Medicare Managed Care Manual Chapter 5

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Compliant Processes for Health Plan and Delegated Entities SAS Institute

The federal government operates six major health care programs that serve nearly 100 million Americans. Collectively, these programs significantly influence how health care is provided by the private sector. Leadership by Example explores how the federal government can leverage its unique position as regulator, purchaser, provider, and research sponsor to improve care - not only in these six programs but also throughout the nation â € ™s health care system. The book describes the federal programs and the populations they serve: Medicare (elderly), Medicaid (low income), SCHIP (children), VHA (veterans), TRICARE (individuals in the military and their dependents), and IHS (native Americans). It then examines the steps each program takes to assure and improve safety and quality of care. The Institute of Medicine proposes a national quality enhancement strategy focused on performance measurement of clinical quality and patient perceptions of care. The discussion on which this book focuses includes recommendations for developing and pilot-testing performance measures, creating an information infrastructure for comparing performance and disseminating results, and more. Leadership by Example also includes a proposed research agenda to support quality enhancement. The third in the series of books from the Quality of Health Care in America project, this well-targeted volume will be important to all readers of To Err Is Human and Crossing the Quality Chasm - as well as new readers interested in the federal government â € ™s role in health care.

Medicare Law Jones & Bartlett Learning

Recent debates on Medicare reform focus on prescription drug coverage, expanding managed-care choices, or technical issues of payment policy. Despite all the heat generated by these issues, Edward F. Lawlor's new book, Redesigning the Medicare Contract, demonstrates that fundamental questions of purpose and policy design for Medicare have been largely ignored. Challenging conventional ideas, Lawlor suggests that we look at Medicare as a contract between the federal government, the program's beneficiaries, and health care providers. Medicare reform, then, would involve rewriting this contract so that it more successfully serves the interests of both beneficiaries and taxpayers. To do this, Lawlor argues that we must improve the agency of the program—the informational, organizational, and incentive elements that assure Medicare program carries out beneficiary and taxpayer interests in providing the most appropriate, high-quality care possible. The book includes a chapter devoted solely to concepts and applications that give definition to this brand of agency theory. Lawlor's innovative agency approach is matched with lucid explanation of the more comprehensive groundwork in the history and politics of the Medicare program. Lawlor's important and timely book reframes the Medicare debate in a productive manner and effectively analyzes alternatives for reform. Lawlor argues that effective policy design for Medicare requires greater appreciation of the vulnerability of beneficiaries, the complexity of the program itself, its wide geographical variations in services and financing, and the realistic possibilities for government and private sector roles. Tackling difficult problems like end-of-life and high-tech care—and offering sensible solutions—Redesigning the Medicare Contract will interest political scientists, economists, policy analysts, and health care professionals alike.

Section 1557 of the Affordable Care Act Elsevier Health Sciences

In Unmanageable Care, anthropologist Jessica M. Mulligan goes to work at an HMO and records what it's really like to manage care. Set at a health insurance company dubbed Acme, this book chronicles how the privatization of the health care system in Puerto Rico transformed the experience of accessing and providing care on the island. Through interviews and participant observation, the book explores the everyday contexts in which market reforms were enacted. It follows privatization into the compliance department of a managed care organization, through the visits of federal auditors to a health.

Health Insurance and Managed Care LexisNexis

Medicare is a federal program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act to provide health insurance to individuals 65 and older, and has been expanded over the years to include permanently disabled individuals under 65. Medicare, which consists of four parts (A-D), covers hospitalizations, physician services, prescription drugs, skilled nursing facility care, home health visits, and hospice care, among other services. Generally, individuals are eligible for Medicare if they or their spouse worked for at least 40 quarters in Medicare-covered employment, are 65 years old, and are a citizen or permanent resident of the United States. Individuals may also qualify for coverage if they are a younger person with a permanent disability, have End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant), or have amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease). The program is administered by the Centers for Medicare & Medicaid Services (CMS), and by private entities that contract with CMS to provide claims processing, auditing, and quality oversight services. In FY2013, the program will cover approximately 52 million persons (43 million aged and 9 million disabled) at a total cost of about $606 billion, accounting for approximately 3.7% of GDP. Spending under the

program (except for a portion of administrative costs) is considered mandatory spending and is not subject to the appropriations process. Services provided under Parts A and B (also referred to as "traditional Medicare"), are generally paid directly by the government on a "fee-for-service" basis, using different prospective payment systems or fee schedules. Under Parts C and D, private insurers are paid a monthly "capitated" amount to provide enrollees with at least a minimum standard benefit. Medicare is required to pay for all covered services provided to eligible persons, so long as specific criteria are met. Since 1965, the Medicare program has undergone considerable change. For example, during the 111th Congress, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148 and P.L. 111-152) made numerous changes to the Medicare program that modify provider reimbursements, provide incentives to increase the quality and efficiency of care, and enhance certain Medicare benefits. However, in the absence of further congressional action, the Medicare program is expected to be unsustainable in the long run. The Hospital Insurance (Part A) trust fund has been estimated to become insolvent in 2024. Additionally, although the Supplementary Medical Insurance (Parts B and D) trust fund is financed in large part through federal general revenues and cannot become insolvent, associated spending growth is expected to put increasing strains on the country's competing priorities. As such, Medicare is expected to be a high-priority issue in the 113th Congress, and Congress may consider a variety of Medicare reform options ranging from further modifications of provider payment mechanisms to redesigning the entire program.

Leadership by Example Simon and Schuster

This guide is a general summary that explains certain aspects of the Medicare Program, but is not a legal document.

Quality Improvement in Behavioral Health T L C Medical Publishing

"Explains for those 65 and older how to make [choices] in the annual Medicare enrollment period to maximize your health coverage without overpaying"--

The Nation's Health Jones & Bartlett Publishers

The origins of managed health care -- Types of managed care organizations and integrated health care delivery systems -- Network management and reimbursement -- Management of medical utilization and quality -- Internal operations -- Medicare and Medicaid -- Regulation and accreditation in managed care.

Applying Medicare's Rules to Clinical Practice NYU Press

The Medicare HandbookManaged CareWhat It Is and How It WorksJones & Bartlett Learning

Essentials of Managed Health Care The Medicare HandbookManaged CareWhat It Is and How It Works

SAS Programming with Medicare Administrative Data is the most comprehensive resource available for using Medicare data with SAS. This book teaches you how to access Medicare data and, more importantly, how to apply this data to your research. Knowing how to use Medicare data to answer common research and business questions is a critical skill for many SAS users. Due to its complexity, Medicare data requires specific programming knowledge in order to be applied accurately. Programmers need to understand the Medicare program in order to interpret and utilize its data. With this book, you'll learn the entire process of programming with Medicare data—from obtaining access to data; to measuring cost, utilization, and quality; to overcoming common challenges. Each chapter includes exercises that challenge you to apply concepts to real-world programming tasks. SAS Programming with Medicare Administrative Data offers beginners a programming project template to follow from beginning to end. It also includes more complex questions and discussions that are appropriate for advanced users. Matthew Gillingham has created a book that is both a foundation for programmers new to Medicare data and a comprehensive reference for experienced programmers. This book is part of the SAS Press program.

Redesigning the Medicare Contract Elsevier Health Sciences

Health Insurance and Managed Care: What They Are and How They Work (formerly titled Managed Care: What It Is and How It Works) is a concise introduction to the foundations of the American managed health care system. Written in clear and accessible language, this handy guide offers an historical overview of managed care and then walks the reader through the organizational structures, concepts, and practices of the managed care industry. The Fourth Edition is a thorough update that addresses the impact of the Affordable Care Act throughout the industry including: - New underwriting requirements - New marketing and sales channels - Limitations on sales, governance, and administrative (SG&A) costs and profits - New provider organizations such as Patient Centered Medical Homes (PCHMs) and Accountable Care Organizations (ACO's) - New payment mechanisms such as shared savings with ACOs, and severity-adjusted diagnosis related groups - Changes to Medicare Advantage - Medicaid expansion and reliance on Medicaid managed care

Medicare & You Aspen Pub

Elder Law Practice in Tennessee covers all aspects of elder law as it currently exists in Tennessee. This one volume treatise addresses senior citizens and the law relevant to the legal practitioner and others providing allied services. Using this book as a guide, you can feel confident when: • planning for medical, financial, and quality of life decisions, • setting up a conservatorship, • making ethical considerations in elder law practice, • choosing housing options for an elderly client, and • planning for long-term care. The appendices include an Elder Law Planning Questionnaire for client use, a table of current public benefits figures, life estate and life expectancy tables, as well as a resource directory.

Consumer Bill of Rights and Responsibilities University of Chicago Press

Long-Term Care Skilled Services: Applying Medicare's Rules to Clinical Practice Avoid common mistakes that compromise compliance and payment Take the mystery out of skilled services and know when to skill a resident based on government regulations, Medicare updates, the MDS 3.0, and proven strategies. "Long-Term Care Skilled Services: Applying Medicare's Rules to Clinical Practice" illustrates the role played by nurses, therapists, and MDS coordinators in the application and documentation of resident care. Don't miss out on the benefits and reimbursement you deserve, as author Elizabeth Malzahn delivers clear, easy-to-understand examples and explanations of the right way to manage the skilled services process. This book will help you: Increase your skilled census and improve your facility's reputation with the support of your entire staff Avoid under- and overpayments from Medicare with easy-to-understand explanations of complex rules and regulations Provide necessary skilled

services to each resident through a complete understanding of eligibility requirements Accurately document skilled services using proven, time-saving solutions Properly assess skilled services under the MDS 3.0 Improve communication to increase resident and family satisfaction Reduce audit risk and prove medical necessity through accurate documentation Table of Contents Rules and Regulations Original law - Social Security and Medicare Act CMS publications Manuals Transmittals MLN matters National and local coverage determinations "RAI User's Manual " Hierarchy of oversight CMS-MAC/FI, OIG, GAO, etc. Technical Eligibility for Skilled Services in LTC Eligibility basics Verification of current benefits How enrollment in other programs impacts coverage under traditional Medicare Hospice HMO/managed care/Medicare Advantage Medicaid/Medi-Cal Hospital stay requirement30-Day transfer rule for hospital or SNFUnderstanding benefit periodsCare continuation related to hospitalizationHow does a denial of payment for new admissions impact Medicare SNF admissions?Meeting the Regulatory Guidelines For "Skilled" Services Skilled services defined Regulatory citations and references Clinical skilled services Therapy skilled services Physician certifications and recertificationPresumption of coverageUnderstanding "practical matter" criteria for nursing home placement Impact of a leave of absence on eligibility MDS 3.0 - Assessments, Sections and Selection...Oh My! Brief history of MDS 3.0 Types of MDS assessments The assessment schedule Items to consider Importance of timing Review of each care-related section of the MDS 3.0Proper Communication During the Part A Stay Medicare meeting Timinng Agenda What to discuss for each resident Ending skilled services Notification requirements Discharging Other notification requirements and communicationOther Important Things to Know Medicare myths Consolidated billing Medical review Audience Administrators, CFO/CEOs, directors of nursing, MDS coordinators, directors of rehab, therapy directors, PT/OT/ST, DONs.

Medicare Provider Reimbursement Manual National Academies Press

Remington Education: Drug Information & Literature Evaluation teaches students how to effectively and efficiently locate and analyze up-to-date drug information and literature. It succinctly examines key drug information and literature-evaluation principles - the proper approach for answering drug/health information questions, tertiary and secondary resources, and practice guideline, systematic reviews and meta-analyses. Every chapter includes self-assessment questions; answers are located at the back of the book.

The Medicare Handbook National Academies Press

Health Sciences & Professions

Medicare and You 2006 Government Printing Office

An introductory textbook derived from the bestseller the Managed Health Care Handbook, Second Edition, this text provides all the basic information needed to learn critical concepts of managed care. Everything from types of managed care organizations, negotiating and contracting to controlling utilization and using data reports in medical management. An instructor's manual is available upon request.

Medicare Hospice Benefits NYU Press

Health Insurance and Managed Care: What They Are and How They Work is a concise introduction to the workings of health insurance and managed care within the American health care system. Written in clear and accessible language, this text offers an historical overview of managed care before walking the reader through the organizational structures, concepts, and practices of the health insurance and managed care industry. The Fifth Edition is a thorough update that addresses the current status of The Patient Protection and Affordable Care Act (ACA), including political pressures that have been partially successful in implementing changes. This new edition also explores the changes in provider payment models and medical management methodologies that can affect managed care plans and health insurer.

Coordinating Government Roles in Improving Health Care Quality Jones & Bartlett Learning

This combination textbook and workbook, explains each phase of the medical claim cycle, from the time the patient calls for an appointment until the financial transaction for the encounter is completed. Coverage includes types of insurance payers, basic coding and billing rules, and standard requirements for outpatient billing using the CMS-1500 claim form. It also emphasizes legal aspects related to each level of the medical claim cycle and the importance of the medical office employee, showing their responsibility for and impact on successful reimbursement. 3 separate chapters offer coverage of the basic concepts of medical coding.A comprehensive overview of the CMS-1500 claim form with step-by-step guidelines and illustrations thoroughly covers reimbursement issues and explains the billing process.Includes detailed information on various insurance payers and plans including Medicare, government medical plans, disability plans, private indemnity plans, and managed care.Stop & Review sections illustrate how the concepts presented in each chapter relate to real-life billing situations.Sidebars and Examples highlight key concepts and information related to the core text lesson.A companion CD-ROM contains sample patient and insurance information that readers can use to practice completing the accompanying CMS-1500 claim form, as well as a demonstration of Altapoint practice management software. Features completely updated information that reflects the many changes in the insurance industry.Contains a new chapter on UB-92 insurance billing for hospitals and outpatient facilities.Includes a new appendix, Quick Guide to HIPAA for the Physician's Office, to provide a basic overview of the important HIPAA-related information necessary on the job.

The Promise of Assistive Technology to Enhance Activity and Work Participation Simon and Schuster

A managed care expert overviews the history, structure, regulation, and issues of the complex US health care system. This second edition work was originally published by Aspen in 2002. Much of the information is distilled from another of the doctor's books, The Managed Care Handbook, 4th ed. An extensive glossary is included, but there are no refer

Conditions of Participation for Hospitals American Dental Association

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). This brief guide explains Section 1557 in more detail and what your practice needs to do to meet the requirements of this federal law. Includes sample notices of nondiscrimination, as well as taglines translated for the top 15 languages by state.

Managing Managed Care Jones & Bartlett Learning

"A must-read for both current and future retirees." —Robert Powell, Retirement Daily Includes the Most Up-to-Date Information for 2020-2021 Confused by Medicare? Get answers from Maximize Your Medicare, an informative guide by nationally recognized expert Jae W. Oh. Maximize Your Medicare helps readers understand how and what to choose when deciding on Medicare options. This book shows readers how to: Enroll in Medicare and avoid never-ending penalties Compare Medigap vs. Medicare Advantage Discern the differences among Parts A, B, and D Increase benefits every year Avoid costly errors Deal with special circumstances Get the most from the plan Written in a clear and concise style, Maximize Your Medicare is a vital resource for every American aged sixty-five or older, as well as for their families and care coordinators.