Insurance Information and terminology to know:

CMS - The **Centers for Medicare & Medicaid Services** , previously known as the **Health Care Financing Administration** (**HCFA**), is a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (CHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities (more commonly referred to as nursing homes) through its survey and certification process, clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments, and oversight of HealthCare.gov.
Website - www.cms.gov

CPT Codes - The Current Procedural Terminology code set is a medical code set developed and maintained by the American Medical Association (AMA) through the CPT Editorial Panel.[1] The CPT code set (copyright protected by the AMA) describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

New editions are released each October. The current version is the CPT 2014. It is available in both a standard edition and a professional edition.[3][4]

CPT coding is similar to ICD-9 and ICD-10 coding, except that it identifies the services rendered rather than the diagnosis on the claim. ICD code sets also contain procedure codes but these are only used in the inpatient setting.[5]

CPT is currently identified by the Centers for Medicare and Medicaid Services (CMS)[6] as Level 1 of the Health Care Procedure Coding System.
Codes can be looked up through www.cms.gov

FSA - Flexible spending account; also known as a **flexible spending arrangement**, is one of a number of tax-advantaged financial accounts that can be set up through a cafeteria plan of an employer in the United States. An FSA allows an employee to set aside a portion of earnings to pay for qualified expenses as established in the cafeteria plan, most commonly for medical expenses but often for dependent care or other expenses. Money deducted from an employee's pay into an FSA is not subject to payroll taxes, resulting in substantial payroll tax savings. Before the Affordable Care Act, also known as "Obamacare", one significant disadvantage to using an FSA is that funds not used by the end of the plan year are lost to the employee, known as the "use it or lose it" rule. Under the terms of the Affordable Care Act, employees can carryover up to $500 into the next year without losing the funds.

The most common type of flexible spending account, the **medical expense FSA** (also **medical FSA** or **health FSA**), is similar to a health savings account (HSA) or a health reimbursement account (HRA). However, while HSAs and HRAs are almost exclusively used as components of

a consumer-driven health care plan, medical FSAs are commonly offered with more traditional health plans as well. In addition, funds in a health savings account are not lost when the plan year is over, unlike funds in an FSA. Paper forms or an FSA debit card, also known as a Flexcard, may be used to access the account funds.

HCF – 1500 - Health Insurance Claim Form: Professional paper claim form (CMS-1500)
The CMS-1500 form is the standard claim form used by a non-institutional provider or supplier to bill Medicare carriers and durable medical equipment regional carriers (DMERCs) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. It is also used for billing of some Medicaid State Agencies. Please contact your Medicaid State Agency for more details.

The National Uniform Claim Committee (NUCC) is responsible for the design and maintenance of the CMS-1500 form. CMS does not supply the form to providers for claim submission. In order to purchase claim forms, you should contact the U.S. Government Printing Office at 1-866-512-1800, local printing companies in your area, and/or office supply stores. The only acceptable claim forms are those printed in Flint OCR Red, J6983, (or exact match) ink. Although a copy of the CMS-1500 form can be downloaded, copies of the form cannot be used for submission of claims, since your copy may not accurately replicate the scale and OCR color of the form. The majority of paper claims sent to carriers and DMERCs are scanned using Optical Character Recognition (OCR) technology. This scanning technology allows for the data contents contained on the form to be read while the actual form fields, headings, and lines remain invisible to the scanner. Photocopies cannot be scanned and therefore are not accepted by all carriers and DMERCs.

You can find Medicare CMS-1500 completion and coding instructions, as well as the print specifications in Chapter 26 of the Medicare Claims Processing Manual (Pub.100-04).
Websites: www.nucc.org and www.cms.gov

HIPAA - The **Health Insurance Portability and Accountabilit**y Act of 1996 (HIPAA; Pub.L. 104–191, 110 Stat. 1936, enacted August 21, 1996) was enacted by the United States Congress and signed by President Bill Clinton in 1996. It has been known as the Kennedy–Kassebaum Act or Kassebaum-Kennedy Act after two of its leading sponsors. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers.
Website - www HHS.gov

HSA - Health savings account is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high-deductible health plan (HDHP).[1][2] The funds contributed to an account are not subject to federal income tax at the time of deposit. Unlike a flexible spending account (FSA), funds roll over and accumulate year to year if not spent. HSAs are owned by the individual, which differentiates them from company-owned Health Reimbursement Arrangements (HRA) that are an alternate tax-deductible source of funds paired with either HDHPs or standard health plans. HSA funds may currently be used to pay for

qualified medical expenses at any time without federal tax liability or penalty. However, beginning in early 2011 OTC (over the counter) medications cannot be paid with HSA dollars without a doctor's prescription.[3] Withdrawals for non-medical expenses are treated very similarly to those in an individual retirement account (IRA) in that they may provide tax advantages if taken after retirement age, and they incur penalties if taken earlier. These accounts are a component of consumer-driven health care.

Proponents of HSAs believe that they are an important reform that will help reduce the growth of health care costs and increase the efficiency of the health care system. According to proponents, HSAs encourage saving for future health care expenses, allow the patient to receive needed care without a gatekeeper to determine what benefits are allowed and make consumers more responsible for their own health care choices through the required High-Deductible Health Plan.

Opponents of HSAs say they may worsen, rather than improve, the U.S. health system's problems because people may hold back the healthcare spending that would be covered by their Health Savings Accounts, or may spend it unnecessarily just because it has accumulated and to avoid the penalty taxes for withdrawing it, while people who have health problems that have predictable annual costs will avoid HSAs in order to have those costs paid by insurance. There is also debate about consumer satisfaction with these plans.
For more information: http://www.irs.gov/publications/p969/ar02.html

ICD - The International Statistical Classification of Diseases and Related Health Problems, usually called by the short-form name **International Classification of Diseases** (**ICD**), is the international "standard diagnostic tool for epidemiology, health management and clinical purposes".[1] The ICD is maintained by the World Health Organization, the directing and coordinating authority for health within the United Nations System.[2] The ICD is designed as a health care classification system, providing a system of diagnostic codes for classifying diseases, including nuanced classifications of a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. This system is designed to map health conditions to corresponding generic categories together with specific variations, assigning for these a designated code, up to six characters long. Thus, major categories are designed to include a set of similar diseases.

The International Classification of Diseases is published by the World Health Organization (WHO) and used worldwide for morbidity and mortality statistics, reimbursement systems, and automated decision support in health care. This system is designed to promote international comparability in the collection, processing, classification, and presentation of these statistics. As in the case of the analogous (but limited to mental and behavioral disorders) Diagnostic and Statistical Manual of Mental Disorders (DSM, currently in version 5), the ICD is a major project to statistically classify health disorders, and provide diagnostic assistance. The ICD is a core statistically-based classificatory diagnostic system for health care related issues of the WHO Family of International Classifications (WHO-FIC).

The ICD -9 is currently used in the United States, on October 1, 2015 **ICD-10** is scheduled to be implemented. **ICD-9 look-up: http://www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx**

National Center for Complementary and Alternative Medicine (**NCCAM**), formerly the **Office of Alternative Medicine** (**OAM**), is a United States government agency that investigates complementary and alternative medicine (CAM) healing practices in the context of rigorous scientific methodology, in training complementary and alternative medicine researchers, and in disseminating authoritative information to the public and professionals.
The NCCAM is one of the 27 institutes and centers that make up the National Institutes of Health (NIH) within the Department of Health and Human Services of the federal government of the United States. The NIH is one of eight agencies under the Public Health Service (PHS) in the Department of Health and Human Services (DHHS).

Focus
The four primary areas of focus are:

- **Research** – support clinical and basic science research projects in CAM by awarding grants across the country and around the world; we also design, study, and analyze clinical and laboratory-based studies on the NIH campus in Bethesda, Maryland.
- **Research training and career development** – award grants that provide training and career development opportunities for predoctoral, postdoctoral, and career researchers.
- **Outreach** – sponsor conferences, educational programs, and exhibits; operate an information clearinghouse to answer inquiries and requests for information; provide a Web site and printed publications; and hold town meetings at selected locations in the United States.
- **Integration** – integrate scientifically proven CAM practices into conventional medicine by announcing published research results; studying ways to integrate evidence-based CAM practices into conventional medical practice; and supporting programs to develop models for incorporating CAM into the curriculum of medical, dental, and nursing schools.

The forms of medical systems covered include:[4]

- **Whole medical systems** such as homeopathy, naturopathy, traditional Chinese medicine, and ayurveda.
- **Mind-body medicine** such as meditation, prayer, mental healing, art therapy, music therapy, and dance therapy.
- **Biologically based practices** such as dietary supplements, herbal supplements, and scientifically unproven therapies such as shark cartilage.[5]
- **Manipulative and Body-Based Practices** such as spinal manipulation (both chiropractic and osteopathic) and massage.
- **Energy therapies** such as qigong, reiki, therapeutic touch, and electromagnetic therapy.

Website: **http://nccam.nih.gov**

NCD - National Coverage Determination
National coverage determination (**NCD**) is a determination of whether Medicare will pay for an item or service. Medicare coverage is limited to items and services that are considered "reasonable and necessary" for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). In the absence of a NCD, an item or service is covered at the discretion of the Medicare contractors based on a Local Coverage Determination (LCD).

The Secretary of the Department of Health and Human Services determines whether or not a particular item or service is covered nationally by Medicare. The formal name for this process, which essentially grants, limits, or excludes Medicare coverage, is the National Coverage Determination (NCD). NCDs are binding on all Medicare carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans and health care prepayment plans.

Who can request an NCD?
Anyone can request a national coverage determination from the Centers for Medicare and Medicaid Services (CMS), however "aggrieved" beneficiaries, defined by CMS as "individuals entitled to benefits under Part A, or enrolled under Part B, or both, who are in need of the items or services that are the subject of the coverage determination", are given priority for requesting a NCD. CMS has outlined a specific process for requesting a NCD, which takes approximately 9 months from the date the complete NCD request is received by CMS to the date that coverage changes are implemented.

What is the MCAC?
The Medicare Coverage Advisory Committee (MCAC) advises CMS on whether specific medical items and services are reasonable and necessary under Medicare law related to certain NCD submissions. The MCAC adds to CMS's internal groups that analyze NCD requests. The MCAC performs a detailed analysis and provides comments regarding specific clinical and scientific issues in an open and public forum. Although the MCAC participates in certain NCD reviews, they are advisory in nature, as the final decision on all coverage issues is made by CMS. CMS selects members of the MCAC based on their background, education, and expertise in a wide variety of scientific, clinical, and other related fields. In composing
Website: http://www.cms.gov/Medicare/Coverage/DeterminationProcess/

NIH - National Institute of Health: NIH's mission is to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability.
The goals of the agency are:

- to foster fundamental creative discoveries, innovative research strategies, and their applications as a basis for ultimately protecting and improving health;
- to develop, maintain, and renew scientific human and physical resources that will ensure the Nation's capability to prevent disease;
- to expand the knowledge base in medical and associated sciences in order to enhance the Nation's economic well-being and ensure a continued high return on the public investment in research; and
- to exemplify and promote the highest level of scientific integrity, public accountability, and social responsibility in the conduct of science.

In realizing these goals, the NIH provides leadership and direction to programs designed to improve the health of the Nation by conducting and supporting research:
in the causes, diagnosis, prevention, and cure of human diseases;

- in the processes of human growth and development;
- in the biological effects of environmental contaminants;
- in the understanding of mental, addictive and physical disorders; and

- in directing programs for the collection, dissemination, and exchange of information in medicine and health, including the development and support of medical libraries and the training of medical librarians and other health information specialists.

Website: http://www.nih.gov

NPI - National Provider Identifier.

A National Provider Identifier or NPI is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The NPI has replaced the unique provider identification number (UPIN) as the required identifier for Medicare services, and is used by other payers, including commercial healthcare insurers. The transition to the NPI was mandated as part of the Administrative Simplifications portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and CMS began issuing NPIs in October 2006.[1] The Center for Medicare and Medicaid (CMS) developed the National Plan and Provider Enumeration System (NPPES) to provide and over site of taxonomy numbers.

HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans were required by regulation to use only the NPI to identify covered healthcare providers by May 23, 2007. CMS subsequently announced that as of May 23, 2008, CMS will not impose penalties on covered entities that deploy contingency plans to facilitate the compliance of their trading partners (e.g., those healthcare providers who bill them). The posted guidance document can be used by covered entities to design and implement a contingency plan. Details are contained in a CMS document entitled, "Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule." Small health plans have one additional year to comply.

All individual HIPAA covered healthcare providers (physicians, physician assistants, midwives, nurse practitioners, nurse anesthetists, dentists, denturists, chiropractors, clinical social workers, physical therapists, athletic trainers etc.) or organizations (hospitals, home health care agencies, nursing homes, residential treatment centers, group practices, laboratories, pharmacies, medical equipment companies, etc.) must obtain an NPI for use in all HIPAA standard transactions, even if a billing agency prepares the transaction. Once assigned, a provider's NPI is permanent and remains with the provider regardless of job or location changes.
Other health industry workers, such as admissions and medical billing personnel, housekeeping staff, and orderlies, who provide support services but not health care, are not required to obtain the NPI.

Optional Uses

The NPI must be used in connection with the electronic transactions identified in HIPAA. In addition, the NPI may be used in several other ways:

1. by health care providers to identify themselves in health care transactions identified in HIPAA or on related correspondence;
2. by health care providers to identify other health care providers in health care transactions or on related correspondence;

3. by health care providers on prescriptions (however, the NPI will not replace requirements for the Drug Enforcement Administration number or State license number);
4. by health plans in their internal provider files to process transactions and communicate with health care providers;
5. by health plans to coordinate benefits with other health plans;
6. by health care clearinghouses in their internal files to create and process standard transactions and to communicate with health care providers and health plans;
7. by electronic patient record systems to identify treating health care providers in patient medical records;
8. by the Department of Health and Human Services to cross reference health care providers in fraud and abuse files and other program integrity files;
9. for any other lawful activity requiring individual identification

Sign-up Process

The NPI number can be obtained online through the National Plan and Provider Enumeration System (NPPES) pages on CMS's website. Turnaround time for obtaining a number is from 1 to 20 days. NPI numbers can be searched on the CMS website listed in external links 'National Plan and Provider Enumeration System information from CMS'.

Currently there is NO taxonomy number for Healing Touch practitioners or any energy therapy, to obtain a NPI number would need to have a license or certification as a physician, nurse, massage therapist, acupuncture, reflexologist, and physical therapist. Application in process of filing in 2014.

Website: www.nppes.cms.hhs.gov

NUCC - The National Uniform Claim Committee is a voluntary organization that replaced the Uniform Claim Form Task Force in 1995. The committee was created to develop a standardized data set for use by the non-institutional health care community to transmit claim and encounter information to and from all third-party payers. It is chaired by the American Medical Association (AMA), with the Centers for Medicare and Medicaid Services (CMS) as a critical partner. The committee is a diverse group of health care industry stakeholders representing providers, payers, designated standards maintenance organizations, public health organizations, and vendors.

The NUCC was formally named in the administrative simplification section of the HIPAA of 1996 as one of the organizations to be consulted by the American National Standards Institute's accredited SDOs and the Secretary of HHS as they develop, adopt, or modify national standards for health care transactions. As such, the NUCC is intended to have an authoritative voice regarding national standard content and data definitions for non-institutional health care claims in the United States. The NUCC's recommendations in this area are explicitly designed to complement and expedite the work of the Accredited Standards Committee Electronic Data Interchange (ASC X12N) in complying with the provisions of P.L. 104-191.

The NUCC is comprised of the key parties affected by health care electronic data interchange (EDI) - those at either end of a health care transaction, generally payers and providers. Criteria for membership include a national scope and representation of a unique constituency affected by health care EDI, with an emphasis on maintaining or enhancing the provider/payer balance. Each committee member is intended to represent the perspective of the sponsoring organization and

the applicable constituency. Representatives are responsible for communicating information between the committee and the group(s) they represent.

Website: **www.nucc.org**