SAMPLE REPORT

REVENUE CYCLE
PERFORMANCE IMPROVEMENT

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Revenue Cycle Performance Improvement

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1. ADVANCED BENEFICIARY NOTICE

SUBJECT: Update- New ABN Form

CMS has released a new Advanced Beneficiary Notice (ABN) form.

Information of interest to:

- ALL Departments

Summary:

CMS has revised the Advance Beneficiary Notice of Noncoverage (ABN) form.

Highlights of the new form include:

- New official title "Advance Beneficiary Notice of Noncoverage (ABN)"
- Replaces both the existing ABN-G (general use) and ABN-L (laboratory)
- Can be used for voluntary notifications, in place of the Notice of Exclusion from Medicare Benefits (NEMB)
- Mandatory field for cost estimates of the items/services
- New beneficiary option
  - Individual may choose to receive an item/service and pay for it out-of-pocket, rather than have a claim submitted to Medicare

Although the new ABN form has been released and was available for use on March 8, 2008, it is not mandatory to use it until September 1, 2008.

The new form, instructions, and FAQs can be viewed by going to Linked Docs and scrolling to Revised ABN Form, Revised ABN Form Instructions and Revised ABN Form FAQs. Or, you may view each document by clicking on the above title(s).

Effective Date: March 8, 2008

Implementation Date: September 1, 2008

REVISED ABN FREQUENTLY ASKED QUESTIONS

Q1. What changes have been made to the current ABN?

A1. Some key features of the revised ABN are that it:

- Has a new official title, the "Advance Beneficiary Notice of Noncoverage (ABN)", in order to more clearly convey the purpose of the notice;
- Replaces both the existing ABN-G and ABN-L;
- May also be used for voluntary notifications, in place of the Notice of Exclusion from Medicare Benefits (NEMB);
- Has a mandatory field for cost estimates of the items/services at issue; and
- Includes a new beneficiary option, under which an individual may choose to receive an item/service, and pay for it out-of-pocket, rather than have a claim submitted to Medicare.

Q2. How long will the transition period be for use of the revised form?

A2. Providers and suppliers may begin using the new ABN on March 3, 2008. CMS will allow a 6-month transition period from the date of implementation for use of the revised form and instructions. Thus, all providers and suppliers must begin using the new ABN (CMS-R-131) no later than September 1, 2008.

Q3. Where can we access the revised ABN and instructions?

A3. The revised ABN and form instructions can be accessed online at www.cms.hhs.gov/bni.

Q4. May we translate the revised ABN into other languages?

A4. The ABN is an OMB-approved form and cannot be altered except as permitted by the accompanying instructions. The ABN is available in English and will soon be available in Spanish. Notifiers should choose the appropriate version of the ABN based on the language the beneficiary best understands.

When Spanish-language ABNs are used, the notifier should make insertions on the notice in Spanish. For beneficiaries who speak languages other than English or Spanish, verbal assistance in other languages may be provided to help beneficiaries understand the notice. Notifiers should document any translation assistance that they provide in the "Additional Information" section of the notice.

Q5. Are there manual instructions for the revised form?

A5. We will post detailed manual instructions for the revised form to the Medicare Online Claims Processing Manual in the near future. Please check the BNI webpage for updates at www.cms.hhs.gov/bni .

Q6. Where can we send questions regarding the revised ABN?

A6. Questions regarding the revised ABN can be sent to RevisedABN_ODF@cms.hhs.gov .

Q7. Will SNFs be required to use the revised ABN?

A7. No, the revised SNFABN will cover all Part B items/services delivered in a SNF and will be available before September 1, 2008. Therefore, SNFs may continue using the current ABN-G for Part B items/services until the revised SNFABN is implemented.

ANNOUNCEMENT OF THE IMPLEMENTATION OF THE REVISED ABN MARCH 3, 2008

On Monday, March 3, 2008, CMS will implement use of the revised Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131). This form replaces the General Use ABN (CMS-R-131-G), and the Lab ABN (CMS-R-131-L) for physician ordered laboratory tests. The form and notice instructions will be posted on the Beneficiary Notice Initiative web page (www.cms.hhs.gov\bni). We will post updated manual instructions and the Spanish version of the form on the BNI web page in the near future.

Some key features of the new form are that it:

- Has a new official title, the "Advance Beneficiary Notice of Noncoverage (ABN)", in order to more clearly convey the purpose of the notice;
- Replaces both the existing ABN-G and ABN-L;
- May also be used for voluntary notifications, in place of the Notice of Exclusion from Medicare Benefits (NEMB);
- Has a mandatory field for cost estimates of the items/services at issue; and
- Includes a new beneficiary option, under which an individual may choose to receive an item/service, and pay for it out-of-pocket, rather than have a claim submitted to Medicare.

CMS will allow a 6-month transition period from the date of implementation for use of the revised form and instructions. Thus, all providers and suppliers must begin using the new ABN (CMS-R-131) no later than September 1, 2008. Questions about the new ABN may be sent to RevisedABN_ODF@cms.hhs.gov .

2. MEDICARE SECONDARY PAYER

MSP Policies and Procedures

Medicare Secondary Payer (MSP) information is obtained for each Medicare patient utilizing a Medicare Questionnaire. This information is solicited during admission. Each Medicare patient, or their appropriate representative, is interviewed in order to glean accurate information determining the proper payer order. Any missing information is obtained as soon as it is available by following up with each patient, or their appropriate representative.

Staff training surrounding Medicare Secondary Payer is done _____ times annually during staff meetings or upon receipt of any new information surrounding Medicare Secondary Payer. Regular audits for each staff member are done _______ times annually to ensure that staff members understand the admission questions thoroughly.

The Medicare Questionnaire is to be readministered with each patient visit. The only exceptions to this rule are that no questionnaire is obtained for nonpatient reference lab services and that Medicare Questionnaires are viewed as having a shelf life of 90 days for recurring services.

The information contained on each Medicare Questionnaire is retained for a period of at least 10 years. This information is made available to the billing department to ensure that the proper primary payer is identified for each Medicare patient.

Guide to MSP Rules

There are seven basic groups of individuals to whom MSP rules may apply:

• Individuals who are 65 or older and spouses aged 65 or older of employed individuals of any age (working)
• Disabled people who are younger than 65
• ESRD patients who are younger than 65
• Victims of automobile and other non-work-related accidents
• People with black lung
• Individuals of work-related illnesses or injuries (workers' compensation beneficiaries)
• Veterans

In addition to Medicare, one or more of the following types of insurance may cover these people:

• Employer group health plan (EGHP)--patient's own, a family member's, or both
• Automobile medical or no-fault insurance
• Liability insurance
• Federal Black Lung Program
• Veterans Affairs (VA) program

Medicare is the secondary payer for individuals who have healthcare coverage under another insurance plan or program after the primary payer has met its obligation to pay.

In some cases, Medicare may be the tertiary payer, for example, when both an automobile and a liability insurer cover a beneficiary.

Medicare is the primary payer when covered services are furnished to a Medicare beneficiary if any of the following three conditions are met:

• Who elected not to enroll in a Group Health Plan (GHP) but who is eligible for coverage
• Whose primary insurance benefits have been exhausted under the plan and
• Who is not covered under another primary insurance plan

Definitions of Employment Status

Clergy

A member of the clergy or a religious order who has not taken a vow of property is considered employed if the church or religious order pays the individual for services rendered, whether or not the earnings are exempt from Social Security taxes. The individual is considered retired if the church or religious order pays retirement benefits rather than remunerates the individual for services rendered. Non-cash compensation of members of religious orders who have taken vows of poverty are considered earnings for Social Security and tax purposes, depending on the services rendered. An individual who has taken a vow of poverty is considered retired if the religious order agreed to waive its exemption from paying FICA taxes on behalf of members and the individual has retired and the order has or will report the retirement on its tax return.

Director of Corporation

A person serving on a board of directors of a corporation who is not an officer of the corporation is considered self-employed. A director serving on the board who receives no remuneration is not considered employed. A director receiving deferred compensation is considered to be an employed individual. (Deferred compensation is an amount earned but not payable until a future date, usually when the individual reaches 70 and is no longer subject to Social Security taxes.)

Insurance Agent

A self-employed insurance agent is considered employed if he or she conducts business on behalf of the insurance company. It is not enough to represent the company, e.g., to write policies on behalf of the company. A full-time life-insurance agent is considered an employee for Social Security purposes and for purposes of the Working Aged provision.

Elected/Appointed Government Officials

Medicare is considered secondary for elected or appointed government officials covered by Group Health Plans by reason of current employment. The term employment is very broad and includes coverage through work activity of any type for which an individual receives remuneration. When remuneration is not provided, the relationship between the individual and the entity that permits him to be covered by an EGHP is reviewed. Elected or appointed officials engage in work activities (i.e., attending meetings and attending the needs of their constituents) that constitute a method of carrying out their occupation.

Senior Federal Judge

A senior federal judge is a retired judge of the U.S. court system and the tax court. A senior federal judge is entitled to a full salary as a retirement benefit whether or not he or she continues to perform judicial services for the government. This remuneration is not considered a wage for Social Security retirement purposes. Therefore, the judge is considered retired under the Working Aged provision.

Volunteer

A volunteer is not considered to be employed unless he or she performs services or is available to perform services for an employer and receive remuneration for the services. For example, VISTA volunteers are considered employed by the federal government since they received remuneration.

Vow of Poverty

An individual who has taken a vow of poverty is exempt from the MSP provisions dating back to 1981. Employers are required to certify that an individual has taken a vow of poverty with respect to the work activity that is the basis for qualifying for group health insurance.

MSP Procedures for Admitting and Registration

Identifying the appropriate payers for hospital and other claims billed to the Medicare fiscal intermediary (hospital inpatient and outpatient, home health, etc.) is the responsibility of this facility's admission and registration department. If the information is not obtained from the beneficiary during the admission or registration process, it is then obtained via follow-up done by all departments.

Frequently, the proper primary payer is identified incorrectly because existing account files on the patient are not current or relevant information is not available. To avoid this mistake and to be compliant with Medicare's guidelines, registration and billing staff should update and review their files each time the patient is registered.

MSP Development

The purpose of MSP development is to identify other insurance coverage that the Medicare patient may have and to determine which payer is primary. Accurate MSP development helps avoid incorrect claims being submitted to Medicare and other insurers and prevents mistaken payments. There may be situations where more than one insurer is primary to Medicare (e.g., an automobile insurer and an EGHP). In order to conform to the law and regulations, we will determine whether Medicare is a primary or secondary payer for each inpatient admission of a Medicare beneficiary and outpatient encounter with a Medicare beneficiary prior to submitting a bill to Medicare.

Whenever possible, obtain complete Medicare Questionnaire information directly from the patient or beneficiary. One way to accomplish this is to begin the MSP development procedures for inpatients during the time of preadmission. Another way is to contact the patient by telephone to complete as much of the MSP development information as possible.

If the patient or beneficiary is not able to answer the questions, it is suggested that you interview a family member or, if necessary, contact the beneficiary's employer with questions related to insurance coverage.

Hospitals must collect MSP information from the beneficiary or their representative for hospital outpatients receiving recurring services. Following the initial collection, the MSP information should be verified every 90 days. If the MSP information collected by the hospital from the beneficiary or their representative is no older than 90 calendar days from the date the service was rendered, then the same information may be used to bill Medicare for recurring outpatient services furnished by hospitals. NOTE: A Medicare beneficiary is considered to be receiving recurring services if he or she is receiving identical services and treatments on an outpatient basis more than once within a billing cycle.

The Centers for Medicare & Medicaid Services ***(CMS) will not require independent reference laboratories to collect MSP information in order to bill Medicare for reference laboratory services***. Reference laboratory services are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the Medicare beneficiary and the hospital

involved and in which, the hospital submits a claim only for such test or interpretations. Therefore, CMS will not require hospitals to collect MSP information in order to bill Medicare for reference laboratory services as described above.

Policy for Medicare Secondary Payer Retirement Dates

When a beneficiary cannot recall his or her retirement date but knows it occurred prior to the Medicare entitlement date, as shown on the Medicare card, hospitals report the Medicare A entitlement date as the date of retirement. If the beneficiary is a dependent under a spouse's group health insurance and the spouse retired prior to the beneficiary's Part A entitlement date, hospitals report the beneficiary's Medicare entitlement date as the spouse's retirement date. This information can be reported on the Medicare claim by using occurrence code 18 or 19 with the retirement date.

General Information

The purpose of the Medicare Questionnaire is to obtain basic information about the beneficiary. If the patient is eligible for Medicare, he or she is classified as a beneficiary even if entitlement is based on the work history of another (e.g., husband and wife, parent and disabled child, child and elderly parent). A key component of the questionnaire is identifying the reason the patient is entitled to Medicare.

People are entitled to Medicare if they are eligible for Social Security or Railroad Retirement Benefits. In some cases "survivor" beneficiaries under either program may also be entitled to Medicare benefits. An individual's Medicare benefits usually begin on the first day of the month he or she reaches the age of 65, unless they are entitled to Medicare on the basic of ESRD or disability.

Medicare will issue the beneficiary a health insurance card as evidence of entitlement to hospital (Part A) and medical (Part B) insurance benefits. The card will list the name of the beneficiary, their Health Insurance Claim Number (HICN), sex, type of entitlement (age, ESRD, disability) and effective date of the entitlement. The date of entitlement does not change if an individual entitled to Medicare based on one provision later becomes entitled based on another provision, unless there is a total break in Medicare entitlement.

If the patient is entitled to Medicare solely on the basis of ESRD or solely on the basis of disability, be sure to ask if he or she has coverage under an employer group health plan.

Identifying the Primary Payer

It is important to be sure that any and all possible insurers that may be primary to Medicare are identified.

Dual Entitlement

There are many cases when a Medicare beneficiary may be entitled to Medicare benefits based upon two reasons, for example, when a disabled or Age-entitled beneficiary develops ESRD.

Group Health Plan

An employer group health plan provides medical benefits, directly or through insurance coverage or reimbursement, to employees and their families. When the employer group is self-funded, it is authorized by state law to carry its own risk instead of insuring through an insurance carrier.

An employer may be an individual, an organization engaged in trade or business, an organization exempt from income tax (such as religious, charitable and educational institutions) and the United States government, the District of Columbia, and individual states and territories.

The Centers for Medicare and Medicaid Services define an individual with current employment status as an employee, employer or someone associated with the employer in a business relationship. Self-employed individuals are classified as employers.

Working Aged

Medicare benefits are secondary to benefits payable under a GHP for individuals age 65 or over who have GHP coverage as a result of:

- Their own current employment status with an employer that has 20 or more employees; or
- The current employment status of a spouse of any age with such an employer.

Disability

OBRA 1986 and OBRA 1990 initiated the MSP rules pertaining to disabilities other than ESRD. Under these rules, Medicare is the secondary payer for services provided to permanently disabled individuals who are younger than 65 and have Medicare because of the disability and are covered by a GHP, either because of their own current employment status or that of their spouse or other family member. When the disabled individual turns 65, Medicare becomes secondary based on the Working Aged provision.

End-Stage Renal Disease

Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30 months if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that the individual became eligible or entitled to Medicare on the basis of ESRD. EGHP's are required by law to provide coverage for employees who are eligible for Medicare because they are ESRD patients.

Automobile Medical or No-Fault Insurance

Medicare is secondary to any no-fault insurance, including all forms of automobile no-fault insurance, automobile medical payments, and nonautomobile no-fault insurance. No-fault insurance is a form of insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile regardless of who may have been responsible for causing the accident. MedPay is a form of no-fault insurance even when included in automobile insurance of any type.

Black Lung Program

The Federal Black Lung Program provides medical benefits to coal miners, regardless of age, who are disabled due to lung disease or conditions attributable to mining. Medicare is the secondary payer for services provided to treat lung disease or other conditions attributable to mining. However, Medicare is the primary payer for any medical services provided to treat conditions not related to coal mining, unless the beneficiary has other insurance coverage that would be primary.

Veterans Affairs Program

The VA provides medical benefits to all eligible veterans. The MSP rules pertaining to veterans have been in effect since the inception of the Medicare program in 1966. **Veterans who are entitled to**

Medicare may choose whether Medicare or the VA will be the primary payer for services covered by both programs.

Workers' Compensation

Medicare is the secondary payer for all services covered under any workers' compensation law or plan in the United States or individual states. Medicare remains the primary payer for medical services that are not related to the work-related injury. Medicare would need to review a copy of the joint petition to determine the settlement conditions of a workers' compensation case. Once future medical, set aside proceeds or lump sum settlements have been documented as exhausted, Medicare becomes the primary payer for all claims unless other MSP provisions apply.

Policies and Procedures (short version)

Medicare Secondary Payer information is obtained for each Medicare patient, utilizing a Medicare Questionnaire. This information is solicited during admission. Each Medicare patient, or their appropriate representative, is interviewed in order to glean accurate information determining the proper payer order. Any missing information is obtained as soon as it is available by following up with each patient, or their appropriate representative.

Staff training surrounding Medicare Secondary Payer is done _____ times annually during staff meetings or upon receipt of any new information surrounding Medicare Secondary Payer. Regular audits for each staff member are done _______ times annually to ensure that staff members understand the admission questions thoroughly.

The Medicare Questionnaire is to be readministered with each patient visit. The only exceptions to this rule are that no questionnaire is obtained for nonpatient reference lab services and that Medicare Questionnaires are viewed as having a shelf life of 90 days for recurring services.

The information contained on each Medicare Questionnaire is retained for a period of at least 10 years. This information is made available to the billing department to ensure that the proper primary payer is identified for each Medicare patient.

CMS' Medicare Questionnaire

https://www.noridianmedicare.com/dme/claims/docs/msp_questionnaire.pdf

PART I

1. Are you receiving Black Lung (BL) Benefits?

___ **Yes**; Date benefits began: MM/DD/CCYY

BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL.

___ **No**.

2. Are the services to be paid by a government research program?

___ **Yes**.

GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.

___ **No**.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?

___ **Yes**.

DVA IS PRIMARY FOR THESE SERVICES.

___ **No**.

4. Was the illness/injury due to a work-related accident/condition?

___ **Yes**; Date of injury/illness: MM/DD/CCYY

Name and address of workers' compensation plan (WC) plan:

____

____

____

____

Policy or identification number: ____________

Name and address of your employer:

____

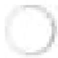
____

____

____

WC IS PRIMARY PAYER ONLY FOR CLAIMS FOR WORK-RELATED INJURIES OR ILLNESS, GO TO PART III.

___ **No**. GO TO PART II.



PART II

1. Was illness/injury due to a non-work-related accident?

___ **Yes**; Date of accident: MM/DD/CCYY

___ **No**. GO TO PART III

2. Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)

___ **Yes**.

Name and address of no-fault insurer(s) and no-fault insurance policy owner:

____

____

____

____

____

____

____

____

Insurance claim number(s): ____________________

___**No**.

3. Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)

___**Yes**.

Name and address of liability insurer(s) and responsible party:

____

____

____

____

____

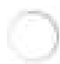
____

____

____

Insurance claim number(s): ____________________

___**No**.



NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE ACCIDENT.

LIABILITY INSURANCE IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE LIABLITY SETTLEMENT, JUDGMENT, OR AWARD. GO TO PART III.

PART III

1. Are you entitled to Medicare based on:

___ Age. Go to PART IV.

___ Disability. Go to PART V.

___ End-Stage Renal Disease (ESRD). Go to PART VI.

Please note that both "Age" and "ESRD" OR "Disability" and "ESRD" may be selected simultaneously. An individual cannot be entitled to Medicare based on "Age" and "Disability" simultaneously. Please complete ALL "PARTS" associated with the patient's selections.

PART IV – AGE

1. Are you currently employed?

___ **Yes.**

Name and address of your employer:

____

____

____

____

___ **No.** If applicable, date of retirement: MM/DD/CCYY_________

___ **No**. Never Employed.

2. Do you have a spouse who is currently employed?

___ **Yes**.

Name and address of your spouse's employer:

____

____

____

____

___ **No**. If applicable, date of retirement: MM/DD/CCYY___________

___ **No**. Never Employed.

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

___ **Yes**, both.

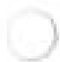
___ **Yes**, self.

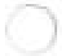
___ **Yes**, spouse.

___ **No**. STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

4. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees?

___ **Yes**. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.





Name and address of GHP:

____

____

____

____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): ______________________

Group identification number: ______________________

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient):

____

Name of policyholder/named insured: ___________________________

Relationship to patient: ____________________________

___ **No.**

5. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 20 or more employees?

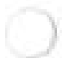
___ **Yes**. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

Name and address of GHP:

____

____

____



____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): ________________________

Group identification number: ________________________

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient):

____

Name of policyholder/named insured: ______________________________

Relationship to patient: _______________________________

___ **No**.

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 4 AND 5, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

PART V – DISABILITY

1. Are you currently employed?

___ **Yes**.

Name and address of your employer:

____

____

____

____

___ **No**. If applicable, date of retirement: MM/DD/CCYY____________

___ **No**. Never Employed.

2. Do you have a spouse who is currently employed?

___ **Yes**.

Name and address of your spouse's employer:

____

____

____

____

___ **No**. If applicable, date of retirement: MM/DD/CCYY

___No. Never Employed.

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

___ **Yes**, both.

___ **Yes**, self.

___ **Yes**, spouse.

___ **No**.

4. Are you covered under the GHP of a family member other than your spouse?

___ **Yes**.

Name and address of your family member's employer:

____

____

____

____

___ **No**.

IF THE PATIENT ANSWERED "NO" TO QUESTIONS 1, 2, 3, AND 4, STOP.

MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO

QUESTIONS IN PART I OR 11.

5. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 100 or more employees?

___ **Yes**. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

Name and address of GHP:

____

____

____

____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): ____________________

Group identification number: ____________________

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient):

____

Name of policyholder/named insured: ________________________

Relationship to patient: ________________________

___ **No**.

6. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 100 or more employees?

___ **Yes**. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

Name and address of GHP:

____

____

____

____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): ____________________

Group identification number: ____________________

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient):

____

Name of policyholder/named insured: _________________________

Relationship to patient: _________________________

___ **No**.

7. If you have GHP coverage based on a family member's current employment, does your family member's employer, that sponsors or contributes to the GHP, employ 100 or more employees?

___ **Yes**. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

Name and address of GHP:

____

____

____

____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): ____________________

Group identification number: ____________________

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient):

____

Name of policyholder/named insured: _________________________

Relationship to patient: _________________________

___ **No.**

IF THE PATIENT ANSWERED "NO" TO QUESTIONS 5, 6, and 7, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

PART VI – ESRD

1. Do you have group health plan (GHP) coverage?

__ **Yes.**

IF APPICABLE, YOUR GHP INFORMATION:

Name and address of GHP:

____

____

____

____

Policy identification number (this number is sometimes referred to as the health insurance

benefit package number: ______________________

Group identification number: ______________________

Membership number (prior to HIPAA, this number was frequently the individual's SSN;

it is the unique identifier assigned to the policyholder/patient):

____

Name of policyholder /named insured: ____________________________

Relationship to patient: ____________________________

Name and address of employer, if any, from which you receive GHP coverage:

____

____

____

____

IF APPICABLE, YOUR SPOUSE'S GHP INFORMATION:

Name and address of GHP:

____

____

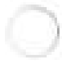
____

____

Policy identification number (this number is sometimes referred to as the health insurance

benefit package number: ______________________

Group identification number: ______________________



Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient):

____

Name of policyholder /named insured: ____________________________

Relationship to patient: _____________________________

Name and address of employer, if any, from which your spouse receives GHP coverage:

IF APPICABLE, YOUR FAMILY MEMBER'S GHP INFORMATION:

Name and address of GHP:

____

____

____

____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number: ______________________

Group identification number: _______________________

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient):

____

Name of policyholder /named insured: ____________________________

Relationship to patient: _____________________________

Name and address of employer, if any, from which your family member receives GHP coverage:

____

____

____

____

___ **No**. STOP. MEDICARE IS PRIMARY.

2. Have you received a kidney transplant?

___ **Yes**. Date of transplant: MM/DD/CCYY_____________

___ **No**.

3. Have you received maintenance dialysis treatments?

___ **Yes**. Date dialysis began: MM/DD/CCYY_____________

If you participated in a self-dialysis training program, provide date training started:

MM/DD/CCYY_____________

___ **No**.

4. Are you within the 30-month coordination period that starts MM/DD/CCYY? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis). If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)

___ **Yes**.

___ **No**. STOP. MEDICARE IS PRIMARY.

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

___ **Yes**.

___ **No**.

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

___ **Yes**. STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.

___ **No**. INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.

7. Does the working aged or disability MSP provision apply (i.e., is the GHP already primary based on age or disability entitlement)?

___ **Yes**. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.

___ **No**. MEDICARE CONTINUES TO PAY PRIMARY.

'laim Services Inc.

Medicare Secondary Payer Questionnaire

Medicare Patient Information:

Patient Name: ____________________________ Patient Account #:___ ______________

HIC#: ___________________________ DCN: ____________________________________

Provider #: ___________________ Date of Service – From: _____ Through: ___________

Information supplied by: __________________ Relationship to Patient: ______________

Hospital Representative: ________________________ Date: _________________________

1. Workers' Compensation (WC):

Should the illness/injury be covered by a WC claim? _____ Yes _____ No **(If "No," go to #2)**

If yes, this should be an MSP claim, not Medicare primary. Please note: WC is primary only for claims related to a WC injury.

Original Date of Illness/Injury: _________________ Claim Number: ________________

Name of WC Plan: ____

Mailing Address: ____

City: _____________________________ State: _______________ Zip: ____________

Name of Employer: ____

Mailing Address: ____

City: _____________________________ State: _________________ Zip: __________

2. Federal Black Lung (BL):

Is the patient covered by the BL program? _____ Yes _____ No **(If "No," go to #3)**

Date Benefits Began: ____________________ *(BL is primary **only** for claims related to BL.)*

3. Department of Veterans Affairs (DVA):

Is the patient entitled to benefits through the DVA? _____ Yes _____ No **(If "No," go to #4)**

If yes, has the DVA authorized and agreed to pay for care at this facility? _____ Yes _____ No

4. Public Health Services (PHS) or Government Grant:

Are the services to be paid by a government program such as a research grant? ____Yes ___ No **(If "No," go to #5)**

If yes, the government program will pay primary benefits for these services.

What is the name of the PHS? ____

Mailing Address: ____

City: _____________________________ State: ___________ Zip: _________________

5. Accident:

Are these services the result of a non-work-related accident? ______ Yes ______ No **(If "No," go to #6)**

If yes, what type of accident was this--or give a description of the accident (for example: auto, slip and fall, malpractice, product liability, homeowner's)? ___________________________

Date of Accident: ___________ Location of Accident (home, restaurant, etc.): ____________

A. Non-Liability/No-Fault Insurance:

Is non-liability insurance available (e.g., premises medical, auto medical coverage, no-fault, homeowner's)?_____ Yes _____ No

If yes, name of the insurance company: ____

Mailing Address: ____

City: ______________________________ State: _______________ Zip: ________________

Who is listed as the insured?____________________ Claim Number: ___________________

B. Liability Insurance:

Does the patient feel someone else is responsible for the accident/injury*? _____ Yes _____ No

**The act of holding an entity responsible entails pursuing and/or receiving financial reimbursement as a result of the accident.*

If yes, name of responsible party's insurance company: __________________________________

Mailing Address: ____

City: ____________________________ State: _______________ Zip: __________________

Name of Responsible Insured Party:___________ Claim Number: _______________________

6. Working Aged:

Is the patient 65 years old or older? _____ Yes _____ No. **(If "No," go to #7)**

Is the patient currently employed by an employer of 20 or more employees? ____ Yes ____ No

If yes, name of the employer: ____

Mailing Address: ____

City: ______________________________ State: _______________ Zip: __________________

If the patient is no longer employed, please give a retirement date*: ________ (MM/DD/YYYY)

**If more than five years ago, default to five years from today. If on or prior to Medicare entitlement, may also default to Medicare entitlement.*

Is the spouse currently employed by an employer of 20 or more employees? ____ Yes ____ No

If yes, name of the employer: ____

Mailing Address: ____

City: ______________________________ State: _______________ Zip: __________________

If the spouse is no longer employed, please give a retirement date*: ________ (MM/DD/YYYY)

** If more than five years ago, default to five years from today. If on or prior to Medicare entitlement, may also default to Medicare entitlement.*

If the patient or spouse is employed by an employer of 20 or more employees, is the patient covered by that Group Health Plan (GHP)? ____ Yes _____ No

If yes, name of the GHP: ____

Mailing Address: ____

City: ______________________________ State: _______________ Zip: __________________

Policy #: ________________________________ Group Identification #: __________________

Name of Policy Holder: __________________Relationship to the Patient: ________________

(Continue with Question #8)

7. Disability:

Is the patient under the age of 65? _____ Yes _____ No **(If "No," go to #8)**

If yes, is the patient entitled to Medicare due to a disability other than end-stage renal disease?

_____ Yes _____ No

(If "No," go to #8)

If yes, is the patient currently employed by an employer of 100 or more employees? ____Yes ____No
If yes, name of employer:____
Mailing Address: ____
City: ________________________ State: ____________ Zip: ______________
If the patient is no longer employed, please give a retirement date*: _________ (MM/DD/CCYY)
** If more than five years ago, default to five years from today. If on or prior to Medicare entitlement, may also default to Medicare entitlement.*
Is a family member currently employed by an employer of 100 or more employees? ____ Yes _____ No
If yes, name of employer:____
Mailing Address: ____
City: ________________________ State: ____________ Zip: ______________
Is the patient covered by that Group Health Plan (GHP)? _____ Yes _____ No
If yes, name of GHP: ____
Mailing Address: ____
City: ________________________ State: ____________ Zip: ______________
Policy #: ____________________ Group Identification #: ____________________
Name of Policy Holder: ____________ Relationship to the Patient: ________________
(Continue With Question #8)

8. End-Stage Renal Disease:

Is the patient entitled to Medicare due to end-stage renal disease (ESRD)? _____ Yes _____ No
Is the patient covered by a GHP through a current or former employer of any size? _____ Yes _____ No
If yes, name of GHP: ____
Mailing Address: ____
City: ________________________ State: ____________ Zip: ______________
Policy #: ____________________ Group Identification #: ____________________
Name of Policy Holder: ____________ Relationship to the Patient: ________________
Name of Employer Sponsoring GHP: ____
Mailing Address: ____
City: ________________________ State: ____________ Zip: ______________
Is the patient within the 30-month coordination period? _____ Yes _____ No
Month/year of first regular dialysis: ____________ (MM/CCYY)
If the patient participated in a self-dialysis training program, provide date training started: ______________________
Has the patient had a successful kidney transplant? _____ Yes _____ No
Date of transplant: ______________________ (MM/DD/YY)
***Note:** If the patient is within the 30-month coordination period, the GHP should be primary.*

9. Dual Entitlement:

Is the patient entitled to Medicare on the basis of both ESRD and Working Aged or ESRD and Disability?_____ Yes _____ No **(If "Yes," portion #6 or #7 should be completed w/ #8)**
Was the patient's initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?_____ Yes _____ No
Do either the Working Aged or Disability MSP provision apply? _____ Yes _____ No

***Note:** If yes to the last question, the GHP remains primary for the 30-month coordination period.*

3. PHYSICIANS OUTPATIENT REQUISITION

PHYSICIAN'S OUTPATIENT TEST REQUISITION

Patient Name DOB: Date: Patient Number:

All GI procedures and Bone Scans must pre-register at hospital Registration 48 hours before test will be performed.

Diagnoses - Check all that apply below

Diagnosis	Code	Diagnosis	Code	Diagnosis	Code
Allergic Rhinitis	477.9	Fever	780.60	Pain-Neck	723.1
Anemia	285.9	Gastroenteritis	558.9	Pain-Pelvic Female	625.9
Anemia, Iron deficiency	280.9	GERD	530.81	Pain-Pelvic Male	789.00
Annual Physical	V70.0	Gout	274.9	Pain-Precordial	786.51
Anxiety	300.00	HCVD	402.90	Pain-Rib	786.50
Arthritis	716.90	Hematuria	599.70	Pain-Shoulder	719.41
Asymmetric Hearing Loss	389.8	Hemoptysis	786.3	Pain-Wrist	719.43
Atrial Fibrillation	427.31	High Risk Medical Eval	V67.51	Palpitations	785.1
BPH	600.00	High Risk Medication	V58.69	Pharyngitis	462
Bronchitis, acute	466.0	Hyperlipidemia	272.4	Pneumonia	486
Bronchitis chronic	490	Hypercholesterolemia	272.0	Pre-Employ Physical	V70.5
CAD	414.00	Hyperplasia Prostate	600.90	PSA - Elevated	790.93
Change in mental status	780.97	Hypertension	401.9	Rash	782.1
CHF	428.0	Hyperthyroidism	242.90	Renal Insufficiency	593.9
Coccydynia	724.79	Hypokalemia	276.8	Rhinitis	472.0
Convulsions/Seizure	780.39	Hypothyroidism	244.9	Sciatica	724.3
COPD	496	Injury Knee	959.7	Screening Mammogram	V76.12
Coronary Artery Dis	414.00	Long Term Use of Meds	V58.69	Screening Occult Blood	V82.89
Cough	786.2	Loss of Appetite	783.0	Screening PAP (Medicare)	V76.2
Coumadin Therapy	V58.61	Nausea	787.02	Screening PAP (Other)	V72.3
Dehydration	276.51	Otitis Media	382.9	Screening PSA	V76.44
Depression/Anxiety	300.4	Pain-Abdomen Epigastric	789.06	Shortness of Breath	786.05
Diabetes Type 1 controlled	250.01	Pain-Abdomen Generalized	789.07	Sinusitis	473.9
Diabetes Type 1 Uncontrolled	250.03	Pain-Abdomen Unspecified	789.00	Skin Lesion	709.9
Diabetes Type 2 controlled	250.00	Pain-Arm	729.5	Sore Throat	462
Diabetes Type 2 Uncontrolled	250.02	Pain-Back	724.5	Syncope	780.2
Diarrhea	787.91	Pain-Chest	786.50	Tachycardia	785.0
Dizziness (Vertigo)	780.4	Pain-Chest wall	786.52	URI	465.9
Drug Reaction	995.20	Pain-Ear	388.70	Urinary Frequency	788.41
Dyspepsia	536.8	Pain-Headache	784.00	Vaginal bleeding	623.8
Dyspnea	786.09	Pain-Hip	719.45	Vomiting	787.03
Edema	782.3	Pain-Joint	719.40	Weakness/Malaise	780.79
Elevated blood sugar	790.29	Pain-Knee	719.46	Weight Gain	783.1
Elevated Cholesterol	272	Pain-Limb	729.5	Weight Loss	783.21
Fatigue	780.79	Pain-Low Back	724.2	Wheezing	786.07

Additional Diagnoses

1

2

3

4

5

6

Radiology

ABDOMEN KUB	FEMUR	LUMBAR SPINE
ABDOMEN-2 VIEW	FINGER	LUMBAR SPINE LIMITED
ANKLE	FOOT	PELVIS
BMD SCAN	FOREARM	RIBS UNI LATERAL
CERV. SPINE LTD FLEX EXT	HAND	SHOULDER WITH INT & EXT
CERVICAL SPINE	HIP 2 VIEW	SINUSES
CHEST 1 VIEW	IVP	SKULL
CHEST 2 VIEW	KNEE	THORACIC SPINE
ELBOW	LEG	UGI c AIR
FACIAL BONES		WRIST

MRI

ABDOMEN W & WO	JOINT LOWER EXT W/O	LUMBAR SPINE W & W/O
CERVICAL W/O CONTRAST	JOINT UPPER EXT W/O	NECK W & W/O
HEAD W & W/O	LOWER EXT W/O	THORACIC SPINE W/O
HEAD W/O CONTRAST	LUMBAR SPINE W	

PHYSICIAN'S OUTPATIENT TEST REQUISITION

Patient Name		DOB:	Date:	Patient Number:	
		ULTRASOUND			
ABDOMEN ULTRASOUND		EXT ARTERY LOW/BILAT W/DP		PELVIS	
CAROTID ULTRASOUND		EXT VENOUS UNILAT W/DOP		RENAL	
ECHOCARDIOGRAPHY		GALLBLADDER		THYROID	
ECHOCARDIOGRAPHY DOPPLER		OB ULTRASOUND		VENOUS BOTH LEGS	
		CT SCAN			
ABDOMEN W/O CONTRAST		CHEST W/CONTRAST		LUMBAR SPINE W/O	
ABDOMEN W/WO CONTRAST		CHEST W/O CONTRAST		PARANASAL SINUSES W/O	
ABDOMEN WITH CONTRAST		CT CORONAL/OBL		PELVIS W/CONTRAST	
ABDOMINAL AORTA W/WO		HEAD AREA W/O CONTRAST		PELVIS W/O CONTRAST	
CERVICAL SPINE W/O		HEAD AREA W/WO CONTRAST		PELVIS W/WO CONTRAST	
		LABORATORY			
AMYLASE-SERUM	13360	FOLIC ACID	13272	PROSTATIC SPEC ANTIG (PSA	
BASIC METABOLIC PANEL	13760	GLUCOSE-SERUM	13296	PROTHROMBIN TIME (PT)	13100
BNP		GLYCOSYLATED HGB (A1C)		PTT (PARTIAL THROMBOPL	13560
BUN		GRAM STAIN		R A LATEX	
CBC W/AUTO DIFF	13010	HELICOBACTER PYLORI		RENAL FUNCTION PANEL	
CBC W/MANUAL DIFF		HEMATOCRIT		RETICULOCYTE COUNT	
CKMB		HEMOGLOBIN		SEDIMENTATION RATE (WE	13160
CLT-BLOOD		HEPATIC FUNCTION/LIVER PL		STREP	13564
CLT-OTHER SOURCE		IGG		T3 TOTAL	
CPK	13075	IGM		T4 (THYROXINE FREE	
C-REACTIVE PROTEIN	13278	IRON (Fe+)		T4 (TTL THYROXINE)	
CREATININE-SERUM	13300	IRON BINDING CAPACITY		TROPONIN	13666
CROSSMATCH	13240	LIPID PROFILE	13998	TSH	13675
DIGOXIN	13480	LYMES DIS ANTIBODY		URIC ACID-SERUM	13110
DILANTIN (PHENYTOIN)	13650	MAGNESIUM (Mg+)	13051	URINE/CULTURAL	13070
DRUG SCREEN-URINE		MONO TEST		URINE-ROUTINE	
ELECTROLYTES	13720	MYOGLOBIN-SERUM	13867	VITAMIN B-12	13105
FECES-OCC BLOOD	13440	POTASSIUM (K+)	13050		
FERRITIN		PREG TEST QUAL-UR OR SER	13040		
		PHYSICAL THERAPY/OCCUPATIONAL THERAPY/SPEECH THERAPY			
OT ADL TRAINING-15MIN		PT GAIT TRAINING 1 UNIT		PT THERAPEUTIC EXER-15 MIN	
OT INITIAL EVALUTION		PT INITIAL EVALUATION		ST EVALUATION-SP/LA/VO/CO	
OT NEUROMUSCULAR RE-ED		PT SELECTIVE DEBRIDEMENT		ST TREATMENT-SP/LA/VO/CO	
OT THERAPEUTIC EXER-15MIN		PT THERAPEUTIC ACT-15MIN		ST TX SWALLOW & OR	
OT THERAPEUTIC/ACT/TRAIN					
		ADDITIONAL TESTS NOT LISTED ABOVE			
1		4		7	
2		5		8	
3		6		9	

CBC IS REQUIRED WHEN ORDERING PROCRIT

OTHER INSTRUCTIONS

PHYSICIAN SIGNATURE DATE

4. REVENUE CYCLE POLICY & PROCEDURE

Policy and Procedure

Subject: Revenue Cycle Policy & Procedures	Page: 1 of
Department: Patient Financial Services	Original:
Tab: Number:	Revised:

Statement of Purpose:
To ensure accurate and timely coding and billing for all services.

Scope of Service:

1. All new employees will attend an orientation program that provides guidelines and procedures for
coding accuracy, data quality, medical records processing, and claims preparation and submission.
2. All employees will receive no less than annual training on the following issues and what is required
for compliance. Attendance is mandatory and documented.

- The 72-hour rule
- Advance beneficiary notice
- Medicare secondary payer
- Discharges vs. transfers
- Bad debts
- Credit balances
- Duplicate billing
- Emergency Medical Treatment and Active Labor Act guidelines

3. Employees not following standard protocol will be disciplined, up to and including termination.
4. Internal audit and monitoring procedures are established to detect errors by sampling claims, reviewing claim denials and return to provider notices, and tracking the billing of specific procedures.
5. All employees will report potential problems to their immediate supervisor or manager.
6. Patient complaints/concerns are documented on a specific form and forwarded to the department manager.
7. All potential issues will be logged and followed up on within 48 hours.
8. An outside consultant will be used periodically to review general billing procedures and the charge master.

5. PRE-REGISTRATION POLICY & PROCEDURE

Policy and Procedure

Subject: Revenue Cycle Policy & Procedure	Page: 1 of
Department: Preregistration	Original:
Tab: Number:	Revised:

Statement of Purpose: The revenue cycle begins with preregistration. The complete and accurate gathering of patient demographic and insurance information is the key to quick turnaround for payment. The goal is 100 percent of patients who are scheduled in advance for a procedure or outpatient services will be preregistered.

Scope of Services:

1. Physician's office will fax/email outpatient order with diagnosis along with patient's demographics to the Patient Registration Department
2. Patient Registration will confirm insurance coverage with prior authorization, if needed, deductible and any outstanding hospital balances. Staff will arrange for payment plan if needed.
3. Patient Registration staff will check the diagnosis for Medical Necessity; Call physician's office if
   procedure or test is not covered by patient diagnosis; Print ABN's if necessary.
4. Patient Registration staff will call patient to communicate:
   - date and time scheduled for outpatient procedure
   - the amount due at time of procedure
     - Medicare only – 20% of procedure charge; if deductible is
       not met patient is responsible for the total amount of procedure.
     - Medicaid - $3.00 if over the age of 18 years of age
     - Commercial – Co-pay or total amount if deducible has not been met
     - Self Pay – 50% of procedure charge
     - If patient is unable to pay, registration staff **must** notify hospital administration for approval.
5. Patient Registration staff will assist patient to the appropriate department.

6. REGISTRATION POLICY & PROCEDURE

Policy and Procedure

Subject: Revenue Cycle Policy & Procedures	Page: 1 of
Department: Patient Registration	Original:
Tab: Number:	Revised:

Statement of Purpose:
The area responsible for registering patient information can have the greatest impact to the revenue cycle. The registration manager should review accounts daily for accuracy and completeness.

Scope of Service:

1. Development of Admissions Staff

The most important job for the admissions manager is to insure correct information is collected. Inaccurate information can impact patient safety concerns as well as being essential to the Medical Record, Billing and Collections process. The development and monitoring of the staff should take priority over all other duties.

2. Inter-Department Communications

The Admissions Department should routinely confer with the Patient Financial Services and Health Information departments to determine data deficiencies. These meetings will assist the Admissions Manager in developing appropriate training for the admissions staff.

3. Monitoring Accuracy of Patient Data

The admissions manager monitors the collection of data by accessing the following reports on a daily basis:
Registration Follow-up Report
Check Prior Admission Data Report
New Account with New Medical Record Number
Medicare Secondary Payer Questionnaire
MSP Follow Up Reports

4. Front-end Collections

Collections are most effective at the time of registration before the service is rendered. This requires verification of coverage, deductibles and co-pays, communicating the total amount of the patient's responsibility and collecting monies due. A minimum of fifty dollars of total amount is expected before an outpatient service is administered. This does not apply to Emergency Room patients.

If patients are unable to pay approval must be obtained from hospital administration.

7. REGISTRATION TRACKING FORMS

DATE	PATIENT NAME	ADMISSION CLERK	ADMIN APPROVAL

MONTHLY ADMISSIONS TOTALS							
JANUARY	Total Registrations	Days Worked	Perc Daily Reg	Total Checked	Total Correct	Total with Errors	PERCENTAGE
Employee 1	87	7	12	87	87	0	100%
Employee 2	28	6	5	28	27	1	96%
Employee 3							
Employee 4	102	5	20	102	95	7	93%
Employee 5	144	6	24	144	135	9	94%
Employee 6	124	5	25	124	114	10	92%
Employee 7	71	5	14	71	69	2	97%

ADMISSION TRACKING FORM							
13-Jan	Employee 1	Employee 2	Employee 3	Employee 4	Employee 5	Employee 6	Employee 7
PATIENT INFORMATION							
Patient Name							
Date of Birth							
Address							
Social Security #							
Marital Status							
Telephone Number #							
MR # (not duplicate)							
ER Contacts							
Drivers License Scanned							
Employer Information							
Race Code							
Patient Type							
4 Digit Zip Code							
	0	0	0	0	0	0	0
GUARANTOR INFORMATION							
Guarantor Name							
Date of Birth							
Address							
Social Security #							
Telephone Number #							
Guarantor #							
Employer Information							
	0	0	0	0	0	0	0
INSURANCE INFORMATION							
Correct Payor/Plan/FC							
Subscriber ID #							
Group #							
Subscriber Name							
Date of Birth (Sub)							
Social Security # (Sub)							
Medicare Outpatient - Nursing Home Resident Service s/b billed to							
Medicare primary but eligibility shows OHI?							
Medicare primary but shows Hospice enrolled? Hospice auth to bill Medicare or Hospice							
Medicare primary but shows HMO on eligibility?							
Medicare A only (and registered with reg. Medicare							
Medicare B only (and registered with reg. Medicare							
Medicare "not Active"							
Relationship							
Filing Sequence							
Ins Type							
	0	0			0	0	
MISC. INFORMATION							
Occurrence Code							
Primary Lang							
Consent Scanned							
Ins Scanned							
Advance Directive							
Net Comp Verified							
MSP Questionnaire							
Recurring Accts only one							
Accident information							
Misc Ins Address							
Ambulance Information							
Collections Information							
Precert #							
Physician #							
Radiology Diagnosis							
Demographics Scanned							
IMP MESSAGE FROM MED							
Order Scanned							
Total Errors							
Operational Issues:							
ER nurses/patients not directed back to admissions:							
Physicians not completing documentation after reminders:							

DAILY ADMISSION CLERKS TOTALS

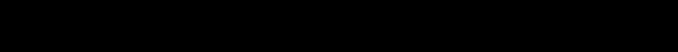
JAN	1-Jan	2-Jan	3-Jan	4-Jan	5-Jan	6-Jan	7-Jan	8-Jan
Employee 1								
Employee 2								
Employee 3								
Employee 4								
Employee 5								
Employee 6								
Employee 7								
	11-Jan	12-Jan	13-Jan	14-Jan	15-Jan	16-Jan	17-Jan	18-Jan
Employee 1								
Employee 2								
Employee 3								
Employee 4								
Employee 5								
Employee 6								
Employee 7								
	21-Jan	22-Jan	23-Jan	24-Jan	25-Jan	26-Jan	27-Jan	28-Jan
Employee 1								
Employee 2								
Employee 3								
Employee 4								
Employee 5								
Employee 6								
Employee 7								

8. FINANCIAL ARRANGEMENT POLICY & PROCEDURE

[redacted] Hospital

DISCHARGE FINANCIAL ARRANGEMENT FORM

SS#:	Patient Name: (last, first, middle)	
Mailing Address:		
City:	State:	Zip:
Home Phone: ( )	Business/Alternate Phone: ( )	
Date of Birth:	Age:	Male / Female (circle one)
Marital Status: Single / Married / Divorced / Widow / Separated		
Employer:	Employer's Address:	
Occupation:	Drivers License #:	State:
Responsible party's name:	Relationship:	
Address:		
City:	State:	Zip:
Home Phone: ( )	Business/Alternate Phone: ( )	

 **Hospital**

FINANCIAL POLICY

ALL CO-PAYMENTS, DEDUCTIBLES AND SERVICES NOT COVERED BY INSURANCE ARE DUE AT THE TIME OF SERVICE.

Insurance will be filed in accordance with your insurance contract. I authorize payment directly to Patient's Choice of Humphreys County Hospital . I understand that I am responsible for my entire bill pending insurance payment in a timely manner by my insurance company.

Total Amount Due at Discharge $________________.

Cash_____ Credit Card_____ Check______ Payment Arrangements Completed_____

____

Patient or Legal Guardian's Signature

____

Date

Financial Worksheet

All Information is Personal & Confidential

Patient Name: ___________________________________ Account #: ______________________________

Guarantor: _______________________________________ Phone #: ________________________________

Address: ____

Employer: _______________________________________ Occupation: _____________________________

Spouse's Employer: ______________________________ Occupation: _____________________________

Number of Dependents: ___________________________ Total # in Household: _________________

Guarantor's Monthly Income: _____________________ Spouse Income: __________________________

Dependents Names: _______________________________ Date of Birth: ___________________________

____ Date of Birth: ___________________________

____ Date of Birth: ___________________________

Documents required: Payroll check stubs, W-2's, Income Tax Return, Bank Accounts, Rent/House Payment, Utility Bills, etc.

Source of Income:

Monthly Salaries	$_________________
Public Assistance	$ _________________
Social Security Benefit	$ _________________
Unemployment	$ _________________
Other Sources	$ _________________

Monthly Expenses:

Food	$_________________
Child Care	$_________________
Utilities	$ _________________
Travel (gas)	$ _________________
Telephone	$ _________________

Assets:

Checking Account (s)	$ _________________
Savings Account (s)	$__________________
CD/Stock/Bonds	$ __________________
Real Estate -Rentals	$ __________________
Alimony	$ __________________
Other Assets	$ __________________

Total Assets: **$ __________________**

Other Creditors:

Rent/Mortgage	$ _________________
Auto Loans (s)	$ __________________
Insurance	$ __________________
Credit Cards	$ __________________

Total Monthly Expensed:

$ __________________

Total Monthly Income:

$ __________________

I hereby acknowledge that the information given herein is true and correct. I authorize YOUR OFFICE NAME to verify any information contained in this document for the sole purpose of assessing my financial request.

____ ____

Patient/Guarantor Signature Date Facility Manager Date

9. PRIVATE PAY AGREEMENT

PRIVATE PAY PAYMENT AGREEMENT

______________________________ __________________

PATIENT ACCOUNT NUMBER DATE

FOR VALUE RECEIVED, I PROMISE TO PAY TO THE ORDER OF ________(NAME OF HOSPITAL)____________

THE SUM OF $________________ ON OR BEFORE ____________________________________

OR

THE SUM OF $___________________IN MONTHLY INSTALLMENTS COMMENCING ON

______________________________ IN THE AMOUNT OF $___________________ EVERY

MONTH UNTIL THE TOTAL AMOUNT OF **$**__________________**(** 60% OF THE BILL TOTAL)

IS PAID AND AT THIS TIME THE BALANCE OF $ ___________ (40% OF THE BILL) WILL BE

DISCOUNTED OFF.

IF ANY INSTALLMENT IS NOT PAID WHEN DUE, AND THE TERMS OF THIS PAYMENT PLAN ARE BROKEN THEN NO DISCOUNT WILL BE GIVEN .

____

PATIENT OR RESPONSIBLE PARTY

____

WITNESS

____

WITNESS

10. CHARITY CARE PROGRAM

__________________ Hospital						MANUAL: ADMINISTRATION SECTION: Finance
Subject: CHARITY CARE						Page 1 of 3 Supersedes: N/A Effective: 07/16/04
Date of Origin: 07/16/04	**Review Date:**	10/12/05				
	Revised Date:	10/20/05				

PURPOSE: Identify the process and criteria for determining Charity Care eligibility.

POLICY: [redacted] Hospital, as a part of the hospital's mission, will not deny necessary, urgent or emergency healthcare to any individual regardless of his/her ability to pay. [redacted] Hospital will also provide inpatient medical care regardless of a patient's ability to pay. The mission of [redacted] Hospital recognizes that we must be prudent in the use of money so that a sound financial base will allow for continued good quality of care to our patients. Therefore, a clear distinction between charity and bad debt is needed to assure accurate measurement of collection efforts and to what extent patients who are unable to pay use the hospital's resources. Bad debts are a result of a patient's unwillingness to pay. Charity patients have the willingness to pay, but do not possess the means.

PROCEDURE: Information regarding a patient's possible inability to pay will be referred to appropriate staff in the Business Office. A determination of ability to pay shall be made after all relevant financial information has been examined and evaluated.

Each case will be evaluated using the following criteria. The Charity Care allowance is the amount that will be deducted from the patient account balance because of this process.

1. The care provided must be related to an inpatient stay or to an emergency service provided by and in the emergency department or ambulances of [redacted] Hospital or to a medically necessary and non-elective outpatient service or procedure or series of outpatient medically necessary and non-elective outpatient services or procedures.
   a) Urgent or emergency care is defined as: necessary care, first-aid treatment or assistance needed by a person suffering from an injury or medical condition which is in need of immediate medical attention, for which the absence of such medical attention would likely result in either a loss of

life, increased injury, physical deterioration, or prolonged suffering.

b) An inpatient's medical need is defined by using interqual criteria in consultation with the attending physician. Continued stay criteria are based on the same criteria.

c) Elective or cosmetic procedures do not qualify for Charity Care.

2. Qualification for Charity Care is based on gross household income and the number of members in the household claimed as dependents for tax purposes. This includes but may not be limited to domestic partners. The Charity Care allowance is determined using the most current Federal Poverty Income Guidelines showing family size and income levels. Those individuals seeking treatment whose household's gross income falls below 125% of the Federal Poverty Income Guidelines qualify for Charity Care. An individual may also qualify for Charity Care if their household income minus any routine reoccurring medical expenses lowers their net household income to less than 200% of the Federal Poverty Income Guidelines. (see page 4) Routine reoccurring medical expenses are defined as any medical expense that reoccurs on a monthly basis and is predicted to continue for 6 months or more. The cost of elective or cosmetic procedures will not qualify as a routine reoccurring medical expense.
3. Before a patient may be considered for Charity Care, the patient must submit all required documentation and sign the financial statement application. All possible other sources of payment must be considered. Evidence of recurring medical expenses must also be submitted to be considered if the individual wants these expenses netted against their income. Failure to use best efforts in submitting all reasonable documentation requested by the hospital staff in the periods stated will result in a denial of the application.
4. In lieu of submission of information required herein, the Hospital may accept as satisfaction of such criteria a sworn statement from the administrator of a healthcare facility that all of its residents meet the criteria contained herein. Such statement shall be made before a notary public and shall include an express acknowledgment from the affiant that he or she acknowledges that his or her statement will be used in connection with a federal healthcare program.
5. Annual income is defined as income from the preceding 12 month and includes the following:

Wages earned by the members of the household during the past year and/or possible future wages.

- Income from interest, dividends.
- Self-employment income.
- Child support or alimony, which may require a copy of court record.
- Unemployment benefits.
- Workers Compensation.
- Life insurance proceeds.
- Pension or profit sharing payments.
- Social Security.
- Other income deemed taxable by either the Internal Revenue Service or the Mississippi Department of Taxation.
- Any insurance coverage the patient may have.
- Any third party coverage i.e., Crime Victims.

6. A patient applying for a Charity Care must provide proof of annual income, which may consist of:
   - The most recently filed federal income tax return.
   - Copies of past and current pay stubs.
   - Written verification of income from employer.
   - Other documents as deemed necessary by the Business Office Representative.
7. Due to the administrative costs of the program, applications for Charity Care will not be required for balances less than $100. Business Office Representatives shall be responsible to determine whether these accounts qualify for Charity Care or bad debt based on information available.
8. The Business Office screens charity applications and refers all applications over $100 to the Business

Office Manager for Charity Care allowance.

- The Business Office Manager may approve a Charity Care allowance up to $5,000.
- The CFO must approve any Charity Care allowances above $5,000.
- The Administrator of [redacted] Hospital must approve any Charity Care allowance in circumstances in which Charity Care is not allowed under the above criteria in cases of catastrophic illness or injury.

9. Applications for accounts in collection will be denied unless the patient/guarantor can demonstrate, in an interview with Business Office staff, that the apparent unwillingness to pay was based upon lack of knowledge of the Charity Care Policy and an inability to pay. The burden of proof concerning lack of knowledge is on the patient/guarantor.
10. After a Charity Care determination has been made, the appropriate letter (approval or denial) will be sent to the patient/guarantor notifying them of the hospital's decision. The patient/guarantor has 30 days from receipt of the letter to appeal any denial to the hospital administrator.
11. The patient/guarantor may reapply in any month thereafter for consideration or further reduction.
12. Should the patient fail to make satisfactory payments (if required) the account will be processed in the usual manner as bad debt.
13. When Charity Care is granted, the adjustment portion of the patient account will be recorded as a Charity Care adjustment in the accounting system.
14. All activities involved in the Charity Care application process, including requests for additional information and discussions with the patient, should be documented in the computer and be kept confidential
15. Information in hard copy should be maintained in accordance with regular data retention parameters for patient account records.

125% of 2006 HHS Poverty Guidelines

Size of Family Unit	48 Contiguous States and D.C.
1	12,250
2	16,500
3	20,750
4	25,000
5	29,250
6	33,500
7	37,750
8	42,000
For each additional person, add	3,260

Patient Request for Hardship Care

Under Federal law each medical practice must attempt to collect any unpaid portion of the deductible and co-payment from the beneficiary whether or not the payer is a Federal, State or private payer. All patients are responsible for one-hundred percent of all cost incurred when not paid by a third party. Reasonable efforts are made to collect any amounts due from the patient or beneficiaries. Failure by the practice to attempt to collect deductibles and co-payments is a violation of federal regulations and the practice could be subject to penalties and sanctions by the Office of the Inspector General resulting in fines, criminal charges or exclusion from the Medicare program.

For those individuals who request and who qualify as "medically indigent patients," we (Your office name) will consider **hardship care for services rendered during a thirty day period.** Proof of hardship is required (i.e.: no insurance or inadequate means of paying for needed care).

Physicians and staff should not advertise that the office (Your office name) will accept "insurance only" or "insurance as payment in full." This may be construed as:

- Inducing referrals by passing along out-of-pocket cost reductions to patients.
- Representing a lower than customary charge.
- Unfair competition

ELIGIBILITY CRITERIA:

Charity care is secondary to all other financial resources available to the patient, including group or individual medical plans, workers' compensation, Medicare, Medicaid or medical assistance programs, other state, federal or military programs, third party liability situations such as auto accidents or personal injury, or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services.

In those instances where no primary payment sources are available, patients shall be considered for charity care under this policy based on the following criteria as calculated for the twelve (12) months prior to the date of the request:

1. The full amount of medical care in this office will be determined to be charity care for any patient whose gross family income is at or below 150% of the current federal poverty guidelines (as listed in the Federal Register for the current year).
2. The office may choose to grant charity care based solely on a request for such care when the request is received from any hospital served by the office based solely on the hospital's evaluation of the patient's financial need. In such cases, the office will also complete full verification or documentation of any request.
3. The Office may also write off as charity care amounts for patient with family income in excess of 150% of the federal poverty standard when circumstances indicate severe financial hardship or personal loss (i.e.: catastrophic charity care, loss of head of household, etc.).
4. All patients or guarantors of financial accounts who state their deductible, co-payment or full bill will be a hardship should be referred to the Office Manager. Hardship applications or monthly financial arrangements will be made based upon proven financial need.

ELIGIBILITY DETERMINATION:

Charity care forms and instructions shall be furnished to patients when charity care is requested, when need is indicated, or when financial screening indicates potential need. All applications should be accompanied by documentation to verify income amounts indicated on the application form. One or more of the following types of documentation may be acceptable for the purpose of verifying income:

1. W-2 withholding statements for all employment during the relevant time period;
2. Pay stubs for all employment during the 12 months prior to the date of request;
3. Income tax return from the most recently filed calendar year;
4. Forms approving or denying eligibility for Medicaid and/or state-funded Medical Assistance;
5. Forms approving or denying unemployment compensation; or
6. Written statements from employers or welfare agencies.

Patients will be asked to provide verification of ineligibility for Medicaid or Medical Assistance. Income shall be annualized from the date of application based upon documentation provided and upon verbal information provided by the patient. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income.

Denials for charity care will be written and will include instructions for reconsideration. If additional verification/documentation of financial need is received to support charity care, the case will be reviewed and reconsidered per the above guidelines.

DOCUMENTATION & RECORDS:

CONFIDENTIALLY: All information relating to the application will be kept confidential. Copies of the documents that support the application will be kelp with the application form and will not be a part of the patient's medical record. Patients must request, sign and provide all necessary information to the office (your office name) within 15 working days (Monday through Friday) after the date of their request for hardship consideration. Utility bills, child care, car or house payments must be proven.

FEDERAL POVERTY GUIDELINES – 2002

Source: **U. S. Department of Health and Human Services,** 2002 Federal Register, Federal Poverty Guidelines for all states except Alaska and Hawaii. http;//www.gov/poverty/02computations.htm

Size of Family	**Poverty Guidelines**	**150%**
1	$ 8,860.00	$13,290.00
2	11,940.00	17910..00
3	15,020.00	22,530.00
4	18,100.00	27,150.00
5	21,180.00	31,770.00
6	24,460.00	36,690.00
7	27,340.00	41,010.00
8	30,420.00	45,630.00
Each additional member. 8	3,080.00	4,620.00

Federal and state programs will be suggested to the patient/guarantor for future healthcare coverage. Our suggestion will be a courtesy suggestion based upon "need to know" and not a requirement of the applicant.

Attachments include:

1. Written **Hardship Care Request Form** - **signed** by patient/guarantor.
2. **Financial Worksheet** – completion required by office manager.
3. **Assistant Programs** – federal & state – for information only.
4. **Accounts Receivable Adjustment Form** – completed by the Office. This special adjustment form requires the signature of a Physician.

Hardship Request

<u>Request must be made by the Patient or Patient's Legal Guardian – Step One</u>

On the behalf of (patient's name) _________________________________. I am requesting consideration of Hardship services from (Your office name).

I have been given a copy of your (office name) policy which clearly states the Federal Poverty guidelines and which explains my responsibility. I have seen a copy of your office financial worksheet and I agree to produce all necessary documents required to process my financial hardship request.

If approved, I agree to inform the staff at your office (office name) if there are any changes in my income or the number of people in my family.

________________________ ___/___/___ ________________________ ___/___/___

Signature of Patient/Guardian) Date Signature of Witness Date

If a patient uses a mark "X" – a witness also must sign this form.

****

Office Use Only

Request must be accompanied by ALL required documents – Step Two

Received by: ______________________________ Date: ____/____/____

(Office Manager Name and Title)

Date of Service for which Hardship Discount was requested: ______________________

(Dates of Service can only span thirty days of care. Complete the Financial Worksheet.)

Approval/Denial

Hardship discount can only be given after ALL Federal, State and third parties have remitted ALL payments applicable to these services. A computer generated account balance must accompany this final decision. – Step Three

Approved/Denied: (Reason) ____

Amount of Hardship Discount: _______________ Patient Account #: ______________

Approved By: ____________________________ Date approved: ____/____/____

Note: Approval to discount balance must be signed by the Physician.

This original final decision form must be placed with all patient financial data which supports this approval/denial. A copy of the final decision will be given to the patient/guardian who made the original request.

Computer Transaction Code: _________________ Date entered: ____/____/____

CHARITY CARE APPLICATION

Patient Name: _________________________ Account____________________

* If a minor, name of parent applying: _______________________

Address___________________________________

____

Types of Income from all household members:

Yearly Gross Wage Income	$___________________
SSI Income	$___________________
Social Security Income	$___________________
Unemployment Income	$___________________
Child Support or Alimony	$___________________
Worker's Compensation	$___________________
Life Insurance Proceeds	$___________________
Retirement & Pension	$___________________
Interest or Dividends	$___________________
Any Other Income	$___________________

Household Size (List anyone who lives in your household)

1.______________________ 5.________________________

2.______________________ 6.________________________

3.______________________ 7.________________________

4.______________________ 8.________________________

I ______________________________ hereby apply for indigent care assistance for the emergency services rendered by [redacted] Hospital.

I certify that all the above information is true and I know that anyone who makes a false statement commits a crime punishable by law, and can be fined or put in jail for fraud and /or perjury.

Signed: ___________________________ Date: ______________

Witness: __________________________ Date: _______________

Please attach one of the following with the application

*** Most recently filed federal income tax return***

*** Copies of past and current pay stubs***

Copies of Social Security or SSI checks

** RETURN WITHIN 10 DAYS IN THE ENVELOPE PROVIDED**

HOSPITAL

CHARITY CARE POLICY

You may qualify for Charity Care for your Inpatient Services, Emergency Room, Ambulance, Ultrasounds, Outpatient Injections, Laboratory and Radiology Services.

If you're house hold income falls below the current Federal Poverty Income Guideline plus 25%.

Please Ask in Admission /Business Office for an Application

2008 HHS Poverty Guidelines Plus 25%

Size of Family Unit	48 Contiguous States and D.C
1	$12,762
2	$17,112
3	$21,462
4	$25,812
5	$30,162
6	$34,512
7	$38,862
8	$43,212
For each additional person add	$3480

Hospital CHARITY CARE GUIDELINES

Charity Care includes the following:

- All Laboratory Orders
- All Radiology Orders
- Ultrasounds
- Inpatient Services
- Ambulance
- Emergency Room Services
- Outpatient Injections
- Ambulance

Charity Care does not include the following:

- Doctor Visits
- MRI's & CT Scans
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Radiologist bills

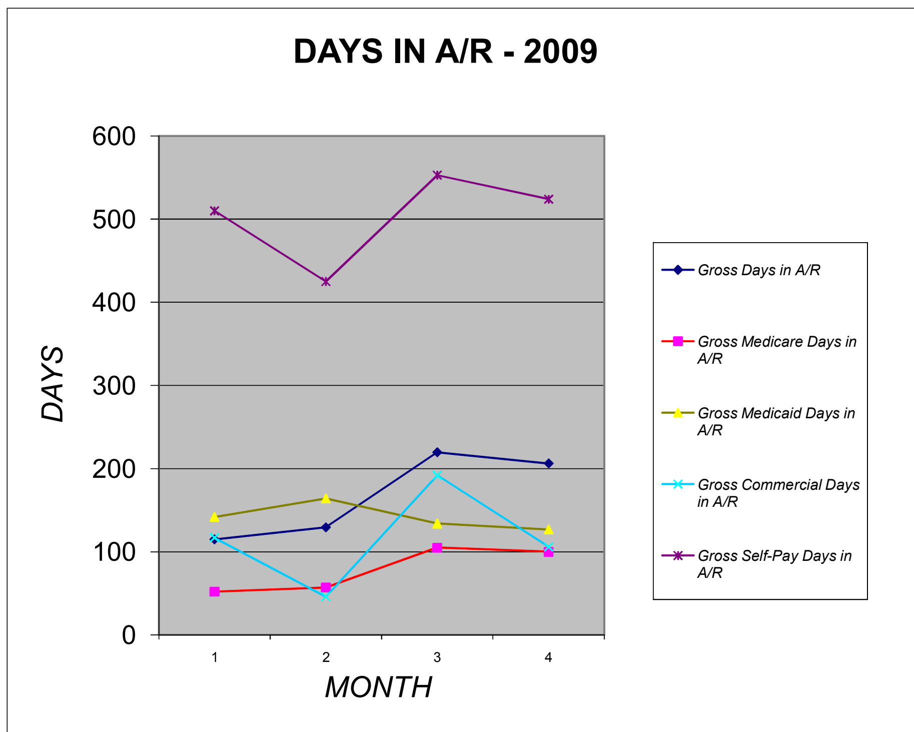
*******Your Application is Valid only for 1 Year********

11. BUSINESS OFFICE PERFORMANCE IMPROVEMENT

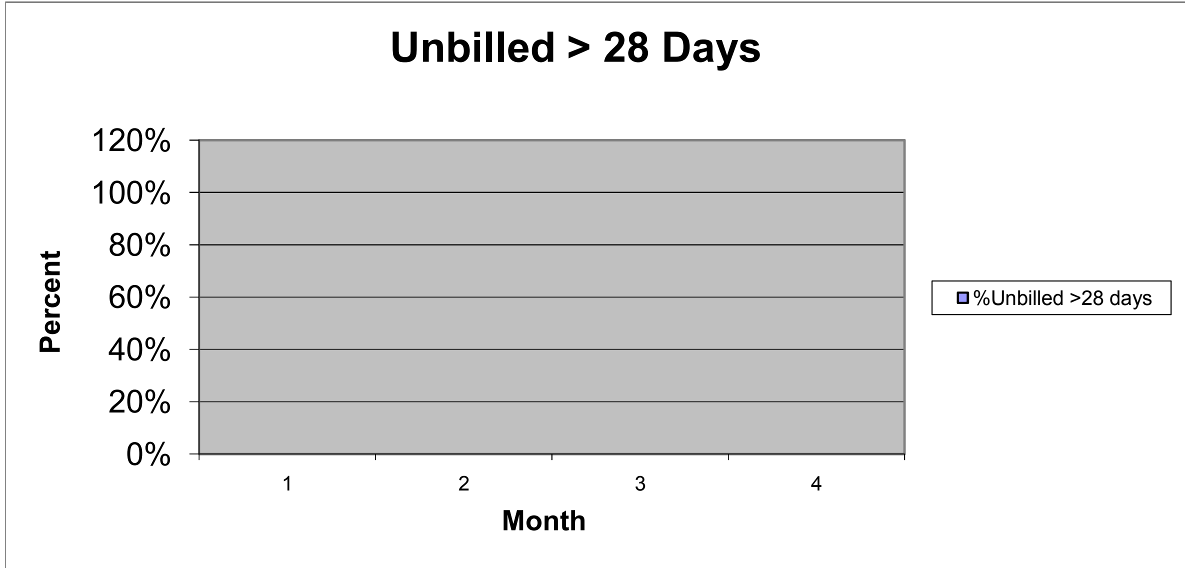
Performance Improvement - Business Office Year 2009

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD			
Admissions	90	78	84	91											medical record stats	
% Patient Regis. Checklist Comp	0%	0%	0%	0%									100%			
Billing																
Monthly Gross Revenue	2,092,613	1,677,547	1,099,921	1,127,973	0	0	0	0	0	0	0	0	5,998,054		month end department recap repo	
Monthly Net Revenue	$77,059	$600,338	$624,238	$655,371	$0	$0	$0	$0	$0	$0	$0	$0	1,957,006		month end department recap repo	
Monthly A/R Receipts	$1,097,035	$625,896	$594,386	$691,901									3,009,218		monthly cash receipts by payor report	
% Receipts to Net Rev. Avg.	1424%	104%	95%	106%	#DIV/0!	#DIV/0!	0%	0%	0%	0%	0%	0%	154%			
Avg Daily Revenue	$67,504	$59,912	$35,481	$37,599	$0	$0	$0	$0	$0	$0	$0	$0	16433		monthly gross revenue/number da	
Accounts Receivable	7,763,393	7,756,076	7,793,110	7,757,473	0	0	0	0	0	0	0	0		**GOAL**		
Gross Days in A/R	**115**	**129**	**220**	**206**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**		**69 days**		
Gross Medicare Days in A/R	**52**	**57**	**105**	**100**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**		11 days		ARA
Gross Medicaid Days in A/R	**142**	**164**	**134**	**127**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**		6 days	37 days total	ARA
Gross Commercial Days in A/R	**117**	**46**	**192**	**106**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**		17 days		ARA
Gross Self-Pay Days in A/R	**510**	**425**	**553**	**524**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**		31 days		ARA
Accounts Unbilled >28 days													#DIV/0!		ARA	
%Unbilled >28 days													#DIV/0!			
Amount Unbilled >28 days													#DIV/0!			
Claims Accepted													0			
Claims Rejected													0			
% Rejected			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
Bad Debts	$14,809,998	$14,791,796	$14,784,613	$14,783,721									$59,170,128	this is YTD amount entered for each month		
Total Bad Debt from E/R													$0		rev by phys	
Percent of Bad Debts from E/R					#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0%			
Recoveries													$0		from rev by f.c.	
Net Bad Debt % of Gross Rev.	708%	882%	1344%	#REF!	#REF!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	986%			
Admin Write Offs	$5,093	$13,931	$18,708	$9,344											GL 55261	
Diagnosis does not match													$0		60541000	
Untimely Filing													$0		60542000	
Not Preapproved													$0		60543000	
Not Medicaly Necessary																
Late Charge Write Off													$0		60553000	
Uninsured Discount													$0		60554000	
Charity Care Write Off													$0		60558000	
All Other													$0		60550000	

GOAL: 69 days



GOAL: 5%



Time: 16:41 Accounts Receivable Analysis Prog: ara
User: css Ver: 9.1

PAY TYPE	REVENUES CURRENT MONTH	%	YEAR TO DATE	%	AR BALANCE CURRENT MONTH	%	*REV DAYS IN AR
MEDICARE	415,344.16	59.00	3,884,110.16	70.00	2,105,968.02	27.00	152.11
MEDICAID	163,800.92	23.00	919,748.38	16.00	1,167,451.75	15.00	213.82
BLUE CROSS	22,183.94	3.00	119,962.92	2.00	30,143.81		40.76
COMMERCIAL	41,920.31	6.00	247,903.68	4.00	288,737.30	4.00	206.63
OTHER	62,207.18	9.00	403,811.29	7.00	4,172,591.37	54.00	2,012.27
TOTALS	705,456.51	100.00	5,575,536.43	100.00	7,764,892.25	100.00	330.21

STATUS REVIEW

STATUS	MEDICARE	MEDICAID	BLUE CROSS	COMMERCIAL	SELF PAY
INHOUSE	214,466.40	32,570.75	-	-	-
WAIT DIAG.	263,277.25	58,582.24	6,319.28	5,093.60	-
NOT BILLED	3,008.89	5,604.64	-	1,928.65	-
INS. FILED	756,790.20	118,231.48	20,090.89	76,349.83	-
SUSPENDED	158,677.73	974,681.31	1,920.17	11,624.33	1,509,092.78
COLL. CO.	-	-	-	-	1,805,363.45
OTHER	709,747.55	(22,218.67)	1,813.47	193,740.89	858,135.14
TOTALS 2	,105,968.02	1,167,451.75	30,143.81	288,737.30	4,172,591.37

SUMMARY BY STATUS

STATUS	TOTAL BY STAT	%
INHOUSE	247,037.15	3
WAIT DIAG.	333,272.37	4
NOT BILLED	10,542.18	0
INS. FILED	971,462.40	13
SUSPENDED	2,655,996.32	34
COLL. CO.	1,805,363.45	23
OTHER	1,741,218.38	22
TOTALS	7,764,892.25	100

* MONTH-TO-DATE REVENUE AND DAYS OF MONTH USED (30)

*** End of Report ***

12. RADIOLOGY MANAGEMENT REPORT

Performance Improvement - Radiology Department-Year 2009

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Procedures													
X-Rays Actual													
X-Rays Budget	300	300	300	300	300	300	300	300	300	300	300	300	3,600
Difference													
Bone Scans Actual													
Bone Scans Budget	12	12	12	12	12	12	12	12	12	12	12	12	144
Difference													
GI procedures Actual													
GI procedures Budget	15	15	15	15	15	15	15	15	15	15	15	15	180
Difference													
Echos Actual													
Echos Budget	18	18	18	18	18	18	18	18	18	18	18	18	216
Difference													
Ultra Sound Actual													
Ultra Sound Budget	15	15	15	15	15	15	15	15	15	15	15	15	180
Difference													
Total Procedure Actual	360	360	360	360	360	360	360	360	360	360	360	360	4320
Total Procedure Budget													
Difference													
Revenue													
X-Rays Actual													
X-Rays Budget	$75,000	$75,000	$75,000	$75,000	$75,000	$75,000	$75,000	$75,000	$75,000	$75,000	$75,000	$75,000	900,000.00
Bone Scans Actual													
Bone Scans Budget	$12,000	$12,000	$12,000	$12,000	$12,000	$12,000	$12,000	$12,000	$12,000	$12,000	$12,000	$12,000	144,000.00
GI procedures Actual													
GI procedures Budget	$18,000	$18,000	$18,000	$18,000	$18,000	$18,000	$18,000	$18,000	$18,000	$18,000	$18,000	$18,000	216,000.00
Ultra Sound Actual													
Ultra Sound Budget	$48,000.00	$48,000.00	$48,000.00	$48,000.00	$48,000.00	$48,000.00	$48,000.00	$48,000.00	$48,000.00	$48,000.00	$48,000.00	$48,000.00	576,000.00
Avg Daily Revenue													
Expenses													
CT													
Radiology Supplies	$2,100	$2,100	$2,100	$2,100	$2,100	$2,100	$2,100	$2,100	$2,100	$2,100	$2,100	$2,100	25,200.00
Office/Departmental Supplies	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	**3,000.00**
Employee Hours Actual													
Employee Hours Budget													
Employee Salary Actual													
Employee Salary Budget													
Productivity													
Productivity Standard													
Productivity Actual													
Productivity Difference													