HOSPITAL BILLS AND THE BILLING PROCESS:

A Consumer Guide

The Florida Hospital Association has developed this tool for hospitals and the patients they serve.

Florida Hospital Association
Mission to Care. Vision to Lead.

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Hospital Bills and the Billing Process: A Consumer Guide

Introduction

The hospital billing process is complex, confusing, and often results in frustration and even anger for the patient. While the claims submitted to payers – whether electronic or paper – have a common, standardized format, the bill and subsequent statements sent to the patients will vary from provider to provider. Understanding the billing process is essential for today's informed consumer.

Growth in "out-of-pocket" expenses and the new focus on consumer-driven health care have contributed to an atmosphere of increased customer awareness, skepticism, and concern over hospital billing practices. Adding to this is the government's current focus on health care expenditures, the effect of these expenditures on national and state budgets, increased complexity of insurance coverage for the consumer, and the variety of contractual arrangements between the hospitals and the payers. All of these events make it more difficult to provide easily understood answers to customers' questions.

The Florida Hospital Association has developed *Hospital Bills and the Billing Process: A Consumer Guide* as a tool for hospitals and the patients they serve. Providing clarification of basic terms and processes, hospitals are encouraged to make the information contained in this guide available to their patients or potential patients through their website and other resources for consumer education. A CD-version of the guide is also included in this packet to allow such posting and customization. Additional copies of the guide can also be purchased for distribution to patients and physicians.

Questions on FHA's *Hospital Bills and the Billing Process: A Consumer Guide* should be directed to Kathy Reep, FHA Vice President/Financial Services, at 407-841-6230 or kathyr@fha.org.

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Admitting/Registration

Patient Types

Simplistically, we think in terms of a hospital being oriented between *inpatient* and *outpatient* services. Understanding if you are an inpatient or an outpatient is very important as this status could impact your insurance coverage and any out-of-pocket liability. Unfortunately, there is no clear definition for either term that is consistent across the various payers. Medicare defines an inpatient as "…a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally a person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged or transferred to another hospital and does not actually use a hospital bed overnight." An outpatient is a person who has not been admitted to the hospital as an inpatient, but is registered on the hospital records as an outpatient and receives services from the hospital.

Changes in the delivery of health care have resulted in many additional classifications of patients, representing specialized clinical services in environments which serve to minimize the costs incurred. These changes have occurred primarily in the outpatient arena to the degree that we now have specialized clinical care programs for:

- Ambulatory surgery or same day surgery is to accommodate elective surgical procedures which are not life-threatening. Most ambulatory surgery procedures are scheduled in advance and patients are pre-registered.

- Observation patients, although occupying a hospital bed, are still considered an outpatient. Patients are placed in observation following a physician order. The purpose of observation is to determine the need for further treatment or for inpatient admission. A patient in observation may improve and be released, or be admitted as an outpatient.

The physician responsible for the patient's care determines the patient's status as an inpatient or outpatient, although various insurance companies have developed payment policies that, in effect, override the physician's order. Many insurers determine inpatient/outpatient status based upon the number of hours the patient remained in the hospital.

Non-patients are those receiving services without visiting the hospital. Typically, non-patients are those for whom laboratory services are provided by the hospital, using a specimen obtained outside the hospital setting.

Preadmission

Preadmission functions are possible for patients who can be scheduled for services such as elective surgery or non-urgent medical care. The following functions are required as a part of the preadmission process:

- Patient identification – the completion of patient identification information with a search for prior medical record number, address, insurances, existing accounts, and confirmation of services to be provided;
- Insurance verification – validation of insurance coverage for the services to be provided and the payment methodology;
- Scheduling of services – includes pre-operative orientation and instructions;
- Completion of consents and other legal documents prior to admission or provision of services on an outpatient basis; and
- Discussion of alternatives for payment arrangements for patient portion of the charges incurred.

Insurance Verification

To ensure payment for services rendered, hospitals accept proof of third party coverage. Verification of insurance allows the provider to determine coverage as well as –

- Benefits available;
- Deductible and other cost-sharing information; and
- Authorization for services.

Financial Counseling

Hospitals generally identify balances due from patients, referred to as self pay balances or out-of-pocket liability, and advise them of their potential financial liability at preadmission/preregistration or upon admission/registration. Identifying potential liability allows the hospital to work with the patient to establish financial arrangements including, but not limited to, deposit requirements, application for Medicaid or other assistance, determining other payer sources, and determining eligibility for charity care.

Estimates

Patient's may request a written estimate of their bill prior to the delivery of services. Florida law (F.S. 395.301) requires hospitals to provide, prior to provision of non-emergency medical services, a written good-faith estimate of reasonably anticipated charges for the facility to treat the patient's condition, upon the written request of the prospective patient. Hospitals are to provide the written estimate within 7 business days after the receipt of the request. The law allows the hospitals to provide the estimate based on the average charges for a particular diagnosis-related group (DRG) or the average charges for a specific procedure.

Billing Process

Pricing: The Charge Master

The basis for all hospital charges is the *charge master* – a multi-purpose data file containing descriptions for individual services, procedures, supplies, drugs and other items and their assigned charge. Each item within the charge master includes a description, a service code, a revenue code, and, where applicable, a procedure code.

Hospitals adjust their charges – often annually – in order to maintain their financial viability. Hospitals adjust their charges to assure that payments cover the costs of providing patient care as well as the costs of maintaining essential public services, keeping buildings and technologies up-to-date, and supporting the health care needs of their communities. Setting charges is both complex and challenging as a hospital must anticipate what will happen both to their costs and to their payments.

Charges for Patient Services

Hospital "charging" practices do not follow the same pattern as they do for other businesses. For example, charges in a grocery store typically equal payments. If you want what the store has to sell, you buy it at the charge the grocery store sets. Charges and payments are basically the same. For the hospital, however, charges are seldom the same as payments. Because questions are frequently raised about hospital charges, some general understanding of the "hows and whys" of hospital charges is important. It should be noted that this is a complex situation and the information provided is a simplified overview of hospital charging practices.

Charges originally were established to cover the cost of services, with an additional amount to cover charity care and bad debts. In addition, hospitals needed an amount over their costs to cover future capital needs. With the advent of the Medicare and Medicaid programs, however, charges took on a new significance. Essentially, charges are used to determine each program's share of the hospital's costs for reimbursement purposes. For example, if *charges* for Medicare patients are 25 percent of the total charges in the operating room, Medicare's share of operating room *costs* is assumed to be 25 percent.

The *Medicare Provider Reimbursement Manual*, Part I, §2203, states that for charges to be used to opportion costs, "…each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably consistent related to the cost of providing the services."

Charges are driven by the hospital's charge master – a comprehensive file that lists all supplies and services provided by the hospital, along with the fee associated with each item. All services provided at the hospital are based on physician orders. Documentation of such orders is contained in the patient's medical record. While all patients are billed the same amount for the same service, various managed care contract terms, government

regulations, and provider-offered discounts impact the actual amount paid by the patient or the insurance payer.

Hospitals provide necessary care for patients regardless of their ability to pay or the extent of their insurance coverage. Anytime a hospital is paid less than what is spent to treat a patient, the hospital incurs unrecovered costs. This occurs when hospitals care for patients who have no insurance, have inadequate insurance coverage, or when they treat patients covered under governmental programs such as Medicare and Medicaid that pay less than costs. When the cost of caring for a patient exceeds payments, hospitals are placed in a financially vulnerable situation and could be forced to pass these unrecovered costs on to other payers/patients.

Why Charges Vary for the Same Procedure

There are many reasons for variations on bills for the same procedure. Bills for outpatient services are generally lower than those for inpatient services. For procedures that could safely be performed on either an inpatient or an outpatient basis, the ordering physician – possibly in consult with the applicable insurance payer – determines the most appropriate setting for the individual patient.

Charges for a hospital stay or outpatient encounter are based on the services provided. The patient's age, the severity of the condition and any complicating conditions influence the total charges for a hospital visit. For example, the cost of a hip replacement will be higher for an 85-year-old female with diabetes and a heart condition than for a healthy 60-year-old woman with no other serious health condition.

In addition, charges are influenced by the practice or ordering patterns of the attending physician. Physician preference for specific supplies and equipment, plus varying procedure and operating room times, will have an impact on the final bill. One physician may have standing orders for a particular lab test while other physicians do not or one physician may prefer to use a different, more costly implant than another physician providing the same service.

Charges for the same procedure may also differ due to hospital staffing practices, use of the latest technology, how the hospital allocates overhead charges, capital costs, and the range of services provided.

Covered/Non-covered Charges

Insurance contracts with their enrollees – and ultimately the hospital's patients – identify those services that are considered as "covered" under a particular policy. Medicare and Medicaid also have defined benefits – services that are considered covered and, therefore, eligible for payment. Services outside the scope of the policy are considered non-covered and become the responsibility of the patient. As an example, many insurers provide coverage for a limited number of days for mental health services and others do not cover

dental services, cosmetic surgery, or items and services determined that, although ordered by a physician, are not medically necessary.

Multiple Claims from Different Providers

The professional fees for physician services are normally billed separately from the hospital bill. Your hospital bill usually does not include charges from your attending physician, surgeon, anesthesiologist, pathologist, radiologist, or other physicians who may treat you in the emergency department or during your hospital visit.

Most physicians are independent contractors and are not employed by the hospital. Physicians independently establish their fees and decide whether or not to participate or contract with various payers, such as Medicare, Medicaid, and Blue Cross. If you have questions on a bill from a physician, please call the telephone number listed on that statement.

Refunds/Credit Balances

Refunds are necessitated when total payments and adjustments exceed the patient account liability. The overpayment on the account results in a credit balance, requiring the hospital to determine if the refund should be sent to the patient or to their insurer.

Services Provided by Other Providers

Hospitals often refer inpatients to other health care providers for services not provided at the originating hospital, such as MRIs or PET scans. As required by Medicare, and therefore generally accepted for other payers, the receiving hospital must bill such services to the originating hospital and the charges are consolidated by that facility on their inpatient account.

Types of Bills

A hospital bill is a communication in writing to the patient or other responsible party, known as the guarantor, of the charges incurred at the health care facility for services rendered or supplied during the care of the patient. Charges for the hospital visit are reflected on a *summary* bill to the patient/guarantor and on the UB-92/UB-04 or its electronic equivalent submitted to the insurer. An *itemized* bill provides specific details on the services provided, including dates and charges for each item of service. Under Florida law, hospitals are required to notify the patient of his/her right to receive an itemized bill upon request. Finally, patients receive a "billing statement" which shows the dates of service, the amount billed, the account status, the amount paid by the insurer, and the balance due from the patient. Billing statements are issued on a hospital-determined frequency, often monthly.

Billing Terminology

Summary bills are often consolidated at a service category level, such as pharmacy, laboratory, room and board, and operating room, based on *revenue codes*. Each revenue code carries a descriptor and explanation developed by payers and providers serving on the National Uniform Billing Committee.

Reimbursement/Payers

While what a hospital *charges* all patients is the same, what the hospital actually receives as *payment* for the care provided is very different. Various payers have established defined payment policies, as well as coverage decisions. Payers include –

Medicare covers senior citizens, as well as certain individuals who are disabled and those with end-stage renal disease. It is a federal program, administered by the Centers for Medicare & Medicaid Services (CMS). While the current majority of Medicare beneficiaries are enrolled in *traditional* or *fee-for-service* Medicare, many have opted to participate in a Medicare managed care, or Medicare Advantage plan. Managed care options include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs).

Services covered by traditional Medicare are subject to beneficiary cost-sharing through deductibles and coinsurance. Medicare managed care plans have varying requirements for patient liability, defined at the individual contract or plan level.

The Medicare program statutorily excludes payment for certain services, while others must meet the requirement to be medically necessary. Providers are required to inform beneficiaries when a service might not be covered by Medicare (see section on Advance Beneficiary Notice). Patients covered by Medicare may purchase supplemental insurance – Medigap – to assist with payment of beneficiary liability.

Medicaid is a joint state-federal program that provides health care coverage for low income populations that meet certain eligibility requirements. As with Medicare, enrollees are in either "fee-for-service" Medicaid or have joined a Medicaid HMO or provider service network (PSN). Medicaid managed care plans have specific requirements about where, from whom, and how the patient receives health care services. It is vital that Medicaid plan enrollees understand the requirements of their individual plan and make sure that the requirements have been met.

Managed care plans, such as HMOs and PPOs, are more restrictive about where, from whom, and how the enrollee receives health care services. These plans often require that the patient have referrals or authorizations to receive hospital or physician services. It is the patient's responsibility to make sure that the requirements of his or her plan have been met. If the plan's requirements are not met, the patient may be financially responsible for all or part of the services provided.

Self pay patients either have no insurance coverage, are totally responsible for paying their health care bill, or must pay the balance of the cost of their care after their insurance has paid its share of the claim.

Payer Payment Methodologies

The various insurance payers, including Medicare and Medicaid, pay for the services provided using numerous methodologies. The most prevalent payment methodologies include –

- Diagnosis-Related Group (DRG) Under this payment methodology, each patient condition is classified into a diagnosis-related group to which a numerical weight has been assigned by the payer. This weight represents the relative hospital resources necessary to treat the average case classified into that DRG, compared with the average DRG. The amount of the basic DRG payment is determined by multiplying the weight for the DRG by a payment rate. The basic DRG payment is often modified through adjustments for outliers, transfers, and other factors.

- Per Diem This single rate per patient day includes payment for all of the services the patient receives during that time. Per diems may be all inclusive or different per diems could apply the different categories of service, such as ICU, med/surg, etc.

Many payers negotiate a discount or percentage reduction from the charges on the claim. Discounts are also often available to individuals for the self-pay portion of their claim. These discounts are often tied to individual income/asset thresholds, but can also be offered for prompt payment of the claim.

Explanation of Benefits (EOB) are prepared by the payer and presented to the insured, explaining the benefits paid on their behalf. A similar document is also sent with the payment to the hospital. In many instances, the EOB received by the patient does not truly reflect the amount paid to the hospital, but rather the payment and contractually agreed upon adjustments to the balance, leaving only the patient responsibility.

Coordination of Benefits (COB) define the order in which multiple payers are determined responsible for a claim and allows secondary payers to reduce their benefits so that the combined benefits from all payers do not exceed the total amount of the claim. Key provisions under COB include:

- The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.
- A plan may consider the benefits paid or provided by another plan only when it is secondary to that other plan.

The first of the following rules that describe which plan pays its benefits before another plan is the rule to use:

- The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person as a dependent is secondary.

- The order of benefits when a child is covered by more than one plan is:

  – The primary plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married;
    - The parents are not separated, whether or not they have ever been married; or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

  – If both parents have the same birthday, the plan that covered either of the parents longer is primary.

  – If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary.

  – If the parents are not married, or are separated whether or not they have ever been married, or are divorced, the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the noncustodial parent; and
    - The plan of the spouse of the noncustodial parent.

Patient Responsibility

Many insurance products include elements of patient liability or cost-sharing. Patient responsibility is usually limited to a deductible and either coinsurance or copayment. When these amounts can be determined in advance of the payment by the insurer, many hospitals will ask patients to settle their liability, or a portion of that liability, when services are rendered.

Deductible

This represents the initial amount of covered expenses that the patient will have to pay before benefits are paid under their insurance policy. Deductible could be required annually, per service, or for a "benefit period" – a period of time without additional services provided.

Coinsurance

This is the share of covered expenses, usually expressed as a percentage, that the patient must pay, in addition to any applicable deductible, for the service provided. Often, the coinsurance is limited by an out-of-pocket maximum.

Copayment

Expressed as a flat dollar amount, copayments represent a specified amount that the patient must pay for services provided.

Deductibles, coinsurance percentage, copayments, and maximum out-of-pocket costs are defined by the patient's insurance coverage. If the patient is unable to pay the expected cost-share, it is important that he/she inform the provider so that payment arrangement can be developed.

Advance Beneficiary Notice

Medicare will only pay for services that it determines to be "reasonable and necessary." In instances in which Medicare determines that specified items or services that would otherwise be covered, will not be paid for a particular beneficiary on a particular occasion, the provider is required to issue an Advance Beneficiary Notice (ABN). The ABN allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he/she may have to pay out-of-pocket or through other insurance.

Interest on Account Balances

Some hospitals have made the decision to charge interest on the unpaid portion of the patient bill. This is allowed under Florida law even though there is usually no stated provision for interest included in the forms that are signed at the time of service.

Charity Care

The charges for uninsured patients who cannot pay their bill – whether because of financial or medical indigency – are written off by the hospital as charity care. While Florida's Agency for Health Care Administration (AHCA) defines charity care as that portion of hospital charges for which there is not compensation for care provided to a patient whose family income is less than or equal to 200 percent of the federal poverty level, or the amount of hospital charges due from the patient exceeds 25 percent of the annual family income, many hospitals have sliding scale formulas for determining charity care – often at greater than 200 percent of federal poverty.

Patients unable to pay their bill should speak with a financial counselor at the hospital. A financial counselor can discuss payment alternatives, including extended payments, government programs, or charity care.

The federal poverty guidelines are revised in early February and are available through the Department of Health and Human Services at http://aspe.hhs.gov/poverty/.

Florida's Patient's Bill of Rights and Responsibilities

The Florida Patient's Bill of Rights and Responsibilities, found at Florida Statute 381.026, is intended to promote the interests and well-being of the patients of health care providers and health care facilities and to promote better communication between the patient and the health care provider. It was the intent of the Legislature that health care providers understand their responsibility to give their patients a general understanding of the procedures to be performed on them and to provide information pertaining to their health care so that they can make decisions in an informed manner, after considering the information related to their condition, the available treatment alternatives, and substantial risks and hazards inherent in the treatments. In addition, it is important that patients have a general understanding of their responsibilities toward health care providers and health care facilities.

The rights afforded patients in Florida, as well as the associated responsibilities, are as follows:

Individual Dignity

1. The individual dignity of a patient must be respected at all times and upon all occasions.

2. Every patient who is provided health care services retains certain rights to privacy, which must be respected without regard to the patient's economic status or source of payment for his or her care. The patient's rights to privacy must be respected to the extent consistent with providing adequate medical care to the patient and with the efficient administration of the health care facility or provider's office.

3. A patient has the right to a prompt and reasonable response to a question or request. A health care facility shall respond in a reasonable manner to the request of a patient's health care provider for medical services to the patient. The health care facility shall also respond in a reasonable manner to the patient's request for other services customarily rendered by the health care facility to the extent such services do not require the approval of the patient's health care provider or are not inconsistent with the patient's treatment.

4. A patient in a health care facility has the right to retain and use personal clothing or possession as space permits, unless for him or her to do so would infringe upon the right of another patient or is medically or programmatically contraindicated for documented medical, safety, or programmatic reasons.

Information

1. A patient has the right to know the name, function, and qualifications of each health care provider who is providing medical services to the patient. A patient may request such information from his or her responsible providers or the health care facility in which he or she is receiving medical services.

2. A patient in a health care facility has the right to know what patient support services are available in the facility.

3. A patient has the right to be given by his or her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information.

4. A patient has the right to refuse any treatment based on information required by this paragraph, except as otherwise provided by law. The responsible provider shall document any such refusal.

5. A patient in a health care facility has the right to know what facility rules and regulations apply to patient conduct.

6. A patient has the right to express grievances to a health care provider, a health care facility, or the appropriate state licensing agency regarding alleged violations of patients' rights. A patient has the right to know the health care provider's or health care facility's procedures for expressing a grievance.

7. A patient in a health care facility who does not speak English has the right to be provided an interpreter when receiving medical services if the facility has a person readily available who can interpret on behalf of the patient.

Financial Information and Disclosure

1. A patient has the right to be given, upon request, by the responsible provider, his or her designee, or a representative of the health care facility full information and necessary counseling on the availability of known financial resources for the patient's health care.

2. A health care provider or a health care facility shall, upon request, disclose to each patient who is eligible for Medicare, in advance of treatment, whether the health care provider or the health care facility in which the patient is receiving medical services accepts assignment under Medicare reimbursement as payment in full for medical services and treatment rendered in the health care provider's office or health care facility.

3. A health care provider or a health care facility shall, upon request, furnish a person, prior to provision of medical services, a reasonable estimate of charges for such services. Such reasonable estimate shall not preclude the health care provider or health care facility from exceeding the estimate or making additional charges based on changes in the patient's condition or treatment needs.

4. Each licensed facility not operated by the state shall make available to the public on its Internet website or by other electronic means a description of and a link to the performance outcome and financial data that is published by the agency pursuant to §408.05(3)(l). The facility shall place a notice in the reception area that such information is available electronically and the website address. The licensed facility may indicate that the pricing information is based on a compilation of charges for the average patient and that each patient's bill may vary from the average depending upon the severity of illness and individual resources consumed. The licensed facility may also indicate that the price of service is negotiable for eligible patients based upon the patient's ability to pay.

5. A patient has the right to receive a copy of an itemized bill upon request. A patient has a right to be given an explanation of charges upon request.

Access to Health Care

1. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

2. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide such treatment.

3. A patient has the right to access any mode of treatment that is, in his or her own judgment and the judgment of his or her health practitioner, in the best interests of the patient, including complementary or alternative health care treatments, in accordance with the provisions of §456.41.

Experimental Research

A patient has the right to know if medical treatment is for purposes of experimental research and to consent prior to participation in such experimental research. For any patient, regardless of ability to pay or source of payment for his or her care, participation must be a voluntary matter; and a patient has the right to refuse to participate. The patient's consent or refusal must be documented in the patient's care record.

Responsibilities of Patients

Each patient of a health care provider or health care facility shall respect the health care provider's and health care facility's right to expect behavior on the part of patients which, considering the nature of their illness, is reasonable and responsible. Each patient is responsible for –

- Providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to his or her health;

- Reporting unexpected changes in his or her condition to the health care provider;
- Reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her;
- Following the treatment plan recommended by the health care provider;
- Keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health facility.
- His or her actions if he or she refuses treatment or does not follow the health care provider's instructions;
- Assuring that the financial obligations of his or her health care are fulfilled as promptly as possible; and
- Following health care facility rules and regulations affecting patient care and conduct.

Comparing Charges and Outcomes

Hospitals are often compared based on quality, charges, and patient satisfaction. Before making comparisons using any indictors from hospital to hospital, it is important to understand what the various measurements entail. As an example, when comparing hospitals on the basis of charges, the type of hospital, type of patients treated, bed size, location, and product lines offered should all be considered. Additionally, charges should be adjusted for severity, case mix, geographic location, and other factors.

Current state and federal initiatives are under development that will provide comparative data on hospitals. The Florida Legislature, in HB 1629 passed in 2004, requires the Agency for Health Care Administration (AHCA) to make available to consumers via an interactive Web site comparative financial and performance data on hospitals, health plans, physicians, and pharmaceuticals. Information on hospital charges is available on AHCA's Web site at www.floridahealthstat.com.

In November 2001, HHS Secretary Tommy G. Thompson announced the national Quality Initiative, his commitment to assure quality health care for all Americans through published consumer information. The Quality Initiative was launched nationally in 2002 as the Nursing Home Quality Initiative (NHQI) and expanded in 2003 with the Home Health Quality Initiative (HHQI) and the Hospital Quality Initiative (HQI). These initiatives are part of a comprehensive strategy to improve quality of care in all health care settings.

Privacy Rights

All hospitals have a strong commitment to protecting the private health information of its patients. In addition to state laws related to confidentiality of patient information, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated regulations from the federal perspective that govern privacy standards for health care information. HIPAA regulations specify the purposes for which information may and may not be released without authorization from the patient.

At the time of initial service, the hospital will provide a written notice that describes:

- How the hospital may use and disclose protected health information about an individual;
- The individual's rights with respect to the information and how the individual may exercise those rights, including how to complain to the hospital;
- The hospital's legal duty with respect to the information, including a statement that it is required by law to maintain the privacy of protected health information; and
- Who the individual should contact for additional information about the hospital's privacy practices.

A hospital's privacy notice is also available on its Web site.

Managed Care Grievances

Florida law requires that all managed care organizations have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances. You should refer to your plan contract for details of a specific grievance procedure.

In addition, Florida law also requires the Agency for Health Care Administration (AHCA) to implement a program to provide assistance to subscribers, including those whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber. Once the internal complaint is file, the plan has 60 days to respond to or correct the problem.

If after 60 days the problem has not been resolved, you can appeal to the Statewide Provider and Subscriber Assistance Program panel. This six-member panel consists of three representatives from the Department of Financial Services and three representatives from the Agency of Health Care Administration. The panel reviews the grievances and recommends the appropriate action to resolve the problem. For further information, call the Agency for Health Care Administration, toll-free at 1-888-419-3456.

If the grievance is about coverage or payment for Medicare beneficiaries, the administrative appeals procedure is available through the Centers for Medicare & Medicaid Services (CMS). For more information call CMS at 404/562-7500, or call the Consumer Helpline toll-free at 1-800-342-2762. If you have a question or problem involving billing or enrollment, call the Consumer Helpline at 1-800-342-2762. If the problem involves a quality of care issue with an HMO, call the Agency for Health Care Administration toll-free at 1-888-419-3456.

Definitions

Accomodations – Description of the type of room assigned to an individual while a patient (inpatient or outpatient) in the hospital; for example, private room, semi-private room, ward bed, ICU bed, observation bed.

Account – A record of the demographic and financial transactions made on behalf of the patient by the hospital.

Account Number – A number assigned to each patient account at the time of admission/registration and used to identify the charges and payments relative to that account.

Acute Care Facility – A hospital that provides services to patients in critical, urgent, and emergency classification, as well as elective cases.

Adjustment – A modification, correction, or resolution of the balance of a patient claim. Adjustments can be positive or negative transactions.

Advance Directives – A document, commonly known as a "living will," used to instruct caregivers how a patient wants to be treated if he/she cannot communicate.

Age of Majority – The state-specific age when an individual becomes responsible for his or her actions and financial responsibilities. In most states, this is age 18.

Agency for Health Care Administration (AHCA) – The state agency established in 1992 to oversee all health related activities.

Ambulatory Care – A type of service rendered to hospital patients usually for minor surgery or testing procedures on an outpatient basis. Outpatient surgery and same-day surgery are examples of ambulatory care.

Ambulatory Payment Classification (APC) – A grouping of outpatient services for payment purposes. Services in an APC are clinically cohesive and similar in resource codes.

Ambulatory Surgical Center (ASC) – Freestanding centers that perform surgeries that do not require an overnight stay.

Ancillary Care Services – Diagnostic or therapeutic services performed by non-nursing departments. These include, but are not limited to, surgery, laboratory, radiology, pharmacy, and physical therapy.

Assignment of Benefits – Transfer of insurance benefits by the policy holder (either patient or guarantor), known as the assignor, to the hospital in lieu of payment at time of

service. The policy holder must execute this transfer in writing per insurance policy guidelines.

Average Length of Stay (ALOS) – The average length of time in days that a patient is in the hospital; calculated from date of admission up to but excluding the date of discharge.

Bad Debt – An accounts receivable that is regarded as uncollectible and is charged off as a credit loss even though the patient has the ability to pay.

Birthday Rule – A method used by the insurance industry to determine which policy is primary when there are multiple insureds. Use the birth date of the policy holder whose month and date occur first.

Capitation – A method of payment for health services in which an individual or institutional provider is paid a fixed, per capita amount for each patient served without consideration of the actual number or nature of services provided to each person.

Case Mix Index (CMI) – The case mix index reflects the types of patients treated by a hospital compared to the national mix of patients. A hospital's case mix score is determined by the number of patients by DRG and the relative costliness of treating those patients in each DRG. A hospital with a high case mix score above 1.0 treats patients which consume more resources than a hospital with a low case mix below 1.0.

Centers for Medicare & Medicaid Services – The federal agency in the Department of Health and Human Services that oversees the Medicare program and the federal portion of state Medicaid programs.

Charity Care – Medical services provided to an individual who has insufficient resources or assets to pay for needed medical care.

Consent – The authorization by the patient or legal representative for the hospital to provide necessary medical treatment.

Continuum of Care – A range of medical, nursing treatments and social services in a variety of settings that provide services most appropriate to the level of care required.

Coordination of Benefits (COB) – Insurance terminology for comparing two or more insurance policies per patient to identify the amount to be paid by each payer up to 100% of the balance.

Copay/Coinsurance – The amount unpaid on an account by the third party payer that is now the patient's responsibility.

Deductible – Portion of a patient claim assigned by a third party payer per patient benefits policy as the patient's responsibility for payment.

Diagnosis Related Group (DRG) – Grouping of diagnoses that reflect the acuteness of the patient's condition. DRGs may be utilized by third party payers to determine reimbursement by assigning a specific charge or payment to the diagnosis or procedure.

Emancipated Minor – A juvenile who has not yet reached the age of majority, but who is self-supportive financially and acts on his or her own behalf, and who does not live with parents.

Explanation of Benefits (EOB) – Insurance terminology for a notice sent to the hospital or the patient to explain what the payer is or is not paying on the patient's account.

Guarantor – A person who accepts the responsibility for paying the patient's hospital bill.

Health Insurance Portability and Accountability Act (HIPAA) – Enacted in 1996, HIPAA provided for expanded insurance coverage and portability, expanded fraud and abuse provisions to include all federal health care payers, and provided administrative simplification provisions intended to promote uniformity in electronic data interchange of health information and to ensure the confidentiality of health information.

Health Maintenance Organization (HMO) – A prepaid health care plan where people enroll by paying a set annual fee. Medical services are provided through a group of affiliated physicians and hospitals, often with no additional copayment or fees.

Inpatient – A patient who is provided with room, board, continuous nursing service and other institutional services under the orders of a physician.

Joint Commission of Accreditation of Healthcare (JCAHO) – The Joint Commission is a private not-for-profit organization that establishes standards for the operation of health facilities and services, conducts surveys, and awards accreditation for those that meet the standards.

Liability Insurance – Insurance covering risks or losses arising from injury or damage to another person or property.

Managed Care – A type of health care organization that organizes networks of physicians and hospitals to enhance the cost-effectiveness of patient care. It seeks to control costs by monitoring how member doctors and hospitals treat patients, and by limiting access to specialists and costly procedures. HMOs and PPOs are the most common types of managed care organizations.

Medicaid – Title XIX of the Social Security Act designed to provide medical care to the poor through state and federal funding. The federal government specifies minimum eligibility requirements and designates covered services.

Medigap – Private insurance policies that supplement Medicare coverage.

Medically Indigent – Individuals with little or no health insurance and without sufficient resources to pay for essential health care.

Medicare – Title XVIII of the Social Security Act designed to provide medical care to Americans age 65 or older, disabled, and individuals with end-stage renal disease. The program is funded by Congress and is monitored by the Centers for Medicare & Medicaid Services (CMS).

Non-covered Charges – Non-covered charges are those charges that are not reimbursed by the third party payer due to policy exclusions.

Payer Mix – The ratio of admissions or patient days for each payer category – Medicare, Medicaid, commercial, HMO, PPO, and others – to total admissions or patient days.

Pre-Existing Condition – Any medical condition that has been diagnosed or treated within a specified period immediately preceding the covered person's effective date of coverage.

Preferred Provider Organization (PPO) – A managed care plan where the insured has incentives to go to "preferred" providers but are not prohibited from using providers outside the system.

Preventive Care – Comprehensive care emphasizing patients' behaviors that encourage health promotion and disease prevention, early detection, and early treatment of conditions, generally including routine physical examinations, immunizations, and well-person care.

Remittance Advice (RA) – The explanation sent by the payer to the provider explaining the payment and any adjustments that were made on the account according to the contract or benefit terms.

Statement – Notification of financial responsibility on outstanding charges; can be informational only pending insurance benefits.

Third Party Payer – An agency or company that contracts with hospitals or patients to pay for care. Includes Medicare, Medicaid, HMOs and Blue Cross.

Acronyms

AHCA	Agency for Health Care Administration
ALOS	Average Length of Stay
APC	Ambulatory Payment Classification
ASC	Ambulatory Surgical Center
CMI	Case Mix Index
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
DRG	Diagnosis Related Group
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
HHA	Home Health Agency
HHQI	Home Health Quality Initiative
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HQI	Hospital Quality Initiative
JCAHO	Joint Commission of Accreditation of Healthcare
NHQI	Nursing Home Quality Initiative
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PSN	Provider Service Networks
PSO	Provider Sponsored Organization

RA	Remittance Advice
SNF	Skilled Nursing Facility