A Fee For Service Plan With A Preferred Provider Organization

Intended to provide the reader with the information needed to take full advantage of their Medicare benefits. Discusses who's eligible for Medicare benefits (Part A & B), & how to enroll for Medicare, as well as what hospitals & medical expenses are covered by the plan. Explains what portion of your medical bill you are responsible for. Provides information about managed care plans & Medicare supplemental insurance. Also covers: home health care, hospice care, blood coverage, & more. Medicare Beneficiary Resource Directory. Glossary.

The history of health insurance in the United States has perpetuated and enabled a health care industry that has been rewarded for increased spending rather than cost control. With the original plan setting no spending limit on health care providers, fee-for-service reimbursement provided greater incentive to spend than to contain costs. Attempts to control the soaring costs of health care services have given rise to managed care insurance plans that base reimbursement on health outcome data. Given that the birth of managed care includes stringent reimbursement guidelines and ensuing controversy over services provided or not provided, this study sought to determine if differences in quality of care existed between two common types of health insurance, fee-for-service (FFS) and health maintenance organization (HMO) insurance plans for the most costly chronic illness, congestive heart failure (CHF). Utilizing primary and secondary data obtained from an ongoing CHF study at the University of Tennessee Medical Center in Knoxville, Tennessee, this study compared CHF health outcomes between FFS and HMO insurance plans. With an N of 154 cases, results revealed 0.37 of a day shorter length of stay in HMO members with an average of 4.95 and 5.32 days for HMO & FFS members respectively. In addition, HMO members displayed higher readmission rates with 25.6% of HMO members and 22.6% of FFS members readmitted to the hospital within 30 days of discharge with a related diagnosis. For the previously stated outcomes, no statistically significant difference was found between the insurance plans. Other findings included all six cases of mortality found in FFS insurance plans, however an exposed odds ratio test did not indicate a statistically significant difference in mortality rates due to sample size and distribution. All six cases of mortality were found in patients ages 67 and up with an association between being age 67+ and enrolled in a FFS insurance plan. Recommendations for future research include further study into length of stay and the possible effect on readmission rates for members of HMO insurance plans. Investigation into documentation of teaching, follow-up scheduled at discharge, and the effect on readmission rates could provide data supporting the need for adequate teaching and follow up to decrease exacerbations and subsequent higher readmission rates.

Although private health plans were originally envisioned in the 1980s as a potential source of Medicare savings, such plans have generally increased program spending. In 2006, Medicare paid $59 billion to Medicare Advantage (MA) plans -- an estimated $7.1 billion more than Medicare would have spent if MA beneficiaries had received care in Medicare fee-for-service (FFS). MA plans receive a per member per month payment to provide services covered under Medicare FFS. For this testimony, the author examined MA plans¿: (1) projected allocation of rebates; (2) projected cost sharing; and (3) projected revenues and expenses. Charts and tables.

No one misses the onslaught of claims about reforming modern medical care. How doctors should be paid, how hospitals should be paid or governed, how much patients should pay when sick in co-payments, how the quality of care could be improved, and how governments and other buyers could better control the costs of care ? all find expression in the explosion of medical care conference proceedings, op-eds, news bulletins, journal articles, and books. This

collection of articles takes up a key set of what the author regards as particularly misleading fads and fashions ? developments that produce a startling degree of foolishness in contemporary discussions of how to organize, deliver, finance, pay for and regulate medical care services in modern industrial democracies. The policy fads addressed include the celebration of explicit rationing as a major cost control instrument, the belief in a ?basic package? of health insurance benefits to constrain costs, the faith that contemporary cross-national research can deliver a large number of transferable models, and the notion that broadening the definition of what is meant by health will constitute some sort of useful advance in practice.Contents: Fads in Medical Care Policy and Politics: The Rhetoric and Reality of ManagerialismHow Not to Think About ?Managed Care?Medical Care and Public Policy: The Benefits and Burdens of Asking Fundamental QuestionsMedicare and Political Analysis: Omissions, Understandings, and MisunderstandingsComparative Perspectives and Policy Learning in the World of Health CareHow Not to Think About Medicare Reform Readership: Graduate students in public policy, comparative politics, management, nursing, medicine, and social sciences; medical writers; medical professionals.

Medicare Advantage Private Fee-for-Service plans: hearing before the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, One Hundred Tenth Congress, first session, May 22, 2007.

America's Health Care Safety Net explains how competition and cost issues in today's health care marketplace are posing major challenges to continued access to care for Americaâ€™s poor and uninsured. At a time when policymakers and providers are urgently seeking guidance, the committee recommends concrete strategies for maintaining the viability of the safety net--with innovative approaches to building public attention, developing better tools for tracking the problem, and designing effective interventions. This book examines the health care safety net from the perspectives of key providers and the populations they serve, including: Components of the safety net--public hospitals, community clinics, local health departments, and federal and state programs. Mounting pressures on the system--rising numbers of uninsured patients, decline in Medicaid eligibility due to welfare reform, increasing health care access barriers for minority and immigrant populations, and more. Specific consequences for providers and their patients from the competitive, managed care environment--detailing the evolution and impact of Medicaid managed care. Key issues highlighted in four populations--children with special needs, people with serious mental illness, people with HIV/AIDS, and the homeless.

If you've been seeking accurate, reliable, and practical information about starting a medical billing business, this book is the very first book you will want to read - and perhaps the only one you'll want to read. "Claim Success " is written to provide entrepreneurs, business people, and anyone investigating medical billing as a potential career, with completely up-to-date, comprehensive information about literally everything you will need to know to decide if running a medical billing and practice management company is a good business for you to consider. More in-depth, forthright, and accurate than any other book on the market in this industry, "Claim Success " goes into extensive detail on every aspect of launching a viable medical billing business. You will learn about all the types of medical insurance and how each one works; the inner workings of medical offices and types of financial problems doctors encounter that lead to their need to hire a professional biller; the trends and movements in the medical industry regarding electronic claims, electronic medical records, and other advancements that are challenging medical practices of all sizes. You will see why doctors are experiencing problems with insurance companies and what tactics they increasingly resort to in order to run their practices more efficiently and profitably. The meat of "Claim Success " deals with how to decide if this is a business you want to own, and if so, how to get your company off the ground. The book provides chapters that go into more detail than you will find anywhere else, on how

to start your business, seven methods of conducting marketing campaigns to attract doctors to your services, how to conduct a formal business meeting with a prospective doctor, what to say and not to say to win the contract, and how to close a sale that gets you the business. Once you have clients, the book does not leave you cold and dry. It explains how to set up your office so you can be effective in your business, how to use medical billing software, how to select a clearinghouse, how to file electronic and paper claims, and how to price your services. "Claim Success " goes into great detail about eight additional services you can add on to your business to make your billing service a one-stop shop that fulfills other needs that many medical offices will have, including electronic fund transfer, digital archiving, and even software sales. The book also explains how you can set yourself up to sell the most advanced software that doctors must soon transition to using, Electronic Medical Records. "Claim Success " aims to be the most authoritative book you will find about this industry. It contains extensive, down-to-earth, practical information about the medical billing profession in today's real world. The book is written in a clear, straightforward manner, without glorifying the profession or hyping the ease of success, as so many medical billing publications tend to do. If you want to feel like you did not waste your time reading fluff and that you received detailed information that helps you make a good decision about starting a medical billing business, "Claim Success " is the right choice and worth every penny of your research investment.

Focuses on how Congress & the Administration can provide better information to Medicare beneficiaries when they are trying to select the right health plan to meet their health care needs. Contains statements from U.S. Senate Committee on Aging members as well as testimony from the Medicare Rights Center in New York City, the Institute of Medicine in Stanford, CA, the Health Benefits Service of the California Public Employees Retirement System, & a Medicare beneficiary. Includes General Accounting Office responses to Senate questions on the operations of the Health Care Financing Administration.

While health maintenance organizations (HMOs) have lower medical costs than fee-for-service plans with the same benefits, it has not been clear whether the cost reductions in HMOs, achieved largely by reductions in hospital admissions, have adverse effects on health. This study addresses this important issue for nonaged adults. It describes the RAND Health Insurance Experiment, including the sample and methods of analysis. The findings indicate that the nonpoor suffer no harm to health through participation in an HMO and their enrollment should be encouraged. Low-income people who have health problems when they join an HMO appear to be worse off at the HMO compared with a fee-for-service plan.

Shows how to evaluate coverage of different health plans, compares costs, and provides tips on obtaining the maximum benefits

The goals of universal health coverage (UHC) are to ensure that all people can access quality health services, to safeguard all people from public health risks, and to protect all people from impoverishment due to illness, whether from out-of-pocket payments for health care or loss of income when a household member falls sick. Countries as diverse as Brazil, France, Japan, Thailand, and Turkey have shown how UHC can serve as a vital mechanism for improving the health and welfare of their citizens and lay the foundation for economic growth and competitiveness grounded in the principles of equity and sustainability. Ensuring universal access to affordable, quality health services will be an important contribution to ending extreme poverty by 2030 and boosting shared prosperity in low-income and middle-income countries, where most of the world s poor live. Universal Health Coverage for Inclusive and Sustainable Development synthesizes the experiences from 11 countries Bangladesh, Brazil, Ethiopia,

France, Ghana, Indonesia, Japan, Peru, Thailand, Turkey, and Vietnam in implementing policies and strategies to achieve and sustain UHC. These countries represent diverse geographic and economic conditions, but all have committed to UHC as a key national aspiration and are approaching it in different ways. The book examines the UHC policies for each country around three common themes: (1) the political economy and policy process for adopting, achieving, and sustaining UHC; (2) health financing policies to enhance health coverage; and (3) human resources for health policies for achieving UHC. The findings from these country studies are intended to provide lessons that can be used by countries aspiring to adopt, achieve, and sustain UHC. Although the path to UHC is specific to each country, countries can benefit from the experiences of others in learning about different approaches and avoiding potential risks.

In 1996, the Institute of Medicine (IOM) released its report Telemedicine: A Guide to Assessing Telecommunications for Health Care. In that report, the IOM Committee on Evaluating Clinical Applications of Telemedicine found telemedicine is similar in most respects to other technologies for which better evidence of effectiveness is also being demanded. Telemedicine, however, has some special characteristics-shared with information technologies generally-that warrant particular notice from evaluators and decision makers. Since that time, attention to telehealth has continued to grow in both the public and private sectors. Peer-reviewed journals and professional societies are devoted to telehealth, the federal government provides grant funding to promote the use of telehealth, and the private technology industry continues to develop new applications for telehealth. However, barriers remain to the use of telehealth modalities, including issues related to reimbursement, licensure, workforce, and costs. Also, some areas of telehealth have developed a stronger evidence base than others. The Health Resources and Service Administration (HRSA) sponsored the IOM in holding a workshop in Washington, DC, on August 8-9 2012, to examine how the use of telehealth technology can fit into the U.S. health care system. HRSA asked the IOM to focus on the potential for telehealth to serve geographically isolated individuals and extend the reach of scarce resources while also emphasizing the quality and value in the delivery of health care services. This workshop summary discusses the evolution of telehealth since 1996, including the increasing role of the private sector, policies that have promoted or delayed the use of telehealth, and consumer acceptance of telehealth. The Role of Telehealth in an Evolving Health Care Environment: Workshop Summary discusses the current evidence base for telehealth, including available data and gaps in data; discuss how technological developments, including mobile telehealth, electronic intensive care units, remote monitoring, social networking, and wearable devices, in conjunction with the push for electronic health records, is changing the delivery of health care in rural and urban environments. This report also summarizes actions that the U.S. Department of Health and Human Services (HHS) can undertake to further the

use of telehealth to improve health care outcomes while controlling costs in the current health care environment.

A basic guide to hospital billing and reimbursement, Understanding Hospital Billing and Coding, 3rd Edition helps you understand, complete, and submit the UB-04 claim form that is used for all Medicare and privately insured patients. It describes how hospitals are reimbursed for patient care and services, showing how the UB-04 claim form reflects the flow of patient data from the time of admission to the time of discharge. Written by coding expert Debra P. Ferenc, this book also ensures that you understand the essentials of ICD-10-CM and develop skills in both inpatient coding and outpatient/ambulatory surgery coding. UB-04 Claim Simulation on the companion Evolve website lets you practice entering information from source documents into the claim form. Over 300 illustrations and graphics bring important concepts to life. Detailed chapter objectives highlight what you are expected to learn. Key terms, acronyms, and abbreviations with definitions are included in each chapter. Concept Review boxes reinforce key concepts. Test Your Knowledge exercises reinforce lessons as you progress through the material. Chapter summaries review key concepts. Practice hospital cases let you apply concepts to real-life scenarios. UPDATED content reflects the most current industry changes in ICD-10, MR-DRGs, PPS Systems, and the Electronic Health Record. NEW Hospital Introduction chapter includes a department-by-department overview showing how today's hospitals really work NEW Health Care Payers and Reimbursement section follows the workflow of the hospital claim by including successive chapters on payers, prospect payment systems, and accounts receivable management.

The objectives of this study are to describe experiences in price setting and how pricing has been used to attain better coverage, quality, financial protection, and health outcomes. It builds on newly commissioned case studies and lessons learned in calculating prices, negotiating with providers, and monitoring changes. Recognising that no single model is applicable to all settings, the study aimed to generate best practices and identify areas for future research, particularly in low- and middle-income settings. The report and the case studies were jointly developed by the OECD and the WHO Centre for Health Development in Kobe (Japan).

Clueless? Feel Like a Dummy? Get Demystified! This handy resource clearly explains the principles and practices used by medical offices, hospitals, and health facilities to encode medical services in order to receive payment from government agencies and insurance companies.

Pamphlet from the vertical file.

The New Public Health has established itself as a solid textbook throughout the world. Translated into 7 languages, this work distinguishes itself from other public health textbooks, which are either highly locally oriented or, if international, lack the specificity of local issues relevant to students' understanding of applied public health in their own setting. This 3e provides a unified approach to public health

appropriate for all masters' level students and practitioners—specifically for courses in MPH programs, community health and preventive medicine programs, community health education programs, and community health nursing programs, as well as programs for other medical professionals such as pharmacy, physiotherapy, and other public health courses. Changes in infectious and chronic disease epidemiology including vaccines, health promotion, human resources for health and health technology Lessons from H1N1, pandemic threats, disease eradication, nutritional health Trends of health systems and reforms and consequences of current economic crisis for health Public health law, ethics, scientific d health technology advances and assessment Global Health environment, Millennium Development Goals and international NGOs

The Social Security Administration (SSA) administers two programs that provide benefits based on disability: the Social Security Disability Insurance (SSDI) program and the Supplemental Security Income (SSI) program. This report analyzes health care utilizations as they relate to impairment severity and SSA's definition of disability. Health Care Utilization as a Proxy in Disability Determination identifies types of utilizations that might be good proxies for "listing-level" severity; that is, what represents an impairment, or combination of impairments, that are severe enough to prevent a person from doing any gainful activity, regardless of age, education, or work experience.

The health insurance issues and background covered in this new book encompass the latest and most controversial problems and events in an area of crucial interest to everyone. The latest statistics indicate more than 45 million people are currently uninsured; a number which is consistently increasing. This dire situation forms part of a sociological crisis in America where a large segment of the population will be subject to severe health problems while the wealthy enjoy first rate medical care and longevity. Contents: Introduction; Health Insurance and Medical Care: Physician Services under Managed Care; Health Insurance: Reforming the Private Market; The Health Insurance Portability and Accountability Act; HIPAA): Summary of the Administrative Simplification Provisions; Health Insurance: Explaining Differences in Counts of the Uninsured; Health Insurance: Federal Data Sources for Analyses of the Uninsured; Health Insurance Continuation Coverage under COBRA; Health Insurance for Federal Employees and Retirees; Health Insurance for Displaced Workers; Health Insurance: Uninsured by State, 2001; Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 20

In 2006, the fed. govt. spent $59 billion on Medicare Advantage (MA) plans, an alternative to the original Medicare fee-for-service (FFS) program. Although health plans were originally envisioned as a source of Medicare savings, such plans have generally increased program spending. Payments to MA plans have been estimated to be 12% greater than what Medicare would have spent in 2006 had MA beneficiaries been enrolled in Medicare FFS. This report examines for 2007: (1) MA plan¿s projected rebate allocations; (2) additional benefits MA

plans commonly covered & their costs; (3) MA plans¿ projected cost sharing; & (4) MA plans¿ allocation of projected revenues and expenses. Tables and graphs.

First published in 1999, this volume responds to a large and growing interest among health policy and research circles on the use of purchasing alliances to leverage change in health care. This book gives detailed and useful specifics on how a leading alliance has fared in California, the most competitive health care market in the United States. Although it is generally accepted that large organizations are more effective purchasers of health insurance, little work has been done to carefully examine the reasons that underlie that phenomenon. Yet, creating interventions and designing potential solutions requires a thorough understanding of the issues. The econometric analysis adds to the limited literature on the influence of premium on choice behaviour for employees of small firms, and introduces an analysis of choice behaviour in a purchasing cooperative setting. The political section of this book presents a much more detailed historical account and analysis of California's small group market reforms, the most significant health-related legislation in the state in the prior decade, than has been previously available. The conclusions are becoming particularly relevant, both in California and elsewhere, as the issues of reform of the individual market for health insurance comes to the forefront.

Private fee-for-service plans in Medicare Advantage: a closer look: hearing before the Committee on Finance, United States Senate, One Hundred Tenth Congress, second session, January 30, 2008.

Medicare Advantage Private Fee-for-Service plans : hearing before the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, One Hundred Tenth Congress, first session, May 22, 2007.