CRCE Exam Study Manual
Update for 2017

This document reflects updates made to the instructional content from the Certified Revenue Cycle Executive (CRCE-I, CRCE-P) Exam Study Manual - 2016 to the 2017 version of the manual. This does not include updates to Knowledge Checks and Answers or the Glossary.

Table of Contents

Edit to page 2-2: Centers for Medicare & Medicaid Services (CMS) ................................................................. 3
Edit to page 2-2: Food & Drug Administration (FDA) .......................................................................................... 3
Edit to page 2-2: National Institutes of Health (NIH) ...................................................................................... 3
New topic on page 2-2: Substance Abuse and Mental Health Services Administration (SAMHSA) ..................... 3
Edit to page 2-2: Social Security Administration (SSA) .................................................................................... 3
Edit to page 2-5: Federal Regulations ............................................................................................................... 3
Edit to page 2-7: Security Rule ......................................................................................................................... 4
Edit to page 2-7: Right to Participate in Treatment Decisions ........................................................................ 4
Edit to page 3-23: Consent Types, Requirements, and Results ......................................................................... 4
Edit to page 3-29: Medical Records ............................................................................................................... 4
Edit to page 4-4: Part C – Medicare Advantage ............................................................................................. 5
Edit to page 4-9: Dual Eligibles and Qualified Medicare Beneficiaries .......................................................... 5
Edit to page 4-12: TRICARE ............................................................................................................................ 5
Edit to page 4-29: Evaluation & Management (E&M) Levels ......................................................................... 5
New objective on page 5-1: 501(r) ................................................................................................................... 5
Edit to page 5-4: Extended Payment Plans ....................................................................................................... 5
New topic on page 5-11: 501(r) ....................................................................................................................... 5
Edit to page 6-6: Expenses ............................................................................................................................... 6
Edit to page 6-12: Monitoring Managed Care Payments .................................................................................. 6
Edit to page 6-13: Compliance Plans ............................................................................................................... 6
Edit to page 6-15: RAC Audits ........................................................................................................................ 7
Edit to page 6-16: Other Audits ....................................................................................................................... 7
Edit to page 6-18: Americans with Disabilities Act (ADA) .............................................................................. 7
Note: Unless otherwise stated, information in yellow below has been inserted and information struck through has been deleted.

**Edit to page 2-2: Centers for Medicare & Medicaid Services (CMS)**

CMS, originally called the Health Care Finance Administration (HCFA), was formed in 1977. CMS is responsible for developing rules and regulations that govern Medicare and Medicaid. It also contracts with entities who administer Medicare benefits in various regions of the country.

**Edit to page 2-2: Food & Drug Administration (FDA)**

The FDA is responsible for approving or rejecting new drugs and medical devices, as well as safety in the medical and food industries. The FDA is responsible for assuring the safety and efficiency of pharmaceuticals. They approve or reject new pharmaceuticals and medical devices and assure safety in the medical and food industries.

**Edit to page 2-2: National Institutes of Health (NIH)**

The NIH is the primary federal agency for conducting and supporting medical research. It is composed of 27 institutes and centers.

**New topic on page 2-2: Substance Abuse and Mental Health Services Administration (SAMHSA)**

The SAMHSA works to improve the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illness.

**Edit to page 2-2: Social Security Administration (SSA)**

Formerly part of HHS, the SSA became independent in 1995. The mission of the SSA is to protect the economic security of citizens. Its fundamental responsibility is to help shape its programs, educate the public about social security, and plan for the long-term future. This agency is responsible for administering Medicare eligibility, including for disability and end stage renal disease (ESRD).

**Edit to page 2-5: Federal Regulations**

The major areas of regulations addressed in this manual are:

- **Patient rights Patient’s Bill of Rights**
  - Right to privacy and security of health information
  - Right to participate in treatment decisions
- Patient anti-dumping
- Anti-fraud and abuse
- Credit and collections
- Administrative simplification
- Data storage and recovery
- Performance improvement

**Patient Rights Patient’s Bill of Rights**

The Patient’s Bill of Rights was adopted by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry in order to reach three major goals. It was designed to help patients feel more confident in the U.S. healthcare system. A "Patient’s Bill of Rights" refers to expectations that patients and their families can have about how they will be treated in healthcare situations. It helps give patients a way to address problems they may have and it encourages patients to take an active role in their healthcare. It stresses the important of a strong relationship between patients and their healthcare providers and stresses the key role patients play in their healthcare.

Although the conversation about patients' rights involves a variety of topics, this manual covers two: Right to Privacy and Security of Health Information and Right to Participate in Treatment Decisions.
Right to Privacy and Security of Health Information

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996 with the primary objective of protecting insurance subscribers from loss of coverage due to job changes. Since there was great concern over the safety of the Internet and other forms of electronic information exchange, during the same time, it was recognized that advances in electronic technology and data sharing posed potential privacy concerns. As a result, HHS issued the Privacy Rule and Security Rule as part of HIPAA.

Edit to page 2-7: Security Rule

The HIPAA Security Rule has resulted in its own impacts. In the Billing department, for example, the Security Rule means new or revised policies, data back-up requirements, education of staff, security audits, increased costs of hardware and software upgrades, and so on. It also requires that covered entities have contracts in place with their business associates that also safeguard the data they receive, create, or maintain on behalf of the covered entity.

Edit to page 2-7: Right to Participate in Treatment Decisions

Congress passed the Patient Self Determination Act in 1990 to assure that patients understood their right to participate in decisions about their own healthcare and to provide means to assure it.

Edit to page 3-23: Consent Types, Requirements, and Results

Informed consent means that the patient has been made aware of the risks and benefits of the services he or she is about to receive. Typically there is separate consent for anesthesia and a related procedure. Clinical providers explain the potential adverse outcomes of the services, such as injury or death, and sign with the patient to show understanding and agreement. (This form cannot be signed with Patient Access as a witness.) This type of consent is important in case there are problems that are dealt with later on a legal basis.

Edit to page 3:29: Medical Records

- Known allergies

It is imperative that this information is recorded accurately at the time the patient presents for services. If a patient is assigned an incorrect medical record number, it can have negative impacts throughout the revenue cycle.

The impact of assigning a wrong medical record number can include the following:

- HIPAA violations
- Physicians receiving reports that are not theirs
- Delays in reporting results to the correct physician
- Delays in diagnosis and treatment
- Patient dissatisfaction
- Incorrect billing
- Compromised integrity of the medical record
Part C or Medicare Advantage (formerly Medicare+Choice), replaces traditional fee-for-service Medicare and often offers better benefits such as vision, dental, or more preventative services. Premiums are often lower than the cost of regular Medicare plus a supplement. (If people have one of these plans, they don’t need a Medigap policy.) Physicians who treat Medicare Advantage patients and do not have a contract with their Medicare Advantage plan receive Medicare rates.

Medicare Advantage plans are paid a premium by the federal government to induce them to offer coverage in wide geographic areas. This ensures that most rural beneficiaries will have at least one Medicare Advantage plan to select if they want to do so.

Medicare Advantage plans include the following types of coordinated care plans (CCPs):

**Dual Eligibles and Qualified Medicare Beneficiaries**

Dual Eligibles **Eligibility** and Qualified Medicare Beneficiaries

**TRICARE**

A non-availability statement is a form provided by the from a military hospital that indicates that it cannot provide the care needed and authorizes payment to be made directly to the facility providing service. A non-availability form is not required if the service provided was emergent or when other insurance is primary.

**Evaluation & Management (E&M) Levels**

One range of CPT codes applies to evaluation and management (E&M). In 2010, CMS eliminated use of consultation CPT codes and provided guidance on using E&M codes instead. E&M refers to both the process of and the charge for examining a patient and formulating a treatment plan. The provider performs the evaluation and management, and assigns a level based on seven components described below. The place of service and whether the patient is new or established is then combined with the level to determine the CPT code.

New objective on page 5-1: 501(r)

- Explain the general provisions of Medicare's bad debt policies.
- **Explain requirements on charitable tax-exempt hospitals imposed by Section 501(r) of the PPACA.**
- Calculate key collection metrics.

**Extended Payment Plans**

When finance charges are applied, the provider is compensated for holding the debt for an extended period of time. The patient is given an option instead of small payments over a long time and, as a result, can build his or her credit score.

New topic on page 5-11: 501(r)

501(r)

Section 501(r) is part of the PPACA which imposes new requirements on charitable tax-exempt hospitals. Requirements include the obligation to perform a community health needs assessment every three years, the obligation to establish written policies on financial assistance and emergency care, and certain limitations on billing and collection actions.

Based on the proposed rules, charity hospitals cannot engage in extraordinary collection activities before making reasonable efforts to determine whether a patient is eligible for financial assistance.
Expenses arise when the business has to pay for things. Expenses may be classified as operating or non-operating. Examples of expenses include salaries, collection agency fees, office supplies, equipment, and postage, just to name a few.

Monitoring Managed Care Payments

It is important to have procedures in place to monitor the accuracy of payments received. This can be quite challenging, given the complexity and variety of contracts, but is necessary. Incorrect payments should be taken seriously and challenged. Some steps to ensure that the facility is receiving proper payments include:

- Develop and update regularly a matrix of managed care contracts with payment terms and expiration dates.
- Educate staff on contract payment terms.
- Conduct routine audits of all managed care contracts and payments.
- Investigate software that monitors payment of contracts.
- Determine if exclusions can be billed to patients.
- Create separate financial or insurance classes for managed care contracts.
- Outsource paid/zero balance managed care accounts to a professional agency to identify and recover any underpayments not previously identified.
- Train registration staff and financial counselors to identify potential managed care patients.
- Report results of audits and payments to administration.
- Initiate a managed care task force to discuss problems; include Registration, Health Information Management, Utilization Management (UR), Billing, and Accounting.

Compliance Plans

A compliance plan is developed to help a provider avoid, find, and remedy instances of noncompliance with rules and regulations. A good plan can help mitigate penalties if fraud or abuse is found. More importantly, a working plan shows the government that the provider takes compliance seriously. As part of healthcare reform in 2010, compliance plans became mandatory.

Fraud

The term describes an internal deception or misrepresentation that an individual knows to be false or does not believe to be true, and knows that the deception could result in some unauthorized benefit to himself or herself or some other person.

The most frequent kind of fraud arises from false statements or misrepresentations made, or caused to be made, which are material to entitlement or payment under the Medicare program. The violator may be a participating provider, a beneficiary, or some other person or business entity. Some examples of fraud would be billing for services not rendered, misrepresentation of service or coding, misrepresentation of diagnosis, kickbacks, or the waiving of coinsurance or deductible.

Abuse

Abuse describes incidents or practices of providers, physicians, or suppliers of services that, although not usually considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices, directly or indirectly, resulting in unnecessary costs to the Medicare program, improper reimbursement for services that fail to meet professionally recognized standards of care or that are medically unnecessary.

A major form of abuse to which the program is vulnerable is the over-utilization of services. Such over-utilization occurs when a patient receives services that are not medically necessary or reasonable. Some examples of abuse would be: services not medically necessary, screening services, and violation of assignment.
Edit to page 6-15: RAC Audits

As part of the so-called Medicare Modernization Act of 2003, CMS conducted a Recovery Audit Contractor (RAC) demonstration project.

Edit to page 6-16: Other Audits

Zone Program Integrity Contractors (ZPICs) - CMS's Benefit Integrity (BI) program has various types of contractors review different aspects of Medicare billing and payment. The ZPICs are organized into seven different regions. The CMS Program Integrity Manual states, "The primary goal of the ... ZPIC BI unit is to identify cases of suspected fraud, develop them thoroughly and in a timely manner, and take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid out and that any mistaken payments are recouped." Similar to RAC audits, ZPIC audits can be performed pre-payment or post-payment.

Edit to page 6-18: Americans with Disabilities Act (ADA)

The ADA was established in 1990. It requires employers to make reasonable adjustments to the work site to accommodate a disabled employee's ability to perform the job as outlined in the job description. (Note, however, that employers are not legally responsible to maintain job descriptions for their employees.) In addition, it requires buildings to be accessible to those with disabilities.

Edit to page 6-19: Discrimination

It is unlawful to discriminate against an employee on the basis of age, sex, religion, race, marital status, sexual orientation, pregnancy status or plans, national origin, disability, or genetics. Job interviews, evaluations, promotions, discipline, terminations, and the like should be done carefully and objectively to avoid any appearance of favoritism. For example, asking consistent questions of each applicant for a position lessens the risk of the appearance of discrimination and provides a basis for objective comparison of candidates. It is always best to have good documentation for any of the above, should proof be required later in court.