

Healthcare Financial Management Association
Certification Course 2009-2010

Patient Financial Services Specialty
Course Overview

For examination period January 2009 through December 2010

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Patient Financial Services Specialty



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Delivery Method: Self Study **Field of Study:** Specialized Knowledge and Application

Program content: Key areas related to the revenue cycle including accounts receivable management, financial analysis techniques, access management, claims processing, physician entities, and legal aspects. Specific **learning objectives** are on the following pages.

Program Level: Intermediate. The *intended audience* is anyone who will be completing the corresponding Patient Financial Services certification exam. This course can also serve as a reference for individuals working in related areas of the healthcare industry. The *estimated completion time* is time is about 9.5 hours, based on the actual average completion time of persons who completed this course. Actual completion times may vary based on current knowledge level, learning style, and other factors.

Pre-requisites: Working knowledge of the revenue cycle process

Advance Preparation: None

Amount of CPE: This course is eligible for 9.5 CPE when the course activities are completed at the minimum required level, as stated in the course, and required documentation submitted within one year of purchasing the course and prior to the expiration date of the course materials (12/31/10). CPE will not be issued if the required documentation is submitted after 12/31/10.

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The topics in this course are as follows. The topic outline and learner objectives for each chapter are on the pages that follow.

	Introduction
Chapter 1	Organizational Forecasting
Chapter 2	Accounts Receivable Management
Chapter 3	Financial Analysis Techniques
Chapter 4	Information Technology
Chapter 5	Policy, Planning, and Evaluation
Chapter 6	Access Management
Chapter 7	Claims Processing
Chapter 8	Managed Care
Chapter 9	Legal Aspects
Chapter 10	Physician Entities
Chapter 11	Other Related Entities

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Chapter 1. Organizational Forecasting

- 1.0 Here's What You'll Learn
- 1.1 Planning
- 1.2 From Planning to Budgeting
- 1.3 The Budgeting Process and Concepts for Not-for-Profit Entities
- 1.4 The Cash Budget
- 1.5 Forecasting Cash Receipts
- 1.6 Analyzing Cost Centers
- 1.7 Self Assessment Exercise

Learner Objectives

- Define strategic planning and operational planning.
- Recognize the four different types of budgets and procedures.
- Define and give an example of a line-item budget, a program budget, and a zero-based budget.
- Define the term “cash budget” and explain what other budgets are required as input before it can be prepared.
- Describe how a healthcare organization develops a yearly cash receipts forecast.
- Define and give several examples of cost centers in a healthcare environment.

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Chapter 2. Accounts Receivable Management

- 2.0 Here's What You'll Learn
- 2.1 Introduction to Key A/R Functions
- 2.2 Overall Management of Uncollected Revenues
- 2.3 Valuation of Receivables
- 2.4 Techniques Used to Perform an Accounts Receivable Valuation Review
- 2.5 Third-Party Receivables Management: Billing
- 2.6 Third-Party Receivables Management: Types of Reimbursement Arrangements – Medicare
- 2.7 Third-Party Receivables Management: Cash and Adjustment Posting
- 2.8 Self-Pay Receivables Management
- 2.9 Charity Care Guidelines
- 2.10 Bad Debt Under Medicare
- 2.11 Qualifying Bad Debt and Charity Accounts
- 2.12 **PATIENT FRIENDLY BILLING®**
- 2.13 Financing and Payment Calculations
- 2.14 National/State Uninsured and Underinsured
- 2.15 Federal Credit Regulations
- 2.16 Consumer Credit Protection Act
- 2.17 Liens
- 2.18 Self Assessment Exercise

Learner Objectives

- Describe the process steps of A/R operations.
- Discuss the steps a healthcare organization can take to reduce the bottlenecks of the billing and collection functions.
- Identify documents that govern the internal and external reporting of healthcare receivables.
- Describe the key components of an A/R valuation review.
- Classify categories of data found on a UB92 or HCFA 1500 claim form.
- Explain how a Medicare claim must be billed and identify the time period in which Medicare must pay claims.
- Explain coordination of benefits (COB), diagnosis related group (DRG), and ambulatory payment classification (APC).
- Explain how Medicare uses the Fee Schedule system to pay a physician's charges for services to a beneficiary.
- Discuss reimbursement methodologies available under managed care.
- Describe how to implement the installment method of payment for healthcare services to a patient classified as self-pay.

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Chapter 2. Accounts Receivable Management

Learner Objectives (cont'd)

- Describe how a healthcare organization can use the Federal Income Poverty Guidelines to determine a patient's ability to pay the account.
- Define charity care and bad debt.
- Describe the conditions under which a healthcare organization can recover Medicare bad debts as reimbursable on the cost report.
- Discuss payment alternatives the healthcare organization can make available to its patients.
- Describe activities prohibited by a debt collector while skiptracing.
- Describe under what circumstances Regulation Z of the Truth in Lending Act applies.
- Under the Fair Credit Reporting Act, list the kinds of information typically found and when items must be removed from the list.
- Describe three types of liens.

Chapter 3. Financial Analysis Techniques

- 3.0 Here's What You'll Learn
- 3.1 Types of Ratios
- 3.2 Net Days in Patient Accounts Receivable (A/R)
- 3.3 Days Cash on Hand
- 3.4 Average Payment Period
- 3.5 Cost to Collect
- 3.6 Examples of Healthcare Ratios
- 3.7 Benchmarking
- 3.8 Contractual Allowance and Reserve Calculation
- 3.9 Self Assessment Exercise

Learner Objectives

- Describe the four types of ratios that a healthcare organization uses to analyze its financial position.
- List the formula for days in patient A/R and explain the desired position.
- State the formula for days cash on hand and explain what its trends mean.
- Describe the relationship between the days in cash on hand ratio and the patient accounts receivable ratio.
- Explain the formula for the average payment period.
- Discuss the relationships among the three ratios listed: days in patient accounts receivable, days cash on hand, and average payment period.
- Discuss key benchmarking methods.
- Discuss contractual allowances and reserve calculations.

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Chapter 4. Information Technology

- 4.0 Here's What You'll Learn
- 4.1 Electronic Data Interchange (EDI)
- 4.2 The Health Care Claim Payment/Advice (835)
- 4.3 Moving Money Electronically
- 4.4 EDI Glossary
- 4.5 Electronic Cash Processes
- 4.6 Information Systems for Managed Care
- 4.7 Selecting and Installing a Management Information System
- 4.8 Systems Applications
- 4.9 Healthcare Insurance Portability and Accountability Act (HIPAA)
- 4.10 Self Assessment Exercise

Learner Objectives

- Describe what paper-based procedures in a healthcare organization that EDI is able to automate.
- Recognize the four levels of automation that healthcare providers can choose for processing remittance data.
- Discuss mechanisms for processing EDI payments, such as wire transfers and the automated clearinghouse.
- Define the most common EDI terms applied in a healthcare setting.
- Discuss how healthcare providers are using electronic billing processes and software to speed collections of their A/R.
- List the different types of information systems' functions required in a managed care information system that supports both providers and payer functions.
- Explain the basics of how to select a computer system vendor.
- List common computer software systems and applications within the healthcare provider world.

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Chapter 5. Policy, Planning, and Evaluation

- 5.0 Here's What You'll Learn
- 5.1 Business Planning
- 5.2 Establish Goals and Objectives
- 5.3 Internal Control
- 5.4 Performance Standards and Measurements
- 5.5 Transfer of Receivables
- 5.6 Outsourcing
- 5.7 Evaluating Collection Agency/Outsourcing Performance
- 5.8 Self Assessment Exercise

Learner Objectives

- Explain the stages for the three principal phases of developing a business plan for receivables management.
- Describe the categories of internal controls.
- Describe receivables management internal controls that are present in the charging, billing, cash receipts, accounts receivable, and refunds areas of a healthcare entity.
- Describe examples of performing and non-performing assets.
- Discuss typical process measures in healthcare receivables management.
- Calculate some typical healthcare outcome measures.
- Describe examples of timeliness cycle points and critical quality criteria.
- Explain how opportunity costs are calculated.
- Describe the three methods of transferring healthcare receivables to a third party for cash.
- Explain factoring of a healthcare organization's accounts receivable.
- Explain the benefits and steps of outsourcing in a healthcare environment.
- Discuss how a healthcare organization should analyze a collection agency's performance.

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Chapter 6. Access Management

- 6.0 Here's What You'll Learn
- 6.1 Customer Relations
- 6.2 Encounter Practice Guidelines
- 6.3 Pre-Care Financial Functions
- 6.4 Precare Financial Authorization (Precertification, Preadmission and Payer Verification)
- 6.5 Other Encounter Processing
- 6.6 Financial Counseling
- 6.7 Self Assessment Exercise

Learner Objectives

- Explain the patient accounts manager's role in retaining healthcare organization customers.
- Explain how healthcare providers can improve service to their patients.
- Explain the Emergency Medical Treatment and Active Labor Act (EMTALA).
- Explain the use of advanced beneficiary notice (ABN)
- Explain Medicare-as-secondary-payer (MSP) requirements.
- Explain the benefits of an effective preadmission process, including steps for collecting cash up front.
- Identify activities and goals of financial counseling of a patient
- Describe the credit evaluation process that a healthcare organization can use.
- Describe under what circumstances patient discounts are appropriate.
- Discuss guidelines for determining advance deposits
- Describe payment alternatives, including those that a healthcare organization can make available to its patients as well as those a hospital may use to increase payment by self-pay patients.
- Discuss how hospitals can secure bank financing for a patient to pay their bill.
- Recognize the qualifications for determining Medicaid eligibility.
- Explain National Provider (NPI) initiative.
- Recognize Present on Admission (POA) options.

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Chapter 7. Claims Processing

- 7.0 Here's What You'll Learn
- 7.1 Charge Management
- 7.2 Coding and Reimbursement
- 7.3 Health Information Systems, Medical Records, Quality Assurance, Case Management, and Peer Review Organizations
- 7.4 Medicare Denials and Appeals
- 7.5 Claims Denial Management
- 7.6 Appeals
- 7.7 Stop-Loss Claims Management
- 7.8 Fraud and Abuse Controls
- 7.9 Professional Billing
- 7.10 Self-Assessment Exercise

Learner Objectives

- Explain why it is critical for a healthcare organization to accurately capture charges.
- Describe a typical charge process used by a healthcare organization.
- Discuss the three principal coding systems used by healthcare organizations, including coding modifiers.
- Explain how coding accuracy can affect provider reimbursement
- Explain prospective, concurrent, and retrospective review of cases under hospital utilization management.
- Describe the function and activities of the utilization management nurse.
- Differentiate case management from disease management.
- Define quality improvement organization (QIO) and explain its purpose.
- Describe the appeal process Medicare uses when a beneficiary disputes entitlement to certain medical services or the amount of money Medicare will pay.
- Describe use of the appeals process.
- Describe an effective process for managing denials
- Describe stop-loss and how it impacts reimbursement
- Differentiate Medicare fraud and abuse and describe penalties assessed under the Medicare-Medicaid Anti-Fraud and Abuse Amendments.
- Identify the forms used for professional and facility billing.
- Discuss advantages and disadvantages of combining responsibility for professional and facility billing.

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Chapter 8. Managed Care

- 8.0 Here's What You'll Learn
- 8.1 Introduction to Managed Care Realities
- 8.2 Introduction to Managed Medicare
- 8.3 Operationalizing Managed Care Contracts
- 8.4 Managed Care Contract Staffing Implications
- 8.5 Improving Managed Care Contracting Knowledge
- 8.6 Operational Evaluation
- 8.7 Managed Care Brings New Commitments to Patient Education
- 8.8 Making Managed Care Profitable
- 8.9 Trends in Managed Care
- 8.10 Accreditation
- 8.11 Self-Assessment Exercise

Learner Objectives

- Define the term “managed care.”
- Define the term “capitation,” both financially and operationally.
- Explain capitated managed care.
- Describe the common schemes of managed care reimbursement.
- Identify elements that should be incorporated into contract terms databases after a managed care contract is signed.
- Discuss methods that a healthcare organization can use to track managed care contract performance.
- Differentiate enrollee education from patient education.
- Describe why disease populations should be managed.
- Distinguish between traditional and reverse gatekeeping.
- Describe why disease populations should be managed.
- Describe key measures that would identify the effectiveness of providers, payers and physicians in a managed care environment.
- Describe the Utilization Review Accreditation Commission (URAC) process.

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Chapter 9. Legal Aspects

- 9.0 Here's What You'll Learn
- 9.1 Bankruptcy
- 9.2 Contracts
- 9.3 Third-Party Beneficiary Contracts (Insurance)
- 9.4 Litigation Policies and Procedures
- 9.5 Patient and Healthcare Provider Rights/Obligations
- 9.6 Regulatory Updates
- 9.7 Compliance Issues Related to PFS
- 9.8 Self Assessment Exercise

Learner Objectives

- Describe the steps involved in a Chapter 7 bankruptcy proceeding, including the order in which the general creditors are paid.
- List property exempt from distribution by the trustee in a Chapter 7 proceeding.
- List the types of debt that cannot be discharged.
- Define debtor reorganization bankruptcy (Chapter 11).
- Define debtor rehabilitation (Chapter 13).
- Describe the four elements necessary for a valid contract.
- Provide several examples of illegal agreements.
- Explain when oral contracts are enforceable.
- Describe the stages of litigation.
- Explain the rules of evidence that are followed in a judicial proceeding.
- Describe elements often contained in a healthcare organization's patient bill of rights.
- Describe under what circumstances the healthcare organization has to disclose patient records.
- Define the major components of HIPAA (Healthcare Insurance Portability and Accountability Act).
- Describe the role of regulatory agencies, including The Joint Commission, ORYX, Outcome Assessment and Information Set (OASIS), and Minimum Data Set (MDS).
- Express the objectives of Stark II Regulations.
- Recognize and identify compliance issues related to PFS (Patient Financial Services).
- State current issues about increased focus on uninsured and underinsured patients.

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Chapter 10. Physician Entities

- 10.0 Here's What You'll Learn
- 10.1 Practice Management
- 10.2 A/R Valuation
- 10.3 Physician Reimbursement Under Resource-Based Relative Value Scale (RBRVS)
- 10.4 Coding Accuracy
- 10.5 Practice Audits
- 10.6 Integration
- 10.7 Self-Assessment Exercise

Learner Objectives

- Differentiate operations of fee-for-service (FFS) and prepaid services (PPD) of physician practices/medical groups.
- Explain how tools are used to manage physician receivables, collections, and claims outstanding, including payment pattern approaches, ratio contracts, and aging structures.
- Explain elements of the physician work component of the Resource-Based Relative Value Scale (RBRVS).
- Explain use of the conversion factor and geographic adjustment in determining Medicare reimbursement to physicians.
- Explain potential situations for coding errors and tactics for addressing them.
- Differentiate consults from referrals.
- Describe the chart audit process and list the typical deficiencies discovered as a result.
- Explain the challenges in creating an effective integrated delivery system (IDS).
- Describe characteristics of a successful IDS.

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Chapter 11. Other Related Entities

11.0 Here's What You'll Learn

11.1 Other Related Entities Beyond the Acute Care Provider Setting

11.2 Skilled Nursing Facilities

11.3 Home Health Care

11.4 Hospice Care

11.5 End-Stage Renal Disease and Dialysis Care (ESRD)

11.6 Self Assessment Exercise

Learner Objectives

- Discuss requirements of a skilled nursing facility (SNF) to participate in the Medicare program, including physician certification and recertification statements, length of a benefit period, and coinsurance for a SNF benefit period.
- Define Medicare coverage conditions for home health agency (HHA).
- Explain situation in which an HHA may have arrangements with another health organization or person to provide home health services to patients.
- Describe the conditions that must be met for Medicare coverage of any home health service.
- Explain parameters for Medicare coverage of home health services, including recertification requirements for therapy and speech pathology services provided, coverage rules for ambulance service, and an intermediary review.
- Describe key concepts of the Home Health Resource Groups (HHRG) reimbursement system.
- Explain hospice care including who is eligible, the types of services covered, and how many periods of hospice care Medicare may cover.
- Differentiate routine care, continuous care, and respite care for hospice.
- Recognize the two methods of billing and payment for End-Stage Renal Disease and Dialysis Care (ESRD).