

## Registration Packet Instructions

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### ***Patient Registration Form***

1. Please encourage the patient/family to fill out the form completely. The form helps to meet several HIPAA and Compliance regulations as follows:
  - Ties the use of all phone numbers to the HIPAA brochure giving permission to use them.
  - Getting the patient to fill in the **Primary** and **Secondary Insurance** helps to meet the Medicare Secondary Payor (MSP) screening rule making sure Medicare is the primary insurance.
  - Supplies information to the billing department that is crucial for billing purposes.
2. Under HIPAA the patient does not have to supply you with any social security numbers unless needed for billing the insurance. In the future no SS# will be needed to bill any insurance.
3. Asking if the patient is in a SNF or Convalescent Home is very important if the patient marks “Yes” and has Medicare insurance. If the patient marks “Yes” and has Medicare,
  - Under the Consolidated Billing Act we **MUST** bill Medicare Part B for the professional services only. We **MUST** bill the SNF or Convalescent Home for the technical as long as the patient is under a “**Part A Stay**”.
  - A call will need to be made **daily** to the SNF or Convalescent Home see if the patient is under a “**Medicare Part A Stay**” every day until the patient is no longer under a “**Part A Stay**”.
  - A “**Part A Stay**” means the patient is still critical and services are being reimbursed the same as if the patient is still in the hospital.
  - The “**Part A Stay**” is only good for 30 days from the date the patient was admitted to the hospital.
  - **Example:** If the patient is in the hospital for 15 days and then is transferred to the SNF or Convalescent Home the patient may continue to be under a “**Part A Stay**” for only another 15 days which = 30 days or until the patient is stable- which ever comes first.
  - The patient may remain under a “**Part A Stay**” in the SNF or Convalescent Home only while the patient is critical or unstable. Once the patient is stable the SNF must take the patient off the “**Part A Stay**” meaning we will bill Medicare Part B for both technical and professional side of the services.
  - Notify the Billing Department either by email or phone call daily until the patient is not longer under a “**Part A Stay**”.
4. Make sure the patient/guardian or family member signs the registration form so we can meet the MSP rule.

### ***Assignment of Benefits Form***

1. **Medicare Lifetime Assignment of Benefits** must be signed by all patients with Medicare whether primary or as a secondary insurance and make sure the patient enters a date.
2. **Medigap (Medicare supplemental insurance) Assignment of Benefits** must be signed by all Medicare patients with a Medigap or supplemental insurance. This is an insurance that covers all Medicare co-pays and will state either **Medigap** or **Supplemental** on the insurance card and make sure the patient enters a date.
3. **General Assignment of Benefits** is for all other types of insurance and those with no insurance. The statement made in this section **does not** take the place of an Advanced Beneficiary Notice or ABN form. If it is possible the services may not be covered and you intend to hold the patient financially responsible an ABN form must be completed **Before** services that may not be covered are rendered. The consult is always covered but IMRT planning and treatment may not be covered so the ABN would need to be completed before the IMRT planning and treatment begin. (see ABN form and instructions)
4. **HIPAA Receipt of Notice of Privacy Practices** must be signed by all patients once you have handed them the HIPAA Notice of Privacy Practice Brochure. The patient signature here not only proves you gave the patients the brochure it also proves the patient has agreed to our use of all phone numbers on the Patient Registration form. If a patient wants their information restricted you will log the restriction on the HIPAA Restriction Log which will be available in your HIPAA Handbook (release date October 15<sup>th</sup>). The brochure takes the place of the two page HIPAA notice you are currently handing to the patient.

***Authorization to Release Medical Information***

1. You may only use this form to obtain a release from the patient to send or obtain medical records when you have a specific person/entity that you are sending or releasing records to.
2. Please do not obtain a signature of the patient/guardian if the page is blank. This is called a “blanket release” which is not HIPAA compliant. HIPAA prohibits keeping a signed blank release on file “in case” you need medical records. Risk is use of the form to obtain medical information not authorized by the patient.
3. Before sending or obtaining medical records from any source that requires this release you must allow the patient to complete the form giving specific authorization on what information may be sent or requested.
4. The patient also must be allowed to limit the dates or service and how long the authorization is good for.
5. HIPAA does not apply to “Treatment or Payment Operations” meaning you should not need this form to share or obtain information with entities that are involved in the patient’s “current condition”. Or with any insurance that is going to pay for the services. Some offices and hospitals have raised the bar and request this form even though it is not necessary under HIPAA just to be safe. If they request the release to share records it is best to send them the release as getting them to change their policy usually does not work.
6. A HIPAA Handbook and education is coming soon and will have detailed guidance on records release. In the meantime, if you have a question about whom you may release records to please call Nicki Valero, Compliance Auditor at 310-793-6398 or Joan Wendel, RN, Director of Clinical Operations at 310-335-4061 for assistance.

***Insurance Verification***

1. Verify all insurances to make sure it is effective and to obtain what deductibles and co-pays need to be paid by the patient.
2. Make sure to verify the mailing address for claims as the address on the card is often incorrect.

***New Patient Referral Worksheet***

1. If you use a different referral workup sheet that the two examples included, please forward to the Compliance Auditor, Nicki Valero, at [nicki.valero@vantageoncology.com](mailto:nicki.valero@vantageoncology.com) or via fax at 310-416-8932 for review.
2. Language was altered to make it clear the patient was referred for an opinion by our Radiation Oncologist in regards to the use of radiation therapy for the patient’s cancer.
3. A patient referred for a ***Consultation*** is different from a patient referred for ***Consult and Treat***.
  - A request for ***Consult & Treat*** must be billed as a New Patient Visit and not a Consultation as it has already been determined that the patient will have radiation therapy before the Consultation.
  - A ***Consult*** is for an opinion first, then if the Radiation Therapist decides during the Consultation that the patient would benefit from radiation therapy, the Radiation Oncologist may proceed with planning and treatment as they have notified the referring doctor of the recommendation and plan to proceed via the Consultative letter sent to the referring doctor.