HIPAA Regulations for Third Party Medical Billers

Searce Healthcare

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What is HIPAA?

The Health Information Portability and Accountability Act, more commonly referred to as HIPAA was enacted in 1996. HIPAA was designed to provide uniformity in data exchange, promote patient privacy and establish security standards for electronic storage of health data. The purpose of this law is to improve the portability and continuity of health insurance coverage using national standards for electronic data interchange (EDI) for certain administrative and financial transactions. HIPAA also mandates strict standards for ensuring the privacy, confidentiality and security of health care information utilized in such transactions. HIPAA regulation protects all communications – spoken, written or electronic, that can reveal the identity of a patient. The U.S. Department of Health and Human Services (HHS) is responsible for the development of the standards, which are being released one regulation at a time.

The HIPAA legislation has four primary objectives:

1. Assure health insurance portability by eliminating job-lock due to pre-existing medical conditions.
2. Reduce healthcare fraud and abuse.
3. Enforce standards for health information.
4. Guarantee security and privacy of health information.

HIPAA Legislation

Legislation Title I

Portability

This principle ensures that individuals can move from one employer to another with continuity in health coverage. Portability benefits individuals who change or have been terminated from employment and disallows for denial of health coverage under pre-existing condition clauses.

Legislation Title II

Accountability

Accountability is also known as Fraud Enforcement. The federal government has increased authority to penalize violators of the HIPAA regulations. Individuals and organizations are subject to the full extent of the HIPAA sanctions under this legislation

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Administrative Simplification

Administrative simplification aims to lower healthcare costs by simplifying claims processing, protecting Individually Identifiable Health Information (I.I.H.I) from actual or potential threats, and, providing patients with greater control over their medical records.

The administrative simplification element comprises of the following four sets of standards:

1. Standardized Transaction Code Sets

This clause enforces HIPAA standards on any of the following electronic transactions:

- Submitting claims for payment and remittance
- Enrolling and dis-enrolling an individual in a health plan
- Paying health care premiums
- Checking eligibility for health care benefits and coverage
- Requesting authorization for services
- Responding to requests for additional information to support claim
- Coordinating the processing of a claims across different insurance companies
- Notifying the provider about the payment of a claim

The medical code sets to be used for the transactions listed above are:

- International Classification of Diseases (ICD-9-CM), for reporting diagnosis and inpatient hospital procedures.
- Health Care Financing Administration Common Procedure Coding System (HCPCS) and the Current Procedure Terminology (CPT-IV), for provider and other medical services including outpatient hospital procedures.
- National Drug Codes (NDC) for drugs and biologics
- The American Dental Association's Codes on Dental Procedures and Nomenclature for dental services

2. Privacy

The Privacy Rule establishes standards to protect the confidentiality of personal health information. These standards set specific parameters in regards to:

- The use and disclosure of health information.
- Individual's rights to access their health information.
- Disclosure of health information to the minimum needed for the intended purpose.
- Penalties for intentionally disclosing health information or obtaining information under false pretenses.

3. Security

The proposed security rule establishes standards based on best business practices for safeguarding and protecting electronic health information systems from improper

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access or alteration. These practices include:

- Development, implementation and enforcement of security policies and procedures.
- Documentation of security management processes.
- Certification and internal audit of system security.
- Implementation of physical access and audit controls.

4. Unique Identifiers

HIPAA enforces the use of following unique identifiers for the employer, provider and health plans:

- **Employer Identifier Number**: Adopts the existing Employer Identification Number (EIN) assigned by the Internal Revenue Service for employers in the health care industry as a unique identifier when conducting transactions for health plan enrollments/premium payments.
- **National Provider Identifier**: Proposes use of a standard identifier for hospitals, doctors, nursing homes, and other health care providers when filing electronic claims with public and private insurance programs.
- **National Health Plan Identifier**: Proposes a unique identifier for health plans, making it easier for health care providers to conduct transactions with different health plans.

Is it Mandatory?

As per the new guidance, third-party billing companies are not mandated to have formal compliance programs and are allowed to be somewhat selective about which aspects of the guidance they incorporate into a compliance program. The new guidance recognizes that a compliance program "can be tailored to fit the needs and financial realities of a particular billing company, large or small, regardless of the type of services offered," although a compliance program "should strive to accomplish the objectives and principles underlying" the OIG's stated guidance.

Even though the adoption of compliance program by a third party biller is strictly voluntary; the existence of an effective compliance program could mitigate any action taken against a billing company caught in subsequent wrongdoing. Hence billing organizations need to quickly react to this guidance and begin to create a program that contains all of the critical elements. Paper documentation will not be enough. To be effective, a plan must be a working organizational reaction to the guidance.

Providers that use an electronic clearinghouse to process their transactions do not have to modify their systems at present to assure compliance, however providers will have to make some modifications to ensure ancillary and departmental systems are capturing HIPAA required information and transmitting that data.

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Benefits of a Compliance Program

An effective HIPAA compliance program provides a mechanism that brings the public and private sectors together to reach mutual goals of reducing fraud and abuse, improving operational quality, improving the quality of health care and reducing the costs of health care.

The benefits for third-party medical billers include:

- Enhancement of the structure of the billing company's operations and the consistency between separate business units.
- Early detection and reporting, thereby reducing the billing company's exposure to civil damages and penalties, criminal sanctions, and administrative remedies, such as program exclusion;
- Improved medical record documentation;
- Improved collaboration, communication and cooperation among health care providers and those processing and using health information;
- The formulation of effective internal controls to assure compliance with Federal regulations, private payer policies and internal guidelines;
- The ability to more quickly and accurately react to employees' operational compliance concerns and the capability to effectively target resources to address those concerns;
- A more efficient communications system that establishes a clear process and structure for addressing compliance concerns quickly and effectively;
- The ability to obtain an accurate assessment of employee and contractor behavior relating to fraud and abuse;
- Procedures that allow the prompt, thorough investigation of possible misconduct by corporate officers, managers, employees and independent contractors, who can impact billing decisions;
- An improved relationship with the applicable Medicare contractor

Additionally as a part of Corporate Social Responsibility, it is the moral duty of a billing company to ensure patient information confidentiality, since Individually Identifiable Health Information (IIHI) in the wrong hands can have serious repercussions:

Example # 1

In North Carolina, a company fired an employee after it had learned that the employee tested positive for a genetic illness that could have led to lost work time and increased insurance cost

Example # 2

In California a woman sued a pharmacy that released her medical information to her husband who used it to damage her reputation in a divorce proceeding.

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The OIG recognizes the implementation of an effective compliance program may not entirely eliminate fraud, abuse and waste from an organization. However, a sincere effort by billing companies to comply with applicable Federal and State standards, as well as the requirements of private health care programs, through the establishment of an effective compliance program, significantly reduces the risk of unlawful or improper conduct.

Compliance Requirements

The Office of Inspector General (OIG) has laid out compliance programs in order to promote a high level of ethical and lawful corporate conduct. This guidance is designed to assist companies and individuals that process bills for the nation's health care providers.

Some billing companies code the bills for their provider clients, while others only process bills that have already been coded by the provider. Some billing companies offer a spectrum of management services, including accounts receivable management and bad debt collections, while others offer only one or none of these services. Clearly, variations in services give rise to different policies to ensure effective compliance. Regardless of the billing company's size and structure, The Office of the Inspector General believes every billing company can and should strive to accomplish the objectives and principles underlying all of the compliance policies and procedures recommended within this guidance.

It is incumbent upon a billing company's corporate officers and managers to provide ethical leadership to the organization and to assure that adequate systems are in place to facilitate and promote ethical and legal conduct. Employees, managers and the Government will focus on the words and actions of a billing company's leadership as a measure of the organization's commitment to compliance.

"Compliance Program Guidance for Third-Party Medical Billing Companies" from the Office of the Inspector General outlines the following seven broad areas that a billing company must address in order to adopt an effective compliance program:

1. Written Policies and Procedures

Billing companies should develop standards of conduct for all affected employees that include a clearly outlined commitment to compliance by the billing company's senior management and its divisions. A billing company's standards of conduct should reflect a commitment to the highest quality health data submission, as evidenced by its accuracy, reliability, timeliness and validity.

The following section provides a high level guidance for the policies and procedures related to the billing/coding process, IT systems, and documentation.

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Processes

The policies must create a mechanism for the billing or reimbursement staff to communicate effectively and accurately with the health care provider. Policies and procedures should:

- Ensure proper and timely documentation of services prior to billing
- Maintain documentation about the claim in legible form along with the supporting documents for each claim submitted
- Indicate that the diagnosis and procedures reported on the reimbursement claim should be based on the medical record
- Provide that the compensation for billing department coders and billing consultants should not provide any financial incentive to improperly upcode claims
- Establish and maintain a process of review of each claim to ensure accuracy
- Obtain clarification from the provider when documentation is confusing or lacking adequate justification
- Designate at least one person to track, record, report, and maintain a complete audit trail of all credit balances.
- Compliance programs should require that the promotion of, and adherence to, the elements of the compliance program be a factor in evaluating the performance of all employees. Employees should be periodically trained in new compliance policies and procedures.
- Maintain an up-to-date, user-friendly index for coding policies and procedures to ensure that specific information can be readily located
- Establish policies and procedures regarding the creation, distribution, retention, storage, retrieval and destruction of documents
- Use the Minimum Necessary Standard: Disclose only the minimum amount that is needed to do the job.

IT systems

With the increasing use of electronic data interchange (EDI) to conduct business more quickly and efficiently, billing companies should establish procedures for:

- Regular data back ups (either by diskette, restricted system or tape).
- Maintain complete and accurate audit trail.
- Information system should have the ability to print out the individual patient accounts that reflect a credit balance in order to permit simplified tracking of credit balances.
- Ensure data protection against unauthorized access or disclosure. This includes the use of firewall protection and regularly scheduled virus checks.

Documentation

The types of documents developed should include:

1. All records/documentation required by either Federal or State law. For billing companies, this includes all documents related to the billing and coding process.

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2. All records listing the persons responsible for implementing each part of the compliance plan, and
3. All records necessary to protect the integrity of the billing company's compliance process and confirm the effectiveness of the program.

Finally, all policies and written procedures should emphasize the importance of safeguarding the confidentiality of medical, financial and other personal information in individual possession.

2. Compliance Officer and Compliance Committee

Compliance Officer

Every billing company should designate a compliance officer to serve as the focal point for compliance activities.

The compliance officer's primary responsibilities should include:

- Overseeing and monitoring the implementation of the compliance program;
- Reporting on a regular basis to the billing company's governing body and assisting in establishing methods to reduce the billing company's vulnerability to fraud, abuse and waste;
- Periodically revising the program in light of changes in the organization's needs and in the law and policies and procedures of Government and private payer health plans;
- Reviewing employees' certifications that they have received, read and understood the standards of conduct;
- Developing, coordinating and participating in a multifaceted educational and training program
- Assisting the billing company's financial management in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments;
- Independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action
- Developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation;
- Continuing the momentum of the compliance program and the accomplishment of its objectives long after the initial years of implementation.

Compliance Committee

The OIG recommends, where feasible, that a compliance committee be established to advise the compliance officer and assist in the implementation of the compliance program.

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3. Effective Training and Education

The proper education and training of corporate officers, managers, employees, and the continual retraining of current personnel at all levels, are significant elements of an effective compliance program. The OIG suggests all relevant levels of personnel be made part of various educational and training programs of the billing company. Employees should be required to have a minimum number of educational hours per year, as appropriate, as part of their employment responsibilities. Besides, seminars and training sessions should be arranged to provide continuing education on compliance issues.

4. Established Lines of Communication

Access to the Compliance Officer

An open line of communication between the compliance officer and the billing company personnel is equally important to the successful implementation of a compliance program and the reduction of any potential for fraud, abuse and waste.

Hotlines and Other Forms of Communication

The OIG encourages the use of hotlines (including anonymous hotlines), e-mails, written memoranda, newsletters and other forms of information exchange to maintain these open lines of communication. Employees should be permitted to report matters on an anonymous basis.

5. Well-Publicized Disciplinary Guidelines

The OIG believes the compliance program should include a written policy statement setting forth the degrees of disciplinary actions that may be imposed upon corporate officers, managers and employees for failing to comply with the billing company's standards and policies and applicable statutes and regulations. Intentional or reckless non-compliance should subject transgressors to significant sanctions.

6. Auditing and Monitoring

An ongoing evaluation process is critical to a successful compliance program. The OIG believes an effective program should incorporate thorough monitoring of its implementation and regular reporting to senior company officers.

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Monitoring techniques may include sampling protocols that permit the compliance officer to identify and review variations from an established baseline. Significant variations from the baseline should trigger a reasonable inquiry to determine the cause of the deviation.

The billing company should document its efforts to comply with applicable statutes, regulations and Federal health care program requirements. In addition, the billing company should maintain records relevant to the issue of whether its reliance was "reasonable," and whether it exercised due diligence in developing procedures to implement the advice.

7. Response and Corrective Action Initiatives

Violations and Investigations

Upon reports or reasonable indications of suspected non-compliance, it is important that the chief compliance officer or other management officials promptly investigate the conduct in question to determine whether a material violation of applicable law, rule or program instruction or the requirements of the compliance program has occurred, and if so, take steps to correct the problem. As appropriate, such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan, a report to the Government, and the notification to the provider of any discrepancies or overpayments, if applicable.

- **Obligations based on Billing Company Misconduct**

  If the compliance officer, compliance committee or a management official discovers credible evidence of misconduct by the billing company from any source and, after reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil or administrative law, then the billing company should report the existence of misconduct promptly to the appropriate Government authority within a reasonable period, but not more than sixty (60) days after determining that there is credible evidence of a violation.

- **Obligations based on Provider Misconduct**

  If the billing company discovers credible evidence of the provider's continued misconduct or flagrant fraudulent or abusive conduct, the billing company should: (1) refrain from submitting any false or inappropriate claims; (2) terminate the contract; and/or (3) report the misconduct to the appropriate Federal and State authorities within a reasonable time, but not more than sixty (60) days after determining that there is credible evidence of a violation.

Corrective Actions

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Billing companies should take appropriate corrective action, including prompt identification of any overpayment to the provider and the affected payer and the imposition of proper disciplinary action, if applicable.

A billing company should provide all evidence relevant to the alleged violation of applicable Federal or State law(s) and the potential cost impact, when reporting any non-compliance. The compliance officer, with guidance from the governmental authorities, could be requested to continue to investigate the reported violation, after which, the officer has to notify the appropriate governmental authority of the outcome of the investigation.

Violations and Enforcement

The DHHS Office of Civil Rights (OCR) enforces the privacy standards, while the Centres for Medicare & Medicaid (CMS) enforces both the transaction and code set standards and the security standards (65 FR 18895). Enforcement of the civil monetary provisions has not yet been tasked to an agency. While HIPAA protects the health information of individuals, it does not create a private cause of action for those aggrieved (65 FR 82566). State law, however, may provide other theories of liability.

Every institution has a commitment to protect patient privacy. Before HIPAA, no federal framework existed to protect patient information from being exploited for personal gain. As the number of incidents rise, Congress is taking increasing steps to make providers do more to protect health information. Hospitals must adopt policies and procedures to implement administrative requirements designed to protect privacy. However, incidental disclosures are not considered a violation of the regulations as long as the minimum necessary standard is met and reasonable safeguards are in place. (Example: Sign-in sheets, and overheard conversations). HIPAA laws require an institution to designate privacy and security officers to carry out and enforce these policies and procedures.

Types of Penalties

1. Civil Penalties

Violations of the Administrative Simplification Regulations can result civil monetary penalties of $100 per violation, up to $25,000 per year.

2. Criminal Penalties

Any person who knowingly obtains or discloses individually identifiable health information in violation of the Administrative Simplification Regulations faces a fine of up to $50,000, as well as imprisonment up to one year. Offences committed under false pretences allow penalties to be increased to a $100,000 fine and up to five years in prison. Finally, offences committed with the intent to sell, transfer or use individually identifiable health

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information for commercial advantage, personal gain or malicious harm permit fines of $250,000, and imprisonment for up to ten years.

3. Exclusion

The Department of Health and Human Services (DHHS) has the authority to exclude from participation in Medicare any covered entity that was not compliant with the transaction and code set standards by October 16, 2003 (where an extension was obtained and the covered entity is not small) (68 FR 48805).

Glossary

A

Account
The number a patient is given by the doctor or hospital for a medical visit.

Accounts receivable
The total amount of money owed for professional services provided.

Adjudication
The final determination of the issues involving settlement of an insurance claim, also known as a claim settlement.

Adjustment
The portion of the bill that the doctor or hospital has agreed not to charge you.

Advance Beneficiary Notice (ABN)
An agreement given to the patient to read and sign before providing a service if the participating physician thinks that it may be denied for payment because of medical necessity or limitation of liability by Medicare. Once a patient signs the ABN and if Medicare does not pay for it, then the patient will have to pay the physician for it. The patient agrees to pay for the service; also known as a waiver of liability agreement or responsibility statement.

Appeal
To request correct payment by asking for a review of an insurance claim that has been paid or denied by an insurance company.

Applicant
Person applying for insurance coverage.

Approved Amount

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The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

B

Beneficiary
Person covered by health insurance or Medicare benefits.

Benefit
The amount your insurance company pays for medical services.

Benefit period
A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Blue Cross and Blue Shield Association (BSBSA)
An association that represents the common interests of Blue Cross and Blue Shield health plans. The BCBSA serves as the administrator for the Health Care Code Maintenance Committee and also helps maintain the HCPCS Level II codes.

C

Capitation
A fixed amount of money, per capita amount for each patient enrolled over a stated period of time, paid to a health plan or doctor (regardless of the type and number of services provided). This is used to cover the cost of a health plan member's health care services for a certain length of time.

Centers for Medicare and Medicaid Services (CMS)
Formerly known as the Health Care Financing Administration (HCFA). CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

Claim Control Number
A number assigned by the Medi-Cal fiscal intermediary on a Treatment Authorization Request and used for reference when processing the request.

Claims Inquiry Form (CIF)
A Medi-Cal form used for tracing a claim, resubmitting a claim after a denial, or when requesting an adjustment for underpaid or overpaid claims.

Clean Claim

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A completed insurance claim form submitted within the program time limit that contains all the necessary information without deficiencies so it can be processed and paid promptly.

Clearinghouse
A company that, for a fee, electronically receives batches of claims from providers or billing centers in a single format, reformats the claims data according to the software requirements of the indicated insurance carriers or governmental agencies, and retransmits the data electronically to those designated payers. There is a contractual financial relationship between the clearinghouse and the payer. The electronic claims are edited upon arrival at the clearinghouse terminal. A report is issued describing on the requirements of the ultimate payer.

Coding
A system whereby a numerical code is applied to medical descriptions of diagnoses, procedures, pharmaceutical elements, and durable medical equipment. These numerical descriptions permit easy accounting procedures for statistical classification.

Coinsurance
A fixed percentage of the total amount paid for a health care service that can be charged to a beneficiary on a per service basis.

Collection ratio
The relationship between the amount of money owed and the amount the money collected in reference to the doctor's accounts receivable.

Contractual Adjustment
A part of the bill that the doctor or hospital must write off (not charge the patient) because of billing agreements with his/her insurance company.

Coordination of Benefits (COB)
A process that determines which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare health plan, Federal law may decide who pays first.

Copayment
A copayment is usually a specified flat amount you pay for a service (e.g., $10 per visit, $25 per inpatient hospital day), with the insurer paying the balance. Also referred to as coinsurance.

CPT codes
A coding system used to describe what treatment or services were given to the patient by the doctor.

Crossover claim
Bill for services rendered to a patient receiving benefits simultaneously from Medicare and Medicaid.

Current Procedural Terminology (CPT)

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A reference procedural codebook using a numerical system for procedures, established by the American Medical Association.

D

Date of Service (DOS)
The date(s) when a patient was treated.

Day Sheet
A register for recording daily business transactions (charges, payments, or adjustments); also known as daybook, daily log, or daily record sheet.

Deductible
Specific dollar amount that must be paid by the insured before a medical insurance plan or government program begins covering health care costs.

Defense Enrollment Eligibility Reporting System (DEERS)
An electronic database used to verify beneficiary eligibility for those individuals in the TRICARE programs.

Denied claim
Insurance claims submitted to an insurance company in which payment has been rejected due to technical error or because of medical coverage policy issues.

Diagnosis Code
A code used for billing that describes the illness.

Diagnosis-Related Groups (DRGS)
A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.

Direct Referral
Certain services in a managed care plan may not require preauthorization. The authorization request form is completed and signed by the physician and handed to the patient to be done directly.

Dirty Claim
A claim submitted with errors or one that requires manual processing to resolve problems or is rejected for payment.

Downcoding
Reduce the value and code of a claim when the documentation does not support the level of service billed by a provider. The insurance company computer system converts the code submitted to the closest code in use, which is usually down one level from the submitted code, generating decreased payment.

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E

E codes
A classification of ICD-9-CM coding used to describe environmental events, circumstances, and conditions as the external cause of injury, poisoning, and other adverse effects. E codes are also used in coding adverse reactions to medications.

Electronic Claim
Insurance claim submitted to the insurance carrier via a central processing unit (CPU), tape diskette, direct date entry, direct wire, dial-in-telephone, digital fax, or personal computer download or upload.

Electronic Claims Professional (ECP)
Individual who converts insurance claims to standardized electronic format and transmits electronic insurance claims date to the insurance carrier or clearinghouse to help the physician receive payment.

Electronic Funds Transfer
A paperless computerized system enabling funds to be debited, credited, or transferred, eliminating the need fore personal handling of checks.

Employer Identification number (EI)
An individual's federal tax identification number issued by the Internal Revenue Service for income tax purposes.

Explanation of Benefits (EOB)
An explanation of services periodically issued to recipients or providers on whose behalf claims have been paid. It tells what was billed, the payment amount approved by the insurance, the amount paid, and what the patient has to pay. It also gives the reasons for denying a claim.

Explanation of Medical Benefits (EOMB)
An explanation of Part B services under the Original Medicare Plan sent to patients and/or physicians on whose behalf claims have been paid. This notice explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

F

Fiscal Intermediary
A private company that has a contract with Medicare to pay Part A and some Part B bills. For TRICARE and CHAMPVA, the insurance company that handles the claims for care received within a particular state or country.

G

Group provider number

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A number assigned to a group of physicians submitting insurance claims under the group name and reporting income under one name; used instead of the individual's physician's number for the performing provider.

Guarantor
Someone other than the patient who has agreed to pay the bill on the patient's behalf.

H

Health Care Financing Administration (HCFA), now changed to CMS
Formerly known as the Social Security Administration, HCFA is that part of the Department of Health and Human Services that oversees Medicare, among other governmental health programs. Health Insurance – known at Medicare part A. A program providing basic protection against the costs of hospital and related post hospital services for individuals eligible under the Medicare program. Pronounced "Hick-fa".

Health Maintenance Organization
An insurance plan that pays for preventative and other medical services provided by a specific group of participating providers.

Health Maintenance Organization (HMO)
A type of health care program in which enrollees receive benefits when they obtain services that are provided or authorized by selected providers, usually with a primary care physician "gatekeeper." In general, enrollees do not receive coverage for the services of providers who are not in the HMO network, except for emergency services.

Healthcare Common Procedure Coding System (HCPCS)
A medical code set, which has been selected for use in the HIPAA transactions, identifies health care procedures, equipment, and supplies for claim submission purposes. HCPCS Level I contains numeric CPT codes which are maintained by the AMA. HCPCS Level II contains alphanumeric codes used to identify various items and services that are not included in the CPT medical code set. These are maintained by HCFA, the BCBSA, and the HIAA. HCPCS Level III contains alphanumeric codes that are assigned by Medicaid state agencies to identify additional items and services not included in levels I or II. These are usually called "local codes", and must have "W", "X", "Y", or "Z" in the first position. HCPCS Procedure Modifier Codes can be used with all three levels, with the WA - ZY range used for locally assigned procedure modifiers.

HIPAA
Health Insurance Portability and Accountability Act. This federal act sets standards for protecting the privacy of your health information.

I

I.I.H.I
Individually Identifiable Health Information are data elements which include:

- Names/relative's names

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- Addresses
- Employers
- D.O.B
- SSN
- Medical Record number
- Telephone, fax and email addresses

Inpatient
A term used when a patient is admitted to the hospital for overnight stay.

Insurance balance billing
A statement sent to the patient after his or her insurance company has paid its portion of the claim.

Insurance Billing Specialist
A practitioner who carries out claims completion, coding, and billing responsibilities and may or may not perform managerial and supervisory functions; also known as an insurance claims processor or reimbursement specialist.

M

Major Diagnostic Categories (MDCs)
A broad classification of diagnoses. There are 83 coding system-oriented MDCs in the original DRGs and 23 body system-oriented MDCs in the revised set of DRGs.

Managed Care Organizations (MCOs)
Entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. May apply to EPO, HMO, PPO, integrated delivery system, or other weird arrangement, MCOs are usually prepaid group plans, and physicians are typically paid by the capitation method.

Managed Care Plans
An insurance plan that requires patients to see doctors and hospitals that have a contract with the managed care company, except in the case of medical emergencies or urgently needed care if you are out of the plan's service area.

Manual Billing
Processing statements by hand; may involve typing statements or photocopying the patient’s financial accounting record and placing it in a window envelope, which then becomes the statement.

Medicaid (MCD)
A federal aided, state-operated and administered program that provides medical benefits for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. California’s Medicaid program is known as Medi-Cal.

Medical Record Number

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The number assigned by the doctor or hospital that identifies a patient's individual medical record.

Medicare Assignment
Doctors and hospitals that have accepted Medicare patients and agreed not to charge them more than Medicare has approved.

Medicare Medical Savings Account
A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Policy with a high deductible. The other part is a special savings account, called a Medicare MSA.

Medicare Part A
Usually referred to as Hospital insurance, it helps pay for inpatient care in hospitals and hospices, as well as some skilled nursing costs.

Medicare Part B
Helps pay for doctor services, outpatient care and other medical services not paid for by Medicare Part A.

Medigap
A specialized supplemental insurance policy devised for the Medicare beneficiary that covers the deductible and copayment amounts typically not covered under the main Medicare policy written by a non-governmental third-party payer. Also known as Medifill.

Medigap Policy
A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. It may pay deductible, coinsurance amounts, and so forth. It does not include limited benefit coverage, such as "specified disease" or "hospital indemnity" coverage. It excludes a policy or plan offered by an employer or labor organization.

Modifier
In CPT coding, a two-digit add-on or five-digit number, representing the modifier, placed after the usual procedure code number. The two-digit modifier may be separated by a hyphen. In HCPCS coding, one-digit or two-digit add-on alpha characters, placed after the usual HCPCS code number.

N

National Association of Claims Assistance Professionals
A national professional society for those that submit manual and/or electronic health insurance claims.

NEC
Not Elsewhere Classifiable. This term is used in ICD-9-CM when the coder lacks the information necessary to code the term in a more specific category.

Non-Covered Charges

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Charges for medical services denied or excluded by the patient's insurance. He/she may be billed for these charges.

Non-Participating Provider
A doctor, hospital or other healthcare provider that is not part of an insurance plan's doctor or hospital network.

NOS
Not Otherwise Specified, unspecified. Used in ICD-9-CM.

O

Old Age survivors, Health and Disability Insurance (OASHDI) Program (C)
A group that in entitled to benefits under the Medi-Cal program.

Original Medicare Plan
The traditional pay-per-visit arrangement that covers Part A and Part B services.

Out-of-Network Provider
A doctor or other healthcare provider who is not part of an insurance plan's doctor or hospital network. Same as non-participating provider.

Outpatient
A patient who receives services in a health care facility, such as a physician's office, clinic, urgent care center, emergency department, or ambulatory surgical center and goes home the same day.

P

Participating Provider
A doctor or hospital that agrees to accept a patient's insurance payment for covered services as payment in full, minus the deductibles, co-pays and coinsurance amounts.

Patient Type
A way to classify patients - outpatient, inpatient, etc.

PHI
Protected Health Information (PHI) is any information received or created that may be used to identify either a patient or a patient's health; or the health care services the patient receives, whether in the past, present or future.

PHI will be limited to those who need the information to:

- provide care
- handle payment
- manage health care operations

Point of Service Plan (POS)

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An insurance plan that allows a patient to choose doctors and hospitals without having to first get a referral from his/her primary care doctor.

Preauthorization
A requirement of some health insurance plans to obtain permission for a service or procedure before it is done and to see whether the insurance program agrees it is medically necessary.

Precertification
To find out whether treatment (surgery, tests, hospitalization) is covered under a patient's health insurance policy.

Predetermination
To determine before treatment the maximum dollar amount the insurance company will pay for surgery, consultations, postoperative care, and so forth.

Preferred Provider Organization (PPO)
A type of health benefit program in which enrollees receive the highest level of benefits when they obtain services from a physician, hospital, or to her health provider designated by their program as a "preferred provider". Enrollees may receive substantial, though reduced, benefits when they obtain care from a provider of their own choosing who is not designated as a "preferred provider" by their program.

Primary Care Physician (PCP)
A physician who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems and may talk with other doctors and health care providers about your care and refer you to them. In many Medicare managed care plans, you must see your primary care doctor before you see any other health care provider.

Primary Insurance Company
The insurance company responsible for paying a patient's claim first. If he/she has another insurance company, it is referred to as the Secondary Insurance Company.

Private Fee-for-Service Plan
A private insurance plan that accepts Medicare beneficiaries.

Procedure Code (CPT)
A code given to medical and surgical procedures and treatments.

Provider
A person, organization, or institution enrolled and certified to provide health care services authorized under Medicaid, Medicare, or managed care programs. For CHAMPUS, the doctor, hospital, or other person or place that provides medical services and/or supplies.

R

Reauthorization

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Requirement in some health insurance plans to obtain permission for service or procedure before it is done and to see whether the insurance program agrees it is medically necessary.

Referral
Permission from your primary care doctor for you to see a specialist or get certain services. In many Medicare managed care plans, you need to get a referral before you get care from anyone except your primary care doctor.

Responsible Party
The person(s) responsible for paying a patient's hospital bill-usually referred to as the guarantor.

S

Scrubbing
The process in which computer software checks for errors before a claim is submitted to an insurance carrier for payment; also known as edit check or cleaning the bill.

Secondary Insurance
Extra insurance that may pay some charges not paid by the patient's primary insurance company. Whether payment is made depends on his/her insurance benefits, the coverage and the benefit coordination.

Secondary Payer (SP)
An insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other health insurance depending on the situation.

Skilled Nursing Facility
An inpatient facility in which patients who do not need acute care are given nursing care or other therapy.

Special Protection
Under HIPAA or state law, certain types of information receive special protection. This would include:

- Psychotherapy notes;
- Mental Health information;
- HIV- related information; and
- Alcohol, substance abuse and genetic information.

Supplemental Insurance Policy
An additional insurance company that handles claims for deductibles and coinsurance reimbursement. Many private insurance companies sell Medicare Supplemental Insurance.

Supplementary Medical Insurance (SMI)
The Medicare program that pays for a portion of the costs of physicians' services, outpatient hospital services, and other related medical and health services for voluntarily insured aged and disabled individuals. Also known as Medicare Part B.

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U

UB-92
A uniform Bill insurance claim form developed by the National Uniform Billing Committee for hospital inpatient billing and payment transactions.

UPIN
The Unique Physician identification Number given to each physician providing services paid by Medicare. This six-place Alpha-numeric UPIN is in effect throughout Medicare affiliation in the physician's current state and any other subsequent states. It is used for assigned or unassigned claims.

Urgently Need Care
Unexpected illness or injury that needs immediate medical attention, but is not life threatening.

Usual, Customary and Reasonable (UCR)
A method used by insurance companies to establish their fee schedules. UCR uses the conversion factor method of establishing maximums; the method of reimbursement used under Medicaid B which state Medicaid programs set reimbursement rates using the Medicare method or a fee schedule, whichever is lower.

Utilization Review (UR)
Hospital staff who work with doctors to determine whether a patient can get care at a lower cost or as an outpatient.

V

V Codes
A classification of ICD-9-CM coding to identify health care encounters for reasons other than illness or injury and to identify patients whose injury or illness is influenced by special circumstances or problems.

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