

Business Medicine

Topics

- HIPAA
- CMS
- Medicare
- Medicaid
- SOAP
- RBRVS
- Medical Necessity (LCD/NCD)
- ABN
- HITECH
- Fraud & Abuse
- OIG
- Compliance
- MIPS
- Knowledge about EMR/EHR

HIPAA

Health Insurance Portability & Accountability Act 1996

PHI – Protected Health Information

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PHI includes:

- a patient's name, address, birth date and Social Security Number;
- an individual's physical or mental health condition;
- any care provided to an individual; or
- information concerning the payment for the care provided to the individual that identifies the patient, or information for which there is a reasonable basis to believe could be used to identify the patient.

Covered Entities and Business Associates

Individuals, organizations, and agencies that meet the definition of a **covered entity** under HIPAA must comply with the Rules' requirements to protect the privacy and security of health information and must provide individuals with certain rights with respect to their health information.

A Health Care Provider	A Health Plan	A Health Care Clearinghouse
<p>This includes providers such as:</p> <p>Doctors</p> <p>Clinics</p> <p>Psychologists</p> <p>Dentists</p> <p>Chiropractors</p> <p>Nursing Homes</p> <p>Pharmacies</p> <p>...but only if they transmit any information in an electronic form in connection with a transaction for which HHS has adopted a standard.</p>	<p>This includes:</p> <p>Health insurance companies</p> <p>HMOs</p> <p>Company health plans</p> <p>Government programs that pay for health care, such as Medicare, Medicaid, and the military and veterans health care programs</p>	<p>This includes entities that process nonstandard health information they receive from another entity into a standard (i.e., standard electronic format or data content), or vice versa.</p>

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Minimal standard doesn't apply

Treatment purposes

DHHS

Under Law

Examples of business associates include:

- Third-party administrator that assists a health plan with claims processing
- Consultant that performs utilization reviews for a hospital
- Health care clearinghouse that translates a claim from a nonstandard format into a standard transaction on behalf of a health care provider, and forwards the processed transaction to a payer
- Independent medical transcriptionist that provides transcription services to a physician

Also, a covered health care provider, health plan, or health care clearinghouse can be a business associate of another covered entity.

Question: 1

Not covered under HIPAA

- A) Doctors
- B) HMOs
- C) Clearinghouses
- D) Patients

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CMS - Center for Medicare & Medicaid Services

www.cms.gov

Medicare (MC)

- Age 65 years and above
- Blind, Disabled, ESRD, Hospice conditions

Part A – Inpatient (IP), SNF, HH, Hospice, Acute Care

- ICD-10-PCS
- **Form UB-04**

Part B – Physician visits, Out Patient (OP), Preventive care, clinics, free standing sleep labs, DME, etc

- Anything not covered in Part A
- **Form CMS-1500**

Part C – Medicare Advantage (Part A + Part B) (i.e. managed care)

- Sometimes Part D

Part D – Drugs & Supplies (HCPCS)

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Insurance Company Name
Address
Payer ID

<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHIP/PA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> HEALTH PLAN <input checked="" type="checkbox"/> OTHER		16. INSURED'S ID NUMBER ABC4444333	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smithwick, John		3. PATIENT'S BIRTH DATE 03 12 1999	
5. PATIENT'S ADDRESS (No., Street) 4433 Pub Street		7. INSURED'S ADDRESS (No., Street) 4433 Pub Street	
CITY Anycity		CITY Anycity	
ZIP CODE 33777		ZIP CODE 33777	
TELEPHONE (Include Area Code) (444) 44-4444		TELEPHONE (4	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 		11. INSURED'S POLICY (GROUP OR INDIVIDUAL) 12345	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		12. REQUIRED: DATE OF BIRTH 03 12 1999	
13. INSURED'S POLICY OR GROUP NUMBER 		14. REQUIRED: DATE OF BIRTH 03 12 1999	
15. RESERVED FOR NUCC USE 		16. OTHER CLAIM ID (Designated by NUCC) 	
17. RESERVED FOR NUCC USE 		18. INSURANCE PLAN NAME OR PROGRAM 	
19. INSURANCE PLAN NAME OR PROGRAM NAME 		20. IS THERE ANOTHER HEALTH BENEFIT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. Signature on file		22. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. Signature on file	
23. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (EMP) MM DD YY 		24. OTHER DATE MM DD YY 	
25. NAME OF REFERRING PROVIDER OR OTHER SOURCE 		26. HOSPITALIZATION DATES RELATED TO FROM MM DD TO MM DD YY 	
27. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 		28. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
29. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY (Include ALL ICD-9-CM codes) F43.20		30. REQUIRED: REVISION CODE 	
31. PRIOR AUTHORIZATION NUMBER 			
32. A. DATES OF SERVICE From MM DD YY To MM DD YY 		33. B. RACE 	
34. C. PROCEDURE, SERVICE, OR SUPPLY (Specify: Physical, Chiropractic, etc.) 		35. D. CHARGES 	
36. E. CHARGES 		37. F. CHARGES 	
38. G. CHARGES 		39. H. CHARGES 	
40. I. CHARGES 		41. J. CHARGES 	
42. K. CHARGES 		43. L. CHARGES 	
44. M. CHARGES 		45. N. CHARGES 	
46. O. CHARGES 		47. P. CHARGES 	
48. Q. CHARGES 		49. R. CHARGES 	
50. S. CHARGES 		51. T. CHARGES 	
52. U. CHARGES 		53. V. CHARGES 	
54. W. CHARGES 		55. X. CHARGES 	
56. Y. CHARGES 		57. Z. CHARGES 	
58. AA. CHARGES 		59. AB. CHARGES 	
60. AC. CHARGES 		61. AD. CHARGES 	
62. AE. CHARGES 		63. AF. CHARGES 	
64. AG. CHARGES 		65. AH. CHARGES 	
66. AI. CHARGES 		67. AJ. CHARGES 	
68. AK. CHARGES 		69. AL. CHARGES 	
70. AM. CHARGES 		71. AN. CHARGES 	
72. AO. CHARGES 		73. AP. CHARGES 	
74. AQ. CHARGES 		75. AR. CHARGES 	
76. AS. CHARGES 		77. AT. CHARGES 	
78. AU. CHARGES 		79. AV. CHARGES 	
80. AW. CHARGES 		81. AX. CHARGES 	
82. AY. CHARGES 		83. AZ. CHARGES 	
84. BA. CHARGES 		85. BB. CHARGES 	
86. BC. CHARGES 		87. BD. CHARGES 	
88. BE. CHARGES 		89. BF. CHARGES 	
90. BG. CHARGES 		91. BH. CHARGES 	
92. BI. CHARGES 		93. BJ. CHARGES 	
94. BK. CHARGES 		95. BL. CHARGES 	
96. BM. CHARGES 		97. BN. CHARGES 	
98. BO. CHARGES 		99. BP. CHARGES 	
99. BQ. CHARGES 		100. BR. CHARGES 	

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Sample UB-04 Claim Form — INFUSION ROOM/CHEMOTHERAPY SER
Single Drug with unique separately payable HCPCS
Drug classification supports assignment of Chemotherapy Administration
HCPCS has "K" status indicator meaning that the drug is separately payable u

1 PATIENT NAME Smith, Jane, D.										2 PATIENT ADDRESS 123 Main Street, Anytown, Anystate 12										3 PATIENT DATE OF BIRTH MM/DD/YY										4 PATIENT SEX F										5 PATIENT AGE MM/DD/YY										6 PATIENT RACE F										7 PATIENT ETHNICITY F										8 PATIENT MARITAL STATUS F										9 PATIENT RELIGION F										10 PATIENT OCCUPATION F										11 PATIENT SOURCE OF REFERRAL F										12 PATIENT REFERRAL DATE MM/DD/YY										13 PATIENT REFERRAL FROM F										14 PATIENT REFERRAL TO F										15 PATIENT REFERRAL TYPE F										16 PATIENT REFERRAL DATE MM/DD/YY										17 PATIENT REFERRAL FROM F										18 PATIENT REFERRAL TO F										19 PATIENT REFERRAL TYPE F										20 PATIENT REFERRAL DATE MM/DD/YY										21 PATIENT REFERRAL FROM F										22 PATIENT REFERRAL TO F										23 PATIENT REFERRAL TYPE F										24 PATIENT REFERRAL DATE MM/DD/YY										25 PATIENT REFERRAL FROM F										26 PATIENT REFERRAL TO F										27 PATIENT REFERRAL TYPE F										28 PATIENT REFERRAL DATE MM/DD/YY										29 PATIENT REFERRAL FROM F										30 PATIENT REFERRAL TO F										31 PATIENT REFERRAL TYPE F										32 PATIENT REFERRAL DATE MM/DD/YY										33 PATIENT REFERRAL FROM F										34 PATIENT REFERRAL TO F										35 PATIENT REFERRAL TYPE F										36 PATIENT REFERRAL DATE MM/DD/YY										37 PATIENT REFERRAL FROM F										38 PATIENT REFERRAL TO F										39 PATIENT REFERRAL TYPE F										40 PATIENT REFERRAL DATE MM/DD/YY										41 PATIENT REFERRAL FROM F										42 PATIENT REFERRAL TO F										43 PATIENT REFERRAL TYPE F										44 PATIENT REFERRAL DATE MM/DD/YY										45 PATIENT REFERRAL FROM F										46 PATIENT REFERRAL TO F										47 PATIENT REFERRAL TYPE F										48 PATIENT REFERRAL DATE MM/DD/YY										49 PATIENT REFERRAL FROM F										50 PATIENT REFERRAL TO F										51 PATIENT REFERRAL TYPE F										52 PATIENT REFERRAL DATE MM/DD/YY										53 PATIENT REFERRAL FROM F										54 PATIENT REFERRAL TO F										55 PATIENT REFERRAL TYPE F										56 PATIENT REFERRAL DATE MM/DD/YY										57 PATIENT REFERRAL FROM F										58 PATIENT REFERRAL TO F										59 PATIENT REFERRAL TYPE F										60 PATIENT REFERRAL DATE MM/DD/YY										61 PATIENT REFERRAL FROM F										62 PATIENT REFERRAL TO F										63 PATIENT REFERRAL TYPE F										64 PATIENT REFERRAL DATE MM/DD/YY										65 PATIENT REFERRAL FROM F										66 PATIENT REFERRAL TO F										67 PATIENT REFERRAL TYPE F										68 PATIENT REFERRAL DATE MM/DD/YY										69 PATIENT REFERRAL FROM F										70 PATIENT REFERRAL TO F										71 PATIENT REFERRAL TYPE F										72 PATIENT REFERRAL DATE MM/DD/YY										73 PATIENT REFERRAL FROM F										74 PATIENT REFERRAL TO F										75 PATIENT REFERRAL TYPE F										76 PATIENT REFERRAL DATE MM/DD/YY										77 PATIENT REFERRAL FROM F										78 PATIENT REFERRAL TO F										79 PATIENT REFERRAL TYPE F										80 PATIENT REFERRAL DATE MM/DD/YY										81 PATIENT REFERRAL FROM F										82 PATIENT REFERRAL TO F										83 PATIENT REFERRAL TYPE F										84 PATIENT REFERRAL DATE MM/DD/YY										85 PATIENT REFERRAL FROM F										86 PATIENT REFERRAL TO F										87 PATIENT REFERRAL TYPE F										88 PATIENT REFERRAL DATE MM/DD/YY										89 PATIENT REFERRAL FROM F										90 PATIENT REFERRAL TO F										91 PATIENT REFERRAL TYPE F										92 PATIENT REFERRAL DATE MM/DD/YY										93 PATIENT REFERRAL FROM F										94 PATIENT REFERRAL TO F										95 PATIENT REFERRAL TYPE F										96 PATIENT REFERRAL DATE MM/DD/YY										97 PATIENT REFERRAL FROM F										98 PATIENT REFERRAL TO F										99 PATIENT REFERRAL TYPE F										100 PATIENT REFERRAL DATE MM/DD/YY									
42 REVENUE CODE 331										43 DESCRIPTION Chemotherapy Injected (Anti-neoplastic hormonal injection)										44 HCPCS / RATE / WIPPS CODE 96402										45 SERVICE DATE MM/DD/YY										46 SERVICE UNITS X										47 TOTAL CHARGES \$\$\$																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
42 REVENUE CODE 636										43 DESCRIPTION Drugs/Detail Code (Epoetin Alfa Non-ESRD, 1000 units)										44 HCPCS / RATE / WIPPS CODE J0885										45 SERVICE DATE MM/DD/YY										46 SERVICE UNITS X										47 TOTAL CHARGES \$\$\$																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					

Column 43 — Description
 • Description of services/products provided.

Column 42 — Revenue Code(s)
 Enter appropriate revenue codes for services provided.

Product Revenue Codes:
 • Enter appropriate revenue code for product administered (Ex. 250- General Pharmacy, 636 - Drugs That Require Detail Coding)

Procedure Revenue Codes:
 • Enter appropriate revenue code for type of service/procedure

Column 44 — Product/Procedure Code(s):
 • Enter the appropriate HCPCS or CPT codes plus modifiers (if applicable) to identify the product/service administered

Column 46 — Service
 • Enter the number of units/service administered

Column 47 — Total Charges
 • Indicate the total charges and payment

CREATION DATE
 51 HEALTH PLAN ID
 52 NPI
 53 NPI
 54 PRIOR PAYMENTS
 55 EXT. AMOUNT DUE
 56 NPI
 57

TOTALS
 58

National Provider Id
 • Enter appropriate NPI (Note: see also Box 57)

Diagnosis Codes (Box 67)
 • Enter appropriate ICD-9-CM diagnosis code corresponding to a particular patient's diagnosis.

XXX.XX

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Medicaid

Low income/Economically poor/Below Poverty Line
Pregnant women
Children up to age of 21 years

Medical Necessity (LCD/NCD)

The term medical necessity relates to whether a procedure or service is considered appropriate in each circumstance. e.g partial amputation of a limb may be medically necessary to eradicate a tumor or severe infection, but it's certainly not medically necessary to treat a splinter.

Local Coverage Determination (LCD)
National Coverage Determination (NCD)
Correct Coding Initiative (CCI Edit)
National Correct Coding Initiative (NCCI Edit)

ABN – Advance Beneficiary Notice

1. Physician has to inform well in advance to the patient about the service.
2. Physician has to take the ABN signature from patient prior to the procedure/service performed.

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A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- ☐ **OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- ☐ **OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- ☐ **OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
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CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 06/30/2023)

Form Approved OMB No. 0938-0566

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Modifier

GA – Patient is Liable

GK – Item/service ordered by physician

GL – Medically unnecessary upgrade; no ABN, no charge

GX – Notice of liability under payer policy, voluntary

GY – Item or service is statutorily excluded or do not meet definition of a Medicare benefit

GZ – Provider is Liable

EY – No Physician or other licensed healthcare provide order for item/service

GA Modifier:

Waiver of Liability Statement Issued as Required by Payer Policy.

- This modifier indicates that an ABN is on file and allows the provider to bill the patient if not covered by Medicare.
- Use of this modifier ensures that upon denial, Medicare will automatically assign the beneficiary liability.

GK

GL

GX Modifier:

Notice of Liability Issued, Voluntary Under Payer Policy.

- Report this modifier only to indicate that a voluntary ABN was issued for services that are not covered.
- Medicare will automatically reject claims that have the –GX modifier applied to any covered charges.
- Modifier –GX can be combined with modifiers –GY and –TS (follow up service) but will be rejected if submitted with the following modifiers: EY, GA, GL, GZ, KB, QL, TQ.

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GY Modifier:

GZ Modifier:

Item or Service Expected to Be Denied as Not Reasonable and Necessary. This modifier should be applied when an ABN may be required but was not obtained.

ADVANCE BENEFICIARY NOTICE (ABN)

The ABN is a standardized form that explains to the patient why Medicare may deny the particular service or procedure. An ABN protect the provider's financial interest by creating a paper trail that CMS requires before a provider can bill the patient for payment if Medicare denies coverage for the stated services or procedure.

ABN should be within \$100 or 25 percent of the actual costs, whichever is greater

ABN modifier

If you use the –GA modifier, you do not need to submit a copy of the signed ABN form with the claim.

GY. Use this modifier to indicate that the item or service you provided is statutorily excluded from coverage or does not meet the definition of any Medicare benefit.

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SOAP

S – Subjective (History)
O – Objective (PE)
A – Assessment (MDM)
P – Plan (MDM)

RBRVS - Resource Based Relative Value Scale

Physician Work – 52%
Practice Expense – 44%
Professional Liability Insurance (PLI) - 4%

HITECH

The Health Insurance Technology for Economic and Clinical Health Act

- Allows the patient to request an audit trail

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FRAUD & ABUSE

What is health care fraud and abuse?

Fraud

To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced.

Examples of Fraud

- Submitting claims for services not provided or used
- Falsifying claims or medical records
- Misrepresenting dates, frequency, duration or description of services rendered
- Billing for services at a higher level than provided or necessary
- Falsifying eligibility
- Failing to disclose coverage under other health insurance

Abuse means actions that are improper, inappropriate, outside acceptable standards of professional conduct or medically unnecessary.

Payment for items or services that are billed by mistake by providers, but should not be paid for by Medicare. This is not the same as fraud.

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Examples of Abuse

- A pattern of waiving cost-shares or deductibles
- Failure to maintain adequate medical or financial records
- A pattern of claims for services not medically necessary
- Refusal to furnish or allow access to medical records
- Improper billing practices

OIG - Office of Inspector General

Compliance

The 7 Elements of a Compliance Program Are as Follows:

1. Implementing written policies, procedures, and standards of conduct.
2. Designating a compliance officer and compliance committee.
3. Conducting effective Training and Education.
4. Developing effective lines of Communication.
5. Conducting internal monitoring and auditing.
6. Enforcing standards through well-publicized disciplinary guidelines.
7. Responding promptly to detected offenses and undertaking corrective action.

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MIPS - Merit based Incentive Payment System

1. Quality (PQRS) 40%
2. Promoting Interoperability (PI) 25%
3. Improvement Activities 15%
4. Cost 20%

1. Quality: Physician Quality Reporting System (PQRS)

The goal of the quality performance category is to assess the value of care to ensure patients get the right care at the right time.

2. PI:

The goal of the promoting interoperability performance category is to promote the secure exchange of health information and the use of certified electronic health record technology (CEHRT) for coordination of care.

3. Improvement Activities

The goal of the Improvement Activities performance category is to promote practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, participation in an APM, health equity, emergency preparedness and response, and integrated behavioural and mental health.

4. Cost

The goal of the Cost performance category is to create efficiencies in Medicare spending. No reporting/data

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submission is required; CMS analyses data from both Part A and Part B claims to calculate the overall cost of patient care.