CRCP Exam Study Manual
Update for 2018

This document reflects updates made to the instructional content from the *AAHAM Certified Revenue Cycle Professional (CRCP-I, CRCP-P) Exam Study Manual - 2017* to the 2018 version of the manual. This does not include updates to Knowledge Checks and Answers or the Glossary.

Table of Contents

Edit(s) to page 2-2: Federal Regulations 3

Edit(s) to page 2-7: Anti-Fraud and Abuse 3

Edit(s) to page 2-8: Anti-Kickback Statute and False Claims Act 4

Edit(s) to page 2-9: Fair Debt and Collection Practices Act (FDCPA) 4

Edit(s) to pages 2-10 and 2-11: Clinical Laboratory Improvement Amendments (CLIA) 5

Edit(s) to page 3-24: Levels of Patient Care 5

Edit(s) to pages 4-3 and 4-4: Part A Deductibles, Coinsurance, and Copayments 6

Edit(s) to page 4-5: Part B Deductibles, Coinsurance, and Copayments 6

Edit(s) to pages 4-6 thru 4-11: Part B Preventive Services 7

Edit(s) to page 4-17: Health Insurance Claim Number 12

Edit(s) to page 4-17: Medigap 13

Edit(s) to page 4-19: Liability Insurance 13

Edit(s) to page 4-36: 14

Edit(s) to page 4-39: HCPCS and CPT Modifiers 14

New topic on page 4-39: NPIs and Taxonomy Codes 14

Edit(s) to pages 4-54 and 4-55: 1500 and 837P 15

Edit(s) to page 4-56: Medicare 3-Day and 24-Hour Rule 15

Edit(s) to page 4-58: Medically Unlikely Edits (MUE) 15

Edit(s) to page 6-1: Objectives 16

Edit(s) to pages 6-3 and 6-4: Accounting Terminology 16

New topic on page 6-6: Eight Steps in the Accounting Cycle 17

Edit(s) to page 6-7: Managing Deductions from Revenue and Income 17

Edit(s) to page 6-8: Handling Credit Balances 17

Edit(s) to page 6-23: Outsourcing Considerations 18

Note: Unless otherwise stated, information in yellow below has been inserted and information struck through has been deleted.

Edit(s) to page 2-2: Federal Regulations

Description of change: Deleted the icons previously related to Performance improvement, Clinical Laboratory Improvement Amendments (CLIA). This topic is relevant for both the CRCP-I and CRCP-P exams.

Edit(s) to page 2-7: Anti-Fraud and Abuse

> *Fraud*
>
> The term describes a 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 him- or herself or some other person.
>
> Examples of fraud include billing for services not rendered, misrepresentation of service or coding, misrepresentation of diagnosis, kickbacks, and waiving of coinsurance or deductibles.

It is illegal to defraud the federal government. Defrauding payers exposes individuals or entities to potential criminal and civil liability. It can lead to penalties, fines, or imprisonment.

> *Abuse*
>
> The term 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 and 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 Medicare 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.
>
> Examples of abuse include services not medically necessary, screening services, and violation of assignment, and waiving of coinsurance and/or deductibles.

Providers are expected to know and follow the regulations concerning the provision and billing of healthcare. A reckless disregard for the rules can be considered an abuse or even fraud, as recent ~~in 2010~~ healthcare reform blurred the line between fraud and abuse. Intent is no longer a necessary criterion for fraud. Because of the potential risk, a number of federal programs and regulations target fraud and abuse in the healthcare system.

Edit(s) to page 2-8: Anti-Kickback Statute and False Claims Act

The Anti-Kickback Statute and False Claims Act both prohibit offering "free or discounted services to a physician associated with, or who refers patients to, another healthcare facility." Among other things, this means that hospitals and physicians should be very careful about offering "professional courtesy" discounts or write-offs to other physicians, as they may appear to be a kickback. For example, a hospital that leases or rents space to a physician must charge only market rent. Anything that could appear to be remuneration for referrals is better left on the table.

A civil liability can be imposed on any person who knowingly submits or causes the submission of a false claim to the federal government. The terms "knowing" or "knowingly" mean a person has actual knowledge of information or acts in deliberate ignorance or disregard of the truth, in this case regarding information on a claim. There is a criminal statue in place which states that entities or individuals that submit false claims can be imprisoned and/or face fines.

Edit(s) to page 2-9: Fair Debt and Collection Practices Act (FDCPA)

Description of change: Inserted text; expanded, revised, and reformatted the bullet list.

This law went into effect in 1996 to amend the Consumer Credit Protection Act and was designed to eliminate abusive, deceptive, and unfair debt collection practices. It also protects reputable debt collectors from unfair competition and encourages consistent state action to protect consumers from abuses in debt collection. The law applies to "consumer debt," which is money owed for personal goods or services. FDCPA:

***

A debt collector may not:

- Call a debtor before 8:00 a.m. or after 9:00 p.m. unless express permission is given to call at other times
- Make contact at any place that is inconvenient to the debtor unless the debtor or a court of competent jurisdiction has given permission for such contacts
- Contact the consumer at his or her place of employment if the collector has reason to believe the employer prohibits such communications
- Contact the debtor directly if the debt collector knows that the debtor has retained an attorney to handle the debt and can easily ascertain the attorney's name and address unless the attorney is unresponsive or agrees to allow direct communication with the debtor
- Annoy, abuse, or harass persons by repeatedly calling their telephone number or allowing their telephone to ring continually
- Make telephone calls without properly identifying themselves except to obtain location information
- Use obscene or profane language
- Tell the debtor that he or she will be jailed because this is an action that cannot be carried out
- Threaten a lawsuit unless they do indeed clearly intend to file suit

- Violate the debtor's privacy by sending something that looks like an official or court document if it is not, or contacting the debtor by postcard

Edit(s) to pages 2-10 and 2-11: Clinical Laboratory Improvement Amendments (CLIA)

Description of change: Deleted the icons previously related to Performance improvement, Clinical Laboratory Improvement Amendments (CLIA). This topic is relevant for both the CRCP-I and CRCP-P exams.

Edit(s) to page 3-24: Levels of Patient Care

Inpatient – On doctor's orders, the patient is admitted to a bed with the expectation that the patient will require hospital care that will span at least two midnights. This is often called "acute care." These are the sickest patients who require the highest level of care and often stay for many days. Inpatients have a room charge posted to their accounts every night they are in the hospital. Some facilities have acute rehabilitation and/or acute psychiatric beds for patients who require around-the-clock care to maximize their recovery.

~~*NOTE:* When an admission order has not been written, it is appropriate to admit the patient to a bed without a status.~~

Observation – Though these patients occupy a bed, they are outpatients. Observation time is intended for monitoring of the patient's acute condition, which may resolve or worsen. Because of this, observation is not the kind of service that can be scheduled in advance. It is also not intended for routine use such as surgical recovery. Many commercial insurance payers require most one-day stays to be classified as observation. Some limit these stays to 23 hours.

The Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, enacted in 2015, states that hospitals must inform patients who are hospitalized for more than 24 hours that they are in observation status. No later than 36 hours after a patient begins to receive observation services, the patient must be informed, both orally and in writing, of his or her observation status.

The NOTICE Act applies to Medicare Part A and Medicare Advantage beneficiaries as well as patients in Psychiatric and Critical Access Hospitals.

Edit(s) to pages 4-3 and 4-4: Part A Deductibles, Coinsurance, and Copayments

Medicare Part A		
Service	Beneficiary Obligation	2018 Amount
Hospital stay – Semi-private room, meals, general nursing, other hospital services, and supplies. This includes care in critical access hospitals. This does not include private duty nursing or a television or telephone in the room. It also does not include a private room, unless medically necessary. Inpatient mental healthcare in an independent psychiatric facility is limited to 190 days in a lifetime.	Days 1 through 60*: ▪ Part A current year inpatient deductible *Renewable during the next benefit period	$1,340 ~~1,316~~ per spell of illness
	Days 61 through 90*: ▪ Part A coinsurance (1/4 or 25% of current year inpatient deductible) *Renewable during the next benefit period	$335 ~~329~~ per day
	Days 91 through 150*: ▪ Part A lifetime reserve (LTR, 1/2 or 50% of current year inpatient deductible) *Nonrenewable; hospitals alert patients when they have 5 days of coinsurance left so they can choose whether to use LTR	$670 ~~658~~ per day
SNF care – Semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a three-day hospital stay).	Days 1 through 20: ▪ No deductible or coinsurance	$0 per benefit period
	Days 21 through 100: ▪ 1/8 of current year inpatient deductible	$167.50 ~~164.50~~ per day

Edit(s) to page 4-5: Part B Deductibles, Coinsurance, and Copayments

Medicare Part B		
Service	Beneficiary Obligation	2018 Amount
Medical and other services – Doctors services (except for routine physical exams); outpatient medical and surgical services; supplies; diagnostic tests; ambulatory surgery center facility fees for approved procedures; and DME. Also covers second surgical opinions; outpatient physical, occupational, and speech therapy; and outpatient mental healthcare.	Medical and other services: ▪ Current year deductible, then coinsurance (20% of Medicare-approved amount, except in the outpatient setting)	$183 per year, then 20% of Medicare-approved amount
	Outpatient physical, occupational, and speech-language therapy services: ▪ Coinsurance	20% of Medicare-approved amount
	Outpatient mental healthcare: ▪ Coinsurance	20% of Medicare-approved amount

Edit(s) to pages 4-6 thru 4-11: Part B Preventive Services

Description of change: Reorganized the table in alphabetical order by the Service column; expanded and updated the services.

Medicare Part B – Covered Preventive Services		
Service	Who Is Covered	Beneficiary Obligation in the Original Medicare Plan
Annual wellness visit (AWV) – Initial visit for AWV once in a lifetime; subsequent visits allowed annually.	All Medicare beneficiaries who are more than 12 months after the effective date of their Medicare Part B coverage and who also have not received an IPPE or AWV within 12 months	Copayment, coinsurance, and deductible waived
Bone mass measurements – Varies with health status; covered once every 24 months or more often if determined to be medically necessary.	Certain beneficiaries at risk for losing bone mass or developing osteoporosis	Copayment, coinsurance, and deductible waived
Cardiovascular disease screening (lipid panel, cholesterol, lipoprotein, and triglycerides) – Once every 5 years.	All asymptomatic Medicare beneficiaries	Copayment, coinsurance, and deductible waived
Colorectal cancer screening – Fecal occult blood test (FOBT): once every 12 months; flexible sigmoidoscopy: once every 4 years or once every 10 years after having a screening colonoscopy; screening colonoscopy: once every 24 months if at high risk for colon cancer or once every 10 years if not at risk; barium enema: once every 24 months if at high risk or once every 4 years if not at high risk.	Beneficiaries age 50 and older (However, there is no age limit for having a colonoscopy.)	FOBT, flexible sigmoidoscopy, colonoscopy - Copayment, coinsurance, and deductible waived Barium enema - Coinsurance applies; deductible waived Multitarget stool DNA test - if polyp found and removed, 20% copayment applies

Medicare Part B – Covered Preventive Services		
Service	Who Is Covered	Beneficiary Obligation in the Original Medicare Plan
Diabetes screening test – Coverage for glucose monitors, test strips, and lancets; diabetes self-management training; 2 screening tests per year for beneficiaries diagnosed with pre-diabetes or 1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested.	Beneficiaries who have certain risk factors for diabetes or who have been diagnosed with pre-diabetes (Beneficiaries previously diagnosed with diabetes are not eligible for this benefit.)	Copayment, coinsurance, and deductible waived
Diabetes Self-Management Training (DSMT) – Up to 10 hours of initial training within a 12-month period. In subsequent years, up to 2 hours of follow-up training are allowed each year.	Beneficiaries who have been diagnosed with diabetes, or who have previously been diagnosed with diabetes	Copayment, coinsurance, and deductible apply
Glaucoma screening – Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in the beneficiary's state of residence.	Beneficiaries at high risk of glaucoma, including people with diabetes or a family history of glaucoma; African-Americans who are age 50 and older; and Hispanic-Americans age 65 and older	Copayment, coinsurance, and deductible apply
Hepatitis B (HBV) vaccine and administration - Scheduled dosages, as required.	Beneficiaries who are at intermediate or high risk for contracting Hep B (but beneficiaries who are currently positive for antibodies for Hep B are not eligible for this benefit)	Copayment, coinsurance, and deductible waived
Hepatitis C Virus (HCV) screening – Annually for high-risk beneficiaries with continued illicit drug use with injection, or who had a blood transfusion before 1992. Once in a lifetime if born between 1945 and 1965 and not at high risk.	Beneficiaries who are at high risk for HCV infection or who were born between 1945 and 1965	Copayment, coinsurance, and deductible waived

Medicare Part B – Covered Preventive Services		
Service	Who Is Covered	Beneficiary Obligation in the Original Medicare Plan
Human immunodeficiency virus (HIV) screening – Annually for high-risk cases and three times per pregnancy (one screening per trimester) for those beneficiaries who are pregnant.	Beneficiaries who are at an increased risk for HIV, who may be pregnant, or who are between ages 15-65 and ask for the test	Copayment, coinsurance, and deductible waived
Initial preventive physical examination (IPPE, the "Welcome to Medicare Physical Exam") - Once in a lifetime.	All new Medicare beneficiaries who are within the first 12 months of their first Medicare Part B coverage period	IPPE: ▪ Copayment and coinsurance apply; deductible waived IPPE with EKG: ▪ Copayment, coinsurance, and deductible apply
Intensive behavioral therapy (IBT) for cardiovascular disease (CVD) - One CVD risk reduction visit annually.	All Medicare beneficiaries who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting	Copayment, coinsurance, and deductible waived
Intensive behavioral therapy for obesity - Annually for all beneficiaries; frequency of coverage includes one visit every week for month 1; one visit every other week for months 2-6; and one visit every month for months 7-12.	Beneficiaries with a BMI≥30 kg/m^2, who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting	Copayment, coinsurance, and deductible waived

Medicare Part B – Covered Preventive Services		
Service	Who Is Covered	Beneficiary Obligation in the Original Medicare Plan
Lung cancer screening - Annually for beneficiaries between ages 55-77.	Beneficiaries who show no signs or symptoms of lung cancer and who have a history of smoking at least 30 pack–years (one pack-year is equal to smoking one pack per day for one year; one pack equals 20 cigarettes); who are current smokers; or who have quit smoking within the past 15 years. There also must be a written order for the service that meets specific criteria established by CMS.	Coinsurance and deductible waived if all criteria are met, there is a written order, and the physician accepts assignment
Mammogram, screening – One baseline screening for females between age 35 through 39, then once every 12 months for females over age 40. Reminder: If screening and diagnostic mammograms are billed on the same day, a modifier –GG should be used to show a screening mammogram was turned into a diagnostic mammogram at the time of service.	Female beneficiaries age 35 and older	Copayment, coinsurance, and deductible waived
Mammogram, diagnostic Reminder: If screening and diagnostic mammograms are billed on the same day, a modifier –GG should be used to show a screening mammogram was turned into a diagnostic mammogram at the time of service.	Female beneficiaries, when the service is medically necessary	Coinsurance and deductible may apply
Medical nutrition therapy (MNT) - First year: 3 hours of one-on-one counseling; subsequent years: 2 hours of one-on-one counseling.	Beneficiaries diagnosed with diabetes or a renal disease or who have received a kidney transplant within the last 3 years	Copayment, coinsurance, and deductible waived Note: If the patient is receiving dialysis in a dialysis facility, Medicare will cover MNT as part of the overall dialysis care.

Medicare Part B – Covered Preventive Services		
Service	Who Is Covered	Beneficiary Obligation in the Original Medicare Plan
Pap smear and pelvic examination (including a clinical breast exam) – Once every 24 months or once every 12 months if at risk for cervical or vaginal cancer or of childbearing age with an abnormal Pap smear in the preceding 36 months.	Female beneficiaries	Copayment, coinsurance, and deductible waived
Prostate cancer screening – Digital rectal examination: once every 12 months; prostate-specific antigen (PSA) test: once every 12 months.	Male beneficiaries age 50 and older (beginning the day after the 50th birthday)	Digital rectal exam - Copayment, coinsurance, and deductible apply PSA test - Copayment, coinsurance, and deductible waived
Screening and behavioral counseling to reduce alcohol misuse - Annually for all beneficiaries; face-to-face counseling up to four times per year for those who screen positive up to four times per year.	All Medicare beneficiaries Medicare beneficiaries who screen positive are eligible for counseling if: • They are competent and alert at the time that counseling is provided and, • Counseling is furnished by qualified physicians in a primary care setting.	Copayment, coinsurance, and deductible waived
Screening for cervical cancer with human papillomavirus (HPV) tests – Once every five years.	All asymptomatic female Medicare beneficiaries aged 30 to 65 years	Copayment, coinsurance, and deductible waived
Screening for depression - Annually for all beneficiaries.	All Medicare beneficiaries	Copayment, coinsurance, and deductible waived
Sexually transmitted infection (STI) screenings and high intensity behavioral counseling to prevent STIs - Annually for all beneficiaries; frequency of coverage depends on the type of STIs being treated.	Adolescent and adult beneficiaries who are sexually active and are at an increased risk for STIs	Copayment, coinsurance, and deductible waived Behavioral counseling sessions conducted in an inpatient setting will not be covered as preventive services.

Medicare Part B – Covered Preventive Services		
Service	Who Is Covered	Beneficiary Obligation in the Original Medicare Plan
Smoking and tobacco use cessation counseling - 2 cessation attempts per year; each attempt includes a maximum of 4 intermediate or intensive sessions; up to 8 sessions within a 12-month period.	Beneficiaries who use tobacco and have a disease or adverse health effect linked to tobacco use	Copayment, coinsurance, and deductible waived
Ultrasound screening for abdominal aortic aneurysm (AAA) – Once in a lifetime.	Beneficiaries with certain risk factors for AAA who receive a referral from their physician, physician assistant, nurse practitioner or clinical nurse specialist	Copayment, coinsurance, and deductible waived
Vaccinations – Flu shot: once a year, per flu season; pneumonia shot: to prevent pneumococcal infections, one shot can be followed by a second, different shot one year later.	All beneficiaries with Part B coverage	Copayment, coinsurance, and deductible waived

Edit(s) to page 4-17: Health Insurance Claim Number

T	An individual entitled to Part A benefits but not to retirement and survivor's or Railroad Retirement insurance; or who is ~~nor are they~~ entitled to Medicare based on chronic renal disease.

***

NOTE: Beginning in April 2018, CMS will start mailing new Medicare cards. The Medicare Access and CHIP Reauthorization Act of 2015 requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards by 2019. The current process of basing the HICN on the patient's SSN violates HIPPA. This change is important because CMS will be better able to protect private health care and financial information and protect federal health care benefits and service payments.

The new identifier (known as the MBI, Medicare Beneficiary Identifier) will:

- Have the same number of characters (11) as the HICN.
- Contain uppercase letters and numeric characters, but no special characters.
- Occupy the same field on HICN transactions.
- Be unique to each beneficiary (i.e., husband and wife have their own MBIs).
- Be easy to read and limit the possibility of misinterpretation (uppercase letters only and no commonly misread letters S, L, O, I, B, and Z).
- Not contain inappropriate combinations of numbers or strings that may be offensive.

Edit(s) to page 4-17: Medigap

Medigap refers to a supplementary coverage available only to persons enrolled in Medicare Part A and Part B. (Enrollees in Medicare Advantage plans do not need a Medigap policy.) Medigap covers the deductible and coinsurance amounts for which the patient is responsible under Medicare. Some Medigap policies also cover the difference between Medicare's covered charge and the actual charge.

Edit(s) to page 4-19: Liability Insurance

Description of change: Inserted text and reformatted as a bullet list.

- Med-pay coverage is often quite limited, but will pay quickly.
- No-fault coverage is currently offered in 12 states and follows state no-fault laws. Typically each injured party in an accident must file a claim with his or her own auto insurance.
- Liability coverage may be much more extensive, but, especially in the case of a serious accident, may take a long time to pay. Generally liability coverage will not pay until the patient has completed all treatment and agreed to a settlement. In these instances, it may be helpful to seek payment from the health insurance. Some health insurance companies will pay the medical expense for the patient and then subrogate with the liability carrier to recover monies retroactively.

Edit(s) to page 4-36:

Code Set	Acronym	Use
International Classification of Diseases	ICD ~~ICD-9, for the ninth revision~~ ICD-10, for the 10th revision	Diagnoses and inpatient procedures (As of October 2015, the DHHS has mandated that providers must code all claims using ICD-10 codes.)
Present on Admission Indicators	POA	Inpatient claims
Current Procedural Terminology	CPT® (CPT-4, for the fourth revision)	Outpatient procedures
Healthcare Common Procedure Coding System	HCPCS	
National Provider Identification	NPI	Provider identification, as dictated by CMS's Administrative Simplification Identifier Standards
Taxonomy Code		Type and specialty of a provider

Edit(s) to page 4-39: HCPCS and CPT Modifiers

Other modifiers deal specifically with the use of ABNs:

- GA – used when it is expected that Medicare will deny the item or service and there is a signed ABN on file; the patient is responsible for charges incurred for the service
- GX – used to report that a voluntary ABN was issued for a service ("Notice of Liability Issued, Voluntary Under Payer Policy")
- GY – used when it is known that the item or service is noncovered, ~~or~~ is not a Medicare benefit, or is statutorily excluded; the patient is responsible for charges incurred for the service
- GZ – used when it is expected that Medicare will deny the item or service and no ABN was obtained; the provider is responsible for charges incurred for the service

New topic on page 4-39: NPIs and Taxonomy Codes

An NPI is a unique, 10-digit identifier issued to health providers in the United States by the CMS.

Taxonomy codes are designed to categorize the type, classification, and/or specialization of health care providers. The taxonomy code set is a hierarchical code that consists of codes, descriptions, and definitions.

Edit(s) to pages 4-54 and 4-55: 1500 and 837P

Description of change: Deleted the icons previously related to 1500 and 837P*. This topic is relevant for both the CRCP-I and CRCP-P exams. Inserted text.*

In the rare instance that a provider qualifies for a waiver from HIPAA-mandated electronic claims submission, the CMS 1500 form is the standard claim form used. The 1500 form is also used for billing some Medicaid state agencies and many times hospitals use this form to bill for professional fees such as reading an EKG, billing for Medicaid labs, etc. The HIPAA standard transaction that replaces the 1500 and is required of almost all physicians is the 837P.

Edit(s) to page 4-56: Medicare 3-Day Rule

Medicare 3-Day and 24-Hour Rule

Under provider-based billing requirements, Medicare's 3-day rule ~~(or, for certain hospitals, the 1-day or 24-hour rule)~~ requires all diagnostic or outpatient services furnished in connection with the principle admitting diagnosis within three days ~~(or 24 hours)~~ prior to the hospital admission to be bundled with the inpatient services for Medicare billing. Certain hospitals must comply with a similar rule that has a 24-hour timeframe. These include inpatient psychiatric hospitals, inpatient rehabilitation facilities, long term care facilities, and children's and cancer hospitals.

- This provision does not apply to ambulance services and non-diagnostic outpatient services not related to the primary diagnosis provided within three days of the admission. For these, the services are not bundled.
- This rule is a Medicare requirement; it does not apply to Critical Access Hospitals and does not apply to all commercial payers.

Edit(s) to page 4-58: Medically Unlikely Edits (MUE)

In many cases, an MUE cannot be appealed (but see the information below about MUEs of Level 3). A provider who disagrees with an MUE should contact Correct Coding Solutions, the contractor who developed the program.

MUE Adjudication Indicator

In 2013, CMS modified the MUE program so that some MUE values are date of service edits rather than claim line edits. There is a data field in the MUE edit table termed "MUE adjudication indicator," or MAI. There is an MAI assigned to each HCPCS code and there are three levels of MAI:

- Level 1 indicates the MUE will continue to be adjudicated as a claim line edit.
- Level 2 indicates the MUE will be based on an absolute date of service. These are per day edits based on policy.
- Level 3 indicates the MUE will be based on date of service. These are per day edits based on clinical benchmarks. MUEs of Level 3 can be appealed with medical records.

Edit(s) to page 6-1: Objectives

- Define key accounting terms.
- List the eight steps in the accounting cycle.
- Define deductions from revenue and income, and list steps to reduce deduction rates.

Edit(s) to page 6-3: General Overview of Management Roles

Description of change: Made text bold for emphasis.

Effective management contributes to a productive and positive work environment. Ineffective management creates the risk of serious consequences up to and including litigation over regulatory requirements, business practices, conflict of interest issues, inappropriate use of resources, breach of confidentiality, and inappropriate relationships with subordinates.

Edit(s) to pages 6-3 and 6-4: Accounting Terminology

- **Assets** are those things the business owns that have a value.

Assets = Liabilities + Owner's Equity + Revenue - Expenses

***

- **Liabilities** are ~~those things that the business owes. Like assets, these can be current or long-term.~~ obligations of an entity arising from past transactions, the settlement of which may result in transfer of assets, provision of services, or other yielding economic benefits in the future.
    - A liability is defined by the following characteristics:
        - Any type of borrowing for improving a business income
        - A responsibility to others that entails settlement by future transfer of assets, provision of services, or other transactions
        - A responsibility that obligates the entity to another, leaving it little or no discretion to avoid settlement
    - Like assets, liabilities can be current or long-term.

New topic on page 6-6: Eight Steps in the Accounting Cycle

There are eight steps in the accounting cycle:

1. Analyze transactions by examining source documents.
2. Journalize transactions in the journal.
3. Post journal entries to the accounts in the ledger.
4. Prepare a trial balance of the accounts and complete the worksheet.
5. Prepare financial statements.
6. Journalize and post adjusting entries.
7. Journalize and post closing entries.
8. Prepare a post-closing trial balance.

Edit(s) to page 6-7: Managing Deductions from Revenue and Income

- Evaluate and replace low-performing collection agencies with better-performing ones.
- Use automation to improve efficiency and effectively manage staffing numbers.

Edit(s) to page 6-8: Handling Credit Balances

Another critical part of revenue cycle management is dealing with any credit balances, which are accounts with a negative balance. Situations that create a credit balance include:

- Overpayment by third party payer or patient (guarantor)
- Payment for services planned but not performed
- Overpayment due to errors made in calculating beneficiary deductible and/or coinsurance amounts
- A hospital that bills and is paid for outpatient services included in a beneficiary's inpatient claim
- Miscalculation of contractual allowance

***

- Medicare requires that overpayments be repaid quickly and requires a quarterly Medicare Credit Balance Report (the 838) even if there are no credit balances.
  - An 838 report is specifically used to monitor identification and recovery of “credit balances” owed to Medicare. A credit balance is an improper or excess payment made to a provider as a result of patient billing or claims processing errors.
  - Only Medicare credit balances are reported on the 838.
- Failure to file the 838 will result in Medicare’s withholding of payments.

Edit(s) to page 6-23: Outsourcing Considerations

When evaluating whether to use an outside company, total costs (including non-monetary) should be compared to benefits. Once you decide to move forward, develop a Request for Proposal (RFP) and send it to several potential partners. An RFP should:

1. Clearly define the job you want done.
2. List work requirements.
3. List key performance indicators (KPIs) that will be used to measure the vendor's performance.
4. Ask for specific pricing.
5. Ask vendors to explain their credentials and what makes them the best choice.
6. Ask about the vendor's staff experience.
7. Ask for references.

***

Once the vendor is selected and the contracts signed:

- Implement carefully, making sure the process works correctly and as sold.
- Establish regulatory frameworks.
- Develop a well-trained team.
- Deploy knowledge retention strategies.
- Create a compliant workforce culture.
- Maintain accountable processes.
- Monitor the process on an ongoing basis to make sure it gets the results needed.
- Periodically compare other companies/products to the initial selection.