

CRCE Exam Study Manual

Update for 2020

This document reflects updates made to the instructional content from the *Certified Revenue Cycle Executive (CRCE) Exam Study Manual 2019* to the 2020 version of the manual. This does not include updates to Knowledge Checks and Answers, the Glossary, spelling, punctuation, grammar or capitalization.

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Note: Throughout the manual, “I” icons flagging content for institutions have been replaced with “F” icons representing facilities. “P” icons now flag content for provider practices. But **all** the information in the 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.

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

Edit(s) to page 2-14: Data Storage and Recovery

Yet another element of HIPAA was to require providers to prepare for potential disaster by requiring a back-up plan for data storage and recovery. The need for this became evident following Hurricane Katrina and the destruction of entire hospitals and patient records along the Gulf Coast. The effects of this catastrophe are still being dealt with today. The lessons learned with Katrina ~~helped hospitals that were faced with Hurricane Sandy in 2012~~ **have helped hospitals that face hurricanes and other natural disasters.**

These back-up plans are also critical in responding to a growing digital extortion technique. Criminals are increasingly using various methods to hijack patient data and hold it hostage for ransom. When this happens, providers must weigh the decision to pay a ransom to the hackers to restore their data versus the time and effort needed to retrieve their own back-up files.

Edit(s) to page 2-33: Physician Quality Reporting System (PQRS)

(The entire PQRS section has been deleted.)

Edit(s) to page 2-33: Quality Payment Program (new topic)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have significantly cut payment rates for participating Medicare clinicians. MACRA requires us to implement an incentive program, the Quality Payment Program. There are two ways clinicians can choose to participate in the Quality Payment Program:

The Merit-based Incentive Payment System (MIPS) – If you’re a MIPS eligible clinician, you’ll be subject to a performance-based payment adjustment through MIPS.

Advanced Alternative Payment Models (APMs) – If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

TIP: Detailed information regarding Value Based Programs can be found at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html>.

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

Medicare Part A		
Service	Beneficiary Obligation	2020 19 Amount
<p>Inpatient hospital stay – Semi-private room, meals, general nursing, other hospital services, and supplies. This includes care in critical access hospitals, but does not include private duty nursing, television, or telephone service in the room if billed separately. It also does not include a private room, unless medically necessary.</p> <p>Inpatient mental healthcare in an independent psychiatric facility is limited to 190 days in a lifetime.</p>	<p>Days 1 through 60*:</p> <ul style="list-style-type: none"> Part A current year inpatient deductible <p>*Renewable during the next benefit period</p>	\$ 1,408 1,364 per spell of illness
	<p>Days 61 through 90*:</p> <ul style="list-style-type: none"> Part A coinsurance (1/4 or 25% of current year inpatient deductible) <p>*Renewable during the next benefit period</p>	\$ 352 341 per day
	<p>Days 91 through 150*:</p> <ul style="list-style-type: none"> Part A lifetime reserve (LTR, 1/2 or 50% of current year inpatient deductible) <p>*Nonrenewable; hospitals alert patients when they have 5 days of coinsurance left so they can choose whether to use their LTR days</p>	\$ 704 682 per day
<p>SNF care – Semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies. (Patients need three midnights as an inpatient to qualify for Medicare coverage in a SNF.)</p>	<p>Days 1 through 20:</p> <ul style="list-style-type: none"> No deductible or coinsurance 	\$0 per benefit period
	<p>Days 21 through 100:</p> <ul style="list-style-type: none"> 1/8 of current year inpatient deductible 	\$ 176 170.50 per day

Edit(s) to page 4-7: Part B Deductibles, Coinsurance, and Copayments (new topic)

Part B deductibles, coinsurance, and copayments are outlined below.

Medicare Part B		
Service	Beneficiary Obligation	2020 Amount
Medical and other services – Doctors services (except for routine physical exams); outpatient medical and surgical services; supplies; diagnostic tests; ambulatory surgery center facility fees for approved procedures; and DME. Also covers second surgical opinions; outpatient physical, occupational, and speech therapy; and outpatient mental healthcare.	Medical and other services: <ul style="list-style-type: none"> Current year deductible, then coinsurance (20% of Medicare-approved amount, except in the outpatient setting) 	\$198 per year, then 20% of Medicare-approved amount
	Outpatient physical, occupational, and speech-language therapy services: <ul style="list-style-type: none"> Coinsurance 	20% of Medicare-approved amount
	Outpatient mental healthcare: <ul style="list-style-type: none"> Coinsurance 	20% of Medicare-approved amount
Clinical laboratory service – Blood tests, urinalysis, and more.	Medicare-approved service: <ul style="list-style-type: none"> No deductible or coinsurance 	\$0
Home health care – Part-time skilled care, home health aide services, DME when supplied by a home health agency while getting Medicare-covered home health care, and other supplies and services.	Medicare-approved service: <ul style="list-style-type: none"> No deductible or coinsurance 	\$0
	DME: <ul style="list-style-type: none"> Coinsurance (20% of Medicare-approved amount) 	Depends on value of DME
Outpatient hospital services – Services for the diagnosis or treatment of an illness or injury.	Medicare-approved service: <ul style="list-style-type: none"> Coinsurance or fixed copayment, which varies according to the service 	Varies
Blood – Blood received as an outpatient or as part of a Part B covered service.	Blood: <ul style="list-style-type: none"> Current blood deductible (unless the patient or someone else donates to replace the blood received), then coinsurance 	First 3 pints per year, then 20% of the Medicare-approved amount

Edit(s) to page 4-12: Medicare Administrative Contractor (MAC)

Medicare Administrative Contractors (MACs) are the private firms that process Medicare Part A and Part B medical claims or DME claims for Medicare FFS beneficiaries. MACs were formerly known as fiscal intermediaries or carriers. MACs also serve as the primary operational contact for providers. They enroll providers in the Medicare program, provide education on Medicare billing requirements, and answer both provider and patient inquiries.

Currently there are 12 Part A / Part B MACs and four DME MACs **jurisdictions** in the program that process Medicare FFS claims based on the geographical location of the provider.

Edit(s) to page 4-14: Medicare Cards

TIP: When submitting a claim to Medicare, the name on the claim must match the name on the card exactly. Therefore, it is helpful to obtain a copy of the card when providing services.

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

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

The Medicare Access and CHIP Reauthorization Act of 2015 required CMS to remove Social Security Numbers (SSNs) from all Medicare cards by 2019. The process of basing the previous Health Insurance Claim Number (HICN) on the patient's SSN violates HIPAA. Information such as member name and effective dates will still be present on the Medicare card. Each person is assigned their own unique identifier, known as the MBI, Medicare Beneficiary Identifier. Starting January 1, 2020, you **MUST** submit claims using MBIs (with a few exceptions), no matter what date you performed the service. The new MBI will:

- Have the same number of characters (11) as the HICN
 - Contain uppercase letters and numeric characters, but no special characters
 - Occupy the same field on HICN transactions
 - Be unique to each beneficiary (in other words, husband and wife have their own MBIs)
 - Be easy to read and limit the possibility of misinterpretation (uppercase letters only and no commonly misread letters S, L, O, I, B, and Z)
 - ~~▪ Not contain inappropriate combinations of numbers or strings that may be offensive~~
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Edit(s) to page 4-91: Medicare Appeals

3. **Administrative Law Judge** – Provider must file with the ALJ within 60 days from the date of receipt of the reconsideration. The amounts in controversy are as follows:
 - 2020 dates of service (DOS) – \$170
 - 2019, 2018, and 2017 DOS – \$160
 - 2016 and 2015 DOS – \$150
4. **Review by the Medicare Appeals Council** – Provider must file within 60 days from the date of receipt of the ALJ hearing decision.
5. **Judicial Review by the Federal District Court** – Provider must file within 60 days from the date of receipt of the Medicare Appeals Council decision or declination of the review. The amounts in controversy are as follows:
 - 2020 DOS – \$1,670
 - 2019 DOS – \$1,630
 - 2018 DOS – \$1,600
 - 2017 DOS – \$1,560
 - 2016 DOS - \$1,500
 - 2015 DOS - \$1,460

Edit(s) to page 6-32: RAC Audits

As part of the Medicare Modernization Act, CMS conducted a Recovery Audit Contractor (RAC) demonstration project. These RACs are private firms charged with identifying under- and overpayments in Medicare and earning a contingency fee for denial of previously paid claims.

RACs perform ~~two~~ three different types of reviews:

1. **Automated** – The RAC merely identifies a potential issue and uses its database to find improper payments. The provider is then given notification of denied claims.
2. **Complex** – The RAC requests medical records and makes its determination from them.
3. ~~**Prepayment** – The RAC reviews claims prior to Medicare payment, based on preset criteria. (CMS launched prepayment reviews as part of a demonstration project effective in 2012 and limited to only a few states.)~~

In any case, providers have 15 days to question any denials, and then can undergo the regular appeal process, which can be quite lengthy. CMS now allows outpatient charges to be billed when an inpatient level of care is denied.