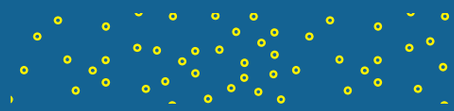

Medical Insurance

A Revenue Cycle Process Approach

Eighth Edition

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Brief Contents

Contents

Preface

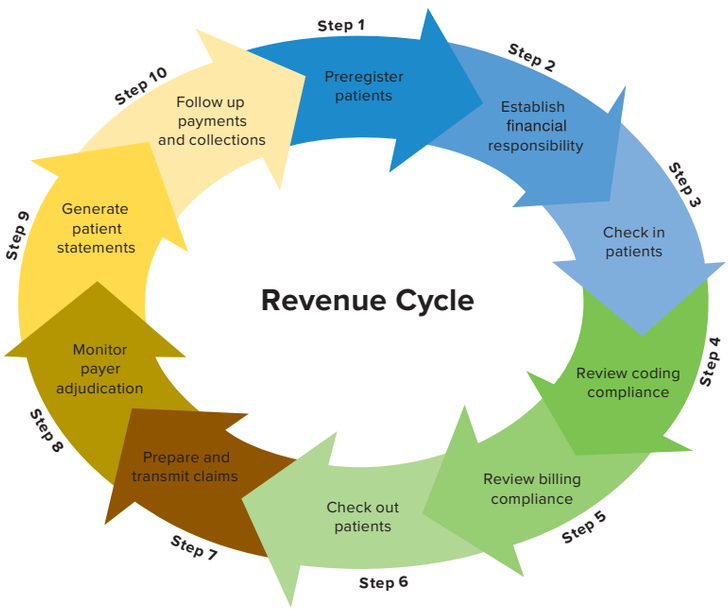
Follow the Money!

Medical insurance plays an important role in the financial well-being of every healthcare business. The regulatory environment of medical insurance is now evolving faster than ever. Changes due to healthcare reform require medical office professionals to acquire and maintain an in-depth understanding of compliance, electronic health records, medical coding, and more.

The eighth edition of *Medical Insurance: A Revenue Cycle Process Approach* emphasizes the **revenue cycle**–ten steps that clearly identify all the components needed to successfully manage the medical insurance claims process. The cycle shows how administrative medical professionals "follow the money."

Medical insurance specialists must be familiar with the rules and guidelines of each health plan in order to submit proper documentation. This ensures that offices receive maximum, appropriate reimbursement for services provided. Without an effective administrative staff, a medical office would have no cash flow!

The following are some of the key skills covered for you and your students in *Medical Insurance, 8e:*



Skills	Coverage
Procedural	**Learning** administrative duties important in medical practices as well as how to bill both payers and patients
Communication	**Working** with physicians, patients, payers, and others using both written and oral communication
Health information management	**Using** practice management programs and electronic health records technology to manage both patient records and the billing/collections process, to electronically transmit claims, and to conduct research
Medical coding	**Understanding** the ICD-10, CPT, and HCPCS codes and their importance to correctly report patients' conditions on health insurance claims and encounter forms as well as the role medical coding plays in the claims submission process
HIPAA/HITECH	**Applying** the rules of HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Economic and Clinical Health act) to ensure compliance, maximum reimbursement, and the electronic exchange of health information

Medical Insurance is available with McGraw-Hill Education's revolutionary adaptive learning technology, McGraw-Hill SmartBook®! You can study smarter, spending your valuable time on topics you don't know and less time on the topics you have already mastered. Succeed with SmartBook. . . . Join the learning revolution and achieve the success you deserve today!

Organization of *Medical Insurance, 8e*

An overview of the book's parts, including how they relate to the steps of the revenue cycle, follows:

Part	Coverage
1: Working with Medical Insurance and Billing	Covers Steps 1 through 3 of the revenue cycle by introducing the major types of medical insurance, payers, and regulators, as well as the steps of the cycle. Also covers HIPAA/HITECH Privacy, Security, and Electronic Health Care Transactions/Code Sets/Breach Notification rules.
2: Claim Coding	Covers Steps 4 through 6 of the revenue cycle while building skills in correct coding procedures, using coding references, and complying with proper linkage guidelines.
3: Claims	Covers Step 7 of the revenue cycle by discussing the general procedures for calculating reimbursement, how to bill compliantly, and preparing and transmitting claims.
4: Claim Follow-Up and Payment Processing	Covers Steps 8 through 10 of the revenue cycle by describing the major third-party private and government-sponsored payers' procedures and regulations along with specific filing guidelines. Also explains how to handle payments from payers, follow up and appeal claims, and correctly bill and collect from patients. This part includes two case studies chapters that provide exercises to reinforce knowledge of completing primary/secondary claims, processing payments from payers, and handling patients' accounts. The case studies in Chapter 15 can be completed using Connect for simulated exercises. The case studies in Chapter 16 can be completed using the CMS-1500 form.
5: Hospital Services	Provides necessary background in hospital billing, coding, and payment methods.

New to the Eighth Edition

Medical Insurance is designed around the revenue cycle with each part of the book dedicated to a section of the cycle followed by case studies to apply the skills discussed in each section. The revenue cycle now follows the overall medical documentation and revenue cycle used in practice management/electronic health records environments and applications.

Medical Insurance offers several options for completing the case studies at the end of Chapters 8–12 and throughout Chapter 15:

- **Paper Claim Form:** If you are gaining experience by completing a paper CMS-1500 claim form, use the blank form supplied to you (from the back of *Medical Insurance*) and follow the instructions in the text chapter that is appropriate for the particular payer to fill in the form by hand.
- **Connect Simulations:** The ability to understand and to use Electronic Health Records (EHR) systems are critical job skills and competencies required for employment in a Medical Office or Hospital. In the past, teaching students the hows and whys of using an EHR has been challenging. Live software solutions require complex installation and support, and often don't translate well into the classroom. Simulated educational solutions often fall short in giving students the realistic experience of working in real world scenarios.

  McGraw-Hill Education is proud to introduce **EHRclinic,** the educational EHR solution that provides the best of both worlds, both the experience of working in a

live, modern EHR application, along with the convenience and reliability of simulated educational solutions.

EHRclinic is integrated into **Connect, McGraw-Hill's** digital teaching and learning environment that saves students and instructors time while improving performance over a variety of critical outcomes.

For *Medical Insurance,* Connect provides simulated, auto-graded exercises in multiple modes to allow the student to use EHRclinic to complete the claims. If assigned this option, students should read the User Guide at www.mhhe.com/valerius as the first step, and then follow the instructions with each chapter's case studies. Note: some data may be prepopulated to allow students to focus on the key tasks of each exercise.

- **Connect CMS-1500 Form Exercises:** Another way to complete the claims exercises is by using the CMS-1500 form exercises in Connect if directed by your instructor. These exercises allow you to complete the necessary fields of the form in an auto-graded environment.
- Please note that starting with this edition, we will no longer be offering live Medisoft® or Medisoft simulations as part of the options.

Key content features include the following.

- **Pedagogy**
  - Learning Outcomes reflect the range of difficulty levels to teach and assess critical thinking about medical insurance and coding concepts and continue to reflect the revised version of Bloom's Taxonomy.
  - Objective end-of-chapter questions cover all Learning Outcomes.
- **HIPAA-Related Updates**
  - 2018 ICD-10-CM and CPT/HCPCS codes are included.
  - The new Notice of Privacy Practices (NPP) that addresses disclosures in compliance with HITECH is illustrated.
- **Key Chapter Changes**
  - **Chapter 1:** *New:* Thinking It Through 1.7. *Revised:* Thinking It Through 1.2. *Updated:* statistics and data in Figures 1.1 and 1.4; Compliance Guideline on ICD-10-CM implementation.
  - **Chapter 2:** *New:* two HIPAA/HITECH Tips on Texting and Plans Mandated; PHI on the cloud. *Updated:* four WWW features on HHS, Medical Notice of Privacy Practices, HHS Breach Notifications, and CMS HIPAA Enforcement. *Deleted:* old Figures 2.1, 2.2, and 2.6; information on the National Health Information Network.
  - **Chapter 3:** *Deleted:* old Figure 3.7.
  - **Chapter 4:** *Updated:* all ICD-10-CM codes and conventions for 2018; Figures 4.1 and 4.3; Case 4.1 in Applying Your Knowledge. *Deleted:* key term ICD-9-CM.
  - **Chapter 5:** *New:* Billing Tips on Category III Code Sunsets and Revised Guidelines Coming; symbol for telemedicine. *Updated:* all CPT codes, conventions, and modifiers for 2018; WWW features on CPT Updates, AMA Vaccine Code Updates, and Category II and III Updates; all cases in Applying Your Knowledge; Tables 5.2, 5.3, and 5.6; structure of E/M section. *Deleted:* symbol for moderate sedation.
  - **Chapter 6:** *New:* image for Figure 6.3. *Revised:* Figures 6.1 and 6.2. *Updated:* Case 6.1 in Applying Your Knowledge.
  - **Chapter 7:** *New:* key terms 5010A1 version and Healthcare Provider Taxonomy Code (HPTC); text for 5010A1 Version and the CMS-1500. *Revised:* Figure 7.1; art in Cases 7.2, 7.3, and 7.4. *Updated:* all conventions for completing the CMS-1500 and all Item Numbers; WWW features on POS Codes, Current Taxonomy Code Set, and All Administrative Code Sets for HIPAA Transactions. *Deleted:* old Figures 7.2, 7.3, 7.4, 7.5, 7.6, and 7.8; old Table 7.1; Billing Tip on How Many Pointers?

- **Chapter 8:** *New:* item in Thinking It Through 8.9. *Revised:* Figures 8.5, 8.7, 8.9, and 8.10; Case 8.4 introduction and art. *Updated:* high-deductible health plan deductibles; out-of-pocket limits for metal plans in section 8.5.
- **Chapter 9:** *New:* key terms Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Medicare Beneficiary Identifier (MBI), Quality Payment Program (QPP); Figure 9.1; WWW features on New Medicare Card Information and QPP; Medicare coverage text in section 9.3; Medicare incentives text in section 9.4. *Revised:* WWW feature on Beneficiary Preventive Services; Figures 9.7 and 9.9; Applying Your Knowledge introduction; Cases 9.1, 9.2, and 9.3. *Updated:* Billing Tips on Medicare Part A and Part B; WWW features on Medicare FFS Provider Web Pages Bookmark and Medicare Physician Fee Schedule; Thinking It Through 9.8. *Deleted:* key terms Medicare health insurance claim number (HICN), Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBPM); WWW feature on MPFS Online.
- **Chapter 10:** *New:* Thinking It Through 10.7. *Revised:* Figure 10.5; Applying Your Knowledge introduction; Cases 10.1 and 10.2. *Updated:* Medicaid info in intro; Medicaid changes in section 10.1; WWW feature on CHIP; websites in Table 10.1; covered services in section 10.5.
- **Chapter 11:** *New:* key terms Prime Service Area, TRICARE For Life, TRICARE Select; section 11.3 on TRICARE Prime; section 11.4 on TRICARE Select; Figure 11.1. *Revised:* Figure 11.2; Review Questions section; Applying Your Knowledge Introduction; Cases 11.1, 11.2, and 11.3. *Updated:* TRICARE regions in section 11.6. *Deleted:* key terms catchment area, nonavailability statement (NAS), TRICARE Extra, TRICARE Prime Remote, TRICARE Reserve Select, TRICARE Standard, TRICARE Young Adult (TYA); old Figures 11.1, 11.2, 11.3; Compliance Guideline on Preauthorization.
- **Chapter 12:** *Revised:* Figure 12.2; Applying Your Knowledge introduction; Cases 12.1 and 12.2.
- **Chapter 13:** *Revised:* Figures 13.1 and 13.8; Thinking It Through 13.3 and 13.5. *Updated:* key term claim adjustment group code (CAGC); Medicare appeals costs in section 13.6. *Deleted:* question D in Case 13.2.
- **Chapter 14:** Revised: chart in section 14.2; Thinking It Through 14.2; Figures 14.3 and 14.4. *Deleted:* old Figures 14.3a, 14.3b, and 14.3c; relating statements to the PMP section.
- **Chapter 15:** *Updated:* all CPT codes, conventions, and modifiers for 2018; *Updated:* Patient Account Number section so students no longer assign patient chart numbers; *Updated:* Dates for each case study.
- **Chapter 16:** *Updated:* Dates for each case study.
- **Chapter 17:** *New:* Figure 17.3; WWW feature on Medicare Secondary Payer Questionnaire; NUBC information on electronic claim submission. *Updated:* Compliance Guideline What Determines the Correct Code Set for Hospital Coding?

For a detailed transition guide between the seventh and eighth editions, visit the Instructor Resources in *Connect*.

Workbook for Use with Medical Insurance: A Revenue Cycle Process Approach, Eighth Edition (1-260-48914-0, 978-1-260-48914-9)

The *Workbook for Use with Medical Insurance* has excellent material for reinforcing the text content, applying concepts, and extending understanding. It combines the best features of a workbook and a study guide. Each workbook chapter enhances the text's strong pedagogy through:

- Assisted outlining—reinforces the chapter's key points
- Key terms—objective questions
- Critical thinking—questions that stimulate process understanding
- Guided web activities—exercises to build skill in locating and then evaluating information on the Internet
- Application of concepts—reinforcements and extensions for abstracting insurance information, calculating insurance math, and using insurance terms

The workbook matches the text chapter by chapter. It reinforces, applies, and extends the text to enhance the learning process.

Medical Coding Workbook for Physician Practices and 2018–2019 Edition (1-259-63002-1, 978-1-259-63002-6)

The *Medical Coding Workbook* provides practice and instruction in coding and using compliance skills. Because medical insurance specialists verify diagnosis and procedure codes and use them to report physicians' services, a fundamental understanding of coding principles and guidelines is the basis for correct claims. The coding workbook reinforces and enhances skill development by applying the coding principles introduced in *Medical Insurance, 8e,* and extending knowledge through additional coding guidelines, examples, and compliance tips. It offers more than seventy-five case studies that simulate real-world application. Also included are inpatient scenarios for coding that require compliance with *ICD-10-CM Official Guidelines for Coding and Reporting* sequencing rule as explained in Chapter 17 of the text.

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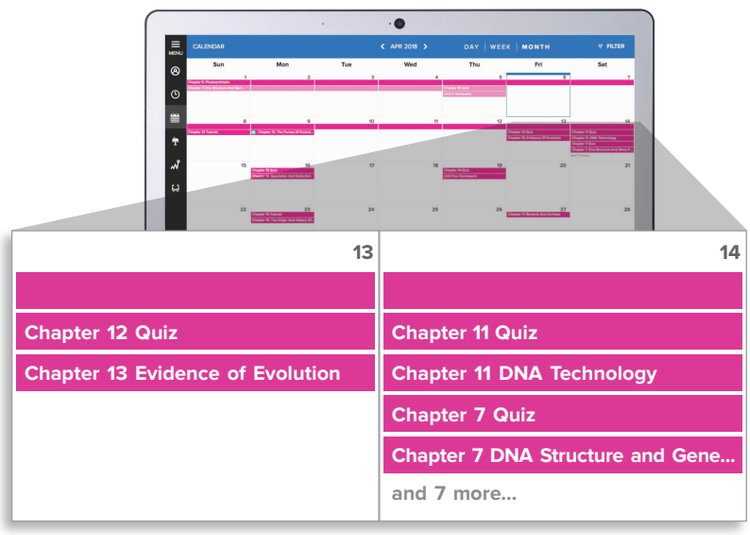

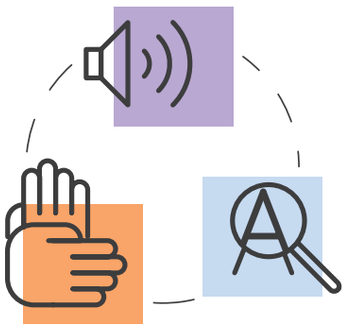

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CONNECT FOR MEDICAL INSURANCE, 8E

McGraw-Hill *Connect for Medical Insurance, 8e* will include:

- All end-of-section questions
- All end-of-chapter questions
- Interactive exercises, such as matching, sequencing, and labeling activities
- Testbank questions
- Simulated CMS-1500 exercises for Chapters 8–12 and 15
- Simulated EHRclinic exercises for Chapters 8–12 and 15

INSTRUCTORS' RESOURCES

You can rely on the following materials to help you and your students work through the material in the book; all are available in the Instructor Resources under the library tab in *Connect* (available only to instructors who are logged in to *Connect*).

Supplement	Features
Instructor's Manual (organized by Learning Outcomes)	• Lesson Plans • Answer Keys for all exercises
PowerPoint Presentations (organized by Learning Outcomes)	• Key Terms • Key Concepts • Accessible
Electronic Testbank	• Computerized and *Connect* • Word Version • Questions tagged for Learning Outcomes, Level of Difficulty, Level of Bloom's Taxonomy, Feedback, ABHES, CAAHEP, CAHIIM, and Estimated Time of Completion.
Tools to Plan Course	• Correlations of the Learning Outcomes to Accrediting Bodies such as ABHES, CAAHEP, and CAHIIM • Sample Syllabi • Conversion Guide between seventh and eighth editions • Asset Map—recap of the key instructor resources as well as information on the content available through *Connect*
EHRclinic Simulated Exercises Resources	• Implementation Guide • Technical Support Information • Steps for students completing the simulated exercises in Connect
CMS-1500 and UB-04 Forms	• PDFs of both forms

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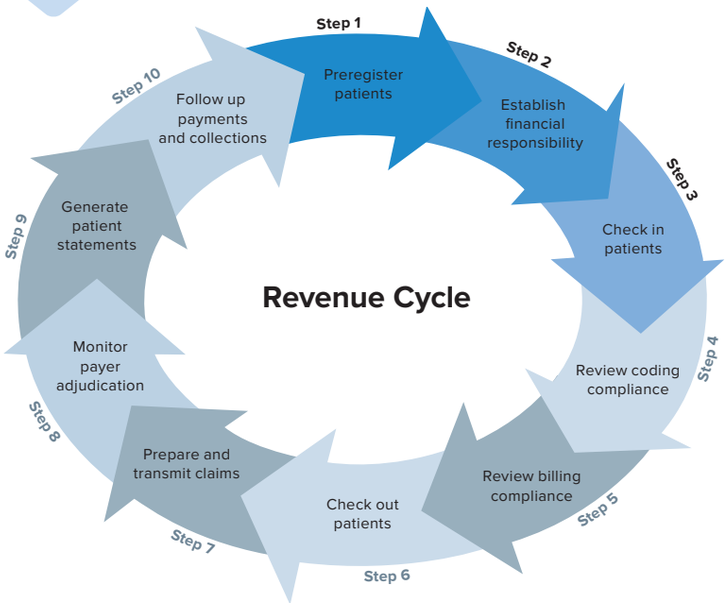
ELECTRONIC HEALTH RECORDS, HIPAA, AND HITECH: SHARING AND PROTECTING PATIENTS' HEALTH INFORMATION

2



Learning Outcomes

After studying this chapter, you should be able to:

- **2.1** Explain the importance of accurate documentation when working with medical records.
- **2.2** Compare the intent of HIPAA, HITECH, and ACA laws.
- **2.3** Describe the relationship between covered entities and business associates.
- **2.4** Explain the purpose of the HIPAA Privacy Rule.
- **2.5** Briefly state the purpose of the HIPAA Security Rule.
- **2.6** Explain the purpose of the HITECH Breach Notification Rule.
- **2.7** Explain how the HIPAA Electronic Health Care Transactions and Code Sets standards influence the electronic exchange of health information.
- **2.8** Describe the four final rules in the Omnibus Rule.
- **2.9** Explain how to guard against potentially fraudulent situations.
- **2.10** Assess the benefits of a compliance plan.

KEY TERMS

abuse
accountable care organization (ACO)
accounting of disclosure
Affordable Care Act (ACA)
audit
authorization
breach
breach notification
business associate (BA)
Centers for Medicare and Medicaid Services (CMS)
clearinghouse
code set
compliance plan
covered entity (CE)
de-identified health information
designated record set (DRS)
documentation
electronic data interchange (EDI)
encounter
encryption
evaluation and management (E/M)
fraud
Health Care Fraud and Abuse Control Program
health information exchange (HIE)
Health Information Technology for Economic and Clinical Health (HITECH) Act
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HIPAA Electronic Health Care Transactions and Code Sets (TCS)
HIPAA National Identifiers
HIPAA Privacy Rule
HIPAA Security Rule
informed consent
malpractice
meaningful use
medical documentation and revenue cycle
medical record
medical standards of care
minimum necessary standard
National Provider Identifier (NPI)
Notice of Privacy Practices (NPP)
Office for Civil Rights (OCR)
Office of E-Health Standards and Services (OESS)

Continued

KEY TERMS *(continued)*

Office of the Inspector General (OIG)
Omnibus Rule
operating rules
password
protected health information (PHI)
relator
transaction
treatment, payment, and healthcare operations (TPO)

Medical insurance specialists work with important clinical data as well as demographic data. Health plans need patient clinical information to assess the medical necessity of claims sent for payment. To provide the right level of care, other physicians need to know the results of tests and examinations that patients have already had. Keeping all patient data safe and secure is the job of everyone on the healthcare team. But it is no longer a job of managing stacks of paper files. Like shopping, buying tickets, banking, and sharing photos online, healthcare records are moving to a digital platform. Working in this environment requires knowledge of electronic health records and of the federal rules that regulate access to them.

2.1 Medical Record Documentation: Electronic Health Records

medical record file containing the documentation of a patient's medical history and related information

A patient's **medical record** contains facts, findings, and observations about that patient's health history. The record also contains communications with and about the patient. In a physician practice, the medical record begins with a patient's first contact and continues through all treatments and services. The record provides continuity and communication among physicians and other healthcare professionals who are involved in the patient's care. Patients' medical records are also used in research and for education.

Medical Records

Medical records, or charts, contain documentation of patients' conditions, treatments, and tests that are created and shared by physicians and other providers to help make accurate diagnoses and to trace the course of care.

COMPLIANCE GUIDELINE

Medical Standards of Care and Malpractice

Medical standards of care are state-specified performance measures for the delivery of healthcare by medical professionals. Medical **malpractice** can result when a provider injures or harms a patient because of failure to follow the standards.

malpractice failure to use professional skill when giving medical services that results in injury or harm

A patient's medical record contains the results of all tests a primary care physician (PCP) ordered during a comprehensive physical examination. To follow up on a problem, the PCP could refer the patient to a cardiologist, also sending the pertinent data for that doctor's review. By studying the medical record, the specialist treating a referred patient learns the outcome of previous tests and avoids repeating them unnecessarily.

documentation recording of a patient's health status in a medical record

Documentation means organizing a patient's health record in chronological order using a systematic, logical, and consistent method. A patient's health history, examinations, tests, and results of treatments are all documented. Complete and comprehensive documentation is important to show that physicians have followed the **medical standards of care** that apply in their state. Healthcare providers are liable (that is, legally responsible) for providing this level of care to their patients. The term *medical professional liability* describes this responsibility of licensed healthcare professionals.

medical standards of care state-specified performance measures for the delivery of healthcare

Patient medical records are legal documents. Good medical records are a part of the physician's defense against accusations that patients were not treated correctly. They clearly state who performed what service and describe why, where, when, and how it was done. Physicians document the rationale behind their treatment decisions. This rationale is the basis for medical necessity—the clinically logical link between a patient's condition and a treatment or procedure.

Advantages of Electronic Health Records

Because of their advantages over traditional paper records, electronic health records are now used by the majority of physician practices. *Electronic health records (EHRs)* are computerized lifelong healthcare records for an individual that incorporate data from all sources that treat the individual.

EHRs are different from electronic *medical* records (EMRs), which are computerized records of one physician's encounters with a patient over time that are the physician's legal record of patient care. EHRs are also different from a third type of electronic record, *personal health records (PHRs),* which are private, secure electronic files that are created, maintained, and controlled by patients and contain data such as their current medications, health insurance information, allergies, medical test results, family medical history, and more.

Documents in electronic health records may be created in a variety of ways, but they are ultimately viewed on a computer screen. For example, one general practice uses a number of medical-history-taking templates for gathering and recording "consistent history and physical information from patients." The computer-based templates range in focus from abdominal pain to depression, with from ten to twenty questions each. The on-screen templates are filled out in the exam rooms. Responsible providers then sign the entries, using e-signature technology that verifies the identity of the signer.

EHRs offer both patients and providers significant advantages over paper records:

- *Immediate access to health information:* The EHR is simultaneously accessible from computers in the office and in other sites such as hospitals. Compared to sorting through papers in a paper folder, an EHR database can save time when vital patient information is needed. Once information is updated in a patient record, it is available to all who need access, whether across the hall or across town.
- *Computerized physician order entry management:* Physicians can enter orders for prescriptions, tests, and other services at any time. This information is then transmitted to the staff for implementation or directly to pharmacies linked to the practice.
- *Clinical decision support:* An EHR system can provide access to the latest medical research on approved medical websites to help medical decision making.
- *Automated alerts and reminders:* The system can provide medical alerts and reminders for office staff to ensure that patients are scheduled for regular screenings and other preventive practices. Alerts can also be created to identify patient safety issues, such as possible drug interactions.
- *Electronic communication and connectivity:* An EHR system can provide a means of secure and easily accessible communication between physicians and staff and in some offices between physicians and patients.
- *Patient support:* Some EHR programs allow patients to access their medical records and request appointments. These programs also offer patient education on health topics and instructions on preparing for common medical tests, such as an HDL cholesterol test.
- *Administration and reporting:* The EHR may include administrative tools, including reporting systems that enable medical practices to comply with federal and state reporting requirements.
- *Error reduction:* An EHR can decrease medical errors that result from illegible chart notes because notes are entered electronically on a computer or a handheld device.

COMPLIANCE GUIDELINE

Documentation and Billing: A Vital Connection

The connection between documentation and billing is essential: If a service is not documented, it cannot be billed.

BILLING TIP

Medical Necessity

Services are medically necessary when they are reasonable and essential for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Such services must also be consistent with generally accepted standards of care.

BILLING TIP

Hybrid Record Systems

Although the majority of physician practices use EHRs, most also still have paper records. The use of electronic along with paper records is called a *hybrid record system.*

Nevertheless, the accuracy of the information in the EHR is only as good as the accuracy of the person entering the data; it is still possible to click the wrong button or enter the wrong letter.

Documenting Encounters with Providers

Every patient **encounter**—the meeting, face-to-face or via telephone or emessaging, between a patient and a provider in a medical office, clinic, hospital, or other location—should be documented with the following information:

encounter visit between a patient and a medical professional

- Patient's name
- Encounter date and reason
- Appropriate history and physical examination
- Review of all tests that were ordered
- Diagnosis
- Plan of care, or notes on procedures or treatments that were given
- Instructions or recommendations that were given to the patient
- Signature of the provider who saw the patient

In addition, a patient's medical record must contain:

- Biographical and personal information, including the patient's full name, date of birth, full address, marital status, home and work telephone numbers, and employer information as applicable
- Records of all communications with the patient, including letters, telephone calls, faxes, and e-mail messages; the patient's responses; and a note of the time, date, topic, and physician's response to each communication
- Records of prescriptions and instructions given to the patient, including refills
- Scanned records or original documents that the patient has signed, such as an authorization to release information and an advance directive
- Drug and environmental allergies and reactions, or their absence
- Up-to-date immunization record and history if appropriate, such as for a child
- Previous and current diagnoses, test results, health risks, and progress
- Records of referral or consultation letters
- Hospital admissions and release documents
- Records of any missed or canceled appointments
- Requests for information about the patient (from a health plan or an attorney, for example), and a detailed log of to whom information was released

Medicare's general documentation standards are shown in Table 2.1.

Evaluation and Management Services Reports

evaluation and management (E/M) provider's evaluation of a patient's condition and decision on a course of treatment to manage it

When providers evaluate a patient's condition and decide on a course of treatment to manage it, the service is called **evaluation and management (E/M).** Evaluation and management services may include a complete interview and physical examination for a new patient or a new problem presented by a person who is already a patient. There are many other types of E/M encounters, such as a visit to decide whether surgery is needed or to follow up on a patient's problem. An E/M service is usually documented with chart notes.

BILLING TIP

SOAP Format

A common documentation structure is the *problem-oriented medical record (POMR)* that contains *SOAP* notes—*S*ubjective information from the patient, and three elements the provider enters: *O*bjective data such as examination and/or test results, *A*ssessment of the patient's diagnosis, and *P*lan, the intended course of treatment, such as surgery or medication.

Table 2.1 Documentation Pointers

1.	Medicare expects the documentation to be generated at the time of service or shortly thereafter.
2.	Delayed entries within a reasonable time frame (twenty-four to forty-eight hours) are acceptable for purposes of clarification, error correction, and addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.
3.	The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference about their origin. Corrections or additions must be dated, preferably timed, and legibly signed or initialed.
4.	Every note stands alone—that is, the performed services must be documented at the outset.
5.	Delayed written explanations will be considered for purposes of clarification only. They cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For that, the medical record must stand on its own, with the original entry corroborating that the service was rendered and was medically necessary.
6.	All entries must be legible to another reader to a degree that a meaningful review can be conducted.
7.	All notes should be dated, preferably timed, and signed by the author.

History and Physical Examination A complete history and physical (H&P) is documented with four types of information: (1) the chief complaint, (2) the H&P examination, (3) the diagnosis, and (4) the treatment plan.

The provider documents the patient's reason for the visit, often using the patient's own words to describe the symptom, problem, condition, diagnosis, or other factor. For clarity, the provider may restate the reason as a "presenting problem," using medical terminology.

The provider also documents the patient's relevant medical history. The extent of the history is based on what the provider considers appropriate. It may include the history of the present illness (HPI), past medical history (PMH), and family and social history. There is usually also a review of systems (ROS), in which the provider asks questions about the function of each body system considered appropriate to the problem.

COMPLIANCE GUIDELINE

Informed Consent

If the plan of care involves significant risk, such as surgery, state laws require the provider to have the patient's **informed consent** in advance. The provider discusses the assessment, risks, and recommendations with the patient and documents this conversation in the patient's record. Usually, the patient signs either a chart entry or a consent form to indicate agreement.

informed consent process by which a patient authorizes medical treatment after a discussion with a physician

The provider performs a physical examination and documents the diagnosis—the interpretation of the information that has been gathered—or the suspected problem if more tests or procedures are needed for a diagnosis. The treatment plan, or plan of care, is described. It includes the treatments and medications that the provider has ordered, specifying dosage and frequency of use.

Other Chart Notes Many other types of chart notes appear in patients' medical records. Progress reports document a patient's progress and response to a treatment plan. They explain whether the plan should be continued or changed. Progress reports include:

- Comparisons of objective data with the patient's statements
- Goals and progress toward the goals
- The patient's current condition and prognosis
- Type of treatment still needed and for how long

Discharge summaries are prepared during a patient's final visit for a particular treatment plan or hospitalization. Discharge summaries include:

- The final diagnosis
- Comparisons of objective data with the patient's statements
- Whether goals were achieved
- Reason for and date of discharge
- The patient's current condition, status, and final prognosis
- Instructions given to the patient at discharge, noting any special needs such as restrictions on activities and medications

Procedural Services Documentation

Other common types of documentation are for specific procedures done either in the office or elsewhere:

- Procedure or operative reports for simple or complex surgery
- Reports for laboratory tests
- Radiology reports for the results of X-rays
- Forms for a specific purpose, such as immunization records, preemployment physicals, and disability reports

Using PM/EHRs: An Integrated Medical Documentation and Billing Cycle

The increased use of electronic health records in physician practices has changed office workflow. In a medical office, a flow of work that provides medical care to patients and collects payment for these services must be in place. When PM/EHRs are used, previous paper-based tasks, such as pulling file folders and making photocopies, are replaced by efficient electronic processes. The **medical documentation and revenue cycle** explains how using EHRs is integrated with practice management programs as the ten-step revenue cycle billing process is performed. This cycle is illustrated in Figure 2.1. The inner circle represents the revenue cycle, as explained in Chapter 1; the outer circle contains the medical documentation cycle.

medical documentation and revenue cycle circle that explains how using EHRs is integrated with practice management programs

As the illustration shows, the two cycles are interrelated. For example, a new patient phones for an appointment. During preregistration, both billing and clinical information must be collected during the phone call. From a billing perspective, the office wants to know whether the patient has insurance that will cover some or all of the cost of the visit or whether the patient will pay for the visit. From a health or medical perspective, the staff wants to know the reason the person needs to see the doctor, known as the *chief complaint,* or CC.

Following the revenue cycle billing steps that establish financial responsibility and handle check-in, the professional medical staff gather clinical information. Often a medical assistant inputs vital signs, such as the patient's temperature, pulse, respiration, blood pressure, height, and weight, in the EHR. The physician then documents the results of the physical examination, relevant history, and planned treatments.

As the medical documentation and billing cycle continues, so does the interaction between the two types of information. The physician or a medical coder assigns medical codes to the patient's diagnosis and procedures, and the charges for those procedures are determined. Based on this information, the biller reviews coding and billing compliance and checks out the patient. When the biller prepares and transmits claims, then documentation may be studied to support medical necessity during claim creation and later during adjudication if a payer requires it. During the steps of claim follow-up, patients' statements and payment and collections are documented, and the process of managing and retaining patient data according to regulations is carried out.

Medical insurance specialists are knowledgeable about this PM/EHR cycle so that they can access the clinical information they need as they complete claims and provide documentation in support of their medical necessity.

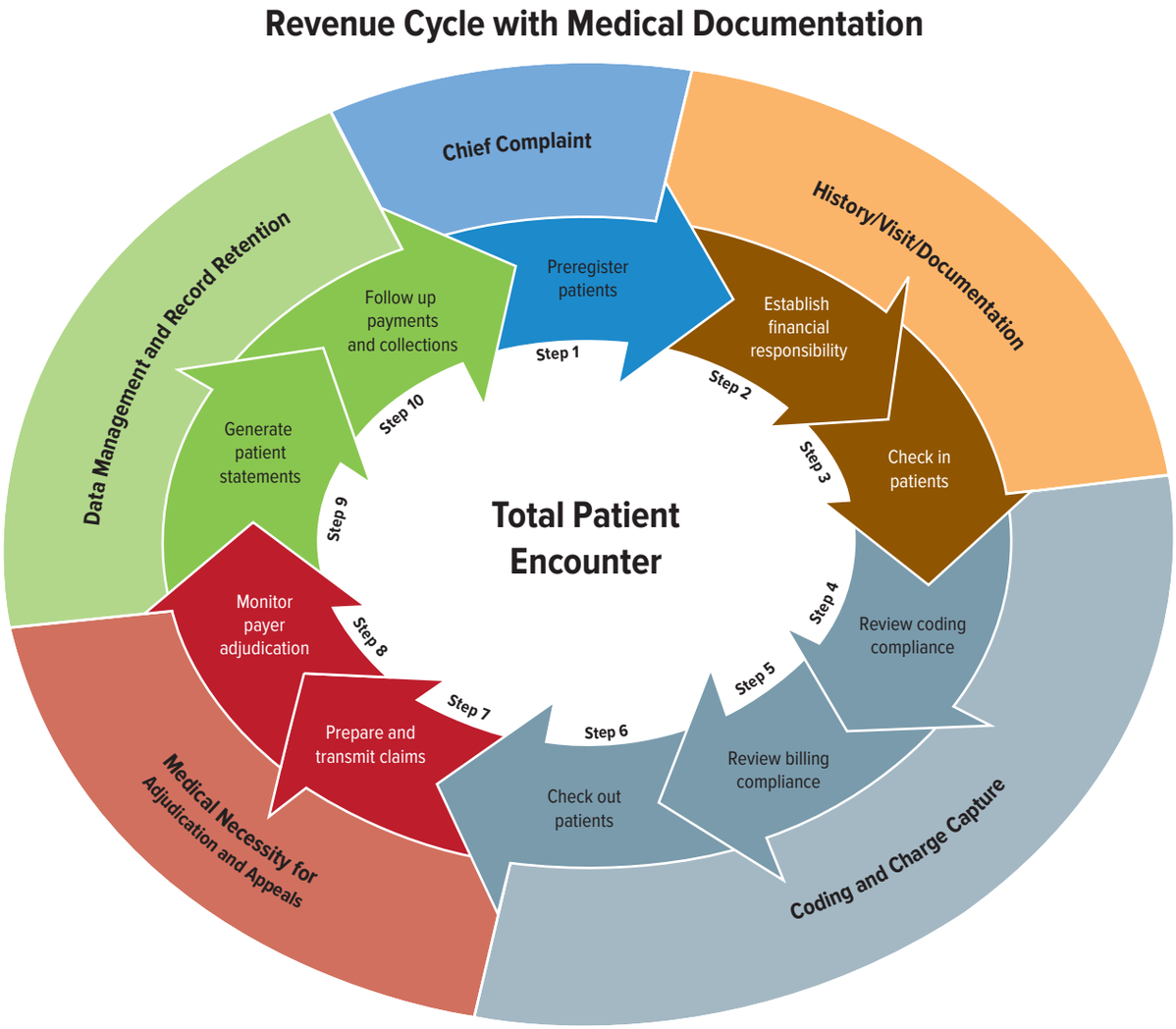


FIGURE 2.1 The Revenue Cycle with Medical Documentation

Source: Susan M. Sanderson, *Practice Management and EHR: A Total Patient Encounter For Medisoft® Clinical*, 1/e. © 2012 McGraw-Hill Companies, Inc. Reprinted with permission.

THINKING IT THROUGH 2.1

1. Review the following letter that is in the patient medical record of John W. Wu.

Nicholas J. Kramer, MD
2200 Carriage Lane
Currituck, CT 07886
Consultation Report
on John W. Wu
(Birth date 12/06/1949)
Dear Dr. Kramer:

(continued)

(concluded)

At your request, I saw Mr. Wu today. This is a seventy-seven-year-old male who stopped smoking cigarettes twenty years ago but continues to be a heavy pipe smoker. He has had several episodes of hemoptysis; a small amount of blood was produced along with some white phlegm. He denies any upper respiratory tract infection or symptoms on those occasions. He does not present with chronic cough, chest pain, or shortness of breath. I reviewed the chest X-ray done by you, which exhibits no acute process. His examination was normal.

A bronchoscopy was performed, which produced some evidence of laryngitis, tracheitis, and bronchitis, but no tumor was noted. Bronchial washings were negative.

I find that his bleeding is caused by chronic inflammation of his hypopharynx and bronchial tree, which is related to pipe smoking. There is no present evidence of malignancy.

Thank you for requesting this consultation.

Sincerely,

Mary Lakeland Georges, MD

A. What is the purpose of the letter?

B. How does it demonstrate the use of a patient medical record for continuity of care?

2. Consider the process of switching to EHRs from paper records in a practice having 2,000 patients. What are the pros and cons of moving all past patient records to the EHR at once versus doing so gradually?

CMS Home Page
www.cms.gov

2.2 Healthcare Regulation: HIPAA, HITECH, and ACA

To protect consumers' health, both federal and state governments pass laws that affect the medical services that must be offered to patients. To protect the privacy of patients' health information, additional laws cover the way healthcare plans and providers exchange this information as they conduct business.

Federal Regulation

Centers for Medicare and Medicaid Services (CMS) federal agency that runs Medicare, Medicaid, clinical laboratories, and other government health programs

The main federal government agency responsible for healthcare is the **Centers for Medicare and Medicaid Services,** known as **CMS** (formerly the Health Care Financing Administration, or HCFA). An agency of the Department of Health and Human Services (HHS), CMS administers the Medicare and Medicaid programs to more than 90 million Americans. CMS implements annual federal budget acts and laws such as the Medicare Prescription Drug, Improvement, and Modernization Act that has created help in paying for drugs and for an annual physical examination for Medicare beneficiaries.

CMS also performs activities to ensure the quality of healthcare, such as:

- Regulating all laboratory testing other than research performed on humans
- Preventing discrimination based on health status for people buying health insurance
- Researching the effectiveness of various methods of healthcare management, treatment, and financing
- Evaluating the quality of healthcare facilities and services

CMS policy is often the model for the healthcare industry. When a change is made in Medicare rules, for example, private payers often adopt a similar rule.

BILLING TIP

State-Mandated Benefits

States may require benefits that are not mandated in federal regulations. For example, some states mandate coverage of infertility treatments for women, and many states mandate chiropractic services coverage.

State Regulation

States are also major regulators of the healthcare industry. Operating an insurance company without a license is illegal in all states. State commissioners of insurance investigate consumer complaints about the quality and financial aspects of healthcare. State laws ensure the solvency of insurance companies and managed care organizations so that they will be able to pay enrollees' claims. States may also restrict price increases on premiums and other charges to patients, require that policies include a guaranteed renewal provision, control the situations in which an insurer can cancel a patient's coverage, and require coverage of certain diseases and preventive services.

BILLING TIP

Any Willing Provider

Many states have "any willing provider" laws that require a managed care organization to accept all qualified physicians who wish to participate in its plan. This regulation helps reduce the number of patients who have to switch physicians if they change from one plan to another.

HIPAA

The foundation legislation for the privacy of patients' health information is called the **Health Insurance Portability and Accountability Act (HIPAA) of 1996.** HIPAA contained five provisions called *titles* that focused on various aspects of healthcare:

Title I: Healthcare Access, Portability and Renewability

Title II: Preventing Healthcare Fraud and Abuse; Administrative Simplification

Title III: Tax-Related Health Provisions

Title IV: Application and Enforcement of Group Health Plan Requirements

Title V: Revenue Offsets

This law is designed to:

- Protect people's private health information
- Ensure health insurance coverage for workers and their families when they change or lose their jobs
- Uncover fraud and abuse
- Create standards for electronic transmission of healthcare transactions

Health Insurance Portability and Accountability Act (HIPAA) of 1996 federal act with guidelines for standardizing the electronic data interchange of administrative and financial transactions, exposing fraud and abuse, and protecting PHI

HITECH

The *American Recovery and Reinvestment Act (ARRA) of 2009,* also known as the *Stimulus Package,* contains additional provisions concerning the standards for electronic transmission of healthcare data. The most important rules are in the **Health Information Technology for Economic and Clinical Health (HITECH) Act,** which is Title XIII of the ARRA. This law guides the use of federal stimulus money to promote the adoption and meaningful use of health information technology, mainly using EHRs. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of HIPAA rules.

Health Information Technology for Economic and Clinical Health (HITECH) Act law promoting the adoption and meaningful use of health information technology

Meaningful Use

HITECH provides financial incentives to physicians, hospitals, and other healthcare providers. Physicians who adopt and use EHRs have been eligible for bonus payments.

To be eligible, providers must do more than simply purchase EHRs; they must demonstrate meaningful use of the technology. **Meaningful use** is the utilization of certified EHR technology to improve quality, efficiency, and patient safety in the healthcare system. Incentives for achieving meaningful use are divided into three stages. The government has specified a series of objectives that determine whether meaningful use requirements have been met. Table 2.2 lists the criteria for the first stage.

meaningful use utilization of certified EHR technology to improve quality, efficiency, and patient safety

Regional Extension Centers

Even with government financial incentives, successful implementation of EHRs is not expected to be quick or easy. Small practices, where most primary care is delivered, may

Table 2.2 Meaningful Use Objectives

Core Set
Use computerized physician order entry for medications
Implement drug-drug and drug-allergy interaction checks
Generate and transmit permissible prescriptions electronically
Record patient demographics
Maintain up-to-date problem list of current and active diagnoses
Maintain active medication list and active medication allergy list
Record and chart vital signs
Record smoking status
Implement one clinical decision support rule and have the ability to track compliance with rule
Calculate and transmit Centers for Medicare & Medicaid Services Quality Measure
Protect electronic copy of health information
Provide clinical summaries
Exchange key clinical information
Ensure privacy and security
Menu Set
Implement drug formulary checks
Incorporate clinical laboratory test results into EHR system as structured data
Generate patient lists
Send patient reminders
Provide timely electronic access to health information
Identify patient-specific information
Perform medication reconciliation
Provide summary of care
Submit electronic immunization data to registries or information systems
Submit laboratory results to public health agencies
Submit electronic syndromic surveillance data to public health agencies

lack the expertise and resources required to purchase, install, and use the new technology. Recognizing the challenges associated with implementing HIT, the HITECH Act called for the creation of *regional extension centers (RECs).* Patterned after the agriculture extension service the government created almost a century ago, the RECs offer information, guidance, training, and support services to primary care providers who are in the process of making the transition to an EHR system.

Health Information Exchanges

To meet meaningful use criteria, providers must also be able to exchange clinical information outside the organization. One of the ways that providers share information is

through the use of local, state, and regional health information networks. A **health information exchange (HIE)** enables the sharing of health-related information among provider organizations according to nationally recognized standards. Examples of the use of an HIE include sharing patient records with physicians outside the physician's own medical group, transmitting prescriptions to pharmacies, and ordering tests from an outside lab. The goal of an HIE is to facilitate access to clinical information for the purpose of providing quality care to patients.

health information exchange (HIE) enables the sharing of health-related information among provider organizations

Patient Protection and Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act, known as the **Affordable Care Act (ACA),** has had a number of impacts since its adoption in 2010. Reducing the number of people without health insurance has been a major result, as explained in the chapter on private payers. The ACA also fostered the formation and operation of **accountable care organizations (ACOs).** An ACO is a network of doctors and hospitals that shares responsibility for managing the quality and cost of care provided to a group of patients. A network could include primary care physicians, specialists, hospitals, home healthcare providers, and so on. By making this group of providers jointly accountable for the health of their patients, the program provides incentives to coordinate care in a way that improves quality and saves money by avoiding unnecessary tests and procedures.

Affordable Care Act (ACA) health system reform legislation that offers improved insurance coverage and other benefits

accountable care organization (ACO) network of doctors and hospitals that shares responsibility for managing the quality and cost of care provided to a group of patients

THINKING IT THROUGH 2.2

1. Discuss the purpose of HITECH as it relates to electronic health records.

BILLING TIP

Notices of Proposed Rulemaking

The process of transforming acts of Congress into law involves first a proposed rule, followed by a specified period of time for the public to comment, and then, at last, a Final Rule. This process can span a number of years from mandate to regulation to enforcement.

2.3 Covered Entities and Business Associates

Patients' medical records—the actual progress notes, reports, and other clinical materials—are legal documents that belong to the provider who created them. But the provider cannot withhold the information in the records unless providing it would be detrimental to the patient's health. The information belongs to the patient.

Patients control the amount and type of information that is released except for the use of the data to treat them or to conduct the normal business transactions of the practice. Only patients or their legally appointed representatives have the authority to authorize the release of information to anyone not directly involved in their care.

Medical insurance specialists handle issues, such as requests for information from patients' medical records. They need to know what information about patients' conditions and treatments can be released. What information can be legally shared with other providers and health plans? What information must the patient specifically

authorize to be released? The answers to these questions are based on HIPAA Administrative Simplification provisions and their expansion under HITECH and the ACA.

Congress passed the Administrative Simplification provisions partly because of rising healthcare costs. A significant portion of every healthcare dollar is spent on administrative and financial tasks. These costs can be controlled if the business transactions of healthcare are standardized and handled electronically.

Electronic Data Interchange

electronic data interchange (EDI) computer-to-computer exchange of data in a standardized format

transaction electronic exchange of healthcare information

The Administrative Simplification provisions encourage the use of **electronic data interchange (EDI).** EDI is the computer-to-computer exchange of routine business information using publicly available standards. Practice staff members use EDI to exchange health information about their practices' patients with payers and clearinghouses. Each electronic exchange is a **transaction,** which is the electronic equivalent of a business document.

EDI transactions are not visible in the same way as an exchange of paperwork, such as a letter. An example of a nonmedical transaction is the process of getting cash from an ATM. In an ATM transaction, the computer-to-computer exchange is made up of computer language that is sent and answered between the machines. This exchange happens behind the scenes. It is documented on the customer's end with the transaction receipt that is printed; the bank also has a record at its location.

Staying Current with HIPAA

HIPAA laws have a lengthy review process before being released as final rules. Future changes are expected. Medical insurance specialists need to stay current with those that affect their areas of responsibility.

The Three Administrative Simplification Provisions

The three parts of the *Administrative Simplification* provisions are:

1. *HIPAA Privacy Rule:* The privacy requirements cover patients' health information.
2. *HIPAA Security Rule:* The security requirements state the administrative, technical, and physical safeguards that are required to protect patients' health information.
3. *HIPAA Electronic Transaction and Code Sets Standards:* These standards require every provider who does business electronically to use the same healthcare transactions, code sets, and identifiers.

Complying with HIPAA

covered entity (CE) health plan, clearinghouse, or provider who transmits any health information in electronic form

Healthcare organizations that are required by law to obey HIPAA regulations are called **covered entities (CEs).** A covered entity is an organization that electronically transmits any information that is protected under HIPAA. Other organizations that work for the CEs must also agree to follow HIPAA rules.

Covered Entities

Under HIPAA, three types of CEs must follow the regulations:

- *Health plans:* The individual or group plan that provides or pays for medical care
- *Healthcare* **clearinghouses:** Companies that convert nonstandard transactions into standard transactions and transmit the data to health plans, and the reverse process
- *Healthcare providers:* People or organizations that furnish, bill, or are paid for healthcare in the normal course of business

clearinghouse company that converts nonstandard transactions into standard transactions and transmits the data to health plans, and the reverse process

HHS HIPAA Home Page
www.hhs.gov/hipaa

Many physician practices are included under HIPAA. Exempt providers are only those who do not send any claims (or other HIPAA transactions) electronically *and* do not employ any other firm to send electronic claims for them. Because CMS requires practices to send Medicare claims electronically unless they employ fewer than ten full-time or equivalent employees, practices have moved to electronic claims. Electronic claims have the advantage of being paid more quickly, too, so practices may use them even when they are not required.

COMPLIANCE GUIDELINE

Business Associate Contracts

Contracts with BAs should specify how they are to comply with HIPAA/HITECH in handling the practice's PHI.

Business Associates

Business Associates (BAs) are people or organizations that work for CEs but are not themselves CEs. Examples of BAs include law firms; outside medical billers, coders, and transcriptionists; accountants; collection agencies; and vendors of PHRs. BAs are as responsible as CEs for following HIPAA rules.

business associate (BA) person or organization that performs a function or activity for a covered entity

THINKING IT THROUGH 2.3

1. Describe the responsibilities of BAs.

2.4 HIPAA Privacy Rule

The HIPAA Standards for Privacy of Individually Identifiable Health Information rule is known as the **HIPAA Privacy Rule.** It was the first comprehensive federal protection for the privacy of health information. Its national standards protect individuals' medical records and other personal health information. Before the HIPAA Privacy Rule became law, the personal information stored in hospitals, physicians' practices, and health plans was governed by a patchwork of federal and state laws. Some state laws were strict, but others were not.

HIPAA Privacy Rule law regulating the use and disclosure of patients' protected health information

The Privacy Rule says that covered entities must:

- Have a set of privacy practices that are appropriate for its healthcare services
- Notify patients about their privacy rights and how their information can be used or disclosed
- Train employees so that they understand the privacy practices
- Appoint a privacy official responsible for seeing that the privacy practices are adopted and followed
- Safeguard patients' records

BA Agreements

All BAs that transmit, create, receive, or maintain PHI must sign business associate agreements (BAAs) to safeguard it.

Protected Health Information

The HIPAA Privacy Rule covers the use and disclosure of patients' **protected health information (PHI).** PHI is defined as individually identifiable health information that is transmitted or maintained by electronic media, such as over the Internet, by computer modem, or on magnetic tape or compact disks. The rule also covers PHI that is sent via the Internet to "the cloud," remote servers used to store and manage data. This information includes a person's:

protected health information (PHI) individually identifiable health information transmitted or maintained by electronic media

- Name
- Address (including street address, city, county, ZIP code)
- Names of relatives and employers
- Birth date
- Telephone numbers
- Fax number
- E-mail address
- Social Security number
- Medical record number
- Health plan beneficiary number
- Account number

Privacy Officers

The privacy official at a small physician practice may be the office manager who also has other duties. At a large health plan, the position of privacy official may be full time.

- Certificate or license number
- Serial number of any vehicle or other device
- Website address
- Fingerprints or voiceprints
- Photographic images
- Genetic information

Use and Disclosure for Treatment, Payment, and Healthcare Operations

Patients' PHI under HIPAA can be used and disclosed by providers for treatment, payment, and healthcare operations. *Use of PHI* means sharing or performing analysis *within* the entity that holds the information. *Disclosure of PHI* means the release, transfer, and provision of access to or divulging of PHI *outside* the entity holding the information.

Both use and disclosure of PHI are necessary and permitted for patients' **treatment, payment, and healthcare operations (TPO).** *Treatment* means providing and coordinating the patient's medical care; *payment* refers to the exchange of information with health plans; and *healthcare operations* are the general business management functions.

treatment, payment, and healthcare operation (TPO) legitimate reason for the sharing of patients' protected health information without authorization

Minimum Necessary Standard When using or disclosing PHI, a covered entity must try to limit the information to the minimum amount necessary for the intended purpose. The **minimum necessary standard** means taking reasonable safeguards to protect PHI from incidental disclosure. *Incidental use* or *disclosure* is a secondary use of patient information that cannot reasonably be prevented, is limited, and usually occurs as the result of another permitted use.

minimum necessary standard principle that individually identifiable health information should be disclosed only to the extent needed

Examples of HIPAA Compliance

A medical insurance specialist does not disclose a patient's history of cancer on a workers' compensation claim for a sprained ankle. Only the information the recipient needs to know is given.

- A physician's assistant faxes appropriate patient cardiology test results before scheduled surgery.
- A physician sends an e-mail message to another physician requesting a consultation on a patient's case.
- A patient's family member picks up medical supplies and a prescription. ◂

HIPAA Exemptions

Certain benefits are always exempt from HIPAA, including coverage only for accident, disability income coverage, liability insurance, workers' compensation, automobile medical payment and liability insurance, credit-only insurance (such as mortgage insurance), and coverage for on-site medical clinics.

Designated Record Set A covered entity must disclose individuals' PHI to them (or to their personal representatives) when they request access to, or an accounting of disclosures of, their PHI. Patients' rights apply to a **designated record set (DRS).** For a provider, the DRS means the medical and billing records the provider maintains. It does not include appointment and surgery schedules, requests for lab tests, and birth and death records. It also does not include mental health information, psychotherapy notes, and genetic information. For a health plan, the DRS includes enrollment, payment, claim decisions, and medical management systems of the plan.

Within the DRS, patients have the right to:

designated record set (DRS) covered entity's records that contain protected health information (PHI); for providers, the medical/financial patient record

- Access, copy, and inspect their PHI
- Request amendments to their health information
- Obtain accounting of most disclosures of their health information
- Receive communications from providers via other means, such as in Braille or in foreign languages
- Complain about alleged violations of the regulations and the provider's own information policies

Notice of Privacy Practices Covered entities must give each patient a notice of privacy practices at the first contact or encounter. To meet this requirement, physician practices give patients their **Notice of Privacy Practices (NPP)** (Figure 2.2) and ask them to sign an

Notice of Privacy Practices (NPP) description of a covered entity's principles and procedures related to the protection of patients' health information

Valley Associates, PC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PRIVACY OBLIGATIONS

The law requires us to maintain the privacy of certain health information called "Protected Health Information" ("PHI"). Protected Health Information is the information that you provide us or that we create or receive about your healthcare. The law also requires us to provide you with this Notice of our legal duties and privacy practices. When we use or disclose (share) your Protected Health Information, we are required to follow the terms of this Notice or other notice in effect at the time we use or share the PHI. Finally, the law provides you with certain rights described in this Notice.

WAYS WE CAN USE AND SHARE YOUR PHI WITHOUT YOUR WRITTEN PERMISSION (AUTHORIZATION)

In many situations, we can use and share your PHI for activities that are common in many offices and clinics. In certain other situations, which we will describe below, we must have your written permission (authorization) to use and/or share your PHI. We do not need any type of permission from you for the following uses and disclosures:

A. Uses and Disclosures for Treatment, Payment and Healthcare Operations

We may use and share your PHI to provide "Treatment," obtain "Payment" for your Treatment, and perform our "Healthcare Operations." These three terms are defined as:

Treatment:

We use and share your PHI to provide care and other services to you—for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment options. We may tell you about other health-related benefits and services that might interest you. We may also share PHI with other doctors, nurses, and others involved in your care.

Payment:

We may use and share your PHI to receive payment for services that we provide to you. For example, we may share your PHI to request payment and receive payment from Medicare, Medicaid, your health insurer, HMO, or other company or program that arranges or pays the cost of some or all of your healthcare ("Your Payer") and to confirm that Your Payer will pay for healthcare. As another example, we may share your PHI with the person who you told us is primarily responsible for paying for your Treatment, such as your spouse or parent.

Healthcare Operations:

We may use and share your PHI for our healthcare operations, which include management, planning, and activities that improve the quality and lower the cost of the care that we deliver. For example, we may use PHI to review the quality and skill of our physicians, nurses, and other healthcare providers.

B. Your Other Healthcare Providers

We may also share PHI with other healthcare providers when they need it to provide Treatment to you, to obtain Payment for the care they give to you, to perform certain Healthcare Operations, such as reviewing the quality and skill of healthcare professionals, or to review their actions in following the law.

C. Disclosure to Relatives, Close Friends, and Your Other Caregivers

We may share your PHI with your family member/relative, a close personal friend, or another person who you identify if we

(1) First provide you with the chance to object to the disclosure and you do not object;
(2) Infer that you do not object to the disclosure; or
(3) Obtain your agreement to share your PHI with these individuals. If you are not present at the time we share your PHI, or you are not able to agree or disagree to our sharing your PHI because you are not capable or there is an emergency circumstance, we may use our professional judgment to decide that sharing the PHI is in your best interest. We may also use or share your PHI to notify (or assist in notifying) these individuals about your location and general condition.

D. Public Health Activities

We are required or are permitted by law to report PHI to certain government agencies and others. For example, we may share your PHI for the following:

FIGURE 2.2 Example of a Notice of Privacy Practices (*Continues on the following pages*)

PHI and Release of Information Document

A patient release of information document is not needed when PHI is shared for TPO under HIPAA. However, state law may require authorization to release data, so many practices continue to ask patients to sign releases.

Healthcare Providers and the Minimum Necessary Standard

The minimum necessary standard does not apply to any type of disclosure—oral, written, phone, fax, e-mail, or other— among healthcare providers for treatment purposes.

Posting and Amending the NPP

The NPP should be posted on the practice's website.
When the NPP is updated or changed, all patients who received the previous version must be notified.

(1) To report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability;
(2) To report abuse and neglect to the state Department of Children and Family Services, the state Department of Human Services, or other government authorities, including a social service or protective services agency, that are legally permitted to receive the reports;
(3) To report information about products and services to the U.S. Food and Drug Administration;
(4) To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of developing or spreading a disease or condition;
(5) To report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; and
(6) To prevent or lessen a serious and imminent threat to a person for the public's health or safety, or to certain government agencies with special functions such as the State Department.

E. Health Oversight Activities

We may share your PHI with a health oversight agency that oversees the healthcare system and ensures the rules of government health programs, such as Medicare or Medicaid, are being followed.

F. Judicial and Administrative Proceedings

We may share your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

G. Law Enforcement Purposes

We may share your PHI with the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a subpoena.

H. Decedents

We may share PHI with a coroner or medical examiner as authorized by law.

I. Organ and Tissue Procurement

We may share your PHI with organizations that facilitate organ, eye, or tissue procurement, banking, or transplantation.

J. Research

We may use or share your PHI in related research processes.

K. Workers' Compensation

We may share your PHI as permitted by or required by state law relating to workers' compensation or other similar programs.

L. As Required by Law

We may use and share your PHI when required to do so by any other law not already referred to above.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN PERMISSION (AUTHORIZATION)

A. Use or Disclosure with Your Permission (Authorization)

For any purpose other than the ones described above, we may only use or share your PHI when you grant us your written permission (authorization). For example, you will need to give us your permission before we send your PHI to your life insurance company.

B. Marketing

We must also obtain your written permission (authorization) prior to using your PHI to send you any marketing materials. However, we may communicate with you about products or services related to your Treatment, case management, or care coordination, or alternative treatments, therapies, healthcare providers, or care settings without your permission. For example, we may not sell your PHI without your written authorization.

C. Uses and Disclosures of Your Highly Confidential Information

Federal and state law requires special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including any portion of your PHI that is:

(1) Kept in psychotherapy notes;
(2) About mental health and developmental disabilities services;
(3) About alcohol and drug abuse prevention, treatment and referral;
(4) About HIV/AIDS testing, diagnosis or treatment;
(5) About sexually transmitted disease(s);
(6) About genetic testing;

Patient Complaints

Patients who observe privacy problems in their providers' offices can complain either to the practice or to the Office for Civil Rights of the Department of HHS. Complaints must be put in writing, either on paper or electronically, and sent to OCR within 180 days.

Medical Notice of Privacy Practices

www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html

FIGURE 2.2 (*Continued*)

(7) About child abuse and neglect;
(8) About domestic abuse of an adult with a disability;
(9) About sexual assault; or
(10) In vitro Fertilization (IVF). Before we share your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written permission.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

A. For Further Information; Complaints

If you want more information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact our Compliance Officer. You may also file written complaints with the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services. When you ask, the Compliance Officer will provide you with the correct address for the OCR. We will not take any action against you if you file a complaint with us or with the OCR.

B. Right to Receive Confidential Communications

You may ask us to send papers that contain your PHI to a different location than the address that you gave us, or in a special way. You will need to ask us in writing. We will try to grant your request if we feel it is reasonable. For example, you may ask us to send a copy of your medical records to a different address than your home address.

C. Right to Revoke Your Written Permission (Authorization)

You may change your mind about your authorization or any written permission regarding your PHI by giving or sending a written "revocation statement" to the Compliance Officer. The revocation will not apply to the extent that we have already taken action where we relied on your permission.

D. Right to Inspect and Copy Your Health Information

You may request access to your medical record file, billing records, and other records used to make decisions about your Treatment and payment for your Treatment. You can review these records and/or ask for copies. Under limited circumstances, we may deny you access to a portion of your records. If you want to access your records, you may obtain a record request form and return the completed form to the registration desk. If you request copies, we will charge you the amount listed on the rate sheet. We will also charge you for our postage costs, if you request that we mail the copies to you. For a copy of records, material, or information that cannot routinely be copied on a standard photocopy machine, such as x-ray films or pictures, we may charge for the reasonable cost of the copy.

E. Right to Amend Your Records

You have the right to request that we amend PHI maintained in medical record files, billing records, and other records used to make decisions about your Treatment and payment for your Treatment. If you want to amend your records, you may submit an amendment request form to the Compliance Officer. We will comply with your request unless we believe that the information that would be amended is correct and complete or that other circumstances apply. In the case of a requested amendment concerning information about the Treatment of a mental illness or developmental disability, you have the right to appeal to a state court our decision not to amend your PHI.

F. Right to Receive an Accounting of Disclosures

You may ask for an accounting of certain disclosures of your PHI made by us on or after April 14, 2003. These disclosures must have occurred before the time of your request, and we will not go back more than six (6) years before the date of your request. If you request an accounting more than once during a twelve (12) month period, we will charge you based on the rate sheet. Direct your request for an accounting to the Compliance Officer.

G. Right to Request Restrictions

You have the right to ask us to restrict or limit the PHI we use or disclose about you for treatment, payment, or healthcare operations. With one exception, we are not required to agree to your request. If we do agree, we will comply unless the information is needed to provide emergency treatment. Your request for restrictions must be made in writing and submitted to the Compliance Officer. We must grant your request to a restriction on disclosure of your PHI to a health plan if you have paid for the healthcare item in full out of pocket.

H. Right to Receive Paper Copy of this Notice

If you ask, you may obtain a paper copy of this Notice, even if you have agreed to receive the notice electronically.

You may contact the compliance officer at:
Valley Associates, PC
ATTN: Compliance Officer
1400 West Center Street
Toledo, OH 43601-0123
555-321-0987

PHI and Medical Office Staff

Be careful not to discuss patients' cases with anyone outside the office, including family and friends. Avoid talking about cases, too, in the practice's reception areas where other patients might hear. Close charts on desks when they are not being worked on. Position computer screens so that only the person working with a file can view it.

Questions and Answers on HIPAA Privacy Policies
www.hhs.gov/ocr/privacy

Charging for Copying

Practices may charge patients a fee for supplying copies of their records but cannot hold records "hostage" while awaiting payment.

acknowledgment that they have received it (see the chapter about patient encounters and billing information). The notice explains how patients' PHI may be used and describes their rights.

Practices may choose to use a layered approach to giving patients the notice. On top of the information packet is a short notice, like the one shown in Figure 2.2, that briefly describes the uses and disclosures of PHI and the person's rights. The longer notice is placed beneath it.

PHI and Accounting for Disclosures Patients have the right to an **accounting of disclosure** of their PHI other than for TPO. When a patient's PHI is accidentally disclosed, the disclosure should be documented in the individual's medical record because the individual did not authorize it and it was not a permitted disclosure. An example is faxing a discharge summary to the wrong physician's office.

Also, under HITECH, patients can request an accounting of all disclosures—not just those other than for TPO—for the past three years if their PHI is stored in an EHR.

accounting of disclosure documentation of the disclosure of a patient's PHI in that person's medical record in unauthorized cases

authorization (1) document signed by a patient to permit release of medical information; (2) health plan's system of approving payment of benefits for appropriate services

Authorizations for Other Use and Disclosure

For use or disclosure other than for TPO, the covered entity must have the patient sign an **authorization** to release the information. Information about substance (alcohol and drug) abuse, sexually transmitted diseases (STDs) or human immunodeficiency virus (HIV), and behavioral/mental health services may not be released without a specific authorization from the patient. The authorization document must be in plain language and include the following:

- A description of the information to be used or disclosed
- The name or other specific identification of the person(s) authorized to use or disclose the information
- The name of the person(s) or group of people to whom the covered entity may make the use or disclosure
- A description of each purpose of the requested use or disclosure
- An expiration date
- The signature of the individual (or authorized representative) and the date

In addition, the rule states that a valid authorization must include:

- A statement of the individual's right to revoke the authorization in writing
- A statement about whether the covered entity is able to base treatment, payment, enrollment, or eligibility for benefits on the authorization
- A statement that information used or disclosed after the authorization may be disclosed again by the recipient and may no longer be protected by the rule

A sample authorization form is shown in Figure 2.3.

Uses or disclosures for which the covered entity has received specific authorization from the patient do not have to follow the minimum necessary standard. Incidental use and disclosure are also allowed. For example, the practice may use reception-area sign-in sheets.

Marketing

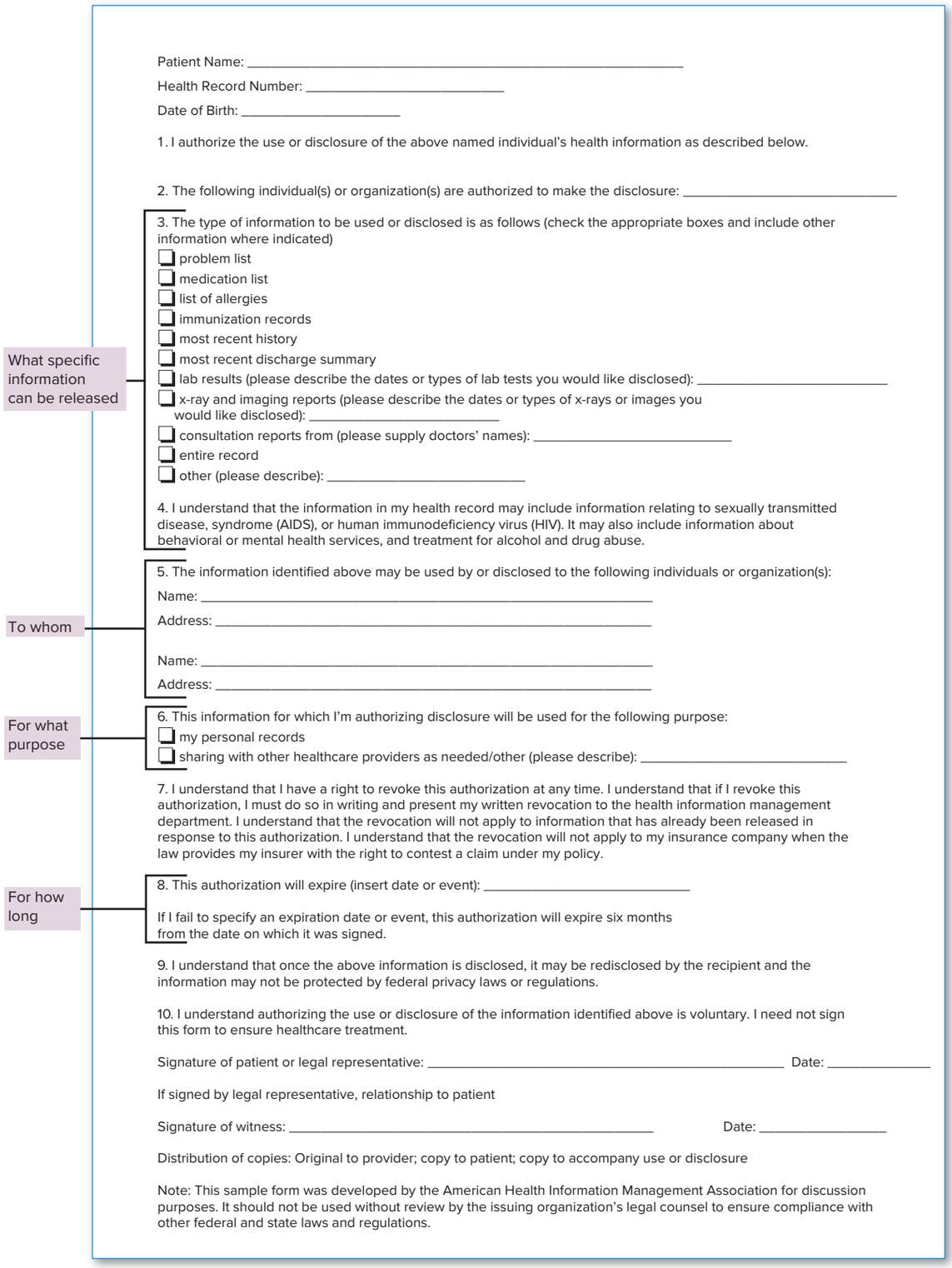
PHI can be used for marketing—communications that influence others to use or purchase a product. In most cases, no patient authorization is needed.

Exceptions

There are a number of exceptions to the usual rules for release:

- Emergencies
- Court orders
- Workers' compensation cases
- Statutory reports
- Research
- Self-pay (patient rather than insurance pays for the service) requests for restrictions

All these types of disclosures must be logged, and the release information must be available to the patient who requests it.



Patient Name: _____

Health Record Number: _____

Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure: _____

3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)

- ☐ problem list
- ☐ medication list
- ☐ list of allergies
- ☐ immunization records
- ☐ most recent history
- ☐ most recent discharge summary
- ☐ lab results (please describe the dates or types of lab tests you would like disclosed): _____
- ☐ x-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed): _____
- ☐ consultation reports from (please supply doctors' names): _____
- ☐ entire record
- ☐ other (please describe): _____

What specific information can be released

4. I understand that the information in my health record may include information relating to sexually transmitted disease, syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. The information identified above may be used by or disclosed to the following individuals or organization(s):

Name: _____

Address: _____

Name: _____

Address: _____

To whom

6. This information for which I'm authorizing disclosure will be used for the following purpose:

- ☐ my personal records
- ☐ sharing with other healthcare providers as needed/other (please describe): _____

For what purpose

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

For how long

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal representative: _____ Date: _____

If signed by legal representative, relationship to patient

Signature of witness: _____ Date: _____

Distribution of copies: Original to provider; copy to patient; copy to accompany use or disclosure

Note: This sample form was developed by the American Health Information Management Association for discussion purposes. It should not be used without review by the issuing organization's legal counsel to ensure compliance with other federal and state laws and regulations.

FIGURE 2.3 Example of an Authorization to Use or Disclose Health Information

PHI and Authorization to Release

To legally release PHI for purposes other than treatment, payment, or healthcare operations, a signed authorization document is required.

Emergencies Emergency guidance from HHS states that CEs may disclose PHI without the patient's consent for the following reasons:

- To treat the patient or another patient, which includes coordinating and managing care and services by one or more healthcare providers and others, or for consultation between providers and referrals
- To grant public health authorities (e.g., the Centers for Disease Control and Prevention) access to PHI that is critical to carrying out its public health mission
- To provide information for the patient's family members, relatives, friends, or other persons identified by the patient as involved in the patient's care
- As necessary to identify or locate a patient and notify his or her family, guardians, or anyone else responsible for the patient's care of the patient's location, general condition, or death
- To prevent or lessen a serious and imminent threat to the health and safety of a person or the public

Release Under Court Order If the patient's PHI is required as evidence by a court of law, the provider may release it without the patient's approval if a judicial order is received. In the case of a lawsuit, a court sometimes decides that a physician or medical practice staff member must provide testimony. The court issues a *subpoena,* an order of the court directing a party to appear and testify. If the court requires the witness to bring certain evidence, such as a patient medical record, it issues a *subpoena duces tecum,* which directs the party to appear, testify, and bring specified documents or items.

PHI and Practice Policy

The release of protected health information must follow the practice's policies and procedures. The practice's privacy official trains medical insurance specialists on how to verify the identity and authority of a person requesting PHI.

Workers' Compensation Cases State law may provide for release of records to employers in workers' compensation cases (see the chapter about workers' compensation). The law may also authorize release to the state workers' compensation administration board and to the insurance company that handles these claims for the state.

Statutory Reports Some specific types of information are required by state law to be released to state health or social services departments. For example, physicians must make statutory reports for patients' births and deaths and for cases of abuse. Because of the danger of harm to patients or others, communicable diseases, such as tuberculosis, hepatitis, and rabies, must usually be reported.

A special category of communicable disease control is applied to patients with diagnoses of HIV infection and acquired immunodeficiency syndrome (AIDS). Every state requires AIDS cases to be reported. Most states also require reporting of the HIV infection that causes the syndrome. However, state law varies concerning whether just the fact of a case is to be reported or if the patient's name must also be reported. The practice guidelines reflect the state laws and must be strictly observed, as all these regulations should be, to protect patients' privacy and to comply with the regulations.

Research Data PHI may be made available to researchers approved by the practice. For example, if a physician is conducting clinical research on a type of diabetes, the practice may share information from appropriate records for analysis. When the researcher issues reports or studies based on the information, specific patients' names may not be identified.

Self-Pay Requests for Restrictions Under HITECH, patients can restrict the access of health plans to their medical records if they pay for the service in full out of pocket at the time of the visit.

De-Identified Health Information

de-identified health information medical data from which individual identifiers have been removed

There are no restrictions on the use or disclosure of **de-identified health information** that neither identifies nor provides a reasonable basis to identify an individual. For example, these identifiers must be removed: names, medical record numbers, health plan beneficiary numbers, device identifiers (such as pacemakers), and biometric identifiers, such as fingerprints and voiceprints.

Psychotherapy Notes

Psychotherapy notes have special protection under HIPAA. According to the Department of HHS,

> Under the HIPAA Privacy Rule, psychotherapy notes are notes recorded by a mental health professional documenting or analyzing the contents of a conversation and that are separate from the rest of a patient's medical record. Psychotherapy notes are treated differently because they contain particularly sensitive information and are not typically useful for treatment, payment, or health care operations purposes. Therefore, the Privacy Rule generally requires CEs to obtain patient authorization for any kind of disclosure except in cases where disclosure is required by another law. (Available online at www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html)

State Statutes

Some state statutes are more stringent than HIPAA specifications. Areas in which state statutes may differ from HIPAA include the following:

- Designated record set
- Psychotherapy notes
- Rights of inmates
- Information compiled for civil, criminal, or administrative court cases

Each practice's privacy official reviews state laws and develops policies and procedures for compliance with the HIPAA Privacy Rule. The tougher rules are implemented.

THINKING IT THROUGH 2.4

Based on the information in Figure 2.2:

1. Is permission needed to share a patient's PHI with his or her life insurance company?
2. Is written authorization from a patient needed to use or disclose health information in an emergency?
3. What is the purpose of an "accounting of disclosures"?

2.5 HIPAA Security Rule

The **HIPAA Security Rule** requires covered entities to establish safeguards to protect PHI. The security rule specifies how to secure such protected health information on computer networks, the Internet ("cloud storage"), and storage disks such as CDs.

Encryption Is Required

Information security is needed when computers exchange data over the Internet. Security measures rely on **encryption,** the process of encoding information in such a way that only the person (or computer) with the key can decode it. Practice management programs (PMPs) encrypt data traveling between the office and the Internet so that the information is secure.

Security Measures

A number of other security measures help enforce the HIPAA Security Rule. These include:

- Secure Internet connections
- Access control, passwords, and log files to keep intruders out
- Backups to replace items after damage
- Security policies to handle violations that do occur

PHI and Answering Machines

If possible, ask patients during their initial visit whether staff members may leave messages on answering machines or with friends or family. If this is not done, messages should follow the minimum necessary standard; the staff member should leave a phone number and a request for the patient to call back. For example: "This is the doctor's office with a message for Mr. Warner. Please call us at 203-123-4567."

PHI and Reports

The Association for Healthcare Documentation Integrity (AHDI) (formerly the American Association for Medical Transcription) advises against using a patient's name in the body of a medical report. Instead, place identification information only in the demographic section, where it can be easily deleted when the report data are needed for research.

HIPAA Security Rule law requiring covered entities to establish safeguards to protect health information

encryption method of converting a message into encoded text

BILLING TIP

Internet Security Symbol

On the Internet, when an item is secure, a small padlock appears in the status bar at the bottom of the browser window.

Access Control, Passwords, and Log Files

password confidential authentication information

Most practices use role-based access, meaning that only people who need information can see it. Once access rights have been assigned, each user is given a key to the designated databases. Users must enter a user ID and a **password** (the key) to see files to which they have been granted access rights.

For example, receptionists may view the names of patients coming to the office on one day, but they should not see those patients' medical records. However, the nurse or physician needs to view the patient records. Receptionists are given individual computer passwords that let them view the day's schedule but that deny entry to patient records. The physicians and nurses possess computer passwords that allow them to see all patient records.

The PMP also creates activity logs of who has accessed—or tried to access—information, and passwords prevent unauthorized users from gaining access to information on a computer or network.

COMPLIANCE GUIDELINE

Don't Share!

Never share your log-in or passwords. Sharing makes *you* responsible if someone else access and breaches HIPAA information with your identification.

Internet Security

Information is exchanged over the Internet between the practice and those outside of the office in a number of ways, especially by e-mail, the most important business communication method. Additionally, practices may have their own websites and patient portals for access to the physicians and for marketing purposes; take calls from patients' mobile phones; and send medical records to health plans via attachments. HIPAA, HITECH, and many states have laws for data security that require the use of antivirus software programs and encrypting confidential patient data that are transmitted.

Texting

Physicians and other providers can text patient data if a secure messaging platform is used.

Backups

Backing up is the activity of copying files to another medium so that they will be preserved in case the originals are no longer available. A successful backup plan is critical in recovering from either a minor or major security incident that jeopardizes critical data. To be secure, backups must also be encrypted.

THINKING IT THROUGH 2.5

1. Imagine that you are employed as a medical insurance specialist for Family Medical Center. Make up a password that you will use to keep your files secure.
2. As an employee, how would you respond to another staff member who asked to see your latest claim files in order to see how you handled a particular situation?

Security Policy

Practices have security policies that inform employees about their responsibilities for protecting electronically stored information. Many practices include this information in handbooks distributed to all employees. These handbooks contain general information about the organizations, their structures, and their policies as well as specific information about employee responsibilities.

2.6 HITECH Breach Notification Rule

breach impermissible use or disclosure of PHI that could pose significant risk to the affected person

The HITECH Act requires covered entities to notify affected individuals following the discovery of a breach of unsecured health information. A **breach** is an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of PHI.

Guidance on Securing PHI

The HITECH Act refers to *unsecured PHI* as unprotected health information that is not secured through the use of technologies or methods that HHS has specified. These methods involve either encrypting or destroying the data. If PHI has not been secured through one or more of these methods and there is a breach, covered entities are required to follow the provision's breach notification procedures.

Although covered entities do not have to follow the guidance on acceptable methods, if the encryption and destruction methods specified are used to secure data, covered entities may be exempt from the breach notification requirements for breaches of that data. In addition, the rule notes several exceptions to the definition of "breach," including certain good faith uses and disclosures among a company's workforce members, as long as the private information is not further acquired, accessed, used, or disclosed without authorization.

Breach Notification Procedures

Following the discovery of a breach of unsecured PHI, a covered entity must notify each individual whose unsecured PHI has been, or is reasonably believed to have been, inappropriately accessed, acquired, or disclosed in the breach. Additionally, following the discovery of a breach by a business associate, the business associate must notify the covered entity of the breach and identify for the covered entity the individuals whose unsecured PHI has been, or is reasonably believed to have been, breached. If not going ahead with notification, the covered entity must document the reason this was not done. The act requires the notifications to be made within 60 calendar days after discovery of the breach. An exception may be made to the 60-calendar-day deadline only in a situation in which a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security.

HITECH specifies the following:

- Notice to patients of breaches "without reasonable delay" within 60 days
- Notice to covered entities by BAs when BAs discover a breach
- Notice to "prominent media outlets" on breaches involving more than 500 individuals
- Notice to "next of kin" on breaches involving patients who are deceased
- Notice to the secretary of HHS about breaches involving 500 or more individuals without reasonable delay
- Annual notice to the secretary of HHS about breaches of "unsecured PHI" involving less than 500 individuals that pose a significant financial risk or other harm to the individual, such as reputation

The document notifying an individual of a breach, called the **breach notification,** must include the following points: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known; (2) a description of the types of unsecured PHI that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code); (3) the steps individuals should take to protect themselves from potential harm resulting from the breach; (4) a brief description of what the covered entity involved is doing to investigate the breach, to mitigate losses, and to protect against any further breaches; and (5) contact procedures for individuals to ask questions or learn additional information, which include a toll-free telephone number, an e-mail address, website, or postal address.

In addition, as part of the rule, the secretary of HHS must annually prepare and submit to Congress a report regarding the breaches for which the secretary was notified and all enforcement actions taken. This means that covered entities must maintain a log of breaches involving fewer than 500 individuals, which they submit annually to HHS. HHS must post the report on the HHS public website.

Selecting Good Passwords

- Security experts suggest a combination of letters, numbers, and symbols that are at least 12 characters long, that are not real words, and that are not obvious (like a birth date).
- Do not use a user ID (logon, sign-on) as a password. Even if an ID has both numbers and letters, it is not secret.
- Select a mixture of uppercase and lowercase letters if the system permits, and include special characters, such as @, $, or &, if possible.
- Change passwords periodically, but not too often. Forcing frequent changes can actually make security worse because users are more likely to write down passwords.
- Electronically stored passwords should be encrypted.

COMPLIANCE GUIDELINE

Federal Versus State Regulations

State insurance departments may have additional, more stringent breach notification regulations.

breach notification document notifying an individual of a breach

HHS Breach Notifications Website

www.hhs.gov/hipaa/for-professionals/breach-notification/index.html

HHS Health Data Privacy and Security Resources

www.hhs.gov/ocr/privacy/

THINKING IT THROUGH 2.6

1. Review the HITECH specifications regarding breaches and business associates. If a business associate causes a breach, who is responsible for notifying the individuals affected?

2.7 HIPAA Electronic Health Care Transactions and Code Sets

HIPAA Electronic Health Care Transactions and Code Sets (TCS) rule governing the electronic exchange of health information

The **HIPAA Electronic Health Care Transactions and Code Sets (TCS)** standards make it possible for physicians and health plans to exchange electronic data using a standard format and standard code sets.

CMS eHealth

www.cms.gov/eHealth
Website for health information technology and electronic standards programs

Standard Transactions

The HIPAA transactions standards apply to the electronic data that are regularly sent back and forth between providers, health plans, and employers. Each standard is labeled with both a number and a name. Either the number (such as "the 837") or the name (such as the "HIPAA Claim") may be used to refer to the particular electronic document format.

Number	*Official Name*
X12 837	Healthcare Claims or Equivalent Encounter Information/Coordination of Benefits—*coordination of benefits* refers to an exchange of information between payers when a patient has more than one health plan
X12 276/277	Healthcare Claim Status Inquiry/Response
X12 270/271	Eligibility for a Health Plan Inquiry/Response
X12 278	Referral Certification and Authorization
X12 835	Healthcare Payment and Remittance Advice
X12 820	Health Plan Premium Payments
X12 834	Health Plan Enrollment and Disenrollment

BILLING TIP

Healthcare Claims

The X12 837 is usually referred to just as "Healthcare Claims," dropping the "or Equivalent Encounter Information," for short.

Medical insurance specialists use the first five transactions in performing their jobs. Each of these is covered in later text chapters.

Operating Rules

operating rules rules that improve interoperability between the data systems of different entities

The ACA requires the adoption of **operating rules** for each of the HIPAA standard transactions. The operating rules improve interoperability between the data systems of different entities, such as health plans and providers, and so increase their usefulness. They define the rights and responsibilities of those who are conducting the transactions, setting forth the security requirements, EDI transmission formats, response times, and error resolution.

Standard Code Sets

code set alphabetic and/or numeric representations for data

Under HIPAA, a **code set** is any group of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnosis codes, or medical procedure codes. Medical code sets used in the healthcare industry include coding systems for diseases; treatments and procedures; and supplies or other items used to perform these actions. These standards, listed in Table 2.3, are covered in later text chapters.

Table 2.3 HIPAA Standard Code Sets

Purpose	Standard
Codes for diseases, injuries, impairments, and other health-related problems	Before October 1, 2015: *International Classification of Diseases,* 9th Revision, *Clinical Modification* (ICD-9-CM), Volumes 1 and 2 After October 1, 2015: *International Classification of Diseases,* 10th Revision, *Clinical Modification*
Codes for procedures or other actions taken to prevent, diagnose, treat, or manage diseases, injuries, and impairments	Physicians' Services: *Current Procedural Terminology* (CPT) Before October 1, 2015: Inpatient Hospital Services: *International Classification of Diseases, 9th Revision, Clinical Modification,* Volume 3: *Procedures* After October 1, 2015: *International Classification of Diseases, Procedure Coding System*
Codes for dental services	*Current Dental Terminology* (CDT-4)
Codes for other medical services	Healthcare Common Procedures Coding System (HCPCS)

HIPAA National Identifiers

HIPAA National Identifiers are for:

HIPAA National Identifiers identification systems for employers, healthcare providers, health plans, and patients

- Employers
- Healthcare providers
- Health plans
- Patients

Identifiers are numbers of predetermined length and structure, such as a person's Social Security number. They are important because the unique numbers can be used in electronic transactions. These unique numbers can replace the many numbers that are currently used. Two identifiers have been set up, and two—health plans and patients—are to be established in the future.

Employer Identification Number (EIN)

The employer identifier is used when employers enroll or disenroll employees in a health plan (X12 834) or make premium payments to plans on behalf of their employees (X12 820). The Employer Identification Number (EIN; also called the *tax identification number*) issued by the Internal Revenue Service is the HIPAA standard.

National Provider Identifier (NPI)

The **National Provider Identifier (NPI)** is the standard for the identification of providers when filing claims and other transactions. The NPI has replaced other identifying numbers that had been used, such as the UPIN (Unique Physician Identification Number) for Medicare and the numbers that have been assigned by each payer to the provider. The older numbers are known as *legacy numbers.*

National Provider Identifier (NPI) unique ten-digit identifier assigned to each provider

The NPI has nine numbers and a check digit, for a total of ten numbers. The federal government assigns the numbers to individual providers, such as physicians and nurses, and to provider organizations such as hospitals, pharmacies, and clinics. CMS maintains NPIs as they are assigned in the National Plan and Provider Enumerator System (NPPES), a database of all assigned numbers. Once assigned, the NPI will not change; it remains with the provider regardless of job or location changes.

All healthcare providers who transmit health information electronically must obtain NPIs, even if they use business associates to prepare the transactions. Most health plans, including Medicare, Medicaid, and private payers, and all clearinghouses, must accept and use NPIs in HIPAA transactions. This includes small health plans as well.

BILLING TIP

Physician and Group NPIs

If a physician is in a group practice, both the individual doctor and the group have NPIs.

THINKING IT THROUGH 2.7

1. Gloria Traylor, an employee of National Bank, called Marilyn Rennagel, a medical insurance specialist who works for Dr. Judy Fisk. The bank is considering hiring one of Dr. Fisk's patients, Juan Ramirez, and Ms. Traylor would like to know if he has any known medical problems. Marilyn, in a hurry to complete the call and get back to work on this week's claims, quickly explains that she remembers that Mr. Ramirez was treated for depression some years ago but that he has been fine since that time. She adds that she thinks he would make an excellent employee.

   A. In your opinion, did Marilyn handle this call correctly?

   B. What problems might result from her answers?

COMPLIANCE GUIDELINE

HPID

A ten-digit "health plan identifier" is assigned to covered entities such as health plans.

BILLING TIP

OEID

An "other identity" identifier is assigned to entities that are not required to have NPIs but need to be identified in the standard transactions, such as third-party administrators who work for health plans.

2.8 Omnibus Rule and Enforcement

Omnibus Rule set of regulations enhancing patients' privacy protections and rights to information and the government's ability to enforce HIPAA

The **Omnibus Rule** contains regulations that enhance patients' privacy protections, provide individuals new rights to their health information, and strengthen the government's ability to enforce HIPAA in an increasingly digital period. All major parts of this rule were included in the appropriate sections earlier in this chapter, and that content is up-to-date. This brief section outlines the four final rules:

1. Strengthening previous HIPAA/HITECH rules, such as making BAs directly liable for compliance with privacy and security law
2. Increasing the civil monetary penalties for violations
3. Restating the standard that determines when to report breaches with more objective measures
4. Prohibiting health plans from using or disclosing genetic information for determining insurance coverage

Enforcement and Penalties

Enforcing HIPAA is the job of a number of government agencies. Which agency performs which task depends on the nature of the violation.

Office for Civil Rights

Office for Civil Rights (OCR) government agency that enforces the HIPAA Privacy Act

OCR Compliance and Enforcement

www.hhs.gov/hipaa/for-professionals/compliance-enforcement/index.html

Civil violations (those that are based on *civil law,* such as trespassing, divorce cases, and breech of contract proceedings) of the HIPAA privacy and security standards are enforced by the **Office for Civil Rights (OCR),** an agency of HHS. OCR has the authority to receive and investigate complaints as well as to issue subpoenas for evidence in cases it is investigating. It is charged with enforcing the privacy standards because privacy and security of one's health information are considered a civil right. It is important to note, though, that individuals themselves do not have the right to sue a covered entity that may have disclosed their PHI inappropriately; OCR must take action on individuals' behalf.

Department of Justice

Criminal violations (those that involve crimes, such as kidnapping, robbery, and arson) of HIPAA privacy standards are prosecuted by the federal government's. Department

of Justice, which is America's "law office" and central agency for enforcement of federal laws.

Office of E-Health Standards and Services

The other standards are enforced by the **Office of E-Health Standards and Services (OESS),** part of CMS. In addition to its major task of administering the Medicare and Medicaid programs, HHS has also authorized CMS to investigate complaints of noncompliance and enforce these HIPAA standards:

- The Electronic Health Care Transaction and Code Set Rule (TCS)
- The National Employer Identifier Number (EIN) Rule
- The National Provider Identifier Rule

Office of E-Health Standards and Services (OESS) part of CMS that helps to develop and coordinate the implementation of a comprehensive e-health strategy

Office of Inspector General

The Office of Inspector General was directed by the original HIPAA law to combat fraud and abuse in health insurance and healthcare delivery.

Most billing-related accusations under the False Claims Act are based on the guideline that providers who *knew or should have known* that a claim for service was false can be held liable. The intent to commit fraud does not have to be proved by the accuser in order for the provider to be found guilty. Actions that might be viewed as errors or occasional slips might also be seen as establishing a pattern of violations, which constitute the knowledge meant by "providers knew or should have known."

OIG has the authority to investigate suspected fraud cases and to **audit** the records of physicians and payers. In an audit, which is a methodical examination, investigators review selected medical records to see whether the documentation matches the billing. The accounting records are often reviewed as well. When problems are found, the investigation proceeds and may result in charges of fraud or abuse against the practice.

Although OIG says that "under the law, physicians are not subject to civil, administrative, or criminal penalties for innocent errors, or even negligence," decisions about whether there are clear patterns and inadequate internal procedures can be subjective at times, making the line between honest mistakes and fraud very thin. Medical practice staff members must avoid any actions that could be perceived as noncompliant.

CMS HIPAA Enforcement
www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html

audit formal examination of a physician's or a payer's records

Monetary Penalties

Many privacy complaints have been settled by voluntary compliance. But if the covered entity does not act to resolve the matter in a way that is satisfactory, the enforcing agency can impose *civil money penalties (CMPs).* Fines of up to $50,000 for "willful neglect" and $1.5 million (per provision) for multiple violations of identical provisions may be imposed.

COMPLIANCE GUIDELINE

Ongoing Compliance Education

As explained in Section 2.10, many medical office staff members receive ongoing training and education in current rules so that they can avoid even the appearance of fraud.

THINKING IT THROUGH 2.8

1. Mary Kelley, a patient of the Good Health Clinic, asked Kathleen Culpepper, the medical insurance specialist, to help her out of a tough financial spot. Mary's medical insurance authorized her to receive radiation treatments for her condition, one every thirty-five days. Because she was out of town, she did not schedule her appointment for the last treatment until today, which is one week beyond the approved period. The insurance company will not reimburse Mary for this procedure. She asks Kathleen to change the date on the record to last Wednesday so that it will be covered, explaining that no one will be hurt by this change and, anyway, she pays the insurance company plenty.

   A. What type of action is Mary asking Kathleen to do?

   B. How should Kathleen handle Mary's request?

OIG Home Page
http://oig.hhs.gov

2.9 Fraud and Abuse Regulations

Almost everyone involved in the delivery of healthcare is trustworthy and is devoted to patients' welfare. However, some people are not. Healthcare fraud and abuse laws help control cheating in the healthcare system. Is this really necessary? The evidence says that it is. The National Health Care Anti-Fraud Association has projected that of the estimated $2 trillion spent on healthcare every year, at least 3 percent—or $50 billion—is lost to fraud.

The Health Care Fraud and Abuse Control Program

Health Care Fraud and Abuse Control Program government program to uncover and prosecute fraud and abuse in federal healthcare programs

Office of the Inspector General (OIG) government agency that investigates and prosecutes fraud

HIPAA's Title II required the **Health Care Fraud and Abuse Control Program** to uncover and prosecute fraud and abuse. The HHS **Office of the Inspector General (OIG)** has the task of detecting healthcare fraud and abuse and enforcing all laws relating to them. OIG works with the U.S. Department of Justice (DOJ), which includes the Federal Bureau of Investigation (FBI), under the direction of the U.S. attorney general to prosecute those suspected of medical fraud and abuse.

False Claims Act, Fraud Enforcement and Recovery Act, and State Laws

relator person who makes an accusation of fraud or abuse

The federal False Claims Act (FCA) (31 USC § 3729), a related law, prohibits submitting a fraudulent claim or making a false statement or representation in connection with a claim. It also encourages reporting suspected fraud and abuse against the government by protecting and rewarding people involved in *qui tam,* or whistle-blower, cases. The person who makes the accusation of suspected fraud is called the **relator.** Under the law, the relator is protected against employer retaliation. If the lawsuit results in a fine paid to the federal government, the whistle-blower may be entitled to 15 to 25 percent of the amount paid. People who blow the whistle are current or former employees of insurance companies or medical practices, program beneficiaries, and independent contractors.

The federal *Fraud Enforcement and Recovery Act (FERA)* of 2009 strengthens the provisions of the FCA. Also enforced by DOJ, FERA extends whistle-blower protection to agents and contractors of an employer as well as to employees. It also makes it illegal to knowingly keep an overpayment received from the government. (Handling such overpayments correctly is covered in the chapter about payments, appeals, and secondary claims.)

The ACA further strengthened the tools that DOJ and HHS have to pursue fraud investigations. The act provides additional funding so that providers can be subject to fingerprinting, site visits, and criminal background checks before they are allowed to bill the Medicare and Medicaid programs.

Nearly half of the states also have passed versions of the federal False Claims Act. These laws allow private individuals to bring an action alone or by working with the state attorney general against any person who knowingly causes the state to pay a false claim. These laws generally provide for civil penalties and damages related to the cost of any losses sustained because of the false claim.

COMPLIANCE GUIDELINE

The False Claims Act

The U.S. Department of Justice (DOJ) recovered a record-breaking $5.69 billion in False Claims Act settlements in fiscal year (FY) 2014.

Additional Laws

Additional laws relating to healthcare fraud and abuse control include:

- An antikickback statute that makes it illegal to knowingly offer incentives to induce referrals for services that are paid by government healthcare programs. Many financial actions are considered to be incentives, including illegal direct payments to other physicians and routine waivers of coinsurance and deductibles.
- Self-referral prohibitions (called *Stark rules*) that make it illegal for physicians (or members of their immediate families) to have financial relationships with clinics to which they refer their patients, such as radiology service clinics and clinical laboratory services. (Note, however, that there are many legal exceptions to this prohibition under various business structures.)

Extending Laws to Private Payers

HIPAA extended existing laws governing fraud in the Medicare and Medicaid programs to all health plans.

- The Sarbanes-Oxley Act of 2002 that requires publicly traded corporations to attest that their financial management is sound. These provisions apply to for-profit healthcare companies. The act includes whistle-blower protection so that employees can report wrongdoing without fear of retaliation.

Definition of Fraud and Abuse

Fraud is an intentional act of deception used to take advantage of another person. For example, misrepresenting professional credentials and forging another person's signature on a check are fraudulent. Pretending to be a physician and treating patients without a valid medical license are also fraudulent. Fraudulent acts are intentional; the individual expects an illegal or unauthorized benefit to result.

fraud intentional deceptive act to obtain a benefit by taking advantage of another person

Claims fraud occurs when healthcare providers or others falsely report charges to payers. A provider may bill for services that were not performed, overcharge for services, or fail to provide complete services under a contract. A patient may exaggerate an injury to get a settlement from an insurance company or may ask a medical insurance specialist to change a date on a chart so that a service is covered by a health plan.

In federal law, **abuse** means an action that misuses money that the government has allocated, such as Medicare funds. Abuse is illegal because taxpayers' dollars are misspent. An example of abuse is an ambulance service that billed Medicare for transporting a patient to the hospital when the patient did not need ambulance service. This abuse—billing for services that were not medically necessary—resulted in improper payment for the ambulance company. Abuse is not necessarily intentional. It may be the result of ignorance of a billing rule or of inaccurate coding.

abuse action that improperly uses another's resources

Examples of Fraudulent or Abusive Billing Acts

A number of billing practices are fraudulent or abusive. Investigators reviewing physicians' billing work look for patterns like these:

- Intentionally billing for services that were not performed or documented
  Example A lab bills Medicare for two tests when only one was done.
  Example A physician asks a coder to report a physical examination that was just a telephone conversation.
- Reporting services at a higher level than were carried out
  Example After a visit for a flu shot, the provider bills the encounter as a comprehensive physical examination plus a vaccination.
- Performing and billing for procedures that are not related to the patient's condition and therefore not medically necessary
  Example After reading an article about Lyme disease, a patient is worried about having worked in her garden over the summer, and she requests a Lyme disease diagnostic test. Although no symptoms or signs have been reported, the physician orders and bills for the *Borrelia burgdorferi* (Lyme disease) confirmatory immunoblot test. ◀

BILLING TIP

Fraud Versus Abuse

To bill when the task was not done is fraud; to bill when it was not necessary is abuse. Remember the rule: If a service was not documented, in the view of the payer, it was not done and cannot be billed. To bill for undocumented services is fraudulent.

THINKING IT THROUGH 2.9

1. Discuss the difference between fraud and abuse. Which is likely to create the most severe punishment?

2.10 Compliance Plans

Because of the risk of fraud and abuse liability, medical practices must be sure that all staff members follow billing rules. In addition to responsibility for their own actions, physicians are liable for the professional actions of employees they supervise. This responsibility is a result of the law of *respondeat superior,* which states that an employer

Plans Mandated

Under the ACA, practices are now required to have compliance plans in place.

is responsible for an employee's actions. Physicians are held to this doctrine, so they can be charged for the fraudulent behavior of any staff member.

compliance plan a medical practice's written plan for complying with regulations

A wise slogan is that "the best defense is a good offense." For this reason, medical practices write and implement **compliance plans** to uncover compliance problems and correct them to avoid risking liability. A compliance plan is a process for finding, correcting, and preventing illegal medical office practices. It is a written document prepared by a compliance officer and committee that sets up the steps needed to (1) audit and monitor compliance with government regulations, especially in the area of coding and billing, (2) have policies and procedures that are consistent, (3) provide for ongoing staff training and communication, and (4) respond to and correct errors.

The goals of the compliance plan are to:

- Prevent fraud and abuse through a formal process to identify, investigate, fix, and prevent repeat violations relating to reimbursement for healthcare services
- Ensure compliance with applicable federal, state, and local laws, including employment and environmental laws as well as antifraud laws
- Help defend the practice if it is investigated or prosecuted for fraud by substantiating the desire to behave compliantly and thus reduce any fines or criminal prosecution

Having a compliance plan demonstrates to outside investigators that the practice has made honest, ongoing attempts to find and fix weak areas.

Compliance plans cover more that just coding and billing. They also cover all areas of government regulation of medical practices, such as Equal Employment Opportunity (EEO) regulations (for example, hiring and promotion policies) and Occupational Safety and Health Administration (OSHA) regulations (for example, fire safety and handling hazardous materials such as blood-borne pathogens).

Parts of a Compliance Plan

Generally, according to OIG, plans should contain seven elements:

1. Consistent written policies and procedures
2. Appointment of a compliance officer and committee
3. Training
4. Communication
5. Disciplinary systems
6. Auditing and monitoring
7. Responding to and correcting errors

Model Compliance Programs

https://oig.hhs.gov/compliance/compliance-guidance/index.asp

Following OIG's guidance can help in the defense against a false claims accusation. Having a plan in place shows that efforts are made to understand the rules and correct errors. This indicates to OIG that the problems may not add up to a pattern or practice of abuse but may simply be errors.

Compliance Officer and Committee

To establish the plan and follow up on its provisions, most medical practices appoint a compliance officer who is in charge of the ongoing work. The compliance officer may be one of the practice's physicians, the practice manager, or the billing manager. A compliance committee is also usually established to oversee the program.

Code of Conduct

The practice's compliance plan emphasizes the procedures that are to be followed to meet existing documentation, coding, and medical necessity requirements. It also has a code of conduct for the members of the practice, which covers:

- Procedures for ensuring compliance with laws relating to referral arrangements
- Provisions for discussing compliance during employees' performance reviews and for disciplinary action against employees, if needed

- Mechanisms to encourage employees to report compliance concerns directly to the compliance officer to reduce the risk of whistle-blower actions

Promoting ethical behavior in the practice's daily operations can also reduce employee dissatisfaction and turnover by showing employees that the practice has a strong commitment to honest, ethical conduct.

Ongoing Training

Physician Training

Part of the compliance plan is a commitment to keep physicians trained in pertinent coding and regulatory matters. Often, the medical insurance specialist or medical coder is assigned the task of briefing physicians on changed codes or medical necessity regulations. The following guidelines are helpful in conducting physician training classes:

- Keep the presentation as brief and straightforward as possible.
- In a multispecialty practice, issues should be discussed by specialty; all physicians do not need to know changed rules on dermatology, for example.
- Use actual examples, and stick to the facts when presenting material.
- Explain the benefits of coding compliance to the physicians, and listen to their feedback to improve job performance.
- Set up a way to address additional changes during the year, such as an office newsletter or compliance meetings.

Staff Training

An important part of the compliance plan is a commitment to train medical office staff members who are involved with coding and billing. Ongoing training also requires having the current annual updates, reading health plans' bulletins and periodicals, and researching changed regulations. Compliance officers often conduct refresher classes in proper coding and billing techniques.

THINKING IT THROUGH 2.10

1. As a medical insurance specialist, why would ongoing training be important to you?

COMPLIANCE GUIDELINE

Medical Liability Insurance

Medical liability cases for fraud often result in lawsuits. Physicians purchase professional liability insurance to cover such legal expenses. Although they are covered under the physician's policy, other medical professionals often purchase their own liability insurance. Medical coders and medical insurance specialists who perform coding tasks are advised to have professional liability insurance called error and omission (E&O) insurance, which protects against financial loss due to intentional or unintentional failure to perform work correctly.

COMPLIANCE GUIDELINE

Have It in Writing!

Do not code or bill services that are not supported by documentation, even if instructed to do so by a physician. Instead, report this kind of situation to the practice's compliance officer.

Chapter 2 Summary

Learning Outcomes	Key Concepts/Examples
2.1 Explain the importance of accurate documentation when working with medical records.	• Medical records are created based on a variety of different types of documentation for patient encounters to provide the best possible care. • Both EHRs and paper records are forms of medical documentation. EHRs offer several advantages: • Immediate access to health information • Computerized physician order management • Clinical decision support • Automated alerts and reminders • Electronic communication and connectivity • Patient support • Administration and report • Error reduction

chapter 2 review chapter 2 review chapter 2 review chapter

Learning Outcomes	Key Concepts/Examples
2.2 Compare the intent of HIPAA, HITECH, and ACA laws.	HIPAA is a law designed to: • Protect people's private health information • Ensure health insurance coverage for workers and their families when they change or lose their jobs • Uncover fraud and abuse • Create standards for electronic transmission of healthcare transactions The HITECH Act: • Contains additional provisions concerning the standards for electronic transmission of healthcare data • Guides the use of federal stimulus money to promote the adoption and meaningful use of health information technology, mainly using EHRs The ACA: • Reduces the number of people without health insurance • Fosters the formation and operation of ACOs
2.3 Describe the relationship between covered entities and business associates.	• Under HIPAA, a covered entity is a health plan, healthcare clearinghouse, or healthcare provider who transmits any health information in electronic form in connection with an HIPAA transaction. • A business associate, such as a law firm or billing service that performs work for a covered entity, must agree to follow applicable HIPAA regulations to safeguard PHI. • Electronic data interchange is used to facilitate transactions of information.
2.4 Explain the purpose of the HIPAA Privacy Rule.	• It regulates the use and disclosure of patients' PHI. • Both use and disclosure of PHI are necessary and permitted for patients' TPO. • PHI may also be released in some court cases, workers' compensation cases, statutory reports, and research. • Providers are responsible for protecting their patients' PHI, following the minimum necessary standard in releasing it, and creating procedures to follow in regard to PHI.
2.5 Briefly state the purpose of the HIPAA Security Rule.	• The rule requires covered entities to establish administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of health information. • Providers follow this rule through the use of encryption, access control, passwords, log files, backups to replace items after damage, and by developing security policies to handle violations when they do occur.
2.6 Explain the purpose of the HITECH Breach Notification Rule.	• The rule requires covered entities to notify affected individuals following the discovery of a breach of unsecured health information. • Covered entities have specific breach notification procedures that they must follow in the event of a breach. • When a breach occurs, covered entities must send the corresponding individual a breach notification, which must include five key points of information.
2.7 Explain how the HIPAA Electronic Health Care Transactions and Code Sets standards influence the electronic exchange of health information.	• TCS establishes standards for the exchange of financial and administrative data among covered entities. • The standards require the covered entities to use common electronic transaction methods and code sets. • The four National Identifiers are for employers, healthcare providers, health plans, and patients.

Learning Outcomes	Key Concepts/Examples
2.8 Describe the four final rules in the Omnibus Rule.	• The rule strengthens previous HIPAA/HITECH rules. • It increases the civil monetary penalties for violations. • The rule restates the standard for reporting breaches. • It prohibits health plans from using or disclosing genetic information for determining insurance coverage.
2.9 Explain how to guard against potentially fraudulent situations.	• Fraud and abuse regulations have been enacted to prevent fraud and abuse in healthcare billing. • OIG has the task of detecting healthcare fraud and abuse and related law enforcement. • The FCA prohibits submitting a fraudulent claim or making a false statement or representation in connection with a claim. • FERA strengthens the provisions of the FCA.
2.10 Assess the benefits of a compliance plan.	Compliance plans include: • Consistent written policies and procedures • Appointment of a compliance officer and committee • Training plans • Communication guidelines • Disciplinary systems • Ongoing monitoring and auditing of claim preparation • Response to and correction of errors • A formal process that is a sign that the practice has made a good-faith effort to achieve compliance

Review Questions

Match the key terms with their definitions.

1. **LO 2.4** HIPAA Privacy Rule
2. **LO 2.6** breach
3. **LO 2.4** minimum necessary standard
4. **LO 2.3** business associate
5. **LO 2.3** clearinghouse
6. **LO 2.4** Notice of Privacy Practices
7. **LO 2.7** code set
8. **LO 2.5** HIPAA Security Rule
9. **LO 2.3** covered entity

A. Law under the Administrative Simplification provisions of HIPAA requiring covered entities to establish administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of health information

B. The systematic, logical, and consistent recording of a patient's health status—history, examinations, tests, results of treatments, and observations—in chronological order in a patient's medical record

C. A person or organization that performs a function or activity for a covered entity but is not part of its workforce

D. The principle that individually identifiable health information should be disclosed only to the extent needed to support the purpose of the disclosure

E. Under HIPAA, a health plan, healthcare clearinghouse, or healthcare provider who transmits any health information in electronic form in connection with a HIPAA transaction

F. Law under the Administrative Simplification provisions of HIPAA regulating the use and disclosure of patients' protected health information—individually identifiable health information that is transmitted or maintained by electronic media

10. **LO 2.1** documentation
11. **LO 2.2** CMS
12. **LO 2.8** Omnibus Rule
13. **LO 2.10** compliance plan
14. **LO 2.9** OIG

G. A HIPAA-mandated document that presents a covered entity's principles and procedures related to the protection of patients' protected health information

H. A coding system used to encode elements of data

I. A company that offers providers, for a fee, the service of receiving electronic or paper claims, checking and preparing them for processing, and transmitting them in proper data format to the correct carriers

J. Impermissible use or disclosure of PHI that could pose significant risk to the affected person

K. Agency that investigates and prosecutes fraud

L. Regulations that enhance privacy protections, rights to information, and the government's ability to enforce HIPAA

M. A practice's written plan for complying with regulations

N. Agency that runs Medicare, Medicaid, clinical laboratories, and other government health programs

Select the answer choice that best completes the statement or answers the question.

15. **LO 2.2** Which of the following laws is designed to uncover fraud and abuse?
A. Fraud and Abuse Act
B. ARRA
C. HIPAA
D. HITECH Act

16. **LO 2.4** A Notice of Privacy Practices is given to
A. a practice's patients
B. a practice's business associates
C. the health plans with which a practice contracts
D. all physicians who refer patients to the practice

17. **LO 2.4** Patients' PHI may be released without authorization to
A. local newspapers
B. employers in workers' compensation cases
C. social workers
D. family and friends

18. **LO 2.4** Which government group has the authority to enforce the HIPAA Privacy Rule?
A. CIA
B. OIG
C. OCR
D. Medicaid

19. **LO 2.4** Patients always have the right to
A. withdraw their authorization to release information
B. alter the information in their medical records
C. block release of information about their communicable diseases to the state health department
D. restrict the release of all de-identified health information associated with them

20. **LO 2.4** The authorization to release information must specify
A. the number of pages to be released
B. the Social Security number of the patient
C. the entity to whom the information is to be released
D. the name of the treating physician

21. **LO 2.4** Health information that does not identify an individual is referred to as
A. protected health information
B. authorized health release
C. statutory data
D. de-identified health information

22. **LO 2.6** Analyze the following scenarios to determine which would likely warrant a breach notification.
A. De-identified health information is accessed by an outside provider.
B. A company's workforce members use information in good faith.
C. The database of a large insurance company is accessed by a hacker.
D. Information is released to the government for statistical purposes.

23. **LO 2.5** The main purpose of the HIPAA Security Rule is to

A. regulate electronic transactions

B. protect research data

C. control the confidentiality and integrity of and access to protected health information

D. protect medical facilities from criminal acts such as robbery

24. **LO 2.10** A compliance plan contains

A. consistent written policies and procedures

B. medical office staff names

C. the practice's main health plans

D. a list of all the practice's patients

25. Define the following abbreviations:

A. **LO 2.8** **OCR**

B. **LO 2.4** **PHI**

C. **LO 2.7** **TCS**

D. **LO 2.4** **DRS**

E. **LO 2.1** **EHR**

F. **LO 2.1** **CC**

G. **LO 2.7** **NPI**

H. **LO 2.4** **NPP**

I. **LO 2.9** **OIG**

Applying Your Knowledge

Case 2.1 Working with HIPAA

In each of these cases of release of PHI, was the HIPAA Privacy Rule followed? Why or why not?

A. **LO 2.4** A laboratory communicates a patient's medical test results to a physician by phone.

B. **LO 2.4** A physician mails a copy of a patient's medical record to a specialist who intends to treat the patient.

C. **LO 2.4** A hospital faxes a patient's healthcare instructions to a nursing home to which the patient is to be transferred.

D. **LO 2.4** A doctor discusses a patient's condition over the phone with an emergency room physician who is providing the patient with emergency care.

E. **LO 2.4** A doctor orally discusses a patient's treatment regimen with a nurse who will be involved in the patient's care.

F. **LO 2.4** A physician consults with another physician by e-mail about a patient's condition.

G. **LO 2.4** A hospital shares an organ donor's medical information with another hospital treating the organ recipient.

H. **LO 2.4** A medical insurance specialist answers questions from a health plan over the phone about a patient's dates of service on a submitted claim.

Case 2.2 Applying HIPAA

LO 2.4 Rosalyn Ramirez is a medical insurance specialist employed by Valley Associates, PC, a midsized multispecialty practice with an excellent record of complying with HIPAA rules. Rosalyn answers the telephone and hears this question:

"This is Jane Mazloum, I'm a patient of Dr. Olgivy. I just listened to a phone message from your office about coming in for a checkup. My husband and I were talking about this. Since this is my first pregnancy and I am working, we really don't want anyone else to know about it yet. Has this information been given to anybody outside the clinic?" How do you recommend that she respond?

Patient Name: Angelo Diaz

Health Record Number: ADI00

Date of Birth: 10-12-1945

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure: Dr. L. Handlesman

3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)

- ☐ problem list
- ☐ medication list
- ☐ list of allergies
- ☐ immunization records
- ☑ most recent history
- ☐ most recent discharge summary
- ☐ lab results (please describe the dates or types of lab tests you would like disclosed): _____
- ☑ x-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed): _____
- ☐ consultation reports from (please supply doctors' names): _____
- ☐ entire record
- ☑ other (please describe): Progress notes

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. The information identified above may be used by or disclosed to the following individuals or organization(s):

Name: Blue Cross & Blue Shield

Address: _____

Name: _____

Address: _____

6. This information for which I'm authorizing disclosure will be used for the following purpose:

- ☐ my personal records
- ☐ sharing with other healthcare providers as needed/other (please describe): _____

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal representative: *Angelo Diaz* Date: 3-1-2029

If signed by legal representative, relationship to patient

Signature of witness: _____ Date: _____

Distribution of copies: Original to provider; copy to patient; copy to accompany use or disclosure

Note: This sample form was developed by the American Health Information Management Association for discussion purposes. It should not be used without review by the issuing organization's legal counsel to ensure compliance with other federal and state laws and regulations.

Case 2.3 Handling Authorizations

LO 2.4 Angelo Diaz signed the authorization form on the preceding page. When his insurance company called for an explanation of a reported procedure that Dr. Handlesman performed to treat a stomach ulcer, George Welofar, the clinic's registered nurse, released copies of his complete file. On reviewing Mr. Diaz's history of treatment for alcohol abuse, the insurance company refused to pay the claim, stating that Mr. Diaz's alcoholism had caused the condition. Mr. Diaz complained to the practice manager about the situation.

Should the information have been released?

Case 2.4 Working with Medical Records

The following chart note contains typical documentation abbreviations and shortened forms for words.

> 65-yo female; hx of right breast ca seen in SurgiCenter for bx of breast mass. Frozen section reported as benign tumor. Bleeding followed the biopsy. Reopened the breast along site of previous incision with coagulation of bleeders. Wound sutured. Pt adm. for observation of post-op bleeding. Discharged with no bleeding recurrence.
>
> Final Dx: Benign neoplasm, left breast.

Research the meaning of each abbreviation (see the Abbreviations list at the end of the text) and write their meanings:

A. **LO 2.1** yo

B. **LO 2.1** hx

C. **LO 2.1** ca

D. **LO 2.1** bx

E. **LO 2.1** Pt

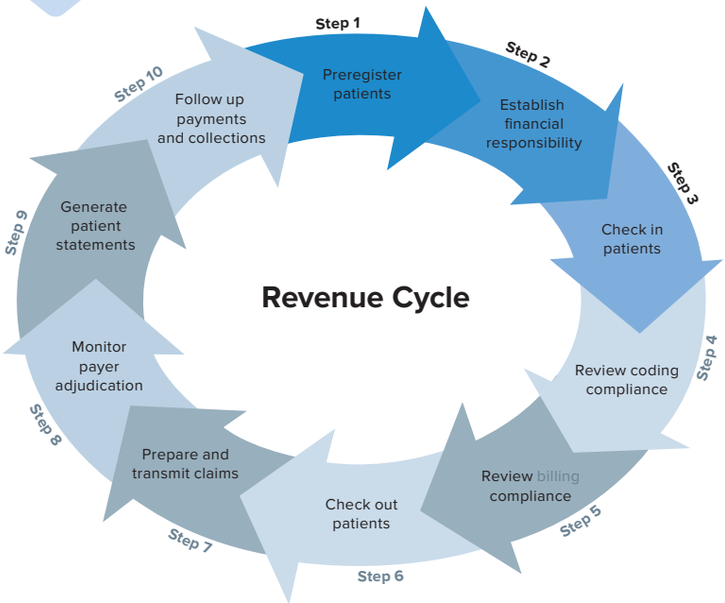
F. **LO 2.1** adm.

G. **LO 2.1** op

H. **LO 2.1** dx

PATIENT ENCOUNTERS AND BILLING INFORMATION

3



Learning Outcomes

After studying this chapter, you should be able to:

- **3.1** Explain the method used to classify patients as new or established.
- **3.2** Discuss the five categories of information required of new patients.
- **3.3** Explain how information for established patients is updated.
- **3.4** Verify patients' eligibility for insurance benefits.
- **3.5** Discuss the importance of requesting referral or preauthorization approval.
- **3.6** Determine primary insurance for patients who have more than one health plan.
- **3.7** Summarize the use of encounter forms.
- **3.8** Identify the eight types of charges that may be collected from patients at the time of service.
- **3.9** Explain the use of real-time adjudication tools in calculating time-of-service payments.

KEY TERMS

accept assignment
Acknowledgment of Receipt of Notice of Privacy Practices
assignment of benefits
birthday rule
certification number
charge capture
chart number
coordination of benefits (COB)
credit card on file (CCOF)
direct provider
electronic eligibility verification
encounter form
established patient (EP)
financial policy
gender rule
guarantor
HIPAA Coordination of Benefits
HIPAA Eligibility for a Health Plan
HIPAA Referral Certification and Authorization
indirect provider
insured/subscriber
new patient (NP)
nonparticipating provider (nonPAR)
partial payment
participating provider (PAR)
patient information form
portal
primary insurance
prior authorization number
real-time adjudication (RTA)
referral number
referral waiver
referring physician
secondary insurance
self-pay patient
supplemental insurance
tertiary insurance
trace number

From a business standpoint, the key to the financial health of a physician practice is billing and collecting fees for services. To maintain a regular cash flow—the movement of monies into or out of a business—specific medical billing tasks must be completed on a regular schedule. Processing encounters for billing purposes makes up the pre-claim section of the revenue cycle. This chapter discusses the important aspects of these steps:

- Information about patients and their insurance coverage is gathered and verified.
- The encounter is documented by the provider, and the resulting diagnoses and procedures are posted.
- Time-of-service payments are collected.

Patient charges represent an increasing percentage of practice revenues. Patients must leave the encounter with a clear understanding of their financial responsibilities and the next steps in the revenue cycle: filing claims, insurance payments, and paying bills they receive for balances they owe.

BILLING TIP

Defining "Provider"

The *provider* is defined as either a physician or a qualified healthcare professional, such as a physician assistant.

3.1 New Versus Established Patients

To gather accurate information for billing and medical care, practices ask patients to supply information and then double-check key data. Patients who are new to the medical practice complete many forms before their first encounters with their providers. A **new patient (NP)** is someone who has not received any services from the provider (or another provider of the same specialty/subspecialty) who is a member of the same practice within the past three years. A returning patient is called an **established patient (EP).** This patient has seen the provider (or another provider in the practice who has the same specialty) within the past three years. Established patients, review and update the information that is on file about them. Figure 3.1 illustrates how to decide which category fits the patient.

new patient (NP) patient who has not seen a provider within the past three years

established patient (EP) patient who has seen a provider within the past three years

THINKING IT THROUGH 3.1

1. Why is it important to determine whether patients are new or established in the practice?

3.2 Information for New Patients

When the patient is new to the practice, five types of information are important:

1. Preregistration and scheduling information
2. Medical history
3. Patient or guarantor and insurance data
4. Assignment of benefits
5. Acknowledgment of Receipt of Notice of Privacy Practices

Preregistration and Scheduling Information

The collection of information begins before the patient presents at the front desk for an appointment. Most medical practices have a preregistration process to check that patients' healthcare requirements are appropriate for the medical practice and to schedule appointments of the correct length.

Preregistration Basics

When new patients call for appointments, basic information is usually gathered:

- Full legal name as it appears on the patient's insurance card
- Telephone number

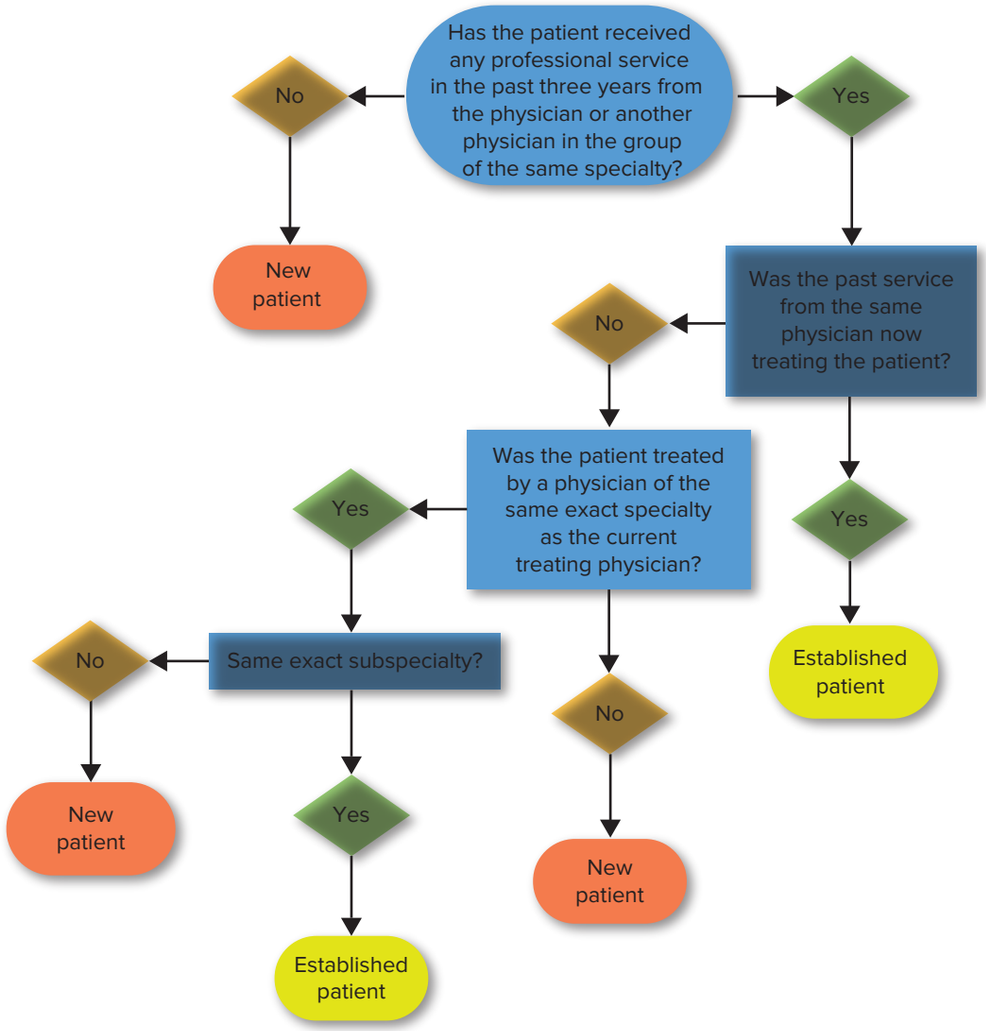


FIGURE 3.1 Decision Tree for New Versus Established Patients

- Address
- Date of birth
- Gender
- Reason for call or nature of complaint, including information about previous treatment
- If insured, the name of the health plan and whether a copay or coinsurance payment at the time of service is required
- If referred, the name of the referring physician

BILLING TIP

Referring Physician

A **referring physician** sends a patient to another physician for treatment.

referring physician physician who transfers care of a patient to another physician

Scheduling Appointments

Front office employees handle appointments and scheduling in most practices and may also handle prescription refill requests. Patient-appointment scheduling systems are often used; some permit online scheduling. Scheduling systems can be used to automatically

send reminders to patients, to trace follow-up appointments, and to schedule recall appointments according to the provider's orders. Some offices use open-access scheduling that allows patients to see providers without having made advance appointments; follow-up visits are scheduled.

BILLING TIP

MCOs and Appointments

Many managed care organizations (MCOs) require participating physicians to see enrolled patients within a short time of their calling for appointments. Some also require primary care physicians (PCPs) to handle emergencies in the office, rather than sending patients to the emergency department.

Provider Participation

New patients, too, may need information before deciding to make appointments. Most patients in preferred provider organizations (PPOs) and health maintenance organizations (HMOs) must use network physicians to avoid paying higher charges. For this reason, patients check whether the provider is a **participating provider, or PAR,** in their plan. When patients see **nonparticipating, or nonPAR, providers,** they must pay more—a higher copayment, higher coinsurance, or both—so a patient may choose not to make an appointment because of the additional expense.

participating provider (PAR) provider who agrees to provide medical services to a payer's policyholders according to a contract

nonparticipating provider (nonPAR) provider who does not join a particular health plan

Medical History

New patients complete medical history forms. Some practices give printed forms to patients when they come in. Others make the form available for completion ahead of time by posting it online or mailing it to the patient. Practices may also enable the patient to complete the medical history electronically in the reception area using portable check-in devices such as a tablet or wireless clipboard.

An example of a patient medical history form is shown in Figure 3.2. The form asks for information about the patient's personal medical history, the family's medical history, and the social history. Social history covers lifestyle factors such as smoking, exercise, and alcohol use. Many specialists use less-detailed forms that cover the histories needed for treatment.

The physician reviews this information with the patient during the visit. The patient's answers and the physician's notes are documented in the medical record.

BILLING TIP

Social Security Numbers (SSNs)

Although claim completion does not require SSNs, many practices still use these numbers as identifiers and request them on their patient information forms. Some patients may not provide SSNs. When the Health Insurance Portability and Accountability Act (HIPAA) national patient identifier rule is enacted, the numbering system the law will create will replace the use of SSNs in healthcare.

BILLING TIP

Know Plan Participation

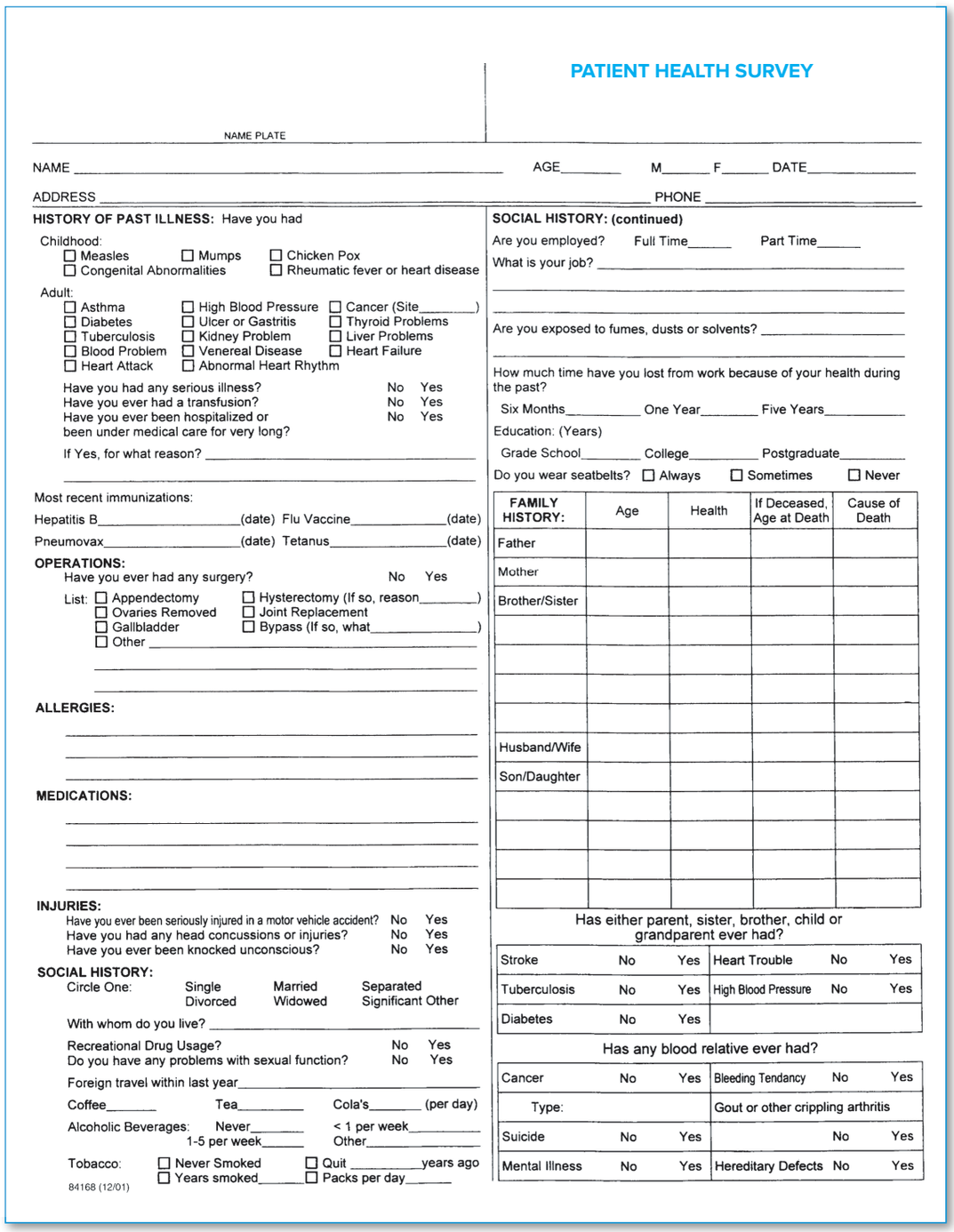
Administrative staff members must know what plans the providers participate in. A summary of these plans should be available during patient registration.

Patient or Guarantor and Insurance Data

patient information form form that includes a patient's personal, employment, and insurance company data

A new patient arriving at the front desk for an appointment completes a **patient information form** (see Figure 3.3). It is used to collect the following demographic information about the patient:

- First name, middle initial, and last name
- Gender (*F* for female or *M* for male)
- Race and ethnicity
- Primary language
- Marital status (*S* for single, *M* for married, *D* for divorced, *W* for widowed)
- Birth date, using four digits for the year
- Home address and telephone numbers (area code with seven-digit number)



PATIENT HEALTH SURVEY

NAME PLATE

NAME _____ AGE_____ M_____ F_____ DATE_____

ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Have you had

Childhood:
☐ Measles ☐ Mumps ☐ Chicken Pox
☐ Congenital Abnormalities ☐ Rheumatic fever or heart disease

Adult:
☐ Asthma ☐ High Blood Pressure ☐ Cancer (Site_____)
☐ Diabetes ☐ Ulcer or Gastritis ☐ Thyroid Problems
☐ Tuberculosis ☐ Kidney Problem ☐ Liver Problems
☐ Blood Problem ☐ Venereal Disease ☐ Heart Failure
☐ Heart Attack ☐ Abnormal Heart Rhythm

Have you had any serious illness? No Yes
Have you ever had a transfusion? No Yes
Have you ever been hospitalized or been under medical care for very long? No Yes

If Yes, for what reason? _____

Most recent immunizations:

Hepatitis B_____(date) Flu Vaccine_____(date)

Pneumovax_____(date) Tetanus_____(date)

OPERATIONS:
Have you ever had any surgery? No Yes

List: ☐ Appendectomy ☐ Hysterectomy (If so, reason_____)
☐ Ovaries Removed ☐ Joint Replacement
☐ Gallbladder ☐ Bypass (If so, what_____)
☐ Other _____

ALLERGIES:

MEDICATIONS:

INJURIES:
Have you ever been seriously injured in a motor vehicle accident? No Yes
Have you had any head concussions or injuries? No Yes
Have you ever been knocked unconscious? No Yes

SOCIAL HISTORY:
Circle One: Single Married Separated
Divorced Widowed Significant Other

With whom do you live? _____

Recreational Drug Usage? No Yes
Do you have any problems with sexual function? No Yes

Foreign travel within last year_____

Coffee_____ Tea_____ Cola's_____ (per day)

Alcoholic Beverages: Never_____ < 1 per week_____
1-5 per week_____ Other_____

Tobacco: ☐ Never Smoked ☐ Quit _____years ago
☐ Years smoked_____ ☐ Packs per day_____

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SOCIAL HISTORY: (continued)

Are you employed? Full Time_____ Part Time_____

What is your job? _____

Are you exposed to fumes, dusts or solvents? _____

How much time have you lost from work because of your health during the past?

Six Months_____ One Year_____ Five Years_____

Education: (Years)

Grade School_____ College_____ Postgraduate_____

Do you wear seatbelts? ☐ Always ☐ Sometimes ☐ Never

FAMILY HISTORY:	Age	Health	If Deceased, Age at Death	Cause of Death
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has either parent, sister, brother, child or grandparent ever had?

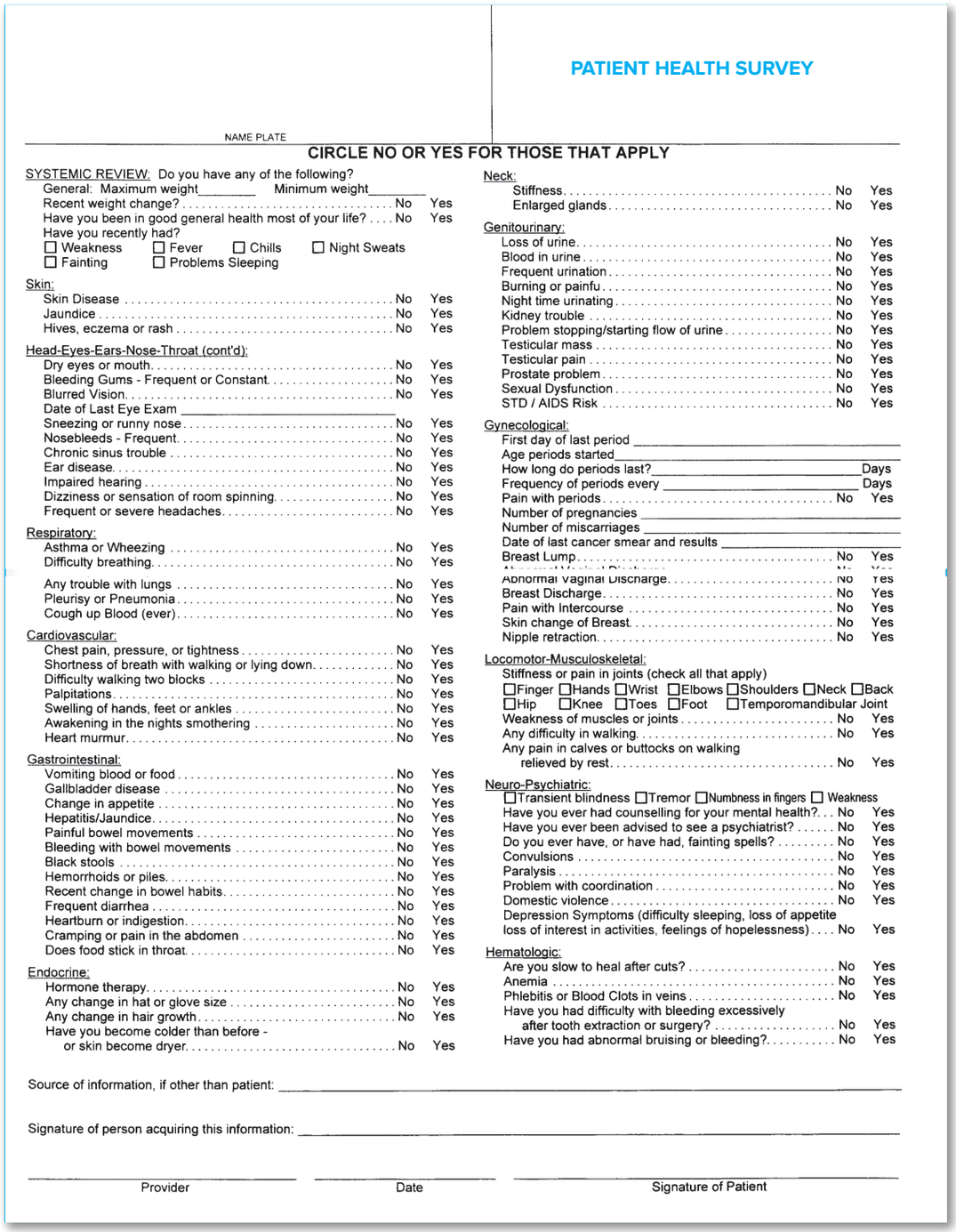
Stroke	No	Yes	Heart Trouble	No	Yes
Tuberculosis	No	Yes	High Blood Pressure	No	Yes
Diabetes	No	Yes			

Has any blood relative ever had?

Cancer	No	Yes	Bleeding Tendancy	No	Yes
Type:			Gout or other crippling arthritis		
Suicide	No	Yes		No	Yes
Mental Illness	No	Yes	Hereditary Defects	No	Yes

FIGURE 3.2 Medical History Form

- E-mail address
- Employer's name, address, and telephone number
- For a married patient, his or her employer's name or the name and employer of the spouse
- A contact person for the patient in case of a medical emergency
- If the patient is a minor (under the age of majority according to state law) or has a medical power of attorney in place (such as a person who is handling the medical



PATIENT HEALTH SURVEY

NAME PLATE

CIRCLE NO OR YES FOR THOSE THAT APPLY

SYSTEMIC REVIEW: Do you have any of the following?
General: Maximum weight_____ Minimum weight_____
Recent weight change? ... No Yes
Have you been in good general health most of your life? ... No Yes
Have you recently had?
☐ Weakness ☐ Fever ☐ Chills ☐ Night Sweats
☐ Fainting ☐ Problems Sleeping

Skin:
Skin Disease ... No Yes
Jaundice ... No Yes
Hives, eczema or rash ... No Yes

Head-Eyes-Ears-Nose-Throat (cont'd):
Dry eyes or mouth ... No Yes
Bleeding Gums - Frequent or Constant ... No Yes
Blurred Vision ... No Yes
Date of Last Eye Exam _____
Sneezing or runny nose ... No Yes
Nosebleeds - Frequent ... No Yes
Chronic sinus trouble ... No Yes
Ear disease ... No Yes
Impaired hearing ... No Yes
Dizziness or sensation of room spinning ... No Yes
Frequent or severe headaches ... No Yes

Respiratory:
Asthma or Wheezing ... No Yes
Difficulty breathing ... No Yes
Any trouble with lungs ... No Yes
Pleurisy or Pneumonia ... No Yes
Cough up Blood (ever) ... No Yes

Cardiovascular:
Chest pain, pressure, or tightness ... No Yes
Shortness of breath with walking or lying down ... No Yes
Difficulty walking two blocks ... No Yes
Palpitations ... No Yes
Swelling of hands, feet or ankles ... No Yes
Awakening in the nights smothering ... No Yes
Heart murmur ... No Yes

Gastrointestinal:
Vomiting blood or food ... No Yes
Gallbladder disease ... No Yes
Change in appetite ... No Yes
Hepatitis/Jaundice ... No Yes
Painful bowel movements ... No Yes
Bleeding with bowel movements ... No Yes
Black stools ... No Yes
Hemorrhoids or piles ... No Yes
Recent change in bowel habits ... No Yes
Frequent diarrhea ... No Yes
Heartburn or indigestion ... No Yes
Cramping or pain in the abdomen ... No Yes
Does food stick in throat ... No Yes

Endocrine:
Hormone therapy ... No Yes
Any change in hat or glove size ... No Yes
Any change in hair growth ... No Yes
Have you become colder than before - or skin become dryer ... No Yes

Neck:
Stiffness ... No Yes
Enlarged glands ... No Yes

Genitourinary:
Loss of urine ... No Yes
Blood in urine ... No Yes
Frequent urination ... No Yes
Burning or painfu ... No Yes
Night time urinating ... No Yes
Kidney trouble ... No Yes
Problem stopping/starting flow of urine ... No Yes
Testicular mass ... No Yes
Testicular pain ... No Yes
Prostate problem ... No Yes
Sexual Dysfunction ... No Yes
STD / AIDS Risk ... No Yes

Gynecological:
First day of last period _____
Age periods started _____
How long do periods last? _____ Days
Frequency of periods every _____ Days
Pain with periods ... No Yes
Number of pregnancies _____
Number of miscarriages _____
Date of last cancer smear and results _____
Breast Lump ... No Yes
Abnormal Vaginal Discharge ... No Yes
Breast Discharge ... No Yes
Pain with Intercourse ... No Yes
Skin change of Breast ... No Yes
Nipple retraction ... No Yes

Locomotor-Musculoskeletal:
Stiffness or pain in joints (check all that apply)
☐Finger ☐Hands ☐Wrist ☐Elbows ☐Shoulders ☐Neck ☐Back
☐Hip ☐Knee ☐Toes ☐Foot ☐Temporomandibular Joint
Weakness of muscles or joints ... No Yes
Any difficulty in walking ... No Yes
Any pain in calves or buttocks on walking relieved by rest ... No Yes

Neuro-Psychiatric:
☐Transient blindness ☐Tremor ☐Numbness in fingers ☐ Weakness
Have you ever had counselling for your mental health? ... No Yes
Have you ever been advised to see a psychiatrist? ... No Yes
Do you ever have, or have had, fainting spells? ... No Yes
Convulsions ... No Yes
Paralysis ... No Yes
Problem with coordination ... No Yes
Domestic violence ... No Yes
Depression Symptoms (difficulty sleeping, loss of appetite loss of interest in activities, feelings of hopelessness) ... No Yes

Hematologic:
Are you slow to heal after cuts? ... No Yes
Anemia ... No Yes
Phlebitis or Blood Clots in veins ... No Yes
Have you had difficulty with bleeding excessively after tooth extraction or surgery? ... No Yes
Have you had abnormal bruising or bleeding? ... No Yes

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Provider Date Signature of Patient

FIGURE 3.2 *(continued)*

decisions of another person), the responsible person's name, gender, marital status, birth date, address, e-mail address, telephone number, and employer information are collected. If a minor, the child's status if a full-time or part-time student is recorded. In most cases, the responsible person is a parent, guardian, adult child, or other person acting with legal authority to make healthcare decisions on behalf of the patient.

- The name of the patient's health plan

VALLEY ASSOCIATES, PC
1400 West Center Street
Toledo, OH 43601-0213
555-967-0303

PATIENT INFORMATION FORM

THIS SECTION REFERS TO PATIENT ONLY

Name:	Sex:	Marital Status: ☐S ☐M ☐D ☐W	Birth Date:
Address:	E-mail Address:		
City: State: Zip:	Employer:		Phone:
Home Phone:	Employer's Address:		
Work Phone:	City:	State:	Zip:
Spouse's Name:	Spouse's Employer:		
Emergency Contact:	Relationship:		Phone #:

Race:		Ethnicity:	Preferred Language:
☐ White	☐ Native Hawaiian	☐ Hispanic or Latino	☐ English
☐ Asian	☐ Other Pacific Islander	☐ Not Hispanic or Latino	☐ Spanish
☐ Black or African American	☐ Undefined	☐ Undefined	☐ Other_____
☐ American Indian or Alaskan Native	☐ Refused to report/ unreported	☐ Refused to report/ unreported	☐ Refused to report/ unreported
☐ More than one			

FILL IN IF PATIENT IS A MINOR

Parent/Guardian's Name:	Sex:	Marital Status: ☐S ☐M ☐D ☐W	Birth Date:
Phone:	E-mail Address:		
Address:	Employer:		Phone:
City: State: Zip:	Employer's Address:		
Student Status:	City:	State:	Zip:

INSURANCE INFORMATION

Primary Insurance Company:	Secondary Insurance Company:
Subscriber's Name: Birth Date:	Subscriber's Name: Birth Date:
Plan:	Plan:
Policy #: Group #:	Policy #: Group #:
Copayment/Deductible:	

OTHER INFORMATION

Reason for visit:	Allergy to medication (list):
Name of referring physician:	If auto accident, list date and state in which it occurred:

I authorize treatment and agree to pay all fees and charges for the person named above. I agree to pay all charges shown by statements, promptly upon their presentation, unless credit arrangements are agreed upon in writing.

I authorize payment directly to VALLEY ASSOCIATES, PC of insurance benefits otherwise payable to me. I hereby authorize the release of any medical information necessary in order to process a claim for payment in my behalf.

_____ (Patient's Signature/Parent or Guardian's Signature)

_____ (Date)

I plan to make payment of my medical expenses as follows (check one or more):

_____Insurance (as above) _____Cash/Check/Credit/Debit Card _____Medicare _____Medicaid _____Workers' Comp.

FIGURE 3.3 Patient Information (Registration) Form

- The health plan's policyholder's name (the policyholder may be a spouse, guardian, or other relation), birth date, plan type, policy number or group number, telephone number, and employer
- If the patient is covered by another health plan, the name and policyholder information for that plan

BILLING TIP

Subscriber, Insured, or Guarantor?

Other terms for *policyholder* are **insured** *or* **subscriber.** This person is the holder of the insurance policy that covers the patient and is not necessarily also a patient of the practice. The **guarantor** is the person who is financially responsible for the bill.

insured/subscriber policyholder of a health plan

guarantor person who is financially responsible for the bill

Insurance Cards

For an insured new patient, the front and the back of the insurance card are scanned or photocopied. All data from the card that the patient has written on the patient information form are double-checked for accuracy.

Most insurance cards have the following information (see Figure 3.4):

- Group identification number
- Date on which the member's coverage became effective
- Member name
- Member identification number
- The health plan's name, type of coverage, copayment/coinsurance requirements, and frequency limits or annual maximums for services; sometimes the annual deductible
- Optional items, such as prescription drugs that are covered, with the payment requirements

BILLING TIP

Matching the Patient's Name

Payers want the name of the patient on a claim to be exactly as it is shown on the insurance card. Do not use nicknames, skip middle initials, or make any other changes. Compare the patient information form carefully with the insurance card, and resolve any discrepancies before the encounter.

Photo Identification

Many practices also require the patient to present a photo ID card, such as a driver's license, which the practice scans or copies for the chart.

Assignment of Benefits

Physicians usually submit claims for patients and receive payments directly from the payers. This saves patients paperwork; it also benefits providers because payments are faster. The policyholder must authorize this procedure by signing and dating an **assignment of benefits** statement. This may be a separate form, as in Figure 3.5, or an entry on the patient information form, as in Figure 3.3. The assignment of benefits statement is filed in both the patient medical and billing records.

assignment of benefits authorization allowing benefits to be paid directly to a provider

Acknowledgment of Receipt of Notice of Privacy Practices

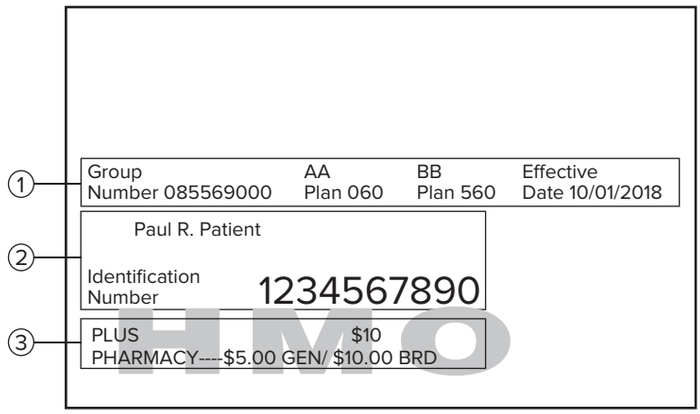
Under the HIPAA Privacy Rule (see the chapter about EHRs, HIPAA, and HITECH), providers do not need specific authorization in order to release patients' protected health information (PHI) for treatment, payment, and healthcare operations (TPO) purposes. These uses are defined as:

1. *Treatment:* This purpose primarily consists of discussion of the patient's case with other providers. For example, the physician may document the role of each member of the healthcare team in providing care. Each team member then records actions and observations so that the ordering physician knows how the patient is responding to treatment.
2. *Payment:* Practices usually submit claims on behalf of patients; this involves sending demographic and diagnostic information.
3. *Healthcare operations:* This purpose includes activities such as staff training and quality improvement.

BILLING TIP

Smart Cards

Smart cards are being introduced by health plans. These have embedded data and a required PIN for access. The goal is to reduce the likelihood of identity theft, fraud, and abuse.



1. ***Group identification number***
   The 9-digit number used to identify the member's employer.

   Plan codes
   The numbers used to identify the codes assigned to each plan; used for claims submissions when medical services are rendered out-of-state.

   Effective date
   The date on which the member's coverage became effective.
2. ***Member name***
   The full name of the cardholder.

   Identification number
   The 10-digit number used to identify each plan member.
3. ***Health plan***
   The name of the health plan and the type of coverage; usually lists any copayment amounts, frequency limits, or annual maximums for home and office visits; may also list the member's annual deductible amount.

   Riders
   The type(s) of riders that are included in the member's benefits (DME, Visions).

   Pharmacy
   The type of prescription drug coverage; lists copayment amounts.

FIGURE 3.4 An Example of an Insurance Card

Providers must have patients' authorization to use or disclose information that is not for TPO purposes. For example, a patient who wishes a provider to disclose PHI to a life insurance company must complete an authorization form (see Figure 2.3 in the chapter about EHRs, HIPAA, and HITECH) to do so.

BILLING TIP

Release Document

State law may be more stringent than HIPAA and demand an authorization to release TPO information. Many practices routinely have patients sign release of information statements.

Under HIPAA, providers must inform each patient about their privacy practices one time. The most common method is to give the patient a copy of the medical office's

COMPLIANCE GUIDELINE

State Law on Assignment of Benefits

Many states have laws mandating that the payer must pay the provider of services (rather than the patient) if a valid assignment of benefits is on file and the payer has been notified of the assignment of benefits.

Assignment of Benefits

I hereby assign to Valley Associates, PC, any insurance or other third-party benefits available for healthcare services provided to me. I understand that Valley Associates has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Valley Associates, I agree to forward to Valley Associates all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian: _____

Date: _____

FIGURE 3.5 Assignment of Benefits Form

Who is Requesting PHI?

Although the HIPAA Privacy Rule permits sharing PHI for TPO purposes without authorization, it also requires verification of the identity of the person who is asking for the information. The person's authority to access PHI must also be verified. If the requestor's right to the information is not certain, the best practice is to have the patient authorize the release of PHI.

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that the providers of Valley Associates, PC, may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand that Valley Associates has the right to change this notice at any time. I may obtain a current copy by contacting the practice's office or by visiting the website at yourvalleyassociates.com.

My signature below constitutes my acknowledgment that I have been provided with a copy of the notice of privacy practices.

_____

Signature of Patient or Legal Representative Date

If signed by legal representative,
relationship to patient:_____

FIGURE 3.6 Acknowledgment of Receipt of Notice of Privacy Practices

Acknowledgment of Receipt of Notice of Privacy Practices form accompanying a covered entity's Notice of Privacy Practices for the patient's signature, indicating that the NPP has been read

privacy practices to read and then to have the patient sign a separate form called an **Acknowledgment of Receipt of Notice of Privacy Practices** (see Figure 3.6). This form states that the patient has read the privacy practices and understands how the provider intends to protect the patient's rights to privacy under HIPAA.

The provider must make a good-faith effort to have patients sign this document. The provider must also document—in the medical record—whether the patient signed the form. The format for the acknowledgment is up to the practice. Only a **direct provider,** one who directly treats the patient, is required to have patients sign an acknowledgment. An **indirect provider,** such as a pathologist, must have a privacy notice but does not have to secure additional acknowledgments.

direct provider clinician who treats a patient face-to-face

indirect provider clinician who does not interact face-to-face with the patient

If a patient who has not received a privacy notice or signed an acknowledgment calls for a prescription refill, the recommended procedure is to mail the patient a copy of the

privacy notice, along with an acknowledgment of receipt form, and to document the mailing to show a good-faith effort that meets the office's HIPAA obligation in the event that the patient does not return the signed form.

THINKING IT THROUGH 3.2

1. Why is it important to verify a patient's insurance coverage before an office visit?

Keeping Acknowledgments on File

Providers must retain signed acknowledgments as well as documentation about unsuccessful attempts to obtain them for six years.

3.3 Information for Established Patients

When established patients present for appointments, the front desk staff member asks whether any pertinent personal or insurance information has changed. This update process is important because different employment, marital status, dependent status, or plans may affect patients' coverage. Patients may also phone in changes, such as new addresses or employers.

To double-check that information is current, most practices periodically ask established patients to review and sign off on their patient information forms when they come in. This review should be done at least once a year. A good time is an established patient's first appointment in a new year. The file is also checked to be sure that the patient has been given a current Notice of Privacy Practices.

If the insurance of an established patient has changed, both sides of the new card are copied, and all data are checked. Many practices routinely scan or copy the card at each visit as a safeguard.

PHI and Minors

A covered entity may choose to provide or deny a parent access to a minor's PHI if doing so is consistent with state or other applicable law and provided that the decision is made by a licensed healthcare professional. These options apply whether or not the parent is the minor's personal representative.

Entering Patient Information in the Practice Management Program

A practice management program (PMP) is set up with databases about the practice's income and expense accounting. The provider database has information about physicians and other health professionals who work in the practice, such as their medical license numbers, tax identification numbers, and office hours. A database of common diagnosis and procedure codes is also built in the PMP. After these databases are set up, the medical insurance specialist can enter patients' demographic and visit information to begin the process of billing.

The database of patients in the practice management program must be continually kept up-to-date. For each new patient, a new file and a new **chart number** are set up. The chart number is a unique number that identifies the patient. It links all the information that is stored in other databases—providers, insurance plans, diagnoses, procedures, and claims—to the case of the particular patient.

chart number unique number that identifies a patient

Usually, a new *case* or record for an established patient is set up in the program when the patient's chief complaint for an encounter is different than the previous chief complaint. For example, a patient might have had an initial appointment for a comprehensive physical examination. Subsequently, this patient sees the provider because of stomach pain. Each visit is set up as a separate case in the PMP.

Communications with Patients

Service to patients—the customers of medical practices—is as important as, if not more important than, billing information. Satisfied customers are essential to the financial health of every business, including medical practices. Medical practice staff members must be dedicated to retaining patients by providing excellent service.

The following are examples of good communication:

- Established and new patients who call or arrive for appointments are always given friendly greetings and are referred to by name.
- Patients' questions about forms they are completing and about insurance matters are answered with courtesy.
- When possible, patients in the reception area are told the approximate waiting time until they will see the provider.
- Fees for providers' procedures and services are explained to patients.
- The medical practice's guidelines about patients' responsibilities, such as when payments are due from patients and the need to have referrals from primary care physicians, are prominently posted in the office (see Figure 3.11, where financial policies are explained).
- Patients are called a day or two before their appointments to remind them of appointment times.

Like all businesses, even the best-managed medical practices have to deal with problems and complaints. Patients sometimes become upset over scheduling or bills or have problems understanding lab reports or instructions. Medical insurance specialists often handle patients' questions about benefits and charges. They must become good problem solvers, willing to listen to and empathize with the patient while sorting out emotions from facts to get accurate information. Phrases such as these reduce patients' anger and frustration:

"I'm glad you brought this to our attention. I will look into it further."

"I can appreciate how you would feel this way."

"It sounds like we have caused some inconvenience, and I apologize."

"I understand that you are angry. Let me try to understand your concerns so we can address the situation."

"Thank you for taking the time to tell us about this. Because you have, we can resolve issues like the one you raised."

Medical insurance specialists need to use the available resources and to investigate solutions to problems. Following through on promised information is also critical. A medical insurance specialist who says to a patient "I will call you by the end of next week with that information" must do exactly that. Even if the problem is not solved, the patient needs an update on the situation within the stated time frame.

Observing HIPAA Privacy and Security Requirements

Front office staff members follow HIPAA requirements in dealing with patients. They use reasonable safeguards, such as speaking softly and never leaving handheld dictation devices unattended, to prevent others from hearing PHI. Computer monitors, medical records, and other documents are not visible to patients who are checking in or to others in the waiting room.

THINKING IT THROUGH 3.3

1. Review these multiple versions of the same name:

   Ralph Smith

   Ralph P. Smith

   Ralph Plane Smith

   R. Plane Smith

   R. P. Smith

   If "Ralph Plane Smith" appears on the insurance card and his mother writes "Ralph Smith" on the patient information form, which version should be used for the medical practice's records? Why?

2. Refer to the following patient information form. According to the information supplied by the patient, who is the policyholder? What is the patient's relationship to the policyholder?

PATIENT INFORMATION FORM			
THIS SECTION REFERS TO PATIENT ONLY			
Name: **Mary Anne C. Kopelman**	Sex: **F**	Marital status: ☐ S ☒ M ☐ D ☐ W	Birth date: **08/24/1992**
Address: **45 Mason Street**	E-mail address: **makopelman@gmail.com**		
City: **Hopewell** State: **OH** Zip: **43800**	**Employer:**		
Home phone: **555-427-6019**	Employer's address:		
Work phone:	City: State: Zip:		
Spouse's name: **Arnold B. Kopelman**	Spouse's employer: **U.S. Army, Fort Tyrone**		
Emergency contact: **Arnold B. Kopelman**	Relationship: **husband**	Phone #: **555-439-0018**	
INSURANCE INFORMATION			
Primary insurance company: **TriCare**	**Secondary insurance company:**		
Policyholder's name: **Arnold B. Kopelman** Birth date: **04/10/1995**	**Policyholder's name:** **Birth date:**		
Plan: **TriCare**	**Plan:**		
Policy #: **230-56-9874** Group #: **USA9947**	**Policy #:** **Group #:**		

3.4 Verifying Patient Eligibility for Insurance Benefits

To be paid for services, medical practices need to establish financial responsibility. Medical insurance specialists are vital employees in this process. For insured patients, they follow three steps to establish financial responsibility:

1. Verify the patient's eligibility for insurance benefits
2. Determine preauthorization and referral requirements
3. Determine the primary payer if more than one insurance plan is in effect

BILLING TIP

Plan Information

Be aware of the copayments, preauthorization and referral requirements, and noncovered services for plans in which the practice participates.

The first step is to verify patients' eligibility for benefits. Medical insurance specialists abstract information about the patient's payer or plan from the patient's information form (PIF) and the insurance card. They then contact the payer to verify three points:

1. Patients' general eligibility for benefits
2. The amount of the copayment or coinsurance required at the time of service
3. Whether the planned encounter is for a covered service that is medically necessary under the payer's rules

These items are checked before an encounter except in a medical emergency when care is provided immediately and insurance is checked after the encounter.

BILLING TIP

Payers' Rules for Medical Necessity

Medicare requires patients to be notified if their insurance is not going to cover a visit, as detailed in the Medicare chapter. Other payers have similar rules.

Factors Affecting General Eligibility

General eligibility for benefits depends on a number of factors. If premiums are required, patients must have paid them on time. For government-sponsored plans for which income is the criterion, such as Medicaid, eligibility can change monthly. For patients with employer-sponsored health plans, employment status can be the deciding factor:

- Coverage may end on the last day of the month in which the employee's active full-time service ends, such as for disability, layoff, or termination.
- The employee may no longer qualify as a member of the group. For example, some companies do not provide benefits for part-time employees. If a full-time employee changes to part-time employment, the coverage ends.
- An eligible dependent's coverage may end on the last day of the month in which the dependent status ends, such as reaching the age limit stated in the policy.

BILLING TIP

Getting Online Information About Patients

portal website that serves as an entry point to other websites

A **portal** is a website that is an entry point to other websites. Many insurers have portals to be used to check patient eligibility for coverage, get information on copayments and deductibles, process claims, and submit preauthorization requests.

If the plan is an HMO that requires a PCP, a general or family practice must verify that (1) the provider is a plan participant, (2) the patient is listed on the plan's enrollment master list, and (3) the patient is assigned to the PCP as of the date of service.

The medical insurance specialist checks online with the payer to confirm whether the patient is currently covered. Based on the patient's plan, eligibility for these specific benefits may also need checking:

- Office visits
- Lab coverage
- Diagnostic X-rays
- Maternity coverage
- Pap smear coverage
- Coverage of psychiatric visits
- Physical or occupational therapy
- Durable medical equipment (DME)
- Foot care

BILLING TIP

Check the Lab Requirements

Because many MCOs specify which laboratory must be used, patients should be notified that they are responsible for telling the practice about their plans' lab requirements so that if specimens are sent to the wrong lab, the practice is not responsible for the costs.

Checking Out-of-Network Benefits

If patients have insurance coverage but the practice does not participate in their plans, the medical insurance specialist checks the out-of-network benefit. When the patient has out-of-network benefits, the payer's rules concerning copayments or coinsurance and coverage are followed. If a patient does not have out-of-network benefits, as is common when the health plan is an HMO, the patient is responsible for the entire bill.

Verifying the Amount of the Copayment or Coinsurance

The amount of the copayment or coinsurance, if required at the time of service, must be checked. It is sometimes the case that the insurance card is out of date and a different amount needs to be collected.

Determining Whether the Planned Encounter Is for a Covered Service

The medical insurance specialist also must attempt to determine whether the planned encounter is for a covered service. If the service will not be covered, that patient can be informed and made aware of financial responsibility in advance.

The resources for covered services include knowledge of the major plans held by the practice's patients, information from the provider representative and payer websites, and the electronic benefit inquiries described in the next section. Medical insurance specialists are familiar with what the plans cover in general. For example, most plans cover regular office visits, but they may not cover preventive services or some therapeutic services. Unusual or unfamiliar services must be researched, and the payer must be queried.

Electronic Benefit Inquiries and Responses

If the practice sends the HIPAA standard transaction, the payer must, under HIPAA rules, return the answering **electronic eligibility verification.** When an eligibility benefits transaction is sent, the computer program assigns a unique **trace number** to the inquiry. Often, eligibility transactions are sent the day before patients arrive for appointments. If the PMP has this feature, the eligibility transaction can be sent automatically.

The health plan responds to an eligibility inquiry with this information:

- Trace number as a double check on the inquiry
- Benefit information, such as whether the insurance coverage is active
- Covered period—the period of dates that the coverage is active
- Benefit units, such as how many physical therapy visits
- Coverage level—that is, who is covered, such as spouse and family or individual

The following information may also be transmitted:

- The copay amount
- Premium amount and status
- The yearly deductible amount and payment status
- The out-of-pocket expenses
- The health plan's information on the first and last names of the insured or patient, dates of birth, and identification numbers
- Primary care provider

Procedures When the Patient Is Not Covered

If an insured patient's policy does not cover a planned service, this situation is discussed with the patient. Patients should be informed that the payer does not pay for the service and that they are responsible for the charges.

X12 270/271 Eligibility for a Health Plan Inquiry/ Response

The **HIPAA Eligibility for a Health Plan** transaction is also called the X12 270/271. The number 270 refers to the inquiry that is sent, and 271 to the answer returned by the payer.

HIPAA Eligibility for a Health Plan HIPAA X12 270/271 transaction in which a provider asks for and receives an answer about a patient's eligibility for benefits

electronic eligibility verification required payer response to the HIPAA standard transaction

trace number number assigned to a HIPAA 270 electronic transaction

BILLING TIP

Double-Checking Patients' Information

Review the payer's spelling of the insured's and the patient's first and last names as well as the dates of birth and identification numbers. Correct any mistakes in the record, so that when a healthcare claim is later transmitted for the encounter, it will be accepted for processing.

BILLING TIP

Processing the Patient Financial Agreement

Patients should be given copies of their financial agreements. A signed original is filed in the patient's record.

Service to be performed: _____
Estimated charge: _____
Date of planned service: _____
Reason for exclusion: _____
_____

I, _____, a patient of _____, understand the service described above is excluded from my health insurance. I am responsible for payment in full of the charges for this service.

FIGURE 3.7 Sample Financial Agreement for Patient Payment of Noncovered Services

Some payers require the physician to use specific forms to tell the patient about uncovered services. These financial agreement forms, which patients must sign, prove that patients have been told about their obligation to pay the bill *before* the services are given. For example, the Medicare program provides a form, called an *advance beneficiary notice (ABN),* that must be used to show patients the charges. The signed form, as explained in the Medicare chapter, allows the practice to collect payment for a provided service or supply directly from the patient if Medicare refuses reimbursement. Figure 3.7 is an example of a form used to tell patients in advance of the probable cost of procedures that are not going to be covered by their plan and to secure their agreement to pay.

THINKING IT THROUGH 3.4

1. What is the advantage of using electronic transactions for verifying a patient's eligibility for benefits?

3.5 Determining Preauthorization and Referral Requirements

Preauthorization

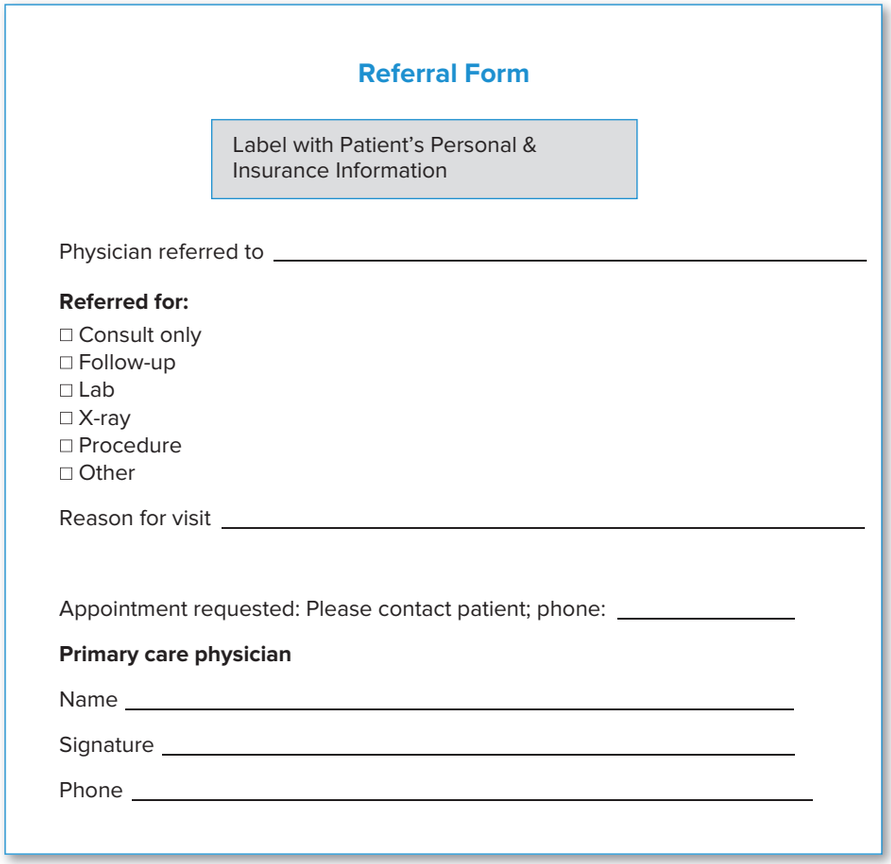
prior authorization number identifying code assigned when preauthorization is required

certification number identifying code assigned when preauthorization is required

A managed care payer often requires preauthorization before the patient sees a specialist, is admitted to the hospital, or has a particular procedure. The medical insurance specialist may request preauthorization over the phone, by e-mail or fax, or by an electronic transaction. If the payer approves the service, it issues a **prior authorization number** that must be entered in the practice management program so it will be stored and appear later on the healthcare claim for the encounter. (This number may also be called a **certification number.**)

To help secure preauthorization, best practice is to:

- Be as specific as possible about the planned procedure when exchanging information with a payer
- Collect and have available all the diagnosis information related to the procedure, including any pertinent history
- Query the provider and then request preauthorization for all procedures that may potentially be used to treat the patient



Referral Form

Label with Patient's Personal & Insurance Information

Physician referred to _____

Referred for:

☐ Consult only
☐ Follow-up
☐ Lab
☐ X-ray
☐ Procedure
☐ Other

Reason for visit _____

Appointment requested: Please contact patient; phone: _____

Primary care physician

Name _____

Signature _____

Phone _____

FIGURE 3.8 Referral

Referrals

Often, a physician needs to send a patient to another physician for evaluation and/or treatment. For example, an internist might send a patient to a cardiologist to evaluate heart function. If a patient's plan requires it, the patient is given a **referral number** and a referral document, which is a written request for the medical service. The patient is usually responsible for bringing these items to the encounter with the specialist.

A paper referral document (see Figure 3.8) describes the services the patient is certified to receive. (This approval may instead be communicated electronically using the HIPAA referral transaction.) The specialist's office handling a referred patient must:

- Check that the patient has a referral number
- Verify patient enrollment in the plan
- Understand restrictions to services, such as regulations that require the patient to visit a specialist in a specific period of time after receiving the referral or that limit the number of times the patient can receive services from the specialist

Two other situations arise with referrals (but always verify the payer's rules):

1. A managed care patient may "self-refer"—come for specialty care without a referral number when one is required. The medical insurance specialist then asks the patient to sign a form acknowledging responsibility for the services. A sample form is shown in Figure 3.9a.
2. A patient who is required to have a referral document does not bring one. The medical insurance specialist then asks the patient to sign a document such as that shown in Figure 3.9b. This **referral waiver** ensures that the patient will pay for services received if in fact a referral is not documented in the time specified.

HIPAA Referral Certification and Authorization

If an electronic transaction is used for referrals and preauthorizations, it must be the **HIPAA Referral Certification and Authorization** transaction, also called the X12 278.

HIPAA Referral Certification and Authorization HIPAA X12 278 transaction in which a provider asks a health plan for approval of a service and gets a response

referral number authorization number given to the referred physician

referral waiver document a patient signs to guarantee payment when a referral authorization is pending

Member Self-Referral Acknowledgment

I, _____, understand that I am seeking the care of this specialty physician or healthcare provider, _____, without a referral from my primary care physician. I understand that the terms of my Plan coverage require that I obtain that referral, and that if I fail to do so, my Plan will not cover any part of the charges, costs, or expenses related to this specialist's services to me.

Signed,

_____ _____
(member's name) (date)

****

Specialty physician or other healthcare provider:

Please keep a copy of this form in your patient's file

(a)

Referral Waiver

I did not bring a referral for the medical services I will receive today. If my primary care physician does not provide a referral within two days, I understand that I am responsible for paying for the services I am requesting.

Signature: _____

Date: _____

(b)

FIGURE 3.9 (a) Self-referral Document, (b) Referral Waiver

BILLING TIP

Billing Supplemental Plans

Supplemental insurance held with the same payer can be billed on a single claim. Claims for supplemental insurance held with other than the primary payer are sent after the primary payer's payment is posted, just as secondary claims are.

THINKING IT THROUGH 3.5

1. What is the difference between a referral and a preauthorization requirement?

3.6 Determining the Primary Insurance

The medical insurance specialist also examines the patient information form and insurance card to see whether other coverage is in effect. A patient may have more than one health plan. The specialist then decides which is the **primary insurance**—the plan that pays first when more than one plan is in effect—and which is the **secondary insurance**—an additional policy that provides benefits. **Tertiary insurance,** a third payer, is possible. Some patients have **supplemental insurance,** a "fill-the-gap" insurance plan that covers parts of expenses, such as coinsurance, that they must otherwise pay under the primary plan.

primary insurance health plan that pays benefits first

secondary insurance second payer on a claim

tertiary insurance third payer on a claim

supplemental insurance health plan that covers services not normally covered by a primary plan

As a practical matter for billing, determining the primary insurance is important because this payer is sent the first claim for the encounter. A second claim is sent to the secondary payer after the payment is received for the primary claim.

Deciding which payer is primary is also important because insurance policies contain a provision called **coordination of benefits (COB).** The coordination of benefits guidelines ensures that when a patient has more than one policy, maximum appropriate benefits are paid, but without duplication. Under the law, to protect the insurance companies, if the patient has signed an assignment of benefits statement, the provider is responsible for reporting any additional insurance coverage to the primary payer.

coordination of benefits (COB) explains how an insurance policy will pay if more than one policy applies

Coordination of benefits in government-sponsored programs follows specific guidelines. Primary and secondary coverage under Medicare, Medicaid, and other programs is discussed in the chapters on these topics. Note that COB information can also be exchanged between provider and health plan or between a health plan and another payer, such as auto insurance.

Guidelines for Determining the Primary Insurance

How do patients come to have more than one plan in effect? Possible answers are that a patient may have coverage under more than one group plan, such as an employer-sponsored insurance and a policy from union membership. A person may have primary insurance coverage from an employer but also be covered as a dependent under a spouse's insurance, making the spouse's plan the person's additional insurance.

General guidelines for determining the primary insurance are shown in Table 3.1.

Guidelines for Children with More than One Insurance Plan

A child's parents may each have primary insurance. If both parents cover a dependent on their plans, the child's primary insurance is usually determined by the **birthday rule.** This rule states that the parent whose day of birth is earlier in the calendar year is primary. For example, Rachel Foster's mother and father both work and have employer-sponsored insurance policies. Her father, George Foster, was born on October 7, 1983, and her mother, Myrna, was born on May 15, 1984. Because the mother's date of birth is earlier in the calendar year (although the father is older), her plan is Rachel's primary insurance. The father's plan is secondary for Rachel. Note that if a dependent child's primary insurance does not provide for the complete reimbursement of a bill, the balance may usually be submitted to the other parent's plan for consideration.

birthday rule guideline stating that the parent whose day of birth is earlier in the calendar year is primary

Another, much less common, way to determine a child's primary coverage is called the **gender rule.** When this rule applies, if the child is covered by two health plans, the father's plan is primary. In some states, insurance regulations require a plan that uses the gender rule to be primary to a plan that follows the birthday rule.

gender rule guideline that states when a child is covered by two health plans, the father's plan is primary

The insurance policy also covers which parent's plan is primary for dependent children of separated or divorced parents. If the parents have joint custody, the birthday rule usually applies. If the parents do not have joint custody of the child, unless

Table 3.1 Determining Primary Coverage

- If the patient has only one policy, it is primary.
- If the patient has coverage under two group plans, the plan that has been in effect for the patient for the longest period of time is primary. However, if an active employee has a plan with the present employer and is still covered by a former employer's plan as a retiree or a laid-off employee, the current employer's plan is primary.
- If the patient has coverage under both a group and an individual plan, the group plan is primary.
- If the patient is also covered as a dependent under another insurance policy, the patient's plan is primary.
- If an employed patient has coverage under the employer's plan and additional coverage under a government-sponsored plan, the employer's plan is primary. For example, if a patient is enrolled in a PPO through employment and is also on Medicare, the PPO is primary.
- If a retired patient is covered by a spouse's employer's plan and the spouse is still employed, the spouse's plan is primary, even if the retired person has Medicare.
- If the patient is a dependent child covered by both parents' plans and the parents are not separated or divorced (or if the parents have joint custody of the child), the primary plan is determined by the birthday rule, which will be defined in a subsequent section.
- If two or more plans cover dependent children of separated or divorced parents who do not have joint custody of their children, the children's primary plan is determined in this order:
  —The plan of the custodial parent
  —The plan of the spouse of the custodial parent if remarried
  —The plan of the parent without custody
- Dependent coverage can be determined by a court decision, which overrules these guidelines.

HIPAA Coordination of Benefits

The **HIPAA Coordination of Benefits** transaction is used to send the necessary data to payers. This transaction is also called the X12 837—the same transaction used to send healthcare claims electronically—because it goes along with the claim.

HIPAA Coordination of Benefits
HIPAA X12 837 transaction sent to a secondary or tertiary payer

otherwise directed by a court order, usually the primary benefits are determined in this order:

- The plan of the custodial parent
- The plan of the spouse of the custodial parent, if the parent has remarried
- The plan of the parent without custody

Entering Insurance Information in the Practice Management Program

The practice management program contains a database of the payers from whom the medical practice usually receives payments. The database contains each payer's name and the contact's name; the plan type, such as HMO, PPO, Medicare, Medicaid, or other; and telephone and fax numbers. Like the patient database, the payer database must be updated to reflect changes, such as new participation agreements or a new payer representative's contact information.

The medical insurance specialist selects the payer that is the patient's primary insurance coverage from the insurance database. If the particular payer has not already been entered, the PMP is updated with the payer's information. Secondary coverage is also selected for the patient as applicable. Other related facts, such as policy numbers, effective dates, and referral numbers, are entered for each patient.

Communications with Payers

Communications with payers' representatives—whether to check on eligibility, receive referral certification, or resolve billing disputes—are frequent and are vitally important to the medical practice. Getting answers quickly means faster payment

for services. Medical insurance specialists follow these guidelines for effective communication:

- Learn the name, telephone number/extension, and e-mail address of the appropriate representative at each payer. If possible, invite the representative to visit the office and meet the staff.
- Use a professional, courteous telephone manner or writing style to help build good relationships.
- Keep current with changing reimbursement policies and utilization guidelines by regularly reviewing information from payers. Usually, the medical practice receives Internet or printed bulletins or newsletters that contain up-to-date information from health plans and government-sponsored programs.

All communications with payer representatives should be documented in the patient's financial record. The representative's name, the date of the communication, and the outcome should be described. This information is sometimes needed later to explain or defend a charge on a patient's insurance claim.

COMPLIANCE GUIDELINE

Payer Communications

Payer communications are documented in the financial record rather than the medical (clinical) record.

THINKING IT THROUGH 3.6

1. When a patient has secondary insurance, the claim for that payer is sent after the claim to the primary payer is paid. Why is that the case? What information do you think the secondary payer requires?

3.7 Working with Encounter Forms

After the registration process is complete, patients are shown to rooms for their appointments with providers. Typically, a clinical medical assistant documents the patient's vital signs. Then the provider conducts and documents the examination. After the visit, the medical insurance specialist uses the documented diagnoses and procedures to update the practice management program and to total charges for the visit.

Encounter Forms

During or just after a visit, an **encounter form**—either electronic or paper—is completed by a provider to summarize billing information for a patient's visit. This may be done using a device such as a laptop computer, tablet PC, or PDA (personal digital assistant), or by checking off items on a paper form. Physicians should sign and date the completed encounter forms for their patients.

encounter form list of the diagnoses, procedures, and charges for a patient's visit

Encounter forms record the services provided to a patient, as shown in the completed office encounter form in Figure 3.10. These forms (also called *superbills, charge slips,* or *routing slips*) list the medical practice's most frequently performed procedures with their procedure codes. It also often has blanks where the diagnosis and its code(s) are filled in. (Some forms include a list of the diagnoses that are most frequently made by the practice's physicians.)

Other information is often included on the form:

- A checklist of managed care plans under contract and their utilization guidelines
- The patient's prior balance due, if any
- Check boxes to indicate the timing and need for a follow-up appointment to be scheduled for the patient during checkout

BILLING TIP

Encounter Forms for Hospital Visits

Specially designed encounter forms (sometimes called *hospital charge tickets*) are used when the provider sees patients in the hospital. These forms list the patient's identification and date of service, but they may show different diagnoses and procedure codes for the care typically provided in the hospital setting.

Paper Preprinted or Computer-Generated Encounter Forms

The paper encounter form may be designed by the practice manager and/or physicians based on analysis of the practice's medical services. It is then printed, usually with carbonless copies available for distribution according to the practice's policy. For

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NPI 8877365552

PATIENT NAME	APPT. DATE/TIME
Deysenrothe, Mae J.	10/4/2029 9:30 am
PATIENT NO.	**DX**
DD001	**1.** Z00.00 Exam, Adult **2.** **3.** **4.**

DESCRIPTION	✓	CPT	FEE	DESCRIPTION	✓	CPT	FEE
OFFICE VISITS				**PROCEDURES**			
New Patient				Diagnostic Anoscopy		46600	
LI Problem Focused		99201		ECG Complete	✓	93000	70
LII Expanded		99202		I&D, Abscess		10060	
LIII Detailed		99203		Pap Smear		88150	
LIV Comp./Mod.		99204		Removal of Cerumen		69210	
LV Comp./High		99205		Removal 1 Lesion		17000	
Established Patient				Removal 2-14 Lesions		17003	
LI Minimum		99211		Removal 15+ Lesions		17004	
LII Problem Focused		99212		Rhythm ECG w/Report		93040	
LIII Expanded		99213		Rhythm ECG w/Tracing		93041	
LIV Detailed		99214		Sigmoidoscopy, diag.		45330	
LV Comp./High		99215					
				LABORATORY			
PREVENTIVE VISIT				Bacteria Culture		87081	
New Patient				Fungal Culture		87101	
Age 12-17		99384		Glucose Finger Stick		82948	
Age 18-39		99385		Lipid Panel		80061	
Age 40-64	✓	99386	180	Specimen Handling		99000	
Age 65+		99387		Stool/Occult Blood		82270	
Established Patient				Tine Test		85008	
Age 12-17		99394		Tuberculin PPD		86580	
Age 18-39		99395		Urinalysis	✓	81000	17
Age 40-64		99396		Venipuncture		36415	
Age 65+		99397					
				INJECTION/IMMUN.			
CONSULTATION: OFFICE/OP				Immun. Admin.	✓	90471	25
Requested By:				Ea. Addl.		90472	
LI Problem Focused		99241		Hepatitis A Immun		90632	
LII Expanded		99242		Hepatitis B Immun		90746	
LIII Detailed		99243		Influenza Immun	✓	90661	68
LIV Comp./Mod.		99244		Pneumovax		90732	
LV Comp./High		99245					
				TOTAL FEES			360

FIGURE 3.10 Completed Encounter Form

example, the top copy may be filed in the medical record; the second copy may be filed in the financial record; and the third copy may be given to the patient.

Alternatively, the form may be printed for each patient's appointment using the practice management program. A customized encounter form lists the date of the appointment, the patient's name, and the identification number assigned by the medical practice. It can also be designed to show the patient's previous balance, the day's fees, payments made, and the amount due.

BILLING TIP

Numbering Paper Encounter Forms

Encounter forms should be prenumbered to make sure that all the day's appointments agree with the day's encounter forms. This provides a check that all visits have been entered in the practice management program for accurate **charge capture.**

charge capture procedures that ensure billable services are recorded and reported for payment

Communications with Providers

At times, medical insurance specialists find incorrect or conflicting data on encounter forms. It may be necessary to check the documentation and, if it is still problematic, to communicate with the physician to clear up the discrepancies. In such cases, it is important to remember that medical practices are extremely busy places. Providers often have crowded schedules, especially if they see many patients, and have little time to go over billing and coding issues. Questions must be kept to those that are essential.

Also, encounter forms (and practice management programs) list procedure codes and, often, diagnosis codes that change periodically. Medical insurance specialists must be sure that these databases are updated when new codes are issued and old codes are modified or dropped (see the chapters about diagnostic and procedural coding). They also bring key changes in codes or payers' coverage to the providers' attention. Usually the practice manager arranges a time to discuss such matters with the physicians.

THINKING IT THROUGH 3.7

Review the completed encounter form shown in Figure 3.10.

1. What is the age range of the patient?
2. Is this a new or an established patient?
3. What procedures were performed during the encounter?
4. What laboratory tests were ordered?

3.8 Understanding Time-of-Service (TOS) Payments

Routine Collections at the Time of Service

Up-front collection—money collected before the patient leaves the office—is an important part of cash flow. Practices routinely collect the following charges at the time of service:

1. Previous balances
2. Copayments
3. Coinsurance
4. Noncovered or overlimit fees
5. Charges of nonparticipating providers
6. Charges for self-pay patients
7. Deductibles for patients with consumer-driven health plans (CDHPs)
8. Charges for supplies and copies of medical records

BILLING TIP

Collecting TOS payments

- Many offices tell patients who are scheduling visits what copays they will owe at the time of service.
- Keep change to make it easier for cash patients to make TOS payments.
- Ask for payment. "We verified your insurance coverage, and there is a copay that is your responsibility. Would you like to pay by cash, check, or credit or debit card?"

COMPLIANCE TIP

Never refuse to provide medical record copies because a patient has a balance due; this is unethical and, in many states, illegal.

Billing for Medical Record Copies

Under HIPAA, it is permissible to bill patients a reasonable charge for supplying copies of their medical records. Costs include labor, supplies, postage, and time to prepare record summaries. Practices must check state laws, however, to see if there is a per-page charge limit.

Previous Balances

Practices routinely check their patient financial records and, if a balance is due, collect it at the time of service.

Copayments

Copayments are always collected at the time of service. In some practices, they are collected before the encounter; in others, right after the encounter.

The copayment amount depends on the type of service and on whether the provider is in the patient's network. Copays for out-of-network providers are usually higher than for in-network providers. Specific copay amounts may be required for office visits to PCPs versus specialists and for lab work, radiology services such as X-rays, and surgery.

When a patient receives more than one covered service in a single day, the health plan may permit multiple copayments. For example, copays both for an annual physical exam and for lab tests may be due from the patient. Review the terms of the policy to determine whether multiple copays should be collected on the same day of service.

Coinsurance

As healthcare costs have risen, employers have to pay more for their employees' medical benefit plans. As a result, employers are becoming less generous to employees, demanding that employees pay a larger share of those costs. Annual health insurance premiums are higher, deductibles are higher, and in a major trend—a shift from copayments to coinsurance—many employers have dropped the small, fixed-amount copayment requirements and replaced them with a coinsurance payment that is often due at the time of service.

BILLING TIP

Copayment Reminder

Many practice management programs have a copayment reminder feature that shows the copayment that is due.

Charges for Noncovered/Overlimit Services

Insurance policies require patients to pay for noncovered (excluded) services, and payers do not control what the providers charge for noncovered services. Likewise, if the plan has a limit on the usage of certain covered services, patients are responsible for paying for visits beyond the allowed number. For example, if five physical therapy encounters are permitted annually, the patient must pay for any additional visits. Practices usually collect these charges from patients at the time of service.

Charges of Nonparticipating Providers

accept assignment participating physician's agreement to accept allowed charge as full payment

As noted earlier in this chapter, when patients have encounters with a provider who participates in the plan under which they have coverage—such as a Medicare-participating provider—that provider has agreed to **accept assignment** for the patients—that is, to accept the allowed charge as full payment. Nonparticipating physicians usually do not accept assignment and require full payment from patients at the time of service. They also do not file claims on patients' behalf. An exception is Medicare, which requires all providers to file claims for patients as a courtesy.

Charges for Services to Self-Pay Patients

self-pay patient patient with no insurance

Patients who do not have insurance coverage are called **self-pay patients.** Because many Americans do not have insurance, self-pay patients present for office visits daily. Medical insurance specialists follow the practice's procedures for informing patients of their responsibility for paying their bills. Practices may require self-pay patients to pay their bills in full at the time of service.

Deductibles for Patients with CDHPs

Patients who have CDHPs must meet large deductibles before the health plan makes a payment. Practices are responsible for determining and collecting those deductibles at the time of service.

Billing for Supplies and Other Services

Many practices bill for supplies and for other services, such as making copies of medical records, at the time of service.

Other TOS Collection Considerations

In the typical revenue cycle, after the routine up-front collections are handled, a claim for insured patients is created and sent. The practice then waits to receive insurance payments, post the amount of payment to the patient's account in the PMP, and bill the patient for the balance. This process is followed because until the claim is adjudicated by the payer, the patient's actual amount due is not known. The adjudication process often results in a change to the amount due initially calculated. Of course, how much of an annual deductible the patient has paid affects that amount. Differences in participation contracts with various payers also may reduce the physician's fee for a particular service (this topic is covered in the chapter about visit charges and compliant billing).

However, following this process creates a problem for the practice in that it delays receipt of funds, reducing cash flow. For this reason, many practices are changing their billing process to increase TOS collections.

For example, a practice may decide to collect patients' unmet deductibles or to adopt the policy of estimating the amount the patient will owe and collecting a **partial payment** during the checkout process. For example, if the patient is expected to owe $600 and practice policy is to collect 50 percent, the patient is asked to pay $300 today and to expect to be billed $300 after the claim is processed.

COMPLIANCE GUIDELINE

Collecting Charges

Some payers (especially government programs) do not permit providers to collect any charges except copayments from patients until insurance claims are adjudicated. Be sure to comply with the payer's rules.

partial payment payment made during checkout based on an estimate

THINKING IT THROUGH 3.8

1. Why is collecting balances from patients at the time of service an important part of revenue cycle management?

3.9 Calculating TOS Payments

What patients owe at the time of service for the medical procedures and services they received depends on the practice's financial policy and on the provisions of their health plans.

Financial Policy and Health Plan Provisions

Patients should always be informed of their financial obligations according to the credit and collections policy of the practice. This **financial policy** on payment for services is usually either displayed on the wall of the reception area or included in a new patient information packet. A sample of a financial policy is shown in Figure 3.11.

financial policy practice's rules governing payment from patients

The policy should explain what is required of the patient and when payment is due. For example, the policy may state the following:

- *For unassigned claims:* Payment for the physician's services is expected at the end of your appointment unless you have made other arrangements with our practice manager.
- *For assigned claims:* After your insurance claim is processed by your insurance company, you will be billed for any amount you owe. You are responsible for any part of the charges that are denied or not paid by the carrier. All patient accounts are due within thirty days of the date of the invoice.
- *Copayments:* Copayments must be paid before you leave the office.

We sincerely wish to provide the best possible medical care. This involves mutual understanding between the patients, doctors, and staff. We encourage, you, our patient, to discuss any questions you may have regarding this payment policy.

Payment is expected at the time of your visit for services not covered by your insurance plan. We accept cash, check, AMEX, Visa, MasterCard, and Discover.

Credit will be extended as necessary.

Credit Policy
Requirements for maintaining your account in good standing are as follows:

1. All charges are due and payable within 30 days of the first billing.
2. For services not covered by your health plan, payment at the time of service is necessary.
3. If other circumstances warrant an extended payment plan, our credit counselor will assist you in these special circumstances at your request.

We welcome early discussion of financial problems. A credit counselor will assist you.

An itemized statement of all medical services will be mailed to you every 30 days. We will prepare and file your claim forms to the health plan. If further information is needed, we will provide an additional report.

Insurance
Unless we have a contract directly with your health plan, we cannot accept the responsibility of negotiating claims. You, the patient, are responsible for payment of medical care regardless of the status of the medical claim. In situations where a claim is pending or when treatment will be over an extended period of time, we will recommend that a payment plan be initiated. Your health plan is a contract between you and your insurance company. We cannot guarantee the payment of your claim. If your insurance company pays only a portion of the bill or denies the claim, any contact or explanation should be made to you, the policyholder. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

Insufficient Funds Payment Policy
We may charge an insufficient funds processing fee for all returned checks and bankcard charge backs. If your payment is dishonored, we may electronically debit your account for the payment, plus an insufficient funds processing fee up to the amount allowed by law. If your bank account is not debited, the returned check amount (plus fee) must be replaced by cash, cashier's check, or money order.

FIGURE 3.11 Example of a Financial Policy

However, a health plan may have a contract with the practice that prohibits physicians from obtaining anything except a copayment until after adjudication. Medicare has such a rule; the provider is not permitted to collect the deductible or any other payment until receiving data on how the claim is going to be paid. In this case, the health plan protects patients from having to overpay the deductible amount, which could occur if multiple providers collected the deductible within a short period of visits.

Estimating What the Patient Will Owe

Many times, patients want to know what their bills will be. For practices that collect patient accounts at the time of service and for high-deductible insurance plans, the physician practice also wants to know what a patient owes.

To estimate these charges, the medical insurance specialist verifies:

- The patient's deductible amount and whether it has been paid in full, the covered benefits, and coinsurance or other patient financial obligations
- The payer's allowed charges for the planned or provided services

Based on these facts, the specialist calculates the probable bill for the patient.

Other tools can be used to estimate charges. Some payers have a swipe-card reader (like a credit card processing device) that can be installed in the reception area and used by patients to learn what the insurer will pay and what the patient owes. Most practice management programs have a feature that permits estimating the patient's bill, as shown below:

		Est. Resp.
Policy 1: Aetna Choice (EMC)		$116.00
Policy 2: Medicare Nationwide		$0.00
Policy 3:		$0.00
Guarantor: Williams, Vereen		−$15.00
Adjustment:		$0.00
Policy Copay: 15.00	OA:	
Annual Deductible:	0.00 YTD:	$0.00

Charges:	$116.00
Adjustments:	$0.00
Subtotal:	$116.00
Payment:	−$15.00
Balance:	$101.00
Account Total:	$101.00

Real-Time Adjudication

The ideal tool for calculating charges due at the time of service is the transaction called **real-time adjudication (RTA).** Offered to practices by many health plans, RTA allows the practice to view, at the time of service, what the health plan will pay for the visit and what the patient will owe. The process is to (1) create the claim while the patient is being checked out, (2) transmit the claim electronically to the payer, and (3) receive an immediate ("real-time") response from the payer. This response

real-time adjudication (RTA) process used to generate the amount owed by a patient

- Informs the practice if there are any errors in the claim, so these can be fixed and the claim immediately resent for adjudication
- States whether the patient has met the plan's deductible
- Provides the patient's financial responsibility
- Supplies an explanation of benefits for this patient, so that any questions the patient has about denial of coverage or payment history can be immediately answered.

Note that RTA does not generate a "real-time" payment—that follows usually within twenty-four hours. This brief waiting period is also a great improvement over the time it normally takes payers to send payments.

BILLING TIP

RTA Versus Estimates

The RTA process generates an actual amount due from the patient, not an estimate of that amount.

Credit Card on File Policy

Many practices have instituted a policy of collecting and retaining patients' credit card information. Known as a **credit card on file (CCOF)** policy, it protects the practice in the event of delays in payment or failures to pay. Patients complete the practice's form (see Figure 3.12) by providing their credit card information and signature to authorize payment for outstanding balances. The practice must keep this information private, in compliance with HIPAA regulations, and may stipulate other conditions, such as billing fees and additional charges.

credit card on file (CCOF) policy of collecting and retaining patients' credit card information

CREDIT CARD ON FILE POLICY

At Valley Associates, PC, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of [$X] will be added to your account for any balances that we must attempt to collect of through mailing monthly statement. Furthermore, an "outstanding balance" change of 1.5 percent of the total bill will change for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Valley Associates, PC to change the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Visa ☐ Mastercard ☐ Discover

Credit Card Number _____

Expiration Date _____ / _____ / _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State _____ Zip _____

I (we), the undersigned, authorize and request Valley Associates, PC to change my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Valley Associates, PC.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to [practice name] in writing and the account must be in good standing.

Patient name (Print): _____

Patient signature: _____

Date: _____ / _____ / _____

FIGURE 3.12 Credit Card on File Policy

Financial Arrangements for Large Bills

If patients have large bills that they must pay over time, a financial arrangement for a series of payments may be made (see Figure 3.13). The payments may begin with a prepayment followed by monthly amounts. Such arrangements usually require the approval of the practice manager. They may also be governed by state laws. Payment plans are covered in greater depth in the chapter about patient billing and collections.

BILLING TIP

Use of Credit and Debit Cards

Accepting credit or debit cards requires paying a fee to the credit card carrier. It is generally considered worth the cost because payments are made immediately and are more convenient for the patient.

THINKING IT THROUGH 3.9

1. Read the financial policy shown in Figure 3.11. If a patient presents for noncovered services, when is payment expected? Does the provider accept assignment for plans in which it is nonPAR?

Patient Name and Account Number

Total of All Payments Due

FEE	$_____	
PARTIAL PAYMENT	$_____	
UNPAID BALANCE	$_____	
AMOUNT FINANCED	$_____	(amount of credit we have provided to you)
FINANCE CHARGE	$_____	(dollar amount the interest on credit will cost)
ANNUAL PERCENTAGE RATE	$_____	(cost of your credit as a yearly rate)
TOTAL OF PAYMENTS DUE	$_____	(amount paid after all payments are made)

Rights and Duties

I (we) have reviewed the above fees. I agree to make _____ payments in monthly installments of $ _____, due on the _____ day of each month payable to _____, until the total amount is paid in full. The first payment is due on _____. I may request an itemization of the amount financed.

Delinquent Accounts

I (we) understand that I am financially responsible for all fees as stated. My account will be overdue if my scheduled payment is more than 7 days late. There will be a late payment charge of $_____ or _____% of the payment, whichever is less. I understand that I will be legally responsible for all costs involved with the collection of this account including all court costs, reasonable attorney fees, and all other expenses incurred with collection if I default on this agreement.

Prepayment Penalty

There is no penalty if the total amount due is paid before the last scheduled payment.

I (we) agree to the terms of the above financial contract.

_____ _____
Signature of Patient, Parent or Legal Representative Date

_____ _____
Witness Date

_____ _____
Authorizing Signature Date

FIGURE 3.13 Financial Arrangement for Services Form

Chapter 3 Summary

Learning Outcomes	Key Concepts/Examples
3.1 Explain the method used to classify patients as new or established.	• Practices gather accurate information from patients to perform billing and medical care. • New patients are those who have not received any services from the provider within the past three years. • Established patients have seen the provider within the past three years. • Established patients review and update the information that is on file about them.

chapter 3 review chapter 3 review

Learning Outcomes	Key Concepts/Examples
3.2 Discuss the five categories of information required of new patients.	Five types of information collected: • Basic personal preregistration and scheduling information • The patient's detailed medical history • Insurance data for the patient or guarantor • A signed and dated assignment of benefits statement by the policyholder • A signed Acknowledgment of Receipt of Notice of Privacy Practices authorizing the practice to release the patient's PHI for TPO purposes
3.3 Explain how information for established patients is updated.	• Patient information forms are reviewed at least once per year by established patients. • Patients are often asked to double-check their information at their encounters. • The PMP is updated to reflect any changes as needed, and the provider strives for good communication with the patient to provide the best possible service.
3.4 Verify patients' eligibility for insurance benefits.	To verify patients' eligibility, the provider: • Checks the patient's information form and medical insurance card (except in medical emergency situations) • Contacts the payer to verify the patient's general eligibility for benefits and the amount of copayment or coinsurance that is due at the encounter, and to determine whether the planned encounter is for a covered service that is considered medically necessary by the payer
3.5 Discuss the importance of requesting referral or preauthorization approval.	• Preauthorization is requested before a patient is given certain types of medical care. • In cases of referrals, the provider often needs to issue a referral number and a referral document in order for the patient to see a specialist under the terms of the medical insurance. • Providers must handle these situations correctly to ensure that the services are covered if possible.
3.6 Determine primary insurance for patients who have more than one health plan.	• Patient information forms and insurance cards are examined to determine whether more than one health insurance policy is in effect. • If so, the provider determines which policy is the primary insurance based on coordination of benefits rules. • This information is then entered into the PMP and all necessary communications with the payers are performed.
3.7 Summarize the use of encounter forms.	• Encounter forms are lists of a medical practice's most commonly performed services and procedures and often its frequent diagnoses. • The provider checks off the services and procedures a patient received, and the encounter form is then used for billing.
3.8 Identify the eight types of charges that may be collected from patients at the time of service.	• Practices routinely collect up-front money from patients at the time of their office visit as an important source of cash flow. Eight different types of charges may be collected from patients at the time of service: 1. Previous balances 2. Copayments 3. Coinsurance 4. Noncovered or overlimit fees 5. Charges of nonparticipating providers 6. Charges for self-pay patients 7. Deductibles for patients with CDHPs 8. Charges for supplies and copies of medical records

Learning Outcomes	Key Concepts/Examples
3.9 Explain the use of real-time adjudication tools in calculating time-of-service payments.	Real-time adjudication tools: • Allow the practice to view, at the time of service, what the health plan will pay for the visit and what the patient will owe • Provide valuable information and checks so that the practice and patients are aware of the expected costs and coverage • Inform or remind patients of the financial policy and give estimates of the bills they will owe

Review Questions

Match the key terms with their definitions.

1. **LO 3.2** direct provider
2. **LO 3.2** assignment of benefits
3. **LO 3.1** new patient
4. **LO 3.6** secondary insurance
5. **LO 3.7** encounter form
6. **LO 3.1** established patient
7. **LO 3.2** insured/subscriber
8. **LO 3.6** coordination of benefits
9. **LO 3.3** primary insurance
10. **LO 3.2** patient information form
11. **LO 3.9** credit card on file (CCOF)
12. **LO 3.5** referral waiver
13. **LO 3.4** trace number
14. **LO 3.8** partial payment

A. Form used to summarize the treatments and services patients receive during visits

B. Policyholder

C. Authorization by a policyholder that allows a payer to pay benefits directly to a provider

D. The insurance plan that pays benefits after payment by the primary payer when a patient is covered by more than one medical insurance plan

E. The provider who treats the patient

F. A clause in an insurance policy that explains how the policy will pay if more than one insurance policy applies to the claim

G. A patient who has received professional services from a provider or another provider in the same practice with the same specialty in the past three years

H. Form completed by patients that summarizes their demographic and insurance information

I. A patient who has not received professional services from a provider, or another provider in the same practice with the same specialty, in the past three years

J. The insurance plan that pays benefits first when a patient is covered by two medical insurance plans

K. The document a patient signs to guarantee payment when a referral authorization is pending

L. A policy of collecting and retaining patients' credit card information

M. The number assigned to a HIPAA 270 electronic transaction

N. A payment made during checkout based on an estimate

Select the answer choice that best completes the statement or answers the question.

15. **LO 3.2** A patient's group insurance number written on the patient information or update form must match
    A. the patient's Social Security number
    B. the number on the patient's insurance card
    C. the practice's identification number for the patient
    D. the diagnosis codes

16. **LO 3.4** If a health plan member receives medical services from a provider who does not participate in the plan, the cost to the member is
    A. lower
    B. higher
    C. the same
    D. negotiable

17. **LO 3.2** What information does a patient information form gather?
    A. the patient's personal information, employment data, and insurance information
    B. the patient's history of present illness, past medical history, and examination results
    C. the patient's chief complaint
    D. the patient's insurance plan deductible and/or copayment requirements

18. **LO 3.6** If a husband has an insurance policy but is also eligible for benefits as a dependent under his wife's insurance policy, the wife's policy is considered _____ for him.
    A. primary
    B. participating
    C. secondary
    D. coordinated

19. **LO 3.5** A certification number for a procedure is the result of which transaction and process?
    A. claim status
    B. healthcare payment and remittance advice
    C. coordination of benefits
    D. referral and authorization

20. **LO 3.9** A practice's rules for payment for medical services are found in its
    A. coordination of benefits
    B. documentation
    C. financial policy
    D. compliance plan

21. **LO 3.7** The encounter form is a source of _____ information for the medical insurance specialist.
    A. billing
    B. treatment plan
    C. third-party payment
    D. credit card

22. **LO 3.9** Under Medicare, what must a provider receive before it is permitted to collect a deductible or any other payment?
    A. the patient's coinsurance
    B. the patient's copayment
    C. authority to accept assignment
    D. data on how the claim is going to be paid

23. **LO 3.8** Which charges are usually collected at the time of service?
    A. copayments, lab fees, and therapy charges
    B. copayments, noncovered or overlimit fees, charges of nonparticipating providers, and charges for self-pay patients
    C. deductibles and lab fees
    D. coinsurance

24. **LO 3.6** The tertiary insurance pays
    A. after the first and second payers
    B. after the first payer
    C. after receipt of the claim
    D. before all other payers

Answer the following questions or provide the information required.

25. Define the following abbreviations:

A. **LO 3.2** nonPAR

B. **LO 3.6** COB

C. **LO 3.2** PAR

D. **LO 3.1** NP

E. **LO 3.1** EP

Applying Your Knowledge

Case 3.1 Abstracting Insurance Information

LO 3.1 Carol Viragras saw Dr. Alex Roderer, a gynecologist with the Alper Group, a multispecialty practice of 235 physicians, on October 24, 2027. On December 3, 2029, she made an appointment to see Dr. Judy Fisk, a gastroenterologist also with the Alper Group. Did the medical insurance specialist handling Dr. Fisk's patients classify Carol as a new or an established patient?

Case 3.2 Documenting Communications

LO 3.3 Harry Cornprost, a patient of Dr. Connelley, calls on October 25, 2029, to cancel his appointment for October 31 because he will be out of town. The appointment is rescheduled for December 4. How would you document this call?

Case 3.3 Coordinating Benefits

Based on the information provided, determine the primary insurance in each case.

A. **LO 3.6** George Rangley enrolled in the ACR plan in 2018 and in the New York Health plan in 2016.

George's primary plan:

B. **LO 3.6** Mary is the child of Gloria and Craig Bivilaque, who are divorced. Mary is a dependent under both Craig's and Gloria's plans. Gloria has custody of Mary.

Mary's primary plan:

C. **LO 3.6** Karen Kaplan's date of birth is 10/11/1985; her husband Carl was born on 12/8/1986. Their child Ralph was born on 4/15/2015. Ralph is a dependent under both Karen's and Carl's plans.

Ralph's primary plan:

D. **LO 3.6** Belle Estaphan has medical insurance from Internet Services, from which she retired last year. She is on Medicare but is also covered under her husband Bernard's plan from Orion International, where he works.

Belle's primary plan:

E. **LO 3.6** Jim Larenges is covered under his spouse's plan and has medical insurance through his employer.

Jim's primary plan:

Case 3.4 Calculating Insurance Math

A. **LO 3.8, 3.9** A patient's insurance policy states:

Annual deductible: $300.00

Coinsurance: 70-30

This year the patient has made payments totaling $533 to all providers. Today the patient has an office visit (fee: $80). The patient presents a credit card for payment of today's bill. What is the amount that the patient should pay?

B. **LO 3.8, 3.9** A patient is a member of a health plan with a 15 percent discount from the provider's usual fees and a $10 copay. The day's charges are $480. What are the amounts that the HMO and the patient each pay?

C. **LO 3.8, 3.9** A patient is a member of a health plan that has a 20 percent discount from the provider and a 15 percent copay. If the day's charges are $210, what are the amounts that the HMO and the patient each pay?