Medicare Managed Care Manual Chapter 5

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Medicare Hospice Benefits Simon and Schuster

Stay up on the latest in insurance billing and coding with Marilyn Fordney s Insurance Handbook for the Medical Office, 14th Edition.Trusted for more than 30 years, this market-leading handbook equips you to succeed as medical insurance specialist in any of today s outpatient settings. Coverage emphasizes the role of the medical insurance specialist in areas such as diagnostic coding, procedural coding, Medicare, HIPAA, and bill collection strategies. As with previous editions, all the plans that are most commonly encountered in clinics and physicians offices are incorporated into the text, as well as icons for different types of payers, lists of key abbreviations, and numerous practice exercises that assist you in accurately filling out claim forms. This new edition also features

expanded coverage of ICD-10, electronic medical records, electronic claims submission, and the HIPAA 5010 keeping you one step ahead of the latest practices and protocols of the profession.Key terms are defined and emphasized throughout the text to reinforce understanding of new concepts and te rminology.Separate chapter on HIPAA Compliance in Insurance Billing, as well as Compliance Alerts throughout the text highlights important HIPAA compliance issues to ensure readers are compliant with the latest regulations. Emphasis on the business of running a medical office and the importance of the medical insurance specialist details the importance of the medical insurance specialist in the business of the medical office.Increased focus on electronic filing/claims submission prepares readers for the industry-wide transition to electronic claims submission.Separate chapter on documentation in the medical office covers the principles of medical documentation and the rationales for it."Service to Patient" features in most chapters offer examples of good customer service.User resources on the Evolve companion website feature performance checklists, self-assessment quizzes, the Student Software Challenge (with cases on different payer types and an interactive CMS-1500 (02-12) form to fill in). NEW! Expanded coverage of ICD-10 prepares users to code ICD-10 with the planned effective date of October 2015.NEW! Added information on the electronic medical record and electronic claims submission including information on the

HIPAA 5010 equips users for the transition between paper and electronic methods of medical records and links the CMS-1500 (02-12) form to the electronic submissions process.NEW! SimChart for the Medical Office (SCMO) application activities on the companion Evolve website adds additional functionality to the insurance module on the SCMO roadmap."

Medicare Physician Guide The Medicare Hand bookManaged CareWhat It Is and How It Works

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.

Managing Managed Care

Jones & Bartlett Learning

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.

Elder Law Practice in Tennessee

National Academies Press

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.

Maximize Your Coverage, Minimize Your

Costs Jones & Bartlett Learning 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.

Medicare & You
Createspace Independent Pub
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.

Unmanageable Care
Government Printing Office
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

An Ethnography of Health Care Privatization in Puerto Rico 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.

Section 1557 of the Affordable Care Act Aspen Pub

Credentialing for Managed Care: Compliant Processes for Health Plan and Delegated Entities Amy M. Niehaus, CPMSM, CPCS, MBA New to managed care credentialing? Whether you work for a health plan or a hospital medical staff services department, this how-to guide answers all of your health plan credentialing and enrollment questions. Learn the regulatory and accreditation requirements related to managed care credentialing, including those from CMS, NCQA, and URAC. Author Amy M. Niehaus, CPMSM, CPCS, MBA, provides readers with the guidance to create a comprehensive and compliant credentialing program to support your health plan or to streamline your hospital's provider enrollment process through delegation. MSPs in all healthcare environments can benefit from understanding credentialing in the managed care world to support their organizational goals of compliance, operational

efficiency, cost savings, and practitioner satisfaction. This book will help you: * Understand NCQA, URAC, and CMS requirements for health plans * Develop a comprehensive and compliant managed care credentialing program * Establish delegated credentialing agreements * Audit credentials files * Recognize how payer credentialing requirements impact other healthcare organizations * Streamline provider enrollment through delegation * Identify the differences between hospital and managed care credentialing * Evaluate whether a credentials verification organization is right for your organization About the author: Amy M. Niehaus, CPMSM, CPCS, MBA, is a consultant with The Greeley Company, an industry-leading healthcare consulting firm. She has over 25 years' experience in the medical services and credentialing profession. In her current role, she advises clients in the areas of accreditation, regulatory compliance, credentialing, process simplification and redesign, credentialing technology, and credentials verification organizations (CVO) development and delegation. Niehaus has worked in multiple environments throughout her career, including acute care hospitals, CVOs, and managed care organizations

(MCO). She has been a member of the National Association Medical Staff Services (NAMSS) since 1991 and achieved her CPMSM certification in 1992 and her CPCS certification in 2002. Niehaus is a NAMSS instructor and previously served as chair of its MCO Task Force, as well as chair and member of the NAMSS Education Committee. She is a former president of the Missouri Association Medical Staff Services and its greater St. Louis area chapter. Niehaus holds a bachelor's degree from the University of Missouri and a master's degree in business administration from Maryville University in St. Louis. Niehaus has developed and presented various programs to local and national audiences on topics such as credentialing and privileging processes; Joint Commission, National Committee for Quality Assurance (NCQA), and URAC accreditation standards; and delegation.

Medicare and You 2006 NYU Press

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.

Drug Information and Literature Evaluation Pharmaceutical Press Health Sciences & Professions

The Promise of Assistive Technology to Enhance Activity and Work Participation NYU Press

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.

Get What's Yours for Medicare Elsevier Health Sciences

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

Coordinating Government Roles in Improving Health Care Quality Jones &

Bartlett Learning

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 plan, and into the homes of health plan members who recount their experiences navigating the new managed care system. In the 1990s and early 2000s, policymakers in Puerto Rico sold off most of the island ' s public health facilities and enrolled the poor, elderly and disabled into for-profit managed care plans. These reforms were supposed to promote efficiency, cost-effectiveness, and high quality care. Despite the optimistic promises of market-based reforms, the system became more expensive, not more efficient; patients rarely behaved as the expected health-maximizing information processing consumers; and care became more chaotic and difficult to access. Citizens continued to look to the state to provide health services for the poor, disabled, and elderly. This book argues that pro-market reforms failed to deliver on many of their promises.The health care system in Puerto Rico was dramatically transformed, just not

according to plan.

Health Insurance and Managed Care

American Dental Association

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.

Medicare Law **T L C Medical Publishing**

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.

Health Insurance and Managed Care

National Academies Press

The U.S. Census Bureau has reported that 56.7 million Americans had some type of disability in 2010, which represents 18.7 percent of the civilian noninstitutionalized population included in the 2010 Survey of Income and Program Participation. The U.S. Social Security Administration (SSA) provides disability benefits through the Social Security Disability Insurance (SSDI) program and the Supplemental Security Income (SSI) program. As of December 2015, approximately 11 million individuals were SSDI beneficiaries, and about 8 million were SSI beneficiaries. SSA currently considers assistive devices in the nonmedical and medical areas of its program guidelines. During determinations of substantial gainful activity and income

eligibility for SSI benefits, the reasonable cost of items, devices, or services applicants need to enable them to work with their impairment is subtracted from eligible earnings, even if those items or services are used for activities of daily living in addition to work. In addition, SSA considers assistive devices in its medical disability determination process and assessment of work capacity. The Promise of Assistive Technology to Enhance Activity and Work Participation provides an analysis of selected assistive products and technologies, including wheeled and seated mobility devices, upper-extremity prostheses, and products and technologies selected by the committee that pertain to hearing and to communication and speech in adults.

Redesigning the Medicare Contract Jones & Bartlett Learning

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

Managed Care Elsevier Health Sciences

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

Report to the President of the United States LexisNexis

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 rece rtificationPresumption of coverageUnderstan ding "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.