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Championship Revenue Cycle:
Passion & Purpose

Revenue Cycle Front End: Patient Access Tips, Tricks and How it Impacts the Claim

Thursday, January 18th, 2018
Gillette Stadium Clubhouse

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Senior Manager, Healthcare Consulting
Baker Newman Noyes

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AGENDA FOR TODAY

- Understand how patient access fits into the revenue cycle
- Importance of accurate information intake
- How patient access impacts the UB04 (claim)
- Understanding the basics of Medicare

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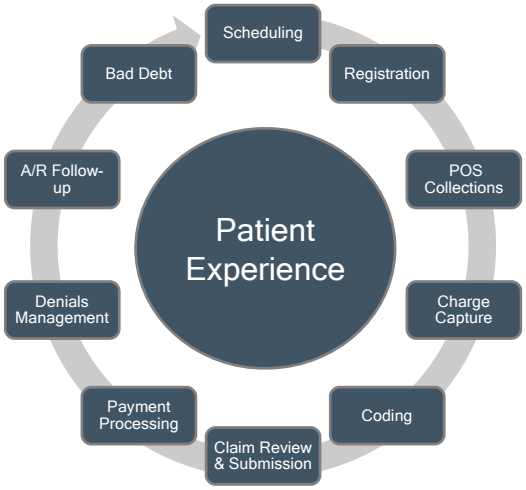
REVENUE CYCLE OPERATIONS



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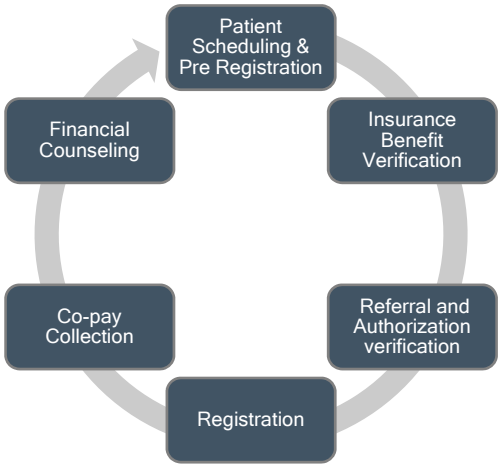
PATIENT ACCESS CYCLE



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THE BEGINNING

Patient Access is the very first point of contact patients have with your organization

- One of the **most important** functions in the revenue cycle
- Can significantly make or break the patient experience
- Incorrect intake can have downstream impacts

DOMINO EFFECT

- Incorrect information will lead to:
  - Denials: eligibility, medical necessity, authorization, etc.
  - Incorrect payment
  - Potentially larger out of pocket responsibility for patient
  - Incorrect internal reporting: ex: contract management
  - Duplicate medical record numbers
- Adverse patient satisfaction

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DUTIES OF PATIENT ACCESS

- According to the National Association of Healthcare Access Management, Patient Access is responsible for the following:
  - Customer Service
  - Positive identification of the patient
  - Providing information to the patient/ family
  - Help determine the needs of the patient
  - Pre-admission services
  - Scheduling of resources and services
  - Pre-certification of insurance

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DUTIES OF PATIENT ACCESS (CONT)

- Distribute and/or obtain signatures on required documents
  - Patient Rights
  - Notice of Privacy
  - Important Message from Medicare
  - Consents
  - Waivers
- Collection of accurate demographics
- MSPQ
- Medical Necessity verification
- Point of service collections

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CUSTOMER SERVICE

CUSTOMER SERVICE

- Patient Access is the first point of contact
  - YOU SET THE TONE! You are making the first impression of the organization
- Remember patients are coming in for a variety of reasons and will range in emotion and behavior

CUSTOMER SERVICE (CONT)

- The golden rule - treat others the way you would want to be treated
  - Smile, listen, make good eye contact, asking patients what name they like to go by and using their preferred name, demonstrate compassion, be aware of your body language
  - Medical centers can be confusing to navigate, be prepared to give good directions or escort the patient if you have the ability to

CUSTOMER SERVICE (CONT)

- Avoid using medical terminology, use simple English when possible
- Be an active listener
- Repeat back questions so the patient knows you understand their concern
- Be patient

INTERVIEWING THE PATIENT

REGISTRATION INTERVIEW WITH PATIENT

- Address
- Phone number
- DOB
- Social Security Number
- Primary language
- Employer information
- Ethnicity/race
- Emergency contact information
- Religion and church affiliation
- Reason for visit
- Guarantor and subscriber information
- Insurance information
- MSPQ
- Attending, primary and referring physician
- Other information: Email, Advance directives, Allergies, Communicable Diseases

INTERVIEW (CONT)

- Once the patient has been found in the system, do not simply read the information and ask if it is correct
- Have the patient state the information to you
  - This ensures that nothing has truly changed and you truly have the correct person
  - Leads to inaccuracies
  - Could lead to identity theft
  - Could potentially disclose PHI

INTERVIEW (CONT)

- Insurances: Understand what is contracted with the organization
- Under-insured: Know if there is a free care program and who to refer the patient to
- Uninsured: Does your organization offer self-pay/prompt pay discounts?
- Liability claims: How does your organization handle
  - Auto accidents
  - Workers comp
  - Other accidents

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DOCUMENTS THAT REQUIRE SIGNATURES

- Consent for treatment (general consent)
- Authorization to release information to the payer
- Assignment of benefits by the patient to provider
- HIPPA Privacy notification
- Important Messages from Medicare
- Advance Directives

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ADVANCE DIRECTIVES

- Definition: a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor
  - A Health Care Advance Directive Form is a standard form that helps individuals develop their advance directive
  - Hospital requirements - conditions of participation with Medicare
    - Maintain written policies
    - Ask patients at or near time of admission if they have completed an advance directive
    - Provide information about advance directives to patients and the community
    - Provide the means for patients to help create these documents

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SELECTING THE CORRECT INSURANCE

- Organizations payer master can be complex.
  - Understand what the most common insurances in the area are
  - There should be continuous communication with patient access staff when modified

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SELECTING THE CORRECT INSURANCE (CONT)

- Selecting the wrong payer could lead to reporting errors
  - Is the correct A/R rep following up on the claim
  - Is the contract management system calculating expected reimbursement correctly

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MEDICAL NECESSITY CHECKING

- Does the service pass Medical Necessity?
  - NCD/LCD
  - Other payer policies
- Does an ABN or waiver need to be issued
  - If Medicare; is the service noncovered?
    - Dental, cosmetic, voluntary sterilization
  - Is the patient aware of the cost of the service?

REGULATIONS TO BE AWARE OF

- Americans with Disabilities Act of 1990
  - Is your patient hearing impaired?
- Emergency Medical Treatment and Active Labor Act (EMTALA)
  - Patients need to be triaged by a clinician to determine degree of illness before discussing financial method of payment
  - This does not prevent from asking the patient for money, but it needs to be done in a manner that does not prevent care from being delivered
  - In an ED setting best practice is to wait until the end of the encounter to collect co-pay

REGULATIONS (CONT)

- Red Flag regulations
  - Warning signs to prevent identity theft
    - Suspicious documents
    - Patient gives information that does not match what you have in the system
    - Suspicious activities such as mail being returned multiple times and patient continues to give same address
  - Covers other items not covered under HIPAA (SSN, credit card information etc.)
- BE VIGILENT!!!

IDENTIFY THE CORRECT PATIENT

- Standard search process to identify if a medical record exists
  - Government issued ID to ensure patients identity
  - The Joint Commission: two identifiers must be utilized for positive identification
    - Correct spelling of names
    - Date of Birth
    - Social Security number
    - Previous names
- Selecting the wrong patient or creating a new patient can lead to many issues

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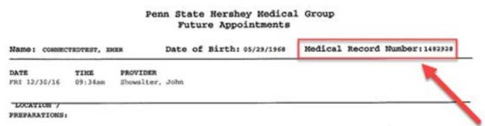
MEDICAL RECORD NUMBER

- The Medical Record number is a number assigned to the patient's legal medical record
  - Duplicates need to be merged: physicians may not have easy access to prior medical history in today EMR's and can lead to safety issues
  - Incorrect patient: the encounter will have to be moved - easy in paper world, electronic… different story


Penn State Hershey Medical Group
Future Appointments

Name: [illegible] Date of Birth: 05/29/1968 Medical Record Number: 1482928

DATE	TIME	PROVIDER
FRI 12/30/16	09:34am	Showalter, John

LOCATION /
PREPARATIONS:

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REGULATIONS (CONT)

- Health Insurance Portability & Accountability Act of 1996 (HIPAA)
  - Goal is to protect patients private information
  - Credit cards can be replaced, medical records cannot
- According to Health and Human Services:
  Specifically, covered entities must:
  - Ensure the confidentiality, integrity, and availability of all e-PHI they create, receive, maintain or transmit
  - Identify and protect against reasonably anticipated threats to the security or integrity of the information
  - Protect against reasonably anticipated, impermissible uses or disclosures
  - Ensure compliance by their workforce

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PRIVACY - WHAT CAN YOU DO?

- Lock your computer
- Make sure your monitor is not in anyone's (employee or patients) line of site
- If your monitor is in someone's line of site request monitor privacy screen
- Do not discuss patients in public areas
- When talking to a patient, do not speak louder than needed
- When sending patient information, always use secure e-mail and test your fax number
- Keep paper PHI locked and shred when done

THE UB-04

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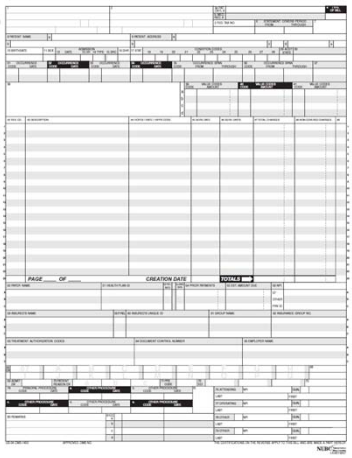
THE UB-04

- The CMS-1450 commonly known as the UB-04
- Facility claim
- Patient access has one of the most important roles in having this form filled out correctly



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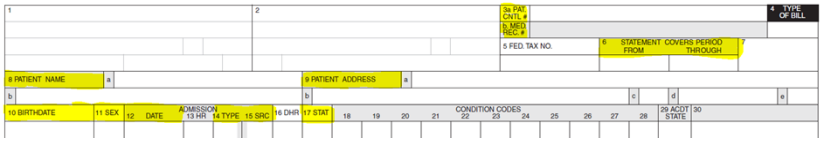
THE UB-04 (CONT)

- 3a: patient control number- patient account number assigned at registration
- 3b: medical record number of patient
- 6: encounter admission through discharge date
- 8 a-b: patient first and last name
- 9 a-e: patient address
- 10: birthdate
- 11: sex
- 12: admission date
- 14: admission type
- 15: admission source
- 17: discharge status



BAKER NEWMAN NOYES

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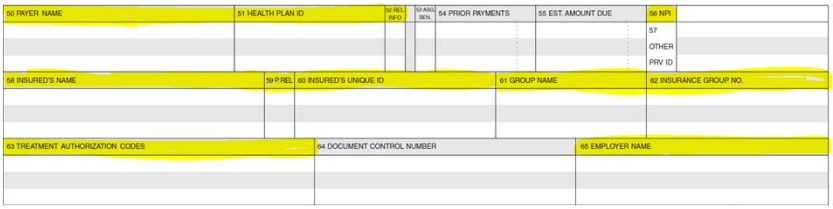
THE UB-04 (CONT)

- 50: Primary through tertiary payers
- 51: ID's associated with each plan
- 52: release of information on file for each
- 56: NPI of facility rendering services
- 58: Insured's name
- 59: relation of patient to policy holder
- 60: Insured's Unique Identifier
- 61: Insured Group Name
- 62: Insured Group Number
- 63: Authorization codes
- 65: Employer name
- 76: Attending provider



ADMISSION TYPE- FL 14

1	Emergency	The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room
2	Urgent	The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation.
3	Elective	The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.
4	Newborn	Use of this code necessitates the use of a Special Source of Admission codes.
5	Trauma Center	Visits to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.
6-8	Reserved for National Assignment	
9	Information Not Available	Visits to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or verified by the American College of Surgeons and involving a trauma activation.

ADMISSION SOURCE - FL 15

The provider enters the code indicating the source of the referral for this admission or visit

1	Non-healthcare Facility Point of Origin ▪ Inpatient: The patient was admitted to this facility. ▪ Outpatient: The patient presents to this facility for outpatient services. This includes patients coming from home or the workplace and patients receiving care at home (such as home health services)
2	Clinic or Physician's Office ▪ Inpatient: The patient was admitted to this facility. ▪ Outpatient: The patient presented to this facility for outpatient services.
3	Reserves for assignment by the NUBC

ADMISSION SOURCE - FL 15 (CONT)

4	Transfer from a hospital (different facility *) ▪ Inpatient: The patient was admitted to this facility as a transfer from a different acute care facility where they were an inpatient or outpatient. ▪ Outpatient: The patient was referred to this facility as an from an acute care facility
5	Transfer from a SNF, ICF, ALF or NF ▪ Inpatient: The patient was admitted to this facility as a transfer from a SNF, ICF, ALF where they were a resident. ▪ Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services from a SNF, ICF, ALF or NF where he or she was a resident.
6	Transfer from Another Health Care Facility ▪ Inpatient: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list. ▪ Outpatient: The patient presented to this facility for services from another health care facility not defined elsewhere in this code list where he or she was an inpatient or outpatient.

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ADMISSION SOURCE - FL 15 (CONT)

7	Reserved for assignment by the NUBC
8	Court/Law Enforcement ▪ Inpatient: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative. ▪ Outpatient: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
9	Information Not Available: The means by which the patient was admitted to this hospital is not known.
A-C	Reserved for assignment by the NUBC

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ADMISSION SOURCE - FL 15 (CONT)

D	Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the payer
E	Transfer from Ambulatory Surgery Center * not valid for Medicare Claims • For Inpatient: The patient was admitted to this facility as a transfer from an ASC • For Outpatients: The patient presented to this facility for outpatient or referenced diagnostic services from an ASC
F	Transfer from Hospice Facility* not valid for Medicare Claims • For Inpatients: The patient was admitted to this facility as a transfer from a hospice facility • For Outpatients: The patient presented to this facility for outpatient or referenced diagnostic services from a hospice.
G - Z	Reserved for assignment by the NUBC.

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DISCHARGE STATUS - FL 17

- **Required**. (For all Part A inpatient, SNF, hospice, home health agency (HHA) and outpatient hospital services.) This code indicates the patient's status as of the "Through" date of the billing period (FL 6).

01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short-term general hospital for inpatient care
03	Discharged/transferred to SNF with Medicare certification in anticipation of covered skilled care
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to a designated cancer center or Children's Hospital

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DISCHARGE STATUS - FL 17 (CONT)

06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care
07	Left against medical advice or discontinued care
08	Reserved for assignment by the NUBC.
09	Admitted as an inpatient to this hospital
10-19	Reserved for assignment by the NUBC.
20	Expired
21	Discharged/Transferred to Court/Law Enforcement
22-29	Reserved for assignment by the NUBC.
30	Still a patient
31-39	Reserved for assignment by the NUBC.
40	Expired at home (hospice only)

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DISCHARGE STATUS - FL 17 (CONT)

41	Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)
42	Expired - place unknown (Hospice claims only)
43	Discharged/transferred to a federal health care facility.
44-49	Reserved for assignment by the NUBC.
50	Discharged/transferred to Hospice - home
51	Discharged/transferred to Hospice - medical facility
52-60	Reserved for assignment by the NUBC.

Championship Revenue Cycle:
Passion & Purpose

DISCHARGE STATUS - FL 17 (CONT)

61	Discharged/transferred within this institution to a hospital based Medicare approved swing bed.
62	Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital
63	Discharged/transferred to long term care hospitals
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharged/transferred to a Critical Access Hospital (CAH).
67-68	Reserved for assignment by the NUBC.
69	Discharged/transferred to a designated disaster alternative care site
70	Discharged/transferred to another typr of healthcare institute not defined elsewhere in this code list.
71-80	Reserved for assignment by the NUBC.
81-95	Planned Readmission codes

POINT OF SERVICE COLLECTION

POINT OF SERVICE COLLECTION

- Patients generally appreciate knowing what their out of pocket expenses are
- Verifying benefits and where in the deductible cycle the patient is
  - Deductible: the amount that is paid before insurance begins to pay
  - Co-payment: fixed amount paid once deductible is met
  - Co-insurance: % of service paid post deductible
- Allows patients to make informed decisions about their care

WHEN PAYMENT CAN BE REQUESTED

- Medicare Claims Processing Manual, Chapter 2 section 10.4
  - Provider may collect deductible or co-insurance amounts only where it appears that the patient will owe and where it is routine and customary policy to request similar pre-payments from non Medicare patients
  - The beneficiary must not be given cause to fear that admission or treatment will be denied for failure to make the advance payment.
  - Cannot violate EMTALA

THE MEDICARE PROGRAM

MEDICARE PROGRAM

Title 18 of the Social Security Act:

- People ages 65 or older
- People under the age of 65 with certain disabilities after a waiting period
  - ALS without a waiting period
- People of any age with End Stage Renal Disease (ESRD)

THE HEALTH INSURANCE PROGRAM

- Part A*
  Hospital Insurance helps cover medically necessary services:
  - Inpatient care in hospitals
  - Skilled nursing facility care
  - Home Health
  - Hospice
  - Automatic enrollment for those receiving social security

*Usually premium free; based on payment into FICA for at least 10 years

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THE HEALTH INSURANCE PROGRAM (CONT)

- Part B*
  Medical insurance helps pay for medically necessary services:
  - Doctors and other Professionals
  - Outpatient medical care:
    - PT, OT, ST, Lab, X-rays, etc.
    - Including some preventive care services

* Monthly premium; usually deducted from Social Security check, standard premium $134 or higher per month based on income

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ONE MUST HAVE PART B IF…

- If one wants to buy a Medigap
- If one wants to join a Medicare Advantage plan
- One is eligible for Tricare for Life or Champva
- VA benefits are separate from Medicare

2018 MEDICARE PATIENT COSTS

- Part A hospital inpatient deductible and coinsurance you pay:
  - $1,340 deductible for each benefit period
  - Days 1-60: $0 coinsurance for each benefit period
  - Days 61-90: $335 coinsurance per day of each benefit period
  - Days 91 and beyond: $670 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime)
  - Beyond lifetime reserve days: all costs
- Part B deductible and coinsurance
  - $183 per year. After your deductible is met, you typically pay 20% of the Medicare-approved amount or most doctor services (including most doctor services while you're a hospital inpatient), outpatient therapy, and durable medical equipment

MEDICARE CHOICES

- Currently two options for Medicare Health Insurance
  - Fee for Service (traditional Medicare)
    - Typically requiring an additional policy referenced as a supplemental insurance
  - Medicare Advantage
    - Sometimes referred to as Medicare Part C
      - Combines Part A and Part B benefits and usually has a Part D option
    - Another nontraditional way to get Medicare coverage
    - Managed by private companies
      - HMO's, PPO's, Private fee for service plans
    - Medicare pays the plan an amount for each members care
    - Variety of choices
      - Some with additional premiums and copay type options

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THE HEALTH INSURANCE PROGRAM

- Part D - Medicare helps pay for prescription drugs:
  - Optional election
    - Monthly premium based on different levels of coverage
    - Subject to deductible and copays
    - Deductibles, stop/loss provisions, State subsidy available for affordability
  - Must have Part A and/or Part B for traditional or Medicare Advantage coverage with drug benefits
  - Live in plans service area
  - Not be incarcerated

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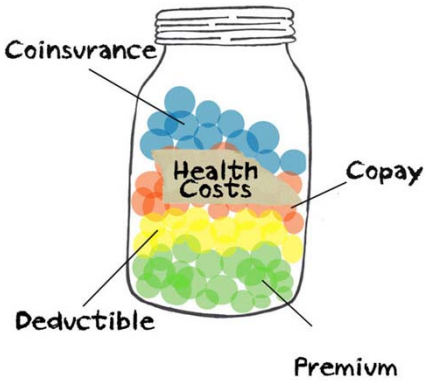
TRADITIONAL VS MEDICARE ADVANTAGE

- The traditional Medicare beneficiary
  - Will carry a supplemental insurance policy to assist with the high deductible and coinsurances
    - Sometimes referred to as a Medigap (Govt approved A-N)
      - Anthem, AARP, many commercial options, etc.
    - Mainecare eligible
- Medicare Advantage beneficiary will usually shoulder the out of pocket costs
  - Copays and deductibles

PEOPLE WITH LIMITED INCOME

- Medicaid
- CHIP
  - Children up to age 19
  - Family income too high for Medicaid



PEOPLE WITH LIMITED INCOME (CONT)

- Qualified Medicare Benefits (QMB)
  - Helps pay for Part A and B premiums and other cost sharing such as deductibles and coinsurance or copayments
- Specified Low Income Medicare Beneficiaries (SLMB)
  - Part B premiums only
- Qualified Individuals (QI)
  - Part B premiums only
- Qualified Disabled and Working Individuals (QDWI)
  - Part A premiums only

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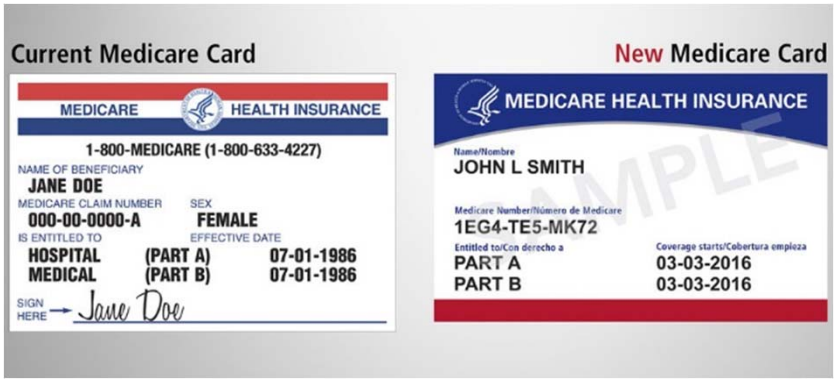
VERIFYING MEDICARE ELIGIBILITY AND ENTITLEMENT



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VERIFYING MEDICARE ELIGIBILITY AND ENTITLEMENT (CONT)

- Review the Medicare card:
  - Check entitlement for Part A/Part B
    - Verify benefits availability - where appropriate
    - Validate and report the name as displayed
    - Validate the health insurance claim number (HIC#)

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VERIFICATION/ADDITIONAL CONSIDERATIONS

- Medicare entitlement/benefits and coverage data
  - Consider using access to the Medicare remote system – FISS or your own tools for E-verification
    - Transaction called HIQA or also an ANSI 270/271
      - Entitlement
      - Hospital and SNF inpatient benefits
      - Medicare Secondary Payer History
      - Hospice and HMO enrollment information
      - Preventive service coverage and eligibility
- If manual process; request and copy the Medicare card
  - Copy it for future reference
    - Primary reason for denied payments is inability for CMS to identify patient

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BE MINDFUL…..

- Medicare Advantage Plans
  - *Important* - employ open-ended questions and active listening skills to identify this type of patient
- Medicare Advantage Plans
  - Use proprietary identification cards
  - Patients will still carry a Medicare Card
- *Confusion* - as a result of marketing practices or lack of patients' understanding of the insurance product
  - Patient may not have been provided sufficient MA Plan Information
    - Many MA plans require prior authorization

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INPATIENT BENEFITS - HOSPITAL AND SKILLED NURSING FACILITY/SWING BED

Benefit Periods

Term used by Medicare to measure benefit day usage:

1. Begins with the First Day of which a patient receives inpatient or skilled nursing care.
2. Ends with the close of 60 consecutive days when patient was not hospitalized or an inpatient of a skilled nursing facility.

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Passion & Purpose

INPATIENT BENEFITS - HOSPITAL AND SKILLED NURSING FACILITY/SWING BED (CONT)

For Each Benefit Period

- 60 full days
- 30 coinsurance days
- 60 optional lifetime reserve days

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HOW IT WORKS

PROVIDER	ADMIT	DISCHARGED	COVERED DAYS
20-0001	2/1/18	2/10/18	09
Medicare A Benefit Period	60/30/60	$1,340.00	1st
PROVIDER	**ADMIT**	**DISCHARGED**	**COVERED DAYS**
20-0010	3/1/18	3/15/18	14
Medicare Same Period	51/30/60		
PROVIDER	**ADMIT**	**DISCHARGED**	**COVERED DAYS**
20-0001	6/1/18	6/11/18	10
Medicare Benefit Period	60/30/60	$1,340.00	2nd

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HOW IT WORKS (CONT)

Benefits 60/30/60* - Patient Elects Usage

Provider 3/1/18/ - 7/4/18 125 covered days (1st benefit period)
- 60 full days - $1340.00
- 30 coinsurance days - (30 x $335.00) = $10,050.00
- 35 lifetime reserve days - (35 x $670.00) = $23,450.00

Patient or other insurance responsible for: $34,840.00

Provider 10/1/18 - 10/5/18 4 covered days (2nd benefit period)
Medicare 60/30/25 $1340.00

Patient responsible for $1340.00

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HOW IT WORKS (CONT)

PROVIDER	ADMIT	DISCHARGED	COVERED DAYS
20-0001	2/1/18	2/20/18	19
Medicare A benefits available on admission $1,340.00		1st Benefit Period	60/30/60 - 20/80
PROVIDER	**ADMIT**	**DISCHARGED**	**COVERED DAYS**
20-5000 (SNF)	3/10/18	5/1/18	
Medicare benefit period	Same Period -Different benefits but SNF prolongs		
PROVIDER	**ADMIT**	**DISCHARGED**	**COVERED DAYS**
20-0007	6/1/18	6/11/18	10
Medicare			41/30/60

MEDICARE SECONDARY PAYER

BAKER NEWMAN NOYES

Championship Revenue Cycle:
Passion & Purpose

MEDICARE SECONDARY PAYER

- CMS requires that providers investigate all options to determine MSP:
  - Use the CMS questionnaire or a provider specific facsimile
    - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf
  - Document ***each*** answer in the patient record
- The CMS questionnaire will instruct:
  - When to bill Medicare as the primary payer
  - How to identify the responsible insurer or entity for billing
- MSP Questionnaire as a hospital record:
  - Retain for 10 years

Championship Revenue Cycle:
Passion & Purpose

MEDICARE SECONDARY PAYER (CONT)

- Frequency of questionnaire:
  - Required for each patient/provider encounter except:
    - Referenced lab (specimen only)
    - Re-occurring accounts (repetitive services)
      - Information pertaining to MSP may not be greater than 90 days old

Championship Revenue Cycle:
Passion & Purpose

MEDICARE SECONDARY PAYER (CONT)

Special conditions affecting billing and payment in MSP situations:

- If a patient refuses to provide MSP screening information during registration
  - Patient will be found liable for payment of services
  - Report to Medicare on a UB claim form with a condition code "08"
    - Must be reported by hospital when billing
- Claim will be reviewed at the Medicare Contractor
  - Contractor will develop claims to determine responsibility
  - Checking diagnosis(s) against MSP information on CWF
  - Claim may become beneficiary liable

Championship Revenue Cycle:
Passion & Purpose

MEDICARE SECONDARY PAYER (CONT)

- A reply to each and every question is required
  - Answers/Defaults - rules for the recording of retirement dates
    - The beneficiary cannot recall his/her retirement date but knows it occurred prior to his/her Medicare entitlement dates, as shown on their Medicare card, hospitals report his/her Medicare A entitlement date as the date of retirement.
    - The beneficiary worked beyond his/her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his/her precise date of retirement.
      - The hospital determines it has been at least five years since the beneficiary retired, the hospital enters the retirement date as five years retrospective to the date of admission or service

Championship Revenue Cycle:
Passion & Purpose

MEDICARE SECONDARY PAYER (CONT)

- Patient Access serves a critical role in securing health insurance information from patients
  - Update insurance information at each encounter
  - Develop policies for making a good faith effort to determine the primary and secondary insurer
- Compliance with MSP regulations is mandatory
  - Noncompliance
    - May find for hospital violation of Mandatory Claim Submission Laws
    - Loss of contract to provide services to Medicare patients
    - Subject to close scrutiny and additional provider audits

Championship Revenue Cycle:
Passion & Purpose

MEDICARE SECONDARY PAYER (CONT)

- Common problems
  - Dates of retirement missing for patient and/or spouse
  - Questions not completely answered
  - MSP not completed for each encounter
  - Ambiguous replies to MSP questions
  - Information not reported on claim

MEDICARE SECONDARY PAYER (CONT)

Categories associated with MSP situations:

Group health plans:
- Working aged - 20 employees
- Disabled - 100 employees
- End Stage Renal Disease (ESRD) – coordination of benefits

• Workers' Compensation:
- Work-related injuries

• No-fault, liability and medical payment provisions of automobile insurance:
- Conditional payments can be allowed in special circumstances - billing office decision

• TORT Liability
- Malpractice
- Slip and Fall
- Other accidents

• Other Secondary Payer Situations:
- Federal Programs
  • PHS, VA, Black Lung

ADVANCED BENEFICIARY NOTICE

Championship Revenue Cycle:
Passion & Purpose

ADVANCED BENEFICIARY NOTICES (ABN)

- An ABN is a written notice (CMS R-131) given to a traditional Medicare patient before medical items or services are provided; when the Medicare provider believes the services are not covered.
  - Informs the patient that Medicare will not pay
  - Allows the patient to make an informed consumer decision
  - Allows the patient to better participate in health care decisions
- Form must be verbally reviewed with the patient or his/her representative
- Form must be signed, and the original notice retained
  - https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/BNI/

Championship Revenue Cycle:
Passion & Purpose

CHANGE MANAGEMENT (CONT)

"There can be no doubt that the statutes and provisions in question, involving Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase."

Federal Judge-Baltimore, MD

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