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**
This includes providers such as: Doctors Clinics Psychologists Dentists Chiropractors Nursing Homes Pharmacies ...but only if they transmit any information in an electronic form in connection with a transaction for which HHS has adopted a standard.	This includes: Health insurance companies HMOs Company health plans Government programs that pay for health care, such as Medicare, Medicaid, and the military and veterans health care programs	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.

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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)

Insurance Company Name
Address
Payer ID

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER			1a. INSURED'S I.D. NUMBER: ABC4444333
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smithwick, John	3. PATIENT'S BIRTH DATE: 03 12 1999 SEX: M		4. INSURED'S NAME: Smithwick, John
5. PATIENT'S ADDRESS (No., Street): 4433 Pub Street	6. PATIENT RELATIONSHIP TO INSURED: Self		7. INSURED'S ADDRESS (No., Street): 4433 Pub Street
CITY: Anycity	STATE: TN	8. RESERVED FOR NUCC USE	CITY: Anycity
ZIP CODE: 33777	TELEPHONE (Include Area Code): (444) 44-4444		ZIP CODE: 33777
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: 12345
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous): NO	a. INSURED'S DATE OF BIRTH: 03 12 1999
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. 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 below.
SIGNED: Signature on file DATE: 9/26/16

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: Signature on file

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0			22. RESUBMISSION CODE ORIGINAL REF. NO.
A. F43.20 B. C. D. E. F. G. H. I. J. K. L.			23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 26 16	09 26 16	11		90837		A	125 00	1			
2											
3											
4											

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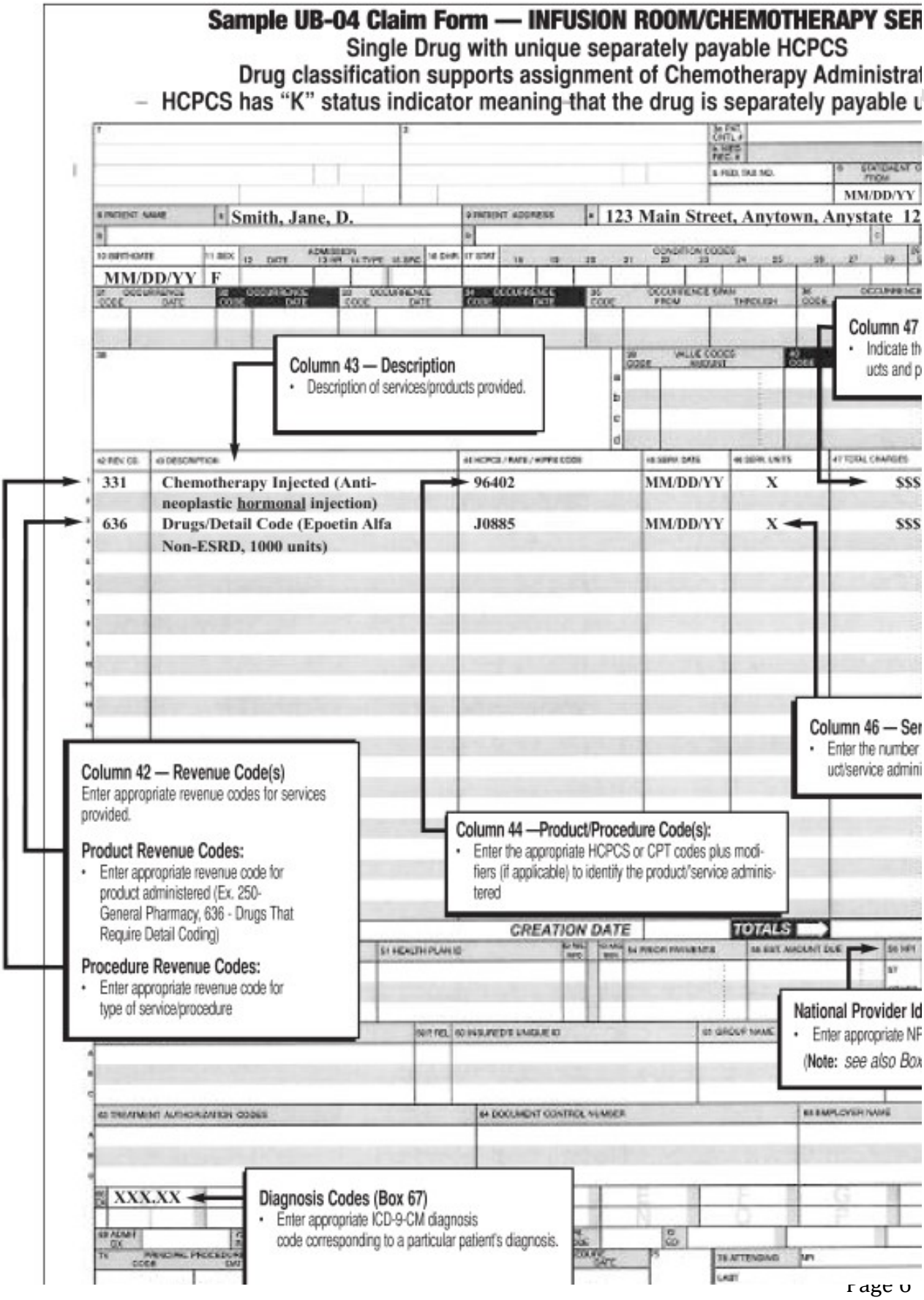

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Medicaid

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.

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:

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.

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.

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.

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

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