Certified Revenue Cycle Specialist (CRCS-I, CRCS-P) Exam Study Outline 2014

December 2013
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(AAHAM)
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Introduction

Overview of this Outline


Knowledge and Skill Requirements for Certification

This outline lists the requirements for each broad topic covered in the exam. Pay careful attention to the wording of the requirements, as it indicates specifically what you must be able to do in order to achieve certification. For example:

- Describe common metrics related to collection.

The wording of this requirement tells you that you should be able to describe the metrics. You should understand the definitions and concepts in these metrics so you can describe them. However, you won't need to do any calculations since the word “calculate” is not used in the requirement.

Icons

Most of the requirements apply to both exams. When a requirement applies to only one exam, it is flagged with an icon as shown in the example below:

- Describe the use of common or required billing and statement “forms.”
  - Superbill
  - UB-04 (and 837I) (including common codes)
  - CMS 1500 (and 5010A1/837P) (including common codes and instructions to complete the form)
  - Itemized Statement
  - Data Mailer
  - Medicare Summary Notice
Glossary

There is an extensive glossary at the back of this outline.

**TIP:** It will be extremely helpful when taking the exam if you are very familiar with the terms and definitions in the glossary.

An Alternative to this Outline

Should you want a more comprehensive and robust study aid, consider purchasing the AAHAM *Certified Revenue Cycle Specialist (CRCS-I, CRCS-P) Exam Study Manual - 2014*. Like this outline, the study manual lists the specific skill and knowledge requirements you must meet to achieve certification. However, the study manual also includes extensive information you can review to prepare for the exam. In addition, the study manual has Knowledge Checks where you can test your ability to apply what you have learned, with answer keys so you can assess your progress.

To purchase the *Certified Revenue Cycle Specialist (CRCS-I, CRCS-P) Exam Study Manual - 2014*, please visit our website at www.aaham.org.

Overview of CRCS-I and CRCS-P Exams

Introduced in 1992 as the Certified Patient Accounts Technician (CPAT) or Certified Clinic Accounts Technician (CCAT) certification and renamed CRCS-I and CRCS-P in 2013, these exams test staff proficiency and provide a resource for patient account managers to ensure staffing competence. The exams test overall understanding of healthcare patient accounting in the areas of admitting, billing, and collections, along with the knowledge of industry-standard abbreviations.

Successful completion will establish individuals as being proficient and competent. Further, the designation, sponsored by AAHAM, will provide recognition from your peers and healthcare executives nationally. In many instances, certification can help you get the job or promotion you really want.
Dual Certification

Dual certification exams are available to current CRCS-I’s or CRCS-P’s only. You cannot take both the CRCS-I and CRCS-P exams during the same exam cycle.

- CRCS-I Dual Exam – for a current CRCS-P individual desiring to become certified
- CRCS-P Dual Exam – for a current CRCS-I individual desiring to become certified

Each dual exam consists of two sections covering patient access services and communications/registration, and third party billing regulations.

Eligibility

Any person involved in the admitting, billing, or collection of patient accounts in healthcare is eligible for the CRCS-I/CRCS-P exams. Membership in AAHAM is not a requirement, although it is encouraged. One year of experience in clinical or hospital patient accounting is recommended.

Applications, Fees, and Deadlines

Applications

There are two ways to apply for an exam:

- Online – go to www.aaham.org; use the online application link on the certification page; and pay with a credit card (amount described under Fees below).
- Mail in – obtain an application from www.aaham.org, Certification tab. Complete and mail the application with a check or money order (amount described under Fees below), payable to AAHAM, to:

  National AAHAM
  Attention Tech Cert
  11240 Waples Mill Rd., Ste. 200
  Fairfax, VA 22030

  If you have any further questions or would like to request a copy of the certification brochure, contact the AAHAM national office at 703-281-4043, ext. 211 or send an e-mail to amanda@aaham.org.
Fees
Examination fees are:

- Full CRCS-I/CRCS-P examination:
  - $100
- Dual certification examination:
  - $80
- Section retake (described under Retake Criteria below):
  - $50
- CCT examination:
  - $100

Deadlines
The application and fee must be received by:

- March 1 for the May exam
- June 1 for the August exam
- September 1 for the November exam
- December 1 for the February exam

Exam Format and Grading
The examination has three sections:

- Patient access services and communication/registration
- Third party billing
- Credit and collections, and third party follow up

Each section also includes relevant regulations and acronyms, and consists of 40 multiple-choice questions, for a total of 120 questions.

A grading report will appear after you submit your results at the completion of your exam. If a printer is available, you may print your scores. These scores will also be sent to you via e-mail to the e-mail address you provide on your application.

You must attain a score of at least 70% in each section to pass that section, and you must pass all three sections to pass the exam. (For dual exams,
you must score at least 70% in each of the two sections, both of which consist of 40 multiple-choice questions.)

Certificates will be sent to your Chapter Certification Chair approximately three weeks after the closing of the examination window. The Chapter will present certificates in one of these ways:

- Present passing examinees their certificates at an AAHAM Chapter meeting.
- Mail certificates to the addresses provided on exam applications. (E-mail amanda@aaham.org if you wish to verify your mailing address.)

**Retake Criteria**

If you pass at least two of the sections but fail the third, you can retake the remaining section within 12 months of the initial exam month. In order to retake a section, you must:

1. Complete another application for the failed section.
2. Remit a check or money order for $50.
3. Submit the application and fee to the national AAHAM office by the appropriate deadline (see Deadlines above) in order to retake the exam within 12 months of the initial examination month.

(For dual exams, you must pass both sections on the same exam day. If you fail to pass both sections on exam day, you must retake the entire exam.)

**Suggested Preparation**

Independent research and hands-on experience will be necessary in order to successfully complete the exam. Be sure to allow enough time for all the preparation you want to do. Finding a “study-buddy” can be very helpful; try to pair up with another person in your chapter and take the exam together.

Many chapters offer coaching sessions to help members prepare. We want you to succeed; therefore, we urge you to attend these sessions.

**TIP:** Because it is one of the largest payers, there are many Medicare questions on the exam. Be sure to be well-versed on Medicare issues and know all current Medicare deductibles and coinsurance amounts.
Exam Logistics

The Chapter Certification Chair determines the exact dates, times, and locations of exams. You should hear from your Chapter Certification Chair by the 7th of your examination month via phone, e-mail, or letter, using the information you provided on your application. If you do not hear from your Chapter Certification Chair by the 7th of that month, contact him or her directly. (There is a directory of Chapter Certification Chairs in the certification section of the AAHAM website, www.aaham.org.)

TIP: Examinations are offered quarterly based on proctor availability, usually during the second and third weeks of February, May, August, and November. For further details, see the home page of www.aaham.org and view the Calendar of Events area.

The day of the exam, you will need current photo identification. You will also need your AAHAM exam confirmation that contains your Test Taker Authorization Code, which you will receive via e-mail approximately 1-2 weeks before your exam date. You will be unable to take the exam without your Test Taker Authorization Code.

WARNING: You will not be able to use study guides, written and/or electronic notes, or verbal and/or signaled help during the exam. Examinees who witness this conduct are required to report it to the examination proctor.

Plan your arrival approximately 15 minutes prior to the examination. This allows you ample time should delays or problems present themselves. Failure to arrive on time will negate sitting for the exam, and result in forfeiture of the application. There are no refunds or postponements, and exam fees are non-transferable.

The exam is taken online in the physical presence of a proctor. You will have 2 hours to complete a full exam, 80 minutes to complete a dual exam, and 40 minutes to complete a section retake.
Re-certification

Your certification is good for a three-year period (note the expiration date on your certificate). You can be re-certified by taking the CRCS-I or CRCS-P exam every three years. There is also an option for earning continuing education units (CEUs) to maintain your certification. This requires maintaining a national AAHAM membership for the three-year period, and earning and submitting 30 CEUs in the three-year period (with 15 CEUs from AAHAM-related events).
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Federal Regulations and Governing Bodies

Knowledge and Skill Requirements

In order to achieve certification, you should be able to:

1. Identify federal agencies playing a major role in healthcare.
   - Department of Health and Human Services (DHHS)
     - DHHS Programs
     - DHHS Operating Divisions
   - Centers for Medicare and Medicaid Services (CMS)
     - CMS Mission
     - Quality Improvement Organization (QIO) Program

2. Describe the general provisions of major federal regulations related to healthcare:
   - Hospital construction (Hospital Survey and Construction Act, or the Hill-Burton Act)
   - Patient rights (the Patient Bill of Rights), including goals and guarantees of the Patient Bill of Rights
     1) Right to privacy and security of health information (the Privacy Act of 1974; The Health Insurance Portability and Accountability Act, or HIPAA, of 1996)
     2) Right to participate in treatment decisions (the Patient Self Determination Act, or PSDA, of 1990), including types of advance directives
   - Affordable care (the Patient Protection and Affordable Care Act, or PPACA, also known as simply the Affordable Care Act, or ACA, and commonly called “Obamacare” or the Federal Health Care Law)
     - Implementation for Tax-Exempt Hospitals
     - Consumer Marketplace (including various ways consumers can learn about the options available for healthcare)
- Anti-fraud and abuse (definitions of “fraud” and “abuse”; the False Claims Act; CMS administrative sanctions; the Criminal Health Care Fraud Statute; exclusions by the Office of Inspector General, or OIG; Health Care Fraud Prevention and Enforcement Action Team, or HEAT)

- Credit and collections (Truth in Lending Act; Fair Credit Billing Act; Fair Credit Reporting Act; Fair Debt Collection Practices Act; Equal Credit Opportunity Act)

- Patient anti-dumping (the Emergency Medical Treatment and Active Labor Act, or EMTALA)

- Laboratory licensing (The Clinical Laboratory Improvement Amendment, or CLIA, of 1988)

- Other areas addressed by HIPAA (Titles I and II of HIPAA)

3. Describe the role of The Joint Commission.

- Accreditation as requirement of participation in Medicare

- Areas in which Patient Access can expect TJC surveys

- Contingency plan requirements
Patient Access Services

Knowledge and Skill Requirements

In order to achieve certification, you should be able to:

1. Describe the primary functions and responsibilities of the Patient Access division/department.
   - Trends in Reengineering the Patient Access Process
   - Primary Functions and Responsibilities
     - Scheduling
     - Pre-registration and pre-admission testing
     - Pre-certification and pre-authorization
     - Inpatient admitting and outpatient registration
     - Insurance verification
     - Financial counseling
       - Collection control points
       - Deposit Collection Program
     - Other
       - Affiliated Health Services
       - Physician Direct Services

2. Describe the roles and responsibilities of Case Management/Utilization Review.
   - Tasks assumed by Case Management

3. Describe different levels of patient care, as differentiated by billing and reimbursement requirements.
   - Acute inpatient
   - Observation (including CMS guidelines)
   - Outpatient
   - Long term care
   - Skilled nursing facility (SNF)
   - Hospice care
3. Describe the types of consent, and the requirements and results of each.

- Consent forms (general and special)
- Types of consent
  - Actual or expressed consent
  - Implied consent – in fact
  - Implied consent – by law
  - Informed consent
- Emancipation

5. Describe guidelines and characteristics of a medical record and requirements for changes to a medical record.

- Clinical and medical personnel authorized to make entries in a medical record

6. List individuals who can accept verbal (telephone) orders from a referring physician and required elements of a verbal (telephone order).

7. Explain the purpose, triggering events, completion, and retention of the Advance Beneficiary Notice (ABN).

8. Differentiate between definitive and non-definitive Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs).


10. Define (and explain how to calculate) key metrics related to Patient Access.

- Average Length of Stay
- Midnight Census
- Average Daily Census
- Percentage of Occupancy
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Hospital and Clinic Billing

Knowledge and Skill Requirements

In order to achieve certification, you should be able to:

1. Describe types of insurance and insurance payers.
   - Medicare
     - Coverage for the elderly (age 65 or older) and those under age 65 who have permanent disabilities or end stage renal disease (ESRD)
     - Medicare’s criteria for medical necessity
     - Part A Deductibles, Coinsurance, and Copayments
     - Part B Deductibles, Coinsurance, and Copayments
     - Part B Preventive Services (including beneficiary obligation)
     - Other Part B Services
     - Items Not Covered by Part A or Part B in the Original Medicare Plan
     - Part C - Types of Medicare Advantage Plans
     - Part D - Purpose
     - Medicare Participating Physician Program
     - Health Insurance Claim Numbers, including suffixes
   - Medigap
   - Medicaid
     - Dual Eligibles
   - Workers’ Compensation
   - Tricare
     - Non-Availability Statement (NAS)
   - Children’s Health Insurance Program (CHIP)

2. Determine proper coordination of benefits.
   - Medicare as Primary vs. Secondary
     - Individuals for whom Medicare is secondary
3. Describe the role of a coordination of benefits contractor.

4. Describe common mandated transaction code sets.
   - ICD-9-CM (Clinical Modification)
     - Guidelines to apply the correct ICD-9-CM code to diagnostic statements on a claim
     - Transition to ICD-10
   - CPT and HCPCS
     - HCPCS Level I and Level II
     - Evaluation & Management (E&M) Levels
     - HCPCS and CPT Modifiers

5. Describe payment methodologies.
   - Diagnosis-Related Group (DRG)
   - Ambulatory Payment Classification (APC)
     - Elements required to assign an APC
     - Examples of packaged services
     - Units Exempt from APCs
   - Critical Access Hospital (CAH)
   - Resource Utilization Group (RUG)
   - Capitation
   - Per Diem

6. Describe methods to determine the value of services.
   - Resource Based Relative Value Scale (RBRVS)
     - Three major elements comprising RBRVS
     - Three elements comprising RVU
     - Usual, Customary, and Reasonable (UCR)

7. Describe the chargemaster.
   - Purpose and use of chargemaster
   - Elements of a chargemaster
8. Describe the use of common or required billing and statement “forms.”
   - Superbill
   - UB-04 (and 837I) (including common codes)
   - CMS 1500 (and 5010A1/837P) (including common codes and instructions to complete the form)
   - Itemized Statement
   - Data Mailer
   - Medicare Summary Notice

9. Describe mandatory filing requirements and exceptions.

10. Explain the significance of billing timeframes.
    - Medicare timely filing
    - Importance of timely filing
    - Medicare 3-Day Rule

11. Describe considerations for electronic claim processing and key Medicare edits.
    - Methods to originate and transfer electronic claims; benefits and problems with electronic billing
    - Medicare Edits
      - Requirement for complete/valid claims
      - Use of Medicare Volume Performance Standard (MVPS) in managing growth in Medicare Part B
      - Medicare Code Editor, including three basic types of edits
      - Non-Standard Claims
      - Unprocessable Claims
      - Incomplete and Invalid Claims
      - Clean Claims
      - National Correct Coding Initiative (NCCI)
      - Medically Unlikely Edits (MUE)

12. Describe guidelines for an effective compliance plan.
    - OIG's seven elements of a compliance plan
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Credit and Collections

Knowledge and Skill Requirements

In order to achieve certification, you should be able to:

1. Define terms related to credit and collections.
   - Charity care
   - Indigent
   - Bad debt
   - Judgment
   - Lien
   - Tort liability
   - Statute of limitations

2. Describe elements of an effective collection policy.

3. Describe types of bankruptcy and explain how they affect the collection process.
   - Types
     - Chapter 7
     - Chapter 11
     - Involuntary bankruptcy
       - Chapter 12
       - Chapter 13
     - Affect on collection process
     - Potential outcomes
       - Discharge of Debtor
       - Dismissal
     - Requirements for counseling sessions

4. Determine the responsible party for a given scenario.

5. Define and list advantages of a courtesy discharge.

7. Explain common debt collection methods and practices.
   - In-House Collection
     - Purpose and importance of following up with third party payers
     - Strategies for collection efforts
     - Steps for making collection calls
   - Collection Agencies
   - Skip Tracing
     - Types of skips
     - Resources to trace skips

8. Describe generally accepted accounting principles for the cashier’s role.

9. Describe common metrics related to collection (and how to calculate them).
   - Average Daily Revenue
   - Average Days of Revenue in Accounts Receivable (ADRR)
Glossary

1-Day Rule a requirement that all diagnostic or outpatient services furnished in connection with the principle admitting diagnosis within one day prior to the hospital admission are bundled with the inpatient services for Medicare billing.

3-Day Rule a requirement that all diagnostic or outpatient services furnished in connection with the principle admitting diagnosis within three days prior to the hospital admission are bundled with the inpatient services for Medicare billing.

5010A1 the American National Standards Institute transaction for a professional claim (the electronic equivalent of the CMS 15000), formerly the 837P

837I the American National Standards Institute transaction for an institutional claim; as a result of HIPAA, it is replacing the electronic UB-04.

837P a former American National Standards Institute transaction for a professional claim (the electronic equivalent of the CMS 15000), since replaced by the 5010A1.

ABN the Advance Beneficiary Notice of Noncoverage; a form given to a Medicare beneficiary before services are furnished when a service does not meet or is not expected to meet medical necessity.

abuse the misuse of a person, substance, service, or financial matter such that harm is caused; some forms of healthcare abuse include excessive or unwarranted use of technology, pharmaceuticals, and services; abuse of authority; and abuse of privacy, confidentiality, or duty to care; it also includes improper billing practices (like billing Medicare instead of primary insurer), increasing charges to Medicare beneficiaries but not to other patients, unbundling of services, and unnecessary transfers of patients.

Accounts Receivable (AR) Days Outstanding an estimate, using average current revenues, of the days required to turn over the accounts receivable under normal operating conditions; in simple terms, this is an estimate of the time needed to collect the accounts receivable.

ACF Administration for Children and Families; one of the DHHS Operating Divisions.
ACL  Administration for Community Living; one of the DHHS Operating Divisions.

actual or expressed consent  written or oral agreement by the patient to the treatment outlined.

acute inpatient  a level of healthcare delivered to patients experiencing acute illness or trauma; it generally occurs in a hospital or emergency room and is generally short-term care rather than long-term or chronic care.

ADC  average daily census; the average number of inpatients maintained in the hospital each day for a specific period of time.

ADRR  Average Days of Revenue in Accounts Receivable; also known as Accounts Receivable (AR) Days Outstanding; an estimate, using average current revenues, of the days required to turn over the accounts receivable under normal operating conditions; in simple terms, this is an estimate of the time needed to collect the accounts receivable.

Advance Beneficiary Notice  the Advance Beneficiary Notice of Noncoverage; a form given to a Medicare beneficiary before services are furnished when a service does not meet or is not expected to meet medical necessity.

AFDC  Aid to Families with Dependent Children; a financial assistance program provided by DHHS.

agents  individuals who help consumers and small businesses complete the application process and enroll in healthcare coverage through the Marketplace; they are able to make recommendations about coverage and may only sell plans from specific health insurance companies.

AHA  the American Hospital Association.

AHRQ  Agency for Healthcare Research and Quality; one of the DHHS Operating Divisions.

ALOS  average length of stay; a metric calculated by dividing the total number of patient days by the number of discharges.

ancillary services  services other than routine room and board charges that are incidental to the hospital stay; they include operating room; anesthesia; blood administration; pharmacy; radiology; laboratory; medical, surgical, and central supplies; physical, occupational, speech pathology, and inhalation therapies; and other diagnostic services.

ANSI  the American National Standards Institute.
APC  ambulatory payment classification; a payment methodology in which services paid under the prospective payment system are classified into groups that are similar clinically and in terms of the resources they require; a payment rate is established for each APC.

APR  annual percentage rate; one of the elements of disclosure required by the Truth in Lending Act.

assignment of benefits  a written authorization, signed by the policyholder (or the patient, in the absence of the policyholder) to an insurance company, to pay benefits directly to the provider; when assignment is not accepted, the payment will be sent to the patient and the provider will have to collect it.

ATB  aged trial balance; a resource for internal collection efforts.

ATSDR  Agency for Toxic Substances and Disease Registry; one of the DHHS Operating Divisions.

average daily census  the average number of inpatients maintained in the hospital each day for a specific period of time.

average daily revenue  the average amount of revenue or charges generated each day over a specified period of time.

Average Days of Revenue in Accounts Receivable  also known as Accounts Receivable (AR) Days Outstanding; an estimate, using average current revenues, of the days required to turn over the accounts receivable under normal operating conditions; in simple terms, this is an estimate of the time needed to collect the accounts receivable.

bad debt  an uncollectible account resulting from the extension of credit.

beneficiary  a person who has healthcare insurance through Medicare.

birthday rule  a rule to determine coordination for benefits for a child covered by both parents; it dictates that the parent with the first birthday in the calendar year will provide the primary coverage; if both parents happen to have the same birthday, the plan that has covered a parent longer pays first.

Black Lung Benefits Act  legislation which provides for medical treatment for coal miners totally disabled from black lung disease.

Bressers  a cross-reference directory used in skip tracing.
brokers  individuals who help consumers and small businesses complete the application process and enroll in healthcare coverage through the Marketplace; they are able to make recommendations about coverage and may only sell plans from specific health insurance companies.

CAH  Critical Access Hospital; a non-profit hospital located in a state that has established a Medicare Rural Hospital Flexibility Program; it must have 25 or fewer beds and an ALOS of 96 hours or less, be located a certain minimum distance from other hospitals, and furnish 24-hour emergency care services; Medicare pays CAHs for most inpatient and outpatient services on the basis of reasonable cost.

Call centers  an option for consumers to ask questions about health coverage options and obtain assistance with the Marketplace application process.

capitation  a method of payment in which a provider is paid a set dollar amount for each patient for a specific time period, and that payment covers all care the group of patients receives for that period, no matter the actual charges.

Case Management  also known as Utilization Review (UR); an area that performs critical tasks during registration and a patient’s stay, such as reducing unnecessary admissions; managing the approved length of stay; ensuring an appropriate level of care for the patient's condition; serving as liaison with the primary and specialty physicians; serving as liaison with the insurance carrier; obtaining approvals, when clinically necessary, for pre-certification/re-certification; advising the patient of discharge; and assisting with appeals for denials, when applicable.

CDC  Centers for Disease Control and Prevention; one of the DHHS Operating Divisions.

CDM  charge description master; the chargemaster or master pricing list that includes services, supplies, devices, and medication charges for inpatient or outpatient services by a healthcare facility.

CERT  Comprehensive Error Rate Testing.

Certified application counselors  individuals (staff members or volunteers) who fulfill some of the same roles as Navigators and non-Navigators; they are not responsible for outreach and education but they do provide free information to consumers about insurance programs, they assist them in applying for coverage, and they help to facilitate the enrollment in health coverage.
CHAMPUS  Civilian Health and Medical Programs of the Uniformed Services; the programs replaced by Tricare to cover healthcare for active duty and retired members of the uniformed services, their families, and survivors.

Chapter 7  a type of bankruptcy applying to individuals and businesses that cannot pay their debts based on their income; except for exempt property as defined by state laws, the debtor's assets are auctioned to satisfy creditor claims; about 70% of all bankruptcy claims are filed under Chapter 7.

Chapter 11  a type of bankruptcy frequently referred to as a "reorganization"; it gives a distressed business a reprieve from creditor claims while it continues to function and works out a repayment plan.

Chapter 12  a type of bankruptcy for a family farmer with "regular annual income."

Chapter 13  a type of bankruptcy designed for individuals with regular income who desire to pay their debts, but currently are unable to do so; the debtor, under court supervision and protection, may propose and carry out a repayment plan under which creditors are paid over an extended period of time.

chargemaster  also known as charge description master (CDM); the master pricing list that includes services, supplies, devices, and medication charges for inpatient or outpatient services by a healthcare facility.

charity care  service provided that is never expected to result in cash flow.

CHIP  the Children’s Health Insurance Program; a program for children whose parents have too much money to be eligible for Medicaid, but not enough to buy private insurance; it is jointly financed by the federal and state governments, and administered by the states.

CLIA  the Clinical Laboratory Improvement Amendment of 1988; legislation requiring all clinical laboratory services furnished to Medicare beneficiaries to be performed by a provider who has a CLIA certificate.

Clinical Laboratory Improvement Amendment (CLIA) of 1988  legislation requiring all clinical laboratory services furnished to Medicare beneficiaries to be performed by a provider who has a CLIA certificate.

CMP  civil monetary penalty.
CMS  Centers for Medicare and Medicaid Services; one of the DHHS Operating Divisions.

CMS 1450  another name for the UB-04 uniform bill form.

CMS 1500  the billing form used to submit physician and professional service claims to Medicare.

CO  compliance officer.

COB  coordination of benefits; the determination of which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits.

Common Working File  a CMS file that contains Medicare patient eligibility and utilization data.

Conditional payment  a payment made when another payer is responsible, but the claim is not expected to be paid promptly (usually within 120 days from receipt of the claim); it prevents the beneficiary from having to pay out of pocket; Medicare then has the right to recover any payments that should have been made by another payer.

Consumer assistance programs  a resource to help to address consumers’ problems or questions about health coverage.

Consumer Credit Protection Act  the first general federal consumer protection legislation; its provisions include the Truth in Lending Act, the Fair Credit Billing Act, the Fair Credit Reporting Act, and the Fair Debt Collection Practices Act.

Coordination of benefits contractor  a contracted entity that assists with the collection, management, and reporting of other health coverage; COB contractors do not process claims for the provider; they gather and disseminate coordination of benefits information to ensure that Medicare is not making primary payment for a service in error.

courtesy discharge  a type of discharge in which a patient’s financial considerations have been met so he or she is allowed to leave the hospital without going through the usual formalities; the patient is billed at a later date.

CPT  Current Procedural Terminology; a system of descriptive terms and five-digit numeric codes that are used primarily to identify medical services and procedures furnished by physicians and other healthcare professionals.

CPU  central processing unit.

CRA  credit reporting agency.
**Criminal Health Care Fraud Statute**  a statute that prohibits willfully or knowingly executing a scheme to obtain any money or property owned by or in control of any healthcare benefit program or defrauding any healthcare benefit program.

**Critical Access Hospital (CAH)**  a non-profit hospital located in a state that has established a Medicare Rural Hospital Flexibility Program; it must have 25 or fewer beds and an ALOS of 96 hours or less, be located a certain minimum distance from other hospitals, and furnish 24-hour emergency care services; Medicare pays CAHs for most inpatient and outpatient services on the basis of reasonable cost.

**custodial care**  care that is primarily for the purpose of meeting personal needs; persons without professional training may provide custodial care; it is not covered by Medicare.

**CWF**  Common Working File; a CMS file that contains Medicare patient eligibility and utilization data.

**data mailer**  a system-generated, free-form statement that is used to communicate the status of a patient’s account and/or to bill the patient for an unpaid amount remaining on the account.

**definitive LCD/NCD**  a policy that discusses and lists specific diagnosis codes, ICD procedure codes, and possibly signs and symptoms to support the need for the item or service being given.

**DHHS**  Department of Health and Human Services; the United States government’s principal agency for protecting the health of all Americans and providing essential human services; it is also the federal government’s largest grant-making agency.

**discharge of debtor**  a potential outcome of bankruptcy that releases the guarantor/patient from financial responsibility of any and all account balances listed on the bankruptcy petition; the account balance is to be written off to the appropriate transaction code.

**dismissal**  a court ruling whereby a bankruptcy is rejected by the court; the most common reason for dismissal is the failure of the debtor to follow through on the filing process and on payment to the attorney, and failure to provide requested documentation; upon dismissal of a bankruptcy, a creditor can bill the debtor directly, refer the account to a collection agency, or pursue litigation.

**DME**  durable medical equipment, such as wheelchairs, hospital beds, oxygen, and walkers.
DMEPOS  durable medical equipment, prosthetics, orthotics, and supplies.

DOJ   Department of Justice; one of the entities, along with the Office of Inspector General (OIG), that coordinates fraud and abuse control.

DSMT  Diabetes Self-Management Training.

dual eligible  an individual who is entitled to Medicare Part A and/or Part B, and also eligible for some form of Medicaid benefit.

Durable Power of Attorney for Healthcare  also known as Healthcare Power of Attorney; a document that designates someone else (known as a healthcare surrogate, agent, or proxy) to make decisions on the patient’s behalf if he or she is unable to do so.

ECOA  Equal Credit Opportunity Act; a law that prohibits credit discrimination on the basis of race, color, religion, national origin, sex, marital status, age, or because someone receives public assistance.

E&M  evaluation and management; both the process of and the charge for examining a patient and formulating a treatment plan.

EGHP  Employer Group Health Plan.

emancipation  a process by which a minor is freed from parental control based on specific criteria (the minor no longer requires parental guidance or financial support, fathered or gave birth to a child, or has reached the age of majority).

Emergency Medical Treatment and Active Labor Act  also known as the Federal Anti-Dumping Statute; legislation enacted in 1986 in response to concerns that hospitals were refusing to treat patients without insurance and even transferring them to other facilities and leaving them there, sometimes without notifying the receiving facility.

EMTALA  Emergency Medical Treatment and Active Labor Act; also known as the Federal Anti-Dumping Statute; legislation enacted in 1986 in response to concerns that hospitals were refusing to treat patients without insurance and even transferring them to other facilities and leaving them there, sometimes without notifying the receiving facility.

EOB  Explanation of Benefits; the former name for the Medicare Summary Notice, which is a remittance advice.

evaluation and management (E&M)  both the process of and the charge for examining a patient and formulating a treatment plan.
**Fair Credit Billing Act**  an amendment to the Truth in Lending Act; it protects consumers from inaccurate or unfair practices by issuers of open-ended credit, requires creditors to inform debtors of their rights and of the responsibilities of the creditor, and has as its principle thrust to provide for prompt settlement of billing disputes.

**Fair Credit Reporting Act**  defines what information from "consumer reports" can be used, by whom, and when; it provides the maximum protection of a consumer’s right to privacy and confidentiality of credit reports.

**Fair Debt Collection Practices Act**  legislation enacted as the result of evidence that debt collectors were using abusive, deceptive, and unfair collection practices; it imposes strict limitations and prohibitions on debt collection practices.

**false**  a type of skip generally caused by clerical error at the time of registration, such as transposed numbers in the street address, an incorrect zip code, or incomplete information.

**False Claims Act**  legislation that prohibits making a false record or statement to get a false/fraudulent claim paid by the government, submission of false/fraudulent claims, and conspiring to have false/fraudulent claims paid by the government.

**FDA**  Food and Drug Administration; one of the DHHS Operating Divisions.

**FDCPA**  Fair Debt Collection Practices Act; legislation enacted as the result of evidence that debt collectors were using abusive, deceptive, and unfair collection practices; it imposes strict limitations and prohibitions on debt collection practices.

**Federal Anti-Dumping Statute**  another name for the Emergency Medical Treatment and Active Labor Act (EMTALA); legislation enacted in 1986 in response to concerns that hospitals were refusing to treat patients without insurance and even transferring them to other facilities and leaving them there, sometimes without notifying the receiving facility.

**FOIA**  Freedom of Information Act.
fraud the intentional or illegal deception or misrepresentation made for the purpose of personal gain, or to harm or manipulate another person or organization; fraud includes incorrect reporting of diagnosis and procedure codes to maximize payments, billing for services not furnished, altering claims to receive payment, accepting kickbacks, the routine waiver of deductible and coinsurance amounts, etc.

GAAP generally accepted accounting principles.

HCFA Health Care Financing Administration; the former name for the Centers for Medicare and Medicaid Services.

HCPCS Healthcare Common Procedure Coding System; the federal government equivalent to the CPT system.

Health Care Fraud Prevention and Enforcement Action Team HEAT, a team that uses government resources to help prevent fraud, waste, and abuse in both the Medicare and Medicaid programs.

Healthcare Power of Attorney also known as Durable Power of Attorney for Healthcare; a document that designates someone else (known as a healthcare surrogate, agent, or proxy) to make decisions on the patient’s behalf if he or she is unable to do so.

HICN Medicare Health Insurance Claim Number.

Hill-Burton Act the Hospital Survey and Construction Act; legislation designed to assist hospitals by providing loans for construction projects; once the hospitals were operational, the funds that were borrowed were to be paid back in the form of charity; also known as Title I.

HIPAA Health Insurance Portability and Accountability Act of 1996; also known as the Kennedy-Kassenbaum Bill; it created federal standards for insurers, HMOs, and employer plans including those who are self-insured.

HMO Health Maintenance Organization; one of five types of Medicare Advantage Plans in which members must generally get healthcare from providers in the plan’s network.

home health care preventative, supportive, rehabilitative, or therapeutic care provided to a patient at home; to be reimbursed by the Medicare program, a physician must certify that the patient is home bound, in need of skilled nursing care on an intermittent basis for physical, occupational, and/or speech therapy, with an established plan of care.
hospice care  coordinated, palliative care provided to terminally ill patients and their families by nonprofit organizations.

HRSA  Health Resources and Services Administration; one of the DHHS Operating Divisions.

HSA  Health Savings Account (formerly known as Medical Savings Account, or MSA).

I-Bill  an itemized statement.

ICD  International Classification of Diseases; a standard transaction set used for 1) chief complaint or diagnosis for professional services and inpatient procedures, and 2) for diagnosis and procedure codes for professional and technical services for both inpatient and outpatient procedures.

ICD-10  the newest version of the International Classification of Diseases.

IEQ  Initial Enrollment Questionnaire; a questionnaire mailed about three months before patients become entitled to Medicare; it asks about any other healthcare coverage that may be primary to Medicare.

IHS  Indian Health Service; one of the DHHS Operating Divisions.

implied consent – by law  consent that occurs in a situation where the patient is unconscious and is taken to the emergency room; the law allows treating the patient.

implied consent – in fact  consent by silence; the patient implies consent to the treatment by not objecting.

imprest  petty cash.

indigent  an individual with no means of paying for services or treatments, who is not eligible for Medicaid or another public assistance program.

informed consent  consent given when the risks and benefits of a treatment are understood and the patient makes an informed decision whether to receive that treatment.

Initial Enrollment Questionnaire (IEQ)  a questionnaire mailed about three months before patients become entitled to Medicare; it asks about any other healthcare coverage that may be primary to Medicare.

initial preventive physical examination (IPPE)  the “Welcome to Medicare Physical Exam” that is offered to each beneficiary once in a lifetime.
initiation  the beginning of the treatment for a new encounter or a new plan of care; one of the times when a triggering event for an ABN can occur.

intentional  a type of skip in which someone avoids paying bills by changing his or her residency and failing to leave a forwarding address, purposely changing his or her name, or intentionally giving false information.

involuntary bankruptcy  a type of bankruptcy in which a debtor can be placed under Chapter 7 or 11 if the debtor has 12 or more creditors, three of which have claims in excess of $5,000 each and are willing to force the issue, or one creditor owed at least $10,775.

IPPE  initial preventive physical examination; the “Welcome to Medicare Physical Exam” that is offered to each beneficiary once in a lifetime.

IPPS  Inpatient Prospective Payment System.

Joint Commission, The (TJC)  the organization that accredits hospitals; formerly called the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); accreditation is extremely important for hospitals as it is a requirement of participation in the Medicare program.

judgment  a legally verified claim against a debtor; a legal right to collect a debt that can be used to obtain a lien.

Kennedy-Kassenbaum Bill  another name for the Health Insurance Portability and Accountability Act of 1996 (HIPAA); it created federal standards for insurers, HMOs, and employer plans including those who are self-insured.

Local Coverage Determination (LCD)  policies developed by Medicare area contractors that specify criteria for services and show under what clinical circumstances an item or service is considered to be reasonable, necessary, and appropriate.

lien  a recorded claim against real or personal property; if the property is sold, the creditor must be paid out of the proceeds of that sale.
**living will**  a document that specifies what treatments a patient does and does not wish to receive; it means that difficult decisions about future care are made while the person is alert; patients can choose the circumstances under which they will die; and patients' desires regarding organ donation are made known.

**long term care**  care generally provided to the chronically ill or disabled in a nursing facility or rest home; among the services provided by nursing facilities are 24-hour nursing care; rehabilitative services such as physical, occupational, and speech therapy; and assistance with daily activities like eating, bathing, and dressing.

**LTR**  lifetime reserve.

**MAAC**  maximum allowable actual charge.

**MCE**  Medicare Code Editor; software that edits claims to detect incorrect billing data that is being submitted.

**MDC**  major diagnostic category; one of 25 groups of DRGs (diagnosis-related groups).

**MDS**  Minimum Data Set; part of the federally required process for clinical assessment of all residents in Medicare- or Medicaid-certified nursing homes; the MDS then determines the Resource Utilization Group (RUG) and hence the payment.

**Medicaid**  a health insurance program for certain low-income people; it is funded and administered through a state-federal partnership.

**Medicare**  a health insurance program for the elderly (age 65 or older) and those under age 65 who have permanent disabilities or end stage renal disease (ESRD).

**Medicare Advantage Plans**  another name for Medicare Part C; managed care coverage provided by private insurance companies approved by Medicare.

**Medicare Code Editor (MCE)**  software that edits claims to detect incorrect billing data that is being submitted.

**Medicare Participating Physician Program**  a program that enables providers to accept assignment of benefits.

**Medicare Secondary Payer (MSP)**  laws that shifted costs from the Medicare program to other sources of payment; MSP information is gathered from each beneficiary to determine the proper coordination of benefits.
**Medicare Summary Notice (MSN)**  a remittance advice; formerly called the Explanation of Benefits (EOB).

**Medigap**  also known as Medicare supplemental insurance; health insurance sold by private insurance companies to fill in the “gaps” in coverage (like deductibles, coinsurance, and copayments) under the Original Medicare Plan; some Medigap policies also cover benefits that Medicare doesn’t cover, like emergency healthcare while traveling outside the United States.

**MIC**  Medicaid Integrity Contractors; review, audit, and educate providers to combat fraud and abuse.

**midnight census**  the number of patients in the hospital at midnight census; determined from the census count for the previous midnight, minus any discharges, plus any admissions, plus/minus any status changes.

**MSN**  Medicare Summary Notice; a remittance advice; formerly called the Explanation of Benefits (EOB).

**MSP**  Medicare Secondary Payer; laws that shifted costs from the Medicare program to other sources of payment; MSP information is gathered from each beneficiary to determine the proper coordination of benefits.

**MSP Questionnaire**  a questionnaire completed on an ongoing basis to help determine if Medicare is primary or secondary; it asks about employment, accidents, and several other relevant subjects.

**MTF**  Military Treatment Facility.

**MUE**  Medically Unlikely Edit; an automated edit for HCPCS/CPT codes for services rendered by a provider to a single beneficiary on the same date of service; it helps to prevent inappropriate payments due to clerical entries and incorrect coding based on anatomic considerations.

**MVPS**  Medicare Volume Performance Standard; the element of the Resource Based Relative Value Scale (RBRVS) for the rates of increase in Medicare expenditures for physician services.

**NAS**  Non-Availability Statement; a requirement before any non-emergent inpatient services may be provided to a Tricare Extra or Standard eligible beneficiary by a non-Military Treatment Facility (MTF).
National Correct Coding Initiative (NCCI)  a Medicare initiative to promote correct coding methodologies and strive to eliminate improper coding; it identifies mutually exclusive CPT-4 and HCPCS codes or those that should not be billed together.

National Coverage Determination (NCD)  medical review policies issued by CMS which identify specific medical items, services, treatment procedures, or technologies that can be covered and paid for by the Medicare program.

Navigators  individuals who help consumers fill out applications for health coverage through the Marketplace; they help determine if consumers qualify for programs to help lower their costs.

NCCI  National Correct Coding Initiative; a Medicare initiative to promote correct coding methodologies and strive to eliminate improper coding; it identifies mutually exclusive CPT-4 and HCPCS codes or those that should not be billed together.

NIH  National Institutes of Health; one of the DHHS Operating Divisions.

Non-Availability Statement (NAS)  a requirement before any non-emergent inpatient services may be provided to a Tricare Extra or Standard eligible beneficiary by a non-Military Treatment Facility (MTF).

non-definitive LCD/NCD  a policy that provides potential coverage circumstances, but most likely does not provide specific diagnoses, signs, symptoms, or ICD-9-CM codes that will be covered or non-covered; when the Medicare contractor considers or utilizes factors and information other than that in the LCD/NCD when making a coverage determination.

non-Navigators  individuals who perform the same functions as Navigators but only in a state-based Marketplace or state partnership Marketplace.

non-standard claim  a claim with extraneous attachments in lieu of data entered correctly in the claim form.

notifier  CMS’ name for an entity that issues ABNs.

NPI  National Provider Identification; a unique identifier for covered healthcare providers.

NPP  non physician practitioner.
NUBC  National Uniform Billing Committee; the entity that determined the data elements used in the UB-04 final format as a cooperative effort with the American Hospital Association (AHA).

Obamacare  one of the common names for the Patient Protection and Affordable Care Act, PPACA.

OBRA  Omnibus Budget Reconciliation Act (OBRA) of 1989; it provided for the Resource Based Relative Value Scale (RBRVS) as a payment reform provision.

observation  services furnished on a hospital premises, including use of a bed and periodic monitoring by a hospital’s nursing staff; services should be reasonable and necessary to evaluate an outpatient condition to assess the need for admission to the hospital; observation services usually do not exceed 24 hours; however, there is no hourly limit on the extent to which they may be used (CMS has indicated that instances would be rare that a patient would remain in observation for more than 48 hours).

office  care provided in a practitioner’s place of business; a practitioner may be a medical doctor, podiatrist, chiropractor, dentist, advanced practice nurse, registered dietitian, physical therapist, psychologist, or one of many other professions.

OIG  Office of Inspector General; one of the entities, along with the Department of Justice, that coordinates fraud and abuse control; it also has identified seven elements of a compliance plan.

ordering physician  a physician who orders non physician services for a patient, such as diagnostic x-rays.

outpatient  treatment received at a hospital, clinic, or dispensary by someone who is not hospitalized; emergency room patients, ambulatory patients, clinic patients, and same-day surgery patients are all examples of the outpatient classification.

Part A  the hospital insurance component of Medicare that helps pay for medically necessary inpatient hospitalization, care in a SNF following a three-day hospital stay, home health care, hospice care, and blood.

Part B  the medical insurance component of Medicare that helps pay for doctor services, outpatient hospital care, and some other medical services that Part A does not cover (such as the services of physical and occupational therapists, and some home health care).
Part C also known as Medicare Advantage Plans; managed care coverage provided by private insurance companies approved by Medicare.

Part D the component of Medicare that helps pay for prescription drugs.

PAT pre-admission testing; the diagnostic medical screening of patients in advance of surgical or invasive procedures to determine hospitalization and/or surgical suitability.

Patient Bill of Rights a development by the American Medical Association that guarantees a patient the right to receive courteous, considerate, respectful treatment in a clean/safe environment; appropriate healthcare; information about his/her health treatment plan in a way that he or she understands; continuity of care; confidentiality; privacy; participation in planning care and treatment; refusal of care; use of grievance mechanisms; treatment without discrimination; an itemized bill and explanation of all charges; and review of the medical record and/or a copy at a reasonable fee.

PCP primary care physician.

per diem Latin for “for each day”; a payment methodology in which providers are paid a predetermined amount for each day an inpatient is in the facility, regardless of actual charges or costs incurred.

percentage of occupancy the ratio of actual patient days to the maximum patient days as determined by bed capacity; a low percentage of occupancy indicates inefficiency while a percentage that is too high will mean difficulty finding available beds, long hold times in ER, etc.

physician extender physician assistant, nurse practitioner, etc.

PPO Preferred Provider Organization; one of five types of Medicare Advantage Plans in which members can see any doctor or provider that accepts Medicare and they don’t need a referral to see a specialist.

PPS prospective payment system.

pre-certification the process of obtaining authorization from an insurance company review organization approving the medical necessity of a hospitalization.

Privacy Act of 1974 legislation that governs patient confidentiality and provides safeguards against an invasion of privacy through the misuse of records by federal agencies.

PSA Physician Scarcity Area.
PSDA  Patient Self Determination Act of 1990; legislation that ensures that patients understood their right to participate in decisions about their own healthcare.

QIO  Quality Improvement Organization; part of a CMS program to monitor and improve utilization and quality of care for Medicare beneficiaries.

RBRVS  Resource Based Relative Value Scale; a payment reform provision comprising three major elements: a fee schedule for payment of physician services, based on the relative value unit (RVU); the Medicare Volume Performance Standard (MVPS) for the rates of increase in Medicare expenditures for physician services; and limits on the amount non-participating physicians can charge beneficiaries, referred to as the limiting charge.

reduction  a decrease in the frequency or duration of care; one of the times when a triggering event for an ABN can occur.

referring physician  a physician who requests an item or service for a beneficiary for which payment may be made under Medicare.

Regulation Z  another name for Title I of the Consumer Credit Protection Act, or the Truth in Lending Act; it requires disclosure of information before credit is extended.

remittance advice  another name for the Medicare Summary Notice; formerly called the Medicare Explanation of Benefits (EOB).

Resource Based Relative Value Scale (RBRVS)  a payment reform provision comprising three major elements: a fee schedule for payment of physician services, based on the relative value unit (RVU); the Medicare Volume Performance Standard (MVPS) for the rates of increase in Medicare expenditures for physician services; and limits on the amount non-participating physicians can charge beneficiaries, referred to as the limiting charge.

Resource Utilization Group (RUG)  a system to determine the payment rate for most skilled nursing care; the provider completes the Minimum Data Set as part of the federally required process for clinical assessment of all residents in Medicare- or Medicaid-certified nursing homes; the MDS then determines the RUG and hence the payment; the patient is re-evaluated at intervals during his or her stay and the RUG rate may be changed.
respite care  short-term, temporary custodial care that allows a family member or other unpaid caregiver to get relief from caring for a physically frail or dependant person at home.

RUG  Resource Utilization Group; a system to determine the payment rate for most skilled nursing care; the provider completes the Minimum Data Set as part of the federally required process for clinical assessment of all residents in Medicare- or Medicaid-certified nursing homes; the MDS then determines the RUG and hence the payment; the patient is re-evaluated at intervals during his or her stay and the RUG rate may be changed.

RVU  relative value unit; the basis for the fee schedule for payment of physician services that is one of the elements of the Resource Based Relative Value Scale (RBRVS).

SAMHSA  Substance Abuse and Mental Health Services Administration; one of the DHHS Operating Divisions.

skip  a debtor who cannot be located by a creditor; there are three types: intentional; unintentional, and false.

SNF  skilled nursing facility; a separate wing of a hospital, a nursing home, or a freestanding facility; to qualify for SNF coverage, Medicare requires a person to have been a hospital inpatient for at least three consecutive days (not including the day of discharge).

spell of an illness  also known as the benefit period; the period of time that begins when a beneficiary enters the hospital and ends 60 days after discharge from the hospital or from a SNF.

statute of limitations  the amount of time in which a claim must be collected before it is deemed paid or satisfied.

superbill  an invoice used to document the services ordered or rendered during a patient visit; it is often referred to as a face sheet and includes patient demographic data plus the CPT, ICD-9-CM, and HCPCS codes for the most common procedures performed in the practice or department; upon completion of treatment, the physician completes the superbill to document all services provided; thus a superbill essentially is a tool to eliminate the need for transcribing medical record notes from a patient chart and streamline the charge capture process.
termination a discontinuation in the services being provided; one of the times when a triggering event for an ABN can occur.

Title XVIII Medicare.

Title XIX Medicaid.

TJC The Joint Commission; the organization that accredits hospitals; accreditation is extremely important for hospitals as it is a requirement of participation in the Medicare program.

tort liability a liability for an injury or wrongdoing by one person to another resulting from a breach of legal duty.

TPA third party administrator.

Tricare a regionally-managed healthcare program for active duty and retired members of the uniformed services, their families, and survivors.

triggering event an event that occurs during initiation, reduction, or termination of a course of treatment that triggers the need for an ABN.

Truth in Lending Act another name for Title I of the Consumer Credit Protection Act; also known as Regulation Z; it requires disclosure of information before credit is extended.

Two Midnight Rule CMS guideline stating that when a physician expects a Medicare patient to remain in the hospital for at least two midnights, the physician should write an inpatient admission order.

UB-04 the uniform bill required of hospital inpatient and outpatient departments, skilled nursing facilities, home health practitioners, comprehensive outpatient rehabilitation facilities, community mental health centers, and the like when billing Medicare.

UCR usual, customary, and reasonable; a method to determine the value of services used by many third party payers; it relies on physician-charge data accumulated over time; after ranking the charges for a given service from lowest to highest, the payer uses a specific point (for example, the 75th percentile) as the basis for UCR payments.

unintentional a type of skip in which someone moves or changes residence and fails to notify creditors; a forwarding address is normally available.

unprocessable a claim that is considered incomplete or invalid due to missing claim form data elements.
**UR**  Utilization Review; also known as Case Management; an area that performs critical tasks during registration and a patient's stay, such as reducing unnecessary admissions; managing the approved length of stay; ensuring an appropriate level of care for the patient's condition; serving as liaison with the primary and specialty physicians; serving as liaison with the insurance carrier; obtaining approvals, when clinically necessary, for pre-certification/re-certification; advising the patient of discharge; and assisting with appeals for denials, when applicable.

**usual, customary, and reasonable (UCR)**  a method to determine the value of services used by many third party payers; it relies on physician-charge data accumulated over time; after ranking the charges for a given service from lowest to highest, the payer uses a specific point (for example, the 75th percentile) as the basis for UCR payments.

**Utilization Review (UR)**  also known as Case Management; an area that performs critical tasks during registration and a patient's stay, such as reducing unnecessary admissions; managing the approved length of stay; ensuring an appropriate level of care for the patient's condition; serving as liaison with the primary and specialty physicians; serving as liaison with the insurance carrier; obtaining approvals, when clinically necessary, for pre-certification/re-certification; advising the patient of discharge; and assisting with appeals for denials, when applicable.

**V code**  a type of ICD-9-CM code used when services or visits relate to circumstances other than disease or injury.

**VA**  the U.S. Department of Veterans Affairs.

**VCIS**  voice case information system; a telephonic system used to perform an on-site check at the bankruptcy clerk’s office.

**workers’ compensation**  a plan that covers injuries sustained by a worker in the course of performing his or her job duties.
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