

CRCP Exam Study Manual Update for 2020

This document reflects updates made to the instructional content from the *AAHAM Certified Revenue Cycle Professional (CRCP) Exam Study Manual 2019* to the 2020 version of the manual. This does not include updates to the Introduction, Knowledge Checks and Answers, or the Glossary.

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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 2-12: 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 2-18: Telephone Consumer Protection

The Telephone Consumer Protection Act (TCPA) restricts telephone solicitations (in other words, telemarketing) and the use of automated tele-phone equipment. The TCPA prohibits contact with a debtor on a cell phone using automated dialing equipment without express consent and limits the use of artificial or prerecorded voice messages, SMS (Short Message Service, or text) messages, and fax machines. It also specifies several technical requirements for fax machines, auto dialers, and voice messaging systems — principally requiring identification and contact information of the entity using the device to be contained in the message.

The TCPA restricts the use of automated dialing equipment when contacting a wireless telephone or any telephone number for which the individual may be charged for the call unless prior express consent has been obtained. Automated dialing equipment is defined as equipment with the ability or the potential ability (including through the addition of software) to store or produce telephone numbers and make calls using a random or sequential number generator. The basic functions of automated dialing equipment are to dial a number without human intervention and to be able to dial thousands of numbers in a short period of time.

In addition, the TCPA requires prior express consent for any call, auto-mated or manual, made to a wireless phone. When a patient provides a wireless phone number to a provider, this is considered prior express consent or permission as long as the patient did not provide any instructions limiting calls to the given telephone number and the provider makes only those calls related to the original consent.

~~Thanks to the ongoing and continuing efforts of our industry, the Federal Communications Commission adopted conditions (FCC 15-72) for calls made by or on behalf of a healthcare provider. Some of those conditions include:~~

- ~~• Text message and voice calls should only be sent to the wireless tele phone number that has been provided by the patient.~~

- ~~Any voice calls or text messages must include the name and contact information of the healthcare provider and must comply with HIPAA privacy rules.~~
- ~~All calls should be one minute in length or less, and text messages should be no longer than 160 characters.~~
- ~~Limit provisions state that healthcare providers can initiate only one call or text per day and no more than three per week.~~
- ~~An opt-out must be offered and, should a patient elect to use it, the healthcare provider must honor the opt-out request immediately.~~

Edit(s) to page 2-23: Performance Improvement

Federal regulations also address two major areas of healthcare performance improvement: laboratory certification and quality **payment** reporting.

Edit(s) to page 2-23: Clinical Laboratory Improvement Amendments (CLIA)

5. Certificate of Accreditation

The CLIA number must be reported on the claim form when the provider is a Medicare participating provider.

NOTE: There are two states that are exempt from CLIA certification. They are Washing-ton and New York.

Edit(s) to page 2-24: Physician Quality Reporting System (PQRS)

(The entire PQRS section has been deleted.)

Edit(s) to page 2-24: 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. MA-CRA 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:

1. 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.
2. 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 3-19: Hospital Issued Notice of Noncoverage

The HINN is similar to an ABN in that it is a liability notice. HINNs affect providers submitting claims to Medicare Administrative Contractors (MACs) for hospital inpatient services. Hospitals provide HINNs to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the items or services the beneficiary is receiving, or is about to receive, are not covered because it is:

- Not medically necessary;
- Not delivered in the most appropriate setting; or
- Custodial in nature.

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.

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> | \$ 1,364 1,408 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> | \$ 341 352 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> | \$ 682 704 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 | \$ 170.50 176 per day |

Edit(s) to page 4-6 and 4-7: Part B Deductibles, Coinsurance, and Copayments

| Medicare Part B | | |
|---|---|---|
| Service | Beneficiary Obligation | 2020 19 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) | \$ 185 198 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 |

Edit(s) to page 4-20: 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 4-22: Medicare Cards

NOTE: **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 HIPPA. 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:**

~~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 HIPPA. This change is important because CMS will be better able to protect private health care and financial information and protect federal health care benefits and service payments.~~

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

- Have the same number of characters (11) as the HICN

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

Edit(s) to page 4-69: UB-OF and 837I

The following are some examples of common codes found on a UB-04/837I:

- Type of Bill - a three-digit code where the first digit is Type of Facility; second digit is Bill Classification; and third digit is Frequency, such as:
 - 111 – Type of Facility: Hospital; Bill Classification: In Patient; Frequency: Admit through Discharge
- Condition Code – a two-digit code that clarifies an event or condition related to the bill that may affect payer processing, such as:
 - 04 – Information only bill (i.e., HMO)

Edit(s) to page 6-27: Types of RAC Reviews

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. Automated reviews are generally based on clear policies outlined in the law, regulations or guidance.
2. Complex – The RAC requests medical records and makes its determination from them. These audits may involve questions of medical necessity, proper documentation, and others where judgment is required.
- ~~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.)~~