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UNDERSTANDING HEALTH INSURANCE

A GUIDE TO BILLING AND REIMBURSEMENT

MICHELLE A. GREEN
MPS, RHIA, FAHIMA, CPC

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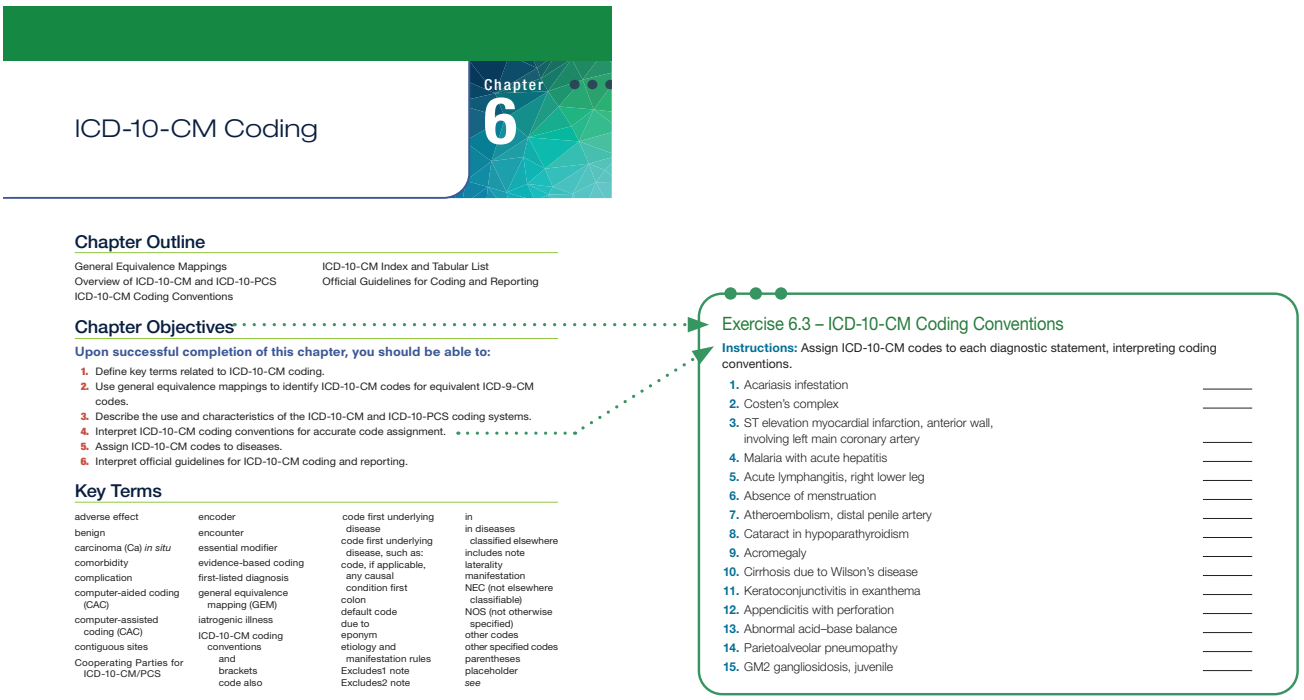
Preface

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 completing additional claims, assigning of APCs and DRGs, and interpreting remittance advice documents.



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 also
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
Excludes1 note
Excludes2 note
in
in diseases classified elsewhere
includes note
laterality
manifestation
NEC (not elsewhere classifiable)
NOS (not otherwise specified)
other codes
other specified codes
parentheses
placeholder
see

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 acute hepatitis _____
5. Acute lymphangitis, right lower leg _____
6. Absence of menstruation _____
7. Atheroembolism, distal penile artery _____
8. Cataract in hypoparathyroidism _____
9. Acromegaly _____
10. Cirrhosis due to Wilson's disease _____
11. Keratoconjunctivitis in exanthema _____
12. Appendicitis with perforation _____
13. Abnormal acid–base balance _____
14. Parietoalveolar pneumopathy _____
15. GM2 gangliosidosis, juvenile _____

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.

NOTE:

Claims completion instructions located in Chapters 11 through 17 of the textbook are based on the National Uniform Claims Committee's CMS-1500 reference instruction manual. For teaching purposes, instructions provide specific guidance for student claims completion. When employed, claims completion instructions specific to payers and government programs that reimburse your providers should be used.

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.
- 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 www.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

Shorter Chapters 2 and 3 from the last edition were consolidated into Chapter 2, Introduction to Health Insurance. Lengthy Chapter 4 from the last edition was split into Chapter 3, Introduction to Revenue Management, and Chapter 4, Revenue Management: Insurance Claims, Credit, and Collections. Application-based assignments were added to the Review at the end of each chapter.

NOTE:

Review questions were revised in accordance with added and updated content in each chapter.

- Chapter 1: Content about the American Disability Act (e.g., flexible work hours, job sharing, and telecommuting) and professional etiquette was added. The chapter Review contains two new assignments: Professionalism and Documenting Telephone Messages.
- Chapter 2: The chapter is now titled Introduction to Health Insurance and Managed Care and includes managed care content from the previous edition's Chapter 3 (Managed Care).
  - Insurance terms (schedule of benefits, covered services, carve-out plan, express contract, implied contract, premium, stop-loss insurance, guaranteed renewal [of health insurance contracts], institutional billing, and professional billing) were added.
  - Content about 21st Century Cures Act provisions of risk adjustment model reporting and prohibition of information blocking, Medicare Improvement for Patients and Providers Act (MIPPA) legislation, consumer-directed health plans, performance measurement, pharmacy management, physician referral, managed care contractual withhold arrangements, and risk pools was added.
  - Key terms Medicare, Medicaid, and CHAMPUS Reform Initiative (CRI) were relocated to Chapter 14, 15, and 16, respectively.
  - The chapter Review contains two new assignments: Introduction to Health Insurance Reimbursement, and Creating a Customized NCQA Health Plan Report Card.
- Chapter 3: The chapter is now titled Introduction to Revenue Management and includes content from the first half of the previous edition's Chapter 4 (Revenue Cycle Management). The previous edition's Chapter 3 (Managed Care) content was incorporated into Chapter 2.
  - Content about accounts payable, copayment (copay), discharged not final billed (DNFB), discharged not final coded (DNFC), facility billing, institutional billing, professional billing, and single-path coding was added.
- Chapter 4: The chapter is now titled Revenue Management: Insurance Claims, Denied Claims and Appeals, and Credit and Collections and includes content from the second half of the previous edition's Chapter 4 (Revenue Cycle Management).
  - Content about emancipated minors, suspended claim; third-party payer peer review by a medical reviewer, medical director, independent external reviewer (or Medicare qualified independent contractor), fragmentation, and skip tracing (or skip tracking) was added.
  - The chapter Review contains three new assignments: Interpreting an Explanation of Benefits, Interpreting a Remittance Advice, and Writing an Appeal Letter.
- Chapter 5: Content about MIPS was removed because it is covered in Chapter 2. Content about the Emergency Medical Treatment and Labor Act, Medicaid Fraud Control Unit (MFCU), minimum necessary standard (of the HIPAA Privacy Rule), and Notice of Privacy Practices (NPP) was added. The following content was updated: False Claim Act of 1863, Privacy Act of 1974, HIPAA Security Rule, HITECH Act, map of the Medicare fee-for-service RAC regions, HIPAA Title II (Preventing Health Care Fraud and Abuse), and designated record set. The following content was added: availability and integrity of electronic protected health information (e-PHI) (associated with the HIPAA Security Rule); Office for Civil Rights periodic audit

to ensure compliance with HIPAA privacy, security, and breach notification rules; HIPAA civil and criminal penalties; Health Care Fraud and Abuse Control Program; HIPAA breach notification rule; direct and indirect treatment relationship between providers and patients; de-identification of protected health information; and treatment, payment, and health care operations (TPO). Content about the National Correct Coding Initiative (NCCI) program was expanded to provide clarification about its use. The Chapter 5 Review contains two new assignments: HIPAA Fraud and Abuse, and HIPAA Privacy and Security Rules.

- Chapter 6: ICD-10-CM guidelines and codes were updated, and applicable general coding guidelines were incorporated into outpatient coding guidelines within shaded boxes to bring attention to them. (*3-2-1 Code It!* is a comprehensive coding textbook that can be referenced for coding clarification.)
- Chapter 7: CPT coding guidelines and codes were updated. Coding step 7 (Review Appendix B in the CPT coding manual to assign appropriate modifiers) was added below the Coding Procedures and Services heading. Clarification was provided about entering CPT codes on the CMS-1500 claim based on highest to lowest reimbursement, along with content about the global period.
- Chapter 8: HCPCS Level II guidance and codes were updated.
- Chapter 9: Content about Never Events, ambulatory surgery center value-based purchasing, and value-based purchasing (VBP) was added, along with an image that summarizes VBP programs. Content about hospital value-based purchasing was clarified. The chapter Review contains three new assignments: Data Analytics for Medicare Part B Reimbursement, Interpreting Medicare Status Indicators and Procedure Discounting Data for Ambulatory Payment Classifications, and Interpreting Medicare-Severity Diagnosis-Related Groups Data.
- Chapter 10: Content about the National Correct Coding Initiative (NCCI) program was clarified. ICD-10-CM, HCPCS Level II, and CPT codes were updated.
- Chapters 11 to 17: ICD-10-CM, HCPCS Level II, and CPT codes were updated. Chapter 13 through 17 content was revised to simplify explanations, and chapter Reviews were revised accordingly. Insurance claims completion instructions and completed CMS-1500 claims were revised according to the latest industry guidelines and standards, as follows:
  - Dates are now entered as a six-character-with-spaces format (e.g., MM DD YY) *except for Blocks 3 and 11a, which require eight-digit dates for dates of birth, and Block 31 that requires no spaces, as MMDDYY*.
  - Hyphens were deleted from 9-digit ZIP codes (e.g., 123456789).
  - More than one diagnosis pointer may be entered in Block 24E *without spaces*, when applicable (e.g., ABC).
- Chapter 11: Content about the UB-04 claim was clarified to indicate that it is used to report institutional services, such as inpatient and outpatient hospital services. The diagnosis pointer letter definition was clarified to explain that it is entered in Block 24E to indicate the medical necessity of the procedure performed or service provided. Clarification about the Administrative Simplification Compliance Act (ASCA) of 2003 was added to describe the continued use of paper claims. The chapter Review contains two new assignments: Identifying CMS-1500 Claims Completion Errors, and Completing the UB-04 Claim for Hospital Outpatient Care.
- Chapter 12: Content about commercial health insurance was clarified, including the addition of new key term *private health insurance*.
- Chapter 13: Content about network participation, BCBS preferred provider networks, utilization management were added.
- Chapter 14: Medicare was changed to a key term, information about Medicare observation status was clarified, an image of the Medicare MAC A/B jurisdiction map was added, and the mandatory claim submission rule was added.
- Chapter 15: Content about applying for Medicaid coverage when relocating to a new state was added.
- Chapter 16: CHAMPUS Reform Initiative (CRI) was changed to a key term, and content about the Privacy Act of 1974 and the Computer Matching and Privacy Protection Act of 1988 was added.
- Chapter 17: Workers' compensation content was updated to reflect current practices.

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 and Managed Care, contains content about basic health insurance and managed care concepts, the history of significant health insurance legislation, managed care plans, consumer-directed health plans, and health care documentation methods. Meaningful use content remains in the chapter to serve as a background for content about the new quality payment program (e.g., Advanced APMs, eCQMs, MIPS).
- Chapter 3, Introduction to Revenue Management, provides an overview of the revenue management process, including information about patient management, using encounter forms and chargemasters, processing insurance claims from patient appointment through claims submission, and posting charges to patient accounts. An introduction to methods of monitoring and auditing for revenue management is also included.
- Chapter 4, Revenue Management: Insurance Claims, Denied Claims and Appeals, and Credit and Collections, explains the stages of the insurance claim cycle, describes how insurance claim files are maintained, outlines the appeals process for denied claims, and explains the role of credit and collections in processing claims.
- 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. 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.

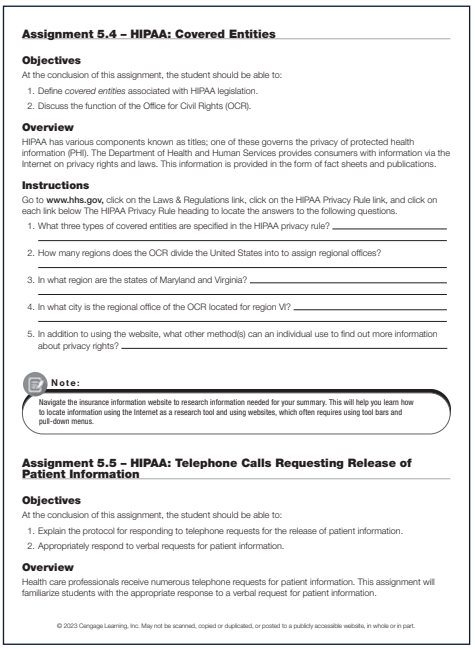
Sign up or sign in at www.cengage.com to search for and access this product and its online resources.

Resources for the Student

Student Workbook (ISBN 978-0-357-62136-3)

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 5.4 – HIPAA: Covered Entities

Objectives

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

1. Define *covered entities* associated with HIPAA legislation.
2. Discuss the function of the Office for Civil Rights (OCR).

Overview

HIPAA has various components known as titles; one of these governs the privacy of protected health information (PHI). The Department of Health and Human Services provides consumers with information via the Internet on privacy rights and laws. This information is provided in the form of fact sheets and publications.

Instructions

Go to **www.hhs.gov,** click on the Laws & Regulations link, click on the HIPAA Privacy Rule link, and click on each link below The HIPAA Privacy Rule heading to locate the answers to the following questions.

1. What three types of covered entities are specified in the HIPAA privacy rule? _____
2. How many regions does the OCR divide the United States into to assign regional offices? _____
3. In what region are the states of Maryland and Virginia? _____
4. In what city is the regional office of the OCR located for region VI? _____
5. In addition to using the website, what other method(s) can an individual use to find out more information about privacy rights? _____

Note:

Navigate the insurance information website to research information needed for your summary. This will help you learn how to locate information using the Internet as a research tool and using websites, which often requires using tool bars and pull-down menus.

Assignment 5.5 – HIPAA: Telephone Calls Requesting Release of Patient Information

Objectives

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

1. Explain the protocol for responding to telephone requests for the release of patient information.
2. Appropriately respond to verbal requests for patient information.

Overview

Health care professionals receive numerous telephone requests for patient information. This assignment will familiarize students with the appropriate response to a verbal request for patient information.

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

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

MindTap

MindTap is a fully online, interactive learning experience built upon authoritative Cengage content. By combining readings, multimedia activities, and assessments into a singular learning path, *MindTap* elevates learning by

providing real-world application to better engage students. Instructors customize the learning path by selecting Cengage resources and adding their own content via apps that integrate into the *MindTap* framework seamlessly with many learning management systems.

The *MindTap* includes:

- Auto-graded Exercises and Chapter Review from the textbook
- Video Quizzes that walk students step-by-step through coding patient cases
- SimClaim™ activities to practice completing CMS-1500 claim forms
- Medical Office Simulation Software Training and Assessment activities to learn how to complete various billing tasks in EHR/PM software
- Learning Labs, a multimedia program designed to engage students in realistic on-the-job scenarios
- Writing Assignments to further engage students in on-the-job scenarios and encourage critical thinking
- Chapter Quizzes

To learn more, visit www.cengage.com/training/mindtap.

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, TopClass), 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.

Reviewers

Special thanks are extended to the reviewers, digital contributors, and technical reviewers 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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- *CPT Professional*
- *HCPCS Level II Professional*
- *ICD-10-CM Professional*
- *ICD-10-PCS Professional*

Feedback

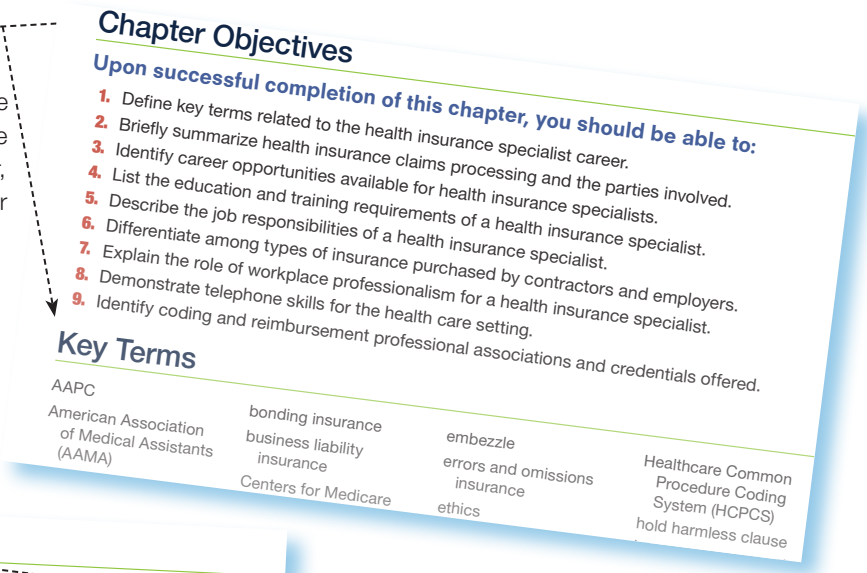
Contact the author at michelle.ann.green@gmail.com with questions, suggestions, or comments about the text or supplements.

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.



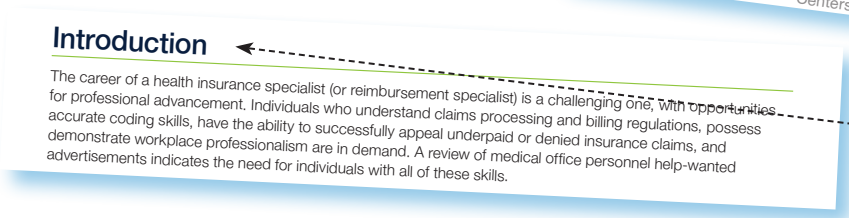
Chapter Objectives

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. Demonstrate telephone skills for the health care setting.
9. Identify coding and reimbursement professional associations and credentials offered.

Key Terms

AAPC
American Association of Medical Assistants (AAMA)
bonding insurance
business liability insurance
Centers for Medicare
embezzle
errors and omissions insurance
ethics
Healthcare Common Procedure Coding System (HCPCS)
hold harmless clause



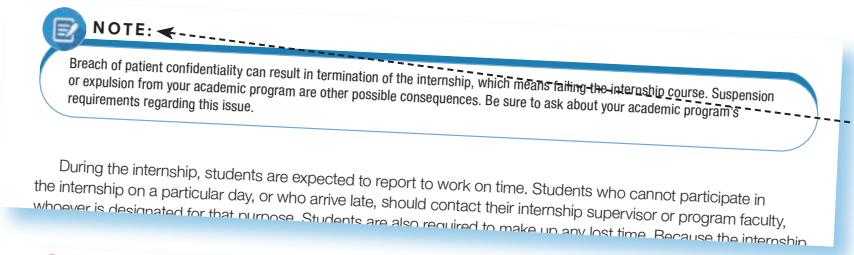
Introduction

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.



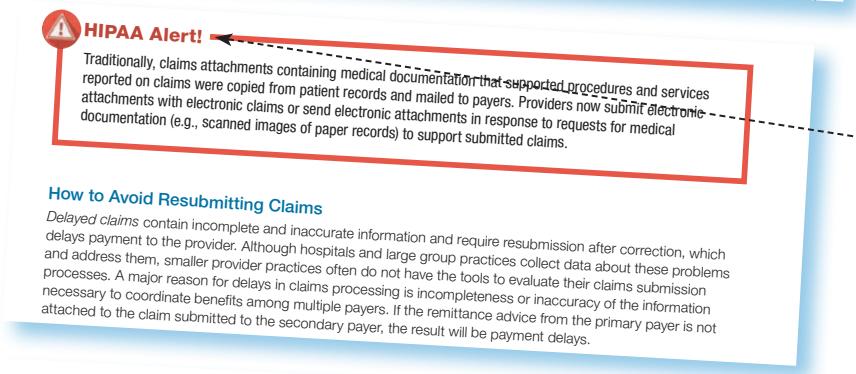
NOTE:

Breach of patient confidentiality can result in termination of the internship, which means failing the internship course. Suspension or expulsion from your academic program are other possible consequences. Be sure to ask about your academic program's requirements regarding this issue.

During the internship, students are expected to report to work on time. Students who cannot participate in the internship on a particular day, or who arrive late, should contact their internship supervisor or program faculty, whoever is designated for that purpose. Students are also required to make up any lost time. Because the internship

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!

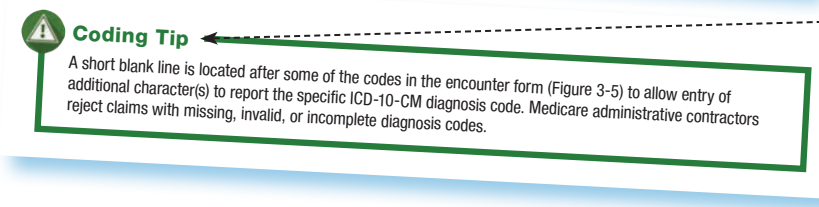
Traditionally, claims attachments containing medical documentation that supported procedures and services reported on claims were copied from patient records and mailed to payers. Providers now submit electronic attachments with electronic claims or send electronic attachments in response to requests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

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, the result will be payment delays.

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 3-5) 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). *Other* indicates automobile, commercial, health maintenance organization (and managed care), liability, or workers' compensation insurance.
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 sex. If the patient's sex 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 hyphen or a space for a 9-digit ZIP code. 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*

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.

Review

1.1 – 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.
2. The Centers for Medicare and Medicaid Services (CMS) is an administrative agency within the

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 inpatient hospital admissions 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 assigned 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 alphabetic index to initially locate codes for conditions and a _____ list to verify codes.
7. The reporting of ICD-10-CM/PCS codes was mandated by _____ legislation.
8. Reporting ICD-10-CM codes on submitted claims ensures the medical _____ of procedures and services provided to patients during an encounter, which is defined as "the determination that a service or procedure rendered is reasonable and necessary for the

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 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 www.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 ICD-10-CM and CPT codes.

General Instructions

- **Blocks 3 and 11a**—Enter dates of birth as MM DD YYYY (with spaces).
- **Blocks 5, 7, 32, and 33**—Do not enter a hyphen or a space for a 9-digit ZIP code.
- **Blocks 14, 15, 16, 18, and 24A**—Enter dates as MM DD YY (with spaces).
- **Block 21**—Do *not* enter decimal points in ICD-10-CM codes.
- **Block 24D**—Enter appropriate multiple diagnosis pointer letters *without spaces*, as ABC, from Block 21. Otherwise, enter a single diagnosis pointer letter.
- **Block 27**—Enter an X in the Yes box.
- **Block 29**—If there is no amount paid indicated on the case study, *leave the field blank.*
- **Block 31**—Enter date as MMDDYY (without spaces).
- **Block 32**—Enter data as required for all Medicare claims. For all the other health insurance payers, enter data 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, complete 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 claim 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 **Payer 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.

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
Telephone Skills for the Health Care Setting
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. Demonstrate telephone skills for the health care setting.
9. Identify coding and reimbursement professional associations and credentials offered.

Key Terms

AAPC
American Association of Medical Assistants (AAMA)
American Health Information Management Association (AHIMA)
American Medical Billing Association (AMBA)
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
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
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 that is electronically or manually submitted to a third-party payer or government program requesting reimbursement for health care procedures and 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**, which means the patient is not responsible for paying what the insurance plan denies; the clause is specified in the contract, and the health care provider cannot collect those 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.

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

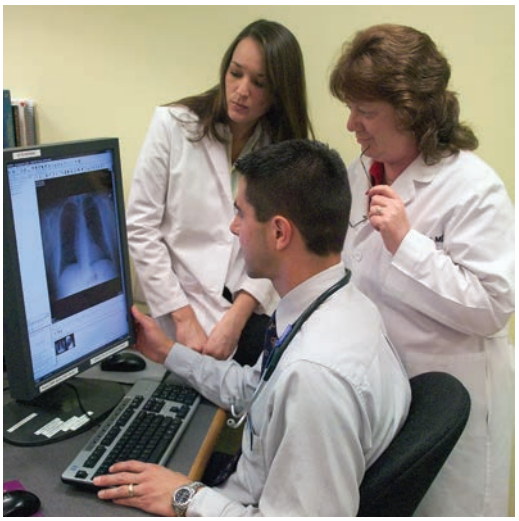


FIGURE 1-1 Health care providers viewing an electronic image of a patient's chest x-ray.

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 to diagnoses, procedures, services, and supplies. Codes contain alphanumeric and numeric characters (e.g., A01.1, 0DTJ0ZZ, 99202, K0003). 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 the following:

- ***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

(On December 31, 2003, CMS phased out the use of HCPCS Level III codes [or local codes]. However, some third-party payers continue to use the codes.)

Medical necessity involves linking every procedure or service code reported on the claim to a condition code (e.g., disease, injury, sign, symptom, other reason for encounter) that justifies the need to perform that procedure or service (Figure 1-2).

Example 1: The provider will *not* receive reimbursement when a claim is submitted with a CPT code for a right knee x-ray and an ICD-10-CM code for shoulder pain. For medical necessity purposes, the provider must document a valid reason for the knee x-ray (e.g., fracture, right patella).

PROCEDURE: Knee x-ray, right

DIAGNOSIS: Shoulder pain

Example 2: The provider will receive reimbursement when a claim is submitted with a CPT code for a chest x-ray and an ICD-10-CM code for severe shortness of breath because medical necessity has been met.

PROCEDURE: Chest x-ray

DIAGNOSIS: Severe shortness of breath

Career Opportunities

According to the *Occupational Outlook Handbook* published by the U.S. Department of Labor—Bureau of Labor Statistics, the employment growth of claims adjusters and examiners will result from more claims being submitted on behalf of a growing older adult population. Rising premiums and attempts by third-party payers to minimize costs will also result in an increased need for examiners to scrupulously review claims. Although technology reduces the amount of time it takes an adjuster to process a claim, demand for these jobs will increase anyway because many tasks cannot be easily automated (e.g., review of patient records to determine medical necessity of procedures or services rendered).

Health insurance specialists (or **reimbursement specialists**) review health-related claims to match medical necessity to procedures or services performed before payment (reimbursement) is made to the provider. A **claims examiner** employed by a third-party payer reviews health-related claims to determine whether the charges are reasonable and for medical necessity.

The claims review process requires verification of the claim for completeness and accuracy, as well as comparison with third-party payer guidelines to (1) authorize appropriate payment or (2) refer the claim to an investigator for a more thorough review.

A **medical assistant** (Figure 1-3) is employed by a provider to perform administrative and clinical tasks that keep the office or clinic running smoothly. Medical assistants who specialize in administrative aspects of

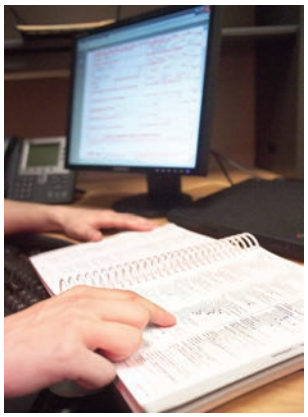


FIGURE 1-2 Health insurance specialist locating codes for entry on CMS-1500.

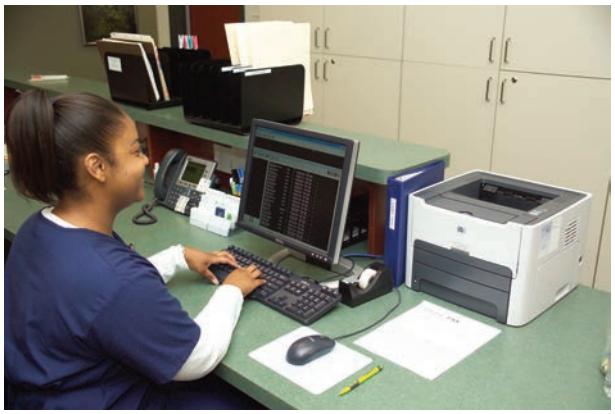


FIGURE 1-3 Medical assistant performing the administrative task of reviewing a record for documentation completeness.

the profession answer telephones, greet patients, update and file patient medical records, complete insurance claims, process correspondence, schedule appointments, arrange for hospital admission and laboratory services, and manage billing and bookkeeping.

Health insurance specialists and medical assistants obtain employment in clinics, health care clearinghouses (process health insurance claims), health care facility billing departments, insurance companies, and physician offices, as well as with third-party administrators (TPAs) (process health insurance claims and provide employee benefits management and other services). When employed by clearinghouses, insurance companies, and TPAs, employees often have the opportunity to work at home, where they process and verify health care claims using an Internet-based application server provider (ASP). (Information about salaries and job opportunities are located at www.bls.gov, www.aapc.com, and www.ahima.org.) Health information technicians also perform insurance specialist functions by assigning codes to diagnoses and procedures and, when employed in a provider's office, by processing claims for reimbursement. (**Health information technicians** manage patient health information and medical records, administer computer information systems, and code diagnoses and procedures for health care services provided to patients.)

In addition to an increase in insurance specialist positions available in health care practices, opportunities are also increasing in other settings. These opportunities include the following:

- Claims benefit advisors in health, malpractice, and liability insurance companies
- Coding or insurance specialists in state, local, and federal government agencies, legal offices, private insurance billing offices, and medical societies
- Medical billing and insurance verification specialists in health care organizations
- Educators in schools and companies specializing in medical office staff training
- Writers and editors of health insurance textbooks, newsletters, and other publications
- Self-employed consultants who assist medical practices with billing practices and claims appeal procedures
- Consumer claims assistance professionals who file claims and appeal low reimbursement for private individuals. In the latter case, individuals may be dissatisfied with the handling of their claims by the health care provider's insurance staff.
- Practices with poorly trained health insurance staff who are unwilling or unable to file a proper claims appeal
- Private billing practices dedicated to claims filing for patients with disabilities or who are older adults

According to the U.S. Equal Employment Opportunity Commission, the federal Americans with Disabilities Act (ADA) prohibits discrimination against individuals with disabilities, and Title I of the ADA covers employment by private employers and state/local government employers with 15 or more employees. (Section 501 of the federal Rehabilitation Act of 1973 prohibits employment discrimination against individuals with disabilities in the federal sector.) A qualified individual is protected from disparate treatment or harassment based on disability and is entitled to reasonable accommodation to perform, or apply for, a job or to enjoy the benefits and privileges of employment unless such accommodation would result in undue hardship to the employer. Some states also enact laws that prohibit employment discrimination due to disability, and they may also provide protections in addition to those enacted by the ADA.

Education and Training

Training and entry requirements vary widely for health insurance specialists, and the Bureau of Labor Statistics' *Occupational Outlook Handbook* states that opportunities will be best for those with a college degree. Academic programs should include coursework (Table 1-1) in general education (e.g., anatomy and physiology, English composition, oral communications, human relations, computer applications,

TABLE 1-1 Training requirements for health insurance specialists

Coursework	Description
Anatomy and Physiology, Medical Terminology, Pharmacology, and Pathophysiology	Knowledge of anatomic structures and physiological functioning of the body, medical terminology, and essentials of pharmacology are necessary to recognize abnormal conditions (pathophysiology). Fluency in the language of medicine and the ability to use a medical dictionary as a reference are crucial skills.
Diagnosis and Procedure/ Service Coding	Understanding the rules, conventions, and applications of coding systems ensures proper selection of diagnosis and procedure/service codes, which are reported on insurance claims for reimbursement purposes.
	Example: Patient undergoes a simple suture treatment of a 3-cm facial laceration. CPT Index main term Suture does not contain a subterm for facial laceration. However, a cross reference below main term Suture directs you to main term Repair. Go to CPT Index main term Repair, subterm Skin, qualifier Wound, and qualifier Simple. Then, go to the appropriate CPT section, subsection, and category (or heading) to review listed codes and select the correct code.
Verbal and Written Communication	Health insurance specialists explain complex insurance concepts and regulations to patients and must effectively communicate with providers regarding documentation of procedures and services to reduce coding and billing errors. Written communication skills are necessary when preparing effective appeals for unpaid claims.
Critical Thinking	Differentiating among technical descriptions of similar procedures requires critical thinking skills.
	Example: Patient is diagnosed with spondy*losis*, which is defined as any condition of the spine. A code from category M47 of ICD-10-CM is assigned. If the diagnosis was mistakenly coded as spondy*lolysis*, which is a defect of the articulating portion of the vertebra, ICD-10-CM category Q76 (if congenital) or M43 (if acquired) codes would be reported in error.
Data Entry	Federal regulations require electronic submission of most government claims, which means that health insurance specialists need excellent keyboarding skills and basic finance and math skills. Because insurance information screens with different titles often contain identical information, the health insurance specialist must carefully and accurately enter data about patient care.
	Example: Primary and secondary insurance computer screens require entry of similar information. Claims are rejected by insurance companies if data are missing or erroneous.
Internet Access	Online information sources provide access to medical references, insurance company manuals, and procedure guidelines. The federal government posts changes to reimbursement methodologies and other policies on websites. Internet forums allow health insurance specialists to network with other professionals.

and so on) and health insurance specialist education (e.g., health information management, medical terminology, pharmacology, coding and reimbursement, insurance processing, and so on). The characteristics of a successful health insurance specialist include an ability to work independently, a strong sense of ethics, attention to detail, and the ability to think critically. The *American Heritage Concise Dictionary* defines **ethics** as the principles of right or good conduct, and rules that govern the conduct of members of a profession.

Student Internship

An **internship** benefits students and facilities that accept students for placement. Students receive on-the-job experience prior to graduation, and the internship assists them in obtaining permanent employment.

Facilities benefit from the opportunity to participate in and improve the formal education process. Quite often, students who complete internships obtain employment at the internship facility. The students report to the internship supervisor at the site. Students are often required to submit a professional résumé to the internship supervisor and schedule an interview prior to acceptance for placement. While this process can be intimidating, students gain experience with the interview process, which is part of obtaining permanent employment. Students should research résumé writing and utilize interview technique services available from their school's career services office. This office typically reviews résumés and provides interview tips. Some offices even videotape mock interviews for students.

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.

NOTE:

Breach of patient confidentiality can result in termination of the internship, which means failing the internship course. Suspension or expulsion from your academic program are other possible consequences. Be sure to ask about your academic program's requirements regarding this issue.

During the internship, students are expected to report to work on time. Students who cannot participate in the internship on a particular day, or who arrive late, should contact their internship supervisor or program faculty, whoever is designated for that purpose. Students are also required to make up any lost time. Because the internship is a simulated job experience, students are to be well groomed and should dress professionally (Figure 1-4). Students should show interest in all aspects of the experience, develop good working relationships with coworkers, and react appropriately to criticism and direction. If any concerns arise during the internship, students should discuss them with their internship supervisor or program faculty.

FIGURE 1-4 Medical assistant and internship student prepare for their next patient.

Job Responsibilities

This section provides an overview of the major responsibilities delegated to health insurance specialists. In practices where just one or two persons work with insurance billing, each individual must be capable of performing all the listed responsibilities. In multispecialty practices that employ many health insurance specialists, each usually processes claims for a limited number of insurance companies (e.g., an insurance specialist may be assigned to processing only Medicare claims). Some practices have a clear division of labor, with specific individuals accepting responsibility for only a few assigned tasks. The following job description lists typical tasks. Regardless of the employment setting, health insurance specialists are guided by a **scope of practice** that defines the profession, delineates qualifications and responsibilities, and clarifies supervision requirements (Table 1-2).

Health Insurance Specialist Job Description

1. Review patient record documentation to accurately code all diagnoses, procedures, and services using ICD-10-CM for diagnoses and CPT and HCPCS Level II for procedures and services. (ICD-10-PCS codes are reported for inpatient hospital procedures only.)

   The accurate coding of diagnoses, procedures, and services rendered to the patient allows a medical practice to

   - Communicate diagnostic and treatment data to a patient's insurance plan to assist the patient in obtaining maximum benefits.
   - Facilitate analysis of the practice's patient base to improve patient care delivery and efficiency of practice operations to contain costs.
2. Research and apply knowledge of all insurance rules and regulations for major insurance programs in the local or regional area.
3. Accurately post charges, payments, and adjustments to patient accounts and accounts receivable records.
4. Prepare or review claims generated by the practice to ensure that all required data are accurately reported and to ensure prompt reimbursement for services provided (contributing to the practice's cash flow).

TABLE 1-2 Scope of practice elements and definitions for health insurance specialists

Element	Definition
Definition of Professional	One who interacts with patients to clarify health insurance coverage and financial responsibility, completes and processes insurance claims, and appeals denied claims.
Qualifications	Graduate of health insurance specialist certificate or degree program or equivalent. One year of experience in health insurance or related field. Detailed working knowledge and demonstrated proficiency in at least one insurance company's billing and/or collection process. Excellent organizational skills. Ability to manage multiple tasks in a timely manner. Proficient use of computerized registration and billing systems and personal computers, including spreadsheet and word processing software applications. Certification through AAPC, AHIMA, AMBA, or NHA.
Responsibilities	Use medical management computer software to process health insurance claims, assign codes to diagnoses and procedures/services, and manage patient records. Communicate with patients, providers, and insurance companies about coverage and reimbursement issues. Remain up-to-date regarding changes in health care industry laws and regulations.
Supervision Requirements	Active and continuous supervision of a health insurance specialist is required. However, the physical presence of the supervisor at the time and place that responsibilities are performed is not required.

5. Review all insurance payments and remittance advice documents to ensure proper processing and payment of each claim. The patient receives an *explanation of benefits (EOB)* from the third-party payer, which is a report detailing the results of processing a claim (e.g., payer reimburses provider $80 on a submitted charge of $100). The provider receives a *remittance advice* (or *remit*), which is a notice sent by the insurance company that contains payment information about a claim.

NOTE:

Chapter 4 contains additional information about EOBs and remits, including samples of each.

6. Correct all data errors and resubmit all unprocessed or returned claims.
7. Research and prepare appeals for all underpaid, unjustly recoded, or denied claims.
8. Rebill all claims not paid within 30 to 45 days, depending on individual practice policy and the payers' policies.
9. Inform health care providers and staff of changes in fraud and abuse laws, coding changes, documentation guidelines, and third-party payer requirements that may affect the billing and claims submission procedures.
10. Assist with timely updating of the practice's internal documents, patient registration forms, and billing forms as required by changes in coding or insurance billing requirements.
11. Maintain an internal audit system to ensure that required pretreatment authorizations are received and entered into the billing and treatment records.
12. Perform audits to compare provider documentation with assigned codes.
13. Explain insurance benefits, policy requirements, and filing rules to patients.
14. Maintain confidentiality of patient information.

Independent Contractor and Employer Liability

Health insurance specialists who are self-employed are considered independent contractors (Figure 1-5). The *'Lectric Law Library's Lexicon* defines an **independent contractor** as "a person who performs services for another under an express or implied agreement and who is not subject to the other's control, or right to control, of the manner and means of performing the services. The organization that hires an independent contractor is not liable for the acts or omissions of the independent contractor."

Independent contractors should purchase **professional liability insurance** (or **errors and omissions insurance**), which provides protection from liability as a result of errors and omissions when performing their professional services (e.g., coding audits). Professional associations often include a membership benefit that allows the purchase of liability insurance coverage at reduced rates.

Example: The American Health Information Management Association makes information about the purchase of a professional liability plan available to its membership. If a member is sued, the plan covers legal fees, court costs, court judgments, and out-of-court settlements. The available coverage varies by state.

A health care facility (or physician) that employs health insurance specialists is legally responsible for employees' actions performed within the context of their employment. This is called ***respondeat superior***,

FIGURE 1-5 Self-employed health insurance specialist.

Latin for "let the master answer," which means that the employer is liable for the actions and omissions of employees as performed and committed within the scope of their employment. Employers purchase many types of insurance to protect their business assets and property (Table 1-3).

Determining Independent Contractor Status

One way to determine independent contractor status is to apply the common law "right to control" test, which includes five factors:

- Amount of control the hiring organization exerted over the worker's activities
- Responsibility for costs of operation (e.g., equipment and supplies)
- Method and form of payment and benefits
- Length of job commitment made to the worker
- Nature of occupation and skills required

The Internal Revenue Service applies a 20-factor independent contractor test to decide whether an organization has correctly classified a worker as an independent contractor for purposes of wage withholdings. The Department of Labor uses the "economic reality" test to determine worker status for purposes of compliance with the minimum wage and overtime requirements of the Fair Labor Standards Act.

TABLE 1-3 Types of professional insurance purchased by employers

Insurance	Description
Bonding Insurance	An insurance agreement that guarantees repayment for financial losses resulting from an employee's act or failure to act. It protects the financial operations of the employer. **Note:** Physician offices should bond employees who have financial responsibilities. The National White Collar Crime Center estimates $400 billion in annual losses to all types of employers due to employees who **embezzle**, or steal, money from an employer.
Business Liability Insurance	An insurance agreement that protects business assets and covers the cost of lawsuits resulting from bodily injury (e.g., customer slips on wet floor), personal injury (e.g., slander or libel), and false advertising. **Medical malpractice insurance**, a type of professional liability insurance, covers physicians and other licensed health care professionals for liability relating to claims arising from patient treatment. **Note:** Liability insurance does not protect an employer from nonperformance of a contract, sexual harassment, race and gender discrimination lawsuits, or wrongful termination of employees. **Note:** An alternative to purchasing liability insurance from an insurance company is to *self-fund*, which involves setting aside money to pay damages or paying damages with current operating revenue should the employer ever be found liable. Another option is to join a *risk retention* or *risk purchasing group*, which provides lower-cost commercial liability insurance to its members. A third option is to obtain coverage in a *surplus lines market* that has been established to insure unique risks.
Property Insurance	An insurance agreement that protects business contents (e.g., buildings and equipment) against fire, theft, and other risks.
Workers' Compensation Insurance	Protection mandated by state law that covers employees and their dependents against injury and death occurring during the course of employment. Workers' compensation is not health insurance, and it is not intended to compensate for disabilities other than those caused by illnesses or injuries arising from employment. The purpose of workers' compensation is to provide financial and medical benefits to those with work-related illnesses or injuries, and their families, regardless of fault.

Example: Dr. Pederson's office employs Linda Starling as a health insurance specialist. As part of the job, Linda has access to confidential patient information. While processing claims, Linda notices that a friend has been a patient and later tells her spouse about the diagnosis and treatment. The friend finds out about the breach of confidentiality and contacts a lawyer. Legally, the friend can sue Dr. Pederson. Although Linda could also be named in the lawsuit, termination by her employer is more likely.

Professionalism

The *Merriam-Webster Dictionary* defines **professionalism** as the conduct, aims, or qualities that characterize a professional person. Health care facility managers establish rules of professional behavior (e.g., codes of conduct, policies, and procedures), so employees know how to behave professionally. Employees are expected to develop the following skills to demonstrate workplace professionalism, which results in personal growth and success.

Attitude, Self-Esteem, and Etiquette

"For success, attitude is equally as important as ability." Harry F. Banks

Attitude impacts an individual's capacity to effectively perform job functions, and employers or colleagues can perceive an employee's attitude as positive, negative, or neutral. This subconscious transfer of feelings results in colleagues determining whether someone has a positive attitude about work. Self-esteem impacts attitude;

low self-esteem causes lack of confidence, and higher self-esteem leads to self-confidence, improved relationships, self-respect, and a successful career. Etiquette is the demonstration of good manners along with behavior that is considered polite among members of a profession. For example, medical assistants should refer to patients by title (e.g., Mrs. Brown) instead of their first name.

Communication

"And he goes through life, his mouth open, and his mind closed."

William Shakespeare

Successful interpersonal communication includes self-expression and active listening to develop understanding about what others are saying. To listen effectively, be sure to understand the message instead of just hearing words. This active involvement in the communication process helps avoid miscommunication.

Conflict Management

"When angry, count to ten before you speak; if very angry, a hundred."

Thomas Jefferson

Conflict occurs as a part of the decision-making process, and the way a person handles it makes it positive or negative. People often have different perspectives about the same situation, and actively listening to the other's viewpoint helps neutralize what could become negative conflict.

Customer Service

"If we don't take care of our customers, someone else will."

Unknown

Health insurance specialists serve as a direct point of contact for a provider's patients, and they are responsible for ensuring that patients receive an excellent level of service or assistance with questions and concerns. It is equally important to remember that colleagues deserve the same respect and attention as patients.

Diversity Awareness

"The real death of America will come when everyone is alike."

James T. Ellison

Diversity is defined as differences among people and includes demographics of age, education, ethnicity, gender, geographic location, income, language, marital status, occupation, parental status, physical and mental ability, race, religious beliefs, sexual orientation, and veteran status. Developing tolerance, which is the opposite of bigotry and prejudice, means dealing with personal attitudes, beliefs, and experiences. Embracing the differences that represent the demographics of our society is crucial to becoming a successful health professional.

Leadership

"The difference between a boss and a leader: a boss says, 'Go!' A leader says, 'Let's go!'"

E. M. Kelly

Leadership is the ability to motivate team members to complete a common organizational goal display. Leaders have earned the trust of their team, which is the reason the entire team is able to achieve its objective and set the standard for productivity, as well as revenue goals. Interestingly, the leader identified by the team might not be the organization's manager or supervisor. Leaders emerge from within the organization because

they have demonstrated beliefs, ethics, and values with which team members identify. Managers who are not threatened by the natural emergence of leaders benefit from team harmony and increased productivity. They receive credit for excellent management skills, and they begin the process to leadership when they begin to acknowledge the work ethic of the team and its leader.

Managing Change

"If we don't change, we don't grow. If we don't grow, we aren't really living."

Gail Sheehy

Change is crucial to the survival of an organization because it is a necessary response to the implementation of new and revised federal and state programs, regulations, and so on. While the organization that does not embrace change becomes extinct, such change disrupts the organization's workflow (and productivity) and is perceived as a threat to employees. Therefore, it is the role of the organization's leadership team to provide details about the impending change, including periodic updates as work processes undergo gradual revision. Employees also need to understand what is being changed and why, and the leadership team needs to understand employees' reluctance to change.

Productivity

"Even if you are on the right track, you'll get run over if you just sit there."

Will Rogers

Health care providers expect health insurance and medical coding/billing specialists to be productive regarding completion of duties and responsibilities. Productivity can include a willingness to work flexible hours (e.g., confirming patient appointments during early evening hours) and participate in job sharing (e.g., two or more employees who work part time to accomplish tasks associated with a position). In addition, employees who have demonstrated an ability to work independently may be allowed to *telecommute* (work from home) in the areas of billing and medical coding; such employees are usually required to attend meetings and perform some tasks on site at the health care organization. Pursuing professional certification and participating in continuing education helps ensure individual compliance with the latest coding rules and other updates. Increased knowledge leads to increased productivity and performance improvement on the job.

Professional Ethics

"Always do right—this will gratify some and astonish the rest."

Mark Twain

The characteristics of a successful health insurance specialist include an ability to work independently, attention to detail, ability to think critically, and a strong sense of ethics. The *American Heritage Concise Dictionary* defines ethics as the principles of right or good conduct, and rules that govern the conduct of members of a profession.

Team-Building

"Michael, if you can't pass, you can't play."

Coach Dean Smith to Michael Jordan in his freshman year

Colleagues who share a sense of community and purpose work well together and can accomplish organizational goals more quickly and easily because they rely on one another. This means colleagues provide help to, and receive help from, other members of the team. Sharing the leadership role and working together to complete difficult tasks facilitates team-building.

Professional Appearance

Appropriate professional attire and personal presentation (Figure 1-6) provide an employee's first impression to colleagues, managers, physicians, patients or clients, and others. Well-groomed employees convey professional images about themselves and the quality of services provided by the organization. Employers establish the dress code policy, which is usually conservative and stylish but not trendy, and some require a uniform.

An employee's appearance provides that important first impression, and well-groomed professionals look self-confident, display pride in themselves, and appear capable of performing whatever duties need to be done. We have all experienced days when we did not feel good about the way we looked, which, in turn, affected our performance. To present yourself in the best possible light, be sure to adhere to the following general guidelines for a professional appearance:

- *Cleanliness* is the first essential for good grooming. Take a daily bath or shower. Use a deodorant or antiperspirant. Shampoo your hair often. Brush and floss your teeth daily.
- *Hand care* is critical. Take special care of your hands. Keep hand cream or lotion in convenient places to use after washing your hands. Because this is done frequently, hands tend to chap and crack, which can allow organisms entry into your body—a risk you cannot afford. Also, keep your fingernails manicured at a moderate length. Those who provide health care services to patients should not use false nails because bacteria and fungi can grow beneath such nails. If you work in a uniform and your organization's policy allows you to use nail polish, choose clear or light shades. Even when wearing street clothes, bright or trendy colors are not appropriate for the office.
- *Hair* must be clean and away from your face. Long hair should be worn up or at least fastened back. It is not appropriate to keep pushing your hair out of the way while working because you can add organisms to your environment and perhaps take them home with you. Patients who receive health care services from employees may also be susceptible to "receiving" something from your hair if you touch them after arranging your hair.
- *Proper attire* may vary with medical specialty. When a uniform is not required, it may be appropriate to wear a white laboratory coat over a dress shirt and slacks or a skirt. Depending on the organization

FIGURE 1-6 Present a professional appearance.

(e.g., pediatric office), it might also be acceptable for the laboratory coat to be a color other than white. For instance, many pediatric practices prefer that medical assistants wear colorful prints with patterns of cartoon characters that children will recognize to help them feel more at ease. Psychiatry and psychology medical office assistants may not be required to wear uniforms, as their clinical duties would be limited. Dressing in professional attire will not only encourage the respect of others for your profession, but will also help you feel like an integral part of the health care team. When uniforms are required, they must be clean, fit well, and be free from wrinkles. Uniform shoes should be kept clean and have clean shoestrings; hose must not have runs. Pay attention to the undergarments that you wear beneath the uniform so that they do not show through the fabric of your uniform.

- *Jewelry*, except for a watch or wedding ring, is not appropriate with a uniform. Small earrings may be worn but still may get in the way when you use the telephone. Not only does jewelry look out of place, but it is a great collector of microorganisms. Novelty piercings, such as nose rings and tongue studs, are not appropriate for professional grooming. Save the wearing of these for after work hours.
- *Fragrances*, such as perfumes, colognes, and aftershave lotions, may be offensive to some patients, especially if they are suffering from nausea. Thus, it is recommended that you not use fragrances.
- *Cosmetics*, if used, should be tasteful and skillfully applied.
- *Gum chewing* is very unprofessional. A large piece of gum interferes with speech, and cracking gum is totally unacceptable. If you feel you need gum for a breath concern, use a breath mint or mouthwash instead.
- *Posture* affects not only your appearance but also the amount of fatigue you experience. The ease at which you move around reflects your poise and confidence. To check your posture, back up to a wall, place your feet apart (straight down from your hips), and try to insert your hand through the space between your lower back and the wall. Pull your stomach in, tuck under your buttocks, and try to place your spine against the wall. Your shoulders should be relaxed with your head held erect. This will probably feel very unnatural, but practice keeping your body straight and head erect when you walk and you will see how much better you look and feel.

Remember! Maintaining personal hygiene benefits patient health and reduces risks of cross-contamination. Daily showering, clean hair, and neatly manicured nails show others that you take pride in yourself and provide a model that others can imitate. A lot of different elements compose our personal characteristics, and each has an impact about how we feel about ourselves and how others perceive us. It is important to evaluate yourself and help identify what you can do to improve your effectiveness when interacting with people. Your course instructor is an excellent resource with whom you could have a private conversation, asking whether there is anything you should be doing differently to improve your professional appearance (and communication skills). For example, during class, an instructor noticed that a student who was otherwise impeccably dressed and groomed frequently flipped long hair from one side to the other. It was recommended to the student that their hair be pulled back for interviews, internships, and employment. Prior to an on-campus interview for employment, the student stopped into the office to ask the instructor whether the hairstyle was appropriate; this was something the instructor did not ask the student to do, and it was impressive that the student incorporated constructive criticism about grooming. And, most importantly, the student got the job!

Telephone Skills for the Health Care Setting

The telephone can be an effective means of patient access to the health care system because a health care team member serves as an immediate contact for the patient. Participating in telephone skills training and following established protocols (policies) allow health care team members to respond appropriately to patients. When processes for handling all calls are developed *and* followed by health care team members, the result is greater office efficiency and less frustration for health care team members and patients. Avoid problems with telephone communication in your health care setting by implementing the following protocols:

Establish a telephone-availability policy that works for patients and office staff. Telephone calls that are unanswered, result in a busy signal, and/or force patients to be placed on hold for long periods frustrate callers (Figure 1-7). The

outcome can be an administrative assistant who sounds impatient and too busy to properly resolve callers' questions and concerns. Avoid such problems by increasing telephone availability so that the calls are answered outside of the typical 9 to 5 workday (which often includes not answering the telephone during lunch). Consider having employees (who have undergone telephone skills training) answer calls on a rotating basis one hour before the office opens, during the noon hour, and one hour after the office closes. This telephone protocol will result in satisfied patients (and other callers) and office employees who do not have to return calls to individuals who otherwise leave messages on voicemail.

NOTE:

Although an administrative assistant is the initial point of contact for the office, all health care team members must effectively handle or transfer telephone calls. This requires sensitivity to patient concerns about health care problems, and the health care professional must communicate a caring environment that leads to patient satisfaction.

Set up an appropriate number of dedicated telephone lines (e.g., appointment scheduling, insurance and billing) based on the function and size of the health care setting. Publish the telephone numbers on the office's website and in an office brochure or local telephone directory, and instruct employees to avoid using the lines when making outgoing calls. Another option is to install an interactive telephone response system that connects callers with appropriate staff (e.g., appointment scheduling, insurance and billing, and so on) based on the caller's keypad or voice responses to instructions provided.

Inform callers who ask to speak with the physician (or another health care provider) that the physician (or provider) is with a patient. Do *not* state, "The physician is busy," which implies that the physician is too busy for the patient and could offend the caller. Ask for the caller's name, telephone number, and reason for the call, and explain that the call will be returned.

Assign 15-minute time periods every 2 to 3 hours when creating the schedule, to allow time for physicians (and other health care providers) to return telephone calls. This allows the administrative assistant to tell callers an approximate time when calls will be returned (and patient records can be retrieved).

NOTE:

Assigning the 15-minute time periods must be approved by physicians because they may prefer to return telephone calls prior to the first appointment of the day or after the last appointment of the day.

FIGURE 1-7 Unanswered telephone calls frustrate callers.

Physically separate front desk check-in/check-out and administrative assistant/patient appointment scheduling offices. It is unlikely that an employee who manages the registration of patients as they arrive at the office (and the check-out of patients at the conclusion of an appointment) has time to answer telephone calls. Office receptionists and appointment schedulers who work in private offices will comply with federal and state patient privacy laws when talking with patients. In addition, appointment scheduling, telephone management, and patient check-in (registration) and check-out procedures will be performed with greater efficiency.

Require office employees to learn professional telephone skills. Schedule professional telephone skills training as part of new employee orientation, and arrange for all employees to attend an annual workshop to improve skills. Training allows everyone to learn key aspects of successful telephone communication, which include developing an effective telephone voice that focuses on tone. During a telephone conversation, each person forms an opinion based on *how* something is said (rather than *what* is said). Therefore, speak clearly and distinctly, do not speak too fast or too slow, and vary your tone by letting your voice rise and fall naturally. The following rules apply to each telephone conversation:

- When answering the telephone, state the name of the office and your name (e.g., "Hornell Medical Center, Shelly Dunham speaking").
- Do not use slang (e.g., nope, yep, uh-huh) or health care jargon (e.g., ICU—the patient hears "eye see you").
- Use the caller's name (e.g., Betty Smith calls the office, and the administrative assistant asks, "How may I help you today, Mrs. Smith?").
- Provide clear explanations when responding to patients (e.g., "The physician will return your call between 3 and 4 PM today").
- Be pleasant, friendly, sincere, and helpful (e.g., smile as you talk with the caller and your tone will be friendly) (Figure 1-8).
- Give the caller your undivided attention to show personal interest, and do not interrupt.
- Before placing the caller on hold or transferring a call, ask for permission to do so (e.g., "May I place you on hold?," "May I transfer you to the appropriate office?").
- When the caller wants to speak with an individual who is unavailable, ask if you can take a message (e.g., "Dr. Smith is with a patient right now. May I take a message and have your call returned after 3 PM?").
- Use a preprinted message form (or commercial message pad) when taking a message (Figure 1-9). Document the following about each call, and file it in the patient's record: date of call, name of patient, name and credentials of individual talking with patient, and a brief note about the contents of the telephone conversation.

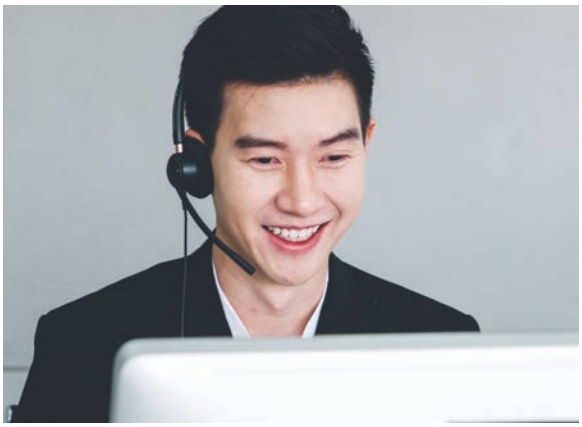


FIGURE 1-8 Smile as you talk with a caller so your tone is pleasant.

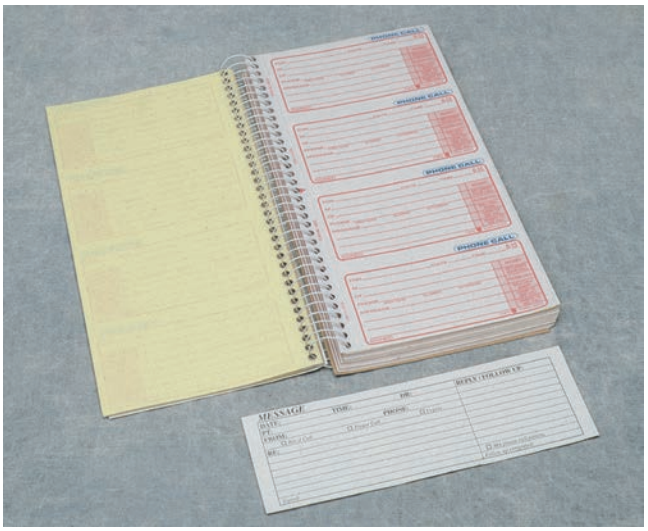


FIGURE 1-9 Message pads with carbonless copy.

Professional Associations and Credentials

The health insurance specialist who joins one or more professional associations (Table 1-4) receives useful information available in several formats, including professional journals and newsletters, access to members-only websites, notification of professional development, and so on. A key feature of membership is an awareness of the importance of professional certification. Once certified, the professional is responsible for maintaining that credential by fulfilling continuing education requirements established by the sponsoring association. Join professional associations by going to their websites to locate membership links. Membership fees (and testing fees) vary, and some associations allow students to join for a reduced fee. Professional certification examination fees also vary according to association. Once students decide where they want to seek employment (e.g., physician's office, hospital), they can research each professional association's website (located in Internet links in this chapter) to research certification examinations offered. For example, a physician's office will require different certifications as compared with hospitals. It is important for students to have an excellent understanding about the career path they want to pursue so as to obtain the appropriate certification credentials. For example, hospitals may prefer the AHIMA credentials, while physician's offices may prefer the AAPC credentials. Other organizations that offer professional certification include the American Medical Billing Association (AMBA) and Ascend Learning's National Healthcareer Association (NHA). AMBA provides industry and regulatory education and networking opportunities for members and offers the Certified Medical Reimbursement Specialist (CMRS) certification. The NHA is a national professional certification agency for health care workers and offers the Certified Billing & Coding Specialists (CBCS) certification.

TABLE 1-4 Professional associations that offer coding and reimbursement credentials

Professional Association	Description, Publications, and Credentials
AAPC	• Founded to elevate the standards of medical coding by providing certification, ongoing education, networking, and recognition for coders • Publishes the *Healthcare Business Monthly* newsmagazine and hosts continuing education • Previously known as the American Academy of Professional Coders • *Credentials:* Certified Professional Biller (CPB), Certified Professional Coder (CPC), Certified Outpatient Coder (COC), Certified Inpatient Coder (CIC), Certified Risk Adjustment Coder (CRC), Certified Professional Coder-Payer (CPC-P), and specialty credentials in many different fields of expertise
American Association of Medical Assistants (AAMA)	• Enables medical assisting professionals to enhance and demonstrate knowledge, skills, and professionalism required by employers and patients, and protects medical assistants' right to practice • Publishes monthly *Certified Medical Assistant* journal • *Credential:* Certified Medical Assistant, abbreviated as CMA (AAMA)
American Health Information Management Association (AHIMA)	• Founded in 1928 to improve the quality of medical records, and currently advances the health information management (HIM) profession toward an electronic and global environment, including implementation of ICD-10-CM and ICD-10-PCS • Publishes monthly *Journal of AHIMA* • *Credentials:* Certified Coding Assistant (CCA), Certified Coding Specialist (CCS), and Certified Coding Specialist-Physician-based (CCS-P) (Additional HIM credentials are offered by AHIMA)
American Medical Billing Association (AMBA)	• Provides industry and regulatory education and networking opportunities for members • *Credential:* Certified Medical Reimbursement Specialist (CMRS)

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 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.

Health insurance specialists are guided by a scope of practice, which defines the profession, delineates qualifications and responsibilities, and clarifies supervision requirements. Self-employed health insurance specialists are independent contractors who should purchase professional liability insurance. Health care providers and facilities typically purchase bonding, liability, property, and workers' compensation insurance to cover their employees. Employees who demonstrate professional behavior are proud of their work, and they are recognized as having integrity and discipline. They earn the respect of their colleagues, develop a reputation for being loyal and trustworthy, and are considered team players. The AAMA, AAPC, AHIMA, AMBA, and Ascend Learning's NHA offer exams leading to professional credentials. Becoming credentialed demonstrates competence and knowledge in the field of health insurance processing as well as coding and reimbursement.

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

1.1 – 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.

2. The Centers for Medicare and Medicaid Services (CMS) is an administrative agency within the
   - **a.** Administration for Children and Families.
   - **b.** Department of Health and Human Services.
   - **c.** Food and Drug Administration.
   - **d.** Office of the Inspector General.

3. A health care practitioner is also called a health care
    a. dealer.
    b. provider.
    c. purveyor.
    d. supplier.

4. Which is the most appropriate response to a patient who calls the office and asks to speak with the physician?
    a. Politely state that the physician is busy and cannot be disturbed.
    b. Explain that the physician is unavailable, and ask if the patient would like to leave a message.
    c. Transfer the call to the exam room where the physician is located.
    d. Offer to schedule an appointment for the patient to be seen by the physician.

5. The process of assigning diagnoses, procedures, and services using numeric and alphanumeric characters is called
    a. coding.
    b. data processing.
    c. programming.
    d. reimbursement.

6. If a health insurance plan's prior approval requirements are not met by providers and the claim is submitted for reimbursement, then
    a. administrative costs are reduced.
    b. patients' coverage is cancelled.
    c. payment of the claim is denied.
    d. they pay a fine to the health plan.

7. Which coding system is used to report diagnoses and conditions on claims?
    a. CPT
    b. HCPCS Level II
    c. ICD-10-CM
    d. ICD-10-PCS

8. Which organization publishes CPT?
    a. ADA
    b. AHIMA
    c. AMA
    d. CMS

9. National codes are associated with
    a. CDT.
    b. CPT.
    c. HCPCS Level II.
    d. ICD.

10. The process of linking procedure/service and condition codes on a CMS-1500 claim justifies
    a. coding.
    b. hold harmless.
    c. medical necessity.
    d. scope of practice.

11. The medical practice that employs a health insurance specialist is legally responsible for their actions when performed within the context of their employment, which is called
    a. *per se.*
    b. *res gestae.*
    c. *respondeat superior.*
    d. subpoena *duces tecum.*

12. Which type of insurance guarantees repayment for financial losses resulting from an employee's act or failure to act?
    a. Bonding
    b. Liability
    c. Property
    d. Workers' compensation

13. Physicians and other health care professionals purchase _____ insurance to protect them from liability relating to claims arising from patient treatment.
    a. bonding
    b. medical malpractice
    c. third-party payer
    d. workers' compensation

14. Which requires health insurance specialists to differentiate among the technical descriptions of similar procedures in the CPT coding manual?
    a. Critical thinking
    b. Data entry
    c. Pathophysiology
    d. Verbal and written communication

15. The American Association of Medical Assistants offers which certification exam?
    a. CCS
    b. CMA
    c. CPC
    d. RHIT

1.2 – Professionalism

Instructions: Complete each statement by entering the appropriate professionalism skill.

1. Increased professional knowledge leads to increased _____ and performance improvement on the job.
    a. ethics
    b. leadership
    c. management
    d. productivity
    e. service

2. An employee who uses active listening to resolve issues as part of the decision-making process is demonstrating effective conflict _____ skills.
    a. ethics
    b. leadership
    c. management
    d. productivity
    e. service

3. An employee who motivates team members so that organizational goals are achieved demonstrates
    a. ethics.
    b. leadership.
    c. management.
    d. productivity.
    e. service.

4. An employee who provides excellent service when addressing questions and concerns from patients and colleagues demonstrates customer
    - **a.** ethics.
    - **b.** leadership.
    - **c.** management.
    - **d.** productivity.
    - **e.** service.

5. Rules that govern conduct of members of a profession are called professional
    - **a.** ethics.
    - **b.** leadership.
    - **c.** management.
    - **d.** productivity.
    - **e.** service.

1.3 – Telephone Messages

Review the voice message case scenario below, which was recorded on Dr. Sickmann's office telephone voicemail during lunch. Enter key elements on the telephone message form provided, including the (1) name of person for whom the message was left; (2) caller's name (obtain correct spelling), company or department, and return telephone number; (3) date and time of the call; (3) message for the health care team member; and (4) action to be taken (e.g., please call …, will call back, urgent, and so on).

Case Scenario: Devon Shane, Front Office Manager, answered the phone. Tristan N. Shout, a returning patient, called at 1:00 PM on 9/20/YYYY to let the office know of a recent job change and new insurance coverage. The message was, "Tristan can now return to our office since Dr. Sickmann is a participating provider in their new insurance network. An annual exam needs to be scheduled before the year is up. Tristan would like to make an appointment for the latest time available on a Friday. Please call (123) 319-6531 as soon as we get the message."

DATE _____ TIME _____

TO _____

WHILE YOU WERE OUT

NAME _____

FROM _____

PHONE _____

TELEPHONED _____ PLEASE CALL BACK _____

CALLED TO SEE YOU _____ WILL CALL AGAIN _____

RETURNED YOUR CALL _____ URGENT _____

MESSAGE:

_____

_____

_____

TAKEN BY _____

Chapter 2

Introduction to Health Insurance and Managed Care

Chapter Outline

Chapter Objectives

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

1. Define key terms related to an introduction to health insurance.
2. Summarize basic health insurance and managed care concepts.
3. Identify major developments in U.S. health insurance.
4. Describe the history, role, and effects of managed care in health care.
5. Explain the characteristics of health insurance and managed care.
6. Describe consumer-directed health plans.
7. Describe health care documentation methods.
8. Discuss the impact of the electronic health record (EHR) on health care.

Key Terms

accreditation
advanced alternative payment models (advanced APMs)
adverse selection
alternative payment models (APMs)
Amendment to the HMO Act of 1973
American Recovery and Reinvestment Act of 2009 (ARRA)
benchmarking
cafeteria plan
capitation
carve-out plan
case manager
clinical practice guidelines
closed-panel HMO
CMS-1500 claim
coinsurance
competitive medical plan (CMP)
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
consumer-directed health plan (CDHP)
continuity of care
copayment (copay)
covered services
customized subcapitation plan (CSCP)
deductible
direct contract model HMO
electronic clinical quality measures (eCQMs)
electronic health record (EHR)
electronic medical record (EMR)
Employee Retirement Income Security Act of 1974 (ERISA)

enrollee
excess insurance
exclusive provider organization (EPO)
express contract
external quality review organization (EQRO)
Federal Employee Health Benefits Program (FEHBP)
Federal Employees' Compensation Act (FECA)
Federal Employers' Liability Act (FELA)
federally qualified HMO
fee schedule
fee-for-service
fee-for-service plans
flexible benefit plan
flexible spending account (FSA)
gag clause
gatekeeper
Gramm-Leach-Bliley Act
group health insurance
group model HMO
group practice without walls (GPWW)
guaranteed renewal
health care
Health Care and Education Reconciliation Act (HCERA)
health care reimbursement account (HCRA)
Health Information Technology for Economic and Clinical Health Act (HITECH Act)
health insurance
health insurance exchange
health insurance marketplace
health maintenance organization (HMO)
Health Maintenance Organization (HMO) Assistance Act of 1973
health reimbursement arrangement (HRA)
health savings account (HSA)
Healthcare Effectiveness Data and Information Set (HEDIS)
Hill-Burton Act
implied contract
indemnity plan
independent practice association (IPA) HMO
individual health insurance
individual practice association (IPA) HMO
integrated delivery system (IDS)
integrated provider organization (IPO)
legislation
lifetime maximum amount
major medical insurance
managed care
managed care organization (MCO)
managed health care
management service organization (MSO)
mandate
meaningful EHR user
meaningful use
medical care
medical foundation
medical record
Medicare contracting reform (MCR) initiative
Medicare Improvement for Patients and Providers Act (MIPPA)
Medicare Prescription Drug, Improvement, and Modernization Act (MMA)
Medicare risk programs
Merit-Based Incentive Payment System (MIPS)
National Committee for Quality Assurance (NCQA)
network model HMO
network provider
Obamacare
Office of Managed Care
Omnibus Budget Reconciliation Act of 1981 (OBRA)
open-panel HMO
Patient Protection and Affordable Care Act (PPACA)
patient record
payer mix
performance measurements
personal health record (PHR)
physician incentive plan
physician incentives
physician referral
physician-hospital organization (PHO)
point-of-service plan (POS)
policyholder
Preferred Provider Health Care Act of 1985
preferred provider organization (PPO)
premium
prepaid health plan
prescription management
preventive services
primary care provider (PCP)
problem-oriented record (POR)
Promoting Interoperability (PI) Programs
public health insurance
quality assessment and performance improvement (QAPI)
quality assurance program
quality improvement (QI)
quality improvement organization (QIO)
Quality Improvement System for Managed Care (QISMC)
quality management program
quality payment program (QPP)
record linkage
report card
rider
risk adjustment model
risk adjustment program
risk contract
risk pool
risk transfer formula
schedule of benefits

second surgical opinion (SSO)
self-insured (or self-funded) employer-sponsored group health plans
self-referral
single-payer health system
socialized medicine
staff model HMO
standards
stop-loss insurance
subscriber (enrollees)
sub-capitation payment
third-party administrators (TPAs)
third-party payer
total practice management software (TPMS)
triple option plan
universal health insurance
utilization review organization (URO)
value-based reimbursement methodology
withhold arrangement

Introduction

According to the *American Heritage Concise Dictionary*, insurance is a contract that protects the insured from loss. An insurance company guarantees payment to the insured for an unforeseen event (e.g., death, accident, and illness) in return for the payment of premiums. In addition to health insurance, types of insurance include automobile, disability, liability, malpractice, property, and life (discussed in Chapter 12 of this textbook). In the United States, insurance oversight is conducted at the state level (with insurance laws enacted by state legislators and signed by governors), and state regulators enforce the laws to ensure insurance company *solvency* (financial ability to pay submitted claims) and implement marketplace regulation (e.g., premium pricing). This chapter includes information about terms and concepts as an introduction to health insurance processing. These terms and concepts are explained in greater detail in later chapters of this text. *Managed health care (managed care)* manages health care costs, utilization, and quality by delivering health plan benefits and additional services through contracted arrangements between individuals or health care programs (e.g., Medicaid) and managed care organizations (MCOs), which accept a predetermined *per member per month* (*capitation*) payment for services. (Managing costs is also called *cost containment*.)

NOTE:

Chapters 12 to 17 of this textbook contain content about different types of health insurance, including definitions, claims completion instructions, and sample completed CMS-1500 claims. Chapter 11 of this textbook contains content about the UB-04 claim, which contains data that is autopopulated by an electronic health record or abstracted by the health information management department, such as for inpatient hospital admissions and outpatient hospital encounters, including emergency department visits.

Overview of Health Insurance and Managed Care

To understand the meaning of the term *health insurance* as used in this text, you must differentiate between medical care and health care. **Medical care** includes the identification of diseases and the provision of care and treatment to persons who are sick, injured, or concerned about their health status. **Health care** expands the definition of medical care to include **preventive services**, which are designed to help individuals avoid health and injury problems. Preventive examinations may result in the early detection of health problems, allowing less drastic and less expensive treatment options. When a health care facility or provider registers a patient, they establish an agreement to provide treatment, resulting in an

- **express contract**, which includes provisions that are stated in the health insurance contract, such as performing an annual physical examination; and
- **implied contract**, which results from actions taken by the health care facility or provider, such as agreeing to provide treatment to a patient.

Stop-loss insurance (or **excess insurance**) provides protection against catastrophic or unpredictable losses and include

- *aggregate stop-loss plans*, which provide a maximum dollar amount eligible expenses during a contract period (e.g., numerous employees who incur inpatient hospitalization expenses during a pandemic); and
- *specific stop-loss plans*, which provide protection against a high claim on an individual (e.g., patient diagnosed with cancer that requires extensive treatment).

Health care insurance or **health insurance** is a contract between a policyholder and a third-party payer or government health program to reimburse the policyholder for all or a portion of the cost of medically necessary treatment or preventive care provided by health care professionals.

Health insurance covers groups (e.g., employer group health plans) and individuals (e.g., private health insurance), with group health insurance usually costing far less for employees because the employer incurs a larger percentage of the premium cost. The employee or individual pays a **premium**, which is the amount paid for a health insurance policy. A **schedule of benefits**, also called **covered services**, includes services covered by a health insurance plan. (*Non-covered services*, such as plastic surgery, are also described in a health insurance policy.) A **carve-out plan** is an arrangement that a health insurance company provides to offer a specific health benefit (usually at an additional cost) that is managed separately from the health insurance plan. The traditional model of health care reimbursement is called **fee-for-service**, for which providers receive payment according to a fee schedule after covered procedures and services are provided to patients. Health plans create a **fee schedule**, which is a list of predetermined payments for health care services provided to patients (e.g., fee assigned to each CPT code). An **indemnity plan** allows patients to seek health care from any provider, and the health plan reimburses the provider according to a *fee schedule; indemnity plans* are sometimes called *fee-for-service plans*.

Example: Davis Vision is a health insurance company that offers vision health plans only. Delta Dental is a health insurance company that offers dental health plans only. While most insurance companies offer behavioral health (mental health) care as part of an overall plan, special support and resources are also available. Optum's UnitedHealthcare assists subscribers in finding behavioral health specialists, provides telephone support, and contracts with Beacon health options, which focuses on behavioral health care and life/work services.

NOTE:

Health insurance plans previously excluded coverage for *pre-existing conditions*, such as diabetes mellitus or hypertension, which are health problems diagnosed prior to the date that new health insurance coverage started. Effective January 1, 2014, health insurance companies are *not* permitted to charge more or deny coverage for pre-existing conditions, and benefits for such conditions cannot be limited. (The exception is individual health insurance policies that were purchased prior to March 2010.)

Managed health care (managed care) are *prepaid health plans* that combine health care delivery with the financing of services provided. Its intent is to manage cost and utilization by providing more affordable quality care to health care consumers and providers who agreed to certain restrictions (e.g., patients would receive care only from providers who are members of a managed care organization). A **prepaid health plan** establishes a capitation contract between a managed health care plan and network providers (e.g., facilities, physicians, and other health care practitioners within a community) who provide specified medical services for a predetermined amount paid on a monthly or yearly basis. The providers are responsible for managing all health care needs of their patient population for that capitated amount. Patients that require less care create a profit for providers, while patients who require more care can create a loss.

A **policyholder** signs a contract with a health insurance company and owns the health insurance policy. An **enrollee** or **subscriber** joins a managed care plan. (Enrollees and subscribers are also associated with traditional health insurance plans. Medicare uses beneficiaries.) The policyholder, enrollee, or subscriber is the insured, and the policy or plan might include coverage for dependents.

A **third-party payer** is a health insurance company that provides coverage, such as BlueCross BlueShield. Because both the government and the general public speak of "health insurance," this text uses that term exclusively. Health insurance is available to individuals who participate in group (e.g., employer sponsored), individual

(or personal insurance), or prepaid health plans (e.g., managed care). Chapters 12 to 17 of this textbook contain content about the following types of health insurance, including definitions, claims completion instructions, sample completed CMS-1500 claims *for professional billing*, and so on. The CMS-1500 claim (2) is submitted to third-party payers for reimbursement physician office procedures and services and inpatient professional services; the electronic version of the claim is abbreviated as ANSI ASC X12N 837P.

CMS refers to the Centers for Medicare & Medicaid Services, which manage government health programs (e.g., Medicaid, Medicare). The UB-04 claim is submitted as part of *institutional billing* for inpatient and outpatient facility care, including emergency department care, and it is covered in Chapter 11 of this textbook. (UB refers to Uniform Bill, and the UB-04 is also called the CMS-1450.) The UB-04 is autopopulated with data from an electronic health record or abstracted data collected by the health information management department. (*Professional billing* and *institutional billing* are covered in Chapter 3 of this textbook.)

Different types of health insurance payments comprise the provider's **payer mix**, and it is important that providers determine the percentage of reimbursement received from each type of payer (e.g., commercial plan, government plan) as part of *revenue management*, which helps ensure the financial viability of a health care facility or medical practice.

The policyholder receives a notice from the insurance company or managed care plan that contains an insurance card and details about the health plan's coverage (often in a separate booklet written in plain language). A certificate of insurance may be provided as proof of insurance, and a summary of benefits and coverage is also included. While medical codes are reported on insurance claims for reimbursement purposes (as part of HIPAA's provision for reporting *treatment, payment, and health care operations [TPO]* on health claims), an insurance company or a managed care plan may request copies of patient records to clarify claims data, and patients are typically required to sign an *authorization to release patient information*. Some plans *may* include an *authorization for the release of patient information* clause in the original contract, which facilitates auditing (reviewing) patient records before processing a claim for reimbursement. In addition, when a health insurance contract contains a **guaranteed renewal** provision, the health insurance company must offer to renew the policy as long as premiums continue to be paid. (Except in some states, guaranteed renewal does not limit how much the individual can be charged to renew coverage.)

Employees who process patient registrations and insurance claims may be required to assist patients with information about copayments, coinsurance, and so on. For detailed information about the patient's insurance coverage, it would be appropriate to refer the patient to their health insurance representative.

A **deductible** is the amount for which the patient is financially responsible before an insurance policy provides payment. A **lifetime maximum amount** is the maximum benefits payable to a health plan participant. Insurance programs can also include **riders**, which increase, limit, delete or clarify the scope of insurance coverage, such as

- *dependent continuation*, which provides continued health insurance coverage for children who meet certain conditions, such as full-time college attendance and under age 26; and
- *special accidental injury riders*, which cover 100 percent of nonsurgical care sought and rendered within 24 to 72 hours (varies according to policy) of an accidental injury.

A **copayment (copay)** is a provision in a health or managed care plan that requires the policyholder or patient to pay a specified dollar amount to a health care provider for each encounter or medical service received. **Coinsurance** is the percentage of costs a patient shares with the health or managed care plan; for example, the plan pays 80 percent of costs, and the patient pays 20 percent. The patient pays a *copayment or coinsurance* amount for services rendered, the payer reimburses the provider according to its *fee schedule*, and the remainder is a *write-off* (or loss).

Example 1: The primary care provider meets with a patient for a follow-up treatment of their recently diagnosed asthma. The physician's fee is $100. The patient pays a copayment of $20 to the provider on the day of the encounter, and per the patient's health plan owes nothing more to the provider. If the payer reimburses the provider $60 for the encounter, the provider will *write off* $20.

If the patient is required to pay coinsurance (instead of a copayment), that is typically calculated as 20 percent of the reimbursement allowed by the payer. In this case, if the payer approves $80 as reimbursement for the encounter, the patient pays a coinsurance of $16 on the day of the encounter. The payer reimburses the provider $64, and the provider will *write off* $20.

Example 2: A patient receives preventive care evaluation and management services from the family practitioner. The total charges are $125, and the patient pays a $20 copayment during the office visit. The third-party payer reimburses the physician the fee schedule amount of $75. The business records the remaining $30 owed as a *write-off*.

Health Insurance Coverage Statistics

In the United States, individuals have many options for obtaining health insurance (or managed care) coverage. The most common forms of health care coverage include group health insurance, individual health insurance, public health insurance, and universal health insurance (as offered through the health insurance marketplace) (Table 2-1). The latest release of U.S. Census Bureau data is from 2020. It is estimated that 91.4 percent of people in the United States are covered by some form of health insurance, with more than 70 million Americans enrolled in some type of managed care program in response to regulatory initiatives affecting health care costs and quality, such as Medicaid managed care state contracts and Medicare Advantage (or Medicare Part C).

- 66.5 percent are covered by private health insurance.
  - 54.4 percent are covered by employment-based plans.
  - 10.5 percent are covered by direct-purchase health insurance plans, which includes marketplace coverage.
- 17.8 percent are covered by Medicaid.
- 18.4 percent are covered by Medicare.
- 3.7 percent are covered by military health care (e.g., CHAMPVA, TRICARE, VA).

The reason the insurance coverage breakdown of covered persons is greater than 100 percent is because some people are covered by more than one insurance plan (e.g., employment-based plan plus direct-purchase health insurance plan, employment-based plan plus Medicare). Thus, they are counted more than once when percentages are calculated.

TABLE 2-1 Glossary of health insurance terms

Term	Definition
Group health insurance	Private health insurance model that provides coverage, which is subsidized by employers and other organizations (e.g., labor unions, rural and consumer health cooperatives). These plans distribute the cost of health insurance among group members to lessen the cost and provide broader coverage than that offered through individual health insurance plans. The Patient Protection and Affordable Care Act (PPACA) of 2010 includes a tax credit to help small businesses and small, tax-exempt organizations afford the cost of covering their employees.
Individual health insurance	A type of private health insurance policy purchased by individuals or families who do not have access to group health insurance coverage (e.g., Aetna).
Public health insurance	Federal and state government health programs (e.g., Medicare, Medicaid, CHAMPVA, CHIP, TRICARE) available to eligible individuals.
Single-payer health system	National health service model adopted by some Western nations (e.g., Canada) and funded by taxes. The government pays for each resident's health care, which is considered a basic social service.
Socialized medicine	A type of single-payer health system in which the government owns and operates health care facilities and providers (e.g., physicians) receive salaries (e.g., Finland, Great Britain).
Universal health insurance	Social insurance model that has the goal of providing every individual with access to health coverage, regardless of the system implemented to achieve that goal, such as a combination of private and public health insurance. For example, the PPACA of 2010 extended health coverage to millions of uninsured Americans by (originally) requiring them to purchase health insurance.

Major Developments in Health Insurance and Managed Care

Since the early 1900s, when solo practices prevailed, managed care and group practices have increased in number, and health care services (like other aspects of society in this country) have undergone tremendous changes (Figure 2-1). This includes *managed care*, which was originally developed as a way to provide affordable, comprehensive, prepaid health care services. Today, many of the features associated with managed care also apply to traditional health insurance and government health plans.

The First Health Insurance Plans

The first health insurance policy was written in 1850 by the Franklin Health Assurance Company of Massachusetts, which provided private health care coverage for injuries that did not result in death. Then, federal legislation was enacted to implement additional health plans. (**Legislation** includes laws, which are rules of conduct enforced by threat of punishment if violated.)

Early in the twentieth century, the **Federal Employers' Liability Act (FELA)** was implemented to protect and compensate railroad workers who are injured on the job, and the **Federal Employees' Compensation Act (FECA)** was implemented to provide civilian employees of the federal government with medical care, survivors' benefits, and compensation for lost wages. The original *Blue Cross* and *Blue Shield* plans (now called *BlueCross BlueShield*), which originated as separate plans for institutional services and professional services, and group health insurance plans were offered for the first time.

- The Blue Shield concept grew out of lumber and mining camps in the region of the Pacific Northwest during the turn of the twentieth century.
- Group health insurance is typically offered by employers.

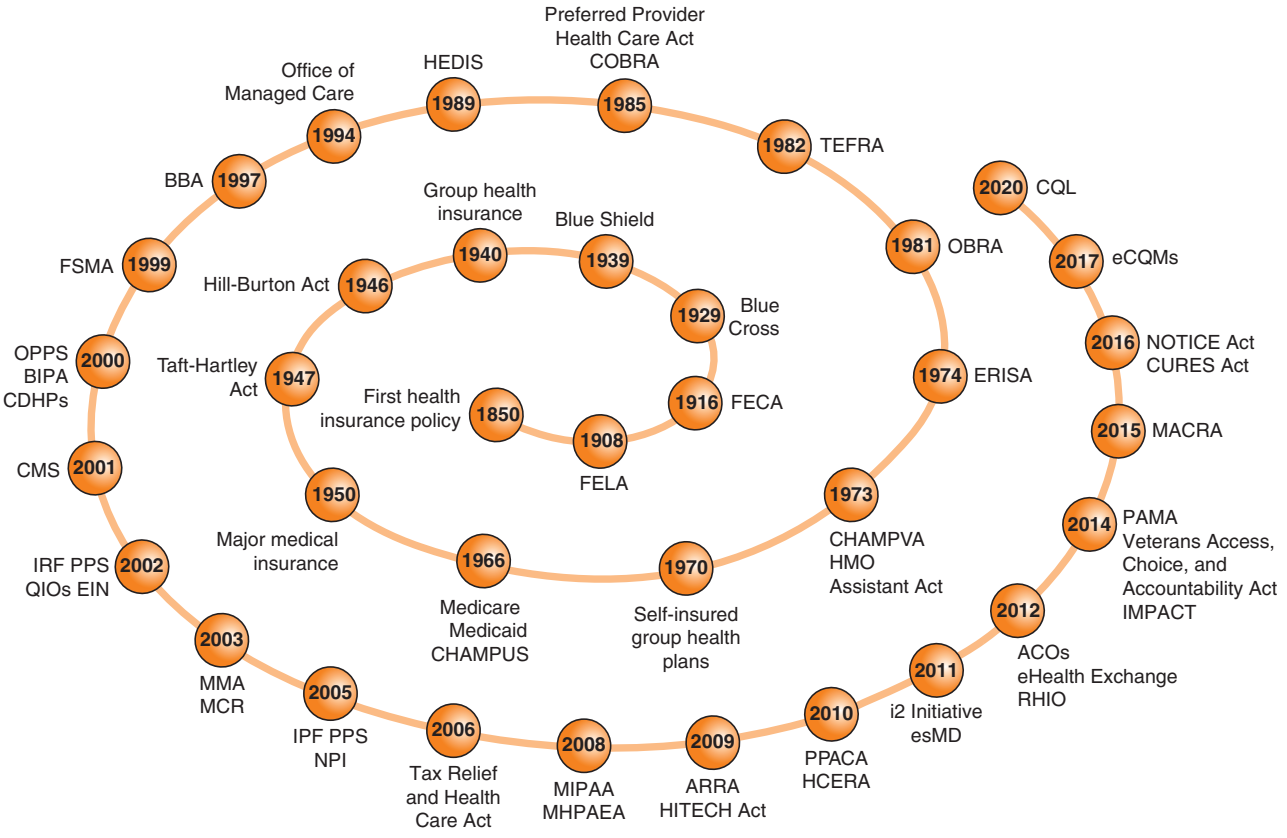


FIGURE 2-1 Timeline of dates and significant events in health care reimbursement.

During the mid-twentieth century, the **Hill-Burton Act** provided federal grants to modernize hospitals that had become obsolete due to the lack of capital investment during the Great Depression and World War II, and in return for federal funds, facilities were required to provide services for free or at reduced rates to patients unable to pay for care. In 1947, the Taft-Hartley Act balanced relationships between labor and management and indirectly resulted in the creation of **third-party administrators (TPAs)**, which administered health care plans, processed claims, and served as a system of checks and balances for labor and management. TPAs also contracted with employers to provide employee benefits management and other services. Insurance companies began offering **major medical insurance**, which provided coverage for catastrophic or prolonged illnesses and injuries. Most of these programs incorporate large deductibles and lifetime maximum amounts.

In 1959, the **Federal Employee Health Benefit Plan (FEHBP)** was enacted by Congress to allow federal employees, retirees, and their survivors to select appropriate health plans that meet their needs. Types of plans include consumer-driven and high deductible plans (that offer catastrophic risk protection with higher deductibles), health savings/reimbursable accounts with lower premiums, fee-for-service (FFS) plans and their preferred provider organizations (PPO), or health maintenance organizations (HMO), depending on where the individual lives and works (and the area serviced by plans).

The Lyndon B. Johnson administration's *War on Poverty* resulted in 1965 legislation that implemented

- *Medicare* (Title XVIII of the Social Security Amendments of 1965): Health care services to Americans over the age of 65;
- *Medicaid* (Title XIX of the Social Security Amendments of 1965): Cost-sharing program between federal and state governments to provide health care services to Americans with low incomes;
- *Civilian Health and Medical Program–Uniformed Services (CHAMPUS)*: Originally designed as a benefit for dependents of personnel serving in the armed forces, uniformed branches of the Public Health Service, and the National Oceanic and Atmospheric Administration. *This program is now known as TRICARE and contains expanded coverage.*

In 1970, **self-insured (or self-funded) employer-sponsored group health plans** were implemented to allow large employers to assume the financial risk for providing health care benefits to employees. (The employer does not pay a fixed premium to a health insurance payer, but establishes a trust fund of employer and employee contributions for self-insurance purposes, out of which claims are paid.)

In 1973, the *Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)* was implemented to provide health care benefits for dependents of veterans rated as 100 percent permanently and totally disabled as a result of service-connected conditions or injuries, veterans who died as a result of service-connected conditions or injuries, and veterans who died on duty with less than 30 days of active service.

The **Health Maintenance Organization (HMO) Assistance Act of 1973** authorized grants and loans to develop HMOs under private sponsorship, defined a **federally qualified HMO** (certified to provide health care services to Medicare and Medicaid enrollees) as one that has applied for and met federal standards established in the HMO Act of 1973, and required most employers with more than 25 employees to offer HMO coverage if local plans were available. In 1985, an **Amendment to the HMO Act of 1973** allowed federally qualified HMOs to permit members to occasionally use non-HMO physicians and be partially reimbursed. In 1994, an **Office of Managed Care** was established to facilitate innovation and competition among Medicare HMOs. The Balanced Budget Act of 1997 (BBA) encouraged the formation of provider service networks (PSNs) and provider service organizations (PSOs); mandated risk-based managed care organizations to submit encounter data related to inpatient hospital stays of members; established the Medicare+Choice program, which expanded Medicare coverage options by creating managed care plans to include HMOs, PPOs, and MSAs (now called Medicare Advantage or Medicare Part C); and required organizations to implement a quality assessment and performance improvement (QAPI) program so that quality assurance activities are performed to improve the functioning of M+C organizations.

The **Employee Retirement Income Security Act of 1974 (ERISA)** mandated reporting and disclosure requirements for group life and health plans (including managed care plans), permitted large employers to self-insure employee health care benefits, and exempted large employers from taxes on health insurance premiums.

A **mandate** is an official directive, instruction, or order to take or perform a certain action; they are also authoritative commands, such as by courts, governors, and legislatures.

The **Omnibus Budget Reconciliation Act of 1981 (OBRA)** expanded the Medicare and Medicaid programs and requires providers to keep copies of government insurance claims and attachments for a period of five years. The *Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)* modified the HMO Act of 1973, creating **Medicare risk programs**, which allowed federally qualified HMOs and competitive medical plans that met specified Medicare requirements to provide Medicare-covered services under a risk contract. TEFRA defined a **risk contract** as an arrangement among providers to provide capitated (fixed, prepaid basis) health care services to Medicare beneficiaries. TEFRA defined a **competitive medical plan (CMP)** as an HMO that meets federal eligibility requirements for a Medicare risk contract but is not licensed as a federally qualified plan. Another important component of TEFRA is the implementation of *diagnosis-related groups*, which is part of the *inpatient prospective payment system* (covered in Chapter 9 of this textbook).

The **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)** allows employees to continue health care coverage beyond the benefit termination date by paying appropriate premiums. COBRA also established an employee's right to continue health care coverage beyond the scheduled benefit termination date (including HMO coverage).

The **Preferred Provider Health Care Act of 1985** eased restrictions on preferred provider organizations (PPOs) and allowed subscribers to seek health care from providers outside of the PPO. The *Balanced Budget Act of 1997 (BBA)* encouraged the formation of *provider service networks (PSNs)* and *provider service organizations (PSOs)* and mandated risk-based managed care organizations to submit encounter data related to inpatient hospital stays of members. The BBA also established the Medicare+Choice program (now called *Medicare Advantage* or *Medicare Part C*), which expanded Medicare coverage options by creating managed care plans to include HMOs, PPOs, and MSAs. A **quality assessment and performance improvement (QAPI) program** was implemented so that quality assurance activities are performed to improve the functioning of Medicare Advantage (or Medicare Part C) organizations.

Legislation and Regulations in the Twenty-First Century

In 2002, CMS announced that **quality improvement organizations (QIOs)** will perform utilization and quality control review of health care furnished, or to be furnished, to Medicare beneficiaries. (QIOs replaced peer review organizations or PROs, which previously performed this function.) In 2003, The **Medicare Prescription Drug, Improvement, and Modernization Act (MMA)** added new prescription drug and preventive benefits, and provided extra assistance to people earning low incomes. A **Medicare contracting reform (MCR) initiative** was also implemented to improve and modernize the Medicare fee-for-service system and to establish a contractual competitive bidding process to appoint Medicare administrative contractors (MACs). The result was an integration of the administration of Medicare Parts A and B fee-for-service benefits, replacing Medicare carriers, DMERCs, and fiscal intermediaries with Medicare Administrative Contractors (MACs). The *Recovery Audit Contractor (RAC) program* was also created to identify and recover improper Medicare payments paid to health care providers under fee-for-service Medicare plans. (RAC program details are covered in Chapter 5 of this textbook.) The *Hospital Inpatient Quality Reporting (Hospital IQR) program* authorized CMS to pay hospitals that successfully report designated quality measures based on a higher annual update to payment rates.

In 2008, the **Medicare Improvement for Patients and Providers Act (MIPPA)** helped lower costs of Medicare premiums and deductibles to benefit eligible Medicare beneficiaries, and the *Mental Health Parity and Addiction Equity Act (MHPAEA)* prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less-favorable benefit limitations on those benefits than on medical/surgical benefits. The **American Recovery and Reinvestment Act of 2009 (ARRA)** authorized an expenditure of $1.5 billion for grants for construction, renovation, and equipment, and for the acquisition of health information technology systems. The **Health Information Technology for Economic and Clinical Health Act (HITECH Act)** (included in American Recovery and Reinvestment Act of 2009) established an Office of National Coordinator for Health Information Technology (ONC) within HHS to improve health care quality, safety, and efficiency. (In 2012, the NHIN evolved into the eHealth Exchange.)

The Affordable Care Act

In 2010, the **Patient Protection and Affordable Care Act (PPACA)** (also called the *Affordable Care Act*) focused on private health insurance reform to provide better coverage for individuals with pre-existing conditions, improve prescription drug coverage under Medicare, and extend the life of the Medicare Trust fund by at least 12 years. Its goal was to provide Americans with quality affordable health care, improve the role of public programs, improve the quality and efficiency of health care, and improve public health. Americans purchase health coverage that fits their budget and meets their needs by accessing the **health insurance marketplace** (or **health insurance exchange**) in their state. The marketplace indicates if individuals qualify for free or low-cost coverage available through Medicaid or the Children's Health Insurance Program (CHIP). (Refer to Chapter 5 for more information about risk adjustment models.) The goal is improved coverage so that consumers—whether they are healthy or sick—can select the best plan for their needs.

The **Health Care and Education Reconciliation Act (HCERA)** amended the PPACA to implement health care reform initiatives, such as increasing tax credits to buy health care insurance, eliminating special deals provided to senators, closing the Medicare "donut hole," delaying taxes on "Cadillac health care plans" until 2018, implementing revenue changes (e.g., 10 percent tax on indoor tanning services) and so on. HCERA also modified higher education assistance provisions, such as implementing student loan reform.

The PPACA implemented the **risk adjustment program** to lessen or eliminate the influence of risk selection on premiums charged by health plans and includes the following:

- **Risk adjustment model**, which provides payments to health plans that disproportionately attract higher-risk enrollees (e.g., individuals with chronic conditions). It uses an actuarial tool to predict health care costs based on the relative actuarial risk of enrollees in risk adjustment covered health plans. For example, the HHS-Hierarchical Condition Categories (HHS-HCC) risk adjustment model uses a hierarchical condition category (HCC) system to summarize diagnosis codes into levels of severity for calculating risk scores. (*Risk adjustment* is a method of adjusting capitation payments to health plans, accounting for differences in expected health costs of enrollees.)
- **Risk transfer formula**, which transfers funds from health plans with relatively lower-risk enrollees to health plans that enroll relatively higher-risk individuals, protecting such health plans against adverse selection. Enrollee risk scores are based on demographic and health status information, and it is calculated as the sum of demographic and health factors, weighted by estimated marginal contributions to total risk, and calculated relative to average expenditures. Thomson Reuters MarketScan® data is the primary source for risk adjustment model calibration, and its database includes data from all 50 states.

Example: An average risk score is 1.0, and the formula for calculating the total risk score is demographic risk factor + health status risk factor. If a 57-year-old patient has a 0.5 demographic risk factor and a 0.7 health status risk factor, the total risk score is 1.2, resulting in the health plan receiving higher payments for care because the risk score is greater than the average. This provides an incentive to the health plan to enroll individuals with higher demographic and health status risk factors. To monetize this example, if the value of 1.0 is $1,000, this individual's risk score monetary average is calculated as $(0.5 \times \$1{,}000) + (0.7 \times \$1{,}000) = \$500 + \$700 = \$1{,}200$.

Health Insurance Marketplace

The *Patient Protection and Affordable Care Act (PPACA)* was signed into federal law on March 23, 2010, and resulted in the creation of a *Health Insurance Marketplace* (or *health insurance exchange*), abbreviated as the Marketplace, effective October 1, 2013. The PPACA is abbreviated as the *Affordable Care Act (ACA)*, and it was nicknamed **Obamacare** (because it was signed into federal law by President Obama). *The Health Insurance Marketplace does not replace other health insurance programs (e.g., individual and group commercial health insurance, Medicaid, Medicare, TRICARE).*

The Marketplace allows Americans to purchase health coverage that fits their budget and meets their needs. It is a resource where individuals, families, and small businesses can

- learn about their health coverage options;
- compare health insurance plans based on costs, benefits, and other important features;
- choose a plan;
- enroll in coverage;

The Marketplace includes information about programs to help people earning a low-to-moderate income and resources pay for health coverage. Information includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and it is accessible through websites, call centers, and in-person assistance. In some states it is run by the state, and in others it is run by the federal government.

Most individuals who do not currently have health insurance through their place of work or otherwise are eligible to use the Health Insurance Marketplace (www.healthcare.gov) to compare and choose a plan. To be eligible for health coverage through the marketplace, individuals must

- be a U.S. citizen or national (or be lawfully present);
- live in the United States;
- not be incarcerated.

In 2017, the Department of Health and Human Services (DHHS) reviewed regulations and guidance related to the Affordable Care Act (ACA) and released the following changes:

- *Helping Patients Keep Their Plan*: DHHS permitted people with ACA-noncompliant plans in the individual and small group markets to renew them, and that policy was set to expire in 2017. On February 23, 2017, DHHS announced that people will be allowed to keep their pre-ACA plans if they like them.
- *More Calendar Flexibility = More Options for Patients*: In 2017, DHHS pushed back a range of deadlines for decisions to be made by insurers, allowing insurers to provide better choices to consumers. DHHS also eliminated a step in the approval process, allowing insurers to reduce regulatory costs and pass the savings on to the individual.
- *Tax Cuts and Job Acts of 2017*: The *health care mandate* was repealed, eliminating the tax penalty under the ACA for individuals who do not buy health insurance.

In 2018, DHHS issued a final rule to allow the sale and renewal of short-term, limited-duration health insurance plans that cover longer periods than the previous maximum period of less than three months. Such coverage includes an initial period of less than 12 months, with a maximum duration of no longer than 36 months in total. It can provide coverage for those transitioning among different coverage options (e.g., individual who is between jobs, student taking time off from school, middle-class families who do not have access to subsidized ACA plans). New legislation also allows states to use federal funding for subsidizing premiums for association health plans and short-term health insurance plans. Consumers can purchase ACA plans with the subsidies, and coverage for pre-existing conditions remains in place (and insurers may not charge higher premiums for individuals with pre-existing conditions).

Managed Care

Managed care (or **managed health care**) is a health care delivery system that is organized to manage cost, quality, and utilization. The delivery of services is provided through contractual arrangements established between individuals or health care programs (e.g., Medicaid) and managed care organizations (MCOs), which accept a predetermined per member per month (capitation) payment for services. In addition, *annual and lifetime*