Certified Revenue Cycle Specialist (CRCS) Exam Study Outline 2020

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Acknowledgments

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Introduction

Overview of this Outline

AAHAM offers this Certified Revenue Cycle Specialist (CRCS) Exam Study Outline 2020 to help you prepare for the CRCS examination.

Knowledge and Skill Requirements for Certification

This outline lists the requirements for each broad topic covered in the exam. Most of the exam questions apply to both facilities and provider practices. When a requirement applies to only one environment, it is shown in a box with a unique border and an icon on the left.

NOTE: The boxes and icons (“F” for facilities and “P” for provider practices) clarify requirements that typically apply to either a facility or provider practice, but not both. But remember that all the information in this study manual could appear on your exam, regardless of whether it is flagged for facilities or provider practices. The certification you are testing for and its exam are no longer separated by facility versus provider practice distinction.
The text below typically applies to the facility environment only.

### Deposit Collection Program
A deposit is the estimated portion of the patient’s bill not covered by insurance. Payment can be made in one installment or financed over time, and can be collected prior to admission, at admission, or at discharge. Advantages of a deposit collection program, when combined with a good preregistration and insurance verification program, include:

- Increased hospital cash collections
- Reduced amount due at discharge
- Reduced overall accounts receivable
- Reduced financial risk and bad debt

Disadvantages of this type of program include the possibility of creating a public relations issue between the hospital and the doctor, the patient and the hospital, or the patient and the doctor.

This text typically applies to provider practices only.

### Front Office Personnel
The primary duty of the Front Office personnel is to act as a liaison between the physician and the patient. Front Office personnel are critical to the physician office — from billing to collections to quality patient care.

### 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 Certified Revenue Cycle Specialist (CRCS) Exam Study Manual 2020 to help you prepare for the examination. 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.


AAHAM Certification Programs

Healthcare revenue cycle professionals across the nation and around the globe are looking for an edge…a way to work smarter, build a career, stay informed, and make the right contacts; an AAHAM certification helps you achieve all of these goals.

AAHAM is the premier association of healthcare revenue cycle professionals. AAHAM members have committed to the highest standards of professionalism, integrity, and competence. They are dedicated to the exchange of knowledge about changes in technology and concepts in the delivery of healthcare.

AAHAM certification is an investment in your personal growth and your professional future, regardless of where you are in your career. Available AAHAM certifications include:

- **Certified Revenue Cycle Executive (CRCE)** - for all senior/executive leaders and directors in the healthcare revenue cycle, to assist in critical thinking, communication, and strategic management skills

- **Certified Revenue Cycle Professional (CRCP)** - for all managers and supervisors in the healthcare revenue cycle, to help in effectively managing key aspects of the revenue cycle
Certified Revenue Cycle Specialist (CRCS) - for frontline revenue cycle staff with responsibilities in the revenue cycle with a focus on specific knowledge required in registration, billing, and credit, and collections

Certified Revenue Integrity Professional (CRIP) - for anyone in the revenue cycle industry to help ensure that facilities effectively manage their chargemaster, and bill and document appropriately for all services rendered to a patient

Certified Compliance Technician (CCT) - for all revenue cycle staff who must meet employers' annual compliance training requirements

In addition to bolstering your resume, earning an AAHAM certification is an essential, proactive step in maximizing your knowledge, income potential, and networking opportunities in the healthcare revenue cycle industry. In particular, many AAHAM members use the CRCS, CRCP, and CRCE certifications as a career ladder to help achieve their professional goals.

Overview of CRCS Exam

Introduced in 1992 as the Certified Patient Accounts Technician (CPAT) or Certified Clinic Accounts Technician (CCAT) certification, this exam tests staff proficiency and provides a resource for patient account managers to ensure staffing competence. The exam tests 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.

Eligibility

Any person involved in the admitting, billing, or collection of patient accounts in healthcare is eligible for the CRCS exam. 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  
  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. 2 or send an email to julia@aaham.org.

Fees

Examination fees are:

- Full examination:
  - $100

- Section retake (described under Retake Criteria below):
  - $50

Deadlines

The application and fee must be received by:

- December 15 for the March exam
- April 15 for the July exam
- August 15 for the November exam
Exam Format and Grading

The examination has three sections:

- Patient Access / Front Desk
- Billing
- Credit and Collections

Each section also includes relevant regulations and acronyms and consists of a mix of 40 multiple-choice and true/false 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 email to the email 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.

Certificates are mailed directly to the examinees, with the address that was listed on their exam application. Examinees receive their certificate by the end of the month following the exam period.

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. Check the exam schedule at aaham.org, Certification page. Be sure to register in time to complete the retake exam within 12 months of the initial exam month.
2. Register for the section you need to retake by one of these methods:

- **Online** — go to www.aaham.org; use the online application link on the Certification page; and pay with a credit card.

- **Mail in** — obtain an application from www.aaham.org, Certification page. Complete and mail the application with a check or money order, payable to AAHAM, to:

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

**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.

Your local Chapter Certification Chair assists in determining the exact dates, times, and locations of exams. You should hear from your Chapter Certification Chair by the 1st of your examination month via phone, email, or letter, using the information you provided on your application. If you do not hear from your Chapter Certification Chair by the 1st 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.)

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*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 exam is taken online in the physical presence of a proctor. Your local AAHAM chapter is responsible for helping you secure a location and a proctor for exam day. You will receive an email from AAHAM approximately 1-2 weeks prior to your exam date with instructions for setting up your account in our testing website.

Plan to arrive approximately 15 minutes prior to the examination and have a photo ID to present to the proctor.

You will be given a maximum of two hours to complete the exam.

You may bring a nonprogrammable calculator and pen or pencil. The proctor will provide blank paper. No electronic devices (such as cell phones or flash drives) are allowed in the exam area. Personal belongings such as purses and briefcases must be left with the proctor for the entire exam.

There are no refunds or postponements for the CRCS exam.

Recertification

To retain the CRCS certification designation, two options are available:

1. Retake and pass the entire exam every three years.

2. Join as a National member prior to your certification expiration date and earn continuing education units (CEUs). Please note that your CEUs begin to accumulate starting the date you join as a National member; therefore, any CEUs earned before joining AAHAM as a member aren't eligible. Members must earn and report 30 CEUs prior to their certification expiration date. Fifteen of the CEUs must be obtained from attendance at AAHAM-related educational programs. If membership and CEUs are not maintained, the designation will be revoked and can no longer be used.
Federal Agencies and Regulations

Knowledge and Skill Requirements

NOTE: The “F” and “P” boxes and icons clarify requirements that typically apply to either a facility or provider practice, but not both. But remember that all the information in this study manual could appear on your exam, regardless of whether it is flagged for facilities or provider practices. The certification you are testing for and its exam are no longer separated by facility versus provider practice distinction.

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

1. List federal agencies playing a major role in healthcare and healthcare change: Department of Health and Human Services, its operating divisions, and Office of Inspector General.


3. Name major federal regulations affecting healthcare and describe their impact in the following areas:
   - Patient rights
   - Administrative simplification
   - Affordable care
   - Anti-fraud and abuse
   - Telephone consumer protection
   - Credit and collections
   - Patient anti-dumping
   - Performance improvement
4. Describe the role of The Joint Commission.
Patient Access / Front Office

Knowledge and Skill Requirements

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

1. Describe the primary functions and responsibilities of Patient Access / Front Office related to:
   - Scheduling
   - Preadmission and preregistration
   - Precertification and preauthorization
   - Registration and admission
   - Insurance verification
   - Financial counseling
   - Collection
   - Compliance

2. Describe the purpose, completion, triggering events, and retention of the Advance Beneficiary Notice of Noncoverage (ABN).

3. Describe the use of the Hospital Issued Notice of Noncoverage (HINN).
4. Describe the roles and responsibilities of Case Management / Utilization Review.

5. Identify the different levels of patient care.

6. Differentiate between general and special consent forms and define various types of consent.

7. Define assignment of benefits.

8. Define emancipation.

9. Describe the purpose and general composition of a medical record and precautions for handling medical records.

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

11. Define the different types of coverage determinations.


13. Describe the purpose and importance of Patient Access / Front Office following a financial policy and strategies to comply with the policy.

14. Explain when and how a practice can terminate a patient-physician relationship.

15. Describe the formulae for key performance indicators in Patient Access / Front Office.
Billing

Knowledge and Skill Requirements

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

1. Describe types of insurance and insurance payers:
   - Medicare
   - Medigap
   - Medicaid
   - Workers’ compensation
   - TRICARE
   - Children’s Health Insurance Program (CHIP)
   - Self-insurance
   - Commercial insurance
   - Liability insurance
   - Self-pay
   - Health Savings Accounts (HSAs)

2. Determine proper coordination of benefits.

3. Describe common HIPAA-required standard transaction sets and codes.

4. Describe the purpose and components of a National Drug Code.
5. Identify payment methodologies:

- Medicare Severity Diagnosis-Related Group (MS-DRG)
- Ambulatory Payment Classification (APC)
- Fee Schedule
- Resource-Based Relative Value Scale (RBRVS)
- Usual, Customary, and Reasonable (UCR)
- Skilled Nursing Facility Prospective Payment System (SNF PPS)
- Critical Access Hospital (CAH)
- Capitation
- Per Diem
- Percent of Charges
- Fee-for-Service

6. Describe the purpose and components of a chargemaster and best practices to update the file.

7. Explain the purpose and importance of insurance payer contracts.

8. Identify circumstances under which a Locum Tenens physician can bill.

9. Describe common/required billing forms.

- List common codes used to complete the UB-04/837I form.

10. Explain mandatory filing requirements and exceptions.

11. Identify and describe the importance of billing time frames.

12. Describe key claim processing edits.

13. Describe guidelines for an effective compliance plan.
Credit and Collections

Knowledge and Skill Requirements

NOTE: The “F” and “P” boxes and icons clarify requirements that typically apply to either a facility or provider practice, but not both. But remember that all the information in this study manual could appear on your exam, regardless of whether it is flagged for facilities or provider practices. The certification you are testing for and its exam are no longer separated by facility versus provider practice distinction.

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

1. Define terms related to credit and collections.
2. Explain how the statute of limitations affects collection efforts.
3. Identify elements of an effective collection policy.
4. Describe typical self-pay options, along with advantages and disadvantages of key options.
5. Identify common types of bankruptcy, how they affect the collection process, and possible outcomes.
6. Identify the responsible party for a given scenario.
7. Define and list advantages of a courtesy discharge.
9. Identify common debt collection methods and practices.
10. List generally accepted accounting principles for the cashier’s role.
11. Describe common metrics related to collection.
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Glossary

1-day payment window rule  a Medicare requirement similar to the 3-day payment window rule that applies to inpatient psychiatric hospitals, inpatient rehabilitation facilities, long term care facilities, and children’s and cancer hospital.

3-day payment window rule  a Medicare requirement that all diagnostic and clinically related non-diagnostic outpatient services provided within three days of an inpatient admission must be combined to the inpatient claim when they are provided by an entity wholly owned or operated by the inpatient hospital (or by another entity under arrangements with the admitting hospital).

837I  the dataset that is utilized to electronically submit hospital claims to the payer.

837P  the billing form used to electronically submit physician and professional service claims to the payer.

ABN  see Advance Beneficiary Notice.

abuse  incidents or practices of healthcare workers that, although not usually considered fraudulent, are inconsistent with accepted sound practices.

Accounts Receivable (AR) Days Outstanding  another name for Average Days of Revenue in Accounts Receivable (ADRR); 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 HHS Operating Divisions.

ACL  Administration for Community Living; one of the HHS Operating Divisions.

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

AHA  the American Hospital Association.

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

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

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 HHS 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 that established the Federal Black Lung Program for individuals who have been diagnosed with pneumoconiosis, or black lung disease.

CAH  see Critical Access Hospital.
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.

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

CDM  see chargemaster.

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); an electronic file that resides in the provider’s information system and that contains charges that can be posted to a patient account.

**charity care**  service provided that is never expected to result in cash flow; it results from a provider’s policy to provide healthcare services free of charge or at a reduced cost to individuals who meet certain financial criteria.

**CHIP**  the Children’s Health Insurance Program; also known as Title XXI, for children whose families fail to qualify for Medicaid but cannot afford to purchase private insurance; jointly financed by the federal and state governments, and administered by the states.

**CLIA**  see Clinical Laboratory Improvement Amendment.

**Clinical Laboratory Improvement Amendment**  CLIA; 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 & Medicaid Services; one of the HHS Operating Divisions.

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

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

**CO**  compliance officer; one of OIG’s seven elements of a compliance plan.

**COB**  coordination of benefits.
commercial insurance  health insurance that covers individuals, usually as an employment benefit but also purchased as an individual policy.

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.

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.

Critical Access Hospital (CAH)  a small hospital that serves a rural community; maintains no more than 25 inpatient beds that may be used for swing bed services; may operate a distinct part rehabilitation/psychiatric unit, each with up to 10 beds; has an ALOS of 96 hours or less per patient for acute care (excluding swing bed services and beds within DPUs); is located more than a 35-mile drive from any hospital or CAH in an area with mountainous terrain or only secondary roads; and furnishes 24/7 emergency care services.

custodial care  help with bathing, dressing, toileting, and eating.

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 / 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.
**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.

**DNR Order** Do Not Resuscitate Order; a document stating that the patient does not wish to have CPR or similar interventions performed in the event of a medical emergency.

**DSMT** Diabetes Self-Management Training; a Medicare Part B covered preventive service.

**dual eligible** an individual who is entitled to Medicare Part A / 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.

**E&M** see evaluation and management.

**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.

**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  EMTALA; also known as the Federal Anti-Dumping Statute; legislation enacted 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.

Emergency Room (ER) or Emergency Department (ED)  a level of patient care; patients in the ER are outpatients.

EMTALA  see Emergency Medical Treatment and Active Labor Act.

EOB  explanation of benefits; a statement sent by a health insurance company to covered individuals explaining what medical treatments/services were paid for on their behalf; similar to an RA; it may or may not have a check attached for payment of services.

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  legislation that protects consumers from inaccurate or unfair practices by issuers of open-ended credit and requires creditors to inform debtors of their rights and of the responsibilities of the creditor.

Fair Credit Reporting Act  legislation that 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 HHS Operating Divisions.

**FDCPA**  see Fair Debt Collection Practices Act.

**Federal Anti-Dumping Statute**  see Emergency Medical Treatment and Active Labor Act.

**Fee-for-service**  the oldest method of payment, in which providers are paid for each medical service rendered to a patient.

**Fee schedule**  a payment methodology for some outpatient services; the schedule lists CPT and HCPCS codes and what Medicare allows for each, before deductible and coinsurance is applied

**fraud**  the intentional or illegal deception or misrepresentation made for the purpose of personal gain, or to harm or manipulate another person or organization.

**GAAP**  generally accepted accounting principles; a common set of accounting principles, standards, and procedures that companies must follow when they compile their financial statements.

**gatekeeper**  the primary care physician, or PCP.

**HCPCS**  Healthcare Common Procedure Coding System; a mandated transaction code set for outpatient procedures.

**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.

**HHS**  U. S. Department of Health and Human Services; the government’s principal agency for protecting the health of all Americans and providing essential human services.

**HINN**  see Hospital Issued Notice of Noncoverage.

**HIPAA**  Health Insurance Portability and Accountability Act; it created federal standards for insurers, HMOs, and employer plans including those who are self-insured; it also established the Privacy and Security Rules.
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  limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, DME, medical supplies, and other services.

hospice  coordinated, palliative care provided to terminally ill patients and their families by nonprofit organizations.

Hospital Issued Notice of Noncoverage (HINN)  a liability notice similar to an ABN; hospitals give HINNs to fee-for-service inpatient hospital beneficiaries who are due to receive specific diagnostic or therapeutic procedures that are separate from treatment covered / paid / bundled into the inpatient stay.

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

HSA  health savings account; a bank account maintained by a patient to pay medical expenses not covered by insurance; funds and interest in the HSA are not taxed; to have an HSA, the subscriber must be enrolled in a specific, high-deductible health plan.

I-Bill  an itemized statement.

ICD  International Classification of Diseases; a mandated transaction code set used for diagnosis and inpatient procedures.

ICD-10  the current version of the International Classification of Diseases used in the United States.

IEQ  see Initial Enrollment Questionnaire.

IHS  Indian Health Service; one of the HHS 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.
Important Message from Medicare  a document required to be given by hospitals to all Medicare and Medicare Advantage beneficiaries who are hospital inpatients within two days of admission and again within two days of discharge.

imprest  petty cash.

incomplete claim  a claim with required information missing.

indigent  an individual who has no means of paying for medical services or treatments and is not eligible for benefits under Medicaid or any other 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; required unless an exception is present, such as the patient’s incapacity to understand the explanation of the procedures or in an emergency situation.

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 triggering events for an ABN.

inpatient  a level of healthcare where, 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; often called “acute care.”

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.

invalid claim  a claim that contains complete and necessary information; however, the information is illogical or incorrect.

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 who is owed at least $10,775.
IPPE  see initial preventive physical examination.

IPPS  Inpatient Prospective Payment System.

itemized statement  a complete listing or detailed account of every service posted to a patient account with DOS, description of service, service code, charge amount, estimated insurance amounts, patient payment amounts, and totals.

Joint Commission, The (TJC)  a private agency that seeks to protect and improve the quality and safety of care; CMS allows TJC to accredit hospitals; it inspects facilities and provides education on issues affecting patient care and safety.

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

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

locum tenens  a temporary substitute, especially for a doctor or member of the clergy.

liability insurance  coverage through property and casualty or auto insurance.

lien  a recorded claim against real or personal property, generally arising out of a debt; if the property is sold by the debtor, the creditor (the provider) must be paid out of the proceeds of that sale.

limiting charge  the limit on the amount non-participating physicians can charge beneficiaries; currently 115% of the fee schedule amount.

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  LTC; 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, and assistance with daily activities.

LTR  lifetime reserve; 60 days of inpatient hospital services that a beneficiary can opt to use after having used 90 days of inpatient hospital services in a benefit period; it comes with a high coinsurance and can be used only once in the beneficiary's lifetime (but can be split among multiple hospital stays).

MAAC  maximum allowable actual charge; it has been replaced by the limiting charge.

MAC  Medicare Administrative Contractor; a private firm that processes Medicare claims; formerly known as fiscal intermediaries or carriers.

MBI  see Medicare Beneficiary Identifier.

MCE  see Medicare Code Editor.

MDC  major diagnostic category; one of 25 groups of MS-DRGs.

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 RUG and hence the payment.

Medicaid  a health insurance program also known as Title XIX; provides coverage for eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities; is administered through a state-federal partnership.

Medicare  a health insurance program also known as Title XVIII; covers individuals who are elderly (age 65 or older) or have permanent disabilities, ESRD, or Lou Gehrig's Disease.

Medicare Advantage  another name for Medicare Part C or a Replacement Plan; managed care coverage provided by private insurance companies approved by Medicare.

Medicare Beneficiary Identifier (MBI)  a number replacing the HICN on the Medicare card.

Medicare Code Editor (MCE)  software that edits claims to detect incorrect billing data that is being submitted.
**Medicare Participating Physician Program**  a program binding a physician to accept assignment for all services provided to Medicare patients for the following year.

**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 quarterly statement to the payee/beneficiary reflecting services received, charges submitted, charges allowed, amount for which the beneficiary is responsible, and the amount that was paid to the provider or beneficiary.

**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.

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

**mini Miranda**  a statement provided by a creditor to a debtor which says something like, “This is an attempt to collect a debt and any information obtained will be used for that purpose.”

**MOON**  Medicare Outpatient Observation Notice; a standardized notice developed to inform beneficiaries when they are an outpatient receiving observation services; established by the NOTICE Act.

**MP**  malpractice insurance expense; one of three RVUs associated with the calculation of a payment under the MPPS.

**MPPS**  Medicare Prospective Payment System.

**MS-DRG**  Medicare Severity Diagnosis-Related Group; a payment methodology system that combines patient age, diagnosis (including severity and comorbidity), discharge disposition, and procedures to determine a payment rate; the MS-DRG payment is the total payment for the case regardless of the actual charges unless an outlier is paid in certain cases with very high charges.
MSA  Medical Savings Account; a type of Medicare Advantage Plan with two parts: a Medicare Advantage high-deductible plan and a Medical Savings Account into which Medicare deposits money that people can use to pay healthcare costs.

MSN  see Medicare Summary Notice.

MSP  see Medicare Secondary Payer.

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 prepayment edit for HCPCS/CPT codes for services rendered by a provider to a single beneficiary on the same date of service; it helps to reduce errors 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  see Non-Availability Statement.

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.

NCCI  see National Correct Coding Initiative.

NIH  National Institutes of Health; one of the HHS 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-MTF.
non-definitive LCD/NCD  a policy that provides potential coverage circumstances, but most likely does not provide specific diagnoses, signs, symptoms, or ICD-10 codes that will be covered or non-covered.

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

Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act  an act requiring hospitals to use the MOON to inform patients who are hospitalized for more than 24 hours if they are in observation status.

notifier  an entity that issues ABNs.

NPI  National Provider Identification; a unique, 10-digit identifier issued to health providers in the United States by the CMS.

NUBC  National Uniform Billing Committee; the entity that governs the UB-04 and 837I forms.

observation  the level of care given a patient who occupies a bed but is an outpatient status; intended for monitoring of an acute condition, which may resolve or worsen; cannot be scheduled in advance and is not intended for routine use, such as surgical recovery.

OCE  Outpatient Code Editor; edits to hospital outpatient services to detect pairs of codes that cannot be billed together and pairs that require modifiers.

office  any care 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; a government agency with the mission to protect the integrity of HHS programs and the health and welfare of the beneficiaries of those programs; it has a major role in investigating fraud and abuse.

outpatient  a level of patient care provided in one of many types of outpatient clinics (urgent care, IV therapy, pain management, substance abuse rehabilitation, wound care, etc.).
Part A  the hospital insurance component of Medicare that covers 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 medically necessary 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  a replacement for traditional Medicare also known as Medicare Advantage or a Replacement Plan; managed care coverage provided by private insurance companies approved by Medicare.

Part D  the component of Medicare that covers medication subject to an annual deductible; the list of covered drugs is known as the “formulary”; drugs are placed into tiers and each tier can have a different cost.

Patient Care Partnership  a plain-language brochure formerly known as the Patient’s Bill of Rights; it states expectations that patients and their families can have about how they will be treated in healthcare situations.

Patient’s Bill of Rights  the former name for the Patient Care Partnership.

PCP  primary care physician, also known as the “gatekeeper.”

PE  practice expense; one of three RVUs associated with the calculation of a payment under the MPPS.

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.

percent of charges  a payment methodology where a claim is paid at a predetermined percentage discount rate.

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.

PHI  protected health information; any data that could be used, individually or in combination, to match patients with medical information.
**Physician extender**  physician assistant, nurse practitioner, etc.; a type of clinical and medical personnel authorized to make entries in the patient’s medical record.

**POA**  Present on Admission; a type of indicator that helps identify non-payable complications, such as hospital-acquired conditions.

**PPACA**  Patient Protection and Affordable Care Act, also known as simply the Affordable Care Act; together with the Health Care and Education Reconciliation Act, part of the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.

**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.

**Precertification**  the process of obtaining authorization from an insurance company review organization approving the medical necessity of services.

**Private Fee-for-Service Plans**  a type of Medicare Advantage Plan which allows members to go to any provider that accepts the plan’s terms; the private company decides how much it will pay and how much members pay for services.

**PSDA**  Patient Self-Determination Act; legislation that ensures that patients understand their right to participate in decisions about their own healthcare; deals with advance directives.

**QIO**  Quality Improvement Organization; part of a CMS program to monitor and improve utilization and quality of care for Medicare beneficiaries; QIOs review all written quality-of-service complaints submitted by Medicare beneficiaries or their designated representatives.

**RA**  remittance advice; a statement sent by a health insurance company to covered individuals explaining what medical treatments/services were paid for on their behalf; similar to an EOB, but an RA should have a check attached or a voucher for an electronic payment which was made directly to the provider’s bank.
**RBRVS**  see Resource-Based Relative Value Scale.

**Recurring**  also known as Series; a level of patient care for outpatients who will be coming regularly for repetitive types of treatment, such as physical therapy or chemotherapy.

**reduction**  a decrease in the frequency or duration of care; one of the triggering events for an ABN.

**Regulation Z**  see Truth in Lending Act.

**Resource-Based Relative Value Scale (RBRVS)**  a payment methodology comprised of three major elements: fee schedule for physician services based on the RVU, MVPS, and limiting charge.

**Resource Utilization Group (RUG)**  a system to determine the payment rate for most skilled nursing care; the provider completes the MDS; 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**  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.

**RTP**  returned to provider; the many processes utilized for notifying the provider that a claim cannot be processed and must be corrected or re-submitted.

**RUG**  see Resource Utilization Group.

**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 HHS Operating Divisions.

**self-insurance**  a company that puts premium payments into a fund to cover services and pays a third party to administer benefits from the fund instead of purchasing group insurance.

**self-pay**  the common term for patients who have no insurance.
**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).

**SNF PPS**  Skilled Nursing Facility Prospective Payment System; the payment methodology for most skilled nursing care; the provider completes the MDS, which determines the RUG and hence the payment.

**Special Needs Plan**  a type of Medicare Advantage Plan which limits all or most of their membership to people in some Long Term Care facilities (such as nursing homes), and who are eligible for Medicare and Medicaid.

**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; no legal proceedings can be initiated after the statute of limitations expires.

**superbill**  also known as an encounter form; the preprinted sheet used to record data related to a patient encounter.

**TCPA**  see Telephone Consumer Protection Act.

**Telephone Consumer Protection Act (TCPA)**  legislation that restricts telephone solicitations (in other words, telemarketing) and the use of automated telephone equipment.

**termination**  a discontinuation in the services being provided; one of the triggering events for an ABN.

**Title XVIII**  Medicare.

**Title XIX**  Medicaid.

**TJC**  see Joint Commission, The.

**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  healthcare coverage for active-duty service members, their spouses, dependents, and retirees unless they are eligible for Medicare.

TRICARE for Life  a healthcare program for qualified service retirees that acts as a supplement to Medicare.

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 Regulation Z; it requires disclosure of information before credit is extended.

UB-04  the hardcopy version of the hospital claim form; also known as the CMS-1450.

UCR  usual, customary, and reasonable; a payment methodology used by many third-party payers where physician-charge data accumulated over time is ranked from lowest to highest and a specific point (for example, the 75th percentile) is the basis for payment.

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  see Utilization Review.

usual, customary, and reasonable (UCR)  a payment methodology used by many third-party payers where physician-charge data accumulated over time is ranked from lowest to highest and a specific point (for example, the 75th percentile) is the basis for payment.

Utilization Review (UR)  also known as Case Management; an area that performs critical tasks during registration and a patient’s stay.

VA  the U.S. Department of Veterans Affairs.

Work RVU  work required; one of three RVUs associated with the calculation of a payment under the MPPS.
**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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