES, SERVICES, OR SUPPLIES</td>
<td></td>
</tr>
<tr>
<td>18. TOTAL CHARGE</td>
<td></td>
</tr>
<tr>
<td>19. BALANCE DUE</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- Please do not staple in this area.
- Reserved for local use.
- Signed date.

**References:**
- APPM-0938-0999 FORM CMS-1500 (08/05)
- NUCC Instruction Manual available at www.nucc.org
### Section 3.1.C - 1500 Form Information

<table>
<thead>
<tr>
<th>Field 1</th>
<th>Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fields 2,3,5,6,8,10,12</td>
<td>Payer Patient Information</td>
</tr>
<tr>
<td>Fields 4,7,11,13</td>
<td>Insured Information</td>
</tr>
<tr>
<td>Field 14</td>
<td>Date of illness, injury, pregnancy or date initiation of Chiropractic</td>
</tr>
<tr>
<td>Field 15</td>
<td>First date of same or similar illness (required by some carriers but not all)</td>
</tr>
<tr>
<td>Field 16</td>
<td>Dates patient unable to work in current occupation</td>
</tr>
</tbody>
</table>
| Field 17 | Referring or ordering physician  
• 17a- National Provider Identifier (NPI/UPIN) |
| Field 18 | Hospitalization dates related to current services |
| Field 19 | See CPAR book for detailed information for this area |
| Field 20 | Diagnostic tests subject to purchase price limitations  
• (If this is “YES” then item 32 must be completed) |
| Field 21 | Patient’s diagnostic/condition (ICD-9) |
| Field 22 | Medicaid resubmission code and original ref. number |
| Field 23 | Prior authorization number; investigational device exemption number; clinical lab improvement act number |
| Field 24A | Dates of Service |
| Field 24B | Place of service (POS) |
| Field 24C | Type of Service (TOS) |
| Field 24D | Procedures, Services, or supplies (using CPT/HCPS Codes) |
| Field 24E | Diagnosis code reference number as shown in Field 21 |
| Field 24F | Charges |
| Field 24G | Units or number of days |
| Field 24H | EPSDT Family Plan Info |
| Field 24I | Emergency (Mark with X) |
| Field 24J | Co-ordination of Benefits (Mark with X) |
| Field 24K | NPI of Performing Provider of Service/Supplier if member of group practice |
| Field 25 | Provider of service or Supplier federal tax ID number. |
| Field 26 | Patient account number |
| Field 27 | Accepts assignment (Mark with X) |
| Field 28 | Total charges |
| Field 29 | Total amount paid by patient on covered services |
| Field 30 | Balance Due |
| Field 31 | Signature of provider |
| Field 32 | Name and address of facility where services were provided |
| Field 33 | Provider of service / supplier’s billing name, address, zip code and telephone number |
SECTION 3.2 OTHER FORMS
Section 3.2.A - HIPAA Notice of Privacy Practices

Introduction
Following is the HIPAA Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Health Care Facilities make and keep records of medical information. While you are a patient of ________________________________, we will use and disclose your medical information

• To provide treatment to you and to keep a record describing your care
• To receive payment for the care we provide
• To administer the hospital properly
• To comply with law

We are required by law
• To keep your medical information confidential in accordance with legal requirements
• To give you this Notice of our legal duties and privacy practices with respect to your medical information
• To follow the terms of the Notice that is currently in effect

When we use the word “we” we mean ________________________________, its affiliates, medical professionals and others who assist us in our business.

Your Privacy Rights

Right to Review and Right to Request a Copy. You have the right to review and request a copy of medical information in your medical and billing records. The Health Information Management (medical records) Department has a form you can fill out to request to review or copy your medical information and to tell you how much it will cost. ____________ will tell you if it cannot fulfill your request. If you are denied the right to see or copy your medical information, you may ask us to reconsider its denial. Depending on the reason for the denial, we may ask a licensed health care professional to review your request and its denial. We will comply with this person’s decision.

Right to Amend. If you feel your medical information in our records is incorrect or incomplete, you may ask us in writing to amend the information. You must provide a reason to support your requested amendment. We will tell you if we cannot fulfill your request.
Right to an Accounting of Disclosures. You have the right to make a written request for a list of certain disclosures _________ has made of your medical information. This list is not required to include all disclosures we make.

Disclosure for treatment, payment, or ______________ administrative purposes, disclosures made before April 14, 2003, disclosures made to you or which you authorized, and other disclosures are not required to be listed. The Contact listed below can help you with this process, if needed, and can tell you how much it will cost.

Right to Request Restrictions on Disclosures. You have the right to make a written request to restrict or put a limitation on the medical information we use or disclose about you for treatment, payment or health care operations.
You also have the right to request a limit on your medical information that we disclose to someone involved in your care or the payment for your care, like a family member or friend. **We are not required to agree to your request.**
However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment or to make a disclosure that is required under law. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your adult children.

Right to Request Confidential Communications. You have the right to make a written request that we communicate with you about medical matters in a certain way. For example, you can ask that we contact you only at work or by mail. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted but you do not need to tell us why. The Contact listed below can help you with these requests if needed.

Right to a Paper Copy of This Notice. You have the right to receive a copy of this Notice at any time even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice at our website, ________________________________ or a paper copy from the Hospital’s Privacy Officer.

PERSONS COVERED BY THIS NOTICE

- All employees, staff and other hospital personnel.
- Our volunteers and medical, nursing and other health care students
- Members of the Medical Staff and other medical professionals involved in your care or performing peer review, quality improvement, medical education and other services for the hospital.
- The following entities, relating to the hospital. In addition, these entities may share medical information with each other for the treatment, payment and administrative purposes described in this Notice.
- Persons or entities performing services for the hospital under agreements containing privacy protections or to which disclosure of medical information is permitted by law
- Persons or entities with whom the hospital participates in managed care arrangements.
USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment. We may use your medical information to provide medical treatment or services to you. We may disclose medical information about you to doctors, nurses, technicians, medical, nursing or other health care students or other personnel taking care of you. For example, a doctor treating you for a cut may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so you can have appropriate meals. Departments of the hospital may share your medical information to schedule the tests and procedures you need, such as prescriptions, laboratory tests and x-rays. We also may disclose your medical information to other health care providers if you need to be transferred from the hospital to another hospital, a nursing home, a home health provider or a rehabilitation center. We also may disclose your medical information to people outside the hospital who are involved in your care after you leave, such as family members or pharmacists.

Payment. We may use and disclose your medical information so that the treatment and services you receive can be billed and collected from you, an insurance company or another third party. For example, we may give your health plan information about surgery you received so your health plan will pay us for the surgery. We also may tell your health plan about a treatment you are going to receive in order to obtain prior approval from your plan to cover payment for the treatment.

Health Care Operations. We may use and disclose your medical information for purposes, such as for peer review, performance improvement, risk management, and our compliance with licensure, accreditation or certification requirements. For example, we may disclose your medical information to physicians on the Medical Staff who review patient care. We may disclose information to doctors, nurses, technicians, medical, nursing or other health care students, and personnel for teaching. We may combine medical information about many patients to decide what services the hospital should offer, and whether new services are cost-effective and how we compare with other health care facilities. Sometimes, we may remove identifying information from this medical information so others may use it to study health care and health care delivery without learning who you are. We may disclose information to other health care providers involved in your treatment to permit them to carry out the work of their facility or to get paid. For example, we may provide information about your treatment to an ambulance company that brought you to the hospital so that the ambulance company can get paid for their services.

Health Services, Treatment Alternatives and Health-Related Benefits. We may use and disclose your medical information to tell you about (i) health-related products or services that we offer, (ii) other providers participating in a health care network that we participate in, (iii) possible treatment options or alternatives, or (iv) health – related benefits or services that may be of interest to you. We also may use that information to communicate with you to coordinate your care. We may use and disclose your medical information to contact and remind you of an appointment for treatment or medical care.

The Hospital Patient Directory. We may include certain information about you in the Hospital Patient Directory while you are a patient. This information may include your name, your room
number, your general condition (fair, stable, etc.) and your religious affiliation. Your religious affiliation may be given to a member of the clergy, such as a priest or a rabbi, even if they don’t ask for you by name. Disclosure of your room will not reveal that you are in a specific unit or area, if such information would reveal that you are at _______ for treatment of rape or attempted rape, HIV/AIDS, or alcohol/drug abuse. The Hospital Patient Directory information, except for your religious affiliation may be released to people who ask for you by name. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing. **If you do not want this information given out, please tell the Patient Registration staff.**

**Individuals Involved in Your Care or Payment for Your Care.** We may release your medical information to the person you named in your Durable Power of Attorney for Health Care (if you have one), or to a friend or family member who is your personal representative (i.e., empowered by law to make health-related decisions for you). We may give information to someone who helps pay for your care. In addition, we may disclose your medical information to an entity assisting in disaster relief efforts so that your family can be notified about your condition.

**Fundraising.** We may disclose information, such as your name, address, telephone number, gender, age and the dates you received treatment. **If you do not want us to contact you for fundraising, please notify the Contact Person listed below in writing.**

**Research.** We may use and disclose your medical information for research purposes. Most research projects, however, are subject to a special approval process. Most research projects require your permission if a researcher will be involved in your care or will have access to your name, address or other information that identifies you. However, the law allows some research to be done using your medical information without requiring your authorization.

**Required By Law.** We will disclose your medical information when federal, state or local law requires it. For example, the hospital must comply with abuse reporting laws and laws requiring us to report certain diseases or injuries to government agencies.

**Serious Threat to Health or Safety.** We may use and disclose your medical information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **Note: Georgia and Federal Law provide protection for certain types of health information, including information about alcohol or drug abuse, mental health and AIDS/HIV, and may limit whether and how we may disclose information about you to others.**

**Our Affiliates.** We may disclose your medical information to our affiliates in connection with your treatment or other hospital activities. Organized Health Care Arrangements in which we participate. For certain activities, the hospital, members of its Medical Staff and other independent professionals are called an Organized Health Care Arrangement. We may disclose information about you to those providers participating in our Organized Health Care Arrangements. Such disclosures would be made in connection with our services, and other activities of the Organized Health Care Arrangement.
IMPORTANT NOTICE

___________may share your medical information with members of the Medical Staff and other independent medical professionals in order to provide treatment and perform other activities such as peer review, quality improvement, medical education and other services. While those professionals may follow this Notice and otherwise participate in the privacy program, they are independent professionals and the Hospital expressly disclaims any responsibility or liability for their acts or omissions.
SPECIAL SITUATIONS

Health Oversight Activities. We may disclose your medical information to a government agency for health oversight activities such as inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with laws.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may release your medical information to the correctional institution or a law enforcement officer. This release would be necessary to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the law enforcement officer or the correctional institution.

Lawsuits and Law Enforcement. We may disclose your medical information to respond to a court or administrative order or a search warrant. We also may disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone else involved in a dispute, but only if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested. Subject to certain conditions, we may disclose your medical information for a law enforcement purpose upon the request of a law enforcement official.

Medical Examiners and Funeral Directors. We may disclose your medical information to a medical examiner or funeral director so they may carry out their duties.

Minors. If you are a minor (under 18 years old), the Hospital will comply with Georgia law regarding minors. We may release certain types of your medical information to your parent or guardian, if such release is required or permitted by law.

Military and Veterans. If you are a member of the U.S. or foreign armed forces, we may release your medical information as required by the military.

National Security. We may disclose your medical information to authorized federal officials for national security activities authorized by law.

Organ and Tissue Donation. If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to aid in its organ or tissue donation and transplantation process.

Protective Services. We may disclose your medical information to authorized federal officials so they may provide protection to the president and other persons.
Public Health. We may disclose your medical information for public health purposes. Examples include:

- To prevent or control disease, injury or disability.
- To report birth and deaths
- To notify a person who may have been exposed to a disease or may be at risk for getting or spreading a disease or condition.
- To report medication reactions
- To notify people of product recalls

Worker’s Compensation. We may release medical information about you for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.

OTHER USES OF MEDICAL INFORMATION
Other uses and disclosures of your medical information not covered by this Notice or the laws that apply to the hospital will be made only with your written permission. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your medical information for the reasons covered by your written authorization, but the revocation will not affect actions we have taken in reliance on your permission. You understand that we are unable to take back any disclosures we have already made your permission, we still must continue to comply with laws that require certain disclosures, and we are required to retain our records of the care that we provided to you.

CHANGES TO THIS NOTICE
We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as for any information we receive in the future. We will post the current Notice in the hospital, clinics and on the hospital website.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a written complaint with the hospital or with the secretary of the Department of Health and Human Services or HHS. Generally, a complaint must be filed with HHS within 180 days after the possible violation, or within 180 days of when you knew or should have known and must name the entity that is the subject of the complaint and describe the alleged violation. To file a complaint with the hospital, contact the Privacy Officer. Filing a complaint will not affect your care at the hospital.

If you have any questions about this notice, please contact The Hospital’s Privacy Officer.
NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGE

I HAVE BEEN GIVEN A COPY OF THE HOSPITALS Notice of Privacy Practices

Signature of Patient or Representative ____________________________

Date ____________________________

Witness ____________________________

Relation of Representative to Patient ____________________________

Please describe the Representative’s authority to act on behalf of the patient:

________________________________________________________________________

________________________________________________________________________

For The Hospital Use Only

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient
Or the patient’s representative, please explain your efforts to obtain their acknowledgement and the
Reason you could not obtain it:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
INFORMED CONSENT FOR VOLUNTARY STERILIZATION

NOTICE

YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

1. I have asked and received information about sterilization from ——-.

2. I have asked for the sterilization. I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment and I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid. I am not getting or for which I may become eligible.

UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN, OR FATHER CHILDREN.

3. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father children in the future. I have rejected these alternatives and chosen to be sterilized.

4. I understand that I will be sterilized by an operation known as ——-. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

5. I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

6. I am at least 21 years of age and was born on ——. The operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

7. I am at least 21 years of age and was born on ——. I have received a copy of this form.

8. I also consent to the release of this form and other medical records about the operation to Representatives of the Department of Health, Education, and Welfare or Employees of programs funded by that Department but only for determining if Federal laws were observed.

Name of Member

Language

IN ORDER FOR THIS FORM TO BE VALID BOTH SIDES MUST BE COMPLETED

DMA-69 (0411).

(Refer to Reverse Side)

IN ORDER FOR THIS FORM TO BE VALID BOTH SIDES MUST BE COMPLETED

DMA-69 (0411).

(Refer to Reverse Side)

INTERPRETER'S STATEMENT

I have translated the information and advice presented orally to the individual to be sterilized by the individual obtaining this consent. I have also read the consent form to the individual in language and explained its contents to him/her to the best of my knowledge and belief. She/she understood this situation.

Name of Member

Language

Signature of Interpreter

Date — Month ——— ——— ———

Day Year

IN ORDER FOR THIS FORM TO BE VALID BOTH SIDES MUST BE COMPLETED

DMA-69 (0411).

(Refer to Reverse Side)
STATEMENT OF PERSON OBTAINING CONSENT

Before                      signed this consent form, I explained to him/her the nature of the sterilization operation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counselled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

<table>
<thead>
<tr>
<th>Statement Of Person Obtaining Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Signed:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
</tbody>
</table>

PHYSICIAN’S STATEMENT

Shortly before I performed a sterilization operation upon                                     I explained to him/her the nature of the sterilization operation and the discomforts, risks and benefits associated with it.

I counselled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

SELECT THE APPROPRIATE PARAGRAPHS: NUMBER (1) OR NUMBER (2)
(Cross out the paragraph which is not used.)

1. At least 30 days have passed between the date of the individual’s signature on this consent form and the date the sterilization was performed.

2. This sterilization was performed less than 30 days but more than 72 hours after the date of the individual’s signature on this consent form because of the following circumstances (check applicable box and fill in information requested):
   - Premature delivery
   - Individual’s date of expected delivery
   - Emergency abdominal surgery (describe circumstances)

Physician’s Signature: ____________________________ Date: ____________________________

DM459 (04A3)
Section 3.2.C - ABN’s Advanced Beneficiary Notice of Non-Coverage

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

Requirements
Medicare beneficiaries must be supplied an ABN as a written notice by their physician or provider of services when services might not be paid for by Medicare. If the ABN has not been signed before service is rendered and Medicare does not pay, the patient cannot be held responsible for payment of their service.

Medically Necessary
Medicare pays for tests considered medically necessary. If the diagnosis provided by the physician is not one Medicare considers medically necessary, Medicare will not pay for the test. Patients have choices on how to proceed with services if their test / procedures do not meet Medicare’s definition of medically necessary.

Options available on the ABN are:
- Option 1- Patient wants the items listed in section (D) of ABN form. Patient may be asked to pay at time of service, but the patient wants Medicare billed for an official decision on payment, which is sent to the patient on a Medicare Summary Notice (MSN). Patient understands that if Medicare doesn’t pay, the patient is responsible for payment, but the patient can appeal to Medicare by following the directions on the MSN. If Medicare does pay, the provider of services will refund any payments the patient made less copays and deductibles. If the patient wants to obtain an official Medicare decision in order to file secondary insurance the patient should choose Option 1.
- Option 2- The patient wants the items listed in section (D) but does not want Medicare billed. The provider of services may ask to be paid now as the patient is responsible for payment. The patient cannot appeal if Medicare is not billed.
- Option 3- The patient does not want the items in section (D) and understands with this choice the patient is not responsible for payment and the patient cannot appeal to see if Medicare would pay.

ABN Form
See following page for form
Advance Beneficiary Notice (ABN)

(A) Notifier(s):  
(B) Patient Name:  
(C) Identification Number:  

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn’t pay for (D)__________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D)__________ below.

<table>
<thead>
<tr>
<th>(D)__________</th>
<th>(E) Reason Medicare May Not Pay:</th>
<th>(F) Estimated Cost:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D)__________ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS:  
Check only one box. We cannot choose a box for you.

- [Q] OPTION 1. I want the (D)__________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

- [Q] OPTION 2. I want the (D)__________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

- [Q] OPTION 3. I don’t want the (D)__________ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-485-2046).

Signing below means that you have received and understand this notice. You also receive a copy.

(l) Signature:  
(J) Date:  

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0565. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PEA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-191 (03/08)  
Form Approved OMB No. 0938-0565
Section 3.2.D – Advanced Directive for Health Care Act

Introduction
This Georgia Advanced Directive for Health Care is codified in Title 31 Chapter 32 of the Official Code of Georgia. This section was amended effective July 1, 2007, and does not affect documents executed prior to that date. The Georgia Advanced Directive for Health Care is a combination of what was previously referred to as a living will and a Health Care power of attorney.

Section 31-32-4
Please refer to the following form regarding the Georgia Advance Directive for Health Care
Section 31-32-4 Form of Georgia Advance Directive for Health Care

"GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE
By: Date of Birth:
(Print Name)
(Month/Day/Year)
This advance directive for health care has four parts:

PART ONE HEALTH CARE AGENT. This part allows you to
choose someone to make health care decisions for you when you cannot (or do
not want to) make health care decisions for yourself. The person you choose
t to is called a health care agent. You may also have your health care agent make
decisions for you after your death with respect to an autopsy, organ donation,
body donation, and final disposition of your body. You should talk to your
health care agent about this important role.

PART TWO TREATMENT PREFERENCES. This part allows you
to state your treatment preferences if you have a terminal condition or if you
are in a state of permanent unconsciousness. PART TWO will become effective
only if you are unable to communicate your treatment preferences. Reasonable
and appropriate efforts will be made to communicate with you about your
treatment preferences before PART TWO becomes effective. You should talk to
your family and others close to you about your treatment preferences.

PART THREE GUARDIANSHIP. This part allows you to
nominate a person to be your guardian should one ever be needed.

PART FOUR EFFECTIVENESS AND SIGNATURES. This part
requires your signature and the signatures of two witnesses. You must
complete PART FOUR if you have filled out any other part of this form.
You may fill out any or all of the first three parts listed above. You must
fill out PART FOUR of this form in order for this form to be effective.
You should give a copy of this completed form to people who might need it,
such as your health care agent, your family, and your physician. Keep a copy
of this completed form at home in a place where it can easily be found if it
is needed. Review this completed form periodically to make sure it still
reflects your preferences. If your preferences change, complete a new advance
directive for health care. Using this form of advance directive for health care is completely
optional. Other forms of advance directives for health care may be used in
Georgia.

You may revoke this completed form at any time. This completed form will
replace any advance directive for health care, durable power of attorney for
health care, health care proxy, or living will that you have completed before
completing this form.

PART ONE HEALTH CARE AGENT
(PART ONE will be effective even if PART TWO is not completed. A physician
or health care provider who is directly involved in your health care may not
serve as your health care agent. If you are married, a future divorce or
annulment of your marriage will revoke the selection of your current spouse as
your health care agent. If you are not married, a future marriage will revoke
the selection of your health care agent unless the person you selected as your
health care agent has a valid assignment of authority.)
health care agent is your new spouse?

(1) Health Care Agent

I select the following person as my health care agent to make health care decisions:

Name: 
Address: 
Telephone (Home, Work, and Mobile) Numbers: 

(2) Back-up Health Care Agent

(This section is optional. Part One will be effective even if this section is left blank.)

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable, unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

Name: 
Address: 
Telephone (Home, Work, and Mobile) Numbers: 

(3) General Powers of Health Care Agent

My health care agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my health care agent communicate my health care decisions.

My health care agent will have the same authority to make any health care decision that I could make. My health care agent's authority includes, for example, the power to:

- Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- Request, consent to, withhold, or withdraw any type of health care; and
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for
health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that under Georgia law:

- My health care agent may refuse to act as my health care agent;
- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and
- My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, developmental disability, or addictive disease.

(4) **Guidance for Health Care Agent**

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in **PART TWO** (if I have filled out **PART TWO**), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

(3) **Powers of Health Care Agent After Death**

(A) **Autopsy**

My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent's power by initialing below.

(Initials) My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) **Organ Donation and Donation of Body**

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Revised Uniform Anatomical Gift Act, unless I have limited my health care agent's power by initialing below.

[Initial each statement that you want to apply.]

(Initials) My health care agent will not have the power to make a disposition of my body for use in a medical study program.

(Initials) My health care agent will not have the power to donate any of my organs.

(C) **Final Disposition of Body**

My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

(Initials) I want the following person to make decisions about the final disposition of my body:

**Name:**

**Address:**

**Telephone**

(Home, Work, and Mobile)

I wish for my body to be:

(Buried) OR

(Cremated)

PART TWO: **TREATMENT PREFERENCES**

---

2014, Georgia HFMA CPAR Program
All Rights Reserved
PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.

(6) Conditions

PART TWO will be effective if I am in any of the following conditions:

Initial: Each condition in which you want PART TWO to be effective.

(A) A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

(B) A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment. My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

(7) Treatment Preferences

Initial: Your treatment preference by initialing (A), (B), or (C). If you choose (C), you may provide additional instructions regarding your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.

If I am in any condition that I initiated in Section (6) above and I cannot communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A) (Initials) Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

OR

(B) (Initials) Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

OR

(C) (Initials) I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:

[Initial each statement that you want to apply to option (C).]
(Initials) If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.
(Initials) If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.
(Initials) If I need assistance to breathe, I want to have a ventilator used.
(Initials) If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

8 Additional Statements
[This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.]

9 In Case of Pregnancy
[PART TWO will be effective even if this section is left blank.] I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.
(Initials) I want PART TWO to be carried out if my fetus is not viable.

PART THREE: GUARDIANSHIP

Guardianship

(10) PART THREE is optional. This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise. [State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.]

(A) (Initials) I nominate the person serving as my health care agent under PART ONE to serve as my guardian.
OR
(B) (Initials) I nominate the following person to serve as my guardian:
Name:
Address:
Telephone:
(Home, Work, and Mobile)

PART FOUR: EFFECTIVENESS AND SIGNATURES

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

(Initials) This advance directive for health care will become effective on or upon and will terminate on or upon .

[You must sign and date or acknowledge signing and dating this form in the presence of two witnesses. Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.]

A witness:

- Cannot be a person who was selected to be your health care agent or back-up health care agent in PART ONE;
- Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death;
- Cannot be a person who is directly involved in your health care.

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

(Signature of Declarant) (Date)

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

(Signature of First Witness) (Date)

Print
Name:
Address:

(Signature of Second Witness) (Date)

Print
Name:
Address:

[This form does not need to be notarized.]

Chapter 4 – Specialty care
SECTION 4.1 SPECIALTY CARE
Section 4.1.A - Durable Medical Equipment DME

Introduction
Durable Medical Equipment is a term of art used to describe any medical equipment used in the home to aid in a better quality of living. Some examples of this equipment are walkers, wheelchairs, power scooters, hospital beds, home oxygen equipment, diabetes self-testing equipment (and supplies) and certain nebulizers and their medications (non-disposable).

Medicare Coverage and Reimbursement
Medicare law limits Part B payment for Durable Medical Equipment (DME) to items or supplies used or delivered in the patient's home. A patient must be entitled to payment for rental or purchase of DME to qualify for Medicare reimbursement.

The decision whether to rent or purchase an item of equipment resides with the beneficiary.

Medicare reimburses the expenses incurred by a beneficiary for the rental or purchase of DME if the following three requirements are met.

1. Equipment meets the definition of DME
2. Equipment is necessary and reasonable for the treatment of the patient's illness or injury or to improve the functioning of his/her abnormal body member.
3. Equipment is used in the patient's home

Definition of Durable Medical Equipment
DME is defined as equipment which:
- Can withstand repeated use
- Is primarily and customarily used to serve a medical purpose
- Generally is not useful to a person in the absence of an illness or injury
- Is appropriate for use in the home

Necessary and Reasonable
Although an item may be classified as DME, it may not be covered in every instance. Coverage is subject to the requirement that the equipment be necessary and reasonable for treatment of an illness or injury or to improve the functioning of a malformed body member. The following considerations will prevent payment for equipment:

- Cannot reasonably be expected to perform a therapeutic function in an individual case
- Will permit only partial therapeutic function in an individual case

Partial payment will be permitted when the type of equipment furnished substantially exceeds that required for the treatment of illness or injury involved.

Definition of Beneficiary's Home
For purposes of rental and purchase of DME, a beneficiary's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. An institution may not be considered a beneficiary's home if it:

- Meets at least the basic requirement in the definition of a hospital or rehabilitation facility
- Meets definition of a skilled nursing facility
• If the individual is a patient in an institution or distinct part, which meets the definition of a hospital or SNF

**Covered Items**
Orthotic and prosthetic devices are not subject to the “home use” requirement for coverage and payment purposes.

Payment may also be made under the provisions for repairs, maintenance, and delivery of equipment as well as for expendable and non-reusable items essential to the effective use of the equipment subject to set conditions.

Medicare covered DME reimbursement may be made for replacement of essential accessories such as hoses, tubes, mouthpieces etc., only if the beneficiary owns or is purchasing the equipment.

Rental payments may not exceed a period of continuous use of longer than 15 months. After 15 months of rental have been paid, the supplier must continue to provide the item, without cost, until medical necessity ends or coverage ceases. However, the supplier may continue to charge for maintenance and servicing fees.

If it is determined to be medically necessary for the beneficiary to change equipment, a new 15-month period will begin.


**Medicare Approved Providers**
All Durable Medical Equipment, Prosthetics, and Orthotics Suppliers (DMEPOS) who serve Medicare beneficiaries must apply for a supplier number in order to submit claims to any one of the four durable medical equipment regional carriers (DMERCS). The National Supplier Clearing house (NSC) is responsible for enrollment of all suppliers nationwide. The NSC website is [www.palmettogba.com](http://www.palmettogba.com).

Suppliers may choose to participate, which means they accept Medicare payment as payment in full or they may be nonparticipating and accept assignment on a case-by-case basis.

Complete supplier requirements may be found in the code of Federal Regulations 42CFR, section 424.57 or on the back of the CMS 855S application to become a supplier.

**Billing Medicare**
The CMS 1500 form is the basic form required by the Centers for Medicare and Medicaid Services for the Medicare program for claims from physicians and suppliers.

**Time limits for filing**
Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. In addition, Section 6404 mandates that claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010. The following rules apply to claims with dates of service prior to January 1, 2010.
Claims with dates of service before October 1, 2009, must follow the pre-PPACA timely filing rules. Claims with dates of service October 1, 2009, through December 31, 2009, must be submitted by December 31, 2010.

**Georgia Carrier**

Palmetto GBA is the carrier for the State of Georgia and can be accessed through the following website.


**Billing Requirements**

The CMS 1500 answers the needs of many health insurers. It is the basic form required by CMS, Champus and Medicaid and many other payers have adopted it. Suppliers can file their Medicare Part B claims in one of two ways: Electronic media or hardcopy 1500 form.

Complete instructions may be found in Medicare Claims Processing Manual, Chapter 26, and sections 10.2-10.4

The following is a brief explanation of the information on the 1500 claim form:

- Items 1-13-Patient and Insured information
- Items 14-33-Provider of service or supplier information

**Pricing Methodology**

The Medicare Pricing Department is responsible for the accurate and appropriate calculation and implementation of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) prices. The beneficiary's permanent address, rather than the location of the DMEPOS supplier will determine the amount allowed by Medicare for a particular item or service. There are three DMEPOS payment methodologies:

1. Fee schedules-updated annually
2. Reasonable charges-updated annually
3. Average Wholesale Pricing (AWP)-applies to drugs-quarterly updates

**Appeals Process**

The Medicare Part B Administrative appeals process is available to beneficiaries and suppliers dissatisfied with initial determinations and appeal determinations/decisions. A completed CMS 1964 form constitutes a request for review.

The EDI helpline number is 866-749-4301

**Electronic Data Interchange**

PALMETTO GBA
P.O. Box 100145
COLUMBIA, SC. 29202-3145

Medicare.EDI@PalmettoGBA.com or www.PalmettoGBA.com
REQUEST FOR REVIEW OF PART 8 MEDICARE CLAIM

Medical Insurance Benefits – Social Security Act

NOTICE - Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

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<th>1. Carrier's Name and Address</th>
<th>2. Name of Patient</th>
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3. Health Insurance Claim Number

4. I do not agree with the determination you made on my claim as described on my Explanation of Medicare Benefits dated:

5. MY REASONS ARE: (Attach a copy of the Explanation of Medicare Benefits, or describe the service, date of service, and physician's name. NOTE: If the date on the Explanation of Medicare Benefits mentioned in Item 4 is more than six months ago, include your reason for not making this request earlier.)

6. Describe illness or injury:

7. ☐ I have additional evidence to submit (Attach such evidence to this form.)
   ☐ I do not have additional evidence.

COMPLETE ALL OF THE INFORMATION REQUESTED. SIGN AND RETURN THE FIRST COPY AND ANY ATTACHMENTS TO THE CARRIER NAMED ABOVE. IF YOU NEED HELP, TAKE THIS AND YOUR NOTICE FROM THE CARRIER TO A SOCIAL SECURITY OFFICE, OR TO THE CARRIER. KEEP THE DUPLICATE COPY OF THIS FORM FOR YOUR RECORDS.

8. SIGNATURE OF EITHER THE CLAIMANT OR HIS REPRESENTATIVE

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<th>Claimant</th>
<th>Representative</th>
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Form CMS-1964 (9/91)

Carrier's Copy
REQUEST FOR REVIEW OF PART B MEDICARE CLAIM

Medical Insurance Benefits – Social Security Act

NOTICE – Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

1. Carrier's Name and Address

2. Name of Patient

3. Health Insurance Claim Number

4. I do not agree with the determination you made on my claim as described on my Explanation of Medicare Benefits dated:

5. MY REASONS ARE: (Attach a copy of the Explanation of Medicare Benefits, or describe the service, date of service, and physician's name. NOTE: If the date on the Explanation of Medicare Benefits mentioned in Item 4 is more than six months ago, include your reason for not making this request earlier.)

6. Describe illness or injury:

7. ☐ I have additional evidence to submit. (Attach such evidence to this form.)
   ☐ I do not have additional evidence.

COMPLETE ALL OF THE INFORMATION REQUESTED. SIGN AND RETURN THE FIRST COPY AND ANY ATTACHMENTS TO THE CARRIER NAMED ABOVE. IF YOU NEED HELP, TAKE THIS AND YOUR NOTICE FROM THE CARRIER TO A SOCIAL SECURITY OFFICE, OR TO THE CARRIER. KEEP THE DUPLICATE COPY OF THIS FORM FOR YOUR RECORDS.

8. SIGNATURE OF EITHER THE CLAIMANT OR HIS REPRESENTATIVE

Claimant

Representative

Address

Address

City, State and ZIP Code

City, State and ZIP Code

Telephone Number

Telephone Number

Date

Claimant's Copy

Form CMS-1964 (9/91)
PRIVACY ACT ADVISORY STATEMENT

COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the CENTERS FOR MEDICARE & MEDICAID SERVICES to ask you for information needed in the administration of the Medicare program. Social Security's authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act, as amended.

The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information about the Medicare benefits you have used to a hospital or doctor.

Additional disclosures are made through routine uses for information contained in systems of records. Disclosures of this information via routine uses may be made to: a congressional office from the record of an individual in response to an inquiry from the congressional office made at the request of that individual; the Department of Justice, to a court or other tribunal, or to another party before such tribunal, when HHS is a party to litigation or has an interest in such litigation; or a contractor for the purpose of collating, analyzing, aggregating or otherwise refining or processing records in this system for developing, modifying and/or manipulating ADP Software. See the notice for system No. 09-70-0512, titled "Review and Fair Hearing Case Files," as last published in the Federal Register, Privacy Act Issuances 1989 Comp., Vol. 1, page 413.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

With one exception, which is discussed below, there are no penalties under social security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0033. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Mailstop N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.
Introduction
According to CMS Home Health Agency Manual, a home health agency (HHA) is a public agency or private organization that is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical therapy, speech-language pathology services, or occupational therapy, medical social services and home health aide services.


Outcome and Assessment Information Set (OASIS) Reporting
Home Health Agencies (HHA) must complete and submit electronically to the state an OASIS on every patient. It is very important that the OASIS be completed accurate. Not only is this information captured for statistical purposes, the OASIS data is the basic input used to determine the HHRG on Medicare patients. A manual regarding completing the OASIS can be found at [www.cms.hhs.gov/oasis/usermanu.asp](http://www.cms.hhs.gov/oasis/usermanu.asp)

Medicare
To qualify for Medicare coverage of home health services, the patient must meet the following criteria:

- Confined to the Home – A physician must certify in all cases that the patient is confined to his/her home. This does not mean that the patient is bedridden, but leaving home should be a considerable and taxing effort. A patient may still be considered homebound if the absences are infrequent and of short duration, or are attributable to the need to receive health care, including, but not limited to, attendance at adult day care centers, receipt of outpatient chemotherapy or outpatient kidney dialysis. A patient may still be considered homebound for occasional absences from the home for non-medical purposes such as an occasional trip to the barber, a walk around the block, a drive, or attendance at a church service if the absences are infrequent and of short duration.

- Services are provided under a Plan of Care that is established and approved by a Physician – The plan of care is the medical treatment plan established by the treating physician with the assistance of the home health care nurse. The plan of care must contain:
  - Pertinent diagnoses including mental status
  - The types of services, supplies, and equipment required
  - The frequency of visits to be made
  - The prognosis
  - The rehabilitation potential
  - The functional limitations
  - Activities permitted
  - Nutritional requirements
  - Ill medications and treatments
  - Safety measures to protect against injury
  - Instructions for timely discharge or referral
  - Any additional items the HHA or physician choose to include

- Patient must be under the care of a physician who is qualified to sign the physician certification and plan of care.
• Patient requires skilled nursing care on an intermittent basis. The patient must require one of the following types of skilled services:
  o Skilled nursing care that:
    ▪ Is reasonable and necessary and provided by a registered nurse, or a LPN under the supervision of a RN, and is safe and effective.
    ▪ Is needed on an intermittent basis. Medicare interprets intermittent as meaning skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours each for periods of 21 days or less. The patient must have a medically predictable recurring need for skilled nursing services.
    ▪ Is not solely needed for venipuncture for the purposes of obtaining blood samples.
  o Physical therapy
  o Speech-language pathology services
  o A continuing need for occupational therapy

**Physician Certification**
The HHA must be acting upon a physician certification that is part of the plan of care (Form CMS-485) and meets the following requirements:

• Content of the Physician Certification. The physician must certify that:
  o The home health services are because the patient is confined to the home.
  o The patient needs skilled nursing services on an intermittent basis
  o A plan of care has been established and is periodically reviewed by a physician
  o The services are furnished while the patient is under the care of a physician

• Periodic Recertification. The physician certification may cover a period less than but not greater than 60 days.

• Signed certification.
  o The physician who signs the certification must be permitted to do so by guidelines given in section 42 CFR 424.22.
  o Must be signed before the final claim is submitted
  o Detailed order for the services to be rendered that is signed and dated by the physician. The verbal order must be recorded in the plan of care. A billable visit must be rendered prior to the submission of a RAP (Request for Anticipated payment).

• Form CMS-485, Home Health Certification and Plan of Care - This form contains the data necessary to meet regulatory and national survey requirements for the physician’s plan of care and certification. Form CMS-485 is also used by the RHHI (Regional Home Health Intermediary) alone or with other medical information to make decisions on home health coverage.

• CMS requires you to obtain a signed certification as soon as practicable after the start of care and prior to submitting a claim to the intermediary. You may provide services prior to obtaining the physician’s written plan of care based on documented verbal orders. If care continues beyond the certification period, you must obtain a recertification from the
physician. The signed CMS-485 must be retained in your files and available upon request by the intermediary.

Prospective Payment System - Home Health Resource Group (HHRG)
The unit of payment under Home Health PPS is a national 60-day episodic rate with applicable adjustments. The 60-day episodic payment rate (HHRG) includes covered Home Health services, including medical supplies, paid on a reasonable cost basis. This includes costs for the six home health disciplines: skilled nursing services, Home Health aide services, physical therapy, speech-language pathology services, occupational therapy services, and medical social services; and the costs for routine and non-routine medical supplies.

Due to the Medicare consolidated billing law; the six Home Health disciplines will be included in the episodic rate, even if one of the disciplines is provided at another type of facility. For example, if a patient is receiving home health services and the physician sends the patient to the hospital for outpatient physical therapy, then the hospital must bill the home health agency and the home health agency in-turn bills Medicare for the physical therapy service. Durable Medical Equipment is excluded from the consolidated billing requirements. The DME continues to be paid on the fee schedule outside of the PPS rate. The osteoporosis drug is also excluded from the episodic rate payment, but must be billed by the Home Health Agency.

Continuous 60-Day Episode Recertification
Home Health PPS permits continuous episode recertification for patients who continue to be eligible for the home health benefit. There is no limit to the number of continuous episodes.

Initial Episodes
The “From” date for the initial certification must match the start of care date which is the first billable date for the 60 day episode. The “To” date can be up to, but never exceed a total of 60 days.

Subsequent Episodes
At the end of the initial 60-day episode, a decision must be made whether or not to recertify the patient for a subsequent 60-day episode. An eligible beneficiary would start the subsequent 60-day episode on day 61.

Split Percentage Payment Approach to the 60 day Episode
The split percentage occurs through the request for anticipated payment (RAP) at the start of the episode and the final claim at the end of the episode. An initial payment of 60 percent of the HHRG will be paid at the beginning of the episode and a final 40 percent will be paid at the end of the episode, unless an applicable adjustment is applied. Subsequent episodes will be paid at a 50/50 split.

Partial Episode Payment Adjustment.
The partial episodic payment adjustment (PEP) accounts for key intervening events in a patient's care defined as:
- A beneficiary elected transfer to another HHA, or
- A discharge resulting from the beneficiary reaching the treatment goals in the original plan of care and returning to the SAME HHA during the 60-day episode.
The PEP adjustment for the original 60 day episode is calculated to reflect the length of time the patient remained under the care of the original HHA based on the first billable visit date through and including the last billable visit date.

**Significant Change in Condition Payment Adjustment (SCIC)**
If the patient experiences a significant change in condition during a 60-day episode that was not envisioned in the original plan of care, the 60-day episodic rate may be changed with a SCIC adjustment to reflect the payment level.

The SCIC payment adjustment is calculated in two parts.
- The first part of the SCIC payment adjustment reflects the adjustment to the payment level prior to the patient’s significant change in condition during the day episode. This is determined by taking the span of days of the first billable visit date through and including the last billable visit date prior to the SCIC.
- The second part of the SCIC payment adjustment reflects the adjustment to the level of payment after the SCIC from the first to last billable date. The HHA does not have to bill for a SCIC for a higher HHRG if the effect is a lower payment. The HHA does have to bill for a SCIC due to unanticipated improvement in patient condition.

**Low Utilization Payment Adjustment (LUPA)**
An episode with four or fewer visits is paid the national per visit amount by discipline adjusted by the appropriate wage index based on the site of service of the beneficiary.

**UB04 Instructions**
**Request for Anticipated Payment (RAP)** - Request for Anticipated Payment (RAP) can be submitted as soon as the OASIS data is completed and the first visit has been made. Each episode will be assigned an HHRG, which will translate to a HIPPS code. Each HIPPS code is assigned a weight. A RAP must be submitted prior to a Final Claim or the final will not be paid. RAP payment will be made within days; RAP’s are not subject to the 14-day payment floor. If the HHA determines that a patient will qualify for a LUPA, then the RAP submission can be omitted. Filing the RAP also locks that patient into that home health agency. The following information is needed to submit a clean RAP:

- Form Locator 1
  Enter the agency name and address

- Form Locator 4
  Enter 322 for Type of Bill

- Form Locator 6
  Enter the effective date of admission, which is the first billable visit in the “from” field. For a subsequent RAP, enter the first date of the new episode. Enter the SAME date in the “through” field and entered in the “from” field. The from and through dates are the SAME.

- Form Locator 12
  Enter the beneficiary’s name as usual

- Form Locator 13
  Enter the beneficiary’s address as usual
o Form Locator 14
Enter the beneficiary’s date of birth: MMDDCCYY

o Form Locator 15
Enter M or F

o Form Locator 17
Must match the date in Form Locator 6

o Form Locator 20
Source of Admission:
B – If transferred from another HHA
C – If discharged and readmitted to your HHA within a 60-day episode
If not a transfer or re-admit, enter the appropriate Code.

o Form Locator 22
Always enter a patient status code of “30” for RAP

o Form Locator 39-41
Enter value code of 61 with the HHA MSA code

o Form Locator 42
Enter revenue code 0023 on first line and 001 for total on Line 2

o Form Locator 44
Enter the HIPPS generated from the OASIS Assessment.

o Form Locator 45
Enter the first billable date which should match statement from and through date and Admission Date.

o Form Locator 47
Enter total charges

o Form Locator 50
Enter payer information (Medicare if primary)

o Form Locator 51
Enter the Agency provider number

o Form Locator 52
Enter Y that HHA has a statement on file

o Form Locator 58
Enter patient’s name as shown on Medicare Card

o Form Locator 60
Enter Health insurance claim number
- Form Locator 63
  Enter the OASIS 18 digit matching key

- Form Locator 67
  Enter principal diagnosis which should match OASIS and 485 diagnosis

- Form Locator 68-75
  Enter all other pertinent diagnoses codes

- Form Locator 82
  Enter UPIN of 485 physician

- Form Locator 85
  HHA representative signature. Stamped Signatures will be accepted.

**Final Claim** - The plan of care must be signed and dated by a physician before the final claim is submitted. The following information is needed to submit a clean Final Claim. If a FL is not listed, then the information should be the same as the RAP.

- Form Locator 4
  Enter 329 for type of bill

- Form Locator 6
  Enter the “from” date the same as the RAP date. For the “through” date enter the last day of the 60-day period, or the discharge or transfer date from the HHA.

- Form Locator 17
  Enter the date of admission from the RAP.

- Form Locator 20
  Same as RAP

- Form Locator 22
  Enter appropriate status code

- Form Locator 42
  The first revenue code on line 1 will be 0023 With the HIPPS code that was on the RAP. If the patient had a SCIC then 0023 will be listed with both HIPPS codes. Use appropriate revenue codes for all services provided e.g., 550-Skilled Nursing, 570-HH aide, 420-PT, 270-supplies.

- Form Locator 44
  Enter the HIPPS code from the RAP
Enter the first billable service date and for 0023 and enter the date of service for all other services

- Form Locator 47
  Enter the total charge

- Form Locator 48
  Enter non-covered charges

**Medicaid**

Part II -Policies and Procedures for Home Health Services – Georgia Department of Community Health, Division of Medical Assistance: Revised: April 1, 2010

**Medicaid – Conditions of Participation**

There are additional requirements for HHA beyond the general conditions that must be met in order to participate in Medicaid: The additional requirements are:

- Licensed by the Standards and Licensure Unit of the Department of Human Resources as a Home Health agency
- Must be certified to render services under Medicare as a HHA.
- HHA established after June 30, 1979 must possess a Certificate of Need from the State Health Planning Agency.

To continue to provide services as a HHA for Medicaid recipients, the HHA must:

- Maintain current clinical records on all patients
- Maintain justification for home health services in the Plan of Care with a copy of the signed physician orders.
- Agree to periodic, on-site reviews
- Not bill more than the rate charged private pay patients.
- Bill only for completed services rendered in the patient’s home
- Not provide Home Health services to members when those services are provided through other Medicaid programs
- Notify Provider Enrollment in writing of changes in enrollment status.
- Submit copies of sub-contractual agreements to the Division.
- Not have an ownership or contractual relationship with any physician certifying home health services for Medicaid members.
- Disclose ownership information to the Division
- Submit two copies of the filed Medicare Cost Report and Medicaid Cost Date Form.
- Have established policies on informing patients of the Patient Bill of Rights and Advanced Directives. This information should be documented in the patient’s record.

**Medicaid - Community Care Services Program**

Home Health services provided to Community Care Services Program (CCSP) members must be provided by CCSP approved Home Health agencies currently enrolled in CCSP. The first 50 visits are under the Home Health Program. The CCSP Care Coordinator must authorize these visits on the Service Authorization Form (SAF). If more than 50 visits are required, then these will be reimbursed under CCSP. Additional visits must be authorized on the SAF. A Home Health agency may not render home health services to a member under both categories of service at the same time.
Referral from HH to Community Care
Once it has been determined that a patient may be referred to Community Care, the agency should notify the local Area Agency on Aging and request that the patient be assessed by the care coordination team for CCSP. CCSP will notify the agency of their determination.

Medicaid Eligibility Criteria
The patient must meet the following criteria for home health services:
- The care must be medically reasonable and necessary for the treatment of the illness or injury, and the services can be met adequately in the place of residence. The patient’s medical record should justify why the services should be provided in the home instead of a physician’s office, or other outpatient setting.
- A referral from the patient’s primary care physician.
- A written Plan of Care must be maintained, signed and dates for all services to be rendered.
- Continued supervision of the patient by the physician at least every (62) days
- Absence or inability of significant others to provide the services
**Medicaid – Prior Approval**

Home Health services do not require prior approval. Prior approval is required for recipients under 21 years of age.

Medicaid will only reimburse for 50 visits per member per calendar year if the patient is 21 years of age or older. If the patient is under 21, then visits over 50 per calendar year must be requested by a physician and determined to be medically necessary at the discretion of the Division. The Division must receive the request for additional visits at least 15 business days before the visits are exhausted. The physician’s letter of medical necessity along with the agency’s letter requesting the number of visits needed must be sent to:

Department of Community Health  
Home Health Program Specialist 37th Floor  
Home Health Services  
Division of Medical Assistance  
2 Peachtree Street, NW  
Atlanta, GA 30303-3159

**Medicaid – Scope of Services**  
The following services are covered in the Home Health Services program:

- Skilled Nursing Services
- Home Health Aide Services – An RN must make a supervisory visit at least once every 2 weeks.
- Therapy Services – must be provided by a licensed physician, speech or occupational therapist or licensed therapist assistant under the supervision of a licensed therapist. Therapy services can be provided by the agency or under contractual arrangement.

Unlike Medicare, Medicaid does not require consolidated billing of all services. If therapy services are provided outside of the home, then the facility can bill these directly to Medicaid.

The HHA must establish and maintain a current clinical record on all patients. The record must include the following:

- Demographic information including directions to the patient’s home
- Name of attending physician
- Pertinent past and current findings
- A signed and dated plan of care at least every 62 days
- Signed and dated clinical notes written by the close of the business day following the date of service.
- Home Health Aide services documentation and supervisory documentation
- Copies of summary reports sent to the physician at least every 62 days
- A discharge summary when applicable

**Medicaid – Reimbursement Methodology**

The Home Health agency is reimbursed a specific rate per visit. The rate is based on the total of the agency’s inflated base rate, any efficiency incentive and a supply. These rates are subject to ceilings.
Each agency must submit two copies of its as-filed Medicare cost report and a completed Medicaid Cost Data Form. These documents must be received by the Division within 150 days after the agency’s fiscal year end.

**Medicaid - HCFA 1500 Instructions**

The 1500 claim form is used in billing Home Health services to Medicaid. The following special instructions must be followed for home health claims:

- Item 18 – Enter the dates of admission and discharge from an inpatient facility related to the current home health services
- Item 24 a – Enter the first date of service in the “from” and the last date of service in the “to”. Claims spanning calendar date or the state fiscal date (June 30 through July 1) should be split.
- Item 24b – Use POS code 12 ONLY.

All other 1500 claim form items should be completed as usual for other services.
Section 4.1.C - Hospice Care

Overview
Hospice provides physical, emotional and spiritual care to families while providing soothing care and treatments to patients who have a terminal diagnosis. It is a philosophy, which is based on quality of life and medical care given to lessen pain and or symptoms, which are caused by the end stage disease process. Hospice does not hasten nor postpone death but assists with the preparation for death through emotional and spiritual support. By teaching families about the disease process, and keeping symptoms and pain managed, patients and their families are able to deal with the preparation allowing them to normalize and understand the grief process.

Standards of care for hospice are federally mandated and do not vary from state to state in the care provided. However billing issues may vary from state to state if Medicaid is involved or if there is a Medicare intermediary. National Hospice Organization (NHO), Medicare, Joint Commission, State Regulatory bodies and Professional regulatory bodies set these standards. Hospice is a Medicare benefit, which was enacted in 1983 by legislation.

Eligibility
Eligibility requirements are very specific and although no one who is eligible can be denied care for any reason, including being indigent, many patients are evaluated who do not meet the standards of eligibility. Hospice is a Medicare benefit and therefore the criteria for enrollment falls under the Medicare auspice. You must have:

- A terminal diagnosis, which is a diagnosis that meets the criteria of having no curative factors
- A prognosis stating you are expected to live six months or less.
- Patients must be a resident of the state where treatment is being rendered (although there can be exceptions)
- Patients and their families must desire palliative over aggressive treatment with an understanding of both

If a patient wants any kind of aggressive treatment they are not hospice appropriate. Hospice does not discourage patients from getting aggressive treatment. During the sign up process patients may find that they are feeling they have not exhausted all the possibilities for treatment and are not ready for hospice care.

Patients are also required to meet the criteria for Medicare enrollment in order to utilize the hospice Medicare benefit. The criteria is as follows:

- 65 or older with the required number of work quarters
- you can be under 65 and disabled for at least 2 years
- diagnosed with chronic renal failure or be on dialysis

Hospice works like managed care in that we become the case managers for the terminal diagnosis. Hospices can utilize a variety of settings to treat their patients and may see patients at their place of residence, which can be a home, or a facility. The hospice Medicare benefits have periods when the utilization review team will work with the team members to determine continued eligibility.
Utilization
The utilization or quality assurance teams will assist in the recertification/decertification process:
- The 1st and 2nd periods end in 90 days
- The 3rd period ends in 60 days and
- A patient review takes place every 60 days thereafter.

The 60 day periods are now unlimited and a patient can continue to utilize the hospice benefit as long as they continue to meet the criteria. In addition to the above criteria the following rules apply:
- A patient must be recertified or decertified at the end of each benefit period
- A patient must continue to meet eligibility criteria by either continuing to be appropriate or showing a decline
- Patient or surrogate can revoke at any time

If the patient no longer meets criteria they are to be discharged from the hospice program. They may still be terminal but no longer have a prognosis of 6 months or less. Patients that have been discharged may be reevaluated upon physician request if they have a change in condition. There is no limit to the number of times a patient can utilize their hospice benefit.

Billing and Reimbursement
Medicare Requirements
Hospice utilizes the Medicare benefit and it does not vary from state to state. Anytime Medicare benefits are used, whether by a managed care organization or a hospice, the Medicare guidelines apply. The hospice benefit covers only those medications, DME and care that are directly related to the terminal diagnosis. Other care and services including doctors may be billed to Medicare Part B as appropriate. Hospice receives a daily capitated rate to cover all care related to the diagnosis.

Medicaid and Payers
Hospice may also obtain reimbursement from Medicaid, private insurances including Medicare supplements, Managed Care or HMO’s, or Private pay. Hospice is billed at the per diem (daily) billing rate for core services provided and it includes the skilled nursing visits, social worker visits, home health aide visits, and pastoral counselor visits, durable medical equipment and medications related to the diagnosis.

Medicaid reimburses for nursing home room and board, or a patient may pay privately when in a nursing home. The hospice benefit does not include room and board of any kind for private caregivers. When hospice bills Medicaid it is used as the payer of last resort when all other pay sources have been exhausted. A valid authorization from the patient or surrogate is required to obtain reimbursement for home health and hospice. Medicaid pending patients are expected to follow through with their application process which can be overwhelming at the time of grief. Social workers and patient accounts work closely with families to help them with these processes but ultimately they are responsible for the application and appointments and can be held responsible.
Financial Responsibility – Other Payers
As with any stressful situation, finances can add tremendous stress and upset to hospice patients and their families. It is very important that we communicate properly and repeatedly to the families as to their responsibility. Often when patients are admitted they are given an overview of hospice services but they quickly forget what they have been told. The staff is trained in handling families with sensitivity when explaining responsibilities of patients and families. All Managed Care policies must be pre-approved and coverage can vary from policy to policy.

The Interdisciplinary Team
Hospice provides an interdisciplinary team approach. Members of the team work together to provide appropriate and quality care. The following are the team members used by hospices and their roles:

- **Primary Physician** - the medical doctor that referred the patient to hospice. This doctor may remain with the patient or transfers medical management to one of the hospice physicians.
- **Hospice Physician** - the hospice doctor works with the primary doctor, will see the patient when they enter the program, and participate in the decertification and recertification process.
- **Nurse LPN** - The Licensed Practical Nurse provides selected nursing care including the treatments and medications to the clients under the direction of the RN.
- **Certified Nurse's Aide or Nursing Assistant** - The nursing assistant is a non professional with training in the supportive services and maintains bodily and emotional comfort to hospice patients.
- **Chaplain** - Chaplains provide spiritual counseling in keeping with the patient and families belief system and values.
- **Social Worker** - The social worker will assess the patient and families psychosocial needs to the home environment, financial resources and availability of community resources. Urgent needs will be addressed immediately and crises intervention will be done when necessary. The social worker will educate and provide referrals on funeral arrangements and advance directives. Hospice provides bereavement counseling to families for up to one year after the patient dies.
- **Hospice Trained Volunteers** - The volunteers are an integral part of the team and they provide other services such as sit and talk to patients, take patients shopping, and read to patients.
- **Specialized Team Members** - On occasion patients will require additional services that are not usually part of the palliative plan of care. These services are provided by hospice and may be done by staff members or contracted out with agencies. These team members are speech therapists, occupational therapist, physical therapists, wound care specialists. These team members are utilized according to patient need and preference and not indicated on a routine basis.

Hospice Care Planning
Regulations require hospice to review and revise care plans every 14 days when a patient is at home or in an assisted living facility. In a skilled facility hospice is able to supplement care to residents and the care plan is updated and revised to include the hospice plan of care. In the acute care setting, a care center, a hospital unit, or a contracted bed, Medicare requires the care plan to be updated every 7 days.
Section 4.1.D - Long Term Acute Care LTAC

Introduction
Long Term Acute Care Hospitals (LTAC), in general are defined as hospitals that have an average inpatient length of stay greater than 25 days. These hospitals typically provide extended medical and rehabilitative care for patients who are clinically complex and may suffer from multiple acute or chronic conditions. Approximately one-half of all patients admitted to LTAC have five or more diagnosis. Services may include comprehensive rehabilitation, respiratory therapy, cancer treatment, head trauma treatment and pain management.

Level of Care
- Structured and programmed for the medically complex often technology dependent patient
- Length of time for hospitalization is greater than Diagnostic Related Group (DRG) mean length of stay (greater than 25 days for Medicare)
- Provide intensive services like an acute hospital; not available at a Skilled Nursing Facility (SNF)
- Patient’s condition requires frequent physician monitoring (at least daily) and a “super-skilled” level of 24-hour nursing care
- Patient is medically stable enough for transfer, but stability is tenuous
- Clinical and ancillary support services are necessary and available on-site
- Specialize in caring for patients with catastrophic illness

The country’s oldest LTAC evolved from tuberculosis and chronic disease hospitals. LTAC can be free-standing or “Hospitals within Hospitals” or within other types of facilities such as Skilled Nursing Facilities. They must be separately certified and distinct facilities. The number one source of admission to the LTAC would be after an acute care hospital stay.

Medicare
LTAC’s are certified under Medicare as short-term hospitals and identified by the last 4 digits of the Medicare Provider number, which range between 2000 and 2299. Medicare has paid long-term care hospitals:
- Based on their reasonable costs since the program was enacted in 1985
- In 1982, the Medicare law amended by Tax Equity and Fiscal Responsibility Act, placed a cap on allowable costs per discharge
- The Balanced Budget Act (BBRA) of 1999 required that a per discharge payment based on DRGs be implemented for cost reporting periods beginning on or after October 1, 2002
- The payment groups are modified to reflect the greater cost involved in caring for patients requiring the longer lengths of stay in long term care hospitals. There are about 500 LTC-DRGs.
- Outlier payments for short stays and high costs apply to Medicare’s LTC-DRG payment when requirements are met.
- For payment purposes, Medicare will not cover any patient stay, even if the patient has remaining Medicare days, if that stay has been determined not to have met the medical necessity, reasonableness, and appropriateness standards of the medical review procedure established under the final rule.
Short Stay Outliers
A short stay outlier is a case that has a length of stay between 1 day and up to and including 5/6th of the average length of stay for the LTC-DRG.

High Cost Outliers
A case will fall into this category if the estimated cost of the case exceeds the outlier threshold (the LTC-DRG payment plus a fixed loss amount). Short stay outliers as described above are also eligible for outlier payments if their costs exceed the outlier threshold.

Interrupted Stays
An interrupted stay is a case in which a LTAC patient is transferred upon discharge to an inpatient care hospital, and inpatient rehabilitation facility (IRF), SNF or Swing Bed and returns to the same LTAC within a specified period of time. An interrupted stay case is treated as one discharge for purposes of payment and only one LTAC PPS payment is made:

- For an acute care hospital: 9 days or less
- For an Inpatient Rehabilitation Facility (IRF): 27 days or less
- For a SNF: 45 days or less
- For a Swing Bed: 45 days or less

If the interrupted stay criteria are met, the bill generated by the original stay in the LTAC should be cancelled because only one claim may be billed for entire stay and only one LTC-DRG paid.

Multiple interrupted stays should be entered as one claim but each interrupted stay should be evaluated individually to determine if they meet the requirement regarding the appropriate number of days at the intervening facility.

If the length of stay at the receiving site of care exceeds the above-specified period of time the return to the LTAC will be a NEW ADMISSION. This means that the second admission could be billed separately.

Beneficiary Liability
The beneficiary liability would only be applicable deductible and co-insurance, calculated in the same way inpatient hospital benefits and spell of illness are calculated.

- The beneficiary has the same rights of election to use or not to use lifetime reserve days
- The beneficiary or their Medigap or other insurance is responsible for any non-covered days where Medicare will not make a LTD-DRG payment
- The difference between the Medicare payment and cost may not be billed to the patient.

Once a stay triggers a full LTC-DRG payment (i.e. it exceeds the short stay outlier threshold), Medicare will pay for the entire stay up to the high cost outlier threshold as it does under Inpatient Prospective Payment System (IPPS), regardless of patient coverage. But Medicare will only pay for covered days for lengths of stay equal to or below 5/6th of the average length of stay for a specific LTC Organization.
Billing
Billing guidelines are the same as inpatient acute care hospital billing to Medicare and Medicaid and most other payers.

Type of bill 11x
- LTAC providers will submit one admit through discharge claim for the stay
- LTAC’s can submit adjustment bills but not late charge bills
- All patient status i.e. discharge disposition codes for type of bill 11x are valid but there are no special payment policies for transfers
- The transfer status codes and condition code 40 should be reported as applicable
- For ancillary services associated with Part A inpatient stay, the traditional revenue codes should be reported
- LTAC’s are required to report the actual charge for each line item
- If a beneficiary’s Part A benefits exhaust during the stay code an occurrence code A3-C3 is used
- If benefits are exhausted prior to the stay, submit a no-pay claim
- Report occurrence code 47 to indicate the first full day of cost outlier status and also use occurrence code 70 for covered non-utilization periods beyond the short stay outlier threshold
- There is an exception if there are not enough regular days to reach the short stay outlier threshold point. For the beneficiary to continue coverage, LTR days must be utilized for the remainder of the entire stay, as available

Reimbursement and Billing Requirements of Other Payers
Other payers usually reimburse in the same manner they would an inpatient acute care hospital claim but some payers are now addressing specific reimbursement for LTAC’s in their contracts. Billing is the same as inpatient hospital billing.
Section 4.1.E - Psychiatric Care

Inpatient Services

Medicare

A patient covered under Medicare hospital insurance is entitled to have payment made for inpatient psychiatric hospital services. There is a 190-day lifetime limitation on payment for inpatient services and there is also a pre-entitlement inpatient psychiatric benefit day’s reduction provision. See the Medicare Hospital Services Manual for more information regarding the benefit day’s reduction provision. Payment for inpatient services are now paid by the inpatient psychiatric facility prospective payment system similar to general hospital diagnoses related groups payment.

Medicare requires that the following requirements be met for services furnished in a psychiatric hospital:

- The physician must certify that the services provided can reasonably be expected to improve the patient’s condition.
- The services must be furnished while the patient was receiving either active treatment or admission and related services necessary for diagnostic study.

For a patient to be covered by Medicare for inpatient psychiatric services, it is crucial to determine that the patient is receiving active treatment. Medicare defines active treatment as follows:

- Services must be provided under an individualized treatment or diagnostic plan
- Services are reasonably expected to improve the patient’s condition or for the purpose of diagnosis
- Services are supervised and evaluated by a physician

Medicaid

Reimbursement for psychiatric services is limited to short term acute care. The maximum length of stay considered for reimbursement by the Department of Community Health is 30 days. Psychiatric admissions, which have a length of stay in excess of 30 days, will be denied reimbursement.

Other Payers

Inpatient psychiatric benefits will vary from payer to payer. Providers must call the payer to verify benefits, check for necessary documentation, and to determine if pre-certification is required.

Billing

For inpatient psychiatric services, bill claims similar to general inpatient using the 11X bill type. Most commercial insurance carriers require revenue code 0114 for room and board charges for psychiatric services in lieu of the generic 0110.

Partial Hospitalization Services

Medicare

A Partial Hospitalization Program (PHP) is structured to provide intensive psychiatric care through active treatment. A PHP program resembles inpatient psychiatric services except the
patient does not stay overnight at the facility. PHP treatment is more intense than outpatient day treatment or psychosocial rehabilitation. Partial Hospitalization must be active treatment that includes:

- An individualized treatment plan
- Incorporates a coordination of services revolving around the patient’s needs
- Includes a multidisciplinary team approach to patient care under the direction of a physician

The patient’s active treatment goals should be:

- Measurable
- Functional
- Time-framed
- Medically necessary
- Directly related to the reason for admission into the partial hospitalization program.

PHP is reimbursed by the Ambulatory Payment Classification (APC) methodology. The partial hospitalization APC is number 0033 with a status indicator of P. This APC is paid once per day. Blue Cross and Blue Shield of Georgia, Medicare A intermediary, has developed a Local Coverage Determination (LCD) for Partial Hospitalization Services. The LCD is No. 2.10 and can be located at [http://www.georgiamedicare.com/LCD/210PHP03042005fu.html](http://www.georgiamedicare.com/LCD/210PHP03042005fu.html)

**Medicaid**

A partial hospitalization program for Medicaid purposes is a comprehensive program that uses a multidisciplinary team approach to provide individualized treatment to patients with one or more psychiatric disorders. Services are designed to prevent hospitalization. In order to qualify for partial hospitalization, services must be:

- Certified by a physician that the PHP is in lieu of needed short-term acute care services
- Must be under the care of a physician and the plan of treatment must be periodically reviewed by the physician
- A plan of treatment must be established within the first 7 days of admission into the PHP
- Reviews must be done every 31 days
- Services must be reasonable and necessary
- There is expectation that the patient will improve or maintain functional level and prevent relapse or hospitalization

Medicaid recipients may attend PHP’s for one to five days per week with a minimum of four hours per day. Treatment includes:

- Individual and group psychotherapy
- Family therapy
- Medication reviews
- On-going assessments
- Expressive therapy, such as dance, art, or psychodrama
- Theme specific (psycho-education) groups, such as communication skills, assertiveness training, stress management, symptom recognition problem solving, relaxation training, and groups which focus on substance abuse issues

Medicaid reimburses partial hospitalization on a cost basis.
Other Payers
Partial Hospitalization Programs benefits will vary from payer to payer. Providers must call the payer to verify benefits, verify coverage for PHP services, check for necessary documentation, and to determine if pre-certification is required. Some payers require a distinct certification for the PHP unit separate from the hospital and the provider must verify if this service is covered.

Billing
Medicare
Hospital outpatient departments bill for partial hospitalization services on Form CMS-1450 (UB04) or electronic equivalent under bill type 13X. Follow outpatient-billing rules with the following exceptions:

- Report condition code 41 in form locators 24-30 on CMS-1450
- Bills must contain an acceptable revenue code and HCPCS code:
  250  not required
  43X  G0129
  904  G0176
  910  90801, 90802, 90899
  914  90816-19, 90821-24, 90826-29
  915  90849, 90853, 90857
  916  90846, 909847, 90849
  918  96100, 96115, 96117
  942  G0177

Medicaid
Hospital outpatient departments bill for partial hospitalization services on Form CMS-1450 (UB04) or electronic equivalent under bill type 13X. Additional requirements for PHP:
- Use occurrence code 51 to indicate the date that treatment was started for psychiatric care.
- Bills must contain condition code 41.
- Use revenue code 912 ONLY with the number of visits in the units of service field.
- Use 81-value code and one unit for each outpatient visit that requires a co-payment. Units must be entered in front of the decimal point (i.e. 1.00). If no co-pay is required, then enter a zero (0).

Commercial Payers
Most commercial payers use the Medicare billing rules for Partial Hospitalization.
Rehabilitation Services
Services generally included in Rehabilitation services area:
 Physical Therapy - PT
 Speech Therapy - ST
 Occupational Therapy - OT
 Audiology

Rehabilitation Services are provided in a number of venues:
 Outpatient Hospital based facilities
 Inpatient Rehabilitation Hospital
 Free standing outpatient facilities

Outpatient Services
A Physician (MD) or other Qualified Healthcare Provider must refer patients seeking outpatient rehabilitation services. Orders must be specific as to the diagnosis, reason treatment is ordered, modality, frequency and length of treatment.

If there is a co-payment due, the treating facility should attempt to collect it from the patient

Insurance Verification
The patient’s insurance should be verified prior to scheduling rehabilitation services. Many payers have limitations on the number of visits allowed annually for rehabilitation services.

Authorization Requirements
1. Managed Care - Treatment must be pre-authorized up front for all patients. Some carriers may require an evaluation prior to authorizing treatment.
2. Kaiser Permanente - Usually requires that Kaiser members receive treatment at Kaiser facilities. However if there are extenuating circumstances pre authorization MUST be obtained.
3. Medicare - If the treatment is ongoing:
    There must be a new certification from the physician after the first 30 days documenting the need for continued care
    After the initial certifications, re-certifications must be obtained every 30 days
    The caregiver must also submit a treatment and progress report
    Continued care requires documentation in treatment records by the care giver that the treatment meets the requirements of reasonable, measurable and sustainable, and progress by the patient

   If at some point it is determined that the Medicare patient is not meeting expectations, the facility can stop treatment or can issue an ABN and let the patient make the decision to continue treatment as a self-pay patient.

4. Medicaid - Coverage must be verified every 30 days
5. Workers Compensation - Treatment must be pre-authorized
Billing Requirements
These are specific billing requirements for Medicare patients only and are applicable for outpatient treatment.

1. Physical Therapy:
   - requires occurrence codes 11, 29 and 35 with the corresponding dates
   - requires value code 50 and the # of units that were billed
   - requires GP modifier on all charges

2. Occupational Therapy:
   - requires occurrence codes 11 and 44 with the corresponding dates
   - requires value code 51 and the number of units that were billed
   - requires modifier GO

3. Speech Therapy:
   - requires occurrence codes 11, 30 and 45 with the corresponding dates
   - requires value code 52 and the number of units billed for
   - requires modifier GN

There are numerous Correct Coding Initiative (CCI) edits that are in place for the rehab HCPCS codes. There are local Medical Review policies for PT, OT, and ST. All other payers are billed as regular outpatient services.

Inpatient Services
Overview of PPS in an Inpatient Rehabilitation Facility
Inpatient Rehabilitation Facilities (IRF) came under Prospective Payment System (PPS) beginning on 01/01/02. Facilities excluded from IRF PPS are:
   - Veterans Administration Hospitals
   - Hospitals reimbursed under State Control Systems
   - Some Demonstration Providers

Effective January 10, 2010 – Required Documentation for admission to IRF and to be considered reasonable and necessary must include:
   - Preadmission Screening
   - Post Admission Physician Evaluation
   - Individualized overall Plan of Care
   - Physician Orders
   - IRF-PAI included in medical record
These assessments are used to determine the Case Mix Group (CMG) which will then be used to determine the IRF payment. There are 100 distinct CMG payment rates, which are adjusted according to geographic variation in wages, percentage for Low Income Patients (LIP) and location in a rural area.

Case level adjustments include those that apply for interrupted stays, transfer cases, short stays, cases in which the patients expire and outlier cases.

1. **Interrupted Stay** - This includes patients discharged and returned within 3 consecutive days. The Length of Stay (LOS) for these cases will be the total length of stay minus the interrupted stay days.
2. **Transfer case** - This is a case in which a Medicare beneficiary is transferred and the LOS is less than the average LOS for a given CMG. The CMG payment will be adjusted.
3. **Short Stay Case** - A separate CMG payment will be made for Short Stay Cases (LOS less than 3 days) that do not meet the definition of a transfer case.
4. **Expired Patient** - CMG will also be used in the case of expiration with a variety of LOS. There are four CMG groups for these cases.
5. **Cost Outlier** - Additional payments will be made for those cases that are high cost outliers using the pre-determined formula.
6. **Adjustments for Percentage of LIP** will be made using Disproportionate Share Hospital (DSH) formula.

**Patient Assessment**

The data gathered in the assessment process is used to document whether or not the services furnished by the IRF, Inpatient Rehabilitation Facilities, to the patient were medically reasonable and necessary.

- The assessment time frame for all Patient Assessment Instrument items is three calendar days.
- Circumstances allow additional time to capture all the clinical information.
- Admission assessment provides the basis for the assignment of the specific CMG.
- Discharge assessment is used to record the relevant weighting factors associated with the patient’s co-morbidities (The presence of additional diseases to an initial diagnosis).
- If the assessment documentation is not transmitted timely, more than 10 days, a penalty reduction of 25% will be applied.

**Billing Requirements**

In general the criteria for a facility to be classified as an IRF remains unchanged from the requirements used to classify entities as exempt from the acute care hospital PPS.

1. **Claims** - Only submit for payment under IRF PPS for institutional providers.
   - the provider number has a “T” as the third digit (xxTxxx) or
   - the last four digits of the provider number are in the 3025-3099 range (xx3025-3099).
2. **Bill Type** - claims should be submitted on a 11x type of bill.
3. **Timeliness Filing** - For dates of service January 1-September 30, the timely filing limit is December 31 of the following year. For dates of service October 1 to December 31, the timely filing limit is December 31 of the second year following the date of service.
4. Interim Bills - Providers should submit only one claim for an entire inpatient stay, however, 60-day interim bills will be allowed.

5. Revenue Code 0024 - Only one revenue code 0024 line is necessary and allowed on a claim.
   - used to indicate that the provider is billing under IRF PPS for reimbursement.
   - should be used in conjunction with HIPPS code in the HCPCS/rate field.

6. Health Insurance Prospective Payment System (HIPPS) - Only one HIPPS code is allowed on a claim.
   - is a five digit code and is placed on the claim in the HCPCS/Rates field.
   - The combination of two other codes, the Co morbidity Code and the Case Mix Group CMG determine the HIPPS.

7. Co morbidities - are arrayed in three categories (or tiers) based on whether the costs are considered high, medium, or low.
   - If a case has more than one co morbidity, the CMG payment rate will be based on the highest payment.
   - There are four co morbidity codes, which relate to the tier in which the ICD-9-CM falls:
     - A = without co morbidities
     - B = co morbidity in tier 1 (high)
     - C = co morbidity in tier 2 (medium)
     - D = co morbidity in tier 3 (low)

8. Case Mix Groups - Each CMG has a separate reimbursement rate, which can be different for each patient and each stay due to various factors. These factors include:
   - case-level adjustments
   - facility-level adjustments
   - outlier payments
   - adjustments due to patient co morbidities.

Special Billing Situations
Interrupted Stays - The patient is discharged and is readmitted to the same IRF within three consecutive calendar days.
   - Patient must be readmitted by midnight of the third day.
   - The two stays are to be combined on one claim and will receive one payment based on the initial stay admission assessment
   - Payable days go in the covered days field
   - Interrupted days go in the non-covered days field
   - Occurrence span code 74 is placed on the claim with the dates of interruption of more than one calendar day

   NOTE: Interruption of four (or more) calendar days is NOT an interrupted stay. Two separate claims will be filed and two payments will be made.

Early Transfers - The length of stay is less than average for the patient’s assigned CMG and the patient is transferred to:
   - A short term acute care hospital, use Patient Status code 02
   - A nursing home that accepts payment under Medicare, Medicaid or both, use Patient Status code 03
• Within this institution to a hospital-based Medicare approved swing bed, use Patient Status code 61
• Another rehabilitation facility, use Patient Status code 62
• A long-term care hospital, use Patient Status code 63

The early transfers do not include discharges where the patient will receive aftercare via home health services or outpatient services.

**New Definition for Patient Discharge Status Code 05 - Effective, per National Uniform Billing Committee (NUBC), on April 1, 2008:**

• 05 - Discharged/Transferred to a Designated Cancer Center or Children’s Hospital

**Usage Note:** Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at [http://cancercenters.cancer.gov/](http://cancercenters.cancer.gov/) on the Internet.
Section 4.1.G - Skilled Nursing Facility (SNF)

Introduction
As defined by the State of Georgia, a “Nursing Home” is a facility which admits patients on medical referral only and for whom arrangements have been made for continuous skilled nursing care, rehabilitative nursing care, and has a satisfactory agreement with a physician and dentist who will be available for any medical and/or dental emergency and who will be responsible for the general medical and dental supervision of the home.

The State of Georgia defines “Skilled Nursing Care” as the application of recognized nursing methods, procedures, and actions directed toward implementation of the physician’s prescribed therapeutic and diagnostic plan, detection of changes in the human body’s regulatory system, preservation of such body defenses, prevention of complications and emotional well-being, including, but not limited to the following:
1. The administration of oral or injectable medications, which cannot be self-administered. Other examples include the administration of oxygen, the use of suction, the insertion or changing of catheters, the application of medicated dressings, and the use of aseptic technique and preparation of the patient for special procedures.

2. Observation in the care of the patient for symptoms and/or physical and mental signs that may develop and which will require attention of the physician and a revision in the patient’s treatment regimen.

“Rehabilitative Nursing” means the use of nursing skills and techniques to combat deformities and helplessness, to maintain or restore body functions, and to promote independence in self-care. Such techniques include, but are not limited to the following:
1. Positioning patients in or out of bed to maintain good body alignment (unless contraindicated by physician’s orders), the use of range of motion exercises to maintain joint mobility.
2. Arranging a progression of self-care activities such as transfer and walking, and attention to bowel and bladder schedules together with retraining when indicated.

The Nursing home must maintain a complete medical record on each patient containing sufficient information to validate the diagnosis and to establish the basis upon which treatment is given. The completed record should normally contain the following information:
- Name, address, birth date, sex, marital status, and religion of the patient.
- Name, address, and telephone number of the physician.
- Name, address, and telephone number of the responsible party to be contacted in case of an emergency.
- Date and time of admission.
- Date and time of discharge or death.
- Admitting diagnosis.
- Final diagnosis.
- Condition of discharge.
- History and physical examination.
- Treatment and medication orders.
Physician’s progress notes (at least monthly).
Nurse’s notes.
Special examinations and reports.
DMA – 6
DMA - 59
Level One
Certification of Admission
Advanced Directives
MDS Schedules

Each facility must also keep patient statistics, including admissions, discharges, deaths, patient days, and percent of occupancy. Statistics must be open for inspection and upon request by the State of Georgia’s Department of Human Resources.

The major sources of reimbursement for nursing homes or skilled nursing facilities are Medicare and Medicaid. Very few commercial insurances offer benefits to cover this type of care, which can be long term. Some managed care payers are negotiating reimbursement plans for short-term care in this setting because the costs are usually lower than in the acute care setting.

NOTE: In this section, the terms “nursing home,” “nursing facility,” and “skilled nursing facility” are used synonymously.

**Medicare SNF Coverage**

**Conditions of Participation**
In order for a SNF to participate in the Medicare program, it must meet the requirements of the Social Security Act and any other requirements set forth by the Secretary of Health and Human Services. In addition, the SNF must comply with the Civil Rights Act and have an agreement with an Intermediary. A SNF must also comply in the following areas:

- Provide 24-hour nursing services.
- Provide procedures for treatments and medication administration.
- Provide adequate physician supervision.
- Maintain records on all patients.
- Have written policies to govern its services.
- Meet state licensing requirements.
- Maintain an annual operating budget and three-year capital budget.
- Meet requirements of disclosure of ownership.
- Provide medical evaluations of all patients.
- Engage in skilled nursing care and/or skilled rehabilitative services.
- Enforce life safety codes.
- Maintain personal fund accounts for the resident

**Eligibility Criteria**
Medicare beneficiaries seeking Medicare coverage of SNF services must meet the following criteria:

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• Skilled nursing services and/or skilled rehabilitation services are required for the patient, and the services can ONLY be provided on an inpatient basis in a SNF.
• The services are ordered on a daily basis.
• The physician orders the services.
• There are available days remaining in the patient’s benefit period.
• Must meet three-day qualifying hospital stay and transfer requirements.

Benefit Period
For Medicare purposes, “benefit period” and “spells of illness” are synonymous. It is the period of time in a SNF, which is covered by Medicare. It begins when the patient is admitted to a Medicare certified bed and receives daily skilled care. Beneficiaries in skilled nursing homes are limited to 100 days of coverage per benefit. The benefit period is broken or ended when the patient has not needed or received skilled care for 60 consecutive days. There are no limits to the number of discharges to and from the hospital, or in and out of a Medicare certified bed during a benefit period. Hospital days begin or open the benefit period, but the 100 eligible skilled days start on the day of the first admission to a SNF. The first 20 days of the benefit period are full days Medicare pays all Medicare covered charges, the next 80 days are coinsurance days and Medicare pays all Medicare covered charges except the daily Medicare SNF coinsurance.

Preadmission/Admission
Eligibility and entitlement for Medicare should be determined prior to admission to a SNF and should involve a coordinated effort between representatives from Nursing, Admissions, Utilization Management, Medical Records, and the Business Office. At the time of admission, consents and guarantees of payment of charges not covered by Medicare should be obtained. Medicare requires that a patient have three-day acute hospital (excluding the day of discharge) stay prior to a SNF admission, and be transferred to the SNF for the same condition within 30 days from discharge from the hospital.

Physician Certifications
It is very important that a SNF obtain physician certification and re-certification of a covered stay. If the physician does not sign because he thinks the patient does not need a daily skilled level of care, Medicare does not cover the care. It is very important that the Utilization Management staff or other facility staff members serve as consultants to the physician to assist in determining if a skilled level of care is still required.

The first re-certification signature from the physician must be obtained on or before the 14th day after admission. Re-certifications must be obtained no later than every 30 days thereafter. The recertification statement must meet the following standards as to its contents: it must contain an adequate written record of the reasons for continued need for extended care services, the estimated period of time the patient will need to remain in the facility, and any plans, where appropriate, for home care. The recertification statement made by the physician has to meet the content standards, unless, for example, all of the required information is in fact included in progress notes, in which case the physician’s statement could indicate that the individual medical record contains the required information and that continued post-hospital extended care services are medically necessary. A statement reciting only that continued extended care services are medically necessary is not, in and of itself, sufficient.

A certification may be mailed, faxed or completed when the physician is onsite.

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If the circumstances require it, the first recertification must state that the continued need for a condition requiring such services that arose after the transfer from the hospital and while the patient was still in the facility for treatment of the condition(s) for which he had received inpatient hospital services.

Where the requirements for the second or subsequent recertification are satisfied by review of a stay of extended duration, pursuant to the utilization review (UR) plan, a separate recertification statement is not required. It is sufficient if the records of the UR committee show consideration was given to the recertification content standards.

**SNF PPS Billing – Medicare Residents**

A SNF resident is defined as a beneficiary who is admitted to a Medicare-participating SNF (or to the nonparticipating portion of a nursing home that also includes a Medicare-participating SNF), regardless of whether Part A covers the stay. Whenever such a beneficiary leaves the facility, the beneficiary’s status as a SNF resident for consolidated billing purposes ends when one of the following events occur:

- The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital or as a resident to another SNF. The beneficiary receives services from a Medicare-participating home health agency under a plan of care.
- The beneficiary receives outpatient services from a Medicare-participating hospital or critical access hospital (but ONLY with respect to those services that are not furnished pursuant to the SNF’s required resident assessment or comprehensive care plan
- The beneficiary is formally discharged (or otherwise departs) from the SNF, unless the beneficiary is readmitted (or returns) to that or another SNF within 24 consecutive hours

Under SNF PPS, beneficiaries must meet the regular eligibility requirements for a SNF stay. That is, the beneficiary must have been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days. In addition, the beneficiary must have been transferred to a participating SNF within 30 days after discharge from the hospital. In certain circumstances the 30-day period may be extended, if the patient’s condition makes it medically inappropriate to begin an active course of treatment in an SNF within 30 days after discharge. To be covered, the extended care services must be needed for a condition which was treated during the patient’s qualifying hospital stay, or for a condition that arose while in the SNF for treatment of a condition for which the beneficiary was previously treated in a hospital.

SNF services included in PPS are post-hospital SNF services for which benefits are provided under Part A (the hospital insurance program) and all items and services which, prior to July 1, 1998, had been paid under Part B (the supplementary medical insurance program) but furnished to SNF residents during a Part A covered stay (other than the exclusions listed below). These services (other than the exclusions) are considered included in the PPS rate and therefore may not be billed separately by any other provider.

Services excluded from SNF PPS that must be billed separately by the rendering provider/supplier are:

- Physician’s services furnished to SNF residents
- Physician assistants working under a physician’s supervision
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician
- Certified nurse-midwives

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• Qualified psychologists
• Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies
• Hospice care related to a beneficiary’s terminal condition
• An ambulance trip that transports a beneficiary to the SNF for the “initial” admission or from the SNF following a “final” discharge
• Certified registered nurse anesthetist services
• Erythropoietin (EPO) for certain dialysis patients
• Certain services involving chemotherapy and its administration
• Radioisotope services
• Certain customized prosthetic devices

In addition, certain services are excluded from the SNF PPS only when furnished on an outpatient basis by a hospital or a CAH: (these services should be billed by the provider of the service-separately)

• Cardiac catheterization services,
• Computerized axial tomography (CT scans),
• Magnetic resonance imaging (MRIs),
• Radiation therapy,
• Ambulatory surgery involving the use of a hospital operating room,
• Emergency services,
• Angiography services,
• Lymphatic and venous procedures,
• Ambulance services that convey a beneficiary to a facility to receive

Reimbursement
Section 1888(e) of the Balanced Budget Act of 1997 provides the basis for the establishment of the per diem Federal payment rates applied under PPS to SNF’s that receive their first payment from Medicare on or after October 1, 1995. A transition period applied for those SNF’s who first accepted payment under the Medicare program prior to October 1, 1995. The BBA sets forth the formula for establishing the rates as well as the data on which they are based.

On August 4, CMS published the final rule for the SNF PPS.

The SNF PPS incorporates adjustments to account for facility case mix, using the system for Classifying residents based on resource utilization known as Resource Utilization Groups, Version III (RUG III). Facilities will utilize information from the most recent version of the Resident Assessment Instrument (RAI), to classify residents into the RUG-III groups. The MDS contains a core set of screening, clinical, and functional status elements, including common definitions and coding categories that form the basis of a comprehensive assessment. Law requires the assessment and is to be performed based on a predetermined schedule for purposes of Medicare payments (see Medicare Assessment Schedule chart below).

For Medicare billing purposes, there is a payment code associated with each of the 44 RUG-III groups, and each assessment applies to specific days within a resident’s SNF stay. SNFs that fail to perform assessments timely are paid a default payment for the days of a patient’s care for which they are not in compliance with this schedule. Facilities will send each beneficiary’s MDS
assessment to the State and claims for Medicare payment to the intermediary on a 30-day cycle.

When the initial Medicare-required 5 day assessment results in a beneficiary being correctly assigned to one of the highest 26 of the 44 RUG-III groups, this effectively creates a presumption of coverage for the beneficiary from admission up to, and including, the assessment reference date for that assessment. The coverage that arises from this presumption remains in effect for as long thereafter as it continues to be supported by the actual facts of the beneficiary’s condition and care needs. However, this administrative presumption does not apply to any of the subsequent assessments.

For a beneficiary assigned to one of these upper 26 groups, the required initial certification essentially serves to verify the correctness of the beneficiary’s assignment to that particular RUG-III group. Rug III hierarchy categories that qualify for the administrative presumption of coverage in connection with the initial Medicare-required, 5 day assessment (assuming services provided are reasonable and necessary) include:
- Rehabilitation
- Extensive care
- Special care or
- Clinically complex

For a beneficiary who is assigned to any of the lower 18 of the 44 RUG-III groups on the initial, Medicare-required, 5 day assessment (or for any beneficiary on a subsequent assessment), the beneficiary is not automatically classified as either meeting or not meeting the SNF level of care definition. Instead, the beneficiary must receive an individual level of care determination using existing administrative criteria and procedures.

<table>
<thead>
<tr>
<th>Medicare Assessment Schedule</th>
<th>Medicare MD Assessment Type</th>
<th>Assessment Window (including authorized grace days)</th>
<th>Maximum Number of days Authorized for Coverage and Payment</th>
<th>Applicable Medicare Payment Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 day</td>
<td>Days 1 – 8*</td>
<td>14</td>
<td>1 through 14</td>
<td></td>
</tr>
<tr>
<td>14 day</td>
<td>Days 11–14</td>
<td>16</td>
<td>15 through 30</td>
<td></td>
</tr>
<tr>
<td>30 day</td>
<td>Days 21-29</td>
<td>30</td>
<td>31 through 60</td>
<td></td>
</tr>
<tr>
<td>60 day</td>
<td>Days 50-59</td>
<td>30</td>
<td>61 through 90</td>
<td></td>
</tr>
<tr>
<td>90 day</td>
<td>Days 80-89</td>
<td>10</td>
<td>91 through 100</td>
<td></td>
</tr>
</tbody>
</table>

*If a patient expires or transfers to another facility before the 5-day assessment is completed, the facility must still prepare an MDS as completely as possible for the RUG-III classification and Medicare payment purposes. Otherwise the days will be paid at the default rate.
Co-Insurance
Medicare Part A co-insurance days for SNF benefits are the 21st through the 100th days of Medicare Part A coverage for each benefit period. The patient does not have any payment responsibility for the first 20 days if Medicare criteria for a continued stay are being met. The Part A co-insurance for 2011 is $141.50 per day. The patient’s portion on Part B is 20% of total allowed charges. The patient, supplemental insurance or Medicaid may reimburse the co-insurance amount due.

Billing
Whether a provider bills manually or electronically, it is important to be aware of common SNF billing problems such as:
- Type of bill not consistent with admit date, status, and statement covers period.
- Covered days inconsistent with status and statement covers period.
- Missing or inconsistent “qualifying hospital stay.”
- Omitting occurrence codes and dates when required.
- Omitting units on therapy bills.
- Billing with bad diagnosis codes.
- Bills out of sequence.
- Combining ancillary services.
- Missed ancillary charges.
- Omitting Rug Codes

NOTE: Medicare rules and regulations pertaining to timely filing periods, Medicare Secondary Payer issues, the appeal process, fraud and abuse etc., are the same for a Skilled Nursing Facility as they are for acute care hospitals.

Medicaid SNF Coverage

Conditions of Participation
In order for a SNF to participate in the Medicaid Program, the Department of Human Resources (DHR) must provide the Department of Medical Assistance (DMA) with the following information:
1. Certification that the facility is in compliance with the requirements for participation, the period of time covered by the certification and any specific conditions pertaining to the certification.
2. License number and effective dates of license to operate a nursing facility.
3. Verification that the entire facility is certified to participate in the Medicaid Program.
4. Public access to state survey results.

Medicaid requires the following general conditions of participation for SNF providers:
1. The facility must agree to accept DMA’s payment as payment in full for covered services. Under no circumstances can a recipient, relative, sponsor, or other interested party be asked or required to make payment for covered services.
2. The facility must not contact Medicaid recipients for the purpose of soliciting their requests for services. Advertising to the general public that seeks to increase patient utilization of the provider’s facility is allowed.
3. The facility is required to participate in the Bed Registry Program to monitor bed availability.
4. Federal law prohibits the facility from discriminating on the basis of handicap, history or condition of mental or physical disease, or disability, race, color, or national origin. Giving preference to private pay patients over Medicaid recipients for any of the above reasons.
constitutes a violation of the conditions of participation and subjects the facility to civil fines as well as programmatic sanctions.

5. A facility may NOT designate a certain number of beds as Medicaid beds. If a Facility is certified for enrollment in Medicaid, then ALL of its beds are certified for use by Medicaid recipients. As long as any bed designated for a prospective Medicaid recipient’s level of care is unoccupied; a Medicaid-enrolled facility may NOT refuse that bed to a recipient on the grounds that it is not certified as a Medicaid bed. Making the bed unavailable on such grounds will subject the facility to the same fines and sanctions as listed above in #4.

6. Providers may not engage in the practice of having prospective residents sign documents in which the prospective resident agrees to reside as a private pay patient at the facility for a minimum period of time prior to becoming a Medicaid-pay patient.

7. Providers may not request or require that prospective Medicaid-eligible patients have family members or friends sign statements that they will be responsible for the patient’s financial affairs.

Program Requirements

In addition to the conditions of participation, DMA also imposes Program Requirements for participation on skilled nursing facilities. For example:

1. Nursing facilities are required to sign a letter of understanding, thereby agreeing to provide all adult individuals with information on Advance Directives as mandated by Section 1902 (a) (57) of the Social Security Act.

2. Nursing facilities must utilize a Resident Assessment Instrument (RAI) that accurately and completely represents the CMS version of this assessment tool.

3. A state-approved program must certify Nurse Aides working in nursing facilities. Nurse Aides are required to have a minimum of 12 hours of in-service education annually in accordance with federal regulations.
Eligibility
In order to be eligible for Medical Assistance in a SNF, an individual must meet the eligibility criteria established by DMA. In addition to the basic eligibility criteria, DMA allows a higher income for individuals who are patients in, or who are seeking admission to, a nursing facility. In addition, nursing home applicants must complete prior approval/admission procedures and communities care assessment.

All individuals seeking nursing home admission must have pre-admission screening for mental illness and mental retardation. The admitting physician will sign a DMA-6 for those who seek Medicaid payment for nursing facility services. The DMA-6 will serve as authorization by the Admitting physician that the resident meets the “nursing home level of care”.

Form DMA-613 (Level I Applicant/Resident I.D. Screening Instrument) must be completed and Signed by the attending physician. The DMA-613 is not necessary if the attending physician certifies before the admission that the admission is for an anticipated stay of not more than 30 days (following hospitalization) for treatment of the same condition for which the individual was hospitalized.

- Medicaid payments can only be made for services during an approved length of stay.
- Medicaid payments cannot be made for services prior to the payment date.
- Additionally, Medicaid payments cannot be made until DFCS determines that the individual is eligible for Medicaid and DMA is notified by Form DMA-59.
- Medicaid payments will not be made for days the individual was not eligible for Medicaid.

If a limited length of stay was approved by GMCF, the facility must submit a new DMA-6 to GMCF to obtain prior approval for continued stay in the facility. If the individual continues to require nursing facility care, GMCF will assign a level of care and another approval length of stay. If the DMA-6 and 59 information are submitted by telephone, the form itself must be received by GMCF within 10 working days for assignment of a payment date. If these procedures are followed, the payment date will be the date the facility submitted the DMA-6 information to GMCF by telephone.

When a person is transferred from one nursing facility in Georgia to another or when a person residing in a nursing facility applies for Medicaid, the facility must submit Form DMA-6 to GMCF for a level of care determination and a payment date.

Medicare and Medicaid Benefits
Patients who appear to be eligible for both Medicare and Medicaid may be admitted as Medicaid if ineligibility for Medicare Part A coverage results from one of the following:
- The person has not been approved (added to eligibility files) for Medicare;
- The person was not admitted to the nursing facility within 30 days following hospitalization;
- The available benefits under Medicare have been exhausted.

Community Care Assessment
The Community Care Assessment is a determination of a person's functional status and capability of remaining in the community, as opposed to entering a nursing facility. After a preadmission determination for nursing facility placement is obtained from GMCF, it is the responsibility of the nursing facility to determine if the patient desires a Community Care
Assessment. It is also the responsibility of the nursing facility to inform the applicant of the Community Care Program.

Nursing facility residents under the Medicaid Program are allowed to retain a personal needs allowance from their income each month, which can be used for clothing and other personal needs while in the facility. The personal needs allowance is currently set at $30.00 per month.

**Reimbursement**
The approved reimbursement rate established for each SNF by DMA is an inclusive rate that covers the cost of the following services and items at no additional charge to DMA, the recipient, or the recipient's representative:

1. Resident's room and board including special diets and special dietary supplements used for tube or oral feedings, when prescribed by a physician;
2. Laundry (including personal laundry);
3. Nursing and routine services. Routine services include all nursing services, supplies, and other equipment related to the day-to-day care of the patient.

Prescription drugs are reimbursed under a separate administrative process and not otherwise included in the nursing facilities per diem rate. The recipient has freedom of choice of pharmaceutical providers. There is no recipient co-payment in the pharmacy program.

Effective with dates of service 07/01/95, and thereafter, a facility's Actual Reimbursement Rate is the amount DMA will reimburse to a facility for nursing services rendered to a particular eligible patient for one patient day and is calculated by subtracting Patient Income from Total Allowed Per Diem Billing Rate.

**Leave of Absence/Bed Hold**
Federal regulations provide that a Medicaid recipient has a right to leave a facility at any time. Recipients may also obtain a leave of absence from the nursing facility when authorized by the attending physician in the patient's plan of care. The nursing facility will be reimbursed when a bed is "held" for the recipient. A "skilled" level of care recipient may spend only two consecutive days at a time away from the facility without a reduction in the amount of reimbursement. An "intermediate" level of care recipient may spend a total of 16 days in any calendar year without reduction in the amount of Medicaid payment.

When a Medicaid recipient in a SNF is hospitalized, the facility's per diem rate will be continued for seven (7) days during the hospital stay. However, it is permissible for the family or other interested party to arrange for the facility to hold the bed for a longer period while the recipient is hospitalized. The facility may charge a mutually agreeable rate not to exceed the total allowable per diem rate that the facility would have been paid had the recipient been in the facility. DMA cannot pay any portion of the cost of services in a facility for the period of time while the patient is hospitalized beyond the seven-day (7) period.

**Billing**
In order to facilitate timely and correct payment of claims, the Division has developed and implemented a Management Information System. This computer system utilizes automated processing and auditing steps in lieu of lengthier and less efficient manual processing steps. The nursing facility billing forms currently in use were developed so as to capture the necessary data to employ the System. The volume of claims received by the Division is such that we must
rely on the computer system to audit all claims. Therefore, it is essential that the billing forms be completed correctly by the nursing facility to prevent delays in payment, denial or rejection of claims.

The Form DMA-59 is used by nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) in requesting vendor payments. All initial admission requests, continued stay request and terminations/discharges require a form DMA-59 to be initiated by the facility. The form must be sent to DFCS. The Form MUST BE TYPED when initiated by the facility. The county will return any un-typed forms to the facility for typing and resubmission.

If the person is not a Medicaid recipient (does not have a Medicaid number), the facility must instruct the individual’s family or representative to make application at DFCS in the county where the nursing facility is located. The form DMA-59 is then completed and sent to DFCS with a letter identifying the family member or representative as having made an application. The Form DMA-59 will not be processed by DCFS until an application is filed.

All Form DMA-59’s are completed by the facility in duplicate. The copy is kept by the facility and placed in the recipient’s case folder. The original is sent to DFCS. The DMA-6 is no longer sent to DFCS. The DMA 59 will serve as the evidence that the resident meets an approved nursing home level of care.

The Pre-Bill is generated on the 15th working day of each month and mailed to the nursing facility (approximately the 24th of the month). If a facility is approved for two levels of care, each level will be listed separately on the Pre-bill.

When a new recipient is admitted to the facility, the recipient's name, Medicaid number, level of care, status code and dates of service must be added to the Pre-bill. Once this information is initially added by the nursing facility, the information will be computer generated for subsequent months until the nursing facility deletes the recipient from the Pre-bill.

The DMA-7 Pre-Bill should be filed to the fiscal agent no later than the return date on the Pre-Bill cover sheet, but no sooner than the first calendar day of the month. Pre-Bills, which are signed and dated prior to the first day of the month following the month of service, will NOT be processed by HP.

As an alternative to billing claims on paper, Electronic Media Claims (EMC) provides a means of submitting weekly nursing facility claims electronically. Once a recipient is entered into the EMC software, the recipient will never have to be added again. Each week the facility will simply make the necessary changes to dates of service, patient's status, level of care, and total days billed. These claims are then transmitted to the fiscal agent for processing and payment.

Three methods of electronic media billing are available: dial-up transmission, magnetic tape, and diskette.

The nursing facility receives the Remittance Advice with the facility's check.

Form DMA-59 is mailed to the appropriate Department of Family and Children’s Services.

Form DMA-295 and DMA 296 are mailed to the fiscal agent. GA Health Partnership
Note: All UB-04 forms are to be completed in their entirety and mailed to:

HP ENTERPRISE SERVICES
PO BOX 105204
Tucker, GA 30085-5204
Chapter 5 – Physician Billing
SECTION 5.1 PHYSICIAN BILLING
Section 5.1.A - Physician Billing

Introduction
For many years physicians graduated from medical school under the impression that they were going to run a “practice.” Businesses were for other professionals. Because of this mentality, many simple administrative procedures were neglected, such as:

- Keeping current with insurance specifications and regulations, so that claims were paid on a timely basis,
- Concentrating on collecting receivables and co-payments,
- Ensuring that fees were kept at the maximum allowable for which insurance carriers were paying, or
- Ensuring that procedure codes were kept current so that claims weren’t suspended or rejected.

For many offices, outstanding receivables grew tremendously and annual bad-debt write-offs became routine. But adequate profit margins allowed medical practices to ignore sound business procedures. Medical practice complacency toward industry change is in the past. Physicians’ heads raised and they began taking note of public opinions toward health care reform issues during 1994 and 1995. With the onslaught of managed care organizations into the industry, physicians are finding profit margins shrinking. They are now alert to the fact that in order to remain in business in the 21st century, they will have to adopt more efficient business practices.

Furthermore, physician practices have seen significant changes in reimbursement methods. Reimbursement methodologies include:

- Fee for service (rare in today’s managed care market)
- Discounted fee for service (based on contractual agreements between the provider and the insurance carrier)
- Capitation.

Another major difference between hospital and physician practice accounts receivable management is the method for maintaining activity on the patient’s account. Most physician specialties maintain a running sequential accounts receivable account for each patient while the hospital’s accounts typically record one account for each encounter with the patient.

As in most facilities, the level of coding expertise varies. Often there are misinterpretations of the appropriate diagnosis to indicate medical necessity for each service provided. Many practices today are employing “certified coders” who are responsible for the appropriate linkage of CPT-4 and ICD-9 codes. Failure to code services accurately can result in the risks of audits, lost charges, and decreased reimbursement. Combined with the Federal and State regulations and third-party payer guidelines for reimbursement, correct coding of services becomes a long-term management problem.
The Front Desk
The front desk of the physician’s practice should be well organized and efficient with sound policies and procedures for handling every aspect of the patient encounter. This will ensure patient satisfaction with minimal wait times, accurate collection of demographic and insurance coverage information, timely filing of claims, collection of copays and coinsurances from the patient, and effective financial control with balancing routines for each encounter.

Many physician practices perform all of these functions at the front desk while larger practices perform only the “front end” processes at the front desk. The “front end” processes include:

- Scheduling of appointments
- Check in and Checkout
- Registration - Obtaining demographic and insurance coverage information
- Insurance eligibility verification
- Collection of the copay and/or coinsurance from the patient due for that day’s services.

The insurance billing/collections department performs the “back end” processes. These processes may include:

- Obtaining precertification or preauthorization for services to be performed
- Timely filing of claims
- Follow-up on claims to ensure reimbursement, and collection of accounts activity
- Payment posting
- Denial posting and resolution

Many larger group practices have a Central Business Office (CBO) where the claim filing, follow-up, and collections activity occur.

The physician billing process is often described as front end and back end. Historically the front end processes were focused on activities performed at the practice site(s) where the patient is seen and back end referred to those activities performed in a billing office. The process has evolved and really the billing process starts when the patient calls the office for an appointment. This critical shift is needed to improve revenue and operational performance in practices.

Timely filing
Timely filing indicates the number of days from date of service available to submit a claim. Timely filing guidelines vary by health plan and ranges from 90 days to 1 year. Also applies to secondary claims processing.

It is important to get accurate insurance information to prevent timely filing denials.
Section 5.1.B – Scheduling and Registration

Scheduling Appointments
Scheduling the initial appointment for a patient is the practice’s best opportunity to project a good first impression. This is also an opportunity to provide information to the patient regarding insurance filing and financial policies.

In a managed care market, it is vital to ascertain if the physician with whom the appointment is being scheduled is a participating physician with the patient’s insurance carrier and if the physician is the patient’s Primary Care Provider (PCP). Verification of the patient’s coverage and PCP through the member roster or member services is a critical function.

This information will make the difference between obtaining reimbursement for the services provided, the patient receiving reduced benefits from their carrier, or a required contractual write-off.

Secondary Coverage
Important to understand the patient’s primary and secondary coverage to avoid issues with coordination of benefits (COB)

The Patient Registration Form
The physician practice’s patient registration form serves as the cornerstone of the financial and administrative relationship between the practice and the patient. The basis of sound billing and collections depends on the type of information collected. Accuracy of the information is of the utmost importance.

The Health Insurance Portability and Accountability Act (HIPAA) passed by Congress in 1996 adds specific rights and requirements to the long tradition of confidentiality in medicine. The initial purpose of the Act was to prevent people from losing their health insurance when they changed jobs. It included measures to standardize the electronic transmission of medical data as a cost saving measure. This led to heightened concern that the confidentiality of this information needed additional protection. In response, the Secretary of the U.S. Department of Health and Human Services (HHS) developed the HIPAA privacy regulations. In total, these requirements prescribe standards for the security of stored information and privacy cautions in the collection, use and transfer of information. Security and privacy are both necessary to ensure confidentiality.

The HIPAA privacy regulations pertain to information in any form – electronic, written, verbal and other media.

One of the most overlooked areas on the registration form is the disclosure and related details about the financially responsible party. To fully process claims, when the patient is not the responsible party, most payers require the insured’s name and date of birth, along with the patient’s identification number assigned by the carrier. Other information required by some carriers includes the plan holder and/or employer name and group number.
The signature of the patient and/or the responsible party should be obtained on the registration form. The signature line should be placed at the end of the statement of financial policy/obligation for services rendered. The box for designating nearest relative (sometimes called next of kin) on the registration form has proven to be the collector’s best friend. In instances where payment has not been made and the patient is unable to be reached at the numbers provided, it is permissible by law to attempt to contact the patient via the next of kin. However, strict standards required by law must be followed when contact is under these circumstances.

Physician practices should make a copy of the patient’s health insurance card (front and back) to be placed with the registration form in the patient’s chart. It is also a good idea to obtain a copy of the patient’s driver’s license to validate the demographic information submitted by the patient. These can also be scanned and attached to the patient’s information within the practice management system.

Registration forms should be reviewed for updated information every six months.

Verifying Coverage and Benefits
Regardless of the type of specialty medicine the physician provides, it is important to determine the patient’s current coverage and benefits information. This information provides the groundwork for collecting the accounts receivable for the patient.

This information can be obtained before or after the patient’s arrival at the office for their designated appointment by several methods:
- Via telephone during appointment scheduling
- By visiting the payer’s website
- Some Practice Management Systems have eligibility integrated

The information to be obtained from the patient includes:
- Subscriber or policyholder’s name
- Subscriber or policyholder’s Social Security Number (SSN)
- Subscriber or policyholder’s date of birth (DOB)
- Subscriber or policyholder’s identification number (ID #)
- Subscriber or policyholder’s group number (Group #)
- Insurance carrier’s name
- Insurance carrier’s phone number to call to verify benefits
- Patient’s Primary Care Provider (PCP), if applicable for this insurance
- Patient’s name
- Patient’s DOB
- Patient’s relationship to the insured

Information to be obtained from the insurance carrier:
- Coverage effective date to ensure it is in effect on the date of service
- Benefits available for this service
- Copays, coinsurance, and deductibles in effect for this policy
- Claims filing address
- Claim follow-up telephone number
Updating Demographic and Insurance Information

Obtaining and updating demographic information at each visit decreases the possibility of returned mail if the patient and/or guarantor of the account have moved. This provides accurate telephone number and employment information in the event it is necessary to begin collection activity on the patient.

Obtaining and updating insurance coverage information decreases the possibility of rejected claims due to timeliness of filing. If an insurance policy is no longer in effect, and updated insurance information is not obtained, the lapse of time for the denial from the incorrect coverage will result in a delay in filing the correct insurance claim. If the correct insurance claim is not filed within the specified time limits, the service will be denied and cannot be balance billed to the patient. The result is financial loss to the practice.

Charge Entries and Check Out

After the patient has received the services for that day, the patient will proceed to the checkout area. Although this is usually located at the front desk, the checkout area can be located elsewhere at the physician’s practice.

With the increase of high deductible and consumer directed plans, many practices are collecting co-pays and deductibles prior to services being rendered.

The services are tallied on the fee ticket or superbill. The patient is asked for the appropriate amount for today’s services. This amount may represent the total amount of the services, coinsurance, deductibles, and/or copay amounts. Collecting the patient’s portion at checkout eliminates the need to generate a statement for the patient, thus decreasing expenses and reducing the accounts receivable.

The patient is provided a copy of the fee ticket or superbill indicating the services provided, the associated diagnoses, dollar amount for the services, payment method, payment amount, and balance remaining. The physician signs the fee ticket indicating these are the services s/he provided to the patient. If the payment method is cash, the patient is also provided a cash receipt.

In the event the practice, as a courtesy, files the insurance and desires the reimbursement to be remitted to the practice, the fee ticket or superbill should be stamped “Not for Insurance Filing.” This will prevent the patient from filing the insurance claim and obtaining payment directly from the carrier.

If you are courtesy filing for the patient, and the patient has paid for their services, stamp the fee ticket or superbill “Pay Patient.” This will reduce the need to make refunds to the patient in the event the insurance carrier remits to the practice instead of the patient.

At checkout, the patient may also be scheduled for a return visit.
**Section 5.1.C – Coding**

**Accurate Coding**
For physician office and outpatient claims processing, never report a code for diagnoses that includes such terms as “rule out,” “suspicious for,” “probable,” “ruled out,” “possible,” or “questionable.” Code either the patient’s symptoms or complaints or do not complete this block until a definitive diagnosis is determined.

Be sure all diagnosis codes are reported to the highest degree of specificity known at the time of the treatment. Verify fourth and fifth digits in the coding manual. Do not assign unspecified codes (xxx.9).

If the computerized billing system displays a default diagnosis code (e.g., condition last treated) when entering a patient’s claim information, determine if the code validates the current procedure/service reported. It may frequently be necessary to edit this code because, although the diagnosis may still be present, it may not have been treated or medically managed during the subject encounter.

**Coding for Optimal Reimbursement**
Medical coding is a key step in the medical billing process. Every time a patient receives professional health care in a physician’s office or ambulatory surgical center (ASC), the provider must code and create a claim to be paid, whether by a commercial payer, the patient or CMS.

For Medicare and other health insurance programs to ensure health care claims are processed in an orderly and consistent manner, standardized coding systems are essential.

Physician practices use the HCPCS system to report services provided to the patient.

HCPCS stands for Healthcare Common Procedure Coding System (HCPCS). The HCPCS Level II code set is one of the standard code sets used by medical coders and billers for this purpose.

HCPCS consists of three unique levels in the coding system.

- **Level I – CPT® (Current Procedural Terminology)**
The CPT consists of 5 digits with descriptive terms to accurately describe services provided to patients. The CPT was first published in 1966 and is copyrighted, maintained, and updated annually by the American Medical Association (AMA). The new codes may be used after October 1st of each year with a deadline for usage of January 1st of the next year.
Services are grouped into six categories:
- Evaluation and Management (E/M)
- Anesthesiology
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine

Under each category, codes are further broken down into subsections specific to body part, service, or diagnosis.

- **Level II – National Codes – This level is often referred to as the HCPCS codes.**
  These codes begin with a single letter (A through V) followed by four numeric digits. These codes are grouped by the type of service or supply provided. HCPCS codes are required to report medical services and supplies provided to Medicare and Medicaid patients. Some private insurance carriers are also requiring their use. The codes are updated annually by CMS.

- **Level III – Local Codes**
  These codes begin with a single letter (W through Z) followed by four numeric digits. These codes are utilized to report services that are not yet a part of Level I or II. These codes are assigned by local carriers.

- **Modifiers**
  Modifiers are used to further describe, alter, or enhance the description of the services provided. There are also three levels of HCPCS modifiers – one for each level of codes.
  - **Level I – CPT modifiers** are two numeric digits. They are maintained and updated annually by the AMA.
  - **Level II – HCPCS/National modifiers** are two alphabetic digits (AA-VP). They are recognized by carriers nationally and are updated annually by CMS.
  - **Level III – Local** modifiers assigned by state Medicare carriers. Physicians are notified of their release and updated via newsletters. The carriers may change, add, or delete as indicated.


ICD-9-CM coding system is utilized to report the diagnoses applicable to each service rendered. Medicare began requiring the usage of the ICD-9-CM codes after the passage of the Medicare Catastrophic Act of 1988. Commercial carriers soon followed.

The original purpose of the ICD system was to provide morbidity statistics for the World Health Organization (WHO). Today, ICD-9 codes are used to report information to support the need for patient care or treatment. They are also still used to provide morbidity and mortality rates.

The purpose of ICD coding is:
- To establish medical necessity to facilitate reimbursement;
• To translate written terms or descriptions into numbers in order to provide a common universal language;
• To evaluate utilization patterns to study appropriateness of health care cost factors.

In a physician practice, the physician should be the chief source for both CPT and ICD-9-CM coding.

Linking CPT and ICD-9
It is critical to associate the correct ICD-9 code to the correct CPT code. This is called “linking”. If not done properly, the insurance carrier will deny payment with a “not medically necessary” reason code. This could increase inappropriate contractual write-offs or create a delay in reimbursement as a result of the necessity to re-file the claim with the appropriate ICD-9 linked to the CPT code. This could also decrease patient satisfaction due to inappropriate balance billing to the patient.

Only conditions affecting today’s care should be included in the diagnoses for each specific visit. Chronic conditions are linked to specific visits when applicable to the care rendered at that visit.

In the absence of a definitive diagnosis, only signs and symptoms are coded. “Rule out” and “possible” should not be used for coding the diagnosis. Using ICD-9 codes to identify an illness or disease that has not been definitively diagnosed can result in the patient being labeled with an incorrect diagnosis. Such occurrences can result in higher premiums for the patient or denied coverage for other types of insurance.

Tips for a Clean Practice
1. Keep neat, accurate records.
2. Be sure to obtain signatures whenever applicable (i.e., permission to treat, file insurance, or assignment of benefits).
3. When correcting an entry, cross out incorrect data with a single line, enter correct data, initial the correction, and give an explanation for the reason of the error.
4. Never use correction fluid or erase information already in the patient’s record.
5. Review insurance forms before mailing them. An insurance company can sue the physician for incomplete records. Be sure to complete all blank lines on the form as a prevention of tampering with your submitted claim.
6. Record missed or cancelled appointments in the patient’s chart. This can assist the office in the event of a malpractice suit.
7. Never release confidential information without a signed permission form from the patient.
8. Avoid having office staff give patients their test or lab results. The physician is the only one qualified to interpret data.
Section 5.1.D - Collections

Tracking Financial Information
Efforts to work down A/R often lead to ongoing billing improvements and that means practices with an A/R at or near the benchmark commonly have a higher overall collection ratio from reduced billing errors such as:

- Pended claim that are never worked.
- Erroneous claims that are not resubmitted.
- Denials for untimely filing.
- Unjustified insurance denials.
- Miscellaneous errors by billing staff.

Detailed Accounts Receivable Analysis:

Practices with rock bottom A/R have an accounts receivable aging profile that is markedly different from practices with higher A/R. The A/R is different in two important ways.

- They have significant collections in the 0-30 day aging category, resulting from timely submission of clean claims.

- They have comparatively how A/R in the 120+ aging category, showing that unresolved claims and self-pay balances do not fall between the cracks.

The following is a detailed review of the characteristics of the accounts receivable aging for a physician practice with an average accounts receivable of 38 days for reimbursement.
**Accounts Receivable 0-30 days:**
In practice with low A/R approximately 30 percent of a month’s charges are adjudicated within the first 30 days. A group that generates $500,000 per month in charges will have approximately $150,000 of those charges resolved by the end of the first month. This is an important statistic to track because the claims resolved in the first month are an indicator of clean claims and the timeliness of payers.

**Accounts Receivable 31 – 60 days:**
In a model practice, approximately 84 percent of charges are resolved within the first two months. If a group’s charges are $500,000 per month, the A/R in this aging category should not exceed $80,000.

The Accounts Receivable in this age range is comprised of claims in process by insurance companies, secondary insurance balances, co-pay and deductible balances and perhaps some claims that have been resubmitted after an initial rejection.

A claim that is 31 days old is certainly within normal limits for timely adjudication by an insurance company. But a claim that is 60 days old is becoming overdue. If the amount in this aging category is substantially higher than the benchmark, there are often problems with payers or the claims have errors that cause them to be pended or rejected.

**Accounts Receivable 61-90 days:**
Over 90 percent of an average month’s charges should be resolved within 90 days. So, following the previous example of a group with $500,000 per month in charges, the total A/R in this aging category should not exceed $50,000.

This category routinely includes self-pay balances or secondary insurance balances, rejected claims not resubmitted by the practice, resubmitted claims being processed by payers, claims pended by insurance companies or those nebulous claims that were billed but “disappeared.”

Generally, accounts in this age range are considered overdue and intensive follow-up should begin at 60 days. Some claims such as worker’s comp and auto accident may appear in this age range without being considered overdue.

**Accounts Receivable 91-120 days:**
In a model practice with a benchmark A/R, 93 percent of monthly charges have been resolved within 120 days of the billing date. The A/R should not exceed $35,000 in a group generating monthly charges of $500,000.

The accounts that will appear in this aging category will include some self-pay balances, litigation accounts and problem insurance claims.

The A/R balance and the percent of average monthly charges in this aging category are generally a measure of the extent of the billing errors in the practice. This category shows the frequency of claim errors and the lack of follow-up. Clean claims and effective follow-up will resolve claims within this time frame.
Accounts Receivable 120+ days:
This aging category is the “catch all” bucket for all unpaid claims or self-pay accounts. The only two non-problem types of accounts that appear in this bucket are litigation accounts and self-pay payment plans. All other accounts in this aging period should be considered problems.

In a high-performing practice, the balance in this aging category may range from 22 percent to 28 percent of a month’s charges. In part, this range is derived from a rule that accounts in the 91-120 day aging category should be definitively resolved within 90 additional days of follow-up. Final resolution of accounts should include collection and bad debt write-offs.

Collection Ratios
The two basic collections ratios every physician practice should review are the gross collection ratio and the net collection ratio.

The gross collection ratio is calculated by dividing a month’s receipts by the same month’s gross charges.

In past years, this figure was the most important in determining how effective the billing operations were in the practice. This can still be effective in a low volume managed care market.

However, in a high volume managed care market where the managed care plans have agreed to pay a certain amount, then the gross collection percentage becomes meaningless. In this instance, the net collection ratio is a more useful and applicable financial formula.

The net collection ratio is calculated by subtracting the contractual adjustments for a specified month from that month’s gross charges. This amount is called the net charge amount. The receipts of that same month are then divided by the net charge amount.

The practice should be very near 100 percent in net collections. This figure represents the total amount of insurance payments, contractual adjustments and any applicable patient payments. Any percentage less than 100 would be the bad debt, uncollectible write-off.

Ratios less than 90 percent may indicate problems in third-party billing, patient billing, collections, and/or accounts receivable management in general.

Bibliography
♦ Adams Guide to Coding and Reimbursement, Mosby Lifeline, 1994, St. Louis, 2014, Georgia HFMA CPAR Program

To view the entire Rule, and for other additional helpful information about how it applies, see the OCR website: http://www.hhs.gov/ocr/hipaa.
Chapter 6 – Affordable Care Act
History of National Health Coverage

The movement for National Health Coverage or socialized medicine began in 1912 when Theodore Roosevelt ran on a platform calling for health insurance for industry. Over the years the American public, as measured in opinion polls as far back as the 1930’s, has generally been supportive of the goals of guaranteed access to health care and health insurance for all, as well as a government role in health financing. However, support typically tapered off when reforms were conditioned on individuals needing to contribute more to the costs.

Prior to the passage of the Affordable Care Act on March 23, 2010 and short of National Health Insurance, major health reforms have been enacted in the last fifty years that have proved to be broadly popular and effective in improving access to healthcare for millions through Medicare, Medicaid, and the Children’s Health Insurance Program. Other attempts had failed.

Attempts at National Insurance Coverage include:

1934-1939 – National Health Coverage and the New Deal
1945-1950 – National Health Coverage and the Fair Deal
1970-1974 - Competing National Health Insurance Proposals
1976-1979 – Cost-Containment Trumps National Health Insurance

The passage of the Affordable Care Act was unpopular to many people. The question was whether the government could mandate an insurance requirement and force states to expand the Medicaid program. The Supreme Court ruled on June 29, 2012. The Supreme Court upheld most of the law stating that the requirement to purchase insurance was like a tax and people could be required to purchase insurance or face a penalty.

A second portion of the law required for the expansion of the Medicaid program to include all individuals under the age of 65 with incomes below 133% of the federal poverty level. The ACA required that States comply with the expansion of the Medicaid program or risk losing Medicaid federal funding. The Court determined that incentivizing States to comply with the Medicaid expansion by threatening to terminate their existing Medicaid funding was unconstitutional. The Court ruled that Congress may offer funds under the ACA to expand the availability of health care and require that States accepting such funds comply with the conditions of their use. However, Congress is not free to penalize States that choose not to participate in the expansion of Medicaid by taking away their existing Medicaid funding.
Affordable Care Act Implementation

Since ACA became law on March 23, 2010, some portions of the law have already been implemented.

1. **Preventative Care for certain items or services** – Insurances have to provide preventative care for items listed as A or B in the current recommendations of the US Preventative Services Task Force. Typically these include well checks for children, mammograms, PAP smears and others listed in the guidelines with no out of pocket to the insured. This means no co-pay, deductible or coinsurance.

2. **Medicare Donut Hole** - This most likely won’t affect any of us but it probably will affect your parents. Medicare recipients are usually covered for drugs under Medicare Part D. There are numerous Medicare Part D plans to choose from but the most common require the recipient to pay 25% of the cost of the drugs until $2800 is met. The recipient then enters the “donut hole” where they pay the total cost of drugs until $4550 out of pocket is met. Under the ACA, beginning in 2011, Medicare recipients receive a 50% discount on brand name drugs and a reduction in generic drugs. The out of pocket will gradually be reduced until the “donut hole” is completely closed by 2020 and the recipient is responsible for only 25% of the reduced amounts.

3. **Insurance Coverage of Children to Age 26** – Parents may continue to insure their children up to age 26 even if they don’t live with the parents, are out of school, are not financially dependent on their parent or are married. If married, the spouse and any children are not covered.

4. **Tax Credits for Small Business Help Pay for Health Insurance** – Employers qualify if they provide health care to their workers, have fewer than 25 full-time employees or the equivalent of 25 full-time employees and provide average annual wages below $50,000. In 2011, the tax credit will cover 35% of health insurance expenses for small businesses and 25% for non-profit businesses. The tax credit will increase to 50% for small businesses and 35% for non-profit organizations starting in 2014.

5. **Pre-Existing Condition Insurance Plan (PCIP)** – Young adults who were previously denied for coverage because of pre-existing condition and who have been uninsured for at least three months may obtain insurance coverage. There are currently three options, the Standard Plan, the Extended Plan and the Health Savings Account. Families can also enroll eligible children at child-only rates. In 2014, individuals will have access to health coverage regardless of their health status.

6. **Elimination of Lifetime Benefits** – This rule applies to employer health coverage and individual insurance policies bought after March 23, 2010. The ban on lifetime limits takes effect with the plan year or policy year that begins on or after September 23, 2010. Health plans can still limit non-essential health care services.
Other provisions of ACA will be phased in with most of them to become effective in 2014. These include the following:

1. **Pre-existing Rule Expanded** – Starting January 1, 2014 health insurance companies will no longer be able to refuse coverage or charge a higher premium because of a pre-existing condition or disability.

2. **State Market Place Insurance Exchanges** – Beginning in 2014, health insurance policies will have to offer a set of essential benefits on a state-based marketplaces called exchanges. The idea behind exchanges is to increase competition among insurers. Those who cannot afford insurance may receive tax credits to help them purchase insurance if they buy through the exchange. The exchange will list health plans offered in the state and allow individuals to compare and shop for plans. All Medicaid state plans must cover the same key benefits. Small employers will also be able to shop for and buy health coverage through exchanges. State insurance exchanges are not mandatory but if the state elects not to establish an exchange, the Federal government will do it for them. There must be at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by Federal Law. States may receive grants and loans to assist them in setting up exchanges through 2015.

3. **Mandatory Purchase of Insurance** – In 2014, most Americans will be required to purchase health coverage that covers essential health benefits. Those who have trouble paying for insurance may receive financial help to offset the cost. Income and citizenship will be documented to validate eligibility and the amount of assistance. Those who choose not to purchase health insurance will be required to pay a penalty. The fee is based on income and will range from $695 to $2,095.

4. **Elimination of Annual Limitations on Coverage** – By 2014, there will be no annual limit on the amount that an insurance company will cover.

5. **Expanded Medicaid Coverage in Some States** – Beginning in 2014, states will have the option to expand Medicaid to cover individuals making up to 133% of the FPL. The guidelines may change by 2014. Based on the Supreme Court ruling, States cannot be penalized by withholding funding they already receive because they elect not to expand Medicaid programs.

6. **Employer Requirement to Offer Insurance** – Employers with 50+ employees will have to offer insurance by 2014 or pay fines. Employers with 200+ employees will be required to enroll employees in health plans. Employees may opt out but then they would have to purchase insurance through the exchange or be subject to a penalty. There are many rules and others to be decided on this requirement. Some believe that it will be cheaper for employers to pay the fines than offer insurance and will drop insurance coverage as a benefit.

7. **Medical Loss Ratio** – Insurance has to spend a certain amount collected on premiums on either medical services or quality improvement. Every year the insurance company spends less than 80% for small group plans and 85% for large group plans, the difference must be refunded to the policy holder as rebates.

8. **Reductions to Flexible Spending Accounts** – Effective 2013, flexible spending contributions will be limited to $2,500.

9. **Increase Itemized Medical Deductions** – Effective 2013. The threshold for the itemized deduction for unreimbursed medical expenses will be increased from 7.5% to 10% of
adjusted gross income for regular tax purposes. The increase will be waived for individuals 65 and older for tax years 2013 through 2016.

10. Increased Medicare Part A Tax on earnings greater than $200,000 – Effective 2013, the Medicare Part A tax rate will increase by 0.9% for individuals making greater than $200,000 and couples making more than $250,000. A 3.8% tax will be imposed on unearned income for higher-income taxpayers.

11. Financial Disclosure – Financial relationships between health entities, including physicians, hospitals, pharmacists, other providers and manufactures and distributors of covered drugs, devices, and biological and medical supplies must be reported by April 2013.

12. Requirements for Non-Profit Hospitals - Additional requirements for non-profit hospitals will be imposed. A community needs assessment will be required every three years and a strategy to meet those needs must be identified. A widely publicized financial assistance policy must indicate whether free or discounted care is available and how to apply for the assistance. Charges to patients who qualify for financial assistance must be limited to the amount generally billed to insured patients and a reasonable attempt must be made to determine eligibility for financial assistance before undertaking extraordinary collection efforts. There will be a $50,000 fine per year for failure to meet the requirements. As part of the enforcement of this provision, the U.S. Department of Treasury has released proposed guidelines.

a. Financial Assistance Policy and a Policy Relating to Emergency Medical Care
   - Each tax exempt hospital must establish a financial assistance policy that clearly describes the eligibility criteria for receiving financial assistance and how to apply for it. The financial assistance policy must include:
     i. Eligibility criteria for financial assistance and whether such assistance includes free or discounted care;
     ii. The basis for calculating amounts charged to patients;
     iii. The method for applying for financial assistance;
     iv. In the case of an organization which does not have a separate billing and collections policy, the actions of the organization may take in the event of nonpayment, including collections action and reporting to credit agencies.
     v. Measures to widely publicize the policy within the community to be served by the organization
     vi. The Emergency Care Policy must require the organization to provide, without discrimination, care for emergency medical conditions regardless of their eligibility under the financial assistance policy.

b. Limitation on Charges – A tax exempt hospital organization must limit amounts charged for emergency or other medically necessary care that is provided to individuals eligible for assistance under the organization's financial assistance policy to not more than the amounts generally billed to individuals who have insurance. Other points of consideration include:
   i. Gross charges may not be used.
   ii. The amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated rates or Medicare rates.
c. **Billing and Collection** - Collection actions are to be limited to allow for the investigation of financial assistance.

   i. Patients must be provided with a plain language summary of the financial assistance policy before discharge and with the first three bills.

   ii. Patients must be given at least 120 days following the first bill to submit an application before commencing certain collection activities.

   iii. An additional 120 days (total 240 days) must be given to allow the patient to complete the application.

   iv. If the patient is determined eligible for financial assistance during these 240 days, the patient must be refunded any excess payments made before applying for financial assistance and any collection activities already commenced will have to be reversed.

   v. A tax-exempt hospital organization must forego *extraordinary collection efforts* against an individual before the organization has made *reasonable efforts* to determine whether the individual is eligible for assistance under the hospital organization’s financial assistance policy.

   vi. Extraordinary Collection Actions as provided in the Joint Committee’s explanation provides examples as “lawsuits, liens on residences, arrests, body attachments, or similar collection processes” each of which requires a court proceeding.
13. Other
   a. **Standard summary of benefits and coverage** - The form must be less than four pages, font greater than twelve, be uniform in insurance terms and definitions, and written in terms the average person will understand.
   b. **Quality Reporting Requirements** – By 2014 reporting will be required from all insurers on effective case management, care coordination, chronic disease management, medication and compliance issues and hospital readmissions.
   c. **Linking Payment to Quality Outcomes in Medicare** – A value-based purchasing program for hospitals launched in 2013 and linked Medicare payments to quality performance on common high-cost conditions such as cardiac, surgical and pneumonia care.
   d. **Encouraging Development of New Patient Care Models** – Accountable Care Organizations that take responsibility for cost and quality received by patients will receive a share of savings they achieve for Medicare.

**Provider Issues**

Although insurance is mandated for most individuals and the individual may have signed up, that doesn’t necessarily mean the patient will have active coverage, even if they have an insurance card. The individual market is made up of people with tentative work histories. They may be self-employed or seasonal workers with surges of income, or they may work several part-time jobs, or they may even be fully employed in good paying positions but their employers don’t provide insurance.

In any case, they are required to pay their own premiums. Insurance companies are attempting to get them on some type of automated payment plan but many don’t have bank accounts or credit cards. As of May 1, 2014, about 20% had not paid premiums on the plans they signed up for. It is expected that the default rate will rise when premiums compete with daily living expenses. There is a grace period of 90 days to allow the insured to catch up their premiums. If the patient defaults on their premiums, the provider will be paid for the first month of the default. The insurance company must also meet the following requirements.

1. Notify HHS of non-payment of the premium.
2. Notify the provider of the possibility of denied claims for the second and third month.
3. Notify the insured that they are in default.
4. Continue to collect the advanced credit on behalf of the policy holder.
5. Return the tax credit for the second and third month to the Treasury if the insured fails to pay the premiums.
6. Issue a termination notice to the insured at the end of the grace period.

Hospitals must verify eligibility at each service to ensure patients have current insurance coverage.

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Chapter 7 – Glossary
Glossary

72-Hour Rule
A Medicare regulation in which all outpatient diagnostic services or other services related to admission performed within the three days prior to a hospital admission must be bundled together on the same bill to Medicare. This general rule applies only to subsection (d) hospitals.

ABN
The abbreviation for the term Advance Beneficiary Notice. It is a notification that the patient may be expected to pay for laboratory testing that Medicare has determined as non-covered services. By signing the ABN, the patient understands they will be financially responsible for the test(s) in the event Medicare denies payment to the hospital. This applies to all patients who are covered by Medicare, regardless whether Medicare is their primary or secondary insurance.

Abuse
When used as a legal term in the business of healthcare, it normally refers to actions that do not involve intentional misrepresentations in billing but which, nevertheless, result in improper conduct. Consequences can result in civil liability and administrative sanctions. An example of abuse is the excessive use of medical supplies.

Access
The patient’s ability to obtain medical care. The ease of access is determined by such components as the availability of medical services and their acceptability to the patient, the location of health care facilities, transportation, and hours of operation and cost of care. An individual’s ability to obtain appropriate health care services. Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers) and sociological (e.g., discrimination, language barriers). Efforts to improve access often focus on providing/improving health coverage.

Accreditation
The process by which an organization recognizes a provider, a program of study or an institution as meeting predetermined standards. Two organizations that accredit managed care plans are the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO). JCAHO also accredits hospitals and clinics. CARF accredits rehabilitation providers.

Accrual
The amount of money that is set aside to cover expenses. The accrual is the plan’s best estimate of what those expenses are, and (for medical expenses) is based on a combination of data from the authorization system, the claims system, lag studies, and the plan's prior history.
**Actuarial**
Refers to the statistical calculations used to determine the managed care company's rates and premiums charged their customers based on projections of utilization and cost for a defined population.

**Actuary**
In insurance, a person trained in statistics, accounting and mathematics who determines policy rates, reserves, and dividends by deciding what assumptions should be made with respect to each of the risk factors involved (such as the frequency of occurrence of the peril, the average benefit that will be payable, the rate of investment earnings, if any, expenses, and persistency rates), and who endeavors to secure as valid statistics as possible on which to base his assumptions. Professionally trained individual, usually with experience or education in insurance, who conducts statistical studies such as determining insurance policy rates, dividend reserves and dividends, as well as conducts various other statistical studies. A capitated health provider would not accept or contract for capitated rates, or agree to a capitated contract without an actuarial determining the reasonableness of the rates.

**Acute Care**
A pattern of health care in which a patient is treated for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Specialized personnel using complex and sophisticated technical equipment and materials usually give acute care in a hospital. Unlike chronic care, acute care is often necessary for only a short time.

**Adjudication**
A pattern of health care in which a patient is treated for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Specialized personnel using complex and sophisticated technical equipment and materials usually give acute care in a hospital. Unlike chronic care, acute care is often necessary for only a short time.

**Adjusted Community Rate (ACR)**
Health plans and insurance companies estimate their ACRs annually and adjust subsequent year supplemental benefits or premiums to return any excess Medicare revenue above the ACR to enrollees. These are the estimated payment rates that health plans with Medicare risk contracts would have received for their Medicare enrollees if paid their private market premiums, adjusted for differences in benefit packages and service use.

**Administrative Costs**
Costs related to utilization review, insurance marketing, medical underwriting, agents’ commissions, premium collection, claims processing, insurer profit, quality assurance programs, and risk management. Administrative costs also refer to certain allowable costs on hospital CMS cost reports, usually considered overhead. Rules exist which disallow certain expenses, such as marketing. Costs not linked directly to the provision of medical care. Includes marketing, claims processing, billing and medical record keeping, among others.
**Administrative Service Organization (ASO)**
A contract between an insurance company and a self-funded plan where the insurance company performs administrative services only and the self-funded entity assumes all risk.

**Admission**
The formal acceptance of inpatients into a hospital or other inpatient health facility. Such inpatients are typically provided with room, board, continuous nursing service and stay at least overnight.

**Admission Certification**
Methods of assuring that only those patients who need hospital care are admitted. Certification can be granted before admission (preadmission) or shortly after (concurrent). Length-of-stay for the patient’s diagnosed problem is usually assigned upon admission under a certification program.

**Admit-through-discharge claim**
An indicator that a bill is expected to be the only one to be received for a course of treatment or inpatient confinement. This will include bills representing a total confinement or course of treatment, and bills that represent an entire benefit period of the third-party payer.

**Admitting Department**
The hospital department that secures patient demographic and financial information on inpatients or registration purposes; schedules preadmission testing; coordinates patient room assignments; records all patient movement including transfers and discharges for the purpose of maintaining accurate census data; and disseminates patient information to other hospital departments.

**Advanced Directives**
Authorizes a hospital to use methods of treatment requested by patient in advance.

**Adverse Event**
An injury to a patient resulting from a medical intervention.

**Affiliated Provider**
A health care provider or facility that is part of the HMO’s network usually having formal arrangements to provide services to the HMO member.

**Affiliation**
An agreement between two or more otherwise independent entities or individuals that defines how they will relate to one another. Agreements between hospitals may specify procedures for referring or transferring patients. Agreements between providers may include joint managed care contracting.

**Aged Trial Balance**
Report generally listing account numbers, patient and insurance balances, financial class, patient type, last payment date and other pertinent data.
**Agency for Health Care Policy and Research (AHCPR)**
The agency of the Public Health Service responsible for enhancing the quality, appropriateness and effectiveness of health care services.

**Aggregate Margin**
This is computed by subtracting the sum of expenses for all hospitals in the group from the sum of revenues and dividing by the sum of revenues. The aggregate margin compares revenues to expenses for a group of hospitals, rather than one single hospital.

**Aid to Families with Dependent Children (AFDC)**
The federal AFDC program provides cash welfare to: (1) needy children who have been deprived of parental support and (2) certain others in the household of such child. States administer the AFDC program with funding from both the federal government and state. The Personal Responsibility and Work Responsibility Act of 1996, enacted in August 1996, replaced AFDC with a new program called Temporary Assistance for Needy Families (TANF).

**All Patient Diagnosis Related Groups (APDRG)**
An enhancement of the original DRG's designed to apply to a population broader than that of Medicare beneficiaries, who are predominately older individuals. The APDRG set includes groupings for pediatric and maternity cases as well as of services for HIV-related conditions and other special cases.

**Allowable Charge**
The maximum charge for which a third party will reimburse a provider for a given service. An allowable charge is not necessarily the same as either a reasonable, customary, maximum, actual, or prevailing charge.

**Allowance**
(1) The amount of money that is written off and not collected due to a contractual obligation with a payer, (2) The fee maximum or amount of money that a particular insurance company "allows" or agrees to pay for a procedure.

**Allowed Amount**
Maximum dollar amount assigned for a procedure based on various pricing mechanisms. Also known as a maximum allowable.

**Allowed Charge**
The is the amount Medicare approves for payment to a physician, but may not match the amount the physician gets paid by Medicare (due to co-pay or deductibles) and usually does not match what the physician charges patients. Medicare normally pays 80 percent of the approved charge and the beneficiary pays the remaining 20 percent. The allowed charge for a nonparticipating physician is 95 percent of that for a participating physician. Non-participating physicians may bill beneficiaries for an additional amount above the allowed charge. The CMS intermediary in each state publishes these rates.
**All-Payer System**
A system in which prices for health services and payment methods are the same, regardless of who is paying. For instance, in an all-payer system, federal or state government, a private insurer, a self-insured employer plan, an individual, or any other payer could pay the same rates. The uniform fee bars health care providers from shifting costs from one payer to another.

**Alternate Delivery Systems**
Health services provided in other than an inpatient, acute-care hospital or private practice. A phrase used to describe all forms of health care delivery except traditional fee-for-service, private practice. The term includes HMOs, PPOs, IPAs, and other systems of providing health care. Examples within general health services include skilled and intermediary nursing facilities, hospice programs, and home health care. Alternate delivery systems are designed to provide needed services in a more cost-effective manner. Most of the services provided by community mental health centers fall into this category.

**Ambulatory Care**
Health services provided without the patient being admitted. Also called outpatient care. The services of ambulatory care centers, hospital outpatient departments, physicians’ offices and home health care services fall under this heading provided that the patient remains at the facility less than 24 hours. No overnight stay in a hospital is required.

**Ambulatory Patient Classification (APC’s)**
System similar to DRGs to be used for outpatients. Current scheme includes 346 APC’s broken into categories of Medical, Diagnostic, Surgical and Radiology and include Emergency Department and partial hospitalization services.

**Ancillary Services (Ancillary Charges)**
Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy that are provided in conjunction with medical or hospital care.

**ANSI**

**Antitrust**
A legal term encompassing a variety of efforts on the part of government to assure that sellers do not conspire to restrain trade or fix prices for their goods or services in the market.

**Appropriateness**
Appropriate health care is care for which the expected health benefit exceeds the expected negative consequences by a wide enough margin to justify treatment. This term is not to be confused with “usual and customary” or “approved” service. The extent to which a particular procedure, treatment, test, or service is clearly indicated, not excessive, adequate in quantity, and provided in the setting best suited to a patient’s or member’s needs. See also Medically Necessary.
Approval
Days authorized for payment after Retrospective Medical and Technical Review. As the term indicates, retrospective authorization takes place after the fact. For example, a patient is admitted, has surgery, and is discharged, and then the plan finds out. It appears that any service rendered without authorization would have payment denied or reduced, but there will be circumstances when the plan will genuinely agree to authorize services after the fact. Except for emergency cases, there are few retrospective authorizations.

Assignment of Benefits
Method used when a claimant directs that payment be made directly to the health care provider by the health plan.

Assisted Living
Broad range of residential care services, but does not include nursing services. Normally lower in cost than nursing homes.

Attending Physician
The name and/or number of licensed physician who would normally be expected to certify and re-certify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.

Attestation
The requirement that the attending physician certify, in writing, the accuracy and completion of the clinical information used for DRG assignment.

Authorization
Consent, permit, approve, give the right to and/or authorize a person medical care. Can be either written or oral and usually involves a number to be used when billing. The real issue is determining what non-primary care services will require authorization. In a tightly controlled system, such as most HMOs, all services not rendered by the PCP require authorization. In other words, any service from a referral specialist, any hospitalization, any procedure, and so forth requires specific authorization, although there may be certain exceptions such as an optometry visit or a routine check up from a gynecologist. In less tightly controlled systems, such as many PPOs and most indemnity plans, the requirements are less stringent. In those cases, it is common for authorization only to be required for elective hospitalizations and procedures, both inpatient and outpatient. In any plan there will be times when a member is unable to obtain prior authorization. This is usually due to an emergency or to an urgent problem that occurs out of area. In those cases, the plan must make provisions for the retrospective review of the case to determine whether authorization may be granted after the fact. Certain rules may also be defined regarding the member's obligation in those circumstances (e.g., notification within 24 hours of the emergency). Be careful that such requirements do not allow for automatic authorization if the plan is notified within 24 hours but only for automatic review of the case to determine medical necessity. Required by a patient for disclosure of clinical data relative to hospital reimbursement claims. An authorization form allows the provider to release to the third party: 1) the admitting diagnosis for determining eligibility and 2) the diagnosis of any procedures performed as needed in claims reimbursement processing.
Categories of Authorization

Authorization may be classified into six types:

Prospective
Concurrent
Retrospective
Pended (for review)
Denial (no authorization)
Sub-authorization

A brief description of the authorization categories follows:

Prospective
Sometimes referred to as precertification. This type of authorization is issued before any service is rendered. This is commonly used in plans that require prior authorization for elective services.

Concurrent
A concurrent authorization is generated at the time the service is rendered. For example, the utilization review nurse discovers that a patient is being admitted to the hospital that day.

Retrospective
As the term indicates, retrospective authorization takes place after the fact. For example, a patient is admitted, has surgery, and is discharged, and then the plan finds out. It appears that any service rendered without authorization would have payment denied or deducted, but there will be circumstances when the plan will genuinely agree to authorize services after the fact. Except for emergency cases, there are few retrospective authorizations.

Pended (For Review)
Pended is a claim term that refers to a state of authorization purgatory. In this situation, it is not known whether an authorization will be issued and the case has been pended for review. This refers to medical review (for medical necessity, such as an emergency department claim) or to administrative review.

Denial
Denial refers to the certainty that there will be no authorization forthcoming. You cannot assume that every claim coming into the plan without an authorization will be denied because there are reasons that an unauthorized claim may be paid.

Sub-authorization
This is a special category that allows one authorization to hitchhike on another. This is most common for hospital-based professional services. For example, a single authorization may
be issued for a hospitalization, and that authorization is used to cover anesthesia, pathology, radiology, or even a surgeon’s or consultant’s fees.

**Auto-assignment**
A term used with Medicaid mandatory managed care enrollment plans. Medicaid recipients who do not specify their choice for a contracted plan within a specified time frame are assigned to a plan by the state.

**Auto-Enrollment**
The automatic assignment of a person to a health insurance plan, typically done under Medicaid plans.

**Bad debt**
An account which is uncollectible from a patient, although the patient has had or may have the ability to pay. This results in a credit loss for the hospital, clinic, or other health care facility. These losses may be reflected as an allowance from revenue or as an expense of doing business of the entity.

**Balance Billing**
The practices of billing a patient for the fee amount remaining after insurer payment and co-payment have been made. Under Medicare, the excess amount cannot be more than 15 percent above the approved charge.

**Base Capitation**
Specified amount per person per month to cover healthcare cost, usually excluding pharmacy and administrative costs as well as optional coverage such as mental health/substance abuse services.

**Bed**
A bed located in a hospital or nursing home used for inpatient. Beds are used as one important measure of an institution’s capacity and size.

**Bed size**
The number of hospital beds, vacant or occupied; maintained regularly for use by inpatients during a reporting period. (The typical reporting period is 12 months.) To determine this amount, first add the total number of beds that are available every day during the hospital's reporting period. Then, divide this amount by the total number of days in the reporting period.

**Behavioral Health, Behavioral Healthcare**
An umbrella term that includes mental health, psychiatric, marriage and family counseling, addictions treatment and substance abuse. Services are provided by a myriad of providers, including social workers, counselors, psychiatrist, psychologists, neurologists and even family practice physicians. Many states have “parity” laws that attempt to require that behavioral health insurance coverage be provided “on par” to physical health coverage.
**Benchmark**
A goal to be attained. These goals are chosen by comparisons with other providers, by consulting statistical reports available or are drawn from the best practices within the organization or industry. Benchmarks are used in quality improvement programs to encourage improvement of care, efficiencies or services. Benchmarks are also used for length of stay comparisons, costs, utilization review, risk management and financial analysis. The benchmarking process identifies the best performance in the industry (health care or non-health care) for a particular process or outcome, determines how that performance is achieved, and applies the lessons learned to improve performance.

**Beneficiary (also eligible; enrollee; member)**
Individual who is either using or eligible to use insurance benefits, including health insurance benefits, under an insurance contract. Any person eligible as either a subscriber or a dependent of a managed care service in accordance with a contract. An individual who receives benefits from or is covered by an insurance policy or other health care financing program.

**Beneficiary Liability**
The amount beneficiaries must pay providers for Medicare-covered services. Liabilities include co-payments, deductibles, and balance billing amounts. CMS has very strict rules about health providers billing patients for their liabilities. Cost based facilities are not allowed to charge non-payment by beneficiaries to bad debt unless a clear history of collection activity is recorded.

**Benefit Package**
Aggregate services specifically defined by an insurance policy or HMO that can be provided to patients. The services a payer offers to a group or individual. The package will specify included cost, limitation on the amounts of services, and annual or lifetime spending limits.

**Benefits**
Benefits are specific areas of Plan coverage’s, i.e., outpatient visits, hospitalization and so forth, that makes up the range of medical services that a payer markets to its subscribers. Also, a contractual agreement, specified in an Evidence of Coverage, determining covered services provided by insurers to members.

**Billed Claims**
Fees submitted by a health care provider for services rendered to a covered person. Fees billed and fees paid are rarely synonymous.

**Billing Number**
Number used as patient's account number for billing purposes, created for each registration (case).

**Birthday Rule**
This rule relates to coordination of benefits and determination of the primary payer when the patient is a child covered by both parents’ health insurance plans. The Rule is: The birthday of the parent born first in the calendar year will be determined as
the primary payer.

**Blue Cross**
A non-profit organization covering hospital, medical, surgical, and major medical. Most Blue Cross subscriber’s sign up for coverage at work under a group plan.

**Board Certified**
Describes a physician who has passed a written and oral examination given by a medical specialty board and who has been certified as a specialist in that area.

**Boarder Baby**
A baby that remains in the hospital after the mother has been discharged.

**Bonus Payment**
An additional amount paid by Medicare for services provided by physicians in Health Professional Shortage Areas. Currently, the bonus payment is 10 percent of Medicare’s share of allowed charges. This is not to be confused with other payments to hospitals, such as the disproportionate share payment or the settlement made to facilities at the end of a cost report year.

**Broker**
One who represents an insured in solicitation, negotiation, or procurement of contracts of insurance, and who may render services incidental to those functions. By law, the broker may also be an agent of the insurer for certain purposes such as delivery of the policy or collection of the premium.

**Bundled Payment**
A single comprehensive payment for a group of related services. Bundled payments have become the norm in recent years and CMS and other payers investigate unbundled services closely. Unbundling service charges has been a common form of fraud as defined by CMS.

**Bundling**
The practice of billing certain outpatient procedures with their corresponding inpatient admissions on the same bill. When a service is bundled with another service, the hospital is paid for only one of the services, not both. Therefore, when a hospital is required to bundle a bill, it is receiving a smaller amount of reimbursement than it would if it were allowed to bill each service separately.

**Business Associate**
Under HIPAA rules, this term refers to an outside person/entity that performs a service on behalf of the health care provider (including a researcher) or the health care institution during which individually identifiable health information is created, used, or disclosed. For example, web hosting or data storage companies will be business associates if they receive protected health information. In addition, third parties that handle billing for a research study, or recruitment and screening will also be business associates. Certain exceptions apply.
**Business Office Manager**
The person responsible for managing accounts receivable.

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**Cafeteria Plan**
Arrangements under which employees may choose their own benefit structure. Sometimes these are varying benefit plans or add-ons provided through the same insurer or 3rd party administrator, other times this refers to the offering of different plans or HMOs provided by different managed care or insurance companies.

**Capitation (Cap, Capped, Capitate)**
Specified amount paid periodically to health provider for a group of specified health services, regardless of quantity rendered. Amounts are determined by assessing a payment “per covered life” or per member. The method of payment in which the provider is paid is a fixed amount for each person served no matter what the actual number or nature of services delivered. The cost of providing an individual with a specific set of services over a set period of time, usually a month or a year. A payment system whereby managed care plans pay health care providers a fixed amount to care for a patient over a given period. Providers are not reimbursed for services that exceed the allotted amount. The rate may be fixed for all members or it can be adjusted for the age and gender of the member, based on actuarial projections of medical utilization.

**Carrier**
An insurer; an underwriter of risk that finances health care. Also refers to any organization, which underwrites or administers life, health or other insurance programs. When an employer has a “self-insured” plan, the carrier (such as Aetna or Blue Cross) may not serve as carrier in this case, but may serve only as a “third party administrator”.
Carve Out
Practice of excluding specific services from a managed care organization’s capitated rate. In some instances, the same provider will provide the service, but they will be reimbursed on a fee-for-service basis. In other instances, carved out services will be provided by an entirely different provider. A payer strategy in which a payer separates (“carves – out”) a portion of the benefit and hires an MCO to provide these benefits. A health care delivery and financing arrangement in which certain specific health care services that are covered benefits (e.g., behavioral health care) are administered and funded separately from general health care services. The carve-out is typically done through separate contracting or sub-contracting for services to the special population. Common carve outs include such services as psychiatric, rehab, chemical dependency and ambulatory services. Increasingly, oncology and cardiac services are being carved out. This permits the payer to create a separate health benefits package and assume greater control of their costs. Many HMOs and insurance companies adopt this strategy because they do not have in-house expertise related to the service “carved-out”. A “carve-out” is typically a service provided within a standard benefit package but delivered exclusively by a designated provider or group. This process may or may not seem transparent to the subscriber, but it often means that separate UR and pre-certification entities are involved as well as different payers and providers. Carve-outs are also called sub-contractors, sub-captivators or junior capitation contracts.

Carve out Days
The period of days in the middle of an otherwise certified patient stays that are denied.

Carve-in
A generic term that refers to any of a continuum of joint efforts between clinicians and service providers; also used specifically to refer to health care delivery and financing arrangements in which all covered benefits (e.g., behavioral and general health care) are administered and funded by an integrated system.

Case
When a patient comes to the Hospital with a new illness or injury (new registration).

Case Management
Method designed to accommodate the specific health services needed by an individual through a coordinated effort to achieve the desired health outcome in a cost effective manner. The monitoring and coordination of treatment rendered to patients with specific diagnosis or requiring high-cost or extensive services. The process by which all health related matters of a case are managed by a physician or nurse or designated health professional. Physician case managers coordinate designated components of health care, such as appropriate referral to consultants, specialists, hospitals, ancillary providers and services. Case management is intended to ensure continuity of services and accessibility to overcome rigidity, fragmented services, and the mis-utilization of facilities and resources. It also attempts to match the appropriate intensity of services with the patient’s needs over time.
**Case Manager**
A nurse, doctor, or social worker who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

**Case Mix**
The mix of patients treated within a particular institutional setting, such as the hospital. Patient classification systems like DRGs can be used to measure hospital case mix. (See also DRGs and Case-Mix Index). Measurement reflecting servicing needs uses of hospital capabilities, and the general rate of hospital admissions. The types of inpatients a hospital or post acute facility treats. The more complex the patients’ needs, the greater the amount spent to patient care. Case mix is generally established by estimating the relative frequency of various types of patients seen by the provider in question during a given time period and may be measured by factors such as diagnosis, severity of illness, utilization of services, and provider characteristics.

**Case Rate**
Flat fee paid for a client’s treatment based on their diagnosis and/or presenting problem. For this fee the provider covers all of the services the client requires for a specific period of time. Also bundled rate, or Flat Fee-Per-Case. Very often used as an intervening step prior to capitation. In this model, the provider is accepting some significant risk, but does have considerable flexibility in how it meets the client’s needs. Keys to success in this mode: (1) properly pricing case rate, if provider has control over it, and (2) securing a large volume of eligible clients.

**Case-Mix Index (CMI)**
The average DRG weight for all cases paid under PPS. The CMI is a measure of the relative costliness of the patients treated in each hospital or group of hospitals. (See also DRG.) A measure of the relative costliness of treating in an inpatient setting. An index of 1.05 means that the facility’s patients are 5 percent more costly than average.

**Catastrophic Charges**
A term used by Medicaid to describe a serious illness that is expected to consume the major share of the recipient’s income and resources.

**Centers for Medicare and Medicaid Services (CMS)**
The Centers for Medicare and Medicaid Services (CMS) is a Federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, State Children’s Health Insurance Program (SCHIP), HIPAA and CLIA. Formerly was HCFA.
Certificate of Need (CON)
In some states, a state agency must review and approve certain proposed capital expenditures, changes in health services provided, and purchases of expensive medical equipment. Before the request goes to the state, a local review panel (the health systems agency or HSA) must evaluate the proposal and make a recommendation. CON is intended to control expansion of facilities and services by preventing excessive or duplicative development of facilities and services. Many states have eliminated their CON processes and requirements.

Certification
The process by which a government or private agency or a health-related association evaluates and recognizes individual, institutional, or educational programs in meeting predetermined standards.

Charges
These are the published prices of services provided by a facility. CMS requires hospitals to apply the same schedule of charges to all patients, regardless of the expected sources or amount of payment. Controversy exists today because of the often wide disparity between published prices and contract prices. The majority of payers, including Medicare and Medicaid, are becoming managed by health plans that negotiate rates lower than published prices. Often these negotiated rates average 40% to 60% of the published rates and may be all-inclusive bundled rates.

Chronic Care
Long term care of individuals with long standing, persistent diseases or conditions. It includes care specific to the problem as well as other measures to encourage self-care, to promote health, and to prevent loss of function.

Civilian Health and Medical Program of the Uniformed Services (TriCare)
A program administered by the Department of Defense that provides benefits for health care services furnished by civilian providers, physicians, and suppliers and to spouses and children of active duty, retired, and deceased members. Now known as TRICARE

Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)
A program administered by both the Department of Defense and the Veterans Administration that provides benefits for health care services furnished by civilian providers, physicians, and suppliers for spouses and children of veterans who are entitled to VA permanent and total disability benefits and to widows and children of veterans who die of service-connected disabilities.

Claim
A request by an individual (or his or her provider) to that individual’s insurance company to pay for services obtained from a health care professional.
Claims Review
The method by which an enrollee’s health care service claims are reviewed prior to reimbursement. The purpose is to validate the medical necessity of the provided services and to be sure the cost of the service is not excessive.

CLIA
See Clinical Laboratory Improvement Amendments.

Clinic
An independent organization of physicians and allied health personnel or a hospital-operated facility designed to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services on an outpatient basis.

Clinic Charges
Clinic (non-emergency/scheduled outpatient visit) charges for providing diagnostic, curative, rehabilitative and education services on a scheduled basis to ambulatory patients.

Clinic Referral
The patient was admitted to this facility upon recommendation of this facility’s clinic physician.

Clinical Data Repository
That component of a computer-based patient record (CPR) which accepts, files and stores clinical data over time from a variety of supplemental treatment and intervention systems for such purposes as practice guidelines, outcomes management, and clinical research. May also be called a data warehouse.

Clinical Laboratory Improvement Amendments (CLIA)
CMS regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). In total CLIA covers approximately 175,000 laboratory entities. The Division of Laboratory Services, within the Survey and Certification Group, under the Center for Medicaid and State Operations has the responsibility for implementing the CLIA Program. The objective of the CLIA program is to ensure quality laboratory testing. Although all clinical laboratories must be properly certified to receive Medicare or Medicaid payments, CLIA has no direct Medicare or Medicaid program responsibilities.

Clinical or Critical Pathways
A “map” of preferred treatment / intervention activities. Outlines the types of information needed to make decisions, the timeliness for applying that information, and what action needs to be taken by whom. Provides a way to monitor care “in real time”. These pathways are developed by clinicians for specific diseases or events. Proactive providers are working now to develop these pathways for the majority of their interventions and developing the software capacity to distribute and store this information.

Clocking
The system is searching for the information requested.
**Closed Access**
Gatekeeper model health plan that requires covered persons to receive care from providers within the plan’s coverage. Except for emergencies, the patient may only be referred to and treated by providers within the plan. A managed health care arrangement in which covered persons are required to select providers only from the plan’s participating providers.

**Closed Panel**
Medical services are delivered in the HMO-owned health center or satellite clinic by physicians who belong to a specially formed, but legally separate, medical group that only serves the HMO. This term usually refers to a group or staff HMO models.

**CMS (formerly HCFA)**
See Centers for Medicare and Medicaid Services.

**COB**
See Coordination of Benefits.

**COBRA**
See Consolidated Omnibus Budget Reconciliation Act.

**Coding**
A mechanism for identifying and defining physicians’ and hospitals’ services. Coding provides universal definition and recognition of diagnoses, procedures and level of care. Coders usually work in medical records departments and coding is a function of billing. Medicare fraud investigators look closely at the medical record documentation, which supports codes and looks for consistency. Lack of consistency of documentation can earmark a record as “upcoded” which is considered fraud. A national certification exists for coding professional and many compliance programs are raising standards of quality for their coding procedures.

**Co-Insurance**
A cost-sharing requirement under a health insurance policy that provides that the insured will assume a portion or percentage of the costs of covered services. Health care cost which the covered person is responsible for paying, according to a fixed percentage for amount. A policy provision frequently found in major medical insurance policies under which the insured individual and the insurer share hospital and medical expenses according to a specified ratio after payment of the deductible. Under Medicare Part B, the beneficiary pays coinsurance of 20 percent of allowed charges. Many HMOs provide 100 percent insurance (no coinsurance) for preventive care or routing care provided “in network”.

**Compliance**
Accurately following the government’s rules on Medicare billing system requirements and other federal or state regulations. A compliance program is a self-monitoring system of checks and balances to ensure that an organization consistently complies with applicable laws relating to its business activities. (See also Fraud, OIG and DOJ)
**Concurrent Review**
Review of a procedure or hospital admission done by a health care professional (usually a nurse) other than the one providing care, during the same time frame that the care is provided. Usually conducted during a hospital confinement to determine the appropriateness of hospital confinement and the medical necessity for continued stay.

**Consent Forms**
The documents that patients are asked to sign giving permission to the hospital or its physicians to perform procedures during the patient’s hospital stay whether as an outpatient or inpatient.

**Consolidated Omnibus Budget Reconciliation Act (COBRA)**
Federal law that continues health care benefits for employees whose employment has been terminated. Employers are required to notify employees of these benefit continuation options, and failure to do so can result in penalties and fines for the employer. An act that allows workers and their families to continue their employer-sponsored health insurance for a certain amount of time after terminating employment. COBRA imposes different restrictions on individuals who leave their jobs voluntarily versus involuntarily.

**Continued Stay Review**
A review conducted by an internal or external auditor to determine if the current place of service is still the most appropriate to provide the level of care required by the client.

**Contract**
A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is limited to a 12-month period and is subject to renewal thereafter. Contracts are not required by statute or regulation, and less formal agreements may be made.

**Contract Provider**
Any hospital, physician, skilled nursing facility, extended care facility, individual, organization, or licensed health care provider that has a contractual arrangement with an insurer for the provision of services under an insurance contract.

**Conversion**
In group health insurance, the opportunity given the insured and any covered dependents to change his or her group insurance to some form of individual insurance, without medical evaluation upon termination of his group insurance.

**Coordination of Benefits (COB)**
Provision regulating payments to eliminate duplicate coverage when a claimant is covered by multiple group plans. The procedures set forth in a Subscription Agreement to determine which coverage is primary for payment of benefits to Members with duplicate coverage. Used by insurers to avoid duplicate payment for losses insured under more than one insurance policy. A coordination of benefits, or “non-duplication”, clause in either policy prevents double payment by making one insurer the primary payer, and assuring that not
more than 100 percent of the cost is covered.

**Co-Payment**
A cost-sharing arrangement in which the HMO enrollee pays a specified flat amount for a specific service (such as $10 for an office visit or $5 for each prescription drug). The amount paid must be nominal to avoid becoming a barrier to care. It does not vary with the cost of the service, unlike co-insurance that is based on some percentage of cost.

**Cost Containment**
Control of inefficiencies in the consumption, allocation, or production of health care services that contribute to higher than necessary costs. Inefficiencies are thought to exist in consumption when health services are inappropriately utilized; inefficiencies in allocation exist when health services could be delivered in less costly settings without loss of quality; and, inefficiencies in production exist when the costs of producing health services could be reduced by using a different combination of resources. Cost containment is a word used freely in healthcare to describe most cost reduction activities by providers.

**Cost Reimbursement**
Payment to hospitals and other providers by a third-party carrier for costs actually incurred by the providers. Cost rates are calculated after the service is rendered.

**Cost Sharing**
Payment method where a person is required to pay some health costs in order to receive medical care. The general set of financing arrangements whereby the consumer must pay out-of-pocket to receive care, either at the time of initiating care, or during the provision of health care services, or both. Cost sharing can also occur when an insured pays a portion of the monthly premium for health care insurance.

**Cost-Benefit Analysis (Evaluation)**
An analytic method in which a program’s cost is compared to the program’s benefits for a period of time, expressed in dollars, as an aid in determining the best investment of resources. For example, the cost of establishing an immunization service might be compared with the total cost of medical care and lost productivity that will be eliminated as a result of more persons being immunized. Cost-benefit analysis can also be applied to specific medical tests and treatments.

**Coverage Code**
Identifies the patient's insurance coverage and its policy limits.

**Covered Days**
The number of days covered by the primary payer, as qualified by the payer organization.
**Credentialing**
Review procedure where a potential or existing provider must meet certain standards in order to begin or continue participation in a given health care plan, on a panel, in a group, or in a hospital medical staff organization. The process of reviewing a practitioner’s credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining if criteria for clinical privileging are met. The recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, professional association membership, or the award of a degree in the field. Certification and licensure affect the supply of health personnel by controlling entry into practice and influence the stability of the labor force by affecting geographic distribution, mobility, and retention of workers. Credentialing also determines the quality of personnel by providing standards for evaluating competence and by defining the scope of functions and how personnel may be used. In managed care arenas, one hears of a new basis for credentialing, referred to as financial credentialing. This refers to an organization’s evaluation of a provider based on that provider’s ability to provide value, or high quality care at a reasonable cost.

A standardized mechanism of reporting services using numeric codes as established and updated annually by the AMA. A manual that assigns five digit codes to medical services and procedures to standardize claims processing and data analysis. The coding system for physicians’ services developed by the CPT Editorial Panel of the American Medical Association; basis of the Medicare coding system for physicians services.

**Customary Charge**
One of the factors determining a physician’s payment for a service under Medicare. Calculated as the physician’s median charge for that service over a prior 12-month period.

**Data**
Information gathered and entered into the computer system.

**Date of Birth (DOB)**
Refers to the patient’s date of birth. Obtained during the registration of a patient and necessary for the billing department.

**Deductible**
The amount of money, or value of certain services (such as one physician visit), a patient or family must pay before costs (or percentages of costs) are covered by the health plan or insurance company, usually per year.

**Default**
The system automatically enters the information into a blank field after pressing the enter key.

**Demographic Information**
The patient’s address, employer and insurance information.
**Dependent**
An insured’s spouse (wife or husband), not legally separated from the insured, and unmarried children who meet certain eligibility requirement, and who are not otherwise insured under the same group policy. The precise definition of a dependent varies by insurer.

**Diagnosis**
The reason the patient requires services. Identified on claim by ICD-9 codes.

**Diagnosis Related Group (DRG Rate)**
A dollar amount used by Medicare to pay hospitals for services rendered. It is based on the average of all patients belonging to a specific DRG adjusted for economic factors, inflation, and bad debts.

**Diagnosis related groups (DRGs)**
A system for classifying hospital stays according to the diagnosis of the medical problem being treated, for the purposes of payment.

**Diagnostic Services**
For purposes of the 72-hour rule, "diagnostic services are defined by the presence of certain billing codes on the hospital's bill to Medicare. Any service that qualifies as a diagnostic service must be bundled if it is performed within the 72-hour window.

**Diagnostic Testing Area**
Area where routine tests are performed. (i.e. Lab, Blood Bank)

**Direct access**
The ability to see a doctor or receive a medical service without a referral from your primary care physician.

**Discharge**
The process whereby the patient leaves the hospital provided certain criteria are met.

**Disease Management**
Programs for people who have chronic illnesses, such as asthma or diabetes that try to encourage them to have a healthy lifestyle, to take medications as prescribed, and that coordinate care.

**Disposable Personal Income**
The amount of a person’s income that is left over after money has been spent on basic necessities such as rent, food, and clothing.

**DMERC**
An acronym for Durable Medical Equipment Regional Contractor.
**DOJ - United States Department of Justice**
One of several federal government offices that is actively pursuing alleged the violators of the 72-hour rule

**DRG**
See Diagnosis-Related Group.

**Durable Medical Equipment (DME)**
Equipment that typically withstands repeated use, improves function or retards further deterioration of a physical condition, and primarily provides a medical function.

**EDI**
(Electronic Data Interchange) – A standardized exchange of information in machine-readable format.

**Effective Date**
The date on which a policy’s coverage of a risk goes into effect.

**Elective**
A healthcare procedure that is not an emergency and that the patient and doctor plan in advance.

**Elective Admission**
The admission of a patient to a hospital prior to the actual scheduled date of admission. This admission can be delayed without potential risk to the health of the individual.

**Electronic Claim**
A digital representation of a medical bill generated by a provider or by the provider’s billing agent for submission using telecommunications to a health insurance payer. Most claims are electronically submitted.

**Electronic Data Interchange (EDI)**
The automated exchange of data and documents in a standardized format. In health care, some common uses of this technology include claims submission and payment, eligibility, and referral authorization.

**Electronic Medical Record (EMR)**
A computer-based record containing health care information. This technology, when fully developed, meets provider needs for real-time data access and evaluation in medical care. Together with clinical workstations and clinical data repository technologies, the EMR provides the mechanism for longitudinal data storage and access.

**Eligible Dependent**
Person entitled to receive health benefits from someone else’s plan.
**Eligible Employee**
Employee who qualifies to receive benefits.

**Emergency**
A medical condition that starts suddenly and requires immediate care.

**Emergency Admission**
The admission of a patient to a hospital immediately or within a very short period of time in order to save the patient’s life or to protect the patient’s health and well-being.

**Emergency Department (ED)**
The department or unit of a hospital organized to provide medical services necessary to sustain life or to prevent critical consequences. This department sometimes provides non-urgent, walk-in care.

**Emergency Department Charges**
Charges for emergency treatment to those ill and injured persons who require immediate, unscheduled, medical or surgical care.

**Emergency Medical Treatment and Labor Act (EMTALA)**
An act pertaining to emergency medical situations. EMTALA requires hospitals to provide emergency treatment to individuals, regardless of insurance status and ability to pay.

**Emergency Patient**
An outpatient, usually acutely ill, who uses a hospital or freestanding emergency department for treatment.

**Employee Retirement Income Security Act (ERISA)**
A Federal act, passed in 1974, that regulates the majority of private pension and welfare group benefit plans in the U.S. It sets forth requirements governing, among many areas, participation, crediting of service, vesting, communication and disclosure, funding, and fiduciary conduct. Key legislative battleground now, because ERISA exempts most large self-funded plans from State regulation and, hence, from any reform activities undertaken at state level – which is now the arena for much healthcare reform.

**Employer Mandate**
Under the Federal HMO Act, describes conditions when federally qualified HMOs can mandate or require an employer to offer at least one federally qualified HMO plan of each type (IPA/network or group/staff). Option that federally qualified HMOs have to exercise over employees, requiring them to have available one or more types of HMOs per plan. This requirement was sunsetted in 1995.

**EMTALA**
An acronym for Emergency Medical Treatment and Active Labor Act.
*Enrollee (Also beneficiary, individual, member)*
Any person eligible as either a subscriber or a dependent for service in accordance with a contract.

*Enrollment*
Initial process whereby new individuals apply and are accepted as members of a prepayment plan. The total number of covered persons in a health plan. Also refers to the process by which a health plan enrolls groups and individuals for membership or the number of enrollees who sign up in any one group.

*EOF (End of Field) Key*
Erases information in a given field.

*Episode of Care*
A term used to describe and measure the various health care services and encounters rendered in connection with identified injury or period of illness.

*Exclusions*
Conditions or situations not considered covered under contract or plan. Clauses in an insurance contract that deny coverage for select individuals, groups, locations, properties or risks. Providers will negotiate for exclusions for outliers and carve-out of certain high cost procedures, while payers will negotiate for exclusions to avoid payment of higher cost care.

*Exclusive Provider Arrangement (EPA)*
An indemnity or service plan that provides benefits only if care is rendered by the institutional and professional providers with which it contracts.

*Exclusive Provider Organization (EPO)*
A plan that limits coverage of non-emergency care to contracted health care providers. Operates similar to an HMO plan but is usually offered as an insured or self-funded product. Sometimes looks like a managed care organization that is organized similarly to a PPO in that physicians do not receive capitated payments, but the plan only allows patients to choose medical care from network providers. If a patient elects to seek care outside of the network, then he or she will usually not be reimbursed for the cost of the treatment. Uses a small network of providers and has primary care physicians serving as care coordinators (or gatekeepers). Typically, an EPO has financial incentives for physicians to practice cost-effective medicine by using a prepaid per-capita rate or a discounted fee schedule, plus a bonus if cost targets are met. Most EPO's are forms of POS plans because they pay for some out-of-network care.

*Exclusivity Clause*
A part of a contract which prohibits physicians, providers or other care entities from contracting with more than one managed care organization. Exclusive contracts are common in staff model HMOs and IPAs but becoming less common in other health plan contracting.
Explanation of Benefits (EOB)
A statement sent to covered individuals explaining services provided, amount to be billed, and payments made. A summary of benefits provided subscribers by the carrier.

Extramural Birth
A birth in a non-sterile environment.

Facesheet
Registration form containing patient's registration information. Also known as the patient record.

Fee Schedule
A listing of accepted fees or established allowances for specified medical procedures. As used in medical care plans, it usually represents the maximum amounts the program will pay for the specified procedures.

Fee-For-Service
Traditional method of payment for health care services where specific payment is made for specific services rendered. Usually people speak of this in contrast to capitation. DRG or per diem discounted rates, none of which are similar to the traditional fee for service method of reimbursement. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or other prepayment systems, where the payment to the physician is not changed with the number of services actually used. Payment may be made by an insurance company, the patient or a government program such as Medicare or Medicaid. With respect to the physicians or other supplier of service, this refers to payment in specific amounts for specific services rendered – as opposed to retainer, salary, or other contract arrangements. In relation to the patient, it refers to payment of an insurance premium or membership fee for coverage, through which the services or payment to the supplier are provided.

Fiduciary
Relating to, or founded upon, a trust or confidence. A legal term. A fiduciary relationship exists where an individual or organization has an explicit or implicit obligation to act in behalf of another person's or organization's interests in matters which affect the other person or organization. This fiduciary is also obligated to act in the other person's best interest with total disregard for any interests of the fiduciary. Traditionally, it was generally believed that a physician had a fiduciary relationship with patients. This is being questioned in the era of managed care as the public becomes aware of the other influences that are effecting physician decisions. Doctors are provided incentives by managed care companies to provide less care, by pharmaceutical companies to order certain drugs and by hospitals to refer to their hospitals. With the pervasive monetary incentives influencing doctor decisions, consumer advocates are concerned because the patient no longer has an unencumbered fiduciary.
**Financial Class**
Code used in billing to identify the insurance type. Example: All of the Commercial insurance plan codes would have a financial class of C.

**Financial Counselor**
Those responsible for interviewing patients and assisting them in making suitable arrangements to meet their financial obligations to the provider.

**Fiscal Intermediary**
The agent (e.g. Blue Cross) that has contracted with providers of service to process claims for reimbursement under health care coverage. In addition to handling financial matters, it may perform other functions such as providing consultative services or serving as a center for communication with providers and making audits of providers’ needs. This entity may also be referred to as TPA or third party administrator. A private organization, usually an insurance company, that serves as an agent for the Center of Medicare and Medicaid Services (CMS), which is part of HHS, that determines the amount of payment due to hospitals and other providers and paying them for the Medicare services they have provided. Intermediaries make initial coverage determinations and handle the early stages of beneficiary appeals.

**Flat Fee-Per-Case**
Flat fee paid for a client’s treatment based on their diagnosis and/or presenting problem. For this fee the provider covers all of the services the client requires for a specific period of time. Often characterizes “second generation” managed care systems. After the MCOs squeeze out costs by discounting fees, they often come to this method. If provider is still standing after discount blitz, this approach can be good for provider and clients, since it permits a lot of flexibility for provider in meeting client needs. DRGs are an example of flat fees paid by diagnosis.

**Flexible Benefit Plan**
Program offered by some employers in which employees may choose among a number of health care benefit options. See also Cafeteria Plan.

**Flow**
Your pathway into the system. A sequence of screen displays.

**Formulary**
An approved list of prescription drugs; a list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care. Organizations often develop a formulary under the aegis of a pharmacy and therapeutics committee. In HMOs, physicians are often required to prescribe from the formulary.

**Fraud**
Intentional misrepresentations that can result in criminal prosecution, civil liability and administrative sanctions.
**Full-time Equivalent (FTE)**
The term used in hospital budgeting and human resources that represents the number of hours that a full-time employee would be expected to work in a given year. In other words, 40 hours a week or 2,080 annual hours. This term is used in hospital budgeting, position control and productivity.

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**Garnishment**
Proceeding whereby property, money, or credits of a debtor in the possession of another are applied to the debts of the debtor.

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**Gatekeeper**
A primary care physician, utilization review, case management, local agency or managed care entity responsible for determining when and what services a patient can access and receive reimbursement for. An arrangement, in which a primary care provider serves as the patient’s agent, arranges for and coordinates appropriate medical care and other necessary and appropriate referrals. A PCP is involved in overseeing and coordinating all aspects of a patient’s medical care. In order for a patient to receive a specialty care referral or hospital admission, the PCP must preauthorize the visit, unless there is an emergency. The term gatekeeper is also used in health care business to describe anyone (EAP, employer based case manager, UR entity, etc.) that makes the decision of where a patient will receive services.

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**Grace Period**
Period past the due date of a premium during which coverage may not be cancelled.

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**Group Insurance**
Any insurance policy of health services contract by which groups of employees (and often their dependents) are covered under a single policy or contract, issued by their employer or other group entity.

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**Group Model HMO, Group Network HMO**
An HMO that contracts with one or more independent group practices to provide services to its members in one or more locations. Health care plan involving contracts with physicians organized as a partnership, professional corporation, or other legal association. It can also refer to an HMO model in which the HMO contracts with one or more medical groups to provide services to members. In either case, the payer or health plan pays the medical group, which is, in turn, responsible for compensating physicians. The medical group may also be responsible for paying or contracting with hospitals and other providers.

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**Group Name/Number**
The name or numerical identification assigned to a specific group of insured parties.
**Group Practice**
A group of persons licensed to practice medicine in the State, who, as their principal professional activity, and as a group responsibility, engage or undertake to engage in the coordinated practice of their profession primarily in one or more group practice facilities, and who in their connection share common overhead expenses if and to the extent such expenses are paid by members of the group, medical and other records, and substantial portions of the equipment and the professional, technical, and administrative staffs. Group practices use the acronyms PA, IPA, MSO and others. Group practices are far more common now than a decade ago because physicians seek to lower costs, increase contracting power and share payer contracts.

**Guarantor**
The person or organization taking financial responsibilities for payment of a patient's bill.

**Hardware**
The machinery used to enter data. (i.e. Computer, Keyboard, Printer)

**HCFA 1500**
The Health Care Finance Administration’s standard form for submitting provider service claims to third party companies or insurance carriers. HCFA is now called CMS.

**HCPCS**
HCFA Common Procedure Coding System-a medical code set using CPT4, alphanumeric and local codes to identify health care procedures, equipment and supplies for claims submission. It is maintained by CMS and has been selected for use in HIPAA transactions.

**Health**
The state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. It is recognized, however, that health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined. The relative importance of various disabilities will differ depending upon the cultural milieu and the role of the affected individual in that culture. Most attempts at measurement have been assessed in terms or morbidity and mortality.

**Health and Human Services (HHS)**
The Department of Health and Human Services that is responsible for health-related programs and issues. Formerly HEW, the Department of Health, Education, and Welfare. The Office of Health Maintenance Organizations is part of HHS and detailed information on most companies is available here through the Freedom of Information Act.

**Health Benefits Package**
The services and products a health plan offers.
Health Care Clearinghouse
An entity that standardizes health information (e.g. a billing service that processes or facilitates the processing of data from one format into a standardized billing format).

Health Care Financing Administration (HCFA)
The federal government agency within the Department of Health and Human Services which directs and oversees the Medicare and Medicaid programs and conducts research to support those programs. It is now called CMS and generally it oversees the state’s administrations of Medicaid, while directly administering Medicare.

Health Care Provider
Providers of medical or health care or researchers who provide health care are health care providers. Normally health care providers are clinics, hospitals, doctors, dentists, psychologists and similar professionals.

Health Insurance
Financial protection against the health care costs of the insured person. May be obtained in a group or individual policy.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Sometimes referred to as the Kennedy-Kassebaum bill, this legislation sets a precedent for Federal involvement in insurance regulation. It sets minimum standards for regulation of the small group insurance market and for a set group in the individual insurance market in the area of portability and availability of health insurance. As a result of this law, hospitals, doctors and insurance companies are now required to share patient medical records and personal information on a wider basis. This wide-based sharing of medical records has led to privacy rules, greater computerization of records and consumer concerns about confidentiality. HIPAA is a federal law that was designed to allow portability of health insurance between jobs. In addition, it required the creation of a federal law to protect personally identifiable health information; if that did not occur by a specific date (which it did not), HIPAA directed the Department of Health and Human Services to issue federal regulations with the same purpose. The Department of Health and Human Services has issued HIPAA privacy regulations as well as other regulations under HIPAA.
**Health Maintenance Organization (HMO)**
HMOs offer prepaid, comprehensive health coverage for both hospital and physician services. The HMO is paid monthly premiums or capitated rates by the payers, which include employers, insurance companies, government agencies, and other groups representing covered lives. The HMO must meet the specifications of the federal HMO act as well as meeting many rules and regulations required at the state level. There are 4 basic models: group model, individual practice association, network model and staff model. An HMO contracts with health care providers, e.g. physicians, hospitals and other health professionals. The members of an HMO are required to use participating or approved providers for all health services and generally all services will need to meet further approval by the HMO through its utilization program. Members are enrolled for a specified period of time. HMOs may turn around and sub-capitate to other groups. For example, it may carve-out certain benefit categories, such as mental health, and subcapitate these to a mental health HMO. Or the HMO may subcapitate to a provider, provider group or provider network. HMOs are the most restrictive form of managed care benefit plans because they restrict the procedures, providers and benefits.

**HHS-OIG**
Office of the Inspector General of the United States Department of Health and Human Service. One of several federal government offices which is actively pursuing alleged violators of the 72-hour rule.

**Hold Harmless Clause**
A clause frequently found in managed care contracts whereby the HMO and the physician hold each other not liable for malpractice or corporate malfeasance if either of the parties is found to be liable. Many insurance carriers exclude this type of liability from coverage. It may also refer to language that prohibits the provider from billing patients if their managed care company becomes insolvent.

**Home Health Care**
Full range of medical and other health related services such as physical therapy, nursing, counseling, and social services that are delivered in the home of a patient by a provider.

**Hospice**
Facility or program providing care for the terminally ill.

**Hospital**
Any institution duly licensed, certified, and operated as a Hospital. In no event shall the term “hospital” include a convalescent facility, nursing home, or any institution or part thereof which is used principally as a convalescence facility, rest facility, nursing facility, or facility for the aged.

**Hospital Information System (HIS)**
A system which collects data from many areas of hospital to provide all levels of hospital management with timely, meaningful information on hospital operation.
**Human Resources**
The department responsible for, in conjunction with other departments, recruitment, selection, orientation, and employee training programs. The department is also responsible for maintaining personnel records and statistics, initiating and maintaining salary and wage administration, and recommending personnel policy and procedure to the administrator.

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**Indemnity**
Health insurance benefits provided in the form of cash payments rather than services. Insurance program in which covered person is reimbursed for covered expenses. An indemnity insurance contract usually defines the maximum amounts that will be paid for covered services. Indemnity insurance plans may have a PPO option, UR and case management features, or include a network or other preferred provider restrictions, but will not have an HMO plan. Indemnity is the traditional form of insurance. Normally when one thinks of indemnity health coverage, one is thinking of the type of plan that does not require “pre-certification” and does not restrict the physicians, drugs or hospitals that will be paid for. Indemnity coverage usually has higher premiums. Indemnity insurance plans are the classic plans – where few restrictions are in place. With these plans, members are normally able to use the providers of their choice and are able to make independent decisions about the type of care they wish to receive. Usually these plans include co-payments, deductibles and maximums but rarely require case management certification or approvals. Managed care, particularly HMO and capitation, has evolved away from the indemnity method. Yet, many people are still covered under indemnity plans.

**Indemnity Carrier**
Usually an insurance company or insurance group that provides marketing, management, claims payment and review, and agrees to assume risk for its subscribers at some pre-determined rate.

**Indemnity Plan**
A plan that reimburses physicians for services performed, or beneficiaries for medical expenses incurred. Such plans are contrasted with group health plans, which provide service benefits through group medical practice.

**Independent Practice Association (IPA) or Organization (IPO)**
A delivery model in which the HMO contracts with a physician organization, which in turn contracts with individual physicians. The IPA physicians practice in their own offices and continue to also see their FFS patients. The HMO reimburses the IPA on a capitated basis; however, the IPA may reimburse the physicians on a FFS or capitated basis.

**Individual Plans**
A type of insurance plan for individuals and their dependents that is not eligible for coverage through employer group coverage.
Informed Consent
Refers to requirements that healthcare providers and researchers explain the purposes, risks, benefits, confidentiality protections, and other relevant aspects of the provision of medical care, a specific procedure or participation in medical research. Informed consent is also required for the authorization of release or disclosure of individually identifiable health care information.

Inpatient
A patient who has been admitted for at least one night to a hospital or other health facility for the purpose of receiving diagnostic treatment or other medical service.

Inpatient Care
Care given a registered bed patient in a hospital, nursing home or other medical or post acute institution.

Insurance Claim
The statement of total charges on patient accounts that are examined by insurance companies for reimbursement purposes. (The standard form is the UB-04).

Insurance Plan Code
Code used to tell the system how and where to send the patients bill.

Interface
A means of communication between two computer systems, two software applications or two modules. Real time interface is a key element in healthcare information systems due to the need to access patient care information and financial information instantaneously and comprehensively. Such real time communication is the key to managing health care in a cost effective manner because it provides the necessary decision-making information for clinicians, providers and payers.

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)
This is the universal coding method used to document the incidence of disease, injury, mortality and illness. A diagnosis and procedure classification system designed to facilitate collection of uniform and comparable health information. The ICD-9-CM was issued in 1979. This system is used to group patients into DRGs, prepare hospital and physician billings and prepare cost reports. Classifications of disease by diagnosis codified into six-digit numbers.

Intestate
One who dies without leaving a Will.
**Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)** Formerly called JCAHO, or Joint Commission on Accreditation of Hospitals, this is the peer review organization which provides the primary review of hospitals and healthcare providers. Many insurance companies require providers to have this accreditation in order to see 3rd party payment, although, many small hospitals cannot afford the cost of accreditation. JCAHO usually surveys organizations once every 3 years, sending a medical and administrative team to review policies, patient records, professional credentialing procedures, governance and quality improvement programs. JCAHO revises it “standards” annually.

**Laboratory Charges**
Charges for the performance of diagnostic and routine clinical laboratory tests.

**Late Charge**
Charges, which are received by the provider after an insurance claim has been submitted.

**Length of Stay (LOS)**
The duration of an episode of care for a covered person. The number of days an individual stays in a hospital or inpatient facility.

**Length of Stay, Average**
The average number of days of service rendered to each patient who is discharged during a given time period. To compute this figure, divide the total number of days spent in the hospital by patients discharged in a given time period by the total number of inpatients discharged during the time period. Example: 120 total patient days for 20 patients discharged. The average length of stay is 120/20 = 6 days.

**Licensing**
A process most states employ, which involves the review and approval of applications from HMOs prior to beginning operation in certain areas of the state. Areas examined by the licensing authority include: fiscal soundness, network capacity, MIS, and quality assurance. The applicant must demonstrate it can meet all existing statutory and regulatory requirements prior to beginning operations.

**Lifetime Limit**
A cap on the benefits paid under a policy. Many policies have a lifetime limit of $1 million, which means that the insurer agrees to cover up to $1 million in covered services over the life of the policy.

**Lifetime Reserve Days**
Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.
**Long-Term Care**
Health and medical care and social services provided on a continual basis to patients suffering from chronic medical and mental conditions.

**Long-Term Care (LTC)**
A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals. Ambulatory services such as home health care, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.

**Managed Behavioral Health Program**
A program of managed care specific to psychiatric or behavioral health care. This usually is a result of a “carve-out” by an insurance company or managed care organization (MCO). Reimbursement may be in the form of sub-capitation, fee for service or capitation.

**Managed Care**
Systems and techniques used to control the use of health care services. Includes a review of medical necessity, incentives to use certain providers, and case management. The body of clinical, financial and organizational activities designed to ensure the provision of appropriate health care services in a cost-efficient manner. Managed care techniques are most often practiced by organizations and professionals that assume risk for a defined population but this is not always the case. Managed care is a broad term and encompasses many different types of organizations, payment mechanisms, review mechanisms and collaborations. Managed care is sometimes used as a general term for the activity of organizing doctors, hospitals, and other providers into groups in order to enhance the quality and cost-effectiveness of health care. Managed Care Organizations (MCO) includes HMO, PPO, POS, EPO, PHO, IDS, AHP, IPA, etc. Usually when one speaks of a managed care organization, one is speaking of the entity that manages risk, contracts with providers, is paid by employers or patient groups, or handles claims processing. Managed care has effectively formed a “go-between”, brokerage or 3rd party arrangement by existing as the gatekeeper between payers and providers and patients. The term managed care is often misunderstood, as it refers to numerous aspects of healthcare management, payment and organization. It is best to ask the speaker to clarify what he or she means when using the term “managed care”. In the purest sense, all people working in healthcare and medical insurance can be thought of as “managing care”. Any system of health payment or delivery arrangements where the plan attempts to control or coordinate use of health expenditures, improve quality, or both. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan.
**Managed Care Organization (MCO)**
A health plan that seeks to manage care. Generally, this involves contracting with health care providers to deliver health care services on a capitated (per-member per-month) basis.

**Managed Care Plan**
A health plan that uses managed care arrangements and has a defined system of selected providers that contract with the plan. Enrollees have a financial incentive to use participating providers that agree to furnish a broad range of services to them. Providers may be paid on a pre-negotiated basis.

**Management Services Organization (MSO)**
Usually an entity owned by a hospital, physician group, PHO or IDS that provides management services and administrative systems to one or more medical practices. The management services organization provides administrative and practice management services to physicians. A hospital, hospitals, or investors may typically own an MSO. Large group practices may also establish MSOs to sell management services to other physician groups.

**Maximum Out-of-Pocket Expenses**
Limit on total number of co-payments or limit on total cost of deductibles and co-insurance under a benefit plan.

**Medicaid**
Government entitlement program for the poor, blind, aged, disabled or member of families with dependent children (AFDC). Each state has its own standards for qualification. A Federally aided, state-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all of the poor, however, but only persons who meet specified eligibility criteria. Subject to broad Federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

**Medicaid Integrity Review Contracts (MIC)**
Contractors used to audit Medicaid providers through the use of statistical claims data. Claim level audits are also conducted to identify potential overpayments, as well as to provide education.

**Medical Necessity**
A determination that a covered service meets all of the necessary conditions for allowing treatment.
**Medical Record**
Patients file containing sufficient information to clearly identify the patient, to justify the patient’s diagnosis and treatment, and to accurately document the results. The record serves as a basis for planning and continuity of patient care and provides a means of communication among physicians and any other professionals involved in the patient’s care. The record also serves as a basis for review, study, and evaluations on serving and protecting the legal interests of the patient, provider, and responsible practitioner.

**Medical Record Department**
The facility’s department responsible for the cataloging, maintenance, processing, and control of patient hospital medical records.

**Medical Services Organization (MSO)**
An organized group of physicians, usually from one hospital, into an entity able to contract with others for the provision of services.

**Medically Necessary – Medical Necessity**
Services or supplies which meet the following tests: They are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; They are provided for the diagnosis or direct care and treatment of the medical condition; They meet the standards of good medical practice within the medical community in the service area; They are not primarily for the convenience of the plan member or a plan provider; and They are the most appropriate level or supply of service which can safely be provided.

**Medically Needy**
Person who are categorically eligible for Medicaid and whose income, less accumulated medical bills, are below state income limits for the Medicaid program. Often seen as a problem among the “working poor” or among the senior population.

**Medicare**
A federal program for the elderly and disabled, regardless of financial status. It is not necessary, as with Medicaid, for Medicare recipients to be poor. A U.S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents that need kidney transplantation or dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).

**Medicare Co-Insurance Amount**
Under Part A, the amount the patient is responsible for paying is equal to one-fourth of the Part A Medicare Cash Deductible for each inpatient day from the 61st to the 90th day. Under Part B, the amount the patient is responsible for paying is equal to 20% of the charges after the annual Part B Medicare Cash Deductible is met.
**Medicare Cost Report (MCR)**
An annual report required of all institutions participating in the Medicare program. The MCR records each institution’s total costs and charges associated with providing services to all patients, the portion of those costs and charges allocated to Medicare patients, and the Medicare payments received.

**Medicare Part A Hospital Insurance**
A basic part of the health insurance program that provides benefits for inpatient hospital care and post hospital extended care furnished by skilled nursing facilities, and home health agencies.

**Medicare Part B or Supplementary Medical Insurance**
A basic part of the health insurance program designed to supplement the basic hospital insurance coverage to include coverage for outpatient procedures such as ambulatory surgery.

**Medicare Recovery Audit Contractors (RAC)**
CMS contracted organizations that identify improper payments of Medicare Part A and Part B claims by conducting post payment reviews to identify overpayments and underpayments and recoup any overpayments they identify. The contractors receive payment based on the amount of improper payments identified.

**Medicare Secondary Payer**
A system which requires providers to identify payers that is primary to Medicare as part of the registration process.

**Medicare Supplemental Policy**
A policy that pays for the cost of services not covered by Medicare, such as coinsurance and deductibles.

**Medicare, Title XVIII of the Social Security Act, Public Law 89-97**
A federal program that pays providers for certain medical and other health services for individuals 65 years of age or older or the disabled, regardless of their income. The program has two parts: hospital insurance (Part A) and medical insurance (Part B). Part B is also known as supplementary medical insurance.

**Medigap**
Private health insurance plans that supplement Medicare benefits by covering some costs not paid for by Medicare. MediGap plans are supplements to Medicare insurance. MediGap plans vary from State to State; standardized MediGap plans also may be known as Medicare Select plans.

**Member**
Used synonymously with the terms enrollee and insured. A member is any individual or dependent who is enrolled in and covered by a managed health care plan.
**Morbidity**
The extent of illness, injury, or disability in a defined population. It is usually expressed in general or specific rates of incidence or prevalence.

**MSA**
Medical Savings Account.

**Network**
An affiliation of providers through formal and informal contracts and agreements. Networks may contract externally to obtain administrative and financial services. A list of physicians, hospitals and other providers who provide health care services to the beneficiaries of a specific managed care organization.

**Network Model HMO**
This type of HMO contracts with more than one physician group and may contract with single or multi-specialty groups as well as hospitals and other health care providers. A health plan that contracts with multiple physician groups to deliver health care to members. Generally limited to large single or multi-specialty groups. Distinguished from group model plans that contract with a single medical group, IPA’s that contract through an intermediary, and direct contract model plans that contract with individual physicians in the community.

**Newborn Admission**
The status of a baby born within a facility.

**No Balance Billing Provision**
A provider contract clause which states the provider agrees to accept the amount the plan pays for medical services as payment in full and not to bill plan members additional amounts (except for co-payments, coinsurance and deductibles)

**Non-Aggregate Deductible**
This term refers to the type of deductible that is based on a certain number of people, rather than on a specific dollar amount.

**Non-Covered Days**
Days of care not covered by the primary payer.

**Non-Participating Physician (or Provider)**
A provider, doctor or hospital that does not sign a contract to participate in a health plan, usually which requires reduced rates from the provider. In the Medicare program, this refers to providers who are therefore not obligated to accept assignment on all Medicare claims. In commercial plans, non-participating providers are also called out of network providers or out of plan providers. If a beneficiary receives service from an out of network provider, the health plan (other than Medicare) will pay for the service at a reduced rate or will not pay at all.
**Non-PPS Hospital**
A hospital that is excluded from the Prospective Payment System and is therefore reimbursed by Medicare based on the Reasonable Cost Reimbursement System. Any hospital that is a psychiatric hospital, rehabilitation hospital, children's hospital, long term hospital, psychiatric or rehabilitation distinct part unit of a general acute care hospital, cancer hospital, or hospital outside of the fifty states, the District of Columbia, or Puerto Rico is a non-PPS hospital.

**Notification Number**
A number given to the provider of service indicating that the provider has been made aware that a third-party client is present at the provider’s site.

**Nurse Practitioner (NP)**
A registered nurse qualified and specially trained to provide primary care, including primary health care in homes and in ambulatory care facilities, long-term care facilities, and other health care institutions. Normally, NPs are licensed and possess a Masters degree. Nurse practitioners generally function under the supervision of a physician but not necessarily in his or her presence. In some states, NPs are able to provide basic medical services without requiring MD or DO supervision. They are either salaried or reimbursed on a fee-for-service basis.

**Occupancy Rate**
A measure of inpatient hospital use. The ratio of inpatient beds occupied to inpatient beds available for occupancy.

**Office of Inspector General (OIG)**
The office responsible for auditing, evaluating and criminal and civil investigating for HHS, as well as imposing sanctions, when necessary, against health care providers.

**One Day Rule**
An exception to the general 72-hour rule. This is a Medicare regulation in which all outpatient diagnostic services or other services related to admission must be bundled together on the same bill to Medicare. This exception applies only to hospitals that do not qualify as subsection (d) hospitals.

**Open Access**
A term describing a member’s ability to self-refer for specialty care. Open access arrangements allow a member to see a participating provider without a referral from another doctor. Health plan member’s abilities, rights or invitation to self refer for specialty care. Also called Open Panel.
Open Enrollment Period
A period during which subscribers in a health benefit program have an opportunity to select among health plans being offered to them, usually without evidence of insurability or waiting periods. A period of time which eligible subscribers may elect to enroll in, or transfer between, available programs providing health care coverage. Under an open enrollment requirement, a plan must accept all who apply during a specific period each year.

Open Panel
A term describing a member’s ability to self-refer for specialty care. Open access arrangements allow a member to see a participating provider without a referral from another doctor. Health plan members’ abilities, rights or invitation to self refer for specialty care.

Other Services Related to the Admission
Non-diagnostic services that are furnished in connection with the principal diagnosis that required the beneficiary to be admitted as an inpatient. These services must be bundled if they are performed within the 72-hour window.

Out of Network Benefits
With most HMOs, a patient cannot have any services reimbursed if provided by a hospital or doctor who is not in the network. With PPOs and other managed care organizations, there may exist a provision for reimbursement of “out of network” providers. Usually this will involve higher co-pay or a lower reimbursement.

Out of Pocket Expense
The maximum amount of money that a patient must pay before his/her insurance will consider benefits at 100%.

Out of Pocket Expenses, Out of Pocket Costs
Costs borne by the member that are not covered by health care plans. Portion of health services or health costs that must be paid for by the plan member, including deductibles, co-payments and co-insurance. In the age of managed care, out of pocket expenses can also refer to the payment of services not covered by or approved for reimbursement by the health plan.

Out of Pocket Limit
A cap placed on out of pocket costs, after which benefits increase to provide full coverage for the rest of the year. It is a stated dollar amount set by the insurance company, in addition to regular premiums.

Outlier
A patient whose length of stay or treatment cost differs substantially from the stays or costs of most other patients in a diagnosis related group. Under DRG reimbursement, outliers are given exceptional treatment subject to peer review and organization review.
**Out-of-Network Provider**
A health care provider with whom a managed care organization does not have a contract to provide health care services. Because the beneficiary must pay either all of the costs of care from an out-of-network provider or their cost-sharing requirements are greatly increased, depending on the particular plan a beneficiary is in, out-of-network providers are generally not financially accessible to Medicaid beneficiaries.

**Outpatient**
A patient receiving ambulatory care at a hospital or other health facility without being admitted as an inpatient.

**Outpatient Care**
Care given a person who is not bedridden. Also called ambulatory care. Many surgeries and treatments are now provided on an outpatient basis, while previously they had been considered reason for inpatient hospitalization.

**Part A Medicare**
Refers to the inpatient portion of benefits under the Medicare Program, covering beneficiaries for inpatient hospital, home health, hospice, and limited skilled nursing facility services. Beneficiaries are responsible for deductibles and co-payments. Part A services are financed by the Medicare HI Trust fund, which consists of Medicare tax payments. Part B, on the other hand, refers to outpatient coverage.

**Part B Medicare**
Refers to the outpatient benefits of Medicare. Medicare Supplementary Medical Insurance under Part B of the Title XVII of the Social Security Act covers Medicare beneficiaries for physician services, medical supplies, and other outpatient treatment. Beneficiaries are responsible for monthly premiums, co-payments, deductibles, and balance billing. Part B services are financed by a combination of enrollee premiums and general tax revenues.

**Partial Hospitalization Program (PHP)**
Acute level of psychiatric treatment normally provided for 4 or more hours per day. Normally includes group therapies and activities with homogeneous patient populations. Is used as a referral step-down from inpatient care or as an alternative to inpatient care. Unlike intensive outpatient or simple outpatient services, PHP provides an attending psychiatrist, onsite nursing and social work. Reimbursed by payers at a rate that is roughly one half of inpatient psychiatric hospitalization day rate. Patients do not spend the night at the partial hospital.

**Participating Physician or Participating Provider**
Simply refers to a provider under a contract with a health plan. A physician or hospital that has agreed to provide services for a set payment provided by a payer, or who agrees to other arrangements, or who agrees to provide services to a set of covered lives or defined patients. Also refers to a provider or physician who signs an agreement to accept assignment on all Medicare claims for one year.
Password
Assigned code to give you entry into the system.

Patient Accounts and Billing Department
The department (traditionally referred to as the business office) responsible for managing patient accounts, hospital receivables, and patient bills.

Patient Liability
The dollar amount that an insured is legally obligated to pay for services rendered by a provider. These may include co-payments, deductibles and payments for uncovered services.

Patient Management System (PMS)
The system used to register, update insurance, add a diagnosis, enter charges and revise patient data.

Patient Responsibility
That portion of the bill that the patient is responsible to pay for services, deductible, co-payment and non-covered services.

Patient Status
Identifies the patient's current registration disposition in the computer system.

Payer
The public or private organization that is responsible for payment for health care expenses. Payers may be insurance companies or self-insured employers.

PCP
Primary care physician who often acts as the primary gatekeeper in health plans. That is, often the PCP must approve all referrals to specialists. Particularly in HMOs and some PPOs, all members must choose or are assigned a PCP.

PCP Capitation
A reimbursement system for healthcare providers of primary care services who receive a pre-payment every month. The payment amount is based on age, sex and plan of every member assigned to that physician for that month.
**Peer Review**
The mechanism used by the medical staff to evaluate the quality of total health care provided by the Managed Care Organization. The evaluation covers how well all health personnel perform services and how appropriate the services are to meet the patient’s needs. Evaluation of health care services by medical personnel with similar training. Generally, the evaluation by practicing physicians or other professionals of the effectiveness and efficiency of services ordered or performed by other members of the profession. Frequently, the peer review refers to the activities of the Professional Review Organizations, and also the review of research by other researchers. This is the most common method utilized in managed care for monitoring the utilization by physicians. In other words, other physicians will review the decisions made by a physician. Much controversy has surfaced in this area in recent years. Some physicians are reluctant to be reviewed by physicians over the phone or by having their written records read. Some consumers suspect that peer review is not true peer review since both the providers and the reviewers often have financial incentives to reduce or increase medical care. Nonetheless, peer review is utilized in all managed care settings.

**Peer Review Organization (PRO)**
An organization established by the Tax Equity and Fiscal Responsibility Act of 1982 to ensure quality of care and appropriateness of admission, readmissions, and discharges for Medicare and Medicaid. These organizations are held responsible for maintaining and lowering admission rates, reducing lengths of stay, while insuring against inadequate treatment. PROs can conduct review of medical records and claims to evaluate the appropriateness of care provided. PROs also exist within private carriers and providers. Peer Review itself is a process whose confidentiality in private organizations is protected by law. This allows hospitals and groups to conduct internal investigation and monitoring of care decisions and outcomes without the production of related documents in court proceedings. Providers have fought for these protections.

**Per Diem**
A pre-established price per day paid for services.

**Per Diem Rates**
A form of payment for services in which the provider is paid a daily fee for specific services or outcomes, regardless of the cost of provision. Per Diem rates are paid without regard to actual charges and may vary by level of care, such as medical, surgical, intensive care, skilled care, psychiatric, etc. Per Diem rates are usually flat all-inclusive rates.

**Physician Organization**
This term describes physician linkages and alliances that allow physicians to manage risk and capitation. Information systems, physician’s relationships, and financial integration allow these organizations to be more integrated than the traditional solo practice or IPA relationship between healthcare providers and/or managed care organizations that are working to develop a “seamless” continuum of healthcare services. Sometimes physician organizations are simply group practices or professional organizations without intention of acting as a contracting entity.
**Physician-Hospital Organization (PHO)**
An organization representing hospitals and physicians as an agent. A legal entity formed by a hospital and a group of physicians to further mutual interests and to achieve market objectives. A PHO generally combines physicians and a hospital into a single organization for the purpose of obtaining payer contracts. A contracted arrangement among physicians and hospitals wherein a single entity, the PHO, agrees to provide services to insurer’s subscribers. The PHO serves as a collective negotiating and contracting unit. A PHO may be structured to share the risk of contracting between hospital and doctors. PHOs may also own, operate or subcontract MSOs, health plans or providers. A PHO can manage risk. It is typically owned and governed jointly by a hospital and shareholder physicians.

**Plan Administration**
A term often used to describe the management unit with responsibility to run and control a managed care plan – includes accounting, billing, personnel, marketing, legal, purchasing, possibly underwriting, management information, facility maintenance, servicing of accounts. This group normally contracts for medical services and hospital care. If an insurance company is the underwriter, it may serve as its own administrator or may contract to a 3rd party administrator. Self-insured plans do the same.

**PMS (Patient Management System)**
The system used to register, update insurance, add a diagnosis, enter charges and revise patient data.

**Point of Service (POS)**
A POS plan is a combination of an HMO and a commercial insurance policy. It is named this because at the point that a patient needs service, he/she determines the benefit level by the way in which he/she access healthcare.

**Point-of-Service Plan (POS)**
A health services delivery organization that offers the option to its members to choose to receive a service from participating or a nonparticipating provider. Generally the level of coverage is reduced for services associated with the use of non-participating providers. Managed care plan that specifies that those patients who go outside of the plan for services may pay more out of pocket expenses. A health insurance benefits program in which subscribers can select between different delivery systems when in need of health care services and at the time of accessing the services, rather than making the selection between delivery systems at time of open enrollment at place of employment. Typically, the costs associated with receiving care from the “in network” or approved providers are less than when care is rendered by non-contracting providers. Or the costs are less if provided by approved providers in either the HMO or PPO rather than “out of network” or “out of plan” providers. This is a method of influencing patients to use certain providers without restricting their freedom of choice too severely.
Portability
Requirement that health plans guarantee continuous coverage without waiting periods for persons moving between plans. The ability for an individual to transfer from one health insurer to another health insurer with regard to pre-existing conditions or other risk factors. This is a new protection for beneficiaries involving the issuance of a certificate of coverage from previous health plan to be given to new health plan. Under this requirement, a beneficiary who changes jobs is guaranteed coverage with the new plan, without a waiting period or having to meet additional deductible requirements. Primarily, this refers to the requirement that insurers waive any pre-existing condition exclusion for beneficiaries previously covered through other insurance.

PPS
See Prospective Payment System.

PPS Hospital
A hospital which is reimbursed by Medicare using the Prospective Payment System. Any hospital that is not a psychiatric hospital, rehabilitation hospital, children's hospital, long term hospital psychiatric or rehabilitation distinct part unit of a general acute care hospital, cancer hospital, or hospital outside of the fifty states, the District of Columbia, or Puerto Rico is a PPS hospital. Therefore, general acute care hospitals are PPS hospitals and must use the Prospective Payment System in order to be reimbursed by Medicare.

Preadmission
The process of obtaining and confirming patient demographic and financial information at least twenty-four hours in advance of arrival.

Preadmission Certification
Review and approval of the necessity and appropriateness for proposed inpatient service. The term also refers to actual admission to an institution prior to the proposed admission time.

Preadmission Review, Pre-Admission Certification, Pre-Certification, or Pre-authorization
Review of “need” for inpatient care of other care before admission. This refers to a decision made by the payer, MCO or insurance company prior to admission. The payer determines whether or not the payer will pay for the service. Most managed care plans require pre-cert. This is a method of controlling and monitoring utilization by evaluating the need for service prior to the service being rendered. The practice of reviewing claims for inpatient admission prior to the patient entering the hospital in order to assure that the admission is medically necessary. A method of monitoring and controlling utilization by evaluating the need for medical service prior to it being performed. The process of notification and approval of elective inpatient admission and identified outpatient services before the service is rendered. An administrative procedure whereby a health provider submits a treatment plan to a third party before treatment is initiated. The third party usually reviews the treatment plan, monitoring one or more of the following: Patient’s eligibility, covered service, amounts payable, application of appropriate deductibles, co-payment factors and maximums.
Pre-Authorization
A cost containment feature of many group medical policies whereby the insured must contact the insurer prior to a hospitalization or surgery and receive authorization for the service.

Precertification
Also known as preadmission certification, preadmission review and precert. The process of obtaining certification or authorization from the health plan for routine hospital admissions (inpatient or outpatient), often involves appropriateness review against criteria and assignment of length of stay. Failure to obtain precertification often results in a financial penalty to either the provider or the subscriber.

Pre-existing Condition
A medical condition developed prior to issuance of a health insurance policy that may result in the limitation in the contract on coverage or benefits. Some policies that exclude coverage of such conditions often exclude them for a period of time or indefinitely. Federally qualified HMOs cannot limit coverage for pre-existing conditions. New statutes in 1997 and 1998 altered the freedom other health plans have enjoyed in setting pre-existing time limits. Certification of prior coverage may mean new insurers would need to waive pre-existing clauses for some subscribers.

Preferred Provider Network (PPN)
A network of physicians and healthcare organizations that provide services to a health plan’s members.

Preferred Provider Organization (PPO)
Some combination of hospitals and physicians that agrees to render particular services to a group of people, perhaps under contract with a private insurer. A health care delivery system that contracts with providers of medical care to provide services at discounted fees to member. Members may see care from non-participating providers but generally are financially penalized for doing so by the loss of the discount and subject to co-payments and deductibles. The services may be furnished at discounted rates and the insured population may incur out-of-pocket expenses for covered services received outside the PPO if the outside charge exceeds the PPO payment rate. A PPO can also be a legal entity or it may be a function of an already formed health plan, HMO or PHO. The entity may have a health benefit plan that is also referred to as a PPO. PPOs are a common method of managing care while still paying for services through an indemnity plan. Most PPO plans are point of service plans, in that they will pay a higher percentage for care provided by providers in the network. Many insurers will offer PPOs as well as HMOs. Generally PPOs will offer more choice for the patient and will provide higher reimbursement to the providers.

Preventive Care
Health care that emphasizes prevention, early detection and early treatment, thereby reducing the costs of healthcare in the long run. Health care that seeks to prevent or foster early detection of disease and morbidity and focuses on keeping patients well.
The principal insurance payer.

**Primary Care**
Basic or general health care usually rendered by general practitioners, family practitioners, internists, obstetricians and pediatricians – who are often referred to as primary care practitioners or PCPs.

**Primary Care Network (PCN)**
A group of primary care physicians who share the risk of providing care to members of a given health plan.

**Primary Care Physician (PCP)**
A “generalist” such as a family practitioner, pediatrician, internist, or obstetrician. In a managed care organization, a primary care physician is accountable for the total health services of enrollees including referrals, procedures and hospitalization.

**Primary Care Provider (PCP)**
The provider that serves as the initial interface between the member and the medical care system. The PCP is usually a physician, selected by the member upon enrollment, who is trained in one of the primary care specialties who treats and is responsible for coordinating the treatment of members assigned to his/her plan.

**Primary Payer**
The insurance carrier or program that takes precedence in the payment of a health care bill when two or more third-party payers have potential responsibility for the reimbursement.

**Principal Diagnosis**
The medical condition that is ultimately determined to have caused a patient’s admission to the hospital. The principal diagnosis is used to assign every patient to a diagnosis related group. This diagnosis may differ from the admitting and major diagnoses.

**Prior Authorization**
A formal process requiring a provider to obtain approval prior to providing particular services or procedures before they are done. This is usually required for non-emergency services that are expensive or likely to be abused or overused. A managed care organization will identify those services and procedures that require prior authorization, without which the provider may not be compensated.

**Prior Authorization (PA)**
A process whereby a provider must justify the need for delivering a particular service to a patient prior to actually providing it.

**Probe**
Use the light pen to select desired function or to change screens.

**Procedure Code**
CPT4 code entered for professional charges.
**Professional Review Organization**
An organization that reviews the services provided to patients in terms of medical necessity professional standards; and appropriateness of setting.

**Proration**
Process of determining the patient’s portion of charges as separate from the insurance portion. Proration enables a hospital to determine what a patient owes at or prior to discharge.

**Prospective Payment System (PPS)**
A payment method that establishes rates, prices or budgets before services are rendered and costs are incurred. Providers retain or absorb at least a portion of the difference between established revenues and actual costs. (1) The Medicare system used to pay hospitals for inpatient hospital services; based on the DRG classification system. (2) Medicare’s acute care hospital payment method for inpatient care. Prospective per-case payment rates are set at a level intended to cover operating costs in an efficient hospital for treating a typical inpatient in a given diagnosis-related group. Payments for each hospital are adjusted for differences in area wages, teaching activity, and care to the poor, and other factors. Hospitals may also receive additional payments to cover extra costs associated with atypical patients (outliers) in each DRG. Capital costs, originally excluded from PPS are being phased into the system.

**Protected Health Information (PHI)**
Under HIPAA, this refers to individually identifiable health information transmitted or maintained in any form.

**Provider**
Usually refers to a hospital or doctor who “provides” care. A health plan, managed care company or insurance carrier is not a healthcare provider. Those entities are called payers. The lines are blurred sometimes, however, when providers create or manage health plans. At that point, a provider is also a payer. A payer can be provider if the payer owns or manages providers, as with some staff model HMOs.

**Provider Relations**
The department within a managed care organization that is responsible for responding to requests from medical providers in relation to rendering care as a participating provider in their network.

**Provider Services Organization (PSO)**
Defined by CMS as a public or private entity that is established or organized by a health care provider or group of affiliated providers; that provides a substantial proportion of the services under its Medicare contract directly through the provider or group of affiliated providers; and in which the provider or affiliated providers directly or indirectly share substantial financial risk and have at least a majority financial interest. Similar to the concept of MSO.
**Quality Improvement (QI)**
Also called performance improvement (PI). This is the more commonly used term in healthcare, replacing QA. QI implies that concurrent systems are used to continuously improve quality, rather than reacting when certain baseline statistical thresholds are crossed. Quality improvement programs usually use tools such as cross-functional teams, task forces, statistical studies, flow charts, process charts, Pareto charts, etc.

**Reasonable and Customary**
The most common fee charged for like professional services in a particular geographical area where the services are rendered.

**Reasonable Cost Reimbursement System**
One of the two systems used by Medicare to reimburse hospitals for services they perform for Medicare beneficiaries. Under this system, Medicare reimburses based on the reasonable costs incurred by the hospital in performing the services, subject to a ceiling that is imposed by Congress.

**Receivable**
Refers to either the total or a portion of patient’s account, which represents uncollected revenue for the facility.

**Recipient ID**
The personal identification number patients receive when they enroll for health care coverage.

**Recurring/Series Patient**
A patient for whom a definite and repeated treatment program is established or an extended period of time (e.g. physical therapy, radiation oncology, prenatal care, etc.)

**Referral**
The process of sending a patient from one practitioner to another for health care services. Health Plans may require that designated primary care providers authorize a referral for coverage of specialty services.

**Referral System**
The process through which a primary care provider authorizes a patient to see a specialist to receive additional care.

**Registration**
Open a case for a patient, assigns a new billing number.
**Reimbursement**
The amount paid to providers for services they provide to patients.

**Reinsurance**
An insurance arrangement whereby the MCO or provider is reimbursed by a third party for costs exceeding a pre-set limit, usually an annual maximum. A method of limiting the risk that a provider or managed care organization assumes by purchasing insurance that becomes effective after set amount of health care services have been provided. This insurance is intended to protect a provider from the extraordinary health care costs that just a few beneficiaries with extremely extensive health care needs may incur. Insurance purchased by an insurance company or health plan from another insurance company to protect itself against losses. A contract by which an insurer procures a third party to insure it against loss or liability by reason of such original insurance. The practice of an HMO or insurance company of purchasing insurance from another company to protect itself against part or all of the losses incurred in the process of honoring the claims of policyholders.

**Reserves**
Monies earmarked by health plans to cover anticipated claims and operating expenses. A fiscal method of withholding a certain percentage of premiums to provide a fund for committed but undelivered health care and such uncertainties as: longer hospital utilization levels than expected, over-utilization of referrals, accidental catastrophes and the like. The fiscal method of providing a fund for committed but undelivered health services or other financial liabilities. A percentage of the premiums support this fund. Businesses other than health plans also managed reserves. For example, hospitals document reserves as that portion of the accounts receivables that they hope to collect but have some doubt about its collectability. Rather than book these amounts as income, hospitals will “reserve” these amounts until paid.

**Revenue Code**
A code on the UB-04 used to identify a specific accommodation charge, ancillary service charge, or a type of billing calculation.

**Rural Health Clinic**
A public or private hospital, clinic or physician practice designated by the federal government as in compliance with the Rural Health Clinics Act. The practice must be located in a Medically Underserved area or a Health Professions Shortage Area and use a physician assistant and/or nurse practitioner to deliver services. A rural health clinic must be licensed by the state and provide preventive services. These providers are usually qualified for special compensations, reimbursements and exemptions.

**Same-day Surgery**
Surgical services received as a diagnostic outpatient.
Secondary Coverage
Health plan that pays costs not covered by primary coverage under coordination of benefits rules. Any insurance that supplements Medicare coverage. The three main sources for secondary insurance are employers, privately purchased Medigap plans and Medicaid.

Secondary Payer
The secondary insurance payer, carrier or program that is secondary to the primary insurance carrier or program (usually billed after the first carrier).

Self-Funding
Employer or organization assumes complete responsibility for health care losses of its covered employees. This usually includes setting up a fund against which claim payments are drawn and claims processing is often handled through an administrative services contract with an independent organization. In this case, the employer does not pay premiums to an insurance carrier, but rather pay administrative costs to the insurance company or health plan, and in essence, treats them as a third party administrator only. However, the employee may not be able to detect any difference because the plan description and membership card may carry the name of the insurance company not the employer.

Self-insured
A type of insurance arrangement where employers, usually large employers, pay for medical claims out of their own funds rather than contracting with an insurance company for coverage. This puts the employer at risk for its employees’ medical expenses rather than an insurance company. Many employers choose to self-insure because they are then exempted from certain insurance laws and also think that they will spend less money in the short run. Employers assume the risks involved and also have full rights to all insurance claim information. The employees or patients will not be able to discern if their employer is self-insured easily since all paperwork or benefits cards usually contain the name of the insurance company overseeing the plan.

Self-Pay
Individuals, institutions or corporations assuming the entire responsibility for payment of hospital and medical bills which otherwise might be covered by an insurance policy.

Sentinel Event
Adverse health events that may have been avoided through appropriate care or alternate interventions. Providers are required to alert JCAHO and often state licensing authorities of all sentinel events, including a review or risk factors, preventative measures and case analysis.

Sick Baby
A baby delivered with medical complications, other than those related to premature status.
**Sign Off/Log Off**
When you clear out of the system.

**Sign On/Log On**
When you enter your ID and your personal password.

**Skilled Nursing Facility (SNF)**
A licensed institution, as defined by Medicare, which is primarily engaged in the provision of skilled nursing care. SNFs are usually DRG or PPS exempt and are located within hospitals, but sometimes are located in rehab facilities or nursing homes.

**Skip**
When a debtor cannot be located by a creditor.

**Skip Tracing**
The act of locating the debtor using information from the initial registration, telephone directories, credit bureau report, etc. so that the hospital can receive payment.

**Social Security Administration (SSA)**
Founded in 1946. This is the bureau of the federal government that is responsible for the administration of Medicare, whose financing is under the direction of the Health Care Financing Administration (HCFA). The SSA is also responsible for administering a number of other programs including the Old Age Survivors and Disability Insurance Program.

**Social Service Department**
The unit responsible for working with patients, their families, and the institution’s professional staff to assist patients with personal, socioeconomic, and environmental problems related to their medical conditions.

**Source of Admission**
Refers to the source from which a patient was admitted to a facility. For example, emergency or transfer from another hospital.

**Specific Stop Loss**
The form of excess risk coverage that provides protection for the employer against high claim on any one individual. This is protection against abnormal severity of a single claim rather than abnormal frequency of claims in total.

**Spend Down**
A term used in Medicaid for persons whose income and assets are above the threshold for the state’s designated medically needy criteria, but are below this threshold for the state’s designated medically needy criteria, but are below this threshold when medical expenses are factored in. The amount of expenditures for health care services, relative to income, that qualifies an individual for Medicaid in States that cover categorically eligible, medically indigent individuals. Eligibility is determined on a case-by-case basis.
**Staff Model HMO**
A model in which the HMO hires its own physicians. All premiums and other revenues accrue to the HMO, which, in turn, compensates physicians. Very much like the group model, except the doctors are employees of the HMO. Generally, all ambulatory health services are provided under one roof in the staff model.

**State Children’s Health Insurance Program**
A program for uninsured children in the United States that is administered by CMS in conjunction with the Health Resources and Services Administration.

**Stop Loss**
Maximum out-of-pocket expenses an insured must pay due to deductibles and co-payments.

**Stop Loss Insurance**
Insurance purchased by an insurance company or health plan from another insurance company to protect itself against losses. Reinsurance purchased to protect against the single overly large claim or the excessively high aggregated claim during a set period. Stop loss may also be used by providers when purchasing Malpractice, Workers Comp and Liability coverage.

**Subrogation**
Procedure where insurance company recovers from a third party when action resulting in medical expense was the fault of another person (e.g. auto accident). The recovery of the cost of services and benefits provided to the insured of one health plan when other parties are liable.

**Subscriber**
Person responsible for payment of premiums, or person whose employment is the basis for membership in a health plan. Employment group or individual that contracts with an insurer for medical services. Usually synonymous with enrollee, covered individual or member.

**Subsection (d) Hospital**
A hospital that must abide by the general 72-hour rule. A subsection (d) hospital is any hospital in the fifty states, the District of Columbia, or Puerto Rico other than a psychiatric hospital, a rehabilitation hospital, a children's hospital, a long term hospital, or a cancer hospital. Therefore, general acute care hospitals are subsection (d) hospitals.

**Supplemental Security Income (SSI)**
A federal cash assistance program for low-income, aged, blind and disabled individuals established by Title XVI of the Social Security Act. States may use SSI income limits to establish Medicaid eligibility.
Teaching Hospital
A hospital providing undergraduate or graduate medical education, usually with one or more medical or dental internships and/or residency programs in affiliation with a medical school.

Tertiary Medicare Care
Highly sophisticated diagnostic and therapeutic services given to patients with complex and serious medical conditions. This type of care is usually rendered at teaching hospitals or at university affiliated hospitals.

Third – Party Payer
Any organization, public or private that pays or insures health or medical expenses on behalf or beneficiaries or recipients. An individual pays a premium for such coverage in all private and in some public programs; the payer organization then pays bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service, the individual or institution providing it and the organization paying for it.

Third - Party Payment
Payment by a financial agent such as an HMO, insurance company or government rather than direct payment by the patient for medical care services. The payment for health care when the beneficiary is not making payment, in whole or in part, in his own behalf.

Third Party Administrator (TPA)
An independent organization that provides administrative services including claims processing and underwriting for other entities, such as insurance companies or employers. Often insurance companies will contract as TPAs with other insurance companies or health plans. TPAs are not always insurance companies. TPAs are organizations with expertise and capability to administer all or a portion of the claims process. Self-insured employers will often contract with TPAs to handle their insurance functions. Insurance companies will sometimes outsource the claims, UR or membership functions to a TPA. Sometimes TPAs will only manage provider networks, only claims or only UR. Hospitals or provider organizations desiring to set up their own health plans will often outsource certain responsibilities to TPAs.

Title XIX (Medicaid)
The title of the Social Security Act that contains the principal legislative authority for the Medicaid program and therefore a common name for the program.

Title XVIII (Medicare)
The title of the Social Security Act that contains the principal legislative authority for the Medicare program and therefore a common name for the program.

Tort Reform
Legislative limits or changes or judicial reform of the rules governing medical malpractice lawsuits and other lawsuits. Tort simply refers to lawsuit. Reform implies that limits can be
placed on individual rights to sue or on the amounts or situations for which they can seek relief. Tort is considered to be by some as the primary cause of the rising costs of health care. Reform, then, would lower health care costs. On the other hand, patient advocates are against tort reform, claiming that the health care industry and managed care industries require monitoring and that lawsuits keep health care providers and payers in check. Congress debates tort reform each session, but, to date, few restrictions have been placed on tort cases.

**Transfer**
Refers to a patient who was admitted to a facility as a transfer from a previous facility where he or she was an inpatient.

**Triage**
Triage is the act of categorizing patients according to acuity and by doing so, determining who needs services first. Most commonly occurs in emergency rooms, but, can occur in any healthcare setting. Classification of ill or injured persons by severity of condition. Designed to maximize and create the most efficient use of scarce resources of medical personnel and facilities. Managed care organizations, health plans and provider systems are setting up programs or clinics called “triage centers”. These centers serve as an extension of the utilization review process, as diversions from emergency room care or as case management resources. These triage centers also serve to steer patients away from more costly care. Triage can also be handled on the telephone and be called a pre-authorization center, crisis center, call center or information line.

**Triage Providers**
Medical personnel who classify ill or injured persons by severity of condition. When providers or insurance companies manage triage on the telephone, this service may be referred to as pre-authorization center, crisis center, and call center or information line. Providers may also managed triage in emergency rooms, walk-in centers, disaster scenes or outreach centers.

**Triple Option Plan**
A triple option plan, which is usually offered either by a single insurance plan or as a joint venture among two or more insurance carriers, provides subscribers or employees with a choice of HMO, PPO, or traditional health insurance plans. It is also called a cafeteria plan (or flexible benefit plan) because of the different benefit plans and extra coverage options provided through the insurer or third-party administrator. Triple option plans are intended to prevent the problem of covering members who are sicker than the general population. A risk pool is created when a number of people are grouped for insurance purposes. The cost of health care coverage is determined by employees’ health status, age, sex and occupation.

**UB-04**
Uniform Billing Code of 2004 – Bill form used to submit hospital insurance claims for payment by third parties. Similar to HCFA 1500, but reserved for the inpatient component of health services.
Unbundling
The practice of providers billing for a package of health care procedures on an individual basis when a single procedure could be used to describe the combined service.

Uncompensated Care
Service provided by physicians and hospitals for which no payment is received from the patient or from third party payers. Some costs for these services may be covered through cost-shifting. Not all uncompensated care results from charity care. It also includes bad debts from persons who are not classified as charity cases but who are unable or unwilling to pay their bill.

Underinsured
People with public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay.

Underwriting
Process of selecting, classifying, analyzing and assuming risk according to insurability. The insurance function bearing the risk of adverse price fluctuations during a particular period. Analysis of a group that is done to determine rates or to determine whether the group should be offered coverage at all.

Uninsured
People who lack public or private health insurance.

Update
All information entered in the system is accepted.

Urgent Admission
That patient requiring admission to the hospital for a clinical condition that would require admission for diagnosis and treatment within 48 hours, otherwise the patient’s life or well being could be threatened. (The other two categories for admission are emergency or elective.)

Usual, Customary and Reasonable (UCR) Charges
The amount a health plan will recognize for payment for a particular medical procedure. It is typically based on what is considered “reasonable” for that procedure in your service area. Commonly charged fees for health services in a certain area. The use of fee screens to determine the lowest value of provider reimbursement based on: (1) the provider’s usual charge for a given procedure, (2) the amount customarily charged for the service by other providers in the area (often defined as a specific percentile of all charges in the community), and (3) the reasonable cost of services for a given patient after medical review of the case. Most health plans provide reimbursement for usual and customary charges, although no universal formula has been established for these rates.

Utilization
Use of services and supplies. Utilization is commonly examined in terms of patterns or rates of use of a single service or type of service such as hospital care, physician visits, and prescription drugs. Measurement of utilization of all medical services in combination is usually done in terms of dollar expenditures. Use is expressed in rates per unit of population at risk for a given period such as the number of admissions to the hospital per 1,000 person over age 65 per year, or the number of visits to a physician per person per year for an annual physical.

**Utilization Management (UM)**
The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria. Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM usually includes new actions or decisions based on the overall analysis of the utilization.

**Utilization Review (UR)**
A formal review of utilization for appropriateness of health care services delivered to a member on a prospective, concurrent or retrospective basis. In a hospital, this includes review of the appropriateness of admissions, services ordered and provided, length of a stay, and discharge practices, both on a concurrent and retrospective basis. A peer review group, or a public agency can do utilization review. UR is a method of tracking, reviewing and rendering opinions regarding care provided to patients. Usually UR involves the use of protocols, benchmarks or data with which to compare specific cases to an aggregate set of cases. Those cases falling outside the protocols or range of data are reviewed individually. Managed care organizations will sometimes refuse to reimburse or pay for services that do not meet their own sets of UR standards. UR involves the review of patient records and patient bills primarily but may also include telephone conversations with providers. The practices of pre-certification, re-certification, retrospective review and concurrent review all describe UR methods.

**Verification**
The process performed by registrars to verify and interpret the patient’s insurance coverage prior to or at the time of registration.

**Visit**
When a patient returns to the hospital to be seen by a physician for the same illness or injury they had been previously registered for.

**Vital Statistics**
Statistics relating to births, deaths, marriages, health, and disease. Vital statistics for the United States are published by the National Center for Health Statistics. Vital statistics can be obtained from CDC, state health departments, county health departments and other
agencies. An individual patient’s vital statistics in a health care setting may also refer simply to blood pressure, temperature, height and weight.

Waiting Periods
The length of time an individual must wait to become eligible for benefits for a specific condition after overall coverage has begun.

Waiver
Approval that the Center for Medicare and Medicaid Services, the federal agency that administers the Medicaid program, may grant to state Medicaid programs to exempt them from specific aspects of Title XIX, the federal Medicaid law. Most federal waivers involve loss of freedom of choice regarding which providers beneficiaries may use, exemption from requirements that all Medicaid programs be operated throughout an entire state, or exemption from requirements that any benefit must be available to all classes of beneficiaries.

Wholly Owned or Operated
Within the 72-hour rule, an entity is "wholly owned or operated" if the hospital is the sole owner or operator of the entity. A hospital does not have to exercise administrative control over the facility in order to operate it. A hospital is the sole operator of a facility if it is exclusively responsible for implementing the policies of the facility, including oversight of routine operation, even if the hospital does not have the power to make the policies. An entity that is "wholly owned or operated" by a hospital that is subject to the 72-hour rule must also comply with the 72-hour rule.

Withhold
Portion of a claim deducted and held by a health plan before payment is made to a capitated physician. A form of compensation whereby a health plan withholds payment to a provider until the end of a period at which time the plan distributes any surplus based on some measure of provider efficiency or performance.

Workers’ Compensation
A state-mandated program providing insurance coverage for work related injuries and disabilities. Several states have either enacted or are considering changes to the Workers Compensation Laws to allow employers to cover occupational injuries and illnesses within their own existing group medical plans. Some employers pay premiums to the sate or to insurance companies for this coverage. Others are self-funded and use third party case management or administrative services to manage this processes.
Chapter 8 – Resources
RESOURCES

http://health.state.ga.us/programs/cms/
http://www.bcbsga.com/home-providers.html
http://www.cahabagba.com
http://www.cms.gov/
http://www.dch.georgia.gov/shbp
http://www.dfcs.dhr.georgia.gov/portal/site/DHS-DFCS/
http://www.dhr.georgia.gov/
http://www.djj.state.ga.us/FacilitiesPrograms/DistrictsMain.shtml
http://www.humana-military.com
http://www.slideshare.net/karna.indian/cms-1450-ub04-instructions-presentation
https://www.oxhp.com/secure/materials/COB_FAQ_Brochure.pdf
http://www.staysmartstayhealthy.com/health_insurance_deductibles
http://health.howstuffworks.com/medicine/healthcare/insurance/deductible-copay.htm
http://questions.medicare.gov/app/answers/detail/a_id/2305/session/L3NpZC9zMTJaVFh1aw%3D%3D