CRCE Exam Study Manual
Update for 2015

This document reflects updates made to the instructional content from the
AAHAM Certified Revenue Cycle Executive (CRCE-I, CRCE-P) Exam Study Manual - 2014
to the 2015 version of the manual.

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Edit to page 2-1: U.S. Department of Health & Human Services (HHS)

Deleted text struck through and inserted text highlighted in yellow:

HHS is the U.S. government’s principal agency for protecting the health of all Americans. HHS is one of the primary governing bodies effecting healthcare change. The work of HHS is conducted by the Office of the Secretary and 11 agencies operating divisions, including those listed below.

Edit to page 2-2: Centers for Medicare & Medicaid Services (CMS)

Deleted text struck through and inserted text highlighted in yellow:

The best resource for the most current information about CMS is http://www.cms.hhs.gov/ http://www.cms.gov/. Here you will find Medicare manuals, information about coverage and benefits and much more.

Edit to pages 2-5 and 2-9: Anti-Patient Dumping

Revised text from Anti-Patient Dumping to Patient Anti-Dumping

Edit to page 2-8: Right to Participate in Treatment Decisions

Deleted text struck through:

Inform each adult patient in writing of his or her right to accept or refuse medical treatment and of his or her right to formulate advance directives. (An adult patient is defined for the purposes of this act as someone who is 18 years or older, emancipated, married, divorced, on active military duty, or emancipated by the courts.)

Edit to page 2-10: Fraud

Deleted text struck through and inserted text highlighted in yellow:

Examples of fraud include billing for services not rendered, misrepresentation of service or coding, misrepresentation of diagnosis, and-kickbacks, and waiving of coinsurance or deductibles.

Edit to page 2-11: Abuse

Deleted text struck through and inserted text highlighted in yellow:

Examples of abuse include services not medically necessary, screening services, and violation of assignment, and waiving of coinsurance and/or deductibles.
Clinical Laboratory Improvement Act (CLIA)

**NOTE:** There are two states that are exempt from CLIA certification. They are Washington and New York.

**Preadmission**

Preadmission is the process of means to gathering information and taking care of as many items as possible prior to the actual date of service.

**Preadmission**

Preadmission has many advantages, such as:

- Patient demographics can be gathered beforehand, by phone, web, or mail.
- Wait times are reduced on the day of service.
- In some cases, the patient can report directly to the area of service.
- Because the patient is not under the pressure of imminent medical treatment, accuracy is improved.
- There is more time to verify benefit information and if a service will not be covered by Medicare or other insurance, it is the ideal time to explain this to patients and inform them of the related requirements (explained later in this section).
- Deductibles and copayments can be identified and collected in advance of service.
- It is possible to identify a need for financial assistance, if available, and expedite the application process.
- Precertification requirements can be satisfied.
- Clinical work can be arranged in advance, resulting in better patient care.
- Special needs can be arranged prior to the day of service (for example, room requirements or dietary needs).

**Preregistration**

Preregistration has many advantages, such as:

- Patient demographics can be gathered beforehand, by phone, web, or mail.
- Wait times are reduced on the day of service.
- Because the patient is not under the pressure of imminent medical treatment, accuracy is improved.
- There is more time to verify benefit information and if a service will not be covered by Medicare or other insurance, it is the ideal time to explain this to patients and inform them of the related requirements (explained later in this section).
- Deductibles and copayments can be identified and collected in advance of service.
- It is possible to identify a need for financial assistance, if available, and expedite the application process.
- Preauthorization, if necessary, can be obtained.

**Edit to page 3-23: Consent Types, Requirements, and Results**

**Inserted text highlighted in yellow:**

- Reaching the age of majority (in which case they are no longer a minor)
  - **NOTE:** The age of majority is determine by each state and is usually between the ages of 18 and 21.

**Edit to page 3-29: National and Local Coverage Determinations**

**Deleted text struck through and inserted text highlighted in yellow:**

National coverage determinations (NCDs) and local coverage determinations (LCDs) are policies that CMS and fiscal intermediaries Medicare Administrative Contractors (MACs) use to pay or deny claims based on medical necessity.

**LCDs**

An LCD is a decision by a fiscal intermediary or carrier Medicare contractor whether to cover a particular service on an intermediary-wide or carrier-wide contractor-wide basis.

**Edit to page 3-31: Hospital-Issued Notice of Noncoverage**

**Deleted text struck through and inserted text highlighted in yellow:**

The Hospital-Issued Notice of Noncoverage (HINN) is similar to an ABN in that it is a liability notice. HINNs affect providers submitting claims to fiscal intermediaries MACs for hospital inpatient services.
In addition to providing patients with required notices, they should also receive a patient information brochure. Information to include in such a brochure includes, as applicable:

- Name, address and phone number of facility
- Directions/map to facility
- Facility hours

Medicare Administrative Contractors (MACs) are the private firms that process Medicare claims. (They were formerly known as fiscal intermediaries or carriers.) As of December 2009, several MAC contracts have been awarded and implemented. Eventually all fiscal intermediaries and carriers will be replaced by MACs. The 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.

* Much of the rest of the world already uses the tenth revision, ICD-10. It does not just expand codes; the entire format and methodology has changed. HHS has mandated that the U.S. switch from ICD-9 by October 2015.

Per diem is the Latin phrase meaning is Latin for “for each day.”

DME is billed to one of four Durable Medical Equipment Regional Carriers (DMERCs), which are different from the hospital and physician MACs services. The beneficiary’s address determines which DMERC should be billed, not the location of the supplier. (Some items of DME are exempt from the DMERC billing requirement and may be billed by a hospital to the MAC fiscal intermediary. These include intraocular lenses, pacemakers, and home dialysis supplies.)
**Edit to pages 4-46 and 4-47: 72-Hour Rule (changed to 1-Day and 3-Day Payment Window Rule)**

**Deleted all text through the two examples and inserted text below:**

The 3-day payment window rule used to be known as the 72-hour rule. This Medicare regulation requires all diagnostic and clinically related non-diagnostic outpatient services provided within three days of an inpatient admission to 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). Outpatient services on the same day as date of admit should always be combined.

Example

If a patient is admitted on a Wednesday, all diagnostic and clinically related non-diagnostic outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are combined to the inpatient claim and included in the inpatient Part A payment.

Hospitals and units excluded from the Inpatient Prospective Payment System (IPPS) follow the 1-day payment window rule rather than the 3-day rule.

Examples

Critical Access Hospitals (CAHs), psychiatric hospitals and units, inpatient rehabilitation facilities (IRF) and units, long-term care hospitals (LTCH), children’s hospitals, and cancer hospitals follow the 1-day payment window rule.

**Deleted text struck through and inserted text highlighted in yellow:**

To ensure compliance, a Patient Accounts Director should:

- Establish a process for program for with the billing software vendor to identifying and merging accounts.
- Establish a computer report to identify exceptions.
- Develop a review system to test claims before and after submission.
- Educate the staff annually.
- Work with the Admissions staff to ask patients if they have had services at this within the provider in the previous three days 72-hour period.

**Edit to page 4-57: Medically Unlikely Edit (MUE) Program**

**Deleted text struck through and inserted text highlighted in yellow:**

Medicare developed the Medically Unlikely Edit (MUE) program to reduce the paid claims error rate for Medicare claims. For example, this program would detect a claim for a person having “ten legs amputated.” According to the CMS FAQ #8733 11350, “MUEs are designed to reduce errors due to clerical entries and incorrect coding based on anatomic considerations, HCPCS/CPT Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code descriptors, CPT coding instructions, established
CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, and unlikely clinical treatment.”

**Edit to page 4-57: Denials**

**Deleted text struck through and inserted text highlighted in yellow:**

Denials are received in several ways. Any electronic claim can be rejected after submission, with a report detailing the error. Medicare claims can end up on the **Return to Provider (RTP) list, or can be denied in the electronic remittance advice (ERA)** RTP (Return to Provider) list, or can be denied in the ERA. Commercial and other claims can be denied via explanation of benefits (EOB) form or letter. Some claims are only found to be denied when a follow-up inquiry is made.

**Edit to page 4-59: Medicare Appeals**

**Deleted text struck through and inserted text highlighted in yellow:**

3. Administrative Law Judge – provider must file with the ALJ within 60 days from the date of receipt of the reconsideration. There must be **$130 $150** in controversy.

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. **There must be $1,460 in controversy.**

**Edit to page 4-62: Selecting Computer Systems**

**Deleted text struck through and inserted text highlighted in yellow:**

- Does the system generate a report to identify claims that need to be combined based on the Medicare **3-Day Payment Window Rule (or the 1-Day Payment Window Rule for CAHs)**? **72-Hour Rule (or the 24-Hour Rule for CAHs)?**

**Edit to page 5-5: Personal Bankruptcy - Types**

**Inserted text highlighted in yellow:**

- 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. 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.
**Edit to page 5-6: Personal Bankruptcy - Requirements**

Deleted text struck through and inserted text highlighted in yellow:

Some types of debts are not dischargeable through bankruptcy (for example, child support obligations, alimony, and criminal fines). These include taxes, student loans, and child support obligations. Bankruptcies must be removed from credit files after 10 years.

**Edit to page 5-6: Determining the Responsible Party**

Deleted text struck through and inserted text highlighted in yellow:

- Spouse are may be responsible for each other’s debts incurred during the marriage, even if the marriage ends or the other spouse dies. This is dependent upon state law.

**Edit to pages 6-2 and 6-3: General Overview of Management Roles**

Deleted text struck through and inserted text highlighted in yellow:

- Use of resources – making sure ensuring that the assets of the employer are being effectively and efficiently used, including monitoring employee performance, using metrics to gauge results, keeping inventory, selecting vendors wisely, collecting effectively, etc.

- Hiring and firing of staff – using effective interview techniques, applying knowledge of employment law and anti-discrimination law, retaining proper documentation, selecting people with the needed skills, etc.

- Motivation of staff – being fair, reliable, and collaborative; providing appropriate rewards; providing opportunities for growth and coaching; developing and monitoring performance indicators; etc.

- Mentoring and training of staff – creating opportunities for employee growth, identifying potential, offering effective feedback, valuing continuing education, coaching, supporting membership in associations and groups, etc.

- Planning – succession planning, targeting staffing needs, identifying trends, etc.

- Budgeting – creating cost awareness; determining the resources, people, equipment, and finances required by an area; providing a basis to track, measure, and evaluate performance, etc.

- Leading – expressing the mission and vision of the organization, and instilling enthusiasm for them; demonstrating the ability to "captain the ship" through tough times or changes, etc.

- Controlling supply inventory – limiting the number of people with authority to order supplies, consolidating supplies in order to avoid duplicating expensive stock, creating and maintaining inventory par levels, establishing a process to charge responsibility centers for supplies, etc.
**Edit to page 6-6: Accounting Terminology**

**Deleted text struck through and inserted text highlighted in yellow:**

- Expenses arise when the business has to pay for things. Expenses can also be operating or non-operating. **Expenses may be classified as operating or non-operating expenses.** Examples of expenses include salaries, collection agency fees, and postage.

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**Edit to page 6-8: Managing Deductions from Revenue and Income**

**Deleted text struck through and inserted text highlighted in yellow:**

Deductions from revenue occur when charges are recognized up-front to be uncollectible by reason of charity care, bad debt, contractual allowance, and discounts. It is important to track and report these deductions by physician and/or specialty. This will **help** identify areas not covering costs due to clientele or services offered.

Once the specific source of the revenue deduction is known, steps can be taken to reduce deduction rates. They can include:

- Reduce or minimize bad debts and/or charity care.
- **Review discount policies and eliminate or make recommendation to reduce their use, where possible.**
- Implement enhanced/more complete diagnostic and procedural coding to maximize reimbursement.
- Ensure proper billing edits are in place.
- Attempt to better manage payer mix.
- Negotiate higher contractual arrangements **with managed care carriers.**
- Discontinue unprofitable contracts.
- **Outsource low-balance payments accounts so that internal resources may focus on higher-balance accounts.**
- Improve internal collection efforts.
- Evaluate and replace low-performing collection agencies.

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**Edit to page 6-9: Improving Cash Flow**

**Deleted text struck through and inserted text highlighted in yellow:**

- Minimize bill hold days (the number of days a bill sits before a claim drops).
  - The main reasons for holding bills are to ensure all charges are in and to check for other accounts in relation to the **1-Day or 3-Day Payment Window Rule**, **72-Hour Rule**. Thus a minimum of three days is suggested, but more than that will cause AR days to be higher.
Edit to page 6-10: Handling Credit Balances

Deleted text struck through and inserted text highlighted in yellow:

Credit balances must be dealt with promptly for several reasons:

- Medicare requires that overpayments be repaid quickly and requires a quarterly Medicare Credit Balance Report (the 838) to be filed—even if there are no credit balances. Failure to file the 838 will cause Medicare to start withholding payments. **Failure to file the 838 will result in Medicare’s withholding of payments.**

Edit to page 6-15: Compliance Plans – Considerations for Updates

Inserted text highlighted in yellow:

- Hotline and/or post office box for reporting **grievances**

Edit to page 6-16: Other Audits

Deleted text struck through and inserted text highlighted in yellow:

Zone Program Integrity Contractors (ZPICs) – CMS’s Benefit Integrity (BI) program has various types of contractors review different aspects of Medicare billing and payment. **The ZPICs are organized into seven different regions.**