



Medicare Critical Access Hospital Astria Health Custom Version

KEY CONCEPTS OUTLINE

Module 1: Revenue Integrity Overview and Resources

- I. It is essential to understand revenue integrity in the context of key functions of the revenue cycle. Revenue cycle functions are often organized into front end, middle, and back end functions.

The following is a general overview of front end, middle and back end revenue cycle functions. Individual hospital processes vary and department names, functions, and interactions can also vary significantly. It's important to learn how your hospital handles these basic revenue cycle functions.

- A. Front end functions include pre-service and time of service processes.
1. Pre-service functions include “credentialing” the provider with the payer (i.e., enrolling), managing referrals and eligibility, managing authorizations and coverage validation, and pre-registration.
 2. Functions at the time of service include registration and demographics collection, creation of account for the encounter or stay, verifying insurance information, and providing required notices to the patient.
 3. Departments who may be involved in front end functions include patient access/patient registration, insurance verification departments, and administrative staff that manage enrollment.
- B. Middle revenue cycle functions include documentation of services, revenue capture and other functions occurring during or shortly after the service delivery.
1. Documentation functions include patient order management, documentation directly into the electronic medical record (EMR) which may include entry of free text or pre-scripted questions or forms, and transcription.
 2. Authorizations for inpatient and emergent services may occur during service delivery by through case management/utilization review, certification and/or authorization and discharge management.

3. At this point, charges are also “capture” for services delivered, the charges are associated with codes through the chargemaster (i.e., “hard coded”) or individually assigned codes (i.e., “soft coded”).
 4. Departments who may be involved in middle revenue cycle processes include patient care staff, case managers/utilization review nurses or physicians, chargemaster personnel (for maintaining the chargemaster) and coding staff, including clinical documentation integrity staff.
- C. Back end functions include the processes required for submission of the claim as well as post submission processes.
1. Claims functions related to submission of the claim include resolution of internal and clearinghouse claim edits and managing special claims processing and billing issues to allow submission of a “clean claim”.
 2. Post submission processes include resolution of external claim edits and follow-up, submission to secondary insurance, posting the payment to the account, verifying the correct payment was made, appealing clinical or billing denials, and even payer contract management.
 3. Departments who may be involved in back end functions include patient accounting, business office, coding staff, denials management staff, administrative staff that manage contracts.
- D. There are “handoff” points between each of these functions that occur in the patient accounting system, in other interfaced systems such as the eligibility checking software, in department information systems such as radiology and pharmacy, in modules within the patient accounting system itself, and finally among staff that perform the functions. Each handoff in the process is an opportunity for error and an opportunity for improvement and potential automation or leverage of people, process, technology, and analytics.
- E. The National Association of Healthcare Revenue Integrity (NAHRI) defines revenue integrity as follows: The basis of revenue integrity is to prevent recurrence of issues that can cause revenue leakage and/or compliance risks through effective, efficient, replicable processes and internal controls across the continuum of patient care, supported by the appropriate documentation and the application of sound financial practices that can withstand audits at any point in time. <https://nahri.org/membership/ethics>

Link: National Association of Healthcare Revenue Integrity (NAHRI) under HCPro Websites

II. Major Types of Insurance

A. Medicare programs (discussed further in the next module)

1. Medicare typically covers individuals 65 and over, disabled patients, and certain end stage renal disease and is a federal benefit program.
2. Part A – Enrollment is required and premium free for those who pay/paid Medicare payroll taxes. Premiums can be paid if payroll taxes were not paid.
3. Part B – Enrollment required with monthly premium payments dependent upon income levels.
4. Medicare Part C—Medicare Advantage requires active enrollment in both Parts A & B. Medicare Advantage plans are offered by private insurance companies and administer the Medicare Part A and B benefits for beneficiaries who choose to enroll in the plan, often through a managed care plan.
5. Medicare Part D—Prescription Drug Program & requires active enrollment & can be included in Part C
6. Medicare supplemental insurance
 - a. Medicare supplemental insurance, or Medigap insurance, is a private health insurance policy designed to fill some gaps in Medicare's coverage. Medigap policies typically pay for patient financial liability expenses for services covered by Medicare, such as deductibles or coinsurance amounts.
 - b. Medigap insurance applies when Medicare is primary. It should not be confused with Medicare Secondary Payer laws and regulations that specify when Medicare is secondary to other insurance.

B. Medicaid and the Children's Health Insurance Program (CHIP)

1. Medicaid benefits generally cover children, the disabled and blind, and low-income individuals.
2. Medicaid and CHIP benefits are provided through a partnership between the state and federal government, with matching funds being provided by the federal government for provision of benefits. Each state has its own benefit plan and structure.
 - a. CHIP is a program that defines minimal Medicaid coverage for children.

(i) All 50 States, DC and US territories have approved CHIP programs and states can design their programs in one of three ways <Medicaid.gov, "CHIP State Program Information" website>

(a) Medicaid expansion (11) states

(b) Separate CHIP programs (2) states

(c) A combination of the Medicaid expansion and separate programs (38) states

3. Medicaid is secondary to Medicare and this situation is often referred to as Medi/Medi. A subset of these "Medi/Medi" patients qualify for low-income assistance and are called Qualified Medicare Beneficiaries (QMB).

a. QMB patients have premium, deductible, and co-insurance liability paid via the QMB program and should not be held financially liable for any of these amounts. <CMS.gov, "Qualified Medicare Beneficiary (QMB Program)" website>

C. Private insurance plans

1. Private insurance plans may be individual or, more commonly, group plans based on membership in a particular group (e.g., an employer, a professional organization, AARP)

a. Employer-sponsored health coverage sometimes referred to as group health coverage, is sponsored by an employer or employee organization (e.g., a union) for a group of employees and may extend to dependents and retirees

b. The Patient Protection and Affordable Care Act, commonly known as the Affordable Care Act (ACA) and colloquially referred to as Obamacare, is a law that allows qualified individuals to purchase insurance through an insurance marketplace or exchange.

c. Some insurance plans are self-funded or self-insured, meaning the costs are borne by the entities providing the plan coverage.

D. Managed care

1. A health maintenance organization (HMO) pays a per member per month amount to a healthcare entity to manage and pay for the care provided to each member. <HealthCare.gov, "Health Maintenance Organization (HMO)" website>

2. A preferred provider organization (PPO) contracts with providers for discounted rates, and providers agree to participate in certain pre-authorization and case management activities. <HealthCare.gov, "Preferred Provider Organization (PPO)" website>
3. An accountable care organization (ACO) is a type of "open" HMO sponsored through the Medicare program to reduce costs. If an ACO achieves cost savings for the Medicare program, the ACO may share in the savings. <CMS.gov, "Accountable Care Organization" website>

E. Health savings accounts (HSA)

1. Individuals with high deductibles under their primary insurance coverage can set up an HSA to pay for certain medical expenses and deductibles under their primary plan
 - a. A HSA is a savings account that allows the patient to put aside money for qualified medical expenses that insurance doesn't cover, like deductibles, coinsurance, copayments or adult dental expenses, and glasses or contacts.
 - b. Compared to Flexible Spending Arrangements (FSA), an HSA is not "use it or lose it." Instead, it's a real savings account, and the funds can earn interest and follow the person throughout their lifetime through job changes or other life events.
2. HSAs are generally not helpful or needed when an individual is covered by more than one medical insurance <IRS.gov, "Publication 969" website>

F. Worker's compensation

1. Workers' compensation insurance is designed to compensate workers for injuries received on the job and is generally limited to coverage of specific job-related injuries.
2. Worker's compensation insurance may be offered through a state fund or through a private insurance company depending on the state.

G. Liability insurance

- a. Liability insurance is often primary to other kinds of insurance such as Medicare, although often the health insurance will pay the claim and seek reimbursement from the liability insurance, referred to as subrogation.

- b. General liability or umbrella policies provide coverage for accidents and injuries where another party may be liable; they frequently involve business or premises liability (e.g., a fall at a store)
 - c. Motor vehicle accident (MVA) insurance provides coverage for injuries from motor vehicle accidents
 - d. Non-MVA insurance policies provide coverage in other special situations (e.g., homeowners' insurance coverage for a fall)
 - e. No-fault insurance or personal injury protection insurance is designed to pay if the insured has a loss, regardless of who's at fault
- H. Other coverage and terms
- 1. Cross-over
 - a. The process where a primary insurance adjudicates the claims, pays according to their plan and forwards the claim information to a secondary insurance who may process the claim for additional payment for services not covered under the primary insurance or the patient's deductible or coinsurance.
 - b. Medicare/Medicaid or "Medi-Medi" cross-overs
 - (i) When a Medicare patient has Medicaid, Medicare, as the primary payer, will adjudicate the claim and forward the claim information to the Medicaid.
 - 2. COBRA
 - a. The Consolidated Omnibus Budget Reconciliation Act, generally known as COBRA, is a law that allows people with group health coverage to continue that health coverage for a period of time after they are no longer qualified for it—for example if a person receiving insurance through an employer is fired or changes jobs. <Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA); CMS.gov, "COBRA" website>

III. Key Concepts for Healthcare Insurance and Revenue Integrity

- A. Revenue integrity requires the provider determine if the patient is eligible for insurance and what type, the service to be delivered is covered under the patient's insurance plan, and how the service will be paid under the patient's insurance plan.

B. Eligibility

1. Eligibility generally requires:
 - a. Premiums have been paid by the beneficiary or someone on their behalf;
 - b. The beneficiary has been enrolled in the plan; and
 - c. The insurer acknowledges the beneficiary as enrolled under their plan product.
2. Typically, an individual enrolls in insurance in the fall, with a change in plans effective January 1 for the entire calendar year.
 - a. Employer-sponsored plans may follow their fiscal year cycle.
 - b. Major life events (e.g., new employment, marital change, birth, or adoption) may cause mid-year changes to eligibility.
3. Patients may be eligible under more than one insurance plan.
 - a. Their employer-sponsored plan;
 - b. Their spouse's employer-sponsored plan;
 - c. Their parents' employer-sponsored plan;
 - d. Worker's compensation insurance;
 - e. Government sponsored plan (e.g., Medicare); or
 - f. Individually purchased plan.
4. Patients may also be covered by liability insurance (e.g., third party, motor vehicle) for specific events, which may take precedence over other insurance for services related to those specific events.
5. Part of the eligibility process includes determining the order (priority) in which multiple insurances are responsible for paying for services rendered. This process is sometimes referred to as coordination of benefits (COB).

C. Coverage

1. After establishing eligibility, the provider must verify the particular service being delivered is covered under the patient's insurance plan.
2. Covered benefits are items or services for which a plan will provide insurance, generally in the form of payment, sometimes with cost sharing by the patient.

- a. Covered benefits may be reimbursed differently if the provider of service has not contracted with the plan (i.e., is out-of-network).
 - b. Covered benefits often vary among the plans offered by an insurer.
 - c. Increasingly, covered benefits vary based upon the site of care. For example, advanced imaging tests may not be covered for outpatients if a freestanding in-network imaging centers exists in the beneficiary's geographic area. Likewise, a surgical procedure may not be covered at a hospital if a freestanding in-network ambulatory surgical center exists in the beneficiary's geographic area.
3. Covered benefits are generally divided between inpatient services provided by facilities (i.e., hospitalization insurance) and benefits for medical services, which include physician professional services and other outpatient services.
 - a. Insurers often have different claims processing systems and define covered benefits differently depending upon whether services are facility or professional services.
4. Medical Necessity
 - a. Most insurance plans will require items or services, that would otherwise be covered benefits, to also be medically necessary.
 - b. Insurers define medical necessity differently, although generally they include some concept of the service being reasonable and necessary to treat the patient or the services are based on evidence-based clinical standards of care.
 - (i) Insurers often publish policies and other guidance describing their requirements for medical necessity both generally and for particular services, including particular documentation requirements or diagnostic information.
 - (ii) Medicare refers to these policies as National Coverage Determinations and Local Coverage Determinations, discussed in a further detail in a later module.
5. Preventative Services
 - a. Generally, preventative services are not considered "medically necessary" because they do not address an illness or injury of the patient. Nevertheless, most plans provide some coverage for preventative services and specifically enumerate coverage for these services in their benefit plans, often without patient cost-sharing.

6. Experimental or Investigational Items or Services

- a. Insurers may not consider experimental or investigational items or services “medically necessary” or covered because there may not be sufficient evidence to prove they provide a medical benefit or improved outcomes for the patient.

7. Excluded Benefits

- a. Most insurance plans will exclude certain services from coverage, even if the service may otherwise be considered generally medically necessary by the patient’s physician. Examples include:
 - (i) Experimental or investigational services;
 - (ii) Services they consider not usual and customary, not evidence based or not meeting generally accepted standards of medical practice;
 - (iii) Workplace injuries;
 - (iv) Dental or vision care; or
 - (v) Adverse events, such as hospital acquired conditions and “never events”.
 - (a) Note that these may be covered under a provider’s own general liability insurance.

8. Prior Authorization

- a. Prior authorization is the process of seeking an affirmative determination of coverage prior to service delivery; however, insurers reserve the right to confirm all required elements of coverage are present and documented after service delivery even when prior authorization is obtained. Therefore, prior authorization is not a guarantee of coverage.
- b. Fee-for-service Medicare has limited prior authorization programs:
 - (a) DME items such as power mobility devices
 - (b) Demonstration for hyperbaric wound therapy
 - (c) Non-emergency scheduled ambulance transports
 - (d) Selected outpatient hospital surgical services in OPSS hospital departments.

D. Payment

1. Payment methodologies can vary significantly depending on the payer and the contractual terms of the contract between the provider and payer.
2. Common Payment System Methodologies
 - a. Fee schedule vs. prospective payment systems
 - (i) Fee schedule payment systems typically have a list of payment rates (fee schedule) for particular services. Generally, each coded and billed service will be paid the lesser of the provider's charge or the fee schedule amount.
 - (ii) Prospective payment systems establish payments based on the average cost for a group of services. The payment amount is generally triggered by the codes submitted by the provider and does not vary based on the type of service provided within the group or the cost or charges of the provider.
 - b. Case rates
 - (i) Case rates make a single payment for an entire case or inpatient stay and are generally based on prospective payment systems, although they may also be fee schedule based.
 - (a) Examples of case rates include the Medicare Severity Diagnosis Related Group (MS-DRG) system for inpatient hospital claims, and the All Patient Refined DRG (APR-DRG) system developed by 3M™.
 - (b) About three-quarters of state Medicaid programs use DRGs, as do many commercial payers. Half of Medicaid programs use All Patient Refined Diagnosis Related Groups (APR-DRG), rather than Medicare DRGs, because APR-DRGs are much more appropriate for neonatal, pediatric, and obstetric care.
 - (ii) Diagnosis and/or procedure case rates
 - (a) Other payers may develop case rates based on their claims experience that deviate from traditional MS-DRG groupings but are based on specific diagnosis and/or procedure codes and perhaps the presence of trauma, transplant, birth, ICU, or other revenue-code-based criteria.
 - (iii) Case rate systems may include additional payments for excessively high costs for individual cases, referred to as stop-loss or outlier, and

may make separate payment for certain high cost drugs, implants or other high cost items and services in addition to the case rate.

c. Per diem

- (i) Per diem rates are a negotiated payment for each day of inpatient care. Per diem reimbursement is the payment of a fixed amount per inpatient day, although the amount may vary based on the length of stay (e.g., the first day is paid more than day 2-4 of a stay).
- (ii) Per diem rates can be by level of care (e.g., medical/surgical, intensive care, NICU, etc. identified by revenue code).
- (iii) Ancillary services may be included in the per diem rate or may be paid separately based on revenue code and other established payment system.
- (iv) Per diem systems may include additional payments for excessively high costs for individual cases, referred to as stop-loss or outlier, and may make separate payment for certain high cost drugs, implants or other high cost items and services in addition to the per diem payments.

d. Percent of charges

- (i) A contract may call for payment of a percent of the charges submitted by the provider, although this payment system is rare today due to concerns by insurance regarding inflated charges and concerns by hospital regarding denial of appropriate charges.

e. Cost-based reimbursement

- (i) Cost reimbursement is applicable to some Medicare providers such as Critical Access Hospitals (CAHs) and generally pays an interim amount at the time of service based on historic cost data and then settles up the true costs of the provider through a cost reporting process. CAH cost based payment will be discussed in detail in a later module.

IV. Healthcare Providers, Facilities, Practitioners, and Suppliers

A. Institutional or facility providers

1. Medicare defines “providers” to include institutional providers such as hospitals, critical access hospitals (CAH), skilled nursing facilities (SNF), home health agencies (HHA), hospices, rehabilitation agencies (outpatient physical and speech therapy), comprehensive outpatient rehabilitation facilities, community mental health centers, and religious non-medical healthcare institutions
 - a. Note that the term provider is often also colloquially used to refer to physician and other non-physician practitioners who can provide professional services similar to a physician.
 - b. A provider may maintain multiple location where they provide inpatient or outpatient services.
 - (i) Medicare refers to outpatient departments of providers as “provider-based departments”. Provider-based departments can provide therapeutic or diagnostic services, subject to coverage requirements discussed in a later module.
 - (ii) Requirements for provider-based departments are found at 42 *C.F.R.* 413.65 and requires clinical, financial, and administrative integration with the main provider.
 - c. Critical Access Hospitals (CAHs) are specially designated hospitals under the Medicare program located in rural areas more than 35 miles from another hospital. They are limited to 25 beds and their length of inpatient stay must generally average no more than 96 hours.
 - (i) The CAH designation allows the hospital to be paid 101% of it’s costs from Medicare rather than be paid under the Medicare prospective payment systems which generally pay the hospital less than their costs for delivering services to Medicare patients.
2. Enrollment with Medicare
 - a. Providers apply for Medicare enrollment by completing Form CMS-855A.
 - b. Each physical address where services are rendered to patients by the hospital must be included in the 855A enrollment, including mobile facilities and portable units. <855A Enrollment Form, Section 4, Practice Location>

- c. The enrolled provider does not have to be a separate legal entity, but rather may be a subpart (i.e., part of an enrolled provider that is a legal entity) or distinct part.
 - d. Most providers are surveyed and certified by the state prior to being approved as Medicare providers, as discussed below and, each entity that is surveyed and certified by a state is separately enrolled in Medicare and considered a Medicare provider.
 - e. Enrolled providers are required to enter into an agreement to participate in Medicare.
 - f. Providers are assigned a CMS Certification Number (CCN) to identify themselves in Medicare claims and other transactions, including Medicare cost reports for providers that are required to file them.
3. Survey and certification
- a. The Social Security Act requires that providers meet minimum health and safety standards in order to participate in the Medicare and Medicaid programs.
 - b. The health and safety standards are specified in the Medicare *Conditions of Participation (CoPs)*.
 - (i) There are individual *CoPs* for different provider types, including hospitals, CAHs, SNFs, HHAs, and hospices.
 - (ii) CMS publishes the *CoPs*, along with Interpretive Guidelines for definition or explanation of the relevant standards, and Survey Procedures for enforcement, in an appendix to the *State Operations Manual*.
 - (iii) The provider must obtain certification that it meets the standards in the *CoPs* through a State Survey Agency or a private accrediting organization that CMS has approved.
 - (a) State Survey Agency ascertains, through a survey conducted by qualified health professionals, whether and how each standard is met and if a standard is not met the State Survey Agency will make a finding of deficiency and require a plan of correction.
 - (b) In lieu of being surveyed by a State Survey Agency, a provider may be accredited by a national accrediting organization (e.g., The Joint Commission, DNV Healthcare) that has been approved by CMS.

1. If the provider meets the requirements of an approved accrediting organization, the provider is deemed to meet the *CoPs* without having a separate state survey to confirm compliance

(iv) The *CoPs* are not conditions for payment and non-compliance generally does not prevent payment for otherwise covered services that meet all conditions of payment.

B. Suppliers

1. Suppliers include rural health centers, federally qualified health centers, laboratories, independent diagnostic testing facilities, portable x-ray suppliers, ambulatory surgery centers, and durable medical equipment companies that provide supplies, diagnostic testing, or therapy rather than sustained patient care
2. Suppliers are generally considered businesses under most state laws, but some suppliers must meet licensure requirements in addition to the licensure of the individual practitioners providing services through the supplier

C. Individual practitioners

1. Individual practitioners are licensed health professionals operating under their respective state scope of practice. For Medicare purposes, individual practitioners fall under the Supplier regulations.
2. Licensure
 - a. Licensure ensures a minimum degree of competency for protection of public health, safety, and/or welfare and requires licensees to meet eligibility requirements, including any or all of the following:
 - (i) Completing degree requirements or graduating from a certification program
 - (ii) Meeting certification requirements of a national organization
 - (iii) Undergoing a specified amount of training or practical experience
 - (iv) Passing a written or practical exam
 - (v) Ongoing continuing education requirements

- b. Typically, licensure is granted at the individual state level, meaning that if a supplier practices in multiple states, that individual must be licensed in each of those states
 - c. Some states may have reciprocity agreements in which each state recognizes the license granted by the other state, allowing individuals to practice in both states without having to meet additional testing and qualification requirements
3. Scope of practice
- a. A scope of practice describes the scope of procedures or services practitioners are permitted to perform under their professional license issued by the jurisdiction in which they practice.
 - b. Each state may decide the scope of practice, education requirements, experience requirements, and competencies for individuals licensed under its laws and practicing within its jurisdiction.
4. Privileging and credentialing
- a. Individual practitioners practicing within an institutional provider generally must also meet the requirements set out by that institution for providing services within the institution, which may entail licensure, education, or experience criteria. This process is generally called privileging or credentialing.
 - b. Privileging of providers may allow them to admit patients or to order or provide specific services within the hospital and its departments.
 - c. The unified and integrated medical staff of the facility must have bylaws, rules, and requirements that describe the facility's process for credentialing and privileging, as well as oversight and peer review.
 - (i) Generally, all physicians and practitioners granted privileges are also appointed as members of the medical staff.

D. Supplier, including Individual Practitioner, Enrollment

- 1. Suppliers apply for Medicare enrollment by completing Form CMS-855A or CMS-855B, depending on the supplier type.
- 2. The enrolled supplier does not have to be a separate legal entity, but rather may be a subpart (i.e., part of an enrolled provider or certified supplier that is a legal entity).

3. Certified suppliers are typically surveyed and certified by the states prior to being approved for enrollment as Medicare certified suppliers.
 - a. For CLIA labs, each practice location at which lab tests are performed must obtain a separate CLIA certificate, with some exceptions
4. Certified suppliers are required to enter into an agreement to participate in Medicare.
5. Certified suppliers are assigned CCNs for purposes of identification within Medicare processes.

E. Participation agreements

1. Among other provisions, a participation agreement requires that the provider or supplier accept the Medicare allowable as payment in full; the provider or supplier also must not balance bill the beneficiary or an entity on behalf of a beneficiary (e.g., secondary insurance) more than the defined cost sharing for services (e.g., deductible, coinsurance, copayment).
 - a. Provider participation agreements are entered when applying for a CCN.
2. Suppliers may be participating (i.e., they signed a provider agreement with Medicare) or non-participating (i.e., they did not sign a provider agreement).

F. Assignment

1. Assignment refers to beneficiaries assigning their benefits to a provider of service, allowing the provider to collect benefits under a beneficiary's insurance on the beneficiary's behalf.
 - a. An assignment agreement between a physician and an enrollee transfers the enrollee's benefits to the physician based on covered services specified on the assigned claim,
 - b. When a physician accepts assignment of an enrollee's claim, the physician agrees to accept the approved charge determination by the contractor as the full charge for the item or service and may not charge the enrollee more than the deductible and coinsurance.

G. Re-Assignment

1. Re-assignment refers to suppliers re-assigning their right to payment to a specific entity, such as an employer. Suppliers must complete an 855R enrollment form for re-assignment.

- a. When a qualified entity accepts assignment for a service furnished by the physician, that entity agrees to collect no more than the Medicare deductible and coinsurance from the beneficiary. The entity is bound by the terms of the enrollee's assignment.
 - (i) The physician may accept from the entity a set fee or other payment that is greater than the reasonable charge without violating the terms of the assignment.
- b. Practitioners who reassign their payment rights to hospitals are still required to meet coverage and payment requirements for their professional services.

Version 02/27/2023
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