Certified Access Manager (CAM) Study Guide

Revised January 2016

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I. NCAHAM-North Carolina Association of Healthcare Access Managers

To improve patient care and community relations to provide a medium for interchange of ideas and decimation of materials related to healthcare access and to create close cooperation among managers and hospital association in matters pertaining to healthcare access.

II. REGISTRATION BASICS

A. FORMS

- **Authorization for Treatment (From patient)**
  Issued to all patients. Signature by patient gives consent for: treatment, assignment of benefits, release of medical information, Medicare and Medicaid information, and payment guarantee.

- **Patient Self Determination Act Notification Form (PSDA) (Policy 2.010)**
  Issued to all Inpatients. Signed form, which has given the information pamphlet regarding their right to advanced directives.

- **Medicare Letter** Information letter from Medicare that must be issued to every Inpatient with Medicare coverage.

- **Champus Letter**
  Information letter from Champus/Tricare that must be issued to every Inpatient with Tricare coverage. Patient must sign one copy as proof that they have received the letter.

- **HIPAA Privacy Notice Consent**
  The last paragraph on the Authorization for Treatment form provides an acknowledgement that the patient has received the Notice of Privacy Practices.

B. PATIENT TYPES

- **Patient types** determine how an account will bill on a **UB04 form.**

III. INSURANCE

A. GENERAL

- **Member Number, Policy Number, Subscriber ID**
  Understand common procedures for identifying policy numbers for common insurance carriers. Know common prefixes and suffixes. (General, not specifics)

  For example: The subscriber would be the individual whose name the policy is written.

- **Group #**
  The group number is a numeric or alpha-numeric number that identifies the patient's employer or other organization that has issued the insurance. Know how to identify group numbers on ID cards.

- **Priority – Coordination of Benefits (COB)**
  Understand general rules for prioritizing patients with multiple sources of insurance coverage. Also - what questions to ask to determine the priority if the patient is unclear.

  Purpose is to rank insurances correctly so that claims drop to the correct primary provider, thus reducing the need to file corrected claims, and reduces denials.

B. MEDICARE (Glossary – Insurance tips for Medicare)

- **Claim Number**
  Know different Medicare claim number formats and what they can indicate. In order for electronic verification to be successful, a patients name on the insurance screen must match the Medicare Database exactly, even if the claim number is correct.

- **Eligibility**
  Know what determines a patients eligibility on the basis of age, disability, or ESRD.

- **MSP Program/Form**

  To be filled out on all Medicare patients as part of the insurance revision.

  Know all Medicare Secondary Payer requirements and how to correctly enter all MSPQ screens. Understand the purpose of answering the MSPF.

Know ESRD rules/timeframes:
https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Downloads/MSP-End-Stage-Renal-Disease-ESRD.pdf

- **ABN (Advanced Beneficiary Notice)**
  An ABN is a notice that must be provided to Medicare patients if we are providing services that are not covered by Medicare. Patient must sign letter as acknowledgement that Medicare will not pay for the services and the patient will receive a bill for these services.

- **Payment and Billing Rules**
  Medicare has several different ways they pay facilities for services.

  - **DRG** - Acute Care hospitals are paid on a DRG (diagnosis related groups) for Inpatient admissions. DRG's payments are based on the patient's diagnosis.
  - **CMG** - Rehabilitation facilities are paid on a CMG (Case Mix Group) for Inpatient services. CMG are based on the patient's initial diagnosis and how well they have improved during their visit.
  - **APC** - Acute Care facilities are paid on an APC (Ambulatory Patient Classification) for outpatient services.

  Medicare Services: **Part A** = Hospital, Skilled Nursing Facility, Home Health Services, & Hospice Care; **Part B** = Physician, Outpatient Hospital, Medical Equipment & Supplies, & other health services & supplies; **Part D** = Prescription Drugs Medicare recipients are now eligible to enroll in Medicare Advantage (Medicare Replacement) plans which cover both medical services and prescription drugs.

  If a patient with Medicare is admitted for Observation, they can stay in the facility for up to 24 hours without being admitted as an Inpatient.

  Medicare 72 Hour Rule:

  - Outpatient/Inpatient combination: any outpatient account 3 days (72 hours) prior to an inpatient account must have the charges and coding combined and billed on the inpatient claim.
  - Outpatient/Outpatient combination: any outpatient account with charges/coding for the same date of service as another outpatient accounts must be combined and billed as one account.

  Medicare has identified certain procedures as "Inpatient Only", meaning that they will only pay on these services if the patient was admitted as an inpatient.

C. MEDICAID

Medicaid is a program that is funded by both the State and Federal Government

- **Recipient ID#**
  What is the standard format for a Medicaid Recipient ID number?

- **CHIP: Children's Health Insurance Plan**
  Coverage offered to families with children who have a total household income that is too high to qualify for Medicaid, but too low to afford the rising health insurance premiums.

- **Eligibility**
  Who is eligible for Medicaid coverage?
  For more information see section on Financial Counseling Programs.

D. CHAMPUS / TRICARE

- **Eligibility**
  Who is eligible for Tricare coverage?
  - Current active duty military personnel are eligible for this coverage.
  - Dependents of active, disabled or retired military and disabled or retired military personnel are eligible for Tricare/ChampVA coverage.
    How do we bill services provided to active duty military personnel?

- **Tricare Letter**
  See Forms section under Registration Basics

E. AFFORDABLE CARE ACT (ACA)

- United States federal statute, intended to increase health insurance quality and affordability by expanding insurance coverage and reducing the cost of healthcare.

F. MISCELLANEOUS

- **Self Pay**
  Know what questions to ask to determine if a patient is self-pay and what the next step would be depending on the type of service (i.e. Emergency Department vs. Scheduled Radiology exam)

IV. Bed/ General Management

A. Census

LOS – Length of Stay
Number of days a patient stays in the hospital used in DRG calculation

Patient Day
The daily amount of money for revenue on inpatient basis

OBS – Observation
24-48 hours normally allowed for outpatient stay otherwise patient is discharged or admitted.

Average Length of Stay- Total patient days for period divided by total number of admits (or discharges) in same time period.

Average Daily Census – Total patient days for time period divided by number of days in period

Percentage of Occupancy – Total patient days for time period divided by number of patient days in time period.

FTE (full time equivalents) Calculation – Total number of staff hours divided by 40 per week (2080 annually)

Example: A department has a total reported payroll deduction of labor hours for a calendar year at 17,000 hours. How many FTEs are in the department? Answer: 17,000/2080 (annual) = 8.17 FTEs

V. Medical Records/Billing

Health Information Systems/Medical Records is the department responsible for charting and coding.

A. INSURANCE VERIFICATION

The Insurance Verification area handles two main functions: verifying insurance and performing non-clinical authorization (NCA), or referral receipt on all IP, OP, and OBS accounts.

- **Insurance Verification**
  Insurance verification is the process of calling or obtaining a patient's insurance benefits by phone or by web from an insurance payer.

  Typically a patient's insurance would require an authorization, which is an approval obtained from an insurance carrier for a service, which represents an agreement for payment.

- **Special Insurance Verification Situations**

    - **Newborn Insurance Eligibility:** Baby's must be added to insurance policies within 30 days of birth. If there is more than one insurance plan that will cover the baby coordination of benefits must be determined.

    - **Referral to Financial Counseling**
      When a patient has no or very low insurance benefits, accounts are referred to the Financial Counseling Department for follow-up.

VI. FINANCIAL COUNSELING (Exam specific)

Know when Patient Registration refers accounts to Financial Counseling? What types of accounts are automatically worked by Financial Counseling?

A. AVAILABLE PROGRAMS & ELIGIBILITY REQUIREMENTS

Medicaid

Qualifying based on Income, family size, federal poverty guidelines. For an adult to be eligible, they must have minor children in the home or be disabled for at least 12 months. Most children will qualify. Must be a US Citizen.

B. PATIENT ACCOUNTING

Billing Forms

There are two billing forms used in Patient accounting:

- The UB04 Form is for billing facility related charges (most commonly used to bill hospital charges)
- The 1500 Form is used for billing physician related charges.

Understand the purpose of ICD-10 coding - Current coding system used, and stands for the International Classification of Diseases, and its codes hold critical information about epidemiology, managing health, and treating conditions.

Medicare 72-Hour Rule

See Medicare Payment and Billing section

VII. COMPLIANCE

A. HIPAA

- What is HIPAA and how does it impact procedures in Patient Registration?
- Office of Civil Rights – The entity charged with the enforcement of the HIPPA regulations.

- Does signing a release form, authorize the facility to release records to insurance payers? – No.

B. ABN

- See Medicare in Insurance section and the glossary for a definition.
- Know what role Patient Registration plays in issuing ABNs to patients.

C. EMTALA

- Known as the "anti-dumping" law.
- The "no delay" provision of EMTALA states that "a hospital may not delay provision of an appropriate medical screening exam (or stabilizing treatment) in order to inquire about the individual's method of payment or insurance stats". It is this provision that most directly affects the processes for upfront cash that are conducted by the Patient Registration Staff.

D. The Joint Commission (The Joint Commission on Accreditation of Healthcare Organizations

- A hospital no longer accredited by TJC is prohibited from receiving Medicare Reimbursement.

E. OSHA – Occupational Safety and health Administration

The mission of OSHA is to save lives, prevent injuries and protect the health of America's workers. To accomplish this, federal and state governments must work in partnership with more than 100 million working men and women and their six and a half million employers who are covered by the Occupational Safety and Health Act of 1970.

In other words, OSHA must consist of employee participation, while providing information and training to their staff, as well as promote hazard prevention and control.

VIII. GLOSSARY

A. FREQUENTLY USED WORDS AND ABBREVATIONS

For your reference, listed below are abbreviations and words that are frequently used within the Patient Registration Department and this manual.

1) **ABN** – Beneficiary Notice; form that a patient is asked to sign, indicating that he/she understands that he/she will personally pay for a procedure not covered by his/her insurance.

2) **AD (Advance Directive)** – Advance Directive; One or multiple sets of documentation which allows patients to make healthcare decisions in

the event they are unable to do so in the future; gives patients the right to refuse life-sustaining medical treatment if they are terminally ill, permanently in a coma, suffering from dementia, or in a persistent vegetative state.

3) **ADA** – Americans with Disabilities Act (1992); prohibits discrimination on the basis of disability and protects qualified applicants and employees from discrimination in all employment practices, including job application procedures, hiring, advancement, job assignments, leaves of absence, transfers, layoffs, demotions, discipline, discharge, compensation and job training. To be protected under the ADA, the Act requires that an individual must be able to perform the essential functions of the job with or without reasonable accommodation.

4) **Benchmarking** – A tool utilized to improve business process through means of comparison with other organizations, identified as best performers.

5) **Cash flow –** The sum of cash receipts you receive and the cash disbursement you pay out in a given period

6) **CDM: Charge Description Master** – Comprehensive price list for all services/charges provided by a healthcare facility, which can be billed to a patient or patients health insurance provider.

7) **Co-insurance** – A fixed percentage of the bill the patient is responsible for paying. Example: 20% coinsurance.

8) **Co-payment** – A fixed amount due for each patient encounter or visit. Example: Emergency Room co-pay $50.00

9) **Deductible** – A fixed amount due from patient during a calendar year. Payment is required to be met before insurance will process or pay any claims.

10) **DHHS: Department of Health and Human Services –** Comprised of several division to include Medicare and Medicaid (CMS), and Center for Disease Control (CDC).

11) **Deposit** – An amount that patients are asked to pay upfront as a deposit toward their bill. Some facilities may relate the deposit to the patient deductible.

12) **EMTALA** – Emergency Medical Treatment and Active Labor Act; federal law that prohibits hospitals from denying treatment or transferring unstable patients for purely financial reasons.

13) **FMLA: Family and Medical Leave Act –** Federal law that guarantees certain employees up to 12 workweeks of unpaid leave each ear with

no threat of job loss. However, the FMLA statues do not cover an employer with less than 50 employees.

14) **HCPOA** – Healthcare Power of Attorney; one type of Advanced Directive a document that designates a person to make healthcare decisions for someone in the event he or she cannot make them for him/herself.

15) **ICD** – International Classification of Diseases; diagnosis codes

16) **Liability** – Insurance plan that pays the responsible party's damages.

17) **Living Will** - Type of Advance Directive; it is a written document stating a person's wish in the event he or she cannot make decisions for him/herself.

18) **MPI** – Master Patient Index

19) **PCP** – Primary Care Physician; referenced in a managed care contract.

20) **Pre-certification/authorization** – Procedure used to authorized procedures, surgeries, and other medical services; patient's insurance company is contacted for review of procedure or hospital stay before services are rendered.

21) **Pre-existing condition** – When a limitation on coverage is applied by the payer for a condition that existed prior to the effective date of insurance coverage.

22) **Tricare** – formerly known as Champus; insurance plan for military personnel, retired military personnel, and their families, and is not considered a commercial payer.

23) **Worker's Compensation** – insurance supplied by an employer that pays for injuries received while working at the place of employment.

B. SAMPLE UP-FRONT CASH CALCULATIONS

- **Formulas:**

Estimated charges (–) deductible amount not met (=) charges to use for co-insurance calculation.

Charges after deductible (x) co-insurance % due by patient (=) co-insurance amount due

Add deductible due (+) co-insurance amount due (=) total amount due

- **Samples:**

1. A patient is having an outpatient surgery with an estimated cost of $2000. Benefits as provided by the patient's insurance company are: yearly deductible of $200 which has not been met, pays 80% to out of pocket maximum of $5000 that has not been met.

   How much will you ask for the patient to pay up-front?

   $2000 (estimated charge) - $200 (deductible amount not met) = $1,800
   $1,800 (from above) x .20 (20%) (co-insurance amount) = $360
   Patient owed both the $200 deductible and the $360 co-insurance amount for a total of **$560**.

2. A patient is having outpatient surgery with an estimated cost of $5000. Benefits as provided by the patient's insurance company are: yearly deductible of $200 of which $100 has been met, pays 90% with no out of packet maximum.

   How much will you ask for the patient to pay up-front?

   $5000 - $100 = $4900
   $4900 x .10 = $490
   $100 + $490 = **$590**

3. A patient is having a PET scan with an estimated charge of $1500. The patient has an HMO policy with a $200 co-pay for outpatient diagnostic procedures and no deductible.

   How much will you ask for the patient to pay up-front?

   $200 – no calculation needed for co-pay

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