CRCS Exam Study Manual
Update for 2018

This document reflects updates made to the instructional content from the *Certified Revenue Cycle Specialist (CRCS-I, CRCS-P) Exam Study Manual - 2017* to the 2018 version of the manual. This does not include updates to Knowledge Checks and Answers, examples, or the Glossary.

Table of Contents

Note: Unless otherwise stated, information in yellow below has been inserted and information struck through has been deleted.

Edit(s) to page 2-5: Patient Rights

The Patient Bill of Rights was developed by the American Medical Association in 1975. The American Hospital Association (AHA) changed The Patient Bill of Rights to the Patient Care Partnership in 2012. The goals of the ~~Patient Bill of Rights~~ Patient Care Partnership are:

Edit(s) to page 2-18: Laboratory Licensing

A state can become exempt from CLIA status if its legal requirements are equal to or more stringent than CLIA's statutory and regulatory requirements. Presently only two states are exempt or partially exempt: New York and Washington.

Edit(s) to page 2-19: Other Areas Addressed by HIPAA

- Enforcement responsibility of States and Secretary of ~~D~~HHS.
- Establishments of Health Savings Accounts HSAs ~~(formerly known as Medical Savings Accounts, or MSAs)~~.

New chapter name on page 3-1: Patient Access Services

Patient Access Services/Front Office

Edit(s) to page 3-3: Pre-registration and Pre-admission Testing

A good pre-registration system will become the cornerstone of a successful collection process. It is recommended that ~~between 70% and 90%~~ 98% of all scheduled admissions be pre-registered within 24 hours of the service date. The following are gathered during this process:

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This is also the time that pre-admission testing (PAT) can be accomplished. This is the diagnostic medical testing ~~screening~~ of patients in advance of surgical or invasive procedures to determine hospitalization and/or surgical suitability.

New topic on page 3-8: Functions of the Front Office in a Clinic/Physician Office

Note: This topic is flagged with a "P" icon because it applies only to the CRCS-P exam.

Functions of the Front Office in a Clinic/Physician Office

The Front Office is where patient scheduling and registration usually happen. The Front Office is often the first department to have contact with a patient and thus sets the tone for the patient's experience. The department has many responsibilities including creating a permanent patient medical record, ensuring the accuracy of the patient account record, and collecting the necessary information to produce a clean claim. Front Office personnel are critical to the physician office — from billing to collections to quality patient care. Without effective Front Office policies, the revenue cycle will fail.

When there is an insurance copayment or deductible, the patient can be reminded to bring it on the day of service. When there is no insurance or when benefits are poor, the patient can be assisted in applying for charity, if available, or in understanding acceptable payment terms.

Edit(s) to page 3-8: Case Management/Utilization Review

As we move forward through the maze of healthcare coverage and usage, the Case Management and/or Utilization Review (UR) areas have assumed an essential role. Close collaboration among Case Management/UR nurses, Patient Access, and the Patient Financial Services areas ~~has developed rapidly over the past 15 years~~ is essential. The specialized Case Management/UR practitioners play critical roles during registration and the patient's stay. Consider the following tasks assumed by this area:

Edit(s) to page 3-17: Levels of Patient Care

~~*NOTE:* If a physician classifies an admission as an emergency, the hospital is obligated to admit the patient, and he or she then is considered an inpatient.~~

Edit(s) to page 3-23: Billing with an ABN

Modifiers for Billing with an ABN		
Modifier	**Description**	**When Used**
GA	Waiver of liability statement issued as required by payer	Report when you issue a mandatory ABN for a service as required. Do not submit a copy of the ABN, but it must be kept on file. Patient will be billed for services.
GX	Notice of liability issued	Report when you issue a voluntary ABN for a service Medicare never covers because it is statutorily excluded or is not a Medicare benefit. This modifier may be used in combination with the GY modifier.
GY	Item or service statutorily excluded, does not meet the definition of any Medicare benefit	Report to obtain a denial of service that provider knows is excluded from coverage. This modifier may be used in combination with the GX modifier.
GZ	Item or service expected to be denied as not reasonable and necessary	Report GZ when an ABN should have been obtained but was not. Services billed with a GZ modifier and denied by Medicare may not be billed to the beneficiary. ~~Report when you expect Medicare to deny payment of the item or service due to lack of medical necessity and no ABN was issued.~~

Edit(s) to pages 3-24 and 3-25: Sample Form

A sample ABN appears on the following page. Specific elements of an ABN are:

- Blank A: Provider/notifier name, address, and telephone number at the top of the notice
- Blank B: Patient name and date of service
- Blank C: Identification number (optional); this number helps link the notice with a related claim
- Blank D: A complete description of the test or tests that are not covered for the diagnosis (i.e., specific item/service/test/procedure/ equipment, etc.)
- Blank E: The reason(s) that denial is likely; why provider believes the services in Blank D will not be covered by Medicare (e.g., “Medicare does not pay for this test for your condition”)
- Blank F: Estimated cost provided by notifier to ensure beneficiary has all available information to make an informed decision about whether to obtain potentially noncovered services; notifiers must make a good faith effort to insert a reasonable estimate for all items or services under Blank D
- Blank G: Beneficiary’s decision about whether to obtain potentially noncovered services; the beneficiary or his representative must choose only one of the three options; under no circumstances can the notifier/provider decide for the beneficiary which of the three boxes to select

- Blank H: Additional information; notifiers may use this space to provide additional clarification
- Blank I: Beneficiary or representative signature
- Blank J: Date that the beneficiary or representative signs the ABN
- Disclosure Statement: Must be in the footer of the notice and is required to be included on the document

- ~~Patient name, Medicare Health Insurance Claim Number (HICN), and date of service~~
- ~~A complete description of the test or tests that are not covered for the diagnosis~~
- ~~The diagnosis from the ordering physician that is the cause for the denial~~
- ~~A statement that the physician, or the laboratory, believes that Medicare is likely to deny payment for the specified test(s) as indicated~~
- ~~The reason(s) that denial is likely~~
- ~~A statement that the patient will be responsible for the charges if Medicare denies payment~~
- ~~The estimated amount of the patient's liability~~
- ~~An area for the patient to sign and date acknowledging he or she understands and agrees to pay for the tests if they are deemed non-covered by the Medicare program when the claim is adjudicated~~

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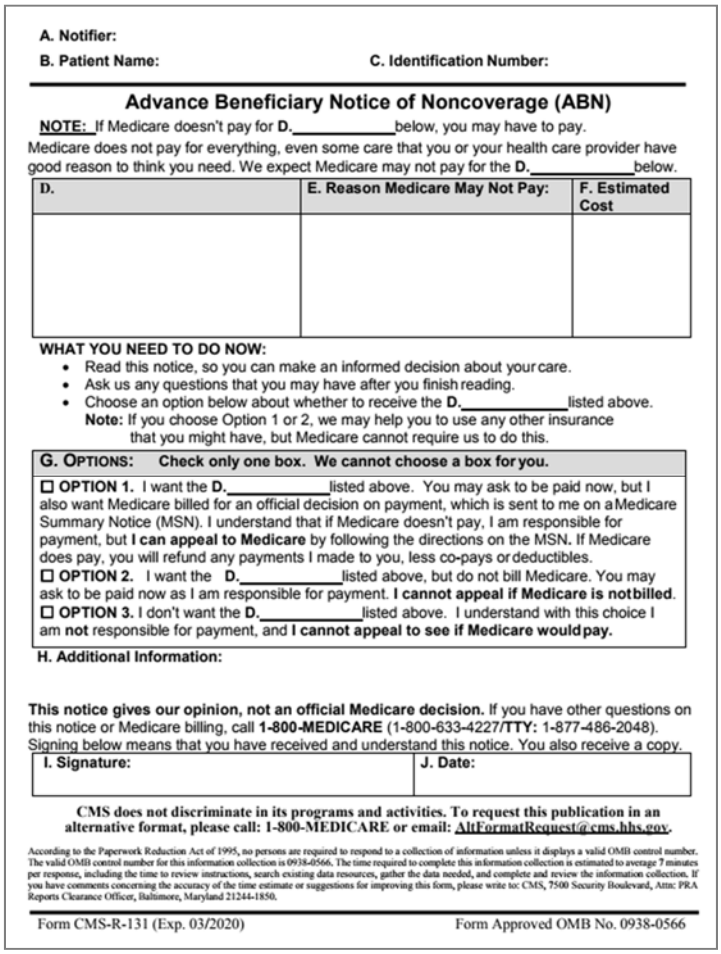

A. Notifier:

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:

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. 03/2020) Form Approved OMB No. 0938-0566

Edit(s) to page 3-27: MSP Questionnaire

- Providers contracted with Medicare Advantage plans should check the provisions of the individual contracts to see if MSPQs are required.
- ~~Beneficiaries who have a Medicare Advantage Plan do not have to complete the MSPQ.~~

Edit(s) to pages 4-3 and 4-4: Part A Deductibles, Coinsurance, and Copayments

Medicare Part A		
Service	**Beneficiary Obligation**	**2018 Amount**
Hospital stay – Semi-private room, meals, general nursing, other hospital services, and supplies. This includes care in critical access hospitals. This does not include private duty nursing or a television or telephone in the room. It also does not include a private room, unless medically necessary. Inpatient mental healthcare in an independent psychiatric facility is limited to 190 days in a lifetime.	Days 1 through 60*: ▪ Part A current year inpatient deductible *Renewable during the next benefit period	$1,340 ~~1,316~~ per spell of illness
	Days 61 through 90*: ▪ Part A coinsurance (1/4 or 25% of current year inpatient deductible) *Renewable during the next benefit period	$335 ~~329~~ per day
	Days 91 through 150*: ▪ Part A lifetime reserve (LTR, 1/2 or 50% of current year inpatient deductible) *Nonrenewable; hospitals alert patients when they have 5 days of coinsurance left so they can choose whether to use LTR	$670 ~~658~~ per day
SNF care – Semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a three-day hospital stay).	Days 1 through 20: ▪ No deductible or coinsurance	$0 per benefit period
	Days 21 through 100: ▪ 1/8 of current year inpatient deductible	$167.50 ~~164.50~~ per day

Edit(s) to page 4-5: Part B Deductibles, Coinsurance, and Copayments

Medicare Part B		
Service	**Beneficiary Obligation**	**2018 Amount**
Medical and other services – Doctors services (except for routine physical exams); outpatient medical and surgical services; supplies; diagnostic	Medical and other services: ▪ Current year deductible, then coinsurance (20% of Medicare-approved amount, except in the outpatient setting)	$183 per year, then 20% of Medicare-approved amount

Medicare Part B		
Service	**Beneficiary Obligation**	**2018 Amount**
tests; ambulatory surgery center facility fees for approved procedures; and DME. Also covers second surgical opinions; outpatient physical, occupational, and speech therapy; and outpatient mental healthcare.	Outpatient physical, occupational, and speech-language therapy services: ▪ Coinsurance	20% of Medicare-approved amount
	Outpatient mental healthcare: ▪ Coinsurance	20% of Medicare-approved amount

Edit(s) to pages 4-6 thru 4-11: Part B Preventive Services

Note: The table has been reorganized into alphabetical order by the Service column and has been expanded and updated. The entire new table appears below. Specific edits are note flagged.

Medicare Part B – Covered Preventive Services		
Service	**Who Is Covered**	**Beneficiary Obligation in the Original Medicare Plan**
Annual wellness visit (AWV) – Initial visit for AWV once in a lifetime; subsequent visits allowed annually.	All Medicare beneficiaries who are more than 12 months after the effective date of their Medicare Part B coverage and who also have not received an IPPE or AWV within 12 months	Copayment, coinsurance, and deductible waived
Bone mass measurements – Varies with health status; covered once every 24 months or more often if determined to be medically necessary.	Certain beneficiaries at risk for losing bone mass or developing osteoporosis	Copayment, coinsurance, and deductible waived
Cardiovascular disease screening (lipid panel, cholesterol, lipoprotein, and triglycerides) – Once every 5 years.	All asymptomatic Medicare beneficiaries	Copayment, coinsurance, and deductible waived

Medicare Part B – Covered Preventive Services		
Service	**Who Is Covered**	**Beneficiary Obligation in the Original Medicare Plan**
Colorectal cancer screening – Fecal occult blood test (FOBT): once every 12 months; flexible sigmoidoscopy: once every 4 years or once every 10 years after having a screening colonoscopy; screening colonoscopy: once every 24 months if at high risk for colon cancer or once every 10 years if not at risk; barium enema: once every 24 months if at high risk or once every 4 years if not at high risk.	Beneficiaries age 50 and older (However, there is no age limit for having a colonoscopy.)	FOBT, flexible sigmoidoscopy, colonoscopy - Copayment, coinsurance, and deductible waived Barium enema - Coinsurance applies; deductible waived Multitarget stool DNA test - if polyp found and removed, 20% copayment applies
Diabetes screening test – Coverage for glucose monitors, test strips, and lancets; diabetes self-management training; 2 screening tests per year for beneficiaries diagnosed with pre-diabetes or 1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested.	Beneficiaries who have certain risk factors for diabetes or who have been diagnosed with pre-diabetes (Beneficiaries previously diagnosed with diabetes are not eligible for this benefit.)	Copayment, coinsurance, and deductible waived
Diabetes Self-Management Training (DSMT) – Up to 10 hours of initial training within a 12-month period. In subsequent years, up to 2 hours of follow-up training are allowed each year.	Beneficiaries who have been diagnosed with diabetes, or who have previously been diagnosed with diabetes	Copayment, coinsurance, and deductible apply
Glaucoma screening – Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in the beneficiary's state of residence.	Beneficiaries at high risk of glaucoma, including people with diabetes or a family history of glaucoma; African-Americans who are age 50 and older; and Hispanic-Americans age 65 and older	Copayment, coinsurance, and deductible apply
Hepatitis B (HBV) vaccine and administration - Scheduled dosages, as required.	Beneficiaries who are at intermediate or high risk for contracting Hep B (but beneficiaries who are currently positive for antibodies for Hep B are not eligible for this benefit)	Copayment, coinsurance, and deductible waived

Medicare Part B – Covered Preventive Services		
Service	**Who Is Covered**	**Beneficiary Obligation in the Original Medicare Plan**
Hepatitis C Virus (HCV) screening – Annually for high-risk beneficiaries with continued illicit drug use with injection, or who had a blood transfusion before 1992. Once in a lifetime if born between 1945 and 1965 and not at high risk.	Beneficiaries who are at high risk for HCV infection or who were born between 1945 and 1965	Copayment, coinsurance, and deductible waived
Human immunodeficiency virus (HIV) screening – Annually for high-risk cases and three times per pregnancy (one screening per trimester) for those beneficiaries who are pregnant.	Beneficiaries who are at an increased risk for HIV, who may be pregnant, or who are between ages 15-65 and ask for the test	Copayment, coinsurance, and deductible waived
Initial preventive physical examination (IPPE, the "Welcome to Medicare Physical Exam") - Once in a lifetime.	All new Medicare beneficiaries who are within the first 12 months of their first Medicare Part B coverage period	IPPE: ▪ Copayment and coinsurance apply; deductible waived IPPE with EKG: ▪ Copayment, coinsurance, and deductible apply
Intensive behavioral therapy (IBT) for cardiovascular disease (CVD) - One CVD risk reduction visit annually.	All Medicare beneficiaries who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting	Copayment, coinsurance, and deductible waived
Intensive behavioral therapy for obesity - Annually for all beneficiaries; frequency of coverage includes one visit every week for month 1; one visit every other week for months 2-6; and one visit every month for months 7-12.	Beneficiaries with a BMI≥30 kg/m^2, who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting	Copayment, coinsurance, and deductible waived

Medicare Part B – Covered Preventive Services		
Service	**Who Is Covered**	**Beneficiary Obligation in the Original Medicare Plan**
Lung cancer screening - Annually for beneficiaries between ages 55-77.	Beneficiaries who show no signs or symptoms of lung cancer and who have a history of smoking at least 30 pack-years (one pack-year is equal to smoking one pack per day for one year; one pack equals 20 cigarettes); who are current smokers; or who have quit smoking within the past 15 years. There also must be a written order for the service that meets specific criteria established by CMS.	Coinsurance and deductible waived if all criteria are met, there is a written order, and the physician accepts assignment
Mammogram, screening – One baseline screening for females between age 35 through 39, then once every 12 months for females over age 40. Reminder: If screening and diagnostic mammograms are billed on the same day, a modifier –GG should be used to show a screening mammogram was turned into a diagnostic mammogram at the time of service.	Female beneficiaries age 35 and older	Copayment, coinsurance, and deductible waived
Mammogram, diagnostic Reminder: If screening and diagnostic mammograms are billed on the same day, a modifier –GG should be used to show a screening mammogram was turned into a diagnostic mammogram at the time of service.	Female beneficiaries, when the service is medically necessary	Coinsurance and deductible may apply
Medical nutrition therapy (MNT) – First year: 3 hours of one-on-one counseling; subsequent years: 2 hours of one-on-one counseling.	Beneficiaries diagnosed with diabetes or a renal disease or who have received a kidney transplant within the last 3 years	Copayment, coinsurance, and deductible waived Note: If the patient is receiving dialysis in a dialysis facility, Medicare will cover MNT as part of the overall dialysis care.

Medicare Part B – Covered Preventive Services		
Service	**Who Is Covered**	**Beneficiary Obligation in the Original Medicare Plan**
Pap smear and pelvic examination (including a clinical breast exam) – Once every 24 months or once every 12 months if at risk for cervical or vaginal cancer or of childbearing age with an abnormal Pap smear in the preceding 36 months.	Female beneficiaries	Copayment, coinsurance, and deductible waived
Prostate cancer screening – Digital rectal examination: once every 12 months; prostate-specific antigen (PSA) test: once every 12 months.	Male beneficiaries age 50 and older (beginning the day after the 50th birthday)	Digital rectal exam - Copayment, coinsurance, and deductible apply PSA test - Copayment, coinsurance, and deductible waived
Screening and behavioral counseling to reduce alcohol misuse - Annually for all beneficiaries; face-to-face counseling up to four times per year for those who screen positive up to four times per year.	All Medicare beneficiaries Medicare beneficiaries who screen positive are eligible for counseling if: • They are competent and alert at the time that counseling is provided and, • Counseling is furnished by qualified physicians in a primary care setting.	Copayment, coinsurance, and deductible waived
Screening for cervical cancer with human papillomavirus (HPV) tests – Once every five years.	All asymptomatic female Medicare beneficiaries aged 30 to 65 years	Copayment, coinsurance, and deductible waived
Screening for depression - Annually for all beneficiaries.	All Medicare beneficiaries	Copayment, coinsurance, and deductible waived
Sexually transmitted infection (STI) screenings and high intensity behavioral counseling to prevent STIs - Annually for all beneficiaries; frequency of coverage depends on the type of STIs being treated.	Adolescent and adult beneficiaries who are sexually active and are at an increased risk for STIs	Copayment, coinsurance, and deductible waived Behavioral counseling sessions conducted in an inpatient setting will not be covered as preventive services.

Medicare Part B – Covered Preventive Services		
Service	**Who Is Covered**	**Beneficiary Obligation in the Original Medicare Plan**
Smoking and tobacco use cessation counseling - 2 cessation attempts per year; each attempt includes a maximum of 4 intermediate or intensive sessions; up to 8 sessions within a 12-month period.	Beneficiaries who use tobacco and have a disease or adverse health effect linked to tobacco use	Copayment, coinsurance, and deductible waived
Ultrasound screening for abdominal aortic aneurysm (AAA) – Once in a lifetime.	Beneficiaries with certain risk factors for AAA who receive a referral from their physician, physician assistant, nurse practitioner or clinical nurse specialist	Copayment, coinsurance, and deductible waived
Vaccinations – Flu shot: once a year, per flu season; pneumonia shot: to prevent pneumococcal infections, one shot can be followed by a second, different shot one year later.	All beneficiaries with Part B coverage	Copayment, coinsurance, and deductible waived

Edit(s) to page 4-13: Items Not Covered by Part A or Part B in the Original Medicare Plan

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WARNING: Deductibles change annually. It is important to review the Federal Register, Medicare Newsletters, or the CMS web site (www.medicare.gov), or call 1-800-633-4227 for yearly updates to deductible and coinsurance allowances. The *Medicare and You* booklet (found at: https://www.medicare.gov/medicare-and-you/different-formats/m-and-y-different-formats.html) will also assist beneficiaries and billing staff in both hospitals and clinic settings to understand preventative coverage.

New topic on page 4-14: Medicare Advantage Billing Period

Medicare Advantage Billing Period

When a patient enrolls or disenrolls in a Medicare Advantage organization during a period of service, two factors determine whether the Medicare Advantage organization is liable for the payment:

1. Whether the provider is included in an inpatient hospital or home health prospective payment system (PPS)
2. The date of enrollment

If the patient changes Medicare Advantage status during the inpatient stay for an inpatient institution, the patient's status at admission or start of care determines liability. If the hospital inpatient was not a Medicare Advantage enrollee upon admission but enrolls before the discharge, the Medicare Advantage organization is **not** responsible for payment.

If the provider is not a PPS provider, the Medicare Advantage organization is responsible for payment for services on and after the day of enrollment up through the day that disenrollment is effective.

Edit(s) to page 4-16: Health Insurance Claim Number

- If the HICN starts with MA, WA, PA, or WCA, it is followed by a six- or nine-digit number (for example, MA123456).

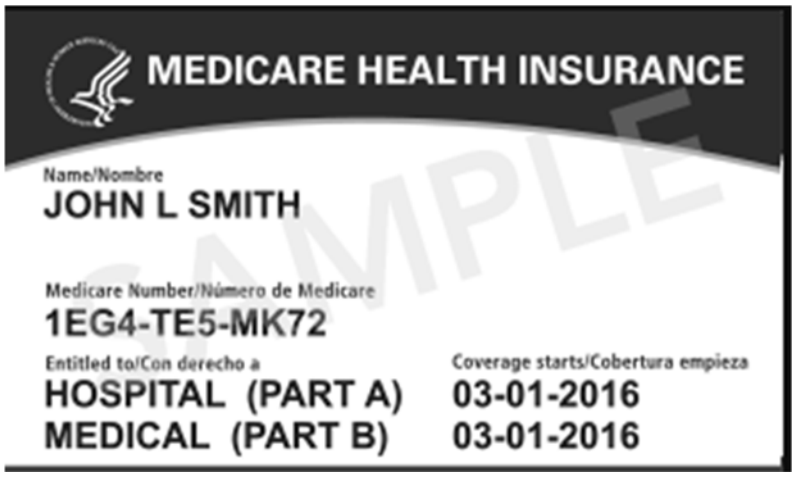
New note on page 4-16: (Transition from HICN to MBI)

NOTE: As of April 2018, the law requires CMS to replace the Social Security numbers on Medicare cards with a Medicare Beneficiary Identifier (MBI). This initiative will start in April 2018 and should be completed by April 2019. Providers need to be ready to accept the new MBI by April 1, 2018.

The new MBI format is still 11 characters long, will contain numbers and uppercase letters, and will be unique to each beneficiary. Each MBI is randomly generated. The MBIs are "non-intelligent," meaning they will have no hidden or special meaning.

There will be a transition period from April 1, 2018, through December 31, 2019. During the transition period, providers may use either the current HICN or the MBI number on claims, but not both.

The new cards are anticipated to look like this:



Edit(s) to page 4-18: HICN Suffixes

T	An individual entitled to Part A benefits but not to retirement and survivor's or Railroad Retirement insurance; or who is ~~nor are they~~ entitled to Medicare based on chronic renal disease.

Edit(s) to page 4-33: Medicare as Primary vs. Secondary

~~Presently,~~ Medicare is the secondary payer for:

Edit(s) to pages 4-39 and 4-40: Evaluation & Management (E&M) Levels

Note: The "P" icon has been deleted to indicate that this topic applies to both the CRCS-I and CRCS-P exams.

Edit(s) to pages 4-44 and 4-45: Resource Based Relative Value Scale (RBRVS)

Note: The "P" icon has been deleted to indicate that this topic applies to both the CRCS-I and CRCS-P exams.

Edit(s) to page 4-45: Charge Master

Note: The spelling of "charge master" as two words has been updated throughout the manual.

The charge master is an electronic file that resides in the provider's information system and that contains ~~all of the~~ charges that can ~~will~~ be posted to a patient account. It is also called the charge description master (CDM), fee schedule, item master, and other similar names. Each item has a system entry that includes the description and price of the item and its CPT or HCPCS codes; identifies the general ledger account it impacts; and, in the case of supplies and medications, includes inventory control information such as supplier and cost.

Delete topic from page 4-55: Superbill

~~Superbill~~

~~A superbill is an invoice used to document the services ordered or rendered during a patient visit. It is often referred to as a face sheet and includes patient demographic data plus the CPT, ICD-10, and HCPCS codes for the most common procedures performed in the practice or department. Upon completion of treatment, the physician completes the superbill to document all services provided. Thus a superbill essentially is a tool to eliminate the need for transcribing medical record notes from a patient chart and streamline the charge capture process.~~

Edit(s) to page 4-69: CMS 1500 (and 5010A1/837P)

The billing form used to submit physician and professional service claims is the CMS 1500. (The equivalent electronic transaction is the 5010A1, formerly the 837P, where the suffix "P" identifies a professional claim.)

The Administrative Simplification Compliance Act requires that Medicare claims be sent electronically unless certain exceptions are met as outlined in the Medicare Claims Processing Manual, Chapter 26, section 10. Providers sending professional claims to Medicare on paper must use form CMS 1500 in a valid version of the form.

Edit(s) to pages 4-71 thru 4-91: Completing the CMS 1500 Form

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NOTE: The primary source of the following information is the Medicare Claims Processing Manual, Chapter 26 – Completing and Processing Form CMS-1500 Data Set, sections 10.1 through 10.9.

Item 11 – This field is required. The insured's policy, group, or FECA (Federal Employees Compensation Act) number should be placed in this field. The FECA number is a 9-digit alphanumeric identifier assigned to a patient claiming work-related conditions under FECA.

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Item 15 – Leave blank. ~~This field requests that any other date related to the patient's condition or treatment be entered. The date should be the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) format.~~

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Item 17a – Leave blank. ~~Enter the ID qualifier 1G, followed by the CMS assigned NPI of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.~~

~~NOTE: Effective May 23, 2008, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.~~

Item 17b Form CMS-1500 – Enter the NPI of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

~~NOTE: Effective May 23, 2008, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.~~

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Item 21 - Enter the patient's diagnosis/condition using the applicable ICD diagnosis indicator ~~should be entered in this field~~:

- ~~0 –~~ ICD-10-CM

The diagnosis codes can be listed on up to 12 lines. The codes should be listed at the highest level of specificity. Do not provide narrative description in this field.

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Item 22 – Leave blank. ~~This field requires the resubmission or reference number for resubmitted claims. When claims are resubmitted, the appropriate bill frequency code should be entered. The options are:~~

- ~~7 - Replacement of a prior claim~~
- ~~8 - Void/cancel of a prior claim~~

Item 23 - The prior authorization number is to be placed in this field. It also includes the referral number, mammography pre-certification number, and the CLIA 10-digit number for the submission of lab services.
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Item 24B - The appropriate 2-digit code from the Place of Service Code list is to be selected for this field. Below are a few of the codes from the list. The complete code list can be found at www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf.

Place of Service Code(s)	Place of Service Name
01	Pharmacy
02	Telehealth
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
09	Prison/ Correctional Facility
10	Unassigned
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment/Worksite
19	Off-Campus Outpatient Hospital
20	Urgent Care Facility
21	Inpatient Hospital
22	On-Campus Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility

Place of Service Code(s)	Place of Service Name
27-30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance—Land
42	Ambulance—Air or Water
43-48	Unassigned
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility-Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-Residential Substance Abuse Treatment Facility
58-59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End-Stage Rental Disease Treatment Facility
66-70	Unassigned
71	State or Local Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Place of Service

Edit(s) to page 4-96: Itemized Statement

One of the basic components of the Patient Care Partnership, formerly known as the Patient Bill of Rights, is to receive an itemized statement and explanation of charges. An itemized statement provides a complete listing or detailed account of every service posted to a patient account to include the date of service, description of service, service code, charge amount, estimated insurance amounts, patient payment amounts, and totals. Most patient accounting systems produce an itemized statement (or "I-Bill") after producing the UB-04.

Edit(s) to page 4-99: Importance of Timely Filing

According to the new timely filing regulations, claims which are submitted with line items date of service will use the line item dates to determine timely filing for outpatient claims. ~~Effective January 1, 2011,~~ Inpatient institutional claims ~~will~~ should include span dates of service. The "From" date is used to determine the date of service for professional claims. The "Through" date on the claim will be used to determine the date of service for filing claims timely.

Edit(s) to page 4-100: Medicare 3-Day Rule

- This rule does not apply to a non-subsection (d) hospital (that is, a hospital not paid under the IPPS). Instead, these hospitals are subject to a 1-Day Rule rather than the 3-Day Rule. Hospitals exempt from the 3-Day Rule, but subject to the 1-Day Rule, include:
  - Psychiatric hospitals and units
  - Inpatient rehabilitation hospitals and units
  - Children's hospitals
  - Long-term care hospitals
  - Cancer hospitals
  - Any hospital outside the 50 states, District of Columbia, and Puerto Rico
  - ~~Critical Access Hospitals (CAHs)~~

Edit(s) to page 4-103: Non-Standard Claims

Medicare will not accept "non-standard claims," which have extraneous attachments in lieu of data entered correctly in the claim form. Claim attachments will be accepted only for information and evidence that cannot be readily entered in designated fields of the standard claim form (for example, medical records, certificates of medical necessity, and other certifications or claim attachments required by law, regulations, or CMS instructions). ~~Therefore, superbills are considered non-standard claims and not accepted by Medicare.~~

Edit(s) to page 4-103: Incomplete and Invalid Claims

An "incomplete" claim is a claim with required information missing (for example, no NPI). An "invalid" claim is a claim that contains complete and necessary information; however, the information is illogical or incorrect (for example, an incorrect NPI). Submissions that are found to be incomplete or invalid are returned to the provider (RTP). The term RTP is used to refer to the many processes utilized for notifying the provider that a claim cannot be processed and must be corrected or resubmitted.

Edit(s) to pages 4-103 and 4-104: Clean Claims

A "clean" claim is one which does not require the carrier or MAC to investigate or develop external to their Medicare operation on a pre-payment basis. A clean claim:

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- Was not developed on a post-payment basis.
- Has all basic information necessary to adjudicate the claim and all supporting documentation.

Edit(s) to page 4-104: National Correct Coding Initiative (NCCI)

- Identify codes that are components of another code and should not be unbundled and billed on the same encounter by the same ~~physician~~ provider.

Edit(s) to page 4-104: Medically Unlikely Edits (MUE)

Just like the NCCI edits, the MUE edit is an automated prepayment edit that helps to prevent inappropriate payments. ~~Implemented by Medicare in 2007~~, The MUE is a unit of service edit for HCPCS/CPT codes for services rendered by a provider to a single beneficiary on the same date of service. MUEs are designed to reduce errors due to clerical entries and incorrect coding based on anatomic considerations. (For example, this program would detect a claim for a person having "ten legs amputated.")

Adding an appropriate modifier (for example, 76 for repeat procedure by the same physician or 91 for repeat clinical diagnostic laboratory test) may ~~will~~ allow the claim to be processed appropriately.

Edit(s) to page 5-2: Defining Terms

- **Charity care** – service provided that is never expected to result in cash flow. Charity care results from a provider's policy to provide healthcare services free of charge or at a reduced cost to individuals who meet certain financial criteria. ~~(However, if the patient has a monthly income but still falls within the federal poverty guidelines, the provider may elect to provide a partial charity write-off to the patient and request a certain percentage of charges be paid by the patient.)~~

Edit(s) to page 5-8: Determining the Responsible Party

- If there is no estate and no other party assumes financial responsibility, write off ~~to the deceased~~ any self-pay balance remaining after insurance liability is paid.

New topic name on page 5-10: In-House Collection

~~In-House Collection~~ Internal Collection Practices

Edit(s) to page 5-11: Internal Collection Practices

- Visit the payer with any problem claims; go one-on-one with the claims representative or provider contract representative.

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- ~~Send thank you cards.~~

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- Elevate issues to a claims supervisor or manager.

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- Bill electronically and check available electronic follow-up options. Most clearing house tools will record the sent date of a claim. Use this tool for proving timely filing.

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- Use denial tracking tools. Track and analyze trends of reasons for nonpayment and provide a recommendation for an overall resolution.

New topic name on page 5-12: Making Collection Calls

Making Patient/Guarantor Collection Calls

Edit(s) to page 5-12: Making Patient/Guarantor Collection Calls

- Prepare all questions and facts. Anticipate what information the patient needs to clarify the balance.
- Prepare an opening statement.
- Remain in control of the call.

The success of the call is measured by the outcome/agreement for payment in full.

Edit(s) to page 5-12: Collection Agencies

A patient account can be forwarded to third party collections any time there is a valid and documented service. It is not necessary to send a statement notifying the patient and/or guarantor of the intent to forward the account to a collection agency. However, there may be public relations problems if patients are not sent these types of notices. Medicare bad debt requirements urge an appropriate sequence of collection attempts before an account is referred to third party collections.

TIP: Refer to Regulation 501(r) in the Federal Regulations and Governing Bodies section of this study manual. Individuals and agencies collecting past due balances from patients need to be aware of 501(r) restrictions.

Edit(s) to pages 5-13 and 5-14: Generally Accepted Accounting Principles (GAAP) Applied to Cashier Functions

Since the cashier function is a fundamental part of collecting revenue, it is important that cash and other receipts be handled carefully. Generally Accepted Accounting Principles (GAAP) are a common set of accounting principles, standards, and procedures that companies must follow when they compile their financial statements. GAAP are a combination of authoritative standards and the commonly accepted ways of recording and reporting accounting information. The following GAAP apply to the cashier functions:

- Endorse checks immediately with "For Deposit Only."
- Issue receipts to customers on all cash payments and deposit them the same day as received.

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- Maintain a payment log.
- Segregate duties (for example, one person posts payments and someone else takes deposits to the bank).
- Do not share passwords.