SECTION TWO

Hospital Billing and Coding Process

Patient Accounts and Data Flow in the Hospital
The Hospital Billing Process
Accounts Receivable (A/R) Management
Chapter 4

Patient Accounts and Data Flow in the Hospital

The purpose of this chapter is to provide a basic understanding of the patient care process and how data flow within a hospital from the time a patient is admitted to when charges are submitted for patient care services. The flow of information is a critical factor in providing efficient patient care and billing for services rendered during the patient visit. The process of admitting, treating, discharging, and billing patient care services requires various departments to perform specific functions simultaneously. One function is to document all information regarding patient care services including the patient's condition, disease, injury, illness, or other reason for treatment. Designated personnel within each department are responsible for documenting patient care services in the patient's medical record. Patient care services are coded and charges are entered by specified personnel in various clinical departments and by the Health Information Management (HIM) Department. Patient charges are submitted to patients and third-party payers after the patient is discharged. The concepts presented in this chapter are critical to understanding the hospital billing and claims process, which will be discussed in the next chapter.

Chapter Objectives

- Define terms, phrases, abbreviations, and acronyms related to patient accounts and data flow.
- Demonstrate an understanding of patient accounts and data flow for outpatient, ambulatory surgery, and inpatient services.
- Define patient admission and discuss procedures required to ensure quality of patient care.
- Outline the patient care process and provide an explanation of each component.
- Demonstrate an understanding of the admission process and forms utilized during the process.
- Provide an explanation of the insurance verification process.
- Describe the relationship between the admission process and billing for patient services.
- Discuss the purpose of medical record documentation and various forms and documents used in the medical record.
- Demonstrate an understanding of patient care services provided by a hospital.
- Provide an explanation of how charges are captured in the hospital.
- State the role of Health Information Management (HIM) in billing patient services.
- Demonstrate an understanding of the hospital billing process including denied, pended, and paid claims, and posting patient transactions.
- Demonstrate an understanding of the importance of accounts receivable management (A/R) and reports utilized.
PATIENT ACCOUNTS AND DATA FLOW

The flow of information in the hospital includes the patient’s demographic, insurance, and medical information. The flow of data begins when the patient reports to the hospital for patient care services. The type of data and flow vary based on the type of service the patient requires. As discussed in the previous chapter, various administrative, financial, operational, and clinical departments perform functions required to provide efficient patient care and submit charges to patients and third-party payers for services rendered. Clinical departments provide patient care services. Various administrative and operational departments perform other critical functions such as human resource management, compliance, health information management, and utilization management. Financial departments are responsible for preparing charges for submission and accounts receivable management. The data flow in a hospital is designed to ensure that required data are accessible for personnel to perform various functions. Automation of the patient’s accounts, order entry, charge capture, billing, and accounts receivable allow greater access to patient information by various individuals within the hospital, as illustrated in Figure 4-1.

The hospital’s health information system allows the recording, storage, processing, and access of data by various departments simultaneously. Departments that perform specific functions may use data entered by another department. This level of automation enhances the flow and use of information throughout the hospital.

The flow of information begins when the patient is received during the admission process. Variations in the

---

**Key Terms**

Accounts receivable (A/R) aging report

Admission

Admission Evaluation Protocol (AEP)

Admission summary

Advanced Beneficiary Notice (ABN)

Advanced directives

Ambulatory payment classification (APC)

Assignment of benefits

Charge capture

Charge Description Master (CDM)

CMS-1450 (UB-92)

CMS-1500

Co-insurance

Co-payment

Concurrent review

Deductible

Diagnosis related group (DRG)

Explanation of Benefits (EOB)

Explanation of Medicare Benefits (EOMB)

Encounter form

Facility charges

Financial class

Guarantor

Informed Consent for Treatment

Insurance verification

Medical necessity

Medical record

Medical record number (MRN)

Patient registration form

Professional charges

Prospective review

Remittance advice (RA)

Retrospective review

Written Authorization for Release of Information

**Acronyms and Abbreviations**

AEP—Admission Evaluation Protocol

ABN—Advanced Beneficiary Notice

APC—Ambulatory payment classification

A/R—Accounts receivable

ASC—Ambulatory Surgery Center

CCS—Certified Coding Specialist

CDM—Charge Description Master

CPC—Certified Professional Coder

DME—Durable medical equipment

DRG—Diagnosis Related Group

EMC—Electronic medical claim

EOB—Explanation of benefits

EOMB—Explanation of Medicare Benefits

ED—Emergency Department

ER—Emergency room

H & P—History and Physical

HIM—Health Information Management

JCAHO—Joint Commission on Accreditation of Healthcare Organizations

MAR—Medication administration record

MRN—Medical record number

OR—Operating room

PFS—Patient Financial Services

PPS—Prospective Payment System

PRO—Peer Review Organization

RA—Remittance advice

RHIT—Registered Health Information Technician

UB-92—CMS-Universal Bill 1992 (CMS-1450)

UM—Utilization management

UR—Utilization review
The flow of information occurs based on whether the patient presents for outpatient services, ambulatory surgery, or inpatient services. The flow of data is similar in each scenario; however, there are some variations in the data and its flow, as illustrated in Figures 4-2, 4-3, and 4-4.

Outpatient

Outpatient services are those that are provided on the same day that the patient is released. The patient is received in various outpatient areas such as the Emergency Department, laboratory, radiology, clinic, or primary care office. Admission tasks required to receive the patient are performed. Patient care services are rendered. Pharmaceuticals and other items such as supplies and equipment may be required. All patient care services are recorded in the medical record. Charges for outpatient services are entered through the Charge Description Master (CDM), commonly referred to as the chargemaster, which is a computerized system used by the hospital to inventory and record services and items provided by the hospital. Charges for services provided in a clinic or primary care office are posted to the patient account. The patient is released and the billing process begins. Accounts are monitored for follow-up to ensure that payment is collected in a timely manner. The flow of data for outpatient services is illustrated in Figure 4-2, A.

Outpatient Data and Flow Variations

Some variations in the type of data collected and how it flows involve the physician’s orders, requisitions, and referrals, Emergency Department services, and physician service charges.

Orders Requisitions, Encounter Forms, and Referrals

A physician order or requisition is required for services provided by hospital ancillary departments such as Cardiovascular, Laboratory, Radiology, or Physical Rehabilitation. These documents provide information to the department regarding the services required. Figure 4-2, B, illustrates an ancillary department requisition for radiology.

Emergency Department Services

Emergency Department visits do not require an order when the patient presents for service. If services are
required from other departments within the hospital, the Emergency Room (ER) physician will prepare an order or requisition.

If the patient is admitted to the hospital, all charges related to the Emergency Department visit are included on the inpatient bill.

**Physician Services**

Various physicians are part of the patient care team within the hospital. They provide services to patients and document those services in the patient’s medical record. Each physician bills charges for his or her service to the patient and third-party payers. Physician services are not billed by the hospital unless the physician is employed by or under contract with the hospital.

**Ambulatory Surgery**

Ambulatory surgery is a surgical procedure that is performed on a patient on the same day the patient is released (sent home). It is considered an outpatient service. Ambulatory surgeries can be performed in a hospital-based ambulatory surgery center (ASC) or in a designated area within the hospital. Physician’s orders are prepared by the surgeon and submitted to the ambulatory surgery unit. The patient is received in the ambulatory surgery unit or the preadmission testing
Outpatient Services

Services are provided in accordance with physician's orders, requisition, or referral. Services are performed and the patient is released on the same day. The following areas are involved:

- Emergency Department
- Laboratory
- Radiology
- Clinic
- Primary care office

area. Admission tasks required to receive the patient are performed. The appropriate clinical departments render patient care services. Pharmaceuticals, supplies, equipment, and other items may be required. All patient care services are recorded in the medical record. Charges for services and items are posted through the chargemaster. The patient is discharged and the billing process begins.

Accounts are monitored for follow-up to ensure that payment is collected in a timely manner. The flow of data for ambulatory surgery services is illustrated in Figure 4-3.
Ambulatory Surgery Data and Flow Variations

Some variations in the type of data collected and how it flows involve the physician services.

Physician Services

Ambulatory surgery involves a team of physicians such as a surgeon and anesthesiologist. Similar to the process for outpatient services, physician services performed for an ambulatory surgery are recorded in the patient’s medical record. Each physician submits charges for services performed. Professional charges for physician services are not billed by the hospital.

Inpatient

In an inpatient admission, the patient is admitted to the hospital with the expectation that he or she will be there for longer than 24 hours. A room/bed is assigned, and 24-hour nursing care is provided. There are several ways a patient can be referred to the hospital for an inpatient admission: through the ER, by outside physician referral, or from another facility.

Physician’s orders are prepared by the admitting physician and provided to the hospital. Admission tasks required to receive the patient are performed. The appropriate clinical departments render patient care services. Pharmaceuticals, supplies, equipment, and other items may be required. All patient care services...
are recorded in the medical record. Charges for services and items are posted through the chargemaster. The patient is discharged and the billing process begins. Accounts are monitored for follow-up to ensure that payment is collected in a timely manner. The flow of data for inpatient services is illustrated in Figure 4-4.

**Inpatient Data and Flow Variations**

Variation in the data and flow of information for an inpatient case varies based on where the patient is admitted. For example, if the patient is admitted through the ER, much of the admission process is performed there. Another variation in the process involves physician service charges.
Section Two: Billing and Coding Process

Patient accounts data flow for inpatient services.

**Inpatient Services**
A patient is admitted with the expectation that he or she will be in the hospital for more than 24 hours.
Services are provided in accordance with physician orders.
The patient is assigned a room/bed.
Nursing care is provided on a 24-hour basis.
Diagnostic and therapeutic services are provided by various clinical departments.

**Admission Process Variations**
Variations in the process and in the information obtained are based on the type of admission, as follows:
- Outpatient
- Emergency Department
- Ancillary departments (Radiology, Pathology/Laboratory, etc.)
- Clinic
- Primary care office
- Ambulatory surgery
- Inpatient
Physician Services

As discussed previously, physician services are documented in the patient’s medical record. Each provider submits charges for his or her services. They are not billed by the hospital. Professional charges for physicians such as the radiologist, cardiologist, surgeon, or anesthesiologist are not billed by the hospital.

Regardless of where the patient is received, the data collected at admission flows to various clinical departments that are involved in the patient’s care. Each department involved in patient care, directly or indirectly, records pertinent information regarding patient care services in the patient’s medical record. Charges are posted to the patient’s account through the chargemaster. The chargemaster is reviewed and updated continually by the HIM Department. When the patient is discharged, the medical record is forwarded to the HIM Department for review, coding, and assignment of the appropriate prospective payment group such as the Diagnosis Related Group (DRG) for inpatient cases or ambulatory payment classification (APC) for outpatient surgical cases.

The Utilization Management (UM) Department is responsible for case management and utilization review of patient cases, as discussed in the previous chapter. UM conducts reviews of patient cases to determine the appropriateness of services provided based on the patient’s condition. The initial review performed by UM is done when the patient is admitted.

The billing process utilizes all information that has accumulated during the patient care process to submit charges to the patient and third-party payers. Outstanding accounts are monitored for follow-up by the Patient Financial Services (PFS) Department, commonly referred to as the Credit and Collections Department. The chargemaster and prospective payment systems will be discussed in detail in future chapters.

To provide a better understanding of the flow of patient account data and the patient care process, we will first discuss the concept of patient admission.

PATIENT ADMISSION

The definition of admission is “the act of being received into a place” or “patient accepted for inpatient services in a hospital.” The admission process consists of various functions required to receive a patient at the hospital facility. Admission functions must be performed regardless of whether the patient presents to the hospital for outpatient services, ambulatory surgery, or inpatient admission. The purpose of the process is to obtain required information, determine patient care needs, and put a system into place to address patient care needs. A patient can be received at various levels in the hospital such as at the Emergency Department, ambulatory surgery, or inpatient hospital level.

A patient admission requires the hospital to follow specific procedures to ensure that quality patient care services are provided such as preadmission testing. Hospitals must meet Admission Evaluation Protocols (AEPs) for admission. Utilization review (UR) is performed to evaluate compliance with AEPs and other standards. Payers also conduct reviews to ensure that services provided are medically necessary, such as those conducted by a Peer Review Organization (PRO).

Preadmission Testing

Preadmission testing is required when a patient is admitted on an inpatient basis or for ambulatory surgery. The admitting physician prepares orders outlining preadmission testing requirements. Preadmission testing will vary based on the reason the patient is being admitted and the patient’s condition. Preadmission testing can include but is not limited to blood tests, EKG, X-ray, urinalysis, ultrasound, and echocardiograms. The purpose of preadmission testing is to identify potential medical problems prior to surgery and to obtain a baseline of health care information on the patient’s body system functions. The tests are done prior to admission to allow time for the results to be reviewed prior to admission of the patient.

BOX 4-7 □ KEY POINTS
Patient Accounts Data Flow
Information collected at admission
Clinical departments render patient care services
Medical record documentation
Charge capture
Patient discharge, medical record forwarded to HIM
PFS prepares charges for submission
Accounts receivable management monitors and follows-up on outstanding accounts

BOX 4-8 □ KEY POINTS
Admission
Admission is defined as “the act of being received into a place” or “patient accepted for inpatient services in a hospital.”
Patients can be received at the Emergency Department, an ancillary department, a clinic, a primary care office, ambulatory surgery, or inpatient admission.
The admission process includes various functions required to receive a patient at the hospital facility for the purpose of obtaining required information to address patient care needs and bill for services rendered.
Utilization Review

The purpose of the UR process, as discussed in the previous chapter, is to ensure that the care provided is medically necessary and that the level where care is provided is appropriate based on the patient’s condition. Medical necessity refers to services or procedures that are reasonable and medically necessary in response to the patient’s symptoms, according to accepted standards of medical practice. The definition of medical necessity varies from payer to payer.

Hospitals have implemented utilization management measures to ensure that patient care standards are met as required by:
- Federal and state licensing requirements
- Joint Commission for Accreditation of Healthcare Organizations (JCAHO) standards
- Participating provider agreements with various payers and government programs
- A PRO, which has the authority to deny payment for services that do not meet stated requirements

The hospital’s UM Department performs various functions to ensure that all guidelines for utilization are met and that hospital services are reimbursed appropriately. The UM Department monitors health care resources utilized at the facility by conducting URs of patient cases to determine whether:
- Services are medically necessary as defined in participating provider agreements
- The level of service for provision of health care is appropriate according to the patient’s condition
- Quality patient care services are provided in accordance with standards of medical care
- The hospital length of stay is appropriate

The UM Department will determine whether documentation provides explanation and support for medical necessity, level of care, length of stay, and quality of care. If the documentation is not sufficient, a request for additional information is submitted to the provider. Discharge planning is another function performed by the UM Department; it includes an evaluation of the patient to determine whether discharge is appropriate and to identify patient needs after discharge. The department assists in developing a discharge plan that addresses patient care needs after discharge and coordinates various medical and financial resources in the community to meet patient care needs.

The UM Department is involved in resource utilization prior to the admission process, during the patient stay, and after the discharge process. URs can be conducted before, during, and after services are rendered.

Admission Evaluation Protocol

As discussed previously, a function of the UM Department is to conduct URs. Requirements for URs implemented under the Prospective Payment System (PPS) mandate that the organizations follow specific criteria for the admission of Medicare patients. Other health care payers such as Blue Cross/Blue Shield (BC/BS), Aetna, and Cigna have also implemented UR measures in their plans. UR criteria will vary from payer to payer. Most payer requirements for appropriateness of hospital cases are based on the patient’s condition. The purpose of the UR requirements is to ensure that hospital services provided are appropriate and medically necessary.

The review of hospital admissions for Medicare patients is designed to determine the appropriateness of an admission, based on the patient’s condition. Appropriateness of admission is determined utilizing the AEP that outlines appropriate conditions for a hospital admission based on standards referred to as the IS/SI criteria. IS refers to the intensity of service criteria. SI refers to the severity of illness criteria.

Hospitals review each patient admission to determine whether the AEP criteria for each specific payer are met. As outlined in Tables 4-1 and 4-2, an admission can be certified if one of the SI or IS criteria is met. Contact is generally made with the payer within 24 hours to obtain admission certification. The purpose of obtaining admission certification is to ensure that the hospital is reimbursed for the hospital stay. Health care providers also conduct URs to determine the appropriateness of admission. Medicare, for example, utilizes a PRO to perform this function.

Peer Review Organization

A PRO is an organization that contracts with Medicare and other payers to review patient cases to assess appropriateness and medical necessity. Medicare provides information on an admission to the PRO for evaluation. The PRO has a direct impact on reimbursement because it has the authority to deny payment for a hospital admission if it is determined that the AEP criteria are not met. The PRO may conduct reviews before the patient is admitted, at the time of admission, or at some point during the inpatient stay. The various reviews

BOX 4-9 KEY POINTS

Utilization Review (UR)
Review patient care services to ensure that:
• Services are medically necessary
• Level of service is appropriate
• Quality patient care services are provided
• Hospital length stay is appropriate
Prospective Review

A prospective review is performed prior to the patient’s admission. Information regarding the patient’s condition is reviewed to determine appropriateness for the admission and length of stay.

Concurrent Review

A concurrent review is generally ongoing throughout the hospital stay; it begins at admission. A review is performed to determine appropriateness of admission and care provided.

Retrospective Review

A retrospective review is performed after the patient is discharged. The review is performed to determine appropriateness of admission and care provided.

THE PATIENT CARE PROCESS

The patient care process is complex, as it involves many departments simultaneously performing various tasks.
## TABLE 4-2 Screening Criteria Designed for Non-Physician Use

<table>
<thead>
<tr>
<th>Intensity of Service</th>
<th>Notes/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Special monitoring every 2 hours or more often as necessary/appropriate for patient’s condition</td>
<td>TPR, B/P, CVP, ABG, pulmonary artery pressure (Swanz-Ganz), arterial lines</td>
</tr>
<tr>
<td>2. Observation and monitoring of neurological status every 2 hours or more often as necessary/appropriate for patient’s condition</td>
<td>Documented in medical record</td>
</tr>
<tr>
<td>3. Intravenous fluids (except KVO) and requiring at least 2000 cc in 24 hours</td>
<td></td>
</tr>
<tr>
<td>4. IV or IM medications every 12 hours or more frequently</td>
<td>If applicable to severity of illness</td>
</tr>
<tr>
<td>5. IV or IM analgesics 3 or more times daily</td>
<td>Pain not controlled as an outpatient</td>
</tr>
<tr>
<td>6. Respiratory assistance</td>
<td>Ventilator, O₂</td>
</tr>
<tr>
<td>7. Surgery performed (excluding outpatient surgery procedures list)</td>
<td>On admission or scheduled within 24 hours in continued stay</td>
</tr>
<tr>
<td>8. IV chemotherapy: antineoplastic agent</td>
<td>Vinblastine sulphate (Velban) or a combination of 2 or more agents</td>
</tr>
<tr>
<td>a. Platinol based agent (initial or maintenance) when dosage is ≥60 mg/m², or</td>
<td></td>
</tr>
<tr>
<td>b. Methotrexate (&gt;500 mg) with Leucovorin rescue, or</td>
<td></td>
</tr>
<tr>
<td>c. Administered intracavitary, intrathoracic, intraarterial, intraperitoneal, or intraabdominal transfusions, or</td>
<td></td>
</tr>
<tr>
<td>d. Continuous or intermittent IV infusion of drugs for more than 1 day, or</td>
<td></td>
</tr>
<tr>
<td>e. Intrathecal administration for meningeal carcinoma with neurological symptoms, or</td>
<td></td>
</tr>
<tr>
<td>f. IV antineoplastic agent with</td>
<td></td>
</tr>
<tr>
<td>i. History of previous severe adverse effect to agent, or</td>
<td>Severe nausea or vomiting</td>
</tr>
<tr>
<td>ii. Initial administration (not maintenance dose) for cancer, or</td>
<td></td>
</tr>
<tr>
<td>iii. Medical condition that prevents monitoring of patient and obtaining laboratory as an outpatient (bed bound)</td>
<td></td>
</tr>
<tr>
<td>9. Radiation</td>
<td></td>
</tr>
<tr>
<td>a. Intracavitary or interstitial therapy</td>
<td></td>
</tr>
<tr>
<td>b. Irradiation of weight-bearing bone subject to fracture</td>
<td></td>
</tr>
<tr>
<td>c. Implantation of radioactive material in head, neck, or in reproductive organs</td>
<td></td>
</tr>
<tr>
<td>d. Isolation required due to radiation implant</td>
<td></td>
</tr>
<tr>
<td>e. IV pain medication necessary during radiation therapy</td>
<td></td>
</tr>
<tr>
<td>f. IV hydration necessary during radiation therapy</td>
<td></td>
</tr>
</tbody>
</table>

### Discharge Indicators

1. Continued care and services could be rendered safely and effectively in an alternate setting
2. Oral temperature <101°F for at least 24 hours without antipyretics
3. Type and/or dosage of major drug unchanged for past 24 hours
4. No parental analgesics/narcotics for last 12 hours | Exception: chronic pain from terminal illness or appropriate transfers to other facility |
5. Voiding or draining urine (at least 800 cc) for last 24 hours or catheter removed and voiding sufficiently
related to patient care services. The process of providing patient care begins when a patient is admitted and continues until the patient is discharged. To provide effective and efficient patient care services and maintain financial stability, it is necessary to obtain all information required to evaluate and treat the patient and to bill for patient care services. All patient care activities must be recorded in the patient’s medical record to ensure that appropriate care is provided based on the patient’s condition. It is critical to capture all charges for submission to patients and third-party payers. Outstanding accounts must be monitored to obtain reimbursement in a timely manner. To achieve high standards of patient care and maintain financial stability, the hospital must have an efficient flow of information through the patient care process. Figure 4-5 illustrates the phases of the patient care process: patient admission, patient care services, medical record documentation, charge capture, coding, patient discharge, HIM – review/coding, billing process, review record and charges, prepare charges for submission, accounts receivable management, monitor and follow-up on outstanding accounts.

### TABLE 4-2 Screening Criteria Designed for Non-Physician Use – Cont’d.

<table>
<thead>
<tr>
<th>Intensity of Service</th>
<th>Notes/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Passing flatus/fecal matter</td>
<td></td>
</tr>
<tr>
<td>7. Diet tolerated for 24 hours without nausea or vomiting</td>
<td></td>
</tr>
<tr>
<td>8. Wound(s) healing; no evidence of infection without documented, appropriate plan of outpatient treatment</td>
<td></td>
</tr>
<tr>
<td>9. Discharged to SNF but refuses available SNF bed</td>
<td></td>
</tr>
<tr>
<td>10. Stable hemoglobin/hematocrit</td>
<td></td>
</tr>
</tbody>
</table>

*ABG, Arterial blood gas; B/P, blood pressure; CVP, central venous pressure; IM, intramuscular; IV, intravenous; KVO, keep vein open; SNF, skilled nursing facility; TPR, temperature, pulse, and respiration; WBC, white blood count.*

### BOX 4-10 ■ KEY POINTS

**Admission Evaluation Protocols (AEPs)**

As mandated under Prospective Payment Systems (PPS), hospitals must follow specific criteria for the admission of a Medicare patient. The appropriateness of an admission is determined utilizing AEP criteria, which outline appropriate conditions for a hospital admission based on the following criteria:

- Intensity of service (IS)
- Severity of illness (SI)

### BOX 4-11 ■ KEY POINTS

**Peer Review Organization (PRO)**

PROs contract with Medicare and other payers to review patient cases to ensure that:

- Services are medically necessary
- Admission Evaluation Protocol (AEP) criteria are met

PROs have a direct impact on reimbursement because they have the authority to deny payment if AEP criteria are not met.

The types of reviews are as follows:

- Prospective
- Concurrent
- Retrospective

---

*Figure 4-5 Phases of the patient care process.*
1. List three types of information included in the flow of information in a hospital.

2. Explain how the hospital's health information system enhances the access and flow of data.

3. Discuss three service types that result in variations of the type of data and its flow.

4. Explain when a physician order, requisition, or referral is required for outpatient, ambulatory surgery, or inpatient services.

5. How does the type of data and flow vary for inpatient services?

6. Explain when physician services are billed by the hospital.

7. List five outpatient areas where a patient may be seen in the hospital.


9. Explain what an inpatient admission is and list three areas a patient can be admitted from.

10. Create a brief outline that illustrates how data flows within the hospital regardless of where the patient is received.

11. Provide a definition of admission and discuss what it means in the hospital.

12. Discuss the purpose of preadmission testing.

13. Provide a brief explanation of the purpose of utilization review.

14. How does utilization review relate to medical necessity?

15. Hospitals are required to follow specific admission criteria for Medicare patients as outlined under what regulations?

16. State the purpose of AEP protocols and list two standards that hospitals follow.

17. Explain what department within the hospital is involved in AEP protocol reviews.

18. What is a PRO?

19. Discuss the impact PRO reviews can have on reimbursement.

20. List and provide a brief explanation of three types of reviews conducted by a PRO.
mentation, charge capture and coding, patient discharge, billing, and accounts receivable management.

THE ADMISSIONS PROCESS

The admissions process refers to the various tasks performed when a patient is received at the hospital or admitted as an inpatient. The phases in the process are standard; however, there are variations based on the type of admission. Variations may involve the forms used and some of the functions. The Admissions Department performs functions required to receive the patient, which involves obtaining all required information. The UR Department conducts a review of the admission to ensure that AEP criteria are met. This process begins with the patient interview and it includes registration of patient information, utilization review, insurance verification, preparation of the patient chart, assignment of a room/bed, preparation of an admission summary (face sheet), and updating the hospital’s census (Figure 4-6).

Patient Interview

The patient interview is conducted for the purpose of obtaining information regarding the patient and his or her insurance. Required consents and authorizations are also obtained during the patient interview, including a signed informed consent for treatment, written authorization for release of information, signed assignment of benefits, the patient’s advanced directives, and an advanced beneficiary notice when appropriate. The information obtained from the patient is entered into

![Figure 4-6 The admissions process.](image)

![Figure 4-7 Sample patient registration form.](image)
the patient’s computer account and placed in the patient’s medical record. It may also be necessary to obtain financial information from the patient to assist the patient in finding alternative resources for payment of health care services.

**Patient and Insurance Information**

Patient information is obtained by the hospital through the use of a patient registration form. The patient registration form varies by hospital. The form generally contains fields for information regarding the patient, insurance carrier, guarantor, diagnosis, and physician, as illustrated in Figure 4-7. The patient registration form is completed by the patient and reviewed by the admission representative.

**Patient Information**

This section is utilized for recording the patient’s demographic information. Demographic information is data about the patient such as the patient’s name, address, phone number, date of birth, sex, religion, and employer. A copy of the patient’s driver’s license is generally obtained for identification purposes.

**Insurance Information**

This section is utilized to record information regarding the insurance carrier or government program under which the patient has coverage. Insurance information includes the name, address, and phone number of the primary and secondary carrier. The plan information is also required, such as plan and group number and patient identification number. The subscriber name is required if the patient is not the policyholder.

Insurance card(s) contain information regarding the insurance plan or government program under which the patient has coverage. A copy of the insurance card is made (front and back) and maintained in the patient’s medical record. It is important to copy both sides of the card since they contain information regarding the patient’s co-payments, the authorization phone numbers, and the insurance company address.

**Guarantor Information**

This section is utilized to record the name, address, phone number, and social security number of the guarantor. The guarantor is the individual who is responsible for paying for services rendered. The patient is the guarantor unless he or she is a minor or incapable. In these situations the patient’s guardian or person holding the power of attorney may be the guarantor, for example, when a power of attorney is designated for an elderly patient who is unable to handle his or her affairs.

**Diagnosis and Physician Information**

Information regarding the patient’s condition and the referring or admitting physician is recorded in this section. It is important to obtain information regarding the patient’s condition as it provides an explanation of the reason for the hospital visit. This information is utilized to determine compliance with AEP criteria, verify insurance, and obtain an advanced beneficiary notice (ABN).

**Financial Information**

It may be necessary to obtain information regarding the patient’s financial status, such as income, expenses, and assets. When the patient does not have insurance coverage, the PFS Department may utilize this information to provide assistance in finding other funding resources for health care services.

**Consents and Authorizations**

Hospitals utilize a variety of forms to obtain consents and authorizations. A facility may use one form that contains the informed consent, authorization, and assignment of benefits (Figure 4-8). Other facilities may have separate forms for such benefit information.

**Informed Consent for Treatment**

The Informed Consent for Treatment form is utilized by the hospital to obtain the patient’s authorization for treatment. The form must be signed by the patient before treatment can be provided. The patient usually signs the Informed Consent for Treatment unless the patient is a minor or incapable. When the patient is unable to sign, a parent, guardian, health surrogate, or an individual with a power of attorney may sign.

**Written Authorization for Release of Medical Information**

The Written Authorization for Release of Medical Information provides the hospital with the authorization to release personal health information when required for treatment and to obtain payment for services. A breach of confidentiality will occur if information is released without authorization from the patient.

**Assignment of Benefits**

The patient signs the Assignment of Benefits form to instruct the insurance company or government plan to forward benefits (payments for services) to the hospital.

**BOX 4-14 □ KEY POINTS**

**Patient and Insurance Information**

- The following information is obtained during the admission process:
  - Patient information (demographic)
  - Insurance information
  - Guarantor information
  - Diagnosis and physician information
  - Financial information
Advanced Directives

The patient’s advanced directives provide instructions regarding measures that should or should not be taken in the event that medical treatment is required to prolong life. The hospital can provide a patient with advanced directive forms for completion if the patient has no advanced directives.

An Advanced Directive can be either a living will or a durable power of attorney. A living will is a written document that allows a competent adult to indicate his or her wishes regarding life-prolonging medical treatment. A durable power of attorney for health care is a written document that is used to appoint a competent adult to make any medical decisions on his or her behalf in the event the person becomes incapacitated.*

Many hospitals use an advanced directives checklist to document that a patient was informed about advanced directives (Figure 4-9).

Advanced Beneficiary Notice

An ABN informs the patient that there is reason to believe the admission will not be covered by Medicare. The patient’s signature is required on this form to acknowledge that he or she will be financially responsible if Medicare does not cover the service (Figure 4-10).
Patient Registration

The patient registration process consists of creating a patient account on the hospital’s computer system and entering patient information obtained during the patient interview. The patient’s account is the computerized record by which the patient information is recorded and maintained. An account and medical record number are assigned to each patient either by the system or by the person entering the information. The account is updated when required to reflect new information or changes in current information. Financial activity is also entered on the patient’s account. Financial activity is discussed in detail in Chapter 5.

Utilization Review

As discussed previously, the UM Department performs a UR to ensure that AEP criteria are met and that patient care services are appropriate and medically necessary.

Insurance Verification

Insurance verification is the process of contacting the patient’s insurance plan to determine various aspects of coverage such as whether the patient’s coverage is active, what services are covered, authorization require-
Insurance verification is required to ensure that the hospital will receive payment for services rendered and to determine the patient’s share of the hospital’s charges, referred to as the patient’s responsibility. The individual responsible for verifying insurance contacts the insurance company or government program to:

- Verify that the patient’s insurance coverage is active
- Ascertain what services will be covered
- Ensure that AEP criteria are met
- Obtain prior authorization or precertification
- Determine the amount for which the patient is responsible (deductible, co-insurance, or co-payment).

The deductible is an annual amount determined by each payer that the patient must pay before the plan pays benefits for services. For example, the patient may be required to meet a $500 deductible annually before the payer will provide reimbursement for services.

Co-insurance is an amount the patient is responsible to pay that is calculated based on a percentage of approved charges. An example of co-insurance may be a plan that requires the patient to pay 20% of the approved amount for health care services.

Co-payment is a set amount that is paid by the patient for specific services. Co-payment amounts vary by service. For example, the patient’s plan may require the patient to pay a $300 co-payment for an ambulatory surgery procedure. Co-payment is commonly referred to as copay.

The insurance verification process can be performed during the preadmission process or on the date of admission. A representative from the Admissions Department or the PFS Department may perform verification.

**Patient’s Medical Record (Chart)**

The patient’s medical record is a chart or folder where the patient’s information is stored, including demographic, insurance, financial, and medical information. Each patient seen in the hospital has a medical record. Medical records are assigned a medical record number. The medical record number (MRN) is a unique identification number assigned by the hospital to each patient’s medical record. The MRN assigned by the hospital generally remains the patient’s medical record number indefinitely. Many hospitals have an electronic medical record system where the patient’s medical information is maintained on a computer system. A bracelet is prepared with the patient’s name, room number, medical record number, and admitting physician’s name. The patient is required to wear the bracelet for the purpose of identification while in the hospital.
Room/Bed Assignment

A patient who is admitted on an inpatient basis is assigned a room and/or a bed. Semiprivate rooms have two beds in each room; therefore the patient would be assigned a room and a bed. Room assignment is also performed in outpatient areas such as Ambulatory Surgery, the Emergency Department, or Observation. The room assignment is recorded on the patient's record.

Admission Summary (Face Sheet)

An admission summary is also known as a face sheet; it is a summary of information about the patient's admission, such as the patient's name and address, insurance company name, reason(s) for admission, attending physician's name, and referring physician's name. The admission summary is prepared and distributed to the appropriate individuals (Figure 4-11).

Census Update

The hospital's census is a daily listing of rooms available for assignment (Figure 4-12). To update the hospital's census list, admissions personnel must record the patient's name next to the room/bed that was assigned. Room assignments are also recorded on the computer system for reporting purposes. The census is maintained daily, and census statistics are frequently reviewed to monitor the hospital's admissions.

Medical Record Documentation

Medical record documentation is critical to the provision of patient care services and for billing patient care services. The HIM Department is involved in both areas as it is responsible for the patient's medical record and performs many important functions related to reimbursement for patient care services.

As discussed previously, all pertinent information regarding patient care services is recorded in the pa-
tient’s medical record. Patient records include various documents gathered throughout the patient stay from admission to after discharge. They are legal documents, and ensuring the confidentiality and security of these records is a critical function of HIM. As discussed previously, HIM is responsible for the organization, maintenance, production, storage, retention, dissemination, and security of patient information. The HIM Department also monitors documentation to ensure that documentation standards are met throughout the hospital. To achieve this goal, HIM may be involved in the development and revision of hospital forms. Two important functions performed by HIM that have a direct impact on the reimbursement process are:

1. Maintenance of the chargemaster.
2. Coding of clinical data for claim submission.

HIM personnel include certified coders whose responsibilities include coding procedures, items, and patient conditions recorded in the patient’s medical record. The codes selected by HIM are recorded in the computer systems, and they are utilized for DRG/APC assignment and to describe what services were performed and why on the claim form.

To understand the significance of the medical record and HIM responsibilities, it is necessary to understand the purpose and content of medical record documentation.

### Purpose of Documentation

The purpose of medical record documentation is to have a detailed accounting of all patient care activities. Medical record documentation serves many purposes in a health care facility, such as enhancing communications, supporting charges billed, improving utilization review, and providing protection from liability.

### Communication

A detailed recording of all information regarding the patient’s condition and patient care services enhances communication between providers involved with the patient’s care. Review of complete and detailed documentation can assist providers in gaining a better understanding of all aspects of the patient case. This knowledge is critical to the provider’s ability to assess the patient’s condition and develop an effective treatment plan.

### Support Charges Billed

The golden rule in coding and billing is “IF IT IS NOT DOCUMENTED, DO NOT CODE IT OR BILL IT.” Comprehensive documentation that includes all services and items provided is necessary for submission of charges to payers. Payers do not provide reimbursement for services that are not medically necessary. A detailed recording of all information regarding the patient’s condition provides an explanation of the medical necessity for services provided.

### Utilization Review

Documentation is utilized for UR conducted within the hospital to determine the appropriateness of care. Documentation is also utilized for payer reviews such as those conducted by the PRO.

### Liability

Thorough and complete documentation is considered the best defense in a liability case. Medical records are

---

**Figure 4-12** Hospital daily census report. (Modified from Abdelhak M, Grostick S, Hanken MA, Jacobs E (editors): Health information: management of a strategic resource, ed 2, St Louis, 2001, Saunders.)
1. Discuss why the patient care process is complex in the hospital.

2. When does the patient care process begin?

3. Explain why it is important to obtain all required information to treat the patient and bill for services.

4. List seven phases in the patient care process and provide a brief overview of the phases.

5. How does the admission process relate to the patient care process?

6. Provide a brief explanation of what the admission process is and its purpose.

7. Outline the major functions performed during the admission process.

8. State the purpose of the patient interview.

9. Describe three types of information obtained during the patient interview.

10. Define guarantor and discuss what guarantor information is required.

11. Discuss four reasons why information regarding the patient’s diagnosis must be obtained.

12. Explain the patient registration process and why it is important to create a patient account.

13. State the purpose of insurance verification and provide a brief overview.

14. Indicate the purpose of the AOB form.

15. Identify the form required to prevent breach of confidentiality.

16. What is the purpose of the patient’s medical record?

17. Discuss how room/bed assignment affects census updating.

18. Provide a brief explanation of an admission summary.

19. Explain the relationship between UR and AEP protocols.

20. State the purpose of an ABN.
reviewed in liability cases to determine negligence with regard to the provision of patient care services.

It is because documentation serves so many purposes that the content of a medical record is very detailed. To provide an understanding of how documentation relates to each of the purposes discussed above, it is necessary to look at the content of a medical record.

**Content of the Patient’s Medical Record**

Documentation is a chronological recording of a patient’s assessment, diagnosis, treatment plan, and outcomes of treatments. Specific elements are required in documentation:

- All conditions, diagnosis, injury, illness, disease, and/or other reasons for the visit
- Plan of care for the treatment of the patient’s condition
- All diagnostic and therapeutic procedures performed
- Outcomes of diagnostic and therapeutic procedures

Documentation is maintained in a chart called the medical record. The chart is organized in sections that contain relative forms and notes. The medical record contains the following documents: admission forms, admission summary, history and physical, physician orders, progress notes, ancillary and other clinical department reports, medication administration records, and discharge summary. Figure 4-13 gives a list of the medical record documents.

**Admitting Forms**

Various forms are obtained when the patient is admitted, including patient registration, authorizations, release of information, written consent for treatment, assignment of benefits, advanced directives, and ABN when required.

**Admission Summary (Face Sheet)**

As discussed earlier, the face sheet is an outline of information regarding the patient’s admission, such as date of admission, admitting diagnosis, admitting physician, referring physician, and insurance. This summary is maintained in the patient’s chart (Figure 4-11).

**History and Physical (H & P)**

The H & P is a detailed accounting of the history, physical examination, and decision making regarding the patient’s condition at the time of admission. The H & P is

**Figure 4-13**  Content of the patient’s medical record.
performed when the patient is admitted and is dictated or written by the admitting physician (Figure 4-14).

**Physician’s Orders**

Physician’s orders outline instructions provided by the admitting physician regarding diagnostic and therapeutic care that the patient is to receive according to the treatment plan, such as lab tests, X-ray procedures, diet, and physical restrictions. Physician’s orders can be written or they can be given orally (Figure 4-15). Physician’s orders and instructions are entered into an order...
entry system and distributed to the appropriate department(s) to render patient care services.

**Physician Progress Notes**

Progress notes outline the patient’s status, results of diagnostic studies, and response to treatments. The physician completes progress notes each time the patient is seen (Figure 4-16).

**Nurse Progress Notes**

The nurse records notes during each shift. The nurse’s progress notes indicate the patient’s status, responses from the patient regarding their condition, and vital signs such as blood pressure, pulse, and temperature (Figure 4-17).

**Ancillary Department Reports**

Various reports prepared by ancillary departments such as Radiology, Laboratory/Pathology, and Respiratory Therapy are also maintained in the patient record. Ancillary services are those that are considered supportive, such as X-rays, blood tests, or respiratory therapy. The report indicates the diagnostic and therapeutic care provided to the patient and the patient’s response to care.

**Clinical Department Reports**

Health care personnel from other clinical departments such as the ED perform various patient care services that are documented in the patient’s medical record. Consultation and specialist’s reports are also maintained in the medical record.

**Emergency Department Record**

When a patient is seen in the ER, information is obtained and an ED record is prepared with informa-
tion regarding the patient and insurance. Clinical personnel in the ER who record information regarding the patient’s condition and patient care services provided utilize this form. The ER physician documents orders for services and items required on the ED record (Figure 4-18).

Consultations and Specialist Reports
All physician consultants and specialists record information regarding the patient visit in the patient’s medical record.

Medication Administration Records (MARs)
MARs are used to record medications administered to the patient. The record contains the name of the medication ordered, the dose, and the route of administration. Clinical personnel, such as a nurse, record administration of a medication. The nurse also places his or her initials, the date, and the time on the record. If medication is refused, the nurse will note this on the record. The medication administration record is sometimes referred to as Med Mars (Figure 4-19).

Discharge Summary
The discharge summary provides an overview of patient care activity during the patient stay, including the patient’s condition at admission, care provided during the course of the hospital stay, and the patient’s history and physical status prior to discharge. Elements of a discharge summary include the admitting diagnosis,
history of present illness, hospital course, discharge diagnosis, and medications. The admitting physician dictates the discharge summary after a detailed history and physical are performed to determine if the patient is ready to be discharged. The admitting physician completes the discharge summary when the patient is discharged (Figure 4-20).

**Hospital-Based Clinic/Primary Care Office**

A patient medical record is also maintained by hospital-based clinics and primary care offices. The record contains all information regarding patient care provided in the clinic or physician office, including patient demographic and insurance information, initial visit and progress notes, and medication information. The record also contains reports from other providers, such as Pathology/Laboratory, Radiology, consultations, and the hospital. As discussed previously, physician services provided in the clinic or primary care office are recorded on the encounter form and used to post charges to the patient’s account for each visit (see Figure 4-2, C).

**PATIENT CARE SERVICES**

The admitting physician directs all services provided within the hospital. The physician’s orders provide instructions detailing patient care services to be provided during the patient stay. The admitting physician reviews the patient status and updates the orders as needed. Outpatient services are directed by the referring physician or, in the case of an ED visit, the ER physician. In accordance with the physician’s orders, various clinical departments are involved in providing patient care services such Nursing, Pharmacy, Pathology/Laboratory, and Radiology. The Central Supply or Sterile Supply Department provides medical supplies and instruments required to perform patient care services. It is important for hospital coding and billing professionals to understand the categories of patient care services provided in a hospital in order to ensure that charges are billed appropriately. A review of categories of hospital services will provide an understanding of the type of patient care services provided by the hospital.

**Common Categories of Hospital Services and Items**

The patient account data flow includes information regarding patient care services provided and supplies or items required to provide those services. Hospital patient care services and items can be categorized as accommodations, medical surgical supplies, pharmacy, and clinical services. Table 4-3 illustrates common categories of services and items required for an inpatient admission as outlined.

**Accommodations**

Patients who are admitted on an inpatient basis are assigned a room/bed. The patient may be assigned a
private room or a semiprivate room. Semiprivate rooms generally have two beds; however, some may have up to four beds. Accommodation services include the room and overhead for nursing coverage during the patient stay.

Operating Room (OR)
Patients requiring surgery are generally placed in an OR suite prior to surgery. Surgery is performed in the OR. The patient is generally moved to the recovery room after surgery. Hospital OR services include the amount of time in each room, which includes the setup and overhead for OR staff such as the OR Technician and the Circulator Nurse. Some procedures are performed in other areas of the hospital such as the catheterization laboratory or endoscopy suite.

Medical Surgical Supplies
Various departments supply materials, supplies, instruments, and durable medical equipment in accordance with physician’s orders. As outlined in the Central Supply requisition in Figure 4-21, medical and surgical supply items may include adult disposable diapers, pressure pads, feeding pumps, and various kits or sterile trays. This department may also supply durable medical equipment.

Pharmacy
Medications and other pharmaceuticals required during the patient stay are provided by the Pharmacy Department in accordance with the physician’s orders. Figure 4-22 illustrates physician’s orders with
medications to be supplied by the pharmacy including Keflex, Theragram, Monopril, and Dalmane. Medications are prepared, labeled, and forwarded to the nursing unit for administration. The Pharmacy Department also supplies pharmaceuticals and other biologicals that are required to perform various therapeutic and diagnostic procedures such as saline solution or contrast.
material. Some durable medical equipment (DME) items are supplied by the pharmacy as well.

Ancillary Services

Various ancillary departments such as Pathology/Laboratory, Radiology, Physical Rehabilitation, and Respiratory Therapy provide diagnostic and therapeutic services ordered by the physician. Figure 4-23 illustrates computerized order screens that highlight examples of the types of services provided by these departments, such as CBC, chest X-ray, training on crutches, and oxygen or other breathing treatments.

Other Clinical Services

Various clinical departments such as Cardiology coordinate and provide patient services as outlined in the physician’s orders. For example, the Cardiology Department is involved in the performance of cardiac catheterizations, and charges related to performing these procedures are posted by the Cardiology Department.

CHARGE CAPTURE

A hospital cannot maintain financial stability if the cost of providing care is not reimbursed appropriately. From the time a patient is received at the hospital to discharge, services and items are provided. The complexity of providing patient care services and capturing charges within a hospital setting requires efficient systems that can capture all data required. It is important to remember that the access to and flow of patient care data are enhanced by the automation of the patient’s account and other functions. Information collected at registration is utilized throughout the patient stay for order entry, rendering of patient care services, and capturing charges.

**BOX 4-23 □ KEY POINTS**

Common Categories of Patient Care Services
- Accommodations
- Operating room
- Medical surgical supplies
- Pharmacy
- Ancillary services
- Other clinical services
### Charge Capture Procedures

**Charge Capture** is the term commonly used to describe the process of gathering charge information and recording it on the patient’s account. The process of capturing charges begins with physician’s orders and is completed when charges are entered on the patient’s account, as illustrated in Figure 4-24.

#### Order Entry

Patient care services are provided in accordance with physician’s orders. Orders are entered into the computer order entry system. Services and items to be provided are communicated to the appropriate departments by computer or by requisition.

#### Patient Care Services Rendered

Physician orders are communicated to various clinical departments involved in the patient’s care. When the department receives the order, the required diagnostic and therapeutic procedures are performed.

#### Documentation

All patient care services are documented in the patient’s medical record, including a detailed description of the service, results, and other information about the service. Items utilized to perform the service are also documented.

#### Charge Posted

The department providing the service or item is generally responsible for posting appropriate charges to the patient’s account through the chargemaster. In addition to the medical record, other documents are utilized to capture charges such as requisitions and encounter forms. As discussed previously, requisitions provide instructions regarding services rendered. The encounter form is utilized by hospital-based clinics or physicians’ offices to record services and procedure items provided during the visit. The medical reason for services rendered is also recorded on the encounter form.

### Hospital Charges

Hospital charges are referred to as “facility” charges, as they represent the technical component of patient care services. The professional component of patient care services is recorded in the patient’s medical record; however, the hospital only bills professional services when the physician is employed by or under contract with the hospital. Figure 4-25 illustrates examples of hospital facility charges. To bill hospital services accurately, it is important for hospital professionals to understand the difference between the technical and professional component of services.

#### Facility Charges—Technical Component

Hospitals bill facility charges for patient care services provided such as laboratory tests, X-rays, or ambulatory surgery. **Facility charges** represent the cost and overhead for the technical component of services, including space, equipment, supplies, drugs and biologicals, and technical staff. Facility charges are posted to the patient’s account by various departments through the chargemaster.

#### Professional Charges: —Professional Component

**Professional charges** represent physician and other non-physician clinical services, the professional component of services performed. As discussed previously, the hospital can bill professional services when the physician is employed by or under contract with the hospital. An example of this situation is a hospital-based primary care office or clinic. Charges for professional services provided by a hospital physician in a hospital-
based primary care office, are posted to the patient utilizing an encounter form.

**PATIENT DISCHARGE**

Prior to discharge, the admitting physician performs an H & P and prepares discharge orders so the patient can be processed for discharge. Patients may be discharged to home or they may be discharged to other facilities such as a rehabilitation center or nursing home. After the patient is discharged, the patient’s record is forwarded to the HIM Department for review and coding of clinical information.

**Health Information Management Procedures**

The functions of the HIM Department were discussed previously. In addition to data maintenance, security, and management of medical records, HIM plays a vital role in the reimbursement process. The HIM Department is responsible for maintenance of the chargemaster. The HIM Department performs periodic reviews of the chargemaster to ensure that codes and various payer edits corresponding to services and items are current. Other functions performed by HIM related to the reimbursement process include review of the patient’s medical record, coding of clinical data, and DRG or APC assignment.

**Medical Record Review**

Patient medical records are sent to the HIM Department after the patient is discharged. HIM performs a detailed review of the medical record to ensure that all documentation requirements are met.

**Coding of Clinical Data**

The HIM Department is also responsible for coding clinical data required for submission of claim forms to

### Box 4-25 - KEY POINTS

**Hospital “Facility” Charges**

The facility charge is determined based on the cost and overhead of providing services and items in the hospital.

Facility charges represent the cost and overhead for the technical component of patient care services, which include space, equipment, supplies, drugs and biologicals, and technical staff.

**Figure 4-25** Examples of hospital “facility” charges.

**Figure 4-26** HIM coding worksheet. (Modified from Davis N, Lacour M: Introduction to health information technology, ed 1, St Louis, 2002, Saunders.)
various third-party payers. A coding worksheet sheet is often utilized to abstract information regarding the patient’s diagnosis (or diagnoses) and procedure(s) (Figure 4-26). The coding worksheet is then utilized to input codes into the computer. Most hospitals utilize a software program called ENCODER that assists HIM personnel with code assignment. Data coded by the HIM Department generally include the principal procedure and other procedures in addition to the admitting, principal, and secondary diagnoses. These codes are placed in the appropriate fields of the claim form. Coding systems utilized in the hospital include HCPCS and ICD-9-CM, as outlined in Figure 4-27, A.

Individuals responsible for coding in the HIM Department are generally certified. Hospitals usually require coding certifications such as Certified Coding Specialist (CCS), Certified Professional Coder (CPC), or Certified Professional Coder-Hospital (CPC-H). Additional certifications may be required such as the Registered Health Information Technician (RHIT). Figure 4-27, B, outlines various credentials that hospital coding professionals may pursue, as discussed in Chapter 2. Coding Systems will be discussed further in later chapters.

THE HOSPITAL BILLING PROCESS

To maintain financial stability the hospital must have an efficient process for obtaining reimbursement from patients and third-party payers. The hospital billing process begins when orders are submitted for patient care services, and it ends when the account balance is

---

**Services/Items**
- HCPCS Level II – Medicare National Codes
- International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM)-Volume III (alphabetical and numerical listing of procedures)

**Conditions**
- International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM)-Volume I & II (alphabetical and numerical listing of diseases, signs and symptoms, encounters and external causes of injury)

---

**Organizations and Credentials**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Credentials</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Academy of Professional Coders (AAPC)</td>
<td></td>
</tr>
<tr>
<td>American Health Information Management Association (AHIMA)</td>
<td></td>
</tr>
<tr>
<td>American Association of Healthcare Administration (AAHAM)</td>
<td></td>
</tr>
</tbody>
</table>

---

**Figure 4-27**  A, Coding systems utilized in the hospital. B, Various credentials obtained by hospital coding and billing professionals. (B Modified from Davis N, Lacour M: Introduction to health information technology, ed 1, St Louis, 2002, Saunders.)

---

**Diagnosis Related Group or Ambulatory Payment Classification Assignments**

Hospitals are reimbursed utilizing various payment methods including the DRG and APC payment system utilized for reimbursement of services provided to Medicare patients. DRG is a PPS implemented to provide reimbursement for hospital inpatient services. Under DRG, the facility is paid a fixed fee based on the patient’s condition and relative treatments. APC is a PPS implemented to provide reimbursement for hospital outpatient services. Under APC, the facility is paid a fixed fee based on the resources utilized to provide the service or procedure. The appropriate DRG or APC group must be assigned for hospital claims.

HIM utilizes a program called GROUPER to assist with the assignment of the DRG or APC group(s). Information required for DRG or APC assignment includes diagnosis and procedure codes and other information regarding the patient. Prospective Payment Systems will be discussed further in later chapters.

---

**BOX 4-26 KEY POINTS**

**Patient Discharge and HIM Procedures**

When the patient is discharged, the medical record is forwarded to the HIM Department for:
- Medical record review to ensure that documentation requirements are met
- Coding of clinical data
- DRG or APC assignments

---

**BOX 4-27 KEY POINTS**

**Computer Software Utilized by HIM**

**Encoder** software allows the HIM professional to enter specified information regarding patient care services and the patient’s condition. The program utilizes the data entered to identify potential codes.

**GROUPER** software allows the HIM professional to enter specified information that the program utilizes to assign an APC or DRG group.
As illustrated previously, automation of the registration, order entry, and charge capture process allows for the gathering of data required for billing throughout the patient stay. These data are utilized by the PFS Department to perform billing functions, which include charge submission and posting.

### Test Your Knowledge - BOX 4-4

**PATIENT CARE SERVICES: CHARGE CAPTURE AND PATIENT DISCHARGE**

1. Explain the relationship between the physician’s orders and patient care services rendered in the hospital.

2. Provide an explanation of how outpatient services are directed.

3. Categories of services provided in the hospital include accommodations. Explain this category.

4. Provide an explanation of patient care services that may be provided by ancillary departments.

5. Discuss the relationship between patient accounts data flow and charge capture.

6. List the automated systems that enhance the flow and access of data related to charge capture.

7. Explain the relationship between charge capture and order entry.

8. State the relationship between documentation and hospital charges.

9. What department is generally responsible for posting charges to the patient’s account?

10. Explain the difference between facility charges and professional service charges.

11. Provide a brief overview of the patient discharge process.

12. List two reasons why the HIM Department reviews patient medical records.

13. What type of document is utilized to abstract information from the patient record regarding the patient’s diagnosis/diagnoses and procedure/procedures performed during the patient stay?

14. List the coding systems utilized in the hospital.

15. Discuss what HIM utilizes GROUPER software for.
of patient transactions. The billing process includes preparation and submission of claim forms to third-party payers, preparation and submission of patient statements, and posting patient transactions such as payments and adjustments. This section will provide a brief overview of the billing process to illustrate the flow of information. The billing process is discussed in detail in Chapter 5.

**Charge Submission**

Hospitals submit charges after the patient is discharged. On discharge the HIM Department receives the patient’s medical record for review, coding, and DRG or APC assignment. When the HIM Department functions are complete, the PFS Department prepares insurance claim forms and patient statements for submission of charges.

**Insurance Claim Forms**

Insurance claim forms are prepared and submitted to third-party payers. The goal is to submit a claim that contains accurate information and is completed in accordance with payer specifications so that it is paid on the first submission. Prior to submission of a claim, an editing process is performed to ensure that the claim is complete and accurate. Hospitals utilize computer software referred to as a claim scrubber to perform this function. The claim scrubber software is programmed to perform various checks to ensure that required fields contain data and also to check codes to make sure they are valid. Common problems identified include:

- Facility information is not complete or missing
- Patient name and identification number are not complete or missing
- Diagnosis or procedure codes are invalid.

The appropriate claim form is prepared. The CMS-1450 (UB-92) is the universally accepted claim form used to submit facility charges for inpatient, ambulatory surgery, emergency room, and ancillary and other department services (Figure 4-29). The universally accepted claim form for submission of physician and outpatient services and charges for durable medical equipment (DME) is the CMS-1500 (Figure 4-30). Claim forms are discussed in detail in Chapter 10.

The claim forms are submitted to payers electronically or manually. Claim forms submitted electronically are referred to as electronic media claims (EMCs). Manual claims are printed on paper and mailed. Payers may require a detailed itemized statement be included with paper claims. Payers receiving electronic claims...
may request a detailed itemized statement after initial review of the claim. Copies of insurance claim forms are filed for follow-up.

**Patient Statements**

Patient statements list dates of service, description of services, charges, payments, and balance due. They are printed and mailed to patients. Patient statements generally include messages regarding outstanding balances.

**Patient Transactions**

Payers review claims submitted to determine payment on the claim. When payment determination is made, the payer communicates how the claim was processed and the payment status with the hospital utilizing a remittance advice (RA), a document prepared by payers to communicate payment determination to hospitals and patients. The RA includes detailed information about the charges submitted and an explanation of how the claim was processed. Payers utilize different names to describe this document, such as an Explanation of Medicare Benefits (EOMB) or Explanation of Benefits (EOB). Patient transactions are posted to the patient’s account when the RA is received (Figure 4-31).

**Third-Party Payer Transactions**

Third-party payers forward an RA to the hospital, which includes detailed information about the charges submitted and an explanation of how the claim was processed. Payer actions on a claim may include:

- Denial or rejection of the claim and reason
- Payment of the claim (covered and noncovered charges)
- Request for additional information
The process of posting transactions to a patient’s account is as follows:

1. Third-party payer payments are posted to the patient’s account.
2. A contractual adjustment is applied where applicable.
3. The balance is billed to the patient or forwarded to a secondary or tertiary payer when applicable.
4. Claim denials require research to determine whether the denial is appropriate.

**Patient Payments**

Patient payments are posted to the patient’s account. Patient statements are generally mailed monthly when the patient account has a remaining balance.

### BOX 4-28  KEY POINTS

**Billing Process**

**Charge Submission**

- Insurance claim forms

**Patient statements**  **Patient Transactions**

- Third-party payer transactions
- Patient payments

### ACCOUNTS RECEIVABLE (A/R) MANAGEMENT

Hospitals monitor outstanding accounts for the purpose of ensuring that payments are received in a timely...
The term used to describe outstanding accounts is accounts receivable. A division of the PFS Department, Credit and Collections is responsible for monitoring outstanding claims to determine accounts that require follow-up. Data required to monitor outstanding accounts are provided through the automated billing system. The PFS Department tracks these accounts to ensure timely payment and resolution of any discrepancies.

### Payer Financial Class Report

<table>
<thead>
<tr>
<th>Financial Class</th>
<th>Patient Name</th>
<th>Service Date</th>
<th>Total Charges</th>
<th>Payment</th>
<th>Contractual Adjustment</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 BC/BS</td>
<td>Adams, Harold</td>
<td>02/02/2002</td>
<td>$1,356.50</td>
<td>$868.16</td>
<td>$271.30</td>
<td>$217.04</td>
</tr>
<tr>
<td></td>
<td>Boyer, Susan</td>
<td>03/17/2002</td>
<td>$27,865.00</td>
<td>$17,833.60</td>
<td>$5,573.00</td>
<td>$4,458.40</td>
</tr>
<tr>
<td></td>
<td>Johns, Tina</td>
<td>06/22/2002</td>
<td>$42,677.97</td>
<td>$11,797.48</td>
<td>$3,686.71</td>
<td>$2,949.37</td>
</tr>
<tr>
<td></td>
<td>Xavier, George</td>
<td>02/25/2002</td>
<td>$18,433.56</td>
<td>$11,797.48</td>
<td>$3,686.71</td>
<td>$2,949.37</td>
</tr>
<tr>
<td></td>
<td>Yohanson, Phil</td>
<td>05/31/2002</td>
<td>$879.97</td>
<td>$563.18</td>
<td>$175.99</td>
<td>$140.80</td>
</tr>
<tr>
<td>02 Commercial</td>
<td>Beard, Bobby</td>
<td>06/22/2002</td>
<td>$42,677.97</td>
<td>$27,313.90</td>
<td>$8,573.90</td>
<td>$6,828.48</td>
</tr>
<tr>
<td></td>
<td>Baxter, Morris</td>
<td>03/17/2002</td>
<td>$27,865.00</td>
<td>$17,833.60</td>
<td>$5,573.00</td>
<td>$4,458.40</td>
</tr>
<tr>
<td></td>
<td>James, John</td>
<td>02/25/2002</td>
<td>$18,433.56</td>
<td>$11,797.48</td>
<td>$3,686.71</td>
<td>$2,949.37</td>
</tr>
<tr>
<td></td>
<td>Hatley, Hanna</td>
<td>02/02/2002</td>
<td>$1,356.50</td>
<td>$868.16</td>
<td>$271.30</td>
<td>$217.04</td>
</tr>
<tr>
<td></td>
<td>Mannie, Minnie</td>
<td>05/31/2002</td>
<td>$879.97</td>
<td>$563.18</td>
<td>$175.99</td>
<td>$140.80</td>
</tr>
<tr>
<td>03 Medicaid</td>
<td>Harold, Adam</td>
<td>02/02/2002</td>
<td>$572.00</td>
<td>$171.60</td>
<td>$400.40</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>Harpo, Harold</td>
<td>03/17/2002</td>
<td>$877.97</td>
<td>$0.00</td>
<td>$614.58</td>
<td>$263.39</td>
</tr>
<tr>
<td></td>
<td>Morris, Baxter</td>
<td>06/22/2002</td>
<td>$256.34</td>
<td>$76.90</td>
<td>$179.44</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>Polo, Marco</td>
<td>02/25/2002</td>
<td>$72.82</td>
<td>$0.00</td>
<td>$50.97</td>
<td>$21.85</td>
</tr>
<tr>
<td></td>
<td>Smith, Ima</td>
<td>05/31/2002</td>
<td>$10,423.00</td>
<td>$0.00</td>
<td>$7,296.10</td>
<td>$3,126.90</td>
</tr>
<tr>
<td>04 Medicare</td>
<td>Anson, Annie</td>
<td>02/02/2002</td>
<td>$1,356.50</td>
<td>$868.16</td>
<td>$271.30</td>
<td>$217.04</td>
</tr>
<tr>
<td></td>
<td>Chan, William</td>
<td>02/25/2002</td>
<td>$18,433.56</td>
<td>$11,797.48</td>
<td>$3,686.71</td>
<td>$2,949.37</td>
</tr>
<tr>
<td></td>
<td>Cato, Cody</td>
<td>03/17/2002</td>
<td>$27,865.00</td>
<td>$17,833.60</td>
<td>$5,573.00</td>
<td>$4,458.40</td>
</tr>
<tr>
<td></td>
<td>Janson, Jonnie</td>
<td>05/31/2002</td>
<td>$879.97</td>
<td>$563.18</td>
<td>$175.99</td>
<td>$140.80</td>
</tr>
<tr>
<td></td>
<td>Williams, Meta</td>
<td>06/22/2002</td>
<td>$42,677.97</td>
<td>$27,313.90</td>
<td>$8,573.90</td>
<td>$6,828.48</td>
</tr>
</tbody>
</table>
outlining categories of claims based on the age of the account is referred to as an accounts receivable report, or A/R report. Common aging report categories are over 30 days, 31 to 60 days, 61 to 90 days, 91 to 120 days, and over 120 days. A/R reports are generated for the purpose of identifying accounts that require follow-up. Hospitals establish policies regarding collection of outstanding accounts that include priorities for collection efforts based on the age of the account. For example, the hospital policy may indicate that collection personnel should concentrate on accounts that are in the 91- to 120-day aging category. The hospital policy may also provide criteria for accounts that should be sent to an outside collection agency or an attorney. A/R management is discussed in detail in Chapter 6.

Financial Class Report

A financial class is a classification of patient accounts and information such as charges, payments, and outstanding balances, grouped according to payer types. All payers are assigned to a financial class. An example of a financial class might be the category “Commercial,” in which data on all commercial carriers may be grouped. Common financial classes are Commercial, Blue Cross/Blue Shield, Medicaid, Medicare, TRICARE, Auto, and Worker’s Compensation. Managed care plans may also have a separate financial class assigned to them. Designation of financial classes allows detailed tracking and reporting of charges, payments, and outstanding balances per payer type. A financial class report can be generated from the computer system to analyze outstanding charges by payer type. A payer financial class report is illustrated in Figure 4-32.

Accounts Receivable Aging Report (A/R Report)

Accounts are also categorized based on the number of days the balance is outstanding. Outstanding balances are referred to as accounts receivable, and the report outlining categories of claims based on the age of the account is referred to as an accounts receivable report, or A/R report (Figure 4-33). Common aging report categories are over 30 days, 31 to 60 days, 61 to 90 days, 91 to 120 days, and over 120 days.

A/R reports are generated for the purpose of identifying accounts that require follow-up. Hospitals establish policies regarding collection of outstanding accounts that include priorities for collection efforts based on the age of the account. For example, the hospital policy may indicate that collection personnel should concentrate on accounts that are in the 91- to 120-day aging category. The hospital policy may also provide criteria for accounts that should be sent to an outside collection agency or an attorney. A/R management is discussed in detail in Chapter 6.
1. Why is the billing process important?

2. Explain when the billing process begins in a hospital.

3. Explain what department performs billing functions and how automation assists with those functions.

4. List functions included in the billing process.

5. When does a hospital bill third-party payers and patients?

6. Discuss types of documents used to submit charges to patients and third-party payers.

7. What computer software is utilized to edit third-party payer claims?

8. Describe two claim forms utilized to submit charges to third-party payers.

9. State the difference between the CMS-1450 and the CMS-1500.

10. Outline the information on a patient statement.

11. List three actions a payer can take on a claim.

12. Provide an outline of the process of posting transactions to a patient's account.

13. State the purpose of accounts receivable management.

14. Define financial class and provide examples.

15. Discuss the purpose and content of an A/R report.
CHAPTER SUMMARY

The patient account and data flow is a critical element in the hospital’s ability to effectively access and utilize data collected throughout the hospital. Automated systems for registration, order entry, charge capture, billing, and accounts receivable management enhance the ability of various departmental personnel to access and utilize data simultaneously. Data collected are utilized through the patient care process for admissions, rendering patient care services, and billing for those services. The patient care process from admission to discharge involves capturing and recording information regarding the patient and care provided. Patient information is stored in the hospital’s health information system and in the patient’s medical record. Services and items provided are recorded in the patient’s record and on the patient’s account. The coding and billing process begins at discharge. The HIM Department receives the medical record for review, coding, and assignment of DRG or APC. The PFS Department prepares claim forms for submission and patient statements to be sent. The Credit and Collections Department monitors outstanding accounts and works to collect outstanding balances from patients, insurance companies, and government payers. It is critical for coding and billing professionals to have complete and accurate information for billing payers and patients.
CHAPTER REVIEW 4-1

True/False
1. Information obtained during the patient admission process is utilized for billing. T F
2. The admission process consists of functions required to discharge a patient. T F
3. Peer Review Organization (PRO) reviews have a direct impact on reimbursement. T F
4. Written Authorization for Release of Medical Information is required before patient information can be released. T F
5. Verification of insurance is required to ensure that appropriate reimbursement for services is received. T F

Fill in the Blanks
6. A form used to provide authorization for a payer to make payment to the hospital is called _________________.
7. Services that are considered appropriate and necessary in response to the patient’s condition are ________________, ________________.
8. A room/bed is assigned to patients who are admitted on an ______________ basis.
9. Health Information Management (HIM) procedures performed after the patient is discharged include: ________________, ________________, and ________________.
10. Testing performed prior to an inpatient/surgical admission is called ________________.

Match the Following Definitions With the Terms Below
11. ______ Specific criteria used to determine whether a patient admission is appropriate and necessary. A. Financial class
    B. CMS-1450 (UB-92)
    C. Grouper
    D. A/R report (aging report)
    E. Admission Evaluation Protocols (AEPs)
12. ______ Universally accepted claim form used to submit charges for hospital inpatient and ambulatory surgery charges.
13. ______ Classification of claims outstanding according to payer.
14. ______ A software program utilized by HIM personnel to assist with the assignment of a DRG or APC group.
15. ______ A listing of categories of outstanding accounts by days outstanding.

Research Project
Refer to the CMS Web site at www.cms.gov.
Find information on general admission procedures in the hospital manual.
Discuss the procedures discussed in Section 300 of the hospital manual.
Discuss how to handle situations where you cannot obtain information in Section 301 of the hospital manual.
GLOSSARY

Accounts receivable (A/R) aging report A report outlining categories of claims based on the age of the account.

Admission The act of being received into a place or a patient accepted for inpatient services in a hospital.

Admission Evaluation Protocols (AEP) Outlines appropriate conditions for a hospital admission based on standards referred to as the IS/IS criteria. IS refers to the intensity of service criteria. SI refers to the severity of illness criteria.

Admission summary A summary of information about the patient’s admission, such as the patient’s name and address, insurance company name, reason(s) for admission, attending physician’s name, and referring physician’s name. The admission summary is also known as a face sheet.

Advanced Beneficiary Notice (ABN) A notice informing the patient that there is reason to believe the admission will not be covered by Medicare. The patient’s signature is required on this form to acknowledge that he or she will be financially responsible if Medicare does not cover the service.

Advanced directives Provide instructions regarding measures that should or should not be taken in the event medical treatment is required to prolong life.

Ambulatory payment classification (APC) A Prospective Payment System (PPS) implemented to provide reimbursement for hospital outpatient services. Under APC, the facility is paid a fixed fee based on the resources utilized to provide the service or procedure.

Assignment of benefits Instructs the insurance company or government plan to forward benefits (payments for services) to the hospital.

Charge capture The process of gathering charge information and recording it on the patient’s account.

Charge Description Master (CDM) A computerized system used by the hospital to inventory and record services and items provided by the hospital. CDM is commonly referred to as the chargemaster.

CMS-1450 (UB-92) Universally accepted claim form used to submit facility charges for hospital inpatient and outpatient services.

CMS-1500 Universally accepted claim form used for submission of physician and outpatient services and Durable Medical Equipment (DME).

Co-insurance An amount the patient is responsible to pay that is calculated based on a percentage of approved charges.

Co-payment A set amount that is paid by the patient for specific services. Co-payment is commonly referred to as a copay.

Concurrent review Ongoing review throughout the hospital stay to determine appropriateness of the admission and care provided.

Deductible An annual set amount determined by each payer that the patient must pay before the plan pays benefits for services.

Diagnosis Related Groups (DRG) A Prospective Payment System (PPS) implemented to provide reimbursement for hospital inpatient services. Under DRG, the facility is paid a fixed fee based on the patient’s condition and relative treatments.

Encounter form A charge tracking document utilized to record services, procedures, and items provided during the visit and the medical reason for the services provided.

Explanation of Benefits (EOB) Another term used for remittance advice.

Explanation of Medicare Benefits (EOMB) Another term used for remittance advice.

Facility charges Charges that represent the cost and overhead for the technical component of patient care services, which include space, equipment, supplies, drugs and biologicals, and technical staff.

Financial class A classification of patient accounts and information such as charges, payments, and outstanding balances, grouped according to payer types.

Guarantor The individual who is responsible to pay for services provided.

Informed Consent for Treatment A form utilized by the hospital to obtain the patient’s authorization for treatment. The form must be signed by the patient before treatment can be provided.

Insurance verification The process of contacting the patient’s insurance plan to determine various aspects of coverage such as whether the patient’s coverage is active, what services are covered, authorization requirements, and patient responsibility.

Medical necessity Services or procedures that are reasonable and medically necessary in response to the patient’s symptoms according to accepted standards of medical practice.

Medical record A chart or folder where patient’s information is stored, including demographic, insurance, financial, and medical information.

Medical record number (MRN) A unique identification number assigned by the hospital to each patient’s medical record. The MRN remains the patient’s medical record number indefinitely.

Patient registration form A form utilized by the hospital to obtain patient information including demographic, insurance, and financial information.

Professional charges Charges that represent physician and other non-physician clinical services, the professional component of patient care services.

Prospective review A review performed prior to the patient admission to determine appropriateness of the admission and length of stay.

Remittance advice (RA) A document prepared by payers to communicate payment determination to hospitals and patients. The RA includes detailed information about the charges submitted and an explanation of how the claim was processed.

Retrospective review A review conducted after the patient is discharged to determine appropriateness of admission and care provided.

Written Authorization for Release of Information Provides authorization for the hospital to release personal health information when required for treatment and to obtain payment for services.