

CRCE Exam Study Manual

Update for 2018

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

Table of Contents

Edit(s) to page 3-3: Precertification and Preauthorization	3
Edit(s) to pages 3-5 and 3-6: Financial Counseling	3
Edit(s) to page 3-7: Compliance	3
Edit(s) to page 3-7: Other Responsibilities.....	3
Edit(s) to page 3-16: Preregistration.....	3
Edit(s) to pages 3-16 and 3-17: During and After the Appointment.....	3
Edit(s) to pages 3-21 and 3-22: Levels of Patient Care	4
Edit(s) to page 3-33: Services that Do Not Require an ABN (or HINN)	4
Edit(s) to page 3-36: Financial Policies in Patient Access/Front Office.....	4
Edit(s) to page 4-2: Introduction.....	5
Edit(s) to pages 4-2, 4-6, and 4-7: Types of Insurance and Payers	5
Edit(s) to page 4-8: Medigap.....	6
Edit(s) to page 4-10: Health Savings Accounts (HSAs)	6
Edit(s) to page 4-30: HCPCS and CPT Modifiers.....	6
Edit(s) to page 5-2: Effective Financial Policies.....	6
Edit(s) to page 5-3: Self-Pay Options	7
Edit(s) to page 5-3: Credit Card Payments.....	7
Edit(s) to page 5-5: Personal Bankruptcy.....	7
New topic on page 5-6: Creditor Actions Upon Notification	8
Edit(s) to page 5-9: Collection Lawsuits	8
Edit(s) and new formatting on page 5-11: 501(r)	8
Edit(s) to page 6-4: Patient Accounts Managers.....	9
Edit(s) to page 6-6: Tip.....	9

Edit(s) to page 6-9: Avoiding Billing Backlogs 9

Edit(s) to pages 6-21 and 6-22: Human Resource (HR) Responsibilities..... 9

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

Edit(s) to page 3-3: Precertification and Preauthorization

Many services require advance insurance approval in order for payment to be secured later. This is called precertification or preauthorization. In some cases, the responsibility rests on the patient or the physician, in other cases with the hospital. Inpatient precertification is often handled by the Case Management department, as ongoing case management may also be required. Many insurance plans now require preauthorization for ~~outpatient imaging services~~ **certain outpatient services such as surgical services, imaging, and chemotherapy,** and often this must be done by the physician. However, if it has not been done, the hospital will not be paid so procedures must be in place to assure that the necessary steps have been followed.

Edit(s) to pages 3-5 and 3-6: Financial Counseling

- ~~Assess patients for ability to pay and/or charity care guidelines.~~
- **Assess patient's ability to pay and follow established charity care guidelines.**

For many staff members, asking for money is uncomfortable. When patients are asked for payment at time of service, they may have many objections. **Providing** training in dealing with these objections is important to maintaining good results and identifying patients with financial need.

Edit(s) to page 3-7: Compliance

Because of their important role in the revenue cycle, Patient Access staff must receive education on fraud and abuse issues both during their initial training period ~~and continuously~~ **as well as throughout their term of employment.**

Edit(s) to page 3-7: Other Responsibilities

The Patient Access department has other important responsibilities. In many facilities, Patient Access is responsible for handling the Important Message from Medicare that is required to be issued within two days of admission and again within two days of discharge. This notice explains to inpatients what to do if they feel they are being discharged too soon. It protects them from financial liability until they have had a chance to appeal. (Many ~~other~~ facilities make this part of the Case Management process rather than handling it in Patient Access.)

Edit(s) to page 3-16: Preregistration

- Patient insurance information (including subscriber **name**, date of birth, ID, etc.)

Edit(s) to pages 3-16 and 3-17: During and After the Appointment

- Greeting and checking the patient in, including:
 - Verifying patient information again.
 - ~~Making copy of current insurance card.~~
 - **Making copies of all current insurance cards.**
 - Collecting patient copayments.

- Obtaining information for the patient information form, including:
 - Name, address, and home telephone number
 - Gender
 - Date of birth and Social Security number
 - Primary and secondary insurance information
 - Subscriber **name**, date of birth and other demographics
 - Occupation and employer information
 - Guarantor information
 - Emergency contact's name, address, and phone number
 - Name and telephone number of individual/group referring patient
 - **Reason for visit/complaint/diagnosis**

All duties of the Front Office personnel are critical to the physician office - from billing to collections to quality patient care. ~~Without successful Front Office personnel~~ **Without effective Front Office policies**, the revenue cycle will fail.

Edit(s) to pages 3-21 and 3-22: Levels of Patient Care

Observation - Though these patients occupy a bed, they are **considered** outpatients. Observation time is intended for monitoring of the patient's acute condition, which may resolve or worsen. Because of this, observation is not the kind of service that can be scheduled in advance. It is also not intended for routine use such as surgical recovery. Many commercial insurance payers require most one-day stays to be classified as observation. Some limit these stays to 23 hours. Except in very rare instances, Medicare limits them to 48 hours.

Hospice - Hospice care is coordinated, palliative care provided to terminally ill patients. Sometimes hospice care is provided in the patient's home; other times in a special facility. It is focused on helping patients and their families through the dying process. To qualify for hospice, Medicare patients must have Part A coverage; have a physician- and hospice medical director-certified condition that is expected to cause death **with**in six months; sign a statement choosing hospice care instead of routine, Medicare-covered benefits for the terminal illness; and receive care from a Medicare-approved hospice program. If patients were in a Medicare Advantage plan, they revert to regular Medicare. The primary payer becomes Hospice and not Medicare. (Medicare coverage is addressed in more detail in the Billing section of this manual.)

Edit(s) to page 3-33: Services that Do Not Require an ABN (or HINN)

- ~~Self-administerable drugs~~
- **Self-administered drugs**

Edit(s) to page 3-36: Financial Policies in Patient Access/Front Office

- **When insurance coverage is in question**, work with physician's office to reschedule elective admissions.

Edit(s) to page 4-2: Introduction

Billing is the process of submitting and following up on claims in order to be paid for healthcare services provided. There are many different types of insurances and insurance payers, and the billing process can be quite complex. It's critical to understand both the conceptual and technical aspects of billing in order to achieve certification

Edit(s) to pages 4-2, 4-6, and 4-7: Types of Insurance and Payers

Medicare

Medicare was signed into effect in July 1966 to assure that the elderly ~~could get~~ received medical care and it is often credited as the single most important factor in raising the elderly out of poverty. (Medicare is also known as Title XVIII, a reference to the amendment to the Social Security Act that first established the program.) In 1972, Medicare was expanded to cover those under age 65 who have permanent disabilities or ESRD. Under Medicare, participating providers can bill a patient only for the applicable deductible and coinsurance of approved charges.

Medicare ~~has~~ is divided into four parts, each paying for a different type of care.

Part A - Hospital Insurance

Part A, ~~hospital insurance~~, covers medically necessary inpatient hospitalization, care in a SNF following a three-day hospital stay, home health care (see Note below), and hospice. Most people pay no premium, having qualified by working a long enough time. Patients pay a deductible for Part A coverage once per spell of an illness.

Part B - Medical Insurance

Part B, ~~medical insurance~~, covers practitioner fees (~~doctors, certified registered nurse anesthetists or GRNAs, psychologists, etc.~~) (doctors, CRNAs (Certified Registered Nurse Anesthetists), psychologists, etc.); outpatient hospital charges; lab and radiology charges; ambulatory surgical center (ASC) charges; durable medical equipment; and some home health care.

Part D - Medicare Prescription Drug Plan

Medicare Part D, ~~Prescription Drug plan~~, covers medication subject to an annual deductible. The Medicare Drug Plan selected has a list of covered drugs, which is known as the "formulary." Drugs are placed into tiers and each tier can have a different cost.

Accepting Assignment

Accepting assignment means that Medicare payments will be sent to the office rather than the patient. The physician accepts ~~what Medicare allows~~ **the Medicare allowable** as payment in full. He or she cannot use an ABN or similar contract to get the patient to pay more than the Medicare-allowed amount. However, the participating physician can bill the patient for deductible, coinsurance, statutorily noncovered items, and other noncovered items if an ABN ~~has been~~ **was** obtained.

When assignment is not accepted, the payment will be sent to the patient, and the office will have to collect it. If a physician chooses not to participate, he or she can only bill for 115% of the allowable Medicare amount. This is called the limiting charge. In addition, this will be based on 95% of the fee schedule.

Physicians can opt whether to accept assignment on a case-by-case basis in many instances.

Edit(s) to page 4-8: Medigap

Medigap refers to a supplementary coverage available only to ~~persons~~ **people** enrolled in both Medicare Part A and Part B. Medigap covers the deductibles, copayments, and coinsurance amounts for which the patient is responsible under Medicare. Some Medigap policies also cover services that original Medicare does not.

Edit(s) to page 4-10: Health Savings Accounts (HSAs)

Either the patient or his or her employer ~~The patient and/or his or her employer~~ may put money into the HSA. If the funds are not spent, the patient can keep them and, if they are never spent, the patient can use them ~~for~~ **in** retirement.

Edit(s) to page 4-30: HCPCS and CPT Modifiers

- XS - Separate structure, a service that is distinct because it was performed ~~by a different practitioner~~ **on a separate organ or structure**

Edit(s) to page 5-2: Effective Financial Policies

- **Minimum acceptable payments** - without clear guidelines, a contract can be created under Regulation Z, which brings to bear additional, significant requirements.
- **Discharge process/courtesy discharge** - a predetermined policy that determines if a patient must go through a formal discharge process where payment is collected, or if the patient meets financial considerations and will be billed at a later date.
- **Charges for returned checks, missing appointments without cancelling, etc.** - these must be communicated to the patient in advance if you wish to charge for them.

Edit(s) to page 5-3: Self-Pay Options

- Post-dated check (where allowed by law)
- Money order
- Supplying a Medicaid application

Edit(s) to page 5-3: Credit Card Payments

- **Advantages:**
 - Immediate assurance of payment
 - Payments made more readily with option of installment payments to the credit card company
 - Method to accept payments over the telephone
 - Ability to get prior authorization to charge balance to a credit card after insurance payment (The authorization form is filled out by the responsible party and signed. It indicates the amount to be deducted and the frequency.)
- **Disadvantages:**
 - Additional costs due to discount rate (percentage of payment retained by the credit card company) and use of electronic response
 - Potentially more paperwork, including additional deposit slips
 - Reconciliation processes for multiple card companies
 - Potentially increased time in handling credit card disputes
 - Potentially public relations problem if patients object to paying interest on medical bills

Edit(s) to page 5-5: Personal Bankruptcy

1. **Chapter 7** - The debtor does not have any means to repay the debts. The assets, if any, are divided among the creditors according to precedence. Legal fees, such as attorney and court costs, are paid first. Secured debts (those with collateral, such as a mortgage) are repaid second and unsecured debts (those with no collateral, such as medical bills) are paid last. In a typical Chapter 7 bankruptcy, the unsecured creditors receive nothing or, at best, pennies on the dollar.

This is the only bankruptcy filing where the debt may be completely dissolved.

In order for a patient to qualify for Chapter 7 bankruptcy, he or she must pass the means test. If the patient's average monthly income for the six months preceding filing for bankruptcy is less than or equal to the median income in his or her state, then the debtor can file for Chapter 7. If the patient's income is too high, he or she must pass the second part of the test, which assesses whether the debtor has enough disposable income to pay some creditors. Once the assessment is completed, the bankruptcy court would convert it to a Chapter 13 bankruptcy if applicable.

2. **Chapter 13** - The debtor has a regular income high enough to support a repayment plan over time, and the court decides how much will be paid on a monthly basis.

Payments under Chapter 13 are to be made directly to the bankruptcy trustee for distribution among creditors and the debtor would have no direct contact with the creditors during the protection period.

Generally after five years, the repayment plan will have cured the debt. ~~Once the plan is successfully completed, the remaining debts are erased. The law is complex and not discussed in detail here.~~

New topic on page 5-6: Creditor Actions Upon Notification

Creditor Actions Upon Notification

Upon receipt of a written notification of bankruptcy, a creditor must take the following steps:

- Flag the patient account, including the chapter, the court jurisdiction, the representing legal counsel, and the telephone number.
- Suspend all collection activity pending final disposition and notice from the bankruptcy courts.
- Cease all contact with the patient demanding payment in full.
- Notify any third party collection agencies handling the patient account of the bankruptcy notice.
- Forward a copy of the bankruptcy notice to any and all third party collection agents.
- Notify all parties if any payments are received on the account.

Edit(s) to page 5-9: Collection Lawsuits

Sometimes the only way to collect a debt is to file a lawsuit against the debtor. This is commonly done by a collection agency acting on behalf of the provider. The following are some legal definitions related to lawsuits:

Edit(s) and new formatting on page 5-11: 501(r)

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

~~Based on the proposed rules, charity hospitals cannot engage in extraordinary collection activities before making reasonable efforts to determine whether a patient is eligible for financial assistance.~~

Section 501(r) is part of the Affordable Care Act (ACA) which imposes new requirements on charitable tax-exempt hospitals. Each 501(c)(3) hospital organization is required to meet four general requirements on a facility-by-facility basis:

1. Establish written financial assistance and emergency medical care policies.
2. Limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital's financial assistance policy.
3. Make reasonable efforts to determine whether an individual is eligible for assistance under the hospital's financial assistance policy before engaging in extraordinary collection actions against the individual.
4. Conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy at least once every three years. (These CHNA requirements are effective for tax years beginning after March 23, 2012.)

The ACA also added new section 4959, which imposes an excise tax for failure to meet the CHNA requirements, and added reporting requirements under section 6033(b) related to sections 501(r) and 4959.

Edit(s) to page 6-4: Patient Accounts Managers

Patient Accounts Managers

~~Managers of a Patient Accounts areas~~ Patient Account Managers have additional unique responsibilities, including assuring that a minimum amount of liquidity is tied up in AR. Effectively managing patient accounts Patient Accounts is important in order to improve cash flow, avoid or reduce costs of borrowing money, and reducing bad debt losses.

Some ~~Patient Accounts managers~~ Patient Account Managers create incentive plans to reward staff who are effective in collecting payments. An incentive plan can improve production of the Patient Accounts staff and increase morale and motivation for participating employees. The plan must be carefully crafted, however, to avoid de-motivating and demoralizing staff who are not included or who do not reach their goals. In addition, the staff must be carefully trained and monitored so they do not become overly aggressive in collection practices or create negative public relations due to a perception of decreased customer service.

Edit(s) to page 6-6: Tip

TIP: Charity and bad debt are similar, but have important differences.

Charity care is and bad debt calculations are based on preset financial guidelines. ~~It is~~ They are a deduction from revenue because ~~it was never~~ they are not expected to be collected. Charity care can be used to show community benefit, which may be important in retaining nonprofit status.

~~In 2012, accounting guidelines were changed so that bad debt is also a deduction from revenue. (Formerly, it was reported as an operating expense.)~~ Most providers attempt to estimate how much of their AR will be ultimately written off as bad debt, and make a reserve entry in the books so their financial statements are more realistic. The estimate can be based on a percentage of accounts receivable, percentage of patient charges, aging of accounts receivable, and/or historical bad debt write-offs. (Although bad debt is now a deduction from revenue, an agency's commission to collect bad debt is still reported as an operating expense.)

Edit(s) to page 6-9: Avoiding Billing Backlogs

Best practices have most claims being billed ~~on the same day they are generated~~ within 24 hours from the date of service. However, many things can keep a claim from being sent. Some are system issues, such as incorrect edits or mapping problems, and some are personnel issues, such as staff shortages or inefficiencies. The number of unbilled claims should be monitored at least weekly, and more often if there is a known issue. When a backlog becomes extreme, a plan should be devised to address both short- and long-term solutions.

Edit(s) to pages 6-21 and 6-22: Human Resource (HR) Responsibilities

Americans with Disabilities Act (ADA)

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

Family Medical Leave Act (FMLA)

~~The FMLA was established in 1993. For~~ **applies to** employers with 50 or more employees, **and** it allows a person who has worked at least 1,250 hours in the last 12 months to take up to 12 workweeks of unpaid leave because of his or her own "serious health condition" or that of a family member, or the birth or adoption of a child. The leave need not be taken as consecutive days. The employee must provide 30 days' advance notice, if possible.

Pregnancy Discrimination Act (PDA)

~~The PDA was enacted in 1978. It~~ prohibits discrimination against employees and applicants on the basis of pregnancy, childbirth, and related medical conditions.