Part 1

Introduction to Polaris Medical Group

LEARNING OUTCOMES

After successfully completing Part 1, you will be able to define the key terms and:

1.1 Name the eight positions held by members of the Polaris Medical Group patient services team.

1.2 List eight facts that are documented in all medical records at Polaris Medical Group.

1.3 Identify the four parts of a SOAP note.

1.4 Describe three rules in the HIPAA Administrative Simplification provisions that set standards for privacy and the electronic transmission of data.

1.5 Describe the qualities of an effective patient services specialist.

1.6 Identify ten tasks that a patient services specialist at Polaris Medical Group performs during a typical day.

KEY TERMS

audit trail
continuity of care
documentation
electronic health record (EHR)
family practitioner
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
HIPAA Electronic Health Care Transactions and Code Sets (TCS)
HIPAA Privacy Rule
HIPAA Security Rule
HITECH Act
internist
medical record
National Provider Identifier (NPI)
NSF (nonsufficient funds) check
primary care physician
protected health information (PHI)
SOAP format

This section is your introduction to Polaris Medical Group. You will learn about the purpose, the people, and the structure of the practice. In addition, you will be introduced to the topics of medical records and patient privacy. All staff members at Polaris Medical Group must understand the proper use and disclosure of patient health information.

Part 1 also provides information about the types of tasks you will complete in Part 3, On the Job. You will learn about your role and your specific responsibilities at Polaris Medical Group, including activities such as scheduling, billing, and responding to patient inquiries.

CiMO 1.1 THE PMG PATIENT SERVICES TEAM

The physicians and staff of Polaris Medical Group (PMG) welcome you as a new member of our healthcare team. We are committed to providing each of our patients with the highest quality of healthcare. We hired you because we are confident that you can contribute to that goal. We are also committed to creating and maintaining a positive work environment for our employees.

At PMG, we work as a patient services team. The physicians, assistants, and medical office staff members work together, sharing information and resources to accomplish our common goals. We treat all patients and staff members with courtesy and patience. The caring environment we create is one reason that patients return to the clinic. A caring environment also makes the workplace a pleasant one for staff members. At PMG, we believe in treating others as we would like to be treated.

Statement of Purpose

Polaris Medical Group provides medical care and services to individuals and families regardless of age, race, color, creed, national origin, gender, or disability. As a family practice, we respond to a broad range of patient needs. Our primary function is to treat illness, disease, injury, and disability through evaluation, examination, and the use of medical procedures. We also educate individuals and families regarding preventive care. Our goal is to help all patients achieve their maximum potential within their capabilities and to accelerate convalescence and reduce the length of the patient's recovery.

Organization and Staff

The organization chart for PMG is illustrated in Figure 1-1. There are two physicians in the practice: Robin C. Crebore, M.D., F.A.A.F.P. (Fellow, American Academy of Family Physicians), and Michael P. Mahabir, M.D., F.A.C.P.

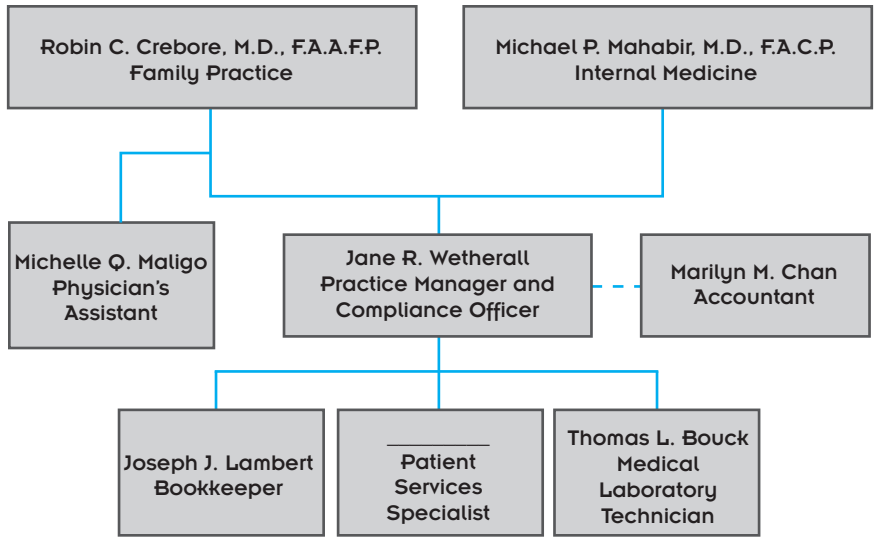


FIGURE 1-1 Organization Chart of Polaris Medical Group

(Fellow, American College of Physicians). Dr. Crebore, a ***family practitioner,*** has a general practice and treats patients of all ages. Dr. Mahabir, as an ***internist,*** specializes in the care of adults.

family practitioner a physician who treats patients of all ages and does not specialize in one area of medicine.

internist a physician who specializes in the care of adults.

The physicians' backgrounds are as follows:

Robin C. Crebore, M.D., F.A.A.F.P.

Specialty: Family Practice
University: Fairfield University, CT
Medical School: Tufts University School of Medicine, MA, 1994
Internship: Presbyterian University of Pennsylvania Medical Center, 1995
Residency: St. Elizabeth's Hospital, MA, 1997
Board Certification Dates:
1997, Family Practice
2003, Recertified Family Practice
2004, Certificate of Added Qualifications in Geriatrics
Memberships: Fellow, American Academy of Family Practitioners; American Geriatrics Society

Michael P. Mahabir, M.D., F.A.C.P.

Specialty: Internal Medicine
University: University of Colorado
Medical School: East Virginia Medical School, VA, 2000
Internship: Medical Center Hospital of Vermont, 2001
Residency: Medical Center Hospital of Vermont, 2003
Board Certification Date: 2003, Internal Medicine
Memberships: American Society of Internal Medicine; Fellow, American College of Physicians; Diplomat, American Board of Internal Medicine

primary care physician a physician in a managed care plan who directs all aspects of a patient's care, including routine services, referrals to specialists, and supervision of hospital admission.

Both physicians offer consultations for private patients, and they accept assignment for Medicare and Medicaid. Both are also identified as ***primary care physicians*** in a number of managed care plans. In this role, they are responsible for overseeing patients' overall healthcare and for referring their patients to specialists, such as cardiologists for cardiovascular disease or dermatologists for skin disease. Michelle Maligo, the office's physician's assistant, works with both physicians.

Jane Wetherall, our practice manager and compliance officer, is responsible for oversight of the medical office. You, the patient services specialist (PSS), report to her, as does Thomas Bouck, the part-time medical laboratory technician. Accounting functions are handled by a bookkeeper, Joseph Lambert, whose work is checked by Marilyn Chan, an outside accountant who reviews the financial aspects of the practice.

Polaris Medical Group is located in a modern medical office building in Columbus, Ohio, three blocks from St. Mary's Hospital. Our offices have a patient reception area and a front office where the business transactions of the medical practice take place. Your desk is located in a glassed-in section of the front office. There is also a separate lunchroom.

Each doctor has a separate office. In addition, there are three examining rooms for the evaluation and treatment of patients and an office laboratory for analyzing blood and urine samples. PMG also contracts with an outside laboratory for other types of lab work. Specimens are picked up from the practice and processed on a daily basis.

CiMO 1.2 MEDICAL RECORDS

medical record a file that includes the patient information form, the patient's medical history, record of care, progress notes, insurance correspondence, and other pertinent documents.

electronic health record (EHR) patient medical record created using a computer.

Patients' records are a critical component of all services and treatments we provide at PMG. ***Medical records*** contain all information pertaining to a patient's health history. They also contain all communications with and about each patient. The medical record begins with a patient's first contact with the practice and continues through all treatments and services. These records provide continuity and communication among physicians and other healthcare professionals who are involved in a patient's care.

In our practice, patient medical records are created on computers, rather than written by hand. In addition to physicians' notes, a patient's ***electronic health record (EHR)*** includes digital files of X-ray images, lab test results, medical history, and a picture of the patient. Electronic health records offer significant advantages over paper records. For example, a patient who is away from home or in an accident can authorize a local physician to access the record to locate

needed history. In addition, large amounts of information gathered over many years about a patient's chronic condition can be organized for quick review.

Information in the Medical Record

Information recorded in the patient's medical record is known as ***documentation.*** Accurate, complete documentation provides the physician with a detailed summary of each of the patient's visits, including information about treatments, progress, and outcomes.

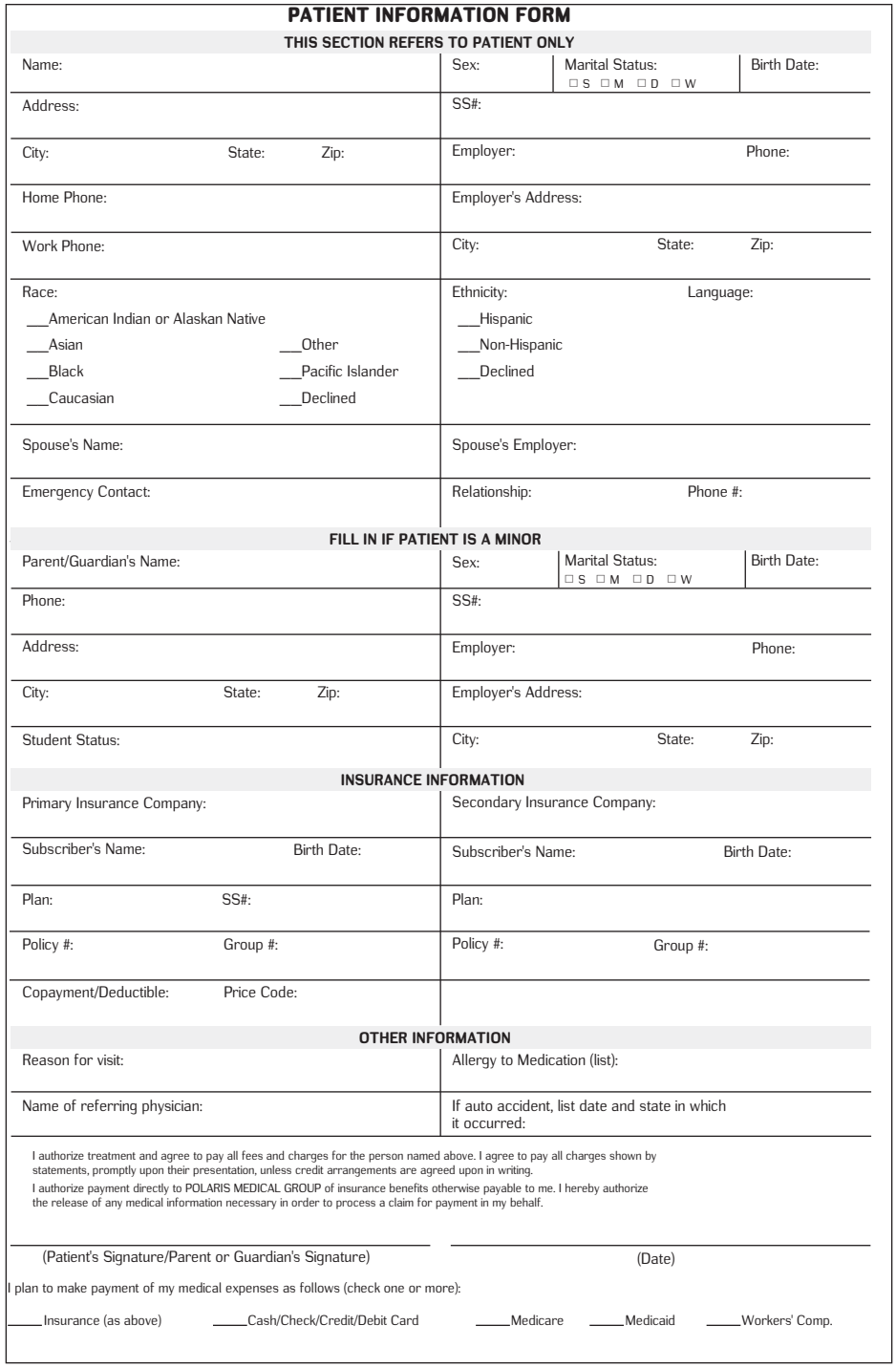
documentation the recording of facts and observations about a patient's health status in a logical, chronological sequence.

The medical record originates when a patient visits the office for the first time. Using the information on the patient information form (see Figure 1-2), a patient chart is created. After that, the medical record is updated each time the patient visits the physician. PMG includes the following eight items in every medical record:

1. Patient's name.
2. Encounter date and reason.
3. Appropriate history and physical examination.
4. Review of all tests that were ordered.
5. Diagnosis.
6. Plan of care, or notes on procedures or treatments that were given.
7. Instructions or recommendations that were given to the patient.
8. Signature of the provider who saw the patient.

In addition, a patient's medical record contains

- Biographical and personal information, including the patient's full name, Social Security number, date of birth, full address and phone numbers, marital status, employer information as applicable, insurance information, and chart number.
- Copies of prescriptions and instructions given to the patient, including refills.
- A list of the patient's known allergies, created and updated as needed.
- A list of medications the patient is taking, created and updated as needed.
- Immunization records.
- Previous and current diagnoses, test results, health risks, and progress notes.
- Copies of all communications with the patient, including letters, telephone calls, faxes, and e-mail messages; the patient's responses; and a note of the time, date, topic, and physician's response to each communication.



PATIENT INFORMATION FORM

THIS SECTION REFERS TO PATIENT ONLY

Name:	Sex:	Marital Status: ☐ S ☐ M ☐ D ☐ W	Birth Date:
Address:	SS#:		
City: State: Zip:	Employer:		Phone:
Home Phone:	Employer's Address:		
Work Phone:	City:	State:	Zip:
Race: ___American Indian or Alaskan Native ___Asian ___Other ___Black ___Pacific Islander ___Caucasian ___Declined	Ethnicity: ___Hispanic ___Non-Hispanic ___Declined	Language:	
Spouse's Name:	Spouse's Employer:		
Emergency Contact:	Relationship:	Phone #:	

FILL IN IF PATIENT IS A MINOR

Parent/Guardian's Name:	Sex:	Marital Status: ☐ S ☐ M ☐ D ☐ W	Birth Date:
Phone:	SS#:		
Address:	Employer:		Phone:
City: State: Zip:	Employer's Address:		
Student Status:	City:	State:	Zip:

INSURANCE INFORMATION

Primary Insurance Company:	Secondary Insurance Company:
Subscriber's Name: Birth Date:	Subscriber's Name: Birth Date:
Plan: SS#:	Plan:
Policy #: Group #:	Policy #: Group #:
Copayment/Deductible: Price Code:	

OTHER INFORMATION

Reason for visit:	Allergy to Medication (list):
Name of referring physician:	If auto accident, list date and state in which it occurred:

I authorize treatment and agree to pay all fees and charges for the person named above. I agree to pay all charges shown by statements, promptly upon their presentation, unless credit arrangements are agreed upon in writing.

I authorize payment directly to POLARIS MEDICAL GROUP of insurance benefits otherwise payable to me. I hereby authorize the release of any medical information necessary in order to process a claim for payment in my behalf.

(Patient's Signature/Parent or Guardian's Signature) (Date)

I plan to make payment of my medical expenses as follows (check one or more):

_____Insurance (as above) _____Cash/Check/Credit/Debit Card _____Medicare _____Medicaid _____Workers' Comp.

FIGURE 1-2 Patient Information Form

- Requests for information about the patient (from a health plan or an attorney, for example), and a detailed log indicating to whom information was released.
- Copies of referral or consultation letters.
- Original documents that the patient has signed, such as an authorization to release information and an advance directive.

The medical record allows healthcare professionals involved in the patient's care to provide continuity of care to individual patients. ***Continuity of care*** refers to coordination of care received by a patient over time and across multiple healthcare providers.

continuity of care coordination of care received by a patient over time and across multiple healthcare providers.

Standards

Information in all patient medical records is recorded in a consistent manner. Without standardization, physicians and other medical office personnel would find locating the information they need difficult and time-consuming. To ensure that medical records are well organized and easy to use, the following standards are followed at PMG:

- *Records must be clear:* Medical records should be complete and accurate. If the records are handwritten, the entries should be legible to others, made in ink (not pencil), and dated.
- *Entries must be signed and dated:* Whether digitally entered by the provider, handwritten, or transcribed, each entry must have the signature or initials and title of the responsible provider and the date.
- *Changes must be clearly made:* An incorrect entry is marked with a single line through the words to be changed; the correct information is entered after it, so that the previous copy can be read. Corrections are also dated and signed by the person making the change. No part of a record should be otherwise altered or removed, deleted, or destroyed.

1.3 SOAP FORMAT

CiMO

The Polaris Medical Group uses *problem-oriented medical records* (POMRs) to organize patient information. The problem-oriented medical record contains a general section with data from the initial patient examination and assessment. When the patient returns for subsequent visits, the reasons for those encounters are listed separately and have their own notes. A problem-oriented medical record contains SOAP notes. In the ***SOAP format*** (see Figure 1-3), a patient's encounter documentation is grouped into four parts: *s*ubjective, *o*bjective, *a*ssessment, and *p*lan:

SOAP format the documentation of medical records according to *s*ubjective data, *o*bjective data, *a*ssessment, and *p*lan of treatment.

S: The *subjective* information is based on the patient's descriptions of symptoms along with other comments.
O: The *objective* information (also called signs) includes the physician's descriptions of the presenting problem and data from examinations and tests.
A: The *assessment,* also called the impression or conclusion, is the physician's diagnosis, or interpretation of the subjective and objective information.
P: The *plan,* also called treatment, advice, or recommendations, includes the necessary patient monitoring, follow-up, procedures, and instructions to the patient.

Name: David Weatherly **Telephone:** 999-555-6798

Date of Birth: 8/12/57

3/7/16 **PROBLEM 1:** Tonsillitis
CHIEF COMPLAINT: Sore throat x2 days.

S: Sore throat, fever, difficulty swallowing.
O: Temperature 101°, pharyngitis with exudative tonsils.
A: Tonsillitis.
P: 1. Throat culture.
2. 1.2 units CR Bicillin.
3. Recheck in 10 days.

Robin Crebore, M.D.

3/17/16 **PROBLEM 1:** Recheck

S: Feels better.
O: Temperature, normal.
A: Problem 1 resolved.
P: Saline gargles, if necessary.

Robin Crebore, M.D.

FIGURE 1-3 SOAP Format

This format provides an orderly system for recording clinical information about a patient encounter.

1.4 HIPAA/HITECH AND PATIENT PRIVACY

Medical records are legal documents. Patients have rights to the information in their medical records. They also control the amount and type of information that is released from their records, except for the use of the data to treat them or conduct the normal business transactions of the practice.

Patient services specialists often handle requests for information from patients' medical records, and they must know what information can be released and under what circumstances. Staff members who work with a medical record are responsible for guarding the patient's privacy and confidentiality. Patient confidentiality is the basis of the physician-patient relationship. A violation of this understanding is not only a breach of trust; it may also violate

federal law. The ***Health Insurance Portability and Accountability Act of 1996,*** known as ***HIPAA,*** is a federal law governing many aspects of healthcare, such as standards for the electronic transmission of information and the security of healthcare records.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) a federal law governing many aspects of healthcare, such as standards for the electronic transmission of information and the security of healthcare records.

The American Recovery and Reinvestment Act (ARRA) of 2009, also known as the stimulus package, contains additional provisions concerning the standards for electronic transmission of healthcare data. The most important rules are in the ***HITECH Act*** (Health Information Technology for Economic and Clinical Health Act), which is Title XIII of ARRA. This law guides the use of federal stimulus money to promote the adoption and meaningful use of health information technology, mainly using electronic health records (EHRs). Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

HITECH Act the Health Information Technology for Economic and Clinical Health Act, part of the American Recovery and Reinvestment Act of 2009, that provides financial incentives to physicians and hospitals to adopt EHRs and strengthens HIPAA privacy and security regulations.

HIPAA's Administrative Simplification provisions contain three rules that are important at PMG and in all medical offices:

1. The HIPAA Privacy Rule—the privacy requirements cover patients' health information.
2. The HIPAA Security Rule—the security requirements state the administrative, technical, and physical safeguards that are required to protect patients' health information.
3. The HIPAA Electronic Health Care Transactions and Code Sets—these standards require every provider who does business electronically to use the same healthcare transactions, code sets, and identifiers.

HIPAA Privacy Rule

The ***HIPAA Privacy Rule*** is the first comprehensive federal protection for the privacy of health information. These national standards protect individuals' medical records and other personal health information. The Privacy Rule must be followed by all health plans, healthcare clearinghouses, and healthcare providers and their business associates. The rules mandate that a provider or other group must

HIPAA Privacy Rule national standards that protect individuals' medical records and other personal health information.

- Adopt a set of privacy practices that are appropriate for its healthcare services.
- Notify patients about their privacy rights and how their information can be used or disclosed.
- Train employees so that they understand the privacy practices.

- Appoint a staff member to be the privacy official responsible for seeing that the privacy practices are adopted and followed.
- Secure patient records containing individually identifiable health information so that they are not readily available to those who do not need them.

Protected Health Information

protected health information (PHI) individually identifiable health information that is transmitted or maintained by electronic media, such as over the Internet, by computer modem, or on magnetic tape or compact disc.

The HIPAA Privacy Rule covers the use and disclosure of patients' ***protected health information (PHI)***. PHI is defined as individually identifiable health information that is transmitted or maintained by electronic media, such as over the Internet, by computer modem, or on magnetic tape or compact disc.

Protected information includes the information below when it is used in connection with health information, such as a diagnosis or condition:

- Name
- Address (including street address, city, county, ZIP code)
- Names of relatives and employers
- Birth date
- Telephone numbers
- Fax number
- E-mail address
- Social Security number
- Medical record number
- Health plan beneficiary number
- Account number
- Certificate or license number
- Serial number of any vehicle or other device
- Website address
- Fingerprints or voiceprints
- Photographic images

Except for treatment, payment, and healthcare operations, the Privacy Rule limits the release of protected health information without the patient's authorization. *Treatment* means providing and coordinating the patient's medical care; *payment* refers to the exchange of information with health plans; and healthcare *operations* are the general business management functions. When using or disclosing protected health information at PMG, staff members must try to limit the information shared to the minimum amount necessary to accomplish the intended purpose.

Notice of Privacy Practices

Under the HIPAA Privacy Rule, physician practices must provide patients with a Notice of Privacy Practices at their first contact or encounter. This document describes the medical office's practices regarding the use and disclosure of PHI. It also establishes the office's privacy complaint procedures, explains that disclosure is limited to the minimum necessary information that is required, and discusses how consent for other types of information release is obtained. Medical practices are required to display the Notice of Privacy Practices in a prominent place in the office. To satisfy this requirement, Polaris Medical Group gives patients a copy of a Notice of Privacy Practices (see Figure 1-4) and asks

POLARIS MEDICAL GROUP
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We respect the privacy of your personal health information and are committed to maintaining our patients' confidentiality. This Notice of Privacy Practices (Notice) applies to all information and records related to your care that our facility has received or created. It extends to information received or created by our employees, staff, volunteers, and physicians. This Notice informs you about the possible uses and disclosures of your personal health information. It also describes your rights and our obligations regarding your personal health information.

We are required by law to:

- Maintain the privacy of your protected health information;
- Provide to you this detailed Notice of our legal duties and privacy practices relating to your personal health information; and
- Abide by the terms of the Notice that are currently in effect.

I. WAYS WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

You will be asked to sign an acknowledgment indicating you have received our Notice of Privacy Practices (Notice) detailing how we will use and disclose your personal health information for purposes of treatment, payment, and healthcare operations. We have described these uses and disclosures below and provide examples of the types of uses and disclosures we may make in each of these categories.

For Treatment. We will use and disclose your personal health information in providing you with treatment and services. We may disclose your personal health information to facility and non-facility personnel who may be involved in your care, such as physicians, nurses, nurse aides, and physical therapists. For example, a nurse caring for you will report any change in your condition to your physician. We also may disclose personal health information to individuals who will be involved in your care after you leave the facility.

For Payment. We may use and disclose your personal health information so that we can bill and receive payment for the treatment and services you receive at the facility. For billing and payment purposes, we may disclose your personal health information to your representative, an insurance or managed care company, Medicare, Medicaid, or another third-party payer. For example, we may contact Medicare or your health plan to confirm your coverage or to request prior approval for a proposed treatment or service.

For Healthcare Operations. We may use and disclose your personal health information for facility operations. These uses and disclosures are necessary to manage the facility and to monitor our quality of care. For example, we may use personal health information to evaluate our facility's services, including the performance of our staff.

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FIGURE 1-4 Page from a Notice of Privacy Practices Booklet

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Polaris Medical Group
2100 Grace Avenue
Columbus, OH 43214-1111

I hereby acknowledge that I received or was provided the opportunity to receive a copy of Polaris Medical Group's Notice of Privacy Practices.

PATIENT INFORMATION

Print Name: _____

Signature: _____

Date: _____

Telephone: _____

PERSONAL REPRESENTATIVE INFORMATION (IF APPLICABLE)

Print Name: _____

Nature of Relationship: _____
(i.e.,– Parent, Guardian, Personal Representative, etc.)

Signature: _____

Date: _____

For Office Use Only:

__ Signed form received.
__ Acknowledgment not obtained.
__ Patient refused.
__ Emergency.
__ Other _____

Print Staff Member's Name: _____

Staff Member's Signature: _____

Date: _____

FIGURE 1-5 Acknowledgment of Receipt of Notice of Privacy Practices Form

patients to sign an Acknowledgment of Receipt of Notice of Privacy Practices, illustrated in Figure 1-5.

Authorizations

For use or disclosure other than for treatment, payment, or operations, the practice must have the patient sign an authorization to release the information. For example, information about alcohol and drug abuse may not be

released without a specific authorization from the patient. The authorization document must be in plain language and include the following:

- A description of the information to be used or disclosed.
- The name or other specific identification of each person authorized to use or disclose the information.
- The name of the person or group of people to whom the covered entity may make the use or disclosure.
- A description of each purpose of the requested use or disclosure.
- An expiration date.
- Signature of the individual (or authorized representative) and date.

In addition, a valid authorization must include

- A statement of the individual's right to revoke the authorization in writing.
- A statement about whether the covered entity is able to base treatment, payment, enrollment, or eligibility for benefits on the authorization.
- A statement that information used or disclosed after the authorization may be disclosed again by the recipient and may no longer be protected by the rule.

A sample authorization form is shown in Figure 1-6.

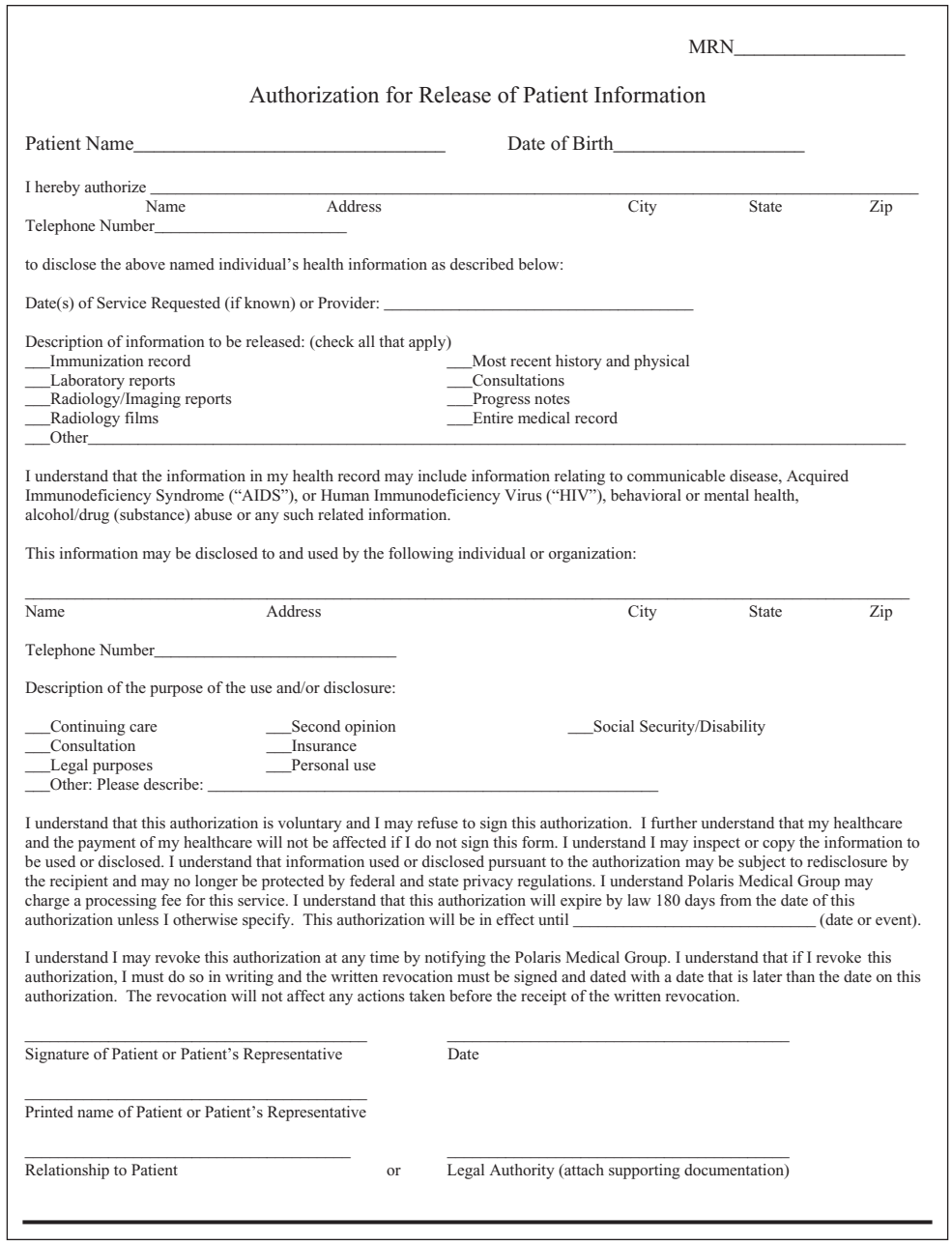
HIPAA Security Rule

The ***HIPAA Security Rule*** outlines safeguards required to protect the confidentiality, integrity, and availability of health information that is stored on a computer system or that is transmitted across computer networks, including the Internet. While the HIPAA Privacy Rule applies to all forms of patients' protected health information, whether electronic, paper, or oral, the Security Rule specifically covers PHI that is created, received, maintained, or transmitted in electronic form.

HIPAA Security Rule national standards that outline the minimum administrative, technical, and physical safeguards required to prevent unauthorized access to protected healthcare information.

The security standards are divided into three categories of safeguards: administrative, physical, and technical.

Administrative safeguards are administrative policies and procedures designed to protect electronic health information. The management of security is assigned to one individual, who conducts an assessment of the current level of data security. Once that assessment is complete, security policies and procedures are developed or modified to meet current needs. Security training is provided to educate staff members on the policies and to raise awareness of security and privacy issues.



MRN_____

Authorization for Release of Patient Information

Patient Name_____ Date of Birth_____

I hereby authorize _____
Name Address City State Zip
Telephone Number_____

to disclose the above named individual's health information as described below:

Date(s) of Service Requested (if known) or Provider: _____

Description of information to be released: (check all that apply)
___Immunization record
___Laboratory reports
___Radiology/Imaging reports
___Radiology films
___Other_____
___Most recent history and physical
___Consultations
___Progress notes
___Entire medical record

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used by the following individual or organization:

_____
Name Address City State Zip

Telephone Number_____

Description of the purpose of the use and/or disclosure:

___Continuing care
___Consultation
___Legal purposes
___Other: Please describe: _____
___Second opinion
___Insurance
___Personal use
___Social Security/Disability

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my healthcare and the payment of my healthcare will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand Polaris Medical Group may charge a processing fee for this service. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (date or event).

I understand I may revoke this authorization at any time by notifying the Polaris Medical Group. I understand that if I revoke this authorization, I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed name of Patient or Patient's Representative

_____ or _____
Relationship to Patient Legal Authority (attach supporting documentation)

FIGURE 1-6 Sample Information Release Authorization Form

Physical safeguards are the mechanisms required to protect electronic systems, equipment, and data from threats, environmental hazards, and unauthorized intrusion. Unauthorized intrusion refers to access by individuals who do not have a need to know. For example, individuals who are not working with confidential patient information should not be able to view this type of information displayed on an office computer monitor. To prevent intrusion, PMG limits physical access to computers. A security measure can be as simple as a lock on the door or as advanced as an electronic device that requires fingerprint authentication to gain access.

Technical safeguards are the automated processes used to protect data and control access to data. Access to information is granted on an as-needed basis. For example, the individual responsible for scheduling may not need access to billing data. Examples of technical safeguards include computer passwords, antivirus and firewall software, and secure transmission systems for sending patient data from one computer to another.

Another type of technical safeguard is an ***audit trail***—an electronic log that works in the background of a computer, tracing who has accessed information and when. When new information is entered or existing data are changed, the log records the time and date of the entry as well as the name of the computer operator. The practice manager reviews the log on a regular basis to detect any irregularities or errors.

audit trail a technical safeguard on a computer that keeps track of who has accessed information and when, which is regularly checked by a manager for errors or irregularities in data entry.

HIPAA Electronic Health Care Transactions and Code Sets

The ***HIPAA Electronic Health Care Transactions and Code Sets (TCS)*** standards are rules that make it possible for physicians and health plans to exchange electronic data using the standard format and standard codes. Under this rule, three types of standards have been set:

HIPAA Electronic Health Care Transactions and Code Sets (TCS) the HIPAA rule governing the electronic exchange of health information.

1. Electronic formats
2. Code sets
3. Identifiers

Electronic Formats

The HIPAA transactions standards apply to the data that are regularly sent back and forth between providers and health plans. HIPAA-covered transactions include electronic documents such as healthcare claims sent by physicians and hospitals to insurance companies, payments sent by the insurance companies in response, and employee enrollment information sent by employers to their insurance companies. Each standard is labeled with both a number and a name. Either the number (such as "the 837," which is the insurance claim form) or the name (such as the "HIPAA Claim") may be used to refer to the particular electronic document format.

Code Sets

There are also standard sets of codes for diseases; treatments and procedures; and supplies or other items used to perform these actions. These standards are listed in Table 1-1.

On October 1, 2014, the use of two new code sets will be required under HIPAA: the ICD-10-CM and the ICD-10-PCS. The ICD-10-CM will replace

TABLE 1-1

HIPAA Standard Code Sets for Diagnoses and Procedures

Purpose	Standard
Codes for diseases, injuries, impairments, and other health-related problems	*International Classification of Diseases,* Tenth Revision, *Clinical Modification* (ICD-10-CM)
Codes for procedures or other actions taken to prevent, diagnose, treat, or manage diseases, injuries, and impairments	Physicians' services: Current Procedural Terminology (CPT®)
	Inpatient hospital services: *International Classification of Diseases,* Tenth Revision, *Procedure Coding System* (ICD-10-PCS)
Codes for other medical services	Healthcare Common Procedure Coding System (HCPCS)

the original HIPAA standards for use in reporting diagnoses (ICD-9-CM, Volumes 1 and 2), and the ICD-10-PCS will replace the original standards for reporting inpatient hospital procedures (ICD-9-CM, Volume 3). The ICD-9 code sets were developed nearly thirty years ago. The new ICD-10 code sets are greatly expanded.

Identifiers

Identifiers are numbers of predetermined length and structure, such as a person's Social Security number. They are important for billing because the unique numbers can be used in electronic transactions. Two identifiers—for employers and for providers—have been set up by the federal government, and two—for patients and for health plans—are to be established in the future.

- The employer identifier is used to identify the patient's employer on claims. The Employer Identification Number (EIN) issued by the Internal Revenue Service is the HIPAA standard.
- The ***National Provider Identifier (NPI)*** is the standard unique health identifier for healthcare providers to use in filing healthcare claims and other transactions. The NPI is ten positions long, with nine numbers and a check digit. It replaces other identifying numbers that had been in use, such as the UPIN for Medicare, and eliminates the need for healthcare providers to use different identification numbers to identify themselves when conducting standard transactions with multiple health plans.

National Provider Identifier (NPI) a unique identifier assigned to a healthcare provider that is used in standard transactions, such as healthcare claims.

Many health plans—including Medicare, Medicaid, and private health insurance issuers—and all healthcare clearinghouses must now accept and use NPIs in standard transactions. The numbers are assigned to individuals, such as physicians and nurses, and also to organizations, such as hospitals, pharmacies, and clinics.

Polaris Medical Group HIPAA Compliance Program

Polaris Medical Group has established a special HIPAA compliance program to help its staff members comply with HIPAA legislation. This is part of the practice's overall compliance program, which includes adherence to all government regulations, including OSHA work-safety guidelines and fair labor laws.

The practice manager, Jane Wetherall, is the compliance officer for PMG. She is responsible for

- Training employees and new hires in all aspects of compliance.
- Monitoring adherence to current policies and procedures.
- Modifying policies and procedures to conform to changes in the HIPAA law.

The compliance officer also establishes the procedures for employees to follow when problems are identified. Every employee is required to sign, initial, and date a compliance form at the onset of employment, to make a record for chart identification purposes in case of legal issues.

1.5 QUALITIES AND ATTITUDES OF THE PATIENT SERVICES SPECIALIST

CiMO

Success as a PSS is not just about following procedures. It is also about the qualities you bring to the job and your attitude. The medical office has many things in common with other offices, but it also has unique environmental characteristics. For example, working in a medical office can be more stressful than working in other office environments because of people's reactions to illness. Some patients who come in for appointments are coping with serious illnesses or disabilities. New patients may be nervous when they see the doctor for the first time. Patients may experience a variety of emotions, ranging from fear to anger. Although the transactions you engage in (such as accepting payment from a patient) may be routine, the emotions you encounter may not be.

In the medical office, patience and enthusiasm are important qualities. It is important to appear calm in a crisis or when frustrations mount. Noise and confusion in the office create unnecessary stress for patients. To complete many of the tasks in the medical office, attention to detail is necessary. Information must be

recorded with extreme accuracy. Finally, sincerity and helpfulness are always important. Be willing to assist other staff members not only when asked but also whenever the opportunity arises.

General Responsibilities

Polaris Medical Group has identified the general responsibilities that are expected of every employee regardless of position.

All staff members must

- Arrive at the office on time and stay until the end of the shift.
- Return from breaks and meals on time.
- Follow office procedures and report issues concerning safety, infection control, and exposure control.
- Observe and follow all office policies, especially those related to confidentiality.
- Dress in a neat and appropriate style, with their identification tags visible at all times.
- Demonstrate effective verbal and written communication skills.
- Demonstrate their willingness to work cooperatively with all patients and coworkers.
- Interact with patients without prejudice with regard to age, gender, race, creed, and disability.
- Organize and prioritize their workloads in an efficient manner.
- Follow verbal and written instructions from supervisors, managers, and physicians.
- Maintain neat and legible records and documentation.
- Seek the advice of a supervisor when the proper or correct course of action is not clear.
- Adapt quickly to changes in the work environment or schedule.
- Learn new concepts and procedures as necessary.
- Juggle more than one task at a time when necessary.
- Complete work assignments within a reasonable time frame.

CiMO 1.6 YOUR TYPICAL DAY AT POLARIS MEDICAL GROUP

In this text-workbook, you are the PSS at PMG. In this role, you are responsible for a variety of tasks. This section provides an overview of the types of tasks you will complete later in Part 3, On the Job.

Like most medical practices, PMG has a Policy and Procedure Manual (PPM), located in Part 2 of this text. The PPM lists the procedures that should be followed when completing the tasks in Part 3. The PPM also contains detailed information on PMG's policies. Following the guidelines in the PPM ensures that all staff members use standard methods to complete tasks.

Polaris Medical Group also maintains a set of PPMs of the insurance carriers and managed care organizations with which the practice has contracts. For your convenience, summaries of these policies and procedures can also be found in PMG's PPM.

Each day, you will perform a variety of tasks. For example, you will interact with patients on the telephone and in the office. You will work on the office computer network to complete scheduling and billing tasks. You will look up information in medical records or in the PPM when necessary. The following sections describe the specific responsibilities of your position.

Scheduling Patients for Appointments Patients call the office to schedule new appointments or reschedule existing appointments. Scheduling tasks include

- Scheduling, rescheduling, and canceling appointments.
- Adding patients to the recall list as appropriate.
- Maintaining computerized office schedules for physicians, including patient appointments, professional obligations, and personal time off.
- Printing copies of the day's schedule as soon as you arrive in the office in the morning; distributing copies to physicians and staff members; and maintaining an up-to-date schedule on the computer.
- On a weekly basis, generating a patient recall list.
- On a daily basis, calling patients on the recall list to schedule appointments.

Recording and Maintaining Patient Information When a patient comes to PMG for the first time, information is collected and recorded in the medical record and in the computer. Similarly, patient records are updated each time the patient phones or visits the office. The patient information tasks include

- Gathering and recording information from a new patient over the telephone at the time the appointment is made.
- Asking new patients to fill out the patient information form (PIF) when they arrive in the office, and reviewing it for completeness, paying particular attention to the insurance section.
- Distributing the Notice of Privacy Practices form to each patient and asking the patient to sign, date, and return the Acknowledgment of Receipt of Notice of Privacy Practices form.

- Asking to see the patient's insurance identification card, photocopying or scanning the front and back of the card, and filing the copy in the patient's electronic health record.
- Inputting data from the PIF and the insurance card (if appropriate) into the computer.
- Asking a patient whose information (such as employer, insurance, or address) has changed since his or her last visit to complete a new PIF, and recording changes in the computer the same day, before new charges are entered.
- Recording information gathered during patient phone calls regarding changes in address, employment, insurance carrier, marital status, and so on.
- Reading and storing e-mail messages.

Maintaining Third-Party Payer Information Information is recorded and updated regarding each patient's insurance carrier or managed care organization. Information about each specific health plan is also recorded. Summary information about the major insurance plans in which PMG participates is listed in the PPM. To produce accurate claims, you must be familiar with the requirements of each third-party payer. Tasks include

- Looking up payer information for each patient as needed.
- Verifying each patient's insurance eligibility online or over the phone.
- Collecting a copayment from the patient at the time of the visit if the patient's insurance plan has a copayment requirement.
- Checking with patients who are participants in managed care plans to see if they need referrals before they can be seen by one of the physicians at PMG; if a referral is needed, checking for a proper referral or contacting the office of the patient's primary care physician for the necessary information.
- Checking for proper preauthorization; if preauthorization is required, contacting the health plan to obtain a preauthorization number.
- Recording referral information in the computer.
- Recording preauthorization numbers in the computer.

Educating Patients and Responding to Patient Inquiries Educating patients often includes informing them about charges and the payment process in general. Some patients do not understand the fees. If the planned services are expected to be costly and are not covered by the patient's insurance, it is PMG's policy to discuss these charges with the patient before the services are

provided. In addition, patients sometimes call or stop by the office to inquire about the status of a particular insurance claim or to ask about an account balance. You are responsible for researching the account and responding to the patient's question in a timely manner. This involves

- Researching and resolving patient inquiries regarding services, billing, or charges.
- Using relevant information to determine the validity of the inquiry and the source of the error, if there is one.
- Contacting the patient to communicate the resolution of the problem.

Recording Charges, Payments, and Adjustments at the Time of an Encounter Every time a PMG physician sees a patient at the office, hospital, or nursing home, a service is performed and a charge needs to be recorded. Similarly, any payments received from patients must be recorded. Adjustments are required when there is a difference between the amount charged and the amount that is accepted as payment.

A new billing tool for collecting payment at the time of service is known as *real-time claims adjudication (RTCA)*. Increasingly used in computerized offices, RTCA is likely the billing model that will be the most widely implemented in the future. With RTCA, a billing assistant submits claims at the time the patient checks out. Once a claim is submitted, assuming the payer has RTCA capabilities, the payer's computer system adjudicates the claim within minutes and sends back a remittance advice (RA). The billing assistant then discusses the payer's decision with the patient in person, and the patient pays any balance due before leaving. If there is a problem with the claim, such as missing information, the billing assistant can work with the patient to resolve the problem and resubmit the claim. The only follow-up for the medical office is to verify that the payer's portion of the payment is received. Payment usually follows within twenty-four hours.

Regardless of whether a medical office uses RTCA or some other form of collecting payments at the time of an encounter, the billing tasks include

- Preparing encounter forms at the beginning of each day for all patients with appointments.
- At the conclusion of an office visit:
  - —Reviewing charges with the patient.
  - —Recording charges on the encounter form and then entering them in the computer.
  - —Estimating the patient's financial responsibility.

- —Collecting payments as appropriate—for example, deductibles, payments for noncovered services, or balances due. (*Note:* Depending on the particular health plan, some patients do not make payments at the time of office visits but are instead billed for the balance after the remittance advice from the plan has arrived.)
- —Recording the amount of payment and type of payment (such as check or credit card) on the encounter form, entering the information in the computer, and applying the payment to the proper charge(s).
- —Thanking patients for their payments and generating walkout receipts at the time payment is received or upon request.

Generating Healthcare Claims Timely submission of claims helps solidify the finances of the practice. The sooner claims are created and submitted, the sooner payment arrives. It is your responsibility to prepare healthcare claims. If a claim is rejected, you must discover whether an error was made and, if so, resubmit the claim as soon as possible. Claim tasks include

- Generating healthcare claims and checking all claims for accuracy before submission, including
  - —Diagnosis and procedure code compliance.
  - —Correct linkage of diagnoses and procedures.
  - —Medical necessity of procedures.
  - —Billing compliance—making sure the charges are billable according to the payer's conditions.
- Reviewing claim acknowledgments to verify that claims have been received.
- Preparing claim status reports on a weekly basis.

Monitoring Payments from Third-Party Payers Once a third-party payer makes a decision on a claim, you are responsible for checking the results. This includes

- Comparing the information on the RA with the expected payment.
- If a claim is denied, reduced, or overpaid, researching the reason and resolving any discrepancies regarding services or billing, analyzing relevant information to determine the validity of the payer's decision or the source of an error, if there is one, and contacting the payer to resolve the problem.
- Appealing denied or rejected claims as necessary.
- Posting payments to patients' accounts.
- Contacting the payer if a claim is not paid within thirty days; following up on and/or resubmitting the claim as necessary.

Generating Patient Statements and Financial Reports The PSS prepares and prints patient statements regularly for billing. Depending on the insurance plan, the patient is billed for any remaining amount after all payers have paid on a claim. A patient who does not have insurance is billed for any amount that was not collected at the time of service.

When a patient makes a payment by check but does not have adequate funds in his or her checking account to cover the check, the check is not honored by the bank. Such a check is referred to as an ***NSF (nonsufficient funds) check,*** commonly called a "bounced" check. When the practice receives an NSF notice from a bank, the PSS posts a negative adjustment to the patient's account, since the patient now owes the practice the amount of the check. The PSS also posts a fee for the returned check to the patient's account. The maximum amount of the fee is governed by state laws. At PMG, the fee for a returned check is $35. These new amounts are reflected on the patient's next statement.

NSF (nonsufficient funds) check a check that is not honored by a bank because the account it was written on does not have sufficient funds to cover it.

In addition, the financial transactions of the medical practice must also be reported daily, weekly, and monthly. Patient day sheets summarize the number of patients seen by the physicians on a given day, the procedures performed, the charges and payments for the day, and other information. Reports that are generated on a weekly or monthly basis include patient and insurance aging reports.

Collecting Overdue Payments from Patients An unpaid account with a balance that is thirty days past due is considered overdue. It is usually the job of the PSS to collect payments on patients' overdue accounts. Each week, the PSS generates an aging report showing which patients' accounts are overdue ("aged") and by how many days. The report indicates whether the account is thirty, sixty, or ninety days past due. Generally, if the account is thirty days past due, the PSS sends out a reminder notice or a second statement or phones the patient about the payment.

In some cases, or for large amounts, the office may decide to extend credit to a patient by setting up a payment plan. Usually the agreement is to divide the bill over a period of months, with the patient making regular monthly payments. Finance charges may or may not be applied. In the case of Polaris Medical Group, finance charges are not applied to the payment plan.

At Polaris Medical Group, when an account is ninety days overdue, the PSS generates a collection letter. If a patient does not respond, additional collection letters are sent. Ultimately, if the office's collection procedures fail, an office may hire an outside collection agency to pursue the matter. If the agency is able to collect money from the patient, the agency retains a portion, for

example, 30 percent, as payment for its services. When the remaining amount is sent to the practice, the PSS posts it to the patient's account using the appropriate billing code.

The office may also decide that the account is uncollectible and write off the uncollected amount as a bad debt. Future services for patients with such accounts are usually on a cash-only basis. It is the job of the PSS to keep track of where an account is in the collection process and to follow up on collections on a weekly basis.

Updating CPT and ICD-10-CM Codes in the Database The Current Procedural Terminology (CPT) and *International Classification of Diseases* (ICD-10-CM) codes are updated annually. New codes are added; existing codes are modified; and old codes are marked inactive. When the practice manager requests it, these changes must be made by the PSS to PMG's computer database.

PART SUMMARY

1.1 Name the eight positions held by members of the Polaris Medical Group patient services team. Pages 2–4	1. Family practitioner 2. Internist 3. Physician's assistant 4. Practice manager/compliance officer 5. Accountant 6. Bookkeeper 7. Patient services specialist (PSS) 8. Medical laboratory technician
1.2 List eight facts that are documented in all medical records at Polaris Medical Group. Page 5	1. Patient's name 2. Encounter date and reason 3. Appropriate history and physical examination 4. Review of all tests that were ordered 5. Diagnosis 6. Plan of care, or notes on procedures or treatments that were given 7. Instructions or recommendations that were given to the patient 8. Signature of the provider who saw the patient
1.3 Identify the four parts of a SOAP note. Pages 7–8	A SOAP note, or SOAP format, groups the clinical information for a patient's encounter into four parts: *S:* The *subjective* information is based on the patient's descriptions of symptoms along with other comments. *O:* The *objective* information includes the physician's descriptions of the presenting problem and data from examinations and tests. *A:* The *assessment*, also called the impression or conclusion, is the physician's diagnosis, or interpretation of the subjective and objective information. *P:* The *plan*, also called treatment, advice, or recommendations, includes the necessary patient monitoring, follow-up, procedures, and instructions to the patient.

1.4 Describe three rules in the HIPAA Administrative Simplification provisions that set standards for privacy and the electronic transmission of data. Pages 9–17	1. The HIPAA Privacy Rule: The privacy requirements cover patients' health information. 2. The HIPAA Security Rule: The security requirements state the administrative, technical, and physical safeguards that are required to protect patients' health information. 3. The HIPAA Electronic Health Care Transactions and Code Sets: These standards require every provider who does business electronically to use the same healthcare transactions, code sets, and identifiers.
1.5 Describe the qualities of an effective patient services specialist. Pages 17–18	An effective patient services specialist is patient, enthusiastic, accurate in attention to detail, sincere, and helpful in dealing with the often stressful environment of a medical office.
1.6 Identify ten tasks that a patient services specialist at Polaris Medical Group performs during a typical day. Pages 18–24	1. Schedules patients for appointments 2. Records and maintains patient information 3. Maintains third-party payer information 4. Educates patients and responds to patient inquiries 5. Records charges, payments, and adjustments at the time of an encounter 6. Generates healthcare claims 7. Monitors payments from third-party payers 8. Generates patient statements and financial reports 9. Collects overdue payments from patients 10. Updates CPT and ICD codes in the database as needed

QUIZ PART 1

For questions 1 through 15, write the letter that corresponds to the correct answer in the space provided.

____ **1.** *[LO 1.1]* An internist specializes in treating:
- **a.** patients of all ages
- **b.** adults
- **c.** diseases of the organs
- **d.** families

____ **2.** *[LO 1.1]* Physicians responsible for overseeing patients' overall healthcare and for referring patients to specialists are known as:
- **a.** family practitioners
- **b.** primary care physicians
- **c.** internists
- **d.** family care physicians

____ **3.** *[LO 1.2]* Which of the following is generally not part of a patient's medical record?
- **a.** insurance correspondence
- **b.** chart notes
- **c.** patient information form
- **d.** remittance advice (RA)

____ **4.** *[LO 1.4]* The HIPAA security standards are divided into which three categories:
- **a.** electronic, paper, and oral
- **b.** Internet, PHI, and networks
- **c.** confidentiality, integrity, and availability
- **d.** administrative, physical, and technical

____ **5.** *[LO 1.3]* The *O* in SOAP refers to:
- **a.** obstetrical
- **b.** observation
- **c.** objective
- **d.** ordinary

____ **6.** *[LO 1.5, 1.6]* Which of the following is not considered a general responsibility of all employees at PMG?
- **a.** Organize and prioritize their workloads in an efficient manner.
- **b.** Seek the advice of a supervisor when the correct course of action is not clear.
- **c.** Update diagnosis and procedure codes in the practice's database.
- **d.** Maintain neat and legible records and documentation.

____ **7.** *[LO 1.2]* The coordination of care received by a patient over time, and across several providers, is known as:
- **a.** electronic health records
- **b.** medical records
- **c.** documentation
- **d.** continuity of care

____ **8.** *[LO 1.3]* The patient's diagnosis is contained in the _____ section of a SOAP note.
- **a.** subjective
- **b.** objective
- **c.** assessment
- **d.** plan

____ **9.** *[LO 1.2]* If an error is made in a patient's medical record, the incorrect information should be:
- **a.** deleted
- **b.** marked with a single line through the words to be changed
- **c.** placed inside parentheses
- **d.** marked with yellow highlighting

____ **10.** *[LO 1.4]* The _____ is the first comprehensive federal protection for the privacy of health information.
- **a.** HITECH Privacy Act
- **b.** American Recovery and Reinvestment Act
- **c.** HIPAA Privacy Rule
- **d.** Meaningful Use Act

____ **11.** *[LO 1.4]* A patient's health information can be released without the patient's authorization when it is for treatment, payment, and:
- **a.** disclosure to family members
- **b.** marketing
- **c.** operations
- **d.** disclosure to pharmaceutical companies

____ **12.** *[LO 1.4]* An audit trail is an example of a(n) _____.
- **a.** code set
- **b.** technical safeguard
- **c.** identifier
- **d.** electronic format

____ **13.** *[LO 1.6]* The Polaris Medical Group sends collection letters to patients when their account is _____ days past due.
- **a.** 30
- **b.** 45
- **c.** 60
- **d.** 90

____ **14.** *[LO 1.6]* The Polaris Medical Group generates a patient recall list once a _____.

a. day
b. week
c. month
d. year

____ **15.** *[LO 1.4]* The _____ guides the use of federal money used to promote the use of electronic health records.

a. Health Insurance Portability and Accountability Act
b. Health Information Technology for Economic and Clinical Health Act
c. Electronic Health Records and Standards Act
d. Centers for Medicare and Medicaid Electronic Health Information Act

Critical Thinking Questions

Answer the questions below in the space provided.

1. *[LO 1.2]* This year, Sam Donovan's primary care physician and his cardiologist began using an electronic health record (EHR) to document Sam's encounters, including related lab work, diagnostic tests, and prescriptions. Each office uses a different software program. The first time Sam's health information was transmitted between the two programs, data in certain fields were lost or truncated. Why is it essential for EHR programs to be compatible? Why is compatibility difficult to ensure?

2. *[LO 1.4]* A medical office has hired Jamaica Townsend to work for one week in the summer to scan patients' paper records. After she is finished, the scanned files will be input into an EHR. Because she has been hired for a very short time and is not an official staff member, Jamaica has not been required to sign a confidentiality agreement. Do you think this policy is in keeping with HIPAA rules? Why?

3. *[LO 1.1, 1.5]* In your role as a patient services specialist at a large medical practice, you notice that two of the physicians in the group are documenting procedures they have not actually performed. Because you are responsible for preparing and following up on their claims, you notice that both physicians are receiving payments regularly for these procedures. What should you do about this problem?

4. *[LO 1.4]* A physician consults by e-mail with another physician about a patient's condition. Has the HIPAA Privacy Rule been followed? Explain your answer.

5. *[LO 1.4]* A medical assistant at a small medical practice took an office laptop home to do some work. The laptop contained clinical and billing information for the practice. The assistant stopped at a coffee shop on the way home and left the laptop on the table while getting a refill. While she was gone, it was stolen. Both the clinical data and the billing database were protected by passwords. An encryption program was also used to protect the data. What types of safeguards do these represent? Do you think these security methods will be enough to block a breach in the patient information? Do you think it was a good idea for the medical assistant to take the laptop home?