CENGAGE

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UNDERSTANDING HEALTH INSURANCE

A GUIDE TO BILLING AND REIMBURSEMENT

MICHELLE A. GREEN
MPS, RHIA, FAHIMA, CPC

AAPC
CEU APPROVED

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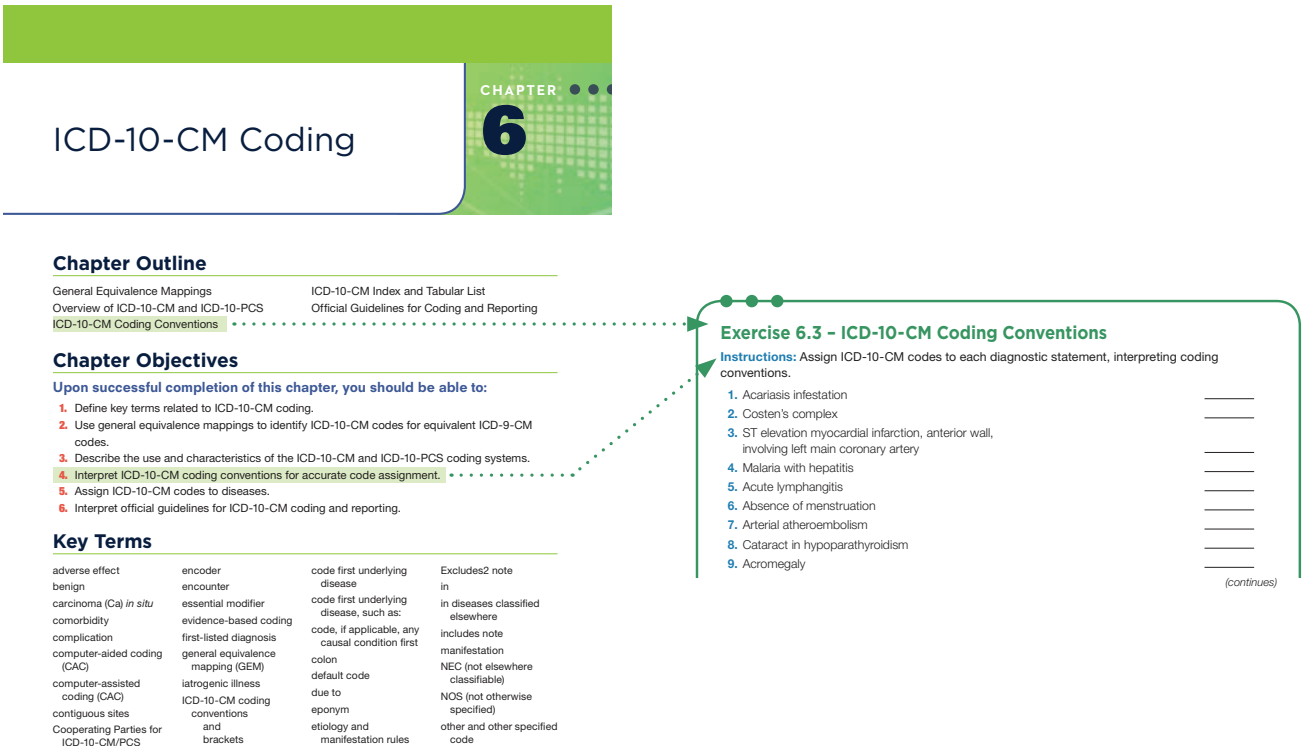
Introduction

Accurate processing of health insurance claims has become more exacting and rigorous as health insurance plan options have rapidly expanded. These changes, combined with modifications in state and federal regulations affecting the health insurance industry, are a constant challenge to health care personnel. Those responsible for processing health insurance claims require thorough instruction in all aspects of medical insurance, including plan options, payer requirements, state and federal regulations, abstracting of source documents, accurate completion of claims, and coding of diagnoses and procedures/services. *Understanding Health Insurance* provides the required information in a clear and comprehensive manner.

The text was designed and revised to support core learning objectives with chapter objectives, content, and assessments aligned to ensure students learn and practice the concepts and skills they'll need on the job. Student learning is supported through chapter outlines and measurable objectives identified at the beginning of each chapter, as well as chapter headings and assessments that clearly map to those chapter outlines and objectives.

Special attention was focused on selecting appropriate Bloom's taxonomy levels for each chapter objective along with mapping assessment items (e.g., exercises, exam questions) to each objective. In addition, the *Workbook to Accompany Understanding Health Insurance* contains assignments that map to higher Bloom's taxonomy levels to provide students with more advanced activity-based learning experiences such as assignment of APCs and DRGs.



CHAPTER 6

ICD-10-CM Coding

Chapter Outline

General Equivalence Mappings
Overview of ICD-10-CM and ICD-10-PCS
ICD-10-CM Coding Conventions
ICD-10-CM Index and Tabular List
Official Guidelines for Coding and Reporting

Chapter Objectives

Upon successful completion of this chapter, you should be able to:

1. Define key terms related to ICD-10-CM coding.
2. Use general equivalence mappings to identify ICD-10-CM codes for equivalent ICD-9-CM codes.
3. Describe the use and characteristics of the ICD-10-CM and ICD-10-PCS coding systems.
4. Interpret ICD-10-CM coding conventions for accurate code assignment.
5. Assign ICD-10-CM codes to diseases.
6. Interpret official guidelines for ICD-10-CM coding and reporting.

Key Terms

adverse effect
benign
carcinoma (Ca) *in situ*
comorbidity
complication
computer-aided coding (CAC)
computer-assisted coding (CAC)
contiguous sites
Cooperating Parties for ICD-10-CM/PCS
encoder
encounter
essential modifier
evidence-based coding
first-listed diagnosis
general equivalence mapping (GEM)
iatrogenic illness
ICD-10-CM coding conventions and brackets
code first underlying disease
code first underlying disease, such as:
code, if applicable, any causal condition first
colon
default code
due to
eponym
etiology and manifestation rules
Excludes2 note
in
in diseases classified elsewhere
includes note
manifestation
NEC (not elsewhere classifiable)
NOS (not otherwise specified)
other and other specified code

Exercise 6.3 – ICD-10-CM Coding Conventions

Instructions: Assign ICD-10-CM codes to each diagnostic statement, interpreting coding conventions.

1. Acariasis infestation _____
2. Costen's complex _____
3. ST elevation myocardial infarction, anterior wall, involving left main coronary artery _____
4. Malaria with hepatitis _____
5. Acute lymphangitis _____
6. Absence of menstruation _____
7. Arterial atheroembolism _____
8. Cataract in hypoparathyroidism _____
9. Acromegaly _____

(continues)

Objectives

The objectives of this text are to:

1. Introduce information about major insurance programs and federal health care legislation.
2. Provide a basic knowledge of national diagnosis and procedure/service coding systems.
3. Explain the impact of coding compliance, clinical documentation improvement (CDI), and coding for medical necessity on health care settings.
4. Simplify the process of completing CMS-1500 and UB-04 claims.

This text is designed to be used by college and vocational school programs to train medical assistants, medical insurance specialists, coding and reimbursement specialists, and health information technicians. It can also be used as an in-service training tool for new medical office personnel and independent billing services, or individually by claims processors in the health care field who want to develop or enhance their skills.

Features of the Text

Major features of this text include:

- Key terms, section headings, and learning objectives at the beginning of each chapter help organize the material. They can be used as a self-test for checking comprehension and mastery of chapter content. Boldfaced key terms appear throughout each chapter to help learners master the technical vocabulary associated with claims processing.
- CPT, HCPCS level II, and ICD-10-CM coverage presents the latest coding information, numerous examples, and skill-building exercises. Detailed content prepares students for changes they will encounter on the job. (Content about ICD-10-PCS guidelines, examples, and coding practice is available at the Student Resources website. Code answers are available at the Instructor Resources website.)
- CMS-1500 claims appear throughout the text to provide valuable practice with manual claims completion, and SimClaim™ practice software, available online within MindTap, presents the electronic version. The UB-04 claim appears in Chapter 11 with its claims completion instructions.
- Coding exercises are located throughout textbook Chapters 6 through 8 and 10, and claims completion exercises are located throughout Chapters 11 through 17. Answers to exercises are available from your instructor.
- Numerous examples are provided in each chapter to illustrate the correct application of rules and guidelines.
- Notes clarify chapter content, focusing the student's attention on important concepts. Coding Tips provide practical suggestions for mastering the use of the CPT, HCPCS level II, and ICD-10-CM coding manuals. HIPAA Alerts draw attention to the impact of this legislation on privacy and security requirements for patient health information.
- End-of-chapter reviews reinforce learning and are in multiple-choice format with a coding completion fill-in-the-blank format available for coding chapters. Answers to chapter reviews are available from your instructor.
- **MindTap** is a fully online, interactive learning platform that combines readings, multimedia activities, and assessments into a singular learning path, elevating learning by providing real-world application to better engage students. MindTap can be accessed at Cengage.com.
- **SimClaim™**, the practice software available online within MindTap, contains case studies that include billing data and patient histories, and allow for data entry on CMS-1500 claims, with immediate feedback. Instructions for using SimClaim™ are located at the end of this Preface.

New to this Edition

- Chapter 1: Content about the National Healthcare Association (NHA) and its Certified Billing & Coding Specialist (CBCS) certification was added.
- Chapter 2: Content about Clinical Quality Language (CQL) was added.
- Chapter 3: Content about HEDIS® and Quality Compass® was revised.
- Chapter 4: Content about data capture automation, optical character recognition, optical scanning, and paper-based claims was removed according to the latest industry guidelines and standards. The chapter now focuses on electronic claims.
- Chapter 5: Content about Targeted Probe and Educate (TPE) process for Medical Review was added.
- Chapter 6: ICD-10-CM guidelines and codes were updated. Content about the new ICD-10-CM Chapter 22: Codes for Special Purposes (U00–U85) was added. The new ICD-10-CM search tool (https://icd10cmtool.cdc.gov) website was also added to the end-of-chapter list of Internet Links.
- Chapter 7: CPT coding guidelines and codes were updated, including CPT 2021 changes to the assignment of Evaluation and Management codes 99202-99215.
- Chapter 8: HCPCS level II guidelines and codes were updated.
- Chapter 9: Content about nonparticipating provider payments by Medicare was revised, and information about the Home Health Prospective Payment System was updated to add the patient-driven groupings model. In addition, data management content about the collection and use of standardized patient assessment data elements (SPADE) for post-acute care (PAC) quality measures was added.
- Chapter 10: ICD-10-CM, HCPCS level II, and CPT codes were updated, and the reference to clinical documentation integrity (CDI) as an alternate meaning of CDI was added.
- Chapters 11 to 17: ICD-10-CM, HCPCS level II, and CPT codes were updated. Insurance claims completion instructions and the CMS-1500 claim were revised according to the latest industry guidelines and standards.
- SimClaim™ practice software available within MindTap, includes updated ICD-10-CM, HCPCS level II, and CPT Codes.

Organization of This Textbook

- Chapter outlines, key terms, objectives, chapter exercises, end-of-chapter summaries, and reviews facilitate student learning.
- Chapter 1, Health Insurance Specialist Career, contains an easy-to-read table that delineates training requirements for health insurance specialists.
- Chapter 2, Introduction to Health Insurance, contains content about health care insurance developments. A table containing the history of significant health insurance legislation in date order simplifies laws and regulations implemented. Meaningful use content remains in the chapter to serve as background for content about the new quality payment program (e.g., Advanced APMs, eCQMs, MIPS).
- Chapter 3, Managed Health Care, contains content about managed care plans, consumer-directed health plans, health savings accounts, and flexible spending accounts. A table contains the history of significant managed health care legislation in date order to organize the progression of laws and regulations.
- Chapter 4, Revenue Cycle Management, contains content about managing the revenue cycle claims processing steps, and the denials/appeals process.

- Chapter 5, Legal and Regulatory Issues, emphasizes confidentiality of patient information, retention of patient information and health insurance records, the Federal False Claims Act, the Health Insurance Portability and Accountability Act of 1996, and federal laws and events that affect health care.
- Chapter 6, ICD-10-CM Coding, contains coding conventions and coding guidelines with examples. An overview about ICD-10-PCS is also provided, and additional content can be found on the Student Resources at Cengage.com. (ICD-10-PCS coding answer keys can be found at the Instructor Companion Site.) The coding conventions for the ICD-10-CM Index to Disease and Injuries and ICD-10-CM Tabular List of Diseases and Injuries are clearly explained and include examples. In addition, examples of coding manual entries are included.

  The chapter review includes coding statements, which are organized according to the ICD-10-CM chapters.

NOTE:

The ICD-10-CM chapter is sequenced before the CPT and HCPCS level II chapters in this textbook because diagnosis codes are reported for medical necessity (to justify procedures and/or services provided).

- Chapter 7, CPT Coding, follows the organization of CPT sections. The chapter review includes coding statements organized by CPT section.
- Chapter 8, HCPCS Level II Coding, contains content about the development and use of the HCPCS level II coding system and its modifiers. The chapter review includes coding statements organized by HCPCS level II section.
- Chapter 9, CMS Reimbursement Methodologies, contains information about reimbursement systems implemented since 1983 (including the Medicare physician fee schedule).
- Chapter 10, Coding Compliance Programs, Clinical Documentation Improvement, and Coding for Medical Necessity, contains information about the components of an effective coding compliance plan, and content about clinical documentation improvement and coding for medical necessity. Coding exercises (e.g., case scenarios, patient reports) are also included.
- Chapter 11, CMS-1500 and UB-04 Claims, contains general instructions that are followed when entering data on the CMS-1500 claim, a discussion of common errors made on claims, guidelines for maintaining the practice's insurance claim files, and the processing of assigned claims. UB-04 claims instructions are included, along with a case study.
- Claims completion instructions in Chapters 12 through 17 are located in an easy-to-read table format, and students can follow along with completion of the John Q. Public claims in each chapter (and complete the Mary Sue Patient claims as homework) by printing the blank CMS-1500 claim (according to instructions in Appendix I) or using MindTap.

Resources for the Instructor

Additional instructor resources for this product are available online. Instructor assets include an Instructor's Manual, Educator's Guide, Solution and Answer Guide, PowerPoint® slides, a test bank powered by Cognero®, and a transition guide.

Sign up or sign in at www.cengage.com to search for and access this product and its online resources.

Instructor's Manual

A downloadable, customizable *Instructor's Manual* contains a complete list of chapter activities and assessments, additional activities and assignments, and a list of additional resources.

Solution and Answer Guides

A downloadable, customizable *Solution and Answer Guide* contains the answers for all textbook questions and a second *Solution and Answer Guide* containing the answers for all workbook questions.

Test Bank

The computerized test bank in Cognero® makes generating tests and quizzes a snap. Test banks can also be downloaded using Respondus® software. With approximately 1,500 questions, you can create customized assessments for your students with the click of a button.

Slide Presentations

Customizable instructor support slide presentations in Microsoft's PowerPoint® focus on key points for each chapter.

Transition Guide

A Transition Guide maps the 2020 Edition to the 2021 Edition.

Updates and Resources

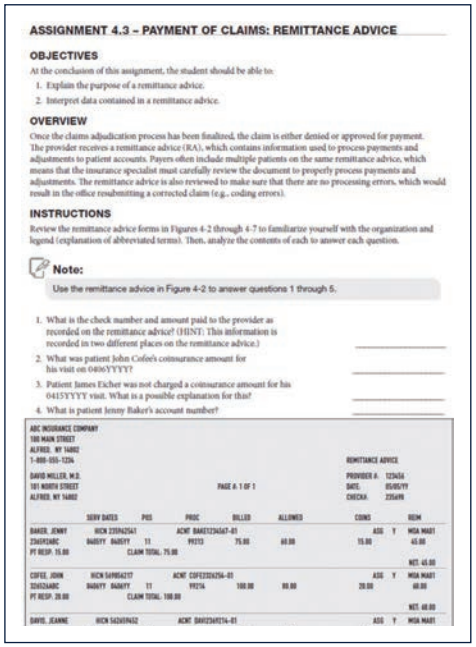
Revisions to the textbook, workbook, Instructor's Manual, SimClaim™, and Cognero® test bank due to coding updates are posted. The Instructor Resources also include access to all student supplements, as well as additional textbook content.

Resources for the Student

Student Workbook (ISBN 978-0-357-51559-4)

The Workbook follows the text's chapter organization and contains application-based assignments. Each chapter assignment includes a list of objectives, an overview of content relating to the assignment, and instructions for completing the assignment. Other components may be present depending on the assignment.

Each chapter contains review questions, in multiple-choice format, to emulate credentialing exam questions. In Chapters 11 through 17, additional case studies allow more practice in completing the CMS-1500 claim.



ASSIGNMENT 4.3 – PAYMENT OF CLAIMS: REMITTANCE ADVICE

OBJECTIVES

At the conclusion of this assignment, the student should be able to:

1. Explain the purpose of a remittance advice.
2. Interpret data contained in a remittance advice.

OVERVIEW

Once the claims adjudication process has been finalized, the claim is either denied or approved for payment. The provider receives a remittance advice (RA), which contains information used to process payments and adjustments to patient accounts. Payers often include multiple patients on the same remittance advice, which means that the insurance specialist must carefully review the document to properly process payments and adjustments. The remittance advice is also reviewed to make sure that there are no processing errors, which would result in the office resubmitting a corrected claim (e.g., coding errors).

INSTRUCTIONS

Review the remittance advice forms in Figures 4-2 through 4-7 to familiarize yourself with the organization and legend (explanation of abbreviated terms). Then, analyze the contents of each to answer each question.

Note:

Use the remittance advice in Figure 4-2 to answer questions 1 through 5.

1. What is the check number and amount paid to the provider as recorded on the remittance advice? (HINT: This information is recorded in two different places on the remittance advice.)
2. What was patient John Cofee's coinsurance amount for his visit on 0406YYYY?
3. Patient James Eicher was not charged a coinsurance amount for his 0415YYYY visit. What is a possible explanation for this?
4. What is patient Jenny Baker's account number?

Student Resources

Additional student resources for this product are available online. Student assets include:

- CMS-1500 and UB-04 claims (blank fill-in forms), additional content related to textbook chapters, and SimClaim™ Case Studies
- CMS Evaluation and management services guidance document
- Revisions to the textbook and workbook due to coding updates
- Final test for AAPC CEU approval

Sign up or sign in at www.cengage.com to search for and access this product and its online resources.

MindTap

Green's *Understanding Health Insurance,* 2021 Edition on MindTap is the first of its kind in an entirely new category: the Personal Learning Experience (PLE). This personalized program of digital products and services uses interactivity and customization to engage students, while offering instructors a wide range of choice in content, platforms, devices, and learning tools. MindTap is device agnostic, meaning that it will work with any platform or learning management system and will be accessible anytime, anywhere: on desktops, laptops, tablets, mobile phones, and other Internet-enabled devices.

MindTap includes:

- An interactive eBook with highlighting and note-taking capability
- SimClaim™ Software
  - Interactive CMS-1500 claims completion software available within MindTap
  - Includes 40 updated coding case studies
- Flashcards for practicing chapter terms
- Computer-graded activities and exercises
  - Self-check and application activities, integrated with the eBook
  - Case studies with videos
- Easy submission tools for instructor-graded exercises

ISBNs: 978-0-357-51561-7 (electronic access code); 978-0-357-51562-4 (printed access card)

ABOUT THE AUTHOR

Michelle A. Green, MPS, RHIA, FAHIMA, CPC, is an educational consultant for health information management academic programs, which involves mentoring program directors as they pursue CAHIIM accreditation, building new online courses (e.g., Blackboard, Moodle), and reviewing existing online course content. She taught traditional classroom-based courses at Alfred State College from 1984 until 2000, when she transitioned all of the health information technology and coding/reimbursement specialist courses to an Internet-based format and continued teaching full-time online until 2016. Upon relocating to Syracuse, New York, she has taught for the health information technology program at Mohawk Valley Community College, Utica, New York, since 2017. Prior to 1984, she worked as a director of health information management at two acute care hospitals in the Tampa Bay, Florida, area. Both positions required her to assign codes to inpatient cases. Upon becoming employed as a college professor, she routinely spent semester breaks coding for a number of health care facilities so that she could further develop her inpatient and outpatient coding skills.

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Special thanks are extended to the reviewers, technical reviewers, and supplement authors who provided recommendations and suggestions for improvement throughout the development of the text. Their experience and knowledge have been a valuable resource for the author.

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To my students, located throughout the world! You always ask me the toughest questions, and you also make me want to find the answers. You are such wonderful critical thinkers!

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- *CPT Professional*
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- *ICD-10-CM Professional*
- *ICD-10-PCS Professional*

Feedback

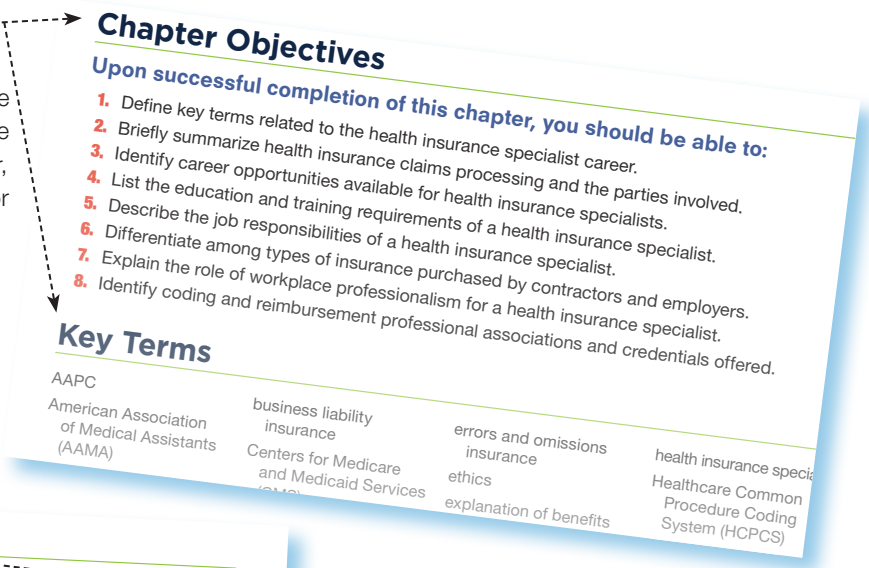
Contact the author at michelle.ann.green@gmail.com with questions, suggestions, or comments about the text or supplements.

HOW TO USE THIS TEXT

Objectives and Key Terms

The **Objectives** section lists the outcomes expected of the learner after a careful study of the chapter. Review the Objectives before reading the chapter content. When you complete the chapter, read the Objectives again to see if you can say for each one, "Yes, I can do that." If you cannot, go back to the appropriate content and reread it.

Key Terms represent new vocabulary in each chapter. Each term is highlighted in color in the chapter, is used in context, and is defined on first usage. A complete definition of each term appears in the Glossary at the end of the text.



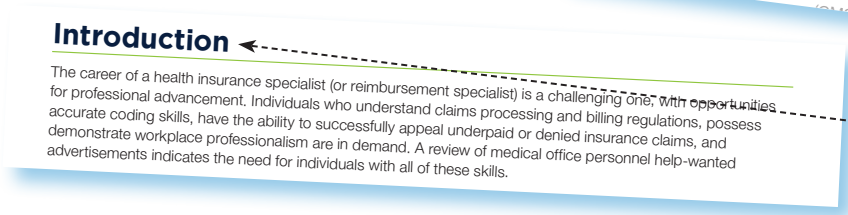
Chapter Objectives

Upon successful completion of this chapter, you should be able to:

1. Define key terms related to the health insurance specialist career.
2. Briefly summarize health insurance claims processing and the parties involved.
3. Identify career opportunities available for health insurance specialists.
4. List the education and training requirements of a health insurance specialist.
5. Describe the job responsibilities of a health insurance specialist.
6. Differentiate among types of insurance purchased by contractors and employers.
7. Explain the role of workplace professionalism for a health insurance specialist.
8. Identify coding and reimbursement professional associations and credentials offered.

Key Terms

AAPC
American Association of Medical Assistants (AAMA)
business liability insurance
Centers for Medicare and Medicaid Services
errors and omissions insurance
ethics
explanation of benefits
health insurance specia
Healthcare Common Procedure Coding System (HCPCS)



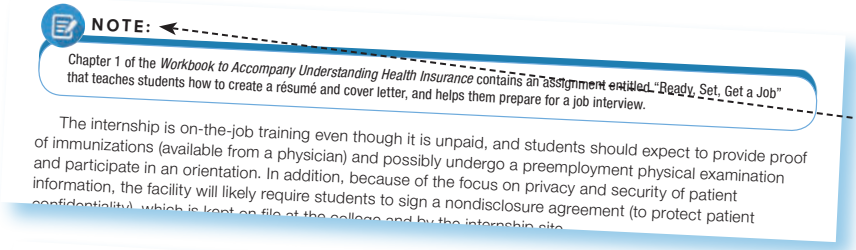
Introduction

The career of a health insurance specialist (or reimbursement specialist) is a challenging one, with opportunities for professional advancement. Individuals who understand claims processing and billing regulations, possess accurate coding skills, have the ability to successfully appeal underpaid or denied insurance claims, and demonstrate workplace professionalism are in demand. A review of medical office personnel help-wanted advertisements indicates the need for individuals with all of these skills.

Introduction

The **Introduction** provides a brief overview of the major topics covered in the chapter.

The Introduction and the Objectives provide a framework for your study of the content.



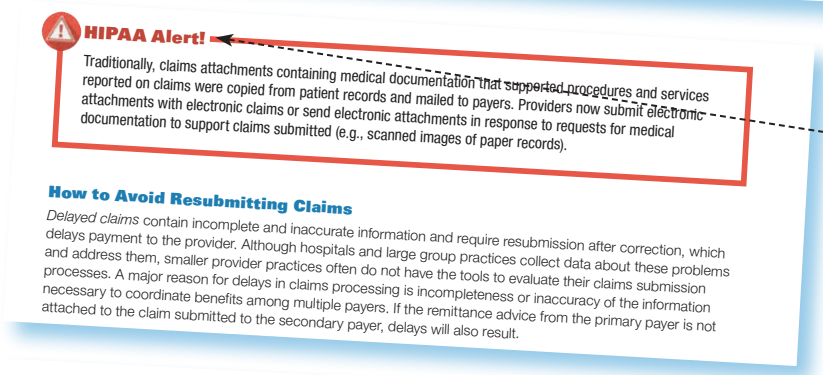
NOTE:

Chapter 1 of the *Workbook to Accompany Understanding Health Insurance* contains an assignment entitled "Ready, Set, Get a Job" that teaches students how to create a résumé and cover letter, and helps them prepare for a job interview.

The internship is on-the-job training even though it is unpaid, and students should expect to provide proof of immunizations (available from a physician) and possibly undergo a preemployment physical examination and participate in an orientation. In addition, because of the focus on privacy and security of patient information, the facility will likely require students to sign a nondisclosure agreement (to protect patient confidentiality), which is kept on file at the college and by the internship site.

Notes

Notes appear throughout the text and serve to bring important points to your attention. The Notes may clarify content, refer you to reference material, provide more background for selected topics, or emphasize exceptions to rules.



HIPAA Alert!

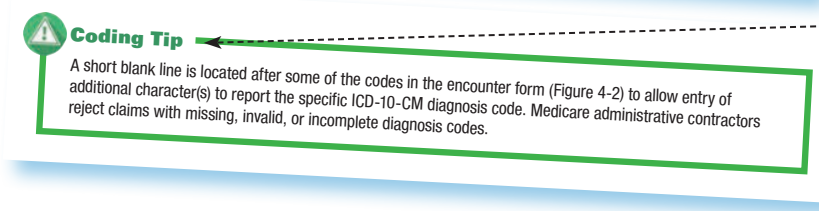
Traditionally, claims attachments containing medical documentation that supported procedures and services reported on claims were copied from patient records and mailed to payers. Providers now submit electronic attachments with electronic claims or send electronic attachments in response to requests for medical documentation to support claims submitted (e.g., scanned images of paper records).

How to Avoid Resubmitting Claims

Delayed claims contain incomplete and inaccurate information and require resubmission after correction, which delays payment to the provider. Although hospitals and large group practices collect data about these problems and address them, smaller provider practices often do not have the tools to evaluate their claims submission processes. A major reason for delays in claims processing is incompleteness or inaccuracy of the information necessary to coordinate benefits among multiple payers. If the remittance advice from the primary payer is not attached to the claim submitted to the secondary payer, delays will also result.

Icons

Icons draw attention to critical areas of content or provide experience-based recommendations. For example, the **HIPAA ALERT!** identifies issues related to the security of personal health information in the medical office.



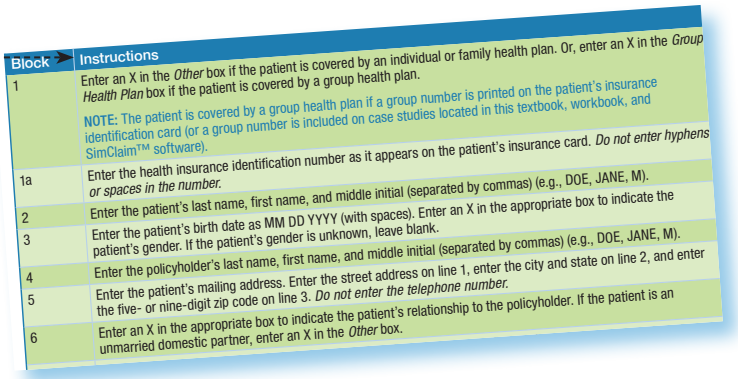
Coding Tip

A short blank line is located after some of the codes in the encounter form (Figure 4-2) to allow entry of additional character(s) to report the specific ICD-10-CM diagnosis code. Medicare administrative contractors reject claims with missing, invalid, or incomplete diagnosis codes.

The **Coding Tip** provides recommendations and hints for selecting codes and for the correct use of the coding manuals. Other icons include **Managed Care Alert, Hint, Remember!**, and **Caution**.

Claims Instructions

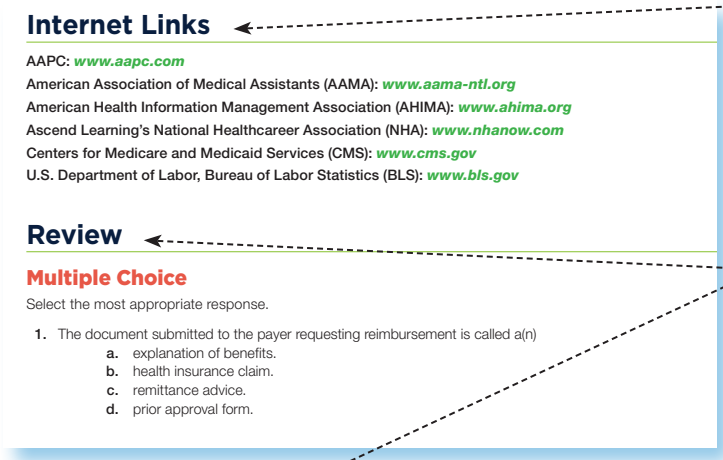
Claims Instructions simplify the process of completing the CMS-1500 for various types of payers. These instructions are provided in tables in Chapters 12 to 17. Each table consists of step-by-step instructions for completing each block of the CMS-1500 for commercial, BlueCross BlueShield, Medicare, Medicaid, TRICARE, and Workers' Compensation payers.



Block	Instructions
1	Enter an X in the *Other* box if the patient is covered by an individual or family health plan. Or, enter an X in the *Group Health Plan* box if the patient is covered by a group health plan. **NOTE:** The patient is covered by a group health plan if a group number is printed on the patient's insurance identification card (or a group number is included on case studies located in this textbook, workbook, and SimClaim™ software).
1a	Enter the health insurance identification number as it appears on the patient's insurance card. *Do not enter hyphens or spaces in the number.*
2	Enter the patient's last name, first name, and middle initial (separated by commas) (e.g., DOE, JANE, M).
3	Enter the patient's birth date as MM DD YYYY (with spaces). Enter an X in the appropriate box to indicate the patient's gender. If the patient's gender is unknown, leave blank.
4	Enter the policyholder's last name, first name, and middle initial (separated by commas) (e.g., DOE, JANE, M).
5	Enter the patient's mailing address. Enter the street address on line 1, enter the city and state on line 2, and enter the five- or nine-digit zip code on line 3. *Do not enter the telephone number.*
6	Enter an X in the appropriate box to indicate the patient's relationship to the policyholder. If the patient is an unmarried domestic partner, enter an X in the *Other* box.

Internet Links

Internet Links are provided to encourage you to expand your knowledge at various state and federal government agency sites, commercial sites, and organization sites. Some exercises require you to obtain information from the Internet to complete the exercise.



Internet Links

AAPC: *www.aapc.com*
American Association of Medical Assistants (AAMA): *www.aama-ntl.org*
American Health Information Management Association (AHIMA): *www.ahima.org*
Ascend Learning's National Healthcareer Association (NHA): *www.nhanow.com*
Centers for Medicare and Medicaid Services (CMS): *www.cms.gov*
U.S. Department of Labor, Bureau of Labor Statistics (BLS): *www.bls.gov*

Review

Multiple Choice

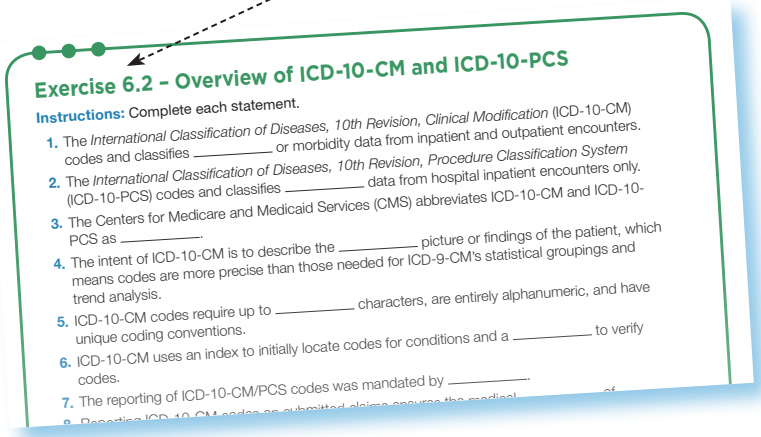
Select the most appropriate response.

1. The document submitted to the payer requesting reimbursement is called a(n)
   a. explanation of benefits.
   b. health insurance claim.
   c. remittance advice.
   d. prior approval form.

Reviews and Exercises

The **Reviews** test student understanding about chapter content and critical thinking ability. Reviews in coding chapters require students to assign correct codes and modifiers using coding manuals. Answers are available from your instructor.

Exercises provide practice applying critical thinking skills. Answers to exercises are available from your instructor.



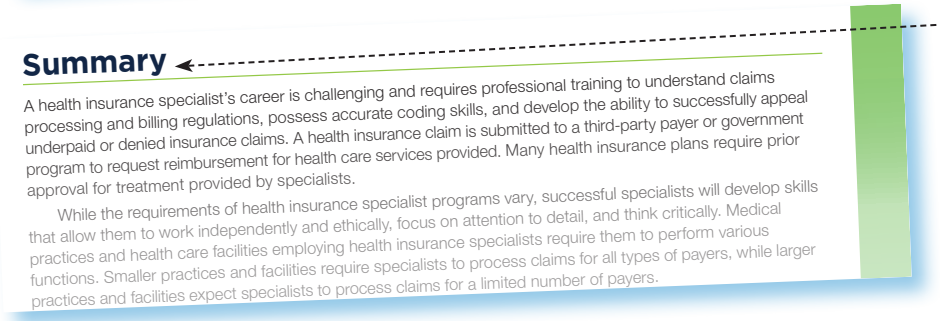
Exercise 6.2 – Overview of ICD-10-CM and ICD-10-PCS

Instructions: Complete each statement.

1. The *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM) codes and classifies _____ or morbidity data from inpatient and outpatient encounters.
2. The *International Classification of Diseases, 10th Revision, Procedure Classification System* (ICD-10-PCS) codes and classifies _____ data from hospital inpatient encounters only.
3. The Centers for Medicare and Medicaid Services (CMS) abbreviates ICD-10-CM and ICD-10-PCS as _____.
4. The intent of ICD-10-CM is to describe the _____ picture or findings of the patient, which means codes are more precise than those needed for ICD-9-CM's statistical groupings and trend analysis.
5. ICD-10-CM codes require up to _____ characters, are entirely alphanumeric, and have unique coding conventions.
6. ICD-10-CM uses an index to initially locate codes for conditions and a _____ to verify codes.
7. The reporting of ICD-10-CM/PCS codes was mandated by _____.

Summary

The **Summary** at the end of each chapter recaps the key points of the chapter. It also serves as a review aid when preparing for tests.



Summary

A health insurance specialist's career is challenging and requires professional training to understand claims processing and billing regulations, possess accurate coding skills, and develop the ability to successfully appeal underpaid or denied insurance claims. A health insurance claim is submitted to a third-party payer or government program to request reimbursement for health care services provided. Many health insurance plans require prior approval for treatment provided by specialists.

While the requirements of health insurance specialist programs vary, successful specialists will develop skills that allow them to work independently and ethically, focus on attention to detail, and think critically. Medical practices and health care facilities employing health insurance specialists require them to perform various functions. Smaller practices and facilities require specialists to process claims for all types of payers, while larger practices and facilities expect specialists to process claims for a limited number of payers.

SIMCLAIM™ CMS-1500 SOFTWARE USER GUIDE

SimClaim™ software is an online educational tool designed to familiarize you with the basics of the CMS-1500 claims completion. Because in the real-world there are many rules that can vary by payer, facility, and state, the version of SimClaim included in this MindTap maps to the specific instructions found in your *Understanding Health Insurance* textbook readings.

How to Access

Student practice software is available online through MindTap, accessed at Cengage.com.

There are three types of SimClaim activities in this MindTap:

- **SimClaim Exercises**—Exercises are included within the chapter reading and are named "Exercise" followed by the chapter number and case number (e.g., Exercise 13.1). These exercises include the diagnosis and procedure codes that will need to be entered on the claim form.
- **SimClaim Cases, Set One**—Cases from Set One have a 1 at the beginning of the case study number (e.g., SimClaim Case **1**-1). These cases include the diagnosis and procedure codes that will need to be entered on the claim form.
- **SimClaim Cases, Set Two**—Cases from Set Two have a 2 at the beginning of the case study number (e.g., SimClaim Case **2**-1.). These cases require you to assign codes.

General Instructions

- **Dates**—Enter all dates as listed on the case study.
- **Block 24E**—Although SimClaim™ allows for more than one diagnosis pointer to be entered, *only one diagnosis pointer is allowed in Block 24E* for each line item as per textbook instructions.
- **Block 29**—If there is no amount paid indicated on the case study, *leave the field blank.*
- **Block 32**—Enter data for all Medicare claims and for all the other health insurance payers only when the facility is other than the office setting, as indicated on the case study.
- **Secondary insurance claims**—If a case study indicates that a patient's primary health insurance payer has paid an amount, fill out a second claim for the secondary insurance payer that reflects the amount reimbursed by the primary insurance payer when indicated. The second claim is available on the Form 2 tab near the top of the CMS-1500 form in SimClaim.

For additional help using SimClaim™, refer to the specific health insurance payer guidelines found in your textbook.

Abbreviations

Blocks 5, 7, 32, 33, (Address Blocks) and the **Carrier Address Block** contain, among other information, address information. These fields allow for the user to enter the address using full spelling and abbreviations as follows:

- "Street" allows for the following entries:
  - STREET
  - ST

- "Avenue" allows for the following entries:
  - AVENUE
  - AVE
- "Road" allows for the following entries:
  - ROAD
  - RD
- "Court" allows for the following entries:
  - COURT
  - CT
- "Highway" allows for the following entries:
  - HIGHWAY
  - HWY
- "Apartment" allows for the following entries:
  - APARTMENT
  - APT
- "Lane" allows for the following entries:
  - LANE
  - LN
- "Drive" allows for the following entries:
  - DRIVE
  - DR

Punctuation is **NEVER** allowed in address blocks, except for the hyphen in a nine-digit zip code.

Non-Entry Fields

Blocks 8, 24C, 24H, and 24I are non-entry fields. These blocks prohibit **ANY** input, meaning users will not even be allowed to select them.

CHAPTER 1

Health Insurance Specialist Career

Chapter Outline

Health Insurance Overview
Career Opportunities
Education and Training
Job Responsibilities
Independent Contractor and Employer Liability
Professionalism
Professional Associations and Credentials

Chapter Objectives

Upon successful completion of this chapter, you should be able to:

1. Define key terms related to the health insurance specialist career.
2. Briefly summarize health insurance claims processing and the parties involved.
3. Identify career opportunities available for health insurance specialists.
4. List the education and training requirements of a health insurance specialist.
5. Describe the job responsibilities of a health insurance specialist.
6. Differentiate among types of insurance purchased by contractors and employers.
7. Explain the role of workplace professionalism for a health insurance specialist.
8. Identify coding and reimbursement professional associations and credentials offered.

Key Terms

AAPC
American Association of Medical Assistants (AAMA)
American Health Information Management Association (AHIMA)
bonding insurance
business liability insurance
Centers for Medicare and Medicaid Services (CMS)
claims examiner
coding
Current Procedural Terminology (CPT)
embezzle
errors and omissions insurance
ethics
explanation of benefits (EOB)
HCPCS level II codes
health care provider
health information technician
health insurance claim
health insurance specialist
Healthcare Common Procedure Coding System (HCPCS)
hold harmless clause
independent contractor
International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

International Classification of Diseases, 10th Revision, Procedural Coding System (ICD-10-PCS)
internship
medical assistant
medical malpractice insurance
medical necessity
national codes
professional liability insurance
professionalism
property insurance
reimbursement specialist
remittance advice (remit)
respondeat superior
scope of practice
workers' compensation insurance

Introduction

The career of a health insurance specialist (or reimbursement specialist) is a challenging one, with opportunities for professional advancement. Individuals who understand claims processing and billing regulations, possess accurate coding skills, have the ability to successfully appeal underpaid or denied insurance claims, and demonstrate workplace professionalism are in demand. A review of medical office personnel help-wanted advertisements indicates the need for individuals with all of these skills.

Health Insurance Overview

Most health care practices in the United States accept responsibility for filing health insurance claims, and some third-party payers (e.g., BlueCross BlueShield) and government programs (e.g., Medicare) require providers to file claims. A **health insurance claim** is the documentation submitted to a third-party payer or government program requesting reimbursement for health care services provided. In the past few years, many practices have increased the number of employees assigned to some aspect of claims processing. This increase is a result of more patients having some form of health insurance, many of whom require *prior approval* for treatment by specialists and documentation of post-treatment reports. If prior approval requirements are not met, payment of the claim is denied. According to BlueCross BlueShield, if an insurance plan has a **hold harmless clause** (patient is not responsible for paying what the insurance plan denies) in the contract, the health care provider cannot collect the fees from the patient. It is important to realize that not all insurance policies contain *hold harmless* clauses. However, many policies contain a *no balance billing* clause that protects patients from being billed for amounts not reimbursed by payers (except for copayments, coinsurance amounts, and deductibles). (Chapter 2 contains more information about these concepts.) In addition, patients referred to nonparticipating providers (e.g., a physician who does not participate in a particular health care plan) incur significantly higher out-of-pocket costs than they may have anticipated. Competitive insurance companies are fine-tuning procedures to reduce administrative costs and overall expenditures. This cost-reduction campaign forces closer scrutiny of the entire claims process, which in turn increases the time and effort medical practices must devote to billing and filing claims according to the insurance policy filing requirements. Poor attention to claims requirements will result in lower reimbursement rates to the practices and increased expenses.

A number of health care providers sign managed care contracts as a way to combine health care delivery and financing of services to provide more affordable quality care. A **health care provider** (Figure 1-1) is a physician or other health care practitioner (e.g., nurse practitioner, physician's assistant). Each new provider-managed care contract increases the practice's patient base, the number of claims requirements and reimbursement regulations, the time the office staff must devote to fulfilling contract requirements, and the complexity of referring patients for specialty care. Each insurance plan has its own authorization requirements, billing deadlines, claims requirements, and list of participating providers or networks. If a health care provider has signed 10 participating contracts, there are 10 different sets of requirements to follow and 10 different panels of participating health care providers from which referrals can be made.

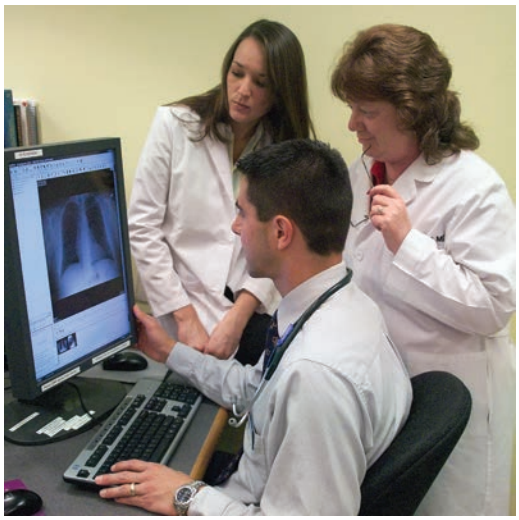


FIGURE 1-1 Health care providers viewing an electronic image of a patient's chest x-ray.

Rules associated with health insurance processing (especially government programs) change frequently; to remain up-to-date, insurance specialists should be sure they are on mailing lists to receive newsletters from third-party payers. It is also important to remain current regarding news released from the **Centers for Medicare and Medicaid Services (CMS)**, which is the administrative agency within the federal Department of Health and Human Services (DHHS). The Secretary of the DHHS, as often reported on by the news media, announces the implementation of new regulations about government programs (e.g., Medicare, Medicaid).

The increased hiring of insurance specialists is a direct result of employers' attempts to reduce the cost of providing employee health insurance coverage. Employers renegotiate benefits with existing plans or change third-party payers altogether. The employees often receive retroactive notice of these contract changes; in some cases, they must then wait several weeks before receiving new health benefit booklets and new insurance identification cards. These changes in employer-sponsored plans have made it necessary for the health care provider's staff to check on patients' current eligibility and benefit status at each office visit.

Health insurance claims must include accurate codes. **Coding** is the process of assigning ICD-10-CM, ICD-10-PCS, CPT, and HCPCS level II codes, which contain alphanumeric and numeric characters (e.g., A01.1, 0DTJ0ZZ, 99202, K0003), to diagnoses, procedures, and services. Diagnoses are documented conditions or disease process (e.g., hypertension). Procedures are performed for diagnostic (e.g., lab test) and therapeutic (e.g., cholecystectomy) purposes, and services are provided to evaluate and manage patient care.

Coding systems include:

- ***International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM)**: coding system used to report diseases, injuries, and other reasons for inpatient and outpatient encounters, such as an annual physical examination performed at a physician's office
- ***International Classification of Diseases, 10th Revision, Procedural Coding System* (ICD-10-PCS)**: coding system used to report procedures and services on inpatient hospital claims
- **Healthcare Common Procedure Coding System (HCPCS**, pronounced "hick picks"), which currently consists of two levels:
  - ***Current Procedural Terminology* (CPT)**: coding system published by the American Medical Association that is used to report procedures and services performed during outpatient and physician office encounters, and professional services provided to inpatients
  - **HCPCS level II codes** (or **national codes**): coding system published by CMS that is used to report procedures, services, and supplies not classified in CPT